CIÊNCIAS SOCIALMENTE APLICÁVEIS:

INTEGRANDO SABERES E ABRINDO CAMINHOS

JORGE JOSÉ MARTINS RODRIGUES
MARIA AMÉLIA MARQUES
(Organizadores)

VOL IX

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APRESENTAÇÃO

O nono volume desta colecção segue a lógica dos livros anteriores. Procura apresentar ao leitor uma coletânea de artigos sobre problemáticas que são transversais ao campo das ciências sociais aplicadas.

Sendo discutível, na metodologia seguida na organização dos vários volumes procurou-se privilegiar artigos que abordassem novas tendências e/ou problemáticas transversais relevantes, adotassem metodologias mais holísticas e/ou modelos de investigação aplicada, apresentassem estudos de caso nacionais e/ou internacionais e procurassem ser reflexivos. Nesse contexto, o nono volume está organizado em quatro grandes eixos – Planeamento e informação, Turismo, Saúde e ergonomia, Direito.

Na construção da estrutura de cada eixo procurou-se seguir uma lógica em que cada artigo possa contribuir para uma melhor compreensão do artigo seguinte, gerando-se um fluxo de conhecimento acumulado que se pretende fluido e em espiral crescente.

Assim, o eixo Planeamento e informação, é constituído por um conjunto de quatro artigos. O planeamento dos territórios urbanos influencia a arquitectura das cidades e os seus equipamentos. Assim, o recurso aos sistemas de informação geográficos e cadastrais, enquanto sistemas geradores de informação e conhecimento, poderão ser bons preditores e auxiliares de gestão do risco, quer das cidades quer dos seus equipamentos.

O eixo Turismo junta um conjunto de sete artigos que, em comum, contribuem para optimizar os serviços e melhorar a imagem do turismo e do património cultural. A afectação ágil de recursos às actividades que mais deles necessitam, em cada momento, é um bom indicador de eficiência e de qualidade do serviço prestado. Esta flexibilidade permite redireccionar os diferentes imaginários e expectativas culturais e espaciais dos turistas, nas diferentes épocas do ano.

No eixo Saúde e ergonomia, composto por seis artigos, subjaz que uma política de avaliação de serviços de saúde necessita da medição dos seus efeitos, da comparação com outros indicadores e de incentivos. Este pressuposto contraria a falácia de quanto mais idade se tem mais se sabe sobre sexualidade e reprodução. Os riscos associados a tal ideia induzem à forte necessidade de formação contínua e treino de competências para a prevenção e promoção da saúde, onde se incluem os métodos ergonómicos, por forma a poupar energia.

O eixo Direito é composto por quatro artigos. Os normativos legais, em geral, obedecem a princípios éticos universais. Contudo, ainda há muitas lacunas a superar, nomeadamente quanto aos direitos femininos, com a ganância e a corrupção sempre à espreita.

Com a disponibilização deste livro e seus artigos esperamos que os mesmos gerem inquietude intelectual e curiosidade científica, procurando a satisfação de novas necessidades e descobertas, motor de todas as fontes de inovação.

Jorge Rodrigues, ISCAL/IPL, Portugal
Maria Amélia Marques, IPS/ESCE, Portugal

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PLANEAMENTO E INFORMAÇÃO

CAPÍTULO 12

INDICATORS FOR QUALITY MONITORING IN HEALTH AND PATIENT SAFETY

Data de submissão: 10/04/2023
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Cristina Maria Antunes Martins d´Arrábida
https://orcid.org/0000-0002-2794-9887

Nuno de Almeida Alves
https://orcid.org/0000-0001-7993-6685

ABSTRACT: The challenges of policy evaluation are related to the measurement of the effects of policies, and the analysis of indicators of public policies for quality and safety in health measures is of the utmost importance. In the scope of the National Strategy for Quality in Health and which includes the National Plan for Patient Safety, in addition to the specific indicators, indicators were defined for monitoring the Quality of the entities of the National Health Service in 2015 and determined its quarterly disclosure. The methodology used was the documentary analysis as an instrument of public policies, based on the analysis and comparison of the drawn graphs, from the national aggregated database accessible on the Central Administration of the Health System I.P. (ACSS) site, registered as having been extracted on December 12, 2017, accessed in 2018, by comparing 2016 and 2017 results and the indicators extracted from the OECD database for 2017. The graphs available on the ACSS website do not allow visualization of the evolution of the defined indicators as well as their quarterly disclosure. The collection of data depends on the sending of information by National Health Service units that still have a duty to advertise on their websites. On-going implementation and results of available indicators, pending notification by hospital entities, fall into the absence of an evaluation policy based on the establishment of a hospital network associated with benchmarking and incentives.
KEYWORDS: Indicators. Quality in health. Patient safety.

INDICADORES PARA MONITORAMENTO DA QUALIDADE EM SAÚDE E SEGURANÇA DO PACIENTE

RESUMO: Os desafios da avaliação de políticas estão relacionados com a medição dos efeitos das políticas, sendo de extrema importância a análise de indicadores de medidas de políticas públicas para a qualidade e segurança em saúde. No âmbito da Estratégia Nacional para a Qualidade na Saúde e que integra o Plano Nacional para a Segurança do Doente, para além dos indicadores específicos, foram definidos indicadores para a monitorização da Qualidade das entidades do Serviço Nacional de Saúde em 2015 e determinada a sua divulgação trimestral. A metodologia utilizada foi a análise documental como instrumento de políticas públicas, com base na análise e

comparação de gráficos elaborados, da base de dados agregados nacionais, acessível no site da Administração Central do Sistema de Saúde I.P. (ACSS), registado como tendo sido extraídos a 12 de dezembro de 2017, acedidos em 2018, comparando resultados de 2016 e 2017 e os indicadores extraídos da base de dados da OCDE para 2017. Os gráficos disponíveis no site da ACSS não permitem a visualização da evolução dos indicadores definidos bem como a sua divulgação trimestral. A recolha de dados depende do envio de informação pelas unidades de saúde do Serviço Nacional de Saúde que ainda têm o dever de publicitar nos seus websites. A implementação em curso e os resultados dos indicadores disponíveis, pendentes de comunicação pelas entidades hospitalares, recaem na ausência de uma política de avaliação assente na constituição de uma rede hospitalar associada a benchmarking e incentivos.
PALAVRAS-CHAVE: Indicadores. Qualidade em saúde. Segurança do doente.

1 INTRODUCTION

At the global level, patient safety is considered a serious public health problem, taking into account the magnitude of the occurrence of adverse events associated with the risk of irreversible damage and social and economic costs (WHO, 2002) [1].

Safety is the critical dimension of quality, the first critical step in improving the quality of health care (IOM, 2000, "Safety is a critical first step in improving quality of care"). About 100 people in the United States die daily due to health care damage, not their illness.[1] The commitment to patient safety around the world has been growing since the 1990s. This growth was motivated by two landmark reports, one previously referred to and "An Organization with a Memory," published in 2000 by the Chief Medical Officer from UK. Both acknowledged that the error is routine during health care and occurs in about 10% of hospital admissions.

In 2002, the World Health Organization (WHO) adopted Resolution 55.18., calling for States to intervene in the prevention of incidents related to health care, considering that many are preventable and cause enormous human suffering and enormous financial impact. In the European Union between 8% and 12% of hospitalized patients are affected by problems related to the health care provided during hospital stay. It is estimated that about 4.1 million patients were victims of health-care-associated infection, with 37,000 deaths. In June 2009, the Council of the European Union adopted a Recommendation on Patient Safety (2009 / C 151/01), including prevention and control of healthcare associated infections.

The aim of the analysis is to disseminate and share the analysis carried out on the indicators for quality monitoring in the health and safety of patients using two accessible databases, the Central Administration of the Health System (ACSS) IP and the OECD in 2017.

In the first part, the framework of the public health policies for quality and safety is presented and in the second part the methodology used followed by the analysis of indicators for Quality monitoring, within the scope of health units performance according to data base of OECD and the Central Administration of the Health System (ACSS) IP Finally, the conclusion.

2 INDICATORS FOR QUALITY MONITORING IN HEALTH AND PATIENT SAFETY

The National Strategy for Quality of Health 2009-2014 approved focused on incident reporting and control of health care associated infections (IACS) in the area of patient safety, in accordance with the Recommendation on Patient Safety (2009 / C 151/01. One year after the end of the Troika intervention, on May 17, 2014) was published the OECD Review on Quality of Care in Portugal (2015) and the National Plan for Patient Safety (NPPS) 2015-2020 which integrates the National Strategy for Quality in Health (NSQH) 2015-2020. This strategy has reinforced the previous one and its main mission is to empower and recognize the quality and safety of health care to guarantee the rights of citizens in their relationship with the health system.

In 2015, a list of indicators for Quality monitoring was also formulated within the scope of health unit performance, in addition to the indicators that make up the NPPS, and its quarterly disclosure of entities of the National Health Service (National Strategy for Quality in health). It is also important to emphasize the importance of reinforcing the information made available, making it extendable to the quality of care provided, reported in a broader and more mandatory manner so as to enable a better understanding of the NHS performance by citizens and communities, by strengthening mechanisms for transparency and accountability management and delivery.

It is incumbent upon the Central Administration of the Health System, I.P (ACSS) to publish on its website the quality indicators of the entities of the National Health Service (SNS) and the ACSS and the Directorate-General for Health, the semester evaluation of the need to revise the published indicators, and, whenever necessary, by means of previous and superior approval, issue, through normative circulars, guidelines on this subject to the entities envolved.

The main tasks of policy evaluation are to measure the results of public policies and, on the other hand, to formulate a value judgment, merit the effects of these policies according to the criteria and standards (relevance, effectiveness, efficiency, economy). The methodological challenges of policy evaluation are related to the measurement of the effects of policies, and the analysis of indicators of policy measures is of the utmost importance.

There is no evaluation policy based on the establishment of a network of hospitals associated with benchmarking and incentives. The implementation in place since the beginning of 2016 at the national level and the results of the available indicators are dependent on the notification of hospitals and there is no evaluation policy based on the establishment of a network of hospitals associated with benchmarking and incentives.

3 METHODOLOGY

This is a description and analysis of indicators for Quality in Health monitoring, using documentary analysis, namely through access to the database of the Central Administration of the Health System (ACSS) I.P and the OECD in 2017.

The data accessible on the ACSS website are recorded as national aggregate data extracted on 12 December 2017 and the charts available there do not allow the evolution of the indicators defined to be visualized. The data sources are the data reported by each business public entity (EPE) (except Psychiatric Hospitals) and public private partnerships (PPP) in the Information System for Contractual and Monitoring and the objects of hospital entities analysis. The data accessible on the ACSS website refer to the extraction on 12 December 2017 and the graphs available on its website do not show the evolution of the defined indicators.

The groups of hospitals (Group B, Group C, Group D and Group E) were determined by the ACSS, using hierarchical clustering after standardization of variables with cost explanatory capacity and principal componente analysis. The indicators of preventive interventions and the pediatric patients are not disclosed. Some indicators of volume and use are available in the ACSS care performance information, compartmentalizing the information in this specific area.

The indicators and the database of indicators of preventive interventions and the pediatric indicators identified in Table 1 are not disclosed. Some indicators of volume and utilization are available in the ACSS care performance information. The collection of data depends on the sending of the information by the health units of the NHS and should also be publicized on the respective websites of each hospital /hospital.

The OECD provided data from Portugal for 2015.

The table 1 shows the list of published indicators of preventive, safety, volume and use and pediatric interventions.[9]

Table 1 - Indicators Area.

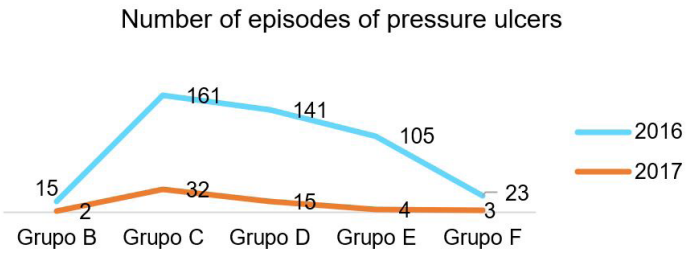
Area	Indicators
Preventive Interventions	Rate of hospitalization for angina Rate of low birth weight newborns Rate of hospitalization for asthma in young adults Rate of hospitalization for asthma or COPD in adults Rate of hospitalization for decompensated diabetes Rate of hospitalization for acute complications of diabetes Rate of hospitalization for chronic complications of diabetes Rate of lower limb amputation in patients with diabetes Rate of hospitalization for hypertension Rate of hospitalization for congestive heart failure Rate of hospitalization for pneumonia
Volume and Usage	Volume of repairs of abdominal aortic aneurysms Volume of resections of the esophagus Volume of pancreas resections Volume of carotid endarterectomies Volume of coronary artery bypass surgery (CABG) Percutaneous transluminal angioplasty volume of coronary arteries (PTCA)
Safety	Pressure ulcer rate Rate of bloodstream infections related to central venous catheter (adults and neonatal) Pulmonary embolism or postoperative deep venous thrombosis Post-operative sepsis Obstetric trauma in vaginal delivery with instrumentation Obstetric trauma in vaginal delivery without instrumentation
Pediatric	Rate of bloodstream infections related to central venous catheter Post-operative sepsis Asthma hospitalization rate Rate of hospitalization for acute complications of diabetes

Source: Accessible in https://www.dgs.pt/qualidade-e-seguranca/monitorizacao.aspx

4 RESULTS

The indicators provided by the ACSS were analyzed through the elaboration of graphs from the available database of ACSS and OECD. The ACSS data refers to procedures performed in adult services in the National Health Service and the indicators are presented for 2016 and 2017, the first two years of its implementation. The following graph shows very different values for the number of episodes of pressure ulcers in 2016 and 2017 in all Groups. On the other hand, the number of episodes of pressure ulcers presented a marked downward trend in all Groups of Hospitals.

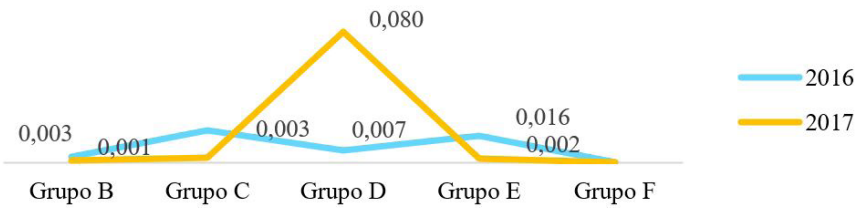
Graph 1- Number of episodes of pressure ulcers.



Source: Administração Central do Sistema de Saúde, I.P of data extracted on December 12, 2017. Accessed on 04-26-18 in http://benchmarking.acss.min-saude.pt/BH_SegurancaDashboard

The following graph shows a marked difference in values in Group D and E in 2016 and 2017. The report of the Program for Prevention and Control of Infections and Resistance to Antimicrobials states that the rate of infection of the bloodstream (ICS) associated with a catheter central venous catheter and 1000 days of central venous catheter is 1.7, while the following chart shows a different figure for all hospitals in 2017. Group D shows a marked increase in the infection rate in 2017 compared to the previous year and the other Groups shows a reduction in 2017.

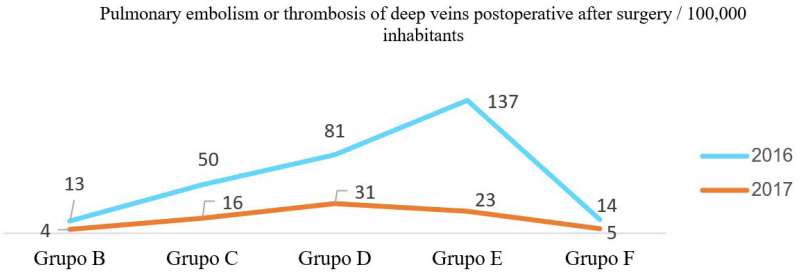
Graph 2 - Rate of bloodstream infections related to central venous cateter.



Source: Administração Central do Sistema de Saúde, I.P of data extracted on December 12, 2017. Accessed on 04-26-18 in http://benchmarking.acss.min-saude.pt/BH_SegurancaDashboard

In the different Groups, there are very different values in relation to episodes of pulmonary embolism or venous thromboembolism, with a notification to the ACSS in 2017, significantly lower than the results of 2016. In Portugal, it is the third with a global annual incidence of 100 to 200 per 100,000 inhabitants.

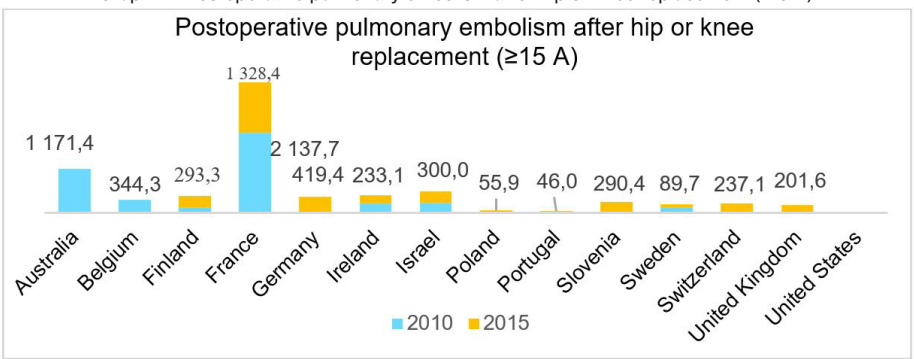
Graph 3 - Pulmonary embolism or deep vein thrombosis after surgery per 100,000 inhab.



Source: Administração Central do Sistema de Saúde, I.P data extracted on December 12, 2017. Accessed on 04-26-18 in http://benchmarking.acss.min-saude.pt/BH_SegurancaDashboard

The graph 4 shows the rate of postoperative pulmonary embolism after hip or knee prosthesis published by the OECD, showing 46 per 100, 000 discharges after surgery in 2015, the lowest rate in all countries.

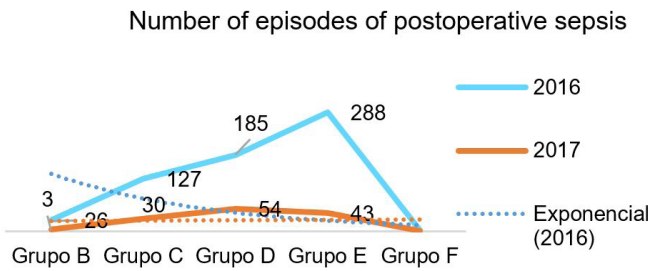
Graph 4 - Postoperative pulmonary embolism after hip or knee replacement (≥15 A).



Source: OECD Health Statistics 2017. Access the 2017 online on 04-28-18 in database em http://www.oecd.org/els/health-systems/health-data.htm

The episodes of postoperative sepsis registered in 2017 are much lower than those of the previous year, with Group E, the highest number of episodes, according to the following graph.

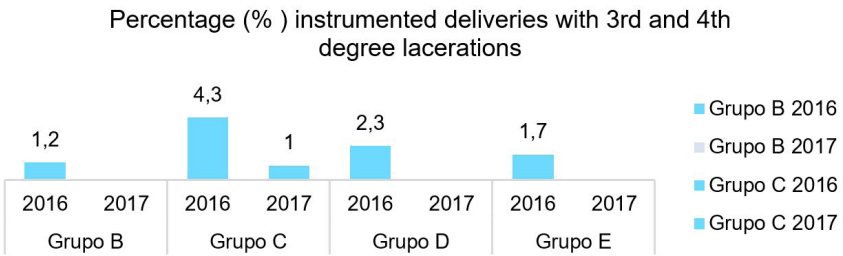
Graph 5- Number of episodes of postoperative sepsis.



Source: Administração Central do Sistema de Saúde, I.P data extracted on December 12, 2017. Accessed on 04-26-18 in http://benchmarking.acss.min-saude.pt/BH_SegurancaDashboard

There are no records of vaginal deliveries instrumented with 3rd and 4th degree lacerations in 2017, except for 1% in Group C, which presented the highest percentage of 4.3% in 2016.

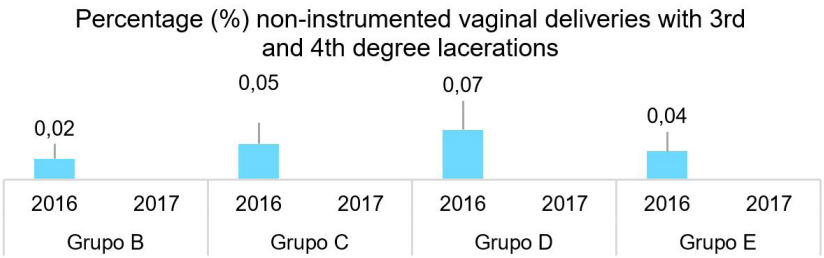
Graph 6 - Percentage of vaginal deliveries instrumented with 3rd and 4th degree lacerations.



Source : Administração Central do Sistema de Saúde, I.P P data extracted on December 12, 2017. Accessed on 04-26-18 in http://benchmarking.acss.min-saude.pt/BH_SegurancaDashboard

In 2016, Group D presented the percentage of 0.7%, followed by Group C with 0.5% of non-instrumented vaginal deliveries with 3rd and 4th degree lacerations. Data for 2017 are not available.

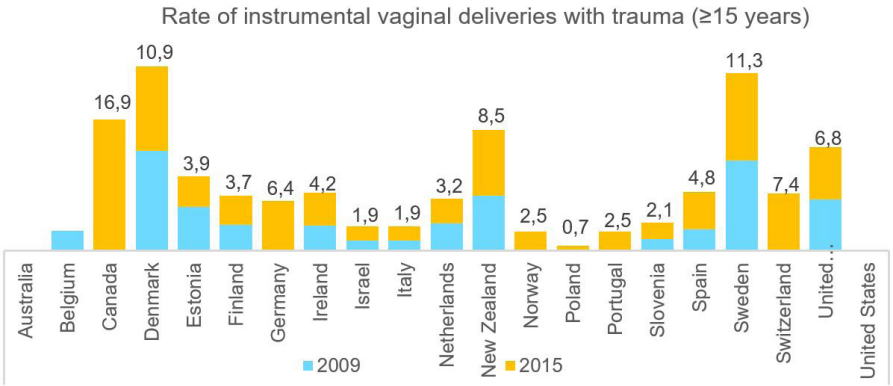
Graph 7- Percentage of non-instrumented vaginal deliveries with 3rd and 4th degree lacerations.



Source: Administração Central do Sistema de Saúde, I.P data extracted on December 12, 2017. Accessed on 04-26-18 in http://benchmarking.acss.min-saude.pt/BH_SegurancaDashboard

Portugal presented a rate of 2.5% of vaginal births instrumented with trauma for 100 births in 2015, with Sweden having the highest rate of 11.3%, followed by Denmark with 10.9% and New Zealand with 8.5 %, as shown in the following chart.

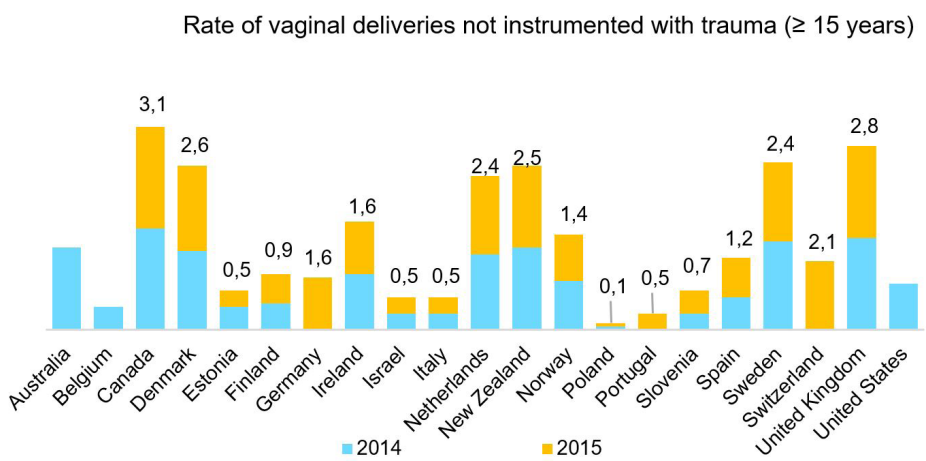
Graph 8- Rate of vaginal deliveries instrumented with trauma for 100 deliveries.



Source: OECD Health Statistics 2017. Access the 2017 online on 04-28-18 in database em http://www.oecd.org/els/health-systems/health-data.htm

According OECD, the chart 9 shows that in 2015, Canada had the highest rate of 3.1% of unassembled vaginal deliveries with trauma for 100 deliveries, followed by the United Kingdom with more than 2.8% and Denmark with 2,6% and New Zealand with 2.5%. Portugal presented a rate of 0.5% equal to that of estonia, Israel and Italy.

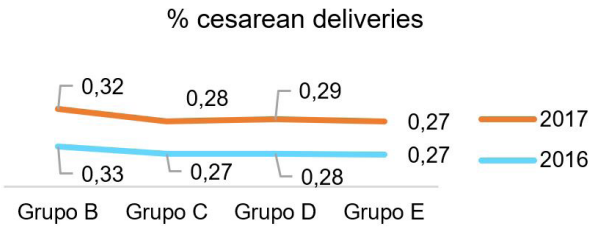
Graph 9 - Rate of vaginal deliveries not instrumented with trauma for 100 deliveries.



Source: OECD Health Statistics 2017. Access the 2017 data online on 28-4-18 in database em http://www.oecd.org/els/health-systems/health-data.htm

The percentage of deliveries by cesarean section declined slightly in 2017, with the exception of Group C and Group D. Group B presented a value above 30%, a limit defined in the context of contracting the ACSS, with a 15% recommendation from the World Organization of Health (WHO).

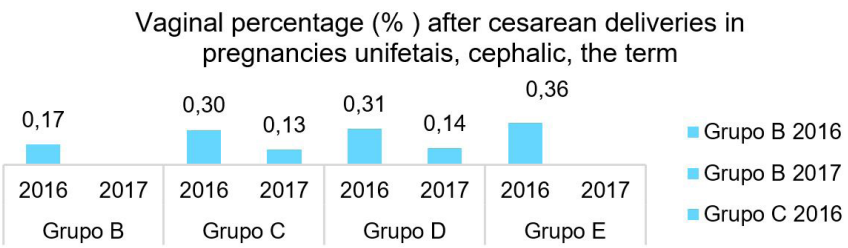
Graph 10 - Percentage of Cesarean deliveries.



Source: Administração Central do Sistema de Saúde, I.P. Benchmarking. Volume and use. Data extracted at 12-12-17. Accessed on 05-10-18 in http://benchmarking.acss.min-saude.pt/BH_DesempAssistencialDashboard

The percentage of vaginal deliveries after cesarean section declined in 2017 to below 15% in Groups C and D, as can be seen in graph 11.

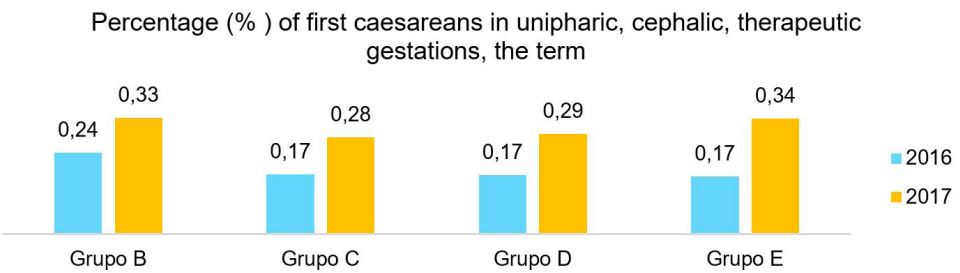
Graph 11 - Percentage of vaginal deliveries after cesarean section.



Source: Administração Central do Sistema de Saúde, I.P. Benchmarking. Volume and use. Data extracted at 12-12-17. Accessed on 05-10-18 in http://benchmarking.acss.min-saude.pt/BH_DesempAssistencialDashboard

According to the following graph, Group E and Group B presented in 2017 the highest percentage of first cesarean delivery, 34% and 33%, respectively. All Groups presented a significantly higher percentage in 2017 of first cesarean section percentage.

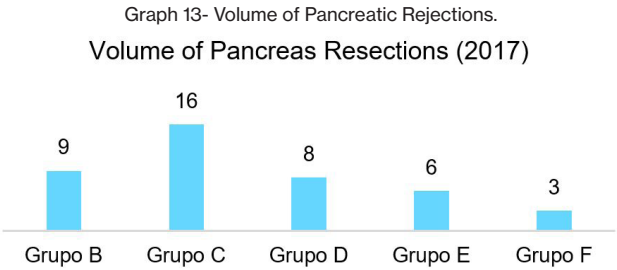
Graph 12 - Percentage of first cesarean delivery.



Source: Administração Central do Sistema de Saúde, I.P. Benchmarking. Volume and use. Data extracted at 12-12-17. Accessed on 05-10-18 in http://benchmarking.acss.min-saude.pt/BH_DesempAssistencialDashboard

The following graph shows the number of pancreas resections performed in 2017 at the National Health Service. The data from previous years are not available.

Graph 13- Volume of Pancreatic Rejections.



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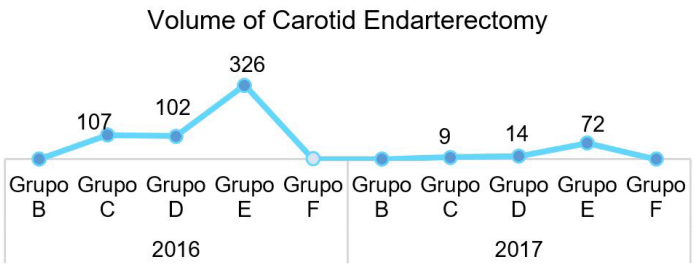
In the graph 14, it is verified that the volume of carotid endarterectomies decreased very significantly in 2017, with Group E presented 326 in 2016 and 72 in 2017, followed by Group D with 102 in 2016 and 14 in 2017 and Group C with 107 in 2016 and 9 in 2017.

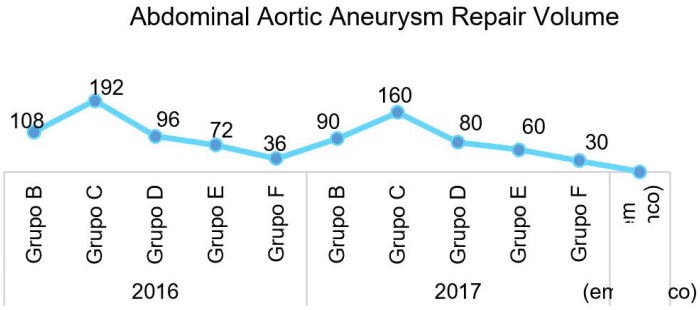
Graph 14- Carotid Endarterectomy Volume.



Source: Administração Central do Sistema de Saúde, I.P. Benchmarking. Volume and use. Data extracted at 12-12-17. Accessed on 05-10-18 in http://benchmarking.acss.min-saude.pt/BH_VolUtilizacaoDashboard

The volume of repairs of abdominal aortic aneurysms decreased in 2017 according to graph 15, with Group C performed 192 in 2016 and 160 in 2017, followed by Group B with 108 in 2016 and 90 in 2017, Group D with 96 in 2016 and 80 in 2017, Group E with 72 in 2016 and 60 in 2017 and Group F with 36 in 2016 and 30 in 2017.

Graph 15- Volume of Abdominal Aortic Aneurysm Repair.



Source: Administração Central do Sistema de Saúde, I.P. Benchmarking. Volume and use. Data extracted at 12-12-17. Accessed on 05-10-18 in http://benchmarking.acss.min-saude.pt/BH_VolUtilizacaoDashboard

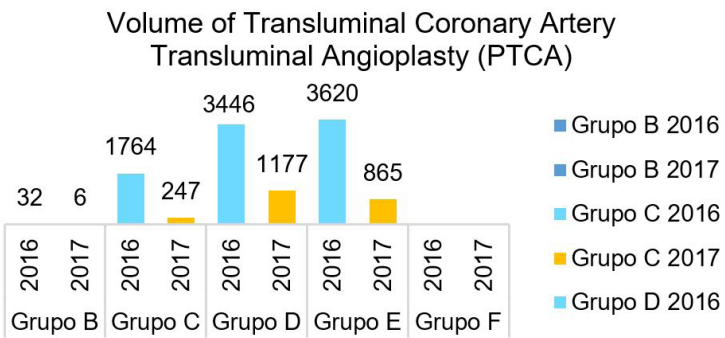
Graph 16 shows that in 2017, the volume of esophageal resections performed in 2017, with Groups E and F having the highest number performed (42), followed by Group D (39), Group C (19) and Group E (42).

Graph 16 - Volume of esophagus.

Source: Administração Central do Sistema de saúde, I.P. Benchmarking. Volume and use. Data extracted at 12-12-17. Accessed on 05-20-18 in http://benchmarking.acss.min-saude.pt/BH_VolUtilizacaoDashboard

The volume of Percutaneous Transluminal Coronary Artery Angioplasty (PTCA) decreased very significantly in 2017, according to the following graph. Group E made 3620 in 2016 and 865 in 2017, followed by Group D with 3446 in 2016 and 1177 in 2017, Group C with 1764 in 2016 and 247 in 2017 and the Group B with 32 in 2016 and 6 in 2017.

Graph 17- Percutaneous Percutaneous Transluminal Angioplasty of Coronary Arteries (PTCA).

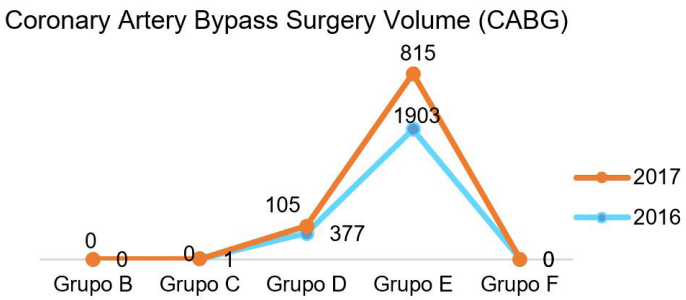


Source: Administração Central do Sistema de Saúde, I.P. Benchmarking. Volume and use. Data extracted at 12-12-17. Accessed on 05-10-18 in http://benchmarking.acss.min-saude.pt/BH_VolUtilizacaoDashboard

In 2017, Coronary Artery Bypass Surgery (CABG) volume increased significantly in Group D with 377 performed in 2016 and 105 in 2017 and in Group E with 1903 performed in 2016 and 815 in 2017.

No activity was observed in the Group C, Group B and Group F in 2016 and 2017.

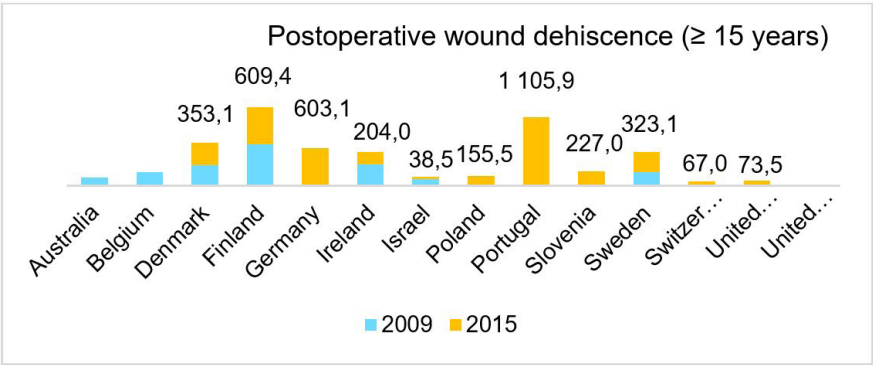
Graph 18 - Volume of Coronary Artery By-Pass Surgery (CABG).



Source: Administração Central do Sistema de Saúde, I.P. Benchmarking. Volume and use. Data extracted at 12-12-17. Accessed on 05-10-18 in http://benchmarking.acss.min-saude.pt/BH_VolUtilizacaoDashboard

OECD, through the Graph 19 shows that in 2015, Portugal had the highest rate of dehiscence of the postoperative wound (infection of the surgical site) per 100 000 discharges related to surgical admissions. The report of the Program for Prevention and Control of Infections and Resistance to Antimicrobials states that of the seven surgical procedures monitored by ECDC, the cumulative incidence of surgical site infection per 100 patients submitted to surgery presents 4.17% in 2017 and 4.93% in 2016.

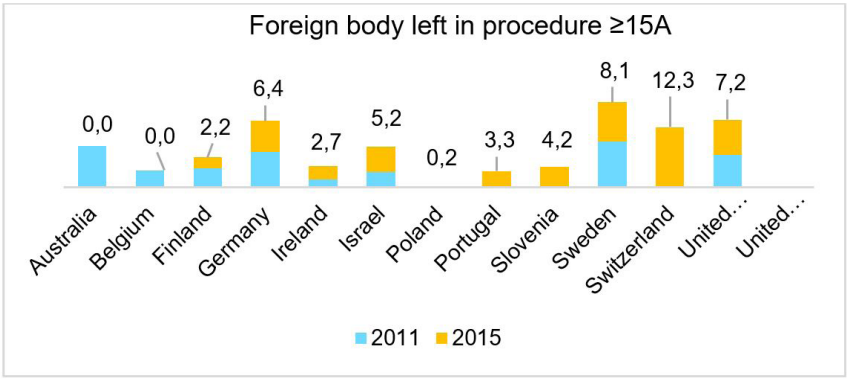
Graph 19 - Postoperative wound dehiscence.



Source: OECD Health Statistics 2017. Access the 2017 online on 04-28-18 in database em http://www.oecd.org/els/health-systems/health-data.htm

Regarding the foreign body left in the procedure performed, in 2015, Portugal presented a rate of 3.3 per 100 000 hospital discharge and a rate of 2.2 per 100 000 hospital discharges, being in the countries with the least number of this incident. Sweden had the highest rate of 4.2 per 100 000 hospital discharge and a rate of 7.7 per 100.000 discharges as seen in the following graph.

Graph 20 - Foreign body left in procedure (≥15 A).



Source: OECD Health Statistics 2017. Access the 2017 online on 04-28-18 in database em http://www.oecd.org/els/health-systems/health-data.htm

5 DISCUSSION

Indicators of preventive and pediatric interventions accordingly, as well as databases have not been disclosed until the end of 2018. Some volume and utilization indicators are available in Central Administration of the Health System I.P. (ACSS) health care performance information.

Data collection depends on the information being sent by the National Health Service units and should also be publicized on their websites.

The ongoing implementation and results of the available indicators, subject to notification by hospital entities, is in progress in the absence of an evaluation policy based on the establishment of a hospital network associated with benchmarking and incentives.

Not ignoring that reporting is dependent on hospitals, a significant improvement in some indicators was noted in 20016 and 2017, namely the number of episodes of pressure ulcers, incidence of pulmonary embolism or deep vein thrombosis after surgery per 100 000 inhabitants, the number of episodes of postoperative sepsis, the carotid endarterectomy volume. Some indicators show no improvement as the percentage of cesarean deliveries and the percentage of first cesarean.

According to the OECD, the 2015 indicators show that Portugal has the lowest rate of postoperative pulmonary embolism after hip or knee prosthesis, the fourth lowest rate of vaginal deliveries instrumented with trauma, the second lowest rate of vaginal deliveries not instrumented. with trauma third rate lower foreign body left in procedure but highest rate of postoperative wound dehiscense.

The results achieved have the potential to allow hospitals to redirect strategies to achieve objectives according to the scientific evidence for each indicator.

6 CONCLUSIONS

Policy evaluation challenges are related to measuring policy effects, with the analysis of indicators of policy measures being of the utmost importance.

In addition to the indicators that integrate domestic public policies in 2015, the indicators for Quality monitoring were published, within the scope of the performance of health units, determines the quarterly disclosure of quality indicators of the entities of the National Health Service. The preventive interventions and pediatric interventions as well as databases are not disclosed. According to the hospitals notification, indicators were published for 2016 and 2017. The OECD provided data from Portugal for 2015.

The results achieved have the potential to allow hospitals to redirect strategies to achieve objectives according to the scientific evidence for each indicator.

At national level, there is no evaluation policy based on the establishment of a hospital network associated with benchmarking and incentives.

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SOBRE OS ORGANIZADORES

Jorge Rodrigues é economista. Licenciado, mestre e doutor em Gestão (ISCTE-IUL), com Agregação (UEuropeia). Mestre e pós-doutorado em Sociologia – ramo sociologia económica das organizações (FCSH NOVA). Professor coordenador com agregação no ISCAL – *Lisbon Accounting and Business School* / Instituto Politécnico de Lisboa, Portugal. Exerceu funções de direção em gestão (planeamento, marketing, comercial, finanças) no setor privado, público e cooperativo. Contabilista certificado. É investigador integrado no Instituto Jurídico Portucalense. Ensina e publica nas áreas de empresa familiar e família empresária, estratégia e finanças empresariais, gestão global, governabilidade organizacional, marketing, planeamento e controlo de gestão, responsabilidade social e ética das organizações.
https://orcid.org/0000-0001-7904-0061

Maria Amélia Marques, Doutora em Sociologia Económica das Organizações (ISEG/ULisboa), Mestre em Sistemas sócio-organizacionais da atividade económica - Sociologia da Empresa (ISEG/ULisboa), Licenciada (FPCE/UCoimbra), Professora Coordenadora no Departamento de Comportamento Organizacional e Gestão de Recursos Humanos (DCOGRH) da Escola Superior de Ciências Empresariais, do Instituto Politécnico de Setúbal (IPS/ESCE), Portugal. Membro efetivo do CICE/IPS – Centro Interdisciplinar em Ciências Empresariais da ESCE/IPS. Membro e Chairman (desde 2019 da ISO-TC260 HRM Portugal. Tem várias publicações sobre a problemática da gestão de recursos humanos, a conciliação da vida pessoal, familiar e profissional, os novos modelos de organização do trabalho, as motivações e expectativas dos estudantes Erasmus e a configuração e dinâmica das empresas familiares. Pertence a vários grupos de trabalho nas suas áreas de interesses.
https://orcid.org/0000-0002-7196-3838

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