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Patient safety in the emergency service of Marataízes-ES: culture and efficiency and quality results

Seguridad del paciente en el servicio de urgencias de Marataízes-ES: cultura y eficiencia y resultados de calidad*Segurança do paciente no pronto atendimento de Marataízes-ES: cultura e resultados de eficiência e qualidade***ABSTRACT**

Objective: Investigate patient safety in the emergency department of Marataízes-ES and determine if there is variance according to the existing safety culture, the waiting and the results of the efficiency and quality variables. **Methodology:** A questionnaire designed based on the premises of the ANVISA protocols on patient safety culture was used to investigate the basic premises that involve patient safety such as hand hygiene, patient identification and safety in the prescription, use and administration of medicines. It was applied to 16 nurses and 27 nursing technicians who work at this location. **Discussion:** The main finding was that the team, despite the knowledge about their duties and performance within the emergency department regarding patient safety, may still have their actions reformulated to improve the efficiency and quality framework. **Conclusion:** There is a concern of the management / coordination of the UPA in relation to maintaining a culture of safety and quality, especially in relation to the waiting time of the patient, using the risk classification and a well-structured technical team to prioritize Urgent and Emergency care.

DESCRIPTORS: Emergency Care; Patient Safety; Efficiency; Quality.

RESUMEN

Objetivo: Investigar la seguridad del paciente en el servicio de urgencias de Marataízes-ES y determinar si existe varianza según la cultura de seguridad existente, la espera y los resultados de las variables de eficiencia y calidad. **Metodología:** Se utilizó un cuestionario diseñado en base a las premisas de los protocolos de ANVISA sobre cultura de seguridad del paciente para investigar las premisas básicas que involucran la seguridad del paciente como la higiene de manos, identificación del paciente y seguridad en la prescripción, uso y administración de medicamentos. Se aplicó a 16 enfermeras y 27 técnicos de enfermería que laboran en este lugar. **Discusión:** El hallazgo principal fue que el equipo, a pesar del conocimiento sobre sus funciones y desempeño dentro del servicio de urgencias en materia de seguridad del paciente, aún puede tener sus acciones reformuladas para mejorar el marco de eficiencia y calidad. **Conclusión:** Existe una preocupación de la gestión / coordinación de la UPA en relación al mantenimiento de una cultura de seguridad y calidad, especialmente en relación al tiempo de espera del paciente, utilizando la clasificación de riesgo y un equipo técnico bien estructurado para priorizar la atención de Urgencias y Emergencias.

DESCRIPTORES: Servicio de Emergencia; Seguridad del Paciente; Eficiencia; Calidad.

RESUMO

Objetivo: Investigar a segurança do paciente no pronto atendimento de Marataízes-ES e determinar se existe variância de acordo com a cultura de segurança existente, a espera e os resultados das variáveis de eficiência e qualidade. **Metodologia:** Utilizou-se questionário elaborado com base nas premissas dos protocolos da ANVISA sobre cultura de segurança do paciente, para investigar as premissas básicas que envolvem a segurança do paciente como higiene das mãos, identificação do paciente e segurança na prescrição, uso e administração de medicamentos. Foi aplicado aos 16 enfermeiros e 27 técnicos de enfermagem que trabalham neste local. **Discussão:** A principal constatação foi que a equipe, apesar do conhecimento sobre suas atribuições e atuação dentro do pronto atendimento quanto à segurança do paciente, ainda pode ter suas ações reformuladas para melhorar o quadro de eficiência e qualidade. **Conclusão:** Há uma preocupação da gerência/coordenação da UPA em relação à manutenção de uma cultura de segurança e qualidade, principalmente em relação ao tempo de espera do paciente, usando a classificação de riscos e uma equipe técnica bem estruturada para priorização dos atendimentos de Urgência e Emergência.

DESCRIPTORES: Pronto Atendimento; Segurança do Paciente; Eficiência; Qualidade.

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INTRODUCTION

Considered one of the sectors with the highest patient load in the entire healthcare organization, the Emergency Care Units (UPA) are characterized by an intermediate level of complexity, where doctors and nurses under great pressure, both mentally and physically, are tasked with create an environment that makes patients feel confident about the care they will receive.

Analyzing the UPA and its work environment, in the context of patient safety, it is possible to assess its role in the health system in order to understand the necessary structural interventions and the services offered in its operation, to reduce the patient's burden in care improve mandatory patient referrals in primary care or other health systems.

However, it is known that, despite the possible necessary interventions, the number of patients treated at the UPA continues to increase each year, revealing an overload that can lead to adverse events and / or incidents arising from conduct incompatible with the rules and guidelines attributed to health professionals.

Serious and recurring problems are also reported, such as patient safety concerns, increased staff workload, lack of certain professional skills, and unhappy patients who are dissatisfied with the long wait before receiving care.

The impact of the continuous flow in the emergency service signals the quality content of the services offered to users of the Unified Health System (SUS), whose weaknesses are known to everyone who, in addition to the initial demands of urgen-

cies and emergencies, faces overcrowding from exacerbated care provided by Basic Health Units (UBS), further inflating the public machinery and deconstructing relevant principles that negatively affect patient care, compromising the safety culture that, in reverse, also puts health professionals at risk.

Another important point perceived in the investigations was that, in addition to the fact that inspections are rarely carried out on the demands and needs of the UPA, when they happen, they do not result in lasting changes, probably due to the lack of evidence to take the necessary measures. Another perceived concern was related to the fact of not having a specialist to be the first contact with patients in the emergency room.

This is the reality of an UPA in the municipality of Marataízes-ES, which recei-

ves local and surrounding patients and, at certain times of the year, absorbs the floating population, a challenging demand for health services to keep patient safety protocols active.

So, this study comes to problematize: What is the impact of the culture of efficient patient safety in the Emergency Unit of Marataízes-ES to achieve efficiency and quality in its services?

As much as there are efficient nursing work techniques, the human nature of this professional, in dealing with the ailments of the public health system, reflected in inadequate salary conditions, deficient infrastructure of many UPAs spread throughout this country, lack of qualified professionals and of medicines, it can make mistakes when it does not go through recycling processes of situations common to the daily work environment, which is the greatest basis for carrying out this study.

METHODOLOGY

A qualitative research was carried out by filling out a structured questionnaire, prepared based on the premises

of the protocols of the National Health Surveillance Agency - ANVISA⁽¹⁾, addressing basic and important aspects for patient safety in an emergency room (hand hygiene, patient identification and safety in the prescription and use and administration of medicines) to nurses and nursing technicians to measure the perception of safety conducts.

Data analysis was also carried out by obtaining data in the descriptive statistical model with tabulation and generation of graphics for analysis and registration of content addressing the considerations of the participants.

The Municipal Medical Emergency Room Dr. Anis Nahssen (PAMM) in Marataízes-ES, has 04 male observation beds, 06 female observation beds, 03 pediatric observation beds, 15 medication administration chairs, 05 physicians' offices, 02 rooms for risk classification, suture room; x-ray room; emergency room; medical care; nursing care; drugstore; Clinical Laboratory; social service; initial attendance to all urgent and emergency demands; dental care; performing emergency procedures; application of injectable drugs; electrocardiogram; application of immu-

nobiological (human anti-rabies care and dT vaccines).

According to data collected at the Municipal Health Secretariat, an average of 5,000 / month visits were performed at PAMM in 2017. Of these, with indication of medication administration, it generated about 60%, followed by 24-hour observation (20%) and 1.2% suture procedures. However, no studies were found that elucidate the culture of patient safety in this regard, nor mention of the Municipal Health Plan 2018-2021⁽²⁾.

Data collection started after approval and signature of the letter of consent by the Institution's Management.

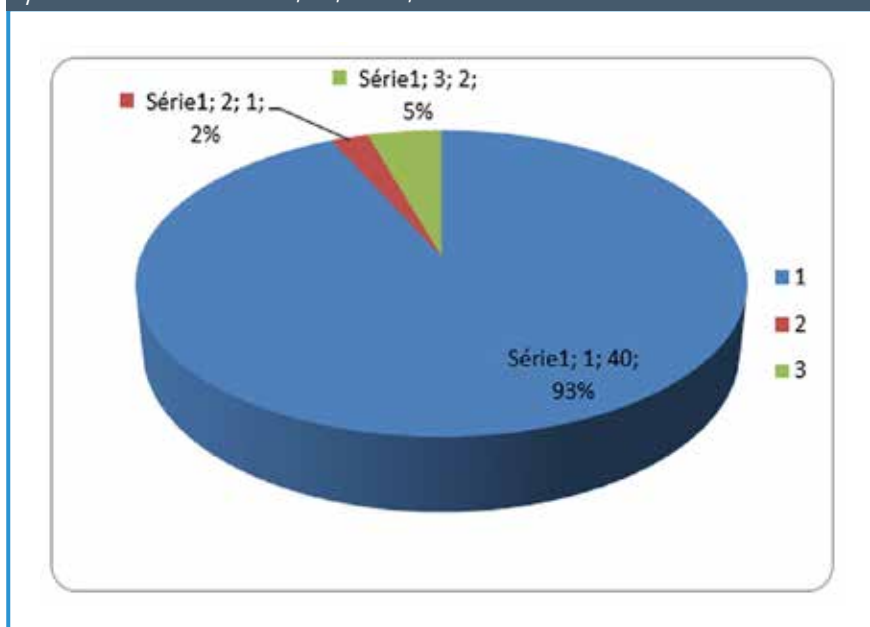
RESULTS AND DISCUSSION

The results and discussion will be presented below, according to the analysis of the responses of the interviews.

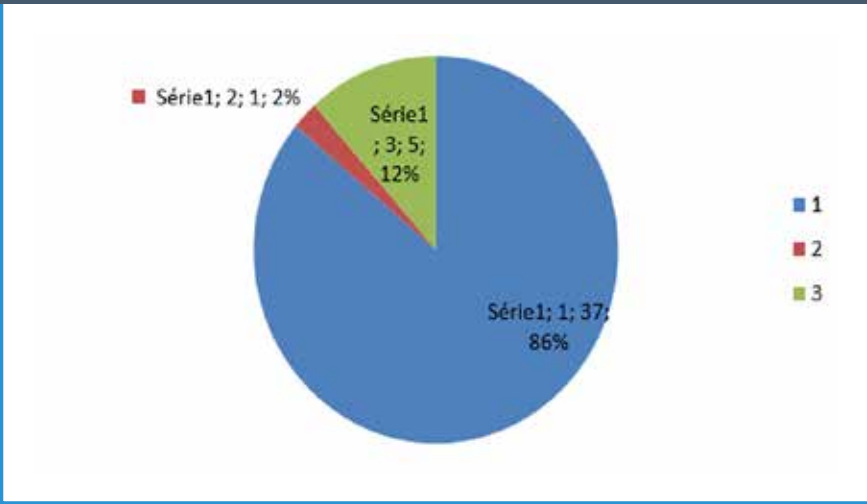
It is possible to observe in Graph 1 that of the 43 employees interviewed, 40 consider failure when they do not wash their hands, 02 do not consider it and 01 sometimes. According to ANVISA⁽³⁾, the World Health Organization (WHO) has set the date of May 5 for the installation of the worldwide campaign Save life: clean your hands. The objective of this day is to invite member countries and health services to promote initiatives on the theme of hand hygiene aimed at both health professionals and citizens. Errors are, by definition, unintentional, while violations are intentional, though rarely malicious, and can become routine and automatic in certain contexts⁽⁴⁾. An example of violation is the non-adherence to hand hygiene by health professionals.

In Graph 2, it is observed that of the 43 employees interviewed, 37 perform the 9-right medication, 01 employees do not and 05 sometimes. According to ANVISA⁽¹⁾, the medication system is complex, since for its implementation it is necessary to correctly comply with several processes, such as those for prescribing the therapeutic regime, dispensing and preparing and administering

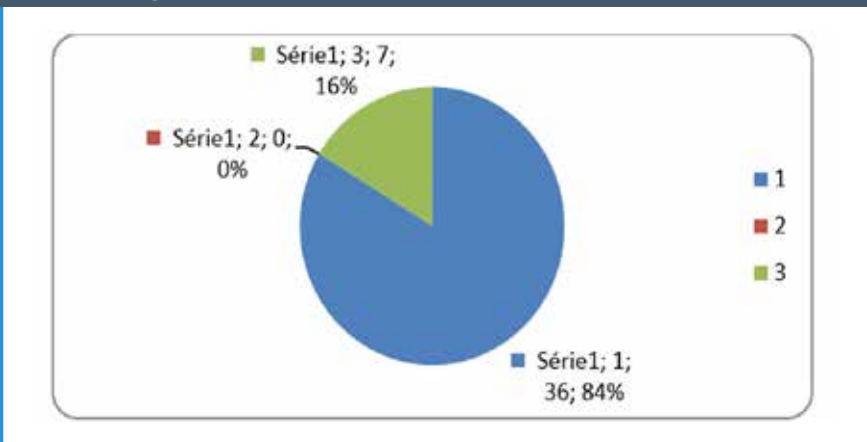
Graph 1. "Do you consider a fault in Patient Safety when you forget to wash your hands?". Marataízes, ES, Brazil, 2019



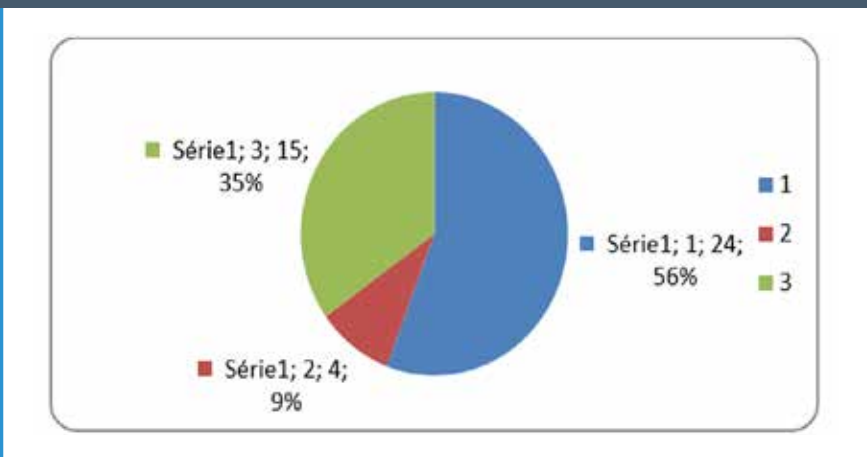
Graph 2. "Do you practice the right 9 method when administering medication?". Marataízes, ES, Brazil, 2019



Graph 3. "When administering medication to the patient, do you observe the risks of iatrogenic?". Marataízes, ES, Brazil, 2019



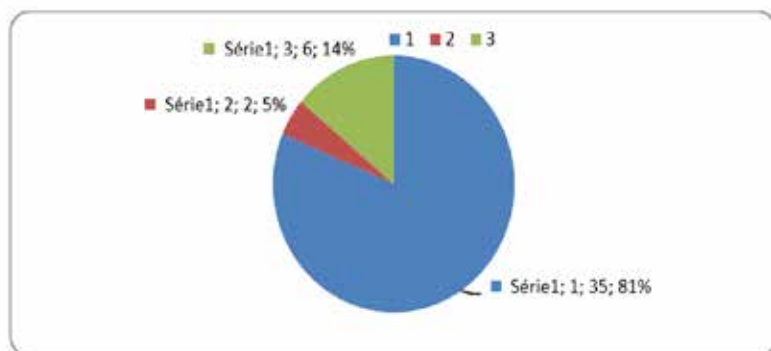
Graph 4. "When using technology equipment do you refer to the manufacturer's instruction manuals?". Marataízes, ES, Brazil, 2019



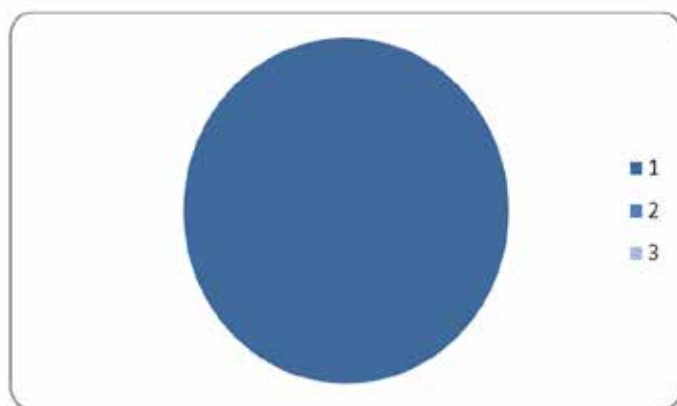
the medication. These aspects, if not observed, make errors frequent in health services and with serious consequences for patients, hospital organizations and society. Check that the information related to the procedure is correct according to the right 9 before administering any medication to the patient, that is, the right patient (use two identifiers for each patient), the right medicine (confirm the medicine with the prescription and check it three times) the label), dose, route and time, drug compatibility, guidance to the right patient, right to refuse the medication and the right entry.

In Graph 3, we observed that of the 43 professionals, 36 observed risks of iatrogenesis, 0 did not observe and 07 sometimes observed. According to ANVISA⁽¹⁾, adverse drug-related events (AME) go beyond situations involving concentrated and highly vigilant drugs. Medication errors (MS) and adverse drug reactions (ADRs) are among the most frequent failures in healthcare and it is important to note that these situations could often have been avoided in the three main phases of the medication process - prescription, dispensing and administration, which involve multiprofessional actions by medical, nursing and pharmaceutical teams. The possibility of preventing and preventing the occurrence of AMI points to the need to assess the causes, as well as the human and structural factors involved in this process, in order to allow the implementation of prevention barriers and to reduce the risks for patients. When patient safety interventions focus on the prevention of potentially harmful situations and procedures, they coincide with aspects and actions already linked to other dimensions of quality, to essential aspects of technical and scientific quality, but with the proviso that the possible failures increase the risk of

Graph 5. "Do you empower your patient / family to help improve your health?". Marataízes, ES, Brazil, 2019



Graph 6. "Do you consider the shift change to be a fundamental tool for patient safety?". Marataízes, ES, Brazil, 2019



iatrogenesis, adverse effects or unnecessary damage.

According to Graph 4, of the 43 professionals, 24 use instruction manuals, 04 do not use it and 15 sometimes use it. According to ANVISA⁽¹⁾, detection is an action or circumstance that results in the discovery of an incident. The detection mechanisms can be part of the system (such as the low saturation alarm on the multi-parameter monitor, a checking or surveillance process) or result from an attitude of greater "awareness" of the situation. Contributing factors to an incident are the circumstan-

ces, actions or influences associated with the origin, development, or increased risk of its occurrence. These must be known by the organization to guide the development of preventive actions. They can be external to the service; organizational; be related to the staff or some factor of the patient. Mitigation factors correspond to actions that are taken with the aim of preventing or moderating the progression of an incident of causing damage to a patient. They are important when the circumstance that can cause damage has already started but has not yet caused da-

mage or the damage has not reached its maximum possible degree. The mitigation factors can be focused on the patient (treatment, apology), the staff (meeting with staff and teamwork), the organization (availability of protocols) or an agent (correction of a therapeutic agent's error). Finally, actions to reduce risk are those that aim to reduce, manage, or control the likelihood of harm to the patient due to an incident in the future, which can be proactive or reactive.

According to Graph 5, of the 43 professionals, 81% answered that they empower, 5% do not and 14% sometimes do. According to ANVISA⁽³⁾, patient empowerment is a new concept applied to care in health services, and is related to patient safety. The WHO defines empowerment as "a process by which people acquire greater control over decisions and actions that affect their health"^(3:161). For patients to actively participate and be fully engaged, they must be convinced that the knowledge that has been offered gives them the opportunity and the right to participate and help to keep their care safer, that is, it is necessary to ensure that the patient or does not perceive that the responsibility of health professionals has been transferred to them.

According to Graph 6, professionals consider this tool to be fundamental to patient safety. According to ANVISA⁽¹⁾, duty shifts between health teams are considered essential tools for preventing failures and errors in patient care, and different strategies can be adopted to exchange relevant information and ensure the continuity and safety of care actions. Some services use recorded, written oral reports, bedside rounds, information boards and panels and verbal reports in joint meetings of the two teams (the one leaving and the one arriving to take

the shift). The transmission of information verbally between teams, with the aid of standardized records is one of the most effective ways for communication to occur clearly and accurately. However, it is important to consider that the conditions of the place, respect for the times, duration and participation of the teams follow a systematized structure with the support of objective, computerized data reports on the changes and evolution of the clinical condition of patients.

CONCLUSION

Reducing the risk of unnecessary harm, such as errors of omission or commission, associated with healthcare to an acceptable minimum is one of the most acceptable concepts of patient safety today. This study sought to understand a little more about patient safety in the emergency room, specifically about the culture, waiting and the results of the efficiency and quality variables, desired by the population in public health institutions.

Thus, we sought to understand, in part, how the perception and implementation of employees about the patient safety culture occurs, more specifically in the Emergency Care Unit (UPA) of Marataízes-ES and what are the possible actions that can be taken. taken to optimi-

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ze the quality of care and, consequently, patient safety.

As for nursing professionals in the setting of the UPA of Marataízes-ES, they are responsible for patient safety in the exercise of a range of actions related to comprehensive care that covers, especially the performance of procedures with the highest quality, which was addressed in the application questionnaire to which the professionals were exposed.

The results showed the fragility of the work process in relation to patient safety at the UPA in Marataízes-ES, characterized as services of medium complexity, high service demand and fundamental in the municipal health care network. Despite knowledge of the risks and the need to guarantee patient safety through protocols for health services in the country, the need to implement basic and fundamental actions through institutional standards and routines was realized, according to the local reality.

However, in relation to these measures, it is necessary to clarify that, when systematized, they contribute to reduce potential risks and promote safety and quality in the health work process. Therefore, public administrators and municipal health professionals are required to recognize this demand for the implementation of public policies and actions in this sector. ■

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