Safety of the elderly in health services

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Simone Rodrigues da Silva Araújo[1], Jardel Robert Henning Rodrigues de Magalhães[2], Camila Ribeiro Frazão[3], Graziele de Fátima Moreira Santos[4], Sanderli Dionísio Pereira Borba[5], Lorenna Arraes Borssari[6], Rebeca Viana Porfírio Mileski[7], Sarah Tavares de Lima[8], Flavia de Sousa Campos[9] and Athos de Brito Barros[10]

ABSTRACT

Aging is defined by the Pan American Health Organization as a sequential, individual, accumulative, irreversible, universal and non-pathological process, specific to all individuals of a species. With advancing age, there is a higher occurrence of chronic non-communicable diseases, therefore, elderly people become dependent on care. Thus, health systems are faced with several challenges to consolidate effective, safe, equitable and comprehensive care. The objective of this narrative review was to analyze and review the main available articles on the safety of older adults in health services. It is possible to establish health services with safe and effective management practices, compatible with the needs of the elderly, since it is a right of the individual and an ethical commitment of the professionals involved in care.

Keywords: Patient safety, Elderly, Health services.

[1] Dr. in Gerontology, Legislative Chamber of the Federal District
[2] Specialist in Psychiatry and Mental Health, Institute of Strategic Health Management of the Federal District
[3] Medical Student, University of Rio Verde
[4] Specialist in Intensive Care Unit, Health Department of the Federal District
[5] Specialist in Quality and Safety in Patient Care, Health Department of the Federal District
[6] Urgency and Emergency Specialist, Ministry of Justice and Public Security
[7] Medical Student, University Center of the Central Plateau Apparecido dos Santos
[8] Specialist in Internal Medicine, Health Department of the Federal District
[9] Specialist in Dermatology and Aesthetics, Health Department of the Federal District
[10] Medical Student, University of Rio Verde

INTRODUCTION

Aging is defined by the Pan American Health Organization (PAHO) as a sequential, individual, accumulative, irreversible, universal and non-pathological process, specific to all individuals of a species (BRASIL, 2006a; BRAZIL, 2006c). It consists of a process of progressive biological and social modifications throughout the individual's life. In this context, the World Health Organization (WHO) states that an elderly person is a person aged 60 years or older, for developing countries, and 65 years for developed countries (SOUSA et al., 2020).

As for the world population over 80 years of age, data from the United Nations (UN) project an increasing growth, which will reach 434 million in 2050, which corresponds to more than three times the 125 million registered in 2015 (BRASIL, 2021).

Also, data from the Brazilian Institute of Geography and Statistics (IBGE) indicate that a person born in Brazil in 2019 has an average life expectancy of 76.6 years, which represented an increase of three months compared to 2018 (76.3). The life expectancy of men increased from 72.8 to 73.1 years and that of women went from 79.9 to 80.1 years (IBGE, 2020).

This scenario impacts health services, because with advancing age, there is a greater occurrence of chronic non-communicable diseases, therefore, elderly people become dependent on care. Thus, health systems are faced with several challenges to consolidate effective, safe, equitable, and comprehensive care (SILVA et al., 2021).

Thus, considering the specificities of the elderly and the fact that patient safety is an important strategy that evaluates the quality of health care, since it consists of a range of actions to prevent risks and damages, or at least reduce them, this study is justified, since both the aging of the population and safe care are themes that need to be considered.

Therefore, the objective of this narrative review was to analyze and review the main available articles on the safety of older people in health services.

METHOD

This is a narrative review of the literature. This type of research addresses the subjects in a broad way. In view of this, it is possible to compile contents from various works in order to present them to the reader in a clear, comprehensive, and evidence-based manner. In this way, it is possible to describe, reflect and include various types of information and sources. To this end, it requires critical and reflective skills on the part of the researcher (RIBEIRO, 2014).

Because of this, the narrative review consists of six stages, namely: 1) choice of theme; 2) literature search; 3) font selection; 4) cross-sectional reading; 5) writing and; 6) References. This type of research is present in all areas, including interdisciplinary (SOUSA et al., 2018).

LITERATURE REVIEW

THE AGING PROCESS

For several years, aging was seen only as a process of decline accompanied by losses, favoring the existence of stereotypes and prejudices against the elderly. Understanding this period taking into account only the negative aspects makes it impossible to perceive important phenomena that are experienced at this stage, such as the experience evidenced by a broader and more general view of human existence. Aging occurs in a singular and complex way and is not associated with functional disability, dependence or absence of social experiences, because even in the face of losses, it is possible to live this successful process with good physical and mental health and involvement with life (GATTI; PINTO, 2019).

To this end, in 2002, the World Assembly on Ageing was held in Madrid, coordinated by the UN, whose theme was "a society for all ages". Strategic guidelines were defined to guide the formulation of public policies for the elderly population. The action plan highlighted three priorities: the need for society to adjust its policies and institutions so that older people are a productive force; the promotion of health and well-being throughout the life cycle; and the creation of contexts that promote policies aimed at the family and the community based on safe aging. This event resulted in proposals based on a new idea of old age, built on the concept of active and healthy aging (CHINA et al., 2021).

Faleiros (2018) states that aging is a personal as well as a social process and, therefore, differs from era to era. As such, it is not the same for all individuals and cultures, reaching not only the person, but also the family and the whole of society.

In the same sense, Caparrol et al (2020) point out that human beings age according to each previous stage experienced and react to the anguish and difficulties of each of them, often in the same way. Cultural and social aspects are capable of interfering with aging and the way the elderly person will settle in this process.

Although this process establishes phenomena specific to human beings, the experience of this period and the way in which elderly people deal with aging are influenced by psychosocial, historical, political, economic, geographic and cultural aspects, as well as by differences related to the context of daily life, beliefs and individual characteristics, making it specific and unique for each person (CAPARROL et al., 2020).

These aspects, for a long time, were not considered pertinent. However, with the high number of elderly people and the increase in life expectancy, the interest in understanding the aging process and the relationships that surround it in order to ensure quality of life for these individuals has also increased. From this perspective, it is necessary to highlight that until the middle of the last century,

studies on aging overvalued losses, wear and devaluation in this phase of life, which were considered exclusive to this age (FERREIRA; MEIRELES; FERREIRA, 2018).

As life expectancy has been increasing, new research has begun to show the possibility of a relationship between the declines evidenced in old age related to lifestyle, habits and behaviors adopted throughout life. Thus, detecting the particularities of successful aging has been the focus of research in several areas of knowledge. Thus, allowing the elderly person to be the protagonist of this process and valuing their perceptions and difficulties faced in daily life are necessary and effective strategies to obtain data that actually contribute to the knowledge of this phenomenon (OLIVEIRA, 2019).

In this context, the aging process raises questions about the living conditions and expectations of different social groups, which contributes to the understanding of this stage in the face of changes in modern society and values the knowledge and experiences of the elderly. In addition, it allows public policies to be formulated to face the new demands resulting from the changes that this phenomenon triggers, as the elderly must have full guarantees of fundamental rights, so that they can age with dignity (FERMENTÃO; THOMAZINI, 2021).

THE OLD

Although aging is characterized by a continuous process, being inseparable from the human condition, being old or being old is a stage of personal and social life characterized by the advancement of age, as well as by its sociocultural conditions (DARDENGO; MAFRA, 2018).

Regarding its heterogeneity, old age is complex, given the combination of losses and gains, as well as the lack of a single social response, as the meaning of being old is related to beliefs and cultural values in contemporary society (FALEIROS, 2018).

In this sense, it is possible to say that there are many patterns of aging and different ways of experiencing it, whose physiological, pathological, psychological, social, cultural, environmental, and economic aspects must be widely considered, as each elderly person is a unique being (CHINA et al., 2021).

Thus, old age is characterized by the way a society determines and understands aging and this is more evident than the perception of the elderly person themselves, a situation that does not always correspond in fact to their state of old age (FALEIROS, 2018).

Considering the terms old age and aging, it is noteworthy that, while the latter is a physiological process of modifications of the human being due to time, the former is a universal phenomenon, in which personal characteristics and the influence of the environment are decisive for aging. Therefore, it is possible to conclude that the term old age was constructed by society, so it can be evidenced as a social invention (DARDENGO; MAFRA, 2018).

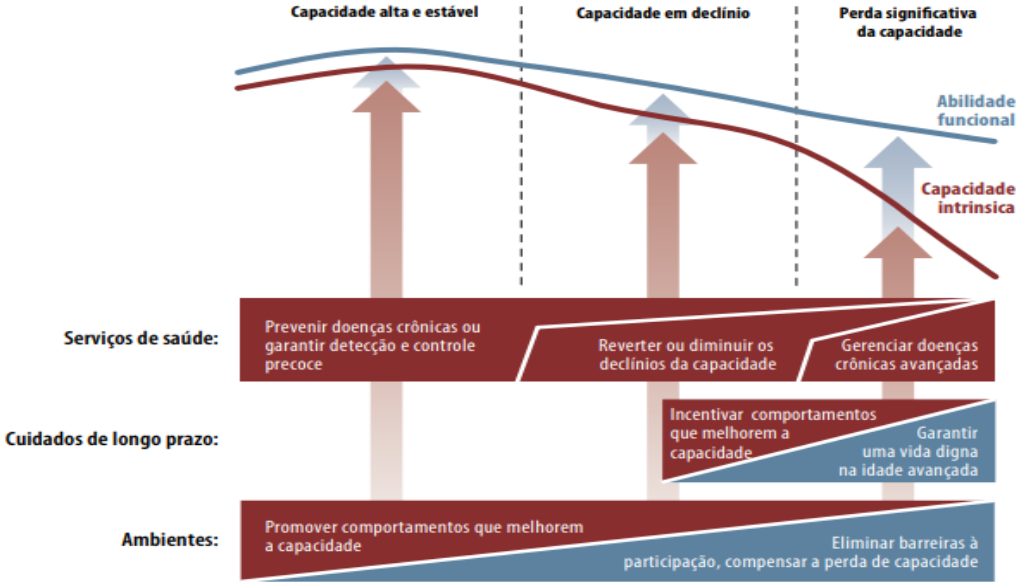
Thus, conceptualizing aging is a difficult and complex task. Nevertheless, it is important to consider it in its entirety, since in addition to being a biological process, it is multifaceted, as it involves social and cultural issues experienced by generations in different contexts and circumstances (BARRETO; CHAVES, 2020).

This complexity in health and functional states seen in the elderly raises fundamental questions, such as how to measure and how to promote. Therefore, new concepts are needed that determine not only the presence or absence of disease, but also how these conditions impact the functioning and well-being of the individual. Extensive evaluations of these health states are excellent predictors of survival, and other outcomes need to be analyzed in addition to the presence of individual diseases or even the degree of comorbidities (BARRETO; CHAVES, 2020).

In view of this, it is necessary to consider that as people age, their health needs are likely to be more chronic and complex. For this reason, health services that encompass the multidimensional demands of advanced age in a comprehensive manner are more effective than those that simply react independently to specific diseases. However, older people often come across services that are designed to treat acute conditions or symptoms. As a result, they deal with health problems in a disjointed and fragmented manner. This favors flawed care, as it does not meet the needs of aging, resulting in great costs not only for individuals, but also for the health system. Thus, promoting healthy aging means, in practice, comprehensive access to individual needs (WHO, 2015).

To this end, new approaches need to be implemented to provide holistic care for older people. These approaches will make it possible to align health systems with the needs of these individuals, namely: to develop and guarantee access to services that guarantee centered and comprehensive care; orient systems with an emphasis on intrinsic capabilities; and ensure the existence of an effective and well-trained health workforce (WHO, 2015).

Figure 1- A public health framework for healthy ageing: opportunities for public health action throughout the life course



Font: WHO (2015)

THE HEALTH OF THE ELDERLY IN THE PACT FOR HEALTH

Throughout its history, the Unified Health System (SUS) has had numerous advances, but also challenges, requiring constant changes and innovations from administrators. Thus, with a view to overcoming the difficulties, SUS managers signed the commitment to build a pact for health, emphasizing the health needs of the population with the definition of priorities articulated and integrated into the three components, which are: pact for life, pact in defense of SUS and pact for SUS management (BRASIL, 2006b).

The pact for life is evidenced by a set of health commitments and priorities defined by the managers of the three spheres of government, which must be executed with a focus on results. Among the priorities, the health of the elderly stands out, which should follow the following guidelines: promotion of active and healthy aging; comprehensive and integrated health care; encouragement of intersectoral actions, aiming at the comprehensiveness of care; implementation of home care services; preferential reception in health units, respecting the risk criterion; provision of resources capable of ensuring quality of health care; strengthening social participation; training and continuing education of health professionals; dissemination and information on the National Health Policy for the Elderly for health professionals, SUS managers and users; promotion of national and international cooperation of experiences in health care; and support for the development of studies and research (BRASIL, 2006b).

To this end, seven strategic actions were highlighted to achieve the agreed commitments: the health booklet for the elderly to enable better monitoring by health professionals; manual of Primary Care and health for the elderly, with emphasis on the guidelines contained in the National Health

Policy for the Elderly; permanent distance education program aimed at Primary Care professionals; reception to cope with access difficulties; pharmaceutical assistance aimed at the access of the elderly population; differentiated care during hospitalization with global geriatric assessment; and home care due to the favorable effect of the family environment on the recovery process (BRASIL, 2006b).

The pact in defense of the SUS encompasses concrete and articulated actions by the three federative instances, with the aim of strengthening the system as a State policy in defense of the principles of universality, integrality and equity, in addition to establishing the commitment of all spheres of government to its financing (MENICUCCI; COAST; MACHADO, 2018).

The management pact determines the main responsibilities, policies, and goals agreed upon in each government entity, in order to make the competencies that each one has more evident and consolidate the shared and solidary management of the public health system (SOUZA, 2018).

It is well known that the publication of the Pact for Life, especially with regard to the health of the elderly, represents an important advance. Nevertheless, there is still much to be done for the health service to provide effective responses to the needs and demands of these individuals, due to the heterogeneity and diversity of the issues presented (BRASIL, 2006c).

Thus, the ultimate goal should be adequate and dignified health care for the elderly, especially for those who, for different and specific reasons, have had an aging process marked by diseases and conditions that have limited their well-being (BRASIL, 2006c).

COMPREHENSIVE AND INTEGRATED HEALTH CARE FOR THE ELDERLY IN THE CONTEXT OF THE NATIONAL HEALTH POLICY

Comprehensive and integrated health care for the elderly should be organized in the model of a line of care, with emphasis on the individual, based on their rights, needs, preferences and abilities. Thus, it is necessary to establish effective bidirectional flows, in order to increase and facilitate access to all levels of care, which, in turn, must be structured according to essential conditions, that is, appropriate physical infrastructure, inputs and qualified personnel for efficient technical quality (BRASIL, 2006c).

To this end, it is also necessary to institute management instruments according to the survey of data on the functional and socio-family capacity of the elderly, in order to favor the participation of health professionals and users in the implementation of action plans to face the difficulties related to the complexity of this individual's health (BRASIL, 2006c).

In addition, it is necessary to incorporate, in primary care, mechanisms that favor the improvement of the quality and problem-solving capacity of care for the elderly, through the

involvement of professionals at this level of care, home care and outpatient care, ensuring effective care centered on the person, family and community (BRASIL, 2006c).

In this context, specialized care should also be encompassed, in order to strengthen actions aimed at the elderly, through the restructuring and implementation of health care networks, aiming at adequate integration, with a view to comprehensive care. To this end, it is necessary to recognize the importance of referral and counter-referral and to consolidate care modalities that consider the needs of the elderly population, including the hospital network and other specialties available in the health system, if necessary, as it is imperative to take advantage of opportunities that reduce hospitalizations and increase the possibilities for self-care (BRASIL, 2006c).

In the context in which urgent and emergency care is necessary, it is vital to use devices and technologies that avoid successive hospitalizations and ensure the problem-solving capacity of the treatment of adult and elderly patients (LIMA et al., 2022).

From this perspective, there is the elderly-friendly hospital, which is based on the report of Age-Friendly Primary Care Centers, published in 2004 by the WHO, whose main precept is to guarantee dignity to elderly patients and their families during treatment (FIOCRUZ, 2019).

In addition, it is based on the concept of active aging, and is evidenced by the process of optimizing opportunities for health, participation, lifelong learning, and safety, with a view to providing quality of life as the individual ages (FIOCRUZ, 2019). Furthermore, as highlighted in the Statute of the Elderly and reinforced in the National Pact on the Rights of the Elderly, aging is a very personal right and its protection is a social right (BRASIL, 2003).

CONTINUING EDUCATION IN HEALTH: A STRATEGY AIMED AT THE SAFETY OF THE ELDERLY IN HEALTH SERVICES

By analyzing the theoretical production and the historical context in which permanent education was implemented in the country in the 1960s, Paiva (1985) describes it as a procedure of State ideology capable of instigating in workers the interest of seeking new ways of working centered on the needs of late capitalism.

As a result, continuing education began to be disseminated by the United Nations Educational, Scientific and Cultural Organization (UNESCO) at the end of the 1960s, being seen as a pedagogical instrument capable of putting the daily work into verification, through the problematization of real situations experienced by individuals in different contexts and territories (JESUS; RODRIGUES, 2022).

As for Continuing Education in Health (PHE), there are reports of its emergence in the mid-1980s, being expanded by PAHO's Human Resources Development Program. This organization

differentiates the terms permanent education and continuing education, the latter guiding significant learning processes with a focus on the effectiveness of results (BARCELLOS et al., 2020).

From this perspective, it is important to mention that the goal of the EPS pedagogical process is to reflect on the work, to identify the difficulties and implications that arise from it, in order to transform the reality found and improve the care provided to users (CAVALCANTI; GUIZARDI, 2018).

In this sense, article 200 of the Federal Constitution of 1988 establishes that the SUS is responsible, in addition to other attributions, for organizing the training of human resources in the context of health (BRASIL, 1988). Thus, the training of professionals came to be seen as fundamental to consolidate the Brazilian health reform. Thus, in 2003, the Secretariat for Work Management and Health Education (SGTES) was created in the Ministry of Health, which agreed on the responsibility of formulating policies that guide the management, training, qualification, and regulation of health workers in Brazil (BRASIL, 2018).

In view of this, it is opportune to conceptualize health education, since it is often used as a synonym for health education and health education. Thus, health education is related to the production and systematization of knowledge aimed at training and development, whose purpose is to act in health, through teaching practices, didactics and curricular approach. Thus, it is recognized as education in health work and has two modalities, i.e., continuing education and continuing education in health (BRASIL, 2012).

Continuing education encompasses actions that require a certain period of time to be carried out and uses, in most cases, traditional teaching methods, such as formal offers at the graduate levels. It also refers to educational activities that aim to promote the sequential and cumulative acquisition of technical-scientific elements by the worker, through formal schooling practices, as well as experiences in the professional performance scenario, in the institutional context or even external to it (BRASIL, 2012).

With regard to EPS, the Ministry of Health defines it as work-based learning, in which learning and teaching are practices incorporated into the daily life of organizations and work. Thus, EPS is based on meaningful learning and the possibility of transforming professional actions in daily work. Therefore, it is characterized as an educational aspect whose potentialities are linked to elements and themes that make it possible to build reflection on the work process, self-management, institutional change and transformation of in-service practices, through the proposal of learning to learn, of working as a team, of building daily lives and constituting themselves as protagonists of individual, collective and institutional learning (BRASIL, 2018).

From this perspective, EPS, as a tool that favors critical analysis and the construction of knowledge about the local reality, should be evidenced and adapted according to the health situation found at each level of complexity of the health system (BRASIL, 2018).

In this political-ideological idealization, in which the conduction is operationalized in the local context of the health region, the subjects must continuously reflect on the imposed reality, in order to then seek creative solutions that overcome the health problems, resulting in the qualification of actions aimed at increasing the problem-solving and efficiency of the health system (DERMINDO; WAR; GONDINHO, 2020).

In this sense, it was found that the National Policy for Permanent Education in Health favored advances related to health education, therefore, it requires efforts in the articulation of institutional partnerships between service and teaching, with emphasis on shared dialogue. With this, the idea is to strengthen EPS, since it guides new practices that guide reflection on collaborative and meaningful learning, with the purpose of favoring teamwork, participatory management, and co-responsibility in the processes, whose ultimate purpose is to achieve the strategic objectives of the SUS (BRASIL, 2018).

These new practices are designed to offer those in need comprehensive, equitable and problem-solving care. As a result, the promotion of patient safety in health services has stood out in recent years, as it is a strategy that aims at the quality of actions (ARAÚJO et al., 2019). In view of this, when the subject is related to the safety of the elderly, it was found that this strategy is even more necessary, and therefore, it should be pursued in a shared way. Thus, safe care should be valued, because in addition to being an individual's right, it is an ethical commitment of the professionals involved in the process.

ERRORS, ADVERSE EVENTS, AND STRATEGIES FOR PROMOTING PATIENT SAFETY

The error or incident can be termed as a situation or circumstance that could have resulted or resulted in unnecessary harm to the individual, and may be intentional or unintentional in nature. Thus, when the damage does not reach the person, or when it is identified before, it is conceptualized as *near miss* . On the other hand, when it strikes but does not cause damage, it is characterized as a non-damage incident. When damage occurs, it is evidenced by incidents with damage or adverse events (BRASIL, 2013b).

In this context, adverse events express the simplest way to recognize error quantitatively, since they cause damage and are more easily recognized, being present in approximately 10% of hospital admissions (MAIA et al., 2018).

A quantitative, exploratory and descriptive study conducted in a public hospital, a cardiovascular referral hospital in Santa Catarina, from September 2014 to September 2015,

concluded that adverse events are still very frequent in inpatient services, which increases the length of stay and exposes the patient to new risks (LANZONI et al., 2019).

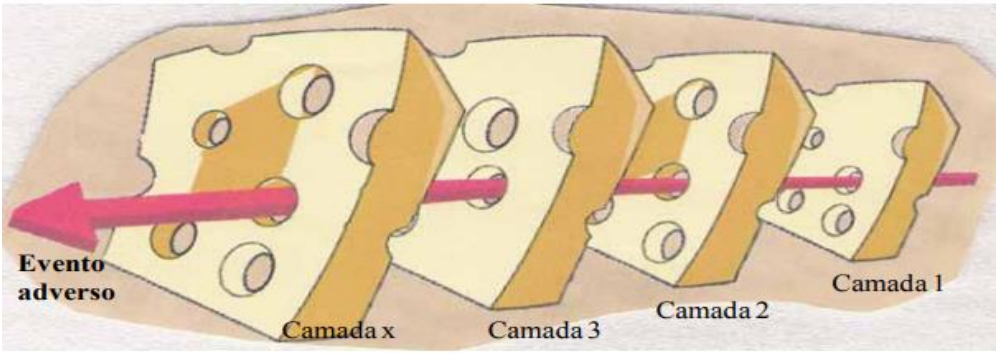
By highlighting this issue, the intention is to promote effective assistance, but failures and incidents may occur during the process, since the error involves complex situations, showing that the planned actions did not occur as planned or the planning was inappropriate according to the intended objective. Therefore, it is important to mention that safe care should be pursued not only by health professionals, but also by users and managers (COSTA et al., 2022).

In this context, James Reason, with the purpose of understanding the mechanisms related to human behavior when an error occurs, used the concepts of human factor and human error in a broad way. The author demonstrated that the error is inherent to the failure of the system, therefore, it should be addressed in a broader way (REASON, 2000).

The comprehension, which involves the factors related to the adverse event in James Reason's conception, is known as the "Swiss cheese" theory, since it compares the weaknesses of the health system to the holes in cheese. Thus, each hole represents a stage of this complex system, namely: source of the problem; active faults; and latent failures. In a hospital unit, these failures may be related to the work environment, inefficient supervision, lack of training or deficient education, stress, overload of activities, and a compromised communication system (BRASIL, 2014b).

Figure 2 shows the Swiss cheese model and points to a comprehensive approach to managing both error and failure. It demonstrates that in the absence of cheese layers (barriers) there is communication between the holes. Thus, the barriers that prevent the risk from reaching the individual are related to up-to-date professionals, the use of clinical protocols and surgical checklists, hand hygiene protocols, and the unit dose of medications, among others (BRASIL, 2014b).

Figure 2- James Reason's Swiss Cheese Model



Source: REASON (2000)

This author starts from the premise that human and technical errors cannot be eliminated, since to err is human. However, there are elements capable of avoiding them and mitigating adverse events. To this end, it is necessary to find an environment conducive to change (REASON, 2000; BRAZIL, 2014b).

The principle that guides this approach is that incidents are not caused by bad people, but by services that have been poorly planned and therefore bring unsatisfactory results. This is transforming the concept of individual error by focusing on system non-conformities. Nevertheless, the core of patient safety lies in the implementation of safe practices, since it is evident that achieving a high level of safety in health institutions requires much more (BRASIL, 2014b).

As a result, several conceptions have emerged, for example, the recognition of greater engagement of individuals in their care and the need for transparency in health actions. Thus, in order to favor the safety culture, six major changes are required, namely: it is necessary to change the search for errors as individual failures, in order to understand them as caused by system inconsistency; it is necessary to move from a punitive scenario to a just culture; it is essential to convert secrecy into transparency; care centred on the person and not on the doctor is indispensable; It is essential to adopt models of care that preserve interdependent, collaborative, and interprofessional professional performance; and it is vital that accountability is global and mutual, so it cannot be from the top to the bottom (BRASIL, 2014b).

Regarding the limitations found to develop safety strategies in the professionals' conception, they include the institutional barrier; the inadequacy of the organization and infrastructure; clinical variability; the deficiency of protocol and leadership; the lack of human and material resources; the overcharging; the absence of incentives and motivation; and the lack of effective safety indicators (ARAÚJO et al., 2019). The occurrence of these issues has negative impacts not only on the person, but also on the family and community, as the damage caused can compromise physical, social and psychological aspects.

In this sense, health services must organize the system in a safe way to minimize errors. However, in the face of an incident, it is necessary to consider that the cause for this is multifactorial in nature. So, professionals are more likely to commit them in the presence of complex and poorly planned processes. Thus, all causes need to be analyzed, with an emphasis on minimizing these events, thus improving the quality of care offered (RESENDE et al., 2020).

The lack of knowledge about adverse events and their causes prevents effective measures from being planned and implemented, which weakens care management and puts the individual's safety at risk. Therefore, mechanisms that inhibit these situations need to be encouraged to ensure safe and quality care (RESENDE et al., 2020).

In health services, patient safety represents one of the most complex challenges aimed at quality excellence, since the environment, responsibilities, organization and technology can interfere in this relationship and impair the care process (DOO; KIM, 2020).

It is evident that professionals perform activities that can trigger errors in care. Thus, actions should be based on attitudes and skills with a view to changing the patient safety culture at all levels of care, through the adoption of evidence-based practices (SIMSEKLER et al., 2020). In this context, it is necessary to plan actions aimed at patient safety and allow the workplace to be both an individual and a collective health provider.

Finally, within this theme, chart 1 summarizes some key concepts of the World Health Organization's International Classification of Patient Safety (BRASIL, 2014a).

Chart 1 - Some Key Concepts on Patient Safety

Segurança do paciente	Reduzir a um mínimo aceitável, o risco de **dano** desnecessário associado ao cuidado de saúde.
Dano	Comprometimento da estrutura ou função do corpo e/ou qualquer efeito dele oriundo, incluindo-se doenças, lesão, sofrimento, morte, incapacidade ou disfunção, podendo, assim, ser físico, social ou psicológico.
Risco	Probabilidade de um incidente ocorrer.
Incidente	Evento ou circunstância que poderia ter resultado, ou resultou, em dano desnecessário ao paciente.
Circunstância Notificável	Incidente com potencial dano ou lesão.
Near miss	Incidente que não atingiu o paciente.
Incidente sem lesão	Incidente que atingiu o paciente, mas não causou dano.
Evento Adverso	Incidente que resulta em dano ao paciente.

Source: BRAZIL (2014a)

CENTER FOR PATIENT SAFETY IN HEALTH SERVICES

The patient safety center is a body designed to enable and support the implementation of safe strategies, so it is an important component for the quality of the actions that will be developed in health services (BRASIL, 2013b).

In this sense, one of the objectives of this center is to promote safe initiatives in various areas of care, through the implementation of risk management in health establishments (BRASIL, 2013a). It also integrates the various instances and considers the individual as the final subject of care, regardless of the process to which he or she is submitted. To this end, it articulates information that impacts health incidents (BRASIL, 2016).

Thus, these centers should be organized in public, private, philanthropic, civil or military health services, as well as in those that carry out activities focused on teaching and research (BRASIL, 2013b). Thus, not only hospitals, but also specialized diagnostic and treatment units and services, for example, dialysis, endoscopy, radiodiagnosis, nuclear medicine, and radiotherapy should structure these centers (BRASIL, 2016).

However, individualized offices, clinical laboratories, mobile and home care services, long-term care facilities for the elderly, and those that provide care services to individuals with disorders resulting from the use, abuse, or dependence of psychoactive substances are excluded from compliance with this rule (BRASIL, 2013b).

On the other hand, it was observed that incidents related to care and adverse events can be identified in all health services, and even institutions that are not included in the structuring of a center can establish strategies aimed at patient safety (BRASIL, 2013b).

Thus, it was recommended that the center adopt the following principles and guidelines: the continuous improvement of care processes and the use of health technologies; the integral propagation of the safety culture; the articulation and systematization of risk management actions; and the protection of good practices so that the health service functions within its scope of action (BRASIL, 2013b).

To this end, the center must work with a multidisciplinary team, minimally composed of a doctor, pharmacist and nurse. These individuals need to know concepts of quality and safety improvement, as well as tools to manage risks in health services. It is recommended that this nucleus should preferably be made up of people who know the institution's work processes and who have a leadership spirit (BRASIL, 2013b).

Figure 3 - Model of the composition of the Patient Safety Center in a health service

Legend: Blue: composition of the NSP; Green: Consultative Bodies
Source: BRAZIL (2016a)

CONCLUSION

Aging is a process that requires attention to health with a view to individuality and specificity. Thus, it is necessary to consider a new practice scenario that favors the safety of the elderly in health services, so that these individuals are seen in their totality. Therefore, it is necessary to invest in continuing education programs, so that health professionals can act with protagonism and autonomy.

With planning, shared management and good will, it is possible to establish health services with safe and effective management practices, compatible with the needs of the elderly, since it is a right of the individual and an ethical commitment of the professionals involved in care.

There is no doubt that there are challenges, but these should be seen as starting points for change in health services. Thus, it is hoped that this study will provide subsidies and foundations for safe, equitable and comprehensive care for the elderly. In addition, it is intended to arouse the interest of researchers, health professionals and academics on this topic, in order to offer adequate care throughout the aging process.

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