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INTERPROFESSIONAL CARE AND ITS IMPLICATIONS FOR PATIENT SAFETY IN PRIMARY CARE

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Highlights: (1) Interprofessional care enhances the provision of resolution-oriented care. (2) A good teamwork environment promotes good healthcare practices. (3) The idea of belonging to a group creates a robust network for providing care.

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INTERPROFESSIONAL CARE AND ITS IMPLICATIONS FOR PATIENT SAFETY IN PRIMARY CARE

ABSTRACT

Objective: Identify possible facilitators or barriers to collaborative interprofessional care in primary health care and its relationship with safe care. **Method**: This is an exploratory qualitative study using a focus group technique with family health teams from a municipality in the interior of São Paulo. The inclusion criterion was to have been part of the team for at least six months. The exclusion criterion was being on vacation or absent during the data collection. A script with guiding questions about collaborative interprofessional practices and safe care was used. The transcript was processed using IRAMUTEQ software and analyzed considering the theoretical framework of collaborative interprofessional practices and safe care. **Results**: Six classes were formed: implementation of safe care, work objectives, decision-making, care construction, team communication, and actions that integrate safe care. How each member performs their role, their understanding of work objectives, communication, how care is provided, and how team disagreements are handled are reflected in work performance and resolution. **Conclusion:** Thus, factors related to safe care and team climate, such as job satisfaction, are influenced by how the team interacts daily.

Keywords: Interprofessional Relations; Patient Safety; Primary Health Care.

INTRODUCTION

The theme of interprofessional collaboration has been emphasized in the health field as one of the requirements for political reform in the training model and the desired model for global health care[1-2]. As the world faces challenges related to the shortage of health professionals, policymakers are looking for innovative strategies to contribute to policies and programs promoting global health[1].

Conceptually, the term interprofessional collaboration is broad and composed of two other terms: collaborative interprofessional practice (CIP), which describes interprofessional collaboration in healthcare settings, and teamwork, which is defined as a deeper level of interdependent and shared work[3-4].

Teamwork is the foundation for quality and safe care, generating personal satisfaction and a sense of belonging among team members. When performed satisfactorily, several benefits

can occur, such as optimization of financial resources, more assertive and decisive care, and improvements in health indicators[5-6].

Good clinical practice, responsibility for disease prevention and health promotion, guaranteed access to services, and interprofessional care capable of strengthening ties in the community and encouraging community participation in self-care are essential to consolidating a universal healthcare system. These challenges need to be explored, worked on, and constantly improved[7].

CIP can improve the appropriate use of clinical resources and safer patient care, reduce hospitalizations, decrease tensions and conflicts between healthcare providers, and minimize care failure and mortality rates, among many other benefits[1].

With the creation of the World Alliance for Patient Safety, measures to reduce global harm have emphasized patient safety as an essential milestone for developing quality care at the national level. However, investments remain concentrated in the hospital setting. Since Primary Health Care (PHC) is the main gateway to the health system and accounts for most of the care, this point of care mustn't be left out of investments and research related to patient safety[8].

For CIP to exist, health teams must collaborate by sharing responsibilities among their members, maintaining interdependence, having clear professional roles, and having well-defined tasks and objectives. The different components need to know these. Ideally, in addition to this collaboration among themselves, there should also be collaboration between other health system services, forming a network system with collaborative behavior[9].

Brazil's Family Health Strategy (FHS) expansion has improved access to and use of health services for the general population and economically and socially vulnerable groups, such as the elderly and people with chronic noncommunicable diseases[10]. The ESF develops strategies for the expansion, qualification, and consolidation of PHC by offering a reorientation of the work process with greater potential to generate effective care and positively impact the health situations of communities[11].

Understanding the role of CIP and its relationship with safer care in the context of PHC may be a way to address contemporary challenges facing the healthcare system. Thus, this study

aimed to identify possible facilitators or barriers to collaborative interprofessional care in PHC and its relationship with safe care.

METHOD

An exploratory qualitative study using the focus group technique allows the researcher to collect information on a specific topic through participatory discussion among individuals gathered in the same place for a particular period. This data collection method is appropriate for those seeking to understand attitudes, preferences, needs, and feelings[12-13].

Health professionals from three FHSs in a city in the interior of the state of São Paulo participated in the study. These teams were identified during the first stage of data collection for a doctoral thesis, which identified the best team climates using the Teamwork Climate Scale (ECTE), a self-administered instrument based on the concepts of shared conceptions and organizational climate. Twenty-three FHSs out of 30 teams were listed as having the best climates. Among the units with the best climates, three were selected for the focus group because they had at least one representative from each professional category on their teams.

Thus, the survey included nurses, nursing technicians, doctors, community health agents, dentists, and dental assistants. The inclusion criterion was to have been part of the FHS team for at least six months. The exclusion criterion was being on vacation or absent during the data collection. The nurse was contacted by telephone, and the day for the group was arranged. Data collection took place during July 2022. The meetings were held at the health unit on the day when team meetings usually occur. Three sessions were held, one at each unit.

At the time of data collection, the objectives of this research stage were presented, questions were clarified, and the free and informed consent form (FICF) was signed, with one copy remaining with the researchers and another with the participant. Participants were also informed about the confidentiality and anonymity of the data and their participation.

In this study, the group was held at the workplace, in the health teams' meeting room. This environment was suitable for discussions and ensured familiarity for the participants. The principal investigator and a previously trained observer, responsible for taking notes during the debate, participated in this stage.

The chairs in the meeting room were arranged in a circle so that everyone could see each other during the discussion. The group dialogues were audio recorded and later transcribed. The meetings lasted an average of 1 hour and 45 minutes.

The moderator used a trigger question to identify the characteristics of teamwork that could facilitate or hinder safe care. After the discussion and notes, the principal investigator read to the group the main points discussed and findings from that meeting to validate the observations recorded.

The audio recordings of the focus group interviews were transcribed. This strategy values interaction between participants and the researcher, emphasizes exchanging experiences and opinions among participants, and thus collectively builds the research results[13]. The transcribed data were processed using the *software Analyses Multidimensionnelles de Textes et de Questionnaires* (IRAMUTEQ), which allows for content analysis of classes[15-16].

IRAMUTEQ considers the total content analyzed as a corpus, and, in this study, the transcription of each audio recording from the three focus groups, consisting of text segments, resulted in a corpus for analysis, with the health unit being the only variable used. The software generated classes based on the study of vocabulary similarity, which was related to the variable of interest analyzed, constituting a single electronic file that, after being processed by the program, resulted in a dendrogram with six classes. Factor analysis retrieved the text segments from each class of the original corpus for subsequent naming of the classes and reading.

This data processing is the basis for the analysis carried out by the researcher, who contextualized each class, reflecting theoretically on the content and retrieving the typical texts and vocabulary used. The interpretation and analysis of the data were based on the relevant literature on patient safety and the characteristics of collaborative interprofessional practice. The intersection between these approaches provided data for the analysis of the material.

The Human Research Ethics Committee approved this study in 2020 under opinion number 4,280,360 and CAAE number 30735120.7.0000.5383.

RESULTS

Twenty-three health professionals, seven from unit A, nine from unit B, and seven from unit C, participated in the three focus groups. All units had at least one representative from each professional category (doctors, nurses, nursing technicians, community health workers, dentists, and dental assistants).

IRAMUTEQ for processing the material analyzed 136 text segments, retaining 101 of the total texts for class elucidation. This corresponds to 74.26% of the text, constituting a good corpus for analysis, which shows the following results:

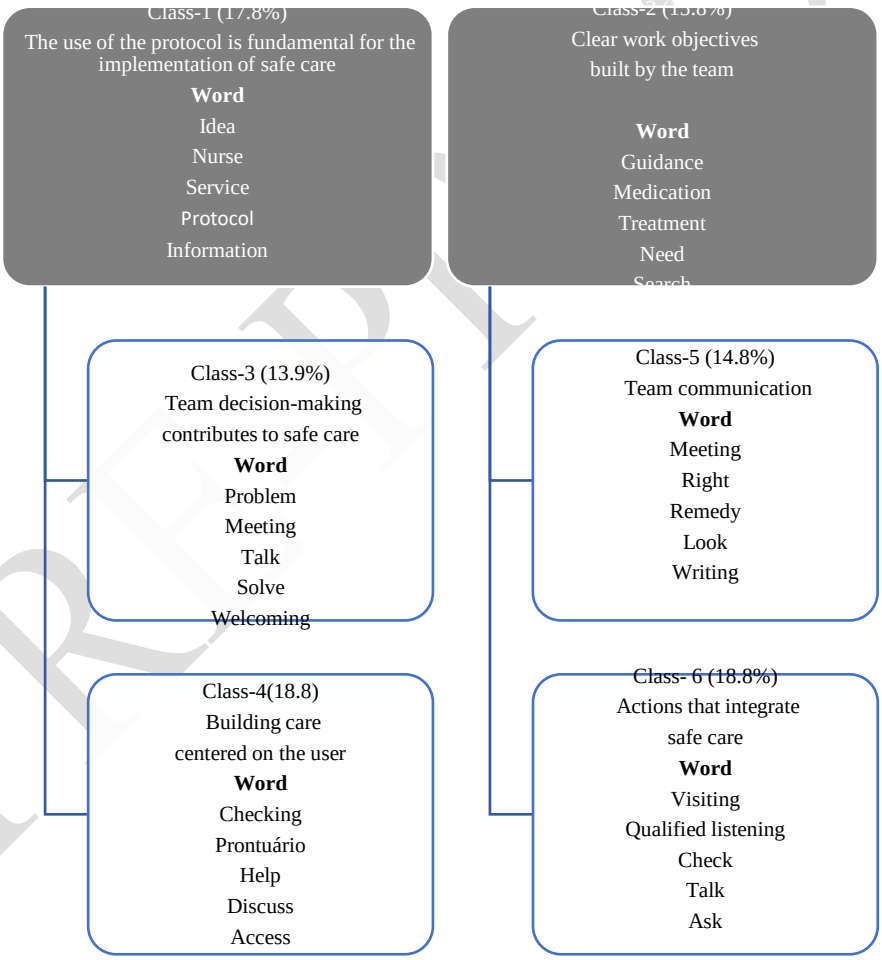

Figure 1. Dendrogram: Team contributions to safe care

Source: Author.

The corpus is made up of six classes, of which classes three and four are related to class one, while classes five and six are related to class two.

Class 1: the protocol is fundamental to the implementation of safe care

These words are examples of actions mentioned by professionals that allow them to provide safer care, as can be seen in the following segments of speech:

> I almost always use protocol. We even continued our education and covered various topics. For example, we made a mural with a flowchart. When requesting a screening test for a patient with diabetes, what should one do if the test is standard, and what should one do if the test is abnormal? (Nurse, Unit A).

> Because what I tell the students who come to the unit is this: we have levels of evidence in science. We do a multicenter study, bringing together thousands of patients to simultaneously test protocols, several centers worldwide, to test a protocol, a treatment. This treatment is favorable, and I have the best level of evidence, level A. It has been tested in several countries, with several teams. Because when a new disease like COVID comes along, oh, because I've treated some patients with Ivermectin in my office, and I've seen them improve. That's the worst level of evidence there is! Because there are many biases, it could have been a coincidence (Doctor, Unit B).

Class 2: clear work objectives constructed by the team

Class two refers to the work's objectives and how these objectives are discussed and dealt with in the team. This can be identified through speech segments such as the following:

> We discussed the objectives at the meeting; we communicated why we needed that visit. Example: Oh, you're going to visit, the one who will think about the Pap smear, but there's a conversation to see if there's a mental health issue. Example: The one who will see you now, we're investigating whether she has a mental health problem, so the observation is already broader. Sometimes we have to go out on a

limb to avoid losing the bond. We have communication to make the objectives and care needs clear (Nurse, Unit A).

I think so. We have set objectives. For example, we have reasonable control of psychotropic drugs and controlled prescriptions. We have a prescription file. We separate the medical records every two weeks, and the doctor leaves them ready on the specific date to pick them up. Furthermore, we separate the medical records by date, so there's no point in the patient coming before (Nurse, unit A).

Initially, we had difficulties, even in our speech. Sometimes, we said, “You have to come because the prescription has expired,” which annoyed the patient. We had to explain the medication's mechanism and use, but that was a construction (Nurse, unit B).

Class 3: Team decision-making contributes to safe care

The words that emerged from this class indicate the importance of dialogue in the team's collective decision-making:

We decide many things together. And it's not like the secretary sent it, the doctor, the nurse, or the dentist. We chose to care for each other. It's horizontal. It's not because one person said it that it's 100% right (Doctor, unit A).

Furthermore, it's not that you're being bad or denying care; you're being unfair to the people who live here in the area, or those who have moved here from outside. We must try to be fair so that you can provide good care for as many people as possible. We're not going to do it in an irrational way of interrupting treatment or prenatal care. (Nursing technician, unit B).

For example, a couple arrived with a four-day-old baby from another area on Monday. When the boy moved here, the woman was in the maternity ward, and she, a first-time mother, came because the child was in respiratory distress. And then another technician who isn't here came and said, “Look, the patient isn't from here; he's doing his chart now because he's just moved. What are we going to do? I said let's take him in, so we took him in, and then we talked about it in

> the team meeting, what we're going to do. We have almost 8,000 people. We experience this nearly every day (Nurse, unit C).

Class 4: Building user-centered care

Class 4 covered terms related to care planning through conversations and practical actions, such as checking medical records and ensuring access to care. The following statements represent the content covered:

> Before we had this control over prescriptions, it used to happen like this: when the patient ran out of prescriptions, he'd get them from a neighbor or a relative. Then, when they didn't have any medicine, they'd show up here, out of their minds, causing the most considerable uproar, wanting the medicine, a challenge for access. So, it was a job of tinkering, of raising awareness. Before the medicine runs out, they come to the unit. We've noticed that there's been a significant reduction in the number of people who freak out in front of us. This also ended up contributing to their better quality of life. (Nurse, unit A).
>
> We've noticed that the person who takes benzodiazepines correctly brings peace of mind to the whole family. So, it's a job for the patient and the entire family. The focus is on bringing quality of life to the patient and the whole family (Nursing technician, unit B).

Class 5: Communication strategies between the team and with the user

This class deals with team communication in favor of patient safety. Below are some excerpts that express this idea:

> There's also one thing: we get very involved with patients because we already take on a lot of care. So, I say, Look, your blood pressure is high. I've already given you the medicine, but I will assess you again. If anyone asks, tell them you've already taken the medicine, okay? I've already told the technicians; I've written it down, but you also tell them. It happened that I was prescribed

> medicine; X; it wasn't a scribble, and you could understand it perfectly. Even though the handwriting was legible, the user went to the pharmacy, got medicine Y, and started taking it. He returned to the unit saying he hadn't improved, and I asked, “Did you take medicine X correctly?” He said no; he was taking Y. It was X. He looked at the prescription and said, “True, it was X. The patient didn't look at the prescription or the medicine” (Doctor, unit A).
>
> Communication happens; I had a case of a patient with a heart problem who needed an extraction. I asked for a visit from the doctor; he went there, assessed it, and there was medication. We also talked to the nurse. These are complex problems that aren't just dental problems. (Dentist, unit B).
>
> When we have communication difficulties, we usually use team meetings to resolve them. One example was this scheduling issue. When we started the meeting, it was tense. Everyone was able to express their difficulties. The biggest questions were: What was for reception and scheduling, and what am I doing right? (Nurse, unit C).

Class 6: Actions that integrate safe care

This class shows the actions described and listed by the teams as activities already carried out, which, in their view, have already contributed to safer care.

> The patient calls for a visit. We ask what's going on and, depending on what they say, we tell them: 'Look, you need to go to the emergency room to get this checked out. Then we can schedule a follow-up visit, but you must be assessed first. You can't wait until the following week'. We try to be welcoming and understand what's going on. The welcome is important (Nurse, unit C).
>
> We ask: 'But are you feeling anything? Do you have chest pain?' If you don't ask, the person says, 'I've come to take your blood pressure,' then they'll wait there for 10- 15 minutes. But they also have chest pain, and they haven't been assessed, and they haven't said anything. It's important to check because, if not, the person thinks they can leave if they check their pressure, and it's fine. But occasionally she has symptoms and isn't well (Doctor, unit A).

> Nursing is comprehensive. They identify the name and the medication. We always must confirm the name twice or thrice because you call one name, and another comes in. So, it's always confirmation because that always happens. I think they get anxious. Medication is the whole scheme: the dose, the medication, the patient's name, the time it was administered, and how it will be administered. The vaccine, guidance on which vaccine is being taken, what the reaction is, whether it's moderate, mild, or severe, the reactions that can be expected (Nursing technician, unit C).
>
> We do procedures; we must carefully fill in the form correctly and make a treatment plan for each patient. These patients usually see us once a month. When we make referrals to a specialized unit, we call them, ask them to come here, give them the referral form, and give them the exact treatment date. We always hit the duplicate keys because some information must be reinforced (Dentist, unit C).

DISCUSSION

The focus groups' findings reflect the importance of using care tools like protocols to provide more effective and assertive care, valuing scientific evidence to guide the team's conduct.

In the statements made by health professionals, the use of protocols is highlighted as a tool that can guide care, especially in diseases that are already known or even new diseases, such as COVID-19. Thus, the use of well-defined flows and protocols, which are constantly updated, is essential for good care[8,17]. Sharing this information with the whole team and, in possible situations, building on it with the team provides more assertive care.

A study carried out in PHC to evaluate the dimensions of work and PIC revealed that care protocols are also used as interaction tools and have the potential to stimulate discussions among the team, especially in situations of arbovirus epidemics. This is because they promote debates about the occurrence of cases, conduct, the general state of health of the population in the area, the number of deaths, among others[18].

According to D'amour *et al.*[19], formalization is present in collaborative processes. It can be exemplified using tools and protocols supporting the entire work process.

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One of the axes of the National Patient Safety Program (PNSP) is to encourage safe care practices involving protocols. Ordinance MS/GM No. 529/2013 establishes a set of basic protocols defined by the World Health Organization (WHO) with some practices that should be developed and implemented, such as hand hygiene in healthcare facilities, safety in the prescription, use, and administration of medicines, patient identification, communication in healthcare facilities, and safe use of equipment and materials, among others[20].

The existence of a protocol alone cannot predict good practice, but rather its adoption by all team members. Cohesion, one of the results of CIP, can contribute to using this standardization and sharing this knowledge. A team with a good working climate is more likely to share conduct and decisions and adopt good practices in a more standardized way. In other words, a team with a good working climate enhances collaborative work and manages to integrate team members for more comprehensive and cohesive care[21] .

The excess of information, some accurate and some not, has made it difficult to find reliable sources and guidelines. This phenomenon, known as an infodemic, can generate misinformation that negatively affects people's lives and leads to behaviors and attitudes not in line with health guidelines. It is important to note that this situation is related to society's social, political, cultural, technological, and educational context. Thus, this phenomenon can occur on a larger or smaller scale depending on the location[22-23].

In addition, keeping objectives clear can promote a cohesive environment where each member understands the purpose of the actions. This is also related to the care provided to the user. When the user is the focus of care, it is essential that all team members clearly understand the objectives, which also facilitates the implementation of the CIP[4].

It is also mentioned that each professional understands how they should contribute to specific cases. Understanding each professional's role aligns with the growing debate about interprofessional, which refers to integrating practices and the intentional and collaborative articulation between different professions. However, I would like to let you know that this process is built on a daily basis[24].

Clearly understanding the objectives of the work being carried out starts from the principle that professional training has prepared the person to work in the area. Professionals without specific training can often work in PHC, especially in an FHS. In this study, most of

the higher education professionals from the FHSs who took part had training in Family Health, residency, or specialization. However, in other parts of the country, this may be different.

The essence of teamwork is centered on interprofessional actions, which can bring together different technical fields and workers with other knowledge and experiences. Objectives and strategies that align with individual and collective needs are needed to maintain patient safety. This includes sharing knowledge and experiences, intersectoral learning, and the management and organization of networked care capable of taking a multidimensional approach[25].

To establish clear goals, it is essential to reflect on the activities that must be carried out to contribute to integration and continuous learning about the team's work process. This factor contributes to interdependence between its members and the CIP. Building a standard care project can reflect well-established goals well and put the user and their family at the center of the care provided[4,26].

Based on the opinions of the professionals who participated in the study, the team meeting was considered an appropriate time to discuss the group's objectives, and this interaction is essential for the development of the work. Furthermore, how the conflicts inherent in the work process are perceived and mediated determines whether the team cohesion is better or worse [27,18].

However, the examples cited in the participants' speeches recognize that the work should be horizontal. This perception is fundamental for the model change expected in an FHS that aims to reorganize the health system.

According to Franco[28] and Santos *et al*.[29], the idea of workers belonging to each other is also a favorable factor for carrying out synchronized actions that generate a robust network for producing care. There is no such thing as self-sufficiency in health work; collective work is necessary to provide care for users, which needs to be centered on their health needs. In this way, the worker always operates in a relational field of agreements and contracts that oscillate between conflict and harmony, capable of sharing knowledge, actions, technologies, and subjectivities.

Strengthening collective spaces for reflecting on practice can contribute to moments of shared decision-making, generating a greater chance of enhancing the connections perceived and introduced by the subjects actively and consciously, contributing to democratizing work[26].

However, an overload of work can damage team relationships. Communication failures and difficulties in the continuity of care provided to users can directly influence the quality and, consequently, the safety of the care provided. These are some of the challenges that have affected Brazilian institutions[30-31].

The 2006 National Primary Care Policy (PNAB) mentions universal coverage, which establishes a relationship between the number of CHAs and 100% coverage of the registered population, with a maximum of 750 people per CHA and 12 CHAs per team. This policy reaffirms that exceeding the maximum number of people registered is not recommended to ensure the quality of the work offered[32]. However, the 2017 PNAB does not mention universal coverage, but does refer to 100% coverage in areas at risk of social vulnerability, considering epidemiological and sociodemographic criteria[32-33] .

With this determination, forming teams with just one CHA is possible. When a policy does not clearly define the number of CHAs per team and makes coverage parameters more flexible, this reinforces the risks of barriers to access and quality of health services. In the case of this study, the problem was not the number of CHAs, but rather the high number of families registered in some units, which, according to the team itself, is detrimental to access and quality of care[33].

To reduce professional overload, it is imperative to have an adequate number of professionals so that safe care can be provided, and it is the responsibility of the institutions to provide adequate conditions in the units. Studies show an association between patient safety and the workload of professionals and point out that in places with fewer users, there are also better indicators of quality of care [34,25].

In addition, according to Magalhães, Dall'agnol and [Marck35], this inadequate determination of the number of people using the service can encourage staff turnover and make it difficult to work safely, due to staff fatigue and illness.

When building user-centered care, the ideal is for everyone to be a protagonist with varying degrees of autonomy and control over the processes. This type of work is living work,

which makes it possible to value the independence and protagonism of the players, encouraging bonds and accountability in practice settings[36,31].

One of the foundations of the ESF is the provision of user—and family-centered care. For this logic to develop, care must not be focused on the health professional but rather on the health needs pointed out by the user. Some instruments can strengthen this logic, such as the interprofessional team, which can provide the necessary assistance, and the extended clinic, which centralizes care based on the user[31].

To build care centered on the user and the family, as provided for in the strategy, a team that can work collaboratively and has adequate support is needed, such as matrix support by a multi-professional team and spaces for discussion and consolidation of continuing education[7].

With the 2017 PNAB, the interprofessional component was weakened by the extinction of accreditation and federal funding for the Family Health Support Center (NASF) in the name of greater autonomy for the municipal manager in the team's composition[8,7].

According to the Brazilian Institute for Patient Safety, effective communication between the team and between the team and the user helps to avoid adverse events and improve patient safety, while inadequate communication is among the leading causes of more than 70% of adverse events, such as care failures in the administration of medication and incorrect identification of the patient[37-38].

Valuing communication in relationships can break down power barriers, strengthen the sharing of knowledge and decisions, shift the focus from the professional to the user, and transform individual knowledge into collective knowledge. Therefore, it is essential to recognize the importance of communication for safer and more collaborative care. The intersection between CIP and patient safety involves effective communication in workplace[38].

It is necessary to educate those who will work in teams. In other words, to demand competencies that favor teamwork, it is essential to develop these skills right from training. Planning the teaching-learning process, guided by the assumptions of interprofessionalism, can improve relations between members of different professions, overcoming the historical difficulty of communication[2,4].

A facilitator for dialogue is an understanding of the shift from professionals' to health service users' interests. This maintains the perspective of comprehensive care and makes it

possible to expand interprofessional communication, share actions, advances, and collaborative skills[9,10].

Regarding safe care, home visits stand out as a care tool in PHC, developed by all health team members, but mainly by the CHA. Visits are considered care instruments, allowing a broader assessment of the population's living conditions and health. They should be planned as part of a team, according to the needs arising from the vulnerabilities and risks in the territories [25].

From the Health Care Network (RAS) perspective, PHC is considered the care coordinator and the user's preferred gateway to the different points of care in the HCN. In 2012, the WHO set up a working group of experts to discuss the safety of care in PHC, considering the importance and complexity of this system[1,25,30].

Regarding the care taken from patient identification to precautions when administering medicines and vaccines, recent studies indicate that the most noticeable risks are related to immunization. Still, several invasive procedures carried out during PHC care could generate an adverse event, such as checking capillary blood glucose, nebulization, dressings, cytopathological examination collection, administration of medicines, among other actions[25].

The reception of spontaneous demand indicates significant changes in how teams work, care models, and professional relationships. Attending to spontaneous demand, valuing fairness, and using responsibility encourages safe care by the team, which is committed to maintaining comprehensive health care[25].

Teamwork is a necessary strategy to deal with the growing complexities of health systems. These systems need an expanded and contextualized approach capable of keeping up with local demographic changes and epidemiological changes, which can be local or global, such as those experienced from 2020[26].

FINAL CONSIDERATIONS

It is possible to identify several components that can contribute to the establishment of PIC, such as the use of care protocols as a tool for interaction and information sharing, favoring safe practice and standardized care, clear work objectives focused on the user, maintaining clear

goals for the entire team, favoring spaces for sharing decisions, valuing assertive communication that breaks down power relations, and stimulating the professional training process with the assumptions of interprofessional practices.

Work overload and a lack of professional numbers are barriers to safe care. These situations can harm communication, continuity of care, and quality indicators. There is also a lack of political support and encouragement for the interprofessional factor. The study was limited to the participation of three family health teams. Still, the good team atmosphere in these units did not exclude the existing challenges, which may prevail in different locations, so the study can contribute to identifying and reflecting on safe work and care in this context.

Given the unprecedented nature of the research in PHC, we suggest that the study be extended to other health teams to identify other possible facilitators or barriers to collaborative interprofessional care in PHC and its relationship with safe care.

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INTERPROFESSIONAL CARE AND ITS IMPLICATIONS FOR PATIENT SAFETY IN PRIMARY CARE

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