Elderly patient safety from the nurse's point of view in an LTIE

Segurança do paciente idoso sob o ponto de vista do enfermeiro em uma ILPI

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RESUMO

Objetivo: Descrever a segurança do paciente na perspectiva dos enfermeiros, técnicos de enfermagem e cuidadores de idosos, acreditando serem estes os profissionais que mantêm maior proximidade do paciente. **Método:** Este estudo, do tipo quantitativo, transversal, de caráter descritivo e analítico, foi aprovado pelo Comitê de Ética em Pesquisa obtendo alvitre positivo, CAAE: 84589717.8.0000.5512. A população estudo foi composta por profissionais de enfermagem que trabalham em uma ILPI no DF. Foram incluídos no estudo técnico de enfermagem, enfermeiro e cuidadores de idosos. **Resultado**: O enfermeiro, enquanto coordenador da equipe de enfermagem, não pode perder de vista que deve liderar a equipe com o compromisso de sempre buscar seu aprimoramento técnico-científico e ético. **Conclusão:** Frente à magnitude da temática segurança do paciente, que avanços no cenário atual das organizações de saúde sejam desafiadores, todavia algumas considerações, no que tange à assistência e ao ensino e pesquisa, tornam-se pertinentes, a fim de contribuir com a instituição pesquisada e de consolidar uma cultura de segurança profícua e construtiva.

Descritores: Segurança; Paciente; ILPI, Cuidadores de idosos, Técnicos de enfermagem e enfermeiros.

ABSTRACT

Objective: to describe patient safety from the perspective of nurses, provide nursing services and care for the elderly, believing that they are the professionals who maintain the patient's closest proximity. **Method:** This quantitative, cross-sectional, descriptive and analytical study was approved by the Research Ethics Committee, obtaining a positive suggestion, CAAE: 84589717.8.0000.5512. The study population was composed of nursing professionals who work at an LTCF in DF. Nursing technicians, nurses and caregivers of the elderly were included in the study. **Result:** The nurse, as coordinator of the nursing team, cannot lose sight of the exercise of his / her role of responding is a team committed to always seek technical-scientific and ethical improvement. **Conclusion:** in view of the magnitude of the patient safety issue, which promotes the current perspective of women's health organizations, and some considerations about teaching and research assistance become forward-looking. to consolidate a constructive and constructive safety culture.

Descriptors: Security; patient; LSIE, caregivers of the elderly, nursing technicians and nurses.

ORIGINAL

Introduction

Increased population growth, due to low fertility rates, or increased life expectancy, a woman's insertion in the labor market, recent family configurations pointed to a scenario of concern in which the use of care of aged people is reported.[1-2] In these events of social change, the family does not always have a caregiver when one of its elderly members requires support and/or direct assistance. Thus, long-term care institution for the elderly (LTIE) appear as an alternative care outside the family.[3] Patient safety is concerned with factors such as human fallibility, weaknesses in healthcare organizations, issues with technology devices, inappropriate communication and scaling between teams and professionals, as well as overwork and limited safety knowledge.[4]

The Nursing Activities Score (NAS) is the most complete validated sizing tool in Brazil to measure the nursing workload, because besides accounting for the time of therapeutic procedures and interventions, it includes administrative tasks and support to patients` familiars.[5-6] In addition, for sizing to be effective, it is important to use the criteria of COFEN Resolution No. 293/2004, which establishes the Technical Safety Index (STI) and the proportion of nurses, according to the degree of complexity of client care. , about the total of nursing professionals.[7]

Good communication, trust, organizational learning, hospital management commitment to safety, leadership, non-punitive approach to error and shared perception of the importance of this theme are pillars of security and institutional culture.[8-9]

Understanding the quality of care is not a new subject and it was the IOM paper entitled "To make a safer health system" (1999) added concern for one of the dimensions of quality: patient safety.[10-11] The publication found that between 44,000 and 98,000 patients died each year in US hospitals due to damage caused during health care. The news gained notoriety and given the scenario presented, governments and international organizations mobilized. Thus, work has begun to support national and international strategies for the prevention and mitigation of health care failures. Thus, health institutions should promote a culture based on these values in order to improve patient safety.

In accordance with article 5 of Ordinance No. 529 of April 1, 2013, the Ministry of Health highlighted a proposal for cultural changes related to safety and defined strategies for the implementation of the National Patient Safety Program. Through these strategies is the promotion of safety culture, which highlights learning and organizational improvement, commitment of professionals and patients in incident prevention, with emphasis on safe systems, thus avoiding the processes of individual commitment.[12]

Healthcare facilities have incorporated such a viewpoint with the aim of providing excellent care, reducing costs and ensuring customer satisfaction. It seeks to establish safety in health organizations as a cultural process, promoting greater awareness of professionals regarding the safety culture, ethical commitment to risk management with consequent commitment to safety for themselves and the clientele served, bridging the gap regarding patient safety.[13]

This gap can be certified in the care process, in which the increasing occurrence of adverse events (AEs), that is, unintentional damage that results in temporary or permanent disability and / or increased length of stay in the institution, should be highlighted. death as a consequence of health care provided.[14]

In this context, the research aimed to describe patient safety from the perspective of nurses, nursing technicians and elderly caregivers, believing that these are the professionals who maintain the closest proximity to the patient.

It is worth mentioning the promotion of patient safety in the quality of nursing care. The reduction of risks and damages and the absorption of good practices favor the effectiveness of nursing care and its safe coordination. This improvement corresponds to the necessary change in the safety culture of professionals, the use of quality indicators, the existence of a registration system, in line with the nationally established patient safety policy.

Method

This quantitative, cross-sectional, descriptive and analytical study was approved by the Research Ethics Committee with a positive report, CAAE: 84589717.8.0000.5512.

The study population consisted of nursing professionals working in an LTIE in the DF. The study included nursing technicians, nurses and elderly caregivers. Professionals who were less than six months working at the LSIE and who did not volunteer for the research were excluded. The final sample consisted of 1 nurse, 2 nursing technicians, 11 caregivers of elderly volunteers, selected by the number who work at the LTIE.

Data collection was performed in July 2018, in an LTIE of the Federal District. The questionnaires were delivered for proper completion. Professionals were informed about the justification, objectives and procedures to be performed, according to guidelines for research with human beings contained in Resolution No. 466/2012 of the National Health Council. After these procedures, the participants signed the Free and Informed Consent Form.

The data obtained were entered into a Microsoft Excel 2010 spreadsheet and statistically analyzed using Statistica 8.0 software. For data distribution analysis, the Mann Whitney Test was performed; Kruskall Wallis test.

As the data presented normal distribution, the results were represented by means (x) and standard deviation (dp) for quantitative variables, followed by independent student's t-test for comparison between groups. Pearson's correlation between quantitative variables was also used. For qualitative variables, frequency and percentage tables were used. The significance level adopted was $p < 0.05$.

Results and Discussion

The collected data were organized and stored in a Microsoft Excel 2018 spreadsheet. They were organized as follows: for the answers regarding the perception of patient safety culture dimensions, numbers were assigned from 1 to 5 (1- Strongly Disagree, 2- Disagree, 3- Neither, 4- Agree, 5- Strongly Agree; 1- Never 2- Rarely, 3- Sometimes, 4- Almost Always, 5- Always); To test the reliability of the questionnaire for its internal consistency, the statistical test of multivariate analysis "Cronbach's Alpha" was applied.

Cronbach's Alpha is an index ranging from 0 to 1, the closer to 1, the better the reliability of the instrument. Values above 0.60 are considered acceptable, and allow us to conclude that the instrument is reliable.[15]

The sociodemographic variables were analyzed from descriptive analysis, through frequency distribution, and presented through a table, in order to characterize the research participants.

The analysis of patient safety culture dimensions and indicators (safety level and number of reported events) was performed using descriptive statistics and specific analytical tests. The adopted significance level was 5%. Program R was used to estimate these statistics.

For the statistical analysis of the patient safety culture, scores from 1 to 5 were used, with 1 being the worst item and 5 being the best. As the questionnaire has the Likert scale technique, the negatively written items were inverted for analysis.

The profile of the participants was identified, which provided understanding, and were organized based on the elaborated themes and their constituents to better expose the findings.

Since its inception, the nursing profession has been performed mostly by women, and this gender issue remains today. In this study, there is a predominance of females in the population studied with 73.3%, however, this result is lower than the Brazilian data, which correspond to 87.2% females.[16]

Table 1 represents the percentage of category responses for each item related to the analysis.

Table 1 - Frequency distribution of patient safety culture dimension responses: "Teamwork in units".

	SD	D	N	A	SA
In this unit, people support each other	0.0%	9.1%	0.0%	63.6%	27.35
We have enough professionals to handle the workload	0.0%	22.2%	11.1%	44.4%	22.2%
When there is a lot of work to be done quickly. we work together without staff to complete it properly	0.0%	22.2%	11.1%	55.6%	11.1%
When there is a lot of work to be done quickly. we work together as a team to properly complete it	0.0%	9.1%	9.1%	72.7%	9.1%
In this unit, people treat each other with respect	0.0%	0.0%	12.5%	75%	12.5%

In this unit. professionals work longer hours than would be best for patient care	0.0%	37.5%	25%	37.5%	0.0%
Technical safety index according to resolution 293/2004 is used	0.0%	50%	0.0%	50%	0.0%
Professionals consider their mistakes. mistakes or failures have led to positive changes here	0.0%	0.0%	33.3%	50%	16.7%
Errors, mistakes or failures have led to positive changes here.	14.3%	71.4%	14.3%	0.0%	0.0%
Errors, mistakes or more serious failures do not happen here just by chance.	0.0%	37.5%	12.5%	37.5%	12.5%
Quando um evento é relatado. parece que o foco recai sobre a pessoa e não sobre o problema	0.0%	42.9%	14.3%	42.9%	0.0%
After implementing changes to improve patient safety. we evaluate the effectiveness.	0.0%	0.0%	25%	75%	0.0%
We work in a "crisis situation" trying to do it really, really fast.	14.3%	28.6%	14.3%	42.9%	0.0%
Patient safety is never compromised due to the greater amount of work to be completed.	0.0%	0.0%	20%	60%	20%
Professionals worry about their mistakes. mistakes or failures are recorded in their functional records.	0.0%	22.2%	0.0%	66.7%	11.1%
In this unit, we have patient safety issues.	14.3%	28.6%	42.9%	14.3%	0.0%
Our procedures and systems are adequate to prevent errors from occurring.	0.0%	11.1%	11.1%	44.4%	33.3%

Caption: SD: Strongly Disagree; D: Disagree; N: Neither; CA I agree; SA: I strongly agree.

The following results are noted: "In this unit, people support each other," 63.6% of respondents said they agree and 27.3% strongly agree, totaling 90.9% positive responses; "We have enough professionals to handle the workload," 44.4% agree and 22.2% strongly agree, totaling 66.6% positive responses; "When there is a lot of work to be done quickly, we work together without staff to complete it properly," 55.6% agree and 22.2% disagree; "In this unit, people treat each other with respect," 75% of respondents agree; "

In this unit, professionals work longer hours than would be better for patient care ", 37.5% disagreed and 37.5% agreed, 25% answered" neither "; "Professionals consider that their mistakes, mistakes or failures have led to positive changes around here," 66,7 responded positively; "The technical safety index according to resolution 293/2004" is used, half of the participants disagreed and the other half agreed; "Mistakes, mistakes or failures have led to positive changes here," 85.7% responded negatively, ie strongly disagree or disagree; "When an event is reported, it seems that the focus is on the person,

not the problem," 42.9% disagree and 42.9% agree; "After implementing changes to improve patient safety, we evaluated effectiveness," 75% agreed; "We worked in a 'crisis situation' trying to do it really, really fast", 49.9% disagree and 42.9% agree and 14.3% neither, but negative results at 49.9% Of professionals who strongly disagree or disagree that the management allows the work process quickly and non-standard, draws attention, given the complexity of activities performed by nursing professionals. Table 2 represents the percentage of category responses for each item related to the analysis.

Table 2 - Frequency distribution of the responses of the patient safety culture dimension: "Supervisory / Chief Expectations".

	SD	D	N	A	SA
My supervisor praises when he sees work done in accordance with established patient safety procedures.	0.0%	18.2%	27.3%	45.5%	9.1%
Does my supervisor / boss really consider professionals' suggestions for improving patient safety?	0.0%	0.0%	27.3%	36.4	36.4%
Whenever the pressure increases my supervisor wants us to work faster. even if it means skipping steps	9.1%	81.8%	9.1%	0.0%	0.0%
My supervisor / manager does not pay sufficient attention to rapidly occurring patient safety issues	9.1%	72.7%	9.1%	9.1%	0.0%

Caption: SD: Strongly Disagree; D: Disagree; N: Neither; CA I agree; SA: I strongly agree.

In the first item, it is observed that there was no answer for those who strongly disagree and 18.2% disagree that the immediate supervisor / boss compliments when presence a task is being performed according to patient safety. On the other hand, there was a response to those who agree or strongly agree with such assertion, totaling 54.6%. These results reveal a higher percentage of positive than negative responses and allow us to infer that, culturally, praise for best practices aimed at strengthening patient safety is not yet widely used by supervisors.

In the second item, there is the same percentage (36.4%) for those who agree and strongly agree that their immediate boss considers the suggestions of workers to improve patient safety and there was no answer for those who strongly disagree or agree. disagrees with that statement. Despite the total of 72.8% of positive responses, a total of 27.3% of neutral responses shows that, predominantly, in the units surveyed, the managers consider the suggestions of the workers.

Regarding the item "Whenever the pressure increases, the immediate supervisor / boss wants professionals to work faster, even if they have to perform the procedures in a non-standard manner", the results show good evaluations, 81, 8% disagree and 9.1% strongly disagree, demonstrating that management preserves the ethical and technical-scientific principles of professional practice. However, there was no answer for those who strongly disagree or disagree that the management allows the work process quickly and non-standardized, which draws attention, given the complexity of activities performed by nursing professionals, predominantly in the care sphere, which

are strongly tied to complex procedures and the handling of hard technology, which requires work environments suitable for its execution.

Given this, it is appropriate to confirm that the nurse, as coordinator of the nursing team, must not lose sight of the fact that in the exercise of their administrative function, they should lead the team with a commitment to always seek their technical, scientific and ethical improvement. Given the complexity and instability of the nursing work process, the nurse's responsibility must ensure a nursing care free of damage resulting from malpractice, recklessness and negligence, based on professional ethics as challenging as it may be.[17] Table 3 represents the percentage of category responses for each item related to the analysis.

Table 3 - Frequency distribution of patient safety culture dimension responses: "area / unit".

	N	R	S	AA	A
We are informed of changes implemented from the event reports.	0.0%	0.0%	20%	40%	40%
We are informed about the errors that happen in this unit	11%	33%	11%	33%	11%
In this unit, we discuss ways to prevent errors by preventing them from happening again.	9.1%	81.8%	9.1%	0.0%	0.0%
Professionals are free to say when they see something that can negatively affect patient care.	0.0%	20%	20%	0.0%	60%
Professionals feel free to question their superiors' decisions	22%	11%	33%	22%	11%
Professionals are afraid of questions when something is not right	27%	55%	18%	0.0%	0.0%

Caption: N: Never; R: Rarely; S: Sometimes; AA: Almost Always; A: Always.

The first item, which questions the frequency with which workers have feedback on changes implemented due to notified AE, reveals that they never and rarely have feedback, 20% sometimes, 40% almost always and only 40% said they always had return. regarding the changes implemented. These data show that the culture of information exchange, in order to generate knowledge and develop a critical-reflexive power among team members, is still incipient.

As for reporting errors that occur in the unit, 11% say they are never reported about them, 33% rarely, 11% sometimes, 33% almost always answered, and 11% said they are always informed about errors occurring in the unit. job. Thus, there is a heterogeneity in the responses, which may be due to the inherent characteristics of the researched units themselves, such as leadership / supervision, hierarchical and peer relations.

In the next item, which mentions the discussion among workers about ways to prevent errors from recurring, it is noted that 9.1% never argue, 81.8% rarely, 9.1% sometimes, and there was

no response. almost always and always for error prevention and promotion of patient safety.

This expressive number of professionals who say they do not always discuss ways to prevent errors from recurring are related to the responses of the learning and continuous improvement dimension, as well as to the evaluation of the effectiveness of the implemented measures. Non-evaluation can be a demotivating aspect for the team, because what is the reason to discuss and implement changes if not evaluate its effectiveness?

It is worth mentioning that the representative number of negative responses, regarding the return of the changes implemented after the notification of adverse events, may also influence workers' motivation to continuously discuss and leverage skills to improve patient safety practices and processes.

As for workers' freedom of expression in relation to something that negatively affects patient care, 20% say they talk sometimes and 60% always. In contrast, 20% responded rarely. These data indicate that the vast majority of professionals feel comfortable discussing events that compromise patient care.

Regarding the questioning of professionals with more authority, 11% said to question whenever necessary, 22% almost always, 33% sometimes, 11% rarely and 22% never. When it comes to the fear that professionals have to ask questions when something seems to be wrong, the results show that 22% never feel afraid, 11% rarely, 33% sometimes, 22% almost always and 11% always show or perceive. fear in the team. The results point to the relevance of power relations, and it is important to build increasingly linear and respectful working relationships, in which each team member has their role and contributes to the proper functioning of the service.

Properly functioning teams determine a range of strategies, with particular emphasis on human resources management training programs to improve communication and teamwork.[18-19] Early strategies focus on ways to lower levels of authority, and these efforts may include simple techniques such as getting the leader to introduce themselves, knowing the names of other professionals, admitting their limitations, and naturally accepting information and alerts. of all members that make up the team. Table 4 represents the percentage of category responses for each item related to the analysis.

Table 4 - Frequency distribution of the responses of the patient safety culture dimension: "about your institution".

	SD	D	N	A	SA
LTIE management provides a working climate that promotes patient safety	0.0%	0.0%	0.0%	70%	3.0%
There is good cooperation between hospital units that need to work together.	0.0%	0.0%	17%	50%	0.0%
The hospital units are not well coordinated with each other.	0.0%	60%	20%	20%	0.0%
The care process is compromised when a patient is transferred from one unit to another.	0.0%	22%	44%	11%	22%
The loss of important patient care information during shift or shift changes is common.	0.0%	33%	30%	33%	30%
It is often desirable to work with professionals from other ILP1 units.	17%	33%	17%	40%	40%

Caption: SD: Strongly Disagree; D: Disagree; N: Neither; CA I agree; SA: I strongly agree.

In the first item, it is observed that there was no response to strongly disagree and disagree that the administration of the LSIE provides a working climate that favors patient safety. On the other hand, 70% responded almost always and 3% always favored a work climate, a fact that refers to hospital administration as a motivator and a healthy work environment, which would favor safety for service users.

As for the cooperation between LTIE units, 60% disagree that there is good cooperation, 20% are indifferent and 20% agree that the units cooperate with each other. This positive result reflects that LTIE units can cooperate to achieve the best customer service.

In this connection, in the third item of commitment of care when the patient is transferred, 22% disagree, 44% adopt a neutral position to the item and 33% agree that there is implication of care.

Regarding the loss of information about care with the elderly during the shift change, 66% agree that there is loss, 30% are indifferent and 33% disagree that there is a loss in shift change.

About the item "It is often desirable to work with professionals from other LTIE units", 40% strongly agree that it is desirable to work, 17% are indifferent and 17% strongly disagree.

Conclusion

The study assured to describe the perception of nursing workers regarding the dimensions of patient safety culture, as well as to identify the intervening factors that influence this. Given this, some considerations, regarding assistance, management and

teaching and research, become pertinent, with the purpose of contributing to the researched institution and to further studies on the theme addressed.

Regarding management, the study allowed us to act as a nurse as a supervisor of the nursing team, the visibility that the nurse performs activities that engage and mobilize the team for patient safety. Thus, it is confirmed that nurses should act based on knowledge from the technical-scientific, ethical-political and socio-educational dimensions, which favor safe care.

With regard to LTIE administration, it should absolve the understanding that patient safety is an extremely relevant component of health quality, making it essential for the organization and its managers to increase safety and to consider the systemic approach to the search for quality. improvement in their processes.

In this sense, the institution should provide means for the patient safety to be effective, for example, the implementation of Patient Safety Committees, which should effectively ensure the care delivery processes in a constructive manner, contributing to decision making. and the dissemination of best care practices. Another initiative would be to sensitize the institution's professionals, so that they become co-responsible with the aspects that encompass patient safety, and in this initiative, the institution's continuing education would be of great performance.

We highlight the importance of the implementation of a risk management system, with the objective of encouraging safety and preventing adverse events, emphasizing the implementation of a confidential and reserved error and adverse event reporting system, providing a notifications and improvement in the causal factors of these events.

Describing patient safety is intended to reflect on the accuracy of clarifying the teaching issue as a basis for composing human resources with competencies to address the issue. Thus, it is believed to be necessary the transversality of the content in multidisciplinary undergraduate curricula, as in technical training courses, with the intention of providing the interactions that surround patient safety.

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