

# SOCIAL REPRESENTATIONS ABOUT PATIENT SAFETY FROM THE PERSPECTIVE OF INTENSIVE CARE NURSES

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## REPRESENTAÇÕES SOCIAIS SOBRE SEGURANÇA DO PACIENTE NA ÓTICA DE ENFERMEIRAS INTENSIVISTAS

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## REPRESENTACIONES SOCIALES SOBRE LA SEGURIDAD DEL PACIENTE DESDE LA PERSPECTIVA DE LAS ENFERMERAS DE CUIDADOS INTENSIVOS

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**Objetivo:** apreender as representações sociais sobre segurança do paciente na ótica de enfermeiras intensivistas. **Método:** estudo de natureza exploratória com abordagem qualitativa, fundamentado na Teoria das Representações Sociais. Foi realizada entrevista semiestruturada com 20 enfermeiras intensivistas de um hospital privado de uma capital brasileira. Os dados foram processados pelo *software* IRAMUTEQ e utilizado análise de similitude e de conteúdo para seu tratamento e interpretação. **Resultados:** na estrutura das representações sociais das enfermeiras intensivistas a segurança é concebida como eixo norteador das práticas de cuidado, objetivada mediante protocolos e normas institucionais, que promovem práticas seguras e gestão de risco. **Conclusão:** as representações sociais revelam que as enfermeiras ancoram suas concepções de segurança do paciente na dinâmica do seu processo de trabalho, por meio de subsídios e estratégias, como conferências/checkagens, utilização de *checklists*, para realizar intervenções que possibilitem assistência livre de danos.

**Descritores:** Enfermagem. Segurança do Paciente. UTI. Cuidado.

*Objective: to grasp the social representations about patient safety from the perspective of intensive care nurses. Method: exploratory study with qualitative approach, based on the Theory of Social Representations. A semi-structured interview was conducted with 20 intensive care nurses from a private hospital in a Brazilian capital. The data were processed by the IRAMUTEQ software and used similarity and content analysis for their treatment and interpretation. Results: in the structure of the social representations of intensive care nurses, safety is conceived as a guiding axis of care practices, objectified through protocols and institutional norms, which promote safe practices and risk management. Conclusion: the social representations reveal that nurses anchor their conceptions of patient safety in the dynamics of their work process, through subsidies and strategies, such as conferences/checks, use of checklists, to perform interventions that enable harm-free care.*

*Descriptors: Nursing. Patient Safety. ICU. Care.*

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*Objetivo: aprehender las representaciones sociales sobre la seguridad del paciente desde la perspectiva de las enfermeras de cuidados intensivos. Método: estudio exploratorio con enfoque cualitativo, basado en la Teoría de las Representaciones Sociales. Se realizó una entrevista semiestructurada con 20 enfermeras de cuidados intensivos de un hospital privado en una capital brasileña. Los datos fueron procesados por el software IRAMUTEQ y utilizaron análisis de similitud y contenido para su tratamiento e interpretación. Resultados: en la estructura de las representaciones sociales de los enfermeros de cuidados intensivos, la seguridad se concibe como un eje rector de las prácticas de atención, objetivado a través de protocolos y normas institucionales, que promueven prácticas seguras y gestión de riesgos. Conclusión: las representaciones sociales revelan que las enfermeras anclan sus concepciones de la seguridad del paciente en la dinámica de su proceso de trabajo, a través de subvenciones y estrategias, tales como conferencias/comprobaciones, uso de checklists, para realizar intervenciones que permitan la atención libre de daños.*

*Descriptor: Enfermería. Seguridad del Paciente. UCI. Cuidado.*

## Introduction

The safety of inpatients at the Intensive Care Unit (ICU) is influenced by complex dimensions, since it is a critical care environment, requiring approximations related to this practice in daily work. In this context, the nurses' care practice is a contributing factor for its achievement, since their work process and patient safety are inseparable elements<sup>(1)</sup>.

The dimensions of the safety of ICU patients go beyond the understanding and operationalization of the risk management process, permeate subjectivity and relationships established in daily work, are triggered by behaviors and attitudes that can be (re)meant by nurses<sup>(2)</sup>, that is, they are linked to their Social Representations (SR), making this understanding the differential for safe care.

SR is a form of socially organized knowledge that contributes to the constitution of a reality common to a given social group<sup>(3)</sup>. It is, therefore, a way to understand nuances and processes of knowledge shared by intensive care nurses about patient safety in their daily work.

The World Health Organization (WHO) considers patient safety as a critical component for improving the quality of care worldwide. Currently, it reflects the challenges that health professionals should seek in improving harm-free care, and should be guided by efficacy, efficiency, technical-scientific knowledge and the mastery of modern technologies<sup>(4)</sup>.

Following the worldwide movement for harm-free care, in Brazil, the Ministry of Health (MH), through Ordinance n. 259 of April 1, 2013, instituted the National Patient Safety Program (PNSP)<sup>(5)</sup>. In July of the same year, the Collegiate Board Resolution (CBR) n. 36, of the National Health Surveillance Agency (ANVISA), proposes actions to improve the quality of health services, approving, through Ordinance n. 2,095, basic patient safety protocols, whose purpose is to institute actions for patient safety in health services at national level, functioning as guides and norms, and containing the best practices<sup>(6)</sup>.

Most of these guidelines and actions for patient safety were considered due to the high occurrence of adverse events to the patient, that is, unnecessary damage in the world and Brazilian health care scenarios<sup>(7)</sup>. However, the ICUs, due to the type of care practices therein developed, anchored in hard technologies, differentiated profile of patients' severity, multiple demands for processes and activities, stand out in the occurrence of adverse events, leading to increased hospitalization time and mortality<sup>(8)</sup>. Thus, there stands out the relevance of studying patient safety in this care scenario.

In this direction, the following research question was outlined: How are social representations about patient safety grasped from the perspective of intensive care nurses?

Thus, seeking to access the knowledge that guides the safety of the ICU patient from the perspective of intensive care nurses, in order to also understand their conducts and actions in daily health, this study aims to: Grasp the social representations about patient safety from the perspective of intensive care nurses.

## Method

Exploratory study with qualitative approach, based on the theoretical methodological contribution of the Theory of Social Representations (TSR)<sup>(9)</sup>. It is a product of the master's dissertation entitled "Social Representations of Intensive Care Nurses on Patient Safety"<sup>(10)</sup>, developed in 2019, in the Professional Master's Program in Nursing (MPN) of the Health Department of the State University of Feira de Santana (UEFS), Bahia, after approval by the Human Research Ethics Committee (REC), Opinion n. 3.239.115.

It was carried out in accordance with the Resolutions of the National Health Council (NHC), n. 466, of December 12, 2012<sup>(11)</sup>, of the Ministry of Health, which ethically regulates researches with human beings, and Resolution n. 510, of 2016<sup>(12)</sup>, which addresses norms applicable to researches in human and social sciences, thus respecting the legal principles of ethics and law. To ensure methodological rigor, the qualitative research checklist was adopted at all stages, following the guidelines of the Consolidated Criteria For Reporting Qualitative Research (COREQ).

The study field was a large-sized private hospital located in a Brazilian capital. The approach to the research scenario occurred in two moments: presentation of the study project in the clinical research session; verbal communication, by coordination, in a meeting with the clinical staff of nurses of the critical units, followed by individual formalization through a printed invitation given to each potential participant of the study. At that moment, the interviewer introduced herself and presented the reasons for the research development, highlighting

that it was a master's dissertation project with intervention scope for the reality studied.

The research participants were intensive care nurses; of the 32 professionals working in the field of study, 23 were selected because they met the inclusion criteria: minimum of six months of service and work in general ICU in direct contact with the critical patient. Nine nurses were excluded because they met the exclusion criteria: absence from the service by maternity leave (2), by health leave (1), vacation (4) and a coordinator, for not developing direct care activity to the patient. There was only one refusal. Three nurses were not interviewed due to the closure of data saturation collection. Thus, the number of participants was defined by the criteria of inclusion/exclusion and data saturation, totaling 20 participants.

Participation in the research was conditional on the acceptance and signing of the Informed Consent Form (ICF), after receiving information on the theme, justification, objectives, benefits and risks of the research. The anonymity of the participants was ensured, and the contents of the speeches nominated by acronyms (ICN-1; ICN-2...), which correspond to the term Intensive Care Nurse (ICN), followed by a number, guided by the order of collection.

The semi-structured interview was chosen as a data collection strategy, since it is a comprehensive technique that privileges social interaction, with the possibility of reaching the subject's own reflections on the reality experienced, that is, of his/her social imaginary, thus enabling the perception of elements of the SR, implicit and latent. The access to dialogue with the subjects about the investigated phenomenon pervades the subjective field of ideas and meanings, through the spontaneity and interaction of the subjects<sup>(13)</sup>.

Data collection occurred between June and August 2019, with the approval of the service, in a reserved room, with only the presence of the interviewer and the participant, and lasted an average of 15 minutes. The interviews were applied by one of the authors, duly trained,

nursing master's student and intensive care nurse, with more than fifteen years of experience in the area, in addition to the experience in teaching.

The previously tested data collection instrument included objective data related to the characterization of participants and subjective questions that sought to meet the objective of this study. The interviews were recorded and transcribed *ipsis litteris* for analysis. The transcriptions were returned to the participants for corrections, with no need for repetition of interviews. The participants also received a partial feedback of the results at the institutional annual activity balance event in December 2019.

Data collection was completed after reaching empirical data saturation, which occurred when the essence of the statements did not indicate new information, and those obtained ensured relevance and consistency, that is, the amount and intensity of implicit and latent contents to meet the objective proposed for this study<sup>(14)</sup>.

After the transcription of each interview, all the material was gathered in a single textual corpus and submitted to the stages of similarity analysis and content analysis. The similarity analysis, which is based on graph theory, allowed identifying the co-occurrences between the elements and their result brought indications of the connection between the terms, helping in the identification of the representational structure, through the textual analysis software IRAMUTEQ (*Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires*)<sup>(15)</sup>.

The software allowed for the study and organization of the elements that compose the investigated representation, through the identification of the link between the words and built the similarity tree, being possible to identify the organization of the SR, that is, the more people resemble in the way of representing a given object, the higher their index of similarity<sup>(16)</sup>.

For this article, a cutout of the maximal similarity tree processed by the software was used, considering the lexicon "safety" and branches. This element presents strong connection to the central term "patient", highlighted in the

schematic representation, and observed by the thickness of the graphs.

As the software does only data processing, the content analysis method was adopted in the second moment seeking to understand the social imaginary, since it allows understanding the content of the participants' statements beyond the meanings contained in their statements. It is worth mentioning that the similarity analysis and the technique of content analysis are complementary, based on the perspective of the communication process as a common point, modes of interpretation of reality, reflecting the behaviors and social practices of the participants.

The content analysis proposed by Bardin<sup>(17)</sup> occurred in three stages: 1<sup>st</sup> stage – Pre-analysis, phase of organization of the material, in which exploration readings were performed, which provide the opportunity to operationalize and systematize the initial ideas; 2<sup>nd</sup> stage – Exploration of the material, moment when the material was coded and gathered in meaning units; in the 3<sup>rd</sup> stage, there were the treatment of results, inference and interpretation, establishing relationships between the object of analysis and its broader context, providing new reflections.

## Results

In the composition of the studied group, the age of the 20 participants ranged from 28 to 53 years, with only 1 male participant; and nursing training/graduation time ranging from 4 to 30 years. While the time of work in critical care units ranged from 2 to 29 years, and the working time in the institution studied ranged from 10 months to 28 years.

As for complementary training, all intensive care nurses had post-graduation in the area of activity, either by specialization or by residency in intensive care. Concerning employment, most of the nurses had a single work relationship, of the CLT type, with a workload of 44 hours per week.

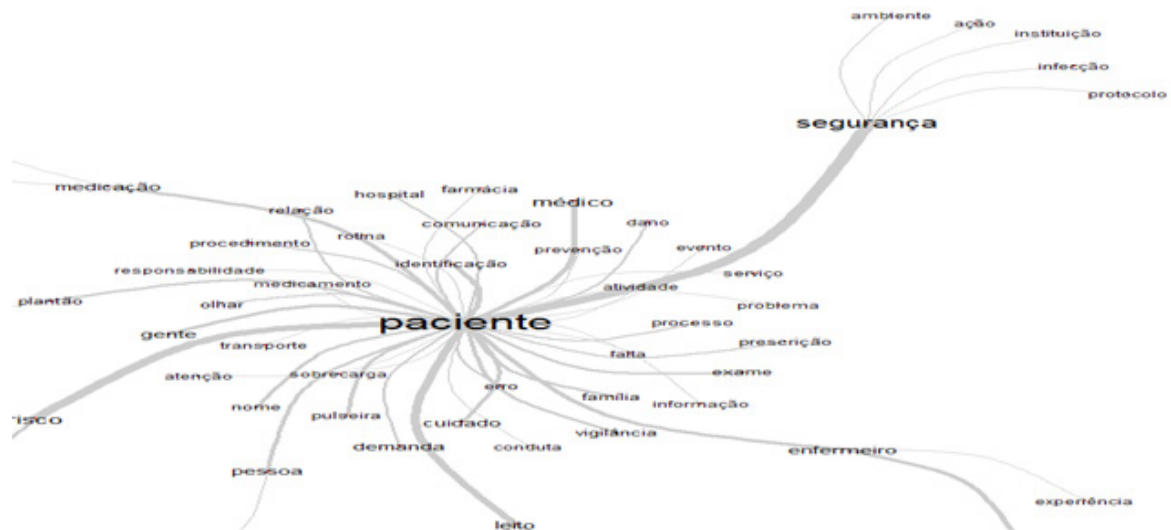
The results grasped through the interlocution between the analysis of similarity and contents

of the discourses reflect knowledge shared and collectively constructed by intensive care nurses about the object “patient safety”.

The cutout of the similarity tree signals safety as a primordial element of development of patient care practices from the perspective of the investigated group. The term “safety”,

in turn, is directly linked to the “environment”, “actions”, “institution”, “infection” and “protocol”, thus revealing aspects of the daily life and professional practice of nurses in the workplace, and converge with the contents of the discourses. Its organizational structure is described in the following schematic representation (Figure 1):

**Figure 1** – Cutout of the maximal similarity tree based on the term “safety”



Source: Created by the Software IRAMUTQ, version 0.7 alpha 2, from the analysis corpus of the interviews<sup>(15)</sup>.

From the convergence process between the analyses of similarity and content and the cutout, a single category emerged, “Safety as the guiding axis of ICU care practices”, which reflects attitudinal, cognitive, symbolic and practical dimensions.

#### *Category – Safety as the guiding axis of ICU care practices*

This category was delineated based on the observation that the participants bring the safety component as the guiding axis of care practices, both in the structure of the SR in the analysis of similarity and in the content of the discourses. However, a predominance of the attitudinal dimension was verified in the representation of the social group studied, that is, attitudes offer dynamics to the representation of patient safety and support daily work actions. Thus, two subcategories were derived from the central

category, reflecting actions, based on knowledge, the movement for patient safety, adherence to safe practices, protocols and institutional risk management.

#### Subcategory 1 – The intensive care nurse’s action for patient safety

The SR grasped from intensive care nurses reflect daily actions involving the safety of critically ill patients, observed in the concern with the correct identification of the patient, with the prescribed therapy, with surveillance, technological monitoring with the configuration of alarms and with the prevention of hospital infection.

*I always get here and look at the patient’s name with the prescription, and check on everything, I check if all the risks, if all the measures for him are prescribed there, I always look at the patient’s wristband with the plate that we wear [...] especially when there is a patient with a similar name. (ICN-11).*

*The first positive parameter we have is patient monitoring, monitored with alarms always active, this is a condition for us, which gives you a little more comfort and safety, and also regarding surveillance. (ICN-6).*

*[...] the devices that patients use to monitor, we have the central monitor that this gives us safety, because our rooms are closed. (ICN-10).*

*I constantly work with the team to prevent hospital infection, the importance of hand hygiene and prevention of cross-infection. (ICN-1).*

## Subcategory 2 – From adherence to safe practices and institutional protocols to risk management

The discourses of intensive care nurses point to SR constructed in daily work, based on institutional safety elements related to adherence to safe practices, protocols and risk management. The dispensing/verification/administration of medications and transport checklist were cited as barriers that reinforce safety in a systemic way:

*The identification of the medications inside the bag with the patient's label, some have the color sign [...] some medications come in red bag, I think this reinforces a little the severity of what you are picking up, and the blue bag that identifies refrigerator medicine, then you try to administer or try to return to the environment, so it is well stored. (ICN-12).*

*Regarding the administration of medications, the double checking of those potentially dangerous drugs, which we have here in the institution, then antineoplastic or chemotherapy, or other types of medications that are on the ANVISA list, they are checked twice or by two nurses or by the pharmacist and the nurse. (ICN-5).*

*Another positive experience is the transport checklist, I think it is very important, even if sometimes we neglect its filling, you manage visualize what you need to take, to at least be able to have an effective transport, without bringing risk to the patient in this path in the hospital. (ICN-3).*

The protocols and institutional norms were pointed out by intensive care nurses as the instrument that help define, standardize and review the way to process direct health care, reflecting on the work organization. Thus, the representations of the participants about the protocols and institutional norms support actions to maintain patient safety.

*One situation that I experience almost every day is when we have access to institutional protocols, so every time I feel insecure about some action I have to take, I*

*resort to the protocol, whose availability makes me feel secure. (ICN-2).*

*We have work process set for almost every procedure we do, and this tends to facilitate our work routine. (ICN-7).*

*[...] here we have very well established routines, with a much closed, researched flowchart [...] it facilitates, even helps us identify the risks to patients. (ICN-4).*

In the collective imaginary of the social group researched permeates the conception that a complex hospital care environment should be based on harm prevention, risk management, raising information management and structured communication. The following discourses refer to the communication process for the construction of the critical patient's therapeutic plan, bringing elements of risk management in their contents:

*Our view is already directed to what is to predict risks and damage to the patient and also facilitate effective communication, communication with the doctor, with everyone in the team. (ICN-8).*

*It is also important to guarantee the shift of the diarist in the multidisciplinary visit [...] because it is where you share everyone's experience with respect to that patient, and all contribute to an environment as safe as possible... (ICN-13).*

*The multidisciplinary visit is a positive mechanism, because it also signals a part of these risks, draws the team's attention. So each one has a risk signaling that is more connected to their area and can also work this prevention. (ICN-9).*

## Discussion

The configuration of the similarity tree, the product of the discourses of intensive care nurses, signals the "patient" as a center of health care and establishes a strong connection with "safety", placing it as a primordial and inseparable element of the work process and critical care practices.

In turn, safety is directly linked to the environment, actions, institution, infection and protocol, thus revealing aspects of professional practice and intensive work routine.

The category "Safety as the guiding axis of ICU care practices" points out SR, which, on the one hand, demonstrate objective implications, such as conference and verification actions, creation of overlapping barriers to minimize the risk of

errors, patient change and adverse events, on the other hand, denote subjective implications, such as responsibility and commitment to the other.

The subjective dimension refers to a more critical look at the patient's safety object and reflects a positive culture, considering that the knowledge of risks, the observance if prevention measures are being prescribed and carried out, are basic points for any issue that involves health, implying a culture of error prevention, risk reduction and consequent patient safety. Thus, the analyses of both similarity and content allowed understanding that there is movement and accountability of the group in relation to the production of safe care for critically ill patients.

In subcategory 1, "The intensive care nurse's action for patient safety", the seized SR establish consonance with the international goal of safety of correct patient identification. In this direction, the PNSP guides the adoption of monitoring indicators included in the patient identification protocol, which are: the number of adverse events due to failures in patient identification and the proportion of patients with standardized wristbands among patients treated in health institutions<sup>(5)</sup>.

The various forms of patient identification, either by the wristband, plate near the bed and in the medical records, are strategies used by organizations in an attempt to ensure safer health care. The negligence on the part of the professionals, due to the non-adherence to the fulfillment of this goal/strategy, produces failures in the monitoring of the identification elements, which can generate from mild to fatal damage.

The surveillance, carried out by the nurses, aiming at patient safety, is anchored in norms, institutional protocols and equipment, and fits into the attitudinal dimension of the SR of the social group under study, provided mainly by the action of paramedical monitoring, with alarms always active. Thus, there is a biological view, with emphasis on hard technologies, aimed at the rapid visualization of clinical alterations that can be captured by monitoring, such as the identification of arrhythmias, critical

heart rate values or changes in ventilatory and mechanical support parameters<sup>(8)</sup>. There is a process of desensitization, reduction of alertness and confidence, and even urgency of these devices, resulting from alarm fatigue, which occurs when a large number of alarms cover up other clinically significant ones, making the team disable, silence or ignore some relevant ones<sup>(18)</sup>. Therefore, it is not only necessary to ensure active monitoring, but to know how to use these devices assertively, which implies knowledge of the patient and adjustments that meet safety needs in an individualized way.

In subcategory 2, "From adherence to safe practices and institutional protocols to risk management", the SR signaled strategies regarding the dispensing, conference and administration of medications, and, consequently, safe use of medications. According to an international and Brazilian study<sup>(19-20)</sup>, each inpatient is subject to medication errors, that is, to preventable adverse events related to the medication cycle. These errors can occur in any of the processes that constitute the medication circuit, with the most frequent classified as errors in prescription, distribution, dispensing, preparation and administration.

The individualized and packaged dispensing in bags of different colors aims to eliminate or reduce the possibility of changing medications by patient. This type of barrier refers to the activation of the sensory system, with attribution of colors to the packaging of medicines, institutional measures that provide an opportunity to reduce harm to the patient.

Anchored to the everyday universe, the institutionalized attitude of double drug verification was described as a positive practice concerning patient safety. In the reified universe, that is, of science and knowledge, the administration of certain high-risk/high-alert/high-surveillance drugs should be followed by double checking, through the prior and judicious establishment of a standardization, aiming at the non-trivialization of the method<sup>(21)</sup>. This action ensures establishing filters against erroneous prescriptions.

In this direction, another safety practice signaled by the researched group refers to the transport checklist, which is shown to be an instrument with potential to improve the safety and quality of care for ICU patients. In general, checklists facilitate the application of complex tasks, decrease variability and ensure better safety during procedures and interventions<sup>(22)</sup>. Thus, the adoption of this instrument is shown to be a valuable institutional tool, which can be adopted by all team members, regarding not only transport, but other procedures.

Thus, the SR reveal that intensive care nurses anchor their conceptions of patient safety in the organization of their work process and in the dynamics of flows, based on subsidies and strategies, such as the use of checklists to perform interventions that enable harm-free care to patients.

The SR grasped in relation to safety also suggest that the actions of intensive care nurses are guided by protocols, because familiarity was observed with this instrument, which appeared in the analysis of similarity and content. The consultation in situations of doubt reflects its use as a risk management tool, as a guide for the accomplishment of organized flows and work routines, and refers to anchorage to the representations before the object of study.

The SR show that, in daily work, the actions around patient safety are guided by better guidance and scientific evidence; from another perspective, subjective dimensions appear, since these professionals seem to have incorporated a culture of positive safety, assuming the commitment for the care quality, to the detriment of acting spontaneously, in a mechanistic or impulsive way, in the definition of a behavior.

In another perspective, they indicate that assertive communication guarantees the correct diagnosis and behaviors, converging with the premise that, in the field of intensive care, the adoption of correct procedures becomes vital<sup>(23)</sup>. In this direction, still in subcategory 2, the SR seized point to the multidisciplinary visit as a moment of alignment, which provides effective

communication through dialogue, interaction, exchange of information, experiences and counterpoints of professionals in the management of the critical individual and his/her risks. Thus, it ensures an integrated therapy, with harmony of behaviors between the teams involved in patient

The interaction, resulting from the discussion of behaviors in the various areas, should be based on the best available evidence, but palpable for each scenario, and should be performed at an opportune time, which is often unfeasible due to the dynamics of the ICU, underusing the potential of reach that the multiprofessional visit has as a risk management tool. This moment is also an opportunity for in-service education, since it allows the exchange of multidisciplinary scientificity<sup>(24)</sup>.

## Conclusion

The SR on patient safety, grasped in this study, through the eyes of intensive care nurses, allowed reflecting on the daily critical care to ensure harm-free care, based on scientificity and the incorporation of an assertive risk management policy, establishing preventive barriers before strategic processes and identifying opportunities for improvements in health care.

Thus, the SR revealed that intensive care nurses anchor their conceptions of patient safety in the organization and dynamics of their work process, through subsidies and strategies, such as conferences/checks, use of checklists, to perform interventions that enable safe patient care.

There is need to know, recognize, reveal and reaffirm the knowledge constructed in the social and collective practice of intensive care nurses in the path to safety in complex care scenarios, in order to advance in the search for the incorporation of new elements into this universe, gradually transforming the ways of thinking, feeling and acting for the safety of the critical patient, considering that social representations direct actions and behaviors in daily health know-how.



## Collaborations:

1 – conception, design, analysis and interpretation of data: Rejane Santos Barreto and Maria Lúcia Silva Servo;

2 – writing of the article and relevant critical review of the intellectual content: Rejane Santos Barreto, Maria Lúcia Silva Servo and Amanda Maria Villas Bôas Ribeiro;

3 – final approval of the version to be published: Rejane Santos Barreto, Maria Lúcia Silva Servo and Amanda Maria Villas Bôas Ribeiro.

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