Original Article

Between error and success: promoting patient safety based on the reporting of adverse events

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ABSTRACT

This documentary, interpretative, qualitative study uses data collected from newspapers from two countries, with the objective of interpreting how news of nursing errors in the media can contribute to the understanding of issues related to patient safety. Hermeneutic analysis was carried out based on Labor Process Theory and the Theory of Communicative Action, with the assistance of Atlas.ti® software. This resulted in three thematic categories that enabled understanding of problems related to healthcare funding, opportunities to provide society with better understanding of the problem and possibilities of representing and strengthening professional identity. It was concluded that communications media can be an important ally to nursing in the pursuit of better working conditions and by providing visibility to problems themselves and the under-funding of healthcare, as the news enables approximation or distancing, if inserted in the historical, political and social context of those involved.

Descriptors: Patient Safety; Communications Media; Nursing; News; Risk Management.

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INTRODUCTION

With the expansion of means of mass communication, information began to be supplied at a rate that is difficult to keep up with. Within this scenario, healthcare occupies media content with issues related to quality of healthcare, especially in reference to overcrowding of emergency services, shortage of healthcare professionals, funding of healthcare services and errors during care[1]. Care errors and adverse events in healthcare have become the target of studies in various countries, especially due to their high incidence and the consequences of these errors, with this problem being neither localized nor easily resolved, hence the need for ongoing discussions with different approaches.

As such, there is a strong worldwide movement signaling important changes in the context of healthcare, with the aim of guaranteeing safer, higher quality environments. These changes have been implemented based on multiple efforts arising from studies that were essential in providing scientific backing for these changes. Issues of patient safety and the quality of healthcare, these being urgent demands of this century, instigated the creation of the "World Alliance For Patient Safety" project of the World Health Organization (WHO), which aims to promote improvements through worldwide campaigns and programs[2].

As a result, each country drew up its own plan to improve healthcare safety and meet the targets established worldwide. In Brazil, the National Patient Safety Program (NPSP) (Programa Nacional de Segurança do Paciente - PNSP) was created in 2013 to reduce the incidence of errors (or adverse events, in the terminology used by the WHO) and later establish the compulsory requirement of implanting the Patient Safety Nucleus (PSN) (Núcleo de Segurança do Paciente - NSP), to put safety plans into practice and notify of adverse events[2].

In Portugal, based on determinants for the quality of healthcare services stipulated by the General Director of Healthcare, the Portuguese Order of Nurses (NO) revised and updated the Quality Standards of Nursing Care, an official document aiming at stimulating high-quality, safe nursing care throughout Portuguese territory[3-4].

Although actions carried out in the name of safer care have promoted and considerably modified healthcare practices around the world – as found in Dutch hospitals that managed to reduce avoidable adverse events by 45% in a period of four years, analyzing 16,000 hospitalizations[5] – in general, cases of errors in healthcare are still common, being reported in journalistic media, whether in print or on television, on social networks or via other forms of communication.

Thus, the necessity arises to broaden the view of this problem, using an approach that seeks to identify ways of understanding the complexity of nursing errors reported in the media. This understanding goes beyond the classic cause-and-effect approach of understanding determined phenomena and through interpretation seeks to reveal content, hitherto immersed in language. Previous studies have shown a predominance of medication errors in news reports, classifying the majority of findings as extremely serious, confirming the necessity to improve medication systems in healthcare institutions[1,6].

The present study is justified by the issue of patient safety, which should be tirelessly and comprehensively pursued, and by the way that information is passed on to society, to be aligned with the complexity these incidents involve, considering that communications media constitutes an effective tool for the disclosure, explanation, problematization and understanding of certain phenomena. Moreover, a lack of studies of this nature has been observed, bearing in mind that the majority of studies on this issue seek to identify risk factors associated with

errors and their complications[7]. Thus, the present study proposes to interpret how news coverage of nursing errors can contribute to the understanding of issues related to patient safety.

METHOD

This retrospective, documentary study adopted a qualitative and interpretative approach, using a data source of news reported in high-circulation newspapers in Brazil and Portugal over the period from January 2012 to December 2016. Data was collected through clipping or temporary subscription to the newspapers and occurred between October 2015 and December 2016, gathering all news stories referring to nursing errors disclosed in the media.

The *corpus* of the study was composed of 112 disclosed news stories that met the inclusion criteria of complete, reported texts referring to an error resulting from nursing care. Of these, 18 reports were published in Portugal and 94 in Brazil. News referring to the errors of other professionals, news related to other forms of conduct considered wrong, such as stealing or harassment, or texts in which nursing participation was not specified were excluded, as this information was considered to be a *sine qua non* condition for the present study.

The collected data were stored on the Atlas.ti® software and text analysis used Karl Marx's labor process theory and Jürgen Habermas' theory of communicative action as reference, with the objective of understanding, through communication, the manifest forms of nursing work that hide social problems, within a historical context. Therefore, the study drew on hermeneutics to achieve the proposed objective, following the steps suggested by Paul Ricoeur, which consist of the initial reading of the text (creating the first recorded notes), the search for meaning, and of appropriation (when the message is revealed). This process enables demonstration of an explicit meaning and hides the other meaning that can only be understood through the first[8].

With regards to ethics, the collected data is available to society electronically and the study did not directly involve people, dispensing with the need for analysis by research ethics committees. Nonetheless, the nurses, patients, families, newspapers and journalists were not identified. The news reports were identified by codes composed of the letter J, with the initial of the country (B – Brazil and P – Portugal), plus letters identifying the region and the order number.

Finally, three principal analytical categories were constructed and the error information was associated with possible units of content interpretation, so as to provide means of understanding that enable comprehension of the problem, without inferring judgments. This was characterized by a dialectic movement in which the explicit and the implicit in the texts were articulated in such a way that the formulated categories demonstrated the relevance for this way of looking at safety.

RESULTS AND DISCUSSION

Interpretative analysis of the results resulted in three principal themes, each of which is related to codified information in the texts, together with possible nuclei of meaning that may somehow contribute to understanding the magnitude of the problem, providing reflection on the possibilities that media exposure can lead to, given the complexity of reported incidents.

Money as an implicit risk factor

The financial factor in healthcare services has always been a problem in various countries. Ambiguously, money is the problem and the solution to most healthcare issues, given that the greater the investment in healthcare actions, in all areas of care provided to the population, the better the healthcare results. Likewise, the absence/lack of money has a direct impact in the form of negative results.

Investment in the healthcare sector, as well as resource management, has been the cause for discussion, precisely because of the budget deficits that countries constantly suffer, especially for not putting health as a priority of political and administrative action[9-10]. Healthcare is seen by the population as a priority in most countries, with the exception of some cases in which other issues related to basic survival, such as employment and income, are seen as having greater relevance[11].

In this sense, it is not possible to disconnect the financial problem of healthcare from issues of patient safety and quality of care, as there is a strong influence of financial incentive on risk and accident management. Thus, based on what was reported on nursing errors, a table was drawn up to identify explicit information enabling association with problems of a budgetary nature.

Table 1: Types of error, consequences, attributed causes and risk factors relating to funding of the healthcare sector.

Type of error	Consequence	Attributed cause	Risk factor	Implicit Factor
Explicit data in the analyzed report			**Data related to the reported error**	
Medication – wrong route	Complications in health situation, increased length of hospitalization	Overwork, substandard equipment	Staff shortages, staff turnover, structural problems	**Funding**
Infection	Death, worsening of health situation, increased length of hospitalization			
Fall	Fracture, surgery, increased length of hospitalization			
Medication – wrong substance	Death, aftereffects, prolonged hospitalization	Similar labels or packaging, storage problems	Problems related to the purchase of materials and supplies, structural problems	
Forgetting material (surgical or clinical).	Surgery, increased length of hospitalization, death, complications in health situation	Distraction, overwork, professional negligence	Staff shortages, staff turnover, lack of training/permanent education	
Risk classification	Death and complications in health situation	Overwork	Staff shortages, staff turnover, lack of training/permanent education	

In Brazil, public spending on healthcare has been a little over 40% of total spending on health in the country, which probably won't improve substantially in the coming years[12-13]. This pessimism has been reinforced as a result of the approval of Constitutional Amendment nº 95/2016, which instituted a new fiscal regime limiting public spending over the next 20 years. Therefore, this is contrary to the forward march of developed countries, in which mean public investment is above 70% (in relation to total spending on healthcare)[12], for countries from the Organization for Economic Cooperation and Development (OECD), a level which should continue or grow, as long as the debate on the universal right to health grows.

In Portugal, problems have emerged in healthcare since the financial crisis of 2010, when there were severe spending cuts and a significant increase in taxes[14]. Faced with the urgent need to restrict expenditure, the area that most suffered the consequences of the crisis, in the short term, was healthcare. It is no accident that threats of nursing strikes or the actual occurrence of strikes occurred on an almost monthly basis. There are thousands of hours owed to professionals who, by contract, do not receive a salary in accordance with what is expected for the profession and don't even have their specialties recognized[15].

The big issue raised here is that the lower the investment in actions increasing patient safety in working environments, the greater the cost of dealing with the consequences of errors and accidents generated by these unsafe environments. Increased hospitalization time, admissions to beds in Intensive Care Units (ICU), the need for new (unforeseen) surgeries and other forms of treatment, recovery and rehabilitation, may generate exorbitant expenses not foreseen in the budgets of institutions, whereby such costs can increase by more than 200% in comparison to foreseen spending on patients not suffering such incidents[16].

The issue of spending also extends to cases that end up being the target of litigious lawsuits, which can generate high costs, especially with damages payments proscribed in the specific legislation of each country. In the case of Brazil, the Federal Constitution, the Consumer Defense Code (CDC) and the Civil Process Code hold up the rights of healthcare consumers when seeking reparation for physical, material or moral injury.

Therefore, this constitutes a result-consequence-result cycle, in which lack of investment in the labor force and in the structure of the institutions with the aim of favoring patient safety, generates negative consequences for the healthcare of the population, which in turn requires further care beyond the necessary, impacting on the budget. Thus, with a compromised budget it becomes more and more difficult to invest in the labor force and in the structure to better manage the risks arising in healthcare.

Errors as a wake-up call – exposure to raise awareness

Media exposure is an effective way of drawing attention to issues that seem immersed in the complexity of healthcare services. As such, the media has the power to influence opinion, mediating the contexts and rules of contemporary sociability, taking root in territory in which, nowadays, the existence of communities is regulated[17].

Communications on healthcare in the media consider three aspects: the context of news production, the capitalist logic of different forms of communication media and the public for whom the information is destined. Thus, healthcare is a recurrent theme and is one with major repercussions for serving issues of a commercial nature (audience and profit) and for winning over the public[18].

The increased media visibility for errors arising from healthcare comes from cases such as that of Boston Globe journalist, Betsy Lehman, who died after receiving high doses of Cyclophosphamide for four consecutive days. This episode resulted in the implementation of actions in the field of safety in the administration of medication, and the team of professionals that took care of the journalist suffered no disciplinary action as there was a raising of awareness as to the problem to avoid further incidents. The event itself resulted in the creation of the “Betsy Lehman Center for Patient Safety and Medical Error Reduction”, which aims to reduce medication errors in hospital care[19].

Therefore, errors reported in the media can serve as impetus for safety actions, both on the part of professionals and of the healthcare institutions, as well as on the part of patients, who tend to become more vigilant with their care. In reported cases, it is shown that denouncing errors can serve as impetus to rethink nursing practices, as there is a fear among professionals that an error with serious consequences may become reality. Fear is also a protective factor and makes people (re)think their daily practices, leaving behind automatic reliance on technology.

In some cases, even the victim's family recognizes the educative character of error visibility and the consequences for professionals. Moreover, healthcare institutions review their care procedures and signpost equipment/medication representing greater danger.

Soon after receiving the wrong medication, the boy's parents sought out the Civil Police and made a statement on the case. "I didn't do this to harm anyone, but to serve as a warning to others" (JBPR11).
Braga Hospital admitted, from the outset, "human error" in the programming of equipment and announced that in light of the seriousness of the occurrence, the executive commission has "immediately" triggered a process of identifying supplementary measures to prevent the occurrence of new errors (JPMI3).

The way in which an error is reported may lead to ideologies that collaborate for the safety of healthcare services. This is not ideology in the form of power and domination, but ideology for the organization of society, serving to direct people, intellectually and morally, in their daily conducts and thinking. As such, healthcare institutions should avoid punitive measures, while communications media should avoid broadcasting errors in an incisive or biased manner, so as to further stimulate a culture of universal safety, without guilty or innocent parties, only thinking of giving the best of oneself, for oneself and for others.

Constant struggle for future glory – professional representation and identity

The exposure of nursing in the media, depending on the way in which the news is published, can constitute a vehicle for the representation and strengthening of professional identity. Even in strongly adverse situations, as in cases involving care errors, this is a rare opportunity to show society the little recognized, or even unknown, aspects of the profession.

Opportunities for professional representation were identified in 23 news reports, with special attention for statements issued by professional representation bodies. The statements refer to information that aims to protect the professionals accused of error, especially when this information shows constant participation in the inspection of healthcare services and in the way administrative or judicial processes are being conducted. Statements also originate from the judiciary, causing problematic situations in healthcare work to be recognized, as seen in the statement of the ruling of a high court judge:

In the opinion of the magistrate, it was unavoidable that at some time the problems confronted at the front line of public healthcare would result in lawsuits in the Justice system. "Every day, what we see are hospitals with substandard conditions of service, understaffed, and with a lack of medication, supplies and equipment. All these situations provoke pressure on the professional, who is then even further overburdened and subject to committing errors", she stated. With high demand and few teams, patients and doctors are in the same situation (JBMG10).

There is a dichotomy in the way the media has approached certain situations surrounding the benefits of unrestricted, rapid circulation of information, and the right to preserving people's intimacy and privacy. That is, there are two aspects, both legal and social; the protection of privacy (more and more vulnerable) and the freedom of expression of the press[20].

As such, by providing a space so that representative entities of nursing may clarify situations and even question some of the information presented, new forms of understanding can be disclosed, protecting the image of the profession. The current context of nursing in the two researched countries is characterized by constant struggles for better working conditions. In Brazil there are two draft bills which have been attempting to regulate working hours and remuneration in nursing for years, as good working conditions are in fact a requirement for safer nursing practices[21]. However, this is a difficult issue to resolve that has been dragging on for decades, especially given that it involves financial resources, and, when it comes to healthcare, this is not a priority on the country's political agenda.

In Portugal, this situation is not much different. Strikes are constant and every year the demands are the same: working hours, salary, overtime, specialist nurses without due recognition and understaffing. In this respect, the Order of Nurses remains supportive of the strikes and grievances, and, as such, uses its own newsletters and statements in the press[22].

In the same way, Brazilian councils and unions attempt to give greater visibility to the struggles of nursing, with a view to increasing appreciation of the profession and the recovery of professional identity, with "respect to the external perception (positive or negative) that society and/or individuals may have of a person, institution or organization"[23]. The image of nursing should not be associated with the negative result of their work. When incidents of errors occur, these should be understood in their totality, to avoid society transposing negative values onto the entire profession based on isolated incidents, which are often not totally clarified.

Media exposure can contribute to society understanding the complexity of the problem better and can also constitute a space of support for the profession, for its struggles and future conquests, which are for the good of all.

FINAL CONSIDERATIONS

Interpretation is always an arduous task and requires an attentive eye on the part of the researcher to what is not shown in the data source. However, it is possible and may clarify other ways of looking at the same phenomenon, so as to expand the investigation beyond what was proposed *a priori*. The present study enables the affirmation that mass communications media, such as newspapers, can be important allies to nursing in the search for improved working conditions, contributing to bringing visibility to the problem itself and to the underfunding of healthcare.

Although news stories are not always totally clear, the texts always enable approximation or distancing in relation to information, inserting it into the historical, political and social context of those involved to go deeper into certain aspects relevant to understanding.

With respect to social relevance, the present study indicates the care journalists should take in the transmission of information when portraying these incidents, which are linked to the clarity of information, issues

in the scope of ethics and politics, the partiality of patient/family information, and to the objective reality for society. From the scientific point of view, this way of investigating the nursing error phenomenon contributed to understanding the diversity of nuances that evolve nursing work and the understanding of its social importance, bearing in mind the many adversities to providing quality work with safety.

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