Identification of the patient in the achievement of safe practices: conceptions and practices

A Identificação do paciente no alcance de práticas seguras: concepções e práticas

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RESUMO

Objetivo: Avaliar as dificuldades, ações e estratégias realizadas pela equipe de enfermagem para alcançar a meta de segurança de identificação dos pacientes em uma unidade de internação de um hospital filantrópico. Método: estudo descritivo com abordagem qualitativa. A coleta de dados foi realizada de junho a julho de 2016, por meio de entrevistas, com roteiro semiestruturado, com vinte profissionais da equipe de enfermagem. Resultados: foram construídas três categorias temáticas: Identificação do Paciente: concepções, ações e dificuldades vivenciadas; Identificação do Paciente: riscos existentes; Estratégias para desenvolver a cultura de segurança do paciente. Conclusão: evidenciou-se a falta de cultura de segurança do paciente nos locais de estudo. Surge a necessidade de criar estratégias educativas que possibilitem uma melhor capacitação, planejamento e organização das ações, assim como as notificações de eventos adversos garantindo qualidade e segurança aos pacientes.

Palavras chave: Segurança do Paciente. Qualidade da Assistência à Saúde. Cultura Organizacional.

ABSTRACT

Objective: To evaluate the difficulties, actions and strategies carried out by the nursing team in order to achieve the goal of identifying patients in an inpatient unit of a philanthropic hospital. Method: descriptive study with qualitative approach. Data collection was performed from June to July, 2016, through interviews, with a semi-structured script, with twenty professionals from the nursing team. Results: three thematic categories were constructed: Patient Identification: conceptions, actions and difficulties experienced; Patient identification: existing risks; Strategies for developing a patient safety culture. Conclusion: the lack of safety culture of the patient in the study sites was evidenced. The need arises to create educational strategies that enable better training, planning and organization of actions, as well as notifications of adverse events, guaranteeing quality and safety to patients.

Keywords: Patient Safety. Quality of Health Care. Organizational Culture.

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INTRODUCTION

Patient safety is integrally related to quality in health services. Globally it has been discussed by government agencies, by the class entities and sectors that provide health services, aiming at quality and optimizing the results in the various services offered to society. Unsafe practice tends to persist in the healthcare and administrative processes of health facilities, making it the focus of discussions over the last decade[1,2].

Health institutions are investing in actions that value quality of care and seek to disseminate a culture of safety to patients, professionals and the environment, which are focused on the six goals recommended by the World Health Organization (WHO), the first of which consists of identification of the patient. When correctly performed, it prevents errors related to the care provided by the multidisciplinary team, at different levels of health care[2,3,4,5].

The correct identification of the patient is the process by which the patient is assured that he is assigned a certain type of procedure or treatment, preventing the occurrence of errors and mistakes that could harm him[6]. Identification has been present in the life of the citizen since birth. When they go to hospital, they become depersonalized, sometimes representing only a body carrying a certain disease and occupying a hospital bed. In health services, it is common practice among professionals, reference to patients by the number of the bed or by the illness that brought it to the service[7].

Misunderstandings in patient identification are worrying factors in health care, since incorrect identification induces a series of adverse events (AD), involving the administration of drugs and blood components, performing procedures or surgeries, incorrect and illegible data , among others[2,3,4,5].

In this context, in April 2013, the National Patient Safety Program (PNSP) was launched by the Ministry of Health (MS), which establishes protocols to meet international safety targets and establishes the creation of Patient Safety Centers in health services. health, aiming to reduce EA and increase the number of safe practices. Thus, health services should identify patients in a variety of ways, such as the use of bracelets, headboards, stickers on clothing and badges, and this is a responsibility of all multidisciplinary teams. In addition, with the launch of the PNSP, institutions need to adjust the devices from what is recommended by the protocol taking into account the patients' wishes[3,5].

Part of the assumption is that health institutions are developing programs with an emphasis on the responsibility of health professionals to correctly identify the patient. It is recommended to standardize the use of identification wristbands containing at least two qualifying elements and contraindicating room or bed numbers. However, a study points to the practice of several forms of identification and is still a neglected conduct by health professionals, especially in users with a long period of hospitalization. The education and awareness of health professionals are aspects that deserve attention, besides the construction of guidelines or protocols[2].

It should be noted that errors during patient identification can occur from the patient's entry into the care system, which may compromise the care process, triggering future damages. All professionals participating in patient admission, whether they are health professionals or not, should be attentive at all times. The identification process by means of the conference of the data of the devices and the information, being confirmed by the patient can and should be seen as an important step in the interaction between patient and health team[5].

In view of the above, the research question arises: how has the nursing team identified the patient to reach the safety goal? Based on this questioning, the following objective was formulated: Evaluate the actions and strategies carried out by the nursing team to achieve the goal of identifying patients in a hospitalization unit of a philanthropic hospital.

METHOD

This is a qualitative case study. The case study aims to analyze a social unit, seeking to answer "how" and "why" these phenomena occur. Therefore, it is ideal for organizational studies that seek to portray reality in a complete and profound way[8].

The research scenario was a teaching hospital located in the Zona da Mata of Minas Gerais, chosen because it is a reference place with comprehensive and medium complexity care, with risk management and patient safety strategies. It is a hospital linked as a Teaching Hospital and has Nephrology, Chemotherapy, Hemodynamics, Urgency and Emergency services, Adult Intensive Care Center type II. It offers hospitalization and emergency services for emergencies and emergencies to the population of the city and to a micro-region of eight municipalities.

The study population consisted of five nurses and 17 nursing technicians (total of the day and night nursing team) who worked in the medical and surgical clinic. The inclusion criteria were: to be a nurse or nursing technician in the units of Clinical Surgical and Medical Clinic that was not removed from the position for any reason, minimum time of bond in the institution of a year. One nursing technician was on leave and two did not meet the one-year minimum criteria. Therefore, the research participants were: five nurses and fourteen nursing technicians.

The choice to expand the sample to the nursing team was for the interest of understanding how the patients are identified under the perspective of these professionals, who have a training in the health area, and because they are the ones who spend more time in direct contact with the patients.

The data collection was carried out from June to July of 2016, through interviews, with semi-structured script, previously elaborated and tested by pilot test by the researcher. The pilot test was performed with two nursing professionals from another sector, with no need to change the questions, and were not included in the data analysis. The questions addressed: the importance of correct identification of patients, actions developed by the nursing team, the existence of training and records of identification errors. The interviews took place within the sector itself, in a reserved room, previously scheduled, which was configured in a favorable place for the participant to expose their experiences with tranquility and security. The statements were recorded with the authorization of study participants with a duration of approximately 30 minutes and later transcribed in full. To ensure the anonymity of the participants were referred to by the letters TE and E, respectively, preceded by the number of interviews.

In order to analyze the data, a content analysis technique was proposed which proposes three fundamental phases: pre-analysis, material exploration and treatment of results, inference and interpretation. Thus, initially a floating and exhaustive reading of interview questions was carried out, in order to interact with the text and obtain an understanding about what the subject sought to convey. He then proceeded to the exploration of the collected material, with categorization and, finally, the treatment of the results where the researcher tried to make them meaningful to the research, analyzed in light of the literature[9].

The research was developed respecting the ethical aspects, according to the Resolution 466/12 of the National Health Council and submitted to the Ethics Committee in Research with Human Beings of the Federal University of Viçosa, with opinion No. 1,512,189.

RESULTS AND DISCUSSION

In relation to sex, the female was predominant (70%), the age group found was between 22 and 53 years old. The training time ranged from 08 to 31 years. A daily work scale of 12 for 36 hours was identified. From the data obtained, it was possible to construct four categories of analysis: Patient Identification: conceptions, actions and difficulties experienced; Patient identification: existing risks; Strategies for developing a patient safety culture.

Patient Identification: conceptions, actions and difficulties experienced

Among the actions carried out by the research participants in the identification of the patient, were: Patient admission, data entry in the chart, identification in the bed, filling of own form at the nursing station and attention to treat the patient always by name and surname, as identified in the statements:

> *"[...] the nurse admits in the Systematization of Nursing Care. [...] we take the patient's name, the patient's name stays in the chart, and every time, the technicians are instructed as soon as they approach the patient, to ask for their name." (E3)*
>
> *"[...] I consider it important because it is a fact that if it is not revealed, it can have serious consequences, it can medicate a wrong patient, take a wrong patient to make an examination, a surgery. So, identification is the basis of everything." (E2)*
>
> *"[...] everytime a patient gets checked in to our sector, they already come with this role of identification within the medical record, since they pass by the reception [...]. Some sectors such as C and D have the girls who are responsible for it, it's the ne! H caretakers, they do this function, but often in their absence or when we are replacing another patient in the sector, the technicians who put and even if the technicians do not put it on I also put it, but I'm always aware of that, of being identified or not."*

The participants' concern was identified with the correct identification of the patient, since it affects the nursing care and generates insecurity on the part of the team and the patients themselves. Research evidences that the identification of the patient has the purpose of determining with confidence the legitimacy of the recipient of the treatment or procedure and ensuring that the action performed is effectively what the patient needs. Failures during the identification phase of the patient may occur from the beginning, at the moment in which he / she enters the care system, not receiving the necessary attention, being able to cause errors in several moments of this process and consequently, failures in the following phases of care, being the primary identification in the guarantee of quality and safety of the service provided[5,7,10].

However, there was a report of not identifying the patient, justifying that in the room was only one patient or due to absence of errors:

> *"[...] I no longer have this custom of putting the name, but this creates more confusion in the infirmary, that can have some similar names even, [...]. That here in the apartments, as it is individual, we put the bed, the medication schedule and the route that will be administered." (TE4)*
>
> *"[...] we do the identification on the bed, at the time of the medication the same thing, we write down the*

room number and the patient's name, even if it is only that little bit of the name, but if it is to, if it is the SUS, for example, is more complicated, it's three in the same room or two in the room, it's good that you put at least a couple of names and the last name to make it easier, because you usually hospitalize a patient with the same name" (TE6).

"[...] I put the name on the bed, the name and the name of the medication. I do not always do this, but I always try to put it that way, I never made the mistake of making these things wrong, but I usually put it on the bed at the time of the prey. (TE2)

The reports show that the participants have little knowledge about the topic of safety in patient identification and lack of specific training. The identification of the patient does not prove to be a safe practice, and it is possible to change names in any procedure to be performed, for several reasons such as: inattention, tiredness, recent patient exchange and room change, but some recognize the subject as and feel the need to inform themselves and state that the hospital should encourage, encourage and invest in this subject, which demonstrates the interest of some in providing quality care and having a safe practice.

Some authors emphasize that it is indispensable to manage the working conditions of the professionals and the responsibility of the companies that provide health services, considering that the ethical occurrences or errors occur when the actions of the professionals are negligent, reckless or even performed without the proper technical skill or knowledge needed to achieve safe and quality nursing care[10].

Participants do not recognize a practice of training performed on the correct identification of patients, according to statements:

"I don't have any information, I don't know if there are any commissions connected. [...] it's a good question (Laughter)" (TE1)

"[...] sometimes, the hospital does not give that much importance. [...] they take the patient in, on our own account, trying to avoid anything, but it is a matter that should be more discussed, as it is of extreme importance." (E2)

"Identification (training)? No, not as far as I remember." (TE3)

It is common practice to consent to be the manager or coordinator of the sector, as the sole responsible for the search for knowledge, compromising the safe practice and increasing the possibility of occurrence of errors. Patient identification is important for the prevention of errors and complications resulting from the delivery of procedures, test results, medication, among others, to the wrong patient. The lack of adherence of the nursing team to the instruments of notification of the AEs indicates insufficient disclosure and clarification, lack of habit, insecurity and even resistance in changing the posture toward AEs[11].

The difficulties experienced by the participants to carry out the correct identification, identifies the work overload, interruptions and the lack of experience of the professionals.

Some survey participants reported overload, fatigue, and disruption. They affirm that it is possible to happen the error, but the identification minimizes the possibility of any type of failure, especially when associated to the difficulty of concentration at the time of carrying out the activities due to the interruptions of the work by several factors: telephone ringing all the time, people calling at all times, which can lead to distraction, resulting in error, according to the reports:

"[...] we have to be alert, I think that's why our heads are always tired when we leave here. We can have two patients and still feel as if there were twelve, cause it is tiring. Because we have a lot of things to think of and remember [...]"(TE 5)

"[...] through the identification you have a lower risk of making mistakes, cause we are all humans and make mistakes. [...] at the same time we are preparing medication, the phone is ringing, a colleague is asking questions, a patient's companion is calling for us, someone is screaming [...]." (TE1)

One study found that approximately 78% of incidents without injury and adverse events in patients were overloaded nursing work increased the number of days of hospitalization of the patients studied. It was demonstrated that the nursing work overload was also associated with an increased risk of mortality of the patients in the ICUs evaluated[12].

Another difficulty identified was the lack of experience of the professionals, lack of continuity of care, newly hired professionals and absence of supervisor on duty, which occurs frequently in the institution studied. Risk factors for the patient, as well as for the professional himself, brought in his reports a concern about possible flaws, which leave them insecure by appealing to their relatives, according to the statements:

"[...] it's good for the patient also if any family members are with them, alert, because we have been having many newbies and some things have been happening. During the night not so much, cause the crew that works the night shift has been working here for longer, have more experience and have more knowledge." (TE4)

"[...]I just don't know how to explain how it is, because I work at night, so we are not caught up on everything that is going on with the assistance, so there is no continuity and it gets harder [...]." (TE8)

In a study developed in a surgical center of a private hospital, it points out challenges to future professionals in all areas of training, being of great complexity and importance, in relation to the university's teachings, but also adequate training of the student. Traditional educational practice causes a mismatch between discourse and demands in human and vocational training. Thus, concomitant with the results of the present research, it is pointed out that teaching about patient safety needs to be expanded and deepened so that professionals take a practice according to protocols and recommendations of the World Health Organization. The insertion and the attempt to unify the Patient safety content is still a recent proposition in Brazilian schools, and is not part of the school objectives[13].

Patient identification: existing risks

According to the participants' statements, the existing risks related to the incorrect identification of the patients are related to the administration of medicines in an insecure way and to the accomplishment of surgeries and wrong diagnostic procedures.

With regard to the administration of incorrect medication, the following statements can be observed:

> *[...] eu já não tenho esse costume de colocar o nome, mas isso confunde mais é na enfermaria, que pode ter uns nomes parecidos mesmo, [...]. Que aqui nos apartamentos, como é individual, a gente põe o leito, o horário da medicação e a via que vai ser administrada. (TE4)*
>
> *"[...] I don't usually write the names anymore, but this makes it more confusing for people in the infirmary, as there are patients with similar names [...]. Here in the apartments, as it is a single room, we set up the bed, the medication time and the way it will be administered." (TE4)*
>
> *"[...] I have heard of people that have had their medicines swapped [...]. He swapped the medication, a medicine that was not for her, but for someone, so he administered the wrong medication" (TE10)*
>
> *"[...] Yeah, the name was different, it already came wrong from the pharmacy and they didn't check, and almost administered the wrong medication [...]." (E1)*

The care provided to hospitalized patients is complex and requires quality execution and does not cause harm to the individual. The professionals reported not having the habit of identifying the patients, relying on their abilities to memorize them in private clinics and also cited errors that could have been avoided with the proper identification of the patient.

Drug-related AEs extrapolate situations involving concentrated, high-vigilance drugs. Medication errors and adverse drug reactions are among the most frequent failures in health care, and it is important to highlight that these situations could often have been avoided in the three main phases of the medication process: prescribing, dispensing and administration, the which involve multiprofessional actions of medical, nursing and pharmaceutical teams, which could be avoided with the correct identification of the patient[7].

Another risk is related to the referral to perform surgeries and wrong procedures, which implies in the goal of safe surgery, as reported below:

> *"[...] The crew working in the sector ask for the patient not by name, but sometimes by the bed number or by saying something like: "get me Dr. Doe's patient". They ask by the doctor's name, and that is a huge problem that has already caused several issues." (E2)*
>
> *"[...] This one time the doctor asked us to get the patient that, in that case, had to get surgery on his leg, so they took the patient to get his chest drained, as the patient had pleural empyema, and nothing came out; they went to check and it wasn't the right patient, which cause a huge argument, cause back then, the surgeon said: "No, we have to fire this employee", and I intervened: "look, alright, the guy made a mistake, but you were the one that opened the patient. You stuck a tube in him without knowing who he was." (E3)*
>
> *"[...] Here in our sector, a patient was called to get a tomography, and it was supposed to have been another patient, and the patient that went down to get the tomography had nothing to do with it, and it was very hard to deal with this patient, to transport, handle, get him out of the bed. People questioned, and the person working at the image center confirmed that it was the right patient, and it was only when he got there that they realized that it wasn't. We've also had patients wrongly sent to the surgery unit [...]" (E2)*

The nursing professionals reported on the difficulties of interpersonal relationship between the health team, in the exchange of information, as well as the disregard and disinterest in knowing the patient and their real situation, and not performing the preanesthetic visit, which generated conflicts and unnecessary procedures.

An analysis of the knowledge of the WHO Safe Surgery Protocol by the Brazilian orthopedists in November 2012 in Rio de Janeiro on the use of the WHO Safe Surgery Protocol found that among the 502 orthopedic respondents, 40.8% reported having experienced the surgery experience in a patient or in the wrong place and 25.6% of them reported "communication failures" as responsible for the error. In all respondents, 36.5% reported not marking the surgical site before referring the patient to the surgical center and 65.3%, totally or partially ignoring the WHO Safe Surgery Protocol. Of these orthopedists, 72.1% were never trained to use the protocol[14].

Strategies for developing a patient safety culture

From the participants' statements, strategies were identified to improve patient identification and, consequently, patient safety, such as continuing education, teamwork with the patient's safety nucleus and the participation of the manager.

The following speech demonstrates how permanent education is indispensable in safe practice:

> *"It has, once a month has the continued education, there, one of the Nurses gives it. Then, he's based on that, identification, [...] asking for correct medication, to be able to administer." (TE4)*
>
> *"Ah, I think it's importantant, because like, it's safe for them and for us workers too, so I for sure think it's important [...]"(TE14)*
>
> *"We have once a month, we have kind of like a continuing education. Then every month is a do something, but are always emphasizing on this, on identifying the patient as soon as he/she arrives." (TE7)*

Some professionals have reported that lifelong education is an essential strategy for preventing errors because it brings knowledge and safety in the workplace.

Educational strategies and management actions improve adherence to patient identification. Research shows that results of analysis and monitoring of the indicator of adherence to patient identification, showing an increase in the percentage, from 42.9% to 57.8% between January and April 2013, to 81.38% to 94.37 % between September and December 2014, which was achieved through efforts to strengthen the safety culture in the institution, along with review of processes and adoption of protocols to prevent adverse events, including failures in patient identification[15].

Another strategy identified was teamwork with the NSP, enriching the team's knowledge with innovative information, emphasizing training, seeking updates, exchanging experiences, working to implant a patient's safety culture:

> *"[...] the CCIH has a ward that specifically mends with this, patient safety [...]. We did a very important training at Einstein there in São Paulo about patient safety, so Nurses are well trained in that regard. [...] Those who were would be multipliers for the others here in the institution." (E3)*

The above statement proves that the training is of paramount importance for learning and updating, as well as being a way that the administration has to support the safety culture of the patient as in the one going to SP, which was fundamental in the preparation of nurses, which would be responsible for disseminating knowledge.

The safety culture encourages professionals to be responsible for their actions through proactive leadership, in which the understanding is enhanced and the benefits are valued, ensuring impartiality in the treatment of AD, without taking punitive measures against the occurrence of the same due to a punitive organizational culture based on blame, can lead to the omission of reports of these events, making it difficult to construct an institutional culture focused on patient safety[1]. Promoting a culture of safety in the health system is a complex phenomenon and recognizing its importance and the impact of safety culture on organizations is imperative to develop any type of safety program[1, 16].

A survey carried out in the largest hospital in the public network of Fortaleza - CE, during the period of November and December 2012, allowed identifying and analyzing strategies to promote patient safety in the hospital context, which were listed by nursing assistants, related to the careful identification of the risks to which patients are subjected during nursing care, the incorporation of good practices in direct and / or indirect assistance and the identification of barriers and opportunities found to promote safety in the institution. Because of this, strategies such as upgrades, trainings, group studies are indispensable[11].

CONCLUSION

It was evidenced in this study many difficulties experienced by the nursing team interfering directly in the correct identification of the patient. It was observed that the working conditions reflect directly in the work process and that permanent education, teamwork with the core of patient safety and the participation of the manager are strategies that need to be strengthened to maintain the safety culture of the patient in the institution.

In order to change this reality, the team studied reports the need for updating, training, constant presence of managers and the hiring of human resources.

In order for the correct identification of the patient to occur correctly and effectively, it is necessary to support and mobilize senior management and workers. Regarding the limitations, the fact that the study was carried out in the Clinic Surgical and Medical Clinic is highlighted, which makes it impossible to express the reality of another hospital. It is recommended that further studies be performed to promote patient safety, focusing on patient identification.

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