



ANALYSIS OF THE COMMUNICATION OF ADVERSE EVENTS UNDER THE PERSPECTIVE OF ASSISTANT NURSES

ANÁLISE DA COMUNICAÇÃO DE EVENTOS ADVERSOS NA PERSPECTIVA DE ENFERMEIROS ASSISTENCIAIS

ANÁLISIS DE LA COMUNICACIÓN DE EVENTOS ADVERSOS EN LA PERSPECTIVA DE ENFERMEROS ASISTENCIALES

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This descriptive study aimed to analyze the process of communicating adverse events in the hospital context, from the nurses' perspective. Data was collected in January 2013 in a public hospital in Fortaleza, Ceará, Brazil. A semi-structured interview was held with 37 nurses, covering guiding questions regarding the communication/recording of adverse events. It was found that communication of adverse events exists in the service, but that cases are under-reported and inadequately analyzed; the nurses were not unanimous in identifying the documents indicated for recording events; and a punitive culture predominates in the situations which generate adverse events, evidenced by reports of practices of reprimanding and punishment of the professionals. It is concluded that encouraging appropriate communication of adverse events in the service is necessary, considering recording as indispensable in the organizational communication process, as this is the source of data for analyzing the occurrence of adverse events and ensures patient safety.

Descriptors: Nursing; Nursing Records; Safety Management; Quality of Health Care; Patient Safety.

Estudo descritivo que objetivou analisar o processo de comunicação de eventos adversos no contexto hospitalar, sob a perspectiva de enfermeiros assistenciais. Os dados foram coletados em janeiro de 2013 em hospital público de Fortaleza-CE, Brasil. Aplicou-se entrevista semiestruturada a 37 enfermeiros, abrangendo questões norteadoras sobre comunicação/registo de eventos adversos. Constatou-se que existe comunicação de eventos adversos no serviço, porém há subnotificação e análise inadequada dos casos; os enfermeiros não foram unânimes na identificação dos documentos indicados para registo dos eventos; e prevalece a cultura punitiva nas situações que geram eventos adversos, evidenciada pelos relatos de práticas de repreensão e punição dos profissionais. Conclui-se que é necessário incentivar a comunicação adequada de eventos adversos no serviço, considerando o registo como indispensável no processo de comunicação organizacional, pois é fonte de dados para análise da ocorrência de eventos adversos e garante segurança ao paciente.

Descritores: Enfermagem; Registros de Enfermagem; Gerenciamento de Segurança; Qualidade da Assistência à Saúde; Segurança do Paciente.

Estudio descriptivo, cuyo objetivo fue analizar el proceso de comunicación de eventos adversos en medio hospitalario, bajo la perspectiva de enfermeros. Los datos fueron recolectados en enero de 2013 en hospital público de Fortaleza-CE, Brasil. Se aplicó entrevista semiestructurada a 37 enfermeros, incluyendo preguntas acerca de la comunicación/registo de eventos adversos. Se encontró comunicación de eventos adversos en el servicio, pero con subregistro de casos y análisis inadecuados; los enfermeros no fueron unánimes en identificar los documentos para registro de eventos; y prevalece la cultura punitiva en situaciones que generan eventos adversos, como señalan los informes de prácticas de amonestación y castigo de los profesionales. En conclusión, es necesario fomentar la comunicación adecuada de eventos adversos en el servicio, teniendo en cuenta que el registro es esencial en el proceso de comunicación organizacional, ya que es fuente de datos para análisis de eventos adversos y garantiza seguridad del paciente.

Descritores: Enfermería; Registros de Enfermería; Administración de la Seguridad; Calidad de la Atención de Salud; Seguridad del Paciente.

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INTRODUCTION

There is a growing preoccupation among health service providers with promoting a different type of care, more focussed on the patient, with less waste, lower costs and better results⁽¹⁾.

In this context, one of the requirements for quality care is that the health organizations have a communication channel which allows the teams to transmit and receive information clearly and precisely⁽²⁾, ensuring improvements in decision-making, in conflict resolution, and in the achievement of institutional goals.

In its turn, clinical recording is indispensable in the process of organizational communication, as it consists of the written form of the transmission of data related to the client provided to him/her during inpatient treatment. Furthermore, it is considered an essential element in the process of human care, as, when drafted in full and in accordance with reality, it allows permanent communication within the multidisciplinary team, as well as being able to be used for other purposes, such as research, audits and legal proceedings, among others⁽³⁾.

On a worldwide scale, it has been made known that communication failures are often the main causes of errors and, consequently, of adverse events⁽²⁾. The former are defined as the non-undertaking of a planned action satisfactorily, or as the application of an incorrect plan. The latter are defined as incidents which result in harm to a patient; for example, if a unit of blood is infused incorrectly and the patient dies from a hemolytic reaction⁽⁴⁾. Such complications affect, on average, 10% of hospital admissions and currently constitute one of the largest challenges to the improvement of quality in the area of health⁽⁵⁾.

In this way, an adequate record of the information in the patient's hospital records is essential for ensuring the patient's safety, as it is considered a source of data for analysis of adverse events, and, at the same time, is an indicator for the quality of the health care⁽⁶⁾.

Nevertheless, it is known that the under-reporting of adverse events is frequent, this being associated with fear of punishment on the part of the health professionals, who are afraid of losing their jobs or becoming involved in ethical-legal processes. This fact hinders reliable analysis of the risks and events which occur, and of the repercussions on the patient's health, in addition to making it impossible to implement measures for the avoidance of further occurrences⁽⁷⁾.

In this perspective, it is of fundamental importance that the health organizations establish specific policies and procedures for the reporting and publicizing of adverse events. Considering the need to develop strategies, products and actions regarding patient safety, directed at managers, health professionals and health service users, which would make it possible to promote the mitigation of the occurrence of adverse events in health care, on the 1st of April 2013 the National Patient Safety Program (PNSP) was instituted. This aims to contribute to the qualification of the health care in all the health establishments in Brazilian territory⁽⁸⁾.

Furthermore, there is greater awareness, at a national level, that health professionals need to be educated in relation to the measures to be taken considering failures, and encouraged to adopt an honest stance regarding errors, without fear of punishment, and be involved in the search for safe care for the patients.

In the largest public hospital in the state of Ceará, for example, the process of communicating adverse events is directed by the Risk Management Service, with professionals from the multiprofessional team responsible for advising the service's workers on how to proceed in the appropriate recording of these events and how to use the existing notification bulletins, as well as on how to undertake an active search for critical incidents in the units.

However, there is still constant publicising of the inconsistency and/or scarcity of nursing records and

notifications of adverse events in the ambit of hospital care.

In the light of the above, it is asked: what is the nurses' view regarding the process of communicating adverse events in the hospital context?

It was aimed, therefore, to analyze the process of communicating adverse events in the hospital context, from the perspective of the nurses directly involved in patient care.

METHOD

This is a descriptive study with a qualitative approach, undertaken in January 2013 in the largest public hospital in Fortaleza (CE). It is an excerpt from research with a larger scope titled: Safety in the management of nursing care: focus on the types of error related to health care.

37 nurses participated in the research, who met the following inclusion criteria: to have worked in the institution for over one year and not to have a managerial position. The nurses were recruited in different units of the hospital, their number being established through theoretical saturation of the data collected in the interviews, as the information provided by further participants added little to the information already obtained, no longer contributing significantly to the improvement of the theoretical reflection grounded in the data which had been collected.

For data collection, a semi-structured interview was used, held after the nurses' shift and recorded with the aim of ensuring the process greater fluency, fidelity and speed, as well as better interaction between interviewer and interviewee.

This interview had two parts: the first, with socio-demographic and professional data (age; sex; period of time since qualification and length of work in the profession, institution and unit; the department the professional worked in; the shift; and post-graduate

qualifications); and the second, which contained the following questions: 1. In your practice, you being the person responsible for, or having witnessed the occurrence of, an adverse event, what is your conduct? 2. In the unit in which you work, are you aware of an instrument which facilitates the recording and measuring of adverse events? If so, what? 3. Is there any incentive to communicate and record adverse events in the unit/institution? Explain.

Following that, the interviews were transcribed in full, and underwent an analytical and descriptive process based on the framework of Content Analysis, considered one of the techniques best suited to qualitative investigation, following the phases of: pre-analysis; exploration of the material; treatment of the results, inference and interpretation. From this analysis, 71 registration units (RU) emerged, that is, 71 phrases which characterized units of meaning to codify⁽⁹⁾.

These RU were presented in three empirical categories, which arose from the reading and in-depth analysis of the discourses, being titled: 1. Attitudes related to the communication of the occurrence of adverse events; 2. Instruments which facilitate the communication of adverse events; 3. The communication of the adverse event and its implications for patient safety.

The interviewees' accounts were transcribed in a Microsoft Word document to form the corpus of analysis, being identified by the letter N (for Nurse), followed by a cardinal number, according to the sequence of the interviews.

The discussion of the findings was undertaken through deepening, comparison and inferences based in the most recent scientific evidence on Patient Safety at a national and international level. This is a conceptual basis which one can consider, currently, to be a theoretical framework within the large area of Nursing knowledge and, more specifically, of the Management of Nursing.

The project followed all the recommendations of Resolution 196/96 of the National Health Council, and data collection was only initiated following the approval of the Research Ethics Committee of the State University of Ceará (N. 181.754/12), authorization from the institution's Nursing Management, and signing of the Terms of Free and Informed Consent (TFIC).

RESULTS

Participation in the study was predominantly of female staff (32), with a mean age range of 33 ± 7.3 years, the majority of whom had postgraduate qualifications (28), allocated to clinical and surgical inpatient units (18), with recent professional qualification, from one to five years previously, and a mean length of service in the institution which was also recent, of up to five years (30).

71 registration units (RU) were noted in the discourses of the nurses interviewed. These were distributed in three categories as presented below:

Category 1. Attitudes related to the communication of the occurrence of an adverse event

In this category, one finds the majority of the RU, 40 (56.3%), addressing the attitudes taken by the nurses in relation to the occurrence of adverse events experienced in their practice. Among the actions, the following stand out: reprimanding the person responsible for the error; establishing efficient communication with those involved regarding the event; proceeding to make a records on forms and clarifying regarding the service's norms and routines for the performance of safe practices: *We work with a multiprofessional team and it's not always the case that everybody has been advised regarding the institution's norms and routines, so, from time to time we see some error or other, we give a reprimand, explain to the colleague how it works, and notify* (N3). *Here in Brazil, the policy is as follows: an error happens, it's punishment. In other countries, no, the error, if it exists, it's there so that it doesn't happen*

again (N6). *The measures applicable in relation to the professional who made the error is that you have to go up to them, you have to talk with them and warn them, or it's a punishment* (N14).

Other nurses stated that they proceed to communicate the event to the nursing management, believing in the latter's responsibility for recording adverse events and ensuring the rapid and efficacious resolution of the event's causes and consequences. *In this unit, we don't record the errors, we pass them on to our coordinator and they record them* (N33). *We communicate to the management to avoid these problems which can cause harm to the work and to the patient* (N21). *The coordinators are very receptive, we communicate any problem there is, in relation to any error* (N9).

Some accounts demonstrate that the interviewees perform their roles as educators in the work environment, through sensitizing the team members regarding the importance of recording/notifying and of commitment to the work process, as they are responsible for the results obtained by the whole team. *These are the actions taken: register the patient's progression in his or her patient chart, write in the nursing occurrences book, establish communication with the doctor and the whole team* (N1). *What I do is act, discreetly speak with the professional and say what is correct* (N30). *We always try to indicate to the team to see if the technicians can be more aware* (N23).

The nursing professionals can also develop strategic attitudes which include the team's involvement in the notification of the adverse events and the discussion of their causes in formal meetings, aiming to implement preventive actions. Such practices were observed in the following accounts: *Having good communication with the team, having a good relationship with the team, and providing best outcomes to the patient* (N17). *There are always meetings, considering that this is a teaching hospital, with lots of residents and academics, so we always leave everything recorded* (N10).

Finally, some interviewees described the practice of informal communication existing in the service, and the omission of the adverse events among those involved, inferring that they only passed on to the management the more serious cases: *The evaluation has been only verbal* (N29). *It stays among us, depending on the seriousness, there are things which management needs to know*

about, but depending, there are things they don't, we sort it out. If it is something resolvable, which doesn't cause significant harm to the patient, we keep it within the team (N7). If we see something, if it was something fatal, an error, it's communicated with urgency to the senior staff member on duty (N8).

Category 2. Instruments which facilitate the communication of adverse events

This category brought together 23 registration units addressing the service's principal instruments which allow the written communication of adverse events in the institution, as reported by the nurses.

The discourses indicate that recording of the occurrence of adverse events exists in the service, demonstrating responsibility and commitment to the patient and the institution. *Everything that is done is recorded on forms and there's a book, which is a nursing report, in which we also record what is done with the patient (N4). There are forms we fill out and forward to the department which takes care of this here in the hospital (N31). Actually, there isn't a specific protocol, we note what we think is important to note in the general report (N15).*

The patient's nursing records were also mentioned as an instrument which facilitates the recording of adverse events, as may be perceived in the following discourses: *The only instrument in which we make records is the patient's medical records and the nursing occurrences book (N37). We can note these things in our own notes on the patient, in the patient records, and in the nursing history (N30).*

On the other hand, one statement stands out, which shows the nurse's perception regarding absence from the records and the link of this with the occurrence of errors: *As there isn't an efficient record, neither is there a result, because it is as if the error never existed (N1).*

Category 3. The communication of the adverse event and its implications for patient safety

This category brought together eight RU. Of these, half reported the need for notification so that the error should not be repeated. *We make the record in the form of a memorandum and we notify our nursing management, which passes it on in the form of meetings so that everybody is aware of the possibilities for error here in this department and to call more attention so that it does not happen again (N18). We notify so that the error is*

not repeated, so that the information can be spread, so that that error should not be repeated (N22). The situation in reality is that we are informed in relation to this, we have to notify so that the same error does not occur again (N34).

Some nurses emphasized aspects which influence decision-making in relation to recording adverse events, as the following accounts show: *People don't want to show that they made a mistake, they don't want to demonstrate that they failed, they don't want to be exposed (N6). We notify of the occurrences in writing, which, often, we can even find complicated, for you to put a situation down on paper, because it's a record, but that's what we use here, and I think that it's not the easiest way (N16).*

DISCUSSION

It may be perceived, first of all, that the majority of the nurses interviewed use the term 'error' rather than 'adverse event' in their accounts. It is believed that the clarification of these concepts should be an activity undertaken by the risk managers or by the service's leadership in the area of management of Quality and Patient Safety. It is important for all the professionals of the team to be familiar with the content and taxonomy of Patient Safety, for a universal language to be used and for all to understand one another when they proceed to communicate incidents, errors and adverse events in the service.

In a recent study, authors have publicised a list of the principal terms and concepts toward an International Classification for Patient Safety. They have demonstrated, in the study, that the consistent use of the principal concepts, definitions and terms shall pave the way to a better comprehension for comparisons between installations and jurisdictions, and the tendencies to be monitored over time. They have also emphasized that changes and improvements, translation to other languages and alignment with other sets of definitions of patient safety will be necessary⁽⁴⁾.

This being the case, the first step toward the effective communication of adverse events in the hospital context would be the training of the health team

with a focus on the taxonomy, tools, strategies, behaviors and indicators of safety currently publicised at the national and international level.

In referring to the attitudes related to the communication of the occurrence of an adverse event (Category 1), the nurses demonstrated the existence of a punitive culture in the institution, as imposed by the health organizations in recent years.

It is known, however, that the process for preventing human error arises from cultural changes and, consequently, from the increase in the identification of adverse events, it being essential for the leadership to believe in a non-punitive culture, through a systemic approach to error; listening to and embracing the professional and providing her with conditions such that the failures should not re-occur. In this way, the professional sees herself as integrated into, and a participant in, the process of seeking safety in the care, and is aware of the need for notification⁽¹⁰⁾.

A study undertaken in a clinical inpatient unit found a result similar to that of this research, regarding professional conduct regarding errors. The authors ascertained the existence of a process of notifying errors to hierarchically-superior professionals, in which the nursing technicians reported communicating the event to the unit's nurses, and that these, in their turn, passed the information on to the doctor assisting that patient, depending on the situation. On the other hand, the study showed that the nurses recorded the event in the patient's electronic patient record without omitting information, a stance which was not mentioned by the nurses interviewed in the present study⁽¹⁰⁾.

It should be noted that the identification of, and the responsabilization for, the error or adverse event must be transversal. All the members of the team must be made aware of the need to report their participation in the events and to outline the strategies for harm reduction and the prevention of further occurrences, always taking into consideration the work with a focus

on the patient and on the safety of the patient, the professional and the environment.

According to researchers, notification is considered a preventive measure, being directly related to risk management, as identifying and investigating the error makes it possible to undertake further training so that the failures may not take place again⁽¹⁰⁾.

In this context, in addition to the promotion of educational strategies for the qualification of the exercising of the profession and for risk prevention, it is essential to communicate the occurrence of adverse events in bulletins which are specific to this purpose and to forward them to the department responsible in the institution, for the adoption of preventive and control measures, so that the harm resulting from the adverse events may be eliminated⁽¹¹⁾.

In this way, one can see the importance of sensitizing and involving the health team in the search for better patient care, free from harm and errors, in which all the health professionals must discuss together strategies and conducts regarding adverse events.

Research with the nursing team found a relationship of sincerity between the nurse and her team in experiencing adverse events in practice, in which the strategy adopted for confronting these was honesty regarding the facts, which included not omitting them, not judging them and resolving them, as well as protecting and supporting the team member involved. Another strategy adopted was the clarification of the situation as soon as possible⁽¹²⁾.

Another relevant aspect in this context is the continuous education of all the institution's staff, because it allows reflection on various questions which are relevant to the routine of work, in addition to offering an opportunity for debate on issues which are relevant to better care practice⁽¹⁰⁾.

However, under-reporting of adverse events in the health organizations is frequent⁽¹³⁾, which may be related to some professionals' lack of knowledge on the issue

and lack of valorization of recording as fundamental in the prevention of further occurrences.

Researchers explain such attitudes by asserting that because of the fact that the adverse events are little known and/or, often, do not compromise an individual's life, the professionals undertake the recording and notification only in the cases considered more serious⁽¹⁴⁾.

A North American study, after making a comparison between patients' reports of the care received and the respective records, found that 23% of the patients had suffered some form of adverse event, but that only 11% of the respective patient records showed any problem in the care given, which reveals the constant under-reporting of these events⁽¹⁵⁾.

Considering this issue, there is an urgent need for a quality risk management program, which should allow the identification of the probable origin of the adverse events, evaluation of the harm caused, and the taking of appropriate decisions concerning these problems⁽¹⁶⁾.

The reports also indicate the importance of a good relationship within the multiprofessional team, so that adverse events which occur may not be omitted. Furthermore, emphasis is placed on the importance of making records for the promotion of strategies which lead to quality care and patient satisfaction.

In the analysis of the discourses on the instruments which facilitate communication of adverse events (Category 2), it was observed that there was no uniformity for undertaking records on the issue, in spite of these being fundamental for the communication of quality and for the continuity of the nursing care.

The result is alarming, bearing in mind that the institution analyzed is a Sentinel Hospital⁽¹⁷⁾ and, as a result, should guarantee the notification of adverse events and technical complaints about health products, so as to afford greater safety and quality to patients and health professionals.

The discourses indicated, therefore, that the nurses interviewed need guidance and training on the

management of the instruments and tools available in their service for reporting, preventing, evaluating and monitoring, for the improvement of quality and reduction of adverse events.

In this context, there is an urgent need to familiarize the professionals from the multiprofessional team with the theoretical frameworks, the scientific evidence, the guidelines and the policies to do with Patient Safety, established by national and international bodies.

The National Program for Patient Safety, launched in 2013 by the Ministry of Health, deserves to be emphasized, as it considers that risk management directed at quality and patient safety encompasses principles and guidelines, such as the creation of a culture of safety; the systematic and structured undertaking of the processes of risk management; the integration with all the processes of care, and articulation with the health services' organizational processes; the best evidence available; transparency, inclusion, responsabilization and sensitization and the capacity to react to change; and taking into account the need to develop strategies, products and actions directed at the managers, professionals and health service users regarding patient safety, making possible the promotion of the mitigation of the occurrence of adverse events in health care⁽⁸⁾.

A study undertaken with intensive care nurses, identifying these professionals' perception considering the iatrogenic occurrences experienced, observed that the majority of interviewees mentioned a form used in the institution for communicating adverse events. This was formed by a table in which the most recurrent events were recorded, followed by an investigation protocol, in the event of a record being made⁽¹²⁾.

There is an urgent need for the dissemination of forms and protocols specifically for dealing with adverse events at a national level, which has influenced the construction and validation of notification bulletins on

the part of nurses. One example is the Adverse Event Notification Bulletin (BNEA), elaborated to establish an instrument for communication between the nursing professionals and the respective management regarding adverse events with patients attended in the hospital, containing the following fields: identification of the patient and unit; types of occurrences; a space for reporting the occurrence and a space for describing the conduct of the person notifying in relation to the fact⁽¹¹⁾.

In this bulletin, the occurrences were separated into two types: adverse event/incident and administrative occurrence (an occurrence which did not directly involve the patient). In analyzing the use of the bulletin, the researchers found a predominance of assistential occurrences, although administrative notifications presented a growing number of records. They also confirmed the instrument's practicality, which viabilized its use also by auxiliary nurses and nursing technicians, emphasizing that the systematized analysis and monitoring of the adverse events associated with communication resources were shown to be fundamental for patient safety⁽¹¹⁾.

It is believed that, in spite of the existence of institutional protocols for error reporting, the patient's hospital records should also be considered a relevant instrument for communicating and tracking adverse events, making it possible to investigate the causes associated with their occurrence and the conducts taken, as well as to outline strategies for their prevention.

Authors add that the patient's hospital records provide a documented record of the care given by the multiprofessional team. However, the record does not always describe the assistential process clearly, which can represent an additional difficulty to be faced in the process of identifying adverse events. The tracking criteria must cover the different parts of the patient's records, including the initial inpatient care form, the medical instructions and actions, the progressions and the laboratory tests⁽¹⁴⁾.

Regarding this aspect, researchers have already stated that the absence of records in the patients' records, as an instrument of communication, can result in various unwanted consequences. Among these, there is the compromising of the quality of the care related to the occurrence itself of adverse events, to the degree that it is through the patient's records that one obtains the information necessary for the specific and appropriate care of each patient⁽⁶⁾.

Finally, in Category 3, the nurses reported the implications of the communication of the adverse event for the patient's safety and emphasized the need for the notification to serve as an example for the team and for the error not to be repeated.

Corroborating this, authors state that the implantation of a system for identifying and reporting adverse events, through the recording and publicising of failures which occur, allows the establishment of improvements for the prevention of further occurrences⁽¹¹⁾.

In addition to this, for a risk management program to be successful, it is necessary to institute a systematic process for identification, quantification and analysis of the error's impact on the care provided, treatment through the institution of safe measures and the communication of the risks such as to allow the service to reduce the undesirable effects.

This communication must be encouraged by the nurse managers and the nurses directly involved in patient care, along with their teams, emphasizing the nursing records as an indispensable tool, as they bring together the information necessary for quality care, allow the documentation of what was undertaken, support the professionals in the event of legal action, integrate all the stages and strengthen the systematization of the nursing care⁽¹⁸⁾.

Emphasis is placed, therefore, on the importance of valuing continuous education directed toward the promotion of patient safety and quality care, through

encouraging professionals to undertake notification, explaining to them the relevance of communicating errors in the care context into which they are integrated. Also, feedback must be guaranteed to the person who carries out the notification, who feeds the system⁽¹¹⁾.

The fear of being exposed and of suffering reprisals, as well as of the possible consequences of her failure, can cause the omission of the adverse event on the part of the professional. A study which evaluated nursing professionals' feelings in relation to errors found that shame was a feeling commonly expressed by the professionals who participated, being associated mainly with the need to reveal the occurrence of the error to the patient and to others from the work environment⁽⁷⁾.

To avoid the fear of reprisals, the institutions must invest in focussing on safety and quality in the care for the patient, with the consequent creation of a culture of safety, allowing the team to feel secure in communicating the occurrence of an adverse event. In addition to this, results indicators such as adverse events, as tools, are fundamental for quality, as they indicate aspects of care which can be improved, making the care for patients free of risks and shortcomings and, therefore, safer⁽¹⁹⁾.

Thus, health institutions need to overcome the traditional culture of blame and punishment, encouraging reporting and learning through the mistakes. For this, it is necessary to provide work conditions which permit the sharing of responsibilities and management which is open to opinions, such that the entire team holds patient safety as an ideal⁽²⁰⁾.

FINAL CONSIDERATIONS

The study made it possible to understand and analyze the experiences of nurses directly involved in patient care in the communication of adverse events in the hospital context, emphasizing the attitudes taken considering the occurrence of the events, the

instruments which facilitate communication and recording, and their implications for patient safety.

It was observed that, in spite of the reporting of there being communication of adverse events in the institution, this was found to be threatened, considering that the cases are not always reported or discussed adequately. Added to this is the fact that the nurses are not unanimous in the identification of the service's forms and documents indicated for recording adverse events, demonstrating inconsistency between the discourse and the practice in a hospital from the sentinel network.

Another worrying result was the observation that the punitive culture still predominates in the situations which lead to errors or adverse events, evidenced by the reports of practices of reprimanding and punishment of members of the nursing team. In this context, the communication barriers result in larger adverse events, to the degree that the feedback of information on the consequences created by the adverse events and the proposing of more efficient alternatives for their management does not occur, impeding satisfactory resolution.

Regarding the gaps identified, it is necessary to undertake further research focussing on the issue of the occurrence and communication of adverse events and their consequences for the service, the professionals and, principally, the patients, in the various health settings. These studies must be publicised to the services and scientific community, with the aim of promoting reflection and behavioral changes in the workers, structural changes in the services, and new health policies directed at patient safety.

Also suggested is encouragement for the efficient communication of adverse events related to nursing care, which can be ensured through the recording and monitoring of risks in the nurse's daily practice, as a means of strengthening the culture of safety and quality, creating satisfaction for the professionals and patients alike.

COLLABORATIONS

Leitão IMT and Oliveira RM contributed with the conception of the study, the literature review, data analysis, the writing in full of the manuscript and the final approval of the version to be published. Sobral MC and Leite SS contributed with data collection, the literature review and the data analysis. Figueiredo SV and Cadete MC contributed with the literature review and the data analysis.

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