CULTURA DE SEGURANÇA DO DOENTE: ESTUDO DE ALGUNS FATORES INTERVENIENTES
PATIENT SAFETY CULTURE: STUDY OF SOME INTERVENING FACTORS
CULTURA DE SEGURIDAD DEL PACIENTE: ESTUDIO DE ALGUNOS FACTORES INTERVENIENTES

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RESUMO

Introdução: A segurança do doente tem um carácter multidimensional e multidisciplinar. No âmbito da sua índole multidimensional a OMS evidencia a importância da qualidade da interação e da comunicação como determinantes da qualidade e da segurança na prestação dos cuidados de saúde.

Objetivo: Analisar em que medida as variáveis sociodemográficas e profissionais influenciam as competências de comunicação dos enfermeiros e qual o impacto das competências comunicacionais dos enfermeiros na cultura de segurança dos cuidados.

Métodos: Estudo, de carácter quantitativo, descritivo/correlacional, analítico e transversal, realizado numa amostra de 138 enfermeiros. Foi utilizada a escala Avaliação da Cultura de Segurança do Doente em Hospitais (Eiras, 2011), e a Escala de Competências de Comunicação Clínica (ECCC) validada por (Ferreira, Silva & Duarte 2016) para avaliação das competências comunicacionais.

Resultados: Os participantes têm uma idade média de 32.51 anos, com um desvio padrão de 7.958. São maioritariamente do sexo feminino (77.54%) com licenciatura (94.4%) e tem, em média 9.41 anos, de experiência profissional. A idade, o estado civil, a experiencia profissional não influenciam a cultura de segurança do doente. Após a análise inferencial através de uma regressão múltipla multivariada, todas as variáveis manifestadas (Anos experiencia profissional, recolhe informação, partilha Informação e permite terminar o diálogo) registam valores significativos. Quanto maior o número de anos de experiencia profissional menor a resposta ao erro não punitiva.

Conclusões: Os resultados apontam para a importância da comunicação sobre algumas variáveis na cultura de segurança do doente. Esta realidade circunscreve-se de novos pressupostos e atitudes dos profissionais que têm que acompanhar, em tempo útil, a evolução do conhecimento, garantindo uma comunicação enfermeiro / utente eficaz e práticas de cuidados seguras, garantindo a qualidade dos cuidados prestados.

Palavras-Chave: Cultura de segurança; Qualidade cuidados; Comunicação.

ABSTRACT

Introduction: Patient's safety has a multidimensional and multidisciplinary character. In its multidimensional nature, WHO highlights the importance of the quality interaction and communication as determinants of quality and safety in health care delivery.

Objetive: To analyze the extent to which sociodemographic and professional variables influence nurses' communication skills and what the impact of nurses' communicational competencies on the safety culture of care.

Methods: A quantitative, descriptive-correlational, analytical and cross-sectional study with a sample of 138 nurses. We used the Hospital survey on Patient Safety Culture (Eiras, 2011), and the Clinical Communication Skills Scale (ECCC), validated by (Ferreira; Silva & Duarte 2016) for the evaluation of communication skills.

Results: The population has 32.51 years as average, with a standard deviation of 7.958. They are mostly female (77.54%) with a degree (94.4%) and have, on average, 9.41 years of professional experience. Age, marital status, work experience does not influence the safety culture of the patient. After the inferential analysis through a multivariate multiple regression, we note that all manifest variables (Years of professional experience, collects information, share information and allows to terminate the dialogue) showed significant values. The greater the years of professional experience less punitive error response.

Conclusions: The results point to the importance of some variables in the patient's safety culture. This reality is circumscribed by new presuppositions and attitudes; Professionals who have to attend, in a timely manner, the evolution of knowledge, ensuring safe practices, assuring the quality of the care provided.

Keywords: Safety culture; Quality of care; Communication.

RESUMEN

Introducción: La seguridad del paciente tiene un carácter multidimensional y multidisciplinario. En el ámbito de su índole multidimensional, la OMS pone de manifiesto la importancia de la calidad de la interacción y de la comunicación como determinantes de la calidad y la seguridad en la prestación de la asistencia sanitaria.

Objetivo: Analizar en qué medida las variables sociodemográficas y profesionales influencian las competencias de comunicación de los enfermeros y cuál es el impacto de las competencias comunicacionales de los enfermeros en la cultura de seguridad del cuidado.

Métodos: Estudio, de carácter cuantitativo, descriptivo / correlacional, analítico y transversal, se realizó en una muestra de 138 enfermeros. Se utilizó la escala Evaluación de la Cultura de Seguridad del Enfermo en Hospitales (Eiras, 2011), y la Escala de Competencias de Comunicación Clínica (ECCC) validada por (Ferreira, Silva & Duarte 2016) para la evaluación de las competencias comunicacionales.

Resultados: Los participantes tienen una edad media de 32.51 años, con una desviación estándar de 7.958. Son mayoritariamente del sexo femenino (77.54%) con licenciatura (94.4%) y tiene, en promedio 9.41 años, de experiencia profesional. La edad, el estado civil, la experiencia profesional no influyen en la cultura de seguridad del paciente. Después del análisis inferencial a través de una regresión múltiple multivariada, todas las variables manifiestas (Años experiencia profesional, recolecta información, compartir información y permite terminar el diálogo) registran valores significativos. Cuanto mayor sea el número de años de experiencia profesional menor la respuesta al error no punitivo.

Conclusiónes: Los resultados apuntan a la importancia de la comunicación sobre algunas variables en la cultura de seguridad del paciente. Esta realidad se circunscribe de nuevos supuestos y actitudes de los profesionales que tienen que acompañar a su debido tiempo la evolución del conocimiento, garantizando una comunicación enfermero / usuario eficaz y prácticas de cuidados seguros, con garantía de calidad de los cuidados prestados.

Palabras clave: Cultura de seguridad; Calidad de cuidados; Comunicación.

1. INTRODUCTION

The provision of health care has a high degree of complexity, determined by the specificities of its focus, which is the patient, as well as the multidimensional, multiprofessional and multidisciplinary character of contexts. One of the characteristics of Health Systems is the production of inaccurate results, often expressing errors and complications with high efficiency costs and increasing degrees of dissatisfaction, both of users and providers (Fragata, Sousa, Santos, 2014). Adverse events constitute the main cause of mortality and morbidity around the world and although estimates related with this reality are vague, many studies warn about the weaknesses in quality and safety of health care. (WHO, 2008). The quantification of the damages suffered by the provision of unsafe and inadequate health care is a difficult and complex process (WHO, 2008; Pimenta, 2013). In 1999, the Institute of Medicine disclosed the report 'To Error is Human: Builkding the Health System' where it estimates that in the United States would die between 44 to 98 thousand people annually as a result of health care errors, a number which is comparable to the daily fall of a Boeing 747 and higher than mortality originated from HIV-AIDS, breast cancer or road accidents (Kohn, 1999). According to literature, medical error is a serious problem in health care in the various countries of Europe. A wide range of investigations on the prevalence of error in health care, estimates that between 3 and 16% of patients are victims of treatment errors that could be avoided (Santos, 2010). In Portugal, available data on this important issue are even scarcer, however, if we consider that Portuguese hospitals have the same reliability of their American counterparts, it will be possible to estimate between 1.300 and 2.900 annual deaths as a consequence of errors committed in the provision of health care (Mendes and Barroso, 2014). Relating these numbers to the morbidity cases originated from the same fact, we realize that we are facing a disturbing reality that requires an immediate multidimensional and multidisciplinary attention, guided by an investigation that allows to identify the problems and challenges concerning patient's safety and to study suitable solutions. In this context, patient's safety is one of the biggest health care challenges of the 21th century. It is the main theme in the scope of the health services quality, which is a worldwide concern, of exponential growth, demanding the involvement of all process partners, health organizations, policy makers, managers, health professionals, patients and their family members. The development of assertive and consistent programs of quality concerning the health and safety of patients, demands this multidimensional and integrated approach. The occurrence of error is an adverse phenomenon that, in one way or another, affects all the links in this chain, namely professionals, which are the operational elements of health care provision (Antunes, 2015). The constant change of work conditions (increased average life expectancy, more complex patients, staff turnover, technological developments that are more and more complex), associated with an ever increasing level of exigency by health care system users, can threaten the functioning of the best team and the excellence of the best professional (Mendes and Barroso, 2014). This way, mistakes are often consequences and not causes. If committing errors is a human condition, recognizing the error and acquiring skills in order to prevent it, is a key requirement for personal and professional development (Santos, 2010). In this context, a new entity known as Culture of Safety is built and becomes important, expressing the commitment of an organization's professionals with the continuous promotion of a safe therapeutic environment and that will have, as expected consequence, a change of behaviours, influencing the results which are the assurance of safe care for the citizen (Reis, 2014). In Portugal, this new paradigm is a priority of the Estratégia Nacional para a Qualidade na Saúde e para o Plano Nacional para a Segurança dos Doentes, that consider the Culture of Safety as an imperative in improvement interventions that should always be assisted by monitoring their evolution (DGS, 2015). Culture of Safety is an integrant and inseparable element of quality programs, defined as the provision of safe, effective, timely and equitable health care (Pimenta, 2013). It should be conveyed through open communication, teamwork, recognition of mutual dependence, continuous learning, reporting of adverse events, this way ensuring the primacy of safety at all levels of the organization (WHO, 2009, cit. in Reis, 2014). Organizations with a positive culture of safety are characterized by a communication based on mutual trust and the effectiveness of preventive measures. The

importance of communication in the health sector has been the subject of several studies over the last decades and WHO considers it as determinant factor of the quality of safety in the provision of health care (Santos et al., 2010). Its importance in the structure, process and results of health care is corroborated by the Joint Commission International. The mission of this commission is to identify problems and challenges related to patient's safety and to develop appropriate solutions that will be based on the sharing of health professionals and of all other elements involved in the health care system. As a result of this pluridisciplinary participation, in 2007, the WHO elaborated a document named "The Nine Patient Safety Solutions", which presents everything that was learned about "where", "how" and "why" adverse accidents happen in health sector (WHO, 2007). One of the nine challenges and solutions identified is related, precisely, to communication (Communication during patient hand-overs), assuming that disturbances or failures in communication inter and intra teams may be the basis of the occurrence of error in diagnosis and treatment, and also of the decrease quality of care and as a consequence, of the potential damages to patients (WHO, 2007). The importance of communication to the work of an interdisciplinary team is determinant in the quality of healthcare provision (Nogueira and Rodrigues, 2015), affecting in a positive way the safety and treatment results (Babiker, 2014). The relationships established with the patient or its family are originated by the nurse's ability to communicate as well as the entire multidisciplinary team's that works with him. This is what allows the understanding between who gives and who receives the information, being a determinant part of the profession and the primacy for the construction of a solid trust relationship (Pereira, 2008). Communication is the main therapeutic tool of the nurse, thus it allows him/her to know the personality, life environment and personal conception of the world. It increases the patient's efforts to preserve himself from the disease or to become aware of the disease and take responsibility for his treatment (Phaneuf, 2005).

2. METHODS

It is a quantitative, descriptive/correlational, analytical and cross-sectional study. The sample, for our convenience, is of non-probabilistic type, consisting of 138 nurses.

In order to perform the study, it was applied a data collection tool, consisting of a questionnaire designed to characterize the sample, which includes sociodemographic and professional variables.

We used the Evaluation Scale of Patient Safety Culture in Hospitals (Eiras, 2011) composed of 7 sections that include 42 items: – A "Your service/work unit", consisting of 18 items; B – "Your hierarchical superior", consisting of 4 items; C – "Communications", consisting of 6 items; D – "Frequency of notification", consisting of 3 items; Section E – "Patient Safety Level", consisting of 1 item; F – "Your hospital" consisting of 11 items; G – "Number of events/occurrences" consisting of 1 item. To analyse the results, we consider that positive results above 75% classify this aspect of the safety culture as strong (very good level), less than 50% represent problematic areas or critical aspects. For the intermediate values (> 50% and <75%), we consider that they are not problematic, but should be seen as an opportunity for improvement.

We also used the Clinical Communication Skills Scale (ECCC) validated by Ferreira; Silva & Duarte (2016). It is a Likert scale consisting of 24 items organized into 7 factors corresponding to the seven essential elements of communication: It builds a relationship; Begins the discussion; Collects information; Perceives the patient's perspective; Shares information; Reaches a consensus; Allows to finish the dialogue. We evaluated some of the metric properties through validity and reliability studies, namely the temporal stability and the internal consistency or items' homogeneity, showing good reliability indices. Data collection took place from February to May 2016.
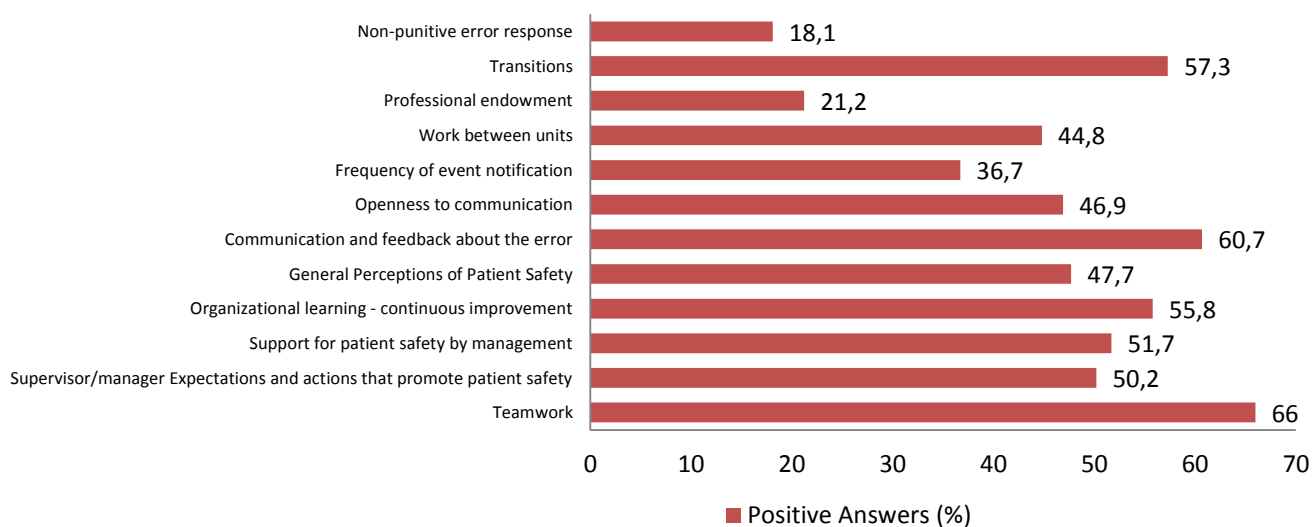
3. RESULTS

The interviewees have an average age of 32.51 years, are mostly female (77.54%) with a degree (94.4%) and have, on average, 9.41 years of professional experience. Nurses over 30 years of age are those who have better communication skills. Health professionals with more years of professional experience (> 10 years = 14,945 ± 2,296) are the ones who present higher averages in the various dimensions of clinical communication skills. We have evaluated the importance given to clinical communication skills and found that: 61.6% of the nurses consider that the most relevant communication skill is the relationship between the professional and the patient (rapport). For 47.1% of the nurses the opening phase of a clinical consultation/interview is relevant, for 19.6% it is in first place and in second place for 27.5%. Collecting information (making clinical history) was considered by 40.6% of the interviewees as the third most relevant communication skill. The competence to understand the perspective of the patient about its problem/illness was in 4th place for 29.7% of the interviewees and in second place for 29.7% Sharing and discussing clinical information with the patient is considered by 39.9% of nurses to be the 5th most relevant competence. 44.9% of the interviewees consider the act of negotiating with the patient an agreement on their problems/diagnoses and therapeutic plan the 6th most relevant competence. We also verified that 119 (86.2%) of the nurses consider the act of closing the interview/consultation the least relevant communication competence. 97.1% of the nurses interviewed are aware of the existence of a department, inside the institution, responsible for implementing a quality policy on health care. Nurses up to the age of 30 present a better safety culture in what concerns the teamwork, patient safety support

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through management, organizational learning – continuous improvement, general perceptions about patient's safety, training of professionals, transitions and error response. Concerning the supervisor/manager expectation subscales and actions that promote patient's safety, communication and error feedback, communication openness, notification frequency, inter-unit work training of professionals, nurses aged> 30 have a better safety culture. Most of the nurses 71 (51.4%) reported some type of event in the last year. Of these, 41 (29.7%) reported 1 to 2 events and 30 (21.7%) reported 3 or more events. 48.6% of the interviewees didn't report any adverse events in the last 12 months.

We conclude that all manifest variables have significant and positive values, except for the information collection (factor 3) with the communication and feedback about the error (r = -0.24) and the years of professional experience with the non-punitive response to error (r = -0.14). We verify that the dimension allows to determine the dialogue that presents the biggest predictive weight in relation to the security culture in the dimensions of event notification, communication and feedback about the error and organizational learning – continuous improvement. We conclude that the higher the number of years of professional experience the lower the error response.

Results from the safety culture indicate that none of the presented aspects has reached the percentage of positive responses needed to be considered as a strong (very good) point in the safety culture. In Graph 1, we identified six dimensions ("General Perceptions of Patient Safety", "Openness to Communication", "Frequency of Event Notification", "Inter-relationship Between Work Units", "Training of Professionals", "Non-punitive response to error") which obtained a percentage of positive responses below 50%, constituting critical points with a lack of priority intervention. The percentage of positive responses from the remaining dimensions is between 50.2% and 66%, being considered "acceptable", although with need of improvement (cf. Graph 1).

Graph 1 - Positive answers by dimension (%)

Figure 1 presents a multivariate regression of the ECCC results with those of the safety culture scale in hospitalized patients and after the inferential analysis we recorded that all the manifest variables (years of work experience, collection of information, information sharing and dialogue) register significant values. We assess that this dimension allows to determine that dialogue has a bigger predictive weight in relation to the security culture regarding the frequency of notification, communication and feedback about error and organizational learning – continuous improvement. The higher the number of years of professional experience the lower the response to the non-punitive error.
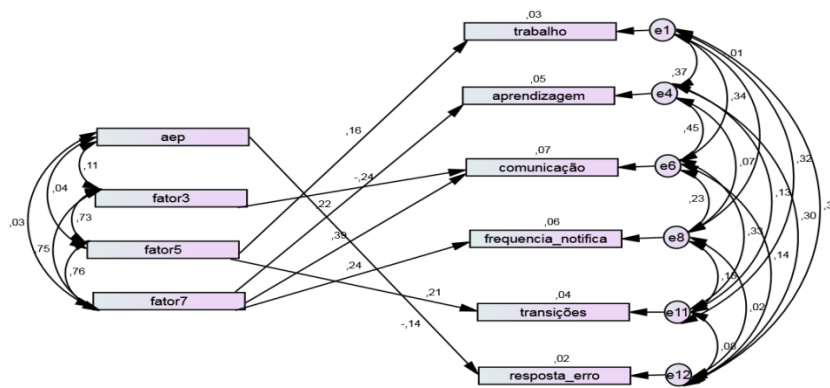
Figure 1 - Multivariate regression of the ECCC results with culture of safety of patients

4. DISCUSSION

The evidence points us to an inevitability of implementing a Culture of Safety, which reflects the commitment of the professionals of an organization with the continuous promotion of a safe therapeutic environment and which will have the desirable consequence, and expected, the change of behaviors influencing, thus, the results, that is, the guarantee of safe care for the citizen (Reis, 2014).

The results show that the majority of nurses in our study (51.4%) have notified some type of event in the last year. Of these 29.7% notified 1 to 2 events and 21.7% notified 3 or more events. The remaining 48.6%, almost half of the study population, did not make any notifications, result that, supported by theoretical support that we had access reveals concern. Other studies carried out in this context present results lower than ours. In the study carried out by Garcia (2015) the majority of nurses (95.6%) did not make any event notification, Costa (2014), inferred that 77.9% of the respondents did not report any event/occurrence. Also the study of de Eiras et al. (2011), shows that the majority of participants, (73%), did not report any events/occurrences. These results demonstrate that underreporting is a reality in many hospitals representing a priority area of intervention, in a patient-centered health system notification of incidents is essential, corroborating the notion that the real dimension of this problem is unknown in Portugal, as well as the consequences that come from the culture of underreporting (Costa 2014). Antunes (2015) states that 62.0% of adverse incidents/events are not reported, although our study presented a notification rate of 51.4% there is a large margin for improvement.

The Culture of Safety must be an integrant and inseparable element of quality programs, (Pimenta, 2013). It must be conveyed by open communication, teamwork, recognition of mutual dependence, continuous learning, ensuring, by this way the primacy of security at all levels of the organization (WHO, 2009 cit. in Reis, 2014). The evaluation of fragilities allows the definition of strategies that ensure uniformity in the acquisition of safety values, promoting sharing as a foundation of the prevention of adverse events and the culture of non-infallibility (culture of reporting events, culture of learning with the trajectories of error, culture of accountability without guilt) (Costa, 2014). In the context of the evaluation of nurses' perception about safety culture of hospitalized patients having as reference the proposal of Eiras et al. (2011), who consider good results when observe medium values positive responses equal or greater than 75% and as opportunities for improvement when values lower than 50% are observed, in our study none of the dimensions reached the necessary values so that the safety culture can be considered a strong point.

Errors are often, consequences and not causes. If erring is human, recognizing the error and acquiring skills to prevent it is a key requirement for personal and professional development (Santos, 2010).

CONCLUSION

Patient Safety in the occurrence dimension of adverse events have assumed a growing concern for organizations given their implication in the quality of care and patient satisfaction issues. Considered by several authors as a public health problem, health care organizations in general, and professionals in particular, should be more concerned with the implementation of measures focus on preventing and reducing undesirable events existent in provision of health care.

Results show the importance of training on incident and adverse event reporting systems, reinforcing the "positive" reporting perspective, highlighting the idea that we learn from the error. Learning from harmful situations allows to understand them, prevented them, and turn them into opportunities for change to best practices, keeping away the idea of punishment.

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It is emphasized the importance of health professionals, specifically nurses, to take notice of adverse events as a useful tool for care delivery and to reduce the rate of adverse events. We also emphasize the importance of continuing education as the only way to follow the evolution of knowledge in this area, assuring safe practices, and the quality of care delivery.

ACKNOWLEDGMENT

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