THE PERCEPTION OF MANAGERS REGARDING HEALTH CARE RISKS AND TOOLS USED IN THE PROCESS OF MANAGEMENT

A PERCEPCIÓN DE GESTORES SOBRE RIESGOS ASISTENCIALES E HERRAMIENTAS UTILIZADAS NO PROCESO DE GERENCIAMIENTO

LA PERCEPCIÓN DE GESTORES SOBRE RIESGOS ASISTENCIALES Y HERRAMIENTAS UTILIZADAS EN EL PROCESO DE ADMINISTRACIÓN

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RESUMEN

Objetivo: entender la percepción de los gestores en relación al gerenciamento de riesgos asistenciales. Método: estudio de campo cualitativo, realizado en un hospital público de la ciudad de Belo Horizonte/MG. Hubo 16 sujetos, entre enfermeros y médicos que tienen cargo de gerencia o coordinación asistencial. Los datos fueron recogidos por medio de entrevistas semiestructuradas y fue utilizado la Técnica de Análisis de Contenido e análisis descriptivo. La investigación cumplió con los lineamientos de la Resolución 196/96 y los lineamientos de la Resolución 2003/8, aprobados por el Consey de Ética. Resultados: el perfil de los entrevistados enseñó edad media de 43 años, de 26 a 66 años, predominio del género femenino (75%), admitidos por concurso público, con carga horaria semanal de 40 horas. Conclusiones: se constató que todos los entrevistados saben discernir conceptos relacionados al gerenciamento de riesgos, 93,75% conocen la herramienta informatizada de notificación de eventos adversos utilizada en este servicio, y 75% reconocieron beneficios tras su implementación. Descriptores: Gerenciamento de Risco; Iatrogenia; Gestor de Saúde; Notificação; Qualidade da Assistência à Saúde.

ABSTRACT

Objective: to understand the perception of managers in relation to the management of health care risks. Method: a qualitative field study, conducted in a public hospital in Belo Horizonte/MG/Brazil. There were 16 subjects, among nurses and doctors who had management or care coordination positions. Data were collected through semi-structured interviews and analyzed using the Content Analysis Technique and descriptive analysis. The research followed the ethical principles of Resolution 196/96, with approval by the Ethics Committee of the hospital in Belo Horizonte/MG, by CAAE. 0061.0.391.216-1. Results: the profile of respondents revealed a mean age of 43 years, ranging between 26 and 66 years old, female predominance (75%), admitted by public contests, with weekly workload of 40 hours. Conclusion: it was found that all respondents discern concepts related to risk management, 93.75% are aware of the computerized tool of adverse events notification used in this service, and 75% recognized benefits after their implementation. Descriptors: Risk Management; Iatrogenesis; Health Manager, Notification, Quality of Health Care.

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INTRODUCTION

The health care should proceed with quality, free of risk and failures, coupled with the commitment to efficiency of the services provided and with customer safety, promoting health without causing damage. Errors related to the processes of care not only violate the security of client in health services, but above all, their dignity and rights associated with it, which relates to the principle of beneficence, lauded by bioethics, which undoubtedly increases the risk of death or sequelae.1

Regarding the issue in question, it is necessary to cover concepts and definitions that are justified by its magnitude. Incidents, adverse events (AE), iatrogenesis or assistance errors can be described as undesirable occurrence, harmful and hurtful, compromising patient safety. In addition to emotional and physical damage, an increased length of hospitalization, suffering by the patient, temporary or permanent disability, and even death can also occur. The consequences are not confined only to the patient and may even reach their relatives.2

Among the AE that occur in the health sector, there is a higher incidence of those related to the inexperience of professionals, to the lack of technical and scientific knowledge and deficiencies in the quantity of professionals required for assistance. Despite many other predisposing factors for the occurrence of errors and/or iatrogenesis, we emphasize the availability of matrix resources such as physical plant, materials and institutional equipments.3 4

The error, understood as an event prone to control or correction measures can be understood by managers of care through two different visions: one individual and another systemic. The first focuses on identifying the individual involved with the event, and therefore enforce, the position of the main “guilty” for the error, leading it to wait for a punitive action; which often causes inhibition of future notifications, as well as terminates the development of prevention mechanisms. In the second, the aim is to promote accurate reflection about all the factors related to the event, without, necessarily, identifying "guilty", and featuring the AE as a failure in the system.2

Studies on the theme focus on the need to implement the systemic vision of AE in the culture of managers of health institutions, since it enables the creation of a conduct surveillance, in order to discover the true origin of the problem, in addition to supporting the implementation of training and guidance as ways to “surround” the error, making the chance of a re-incidence, decrease or not even happen.2 5

It is noteworthy that during patient care, errors and AE are poorly explored and studied. Every event involving damage, or even the one that represents potential damage to the patient, shall be communicated and reported by means of suitable instrument since, although no corresponding injury is generated, the AE are not notified in situations in which error occurs.1

In the view of health professionals, the AE are identified as something unusual, which is why their occurrence, in most situations, is trivialized and not registered.1 2  6 When the error is not recognized, the direct consequence is underreporting and, therefore, the cases that become public knowledge correspond to only the tip of a huge “iceberg” of problems related to failures of risk management.6

Patient safety is the fundamental principle of care and critical component of quality management.7 The prospect that the patient is put at risk when you are in health services, does not come from recent data, but from studies conducted about 30 years ago, in development countries.8

Studies conducted in the United States of America (USA) estimates that annually about 100 thousand people die in hospitals due to AE. This fact evidences a higher mortality rate than the one assigned to patients with acquired immunodeficiency syndrome (AIDS), breast cancer or running overs.9

In Brazil, it is not possible to effectively measure this type of occurrence due to the absence of a single database, which shows the number and analysis of the facts, although there are some initiatives such as the Sentinel Network of the National Health Surveillance Agency (ANVISA) that, in partnership with the Brazilian health services, aim to build a systematization prepared for notification of AE into three categories: technovigilance, hemovigilance and pharmacovigilance.10

From the perspective of consolidating the world culture for the prevention of such events, in 2004, the World Health Organization (WHO) created the project “World Alliance for Patient Safety” which aims to prevent damage, having as one of its core elements, the action called “Global Challenge”, which every two years takes a priority theme to be adopted.11 In Brazil,
where the iatrogenic processes present a negative highlight of the current health scenario, it was necessary that these events were managed, when the risk management emerged, culminating in the deployment of the National Policy of Risk Management in the year 2001.

It is defined by risk management, the culture, structures and processes aimed at recognizing potential opportunities to concurrently manage their adverse effects. This is one of the most discussed topics in hospitals in recent years which, linked to continuous improvement processes, has contributed to the quality of the services provided. Managers have an important role in this scenario, since their activities that involve teamwork are their responsibility, as well as the processes of training and permanent education.

Risk management reduces the incidence of disease and damage, shortens the duration of treatment and/or hospitalization, improves or maintains the functional status of the patient, and increases their sense of well-being. For risk management, financial resources employed in risk control are applied rationally, since its steps allow the selection of what is necessary and priority in the execution of these procedures.

The interest of this study arose after workshops of sensibilization on risk management were conducted and the implementation of an electronic system used to notify AE in a public hospital in Belo Horizonte. These workshops took place in 2010, and were led by multipler-nurses. The target public was composed by members of healthcare teams who provide direct and indirect care to patients.

After this experience the following concerns related to the theme emerged, and became a focus of research << What is the level of knowledge of care managers on risk management in healthcare? >> << What is the perception of care managers regarding the effectiveness of the tools used to manage risk in a public hospital? >> << What actions are taken by these managers at the occurrence of events? >>

When considering that the risk management and reporting of AE are key pieces for the care and patient safety, it became important to understand the perception of care managers about this process, and the evaluation of them on the tools used for risk management, as well as the attitudes that managers and health staff take at AE occurrence and the notification system implemented.

**OBJECTIVE**

- To understand the perception of managers in relation to management of health care risk and to identify the evaluation of the tools used in the institution where they work.

**METHOD**

Field study, descriptive and exploratory, with a qualitative approach. This approach was used in order to allow a more comprehensive evaluation of the results obtained, of the possibilities of description, explanation and understanding of the object of study.

The qualitative method is the one that applies to the beliefs and perceptions; products of the interpretations that people make about their experiences, their way of feeling and thinking. Descriptive studies in turn, aim to describe the characteristics of a given population or phenomenon, while the exploratory research, provides a greater familiarity with the problem, making it more explicit.

The field studied was a large public hospital in the city of Belo Horizonte/MG/Brazil, characterized by the demand for care of clinics and traumatic events in high and medium complexity, which has programs of medical residency, in addition to having an electronic system of AE notification. The subjects were nurses and doctors with the position of managers or coordinators of care support in this hospital. As an inclusion criterion, these subjects had to be for a minimum of 05 months in their functions.

The research project was approved by the Ethics Committee of the hospital in Belo Horizonte-MG, through CAAE No.0061.0.391.216-1 and protocol 0061.0.391.216-1. This study complies with ethical principles of no maleficence, beneficence, justice and autonomy, contained in Resolution 196/96 of the Ministry of Health, by the National Health Council.

The study population consisted of 19 managers. Sixteen interviews were conducted, representing 84.21% of the population, confirming thus the data saturation, a process in which new data fail to arise during collection.

Data were collected in November 2011, through semi-structured interviews, audio-
recorded, transcribed verbatim, and stored in a database. The collection was conducted after signing the Free and Informed Consent Term, and to preserve anonymity, subjects were identified by the letter E, followed by the number corresponding to the interview, according to the order of their execution.

For the content analysis, we followed the steps: pre-analysis, which consists in organizing the data; exploration of the material, which is determined by coding, classification of speeches and drafting relevant categories and the treatment of the results, inference and interpretation of data, which seeks its significance and validation. To proceed to categorization, the answers in the text were dismembered into units that were grouped into categories, according to the analogy of themes. In this process four categories were identified. Simple statistical was also used through calculation of frequency, within a possibility of analysis of the content.  

RESULTS AND DISCUSSION

The profile of interviewees revealed a mean age of 43 years, ranging between 26 and 66 years, with a female predominance (75%). Despite the employment contract, all were admitted through public contest, worked for 40 hours per week and the average working time in the institution was fifteen years and three months. As for the work shift, 81.25% worked at daytime and 18.75% at day and night. Regarding professional training, around 50% were graduated in nursing and 50% in medicine, and, 56% had management positions and 43.75% were support coordinators. Among managers, the majority belonged to the medical category (87.5%) and 12.5% were nurses.

♦ Category 1: Knowledge of managers on risk management in health and notification tools for AE

Hospital risk management is a complex process that combines several areas of knowledge and aims to prevent errors and AE from the use of health products and processes of care, ensuring patient, professional and environmental safety.  

All respondents knew the concept of risk management and AE, noting that the majority (62.5%) participated in workshops that addressed the themes, performed by the institution or during specialization courses. As shown by the speeches:

Adverse event is what comes out of normality. It is what comes out of the routine during a procedure or care and can be harmful to the patient. (E7)

It is any event that occurs with the patient which leads to an injury of any kind. (E8)

It’s everything we can do to prevent the occurrence of AE. (E10)

It is a set of actions within the hospital that involves AE, but that encompasses all areas of activity of the hospital from surgery in safety conditions, infection control and the control of AE themselves in the institution. It’s the set of actions involving safety for the person hospitalized, minimizing avoidable risks. There are risks that we cannot control, an inflammatory response or infection, but the correct treatment of this inflammatory response is part of risk management. (E13)

It is highlighted in the speeches presented above, the speech of E13, characterized by a broader knowledge compared to other respondents, with concepts similar to the author. The author corroborates that the risk manager with academic qualifications and experience, ability to effective communication, attention to detail, willingness for teamwork and thorough knowledge of the principles of risk management, contributes greatly to the survival of any institution.

The manager’s performance is directly related to the organizational structure in which it is inserted, along with the structuration of the methods of risk management. Thus, the need for learning and deepening knowledge of managers will also depend on these elements.

Regarding factors that predispose to error, some respondents noted:

Tumultuous shifts, sometimes we’re crowded, no more vacancies, but if a patient arrives, we have to receive it. So the hazard can come from this, the work overload (E7).

In health the person works in two, three jobs, we work with high demand for patient’s services with reduced shifts, then several hours of work, then all of this contributes to inducing the error. Even the matter of flasks looking similar. (E14)

Thus, it is clear that the prevailing factors, both cited by nurses and by doctors, were busy shifts, followed by work overload. Also cited were the lack of preparation, illegible handwriting, similar flasks of medication and layout of the beds that are very close to each other.

Errors can be influenced by many factors and the AE is rarely caused by a single error,
but rather by a break in the barrier of defense against the occurrence of the events. The low level of theoretical knowledge and lack of professional preparation, are also considered risk factors for the occurrence of errors.  

However, there are situations that predispose to the risk of AE, such as technological advancement, incompatibility of the necessary professional development, deficiency in interdisciplinary actions, professional inattention, illegible prescription medication, delegating care without proper supervision and service overload.  

When asked about the prevalence of AE, speeches showed that the most frequent event is related to venous access (loss, improper exchange, obstruction, fixation) present in 25% of statements and events related to medication (dose, route, patient and exchange), drop, delay and cancellation of surgeries, events related to parenteral nutrition and proximity of patients were cited less frequently, as it is seen in the speeches:

Procedure related to peripheral catheter, loss, obstruction, device and undated solution are the lightest events. (E5)

It is related to process, events with venous access is the most common then is loss of access, incorrect fixation, patient who pulled the catheter and was not being observed. (E6)

The minors AE usually are more related to nursing, but the more serious events are related to medical procedures. In daily nursing is most likely, because of increased contact with patient, its spectrum of action is broader, so it has that possibility.

The medical AE generally are more serious because they are usually more invasive procedures. (E13)

These results are converging to those found by the authors, who point out that the most common AE are related to quality indicators, usually related to medication, patient falls, catheters, tubes, drains and skin integrity.

Although all respondents knew to conceptualize AE, two responded improperly, reporting factors that are not AE, but problems related to communication and material resources, according to the speeches:

One day there was a discussion between physician and nurse[...] the right procedure was to prepare a document explaining that the behavior with the technician was not adequate, then they discussed and agreed by and did not report, and later I reminded them. (E9)

Adverse events are issues with laundry,

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such as lack of bedding, related to pharmacy such as the lack of medicines[...] The lack of kits for the baby, diapers and bed linen. This interferes with the stress of staff for lacking basic things in their work. Thank God our events in relation to laundry have greatly reduced and the staff has worked better this issue. (E3)

Category 2: Tools used for risk management

All interviewee acknowledge the electronic tool implemented in the institution for notification of AE, called "Report is Nice." Among the respondents, some cited other tools such as: Commission of Hospital Infection Control (CHII), safe surgery, commission of death, root cause analysis, and the nursing book, as it is possible to evidence in the speeches:

There is the Report is Nice, it is online on the website of the institution's intranet. (E5)

The Report is Nice is the principal, another tool used is safe surgery in my sector, commission of death, infection control, central catheter's package of infection control. (E13)

Several methods of assessing AE are evidenced in the literature, highlighting among them: voluntary reports of incidents, spontaneous reports with alerts, direct observation, retrospective and prospective review of medical records, interviews with patients, or their combination. Health institutions should choose to adopt techniques and instruments consistent with its mission and values, aiming to promote patient safety, besides the effectiveness of communication between staff, patients and institutions.

Subcategory 2.1: Computerized system for notifying AE "Report is Nice"

The program "Report is Nice" is available on the main page of the hospital intranet. When accessing it through a specific link, it is possible to find the first screen of the program, an informative message about its goal, which is exactly the AE record, focused exclusively on its causes. The program contains two fields where the notifier has the option to register a new notification or previous ones. When you select the option to register new notification, a field to report opens, in which the notifier can identify itself or not. Next, the date, time and place of the event should be informed.

Regarding the classification of the event, you can choose one of the predefined variables in the program: procedure, medication and nutritional therapy, worsening...
preventable infection, way of working and flows and accident. You can still specify the fact of a list of sub-events, or subevents subtypes.

Regarding knowledge of this tool, 68.75% of respondents knew these variables and 31.25% did not know or could not answer during the interview.

This result shows that some managers do not know the tool throughout their effectiveness, which can prejudice the monitoring and understanding of AE, and derail the effectuation of the precepts of the national policy for risk management and security of the Ministry of Health, which advocates ongoing analysis of events and risks, in order to check the minimum requirements to ensure quality, through analysis of documents and processes quickly, covering the largest number of variables in the form of notification.23

The majority of respondents (81.25%) said they are managers and coordinators, responsible for the answers through the program, and less frequently, personally, and in meetings of committees, 18.75% reported some difficulty in responding to notifications due to access, lack of time to respond and no standardized way of response.

The manager has to access, replying takes time, I’m closing notifications from the beginning now, quality calls for a feedback, I’m spending on average four to five months to close the notifications. (E3)

Actually we do not give a return, we discuss some situations in committees, mainly linked to the work process. (E4)

As at the institution only managers have access to the detailed report of the notifications of their unit, the quick and effective feedback should be guaranteed to the notifier that feeds the system. In this sense it would be more feasible to develop continuing education to promote more efficient patient safety.23

Regarding the recognition of the group of hospital quality, 75% of managers said they knew it and reported as this group’s responsibility, to process notifications. Others (12.5%) mentioned that the responsible is the committee for patient safety, without specifying the Quality Group. The remainder (12.5%) claimed not to know how notifications are analyzed. This is exposed in the speeches:

Yes, the quality group. This group gave feedback to managers at a meeting of committees (E3)

It has a team that reviews all notifications

and replies and demands from the management the response to that notification. It is the quality group and others in the institution (E15)

At the hospital the “Quality Group”, which is part of the Patient Safety Committee, comprised of three professionals (01 doctor and 02 nurses) is responsible for examining the content of notifications, sorting according to priorities of interventions, producing statistical reports and monitoring responses and corrective and/or preventive interventions.

The meetings are held weekly and depend on the presence of the entire group for data to be interpreted one by one. To date the interviews had more than 1900 notifications. Of these, only about 600 had been analyzed.

Regarding the feedback given by the Quality Group to managers, 50% claim to have had no return on the statistics of the notifications of their sectors; 31.25% said they had access to the analysis of the notifications and 6.25 of the respondents had access only once, as it is noticed in their speeches:

I don’t have a result to this yet, this issue of the number of events, which ones they are, if it’s working process. (E8)

I do not have such access, which was in the management contract, but I have not been having that. I had once. (E3)

I have because I am part of the group, but this group fails, others do not have access, we cannot pass the information on in appropriate time. (E4)

It is noteworthy that one of the pillars of the functioning of the surveillance system is the commitment to responding to informants in the producing sources, appropriately and timely, demonstrating its contribution to the process. The content of information provided must match the expectations raised in the sources, ranging from simple data consolidation to complex epidemiological analyzes. The credibility of the system depends that health care professionals feel participants and contributors.26

The results presented in this category implies on the need to reorient the service, in order to improve the effectiveness of the notification, the monitoring and the study of AE in the institution.

♦ ■ Subcategory 2.2: Training and participation of staff to use the computerized system of notification

Referring to the training of managers for handling the computerized tool, 62.5% said
they were trained to manipulate it in theoretical training and/or practice, 12.5% say they have not received training.

Yes, we had training for handling; we were even the people who replied it in the committee unit. (E4)

I was trained by the manager and was made an outreach work, where he showed the tool, said it was monitoring and not punitive. (E2)

The training of staff is characterized by the effort expended by organizations to provide learning opportunities to its members. Among the more traditional training purposes are those related to identifying and overcoming deficiencies in the performance of employees, the preparation of professionals to new roles, and re-training for adaptation of staff to the introduction of new technologies at work.27

About the training necessary for notification of AE, 75% of managers reported that all employees of their sectors were trained to use the program. Others reported they were not trained, or the training word was not applied.

Yes we have been trained and we trained our staff too, it was "in loco" by picking up one by one by the hand and sit at the computer and show how it works. (E14)

It was about a year ago, the manager and I performed the training, it was in a committee meeting, by demonstration. (E10)

It was felt that managers were the most responsible for training of their employees. The author28 reinforces that it is through ongoing training that the manager can gather knowledge, sensibility and safety, factors that will help in performing activities together with their co-ordinates.

About joining the program by the multiprofessional team, 62.5% of respondents rated it as poor, as shown in the reports:

Small, people complain a lot, but do not register. (E15)

Of the hospital I think the urgency and emergency sectors are the units that notify more AEs in the reporting system Report is Nice but that is still very low participation. (E14)

In this context, the difficulty of collecting data in Brazilian hospitals is related to poor quality of records on medical records, to the culture that AE are individual errors of health professionals that induce the professional to not expose the observed situation, to the lack of importance, concepts and procedures related to AE.29 There is a need for professionals to form a network of knowledge, collaboration and solidarity for the investigation of AE, which will bring benefits to patients and merit to the institution.30

♦ Category 3: Assessment of "Report is Nice"

Of the respondents, 93.75% rated the program characterizing it as simple, self-explanatory and able to meet most of the events that occur, which for the majority of respondents are facilitating factors for the use of the tool. According to the speeches:

It is very simple, the program was very settled in their construction, in the form of implementation[...] I think it serves us very well. (E6)

It's pretty simple the notification, I think it has to be simple, no need to identify ourselves and is practically self-explanatory, has no complication. (E8)

Any person, even if not very savvy in computing, is able to do it, it's all there in the walkthrough, there's no way to miss. (E7)

Notifications of AE, also made in the database, are important sources of alerts and information, promoting safety in the hospital environment and contributing to the management of nursing care. The practicality of the instrument enables its use with team participation, assessed by a gradual increase in notifications from its introduction.23

Almost all managers (93.75%) indicated that there are factors that hinder (18 different types) notification of AE, with the fear of punishment being the most indicated, followed by lack of time, culture, lack and/or insufficient computers in some sectors, no login and password of the employees, which makes them dependent on others to enter the system, lack of knowledge about the program, and lack of awareness. Some respondents cited even more than one complicating factor:

There is a very large overload, lack of time and lack of the habit of notifying [...] afraid of harming the colleague, thinks it will be towards punitive, many employees do not know. (E2)

There is still fear. The staff even play up the snitch is cool. There is still this culture of safety[...] the change of this vision is complicated. (E8)

These speeches have also been found in other studies showing that factors such as lack of motivation, lack of training, fear of punishment and shame, favor underreporting. These results are justified by the creation, in the past, of a punitive culture, where...
warnings were used to minimize errors.2,23

Managers also reported the existence, in the system, of many reports that could not be categorized as AE, but as of a personal nature, arising from problems of inter-personal relationship, as shown:

The team does not have a correct idea of what the Report is Nice is, it was even given the nickname Snitch is Cool. (E5)

The staff questioned me the prophylaxis of staphylococcus to the employee so I consulted the HICC, occupational medicine and handed him a written response, because it was not EA. (E16)

Although all respondents know the concept of AE, it was noticed that one of the program managers indicated the program to register a disagreement between employees, according to the speech below:

One day there was a discussion between physician and nurse [...] the correct conduct would have been to make a document explaining that the behavior with the technician was not adequate, they then discussed and agreed by and did not notify, and I reminded later. (E9)

Adds to that the importance of disseminating accurate and clear concepts about all kinds of events and what is defined as AE.21

Regarding the evaluation of the program, 32.5% added to their speech, criticism of the program in the sense that events are subjective, it is not possible to analyze the notifications in a real-time manner, difficulty of having an overview of the data by relying on pre analyze.

The events are very subjective, I cannot identify when it is about probes, drains, catheters, for example, I do not know if it's a urinary catheter, if it is nasonoenteric, if it is a problem with the diet, if the reservoir is leaking. (E4)

Due to logistics we cannot analyze notifications in a real-time manner, we have to categorize events. (E12)

♦ Category 4: Manager interventions at AEs reports, benefits and relevant factors

A significant number of respondents (75%) perceived benefits after the implementation of the electronic system for notifying AE. This can be observed in the speeches below:

People have little more attention, more awareness. It improved greatly, sometimes it used to be unnoticed [...] it used to be a very individual thing, giving a warning to the person and forwarding to the COREN. (E1)

The benefit is that we will be always providing a safer sector. (E8)

I had less notifications before in the paper and it was little, I used to pick up AE and today the notification appears more frequently, in a year there are more events than in two years because of the greater notification [...] The system opened up another channel of communication. The notification is a management tool, we cannot be in the sector twenty-four hours, and then it allows anyone to notify a situation that could compromise patient safety. (E13)

Notifications of AEs are fundamental to the understanding of reality, and for strategies to be implemented for continuous quality improvement of services provided to the patient.3 The computerized system creates a common language between different hospital departments, which facilitates the events notification. It is desirable that the way of communication of AEs is fast, enabling prompt action of the management.23 In the speech it is possible to see as a benefit of this process, the implementation of interventions to minimize the occurrence of risk for AE, mediated, at least in part, by data analysis. A quarter (25%) of those involved confirmed this impression:

We had a problem with chest drain [...] it started giving problem first in the first case [...] at the second I asked the resident to formally notify, we began to notify what was happening and prevent the event later we went to notify the pharmacy, the pharmacy notified the supplier and also the ANVISA and we blocked the purchase of the drain. (E13)

Through the last report we prepared a preventive protocol for each group of these more prevalent AE, we only need to multiply it, but it is already done. (E14)

Respondents also suggested, constant work awareness, periodic workshops and training in order to turn the most specific variables to empower them to better surveillance, besides the reduction in the categorization options (variables), to facilitate the registration and access to the database outside the hospital. The statements represent this connotation:

Patient safety is not just a matter of notifying AE, it is to notify, do training, protocols, it is to empower people to work right. (E7)

We should do the analysis of notifications in real-time, to encourage reporting. (E12)

There is little complaint, little notice, I think it needs improving and maybe it really
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In this category it was possible to identify the congruence between the views of managers of the institution and the conception defended by the author, which not only enhances the process by managing risk, identifying, preventing and controlling the occurrence of failures, but as the primary focus of the search for continuous improvement of the quality, motivation, commitment and education.

**CONCLUSION**

For healthcare institutions to ensure quality care, free from damages and losses to professionals, patients and their families it is necessary that the multidisciplinary team knows the goal of the management of AE, and get access to the right tools for managing risks in their work environment.

In this study it was found that all respondents discern concepts related to risk management, 93.75% know the computerized tool for AE notification used in this service and 75% recognized benefits after their implementation.

It was identified that there are some differences in the practice of risk management when compared to literature recommendations. The methodology for the analysis of adverse events has many weaknesses such as the delay in responding to notifications, lack of standardization of these responses, and in some cases, the lack of opinions.

It was highlighted the need to reassess the program and its applicability, adapting it to the needs and realities of the institution. The training and evaluation of the effectiveness of training not only for workers but undoubtedly for managers can be alternatives to improve general statistical analysis and demonstrating better results.

However, it was noticed that the credibility and proper handling of tool for risk management related, essentially, to understanding its true purpose by those who use it.

This study has the limitation of not allowing the generalization of this analysis to other teams and institutions, since it portrays experiences by these subjects, showing the relevance of new studies on this issue in other services.


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