Articles

Administration management in patient safety culture and barriers to adverse event reporting in the nursing profession

Gestión de administración en la cultura de seguridad del paciente y barreras para la notificación de eventos adversos en los profesionales de enfermería

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ABSTRACT

Patient safety is very important in the health field, and for this, parameters such as having quality in the service provided and guaranteeing primary care in an effective manner must be considered. The objective of this article is to know the aspects of the patient safety culture and the safety climate perceived by the nursing staff who work in the participating hospital. The methodology used is a descriptive, cross-sectional observational type; It will be observational because it is a specific type of study that is defined by having a statistical or demographic nature, where 46 health professionals were surveyed. In this investigation, it was identified that there is disagreement with the actions that are implemented, lack of supervision, lack of monitoring, strategies, reports, and high frequency of communication between professionals where the purpose is to provide patient safety and demonstrate all the notifications of adverse events and incidents.

Keywords: security, culture, patients, health, notifications.

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RESUMEN
La seguridad del paciente es muy importante en el ámbito de la salud, y para ello, se deben consideran parámetros como tener calidad en el servicio prestado y garantizar una atención primordial de forma eficaz. El presente artículo tiene como objetivo es conocer los aspectos de la cultura de seguridad de los pacientes y del clima de seguridad percibido por el personal de enfermería que labora en el hospital participante. La metodología utilizada es de tipo descriptivo observacional transversal; será observacional porque es un tipo de estudio concreto que se define por tener un carácter estadístico o demográfico, donde se encuestaron a 46 profesionales de la salud. En la presente investigación Se identifico que existe desacuerdo con las acciones que se implementan, falta de supervisión, falta de monitoreo, estrategias, reportes, informes y alta frecuencia de comunicación entre los profesionales donde la finalidad es brindar seguridad de los pacientes y evidenciar todas las notificaciones de eventos adversos e incidentes.
Palabras clave: seguridad, cultura, pacientes, salud, notificaciones.

INTRODUCTION

The WHO has identified patient safety as a global public health problem, evidenced by the 1.3 million deaths due to blood-borne transmission of viruses such as hepatitis B, C and human immunodeficiency virus (HIV). In addition, around 1 million patients worldwide die from disabling injuries in hospitals as a result of inadequate care, which is why it is recommended to implement measures and procedures for reporting and recording adverse events (Toffoletto & Ramirez, 2013). Therefore, developing and implementing appropriate health management aimed at improving patient safety performance and risk mitigation in clinical practice, together with a safe environment, will reduce the occurrence of adverse events and risks that affect patient safety. In healthcare, the occurrence of errors seriously affects patient safety and quality of care. In the United States, a report ranked medical errors as the third leading cause of death, finding that 1.1 % of hospital admissions resulted in death due to such errors (Hayes & Cocchi, 2021). Most such errors or adverse events are not caused by poor performance, but arise from care delivery problems resulting from conditions at the individual patient level, or from the general work environment. Therefore, adverse event reporting is

crucial both for individual learning and for improving and developing more reliable systems of care (Schwendimann et al., 2018). At the Latin American level, the Ibero-American Study of Adverse Events (IBEAS) estimated a prevalence rate of adverse events associated with hospital care of 10.5 % of patients and 1.8 % of them resulted in the death of the patient, 10 out of every 100 patients in Latin American countries would have suffered harm from healthcare and 20 users suffered an incident resulting in harm as a result of their stay in hospital (WHO-IBEAS, 2015). In this sense, knowing and reducing these error rates that affect patient safety is a vital objective for every healthcare institution, which, in the short and long term, will translate into healthcare benefits for the patient, the institution and the system.

Patient safety is very important in health care, and for this, parameters such as quality of service delivery and ensuring effective primary care must be considered. The knowledge of health care workers should be indispensable as they are the ones who execute all processes. In this context, the needs of each of the areas should be identified in the area that concerns them, the quality controls in the health area allow to identify the correct way of execution of the services of each institution whether public or private and this will generate a better service; the personalised delivery with the patient generates trust and faithful attention, besides being the axis of the quality of service of the health institution, quality is important because based on this, the services are identified and recommended locally and based on the quality, the continuous improvement and the level of its provision is highlighted (WHO, 2018).

There are barriers such as conflicts, prospective views of those involved, lack of communication, experience and motivation on the part of the head of area, which impact on the performance of health professionals. To improve the process of patient care and safety, solutions to the adverse events detected must be proposed and differences of ideas or opinions between the different collaborators must be resolved, relying on the authority and fairness of the leader, seeking a common interest to find a conciliation, avoiding manipulation and partiality of personal interests (Viena de Lima et al., 2019).

In healthcare, the occurrence of administrative errors in communication, diagnosis and drug handling seriously affects patient safety and quality of care. Patient safety culture is related to the barriers to adverse event reporting in the institution where health services are provided. The main actors in these processes are the nursing professionals who are an important part of the process as they have direct contact with patients. Events occur on a daily basis, where the lack of patient safety and communication is presented as barriers to adverse event reporting in nursing professionals, and there is also a relationship between the events reported in each area. The culture, values, customs, perceptions, norms, competencies and practices of the organisational climate of healthcare professionals should be reflected in proactive or reactive safety actions, which make up the patient safety culture (Hayes & Cocchi, 2021).

Nurses who report adverse events verbally and in writing to the immediate coordinator are immersed in notification and patient safety processes as part of their duties.

Ignorance of the safety culture, fear of reprisals and punishment in the workplace are the main causes of non-reporting of adverse events, creating a problem that needs to be addressed. In terms of safety culture, continuing education is recommended to create awareness and confidence that reporting an error will not result in a punitive response, and that by taking this action, an error improvement plan can be implemented to avoid making the same error on another occasion, or in another service, thus improving communication and leadership.

There are barriers such as conflicts, the prospective visions of those involved, lack of communication, experience and motivation on the part of the head of area, which have an impact on the performance of health professionals; to improve the process of patient care and safety, solutions must be proposed to prevent adverse events and resolve discrepancies of ideas or opinions of the different collaborators, relying on the authority and justice of the leader, seeking a common interest by finding a conciliation, avoiding manipulation and partiality of personal interests.

Patient safety culture is the result of values, attitudes, perceptions, skills and behavioural patterns, both individual and group, that determine the organisation's commitment to safety and health management, as well as the approach and skills of such management to reduce harm during medical treatment and to create specific health strategies (Toffoletto & Ramirez, 2013).

Patient safety culture is related to barriers to adverse event reporting in nursing professionals, where there is a relationship between safety from communication and barriers to adverse event reporting in nursing professionals, and there is a relationship between reported events and barriers to adverse event reporting. The culture, values, customs, perceptions, norms, competencies and practices of the organisational climate of healthcare professionals that are reflected in proactive or reactive clinical safety actions make up the patient safety culture (Shiner, 2021).

Barriers to adverse events are embedded in factors that have been identified as facilitators include personal characteristics, dynamics between service providers and clients, social support, knowledge of the disease and patient-specific service adaptation. There are barriers such as conflicts, prospective visions of those involved, lack of communication, experience, motivation on the part of the head of area, this has an impact on the performance of health professionals, to improve the process of patient care and safety should raise solutions to adverse events and resolve differences of ideas or opinions of different partners, relying on the authority and fairness by the leader, seeking a common interest finding a conciliation avoiding manipulation and partiality of personal interests (Giraldo et al., 2016). The role of leadership as possibilities that has been developed within the process of the pandemic with the implication as in the performance involving the nursing staff with their services called as part of the ‘nursing leaders’ in them a joint professional activity is developed with previous experience acquired with experts, safety in the area is developed as a test for the nursing staff where the main characteristics are to face a hard process with critical dimensions and safety in

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patients, developed as challenges, processes and protocols and new procedures are developed to care for patients (Hayes C. , 2020). Nurses reporting adverse events verbally and in writing to the nurse coordinator immediately. Lack of awareness of safety culture, fear of retaliation and punishment in the workplace are the main causes of non-reporting of adverse events. In terms of safety culture, continuing education is recommended to build awareness and confidence that reporting a mistake will not result in a punitive response and that a mistake improvement plan will be implemented to avoid making the same mistake another time, as well as to improve communication and leadership. In our country, patient care and safety problems have been established as the main causes of morbidity, and an influx of a large number of adverse events and complaints against the hospital for negligence has been identified as approximately 15 % according to the report of complaints in the (Attorney General's Office, 2022). According to the World Health Organisation (WHO), medical malpractice comprises the failure of the physician to comply with the standards of care for the treatment of the patient's condition, or lack of knowledge, when providing patient care, which is the direct cause of an accident to the patient, many of them admitted by emergency which leads to a series of breaches in patient safety standards, as the time pressure influences, so that some steps for the correct management of the patient are obviated. The AHRQ survey solicits opinions about patient safety issues, medical errors and incidents reported in a health institution. The objective of its application and study is to find out aspects of the patient safety culture and the safety climate perceived by the staff working in the hospital; this instrument will include the following items: distribution by work area of the staff surveyed, direct interaction with patients, time spent in professional practice, time spent working in the hospital by the staff surveyed, time spent working in the area, weekly working hours of the staff surveyed, possible causes related to the presence of adverse events, staff perception of their work. In the participating institution, patient safety incidents have been reported and their impact can range from minor events or even go unnoticed, to the most serious ones, ending in injury, disability or death where proactive management in prevention will be the success of the system, however, the lack of control and follow-up reports are a reality. In the participating hospital, given the progressive incidence of complications and adverse events in the medical interventions of patients in different areas, strategies should be implemented to foster a culture of patient safety in health professionals and avoid problems in care and the hospital environment that cause adverse events. The aim of the present study is to find out about aspects of the patient safety culture and the safety climate perceived by the nursing staff working in the participating hospital. The analysis of the information shows that the construction of a culture of safety is a process that involves changes in the conceptions and practices of the health personnel, which have yet to be consolidated, but which already show significant advances in the medical services institution.

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MATERIALS AND METHODS

The present research will be of a descriptive observational cross-sectional type; it will be observational because it is a specific type of study defined as having a statistical or demographic nature. It is characterised by the fact that the researcher's work is limited to the measurement of the variables taken into account in the study; and it will be cross-sectional because it is focused on analysing data on different variables on a given sample population, collected over a specific period of time.

The handling of the information will be quantitative, as a survey-type information-gathering instrument will be applied to the participants, after they have signed an informed consent form; the survey will be applied to all the nursing professionals who belong to the institution, a figure that amounts to 46 subjects, therefore, it is not necessary to apply a sampling strategy, as the entire population will be approached.

List of institutions

Public institution

Inclusion criteria

- Staff with a dependency relationship with the institution for more than one year.
- Personnel who voluntarily sign the informed consent form.
- Staff > 19 years and < 65 years.

Exclusion criteria

- Personnel with a dependency relationship with the institution for less than one year.
- Health personnel with administrative functions or with the figure of internships or pre-professional practices.
- Nursing staff in a state of pregnancy.

Before applying the instrument to the participants in the study, they will be informed about the aspects related to the same, they will sign the informed consent form that will demonstrate that their participation is free, voluntary and that they are aware of the use that will be made of the data recorded in the instrument. The handling of the information collected excludes any possibility of affecting the individuality rights of the respondents, commissioned by the researcher who is responsible for the information collection process, detailing that the study will only be applied in the second level Basic Hospital. In the research, the entire population was taken, i.e. 46 health professionals for the study, where non-probabilistic sampling was used to obtain the relevant information on the subject in order to meet the objectives set out; the information was obtained from all the nursing professionals in the human resources department of the second-level basic hospital.

Each participant in the research process is surveyed on a voluntary basis, taking a few minutes of their time and covering the questions for the data collection process, placing them in the medical services institution and carrying out the activities as normal. The surveys are anonymous and the information received will be confidential, as no reproductions will be made of it, and no personal data will be stored in a folder to which

only the main researcher will have access by means of a password; the surveys will be kept in a safe place for seven years, in accordance with the Constitution of Ecuador and the protection of anonymous data.

This research will be carried out through the application of the survey on patient safety in hospitals created by the Agency for Healthcare Research and Quality (AHRQ), recognised as one of the most reliable instruments, which is a valuation instrument to determine the level of safety culture in the institution. Descriptive statistics will be applied and expressed through frequencies for categorical variables as a result of the application of the survey, which will subsequently be socialised in the institution.

The present investigation will be carried out in a public institution of second level of attention categorised as a basic hospital; the data will be compiled in a Microsoft Office Excel spreadsheet; where descriptive statistics will be calculated to carry out the analysis of the variables and their relationship.

This research will be carried out with the aim of finding out what the patient safety culture is in the participating institution, through the application of the Hospital Survey on Patient Safety Culture, created by the Agency for Healthcare Research and Quality (AHRQ), which collects opinions on patient safety issues, medical errors and incidents reported in a health institution, which will allow aspects of the organisation's culture to be measured, identify the aspects that need to be addressed to improve it, and to be able to monitor its evolution. The application of this survey makes it possible to obtain an initial diagnosis of the perception of the hospital's professionals regarding the twelve dimensions that make up the safety culture (Surveymonkey, 2022).

The research will be carried out with the purpose of providing evidence to the scientific community and the participating hospital to improve its patient safety culture, as well as to strengthen teamwork through the diversity of ideas and ingenious solutions that contribute to optimise processes in the institution, solve problems and meet objectives such as the provision of hospital services. For this purpose, the skills and strengths of the team members should be recognised and identified, and exceptional performance with commitment and mutual trust in each other should be achieved, as the institution will benefit.

It is important to develop the research proposal to improve teamwork, which should promote the diversity of ideas and ingenious solutions that contribute to improving processes in the institution, solve problems and meet the objectives such as the provision of hospital services. The skills and strengths of team members should be recognised and identified, optimising results and achieving exceptional performance with commitment and mutual trust between them, which benefits the whole institution because activities are carried out jointly and give good results. The good leader with his charisma is able to generate in his collaborators the need for achievement and the vehement desire to contribute to the goals of the team, it is of great importance in the scientific field for future research of professionals and nursing students, it also

contributes to the institution to make changes and its service delivery is more efficient in patient safety and adverse events.

RESULTS

The characteristics and general information of the respondents, following the application of the questionnaire to the health personnel (graduates and nursing assistants) of the health unit under study, among the variables described are as follows: 71.7% were female and 28.3% male, the age range was 30-39 years, 45.7% were single and 39.1% were married/unmarried.

According to their job position, 80.4% were nursing graduates, while 19.6% were nursing assistants, 73.9% maintained direct contact and prepared monthly reports with the patient, 63% worked between 8-12 hours, followed by a shift of more than 12 hours (30.4%), and 71.7% worked 71.7% of their working day in both day shifts. According to their working hours, 71.7% work both day and night shifts, followed by 23.9% who work only during the day. With regard to their length of service, 67.4% have worked in the institution for more than 5 years, followed by 17.4% for 3-4 years, 73.9% work alone in the institution, while 28.1% have another job.

The perception of health professionals in the area of safety culture and adverse event reporting in the institution chosen for the study shows that 34% and 33% agree with the institution's management of safety culture in the work unit, while 22% were neutral and 11% disagreed with the actions implemented, where supervision stands out with a greater neutral perception (41%) and 33% disagreed, This is evidenced by a lack of monitoring of supervisors in the events that occur in the hospital, in addition there is a lack of communication as it reaches 43% of disagreement of health professionals, while the frequency of events or incidents occurs continuously with 43% with an acceptable degree of patient safety according to 65% of the appreciation of the workers, but there are 11% who consider it bad.

Giraldo, et al (2016), analysed the factors linked to the omission of incidents and adverse events; this study used a descriptive methodology, with the participation of 345 health professionals, using a questionnaire as a data collection instrument. The findings showed that 83% were aware of the reporting system and 74% knew how to access the system; 91% did not report because they found it too complicated, stating that this is due to fear of administrative measures that the institution may take against them for the occurrence of adverse events; this led to the conclusion that the safety culture is based on the reporting of incidents and adverse events, which contributes to higher levels of quality of care and to strengthening the health system. (2019), in Brazil, showed that human errors are a strong factor that generates adverse events, being carelessness and distraction (61.83 %), lack of attention to the patient (44.2 7 %), errors in the administration of medicines (17.56 %), typing errors in medical prescriptions (13.36 %)

the most impacting; these errors condition the occurrence of adverse events in the process of patient care.

According to Raurell, et al, (2020), in their study published on 'Reflections derived from patient safety' highlights that the nursing staff in each area is indispensable for the proper care of patients, even though they work continuously to maintain the well-being of these patients as well as support vital functions, they prove to be fundamental as leaders of nursing teams, for the respective recovery process of the critical patient admitted to critical care units, requiring a variety of interventions which involve the use of advanced technologies to care for those admitted developing good care, specific skills and a high level of knowledge.

Similarly, Shinner, et al, (2021), in their article on Strategies to protect patients from harm in the critical care unit, state that nurses have always pioneered innovative ways of delivering care despite difficult circumstances, and required the integration of innovative approaches with evidence-based practice to meet patient needs, As well as ensuring patient safety while in the acute care setting, patients are vulnerable to various injuries, mental health and local security threats, the ingenuity and adaptability of nursing has identified strategies based on the reality of delivering quality care to protect the most vulnerable population.

Acosta (2017), made an effort to establish adverse events and compliance with reporting and recording; the results showed that most nurses have knowledge about the patient safety manual, however, half consider that it is necessary to implement a culture of safety, based on the notification and reporting of adverse events, concluding that the notification of incidents and adverse events is not adequate. In the present investigation there is disagreement with the actions that are implemented, lack of supervision, lack of monitoring, lack of communication to achieve optimal standards of patient safety and reporting of adverse events and incidents, which is evident from the actions that remain to be implemented in the work unit and in the activities to improve these indicators.

CONCLUSIONS

Patient safety is very important in the field of health, and for this, parameters such as having quality in the service provided and ensuring effective primary care must be considered, but barriers exist and are immersed in factors that have been identified as facilitators include personal characteristics, the dynamics between service professionals and patients, as well as the knowledge and adaptation of the specific unit to care for patients. There are trained professionals in the study unit with years of experience, but there is a need to implement strategies to improve the safety culture and avoid barriers to the reporting of adverse events, which makes an institution more efficient, effective and compliant with health, care and service quality indicators. It was identified that there is disagreement with the actions that are implemented, lack of supervision, lack of monitoring, strategies, reports, reports and high frequency of communication between

professionals where the purpose is to provide patient safety and evidence all notifications of adverse events and incidents.

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