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Behavior of nursing managers and leaders when errors are disclosed in the media

Posicionamento de gestores e lideranças de enfermagem diante dos erros divulgados na mídia

Posicionamiento de gestores y liderazgos de enfermería delante de los errores divulgados en los medios de comunicación

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ABSTRACT

Objective: To analyze the behavior of nursing managers and leaders when nursing errors are disclosed in the media.
Methodology: A qualitative, retrospective, documental study of the collection carried out in newspapers in Brazil and Portugal, between 2012 and 2016. Analysis performed at Atlas.ti, using a Ricoeur technique based on Habermas Theory of Communicative Action.
Results: Managers and caretakers focused on the workforce, continuing with the opening of internal syndication, removal of position and dismissal. How to lead the discipline process, carrying out inspections, requesting documents and questioning about the facts, as well as repudiating some disclosed notes.
Conclusion: Leaderships in nursing played a crucial role in developing a complex problem strategy. However, this was not done efficiently.
Keywords: Patient safety. Nursing. Communications media. Leadership. Risk management.

RESUMO

Objetivo: Analisar o posicionamento de gestores e lideranças de enfermagem acerca dos erros de enfermagem divulgados na mídia.
Metodologia: Estudo qualitativo, retrospectivo y documental. Coleta de dados realizada em jornais do Brasil e de Portugal, entre 2012 e 2016. Análise realizada no Atlas.ti, utilizando a hermenêutica de Ricoeur, fundamentada na Teoria do Agir Comunicativo de Habermas.
Resultados: Gestores e lideranças destacaram as condições de trabalho da enfermagem e prestaram esclarecimentos quanto à ausência de supervisão e déficits na força de trabalho, seguiram com a abertura de sindicância interna, afastamento do cargo e demissão. As lideranças se posicionaram abrindo Processo Ético Disciplinar, realizando fiscalização, solicitando documentos e questionando acerca dos fatos, assim como repudiando algumas notas divulgadas.
Conclusão: As lideranças em enfermagem desempenham papel crucial no momento da divulgação de notícias que envolvem erros assistenciais, a fim de expor uma problemática complexa. Entretanto, isso não tem sido feito de forma eficiente.
Palavras-chave: Segurança do paciente. Enfermagem. Meios de comunicação. Liderança. Gestão de riscos.

RESUMEN

Objetivo: Analizar el posicionamiento de gestores y liderazgos de enfermería sobre los errores de enfermería divulgados en los medios de comunicación.
Metodología: Estudio cualitativo, retrospectivo y documental. Recolección de datos realizada en periódicos de Brasil y Portugal, entre 2012 y 2016. Análisis llevado a cabo a través del Atlas.ti, utilizando la hermenéutica de Ricoeur, fundamentada en la teoría del Actuar Comunicativo de Habermas.
Resultados: Gestores y liderazgos destacaron las condiciones laborales en enfermería y atestiguaron en relación a la ausencia de una supervisión y un déficit en la fuerza de trabajo, siguieron con una apertura de lo sindical internamente, destitución del cargo y despido. Los liderazgos se posicionaron abriendo un Proceso Ético Disciplinario, realizando una fiscalización, solicitando documentos y preguntando sobre los hechos, así como repudiando algunas notas divulgadas.
Conclusión: Los liderazgos en enfermería desempeñan un papel esencial en el momento de divulgar noticias que involucran errores de atención, con el fin de exponer una problemática compleja. Sin embargo, eso no ha sido realizado de forma eficiente.
Palabras clave: Seguridad del paciente. Enfermería. Medios de comunicación. Liderazgo. Gestión de riesgos.

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INTRODUCTION

Patient safety and health care quality have become a recurring issue today. Discussions around this topic have had their genesis at the beginning of this century and point to the incidence of human errors and failures arising from health care in all areas of care.

The data associated with adverse events are alarming when dealing with the consequences of these incidents, which increase hospitalization time, severe sequelae and death of patients[1]. As a result, the costs generated are also exorbitant, and an increase of more than 200% in expenditure can be estimated when there is an intercurrent of this nature[2].

These incidents are not only the focus of scientific studies and reports of organizations. They are constantly becoming an attraction to the media, especially when the outcome of these incidents is associated with serious consequences. Therefore, the media has repeatedly disclosed errors committed by nursing professionals, as well as other information that serves to understand these events, such as the causes of errors, the relationship with the nursing organization, and the analysis of these facts which were carried out by the institutions managers involved and by the nursing leaders and representative organizations of the profession.

There is always an important caveat in this mass disclosure, since there is an unbridled search for the new, for the impact, for what draws readers attention in this process of news production, and thus it may present "only a selective portrait of what is real"[3:25], threatening the integrity of the professional nursing practice.

The professionals involved in these errors are subject to punishment, and in a study carried out in São Paulo, the punishments suffered by nursing professionals were classified as mild (verbal warning), moderate (written warning) and severe (suspension and dismissal). Training, which should be much more used to prevent future incidents, appears at a much lower frequency. There is also the disregard of such events, since much of what happens remains underreported[4]. Fear of punishment hampers notification, hides occurrences that remain unknown, and, fatally, are no longer analyzed. The importance of reporting adverse events is due to the goal of minimizing harm and learning from these errors[5].

Nursing work is very peculiar and is influenced by the organization of this work and, in this complex and dynamic process, a diversity of aspects can be associated to the causality of the errors. Healthcare has some explicit sources of human error that are well known, such as fatigue, routines, overtime, overload, staff turnover, among others[6-8]. In addition, health and nursing work shares the characteristics of variability and simultaneity between production and consumption, that are typical of the service sector. Therefore, this is a setting full of challenges and that needs to be constantly analyzed to ensure the safety of users and professionals.

To create a big deal regarding the error within health institutions and raising important aspects for understanding the issue, news can be an important media for dialogue with society on this issue. Thus, journalistic texts can constitute precious sources of information, provided that this information covers the complexity of this problem, to understand the reasons why certain events occur, and thus, to protect society from the failings derived from nursing care, and to protect nursing professionals when they speak about reported cases.

Based on the above, this study has as a research question: In what way did nursing managers and leaders take a stand on the nursing errors reported in the media in Brazil and Portugal? Thus, it aimed to analyze the behavior of nursing managers and leaders when nursing errors were reported in the media in Brazil and Portugal. Their behavior might indicate ways to go and better analyze this problem which is so important in the current health setting.

METHODOLOGY

Documentary, retrospective, interpretative, qualitative approach, with data collection conducted in 2016 in major newspapers in two countries, Brazil and Portugal, published between 2012 and 2016, since this period includes the latest news. The newspapers used as source in this study were of great national or regional circulation in each country. Access to news was by means of clipping or temporary subscription.

The news was selected from the use of terms: errors, nursing and medical error. All the news items that met the pre-selection criterion (dealing exclusively with a nursing error) were used. The selected news items were grouped in the Atlas.ti software for organization and coding.

The theoretical framework adopted for this research is the Jürgen Habermas' theory of communicative action[9], in which communication is not limited to what is said or written, but also becomes action, because it is through it that individuals interact with others in argumentations. Thus, media communication is action, mainly for expressing opinions and being part of a *continuum* in formulating opinions and ideas.

The analysis of the texts was carried out obeying the steps of Paul Ricoeur's hermeneutics[10], the first step being

the **reading procedures**, with the identification of the codes of meanings primarily found. Following **the identification of possible meanings** allowed units of analysis to be associated with other parts of the text and in search of new meanings. Finally, the **appropriation** gave more meaning to the texts analyzed and enabled the formation of thematic units.

The appropriation made it possible to create three thematic categories that reveal the behaviors performed by health service managers in both countries, and nursing leaders from the Federal (COFEN) and Regional (COREN) Nursing Councils, Unions and Nurses of Portugal (OE), which manifested themselves by newspapers during the period studied.

For issues related to ethics, the data related to the identification of professionals, patients who were victims of errors, institutions, journalists who wrote the material and newspapers were ommited, avoiding even greater exposures, as recommended by current standards and guidelines that consider ethics in research with human beings. Therefore, the selected sections of the newspapers are identified with the letter J, followed by the initial letter of each country and region, and a cardinal numbering corresponding to the order in which they were inserted in the data analysis software.

RESULTS AND DISCUSSION

There were 112 news articles analyzed in which drug administration errors were predominant. Nurses were most of the professionals involved and the consequences for the patients, in most of the news, resulted in death, especially in children. The year with the highest number of occurrences was 2012. Among those, 58 news were found with information regarding the behavior of nursing leaders regarding reported errors.

The great number of nurses in the analyzed news can be explained by two reasons: the first one refers to the choice of Portugal as data source, where only graduate nurses compose the workforce; the second may be related to the Nursing Professional Practice Act in Brazil, which includes the supervision and technical responsibility of the nurses of the entire nursing team, that is, the nurses respond to the incidents together with their nursing teams. In addition, the media pass on information based on common sense, which does not differentiate the category of Nursing, which is composed of Nurses, Technicians and Nursing Assistants in Brazil.

In the media, especially in the journalistic media, there are two ways to talk about health: "one in which subjects are presented in a critical, opinionated and polemical way", and another in which material is produced and contextualized "from its factual character, that is, when subjects are dealt with from events that erupt entropically on the social surface and, instead of enunciated, they are announced in the public sphere"[11:77].

A favorable time to call for help

The journalistic texts analyzed revealed that the managers of the institutions involved in the reported errors incidents, as well as the representative organizations, expressed themselves especially about the working conditions that nurses face every day. The information provided by the newspapers was characterized as a call for help, in order to give more visibility to structural problems and work organization.

> *The [institution name] hospital risk management team and the hospital's neonatal death committee are already evaluating all methods in the industry, including patient care processes and work overload due to the lack of nurses, as also evaluated the president of the Regional Nursing Council (JBSC1). [bold news] [Error in procedure that led to death of 40-day-old baby].*

> *Coren also states, in a note, that [institution name] was inspected by the body, which detected numerous irregularities, including overcrowding of patients and lack of qualified personnel for nursing care (JBPR3). [Medication error, exchange of routes in which feeding was administered intravenously that resulted in the death of an elderly woman].*

> *In response to cases of errors by nursing professionals that caused the death of two elderly women, the Federal Nursing Council (Cofen) said in a statement, on Monday, that "through a decision of the Brazilian Justice, the Nursing Councils cannot supervise the schools and higher nursing courses in the country". The Regional Nursing Council advisory informed that the assignment is the responsibility of the State Department of Education, in the case of technical courses, and of the Ministry of Education when it comes to higher education (JBPR5).[Medication error, exchange of routes in which feeding was administered intravenously that resulted in the death of an elderly woman].*

> *If the exchange of patients at the time of blood collection is true for laboratory analysis, this is no more than an episode of a corollary of errors and bad professional practices*

involving health institutions and professionals, says the union (JPMA1).[Error exchanging blood bags].

The nursing workforce deficit, with consequent work overload, is a problem constantly seen in studies that deal with safety, quality and nursing work itself, and in the safety issue, these problems are strongly related to adverse events. Empirical evidence has revealed that the lack of adequate nursing professional dimensioning is closely linked to the probability of errors and accidents at work[6,12].

The workload of nursing professionals, when it comes to required working hours, is characterized by the needs of each type of patient and considers other activities inherent to the care. The average number of patients assisted daily (each with specific needs and varying degrees of dependence) is considered by the average time of care per patient[13]. And, although the Federal Nursing Council, in the Brazilian case, establishes minimum parameters to be followed for the adequate dimensioning of professionals, through resolution 543/2017[14], there are many difficulties for the health services management to comply with these parameters, since they involve personnel expenses, an important component that constitutes an obstacle to improving health care.

In Portugal, adequate nursing dimensioning should follow the directives of the Nurses' Order for the calculation of safe appropriations which, in turn, follow the recommendations of the European Society of Intensive Care and the Directorate-General for Health[15]. However, this is one of the main struggles of Portuguese nurses; nursing endowments in the country are little known, and even less applied by managers of health institutions[16].

Another issue, especially in Brazil, concerns the lack of supervision, which may be related to staffing problems. The Law of Professional Nursing Practice in the country, 7,498/86, is very clear when defining that nursing activities should always be supervised by a nurse. However, the presence of a nurse in all sectors of all health services during the 24 hours of care is also a difficult problem to solve, since the health sector often does not have enough money to guarantee the presence of the nurse practitioner during the entire working day of the team[14].

Supervision also needs to be considered when it comes to students in the theoretical-practical training phase, and in this sense, nursing schools are responsible for ensuring the supervision of their students by a nurse qualified for such task. In Portugal, legally, nursing care is provided only by nurses with higher education. This is a positive aspect regarding the qualification of the nursing professionals of that country, but that also has problems related to the adequate dimensioning to meet the health needs of the population.

In December 2016, a note in one of the main Portuguese newspapers brought the information that Portuguese hospitals owe more than 539 thousand hours to nurses, which corresponds to more than 67 thousand days off, while there is no contracting forecast due to financial limitation[17]. Another important aspect to consider is the high rate of emigration of Portuguese nurses. In 2014, the number of nurses who applied for leave to perform their duties in other countries reached 2850. This is due, according to OE staff, to the lack of job opportunities, coupled with low pay and the lack of career advancement plans[18].

In both countries, it seems that the problems related to the number of nursing professionals and the overcrowding of health services, especially in the hospital setting, have compromised the safety of users, which was also reported by other authors[19]. Nursing work conditions coupled with the overcrowding of services, especially in public hospitals, foster a negative view of society regarding health care, because they do not feel safe in hospital environments[20].

Another important issue raised by leadership refers to the supervision of nursing schools and the mistakes made by nursing trainees. In Brazil, the responsibility for supervising nursing technical schools is from the State Departments of Education, and the higher education courses are monitored by the Ministry of Education. This dichotomy may constitute a barrier to the quality of professional practice, considering that the Nursing Councils should actively participate in decisions regarding the training of nursing professionals.

In Brazil, there were no reports in the newspapers studied regarding errors involving nursing students. And in Portugal there were no news involving students.

Patient safety – a way of looking at patient advocacy

Other information that came from the nursing health services leaders and representative entities refers to the conduct related to the investigation of the cases of errors and the punishments adopted. In this sense, leadership plays a crucial role in defending people's right to receive quality nursing care, especially when it involves professional negligence. Advocating for the sake of the patient is intended to assist him or her in obtaining safe and quality care[21]. So that it happens, managers and leaders need to make decisions that directly contribute to the assurance of safe care, as shown in Figure 1.

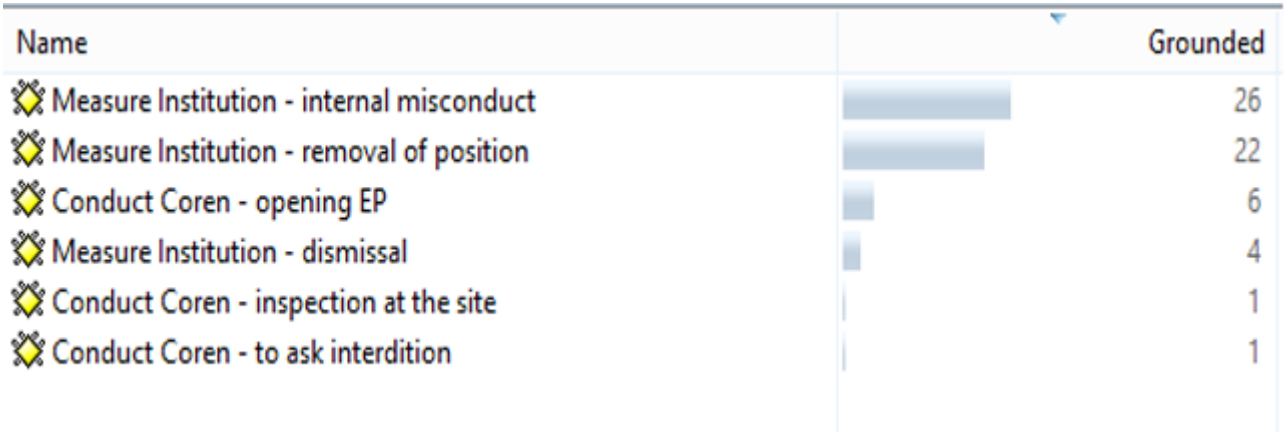

Figure 1 – Conduct and measures taken by nursing managers and leaders regarding the reported errors. Florianópolis, SC, 2017.
Source: Research data taken from Atlas.ti.

The opening of internal administrative misconduct is a common act in the institutions, since it seeks to gather evidence for the materiality of a fact, proving or not guilty of those involved and serves as a precautionary measure for the supervisory bodies, thereby sparing those accused of being guilty unfairly and to avoid possible legal proceedings against the institution[22]. During the investigation or internal inquiries, it is common for the professional involved in the case to be removed from office until all the facts are clarified.

The dismissals reported, and therefore analyzed in the texts, were decided after the result of the investigation. However, when thinking about patient safety issues, this behavior goes against the non-punitive culture that should be adopted by health institutions. Studies show that institutions should avoid such punitive attitudes claiming they do not provide benefits for the safety of care, but rather stimulate a culture of education for professionals in general, by sensitizing them to a patient-centered approach[23].

Regarding the conduct of nursing representative bodies in both countries, they have mostly followed the opening of the Disciplinary Ethical Process, a common behavior before complaints of this nature.

The Code of Ethics of Brazilian Nursing Professionals provides that situations in which the professional puts the patient's life at risk or does not act in accordance with the duties and responsibilities stipulated therein are subject to the opening of a Disciplinary Ethical Process that will be instructed in accordance with the Code of Ethical Proceedings of Nursing Councils. In Portugal, the disciplinary process occurs in the same terms as the Brazilian one and is governed by the Deontological Code of the Nurse.

The Schneider and Ramos study[24] which analyzed factual elements in the disciplinary ethical processes of Santa Catarina's Coren, found that the most recurrent reason is related to nursing errors (iatrogenesis), and in turn, they are associated with recklessness, malpractice or negligence of professionals. For this reason, the conduct of the Professional Councils is very important to clarify the fact and to promote the education of these professionals and others who may participate in this process.

Only one news item portrayed the need for inspection at the incident site.

> *According to Coren, the hospital's management did not want to first inform the name of the employee who injected the soup. Without that information, "the Council was unable to know if the employee has a professional registration and if she is qualified to work in the function, so she will have supervision on the site later this week" (JBSP9). [Medication error, exchange of routes in which feeding was administered by intravenous route resulting in the death of a baby].*

The importance of supervision of professional practice is not limited to qualified professionals but extends to the investigation of persons who illegally exercise the profession, and with that, aims to protect nursing care patients exercised by people who do not possess the knowledge and qualification required to practice nursing. In the two countries studied, supervision has become increasingly effective to guarantee better working and customer service conditions.

The behaviors highlighted in this study direct the readers' perspective to the performance of nursing managers aimed at the punishment of professionals, as a way of prevention and promotion of safe care. On the other hand, the leaderships of the representative entities reinforce the

structural problems, such as the deficits in the workforce, the overload, and the lack of training and education of the teams. Safer care requires safe decision-making to improve organizational processes, permanently educate staff and institute a safety culture that promotes good practices daily, which diverges completely from punitive actions[25-26]. In this sense, the literature is vast in affirming that the behaviors practiced by health institutions when assisting errors should be directed to the education of their professionals and to the revision of the assistance processes[9,10,25-27].

"Nothing about nursing without nursing": opportunities to represent the profession

The media play a vital role in giving visibility to certain problems. At present, with the speed with which information is produced and consumed, media can be characterized as a two-sided tool. Both can be useful for understanding the incidents that occur in health institutions, or can cover up the complexity of reality, showing only the appealing and not clarifying side.

The publication of notes from representative organizations is a valuable opportunity to defend the rights of nursing professionals, clarify doubts and give voice to a series of arguments that can uncover unfounded accusations. Therefore, the leaders of representative nursing organizations showed up in front of the facts requesting documents of the case for analysis, questioning the facts to proceed with the investigation, questioning the investigation itself and using repudiation notes. The Order of Nurses of Portugal issued only one note, alleging that the professional was suspended from her activities due to the fact reported.

> *In a statement issued on Wednesday, Coren dismisses the complaint, saying "it is baseless". The statement declares that [name], referred to as a nursing technician, has no professional registration in the board. In addition, it would not be the technicians' job to supervise the trainees. This is the nurses' job. The statement recalls the report of cadaveric examination, signed by the forensic expert: "According to the report, the blood collected was normal. There were also no signs of cardiac and pulmonary embolism, thus excluding the possibility that the patient received coffee with milk via the venous route. The examination classifies as causes of death pulmonary and urinary infection, pathologies that do not indicate that coffee with milk was administered intravenously. The causes of death are not related to toxicological examination of blood", says an excerpt of the statement (JBDF4). [Medication error, drug overdose that resulted in the death of two children].*

> *[Coren's chairman] says the council has been "closely" following the fact but says that at first "it seems like there's nothing left (guilt) for just one professional, one profession. There is a team inside the health unit. Of course, this is a serious case and whoever must respond for it will respond", he says (JBPR1). [Nurse accused of omission of help in a Care Unit, a 38-year-old woman died].*

> *[Coren's chairman] was also surprised that the investigation opened to determine the occurrence is in the hands of doctors and lawyers. If you are investigating problems with nursing, it is inconceivable that there is no nurse among the members of the investigation. The Coren's chairman also questioned the fact that the State Department of Education was not notified, since it is also responsible for registration, authorization and recognition of the courses, in addition to the training of trainees (JBRJ3).[Medication error, exchange of routes in which the feeding was administered by intravenous route resulting in the death of an elderly woman].*

In the indicated context, it would be of great value if the institutions also explained the pertinent explanations to the cases reported to avoid that the society sees the nursing professionals with bad eyes. Depending on how the news are written, there is a touch of villainy that does not consider relevant aspects of work organization that promote patient safety. By only highlighting the punitive actions in the news, the nursing managers of the institutions expose these professionals to harsh criticism of society, without bringing the reflection of the factors involved in a bad outcome.

In general, nursing and health errors are complex and determined by many factors that are usually associated with so many structural and organizational problems[28]. In this sense, the professional representations have the duty to act with the institutions and other competent bodies in the clarification of the facts, in the incessant search to undo misunderstandings, and to demystify some interpretative gaps that the news tends to leave.

Journalistic production is a very effective way to make public certain problems of society, and in this context, it needs to raise different information as well as different points of view on certain subjects, validating the information and providing subsidies for the understanding of the subject by the attentive eyes of the society. Most of the errors reported are not intentional. They are assistance errors from multiple factors that require careful analysis of their causes to prevent future incidents. However, media discourses tend to foster readers' emotions for the commercialization

of news[29] and end up putting a blame on nursing professionals without proper contextualization.

Two important shortcomings were detected in this research. The first is related to the incipience of statements by the Order of Nurses of Portugal and the Brazilian Nursing Association. In a period of 5 years, with a *corpus* of research on 112 news articles dealing with serious errors in nursing care, we are surprised by this absence. One can think of two hypotheses: the lack of space given by journalists to these entities or the statements being issued in other forms of communication, such as websites, own newspapers, radio and television.

The other shortcoming is linked to the number of news items in which there was no positioning of any leadership or professional representation, leaving it open the various possibilities of understanding the error reported. The limits considered are related to the collection of data that did not consider the radio and television reports, and materials arranged on the Internet, such as the spaces of expression of representative organizations.

FINAL CONSIDERATIONS

Nursing leaders play a crucial role in the disclosure of news that involve errors during care, because they can expose a complex problem, involving different mechanisms. Thus, the reported statements of institutional managers and representative organizations contribute to readers' reflections on the practices of the nursing profession without imposing immediate culpability. However, information coming from managers and leaders has been very incipient, since most of the analyzed news had no pronouncement in this sense, which can be explained by the lack of space on the part of the media and by the fear of exposing the institutions and the nursing professionals.

Addressing the problem of care errors requires an effective discussion that addresses the actions related to the training of nursing professionals, the working conditions to which these professionals are exposed in the daily life of health institutions, and the way managers of the institutions and representatives of the profession intervene to guarantee quality and safety in the professional practice of nursing.

The fight for decent working conditions is unceasing in both countries and is moving towards achieving the desired minimum, especially regarding the number of professionals, working hours and remuneration, which are far below what is desired for a profession of such social relevance. For this reason, the media constitute an unparalleled opportunity to give voice to both the problems related to nursing errors and to the whole conjuncture of the work that can affect them.

The limits considered are related to the collection of data that did not consider the radio and television reports, and materials arranged on the Internet, such as the spaces of expression of representative organizations. As a contribution to nursing, this study serves to guide researchers, professionals and managers of the various levels of care, the importance of strengthening and enhancing the profession before fatalities expressed by the media.

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