

● Original article

PATIENT IDENTIFICATION PRACTICES IN A PEDIATRIC INTENSIVE CARE UNIT

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Objective: to investigate patient identification practices in a pediatric intensive care unit. **Method:** a cross-sectional study was carried out in three public hospitals in the South of Brazil. Data collection (identifying items) was performed in 2015, through non-participant observation and consultation of the medical records. The data were analyzed using descriptive statistics. **Results:** of the 96 patients observed, 94 (98%) had an identification nameplate next to the bed. No identification wristbands were used. The identification nameplates included the child's name (95%), age (31%) and the name of the person responsible (78%). Of those identified by name (n=89), 62 (70%) were complete. In the medical prescription and nursing record there were deficiencies in the registration of the full name, date of birth and names of the parents. **Conclusion:** despite the wide range of resources, there was a deficiency in the systematization of patient identification, affecting (un)safe care.

KEYWORDS: Patient identification systems; Patient safety; Risk management; Pediatric nursing; Intensive care units.

PRÁTICAS DE IDENTIFICAÇÃO DO PACIENTE EM UNIDADE DE TERAPIA INTENSIVA PEDIÁTRICA

Objetivo: investigar práticas de identificação do paciente em unidade de terapia intensiva pediátrica. **Método:** estudo transversal realizado em três hospitais públicos do Sul do Brasil. A coleta de dados (itens identificadores) foi realizada em 2015, por meio de observação não participante e consulta em prontuário. Os dados foram analisados por estatística descritiva. **Resultados:** dos 96 pacientes observados, 94 (98%) tinham identificação próxima ao leito, por placa. Não houve nenhuma identificação por meio de pulseira. Nas placas identificadoras, constavam o nome da criança (95%), a idade (31%), e o nome do responsável (78%). Quando identificados pelo nome (n=89), 62 (70%) eram completos. Na prescrição médica e evolução de enfermagem, houve deficiências nos registros do nome completo, da data de nascimento e do nome dos pais. **Conclusão:** Apesar da vasta gama de recursos, há deficiência na sistematização da identificação do paciente, sendo uma implicação ao cuidado (in)seguro.

DESCRITORES: Sistemas de identificação de pacientes; Segurança do paciente; Gestão de riscos; Enfermagem pediátrica; Unidades de terapia intensiva.

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Objetivo: investigar prácticas de identificación del paciente en unidad de terapia intensiva pediátrica. **Método:** estudio transversal que se realizó en tres hospitales públicos del Sur de Brasil. Se recogieron los datos (identificadores) en 2015, por medio de observación no participante y consulta en prontuario. Se analizaron esos datos por estadística descriptiva. **Resultados:** de los 96 pacientes observados, 94 (98%) tenían identificación cerca del lecho, por placa. No hubo identificación por medio de brazaletes. En las placas identificadoras, había el nombre del niño (95%), la edad (31%) y el nombre del responsable (78%). Cuando estaban identificados por el nombre (n=89), 62 (70%) estos eran completos. En la prescripción médica y evolución de enfermería, hubo deficiencias en los registros de nombre completo, fecha de nacimiento y nombre de los padres. **Conclusión:** A pesar de la gran cantidad de recursos, hay deficiencia en la sistematización de la identificación del paciente, siendo esa una implicación del cuidado (in)seguro.

DESCRIPTORES: Sistemas de identificación de pacientes; Seguridad del paciente; Gestión de riesgos; Enfermería pediátrica; Unidades de terapia intensiva.

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● INTRODUCTION

The complexity of the health sector, the dynamics of social, economic and epidemiological evolution and the need to connect organizational objectives with client satisfaction are factors that should position quality as a legitimate concern for managers. In order to increase the quality of health services, care must be understood as being based on some dimensions, i.e.: effectiveness, efficiency, accessibility, acceptability, equity and, more recently, safety.⁽²⁾ Accordingly, in health, patient safety is understood as the reduction of the risk associated with the care to the minimum possible.⁽³⁾

In order to maximize safe care, the World Health Organization (WHO) established six goals for patient safety in the first decade of the 2000s,⁽²⁾ which are considered as a real challenge to be faced in the context of health in Brazil and worldwide.^(3,4) Proposed as the first goal for safe care,⁽⁵⁾ patient identification is considered a priority factor in health institutions, as its main purpose is to ensure that the care is performed on the right patient, in order to avoid the occurrence of care related adverse events.^(6,7) Patient identification is therefore extremely important because, in the case of an initial error in the identification, the end of the care will tend to be the occurrence of some adverse event, that is, a harmful consequence, of varying magnitude, with a real impact on the health of the patient.⁽⁷⁾

It is known that some factors may increase the chances of errors in the identification process of the patient, with examples being a change of bed, the patient's state of consciousness, pathologies that cause aphasia, lack of a companion, among others.⁽⁷⁾ Accordingly, the need to supervise and control the patient identification process is even more evident, as this measure favors safe care.⁽⁸⁾

In Brazil, the patient identification recommendation are as follows: use of at least two identifiers on a white wristband standardized by the institution, placed on a patient's limb to be checked prior to performing care actions.⁽⁷⁾ In addition, other safety initiatives include the patient identification protocol, with the identification process having to be followed in all healthcare settings, regardless of the type of care performed.⁽⁷⁾

It is recognized that the pediatric patient is more likely to suffer some health damage during hospitalization as the morphological, cognitive, social and emotional particularities are different to those of the adult. In this sense, the pediatric patient may present rapid changes and alterations in the clinical state, requiring complex diagnostic and therapeutic procedures that are commonly associated with intensive and/or semi-critical care.⁽⁹⁾ A study⁽¹⁰⁾ carried out in Spain, which aimed to identify potential risks to pediatric patients, identified 49 opportunities for failures, 60 effects and 252 causes. Patient discharge was identified as the main failure, while parental complaints about the length of the hospitalization, delays in the diagnosis or treatment and unnecessary treatment were the most common effects. Regarding the main causes of the risks, not including the family in the care process, change of shift and incorrect identification of the patient were verified.⁽¹⁰⁾

It should be mentioned that investigating the identification practices used with pediatric intensive care patients is socially and scientifically important, since the results can support decisions that converge for the safe care of this particular clientele. Based on these premises, the following question arose: How are the practices of identification of critical pediatric patient presented? In order to answer this question, the performance of this study was proposed, in which the aim was to investigate patient identification practices in Pediatric Intensive Care Units (P-ICUs).

● METHOD

This descriptive, cross-sectional and quantitative study was carried out in the P-ICUs of three medium and large size, public, general hospitals, located in the southern region of Brazil. Of these, two were state administered and one federal. The data collection was performed randomly in the P-ICUs of the referred hospitals, over 10 consecutive days, from February to May 2015, using the Non-Participant Observation or Systematic Observation technique, which uses data collection *in loco*, by a person that is not involved in the work or in the universe of analysis⁽¹¹⁾. Documentary research in the medical records was also

performed. As inclusion criterion, it was considered that the period of hospitalization of the child should be at least 72 hours (three days) in the respective P-ICU. The absence of a family member/guardian of the pediatric patient prior to data collection was considered as the exclusion criterion, which did not occur. Thus, 96 patients were analyzed.

In the observational phase, the identifiers (name of the child, name of the person responsible, date of hospitalization, date of birth, bed number, and age of the child) were checked for all patients hospitalized in the P-ICU, using the nameplate on the headboard of the bed or box and the identification wristband. The documentary research was performed through the analysis of the records of the same patients previously observed *in loco*. In this stage, the identification items of the patients were verified in the most recent medical prescriptions and nursing records, namely: full name; age of the child; dates of birth and hospitalization; bed number; sector; diagnosis/medical record number; name of the person responsible; and professional registration.

In order to record the observations and documentary research, forms developed for the purposes of this study were used, adapted from the "10 Steps for Patient Safety" Booklet developed by the Brazilian Network of Nursing and Patient Safety.⁽¹²⁾ The systematic non-participant observation and the documentary research collections culminated in the manual extraction of the patient identification variables. All information extracted from the observation and documentary analysis was tabulated in electronic spreadsheets using the Microsoft Excel software, version 2010. Subsequently, the data from the three study sites were analyzed together by means of descriptive statistics, with measures of proportion. All the ethical precepts governing research with human subjects set forth in Resolution 466/2012 of the National Health Council were respected and the project that provoked this study was registered under institutional authorization No. 866.802 of 2014.

● RESULTS

It was found that 94 (98%) of the 96 patients were identified by means of a nameplate on the bed headboard or the door of the box and 2 (2%) did not present any form of identification. Despite the identification by the nameplate on the bed headboard or door of the box, the identification wristband was a resource that was installed and available in the three institutions studied, however, none of the patients in the P-ICU used it. Table 1 shows information on the identification nameplate.

Table 1 - Information contained in the identification nameplate on the patient's bed in Pediatric Intensive Care Units. South of Brazil, 2015

Variable (n=94)	Yes		No	
	n	%	n	%
Name of the child	89	95	5	5
Name of the person responsible*	73	78	21	22
Date of hospitalization	89	95	5	5
Date of birth	51	54	43	46
Bed number	91	97	3	3
Age of the child	29	31	65	69

*Includes parent or caregiver. Source: Study data

Among the nameplates that included the child's name (n=89), 62 (70%) had the full name, while only the first name appeared on the others (n=27; 30%). The results of the analysis performed in the medical records (medical prescription and nursing report) are presented in Table 2.

Table 2 - Identifiers contained in the medical and nursing records of the Pediatric Intensive Care Units. South of Brazil, 2015

Registrations in the medical record	Yes		No	
	<i>n</i>	%	<i>n</i>	%
Medical prescription (n=96)				
Full name	89	93	7	7
Age of the child	93	97	3	3
Date of birth	49	51	47	49
Date of hospitalization	62	65	34	35
Bed number	90	94	6	6
Sector	96	100	0	0
Diagnosis	28	29	68	71
Medical record number	63	66	33	34
Name of person responsible*	12	12	84	88
Professional registration number	51	53	45	47
Nursing record (n=96)				
Full name	88	92	8	8
Age of the child	93	97	3	3
Date of birth	57	59	39	41
Date of hospitalization	58	60	38	40
Bed number	89	93	7	7
Sector	40	42	56	58
Diagnosis	23	24	73	76
Medical record number	51	53	45	47
Name of person responsible*	31	32	65	68
Professional registration number	24	25	72	75

*Includes father, mother or caregiver. Source: Study data

● DISCUSSION

The present study evidenced that the patient identification resource most used in the P-ICUs of the hospitals studied was the identification nameplate, fixed to the headboard of the bed or on the door of the box (n=94, 98%). Another aspect that drew attention was the fact that no patient used the identification wristband. This data conflicts with the study⁽⁸⁾ carried out in a university hospital in the state of Paraná, which evaluated identification in adult patients and found that, of 1068 observations, 250 (23.4%) did not have either of the two patient identification features (the nameplate on the headboard of the bed or the identification wristband).

Although the P-ICUs investigated made use of the nameplate, the lack of an identification wristband exposed the children to risks of adverse events. This is because the absence of the wristband can make it difficult to verify the identity of the patient, generating extreme insecurity, therefore the need was identified for urgent actions that work towards patient identification and safety.⁽⁸⁾ The Patient Identification Protocol, recommended by the Ministry of Health,^(5,7) emphasizes the importance of identifying the patient in order to guarantee care and ensure that the treatment is provided to the patient for whom it is intended, avoiding mistakes and errors arising from the healthcare. In this context, the document mentioned⁽⁷⁾ indicates that the identification should be performed with all patients admitted to the hospital environment and in

any place that offers healthcare, such as diagnostic centers, laboratories, etc., through identification wristbands, which are considered to be safe resources that can reduce possible incidents and adverse events.

It is recognized that the use of the identification wristband is related to safe care. This finding is corroborated by the results of a 45-month study that identified that more than half of the problems with patient identification were related to non-use of the identification wristband.⁽¹³⁾ Based on the aforementioned, the negativity of the findings of this study can be perceived, considering that the use of the wristband is recommended as a national and international patient identification resource. In this sense, the isolated use of identification nameplates on the headboard of the bed or door of the box (98%) may result in risks to the health and safety of the patient, maximizing the potential for harm during hospitalization in the P-ICU.

It is considered that the identification of pediatric patients hospitalized in intensive care units, through a nameplate on the headboard of the bed or door of the box, despite being a demonstration of care of the medical team, is not sufficient to ensure that the care is performed on the intended patient. This form of identification usually does not accompany the patient at the time of discharge or transportation to perform diagnostic or therapeutic procedures outside the P-ICU, that is, moments that, due to the absence of the identification wristband, patient safety can be affected. In the case of discharge of the patient from the P-ICU, the team may forget about the change of the identification plate when it is fixed to the door of the box, resulting in an identification error in the hospitalization of the next child. In addition, the identification nameplates on the headboard of the bed are not transported with the pediatric patient to other healthcare points, which reinforces the need to (re)consider the use of the identification wristband.

In the P-ICU, serious or potentially serious patients are hospitalized, whose age range from 29 days to 14 or 18 years, depending on the institutional routine.⁽¹⁴⁾ Children and adolescents of this age group are usually accompanied by their parents or a caregiver who provides the necessary information, in both the confirmation of the identity of the hospitalized patient and any particularity regarding the patient. However, the characteristics and clinical conditions of the patients, associated with the degree of guidance for the parents or guardians regarding the norms and routines, allow the movement or change of the beds of the children hospitalized in the P-ICU. These factors constitute other possible risks related to errors in the identification of the patient in the absence of the identification wristband.

The P-ICUs are controlled environments and have different working conditions in relation to the other types of hospitalization units, with the care provided in this service being highly complex. The care routines for the medical team are intense, with the need for intervention procedures in the presence of interferences being common and the existence of different behaviors and therapeutic doses of drugs for each age group constituting aspects that make the lack of adequate identification of the patient even more dangerous.⁽¹⁵⁾ Thus, the finding of a high proportion of non-identification of the patient's age on the identification nameplates (the main identification resource in the P-ICUs) should be highlighted, as this may favor a dosing error in the case of emergency medication, for example.

The use of identification nameplates next to the bed does not exclude the need for other identification resources, especially since they do not contain enough data to ensure the correct identification of the patient, as evidenced by the results of this study. Some authors state that adverse events may continue if patients are not using the identification wristband, if it is poorly completed and if its use is not rational.⁽¹⁶⁾ A recent study⁽¹⁷⁾ in the neonatal ICU context reinforces the previous assumption that the identification of young patients by means of a wristband, in addition to its effective positioning, should also include the daily check of the presence and integrity of the wristband; the readability of the information; and the systematic checking of the wristband prior to providing care, this being consistent with the national patient identification protocol.⁽⁷⁾

Although the identification nameplates contained the patient's name and the date of hospitalization (n=89, 94.6%), only 27 (30.3%) included the child's first name. It was also observed that the main identifier of the nameplates was the bed number (Table 1). This result is also related to the identification in the medical prescriptions and nursing reports, which also presented a lack of information or incomplete information, including failures related to the registration of the child's full name (Table 2).

An important interpretation of this is the fact that not identifying patients by name and prioritizing institutional aspects, such as the bed number, or biomedical content, such as the cause of hospitalization and/or pathology, are aspects that depersonalize the care and possibly favor less humanized care relationships. The problematization expressed is not directly related to the concrete data, since the greater proportion of the means of identification included the name of the patient, although not the complete name. However, the caregiver's name was deficient in records of both the medical prescriptions and nursing reports, with this being an important aspect with regard to pediatric care.

It should be emphasized that the allusion expressed is configured as an interpretation of the reality related to the identification of the patient, whereby it was not possible to affirm whether, in the care dynamics, the health team treat the children by name and know the identification of their parents/caregivers. However, the notation of these identifiers in the medical and nursing records could possibly be a contribution to safety in the care, since they could facilitate the recall of which patient has certain action registered in medical records.

The data obtained from the identification nameplates are in agreement with the information of a study carried out in 2011, concerning adverse events related to patient identification, where it was found that between 0% and 24.6% of the errors referred to the use of the incomplete or incorrect name of the patient.⁽¹³⁾ This finding undoubtedly reinforces the risk of pediatric patients hospitalized in the units studied receiving unsafe care.

Regarding the patient's medical record (medical prescription and nursing report), the Joint Commission International⁽⁵⁾ indicated that the patient's identification in the medical record must contain at least the patient's full name, date of birth, full name of the mother and the record of the professional that performed the care. It should be emphasized that the patient's medical record contains the records of the information regarding the care provided by the professionals and therefore is a source of data for auditing and even defense purposes, in cases of legal and/or ethical actions.⁽¹⁸⁾ From this perspective, health institutions should be alert to patient identification being a crucial point for patient and worker safety, as well as that of the organizations.

In view of the above, despite the identification of nameplates on the bed/box being apparently effective (or at least adhered to), there were still areas for improvement, since there is a close relationship between adequate identification, patient safety and quality of the care. Another aspect to be extensively reviewed is the use of the identification wristband, which, although available in all the institutions studied, was not used by any child. To minimize identification related problems, actions are suggested, such as those proposed by the Ministry of Health,^(3,20) which indicate sensitization and monitoring of the health team by the Permanent Education Service, linked to the direct work of the Patient Safety Center (PSC) of the health institutions.

The present study addressed a topic of great relevance, patient safety. In view of the complexity of the work processes in hospital institutions, the identification of the patient is extremely important and is a multidisciplinary responsibility, since it involves the institution, the professionals, and the active participation of the users and their family members/companions.⁽⁷⁾ The fact that the study was performed only in P-ICUs of public hospitals was considered a limitation of this study, as this does not allow generalizations. Furthermore, the data were only investigated using descriptive statistics and were combined for the three institutions, which weakened the situational diagnoses. In spite of this, the presented results advance the knowledge and support reflections on the scope of the hospital work that helps in the academic formation, scientific research and professional development, especially due to indicating the need for continuously (re)planning patient identification as a means of increasing safe care.

● CONCLUSION

It was found that the identification nameplates on the headboard of the bed and door of the box were the most frequently used patient identification resources/practices, however, in no place did the patients (children) use identification wristbands. Other aspects were relevant to the identification of patients in

the P-ICU such as: absence of identification wristband, incomplete data on the identification nameplate on the headboard of the bed and the in the patient's medical record.

It was concluded that the patient identification practices used contained many identifiers, which favors the minimization of errors. However, the use of nameplates alone, the lack of use of wristbands and the information missing from the patient's medical records confirm the urgent need to promote safety barriers in the services studied. In light of the scenario exposed, it is considered that this study directly supports the current search for ways to improve patient safety. In particular, patient identification can be reaffirmed as a primary and legitimate aspect of safe care.

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