Original Article

TEXTO & CONTEXTO ENFERMAGEM
TEXT & CONTEXT NURSING TEXTO & CONTEXTO ENFERMERÍA

NURSING PROFESSIONALS AND ADVERSE EVENT REPORTING

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ABSTRACT

Objective: to identify how nurses report adverse events; to know what elements influence adverse event reporting and which reporting strategies they suggest.
Method: qualitative study with a convergent care research design, conducted in a critical patient unit of a private health center in the region of Magallanes, Chile. Thirteen nurses participate in the study, through interviews and a discussion group.
Results: the nurses who report adverse events do so verbally and in writing to the nurse coordinator immediately. Failure to report adverse events is mainly due to lack of knowledge of the safety culture, fear of reprisals and punishment within the workplace. As adverse event reporting strategies, they suggest continuing education about the safety culture, raising awareness and trust in that error reporting will not be met with punishment and that the error will lead to an improvement plan that avoids committing the same error on another occasion, improving communication and leadership.
Conclusion: although nurses report adverse events, they are concerned with punishment, indicating the need to review the patient safety culture at a critical care unit in the study context.

DESCRIPTORS: Nursing. Intensive care units. Patient safety. Notification. Nursing staff.

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PROFESIONALES DE ENFERMERIA Y LA NOTIFICACIÓN DE LOS EVENTOS ADVERSOS

RESUMEN

Objetivo: identificar como los enfermeros notifican los eventos adversos; conocer los elementos que influencian una notificacion de los eventos adversos e que estrategias sugieren para notificacion.
Metodo: estudio cualitativo, de tipo Pesquisa Convergente Asistencial, realizado en una unidad de paciente crítico de un centro de salud privado en la región de Magallanes, Chile. Participaran do estudio trece enfermeros, por medio de entrevista y grupo de discusión.
Resultados: los enfermeros que realizan notificación de eventos adversos o la hacen de forma verbal y escrita a la enfermera coordinadora inmediatamente. La no realización de notificacion de eventos adversos se da, principalmente, por el desconocimiento de cultura de seguridad, el temor a represalias y castigos dentro del ambiente laboral. Como estrategias para la notificacion de eventos adversos se sugiere educación continua con respecto a cultura de seguridad, crear conciencia y confianza en que notificar un error no va a tener una respuesta punitiva y que del error se realizara un plan de mejora que evite cometer el mismo error en otra oportunidad, mejorar la comunicación y el liderazgo.
Conclusión: a pesar que los enfermeros notifiquen la ocurrencia de evento adverso, existe a preocupación de la punición, señalando la necesidad de revisar la cultura de seguridad del paciente en una unidad de paciente critico en el contexto de estudio.

DESCRIPTORES: Enfermería. Unidad de cuidados intensivos. Seguridad del paciente. Notificación. Personal de enfermería.

PROFISSIONAIS DE ENFERMAGEM E NOTIFICAÇÃO DE EVENTOS ADVERSOS

RESUMO

Objetivo: identificar como os enfermeiros relatam eventos adversos; conhecer os elementos que influenciam a notificação de eventos adversos e quais estratégias eles sugerem para a notificação.
Método: estudo qualitativo, do tipo Pesquisa Convergente Assistêncial, realizada em uma unidade de pacientes críticos de um centro de saúde privado da região de Magallanes, Chile. Treze enfermeiros participarão do estudo, por meio de entrevista e grupo de discussão.
Resultados: enfermeiros que relatam eventos adversos ou o fazem verbalmente e por escrito ao enfermeiro coordenador imediatamente. O não relato de eventos adversos ocorre principalmente devido à falta de conhecimento da cultura de segurança, medo de retaliação e punição no local de trabalho. Como estratégias para relatar eventos adversos, sugerimos educação continuada em relação à cultura de segurança, criando consciência e confiança de que relatar um erro não terá uma resposta punitiva e que um plano de melhoria será feito para evitar cometer o erro. errar outra vez, melhorar a comunicação e liderança.
Conclusão: apesar dos enfermeiros relatarem a ocorrência de um evento adverso, existe uma preocupação com a punição, apontando a necessidade de rever a cultura de segurança do paciente em uma unidade crítica de pacientes no contexto do estudo.

DESCRITORES: Enfermagem. Unidade de cuidados Intensivos. Segurança do paciente. Notificação. Equipe de enfermagem.

INTRODUCTION

The occurrence of care and nursing care-related errors / adverse events is closely related to the adoption of a safety culture. It is considered a key issue in clinical practice. Consciously avoiding the occurrence of any type of injury caused to patients due to the therapy, procedures and behavior adopted is the goal in all health care scenarios.[1]

Through epidemiological studies, the high incidence of human error-caused adverse events that is frequently demonstrated indicated the need to reconsider and modify the care models, linking them up with the countless global campaigns, programs and projects that guide health team actions.[2]

The way healthcare errors are interpreted and acted upon maintains the understanding of punitive or hidden postures. Changing this scenario rests on the health managers' understanding of the error as necessary. And frequently, those adverse events are related to flaws in the health system itself and its processes. Identifying the potentials and weaknesses of the health teams towards adverse events is essential, facilitating the adoption of preventive measures and trust among the professionals.[2]

Adverse event reporting is part of health care management and, therefore, part of the responsibilities to manage and help the nurses. Setting up a reporting system allows the professionals to share responsibilities and develop actions that are integrated with the logic of continuing and continuing in-service education.[2]

In a study aimed at identifying the relation between how many patients a nurse provides care to and the occurrence of adverse events,[3] the findings showed that a larger number of patients per nurse increases the incidence of adverse events. In the same study, it was identified that bad working environments also favor this increase. Health organizations need to establish specific policies and procedures for reporting and disclosing adverse events. Therefore, the needs and the development of strategies should be considered that result from patient safety actions driven by health managers, professionals and users. Those strategies will permit actions to promote patient safety.[1]

In addition, awareness is growing in Chile that the professionals need education about what measures to take towards errors and encouragement to take an honest stand towards the error, without fear of punishments and engaged in the search for safe patient care.[4] Voluntary adverse event reporting has turned into an essential quality improvement tool in health systems. Therefore, it is important for the professional to inform the errors made clearly and timely, with a view to being able to revert the situation when representing a high risk for the patient.[5]

In a study that analyzed patient safety incident reports, these mainly came from nurses, although the responsibility for patient safety should not focus solely on one professional.[6] In view of the above, the aim in this study is to identify how nurses notify adverse events; and to know the elements that influence adverse event reporting and which reporting strategies the nurses suggest.

METHOD

This is a qualitative study with a Convergent Care Research (CCR) design. This focus is directly related to the context of practice. The problem to be investigated lies in practice. This design is based on a proposal that derives from the need to implement measures that produce important changes in health care practice, especially in nursing practice, thus generating the researcher's involvement in the investigated context, being part of both the practice and the research. CCR consists of five procedural stages, namely: design, instrumentation, perscrutation, analysis and interpretation. These stages are not linear but interrelated. In the design stage, the research problem, the objectives and theoretical support are considered. The second stage, called instrumentation, includes the description of the study site, the participants and the data collection techniques. The data were collected as presented in the prescription stage. And, finally, the data analysis and interpretation stages take place.[7]

The design stage started with the identification of the research area and the questions related to the problem. In the course of 2017, 136 adverse events were reported at the ICU where the study was undertaken, most frequently related to nursing care practices, including drug administration errors, chemical phlebitis, pressure ulcers and self-removal of invasive catheters. In 2018, reports increased to 196, 27% of which were cases of chemical phlebitis, 19.3% self-removal of invasive catheters, 15.3% drug administration errors and 13.7% grade 1 and 2 pressure ulcers, while 24.7% of the reports were related to other types of adverse events. It is important to highlight that about 350 patients leave the unit each year. In view of this situation, the guiding question for this study was how nurses report adverse events and suggest measures for reporting to actually happen.

As for the instrumentation stage, the study was conducted in a critical care unit of a private health center in the city of Punta Arenas, Magallanes Region, Chile, involving nursing professionals. To collect the data, semistructured interviews and discussion groups were used. Discussion groups permit rupturing the traditional vertical relationship that exists between health professionals and the subjects of their actions. This strategy facilitates individual expression to clarify the needs, expectations and circumstances of life that influence health.

In the perscrutation stage, the strategies are developed to disclose the way data are obtained. The interviews were held with the 13 nurses from the unit, who accepted to participate by signing the informed consent form. The interviews were held individually and were recorded, with an average length of 30 minutes per professional. The participants were asked to talk about how they reported the adverse event, what justified the motive for the reporting and any new reporting measures. The participants were identified by the letter N for nurse, followed by the number indicating the sequence of the interview.

As for the discussion group, three meetings were held at a private room in the ICU, containing a large table with comfortable chairs, central heating and a television on the wall to project the preparations prepared using a computer. The goal of the meetings was to socialize the interview data, discuss, reflect and collectively propose measures to prevent adverse events. On average, between seven and ten nurses took part in each meeting. The average duration was one hour and thirty minutes and all meetings were recorded.

In all cases, a multimedia device was used. First, I find out about the Research Project, the objectives, how the meetings will be held and they have asked me to talk about your expectations regarding the meetings. During the second meeting, eight nurses participated, the results of the interview were informed to discuss adverse event reporting strategies. Each participant had five minutes at most to present his/her ideas, which were based on answers to the inquiries that originate the proposal of the problem related to the research. In the document, methodological observations were registered. Furthermore, the third and final group meeting was scheduled.

The third meeting served to inform the results of the adverse events informed during 2018, the reporting strategies suggested during the second meeting and to determine the improvement plans to be set forth in 2019. The proposals that originated in the group of participants were concluded. The importance of their participation in this project was highlighted, which served to make important changes in the service, helping to prevent adverse events, thus providing better and safer care to the patients.

For each meeting, a discussion agenda was elaborated, registered in notes, and each meeting was recorded. In the analysis and interpretation stage, information was collected during the care practice. As the researcher is immersed in the place of research, a large amount of data is collected that may be difficult to analyze, requiring good organization and in the same order as the entries in the notes of any type. It is important to maintain the chronological order of these registers. In this stage, all interviews and each answer given, the scores and the agreements obtained during the three

meetings with the research group were coded, categories were obtained and, for each category, an extract of the answer provided in accordance with the objective.

The data collected in the interviews and the three discussion meetings were organized by similarity of information and in accordance with the research objectives, in three categories: Adverse event reporting; Justification for non-reporting of adverse events; Strategies for adverse event reporting.

To develop this research, institutional authorization was required through the ethics committee of the health institution. A research project was submitted to the ethics committee of the University of Magallanes, and was approved under certificate 091/CEC/July 23rd, 2018.

RESULTS

The participants' age ranges between 25 and 35 years. Twelve participants are female and one male. The length of the participants' professional experience at the critical care unit ranges between one and eight years.

How is the adverse event reported?

The nurses emphasize that adverse events occurred at the critical care unit are reported both verbally and in writing. Several participants highlighted the importance of reporting.

First, I inform superiors verbally (n2).

[...] *verbal reporting at the moment the adverse event happens* (n3).

Verbal reporting is done and, soon, a reporting form is completed (n5).

The direct head is informed immediately to find a solution (n8).

It is informed in writing (n9).

It is informed through an incident sheet, which is analyzed and improvement plans are made (n13).

Justification for not reporting the adverse event.

There were different motives for not reporting the adverse events. According to the answers, the majority answered being afraid of the consequences, such as losing one's job.

Lack of knowledge, the professional may commit an event, does not report, I believe it could be fat that (s)he simply does not want to report for another reason (n2).

We have all incorporated the adverse event culture, some people are annoyed, believing that one is committing treason when informing that someone made a mistake (n7).

Fear. In general, people may be afraid to report, which is related to the possibility of getting some punishment that will negatively affect their work (n7).

The fear of what can happen to the job because, when one makes a mistake, one always thinks that it will entail some repercussion, I believe that's the main difficulty (n5).

Mainly fear of informing their direct head, fear of whether this will entail some repercussion for their work (n8).

I observe more difficulties in the professionals when they are novices, they are newer to what it means to perform as an actual nurse, because one arrives with fear, so one gets scared when making a mistake (n9).

Fear because, as the incident reporting culture we still have here is that one will be punished, that is, what offense they will accuse you of, as the belief exists that this will be punitive (n13).

Adverse event reporting strategies

In this category, the strategies the nurses use are evidenced, which are related to in-service education. They signal the importance of the discussion about the consequences of the adverse event for the decision to report the event.

I believe that educating everyone and telling them that this is no theme to kick them out, punitive, it is for all of us to grow as professionals and the quality and safety culture is already established in health, so you need to understand it (n7).

Constantly learning the things that are changing, always updating things involving techniques and knowing when one makes a mistake to know when to report (n9).

But I believe it would be education, this way we learn and know what a report is about, because actually not everyone knows what it is about (n10).

Have things like a space for dialogue, above all the trust of being able to tell the superior, (s) he knows that I made a mistake in that or did that or that happened to me in the shift, during the shift (n11).

I believe this culture, it's easier when we see that everything flows, that if something happens it is said, it is talked about, improvement measures are taken, like when there is a safety culture where everyone works, the right thing will be done, that nobody will be lashed, the measures will serve for everyone to improve and for what happened to the colleague not to happen to any other team member (n12).

Creating this culture inside the service or the institution to reduce this fear and to be able to complete the reporting form freely and inform about the reporting forms, I believe that is well established here at the unit, perhaps not that much in another service, but here we know how to access the printed form as well as the digital version (n13).

DISCUSSION

The lack of educational methods leads to a greater occurrence of adverse events. That is why the professionals are afraid of punishment, underreporting a case and subsequently making a mistake again.[8] As for the reporting form, in our study, the large majority of the answers show great knowledge of how to report. There are two validated forms, informing the error verbally and in writing. The main form is the first one as, depending on the safety incident, it should be informed immediately to the physician on duty during non-working hours and to the nurse coordinator during working hours, with a view to being able to take immediate safeguard measures for the patient. The nurse coordinator is in charge of service quality and, therefore, receives the written reports, being responsible for analyzing them together with the professional who commits the error.

Among the possible strategies to promote patient safety, the nurse coordinator analyzes the factors that contribute to the occurrence of adverse events, indicating which are preventable and reductible and identifying effective solutions together with the health team, based on educative actions that stimulate and maintain the reporting habit.[9]

With regard to the justification for not reporting adverse events, a series of reasons are found, similar to those in the literature. The large majority of the interviewees refer to fear and anxiety, due to the possibility of reprisals at their place of work. This is linked to lack of knowledge about the safety culture established at the institution. It is hard to believe that this is not punitive. This is in line with a study that revealed that the participants indicated barriers for the reporting of errors caused by nursing care, which strengthens the existence of punitive postures and the need to pay attention to the professionals' error perception, which are part of a negative safety culture for the sake of communication.[10]

It is also important that particularly the nurses establish policies for the profession that identify the nursing staff's knowledge about adverse events, their concept, possible tools and strategies to facilitate their use. From this point, changes in the professionals' daily practice can be made.[11]

Adverse event reporting at an intensive care unit is one important form of care quality control, as identifying the errors permits investing in preventive measures, thus avoiding damage for the patients. To reduce the occurrence of non-infectious adverse events, investments are needed in the qualification and updating of the professionals involved in care, sufficient human resources to respond to the demand, and proper physical facilities and technology.[12]

Event studies separately informed by nurses and nursing technicians are still incipient. The same is true for multiprofessional team professionals. The importance of the documentation supports the guaranteed continuity of safety policies, supported by electronic records and qualification and evaluation systems.[13] As for the third category, corresponding to strategies for successfully reporting the adverse event, in our study, we found several answers that point towards permanent education on the safety culture, effective and continuing communication with peers and heads, thus preserving confidence for the professional committing the error to report immediately, with the security that (s) he will not be punished.

Intensive care units are an appropriate location to set up detection and registering systems; it is a complex unit, where great use of drugs and invasive procedures is predominant and patients are vulnerable to damage due to their critical and unstable conditions. Constant monitoring is part of care at these units, as well as the ability to act rapidly in view of the patients' severity. These factors can contribute to the occurrence of adverse events.[14]

For this purpose, the establishment of a safety chain, focused on changes in the organizational culture and climate and the encouragement of efficient communication among professionals, patients and families gains relevance as a support element for possible actions that create safe environments, especially those related to intensive care.[14]

Another aspect to consider, which emerged in this study, is related to professional education. Indicators emerge of graduate education as well as continuing professional training. Studies have been developed in the USA, Australia, United Kingdom, New Zealand, Canada, the Netherlands and Sweden, which found that between 2.9% and 16.6% of the hospitalized patients were victims of adverse events, 50% of which can be prevented. In Brazil, a study developed at a university hospital showed that 50% of the discharged patients and 70% of the deceased patients were victims of at least one adverse events.[4]

In this scenario, nursing should seek solid strategies to offer safe care, as a proactive member and direct participant, responsible for guaranteeing patient safety and the promotion of a safety culture, considering some strategies, such as communication in the work team, errors as a learning opportunity and valuation of the professional through continuing education.[4]

An adverse event reporting system should exist at all health institutions, which should primarily be verbal, so as to take immediate measures to revert the situation if it has caused damage to the patient. This should be followed by written reporting, so that a document exists in which the event can be analyzed and, depending on the severity of the error, an improvement plan can be immediately established that helps to prevent this error from repeating itself. As for the impediments for the professionals to report, a series of feelings are raised that make it difficult to admit the error, mainly fear of a punitive response by the heads, which can entail employment repercussions, such as losing one's job for having committed a severe error. The professionals' lack of knowledge on how to act on the reporting, how to report, due to the professionals' lack of education.[14]

CONCLUSION

In terms of strategies for professionals to report adverse event, education is needed about the safety culture, incorporating concepts of the adverse event reporting culture. This includes acknowledging that we are wrong, that we are susceptible to making errors due to the patients' complexity at a critical care unit and that this error should be informed, so as to analyze the situation and to reconsider step by step what could have been prevented; and implementing improvement plans that help to avoid the errors.

Another concept is to maintain a detailed register of the errors made, which incorporates the immediate measures taken and the patient damage caused; and to maintain continuing education and training to support the professionals to prevent adverse events. The limitations of this study include the lack of monitoring of the work environment after the study, due to the need to close off the research. Another limitation is the development with one group of nurses from a single ICU, permitting no generalizations.

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NOTES

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CONTRIBUTION OF AUTHORITY

Study design: Navarro Maldonado XA, Nascimento ERP.
Data collect: Navarro Maldonado XA.
Data analysis and interpretation: Navarro Maldonado XA, Nascimento ERP.
Discussion of the results: Navarro Maldonado XA, Nascimento ERP, Lazzari DD.
Writing and/or critical review of the content: Navarro Maldonado XA, Nascimento ERP, Lazzari DD.
Review and final approval of the final version: Navarro Maldonado XA, Nascimento ERP, Lazzari DD.

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APPROVAL OF ETHICS COMMITTEE IN RESEARCH

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CONFLICT OF INTEREST

There is no conflict of interest.

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