KNOWLEDGE OF NURSES ON THE CULTURE OF PATIENT SAFETY IN UNIVERSITY HOSPITAL

ABSTRACT

Objectives: to analyze the dimensions of patient safety culture in the organizational framework and working units and raising the knowledge of nurses on patient safety culture. Method: a descriptive exploratory study with a qualitative approach, performed in a teaching hospital in Goiânia (GO), Brazil, with 117 nurses. The production data was performed using the self-report instrument, AND then a descriptive analysis was carried out from analytical categories. Result: nurses have knowledge about the occurrence of adverse events in the context of hospital practice, knowing that the importance of evidence as one of the basic principles for improving the quality and safety of care can be prevented and recognize. Conclusion: the development of safety culture in health care institutions should be prioritized by managers, supported by institutional and governmental policies with the involvement of patients and health professionals.

RESUMO

Objetivos: analisar as dimensões da cultura de segurança do paciente no âmbito organizacional e das unidades de trabalho e levantar o conhecimento dos enfermeiros sobre a cultura de segurança do paciente. Método: estudo descritivo-exploratório, com abordagem qualitativa, realizado em um hospital de ensino de Goiânia (GO), Brasil, com 117 enfermeiros. A produção de dados foi realizada com instrumento autoaplicável e, posteriormente, a análise descritiva a partir de categorias analíticas. Resultado: os enfermeiros têm conhecimento sobre a ocorrência de eventos adversos no contexto da prática hospitalar, sabem que podem ser prevenidos e reconhecem a importância de evidências como um dos princípios básicos para melhoria da qualidade e segurança da assistência. Conclusão: o desenvolvimento da cultura de segurança nas instituições de saúde deve ser priorizado pelos gestores, respaldado pelas políticas institucionais e governamentais com envolvimento dos usuários e profissionais de saúde.

Descriptors: Enfermagem; Segurança do Paciente; Vigilância de Evento Centinela.

RESUMEN

Objetivos: analizar las dimensiones de la cultura de seguridad del paciente en el ámbito organizacional y de las unidades de trabajo y levantar el conocimiento de los enfermeros sobre la cultura de seguridad del paciente. Método: estudio descritivo exploratorio, con enfoque cualitativo, realizado en un hospital de enseñanza de Goiânia (GO), Brasil, con 117 enfermeros. La producción de datos fue realizada con instrumento auto-applicable, en seguida realizada análisis descriptivo a partir de categorías analíticas. Resultado: los enfermeros tienen conocimiento sobre el aparecimiento de eventos adversos en el contexto de la práctica hospitalaria, saben que pueden ser prevenidos y reconocen la importancia de evidencias como uno de los principios básicos para mejorar la calidad y seguridad de la asistencia. Conclusión: el desarrollo de la cultura de seguridad en las instituciones de salud debe ser priorizado por los gestores, respaldado por las políticas institucionales y gubernamentales con envolvimiento de los usuarios y profesionales de salud.

Descriptors: Enfermería; Seguridad del Paciente; Vigilancia de Evento Centinela.
INTRODUCTION

The safety, satisfaction and minimal risks and errors during the service to customers have been the basic principles in the search for quality in health services and, in this perspective, the absence of incidents is a goal to be achieved. 1

Incidents are events or circumstances not expected that may or may not cause damage to patients 1 coming from multiple factors that have a negative influence on health outcomes. Among the types of incidents, adverse events are more worrisome because they result in injury or damage, disability or dysfunction, temporary or permanent, residence time of extension or even death. 1-3

The National Center for Health Statistics the United States (USA) presented a study in 1997 on the death of patients reasons in American hospitals and showed that 44,000 deaths were due to adverse events. 4 The World Health Organization points that every 10 people who need health care, will suffer at least one injury and estimated prevalence of 10% of adverse events. 5

In Brazil, the study performed in three teaching hospitals of Rio de Janeiro found that 8% of hospitalized patients experienced one or more adverse events, of which 67% could have been prevented. 6 The resulting implications of these events reflect the increased length of hospitalization, temporary or permanent disability or death of patients, and also the significant economic costs of association. 6

Given these assumptions, patient safety needs to be treated in health institutions, as a priority to prevent the occurrence of adverse events, particularly on the statement of its avoidable feature. The prevention of adverse events can be strengthened before a management work focused on the use of instruments and monitoring tools and evaluation of the causes of these events, with prospects to develop institutionally, the patient safety culture. 7

During the 55th World Health Assembly of the World Health Organization, held on May 18, 2002, the member countries recognized the need to promote patient safety in all health systems and strengthening of systems based on evidence needed to improve the quality of services. 2

Safety in health care is defined as the execution of a free damage practice, carried out by trained professionals and to justify their actions in the ongoing search for quality in healthcare environment permeated by a not punitive, responsive and flexible organizational culture and that also enables changes to the prevention of errors. 7 Therefore, there is a challenge for all those involved to achieve a positive safety culture, directly or indirectly to the provision of patient care. 5

Considering the nursing as a workforce in significant health, in Brazil and in the world, constituting the largest number of staff in the hospital, because they highlight the development of much of the health care actions of the population and meet continually closer patient, it was emphasized the importance of stimulating the leadership of these professionals in the search for strategies to prevent adverse events and promote patient safety culture. 8

The analysis of incidents allows the knowledge of the complexity and scope of the various types and their relationship with the organizational system 9, demonstrating the lack of professional knowledge about patient safety.

Faced with this, the analysis, diagnosis and suggestions identified by research related to the perception of nurses concerning the occurrence of incidents and on the development of safety culture in the hospital, are valuable tools for the success of programs to improve the quality, increasing productivity and adoption of internal policies in work processes and in the training of health professionals.

It is important to know the perception of nurses on patient safety in the hospital scenario and the occurrence of adverse events considering that knowledge of latent failures on the steps of care and organizational system contributes to the design of strategies promoting the reduction and interception identified faults and proposing improvements through safe practices.

The study aims to:

- Analyze the size of the patient safety culture in the organizational framework and working units.
- Describe the knowledge of nurses on patient safety culture.

METHOD

Descriptive study, developed at the university hospital of the Midwest region with 316 beds, integrating the project of the Hospitals Sentinel Network of National Health Surveillance Agency and it is a local reference in the investigation of incidents.

The population consisted of 138 nurses, supervisors and managers, who worked in the planning, organization, coordination,
assistance and evaluation of nursing care services and interaction with patients and preceptorships together with academics in the health field. The study included 117 nurses; 18 were excluded after five consecutive attempts to approach or absence during the data collection period and three refused to participate.

The production data was conducted from October to December 2011 through a semi-structured questionnaire, tested and used by Sorra and Sieva consisting of two parts. The first part investigates characterization data such as date of birth, gender, work unit, depending on the unit, time of education and work (in the profession, institution, and unit), weekly working hours and type of contact with the patient. The second part addresses the nurses’ opinion on the safety culture related to service quality and patient safety, error or adverse event reports in the hospital.

The reports of the participants were transcribed into a Microsoft Word document to form the corpus of analysis, identified by the letter and followed by a cardinal number as the sequence of interviews. Thematic analysis of the responses was conducted, which were structured according to the dimensions of patient safety culture within the units and in hospitals, according to the proposal by the Agency for Health Research and Quality.

The size of the safety culture of the units consists of eight items:

1) Expectations and safety promotion actions of supervisors and managers, assessing whether the supervisor/manager considers the staff suggestions for improving patient safety, praising the employee or team following the procedures correctly and that not neglecting problems patient safety in their unit;

2) Organizational learning - continuous improvement, which analyzes the unity of learning culture, through error, which can lead to positive changes and should be evaluated;

3) Teamwork in the units, which assesses the work for the safety, support and professional respect;

4) Opening for communication in the unit, evaluating the freedom of the professional to discuss something that can adversely affect the patient and, in this case, feel free to question his superior;

5) Feedback and communication about errors, which assesses whether the professionals are informed about errors that occur, they obtain return on the implemented changes, and discuss ways to prevent errors with the staff of the unit;

6) Answers not punitive to errors: it evaluates whether employees feel that their errors and reported events are not used against them and that the errors are not recorded in their functional forms;

7) Human Resources comparing the staff dimension with the effective execution of the work and proper distribution of hours to provide the best patient care;

8) Support of the hospital management for patient safety, which refers to the promotion of a working environment conducive to security patient.

The size of the patient’s culture in hospitals consists of two items: i) Teamwork among hospitals, which evaluates the cooperation between hospital units to provide the best care for the patient; ii) internal transfers and the shift change), which assesses if important information about the patient’s care is transmitted between hospital units and through changing shifts.

This study is linked to the project: “Analysis of adverse event occurrences in a hospital in the Sentinel Network of the Central West Region”, Protocol 064/2008 and ethical aspects are under Resolution 466/12.

All respondents received and signed the Consent Form.

RESULTS

Of the 117 nurses, 105 (89.7%) were female and 12 (10.3%) were male. The age ranged from 24 to 64 years old, with the majority aged 45-51 years old, mean of 40.6 years old.

As working time in the profession, 35 (30%) reported having 21 years or more; 102 (87%) work 20-39 hours per week and 112 (96%) give direct patient care.

The nurses worked in various hospital units, 16 (13.7%) in the emergency department, 09 (9.7%) in clinical medicine, 08 (6.8%) in each of obstetric clinics, pediatric, surgical and surgical intensive care unit and medical, 07 (6.0%) at the clinic, 06 (5.1%) in the operating room services, pediatric emergencies and renal replacement therapy, 05 (4.3%) in the host orthopedic clinic and neonatal ICU, 04 (3.4%) in tropical clinic, 03 (2.6%) in the center of material and sterilization, 02 (1.7%) in the nursing board and 01 (0.9%) in consulting , hemodynamics and human reproduction.

Safety culture dimensions within the working unit

Regarding the dimension “expectations and actions to promote security by supervisors and managers”, the reports demonstrate the existence of quality improvement actions for...
the care and promotion of security measures through the manager’s job:

Currently, we are implementing the quality indicators of nursing care to guide the actions to continuous improvement of quality and patient safety. (E39)

This December is starting a sensitization work with the nursing staff for the reporting of adverse events by filling out a form and deposit urn, to ensure anonymity. (E76)

Also in this dimension, there was manager’s availability to listen, discuss and implement the suggestions offered by their team to achieve the goals of the unit to achieve quality and patient safety:

We suggest a committee working together in hospital patient safety, so we believe that it directs behavior, seeking assistance and safety improvements. (E59)

The dimension “organizational learning - continuous improvement” was evident that learning from the occurrence of failures is still in its beginning and for this, there is a need for better training and development of continuing education actions in the context of the practice:

From a security point of view [...] it is also necessary a regular training. (E46)

I think management needs to train more staff to help improve the quality and safety and especially errors of professionals. (E91)

Do more courses, seminars on patient safety involving health staff. Put more nurses in health services. Extinguish aid and technical level courses without competence and registration. Greater supervision of professional associations. Rigor in treatment protocols, especially errors of professionals. (E51)

The dimension “teamwork within the units” was well highlighted by the nurses who reported work towards patient safety and said that support and treat others with professional respect, working together as a team:

My team and my manager always meet and discuss the easiest way to solve the problems arising in the day and time. (E49)

The dimension “opening for communication in the unit” was found that nurses discuss cases that negatively affect the patient, however, discussions are limited to team members:

Usually, there are errors counted during the shift itself. When there is security failure, service or report comments on the staff and avoid major problems. (E59)

Nevertheless, they recognize the need for changes in communication, since there is no standardization of the actions against the occurrence of errors or any other incident during service, which will hinder a systemic approach to error:

[...] We need to discuss more openly on our mistakes. (E48)

I believe that adverse event reports are extremely important, but we do not have adequate training to know whom to report. When we have problems with inputs we report and deliver the purchase sector. (E72)

The dimension “feedback and communication about the errors” reinforces this view and points out the weakness in patient safety as the reporting of adverse events is not systematic, does not follow specific protocols and is not a practice known by all nurses, permeating perception that does not occur institutional changes and/or taking action to prevent the reported adverse events:

When we have problems with professionals, it is reported or look for a way to improve care, establishing routines and protocols, but we do not return in the form of guidance to the hospital, it is restricted to printed and nursing reports. (E72)

When adverse events occur we assess, notify and carry out the necessary interventions, but our evaluations of these processes are not yet ready for release. All this takes place internally (E74).

[...] I have doubts about the reports, which describe the errors. Generally, I report the nursing report. I know any form of reporting adverse events. (E85,11)

However, it was highlighted the interest of nurses in research carried out in the institution, which should provide feedback to the results to professionals so that errors can be studied and effective changes:

Currently, the quality of service has improved a lot and it is clear that patient safety as well. As for recorded reports, even those sent to the manager/direction, few of them have answers and solutions. I hope that this questionnaire can change that. (E35)

In the dimension “non-punitive responses to errors” was observed that the errors are not reported for fear of the consequences, which is justified by the perception of some professionals are in favor of punitive measures against the adverse event:

I think the mistake is sometimes not reported for fear because nursing is a disunited class and that does not use error to improve attendance, it would use the mistake to destroy a person's life. (E64)

I think this issue of the AE report is very cultural, people die, but do not speak who made the mistake. Everyone is afraid to
take a serious mistake, as will generate consequences. (E11)

[...] I am in favor of the application and punitive measures to professionals. (E117)

In the dimension “human resources”, it was highlighted that nurses recognize the importance of quantitative adequate staff and that improper sizing associated with comprehensive working hours, which is proper to the professional category, and higher number of patient admitted to the hospital impairing safety:

I believe that the number of professionals (reduced) jeopardizes patient safety and quality service. (E14,16,32).

Many errors occur in nursing by work overload, many of us have a triple shift in the medical team and some events happen for overconfidence and arrogance. (E60)

Many patients in the unit with hospitalization on chairs and couches, patient in not appropriate unit, an insufficient number of employees. (E61)

Regarding the dimension “support of the hospital management for patient safety”, the reports of managers showed that the hospital management offers a working environment that promotes patient safety and demonstrates that patient safety is the highest priority:

These data will feed the indicator of adverse events related to nursing services in all hospital units [...] and the results will be reported to employees and also used. (E76)

However, other reports raise the need for a management engaged in the prevention of adverse events in the institution:

I believe it is essential an institutional protocol establishment of adverse events. (E19)

There is a shy institutional mobilization although an acclaimed need on a personal and global level in the face of iatrogenic damage and reported through studies and surveillance strategies. (E114)

♦ Security cultural dimensions within the hospital organization

Most of the reports emphasized the lack of integration and communication between units, which weakens the dimension “teamwork on hospitals”:

In this hospital, there are a lot of cooperation missing between support services such as laboratory and x-ray, which often requested and are not well attended. (E3)

The event notification is made only in the postoperative ICU. There is no administrative policy for patient safety throughout the hospital. The actions are made in isolation, each employee thinks and acts individually; the public is not prepared for the health care focused on patient safety. (E62)

Also at the institutional level, in the dimension “internal transfers and shift change”, it is observed that there is a systematic routine for the transfer of information and/or documents between different sectors who provide patient care:

[...] And as the laboratory, many tests, samples are lost. Patients and staff are not told and the patient is always the most affected. (E3)

The results show nuances and interests of nurses in developing the patient safety culture, but there are attitudinal and conceptual differences observed that hinder this practice, requiring immediate changes in the dimensions related to communication, feedback, and organizational learning, focusing on not punitive actions.

DISCUSSION

From the reports, it is clear that professionals perceive and have knowledge of adverse events in hospitals, knowing that they can be prevented and recognize that to improve the quality of care, safety culture should be prioritized by managers, which should be supported by institutional and governmental policies and engage patients.

These aspects contribute to the transformation of the workplace and minimizing avoidable damage while providing care.13

Regarding communication of events between the team, it is observed that there is no standardization since professionals do not report and did not report the errors. Possibly the difficulty to accept human error, either by fear of punishment or the incomprehension of the population and also on the error notification be perceived as a problem by other professionals.14,5

A study16 pointed out that many health professionals do not communicate or notify any errors because they feel shame because of their “punitive idea”, for fear of suffering from administrative sanctions, verbal, written, layoffs, civil, legal and ethical punishments. Reports of 5-40% of the nurses suggested as a reason the underreporting fear because of the consequences that this may lead to professional. However, it is disturbing to know that even with all the educational campaigns for event notification at the institutional level, there are still reports of professionals in favor of punitive measures for their mistakes.

Learning to recognize the error and report it makes this initiative a review source of all
the causal process in addition to preventing future situations involving adverse events. It is important to strengthen the replacement of punishment for the evaluation of the process, a safety culture established to notice and filed with the use of tools to analyze the causes of errors, process correction and preventive measures of new fault occurrences.14,17,9

A relevant aspect is a feedback on the occurrence of an adverse event. Besides being an information to be passed to staff by the management, it is an action that must be implemented by all the researchers who conduct research on adverse events since the information for healthcare professionals in the results, help in understanding the etiology of adverse events and the contribution of the hospital system for situational awareness aiming for significant changes in the assistance.20

Nurses for the occurrence of adverse events evidenced possible causes or risk factors. Of them, 14.86% of the reports warn about the inadequacy of quantitative human resources in front of the great demand of patients and nursing staff personnel workload comprehensive result of up to three employment contracts. This points to the need for managers to invest in the organization in the provision of adequate staff and absenteeism, as showed a by a research21 of nursing professionals, where excessive responsibility, exhausting work in two shifts and the daily confrontation of situations of suffering causes the workers increased emotional and burnout increasing the number of absenteeism in the institution.

Another aspect highlighted is the lack of teamwork within the unit and between the hospitals in which the loss or exchange of customer information impair the quality of care and enables fault appearance. The safety culture has reference to the collective attitudes and organizational climate and works in unity. Therefore, an organization committed to patient safety culture is one that reinforces the story on a personal level and at the group level and, therefore, managers should identify weak points of the system as a way to fix them.22

This reality justifies the development of protocols and policy for the prevention of adverse events, as these mistakes can be avoided or minimized through the implementation of simple safety measures that need to be disseminated and adopted the institutions. It involves a systems-based approach that examines all activities in the organization, contributing to the maintenance and improvement of patient safety, such as progress in the performance and management of risks. This process aims to ensure that the activities work together, not in isolation, to improve customer service and security.23,24

Thus, supervision and continuing education of all professionals are critical and were cited in 14.86% of the reports. It is necessary to develop educational programs that elucidate what are the mistakes, discussing scenarios to understand the causes of the problem and proposals for improvement, and collective awareness for safe care.15,19

As the shortcomings and needs for improvement in hospital management actions, the results support the deployment of a multidimensional program, essential to evaluate and improve the quality of healthcare through information production for making decisions.22 This requires standardizing processes on multi-daily practice since such a measure contributes to the reduction of adverse events.17

In the context of this study, being a teaching hospital, it is necessary to train health professionals able to initiate and expand critical thinking and strategic action to disseminate and streamline the care of the health needs of the population.25

The analysis shows that nurses understand that health care is characterized as one of the most complex and dynamic activities carried out by human beings and that knowledge and dissemination of the safety culture dimensions can minimize the occurrence of adverse events that harm health care. If it is accompanied by investments in organizational system and people, the adoption of safe practices can be even more effective since one of the four strategies of institutional organization is to adopt behaviors to prevent errors and convert these behaviors in work habits.26

However, to establish safe practices a cultural change in the whole system is required and, therefore, there must be a change in the attitude of professionals directed to the safety culture.

**FINAL CONSIDERATIONS**

The development of safety culture is strongly influenced by the behavior of health professionals, which in turn is influenced by the form of organization of work and organizational management.

Negative aspects have been identified that influence this process, such as miscommunication between the subsectors of the institution, unit staff and to the adverse events, the absence of a learning routine from
the error, inadequate staff dimensioning, teamwork within insufficient institution, fear of punishment and the need to improve the support of the managers for the development of safety culture.

However, nurses perceived taking actions to improve the quality and safety of care, awareness of health professionals for the reporting of adverse events, teamwork among unit staff, the opening of the managers for discussion of undesirable situations and discussion of adverse events, even in a limited way to team members.

These factors represent safety culture of nuances that need to be strengthened from the necessary changes that hereby are directed by negative factors identified by nurses. The focus should be the adoption of behaviors conducive to patient safety. For that, continuing education is essential as a means of updating knowledge, train competent professionals and correct errors before they can generate major consequences to the patient.

In the case of a university hospital, strengthening the link between teaching and service becomes a challenge, the need to integrate the actions of the academic community and institutional managers in pursuit of excellence of care.

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