

## COMUNICACION AND PATIENT SAFETY: PERCEPTION OF THE NURSING STAFF OF A TEACHING HOSPITAL

### COMUNICAÇÃO E SEGURANÇA DO PACIENTE: PERCEPÇÃO DOS PROFISSIONAIS DE ENFERMAGEM DE UM HOSPITAL DE ENSINO

### COMUNICACIÓN Y SEGURIDAD DEL PACIENTE: PERCEPCIÓN DEL PERSONAL DE ENFERMERÍA DE UN HOSPITAL DE ENSEÑANZA

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#### ABSTRACT

This is a quantitative study with descriptive exploratory design, which investigated perception among the nursing staff at a teaching hospital regarding the possibility of communication and non-punitive response to errors. It also sought to highlight communication as a relevant factor for patient safety. The study was conducted on a teaching hospital with a population of 95 nurses. Data was collected through a questionnaire based on the Agency Health Research Quality, considering communication openness and non-punitive response to errors. The results show that the staff will freely speak up when something does not seem right. We believe this study can contribute to the necessary interventions for the assessed dimensions and to provide subsidies for the improvement of healthcare processes and management with a focus on patient safety.

**Keywords:** Quality of Health Care; Health Service Evaluation; Patient Safety; Nursing.

#### RESUMO

*Trata-se de estudo quantitativo com delineamento exploratório-descritivo, cujos objetivos foram conhecer a percepção dos trabalhadores de enfermagem atuantes em um hospital de ensino acerca da dimensão abertura para as comunicações e respostas não punitivas aos erros e evidenciar a comunicação como fator relevante na cultura de segurança do paciente. O estudo foi desenvolvido em um hospital de ensino e a população foi constituída por 95 profissionais de enfermagem. A coleta de dados ocorreu por meio da aplicação de um questionário baseado na Agency Health Research Quality, considerando as dimensões: abertura para as comunicações e respostas não punitivas aos erros. Como principais resultados do estudo, identificou-se que os profissionais conversam livremente sobre algo que está errado. Acredita-se que este estudo possa contribuir para as intervenções necessárias nas dimensões avaliadas e fornecer subsídios para a melhoria de processos e gestão de cuidados com foco na segurança do paciente.*

**Palavras-chave:** Qualidade da Assistência à Saúde; Avaliação de Serviços de Saúde; Segurança do Paciente; Enfermagem.

#### RESUMEN

*Este es un estudio cuantitativo con un diseño exploratorio descriptivo, que tuvo como objetivo conocer la percepción del personal de enfermería de un hospital universitario acerca de la dimensión apertura para las comunicaciones y respuestas no punitivas a los errores y evidenciar la comunicación como un factor de relevancia en la cultura de la seguridad del paciente. El estudio se llevó a cabo en un hospital de enseñanza, con 95 profesionales de enfermería. Los datos se recogieron mediante un cuestionario de la Agency Health Research Quality, teniendo en cuenta las dimensiones: apertura para las comunicaciones y respuestas no punitivas a los errores. Como principales resultados, podemos mencionar que los profesionales hablaban libremente sobre lo que estaba equivocado. Creemos que este estudio contribuye a las intervenciones necesarias en las dimensiones evaluadas para mejorar los procesos asistenciales y de gestión con un enfoque en la seguridad del paciente.*

**Palabras clave:** Calidad de la Atención de Salud; Evaluación de Servicios de Salud; Seguridad del Paciente; Enfermería.

## INTRODUCTION

The search for quality in health services is essential and patient safety is a priority nowadays.

Even though such discussions have become more expressive in recent years, there is still a gap in terms of patient safety from the perspective of nursing professionals.

To meet users' needs and expectations and attain excellence in services, it is imperative that managers set up and practice a policy of quality with constant monitoring. This leads to more uniformity, reduces non-compliance, costs and waste, and provides more quality.<sup>1</sup>

Healthcare is one of the most complex and dynamic human activities. It appears, however, that economic investments to make this system safe do not keep up with technological development.<sup>2</sup>

Patient safety ensures the healthcare users' safety during their interaction with health services, and attributes the occurrence of adverse events to deficiencies in organizational systems, lack of communication, inadequate training, and deficient working relationships.<sup>3</sup>

In the late 1990s, the Institute of Medicine (IOM)<sup>4</sup> published the report *To Err is Human: Building a Safer Health Care System*, which claimed that between 44,000 to 98,000 Americans died each year because of errors related to healthcare. In addition to highlighting the need for health authorities to prioritize patient safety, the report recommended changes in hospital culture. Thus the term "safety culture", used in nuclear power in the past 30 years, began to be also used in health-related fields.<sup>5</sup>

The concept of a safety culture seems to be a lesson from the Chernobyl disaster, which happened in Ukraine in the 80s. The expression spread quickly and is used in managerial, political and scientific discourses. The International Atomic Energy Agency (IAEA) published in 1987 the most commonly used definition of "safety culture": the set of characteristics and attitudes in organizations and individuals. The underlying idea is that the habit of thinking in terms of safety involves a "systematic questioning attitude, a refusal to be satisfied with the results, a constant concern for perfection and an effort of personal and group responsibility to self-discipline themselves towards safety". This should ensure that all important safety tasks are carried out correctly and promptly, made with sufficient knowledge, good sense, and a sense of responsibility.<sup>6</sup>

Safety culture is thus seen as a safety commitment made by individuals at different levels of responsibility and guidelines. The IAEA estimates that self-control practices, especially feedback, training, and auditing are ways to evaluate and evolve the practices used in organizations.<sup>7</sup>

The Agency Health Research Quality (AHRQ)<sup>8</sup> is known as the primary federal agency for carrying out and supporting research to improve patient safety and quality of healthcare for Americans.

In 2004, AHRQ developed a questionnaire aimed at assisting hospitals to assess how their organizational cultures em-

phasize the importance of patient safety and facilitate the implementation of activities for this purpose. The questionnaire brings out the errors, the perception of errors, and the ten dimensions of patient safety culture.

Safety culture are divided between dimensions that occur within units (seven dimensions) and within hospitals (three dimensions). Two other outcome variables are included in the questionnaire. Each of the measured dimensions is analyzed by means of specific questions in the survey course, which also includes two questions about the degree of patient safety in the unit or work area, and the number of events reported in the last 12 months.

The dimensions of openness and non-punitive responses to errors are among the dimensions that occur within the units. The first concerns how openly staffers can speak out when they perceive something that might negatively affect patients, and whether they feel free to question their superiors. The second refers to whether the professionals believe their own errors could be used against them and entered into their records.

Taking into consideration the relevance of communication on patient safety in healthcare institutions, our research sought to investigate nursing professionals of a public and teaching hospital's perception of these two dimensions— openness for communication and non-punitive responses to errors – as to highlight communication as a relevant factor in the patient safety culture.

## METHODS

This is an exploratory-descriptive study with a quantitative approach carried out at a teaching hospital located in a municipality in the state of São Paulo (SP).

Sample size consisted of 25 nurses, eight nursing technicians and 62 nursing assistants, totaling 95 professionals. We employed the Agency's instrument of employment for Health Research and Quality, focusing on the dimension "openness for communication".

The *Agency for Health Research and Quality's* questionnaire was adopted because it was freely and easily available, as well as because it has been extensively used in different cultural contexts; it also includes psychometric properties. The questionnaire encompasses 10 safety culture dimensions, assessed at the individual, unit, and hospital levels, and has two output variables.

Our data collection follows the model created by Likert in 1932, which evaluated the degree of professionals' compliance on issues related to safety culture. Possible answers ranged from "strongly disagree" to "strongly agree".

Data collection took place after approval by the institution's Ethics in Research Committee, under report 033/10, in the period May-October 2011.

Data were stored in an Excel® spreadsheet for processing. For the analysis, *Microsoft R Excel* and *Statistic Package for Social Sciences (SPSS)* were used, both under Windows.

Results were presented as graphs and data analysis was done using descriptive statistics.

## RESULTS

Of the total participants, 25 were nurses (26.3%), eight (8.4%) nursing technicians and 62 (65.3%) nursing assistants. The prevailing age range was over 40, indicating the predominance of adults. As for training time, the highest numbers were 19 (20%) participants, who had one to five years of education, and 29 (30.5%), of 11 to 15 years. Twenty-one (22.1%) professionals worked in emergency and the adult emergency unit; 15 (15.8%) in emergency and the pediatric emergency unit, and 17 (17.9%) in the intensive care unit.

The findings in Figure 1 show that professionals feel free to talk about negative aspects of healthcare. Thirty-four (35.8%) participants reported that they “sometimes” speak out freely and 31 (32.6%) “almost always.”

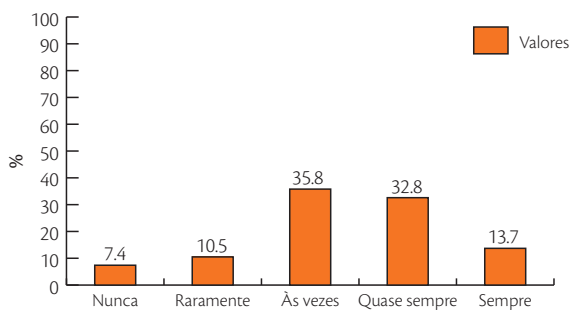


Figure 1 - Distribution of the frequency of responses: professionals feel free to speak out about something that negatively affects patient care. São Paulo (Countryside – SP) – 2012.

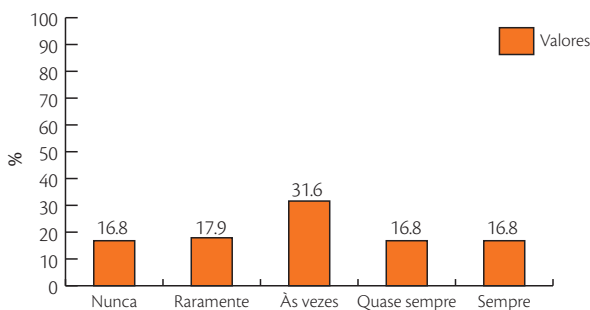


Figure 2 - Distribution of the frequency of responses: professionals feel free to question the decisions or actions of their superiors. São Paulo (Countryside – SP) – 2012.

In Figure 2, (whether professionals feel free to question the decisions or actions of their superiors) there is a proximity of data. Hence there was no clear trend in the responses to this proposition.

Figure 3 (whether professionals are afraid to ask questions when something does not seem right) shows that that 25 (26.3%) never feel afraid, and 26 (27.4%) rarely feel afraid.

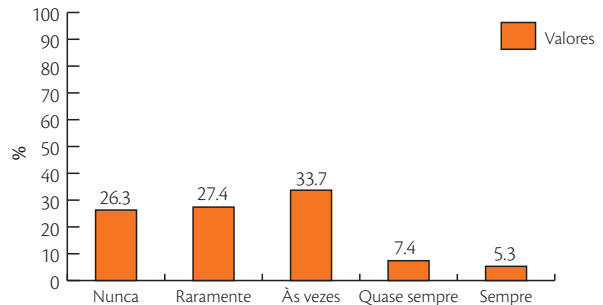


Figure 3 - Distribution of frequency of responses: professionals are afraid to ask questions when something does not seem right. São Paulo (Countryside – SP) – 2012.

Figure 4 indicates that most participants, 48 (50.5%), agreed with the statement and 22 (23.2%) strongly agreed, totaling 70 (73.7%), a result that demonstrates that professionals believe that their mistakes could be used against them.

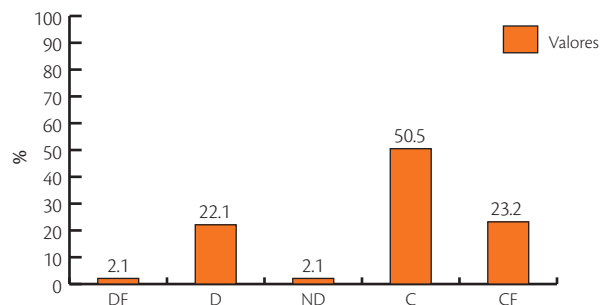


Figure 4 - Distribution of frequency of responses: professionals feel that their mistakes could be used against them. São Paulo (Countryside – SP) – 2012.

Figure 5 shows that 45 (47.4%) agree with the proposition, meaning that workers believe they are the ones who will be seen as accountable for errors.

## DISCUSSION

The structure of nursing services, because of its rigid hierarchy, often leads the supervisor nurse to engage in authoritarian and centralizing practices, which may end up compromising teamwork and preventing the participation of the other professionals.<sup>9</sup>

Nurses experience submission and reproduce this relationship with members of other categories of the staff, namely technicians and nursing assistants.<sup>10</sup>

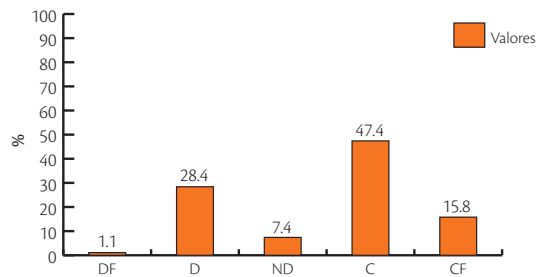


Figure 5 - Distribution of frequency of response: in the case of an adverse event, the focus of blame is the professional, not the error. São Paulo (Countryside – SP) – 2012.

In school, nurses learn that effective health work should be focused on the team. A good working group is one that interacts primarily to share information and make decisions that help each member perform their tasks individually. Collective work, within this construct, is a myth. What exists is the sum of contributions by each member of the group separately—accountability remains individualized. The skills of the group’s members are varied and come together almost by chance. There is no positive synergy that can create a general level of performance greater than the sum of the individual inputs. A team, on the other hand, generates positive synergy through coordinated effort.<sup>11</sup>

We understand, therefore, that professionals are not afraid to question their superiors when they believe something is wrong. In this way, the human being communicates to provide information, to persuade, to generate behavioral changes in an exchange of experiences, and finally to teach and discuss various subjects.

Communication is critical to development of the work between nurses and the other members of the staff, to the transmission of universal information, and to exert direct influence on individuals. Communication is a human skill that allows the manifestation and externalization of what goes on inside.<sup>12</sup>

Quality of care depends on effective communication, thus allowing teams to transmit and receive information clearly and correctly.<sup>13</sup>

Errors should be studied in all their aspects and with a non-punitive approach. Those who report should receive feedback. An independent organization or department should be created to receive reports of errors while protecting the informers’ identities.<sup>14</sup>

Thus, we should note that the inclusion of an organizational culture that enables nursing professionals to identify and explain their mistakes allows the development of safety strategies in order to prevent further errors.

Data from *National Coordinating Council for Medication Error Reporting (NCCMERP)* (1998) emphasize that one should encourage error reporting as a way to access the real causes of adverse events and their possible means of prevention. The search for punishable culprits, it is known, has not led to a decrease in errors or contributed to the development of effective

preventive strategies. Rather, these attitudes have contributed to the under-reporting of errors, which hinders the implementation of prevention protocols.<sup>15</sup>

## FINAL CONSIDERATIONS

This study enabled us to identify nursing professionals’ perception of the dimensions of openness for communication and non-punitive response to errors, as well as to emphasize communication as a key factor in patient safety culture.

Our data shows that fear of punishment and focus on the individual as a culprit are limiting factors in reporting errors and adverse events.

Upon conclusion, we reiterate that addressing quality health is no easy task, especially when it comes to hospital care. Thus, the adequacy of infrastructure services (and their relationship), as well as provision of materials, equipment, specialized human resources, and the reporting of adverse events is essential for everyday patient care to be pursued with quality, safely and flawlessly.

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