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Patient safety: a phenomenological investigation of a research group

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ABSTRACT

Aim: to reveal the typical ideal of members of a research group in nursing regarding patient safety. **Method:** this is a descriptive study, using a qualitative approach that follows, as a theoretical reference, the comprehensive approach of the Social Phenomenology. Data collection took place in March 2015, using the focal group technique. Nine members of a research group from a Public University in North Eastern Brazil participated. Data were analyzed from Schutz's comprehensive approach. **Result:** the characterization of the members of the research group is discussed from the *reasons-to* consolidate patient safety; the *reasons-why* patient safety is not yet consolidated and actions in the world and in everyday life in search of security. **Conclusion:** the members of the research group point out typical actions to consolidate patient safety resulting from multi-professional teamwork and effective patient participation.

Descriptors: Patient Safety; Nursing; Nursing Research.

INTRODUCTION

Patient safety, which is understood as the basic axis of health service quality, has been discussed as a cross-cutting theme that must be understood from a systemic perspective that integrates the training of health professionals, assistance at all levels and research[1-3].

Thus, the aim is to ensure patient safety in the world health landscape as a priority health policy, understanding that the guarantee of safe care is related to a multifaceted context that goes beyond isolated structuring factors regarding the problem of human error[4-5].

In this way, it is recognized worldwide that the first step in promoting health service security is to improve the safety culture, a finding already made in 2003 by the National Quality Forum (NQF) in the United States[6]. Therefore, what is obvious is that the quality of health services should be the result of an overlapping practice of health professionals with regard to safe care.

In other words, it is necessary to foster a safety culture based on the understanding of the multifactorial character underlying the flaws, in the light of the human error theory proposed by James Reason, as well as in the systemic understanding of the quality of health services, based on the elements of the triad structure – process-result, proposed by Donabedian[2], thus carrying out actions that overcome the punitive culture against adverse events, which, in turn, promote effective and safe health practices.

In order to foster a safety culture, it is vital to highlight the training aspect of professionals. The literature shows that, when presented with patient safety at university, future health professionals recognize the relevance of the content for their training. They are encouraged and, as a consequence, a great impact is identified on the care provided to the patient[7].

In this sense, the training of health professionals is considered a key factor to contribute to the promotion of patient safety. For this reason, training institutions should therefore rely on a pedagogical approach that incorporates the theme of quality and safety transversally, so that the professionals in training know their contribution and their responsibility regarding the prevention of adverse occurrences[1,3].

The training of nursing professionals is highlighted in this process because it is understood that the nursing team needs to be represented within the scope of safe care due to their continuous stay with patients and the characteristics of their actions, which generate a potential for both the risk of error and for the promotion of patient safety[3].

Thus, the participation of the nursing team in all the care processes, as well as their involvement with the entire health team, requires training that guarantees competencies to develop actions in favor of quality and patient safety[3].

The discussion, in terms of patient safety, should therefore be inserted at all levels of education - from vocational courses to postgraduate courses - in order to contribute to the training of health professionals who are committed to the practice of health services and also disseminators of a quality culture.

In this sense, it is necessary to reveal subjective human experiences in order to understand a phenomenon better, seeking to systematize the typical ideal of the subjects investigated[8]. Given the importance of understanding how the subject of patient safety has been discussed in the context of research groups linked to graduate nursing programs, the following research question is presented: what is the typical ideal of members of a nursing research group regarding patient safety?

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The objective is, therefore, to unveil the typical ideal of members of a nursing research group regarding patient safety.

METHOD

This is a descriptive study, using a qualitative approach, according to the theoretical framework of the comprehensive approach of Alfred Schutz's Social Phenomenology[8]. Ethical precepts established by Resolution No. 466/2012 of the National Health Council were followed and the study was assessed and approved by the Ethics and Research Committee of the Federal University of Rio Grande do Norte, by means of Opinion No. 972.905 of 02/27/2015, CAAE No. 41871915.7.0000.5537. Thus, the consent was obtained from the voluntary participants, whose anonymity was preserved.

Data collection took place in March 2015, using the focal group technique. The research team was composed of a mediator, a rapporteur and a collaborator. Participants, as research subjects, were members of the Research Group of Care, Safety, Technologies in Health and Nursing (LABTEC), linked to the Post-Graduation Program in Nursing of the Federal University of Rio Grande do Norte (UFRN).

The inclusion criteria were: to be a member of the LABTEC research group. In addition, it was decided that focus groups should have between six and fifteen people, following a literary recommendation, [9-10] in order to ensure their effectiveness. Nine members of the research group, identified by the letter P for participant, followed by a sequential number (P1, P2, P3 up to P9) took part in the meeting.

Assuming that the use of projective techniques contributes to an investigation of unconscious contents, fosters dialogue and creates a favorable environment for the investigation of subjective aspects not revealed in the verbalization[11], the *Pedagogia Vivencial Humanescente* (PVH – Humanistic Experiential Pedagogy) was used to facilitate the expression of the subjectivities of the participants.

PVH is understood as a pedagogical approach that stimulates the subjects' subjective expression, using creativity as a work method through the "assemble-write-speak" triad to stimulate the expression of participants' perceptions from the following guiding activities: 1) set up a scenario using the available materials (thumbnails and modeling mass); 2) write the description of the constructed scenario in a research instrument that contributes to the analysis of what has been said by the subjects surveyed; and 3) talk about their representations, sharing ideas and opinions. The sandplay technique was used, and its key question was "What is patient safety for you?".

The words were transcribed and, for the unveiling of the phenomenon, the analysis of the data was based on the proposal of guiding principles of a research methodology based on Schutz's work, carried out by Zeferino[12].

RESULTS

The *typical ideal* is the key concept that guides the study. It is about how men interpret their attitudes and the attitudes of others according to their histories and their relevance, helping the subjects to situate themselves within the social world and to maintain the various relations with their peers and cultural objects[8].

To trace the typical ideal, it is necessary to reveal the *biographical situation* of the subjects investigated. It is understood by the accumulation of all previous experiences of the subject, organized according to their "stock of

knowledge at hand," determining how each person thinks and acts in a social space[8,12], which influences and is influenced by the motivations of the subjects, encompassing their reasons-for and their reasons-because, and, finally, denoting their *typical actions*.

The *reasons-for* are essentially subjective, because they constitute the goals to be achieved and, therefore, have a temporal structure turned to the future, forming a subjective category of action. On the other hand, the *reasons--because* are based on objectivity, evidenced in the events already completed, thus having a temporal direction turned to the past, and can be understood in retrospect. That is, they are unawareduring the action[8].

The classification of the members of the research group on patient safety is discussed from the following thematic pillars: 1) reasons-to consolidate patient safety; 2) reasons-because patient safety is still not consolidated; and 3) actions in the world and in everyday life which impinge on the search for patient safety.

DISCUSSION

Reasons-to consolidate patient safety

On the basis that the reasons-to refer to the state of things to be established, the project to be carried out and the willingness to do it[8], the members of the research group reflected on the reasons for seeking the consolidation of patient safety, which are synthesized in the possibility of effecting a safe, harmless care, as evidenced in the statements of P5, P3 and P4.

> [...] in order to achieve the assistance that we have idealized, what we wanted, what we thought about, which is to provide a safe care, to safely care for patients, without causing problems, so that they leave with as little damage as possible or none. (P5)

> [...] patient safety is a set of techniques and actions with the purpose of promoting a safe and effective nursing care to the patient. (P3)

> [...] Patient safety, which would be the minimization of acceptable risks, right?! (P4)

It is known that the problem of human error and patient safety in the health system have been the subject of several studies. Historically, the publication of the Institute of Medicine (IOM) in the United States of America stands out, showing that the number of deaths due to errors during health care is greater than those related to auto accidents, breast cancer and immunodeficiency syndrome combined. In the country concerned, some 98,000 people die each year from health care failures[13].

The publication of the IOM - To Err is Human: Building a better health system - and the creation of the World Alliance for Patient Safety by the World Health Organization has contributed to the issue of patient safety so that it can be addressed and considered a challenge in the health system, influencing other countries and considerably increasing the importance of presenting the concepts and principles of the theme in training courses for health professionals.

Recognizing that patient safety is an old goal, P5 reflected on the contributions of Florence Nightingale in the search for safe care in the early days of nursing.

> [...]It is not a current situation [...] this is very old stuff. Since the days when

> Florence had already been talking about patient safety... she was the one who introduced it. (P5)

Since the 2000s, patient safety has entered the agenda of researchers around the world and has become internationally recognized as a fundamental dimension of health quality. The United States and several other countries with distinct health system configurations, such as England, Ireland, Australia, Canada, Spain, France, New Zealand and Sweden, carry out initiatives such as the creation of institutes, associations and organizations to tackle the issue of patient safety[2].

Therefore, the objective of patient safety actions coincides with the concepts of the members of the research group: The objective is to seek health quality, which is defined as the degree to which patient services reduce the likelihood of unfavorable outcomes and increase the likelihood of favorable outcomes, with unfavorable outcomes being understood as adverse situations[2].

In Europe, studies on hospital care revealed that about one in ten inpatients is a victim of adverse events due to the health care received and that more than 50% of these events are classified as preventable[14].

In Brazil, the incidence of adverse occurrences was estimated at 7.6%. The authors observed that, of this total, 67% were classified as avoidable and the most frequent were related to surgery, followed by those associated with clinical procedures[15].

In addition to the damage and harm done to patients and their families, adverse events constitute a considerable financial burden on health systems. In 1999, the total annual cost of avoidable incidents in the US was estimated at between $17 billion and $29 billion[2].

Actions related to patient safety therefore seek to modify this scenario by promoting safe and harmless care. However, health professionals still experience organizational barriers in their work environment, which have been given by members of the research group as reasons-because patient safety actions are not yet consolidated.

Reasons-why patient safety is not yet consolidated

The reasons-because are evidenced in the actions already completed, having a temporal direction turned to the past, and can be understood in retrospect. That is, they are unaware during the action[8]. In this sense, the members of the research group reflected and came to the conclusion that precarious working conditions of health professionals, work overload, multi-employment and health practices based on unsafe actions are reasons-because patient safety is still not consolidated. The words of P4 and P9 reveal such aspects.

> [...] professionals have little time, often related to the workload because they already have two jobs, as it has already been mentioned, or even the accumulation of activities that they have, and this really impairs the assistance progress, right? They often make the assistance in haste, without being careful about what they can do. (P4)

> In relation to time, not only the time administration of care that we promote to patients, but also the time that administer for our lives, so that we do not become too overwhelmed, worn out and, consequently, do not promote patient safety. (P9)

Problems such as limitation or scarcity of resources, work overload due to a lack of enough professionals and lack of qualification in training are pointed out in the literature as factors that negatively influence patient safety.

In the nursing field, this problem becomes even more evident because professionals develop activities of direct care to the patient in a frequent or uninterrupted way and, due to the unsatisfactory remuneration that leads them to multiple employment, fatigue and stress, this can induce errors during care[4].

Studies show that the working conditions of nursing professionals, sometimes characterized by work overload and day shift, are risk factors for patient safety[16].

A Brazilian study, that aimed to analyze the workload of the nursing team and its potential relationship to patient safety in the units of clinical and surgical areas of a university hospital, showed that, for each unit in which the number of patients is increased compared to the number of nurses, the incidence of falls from bed increases by 0.189, infections associated with central venous catheters increase by 0.157, turnover increases by 0.171, and absenteeism increases by 0.268. Likewise, for each unit increase in the ratio of patient to nursing assistant and technician, there was a decrease of 10,799 in patient satisfaction in relation to the nursing team[17

A survey conducted in Uruguay, that sought to know the aspects involved in the nurses' experiences of having been responsible for an adverse incident, revealed that the absence of rest was a common factor in the interviewees' speeches, and, in most cases, the adverse event occurred with overworked professionals[18].

The organizational aspects of health care were also highlighted by a study in two African countries, which talked about obstacles to ensuring safe care in three main areas: material context (including physical infrastructure and equipment); staff (including questions on staff numbers and training) and relational contexts (inter-professional relationships, including teamwork)[19].

It should be emphasized that patient safety is inserted in an expanded context, denoting the main obstacles to its implementation: health care organization and infrastructure; lack of protocol and leadership; scarce material resources; inadequacy in terms of the proportion of professionals and the lack of teamwork; pressure of care and time; lack of incentives and motivation and the absence of reliable safety indicators[20].

With regard to unsafe practices, such as actions that need to be modified, P1 reflected on the existence of training barriers for health professionals.

> [...]We know that we still have to change the mentality of many professionals who are in the service. (P1)

A prospective study at a public university in the city of São Paulo, that aimed to identify the understanding of undergraduate students in nursing and medicine on human error and patient safety, resulted in the fact that one hundred students (91.6%) agreed that there is a big difference between what the professionals know in terms of what is right and what is seen in the day-to-day health care[5].

Similar to the concern highlighted by P1, this research reveals that trained health professionals produce better results in patient care, increasing patient satisfaction and confidence in terms of the care delivery system, but, above all, reducing morbidity and mortality. This is not yet a reality lived by the students in the Brazilian context, and this is an aspect that may lead to a disadvantage regarding the assimilation of the theoretical contents presented by the lack of existence of correlation with practice[5].

It stands out, still, as a reason-because patient safety is not yet consolidated, a concern highlighted by P4: distractions in the work environment.

> [...] distraction inside the work environment, where I mentioned drinking, but which can also be represented by sound, parallel conversations and other types of situations that may occur and that may generate difficulties... This happens very often... So it ends up leading professionals to lose their way. (P4).

A survey conducted in Colombia, that sought to identify the distractions of nursing professionals during the medication administration process, revealed that, of the one hundred and ninety-two processes observed, there were, on average, eighteen distractions by processes performed. The most frequent distractions were: other members of the multiprofessional team and students (34.9%), conversations (32%), telephone calls and doctors (10.5%)[21].

Therefore, prevention of unsafe actions involves multiple factors: from a trained health professional, under adequate working conditions, to structural and organizational aspects, mainly related to the existence of human resources and appropriate materials. Faced with the highlighted obstacles, the members of the research group pointed out typical actions that can contribute to the effectiveness of patient safety.

Actions in the world and everyday life: in search of patient safety

The world and everyday life is the place where men interact with their peers, not only integrating a natural world but also a social, historical and cultural world[8.12]. It is a space where the origins of the subjects' experiences echo, and, in this sense, it constitutes the possibility of understanding the strategies in the micro space of the investigation in question to make patient safety effective. Figure 1 depicts the typical actions evidenced by the subjects and their speeches.

It was emphasized that the prevention of adverse health situations should come from a systemic view, surpassing the minimalist, individual and punitive view of the problem. This systemic view is characterized by the promotion of a patient safety culture, defined as the product of values, attitudes, skills and individual and group behavior patterns, which determine the commitment, style and proficiency of the management of a healthy and safe organization[6].

Therefore, the use of priority strategies underlies the protocols and programs globally, defined as guiding patient safety actions, including the Global Alliance for Patient Safety at the global level and the National Patient Safety Program in the Brazilian context, which defines as priority actions: 1) patient identification; 2) effective communication; 3) prescription, use and administration of medication; 4) safe surgery; 5) hand hygiene; and 6) prevention of falls and pressure ulcers[22].

The use of priority protocols and actions is understood as a fundamental strategy and, therefore, planning is a priority step. To this end, identifying incidents is a challenge, but it is known that it is critical for improving patient safety, which means that efforts to overcome the underreporting problem have resulted in the development of computerized systems as a means of improving the reality[23].

In addition, the application of a *checklist* and the implementation of protocols, besides the Systematization of Nursing Assistance, are

highlighted as important and effective tools. A study in India, that sought to assess the application of a safe surgical checklist, observed that the implementation of a modified WHO checklist on surgical safety was associated with a decrease in mortality and the number of complications. Mortality was significantly lower in the group where this list was used, in comparison to the group in which it was not used (10 vs 5.7%; p=0.04)[24].

An investigation carried out in Taiwan, on the administration of chemotherapeutic drugs, also revealed that the lack of protocols and the underlying poor knowledge of the professionals were the main causes of adverse incidents, and the intervention, with the implantation of protocols, brought a significant decrease in medication errors[25].

The technological resources are thus shown as elements that promote patient safety and it is essential that health professionals are trained so that the resources are used effectively.

The educational aspect was, therefore, highlighted as a fundamental action to consolidate patients' safety, which is also evidenced by the literature[3-5,26]. A study in Nigeria, that aimed to evaluate educational intervention on hand hygiene, showed an increase in the practice of handwashing after the educational action[26], proving that the training aspect is a basic action to promote patient safety, not only in the academic environment but also in the scope of continuing education and in service.

Finally, the safety of the patient is highlighted as a result of multi-professional teamwork and patient involvement. A study on the active participation of hospital patients in their therapy found a positive relationship between the involvement of hospital patients in their own care, their favorable judgment in terms of the quality of the care received, and the reduction of the risk of suffering adversely during hospitalization[27].

Promoting safe care means encouraging patients' participation through their empowerment, which translates into the need to contribute to patients' understanding of their role in promoting, monitoring and restoring their health, meaning that the promotion of a facilitating environment is of the utmost importance[28], so that patients are the last barrier to the interception of an incident, as well as important evaluators of the safety and quality of the care they receive.

CONCLUSION

In this study, the identification of the members of the research group on patient safety was revealed: they point out the reasons-to consolidate patient safety as a way to deliver safe care, but recognize that there are still reasons--because they explain the non-why effect of such actions, which translate into a world in which life is still permeated by poor working conditions; defend the transformation of this life through typical actions that contribute to the realization of safe care, resulting from multi-professional teamwork and effective patient participation.

It is emphasized, therefore, that the presented results represent a specific reality, influenced by the training curriculum of the members of the research group, aspects enough to justify the limitation of the study. From this perspective, it is suggested that the reflections be reproduced in other training institutions for nursing professionals.

It is hoped to contribute to the issue of patient safety being discussed within the scope of the training of health professionals, in order to clarify typical actions that may guide the implementation of safe practices in health care.

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Figure 1 - Typical actions to achieve patient safety. Natal, 2015.

Typical Action	Speeches
Use of priority strategies HIGHLIGHTS: patient identification, correct medication administration, pressure ulcer prevention, hand hygiene and the use of PPE, effective communication, prevention of falls	[...] we still need to take steps to make it effective in our environment, especially here in Brazil. (P5) [...] I have tried to identify [...] some steps [...] that, of course, make up patient's safety. (P3) [...] it represents the steps for patient safety: measures related to medication administration, hand hygiene, involving patients, awareness... (P4)
Correct use of technologies	[...] the correct use of technologies, because it's no use having a new... the best and the newest technology if you don't know how to use it. (P3) [...] today we have more and more advances in resources that will facilitate the patient's safety [...] I thought about the technology of technological resources that we may implement to facilitate the delivery of care. (P6)
Health Professional Training	[...] to prevent it, you must have a scientific basis, for the assistance that you are going to provide, so you have to be well-grounded to apply quality care and improve patient safety. (P2) [...] representing the knowledge that they have and also in relation to the direction they have to follow to perform care, always thinking about how they will act, that is, what will be the first action. (P9)
Effective patient participation	[...] as well as the patient, family and professional involvement, because it is not enough for the professional to work there if the patients do not participate. We have to transfer the responsibility of care to the patients so they can take care of themselves. (P6) [...] patients and professionals must walk together; the professionals must explain the procedures, [...] the educational issue of explaining to the patient so they can take care of themselves, for their recovery. (P7)
Use of Systematization of Nursing Care	[...] the stages of the nursing process are a way for us to promote safe care because, from the moment you systematize care, you systematize your practice, you can carry it out step by step, carefully, reviewing each situation, being able to judge the priority needs of that patient and, consequently, to carry out an effective intervention, you know... always doing the reevaluation. (P6)
Multiprofessional teamwork	[...] the question of multi-professional teamwork, where several professionals come together to provide them with safe care. (P6) [...] and also the multi-professional team, which is very important, since they must also stick together for better assistance. (P7)

Source: research data

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