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INVOLVED IN CARE: AN ANALYSIS OF PATIENT SAFETY

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ABSTRACT: Current paper analyzes patient safety within the context of Primary Health Care and the involvement of the nursing team, patient and family in care process through a descriptive, exploratory and qualitative study conducted in 6 Family Health Centers in Sobral, Ceará, involving 15 professionals from different regions. Results showed the issue of a small team related to patients, a fact that causes dissatisfaction due to excessive workload. In addition, communication between professionals, patient and family was inconsistent and impaired the acquisition of autonomy and the co-responsibility of caregivers and users in the process of treatment, recovery and cure. Nursing should valorize the knowledge of those involved with care to promote new knowledge and allow people to empower themselves on their self-care.

KEY WORDS: Nursing care; Patient safety; Primary health care.

ENVOLVIDOS NO CUIDADO: ANÁLISE DA SEGURANÇA DO PACIENTE

RESUMO: Analisar a segurança do paciente no contexto da Atenção Primária à Saúde e o envolvimento da equipe de enfermagem, paciente e família nesse processo de cuidados. Estudo descritivo, exploratório, com abordagem qualitativa, realizado em seis Centros de Saúde da Família de Sobral, Ceará, envolveu 15 profissionais de distintas regiões. Os resultados mostraram o subdimensionamento da equipe em relação aos usuários, o que gera insatisfação com a carga excessiva de trabalho. Além disso, verificou-se que a comunicação entre profissionais, paciente e família foi inconsistente, o que dificulta a aquisição de autonomia e a corresponsabilização dos cuidadores e usuários no processo de tratamento, recuperação e cura. A enfermagem deve valorizar o saber dos envolvidos com o cuidado, a fim de promover novos conhecimentos, para permitir o empoderamento das pessoas sobre o seu autocuidado.

PALAVRAS-CHAVE: Atenção primária à saúde; Cuidados de enfermagem; Segurança do paciente.

INTRODUCTION

World Health Organization[1] (WHO) defines patient safety as a set of attitudes that control and prevent risks in patient care through assistance quality in health and the absence of preventable harm to a patient during the process of health care and reduction of risk of unnecessary harm with health care to an acceptable minimum. Consequently, the construction of a culture shares values, practices,

behavior and attitudes between service and professionals for the promotion of a culture of safety.

The Brazilian Health Regulating Agency[2] insists that safety culture is a set of activities, competencies and behaviors that determine a commitment with safety administration to replace blame and punishment by the opportunity of learning through one's faults to improve health care. Although patient safety is more associated with hospital milieu, adverse events also occur in Basic Health Care (BHC)[3,4]. A 2015 study evaluated inter-occurrences in care in BHC in Brazil and reported a 1.11% occurrence, of which 82% caused harm to patients [5].

The reorganization and strengthening of BHC in Brazil currently occurs through the Family Health Strategy (FHS) focusing on the family with repercussions on practices concentrated on the integrality of care and health promotion. Nursing integrates the multi-professional team with a high degree of complexity. However, the risks of its performance are only scantily mentioned in the literature [6,7].

Although recently there has been great concern with patient safety, research on basic care are still fledging[3,4,5,8], featuring technical productions of the Ministry of Health and studies developed in institutions of higher education [9,10].

One may ask: What is the involvement of nurses, patient and parent within the safety health care in BHC? Current study investigates the relationship between nursing care, involvement of patient/relatives/caregiver and patient safety.

METHODOLOGY

Current descriptive, exploratory and quality analysis demonstrates scantily known social processes related to special groups and builds new approaches, reviews and the establishment of new concepts and categories during the investigation [11].

The study was conducted in Sobral, a city in the northwestern region of the state of Ceará, Brazil, some 224 km from Fortaleza, the state´s capital city. The city has 11 districts, with total area of 1,729 km², or rather, 1.45% of the state´s territory, with 199,750 inhabitants, according to the 2010 census[12]. There are at present 63 Family Health Teams (FHTs), 40 Mouth Health Teams (MHTs), six Support Nuclei for Family Health (SNFHs) and three teams for home care, active in 36 Family Health Centers to guarantee full FHS attendance within the city and its districts.

Current study was specifically conducted in six FHCs and tried to investigate a significant and intentional sample [13,14] of health units featuring the central regions of the municipalities (Junco, Tamarindo and Pedrinhas), more peripheral regions (Terrenos Novos I and Vila União) and rural area (Jaibaras). Consequently, there was a great variability of professionals and users from different profiles and life styles. Participants were distributed as follows: one nurse from each of the six health units; two assistant nurses of FHC Junco, Terrenos Novos I and Pedrinhas; and an assistant nurse from FHC Vila União, Tamarindo and Jaibaras, totaling 15 professionals (6 nurses and 9 assistant nurses). Inclusion criteria of agents in current study were (1) assistant nurse belonging to the FHS team of the municipality of Sobral, (2) with a minimum 6-month service.

Current paper is a section of a master´s dissertation titled *Análise da Cultura de Segurança do Paciente na Atenção Primária à Saúde*, with research undertaken between March 2015 and April 2017. Data collection comprised documental research, semi-structured interview and non-participating observation, with a triangular design[15]. The method ensures richer and more valuable information from data collection, with a critical analysis and discussion on the object of current study. Information was organized and analyzed by the Content Analysis Technique[16].

Participants in the research were identified according to profession (nurse 1 – 6; assistant nurse 1 - 9). Research complied with ethical principles according to Resolution 466 of the 12th December 2012 of the Brazilian National Council, approved by the Committee for Ethics in Research of the Universidade Estadual Vale do Acaraú (UVA) by protocol 1.484.252/2016.

Data analysis produced two main thematic categories: Dimension of the Team and Patient Safety and Involvement of Patient and Family in Care. The former refers to nurses´ ideas and the latter comprises ideas from non-participating observation.

RESULTS

SIZING TEAM AND PATIENT SAFETY

Analysis of dimension tries to discuss the relationship between size of nursing team and patient safety from the point of view of health professionals. Nurses and assistant nurses were asked in the interview on the approximate amount of people attended per day. All replied that the number was varied since on certain days of the week, such as on Mondays, demand was greater than on other days. Two nurses stated by, as an average, they attended 20 patients per day; another replied 30 patients and three nurses said they attend to more than 60 patients per day. Two assistant nurses replied that they attended to about 35 patients; three attended approximately 50 patients and four attended more than 60 per day.

Participants´ perceptions with regard to the relationship between the number of professionals in the health unit and work demand are given below.

The health professionals stated:

> *"It´s something inhuman for one person to attend to 65 patients per day [...] relationship is not sufficient to assimilate the work load. At least there should be three teams, since the region is very large [...] I am not satisfied with such a work load"* (Nurse 1),

> *"[...] My work is at the counter, even though I have to solve other issues. [...] I know there is overloading. In basic care, nurses coordinate, there are social agents, one is accountable for the whole region, one has to know what´s happening, there is the promotion and prevention issues, a greater bond with patients, we have visits, all this brings about a great work load"* (Nurse 2).

> *"[...] there are places with a great number of people [...] there is something of everything [...] if one 're-divides' areas or if one had another professional [...] there would be more time for a better attendance."* (Nurse 3)

> *"ratio is unequal, isn´t it, since I am in charge of the documents [...] there are not enough people to do the whole work load."* (Nurse 4)

> *"[...] great demand and few professionals, but we have to face and solve these problems. We try to do everything even if we have to stay overtime, if necessary."* (Nurse 5)

> *"Many things to do by few people. Besides the demand of attendance at the 'PSF', all day long we welcome people; in the afternoon, people are scheduled. However, this is a reference unit, the region´s; therefore, if a problem occurs, we are going to attend to it and try to solve things. Work become more and more intense and crowded; besides attendance, there are other things we have to do"* (Nurse 6).

> *"I think a lot goes without doing [...] we are not enough since frequently we are occupied and other people need attendance [...] while collection of material is being done, others need have an injection, people want to measure their arterial pressure, other want their weight taken, all waiting for us to finish the task we are doing. We have a schedule to send tests. Frequently they are angry because they have to wait"* (Assistant nurse 1)

> *"The number of professionals, that´s the problem [...] They are insufficient to meet all the tasks. People desire more, but the system cannot bear it [...]"* (Assistant nurse 2)

> *"[...] enough professionals, professionals, there aren´t! In spite of everything, we do the impossible."* (Assistant nurse 3)

> *"There are few professionals to meet the demand. Overall, things are done, one moves a professional from here to help in another place, but there is always a gap and in the meantime people are not satisfied. We do this to cope with the work."* (Assistant nurse 4)

> *"Certainly the ratios are not good. An overload exists. We solve this, we solve that. We do this procedure and that one, and the queue is waiting. We are stressed while on the task."* (Assistant Nurse 6).

> *"[...] Few professionals to attend to all. Today was a maddening day [...] at times, the unit is full. At the counter, I am sure professionals are required [...] that´s it, [...] they complain since individual attendance was fast [...], we cannot give attention to one only while others are waiting too much. Other professionals are required to attend to people during a certain time."* (Assistant nurse 9)

INVOLVEMENT OF THE PATIENT AND FAMILY IN CARE

Within the context of an analysis on patient safety, another important dimension refers to the involvement of the patient and the family within the health care process. Non-participating observations were undertaken and the involvement patient/family/caregiver were identified during the stages of attendance, procedures and other activities.

Observations revealed that nursing professionals failed to explain to patients and kin the procedure being undertaken prior to, during and after, as a way for their involvement in care. Frequently care is addressed directly to the patient, excluding the caregiver within the process and shunning the holistic idea towards the assisted person. Both procedures are unfavorable for the culture of patient safety.

DISCUSSION

Since most health professionals state that they attend to a great number of patients on a daily basis and all insist on a great workload, the assistance demand reported makes one discuss that excessive overload may be associated to impairment in professional performance and lack of satisfaction.

Scientific evidence shows a positive bond between satisfaction in work and the quality in patient safety, favorable to the promotion of a safety culture[17]. Similar data[18] demonstrate that one of the factors that make difficult patient safety is the great assistance demand and the enormous workload, considered a great pressure which professionals have to endure.

The participants of current study insist on the need for more professionals in health units to better assist the population. Scientific data[3] identified that 31.4% of professionals suggest adequate increase in human resources to attend to demand.

An adequate number of professionals is paramount for safety care. The provision of human resources is an institutional responsibility and should take into account that an adequate number of professionals to attend to the needs of patients makes possible a decrease in patients´ risks[19].

Quantitative data may be retrieved from the literature. One study showed that for each patient added to the average load in nursing, there is a 7% increase in the mortality rate of patients, 23% in nurses´ burnout and 15% in dissatisfaction within the work milieu[20].

Observation of the work process by professionals was based on the aspect "reward, acknowledgement and positive reinforcement". Data from professionals reveal that nurses and assistant nurses are not acknowledged by the administration of the health unit for the work they do. They are not rewarded and they are not acknowledged financially for their work by the authorities. Further, they are not praised by the administration within the process of their professional work. Current study shows the weakness of the dimension satisfaction in the work milieu to guarantee a culture of patient safety in FHCs.

One should underscore the importance of communication with users and thus capacitating participation within the self-care process which is one of the factors that contribute towards safety. An essential requirement for the continuity of patient care and safety is the consistent communication between professionals, patients and kin[21]. WHO recommends initiatives to guarantee patient safety, such as the development of autonomy and co-responsibility of the patient/kin/caregiver within the treatment, recovery and cure process[22].

Therefore, safe care should not be limited to health service, but should be guaranteed at home and in community spaces. The administration model practiced within the NHS (SUS) has been introduced to focus on the supply of service rather than the needs of population health. The population in supply administration is restricted to the number of individuals, without any bond and co-responsibility between professionals and patients.

Consequently, the insertion of the administration model of population health is required through the organization of BHC basic macroprocesses according to risk stratifications (individual biopsychological and chronic conditions), through the elaboration of trustworthy diagnosis [23] and sharing information with those involved in safety care.

BHC is characterized by continuity and integrality of assistance[24]. The continuity of patients´ and family´s involvement in care safety should be underscored, making all responsible for safety, providing them with guidelines and establishing an effective communication between professional-patient-kin.

Patient´s participation, which should go through all safety areas and health care, includes knowledge on preferences, promotion of relationship with health team, elaboration of handouts for patient safety, establishment of counseling committees for families, formulation of policies and promoting changes[22].

At home, the family is essential to guarantee patient safety. Prevention of falls, one of the protocols to guarantee patient safety, shows how family support is basic for good results, especially for bedded patients or with walking difficulties. Similarly, preventive measures for the maintenance of skin integrity, when undertaken with the participation of the family, strengthen safety care and decrease harm.

Vincent and Amalberti (2016)[25] state that more and more families are administrating the complex task of care. A formal evaluation of financial, emotional and practical resources is essential for the coordination of care and the idea that the patient integrates the health team should be considered a need and not a mere idea. It actually represents benefits in terms of patient´s involvement, even though there are risks since they take on the responsibility on the organization and health care. They also become the locus of possible errors that would be attributed to professionals.

Giving and receiving health care should be an act of sharing and trustworthiness between patients and health professionals. Consequently, patient´s involvement and caregiver strengthens safety care[26].

FINAL CONSIDERATIONS

Current research achieved the aim of relating nursing care, satisfaction in work, communication between patients, kin and care givers and safety in assistance. Data show that there is a convergent relationship with other research works that analyzed patient safety in BHC.

Although nurses and assistant nurses have tried to absorb and contribute towards all the FHS attributions, the achievement of these activities goes through several difficulties that should be coped with. Lack of acknowledgement of work done, financial reward and support are indicated as causes of dissatisfaction within the work milieu, with possible implications in safety culture of patients in FHCs.

Several weaknesses in the work process have been mentioned, such as coincidence of activities; lack of privacy in certain procedures that require discretion; constant conflicts of interest between scheduled and repressed demand; time spent on individual attention versus time spent in waiting; less listening to and greater fragility of the professional-patient bonds; dissatisfaction of patients who frequently does not acknowledge the nurses´ task, producing a vicious circle.

Professionals experience stressing situations, emotional and physical deterioration increased by pressure, feeling of helplessness, frustration, despair and pain. Work seems to be a burden.

When nurses exercise their task, they should be valorized for their care so that they may promote new knowledge and increase empowering of the people under their self-care. Guaranteeing dialogue may better forward mobilization and autonomy of patients and care givers and also the prevention of risks and harm.

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