



## THE PROCESS OF PATIENT'S IDENTIFICATION AND ORGANIZATIONAL CULTURE: A REFLECTIVE ANALYSIS

### O PROCESSO DE IDENTIFICAÇÃO DO PACIENTE E A CULTURA ORGANIZACIONAL: UMA ANÁLISE REFLEXIVA

### EL PROCESO DE IDENTIFICACIÓN DEL PACIENTE Y LA CULTURA ORGANIZACIONAL: UN ANÁLISIS REFLEXIVA

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#### ABSTRACT

**Objective:** to reflect on the relationship between the correct identification process of the patient by the health team and the organizational culture of health services. **Method:** reflective analysis by critical reading of original scientific, national and international, articles, published between 2009 and 2014, selected via Virtual Health Library, as well as book chapters and relevant legislation. **Results:** the correct identification process is a component of quality care and is linked in the organizational culture, which involves values, behaviors and skills of managers, professionals, patients and caregivers engaged in promoting safe care. **Conclusion:** reflection on the correct patient identification must be based in the strengths and difficulties of protocol implementation by organizations and healthcare multidisciplinary team in order to overcome barriers, which will result in improvement actions of everyone involved in the care. **Descriptors:** Patient Safety; Patient Identification Systems; Organizational Culture.

#### RESUMO

**Objetivo:** refletir sobre a relação entre o processo de identificação correta do paciente pela equipe de saúde e a cultura organizacional dos serviços de saúde. **Método:** análise reflexiva realizada pela leitura crítica de artigos científicos originais, nacionais e internacionais, publicados entre 2009 e 2014, selecionados via Biblioteca Virtual de Saúde, além de capítulos de livros e legislação pertinente. **Resultados:** o processo de identificação correta é um componente da assistência de qualidade, estando alicerçado na cultura organizacional, a qual envolve valores, comportamentos e competências dos gestores, profissionais, pacientes e acompanhantes engajados na promoção do cuidado seguro. **Conclusão:** a reflexão sobre a identificação correta do paciente deve ser embasada nas potencialidades e dificuldades da implantação de protocolo pelas organizações e equipe multidisciplinar assistencial a fim de transpor barreiras, que resultarão em ações de melhoria de todos os envolvidos no cuidado. **Descritores:** Segurança do Paciente; Sistemas de Identificação de Pacientes; Cultura Organizacional.

#### RESUMEN

**Objetivo:** reflexionar sobre la relación entre el proceso de identificación correcta del paciente por el equipo de salud y la cultura organizacional de los servicios de salud. **Método:** análisis reflexivo realizado por la lectura crítica de artículos científicos originales, nacionales e internacionales, publicados entre 2009 y 2014, seleccionados a través de la Biblioteca Virtual de Salud, además de capítulos de libros y legislación pertinente. **Resultados:** el proceso de identificación correcta es un componente de la asistencia de calidad, estando cimentado en la cultura organizacional, la cual envuelve valores, comportamientos y competencias de los gestores, profesionales, pacientes y acompañantes ligado a la promoción del cuidado seguro. **Conclusión:** la reflexión sobre la identificación correcta del paciente debe ser basada en las potencialidades y dificultades de la implantación de protocolo por las organizaciones y equipo multidisciplinar asistencial, a fin de superar barreras, que resultarán en acciones de mejoría de todos los envueltos en el cuidado. **Descriptores:** Seguridad del Paciente; Sistemas de Identificación de Pacientes; Cultura Organizacional.

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INTRODUCTION

The quality of health care is related to the achievement of the proposed goals, to optimizing the planning and implementation of safe interventions provided to the patient, so that their satisfaction is reached. However, the definition of quality in the health area can be understood subjectively, due to the diversity of health services, work processes, policies and organizational structures.<sup>1</sup>

In the world, safe patient care has been a priority aspect of the quality of health systems of countries. Due to fault in health quality, called incidents are disclosed, which are characterized by events or circumstances that could have resulted, or result in injury to the patient. The incidents that cause harm to the patient are called adverse events (AEs), which are often caused by unintentional errors and violations of actions that are routine of institutions, but they are not malicious. Both errors as violations are performed by health professionals and especially for health services, the agents responsible for the organizational culture in which they live.<sup>1,2</sup>

To achieve the quality care assurance, patient safety must permeate the culture of organizations. Patient safety (PS) comprises reducing the acceptable minimum, within the health care context, risk factors unnecessary harm to the patient.<sup>2</sup> In this sense, actions should be taken, being able to generate data to identify contributing factors to the occurrence of incidents and AEs, the consequences for the patient and for the organization, implementing improvement actions.<sup>3</sup>

In Brazil, the National Health Surveillance Agency (ANVISA), through Resolution of the Board of Directors - RDC n° 36, 2013, shows a definition of safety culture, which refers to the set of behaviors, values and skills that show the commitment to the safety of health services, replacing the culture of punishment before the error by improving opportunity assistance through learning.<sup>4</sup>

The purpose of the safe quality care to patients covers all users of health services. In one study, there was a prevalence of 3% to 16% of AE patients suffering due to unsafe care in hospital hospitalizations. This situation was evidenced in both developed and developing countries; however, most of the data is from developed nations, be able to infer that, in developing countries, the data are more alarming.<sup>5</sup>

In order to reduce these data, significant occurrence for decades, the Joint Commission

International (JCI), in 2005, created the Patient Safety International Goals, which the first one is the correct identification of patients. This goal has a direct influence on other goals, which are: effective communication between health professionals; improvement in safety regulations, improvement in the use and administration of medicines; realization of safe surgery on surgical place, procedure, and correct patient; hand hygiene; and assessing the risk of falls and pressure ulcers.<sup>6</sup>

To achieve the safety goals, especially with regard to the correct identification of the patient, it is essential that health services adopt multidisciplinary work processes strengthened by the commitment of health professionals, ensuring an effective safety culture that reflects the quality of care.<sup>7</sup>

OBJECTIVE

- To reflect on the relationship between the correct identification process of the patient by the health team and the organizational culture in health care.

METHOD

Article originated in the discipline << Patient’s Safety >> of the Graduate Program in Nursing at the University of Brasilia/UnB.

It is a reflective analysis from critical reading of international and national scientific articles, and book chapters and relevant legislation, focusing on the theme of patient’s safety and organizational culture, in a context and broadly way referenced in discipline strictu sensu graduate programs in Nursing.

To deepen the reflection subject, a survey of scientific articles was held through the Virtual Health Library (VHL) by the following keywords: “patient’s safety”, “patient’s identification systems” and “organizational culture”; later, their combination was made, also in English, using the Boolean operator “AND”.

Articles published between 2009 and 2014, available in full and free, on the following topics were selected: patient’s safety, patient’s identification and safety culture, and reaching the object of this reflection.

First, the articles were selected by the titles, then reading the abstracts and, finally, the full text. The reverse search has been performed, using some references cited in the articles chosen.

After reading the studies, there was an evidence of close relationship between the patient’s identification process by the health

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team and the influence of organizational culture in the development of safety culture in health care. Then, these issues were discussed. It should be noted that the subject is still little explored in the Brazilian context.

## RESULTS AND DISCUSSION

### • The Patient's Identification Process and the Role of the Health Team

In a study conducted at a public pediatric hospital in Argentina, which aimed to capture the health team opinion (doctors and nurses) and parents about identifying the patient, the participants mentioned to be aware of the importance of the use of bracelet identification. However, this is not the reality of professional behavior of that hospital, since, out of 281 patients hospitalized, only 96 (34%) were correctly identified.<sup>8</sup>

One of the questions asked to the aforementioned study health professionals, was the understanding of why the implementation of patient's identification was flawed. The answers were related to lack of awareness of the professionals, forgetting the implementation of identification, concerning about the quality of the bracelet and doubts on which professional would be responsible for identifying the patient.<sup>8</sup>

Sometimes the health care team cannot be quite sure of the relevance of correct patient's identification for preventing assistance mistakes. Nevertheless, this measure is not enough to ensure the safe care; however, it is the first goal, that is, one of the main aspects in the totality of assistance to take a step forward for a safe and quality care.<sup>6,8</sup>

Reflecting on the recognition by professionals and caregivers of pediatric patients on the care circumstances leading to AEs, other research showed that medicine process was more susceptible to the occurrence of AEs. In the view of caregivers and health professionals, this process had risks, since it has flaws in correct identification process of the patient, the effective communication between professionals/patients/caregivers, affecting the security of prescriptions, use and administration of medication and carrying unnecessary procedures to children.<sup>9</sup>

Generally, the nursing staff are the professionals responsible for all patient identification process, which must be held since the arrival in the health center, as well as throughout the period of hospitalization and before any procedure. However, assigning this responsibility only for the nursing staff

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reflects on an inappropriate organizational decision-making, because of the insufficient number of professionals, overload and long working hours. Thus, it is evident the decrease in quality of care, and is related to the increase in the number of AEs, failure to comply with the necessary measures to provide secure identification of patients, who have close relationship with effective communication and teamwork.<sup>10-2</sup>

A culturally practice recommended for PS in well-organized health services is the implementation of patient's identification protocol. The compliance goes beyond data conferencing and making bracelets. Thus, before any procedure to check the quality and state of the bracelet, in practice should be extended to all care team responsible for patient care, optimizing the quality of care without the overloading of some professionals.<sup>10-2</sup>

For the successful implementation of the identification protocol through the interaction of the multidisciplinary team, discussion and reflection on the establishment of two-way communication is needed, ensuring that the message was passed clearly by the issuer, with understanding by the recipient, whether patients, caregivers or professionals, valuing the autonomy and the responsibility of individuals for the PS.<sup>11</sup>

For communication to be aggregating in the identification process, it is essential the established protocols be followed carefully. Despite the bond created between staff/patients/caregivers, professionals responsible for identifying should not allow the routine and the recognition of patients being aspects that lead to failure in following the protocol, such as not identifying the Conference of patients before procedures.<sup>11,13</sup>

The fallibility characteristic of the human being should always be remembered, to be planned and implemented safety barriers strategies. The importance of double checking the information in the bracelet must be a point of reflection to be worked through guidance to patients and continuing education of the professionals involved. Based on this, the process to reach the goal of quality care will be developed from the safety culture.<sup>1</sup>

### • The Influence of Organizational Culture in the Patient's Identification Process

It is known that the organizational culture of an institution directly reflects the safety culture adopted in patient's care because, as mentioned above, the safety culture is closely

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related to the values, skills and behaviors of commitment to safety and improvement actions. For this, the commitment of everyone involved in the care is needed, that is managers, health professionals, patients and caregivers.<sup>4,7</sup>

The set of behaviors, values and skills adopted in a health service defines the circumstances under which users are submitted. It is understood by the care circumstances, the contained context of the interventions by healthcare professionals to patients. However, these interventions are not restricted to technical procedures, but are also considered interpersonal relationships, routines and the institution's development plan, which allow a holistic view of the care plan.<sup>9</sup>

The involvement and commitment of professionals in health institutions reflect the culture in which they live. Although studies show that the health team has awareness of the importance and need of the patient identification bracelets implementation through the reduction of risk of damage, if the organization does not have a priority to the patient's safety culture also demonstrated in qualifying and training of professionals, the quality of care will be compromised.<sup>13,14</sup>

Before the commitment of professionals and health organizations to adopt safety barriers, the discussion on the implementation and the improvement of patient's identification protocol is an opportunity for this process to be strengthened as a component of quality care. Along the Patient Safety Centers, the risk management teams should collect data on the potential and difficulties of all involved in the care by the correct identification of the patient.<sup>2,10</sup>

The leaders of health institutions are essential elements in establishing harmony among care workers, management, and patients. Teamwork, optimized for committed and flexible interpersonal relationships in collaborative responsibility in the patient's identification process is an important step to achieve the security goals, starting with the first goal, the correct identification.<sup>8,13,15</sup>

Since, the identification, any member of the health team treating the patient has the right and the duty to defend and protect him during care. For this, clear communication that allows the correct identification of the subjects is essential, based on the establishment of standardized protocols and

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practices that maximize reliability in the proposed quality of care.<sup>15</sup>

The adoption of strategies that encourage the creation of identification protocols should be based on team awareness through the real recognition of the importance of implementing routines that result in a secure care and not by imposing rules that lead to mechanical care, fragmented and ruled by fear of punitive policies.<sup>9,16</sup>

In this process, the organizational culture of health institutions, which are aimed at reaching a safety culture, has a key role in the education of the professionals and empowerment of their patients, since all are involved in the context of care and achieving assistance quality founded on patient's safety.<sup>16-7</sup>

CONCLUSION

A reflection on the health teamwork processes in the correct identification of the patient and the influence of organizational culture of institutions in this process is an elementary aspect to be discussed in the daily care practice.

The discussion of patient's safety as an essential component of quality of health care, should exceed the theoretical barriers and be implemented in Patient Safety Centers, through participation and exposure of strengths and weaknesses that require improvement actions, with the collaboration of healthcare professionals, managers and patients, who are part of the organizational culture of health services.

Awareness of the importance of adopting protocols to guide care and increasing the reliability of the assistance, mainly in the correct identification of the patient, is growing among professionals who provide direct care. However, the implementation of routine safety by identifying patients needs greater investments in education and commitment to safety culture.

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