


The act of caring in mental health: aspects aligned to patient safety culture*


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Objective: to analyze the knowledge about the care given to the person who has mental disorder from the perspective of the patient's safety. **Method:** Integrative literature review, considering the following guiding question: "How can the Patient Safety Policy be incorporated into the production of care for people or subjects in psychic suffering?" **Results:** 12 English language articles were selected from the Scopus and MEDLINE databases. The types of study were: literature review (42%), critical-reflective study (17%) and content analysis (17%). **Conclusion:** patient safety in the context of mental health is more complex when compared to other patients. There is a higher probability of adverse events, violence, barriers to access to services and treatments, as well as low quality, late and unplanned care, having as main justification the stigmatization process. Permanent education and person-centered care are the main tools for solving these cases.

Descriptors: Mentally Ill People; Patient Safety; Empathy; Mental Health.

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O ato de cuidar em saúde mental: aspectos alinhados à cultura de segurança do paciente

Objetivo: analisar o conhecimento sobre o cuidado prestado à pessoa que possui transtorno mental na perspectiva da segurança do paciente. **Método:** revisão integrativa da literatura, considerando-se a seguinte questão norteadora: "Como a Política de Segurança do Paciente pode ser incorporada na produção do cuidado às pessoas ou sujeitos em sofrimento psíquico?". **Resultados:** foram selecionados 12 artigos em língua inglesa nas bases de dados Scopus e MEDLINE. Predominaram os tipos de estudo revisão da literatura (42%), estudo crítico-reflexivo (17%) e análise de conteúdo (17%). **Conclusão:** a segurança do paciente no contexto da saúde mental é mais complexa quando comparada a de outros pacientes. Observa-se maior probabilidade de eventos adversos, violências, barreiras de acesso aos serviços e tratamentos, além de uma assistência de baixa qualidade, tardia e não planejada, tendo, como principal justificativa, o processo estigmatizador. A educação permanente e o cuidado centrado na pessoa são as principais ferramentas de solução desses casos.

Descritores: Pessoas Mentalmente Doentes; Segurança do Paciente; Empatia; Saúde Mental.

El acto de cuidar en salud mental: aspectos alineados la cultura de seguridad del paciente

Objetivo: analizar el conocimiento sobre el cuidado prestado à la persona que posee trastorno mental en la perspectiva de la seguridad del paciente. **Método:** revisión integral de la literatura, considerándose la siguiente cuestión norteadora: cómo se puede incorporar la Política de seguridad del paciente en la producción de atención para personas con problemas psicológicos? **Resultados:** se seleccionaron 12 artículos en inglés, en las bases de datos SCOPUS y MEDLINE. Predominaron los tipos de estudio Revisión de la literatura (42%), Estudio crítico-reflexivo (17%) y Análisis de contenido (17%). **Conclusión:** la seguridad del paciente en el contexto de la salud mental es más compleja en comparación con otros pacientes, se observa mayor probabilidad de eventos adversos, violencias, barreras de acceso a los servicios y tratamientos, además de una asistencia de baja calidad, tardía y no planificada, teniendo como principal justificación el proceso estigmatizador. La educación permanente y el cuidado centrado en la persona son las principales herramientas de solución de estos casos.

Descriptorios: Enfermos Mentales; Seguridad del Paciente; Empatía; Salud Mental.

Introduction

Historically, the madness in Brazil, from the arrival of the Royal Family in the early nineteenth century, suffered interference with the gathering of people appointed as insane in the city of Rio de Janeiro. This proposal aimed to advance socially and economically and, therefore, it was necessary to enhance social control and organize the expansion of the city⁽¹⁾. At this juncture, the psychiatric hospital was born, better known as the insane asylum, an institution that had as its principle the control of the bodies, the removal of people with clinical disorders and who had no socially acceptable behavior.

The service provided to people in this place was precarious: they lived in unhealthy conditions and were met at least in their basic needs. The treatment was medicalizing and, many times, it was done by containment of the bodies as a way to discipline, punish and stop the manifestations of psychiatric crisis.

For years, society has treated the person with mental disorder as a "non-human" being, due to the prejudiced ideas surrounding the disease, which has focused on rejection, asylum and social exclusion.

This type of service has been strengthened, increasing sharply over the centuries in the national territory, being understood as a social ordering. It expanded its financing with the Brazilian Unified Health System (UHS), culminating in a gigantic expansion of hospitalized people until the Brazilian Psychiatric Reform.

This reform had its origin in Italy in 1978, from Law no. 180 or the Italian Psychiatric Reform Law, with Franco Basaglia, the psychiatrist, as its main responsible. This movement sought to transform and indicate the restructuring of assistance provided by professionals working in the psychiatric hospital and the rupture of the paradigm of medical knowledge and treatment of the person or subject in psychic suffering over the years⁽²⁾.

This law and the model it guided influenced the treatment offered to the person or subject in psychic suffering around the world, even having repercussions in Brazil. As policies, re-democratization and sanitary reform advanced, the service provided by the insane asylum in Brazil began to be questioned, which also resulted in workers' demand for better working conditions, as well as the quality of the service offered to people who were confined there.

From this political and social movement, in Brazil, comes the proposal of Bill no. 3,657, by then congressman Paulo Delgado, in 1989, which aimed to promote the Brazilian Psychiatric Reform. Law 10,216 was sanctioned only on April 6, 2001, and it points to "protection and rights of people with mental disorders and redirects the mental health care model. This framework reaffirmed the State's responsibility towards mental health policy in Brazil⁽³⁾.

With this, the decline of the insane asylum began, giving rise to new approaches of care for the person who suffers mental disorder, in addition to mental health equipment structured by the Psychosocial Care Network (PSCN), which aims to be a point of attention for people or subjects in psychic suffering according to Ordinance of GM No. 3.088. They are: Therapeutic Residence Services (TRS), housing destined to the person who stayed for a long period of time inside the psychiatric hospital and who lost family ties; Psychosocial Care Center (PSCC), a territorial-based service of the user composed of a multidisciplinary team and whose mission is to be a point of attention to the health of the person with mental disorder, as well as to attend to crisis situations, among others⁽⁴⁾.

The concept of mental health care is aligned with UHS principles and Law No. 10,216, in the universality of access to the best services at any level of care, in an inclusive and communitarian manner; in the integrality of actions, being possible to evaluate the whole without distinction and prejudice in a therapeutic environment; in the equity of rights and service offerings with humanity; in the political-administrative decentralization, involving and sharing with other actors the decision-making processes for better development of strategic actions and social control, with the effective participation of civil society, institutions, among others^(3,5).

The composition of this care includes the network of mental health care, the territory and the autonomy of the person or subject with psychic suffering. This community network in the field of mental health is fundamental for health care in the perspective of psychiatric reform, since it composes services that will be able to accommodate the demands, "which can guarantee resoluteness, promotion of autonomy and citizenship for people with mental disorders"⁽⁵⁾. As for the territory, the concept is not located only in the geographical area, but based on the relations constituted in the community, elevating "knowledge and potentialities".

To this end, the concept of care for the person or subject in psychic suffering must be linked to decent housing, the opportunity to work, pharmaceutical assistance, reducing stigma through collective education in the community, ensuring access to services beyond health and (re)assessing laws and public policies that significantly impact the field of mental health⁽⁶⁾.

Currently, in the logic of the quality of care production, the Ministry of Health, together with the World Health Organization (WHO), has been encouraging health institutions to adhere to the Patient Safety Policy. The father of medicine, Hippocrates (460 to 370 B.C.), already thought that the care could bring some kind of harm⁽⁷⁾, today known as adverse event, damage resulting from the care provided.

The Ministry of Health Ordinance No. 529, of April 1, 2013, instituted the National Patient Safety Program throughout the country, with the premise of contributing to the improvement of health care facilities, whether public or private services. In addition, it reinforced the Organic Health Law, where the responsibility of the federal, municipal and state spheres for the elaboration of norms and activities of health services is highlighted, and established the UHS in order to coordinate and define the health surveillance system; control, inspect procedures and products, as well as evaluate actions and services⁽⁸⁾.

Patient safety is a priority with WHO. Therefore, Brazil should encourage multidisciplinary knowledge, thus contributing to the qualification of care, the integration of working-class councils, teaching and research institutions, and support to health unit managers throughout the country. Thus, the National Patient Safety Program (NPSP) was constituted with the objective of creating the patient safety centers, besides encouraging educational activities in each health service; bringing patients and family members together for discussion; disseminating information on patient safety in the community and introducing the topic in technical and higher education institutions (undergraduate and graduate)⁽⁸⁾.

The NPSP is not the solution to all the barriers of a service, but it can promote external and internal articulations together with other public health policies in favor of the quality of care, such as, for example, the (re) organization of the care network, of the primary and tertiary care services; the incentive to the professional as a protagonist in the role he plays and the strengthening of the commitment of the managers of the health units and their public representatives⁽⁸⁾.

The relevance of this study makes it possible to reflect on how care is produced for people or subjects in psychic suffering and how this new policy can be applied to the daily life of mental health services. Added to this, contribute to the enhancement and discussion of safe work processes of health professionals from the perspective of mental health, as well as for students who are interested in the field of Psychiatry. After all, it is necessary to qualify future professionals to exercise responsible activities and security within the health services. With this, it is possible to recognize a lot of research focused on the history of Psychiatry, as well as the Psychiatric Reform. But there are gaps in the knowledge on the area of mental health and patient

safety, because, besides being a recent policy, most published studies have related the themes, focusing on risk management, patient safety protocols and pharmacology, not allowing to reflect on the care of the person with psychic suffering and its peculiarities, not forgetting that "as the effectiveness of health care increases, more and more patients age keeping their diseases under control"⁽⁹⁾. Thus, it aims at analyzing the knowledge on the care provided to the person with mental disorder from the perspective of the patient's safety, based on a literature review with a reflexive analysis of the findings.

Method

This is a narrative review of the international literature from the formulation of the guiding question, with search in online databases, followed by categorization of the findings, evaluation of the studies included, discussion, with analysis and wider interpretations of the results⁽¹⁰⁾. It was considered as a guiding question: "How can the Patient Safety Policy be incorporated into the production of care for people or subjects in psychic suffering?".

For the definition of the descriptors, the PICO strategy was used⁽¹¹⁾ in which P stands for the patient or problem and can describe a single patient, a group of patients with a particular condition or a health problem. In this study, there is reference to people or subjects in psychic suffering. I deals with the proposed intervention, which may include exposure, be therapeutic, preventive, diagnostic, prognostic, administrative or related to economic issues. It was considered the insertion of the Patient Safety Policy in the production of care for mentally ill people. C constitutes control or comparison, however, this element will not be employed. O is the outcome, meaning the expected result, which in this case is to identify how the Patient Safety Policy can be incorporated into the production of care for people or subjects in psychic suffering, thus delimiting the subject of study.

From this, the words were referenced in the Health Science Descriptors (DeCS) and the terms Medical Subject Headings (MESH) in the three electronic databases Cumulative Index to Nursing and Allied Health (CINAHL), Medical Literature Analysis and Retrieval System Online (MEDLINE via PubMed) and Medical Subject Headings (Scopus), as shown in Figure 1 below.

PICO Strategy*	DeCS Descriptors†	Sinonyms	Descriptors MESH‡	Entrytems
Mentally Ill Persons	Mentally Ill Persons	Mentally Ill; Mental Patients.	Mentally Ill Person Person, Mentally Ill Persons, Mentally Ill Mentally Ill Ill, Mentally Mental Patients	Mentally Ill Persons
Patient Safety	Patient Safety	None	Patient Safety	Patient Safety
Care	Empathy	Benevolence; Complacency (Feeling); Condescendence; Compassion; Consideration; Care; Caring; Deference.	- Caring - Compassion	Empathy

*PICO Strategy; †DeCS = Health Sciences Descriptors; ‡MESH = Medical Subject Readings

Figure 1 - Definition of the descriptors. Rio de Janeiro, RJ, Brazil, 2018

For all database searches, the strategy of Boolean and or operators was used, allowing associations to be made.

The following inclusion criteria were established: articles from 2013 to 2019, in Portuguese, English or Spanish. The following exclusion criteria were defined: duplicate articles and articles that did not meet the research question. Data collection took place from June 2018 to January 2019. 132 studies were identified in the respective databases as shown in Figure 2.

Data bases	Num. of studies (n=132)
CINAHL*	12
MEDLINE†	52
Scopus‡	68

*CINAHL = Cumulative Index to Nursing and Allied Health Literature; †MEDLINE = Medical Literature Analysis and Retrieval System Online; ‡Scopus = SciVerse Scopus

Figure 2 - Numbers of studies in the databases (n=132) included in the integrative review. Rio de Janeiro, Brazil, 2019

Twelve studies were found in the CINAHL database; seven articles were discarded after reading the abstracts and five studies were selected for full reading. In MEDLINE via PubMed, 52 studies were found and 41 articles were discarded after reading the abstracts, with one article being duplicated, which resulted in ten studies for full reading. In the Scopus database, 68 studies were found; of these, 39 were eliminated after reading the abstracts and 29 separate studies for full reading.

In Figure 3, in the flowchart as recommended by PRISMA, the data of exclusion are presented.

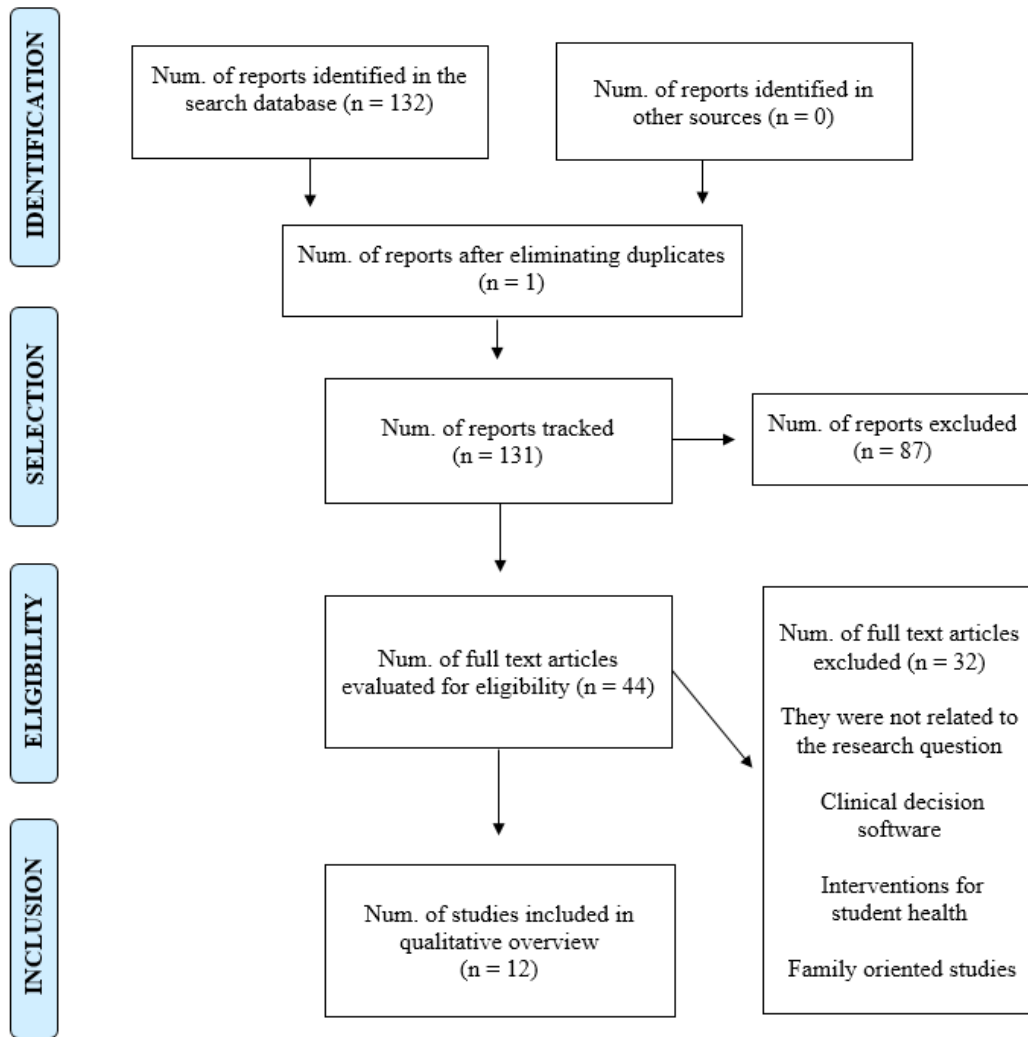


Figure 3 - Flowchart, according to Prisma, for the selection of studies found in the databases. Rio de Janeiro, Brazil, 2019

Results

The final sample consisted of 12 articles, and the following summaries are extracted, according to Figure 4:

author; title; journal; year of publication; type of study; origin; database and Qualis of the scientific journal. The authenticity, ethical aspects and authorship of the published studies were taken into account.

Num.	Authors, title, journal and year of publication	Type of study	Origin	Base	Qualis
01	Johnston D. <i>What makes a difference to patients?</i> <i>IntRevPsychiatry</i> 2013 ⁽⁵⁾ .	Critical and reflective	USA*	Scopus†	B1
02	Kowalski SL, Anthony M. <i>Nursing's evolving role in patient safety.</i> <i>Am J Nurs</i> 2017 ⁽⁶⁾ .	Content analysis	USA*	Scopus†	A1
03	Johnson J, Hall LH, Berzins K, Baker J, Melling K, Thompson C. <i>Mental healthcare staff well-being and burnout: A narrative review of trends, causes, implications, and recommendations for future interventions.</i> <i>Int J Ment Health Nurs</i> 2018 ⁽⁷⁾ .	Literature review	USA*	Scopus†	B2
04	Hannigan B, Simpson A, Coffey M, Barlow S, Jones A. <i>Care coordination as imagined, care coordination as done: Findings from a cross-national mental health systems study.</i> <i>Int J IntegrCare</i> 2018 ⁽⁸⁾ .	Qualitative approach	England	Scopus†	B1

(to be continued...)

Num.	Authors, title, journal and year of publication	Type of study	Origin	Base	Qualis
05	Forouzan AS, Ghazinour M, Dejman M, Rafeiey H, Baradaran Eftekhari M, San Sebastian M. Service users and providers expectations of mental health care in Iran: A qualitative study. <i>Iran J Public Health</i> 2013 ⁽⁹⁾ .	Content analysis	Iran	Scopus [†]	B1
06	Polacek MJ, Allen DE, Damin-Moss RS, Schwartz AJA, Sharp D, Shattell M, et al. Engagement as an Element of Safe Inpatient Psychiatric Environments. <i>J Am PsychiatrNursAssoc</i> 2015 ⁽¹⁰⁾ .	Literature review	USA*	Scopus [†]	A1
07	Grant C, Ballard ED, Olson-Madden JH. An Empowerment Approach to Family Caregiver Involvement in Suicide Prevention: Implications for Practice. <i>Fam J</i> 2015 ⁽¹¹⁾ .	Literature review	USA*	Scopus [†]	B1
08	Ashmore T, Spangaro J, Mcnamara L. 'I was raped by Santa Claus': Responding to disclosures of sexual assault in mental health inpatient facilities. <i>Int J Ment Health Nurs</i> 2015 ⁽¹²⁾ .	Exploratory and description	USA*	Scopus [†]	B2
09	Slemon A, Jenkins E, Bungay V. Safety in psychiatric inpatient care: The impact of risk management culture on mental health nursing practice. <i>NursInq</i> 2017 ⁽¹³⁾ .	Critical and reflective	Canada	Scopus [†]	A1
10	Reeves E, Henshall C, Hutchinson M, Jackson D. Safety of service users with severe mental illness receiving inpatient care on medical and surgical wards: A systematic review. <i>Int J Ment Health Nurs</i> 2018 ⁽¹⁴⁾ .	Literature review	EUA*	Scopus [†]	B2
11	Sandra M, Scott BP, Heather S, Bonnie K, Joy CM. Beyond silence: protocol for a randomized parallel-group trial comparing two approaches to workplace mental health education for healthcare employees. <i>BMC Medical Education</i> 2015 ⁽¹⁵⁾ .	Randomized study	Canada	MEDLINE [‡]	A1
12	Margaret O, Conal W, Sean H. Violence within mental health services: how to enhance risk management. <i>Risk Manag Healthc Policy</i> , 2018 ⁽¹⁶⁾ .	Literature review	Ireland	MEDLINE [‡]	A1

*USA = United States of America; [†]Scopus = SciVerse Scopus; [‡]MEDLINE = Medical Literature Analysis and Retrieval System Online

Figure 4 - Summary of selected publications regarding author, title, journal and year of publication, type of study, origin, database and Qualis of the journal. Rio de Janeiro, Brazil, 2019

The 12 articles selected were published in English. The majority comes from the USA (58.3%) and the other publications had their origin in Canada (16.6%), England (8.3%), Iran (8.3%) and Ireland (8.3%). According to the researched databases, 83% of the articles are located in the Scopus database and 17% in the MEDLINE database. Regarding the type of study, the predominant types were literature review (42%), critical-reflective study (17%) and content analysis (17%); less frequently, randomized studies (8%), exploratory and descriptive studies (1%) and qualitative approach (1%).

Discussion

According to the criteria established for the selection of articles, a relevant fact is that exclusively English language articles were localized, a fact that proves the importance of the scientific dissemination of the study on patient safety and its interface with mental health, including in Brazil.

The selected articles, after reading and analyzing all their contents, were categorized in four thematic axes, aiming to broaden the discussions and reflections on the proposed theme.

Category one: history of psychiatric patient safety in health services^(12-13,20).

The evolution of the role of Nursing in patient safety, until 1919, was focused on asepsis and the new theory of germs. As patient care became more complex, new measures were incorporated and a more holistic view of it was adopted. In 1930, the concept of error prevention and the first standardization of care emerged. These milestones were precursors of the progressive ideas of the 1950s, when different levels of attention were created according to the complexity of the patient (intensive, intermediate, etc.). In the 1960s and 1970s, the sources of hospital infections were recognized and prevention programs were initiated. Finally, from 2000 to 2015, human performance began to be analyzed as a cause of health care in face of systemic factors⁽¹³⁾.

In Psychiatry, patient safety was already discussed worldwide at the end of the 1970s, culminating in the Psychiatric Reform and the Anti-asylum Struggle Movement in Brazil from the manifests of workers, relatives, users and associations. With the caption "for a society without asylums", they were already calling for the suppression of asylums, changes in welfare practices and public policies, the rational use of medicines, with planning

for the relief of suffering, and the non-mercantilization of madness⁽²⁴⁾.

Regarding the discussion of patient safety internationally, in 1998, the Institute of Medicine (IOM) established the Committee on Health Quality in America in order to provide improvements in health care, including mental health. It was noticed that many patients developed or worsened chronic diseases in the long term due to pharmacotherapy applied in the treatment of psychiatric diseases⁽¹²⁾.

The management of care has gone beyond the traditional hospital and approached the patient's lifestyle, adopting counseling as a therapeutic strategy. Patients also became more aware of their diagnosis and records, which helped to prevent medical errors and adherence to treatment⁽¹²⁾.

These notes strengthen the relevance of the movements of Psychiatric Reform. Although the agenda does not bring the term "patient safety" as a highlight, it already denounced several iatrogenic that the psychiatric hospital produced, such as the unregulated use of medications, treatment as punishment, the classic model of medicine as the only source of health care, the social exclusion of the person or subject with mental disorder, the violation of human rights, among others.

Nursing has several safety practices to protect the patient from adverse events in care. The discussion of the patient's safety within mental health is still limited and constantly replaced by the notion of patient risk which, in fact, translates into the damage created by the patient, such as suicide and manifestations of violence⁽²⁰⁾.

It is observed that, historically, issues related to patient safety were attributed to non-human factors, such as pathogenic microorganisms. Over time, there has been a paradigm shift, adding that human factors also represent an important impact on patient safety. As an example of this, personnel errors, technical failures of equipment and lack of continuing education are described.

In the context of mental health, the large quantity of drugs administered increases the possibility of errors, especially in the Nursing sector, due to their proximity to the patient. Moreover, the stigma to which psychiatric patients are submitted contributes to institutionalization, generating a process of rationalization of harmful practices under the justification of maintaining safety, making room for negligence in care⁽²⁰⁾.

The National Policy of Permanent Education in Health (PNEPS) emerged as a strategy of the Ministry of Health to strengthen the UHS, on February 13, 2004, with Ordinance No. 198⁽²⁵⁾. It has the premise of developing the reflexive practice of health field professionals, promoting significant collective learning, corroborating the Patient Safety Policy⁽²⁶⁾.

In this sense, permanent education is a powerful tool in ensuring the safety of the patient by promoting organizational learning by analyzing the processes and actions of daily life, also allowing the worker to be a competent protagonist and problematizer of the act of caring.

Category two: impacts of professionals' mental health on psychiatric patient safety⁽¹⁴⁻²²⁾.

In line with the approach on human factors mentioned in category one, category two is intended to present a picture of the mental health of Psychiatry professionals and how it can impact the safety of psychiatric patients.

Absenteeism is higher in health professionals than in other sectors, which generates costs for organizations. Such costs can be even higher when the worker remains in service despite his/her condition, which can result in poor quality work, leading to errors and accidents⁽²²⁾. Burnout - a state of mental exhaustion in the face of professional life - is often associated with falls in the quality of care and in patient safety, increasing the rate of absenteeism and staff turnover⁽¹⁴⁾.

Among the causes of stress and mental exhaustion of health teams are excessive workload, lack of opportunity to develop skills, lack of support networks, weak leadership, lack of staff training and underfunding of mental health services, and emotional work to care for mentally ill patients and high levels of violence⁽¹⁴⁾.

As provided for by Law 10,216, psychiatric hospitalization can occur in three ways: first - voluntary, with the consent of the user; second - involuntary, that which is given without the consent of the user and at the request of a third party; and third - compulsory hospitalization, determined by the courts⁽³⁾.

It is important to emphasize that the involuntary admission of patients with mental disorders is exhaustive, both for the patients and their caregivers, because some procedures, such as forced medication, containment, confinement and coercive measures, are considered high risk, impacting the patient's safety and the professional caregiver's health.

The greatest record of emotional exhaustion is in the Nursing team⁽¹⁴⁾. Workers with mental health problems usually do not recognize themselves as sick or suffer in silence. Co-workers are unaware of how to help and are sometimes stigmatized. In this sense, educational actions are proposed such as counseling in self-help groups, group discussions on stigma, depression and mental health education, in addition to psychological accompaniment to help employees with mental health problems in the context of health work⁽²²⁾. Professional recognition, combined with participative and democratic management, can also contribute to addressing this problem.

Category three: coordination of mental health care for patient safety.

The third category highlights the coordination of mental health care as designed to “ensure that needs are met and integrated services are provided”, which, in practice, corroborates patient safety⁽¹⁵⁾. For example, the need for temporary shelter due to the crisis, attempted suicide, clinical and dental demands, social and territorial vulnerability, reassessment of their therapeutic project, the space for therapeutic promotion, the offer of medications that favor balance, access to culture and art, among others. This statement meets the seriousness of the mandate of the Psychosocial Care Network regarding the organization of care in which each device (PSCC, TRS, General Hospital, Urgency and Emergency Unit, Reception Unit, Outpatient, among others) has the responsibility to offer, in a safe, unique and responsible manner, the best treatment.

Talking about coordination of care translates the discussion about continuity and case management. Mental health puts the complexity of the patient in psychic suffering in evidence, involving psychosocial and biological issues, which can only be worked successfully in front of teamwork and a multi-professional approach and, for this; case management is an indispensable tool. Coordinating mental health care also poses challenges, bumping into administrative and bureaucratic issues that make access to services difficult, as well as an excessive concern of managers with performance, distorting the main objective of coordinating care. Besides these obstacles, the scarce resources generalize the attributions and the professionals who coordinate the care show concern with the quality of the relation user-service-professional, as well as with the adaptation process among them⁽¹⁵⁾.

Studies have shown that the engagement built between nurses and patients, in the field of mental health, as a protective factor, which adds to the safety of the patient^(15,17). Engagement is understood as “being clinically involved with a patient while the patient moves toward the goals of clinical treatment” or, in an organizational view - involvement of nurses with their work environments. In institutionalized settings, engagement is described by the Institute for Safe Environments (ISE) of the American Psychiatric Nurses Association (APNA) as a factor affecting the safety of the in-patient settings.

Care should be permeated with acts that aim to ensure the coordination of care, taking a broader view of the practice, as well as, it is necessary to implement care management policies to move the clinic and develop person-centered practices⁽⁹⁾.

In general, engagement enables a better connection and communication with the patient, a positive therapeutic relationship, which anticipates more assertive care plans, positively impacting on treatment compliance.

From an organizational point of view, engaging in work in Nursing is closely linked to recognition, to the realization of rewarding experiences, increasing the sense of professional effectiveness. Factors that may hinder engagement include: lack of training, supervision and trust, as well as stigma, threats of violence and the process of denial of psychiatric diagnosis⁽¹⁷⁾.

Category four: Factors that imply in the safety of the patient in psychic suffering^(16-19,21)

Different factors can decisively impact the safety of the patient in psychic suffering⁽¹⁶⁾. The long distances of services, usually located in urban centers, make it difficult for the most distant populations to access them, as well as the waiting time for a vacancy in consultation. The information on health is also difficult, since there is predominance of a technical language, difficult to understand, impacting on the adherence of health promotion practices. Another problem involving accessibility is the scarcity of home services, post-crisis follow-up and community centers.

The quality of interpersonal relationships is also pointed out as an impact factor on patient safety. Relationships built on respect and empathy as a basis, in non-stigmatizing ways; tend to influence positive outcomes, preserving the individuality of the subjects within a humanistic perspective. Participation in decision-making processes within a therapeutic environment is important to maintain a relationship of trust, preserving the autonomy of the subjects. The importance of cultural adequacy within the care process is also highlighted. In contexts of vulnerability, health professionals should consider social aspects, including user training so that effective therapeutic actions can be developed⁽¹⁶⁾.

It is important to emphasize that there are patients who are harmed by the assistance offered. Thus, the care of the vulnerable person becomes a challenge. It is essential to understand that safe care is not only about following protocols. It should be considered first of all as a behavior/knowledge to be adopted and adapted to each case, because it is understood that every person presents themselves in a unique way⁽⁹⁾.

In contrast with the Brazilian psychosocial care network, the importance of working according to the logic of longitudinality and regionalization of services is reaffirmed, rescuing the principles of completeness of care and attributes such as cultural competence, which govern the care services of the single health system.

The family approach is an important link in the production of shared care, involving professionals and caregivers⁽¹⁸⁾. As the authors exemplify, in the face of specific situations, such as the risk of suicide, making educational knowledge available to families reduces the caregiver’s burden, providing information on the

management of risk situations and recognizing the warning signs that indicate when seeking professional help. The study suggested a model of family education called COPE, which consists of health education performed by professional using teaching materials that exemplify cases and act on family empowerment, directing caregivers to prepare themselves before a certain situation occurs.

The factor "risk of sexual violence in psychiatric patients" is understood as worrying within the context of a safe internment environment. Through the presentation of different cases, the authors have explained the complexities of caring for individuals who may be unable to provide coherent reports of aggression, often reviving them in the face of current triggers or even reporting past experiences⁽¹⁹⁾. Faced with this, the professional must be able to approach and identify the differences in the reports, ensuring that unnecessary interventions are not carried out or even those that require action are not stopped.

Some factors may make it difficult for professionals to handle these cases, such as the culture of fear and disciplinary rigor present in institutional environments, and they may act as silencers of complaints, even when the professional identifies them. When the aggressor is a member of the team itself, the implications on the reliability of the report are put in doubt in the face of psychosis⁽¹⁹⁾.

Still in the context of hospitalization, it is analyzed how patients with psychiatric diagnosis are hospitalized in medical and surgical clinics⁽²¹⁾. The subject in psychic suffering is understood, detaching from the concept of traditional Psychiatry, as a unique, private individual who, in addition to a psychiatric comorbidity, may have other health needs of clinical origin.

The probability of a patient suffering from mental disorders presenting adverse effects and complications during hospitalization is higher than in the general population, such as, for example, ulcers and fractures in the postoperative period⁽²¹⁾. This finding is justified by the reduction of care provided to patients, often unplanned or missing, increasing the length of hospitalization and drug therapy, resulting in even higher hospital care costs.

The severity of mental illness increases the probability of injury or death, especially schizophrenia, which has a higher chance of adverse effects than other mental health diagnoses. In an overview, psychiatric patients, when hospitalized for some hospital treatment, receive low quality care, and it is important to plan a systematized assistance that overcomes the stigma and inequalities faced by this population. Strengthening actions in primary and acute health care consists in a strategy to face this problem⁽²¹⁾.

Limitations of the study

The absence of research in Brazil in the period in which studies were selected dealing with patient safety and the process of mental health care. Thus, new researches that explore the subject are lacking.

Contributions of the study

The contributions of this study consisted in divulging the importance of the Patient Safety Policy in the mental health services, as well as in all the assistance equipment, which corroborates discussions and future researches involving the theme.

Conclusion

The literature points out that continuing education, health education and the coordination of care with case management are essential factors to ensure the safety of the person with mental disorder.

However, it is also necessary to pay attention to the health of the professionals in the area since stress and mental exhaustion can impact the quality of care and, consequently, the safety of the patient. Therefore, it is necessary to adopt a solid management that values professional recognition.

The engagement between professional and patient helps in the quality of interpersonal relationships, which, in turn, is closely linked to the recognition and increase of professional effectiveness, while treating the individuality of the patient in a more humane and not stigmatizing manner.

Within the asylum context, people or subjects in psychic suffering, who live institutionalized, are more susceptible to adverse events. Given the vulnerability of this population, discussing the safety of the patient in these spaces is extremely important in the prevention of complications arising from asylum practices. Such discussion favors logic of integral care, which strengthens the process of deinstitutionalization.

Nevertheless, there is a shortage of national literature on the subject within Psychiatry, which may negatively impact assistance. It is necessary to expand research on the safety of the psychiatric patient in order to reduce the occurrence of harm during the care of this population.

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Study concept and design: Marcos Eduardo Pereira de Lima, Elaine Antunes Cortez. Obtaining data: Marcos Eduardo Pereira de Lima. Data analysis and interpretation: Marcos Eduardo Pereira de Lima. Statistical analysis: Marcos Eduardo Pereira de Lima. Drafting the manuscript: Marcos Eduardo Pereira de Lima, Elaine Antunes Cortez. Critical review of the manuscript as to its relevant intellectual content: Marcos Eduardo Pereira de Lima, Elaine Antunes Cortez, Fabíola Chaves Fernandes, Simone Costa da Matta Xavier, Viviane Lins Araújo de Almeida.

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