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DAILY CARE OF FAMILIES IN HOSPITAL: WHAT ABOUT PATIENT SAFETY?¹

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ABSTRACT: Qualitative study, with worth comprehensive approach aimed at understanding the actions of companions that can affect the safety of hospitalized patients. The study was conducted in a public hospital in Bahia, from May to July 2014 with 16 families of patients dependent for self-care. Data were collected through semi-structured interviews. The content was analyzed and discussed using a comprehensive approach. The results showed that the companions care for their relatives and are knowledgeable on infection prevention, the safe use of medication and materials, adopt measures to prevent pressure ulcers and seek to establish an assertive interaction with the nursing team. It was concluded that the actions taken by the companions are aimed at patient safety and established through the emotional environment based on open rationality.

DESCRIPTORS: Patient safety. Family nursing. Hospitalization. Nursing care.

CUIDADO QUOTIDIANO DAS FAMÍLIAS NO HOSPITAL: COMO FICA A SEGURANÇA DO PACIENTE?

RESUMO: Estudo qualitativo, de abordagem compreensiva, que objetivou apreender as ações dos familiares acompanhantes que podem repercutir na segurança do paciente hospitalizado. Realizado no período de maio a julho de 2014, num hospital público da Bahia, com 16 familiares acompanhantes de pessoas com dependência para o autocuidado. Utilizou-se para coleta dos dados um roteiro semiestruturado. Os dados foram submetidos à análise de conteúdo temática e discutidas através da abordagem compreensiva. Os resultados mostraram que no cotidiano, os familiares acompanhantes realizam o cuidado ao seu parente e apresentam conhecimentos quanto à prevenção de infecção, uso seguro de materiais e medicamentos, adotam posturas na tentativa de prevenir úlceras por pressão e buscam estabelecer interação assertiva com a equipe de enfermagem. Concluiu-se que essas ações dos familiares visam a segurança do paciente, e é estabelecida através da ambiência emocional pautada na racionalidade aberta.

DESCRIPTORIOS: Segurança do paciente. Enfermagem familiar. Hospitalização. Cuidados de enfermagem.

CUIDADO COTIDIANO DE FAMÍLIAS EN EL HOSPITAL: ¿I CÓMO SE QUEDA LA SEGURIDAD DEL PACIENTE?

RESUMEN: Investigación cualitativa con enfoque comprensivo, intenta aprehender las acciones de acompañamiento a los familiares en el hospital que puedan afectar a la seguridad del paciente. Se realizó en un hospital público de Bahía, a través de entrevistas semi-estructuradas con 16 familias de personas con dependencia a los cuidados personales, de mayo a julio de 2014. Los datos han sido analizados según la técnica de análisis de contenido temático y discutidos bajo el enfoque comprensivo. Los resultados mostraron que en el cotidiano, los familiares acompañantes hacen el cuidado de prevención de la infección; uso seguro de los medicamentos y materiales; adoptan medidas para la prevención de las úlceras por presión; y buscan establecer interacción asertiva con el personal de enfermería. Concluyese que esas acciones de los familiares objetivan la seguridad del paciente y se establece a través del ambiente emocional guiada en la racionalidad abierta.

DESCRIPTORIOS: Seguridad del paciente. Enfermería de la familia. Hospitalización. Atención de enfermería.

INTRODUCTION

Patient safety is a global public healthcare problem that affects all countries, no matter their level of development. The World Health Organization (WHO) estimates that millions of patients worldwide suffer incapacitating lesions or death every year due to unsafe practices and inadequate care by the healthcare teams. One in every ten patients is harmed during his treatment in hospital environments with state-of-the-art technology. There is no data available on this theme for developing countries, where the risk of harm to the patient can be even greater due to the limitations in infrastructure, technologies and human resources.¹

Patient safety has progressed in less than a decade and has become a relatively insignificant topic in the agenda of regional, local, national and international healthcare managers, service providers and policy makers.²

In Brazil, the Ministry of Health (MS) established the *Programa Nacional de Segurança do Paciente* (National Patient Safety Program-PNSP), through Ordinance MS/GM No. 529, dated 01 April 2013. The purpose of the program is to contribute for healthcare qualification in all health establishments in the national territory, both public and private, in accordance with the priority given to patient safety in the political agenda of the WHO member states and in the resolution approved during the 57th World Health Assembly.³

The first work pertaining to the prevalence and means of preventing iatrogenic events occurred after the creation of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), which is responsible for hospital accreditation as a method of assessing the quality of healthcare institutions.⁴

The current concept of patient safety indicates that the primary factors that lead to the occurrence of adverse events are the deficiencies in the healthcare system: its conception, organization and operation, not only the professionals or only the products.⁵

According to the Institute for Healthcare Improvement (IHI), adverse events or damage are defined as “unintentional body lesion resulting from or provided due to medical care that requires additional follow-up, treatment or hospitalization or which results in death”.^{6,4}

Ever since Hippocrates, it has been believed that the mistakes and errors caused by healthcare professionals during care causes harm and/or prolongs recovery time during hospital admission. He proposed that we should preserve the patients’

safety and life when treating them, and “above anything else, not cause damage”^{6,3} during health care. This Hippocratic proposition admitted that “assistential acts are subject to mistakes and patient safety was already seen as a priority”.^{4,2}

Florence Nightingale, a woman with excellent work, management and leadership capacity, also marked the nursing profession by her concerns on the quality of the care provided. In her publications, she focused on not causing harm during health care. In her 1863 book *Notes on hospitals*, Nightingale reflected on the importance of providing safe care to the patients which she exemplified as follows: “it might sound strange to state that the main requirement in a hospital is not to cause harm to the patients”.^{7,1}

Therefore, investments and studies on patient safety focus on the actions of healthcare professionals. However, other actors are present in this scenario with a certain frequency: family members (companions) who accompany the hospitalized patients.

The presence of the family in hospital admission units has become more frequent, no matter the age range, health/disease status and the admitted patients level of dependence for care. In Brazil, the permanence of the companion in the hospitals has met with difficulties due to the lack of structure and organization, which are important for the patients’ well-being.⁸

During the process of hospital care, the family performs procedures such as body hygiene, feeding and mobility, randomly and without guidance due to the shortage of human resources.⁹

In the hospital environment, the family is involved in the actions of care, but ritualized according to the established care and permeated by feelings and emotions that are characteristic of kinship ties. In this sense, the hospital environment is related to the “emotional” experience of the hospital space, at a time when tragedy is experienced through the illness of an admitted relative.

The presence of the family in the hospital environment is justified by the need to “live” in the collectivity. As a social system, the family tries to be stronger and organize its ties by remaining by the companion’s bedside; the social link is organized from their emotions, passions and affections.¹⁰ The family can be the link in the chain that gives the best sense of understanding and of the affectionate relationship with the patient. It can consolidate the cure through its commitment and support, strengthening relationships, motivating and giving hope of recovery.

According to the Maffesolian perspective, the presence and care provided by the family members in the hospital environment is based on open rationality, on the logic of being together and on the order of sensitivity, which involves sensitive reason.¹⁰ However, norms and routines prevail in this environment and the presence of instrumental reason is marked by the purpose of maintaining the integrity of all those who occupy that space.

The aspects regarding patient safety, such as qualification and training, work process improvement, including the creation of protocols, availability of quantity and quality of materials and equipment, and an adequate number of professionals, among others, belong to the rational order.¹¹

In this context, reflecting on the presence of family members in the hospital environment, we observed that they remain in these spaces not only to monitor but also at the request of the institution's nursing team. In the healthcare environment, the companions are inserted in the unit's dynamics in order to act based on sensitive reason, open rationality - that is, their actions are aimed at preserving their companion's life.

Given the companions' permanence and actions in the hospital environment and the need to adjust the admission units to the PNSP and to the Política Nacional de Humanização (National Humanization Policy - PNH), we proposed to conduct this study to understand the actions of companions in hospital that can have an effect on patient safety. Based on the perspective of the comprehensive sociology proposed by Maffesoli, this study presupposes that life is permeated by scientific instrumental rationality, by open rationality, or by both.

METHOD

Qualitative study comprehensive approach performed in a public university hospital in Bahia. The study received a favorable opinion from the ethics committee for human research, with protocol N. 623.495/2014. Family members who met the following criteria participated in the study: be a companion of patients dependent for self-care, be 18 years old or older, be accompanying a relative and be accommodated in collective rooms.

Data were collected from May to July 2014 in the Medical and Neurological Clinics, where a greater concentration of patients dependent for self-care and accompanied by family members was found. Three scenarios (collective rooms) were eligible for the study and complied with the criterion

of having patients dependent for self-care in all the beds during the data collection period.

The data collection techniques were semi-structured interviews with a script and direct observation. The interviews lasted on average 30 minutes and were performed in a place that was restricted to the investigator and participants. The participants answered the following questions: "what is your daily routine as a companion to your hospitalized relative?" and "what is your relationship with the other companions and with the nursing team?"

A total of 20 companions were invited in the three scenarios, and four refused to participate. The study included 16 companions. The data obtained in the interview were recorded and transcribed. The anonymity of the participants was guaranteed by use of letter "e" followed by a number Arabic, as order of interviews.

After being thoroughly read the records were decoded and submitted to content analysis, thematic modality, following this sequence: material decomposition into parts (theme), theme distribution into categories, description of categorization results, inference of results and interpretation

The themes were "comfort and hygiene care of the hospitalized relative in the hospital environment"; "medication administration"; "prevention and recovery of pressure ulcers"; and "companion's relationship with the nursing team".

These themes are close to the strategies proposed by the PNSP. The categories were nominated using the four PNSP basic strategies, namely: actions aimed at preventing infection in the companion's routine; actions of administering medication and using materials in the companion's routine; actions aimed at preventing and healing pressure ulcers; and actions aimed at the companion's interaction with the nursing team and with the unit routine.

The categories were discussed using the PNSP and a comprehensive approach, under the comprehensive sociology perspective defended by Maffesoli through an analogy with instrumental rationality and open rationality.

RESULTS

The study participants were aged 27-51 years, of which 13 were female and three were male. Regarding kinship, five were sisters, three were mothers, two were fathers; there was one daughter, one granddaughter, one aunt, one sister-in-law, one husband and one wife.

The categories found in the participants' statements showed the care actions provided by companions in hospitals and how these affected patient safety.

Actions aimed at preventing infection in the companion's routine

It was observed that the companion performs actions for infection control and assumes responsibility for guiding other companions, such as separating the rubbish according to the guidelines established by the hospital.

[...] doesn't know what to do, new around here [...]. arrives in the room, and we explain the procedure [...] (e1).

I show how it is done. There are three rubbish bins. One is for infected rubbish and another is for common rubbish (e9).

In another statement, the companion reports that she cleans the room and the toilet and brings bed linen from home. She alleges that she cleans the toilets because they are in a female unit but there is a male companion. The companion states she does this in order not to call the hygiene team and thus avoid what she called "creating trouble".

We do the cleaning, I bring the disinfectant, detergents from home. We bring it all so that there is no lack - first of all, because there is a man in the room, which bothers us and we lose our privacy [...] he pees all over, so in order not to create trouble and talking, we just bring it (e3).

Another aspect that shows the companion's concern regarding infection control and prevention is changing the bed line during the bed bath.

[...] so we put a clean sheet on and remove the dirty sheet to take home and I put it on the chair. I put it on the floor or sometimes in a plastic [...], and then we clean the chair (e3).

[...] we usually bring sheets from home to make it easy on ourselves, but it is very complicated (e4).

The companions in the hospital environment provide care to their relatives and help other companions. They develop a network of solidarity among them by sharing utensils for their comfort, exchanging knowledge and helping in care.

[...] sometimes I am not using the fan so I lend it (e7).

[...] [if] someone needs to have as diaper changed, I do it [...], I help changing sheets, [...] bathing [...]. The person needs help to get up, to lift in order to seat [the patient] and sometimes some people don't know; the person arrives and is not used to this. I've been here for a long time so I go there and help (e9).

The participants have already incorporated actions and knowledge on infection transmission among patients, through their hands. Their speech includes information on their concern about cross infection, when they mention changing gloves and washing hands while helping to care for other patients.

I care for the patient here, I help, I change the gloves; when I look after the other one I wash my hands, put other gloves on and then I help with other gloves so I won't infect anybody else, and won't get an infection [...] could you please help me here? I then tell him to get to gloves there or sometimes I go there myself, get the gloves and hand them out. [...] don't take me wrong, but please wash your hands, let's wear gloves [...] (e9).

Regarding infection control, the actions of the companions during the process show us that they are worried about their relatives' safety while care is being administered.

Actions on administering medication and using materials in the companion's routine

The companions also identified institutional actions that refer to the safe use of medication and materials in the admission unit. Their statements revealed the following, *[...] sometimes the technicians give us the medication so that we administer it, I give water [...] in the tube* (e1).

In another statement, the companion complains of the delays in the medication administration times and the conflicts generated with the nursing team when they are queried.

[...] my mother had to take a medication at 8 o'clock and then she received it at 12 o'clock; and if you complain, they cuss at you, they mistreat you (e8).

Noncompliance with the proper technique and postures during medication administration also causes the undue use of materials, putting the patient at risk.

[...] my grandmother had her tube changed 12 times because it was blocked. This was often because they would inject the medication but did not clean the tube, they didn't wash it with water [...] (e4).

Just the other day they placed the (tray) with my mother's medication on top of the rubbish bin [...] (e8).

Since the companions remain next to their relatives, they can identify nursing team actions that can lead to risk situations. In spite of being aware of this, the companion assumes a natural posture for these actions and sometimes take over in an attempt to minimize the risks. They understand the difficulties of nursing to be closer and provide more

frequent care according to the patient's needs. This was reported as follows: [...] *there are two nurses for I don't know how many patients so they don't have much time to bathe, to help us, to change; so they monitor us more on the medication, stuff like this, they guide us on what we should and should not do* (e11).

Faced with the hospital unit routine, the companions experience the situation of care in these admission units as routine activities, and seldom query the responsibility for the care provided.

Actions aimed at preventing and healing pressure ulcers

Family care is present in preventing and healing existing ulcers. It is clear from what they say that the companions are aware of the care required for healing. They promote measures for the comfort, hygiene and relief of the pain caused by the diseases that have led to admission.

[...] *I bathe her, turn her from one side to the other. Sometimes when she asks to sit, I sit her, when she has to lie down, I lay her down* (e2).

[...] *I make the bed, change her diaper and wipe her with a damp cloth so that she can sleep more refreshed. I wake her up at about 2 a.m. so that I can change her diaper. Her diaper cannot be dirty because she has a bedsore on her back and it cannot be moist. Later, at 5 a.m. the diaper has to be changed again* (e4).

I have to bathe her, [...] change decubitus every 2 [hours] or less, since her body is already quite frail. [...] massage, I monitor her sore, because the bedsore has to heal (e7).

However, not all relatives have the ability and dexterity to perform the recommended care for ulcer prevention and in spite of having knowledge about this care they do not always find support and help for this prevention.

[...] *some girls came from the other room to [...] teach me, they would put it on and help me to put it on. I don't know [...] he gets wet at night* (e17).

The study participants show knowledge of the techniques to prevent skin lesions and report that they do not perform the preventive measures when they do not have enough skill for such care or when they cannot do it by themselves.

Actions aimed at the companion's interaction with the nursing team and the unit routine

Since the participants understand the difficulty the nursing team has to participate more ac-

tively in the care, they report that they only request their presence when their relatives present with any complication such as abnormal vital signs or when they require help for the medication.

I only call one of the nurses if she is poorly or if we notice a difference in her respiration, something like that (e1).

[...] *only for the saline solution or the medication. When the medication arrives I want to know what it is, she shows me the medical chart and what the doctor actually prescribed, which is safer* (e7).

[...] *sometimes the saline solution ends, I close the device; he's also being fed via a tube and then when that finishes I switch it off and talk to the nurse* (e9).

There are usually no conflicts in the families' relationship with the nursing team, for they recognize how difficult it is to provide care with a reduced number of professionals. The companions show a need to have a friendly - almost complicit - relationship, in their speech.

Great, they treat [us] very well, [...] the girls are wonderful [...] We have to take it easy, they are caring for many people not only my [people] (e6).

[...] *when I want something, I go to the nurse, [...] and say I need some gauze [...] a bandage, and then they go get it and give me a sheet* (e9).

[...] *when we call them, they are next to us, [they offer a] friendly shoulder, I haven't come across any difficulty yet [...] everything has been fantastic so far* (E6).

The family members understand and passively accept the care given to their relatives. This practice is so common that it is natural most of the time and has been incorporated into the daily routine.

DISCUSSION

Studies show that patient safety has a multifactor approach and indicate that the primary factors responsible for the occurrence of adverse events are the deficiencies in the healthcare provision system, in its conception, organization and operation, not the professionals or the product isolatedly.⁵

Nonetheless, all findings in the scientific literature show that patient safety progression requires investments that must start with a culture of safety. The culture of safety is a set of individual and group values, attitudes and perceptions that determine the commitment and style with which the issues related to patient safety are dealt with in a health organization. The safety environment that should permeate the institutional environment reflects the

perception professionals have on safety issues at this point in time in their work place. The environment is understood as a measurable part of the culture of safety.¹²

A review of the literature on patient safety has observed that in Brazil there is no comprehensive diagnosis on patient safety problems in hospitals. No reference on the occurrence of adverse events in primary health care has been found.⁵

Therefore, the PNSP is part of the guidelines established by the Ministry of Health for hospital institutions with the aim of reducing risks and unnecessary harm associated to patient healthcare to a minimum acceptable level.³

The standards were defined and idealized for healthcare professionals who care for the admitted person. However, in this environment the family members are involved in the process of patient care. To date there is no outline for the family's action in the process of care: this construction takes place in the daily routine of care practice.

Under the Maffesolian perspective, the hospital environment belongs to the order of environment that "encompasses an organized and animated space, a physical, social and professional space".^{13:134} This environment conditions life in society and determines the activity of those involved in health care for the admitted patients.

The interviewees in this study justify their active participation in care as a result of the insufficient number of professionals that can provide for the needs of the admitted patients. This fact propels the family members to unite and create a collective body in the order of *feeling* - an induced feeling that describes a situationism present in the relationships and interactions among those involved.¹³

Studies performed with children and their mothers in the hospital environment discuss the role of the caring mother who accompanies her child to the hospital environment. The results coincided with the findings from this study, in which the companion assumed attributions, sometimes imposed by the nursing team, to perform care that is the professionals' competence.¹⁴⁻¹⁶

Since care is being delegated to the companion in the hospital environment, the establishment of a culture of patient safety involves a series of investments, primarily because the logic of professional care differs from the logic of family care. Professional care obeys scientific, instrumental rationality and is permeated by norms and routines, whereas family care obeys the logic of open rationality that

involves not only the instrumentalization of actions but also sensitive reasoning.¹⁰

In this manner, the instrumental, scientific rationality supported by norms and routines is no longer the dominant reason and gives space for open rationality, for the emotional environment, which takes over from argumentation and conviction¹⁷ and modifies the norms and routines established by the hospital.

In the results obtained, the participants' speech represent actions that culminate with the prevention of infection in the companion's routine; these actions belong to the order of instrumental reason and are related to caring against infection while providing health care. Thus, what is established in the institution and determined by the norms - instrumental reason - and the process of care reported do not meet the definitions and guidelines established in the PNSP.

Patient safety, which should be present in the actions of the healthcare professionals, was not monitored in this study since the safety environment is associated to adopting safe behaviors, having better communication, undertaking qualification programs, reducing adverse events and others factors that contribute for safe practices in patient care.¹²

Institutional disorder is thus established: the professionals who should provide direct care for the patient are distant and give space for the family members to do what they should do. Nomadism is the manifestation that goes against the established order. It is related to the impermanence of things, a characteristic of that which reminds us of the institutive.¹³ In an analogy with the Maffesolian idea, we have on the one hand the instituted - power, order, direction, hospital environment, and on the other hand, nomadism - families performing tasks which are not of their competence but are necessary in face of such institutional disorder.

Another aspect that reflects institutional disorder pertains to cleaning and hygiene. Due to the characteristics of the hospital environment, cleaning is the responsibility of the, *Serviço de Controle da Infecção Hospitalar* (Department of Hospital Infection Control-SCIH), which establishes the protocol according to the institution, the frequency and the type of products that are more adequate for each surface.¹⁸

Breaking the order established by the hospital is based on suspicion, on the deviation from the norm. In the Maffesolian perspective, this evidence "occurs with saturation, when the system is depleted by wear, by sedimentation of anodyne things, by internal fractures and especially because

the center (the institution) no longer plays the role it should perform".^{13,81}

Some basic care for the admitted patients such as hygiene, comfort and feeding can be shared with the companion as long as there is preparation, instruction and supervision from the nursing team during the performance of these activities.¹⁴

Other deviations were identified in this study, such as the use and packaging of bed sheets and the use of fans to reduce the effects of the heat in the admission unit. The nursing consensus since Nightingale's time is that specific care should be taken to offer the patient a comfortable environment of care, regarding lighting, noises, smells and ventilation, the flow of people and clean and dirty clothes/utensils.¹⁸

The dominant instrumental rationality in the hospital ambience is interconnected to the emotional ambience that revitalizes a rationale based on the sensitive through the saturation of order. The individuals (companions) assume the role of actors, and "do unto others" in a mass environment¹³ in which we identify organic solidarity in their actions. This is expressed through generosity, mutual help, routines, and consideration of human afflictions in times of suffering.¹⁰ Solidarity is expressed by helping during care, when the companions who have been in the units longer are worried about infections, wear gloves and recommend that other companions also do so and wash their hands.

Gloves are considered a Personal Protection Equipment (PPEs) with the purpose of protecting healthcare professionals from exposure to blood and other body fluids such as secretions and excreta. The inadequate use of gloves increases the occurrence of cross infection through the hands. Their indiscriminate use generates a false safety regarding infection prevention and transmission. Hand hygiene is the simplest and most valuable method to control hospital infection, usually acquired through due to poor hand hygiene.¹⁹

Another procedure reported by the companions as part of their routine is medication administration, which the nursing team transfers to them. This transfer does not exempt the nurse and his team from the responsibility or from the occurrence of errors. The same occurs with medication administration via nasogastric tube, which must be properly planned or may become part of potential complications, such as obstructions, and require frequent tube changes.²⁰

The participants show that they have knowledge and instructions on how to prevent and care

for pressure ulcers. Pressure ulcers prevention is an important issue in the context of the global movement for the patient safety. Pressure ulcers are considered one of the negative indicators of quality of health and nursing care.²¹

Therefore, the entry of the companion and his involvement in the process of care, taking over procedures that are the nursing team's responsibility requires a daily reflection by the agents of care. Faced with the scenario, it seems that nursing is losing the dimension of its professional exercise insofar as it bases its work by dividing the care between the team and the family.

The procedures performed by the family and described in the study are foreseen in the PNSP and present strict relation with instrumental rationality (order of the mechanical) and should be performed by healthcare professionals. The scenario we reviewed seems to be a space saturated by the fragilities and difficulties to comply with the norms. This gives rise to the prevalence of deviations and leads to doubts regarding the competencies and responsibilities both of the nursing professionals and of the family in the hospital environment.

These results imply the occurrence of adverse events related to the patient, such as deficiency, physical and psychological trauma and extended admission time. These losses pertain not only to the patients but to the professionals as well, who suffer moral and ethical damage and professional/patient interaction losses. Adverse events cause increased costs, loss of confidence in the institution, and moral and organizational issues to health institutions. All these implications caused by unsafe health practices become a health public health issue and indicate the need to develop strategies to monitor errors and improvements related to patient safety.^{12,22}

Adopting guidelines that foster interdisciplinary work and cooperation can be determining to advance and develop a culture of patient safety and quality in health care.¹⁴

Deviations are naturalized both by the professionals and by the family members. These facts were revealed in the relational process. Relationships between family members and the nursing team in the hospital environment occur in an involuntary manner, i.e. as a result of an illness. However, communication and family involvement in patient safety actions are strategies of the PNSP that require planning with defined and controlled objectives.

In this sense, we observed that the relatives of adult hospitalized patients are inserted in an insecure environment of care, in which the low

number of professionals means the inclusion of family members as the main health caregivers and mobilizes them to use several strategies to protect their admitted relative.

This reality can result from the lack of a culture of safety. The culture of safety involves incorporated attitudes and values that should encourage and reward the identification, notification and resolution of safety-related problems, promotes organizational learning from the occurrence of incidents and provides resources, structure and accountability for the effective maintenance of safety.³

The way in which the family participates in care in the hospital environment potentiates the occurrence of adverse events related to providing health care, often without the support of a professional from the hospital unit. The healthcare practices are executed without considering the evidence of knowledge. Most of the times, it is the family members who decide to care for their admitted relative, based on empirical evidence.

In the health system, one of the primary factors that lead to the occurrence of adverse events is the deficiency of the system itself: the way in which it was thought, organized and works. Given the scientific evidence, it is no longer possible to blame the professional who has committed the error that led to the adverse event or the products isolatedly. According to this logic, the premise is that human beings fail and therefore errors are expected and can be prevented. Errors should be the consequences, not the causes.⁵

The professional relationship between the nursing staff and the companion within the investigated context results from the presence of the local health system that does not value patient safety as the basis for clinical practice. In the local system, we observed the existence of several active and latent flaws that expose the family members to unsafe acts. Active flaws are those that occur at the level of the frontline work operator, through unsafe acts or omissions. Its effects are felt almost immediately. Latent flaws are related to organizational influences such as the structural and procedural characteristics of the system, lack of supervision and preconditions for unsafe acts. Latent flaws are dormant within the system until an event or accident occurs and exposes them.^{5-6,23-24}

In this context, the day-to-day interaction in this site/space raises the need for harmonious two-way interactions between the actors. The family's interaction with the health team is extremely important for both since valuing this interaction is based on its

greater participation in the plan of care. The balance observed in the relationship between these actors in the space of care is based on the open reason, on the need to maintain the harmony that favors care.^{10,25}

Companions must be considered an agent that promotes patient safety and be qualified to perform care actions according to their capacity and responsibility. It is also necessary to stimulate a cooperative practice between the family members and the nursing professionals, and to structure local barriers for the health system into which the family members are included that can minimize the potential risks of adverse events occurring during the provision of care. The promotion of a culture of safety is also urgent.

FINAL CONSIDERATIONS

The results have shown that family members develop care actions for their admitted relative dependent for self-care in the hospital environment. This corresponds to the strategies of the PNSP such as infection prevention through rubbish separation, environmental hygiene, wearing gloves and washing hands, pressure ulcer prevention and healing and materials and medication control and use. The companions aim to maintain a harmonious and assertive relationship with the nursing team.

The companion is an integral and important part in this process in the hospital environment and provides direct care, being concerned with patient safety issues within an inclusive perspective where "one helps the other" and gives rise to open rationality inside the instrumental rationality formed by the hospital norms and routines. Due to the lack of monitoring and instruction from the nursing team during the provision of care, the admitted patients are in an unsafe situation because their relatives perform their actions based on empirical evidence.

The participants revealed that they identify and acknowledge the nursing team's fragility to provide care for their relatives and assume a posture that is akin to solidarity in face of the complicity that is present in the relationships within the hospital environment.

This study's limitations are related to the locus, as the data were collected considering the characteristics of a large public hospital. More studies on this theme are needed for us to bring our reality closer to the ideal recommended by the PNSP and by the PNH in the hospital institutions. This will ensure specialized care to the patients with the least possible harm during their admission to hospital,

providing humanized and sensitive care both for the admitted patient and for his/her family.

The growing initiatives of the PNSP have been considered a challenge for the health institutions due to the need to recognize the existing problems regarding the quality of the care provided and to acknowledge that the program is not the only measure capable of improving these issues. The articulation with actions from other policies, supporting all the actors involved in this process (managers, professionals, users) is required.

The results of this study can be incorporated into the studies of family, especially through the articulation between scientific and open rationality. Thinking of the family and welcoming it are actions that should be observed by managers, healthcare professionals, users and teachers. The institutional and affective dimensions should be considered when questions such as this are answered: "What is the actual role and attribution of the family member and of the health institution in caring for the admitted patient who is dependent for self-care?"

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