Experience Report

REVISTA PREVENÇÃO DE INFECÇÃO E SAÚDE (REPIS)

Correct Patient Identification: Experience with the implementation of a Patient Safety Core

Identificação correta do paciente: experiência da implantação de um núcleo de segurança do paciente

Correcta identificación del paciente: la experiencia de la implementación de un núcleo de la seguridad del paciente

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ABSTRACT

Objective: The study aimed to report and evaluate the implementation of the Patient Safety Center, with emphasis on the identification of patients in a public hospital in Piauí. **Method**: experience report, in which the activities were performed from January to April 2019. The information for analysis came from the situations experienced by the authors in the implementation of the NSP and the patient identification process. **Results**: There was an improvement and facilitation in the work of the multiprofessional team enabling lower risk of patient exchange, and consequent avoidable adverse events. **Conclusion**: the implementation of the NSP was reported and analyzed, with a significant improvement in the organization of services, suggesting improvement with the team, highlighting the importance of protocols for better health care.
Descriptors: Patient Safety; Multiprofessional team; Risk control.

RESUMO

Objetivo: o estudo buscou relatar e avaliar sobre a implantação do Núcleo de Segurança do Paciente, com ênfase na identificação de pacientes em uma instituição hospitalar pública do Piauí. **Método:** relato de experiência, em que as atividades foram realizadas no período de janeiro a abril de 2019. As informações para análise, foram provenientes das situações vivenciadas pelas autoras na implantação do NSP e do processo de identificação do paciente. **Resultados:** observou-se uma melhora e facilitação no trabalho da equipe multiprofissional possibilitando menores risco de troca de pacientes, e consequentes eventos adversos evitáveis. **Conclusão:** relatou-se e analisou-se a implantação do NSP, sendo verificado uma melhora significativa na organização dos serviços, sugerindo-se aperfeiçoamento com a equipe, destacando a importância dos protocolos para melhor assistência à saúde.
Descritores: Segurança do Paciente; Equipe multiprofissional; Controle de risco.

RESUMÉN

Objetivo: El estudio tuvo como objetivo informar y evaluar la implementación del Centro de Seguridad del Paciente, con énfasis en la identificación de pacientes en un hospital público en Piauí. **Método**: informe de experiencia, en el que las actividades se realizaron de enero a abril de 2019. La información para el análisis provino de las situaciones experimentadas por los autores en la implementación del NSP y el proceso de identificación del paciente. **Resultados**: Hubo una mejora y facilitación en el trabajo del equipo multiprofesional que permitió un menor riesgo de intercambio de pacientes y los consecuentes eventos adversos evitables. **Conclusión**: se informó y analizó la implementación del NSP, con una mejora significativa en la organización de los servicios, lo que sugiere una mejora con el equipo, destacando la importancia de los protocolos para una mejor atención médica.
Descriptores: Seguridad del paciente; Equipo multiprofesional; Control de riesgos.

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INTRODUCTION

Several countries have a health technology surveillance system to optimize patient safety and health by minimizing adverse events at various times. In Brazil, for decades, the proper use of health and safety technologies in care practices has been standardized, requiring consistency and articulation of these actions to increase health safety. [1]

Patient safety is a major challenge for health institutions, since there is a high incidence of damage resulting from health care. Patient safety is to ensure that the risks and unnecessary health-related harm are minimized to the minimum acceptable. There are several types of damage such as injury, pain, disability or even death.

The National Health Surveillance Agency (Anvisa) with the Ministry of Health of Brazil, in 2013, established as a requirement that all health services deploy the Patient Safety Center (PSC), created to support and promote the practice of actions aimed at patient safety through protocols to be followed to prevent care failures.

To expand actions to promote patient safety and improve quality in health services, the Collegiate Board Resolution - RDC 36, of July 25, 2013, was instituted by Anvisa. The PSC should have as principles and guidelines: the continued advancement of health care technologies and actions; the spread of safety culture; discussion and relationship of risk control techniques; and safety in the operation of the health service. [2]

There are still other protocols instituted by Anvisa, which guide professionals to a good practice of patient safety in a hospital environment in a systematic way, they are: Hand hygiene; Surgical safety; Safety in the prescription, use and administration of medicines; Safety in the prescription, use and administration of blood and blood components; Safety in the use of equipment and materials; Maintain adequate records of the use of orthoses and prostheses when this procedure is performed; Prevention of patient falls; Prevention of pressure ulcers; Prevention and control of adverse events in health services, including healthcare-related infections; Safety in enteral and parenteral nutritional therapies; Effective communication between health service professionals and between health services; Encourage patient and family participation in the care provided; Promotion of safe environment.[3]

Of the resources exposed to minimize health incidents, the importance of properly identifying patient identification prevents failures in care provided by teams of health professionals at various levels of health care.

Errors in patient identification has been recorded as a concern in health care and can trigger various adverse events in the course of surgery or procedures, medication administration and blood products, laboratory tests, the delivery of newborns family.[4]

Analyzing the seriousness of the theme, the present study sought to report and evaluate the implementation of the Patient Safety Center - PSC, with emphasis on the identification of

patients in a public hospital in the municipality of Pedro II - Piauí. From the results, it was demonstrated that the implementation of the NSP in health institutions, with the correct identification of the patient ensures that care is performed for its intended purpose, minimizing incidents that may lead to errors in health care, lack of color coding standard used in the institution, incorrect information and patients without bracelet.

METHODS

The research is an experience report, which reported and evaluated the process of implementation of the Patient Safety Center with emphasis on the identification of patients through the use of adult and child bracelets, against the backdrop of a public hospital in the municipality of Pedro II - Piauí. Experience report is the characterization of a successful or unsuccessful professional experience, which contributes to the exchange and discussion of ideas that improve health care.

The institution has 28 beds in its structure, including 6 beds for pediatrics, 5 beds in a room, 5 female beds, 4 male beds, 5 beds for isolation cases, 2 pre-delivery beds and 1 resuscitation bed. Other services include 24-hour emergency care and 4-bed emergency, clinical analysis laboratory, X-ray sector, obstetric center and operating room. However, the study was conducted only with the 28 beds that are part of the hospitalization sector, including adults and children, because they have longer length of stay.

The activities were conducted from January to April 2019. The information for analysis came from the record of the situations experienced and observed by the authors in the implementation of the PSC and the patient identification process.

The study reported the importance of the multiprofessional team in the implementation process and discussion of strategies adopted to monitor the safety of patient care. Expectations, difficulties encountered, and benefits of PSC deployment for patients and staff were described.

DEVELOPMENT

The implementation of the Patient Safety Center in the public hospital in the municipality of Pedro II - Piauí began in September 2018, due to the need to monitor and qualify the care provided to patients treated at this hospital unit. At the first moment, a meeting was held where professionals from various sectors were summoned to demonstrate the importance of the creation and implementation of the PSC, which all agreed to collaborate in the process.

At the same time, the members who would be part of the PSC committee, consisting of professionals from various sectors: director general, doctor, nurses, nutritionist, hospital supply manager, nursing manager, x-ray technician, responsible for sterilization, administrative, and a general services profesional.

The members were divided into the elaboration of foundation protocols for the nucleus, according to the area of expertise of

each professional, based on ANVISA, emphasizing the first protocol to be implemented, the identification of patients by means of bracelets on admission. After that, the deadlines for delivery of the protocols to be implemented were determined and the identification of easy-to-write plastic white identification bracelets was requested.

Following implementation of the PSC, health institutions monitor and investigate incidents arising from health care, especially adverse events and deaths, according to normatization rule 36/2013. Its implementation brings the need for progress and adherence of the multidisciplinary team to good patient safety practices, as recommended by specific legislation and preparation of the Patient Safety Plan, based on the management of present risks and local reality.[3]

The Ordinance that established the National Patient Safety Program (NPSC), establishes the implementation of protocols aimed at patient safety, to improve health care assistance: hand hygiene in health institutions; safety in the indication and administration of medicines, blood and blood products; patient identification; safe surgery; fall prevention; pressure ulcers; effective communication in the health facility; safe use of equipment and materials and patient transfer between care points.

Subsequently, the protocols were handed over (previously described) by the committee, and the Internal Rules were presented by the vice-president, and the Patient Safety Center was established, emphasizing as one of the first protocols to put into practice the identification of the patient.

According to ANVISA the intention of this protocol is to promote the identification of the patient correctly, aiming to reduce the occurrence of incidents. This process should ensure that care is offered to the intended person. Proper identification is the way to provide the patient with care, treatment or procedures, avoiding errors and mistakes that may compromise the patient's health.[2]

The protocol of the patient identification bracelet has some peculiarities: color, size, comfort, ease of use, registration of patient identifiers. It also has aspects that need to be evaluated in order to promote the use of wristbands: storage, accessible to the place of storage, filling in patient identifiers, updating information, reading and verifying information, placement on the patient (including choosing the correct size or adequacy to the correct length) and fixation.

With the elaboration of the patient identification protocol, training was first performed with the nursing staff on the implantation and use of the bracelet for identification and, consequently, with the reception staff.

In the hospital where the research was carried out, the patient identification protocol starts at the reception of the institution, with the collection of personal data for hospitalization, and later written with ballpoint pen on the bracelet, the data: full name of the patient, date of birth, ward/bed and date of hospitalization, then the patient referred to bed.

The use of bracelets is the most appropriate method for the correct identification of patients and most commonly used in hospitals. In this present experience report it was found that the agents involved with the provision and placement of the bracelets are the receptionist teams in which it was possible to identify some important flaws that are: incorrect or incomplete late identification, causing non-compliance and leaving the patient exposed to errors.

The difficulties encountered in the process of implementation by the receptionists regarding the implementation of activities, and to follow the protocol correctly, which instead of filling and placing the bracelet at the time of hospitalization, referred the patient to bed and only after the bracelet was placed, and at other times was not even placed. We know that for a implemented process to be successful there must be supervision and charging by the organizing committee to keep monitoring.

After implantation, it was possible to verify as obstacles on the part of the nursing staff to maintain and monitor the use of wristbands because they report work overload. It was also observed that at the beginning there was little resistance on the part of patients to maintain the use of bracelets, since many withdrew before discharge. After continuous guidance, acceptance was improved and the bracelet remained on the arm until discharge.

Among the limitations of the identification process, there were more frequent recurrences of errors in first and last names or even incomplete names; the non-filling of the bracelet at the moment of hospitalization, leaving for identification after bed accommodation; and when the bracelet is placed on the patient's arm, when it comes into contact with water, it loses the integrity of the information, because it is written with a ballpoint pen, and the writing has to be reinforced, and most profesionals are not aware.

In 2017, Anvisa, through Patient Safety and Quality in Health Services Bulletin No. 15, reported the progressive increase in health care related incidents, including adverse events reported during this period. It has been verified that by the Sanitary Surveillance Notification System - Notivisa 2.0 received 53,997 notifications, of which 4,445 are incidents resulting from the failure to identify the patient.[5]

According to protocols of the Brazilian Ministry of Health, to ensure that patients are correctly identified, at least two identifiers must be worn directly written on a standard white wristband, placed on a patient's limb to be checked before care. The health service indicates the limb according to the patient. In common, the place indicated for the adult is the wrist, and for newborns, preferably the bracelet needs to be placed on the ankle. In situations that cannot use upper limbs in adults, lower limb use is indicated.[3]

Full name, date of birth, patient's medical record number and the full name of the patient's mother, are data that should be inserted in the bracelet as recommended, using at least two identifiers. In cases where the patient's identity is not accessible upon admission or the full name is not known, the patient's medical record number and most

pronounced physical characteristics, including gender and race, may be used.

In the institution, it was observed with the implementation of the identification protocol, an improvement and facilitation in the work of the multidisciplinary team, enabling lower risk of patient exchange, and consequent avoidable adverse events, such as: intravenous, intramuscular or subcutaneous drug infusion; blood components; collecting material for laboratory tests; in the preparation and distribution of food, and in the execution of invasive procedures. The bed / ward number is not used as a reference because of the risk of change during the patient's stay. The identification of the newborn requires extra care that must contain at least: NB of (mother's name); birth date; time of birth; baby gender and registration number.

In the 45-month study, the absence of the wristband, patient name and ID number errors are recognized as the most frequent failures in the patient wristband check. It was pointed out that the absence of wristbands accounts for half of the failures (incomplete names, different record numbers, data illegibility and integrity problems) that may occur because nursing professionals have to write patient data on wristbands. identification when taking into account the high workload.[6]

Institutions seeking to minimize errors tend to work on improving the organization of patient safety culture by adopting new technologies to improve the work process, so patient safety should be viewed holistically for better assistance to users.[7]

Consequently, there was a significant improvement regarding service organization and patient compliance with procedures and standards, but there is still a lack of commitment from the general team to follow the protocol. It was analyzed that for the receptionists the bracelet is just another work added to the routine, becoming a nuisance, but performing the process. For the nursing staff, it was noted that most do not follow the identification protocol when performing procedures, such as checking the name if it is correct and not observing who has a bracelet.

FINAL CONSIDERATIONS

In this study, the experience with the implementation of the PSC was reported and analyzed according to the reality of the institution. A significant improvement in the organization of the services was verified, but requiring greater supervision by the PSC committee for the safe and correct execution of the patient identification protocol.

Thus, it was possible to note with the records of the situations experienced during implantation, the importance of all professionals when providing care to the patient, from admission with the placement of the bracelet, during the stay with the identification check, confirming the recommended indicators, until hospital discharge.

Observing that the limitations found overlap with the protocol and PSC, it is suggested improvement through continuing education with the team, highlighting the importance of protocols established in the

institution for better patient health care and support to the professional.

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PEOH and TMT: substantial contributions in the conception or design of the work; data collection, analysis and interpretation; in the writing of the article or its critical review; and in the final version to be published. All authors agree and are responsible for the content of this version of the manuscript to be published.

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CONFLICTS OF INTEREST

There are no conflicts of interest to declare.

AVAILABILITY OF DATA

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Does not apply

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