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ATTENTION TO HIGH-RISK PREGNANCY: PATIENT SAFETY STRATEGIES

ATENÇÃO À GESTAÇÃO DE ALTO RISCO: ESTRATÉGIAS DE SEGURANÇA DO PACIENTE

ATENCIÓN A LA GESTACIÓN DE ALTO RIESGO: ESTRATEGIAS DE SEGURIDAD DEL PACIENTE

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Objective: to identify the patient safety strategies adopted by the multidisciplinary team in high-risk pregnancy. Method: descriptive, qualitative study conducted with the multidisciplinary team responsible for specialized care for high-risk pregnancy in a city in southern Brazil. The interviews took place in March 2020 and the results were grouped into thematic categories. Results: two themes were highlighted: safety in embracement and flow of care to high-risk pregnant women, represented by the role of primary and secondary care in assistance to pregnant women, early identification of risk factors and/or aggravations to pregnancy and guidelines for the safety of high-risk pregnant women, identifying the need for individualized multiprofessional care to the needs of pregnant women. Conclusion: strategies for the safety of high-risk pregnant women go beyond safety protocols and denote the need to adapt to the context of secondary care.

Descriptors: Patient safety. Pregnancy, High-Risk. Risk management. Patient care team. Health Services.

Objetivo: identificar as estratégias de segurança do paciente adotadas pela equipe multiprofissional na gestação de alto risco. Método: estudo descritivo, qualitativo, realizado com a equipe multiprofissional responsável pelo atendimento especializado à gestação de alto risco de um município do sul do Brasil. As entrevistas aconteceram em março de 2020 e os resultados foram agrupados em categorias temáticas. Resultados: evidenciaram-se duas temáticas: segurança no acolhimento e fluxo de atendimento à gestante de alto risco, representado pelo papel da atenção primária e secundária na assistência à gestante, com a identificação precoce dos fatores de risco e/ou agravos à gestação e orientações à segurança da gestante de alto risco, identificando a necessidade de cuidado multiprofissional individualizado às necessidades da gestante. Conclusão: as estratégias para segurança da gestante

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de alto risco ultrapassam os protocolos de segurança e denotam a necessidade de adaptação ao contexto da atenção secundária.

Descritores: Segurança do paciente. Gravidez de alto risco. Gestão de riscos. Equipe de Assistência ao paciente. Serviço de Saúde.

Objetivo: identificar las estrategias de seguridad del paciente adoptadas por el equipo multiprofesional en la gestación de alto riesgo. Método: estudio descriptivo, cualitativo, realizado con el equipo multiprofesional responsable por la atención especializada a la gestación de alto riesgo de un municipio del sur de Brasil. Las entrevistas tuvieron lugar en marzo de 2020 y los resultados se agruparon en categorías temáticas. Resultados: se evidenciaron dos temáticas: seguridad en la acogida y flujo de atención a la gestante de alto riesgo, representado por el papel de la atención primaria y secundaria en la asistencia a la gestante, con la identificación temprana de los factores de riesgo y/o agravios a la gestación y orientaciones a la seguridad de la gestante de alto riesgo, identificando la necesidad de cuidado multiprofesional individualizado a las necesidades de la gestante. Conclusión: las estrategias para seguridad de la gestante de alto riesgo sobrepasan los protocolos de seguridad y denotan la necesidad de adaptación al contexto de la atención secundaria.

Descriptores: Seguridad del Paciente. Embarazo de Alto Riesgo. Gestión de Riesgos. Grupo de Atención al Paciente. Servicios de Salud.

Introduction

The safety of health care has always been a concern of professionals. Hippocrates (460-370 BC), described it as a principle for the exercise of medicine *Primum non nocere*, which means first do not cause harm. Florence Nightingale, entitled the forerunner of modern nursing, stated as the first duty of a hospital not to cause harm to the patient, leading the organization of nursing and support services with a focus on reducing infections. From the principles listed by health sector scholars, the concern with quality and the need for care that values the integrity and safety of the patient has become intrinsic to care provision[1-2].

Concern for Patient Safety intensified with the publication of adverse event rates by the United States Institute of Medicine and solidified from the World Alliance for Patient Safety, 2004, which aimed to define and conceptualize Patient Safety, in addition to highlighting measures to reduce risks and mitigate adverse events[1]. In this perspective, patient safety was defined as the reduction to an acceptable minimum of unnecessary harm associated with health care and, in turn, an adverse event, considered an incident that resulted in damage to health[1].

The National Health Surveillance Agency (ANVISA) in partnership with the Pan American Health Organization and the Ministry of Health's Department of Health Assistance (SAS) have been working in Brazil with the Global Challenges for Patient Safety. The global challenges are: Correct identification of patients; Effective communication; Improve safety in prescription, use and administration of medicines; Ensure surgery in place of intervention, procedure and correct patients; Hand hygiene against possible infections; Reduction of risk of falls and pressure ulcers[3].

In order to align the actions in a systematic way in achieving the goals, the Ministry of Health, through Ordinance 529, of April 10, 2013, established the National Patient Safety Program (PNSP)[4]. Concomitantly, it also launched protocols with the aim of determining good health practices related to the points of attention identified in the goals, to be implemented at all levels of care, although they have a more focused approach to hospital care[5].

It is known that hospital care concentrates the largest number of invasive procedures; however, in order to achieve the global goals, it must be reflected on the applicability of protocols in primary and secondary care. Maternal and child health care is one of the priority areas of action in the prevention of diseases and complications,

compatible with the concepts of adverse events, reinforced by the collective effort to reduce maternal and child mortality rates[6].

Maternal mortality, the main complication in assistance to pregnant women, is defined as the death of a woman within pregnancy or postpartum regardless of the duration or location of pregnancy, due to some related cause or aggravated by pregnancy[7]. Considering that a large part of the causes of maternal death can be avoided, the State Department of Paraná implemented the *Mãe Paranaense* Network in order to reduce maternal mortality, in addition to a more comprehensive and effective care for women[8].

The *Mãe Paranaense* Network Guideline analyzed the main causes related to maternal mortality and established the Risk Stratification of pregnant women and children as a guiding question of the care provided to maternal and child health. They are: the Habitual Risk, Intermediate Risk and High Risk, the latter being subdivided into categories of pre-existing clinical condition and clinical complications[8].

High-risk pregnancy is the condition in which the life of the mother, fetus and/or newborn is at risk due to psychosocial, physical and biological factors[9]. Given this theme, the need for the organization of the care flow and the systematization of comprehensive care to pregnant women is evidenced, since the main causes of maternal mortality can be avoided. In addition, communication between health care networks should be effective for the proper functioning of care, which goes back to issues related to secure communication and correct identification, among other goals of the World Alliance, as a subsidy for ensuring patient safety[6].

Therefore, since patient safety aims to reduce the damage that directly affects the disease health process[1], its applicability is essential for high-risk pregnant women to be fully assisted, in order to explore its biopsychosocial factors, and thus receive in an integral manner the care offered which reinforces the need for research on the subject so that assistance to this public is monitored.

In this interim, the question that surrounds is to understand whether professionals working in health care of high-risk pregnant women understand and apply patient safety protocols? Therefore, this study aims to identify the patient safety strategies adopted by the multidisciplinary team in high-risk pregnancy.

Methodology

This is a descriptive-exploratory study, with a qualitative approach, conducted in the outpatient clinic of specialized care for high-risk pregnant women in a city in southern Brazil. The institution aims to provide specialized multiprofessional care of secondary care for pregnant users of the Unified Health System, being a reference for 28 municipalities. To this end, this institution was chosen to provide assistance to pregnant women stratified as high risk, guided by the guidelines established in the Guiding Line of the *Mãe Paranaense* Network[8].

The sample consisted of members of the multiprofessional team who work in the assistance to the pregnant woman. The service had 10 professionals, being the specialties: obstetrician, resident doctor in gynecology and obstetrics, nursing, psychologist, nutritionist, physiotherapist and social assistance. The sample was premeditated according to the following inclusion criteria: work in the service for at least six months, considering the time required for the knowledge of the protocols and routines of the sector. The exclusion criteria adopted were: absence from the service during data collection due to vacation or any type of leave. Under these conditions, the sample consisted of eight participants.

Data collection was carried out in March 2020, through recorded interviews and guided by the question: "Tell me what are the safety strategies adopted in the care of high-risk pregnant women", in addition to support questions for deepening and understanding the performance of the team before the care of high-risk pregnant women.

The interviews were transcribed in full and analyzed using the Bardin reference and its Thematic Content Analysis, respecting the stages of pre-analysis, exploration of the material and treatment of the data, which culminates in the inference and interpretation of the findings through thematization of the analyzed content[10].

The results are presented through excerpts of the discourses. It should be noted that the language tics and/or repeated terms were removed, without changing the meaning of the speeches. To facilitate comprehension or to suppress parts of the testimonials, terms or phrases were added in brackets. Participants were identified through their profession.

Before starting the interview, the professionals were guided about the objective of the study, methodology, risks and benefits to which they would be exposed if they agreed to participate in it, signed the Informed Consent Form (ICF). The study respected all ethical aspects according to Resolution N. 466/2012 of the National Health Council (CNS - *Conselho Nacional de Saúde*) and was approved by the Ethics Committee of the *Universidade Estadual do Paraná* (UNESPAR), under opinion N. 3.902.242.

Results

Interviews were conducted with two nurses, a doctor, a resident in gynecology and obstetrics, a psychologist, a physiotherapist, a social worker and a nutritionist, who make up the team of specialized care service to high-risk pregnant women. In the content analysis, two thematic categories emerged: "security in the embracement and flow of care to high-risk pregnant women" and "guidelines for the safety of high-risk pregnant women", discussed below.

Security in the embracement and flow of care to high-risk pregnant women

The flow of care to pregnant women begins in the basic health unit (BHU), with the discovery of pregnancy and the identification of risks, based on pre-established national protocols, in order to ensure the safety and quality of care provided. In this sense, the importance of early risk identification and secure communication between the health care network (HCN) is highlighted, as reported in the excerpts below:

> *They make a risk stratification there in the BHU and refer to the high risk, if it's high risk or intermediate risk, and if it's low risk, they stay in the BHU, in primary care.* (Physiotherapist).

> *The patient usually takes the pregnancy test, finds out that is pregnant, and goes to the health center, the primary care doctor, usually clinical doctor, he will assess the whole situation.* (Doctor)

> *The pregnant woman is stratified in the basic health unit, first. She indeed comes here. Comes with the card and her risk.* (Nurse 1).

> *This patient is stratified there in her health post, there in the BHU of her municipality and when she is from Paranavaí, in her territory, in her neighborhood. She comes with this stratification at hand.* (Social Worker).

> *She is referred by the basic health unit, already classified as high or intermediate risk, so when she gets here, she is usually normally embraced, with the obstetrician's team, nurses and such.* (Psychologist).

> *Because sometimes some stratified pregnant women come wrongly, some mainly from glycaemia, the doctor sometimes thinks that she has gestational diabetes and it's not, and then the doctor puts in the care plan.* (Nurse 2).

While the high-risk pregnant woman is inserted in prenatal care, the need for safe and effective communication is evidenced, in order to elucidate her flow within the care network.

> *If she is low-risk, we advise her to return to the BHU, for normal prenatal care and, in case of any complication, any change during this prenatal care, she is forwarded and we stratify her risk again.* (Doctor).

> *When the patient is stable, she returns to the low-risk level, she returns to her BHU, when she is stabilized and always making it clear that the doors will always be open, if there is an altered exam in the second trimester, she can always return.* (Social worker).

Safe and quality care corroborates the prevention of morbidity and mortality of the binomial, in order to meet the needs of each pregnant woman. Thus, individual multidisciplinary consultation allows the recognition of risk factors from the perspective of each professional, according to their theoretical and scientific training, as referred to in the interviews below:

> *In the first consultation all professionals of the team see her and from the second consultation onwards she sees*

the obstetrician, the nursing staff and the professionals she feels greater need for, not necessarily all of them again. (Physiotherapist).

In the first consultation, all professionals see her, because each one will record data, as I can tell you, on that patient. Suddenly, I'm unable to find out everything about that patient who sees me, when she comes from another professional, she ends up discovering something that I couldn't identify in my consultation. (Social worker).

She's assisted by the doctor and after the medical consultation, she's referred to us, in our sector. So she sees the nursing, nutritionist, social worker, physiotherapist and psychologist. (Nurse 2).

The obstetrician evaluates the patient and forwards her to the team. First, she sees nursing, screening is carried out and she's forwarded to all professionals in the first consultation. From the second consultation onwards, screening is also carried out and forwarded to whoever is necessary. (Nutritionist).

In line with the multiprofessional methodology adopted by the team that performs the care of the pregnant woman, there is discussion of cases as a tool that allows the exposure of the various perceptions of professionals, enabling a holistic and quality care:

Every time we hold meetings with the team but, daily during the service, we have contact with the social worker, with the nurses, who are responsible for the program, so each patient who has some change that needs attention daily between doctors, nursing staff, social assistance staff, other specialists, sometimes we need follow-up with an endocrinologist, a rheumatologist, a psychiatry, so daily contact with professionals is discussed on a case-by-case basis and each patient is unique. (Doctor).

We also sit down with the doctor so we can discuss her case, so we have a very smooth communication, we have very open access to the doctors, they are good companions, they also do a nice job with us. It's quite interesting. Pregnant women are well cared for. (Nurse 2).

We make discussion groups depending on the case, if it's a case where we cannot follow the results or if there is resistance from the patient. Discussion groups are made and it remains there and is registered with the municipality, the case of this patient is informed to the municipality. (Nutritionist).

Safe communication, consultation using qualified listening, multiprofessional discussion and supporting pregnant women to safe choices can allow the reduction of morbidity and mortality and anxiety associated with their condition. Such procedures allow a safe embracement, highlighting the importance of methods for guidance based on pre-established scientific and normative evidence, as seen below:

Understand who she is, understand her risk and listening, mainly. I believe that this pregnant woman comes here and hears many things from many professionals. And sometimes here is a listening place, first of all, we listen to what she has to say, how she has been feeling. (Psychologist).

The patient arriving here is embraced in the gynecology sector where she is instructed, her preparation is done and advised that she needs to see a multidisciplinary team. (Nurse 2).

We evaluate the pregnant woman to establish the procedures so as not to advise things that don't assist that pregnant woman. (Nutritionist).

With the pregnant woman, we have to be a little more careful, because of all the hormonal changes happens in this period and just because she's coming here to the [...] *high-risk outpatient clinic, when they come here, they arrive scared and afraid of what will happen.* (Physiotherapist).

Safety guidelines for high-risk pregnant women

Health care during prenatal care should be structured according to the needs of each pregnant woman, providing comprehensive care to the woman. In this sense, the safety strategies adopted by the team consist of an individual assessment and guidelines appropriate to the reality of each patient, being essential for safe and quality care, from pregnancy to postpartum, as shown in the excerpts below:

The guidelines depend on the diagnosis of the pregnant woman, for us to establish the necessary conduct, if it's a pregnant woman who is diabetic: guidelines on what should or should not be consumed; if she's hypertensive, likewise; overweight, same thing. (Nutritionist).

High-risk and intermediate-risk patients will be placed within our protocols, suitable for each pathology she or her fetus has and will follow up with us. (Resident Doctor).

So we explain that it's not because she's at high risk now that she's going to have a whole high-risk pregnancy. (Physiotherapist).

Regarding the integral and individual assistance of women in pregnancy period, the importance of identifying the situation of early social and economic vulnerability is cited, allowing the development of a care plan articulated with other care networks, mainly related to social work:

What I guide the pregnant woman in relation to income is the organization while she has the baby in her womb [...] *we try to prevent this before, in the pregnancy, guiding her to seek all the rights that she has and is given to her by the law and when the time comes for her delivery, this*

> *pregnant woman has her house organized, in financial terms, to receive this baby.* (Social worker).

> *Pregnancy is sometimes unplanned, most pregnant women who come here don't plan pregnancy, but they accept it, so I tell them that care begins when they discover the pregnancy, that care for the child starts from their womb, not only after delivery.* (Nurse 2).

> *Understanding first who this person is, regardless of the pregnancy, who she is, the context she lives in, because that changes a lot, right, how her family is, the city she lives in, where she works, if she works, if she doesn't work,, to completely understand who this woman is in front of me* [...] *Sometimes it's not even a woman, it's a child.* (Psychologist).

Concerning knowledge and application of patient safety protocols, adaptation was observed according to the pre-established individual evaluation and the conduct to be taken by the multidisciplinary team:

> *Hand hygiene protocol, safe surgery protocol, prescription, use and administration of medications. In addition to these, there are our protocols that directly fit high-risk pregnant women, which would be protocols directed to each pathology, diabetes protocol, hypertension protocol, in addition to hygiene and medication.* (Resident Doctor).

> *Pressure ulcer protocol; fall prevention; medication safety, prescription and administration; safe surgery; hand washing; patient hygiene, both environment and personal hygiene, we are always guiding her in this regard.* (Nurse 2).

> *Hand washing, pressure ulcer, fall prevention* [...] *The correct use of medication; when they have a more advanced pregnancy: care with signs of childbirth, pain, if there is bleeding or not, always seek the hospital.* (Nurse 1).

Among the safety protocols applicable to high-risk pregnant women, the professionals highlighted in the reports the use of medicines in pregnancy, in which the guidelines on drug interaction are the importance of following the recommendations and correct use of medications:

> *We always instruct the pregnant woman to follow the doctor's advice for the medications that she's using, not to self-medicate, unless by medical order, on behalf of the baby.* (Nurse 1).

> *So about continuous and correct use and about returns, you can't go once and never go again. I can't say take more or take less, but look for a doctor if you need a second consultation. Here, when we realize the need, if this pregnant woman is not following the correct use of psychotropic drugs, then we refer her to the psychiatrist again.* (Psychologist).

> *There is a list of safe drugs for use during pregnancy and classified into B, C, D with the risks of the medication. So what ANVISA authorizes are the medications we prescribe for pregnant women.* (Doctor).

When analyzing the interviews, it is possible to affirm the importance of the guidelines related to the use of medicines for high-risk pregnant women:

> *But we guide a lot about the use of medication or the use of antihypertensive, insulin, we also have a many pregnant women, the patient has to take metformin and has to eat, she cannot remain without eating for a long time* [...] *The use of antibiotics because there is a lot of urinary infection, taking them correctly, at the right times, on the right days, because sometimes they take 4 days, the symptoms disappear, they think they are cured and they stop the medication.* (Nurse 2).

> *The medications we prescribe here are all based on scientific studies, no medication still under study or without harmless guarantee is prescribed. That's why our protocols exist, the protocols serve precisely as parameters for medications that can be used for certain pathologies.* (Doctor).

Another safety protocol, applied to the context of high-risk pregnant women, is the care that concerns the prevention of falls. Based on the risk established in the stratification, physical effort, bathing care and fall prevention are:

> *We work a lot with fall prevention, changing positions to avoid injuries, both in the spine and in the joints, which is something that changes a lot now during pregnancy.* (Physiotherapist).

> *We advise not to walk barefoot on the wet floor, we ask pregnant women who have difficulties or are overweight to always have someone with them, to remove the rugs from the house, not to leave furniture in the middle of the house, to avoid this type of fall. Bathroom too, have a rug or shower using slippers and always have someone around, bathroom door unlocked.* (Nurse 2).

Discussion

Given the excerpts of the participants, it is noted that the identification of the risk of the pregnant woman early ensures safety in the flow of referrals. In this perspective, late identification of obstetric risks may result in delays in interventions essential to minimize the risks of maternal and child morbidity and mortality. Therefore, the use of risk stratification is cited as a dynamic and individualized process that allows the recognition of immediate risks or health problems, and is a fundamental instrument for establishing the necessary conduct and referrals, in order to ensure adequate identification, safe care and to reduce preventable mortality rates[8].

A study that aimed to analyze risk stratification in prenatal care highlighted the importance of its use as a strategy for organizing obstetric care, however, it showed weaknesses of the health team during the completion of the instrument[11]. These results are in line with the inadequate stratification observed in the excerpt from Nurse 2, This indicates the need for greater training of primary care professionals in identifying risks through permanent education and secure communication between the multidisciplinary team and network.

In relation to the characterization of the risk situation, it is worth noting that although referral to other levels of care is recommended from the identification of risks, it is up to primary care to maintain the monitoring of women, since it is responsible for longitudinal care[12]. From the perspective of a defragmented health system, secondary care is the specialized complement of primary care, acting in the minimization of risk factors and/or resolution of health problems of the binomial, according to the individuality of each patient.[8] According to the Ordinance N. 1.020, of May 29, 2013, the health professional responsible for referring the pregnant woman to other health services should direct the same on the need of the link with primary care, highlighting the importance of integrating health services, as well as their safe and effective communication, providing quality care[13].

Concerning the interpersonal relationships of professionals, the importance of communication between the team is noted, since the construction of a shared care plan corroborates the multiprofessional practice. Moreover, it provides safe assistance in order to promote actions aimed at protecting the patient, with the minimization of adverse events and/or unnecessary damage to health[14].

Communication is a dynamic resource that improves interpersonal relationships, in order to elucidate, guide, prevent and develop actions that promote evolution, as well as obtaining knowledge. Within a health service, it is of paramount importance that the professional establishes effective communication between the team, network and patients in order to reduce the occurrence of errors and conflicts, in addition to providing qualified care and consolidating patient safety[15].

With this study, it was possible to identify a satisfactory multiprofessional communication of the institution, as well as the joint discussion of each case and the conduct to be taken. This strategy consolidates patient safety for high-risk pregnant women, since this theme is linked to tertiary care, which reiterates the need for the scope of this very relevant discussion.

The discussion of multiprofessional cases for the establishment of care goals is the strategy used in other areas of care such as intensive care. In this sense, this study aimed to promote the development of safety culture, as well as the achievement of patient safety goals, thus identifying that the provision of spaces for exclusive discussion for patient quality and safety among sectors that manage care was fundamental to promote safe care in the hospital[16].

The embracement can be characterized as an individual reception of the user in the health service, since their arrival, allowing their comfort in expressing their complaints, beliefs, individualities and insecurities. It should be a transversal process, in order to provide responsible, problem-solving and more comprehensive assistance, stimulating professional-user interaction, which contributes to the purpose of the service[17].

The gestational period implies a series of physical and emotional transformations to which the woman is susceptible, however, it manifests itself specifically for each pregnant woman. In this sense, embracement is fundamental, since it is necessary for the professional to establish a secure bond with the pregnant woman and a therapeutic relationship in order to elucidate the doubts and insecurities of this genuine process of the human being[18-19].

Adequate embracement, offered to high-risk pregnant women, corroborates the achievement of pre-established objectives, in which the woman feels safe with the assistance provided and directed to her need[20]. Therefore, it can be

stated that receptivity to pregnant women and their subsequent participation during prenatal care enable the identification of situations of vulnerability and contribute to safe and quality care.

When reflecting on the model of individual care plan, one should consider the individual characteristics of each woman, considering her biopsychosocial sphere and the context in which she is inserted, since such factors corroborate the probability of maternal morbidity and mortality. In this sense, the surveillance of these gestational risk factors should be constant, since comprehensive care to women provides safe and quality care[21]. To this end, the *Mãe Paranaense* Network Guide Line advocates the guarantee of access to Health in Secondary Care, from a multidisciplinary perspective and humanized assistance, respecting the individual aspects of each pregnant woman[8].

Maternal mortality is one of the public health problems in developing countries, being preventable in about 90% of cases[8]. A study that correlated social vulnerability to causes of death in the state of Alagoas identified that black/brown women with low education are more susceptible to maternal death. Furthermore, a predominance of deaths correlated with hypertensive disorders was observed, which reiterates the influence of social inequality on the health and development of the binomial[22].

Considering the physiological changes of women during pregnancy, the importance of adequate nutritional support is discussed, contributing to better living conditions, well-being and fetal development. However, Brazil is a country that, despite the establishment of several social programs, still presents socioeconomic inequalities that reflect the quality of life of many pregnant women[23].

Because it is a high-risk pregnancy, either by clinical conditions prior to pregnancy such as hypertension or diabetes mellitus, or by obstetric complications such as urinary tract infection (UTI), the use of drugs should be cautious, since it may be associated with prematurity, worsening of high-risk gestational status and teratogenicity[24].

For this, there is a classification system, determined by ANVISA for pharmacological use in pregnancy: Class A, safe drugs in pregnancy; class B, drugs without fetal risk in animals, but without studies in humans; class C, includes teratogenic drugs in animals, but without studies in humans; class D, drugs that provide adverse effects to the fetus, being able to assess the risk-benefit relationship; and class X, contraindicated for teratogenicity in humans[24]. Given the resident doctor's excerpt, it is observed that the team recognizes the risks associated with some medications and avoids their prescription as a way to mitigate adverse events.

In this sense, urinary tract infection (UTI) is a disease with high rates of occurrence in pregnancy, responsible for the increase of complications during pregnancy and puerperium, which justifies the indication of antibiotic therapy for UTI that should be performed after the individual evaluation of the pregnant woman, according to the recurrence of infection, sensitivity of the microorganism and urine culture[24].

Falls are classified as adverse events more complex to avoid, causing serious physical damage as well as psychological, such as feeling insecure and loss of self-confidence, as well as delayed recovery of the patient. Therefore, it is the responsibility of the multidisciplinary team to establish an effective communication with the pregnant woman, since pregnancy comprises a period of several transformations, requiring a constant adaptation of the environment in which the woman is inserted[15].

The Fall Prevention Protocol aims to minimize the occurrence of falls in patients at points of care. Despite being recommended to health institutions, the multidisciplinary team can adapt such measures in both the high-risk outpatient clinic and the reality of each pregnant woman, in order to expand the guidelines of a safe environment also for her residence. As an example, there is the fall risk assessment, requiring a daily company in emergency situations and the use of preventive actions such as the use of adequate footwear, an environment

free of obstacles and non-slip floors or free of fabrics[25].

Faced with a context of uncertainties that permeates the experiences of high-risk pregnant women, it is perceived that safety care goes beyond those indicated by the global goals for patient safety in order to cover in a holistic, humanized and multiprofessional way the health needs of women in the pregnancy cycle.

Conclusion

The safety strategies of high-risk pregnant women go through the consolidated protocols for patient safety and includes specific care for their safety in the flow of the Health Care Network and meeting their individual needs.

With regard to safety in the reception and flow of care to high-risk pregnant women, it is necessary to early identification of the risk of the pregnant woman, for risk stratification and necessary referrals. In this sense, there stands out the communication between the networks in order to promote safe referral and longitudinal care, as well as comprehensive assistance to pregnant women through the shared care plan, and allow the discussion of cases in order to systematize and individualize the assistance to the pregnant woman.

Thus, it is demonstrated the need for continuity of studies that aims to assess the attention of high-risk pregnant women, so that the continuation of care is offered in an absolute way, and this specific group is offered security during this period in which there are numerous adaptations and every moment will need monitoring in the care networks.

Although the present investigation presents geographical limitations, it was possible to identify the safety strategies of high-risk pregnant women, especially based on adequate information based on scientific evidence, the correct use of medications and fall prevention, which suggests the reflection about the adaptation of the other protocols to the context of secondary care, especially to high-risk pregnant women, providing safe and quality care.

Collaborations

1 – conception and planning of the project: Beatriz Sousa da Fonseca; Verusca Soares de Souza; Andréia Queiróz da Silva and Carlos Alexandre Molena Fernandes;

2 – analysis and interpretation of data: Beatriz Sousa da Fonseca; Verusca Soares de Souza; Andréia Queiroz da Silva; Heloá Borim da Costa Christinelli; Maria Antônia Ramos Costa; Carlos Alexandre Molena Fernandes and Taynara de Oliveira Farias Batista;

3 – writing and/or critical review: Beatriz Sousa da Fonseca; Verusca Soares de Souza; Andréia Queiroz da Silva; Heloá Borim da Costa Christinelli; Maria Antônia Ramos Costa; Carlos Alexandre Molena Fernandes and Taynara de Oliveira Farias Batista;

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