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PERSPECTIVES OF THE NURSING TEAM ON PATIENT SAFETY IN AN EMERGENCY UNIT

PERSPECTIVAS DA EQUIPE DE ENFERMAGEM SOBRE A SEGURANÇA DO PACIENTE EM UNIDADE DE EMERGÊNCIA

PERSPECTIVAS DE LA EQUIPO DE ENFERMERÍA SOBRE SEGURIDAD DEL PACIENTE EN UNIDAD DE EMERGENCIA

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ABSTRACT

Objective: to know the perception of Nursing professionals who work in a hospital emergency service regarding aspects of patient safety. **Method:** exploratory, descriptive, qualitative approach. The data were produced through semi-structured interviews, with six nurses and eight Nursing technicians from a philanthropic hospital in the South of Brazil and were submitted to the Content Analysis technique. **Results:** two categories emerged: << Context of Nursing work that prevents errors >>; << Context of work in Nursing that favors the occurrence of errors >>. **Conclusion:** contributions from this study are assumed for emergency Nursing, as it raises questions about the complexity of Nursing management and patient safety. As it deals with the individual perception of the professionals about their work environment, one cannot relegate the internal factors, for example, the motivation and the previous experience, that can interfere in the interpretation of the daily facts. **Descriptors:** Safety Management; Patient Safety; Emergency Hospital Service.

RESUMO

Objetivo: conhecer a percepção dos profissionais de Enfermagem que atuam em um serviço de emergência hospitalar quanto aos aspectos da segurança do paciente. **Método:** estudo exploratório, descritivo, de abordagem qualitativa. Os dados foram produzidos por meio de entrevistas semiestruturadas, com seis enfermeiros e oito técnicos de Enfermagem de um hospital filantrópico do Sul do Brasil e foram submetidos à técnica de Análise de Conteúdo. **Resultados:** emergiram duas categorias: <<Contexto do trabalho em Enfermagem que previne erros>>; << Contexto do trabalho em Enfermagem que favorece a ocorrência de erros>>. **Conclusão:** pressupõem-se contribuições deste estudo para a Enfermagem em emergência, à medida que suscita reflexões sobre a complexidade do gerenciamento de Enfermagem e a segurança do paciente. Como se trata da percepção individual dos profissionais sobre o seu meio de trabalho, não se pode relegar os fatores internos, por exemplo, a motivação e a experiência anterior, que podem interferir na interpretação dos fatos do cotidiano. **Descritores:** Gerenciamento da Segurança; Segurança do Paciente; Serviço Hospitalar de Emergência.

RESUMEN

Objetivo: conocer la percepción de los profesionales de Enfermería que trabajan en servicio de emergencia hospitalario sobre los aspectos de seguridad del paciente. **Método:** estudio exploratorio, descriptivo, con enfoque cualitativo. Los datos fueron producidos a través de entrevistas semiestructuradas con seis enfermeros y ocho técnicos de Enfermería de un hospital filantrópico del sur de Brasil y fueron sometidos a la técnica de Análisis de Contenido. **Resultados:** emergieron dos categorías: << Contexto del trabajo en Enfermería que previene errores>>; << Contexto del trabajo en Enfermería que favorece la ocurrencia de errores>>. **Conclusión:** se presuponen las contribuciones de este estudio para la Enfermería en emergencia, al paso que da lugar a reflexiones sobre la complejidad de la gestión de Enfermería y la seguridad del paciente. Como se trata de la percepción individual de los profesionales acerca de su medio de trabajo, no se puede relegar los factores internos, por ejemplo, la motivación y la experiencia previa, que puede interferir con la interpretación de los fatos de la vida cotidiana. **Descriptor:** Gerenciamiento de Seguridad; Seguridad del Paciente; Servicio de Urgencia en Hospital.

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INTRODUCTION

The debate on health care security has been intensifying in recent decades. Patient safety is conceptualized as the least acceptable reduction of the risk of unnecessary harm associated with health care.¹ The worldwide movement around the theme has been triggered by the publication of the *Institute of Medicine (IOM)*, called *To err is human: building safer health system*, in 1999, which showed the failures in safety, errors, and adverse events (AEs) that occurred in US hospitals.²

Studies³⁻⁴ warn of the magnitude of the problem, noting that millions of patients hospitalized suffer some kind of error or adverse event. In Brazil, falls from the bed, clinical and surgical complications, medication errors and infections are the most frequently reported incidents. However, little is known about the extent of the problem, since there is a shortage of evidence available to measure this reality.⁴

Nevertheless, difficulties in the organization of work and deficient infrastructures expose the health teams to different pressures, such as: the need to achieve certain results; the inability to handle high-tech equipment; mistaken individual or collective clinical judgments; excessive workload and inadequate staffing.⁵⁻⁶ This set of factors may well contribute to the occurrence of adverse events and errors.

This study⁷ shows other elements that interfere with patient safety, among them: absenteeism over 15 days due to complaints of muscle pain and stress; inadequate training of professionals and an employment bond that does not provide stability to the worker. In addition to these issues of internal functional dynamics that undermine the care provided, the media demonstrate, repeatedly, the poor working conditions of professionals, limited resources, overcrowding and long waits in the emergency services of public hospitals. Such reports feed the perception, among the lay population, that health services in Brazil are not safe.⁶

The understanding of security has evolved, broadening the perception beyond the professionals directly involved in the assistance. The contemporary approach to patient safety is concerned with the understanding that systems where care is provided play a key role in the occurrence / prevention of errors and incidents. The current trend is to involve the organization / institution as a whole, management and professionals who are in the front line, in

order to identify possible risks and anticipate strategies so that incidents and errors do not occur.⁸

Studies in the United Kingdom/ UK have reported that the direct involvement of executive directors in the institution's managerial issues has improved the safety and quality of care. They show that the frequent presence of the administrators/managers in the care units promotes greater confidence among the teams, since they are close to the problems and identify them more quickly. From this presence and listening, they can influence internal processes and allocate resources to the priority areas.⁹⁻¹⁰ In this sense, Nursing plays an important role in preventing adverse events, not only by adding the largest contingent of professionals, but also by the frequent contact with patients, perceiving needs and anticipating situations. However, not only the nurse is responsible, but the whole multidisciplinary team has its role in improving the work process and commitment to results. Thus, teams placed in emergency units need adequate management to provide quality care. On the contrary, lack of effective management makes it difficult to deliver assistance, destabilizes staff, and can lead to errors.¹¹

The scenario of this research is the gateway of a large philanthropic hospital of the Southern region of Brazil, which attends patients in a state of urgency and emergency. The institution proposes to assure assistance, with technical and humanistic quality, guaranteeing satisfaction and well-being of the client, seeking the continuous improvement for promotion and recovery of health. It should be noted that the institution has been developing a safety culture policy, both by adhering to the Hospital Accreditation system and by disseminating the internal campaign for patient safety. It also has a multidisciplinary risk management committee, formed in 2010, including the participation of clinical engineering. In the year 2015, the discussion, revision and implementation of the safety protocols listed in the National Patient Safety Program (PNSP) were expanded.

The motivation for this study comes from the experiences of one of the authors in an emergency unit, plus the knowledge acquired during the graduation about the managerial role. The expertise of the other authors, regarding the aspects of patient safety, mobilized the team to research about the topic and answer the research question: what is the perception of Nursing professionals working in a hospital emergency unit on patient safety?

The objective of this study is to know the perception of Nursing professionals working in a hospital emergency service regarding aspects of patient safety.

METHOD

An exploratory, descriptive study of a qualitative approach carried out in an emergency unit of a philanthropic hospital of reference for the northeast region of Rio Grande do Sul. The physical infrastructure of this unit includes four service areas. In the reception room, the risk classification of patients is done and eight armchairs are available to accommodate them; there is an emergency room with four stretchers; an observation room containing eight beds and; a special three-bed infirmary, for those patients who are awaiting beds in the Intensive Care Unit (ICU).

In the study, 14 Nursing professionals (six nurses and eight Nursing technicians) participated. The sample was characterized as intentional non-probabilistic,¹³ being as an inclusion criterion the condition of acting for more than six months in the emergency service. This time is considered minimally necessary for the adaptation of the professional to the routines of the sector and the work team, and, in this way, can contribute more effectively to the research. The exclusion criterion consisted of professionals who were away from work for any reason.

The information collection took place in August 2013, through a semi-structured interview technique, conducted based on a script developed by the researchers. Closing of the interviews occurred due to data saturation.¹³⁻⁴ The interviews, previously scheduled with the participants, had an average duration of 35 minutes and were performed in a reserved room of the hospital emergency unit, ensuring privacy of the participants. To ensure the reliability of the data, the interviews were recorded in audio and transcribed in full. The research complied with the recommendations contained in Resolution CNS 466/1515 and approved the project by the Research Ethics Committee of the Virvi Ramos Cultural and Scientific Association, under number 351712 and CAAE 19839913.7.00000.5523. Participants signed the Informed Consent Form with one way and another was assigned to the team of researchers. To guarantee anonymity, the following codes were used: "N" for nurses and "NT" for Nursing technicians, plus a number that corresponds to the chronological order of

the interviews. For example: N1, N2, NT1, NT2 ...

The information was submitted to the Content Analysis Technique proposed by Bardin¹⁶ contemplating the steps of pre-analysis, material exploration and treatment of results. The pre-analysis and the exploration of the material occurred during the transcription of the interviews, at which time a floating reading was made, seeking to find units of analysis. Finally, two central categories of analysis emerged, which were thus named:

- ◆ Context of Nursing work that prevents errors
- ◆ Context of Nursing work that favors the occurrence of errors

RESULTS

The profile of the participants was characterized by an average age of 30 years. The work time of the Nursing professionals in the emergency ranged from eight months to 15 years. Four participants had professional experience in emergency units of other hospital institutions. All nurses were postgraduates, and of these, four were specialists in Emergency Nursing, one in Intensive Care Nursing and the other in Nursing Management.

Category 1: ◆ Context of Nursing work that prevents errors

A fundamental condition for error prevention, shown by the participants, is to have professionals trained to work in the emergency unit, including the capacity not only for the execution of techniques, but also for the development of cognitive, behavioral and ethical skills, within context. This professional, in addition to keeping up to date, with a view to identifying imminent risk situations, performs correct evaluation of severe patients and gives the referrals quickly. This was reiterated in the following statements:

- [...] we need to have the professional trained within their reality, within their unit [...] if the team knows the routine of the job and understands what an emergency sector is for sure the care provided will happen in a way with the knowledge of the team. (N2)*
- I think that the qualified team [...] the team should have training, continuing education, I believe that if the nurse manager is prepared and that has skill and knowledge to care for serious patients, certainly will reduce the chances of errors, thus giving a greater Patient safety. (NT5)*

[...] a factor that helps to prevent errors, I believe that you have to be and be a well-trained nurse so that the whole team can work properly and to prevent errors. (N3)

The management strategy used to keep the professionals trained and motivated for work, whose outcome improves patient care, was the performance of continuous educational actions with the Nursing team, which simulated reality and were supervised periodically. Equally, the design of the institution's objectives and the knowledge of the norms and routines, not only of the care units, but also in the institution, as a whole, contributes to the prevention of errors. The testimony demonstrates this assertion.

[...] I think internal institutional processes have to be well aligned, right? Well determined and that the team is aware of these aspects of internal processes [...] (N1)
I believe that what contributes is the mapping of processes, is the rules and routines, daily risk assessment, bundles of prevention [...] and continuing education. (N6)

The adequate personnel dimensioning was another factor emphasized by the interviewees who act in the emergency to anticipate adverse situations. To define previously the possibility or not to relocate the team, considering the implication in the quality and the assistance results, if the resources are insufficient and there is work overload. Participants reported that the dimensioning is linked to the demand of patients, the severity of situations and the work process in other sectors of the hospital, which characterizes a Nursing management action, important for actions to occur safely.

I believe that it contributes to bed management, staffing, and demand management. (N5)

I believe team supervision, staffing according to patient severity, patient safety goals, identification and continuing education for the staff. (N4)

[...] another situation we have is from human resource management to check if I have staff to meet the number of patients I have here so many times we have to relocate employees [...] (N1)

The use of management tools such as epidemiological indicators, care protocols and the development of Nursing Care Systematization (NCS) are factors that contribute to the prevention of errors, as expressed by the participants:

I think the use of NCS in its entirety, pre-established protocols, minimize errors, reduce iatrogenies, abide by, follow hospital accreditation standards, and work based on indicators. (N5)

[...] adequate structure, qualified personnel and the use of quality tools, we have the Ishikawa diagram, which [...] gives us parameters for solving the problems that appear in our everyday life and that can cause some sentinel effect to the patient. (N2)

Despite the difficulties inherent in an emergency service, nurses who have the habit of performing the service planning with their team, based on the historical series of care, on the installed capacity, on the staff and patients profile and on the demand analysis, are more apt to organize the service, guarding against undesirable intercurrents.

Category 2: ♦Context of Nursing work that favors the occurrence of errors

Participants reported that they cope with daily difficulties to provide a quality service, amid inadequate structure and excessive patient demand. They recognize the overcrowding of the unit as a factor that leads to a greater probability of errors, according to the statements:

I think that the great demand for patients, the overcrowding and the complexity of the cases we deal with [...] there are a small number of employees [...] (N4)

An inadequate structure also or a greater demand than can be received, the lack of material, medication even the team's disorganization right, because sometimes you have the scale, you have everything organized on paper, but when the team is not cohesive things end up not happening. (N2)

These issues greatly hamper the work of the Nursing management, especially, in the elaboration of service scales, since the instability that involves assistance in the emergency makes it difficult to guarantee the sufficient number of workers for each shift.

Another aspect mentioned is the knowledge, conceived as partial, of the nurses' management aspects. In this sense, the participants report that the lack of knowledge, skill and mastery of nurses makes it difficult to attend:

The lack of leadership, sometimes there is the professional who is not very skilled or who does not have the knowledge that should be to be in an emergency unit, this ends up sometimes causing some disorder [...] (N2)

What makes it difficult, I think, first is the poor preparation of the nurse manager, the manager has to have profile for what he performs right, must have a dexterity to meet the patients who require immediate care I think he has to have mastery of the unit, team I think he has to know what he is

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doing, have to have vision, right, have to have domain I think that's it. (NT4)

Poor management, ah, lack of training at times for professionals such as nurses [...] (N3)

Through these testimonies, it is highlighted that the lack of knowledge of Nursing management aspects is an important factor that causes disorders to the team that can culminate in the occurrence of incidents and even errors or adverse events. An example of this is the difficulty of the nurse organizing the service with the complexity inherent in it.

DISCUSSION

The magnitude of patient error and safety/insecurity rates in Brazilian emergency units is still unknown because there is underreporting.¹⁷ In institutions where indicators are available, they are often used to assess performance, signal deviations from activities and show weaknesses and potential of the service. The results found are indicative for the management to establish pertinent interventions in the work process, to plan and evaluate the service.¹⁸ Knowing these aspects is a basic condition for the professional to organize the service.

Information and up-to-date knowledge are tools that health professionals possess to ensure safe and high-quality care for patients.¹⁹ On the contrary, a lack of knowledge or partial knowledge about the management of health institutions triggers misconceptions in decision making, which facilitates the occurrence of incidents, errors and adverse effects on health care.

The multidisciplinary teams, as well as the managers who work in the area, have the responsibility to manage the service, demonstrating the results obtained through indicators. These are instruments that define minimum parameters of quality, in addition to demonstrating reality as it is. The information obtained provides elements for decision making with the lowest degree of uncertainty.²⁰ By assuming this way of doing it, it improves the atmosphere of the work environment and the discussion of the work process becomes pedagogical.

In this sense, the qualification of the team is an important factor to prevent errors and adverse events, which aligns with what the National Policy of Permanent Education advocates⁽¹⁶⁾ when it determines that the focus of education should be on local and regional specificities and needs. The study²¹ suggests that the institutions implement programs of continuing education and adopt permanent education practices, with a view

to improving care and promoting good practices. The provision of frequent trainings to professionals are actions of hospital management and administration that promote a positive impact on patient safety.²¹ Through these initiatives, the individual and collective difficulties of the institution are identified.

Training of the professionals allowed to identify the lack and even the absence of effective institutional strategies aimed at the improvement of the workers and the dissemination of information essential for the planning, organization and implementation of adequate actions for the prevention.^{22: 3349}

Regarding the workload of the Nursing team and for the correlation with patient safety, studies have shown that this is a serious problem to be faced by health authorities around the world.⁶ In Brazil, aspects such as deficient physical structure, lack of qualified personnel, strenuous working conditions are problems that have assumed an increasing complexity, aggravated by the scarce financing through public resources for the health area.^{6,22}

With regard to the daily assignments of the nurse, dimensioning and elaborating the work scales of the team are actions in which the qualification in the managerial process is evidenced. Participants inferred that the demand situation and care for critically ill patients can be better organized if the nurse is trained in bed management and the size of their staff. However, recent studies²³⁻⁴ show that many nurses do not have sufficient knowledge to perform staffing, which is a complex activity, traversed by subjectivity, which can compromise the results of dimensioning when performed by nurses with partial mastery over the subject or not qualified to do so.

In 2013, the Ministry of Health defined the strategies for implementing actions through the launch of the National Patient Safety Program, which advocates the promotion of a safety culture, calling for the involvement of institutions and professionals in incident prevention. Program supports the implementation of safe practices in hospitals, the creation of an incident reporting system, the development of protocols and the promotion of capacity building processes. The focus of prevention must always be based on the complex systems where health care occurs.

CONCLUSION

The study showed that Nursing professionals experience the same dilemmas

reported in the literature, regarding the context of an emergency unit, such as lack of safety and managerial difficulties.

The use of NCS and epidemiological indicators, the adequate dimensioning of the team, with professionals trained to act in emergency units, are essential management factors that promote patient safety. As for the difficulties for effective management and safety assurance, there was a lack of leadership knowledge, overcrowding of the unit and lack of materials.

Concerning the difficulties for effective management and safety assurance, were the leaders' lack of knowledge, the overcrowding of the unit and the lack of materials. It was also evidenced that the managerial aspects, that contribute to the patient's safety, reside in the professional position of the nurse, in constant search for improvement, through qualifications, to qualify the assistance provided in the emergency unit. However, the external, political, economic and health management, interfere in the organization of internal work, such as overcrowding and the lack of professionals able to attend in this sector.

The contributions of this study are assumed for Emergency Nursing, as it raises questions about the complexity of Nursing management and patient safety, as they interfere in the quality of the service provided and in the rates of errors and adverse events. As it deals with the individual perception of the professionals about their work environment, one cannot relegate the internal factors, for example, the motivation and the previous experience, that can interfere in the interpretation of the daily facts. The information in this search refers to a hospital. In this sense, it is suggested that more studies be developed on this theme, in different scenarios of emergency units and using different research methods, in order to contribute to the advancement of knowledge in patient safety.

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