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FACILITIES AND DIFFICULTIES OF HEALTH PROFESSIONALS REGARDING THE ADVERSE EVENT REPORTING PROCESS

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ABSTRACT

Objective: To describe the facilities and difficulties that health professionals have in relation to reporting adverse events in the hospital context.

Method: a descriptive, exploratory study with a qualitative approach, conducted in a high complexity public cardiovascular hospital in southern Brazil, between april and may 2017 with 39 health professionals. Semi-structured interviews and thematic analysis were used.

Results: Two categories emerged: Facilities for reporting adverse events and obstacles that hinder this process. The practice illustrates the fear of punishment, fragility in knowledge, work overload and lack of commitment of professionals, leading to underreporting. Difficulties occur with regard to non-compliance with routines and unpreparedness to use the reporting form of the institution. Some positive aspects are related to the support of the Patient Safety Center, the feedback of notifications and the recognition of the importance of reporting adverse health events.

Conclusion: The notification process is permeated by positive aspects and some obstacles that need to be overcome. Strategies with a focus on communication and educational practice are needed to disseminate information about the notification process, as well as to promote a culture without culpability and accountability for achieving patient safety.

DESCRIPTORS: Nursing. Patient safety. Medical errors. Notification. Health professionals.

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FACILIDADES E DIFICULDADES DOS PROFISSIONAIS DE SAÚDE FRENTE AO PROCESSO DE NOTIFICAÇÃO DE EVENTOS ADVERSOS

RESUMO

Objetivo: descrever as facilidades e as dificuldades dos profissionais de saúde em realizar o processo de notificação de eventos adversos no contexto hospitalar.

Método: estudo descritivo, exploratório, com abordagem qualitativa, realizado entre abril e maio de 2017 em um hospital público cardiovascular de alta complexidade do sul do Brasil, com 39 profissionais de saúde. Utilizou-se entrevista semiestruturada e análise temática.

Resultados: emergiram duas categorias: Facilidades para realizar a notificação de eventos adversos e obstáculos que dificultam este processo. A prática ilustra o medo da punição, a fragilidade no conhecimento, a sobrecarga de trabalho e o descompromisso dos profissionais, gerando subnotificação. Ocorrem dificuldades em relação ao descumprimento de rotinas e no despreparo para utilizar a ficha de notificação na instituição. Alguns aspectos positivos apontados estão relacionados ao apoio do Núcleo de Segurança do Paciente, ao *feedback* das notificações e ao reconhecimento da importância da notificação dos eventos adversos em saúde.

Conclusão: o processo de notificação está permeado por aspectos positivos e alguns obstáculos a serem superados. Faz-se necessário traçar estratégias com enfoque na comunicação e na prática educacional, com o intuito de disseminar informações sobre o processo de notificação, bem como na promoção de uma cultura sem culpabilidade e com responsabilização para o alcance da segurança do paciente.

DESCRIPTORIOS: Enfermagem. Segurança do paciente. Erros médicos. Notificação. Profissionais de saúde.

FACILIDADES Y DIFICULTADES DE LOS PROFESIONALES DE SALUD ANTE EL PROCESO DE NOTIFICACIÓN DE EVENTOS ADVERSOS

RESUMEN

Objetivo: describir las facilidades y dificultades de los profesionales de la salud para llevar a cabo el proceso de notificación de eventos adversos en el contexto hospitalario.

Método: estudio exploratorio-descriptivo con enfoque cualitativo, realizado entre abril y mayo de 2017 en un hospital cardiovascular público de alta complejidad en el sur de Brasil, con 39 profesionales de la salud. Se utilizaron entrevistas semiestructuradas y análisis temáticos.

Resultados: surgieron dos categorías: Facilidades para informar eventos adversos e impedimentos que obstaculizan este proceso. La práctica demuestra el miedo al castigo, la debilidad en el conocimiento, la sobrecarga de trabajo y la falta de compromiso de los profesionales, lo que lleva a la generación de subregistros. Se presentan dificultades con respecto al incumplimiento de las rutinas y la falta de preparación para utilizar el formulario de registros en la institución. Algunos aspectos positivos están relacionados con el apoyo del Centro de Seguridad del Paciente, la retroalimentación de los registros y el reconocimiento de la importancia de informar eventos adversos para la salud.

Conclusión: el proceso de notificación está impregnado de aspectos positivos y algunos obstáculos que deben superarse. Se necesitan estrategias con un enfoque en la comunicación y la práctica educativa para difundir información sobre el proceso de registro, así como para promover una cultura sin culpabilidad y responsabilidad para lograr la seguridad del paciente.

DESCRIPTORIOS: Enfermería. Seguridad del paciente. Errores médicos. Notificación. Profesionales de la salud.

INTRODUCTION

Health care institutions are increasingly concerned with improving patient safety, which involves quality improvement proposals, enabling the modification of work processes and safe strategies that improve health care.¹ Patient safety issues have been highlighted through the implementation of measures which aim to prevent exposure to risks and damage as a results of health care.²

Thousands of patients worldwide are harmed or die each year from unsafe health care, and it is estimated that one in ten patients may be the victim of adverse events during health care.³

There are limited studies in Brazil on the incidence and prevalence of adverse events in health institutions. A study carried out in Brazilian hospitals, which evaluated the incidence of adverse health events, showed an occurrence of 7.6%, with 66.7% being avoidable, and a ratio of 0.8 adverse events, or 100 patients per day. However, the proportion of avoidable adverse events in Brazilian hospitals was higher than in institutions in other countries which suggests that patient safety problems may be more frequent in Brazil than in developed countries.⁴

Another study evaluated the occurrence of adverse events and their impact on length of stay and mortality in an Intensive Care Unit, showing an incidence rate of 9.3 for adverse events per 100 patients / day, leading to increased hospitalization periods. Other relevant data show that among the 115 patients who presented adverse events, 35.6% died.⁵

One fact worth highlighting is related to the fact that if adverse events associated with hospital care were a group of cause of death, the mortality associated with these events would be between the 1st and 5th position, being one of the most frequent causes of death in the country, representing a huge concern with repercussions for patient safety. Given this context, the Institute for Supplementary Health Studies found alarming data regarding mortality, it found that 2.47 people die every 3 minutes in public or private hospitals as a result of adverse health events.⁶

In order to reduce adverse events, identification and reporting are required, which is considered a means of communication, which enables the institution to be aware of mistakes and errors, and allows the construction of a database and the execution of changes aimed at safer process planning, and the prevention of new adverse events.⁷⁻⁸

In compliance with the National Patient Safety Program, adverse events should be informed and / or reported to the institution's management bodies, including the Patient Safety Center (NUSEP), which aims to implement actions that promote patient safety and improve the quality of health services.⁹

Given this context, this study aims to investigate the reporting process of adverse events by health professionals. Interest in the topic arose from the concern with the scope of the problem, considering that the lack of reporting errors harms both the identification of adverse events, as well as the correction of possible errors arising from the process. It is noteworthy that the non-reporting of adverse events and the non-correction of errors endanger patient safety, with conditions associated with harm and even death.

Thus, the question that guided this study was: what can help and / or hinder health professionals to report adverse health events? To answer this question, the study aimed to describe the facilities and difficulties of health professionals in reporting adverse health events in the hospital context.

It is worth mentioning that the study is relevant, since the description of facilities and difficulties related to the reporting process of adverse health events may contribute to strategies that improve quality and prevent new occurrences, as well as the possibility of producing knowledge on the subject of patient safety, which is widely discussed theme worldwide.

METHOD

This is a descriptive exploratory study with a qualitative approach, developed in a highly complex cardiovascular public hospital in the state of Santa Catarina (Brazil).

Thirty-nine health professionals participated in the study. The inclusion criteria were: be employed, have worked for at least six months in the institution. The exclusion criteria were: absence from service for any reason during the data collection period.

Data collection was performed in April and May 2017, through semi-structured, individualized interviews at the participants' workplace, according to previous scheduling, with voice recording and transcription at a later date. A script consisting of two parts was followed: the first part identified participants and the second part used two guiding questions: In your professional practice have you experienced or learned of a situation experienced by a colleague regarding an adverse events? Comment on it; and what do you think might make it easier and / or more difficult to report an adverse health event?

Participants signed the Informed Consent Form. This stage was completed when the interview content reflected, in quantity and intensity, the multiple dimensions of the studied phenomenon.¹⁰

The thematic analysis technique was used for data analysis, operationalized from the pre-analysis, in which the transcribed material was organized in light of the objectives and then read exhaustively. In the second stage, exploration of the material, the data were separated and encoded in entry units. Thus, in each discourse, the entry units were highlighted and then grouped according to the semantic context. Finally, the treatment of data and interpretation occurred, by selecting significant discourses and apprehending their core meaning, giving rise to the themes and categories.¹¹ The results were discussed based on the literature on the subject.

The ethical principles of research involving human beings were respected, according to Resolution 466/12. In order to ensure participant anonymity, the data were coded by the letter E for interview, followed by an Arabic numeral, according to the order in which they were performed.

RESULTS

The study included a social worker, ten nurses, two pharmacists, three physiotherapists, one speech therapist, four doctors, one nutritionist and 17 nursing technicians. Among these professionals, 35 were female, between 25 and 56 years of age, and four were male, between 34 and 49 years of age. Regarding the work departments, 15 worked in the Coronary Care Unit, ten in the wards, seven in the operating room, two in nuclear medicine, two in pharmacy, one in nursing management, one in the social service and one in the nutrition service.

As for the level of education, one professional had a doctorate, three had master's degrees, 17 had specializations, five had undergraduate degree, three had undergraduate degree, one was a master's degree student and nine had secondary level education. The length of time of practice in the profession ranged from two to 31 years. In relation to the time of work in the institution and the sector, similar results were obtained, ranging from six months to 30 years.

Two categories emerged from the interviews and data analysis, as follows:

Facilities in relation to reporting adverse events

The themes that make up this category are related to knowing how to recognize what is an adverse event; understanding the purpose of the report; the short time between occurrence and reporting, the creation of the Patient Safety Center; the existence of a standardized reporting instrument; feedback from reports. In addition, participants suggested strengthening the continuing

education service in the institution and stressed the importance of educational material as a strategy that can contribute to reporting adverse health events.

Regarding the facilities found by health professionals regarding reporting adverse events, knowledge was a positive point in this process. In this context, health professionals recognize that adverse health events are present in daily care. They express their experiences, exemplifying which events occur most in their work environment. [...] *we encounter some adverse event almost every day [...] a patient who has already removed the tracheostomy more than once, has already removed the nasogastric tube more than once, I think I can think of all the events on the form (E2). I have experienced several adverse events such as adverse events related to medication error, prescription related, medication administration, medication route incorrectly prescribed, pressure injury, injury due to a medical device, phlebitis, fall , I have witnessed several adverse events(E27).*

Participants revealed the importance of reporting an adverse health event, understanding that the purpose of reporting is to track errors and provide actions that can improve patient care. [...] *it is for improvements. Reports are important to track problems, but it's not tracking problems to get somebody in trouble, it's tracking problems in order to minimize harm to the patient. I see it that way, for me, I see no difficulty, I see no problem, for me, it is very good (E21). Reporting improves how we provide proper care to the patient, because we can reduce errors by reporting (E4).*

Another positive aspect is related to the commitment of health professionals to notify adverse events immediately after identification or as soon as they can perform them. [...] *I witnessed adverse events situations and they were almost always reported immediately, still on duty, or not, both with me and with the colleagues I see that they are mostly reported the following day (E36). [...] it took me a while to do the report, but after four days I reported it to NUSEP (E13).*

The professionals highlighted that they discuss adverse events among themselves, as well as the need to make changes in care, in order to avoid further occurrences. [...] *I experienced several adverse events in my practice, before when there was no NUSEP we only notified the nurse of the place where the patient came from if not, if it happened in the coronary unit we would take particular steps [...] (E23).*

They highlighted that an important milestone to improve their actions was the implementation of the Patient Safety Center. After its implementation, patient safety issues permeated the context of care, incorporating the reporting process in this setting. They highlight that discussions about adverse health events intensified, as well as the systematization of the report, its investigation and analysis. NUSEP has been identified as a reference for care and support to health professionals. [...] *After NUSEP came, I reported them, and they evaluated the events and mediate the situations (E22). What could help a lot is this participation that NUSEP has with us. We feel more supported (E14).*

Another factor highlighted as a positive point which aids the reporting process of adverse health events was the existence of a standardized instrument, which is easily accessible, simple to fill in and ensures anonymity. They highlighted that the institution's existing instrument for reporting adverse events and technical complaints addresses these issues. *For example, nowadays we have the NUSEP instrument which is very easy, clear and objective and when it is something outside of what is written there, there is other option, and I have no problem writing, I report everything (E21). One aspect which helps is to have the report form at hand, there is no need to identify yourself, you do not need to say anything to anyone, just pick up the form. You don't even enter the name of the person [...] sometimes you know which employee forgot such a thing, but you cannot enter the employee's name (E5).*

They highlighted the importance of feedback from adverse health event reports considering that this feedback enables health professionals to recognize this process, in order to correct the failures and outline strategies for improving the quality of care and avoid further occurrences. [...] *and*

something else makes it easier for me, I particularly like it, because I see that the adverse events are discussed in large groups, by monthly indicators that are made, so there we know where we need to work on, so for me It makes it a lot easier, so if today in the ICU I have a high pressure injury index, I know what I need to work on pressure injury prevention, so it shows us where we need to work (E27). I think the te post-report conduct makes a difference, [...] the progress that occurs as a result of these reports, if whoever receives this report shows the educational side [...] (E26).

They understand that it is necessary to strengthen the guidelines regarding their routines, understanding it as a strategy that can improve knowledge regarding actions involving patient safety. *[...] the more education the employee has, the more critical he becomes, and the more critical he becomes, the more he becomes responsible for his actions and expects the same from others (E11). [...] understanding from the first day of work in the institution that every adverse event has to be reported and that there is a right to report anonymously (E34).*

They highlighted that educational material can be an ally for better compliance of health professionals, patients and family members to the reporting process, as it addresses concepts and aspects related to adverse events and guides the reporting process. *Educational material is a form of knowledge that you can seek [...] (E1). [...] so I think that educational material will help to warn us about reporting things that are underreported today (E36).*

Obstacles that hinder the adverse event reporting process

There are many barriers that need to be overcome by health institutions and especially by professionals in order to improve the reporting of adverse events, since the reporting process is not intended to identify culprits, but rather to identify the errors that occur in care in order to provide quality care.

The themes that make up this category are: the lack of perception of the occurrence of adverse events; lack of knowledge and lack of information about the reporting process; lack of habit, forgetfulness; lack of awareness, interest and demotivation; the insufficient number of health professionals; lack of leadership support; non-compliance and lack of a reporting routine and unpreparedness to use the reporting form in the institution.

Regarding the difficulties regarding the reporting process, a worrying factor related to the non-perception of health professionals about the occurrence of adverse health events in their work sector was observed. *[...] I realized that I was the only person who knew that this was an adverse event, it was avoidable and it frustrated me because I thought that everyone would have realized it, at the time it wasn't called an adverse event, it was called an error. So I think that this word changed, which was a good thing, and nowadays people are more attentive, but no one understood my first adverse event or they pretended that they did not understand (E34).*

Among other reasons that lead health professionals to avoid reporting adverse health events is ignorance and lack of information regarding the reporting process, as well as which adverse events are reportable, leading to underreporting. *There is a lot of doubt about reporting, [...] especially the nurse technicians, but I see this with some nurses too, they have difficulty, everything that can be reported, which has to be reported sometimes they still have doubts [...] (E36). To tell you the truth, I think it was never said to us that I had to fill out some form [...] at least I don't know that, that you have to make a report (E29).*

They highlighted some factors that interfere with the reporting of adverse health events, such as: lack of habit, forgetting and not prioritizing this action in care. [...] *the habit is missing [...] people don't want to stop to do it, do you understand?* (E30). *One difficulty is sometimes forgetfulness, because the shift is busy*(E22). *So maybe it's not that the team doesn't know how to do it, maybe the team doesn't see it as a priority, they care about caring for the patient, doing other routine things and they don't see this bureaucratic paper work as a priority.* (E2).

Lack of awareness, interest, as well as demotivation compromises the reporting of adverse events and providing patient safety. *The awareness of the professionals, because we have the instrument and the orientation. Everybody has that responsibility that must be fulfilled, that leaflet that is available there* (E19). *What makes it more difficult is ourselves [...] the lack of interest of the employee, because at the time we see, comment, but we don't stop what we are doing and go there [...], sometimes it is not even a matter of time, sometimes it is really lack of stopping and going to do it* (E6).

The insufficient number of health professionals and the demands of activities in each work shift result in an overload of activities, and become an obstacle for reporting adverse health events. *The quantity of professional makes it difficult because sometimes we have so much to do there, you don't make the report at that time, you end up forgetting* (E10). *Sometimes it's time too, I think it depends on the department. There are situations that end up not being reported due to lack of time, being in a rush, lack of employees at that time* (E31).

Given the fact that any professional can report adverse health events, there are still doubts as to who is responsible for reporting, considering that the person who identifies the adverse event is not always the same person who experienced it. *I follow NUSEP, but we seem to be getting into an area that is not ours, do you understand? [...] you see the things that happen, but it seems to be more of a nursing task* (E26). *Because the professionals think that the only person who can report is the nurse, and it is not who sees the event who is the reporter, so it could be a nursing technician, it could be a nutritionist, it could be a doctor, a physiotherapist, so who experiences the event can be responsible for making the report*(E27).

Generally, nursing technicians communicate the adverse event to the nurse, thus transferring the task of the reporting process to this professional. [...] *but many think that it is only the nurse who should report* (E22). [...] *sometimes, I rely on my nurse on duty for that, I tell him or her if I don't have time to do it, he knows, if he can do it or tell me at another time* (E9) [...] *I communicate to the nurse, I call him or her to see the situation, to see what is happening, then he or she goes to get the report form* (E8).

Another aspect is related to the lack of support from managers, which negatively effects the reporting process. *I have an idea today of what is important to do, regardless of who it is, but sometimes I don't have support, sometimes even from the nurse, I needed to have a little more support from her to be able to report the adverse events that happen in the sector* (E13).

It was emphasized that non-compliance and lack of a routine for the process of reporting adverse health events in the institution is a problem in the service. *A protocol is missing. There may even be a protocol, but it does not have a sequence, it is as if each one came here, did as they want, the way they want* (E38). *Actually, there is no standardization, no protocol for this, so I think it depends a lot on the individual practice of each professional, this might make this issue difficult, once this is somehow parameterized, I believe things become mandatory, this starts to become a reporting routine* (E39).

The same occurs with the existing report form in the institution, highlighting the lack of knowledge of this instrument or difficulties regarding its completion. [...] *I did not know that there was a specific form for this, now I know* (E33). *I find that form very complicated [...] there are many options to choose*

from on the form, almost every time I went to report I did not find one that fits, so I described what happened, there is the option to describe what happened (E5).

The process of reporting adverse health events is not related to identifying or punishing those responsible for their occurrence. However, the discourses express the constant fear of punishment and reprisal in the daily life of health professionals. *I think what makes it more difficult ... I'm sure, in any hospital, is the fear of not being anonymous (E34). [...] maybe fear, I think many people avoid reporting because they are afraid of the consequence of their report (E33).*

There is evidence that a reprisal attitude negatively effects the completion of the reporting process. *[...] I had a negative experience recently that caused me to stop making any reports, it was the day I noticed something that I believed deserved to be reported and I was very upset about that, I didn't want to offend anyone or get somebody in trouble(E11).*

The reporting process of adverse health events can lead to situations that cause fear of exposing and / or causing problems for a co-worker, even if identifying professionals is not necessary, but only the description of the adverse event in detail. *[...] we don't want to report because it can cause problems for others [...] (E7). Many people think that when they report, they are in danger getting a reputation in the department because they made a possible error (E25).*

The data also illustrate the need for health professionals to understand and disseminate patient safety culture. This is a delicate process, but it is necessary for the institution to incorporate the adverse event reporting process as a care objective, without placing blame. *Showing that the intention is not to punish, but to improve (E2). [...] I think it's losing the fear that this is being done to cause problems for a co-worker, I think we need to change the mind of who we work with (E3). [...] If the team lose this fear and had a different point of view, that this is for the benefit of the patient and for the sake of our work, I think it would make it easier (E3).*

They demonstrated the need to institute the process of reporting adverse health events continuously, with commitment and responsibility. *[...] I could report more (E28). I don't think that the team sees the importance of reporting, because now that I understand it a little better I see that many things happen, but are not reported(E2).*

DISCUSSION

In the hospital routine, health professionals experience and recognize that adverse health events are present in patient care and that the reporting process is fundamental to improve patient safety. However, in the different care settings, the process of reporting adverse health events is fragmented, this is partly due to the contrasting perspective of professionals regarding the theme, highlighting the facilities and the obstacles that need to be overcome.

As a facilitating aspect, having knowledge about the process of reporting adverse health events and the objective of tracking care errors was cited as an important element for patient safety. The commitment of health professionals to the reporting of adverse events contributes to the development of a database which identifies reported errors and may contribute to the application of new rules and techniques directed at patient care.¹² However, in relation to knowledge, the lack of it and other information surrounding the reporting process, as well as which adverse events are reportable, were cited as obstacles to the effectiveness of the reporting process, contributing to the underreporting of adverse events in institutions.¹³⁻¹⁵

In this scenario, the NUSEP was an important support and a reference for safe care, ratifying the proposal by the National Program for Patient Safety.¹⁶ In this context, the performance of a multiprofessional team is essential to analyze adverse health events, assist in the implementation of safety-related protocols, develop new initiatives and disseminate information on patient safety.^{7,17-18}

Among the actions of NUSEP is the implementation of an anonymous and voluntary adverse events manual, which health professionals highlighted as being useful for making reports, considering its easy access and completion. It is noteworthy that the bases for a patient safety program are voluntary reporting systems, using different methods of reporting, such as the printed or computerized form, via telephone, among others. However, the manual with printed forms are the most used in Brazilian hospitals.¹⁹

In this context, the importance of health institutions having a confidential reporting system for adverse health events which encourages professionals to report is evident as it facilitates the identification of issues regarding care and highlights the need to develop more safer actions to reduce errors.²⁰⁻²¹

The importance of feedback from reports was highlighted as a positive point for professionals to comply with the process of reporting adverse health events. It is believed that the feedback from reports enables the recognition of this process, with the intention to correct the errors and outline strategies for improving the quality of care and preventing these occurrences.²² Likewise, feedback is a management tool that enables the professional to reflect on their care, benefiting professional improvement, and enables the professional to feel like an important part of the process.¹³

In addition, the improvement of educational strategies was identified as a facilitating element to better understand patient safety and the process of reporting adverse health events. The implementation of educational actions, together with measures to support professionals in relation to the occurrence of adverse events, can increase the compliance of professionals to the service, improve knowledge and the communication of risks and the reporting of adverse events.^{6,21,23-25} However, it is clear that institutions and health professionals need to overcome obstacles in order to comply with the process of reporting adverse health events.

The lack of knowledge regarding the report form and / or the difficulty of completing it was highlighted by health professionals as a factor related to the non-compliance of reporting. Thus, it is understood that managers must review the disclosure and / or reformulation of this document, corroborating with the study and the health professionals who recommend readjusting the report form in order to make it more practical and dynamic.²⁶

Health professionals reported not being aware of the reporting process, illustrating the lack of protocols and a written routine regarding adverse health event reports. It is important to adopt behaviors based on protocols, guidelines and standard operating procedures, improving patient safety knowledge when dealing with an adverse event.^{18,27}

Authors of studies performed in Brazil highlight work overload, forgetfulness and non-valuation of adverse health events as factors associated with the non-compliance of reporting events,^{15,25,28} which are issues also referenced in the results of this study.

Health professionals remain unsure regarding who should report the adverse health event, regardless of understanding the importance of the reporting process. This situation is present regardless of the professional category, but is more pronounced in relation to the nursing staff. Although the reporting process is inherent to care and involves the multidisciplinary team, this task often falls on the nurse. One study showed, that according to nursing professionals, as well as other health categories, that the nurse is responsible for reporting adverse events. In this context, it becomes essential to demystify nurse-centered reporting, through guidance, information and encouraging the participation of all professionals in this process.²⁹

It is important to stress that the identification and accountability for the adverse event must be cross-sectional, and health professionals should know to report their participation in the events and outline strategies to reduce harm and avoid further occurrences. Therefore, reporting adverse events is not the responsibility of a single professional category.²⁷⁻²⁸

The lack of support from managers may lead to the underreporting of adverse events in the present study, as highlighted by professionals. Reporting adverse events is understood to be a strategy that combats system errors and should be encouraged by hospital management.³⁰ It is the responsibility of managers and leaders to engage with care professionals in the planning and development of actions aimed at quality service and care.³¹

In relation to the obstacles in the reporting process, we highlight guilt, fear of punishment and reprisal, which demonstrates a punitive culture in the studied setting. The same was also reported by health professionals in other studies.^{12,21,32-33}

In addition, it was also evident that health professionals are concerned about causing problems for their co-workers if they report errors, adding to the findings of the study, when they raised the issue that health professionals fear the reaction of managers and even their colleagues, and demonstrated showing feelings of fear of being punished and reprimanded.¹²

Institutions which use punishment and guilt may cause the omission of adverse health events reports, making it difficult to build a culture of patient safety.^{21,32} Therefore, it is necessary to replace a punitive paradigm in institutions for another which is focused on the education of health professionals, where there is effective communication between professionals, proactivity against adverse events, reporting of adverse events, encouraged by a non-punitive culture, and learning based on their own mistakes, providing a safer patient environment.³⁴

Strategies focused on education were highlighted by health professionals as a way to improve the understanding of patient safety and the process of reporting adverse health events. The implementation of educational actions, together with strategies that support professionals in relation to the occurrence of adverse events, can increase the compliance of professionals to the service, improve knowledge and the communication of risks and reporting of adverse events, with the intention of analyzing, correcting and preventing them.²³⁻²⁴

Given the obstacles presented, it is extremely important to implement strategies for a permanent education program, as well as the implementation of protocols, guidelines and other aspects that should be priorities for managers, the patient safety center and health care professionals.³⁵

Strategies with a focus on communication and educational practice are needed to disseminate information about the reporting process, as well as to promote accountability of health professionals without culpability, aimed at improved prevention practices for safe care.

CONCLUSION

The reporting process is permeated by positive aspects and obstacles that must be overcome. Some positive aspects are related to the support of NUSEP, the feedback from reports and the recognition of the importance of reporting adverse health events.

On the other hand, this practice illustrates the fear of punishment, lack of knowledge, work overload and lack of commitment of professionals, leading to the underreporting of adverse health events. Another aspect that makes the reporting process difficult is related to non-compliance with a routine and unpreparedness to use the reporting form in the institution.

This study found the main difficulties which are also reported in other studies with different contexts and realities, showing a systemic problem which originates in the training of health professionals, the continuity of educational processes and the support of institutional management. In contrast, the subjects understand the importance of working on these aspects for their quality care and patient safety.

As an extension of this study, it is recommended to evaluate the techniques and actions that are being developed, measure their impact on the incentive and strengthen the reporting network in the institution and to seek the most effective educational techniques in this reality, beyond just information, with the involvement health professionals and make them co-responsible for these actions,

so that it does not only come from the needs of management, but also from day to day care, leading to improved identification and reporting of adverse health events.

Thus, constant revision on the subject is foreseen, as well as the insertion of patients and families in this context.

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NOTES

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There is no conflict of interest.

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