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PATIENT SECURITY IN ADULT INTENSIVE THERAPY UNITS: PERCEPTION OF NURSES

Segurança do paciente em unidades de terapia intensiva adulto: percepção dos enfermeiros

Seguridad del paciente en unidades de terapia intensiva adulto: percepción de los enfermeros

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ABSTRACT

Objective: Analyzing the understanding of nurses of Adult Intensive Care Units on patient safety. **Methods:** a qualitative, exploratory, descriptive and cross study. Data collection was performed in March 2018 with 12 nurses from intensive care units of a public-private hospital in the interior of *Rio Grande do Sul*. **Results:** nurses understand that patient safety is not causing harm to patients, using tools to put into practice the same. The increase in the number of employees was one of the strategies listed to improve patient safety, medication errors are the most frequent and half of the sample is favorable to punishment in the face of an error. **Conclusion:** The nurses' understanding of the subject is adequate to the literature, however, it is necessary to develop a safety culture for a better understanding of the error and to promote patient safety.

Descriptors: Patient safety, Critical care, Comprehension, Nursing, Nurse practioners.

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RESUMO

Objetivo: Analisar o entendimento dos enfermeiros de Unidades de Terapia Intensiva Adulto sobre segurança do paciente. **Métodos:** estudo de abordagem qualitativa, caráter exploratório, descritivo e de corte transversal. Realizado em março de 2018, com 12 enfermeiros de unidades de terapia intensiva de um hospital público-privado do interior do Rio Grande do Sul. **Resultados:** os enfermeiros entendem que segurança do paciente é não causar danos aos pacientes, utilizam ferramentas para colocar em prática a mesma. O aumento do número de funcionários foi uma das estratégias elencadas para melhorar a segurança do paciente, os erros de medicação são os mais frequentes e metade da amostra é favorável à punição diante de um erro. **Conclusão:** o entendimento dos enfermeiros sobre o assunto está adequado perante a literatura, porém há a necessidade do desenvolvimento de uma cultura de segurança para um melhor entendimento do erro e para a promoção da segurança do paciente.

Descritores: Segurança do paciente, Cuidados críticos, Compreensão, Enfermagem, Profissionais de enfermagem.

RESUMEN

Objetivo: Analizar el entendimiento de los enfermeros de Unidades de Terapia Intensiva Adulto sobre seguridad del paciente. **Métodos:** estudio de abordaje cualitativo, carácter exploratorio, descriptivo y de corte transversal. Se realizó en marzo de 2018, con 12 enfermeros de unidades de terapia intensiva de un hospital público-privado del interior de Rio Grande do Sul. **Resultados:** los enfermeros entienden que la seguridad del paciente es no causar daños a los pacientes, utilizan herramientas para poner en práctica la misma. El aumento del número de empleados fue una de las estrategias enumeradas para mejorar la seguridad del paciente, los errores de medicación son los más frecuentes y la mitad de la muestra es favorable al castigo ante un error. **Conclusión:** el entendimiento de los enfermeros sobre el tema es adecuado ante la literatura, pero hay la necesidad del desarrollo de una cultura de seguridad para un mejor entendimiento del error y para la promoción de la seguridad del paciente.

Descriptores: Seguridad del paciente, Cuidados críticos, Comprensión, Enfermería, Enfermeras pacticantes.

INTRODUCTION

In 1999, the Institute of Medicine (IOM) published To Err is Human, which estimated that between 44,000 and 98,000 Americans died each year due to errors in health care, warning of the issue of safety.[1]

It is considered necessary to take actions to minimize these failures, contributing to adequate health care. One way to avoid errors is to develop a culture of patient safety, which requires that all workers take responsibility for their own safety and also for the safety of the patient, encouraging the identification, notification and resolution of these problems promote organizational learning.[2]

At the national level, the Ministry of Health instituted the National Patient Safety Program in 2013, with the objective of contributing to the qualification of health care, combining the implementation of the six patient safety goals.[2]

It is known that the hospital is a place where failures occur, including in intensive care units (ICUs), which is a critical area, with critically ill inpatients who require special attention and need intensive treatment to recover their health. [3]

Studies point out high numbers of errors related to nursing care in the ICU.[4-5] Good management of these errors by the nursing team and knowledge about patient safety is necessary in order not to cause harm to the patient.

Thus, nursing must provide safe care, identifying possible failures, providing a continuous search for solutions aimed at effective and safe care. The nurse being the leader of the nursing team must have knowledge and skills to disseminate and promote adequate and safe care.

Knowing the importance of the thematic referent, the objective is: to analyze the understanding of nurses in the Adult ICU on patient safety. Knowing what the nurse understands for patient safety provides a more conducive means for the dissemination of patient safety.

METHODS

Qualitative, exploratory, descriptive and cross-sectional study. Data collection was carried out in adult ICUs in a public-private hospital in the interior of Rio Grande do Sul during March 2018. The study sample consisted of 12 nurses working in these units.

The inclusion criteria used were: being a nurse for at least six months in the adult ICU and accepting to participate in the research. Exclusion criteria were: retired nurses, medical certificates, leave and / or vacation. Data collection was based on a semi-structured interview, which was carried out during the work period, with prior appointment, in a private room.

The nurses' statements were recorded with the aid of a smarthphone and the participants signed the free and informed consent form. The interview followed a script of questions: What do you understand by patient safety? How do you put patient safety into practice? What strategies could improve patient safety in your unit? What mistakes most happen in your unit? What is your opinion about punitive culture in the face of an error? The interviews were transcribed in full and randomly identified in order to maintain the anonymity of each participant. Nurses were identified as E1 through E12.

Data analysis was performed through Bardin's content analysis, composed of three distinct phases: pre-analysis, material exploration and treatment of the results obtained and interpretation.6 For the sake of clarity of the data, the number of nurses from the interviews.

This study complied with the determinations of the Resolution of the National Health Council No. 466 of 2012 with regard to research with human beings, having been approved by the Research Ethics Committee of the University of Caxias do Sul, under No. 2,433,350.

RESULTS AND DISCUSSION

After finalizing the exploration of the content of the interviews, conducted with the 12 nurses, five categories were identified concerning the objective: understanding patient safety, patient safety developed in practice, strategies for improving patient safety, most frequent errors and punitive culture in the face of an error.

Understanding patient safety

From the analysis of this category, the following subcategories emerged: patient safety as care technologies and patient safety as technical care. For the purposes of understanding, care technologies are conceptualized as light, light, hard and hard technologies, in which light technology encompasses the process of communication and relationships; hard light technology includes knowledge and structured knowledge in health disciplines; and hard technology is represented by material, such as equipment and other material resources.[9]

Of the 12 nurses interviewed, seven (58.3%) conceptualize patient safety as care technologies. This can be seen in the statements:

[Patient safety] is when you interact with him and transmit safety. (E1)
Patient safety can be used as a tool to minimize risks and prevent damage. (E2)

Five (41.7%) nurses state that patient safety can be understood as technical care. These statements can be observed below:

There are all the methods, techniques [...] to guarantee the patient's safety in relation to the care, medication, procedures, patient identification. (E7)
It goes from the medication part [...] you have to know what you are doing, perform the correct technique, you cannot do anything that can cause damage. (E8)

Patient safety developed in practice

From this category, three subcategories were revealed: auxiliary tools and actions to prevent errors for patients, patient identification for their safety and training for employees. Of the total number of nurses interviewed, 10 (83.3%) use tools and actions when implementing patient safety.

We have scales [...] our headboard is already painted with care risks [...] these instruments help in patient safety. (E8)
Always reviewing access, reviewing medical prescription, if the bars are elevated, if the patient is well accommodated. (E4)

One nurse (8.3%) uses patient identification and one (8.3%) applies training to employees. In addition, two (20%) of nurses who use actions and tools also believe that patient identification is an indispensable item in patient safety, as can be seen in the following statements:

Through the identification of the patient, who has a prescription on his bedside, with his name. (E7)
I always say to them: do nothing with doubt, and they are well oriented with that, if they have doubts they come to me and I explain. And I do a lot of training. (E3)

Strategies for improving patient safety

Based on this category came the subcategories related to the increase in the number of employees, more training for employees, improvement in physical structure, in addition to other strategies.

Of the 12 nurses, five (41.7%) believe that the increase in staff can improve patient safety:

I would put another nurse and nursing technicians in the unit. (E6)
There should be more qualified and committed nurses at the bedside. (E1)

Two (16.6%) nurses say that more training should take place, two (16.6%) say that a better physical structure would help improve patient safety and three (25%) believe that other strategies would improve patient safety in the units. In addition, one (50%) of the nurses who listed the improvement in physical structure also pointed out the increase in the number of employees as a strategy for improving patient safety:

I think technical capacitation, more frequent training, updates. (E7)
There is also a structural issue, there are ramps to pass, it should be without slopes and inclines. There is always the risk when transporting the patient from a grid to fall. (E12)

The other strategies cited by nurses to improve patient safety are related to the empathy that professionals should have at the time of care, about providing extended visits to the units and the security of access to the patient's electronic medical record:

We should put ourselves and the technicians as if we were the patient. (E4)
Also placing the family in help, having extended visits. (E9)
On the issue of electronic medical records ... all professionals who work in the hospital have access to the system, this is a little questioning if there should not be another barrier that would not let everyone have access to this medical record. (E2)

Most frequent errors

Among the most frequent errors, medication errors, pressure injuries, loss of invasives and other errors were revealed. Eight nurses (66.6%) say medication-related errors occur, two (16.7%) report pressure injury as an error and two (16.7%) report that loss of invasives and other errors happen in the units. It is noteworthy that seven (58.3%) nurses listed more than one of these errors. These errors were reported by nurses as follows:

Skin lesion due to the age of the patients. (E8)
Loss of probe mainly in neurological patient. (E2)
Medication errors, all, in general. Forgetting to turn on the pump, or the pump off by itself and the person does not see, does not pay attention, confuses ... here in the ICU they use the commercial name of the medication a lot, and the pharmacy dispenses with the generic name. (E12)

Among the other reported errors, bloodstream infection, lowered bed rails and some breakages of barriers stand out, as, for example, in the infection control protocol, when the employee stops using a necessary PPE or fails to perform simple actions safety measures such as hand hygiene. This can be seen in the statements:

We had two bloodstream infections as well. (E1)
[...] bed rails lowered in agitated patients, we always take one than the other. (E4)
I think there is a lot of breaking of barriers, according to the CCIH protocol, people forget to put on the glove, they do not clean with alcohol gel before medicating. (E11)

Punitive culture in the face of an error

Regarding the punitive culture, six (50%) nurses believe that punishment is beneficial for the professional who makes mistakes. This is observed by the statements:

In some moments it is beneficial, because through punishment it makes them aware of the process. (E10)
I think the culture could be more punitive. Sometimes mistakes happen and people don't speak, they end up hiding, you end up not knowing, so I think that little punishment is made. (E1)

T*he remaining six (50%) nurses are against punishment:*
I think that punishing an employee will not solve the problem. (E2)
We have to think well about the punitive culture, because the best way is to guide this employee, because if you punish him, he may not be honest in speaking next time. (E7)

The first category corresponds to the nurses' understanding of patient safety. The concepts presented by nurses are in accordance with what was exposed by the WHO, which defines patient safety as "the reduction to an acceptable minimum of the risk of unnecessary damage associated with health care".[8: 15]

It is clear that everyone understands that patient safety is not to cause harm to the patient. For this, it is necessary to apply the techniques correctly, be aware of them and have a communication and trust link between the professional and the patient. Thus, it is noted that in addition to technical care, care technologies are also combined with patient safety.

A study concluded that the union of care technologies in an organized manner and according to the patient's needs is effective for health care and patient safety.[9] When care is effective and brings good results to the service, it is said that care is of quality resulting from science, technology and the application of these in health practices.[10] Thus, it is also clear that, in addition to avoiding harm to patients, nurses indirectly talk about quality care.

The category of patient safety developed in practice refers to the way nurses put it into practice. They use documents, check lists, bundles and care protocols to promote patient safety. A study analyzed the practice of the nursing staff in the ICU and found that nurses also used these tools to promote patient safety, in addition to standardizing health care.[11]

Another emerging subcategory of the patient safety category developed in practice in the study is related to patient identification. It is noticed that the implementation of the first patient safety goal is an item used by nurses to keep the patient safe. Of the responses provided by the interviewees, only this goal was indicated, however it is believed that allied with the bundles, check list and protocols mentioned are included the other goals.

When implemented, each goal portrays an effective practice related to patient safety and together they promote safe care preventing the occurrence of adverse events in patients.

Finally, the last subcategory resulting from the patient safety category developed in practice concerns the training of employees as a way of putting patient safety into practice. According to nurses, the employee must have knowledge of the techniques he performs to keep the patient safe. Studies prove that the training and qualification of professionals provide positive results in care practices in addition to improvements in the quality of the service provided.[12]

In the category of strategies for improving patient safety, the increase in the number of employees was a subcategory that emerged as an improvement proposal for patient safety. Associated with it, there is a need for more training and capacity building for employees.

It is noticed that the limitation of human resources creates a state of alert for patient safety. Allied to this, there must be qualified and committed employees with the patient. The same study corroborates the idea of

professionals who are up-to-date and routinely trained as a strategy for improving the care provided.[12]

Still within this subcategory, having an adequate physical structure and facilitating care is also a way to improve patient safety. A study concluded that ICUs that provide good physical structure reduce stressful effects to professionals, facilitating care and promoting patient safety.[13]

Regarding the electronic medical record, it is clear that through the operating system used by the institution, all professionals have access to the electronic medical record of any patient. The access granted to the electronic medical record favors the occurrence of breaches of patient confidentiality and that there is a difficulty in establishing criteria on the access of patient information in their electronic medical records.[14]

Concomitant to this, the employees' empathy was listed as a strategy to improve patient safety and this is considered a virtue of the nursing professional. Nurses believe that when the professional puts himself in the other's place, the patient feels more secure and confident in his improvement process. A study concluded that there is a need for nurses to improve their humanization, as this will provide an improvement in the quality of care, consequently in patient safety.[15]

Finally, extended visits are part of the strategies for improving patient safety, as listed by nurses. Open visits in the ICU are known to improve the patient's clinical outcome. Extended visits favor the patient's well-being, leaving them more relaxed and secure emotionally and psychologically. Nurses understand that a close family member would assist in care and keep the patient safe.[16]

The other category concerns the main errors that happen in the units. Medication errors are the most frequent in the studied ICUs. There are errors of dilution, administration, schedule and forgetting to turn on the infusion pump. Several studies reveal that the main errors in the ICU are also related to medication.[4,17-18]

The errors that cause pressure injuries have decreased, according to nurses, but they still occur due to the profile of the patients, and finally, the errors regarding loss of invasives happen frequently, especially in neurological patients who are in constant agitation and delirium.

One study showed that the lack or delay in changing the position, as well as the patient's profile, can cause or accelerate the process of pressure injury formation, which is consistent with the report of the nurses in this study. Regarding the loss of invasives, some studies also point out these errors.[4,19-20]

Thus, it is noted that nurses listed care and operational errors and that these are also pointed out in other studies in ICUs. It focuses a lot on the error when it has gone through all the broken barriers, often forgetting to perform a retrospective and see where the system has failed.

It is perceived the need for permanent education with employees in relation to the topic, and mainly, the development of a safety culture in which professionals feel comfortable to communicate the error, providing a learning experience with the situation and proposing changes and improvements to so that the incident does not recur.

The last category refers to the punitive culture in the face of an error. It is noticed that half of the interviewees believe in a more contemporary approach, that of systemic thinking. This approach recognizes that making mistakes is human and realizes that safety depends on the creation of systems that anticipate errors and prevent them from happening, favoring learning from this.[21]

However, there is still a culture of punishment. In addition, they believe that when the employee is punished he is more careful not to make mistakes again. However, errors are often omitted for fear of being punished.

There is a need to create a culture of patient safety, seeking to understand the path taken by failures and not to punish the guilty. To err is human and professionals are liable to error, however the error is not in the person, but in the process. Punishment is not the solution to the problem, it is a means for the error to continue happening and it is intimidation for the professional who made a mistake.

CONCLUSIONS

Patient safety is a topic that deserves discussion and the interest of nurses in the subject is noticeable, which must be rethought and studied routinely by nursing teams.

ICU nurses understand what patient safety is, perform actions in their daily practices for patient safety, but they are closely linked in the operational part of care, failing to mention, for example, effective communication as a practice of safe care.

The strategies were well thought out by nurses. There is an engagement on their part to improve the service for the benefit of patient safety. As for the punitive culture, it is clear that many professionals still believe in punishment.

Institutions must have a careful and engaged look at the safety culture, as this can be an indicator of service quality. If there is an adequate safety culture, there is adequate care, the patient is benefited and there are positive results for the service. However, one must understand that the error is part of a system that fails and one must analyze the process, identify the moment when the failure occurred, learn from this error and prevent it.

The study presented as a limitation the nurses' short time for the interviews, since they were very requested in the units, in addition to the small population under study.

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