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ORIGINALES

Evaluation of patient safety culture from the perspective of intensive care professionals

Avaliação da cultura de segurança do paciente sob a ótica de profissionais da terapia intensiva

Evaluación de la cultura de seguridad del paciente desde la perspectiva de los profesionales de cuidados intensivos

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ABSTRACT:

Objective: To evaluate the patient safety culture from the perspective of professionals who work in Intensive Care Units.

Method: This is a descriptive, exploratory, cross-sectional study of a quantitative character. The sample consisted of 72 professionals, 31 nurses, 21 nursing technicians, 12 (physiotherapists, speech therapists, occupational therapists), 5 doctors, 2 psychologists, 1 nursing assistant who work in intensive care units in the southwest and northwest regions of Paraná and west of Santa Catarina. The data collection carried out between August and October 2020, via online electronic form, through the Google platform, using the questionnaire adapted to Research on Patient Safety in Hospitals. The data were tabulated in the Excel program and, subsequently, a descriptive analysis of the data was performed by using the *Statistical Package for the Social Sciences software* (SPSS 25.0).

Results: Only 2 categories achieved more than 75% positive responses in relation to the unit's safety culture, namely: when there is a lot of work to be done, professionals work as a team to complete it and they are actively doing things to improve the patient's safety.

Conclusion: From the perspective of professionals, patient safety is not effective yet, as in some aspects it needs to be improved as well as in other criteria, it is shown to be weakened.

Keywords: Intensive Care Units; Patient safety; Culture; Quality Inspection of Health Care; Health professionals.

RESUMO:

Objetivo: Avaliar a cultura de segurança do paciente sob a ótica de profissionais atuantes em Unidades de Terapia Intensiva.

Método: Estudo descritivo-exploratório, transversal, com caráter quantitativo. Amostra composta por 72 profissionais: 31 enfermeiros, 21 técnicos de enfermagem, 12 (fisioterapeutas, fonoaudiólogos, terapeuta ocupacional), 5 médicos, 2 psicólogos, 1 auxiliar de enfermagem, atuantes em Unidades de Terapia Intensiva do Sudoeste e Noroeste do Paraná e do Oeste de Santa Catarina. Coleta de dados realizada entre agosto e outubro de 2020, via formulário eletrônico on-line, por meio da plataforma do Google, utilizando-se do questionário adaptado Pesquisa sobre Segurança do Paciente em Hospitais. Os dados foram tabulados no programa Excel e, posteriormente, realizou-se a análise descritiva dos dados, por meio do software Statistical Package for the Social Sciences (SPSS 25.0).

Resultados: Duas categorias atingiram mais de 75% de respostas positivas quanto à cultura de segurança nas unidades pesquisadas, sendo elas: quando há muito trabalho a ser feito, os profissionais trabalham em equipe para concluí-lo; e estar ativamente fazendo coisas para melhorar a segurança do paciente.

Conclusão: Na perspectiva dos profissionais, a segurança do paciente ainda não é efetiva, pois, em alguns aspectos, precisa de melhorias, sendo, ainda, em outros critérios, considerada fragilizada.

Palavras-chave: Unidades de Terapia Intensiva; Segurança do Paciente; Cultura; Inspeção da Qualidade dos Cuidados de Saúde; Profissionais de Saúde.

RESUMEN:

Objetivo: Evaluar la cultura de seguridad del paciente desde la perspectiva de los profesionales que trabajan en Unidades de Cuidados Intensivos.

Método: Se trata de un estudio descriptivo, exploratorio, transversal de carácter cuantitativo. La muestra estuvo conformada por 72 profesionales, 31 enfermeros, 21 técnicos de enfermería, 12 (fisioterapeutas, logopedas, terapeutas ocupacionales), 5 médicos, 2 psicólogos, 1 auxiliar de enfermería trabajando en unidades de cuidados intensivos en el Suroeste y Noroeste de Paraná, y Oeste de Santa Catarina. La recogida de datos se realizó entre agosto y octubre de 2020, por medio de un formulario electrónico on-line, en la plataforma Google, utilizándose el cuestionario adaptado a Investigación en Seguridad del Paciente en Hospitales. Los datos se tabularon en el programa Excel y posteriormente se realizó un análisis descriptivo de los datos utilizándose el software *Statistical Package for the Social Sciences* (SPSS 25.0).

Resultados: Sólo 2 categorías alcanzaron más del 75% de respuestas positivas con respecto a la cultura de seguridad de la unidad, a saber: cuando hay mucho trabajo por hacer, los profesionales trabajan en equipo para completarlo y están activamente haciendo cosas para mejorar la seguridad de la unidad paciente.

Conclusión: Desde la perspectiva de los profesionales, la seguridad del paciente aún no es efectiva, ya que en algunos aspectos necesita mejorar, así como en otros criterios se muestra debilitada.

Palabras clave: Unidades de Cuidados Intensivos; Seguridad del paciente; Cultura; Inspección de la calidad de la atención médica; Profesionales de la salud.

INTRODUCTION

Over the years, several events have raised great concern about Patient Safety (PS) and safety culture; however, the number of complications, Adverse Events (AE) and preventable deaths remain alarming [1].

In Intensive Care Units (ICU), about 20% of patients can experience an AE, pproximately 40% to 45% could have been avoided [2-4].

According to the World Health Organization (WHO), PS is defined as “reducing the risk of unnecessary harm associated with health care to an acceptable minimum” [2:p.24]. The Patient Safety Culture (PSC) is composed of the following items: responsibility of

leaders for safety, open communication, organizational learning, non-punitive approach to reporting AE, teamwork and shared belief in the importance of safety[5,6].

The safety culture aims to prevent and to reduce risks to patients and encourage the reporting of incidents. The negative, punitive and fragile culture that generates fear and shame for professionals should not be incorporated into institutions [7,8].

The global challenge to reduce AEs lies in changing the institution's safety culture and in the involvement and commitment of professionals and hospital management. Unsafe environment and care cause unnecessary risks to the patient, which can result in prolonged hospitalization, injuries, pain, falls, disabilities, dysfunctions and death. They also cause an increase in costs for the institution and a bad impression of the service, frustration and exhaustion of professionals, among other events [9,10].

PS is considered a global priority, so studies have been developed in the area in order to reduce AEs, to improve the patient safety culture and the quality of care provided. Therefore, it is extremely important to produce knowledge for professionals and help institutions to recognize flaws and weaknesses in the work environment [10]. In view of the above, the problem question arose: what is the patient safety culture from the perspective of health professionals working in the ICU? Therefore, the aim was to evaluate the patient safety culture from the perspective of professionals working in Intensive Care Units.

MATERIAL AND METHOD

This is a descriptive-exploratory, cross-sectional research with a quantitative approach, developed online, through an electronic form composed of a questionnaire adapted cross-culturally and validated in Brazil, called the Hospital Surveyon Patient Safety Culture (HSOPSC) questionnaire, prepared by the Agency for Health Care Research and Quality (AHRQ)[11].

The questionnaire was made available through the link https://forms.gle/jyJt6UWiWyVvBtnQ6, through the Google platform, from August to October 2020, for the nursing directors and technical managers of the ICUs of the hospitals surveyed for dissemination among professionals working in this sector field.

The form covers 12 dimensions of the PSC and allows the assessment of the positive and negative aspects of the culture, with closed and open questions. Inclusion criteria were: health professionals of any age, gender and work shift, working in Adult and Pediatric ICUs in the Northwest and Southwest of Paraná, as well as in the West of Santa Catarina. Among the professionals: doctors, nurses, nursing technicians, nutritionists, speech therapists, physiotherapists, occupational therapists and psychologists. As an exclusion criterion, it was decided not to include health professionals who were on vacation, leave or who did not accept to participate in the study, in addition to other professional classes, as well as those working in other sectors.

The sample selection was for convenience, upon acceptance of the Free and Informed Consent Term (FIC), by electronic means. The data were tabulated and their descriptive analysis was submitted to the Statistical Package for the Social Sciences

software (SPSS 25.0). The questions referring to the dimensions studied in the instrument were exclusively known by the researchers, since the research participants were not identified, and the ethical and legal principles were preserved, according to Resolution 466/2012, of the National Health Council. It was approved by the Ethics Committee in Research with Human Beings of Universidade Paranaense – Unipar, according to opinion 4,053,787.

RESULTS

For better understanding, the data are presented in tables and described based on the characterization of the participants. Table 1 describes the profile of the study participants.

Table 1: General information about healthcare professionals. Brazil, 2020.

Variables	N	%
How long have you worked in this hospital?? (years)		
< 1	16	22.2
1 - 5	32	44.4
6 - 10	15	20.8
11 - 15	5	6.9
16 - 20	2	2.8
≥ 21	2	2.8
How long have you been working in your current hospital area/unit?(years)		
< 1	21	29.2
1 - 5	23	31.9
6 - 10	20	27.8
11 - 15	4	5.6
16 - 20	3	4.2
≥ 21	1	1.4
How many hours weekly do you usually work at this hospital?		
Less than 20 hours a week	4	5.6
20 to 39 hours per week	44	61.1
40 to 59 hours per week	20	27.8
60 to 79 hours per week	3	4.2
80 to 99 hours per week	1	1.4
What is your position/function in this hospital?		
Clinical Staff Physician/Assistant Physician	3	4.2
Resident Physician/Doctor in Training	2	2.8
Nurse	31	43.1
Nursing Technician	21	29.2
Nursing assistant	1	1.4
Physical Therapist, Respiratory Therapist, Occupational Therapist or Speech Therapist	9	12.5
Psychologist	2	2.8
Other	3	4.2

In your position/function, in general, do you have interaction or direct contact with patients?		
YES, in general, I have interaction or direct contact with patients	72	100.0
How long have you been working in your current specialty or profession? (years)		
< 1	21	29.2
1 - 5	23	31.9
6 - 10	20	27.8
11 - 15	4	5.6
16 - 20	3	4.2
≥ 21	1	1.4
What is your level of education?		
Incomplete High School	1	1,4
Complete High School	14	19,4
Incomplete Higher Education	5	6,9
Complete Higher Education	13	18,1
Graduate (Specialization Level)	26	36,1
Graduate (Master's or Doctoral Level)	12	16,7
Ignored	1	1,4
Indicate your gender		
Female	66	91,7
Male	4	5,6
Ignored	2	2,8

Source: Research data, authors (2020).

Regarding the aspects related to the work environment, considering the unit of work, the professionals agreed that people supported each other (68.1%); however, they disagreed about the sufficiency of personnel to handle the workload (50%). They pointed out that errors could be used against them (73.6%), but highlighted that the notification of errors motivated positive changes (51.4%).

With regard to the overload of the unit, 56.9% revealed collaboration between professionals. It is noteworthy that when an adverse event is reported, 70.8% of professionals agreed that the focus is on the person and not on the problem. Regarding professionals working in a “crisis situation”, trying to do too much and too quickly, 51.4% agreed with this statement.

Table 2: Perceptions of professionals on aspects related to the work environment, considering the unit of action. Brazil, 2020.

Variables	n	%
In this unit, do people support each other?		
I disagree	5	6.9
I do not agree nor disagree	18	25.0
I agree	49	68.1
Is there enough staff to handle the workload?		
I disagree	36	50.0
I do not agree nor disagree	9	12.5
I agree	27	37.5
When there is a lot of work to be done quickly, do we work together as a team to complete it properly?		
I disagree	16	22.2
I do not agree nor disagree	7	9.7
I agree	56	77.8
In this unit, do people treat each other with respect?		
I disagree	6	8.3
I do not agree nor disagree	13	18.1
I agree	53	73.6
Do the professionals in this unit work longer hours than would be best for patient care?		
I disagree	18	25.0
I do not agree nor disagree	16	22.2
I agree	38	52.8
Are we actively doing things to improve patient safety?		
I disagree	6	8.3
I do not agree nor disagree	11	15.3
I agree	55	76.4
Do we use more temporary outsourced professionals than is desirable for patient care?		
I disagree	31	43.0
I do not agree nor disagree	10	13.9
I agree	30	41.7
Ignored	1	1.4
Do professionals consider that their mistakes can be used against them?		
I disagree	7	9.8
I do not agree nor disagree	12	16.7
I agree	53	73.6
Have mistakes led to positive changes around here?		
I disagree	15	20.9
I do not agree nor disagree	20	27.8
I agree	37	51.4

Source: Research data, authors (2020).

Table 2 shows that 53.6% of the population surveyed agreed that the supervisor/head praised and accepted the suggestions for actions aimed at strengthening safe care. It was also observed that 41.6% said it was unpleasant to work with professionals from other hospital units. Most of the time, the professionals answered that there were problems in the exchange of information between the hospital units (47.2%).

Table 3: Professionals' perceptions of the supervisor/head of the hospital's work unit. Brazil, 2020.

Variables	n	%
Does my supervisor/head give praise when he sees work performed in accordance with established patient safety procedures?		
I disagree	22	31.9
I do not agree nor disagree	10	14.5
I agree	37	53.6
Does my supervisor/head really consider the professionals' suggestions to improve patient safety?		
I disagree	14	19.5
I do not agree nor disagree	20	27.8
I agree	38	52.7
Whenever the pressure increases, does my supervisor/boss want us to work faster, even if it means "skipping steps"?		
I disagree	37	51.4
I do not agree nor disagree	18	25.0
I agree	17	23.6
Does my supervisor/boss not pay enough attention to patient safety issues that happen over and over again?		
I disagree	49	68.1
I do not agree nor disagree	13	18.1
I agree	10	13.9
Does the hospital management provide a work environment that promotes patient safety?		
I disagree	11	15.3
I do not agree nor disagree	13	18.1
I agree	48	66.7
Are hospital units not well coordinated with each other?		
I disagree	28	38.9
I do not agree nor disagree	24	33.3
I agree	20	27.8
Is the care process compromised when a patient is transferred from one unit to another?		
I disagree	27	37.5
I do not agree nor disagree	19	26.4
I agree	26	36.1
Is there good cooperation between hospital units that need to work together?		
I disagree	20	27.8
I do not agree nor disagree	22	30.6
I agree	30	41.7
Is it common to lose important information about patient		

care during shift changes or shifts?		
I disagree	21	29.2
I do not agree nor disagree	10	13.9
I agree	41	57.0
Is it often unpleasant to work with professionals from other hospital units?		
I disagree	21	29.2
I do not agree nor disagree	21	29.2
I agree	30	41.6
How often do problems occur in the exchange of information between hospital units?		
I disagree	18	25.0
I do not agree nor disagree	19	26.4
I agree	34	47.2
Ignored	1	1.4
Do hospital management actions demonstrate that patient safety is a top priority?		
I disagree	9	12.5
I do not agree nor disagree	19	26.4
I agree	43	59.7
Ignored	1	1.4
Does hospital management only seem interested in patient safety when an adverse event occurs?		
I disagree	31	43.1
I do not agree nor disagree	10	13.9
I agree	30	41.7
Ignored	1	1.4
Do hospital units work well together to provide the best care for patients?		
I disagree	16	22.2
I do not agree nor disagree	13	18.1
I agree	43	59.7
In this hospital, are shift changes problematic for patients?		
I disagree	40	55.5
I do not agree nor disagree	16	22.2
I agree	16	22.2

Source: Research data, authors (2020).

Table 4 represents the data regarding the management of adverse events, the changes implemented and the communication between professionals working in the ICU. As for professionals being free to talk about something that could negatively affect patient care, the answer rarely stood out (62.5%).

It should be noted that, for the most part, 54.2% of professionals were always informed about errors that occurred in the work unit. However, professionals rarely felt comfortable questioning superiors' decisions or actions (43.1%). In relation to the last 12 months, the answer “no notification” filled in and presented by the professionals participating in the research predominated (55.6%).

Table 4: Data regarding the management of adverse events, the changes implemented and the communication between professionals working in intensive care units. Brazil, 2020.

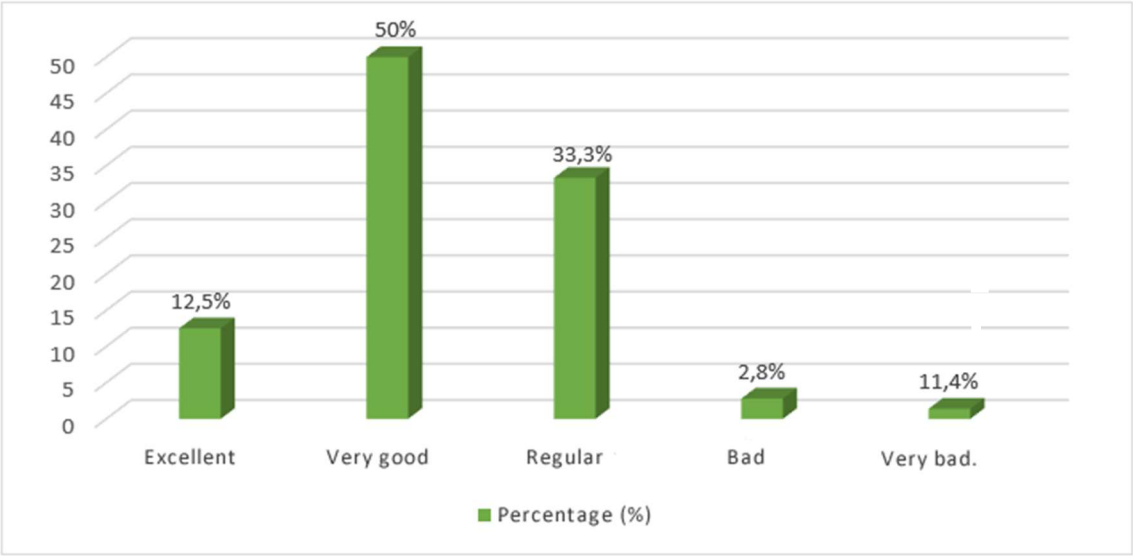
Variables	n	%
Do we receive information about implemented changes from the event reports?		
Rarely	18	25.0
Sometimes	23	31.9
Always	30	41.6
Ignored	1	1.4
Are professionals free to say when they see something that could negatively affect patient care?		
Rarely	9	12.5
Sometimes	18	25.0
Always	45	62.5
Are we informed about errors that happen on this unit?		
Rarely	16	22.3
Sometimes	17	23.6
Always	39	54.2
Do professionals feel free to question the decisions or actions of their superiors?		
Rarely	31	43.1
Sometimes	25	34.7
Always	16	22.2
In this unit, we discuss ways to prevent errors from happening again?		
Rarely	16	22.3
Sometimes	18	25.0
Always	38	52.8
Are professionals afraid to ask when something doesn't seem right?		
Rarely	28	38.9
Sometimes	27	37.5
Always	17	23.6
In the last 12 months, how many event notifications have you filled out and submitted?		
Nenhuma	40	55.6
1 - 2	14	19.4
3 - 5	12	16.7
6 - 10	5	6.9
≥ 21	1	1.4
When an error occurs, but it is noticed and corrected before it affects the patient, how often is it reported?		
Rarely	27	37.5
Sometimes	11	15.3
Always	34	47.2
When an error occurs but there is no risk of harm to the patient, how often is the patient notified?		

Rarely	26	36.1
Sometimes	17	23.6
Always	29	40.2
When an error occurs, which could harm the patient but does not, how often is the patient notified?		
Rarely	23	31.9
Sometimes	12	16.7
Always	37	51.3

Source: Research data, authors (2020).

Regarding the patient safety assessment made by health professionals in the work unit, “very good” (50%) stood out, followed by “regular” (33.3%), “excellent” (12.5%), “very bad” (11.4%) and “bad” (2.8%), as shown in Graph 1.

Graph 1: Patient safety score, according to the perceptions of professionals from the units surveyed. Brazil, 2020.



DISCUSSION

Among the 72 professionals who participated in this study, a profile was found that points out positive and negative aspects related to the patient safety culture.

In this study, two dimensions obtained positive responses above 75%, classified as areas of strength for SP, as recommended by the AHRQ. Responses with a percentage greater than 50%, less than 75% are considered neutral, and areas with potential improvement are those with responses below 50% [1.12]. In this study, results classified as neutral and areas with potential for improvement were found, with “neutral” responses prevailing.

Out of the 12 dimensions included in the instrument, two (75%) reached favorable responses to the safety culture, evidencing weaknesses in the organizational system that directly affect the quality of care offered to the patient. As *a sinequa non* requirement, PS should be considered a priority in any health environment, especially in intensive care, as it is considered a space that houses critically ill patients who require highly complex and resolute interventions, in a short time, at the bedside [13].

It is known that respectful and supportive relationships between professionals and teammates reduce conflicts and improve communication, contributing to the quality of care provided. Conditions that favor the promotion of the PS culture, as they reduce beliefs and judgments and improve the good relationship between the health team [14,15]. It is understood that the lack of professionals compromises patient safety, since the care provided in this way, seeking quantity and not quality, leaves the health professional overloaded, stressed and inattentive, favoring the development of AE [8,9].

Working together reflects on shared responsibility for care, differentiated experience and knowledge, team unity, reduced conflicts and increased productivity. With a pleasant work environment and good communication between the team, benefits will be provided to PS [16].

A study carried out in the southern region of Brazil, with ICU professionals, suggests an increase in the number of professionals, with a reduction in the workload and the weekly scale. Thus, it is reflected that in these units, professionals have an exacerbated workload and work exhaustively, due to complex procedures, serious patients and at risk of death [5].

Good PS practices depend on a number of factors, among which are the workload and schedule compatible with legal recommendations and team capacity. It should be noted that many workers, as a result of low pay, end up working double shifts, greatly increasing the chances of error. Evidences corroborate that longs periods of care can lead to an increase in errors and AE, due to work overload, more than an employment relationship, to fatigue and exhaustion [17, 18].

The health of the worker and the PS are impacted by outsourcing, as a professional who is not well psychologically and physically will not provide fully safe care to the patients served. Outsourcing influences the implementation of a neoliberal model and the precariousness of work relationships [19,20].

There are recommendations from the professionals of the health team to improve the PS, among these, it is important to carry out periodic training, develop and implement protocols, train new employees, prepare manuals on PS, correct inadequate practices of the service, increase the number of professionals, reduce the workload weekly hours, avoid shifts of less than 6 hours and more than 12 hours, minimize the turnover of professionals, improve the remuneration of professionals, promote equality of rights and duties among the team and implement regulations that regulate the behavior of professionals in the work environment [5].

The professionals from the units surveyed agreed that errors can be used against them (73.6%). Health professionals disagreed on the dimension “it is only by chance that more serious errors do not happen” (45.9%), corroborating another survey that showed a disagreement of 38.6%. This can be explained by the lack of attention, work

overload and stress in an ICU. The importance of performing EC/permanent and use of protocols is highlighted [21].

When an AE was reported, professionals agreed that the focus was on the person and not on the problem or system (70.8%). Thus, confirming data from another survey that showed 82.46% of professionals believed that when an error occurs, they focus on the person who made a mistake [1]. With a negative and punitive safety culture in the institution, the chances of occurrence and underreporting of AE are increased, negatively interfering in the teamwork culture [22,23].

Another aspect to be considered is the fact that 73.6% of the professionals were concerned that errors would be recorded in the job sheets. In health institutions, the punitive safety culture still prevails, in which professionals are held responsible for the mistakes made, thus impacting on AE underreporting and evidencing the fear of professionals reporting their own failures [23,24].

In the same way, 50% of the professionals agreed that they had problems in the PS at work. However, they believed that the procedures and systems were adequate to prevent the occurrence of errors (62.5%).

The professionals mostly agreed that the supervisor/boss considered the suggestions for improving the PS, as found in a qualitative study carried out in Goiânia, in which the manager listened and discussed the suggestions offered by the team. It is extremely important that there is a dialogue between the supervisor and the team that is directly in contact with the patients, in order to perceive flaws and weaknesses. Thus, it is possible to intervene in the problem, in order to achieve quality in patient care [25-27].

In the same way, it was found in a research carried out in four type II NICUs of four public hospitals in Florianópolis, in which 75% of the professionals also disagreed, in the item “skipping steps” when the pressure increases [12]. This is considered a positive point for the PS because when the work is done quickly, “skipping steps”, errors are more likely to occur due to the supervisor's existing charge [15].

Regarding the direction of the hospital providing a work climate that promotes PS, 66.7% of professionals agreed. Effective leadership plays a fundamental role in promoting learning and a positive culture in the unit, knowing how to listen and coordinate with love makes the performance of teams proactive in favor of PS. Likewise, hospital management plays a fundamental role, as the entire physical, material and human structure depends on it, which are priority requirements for the implementation of a positive safety culture [26,28].

The care process was not compromised, according to the professionals' responses (37.5%), when a patient was transferred from one unit to another; however, 36.1% of the professionals agreed that the care was impaired. In a study carried out in a public university hospital in Rio de Janeiro, this dimension was positively evaluated by professionals (36.61%). This point is highlighted by the lack of open communication between teams from different sectors and CE is highlighted as an important strategy to improve the exchange of information [26].

As for the actions of the hospital management, the professionals agreed that the management demonstrated that the PS was the main priority (59.7%). However, in another study, it was found that 89.84% of the participants disagreed that PS would be a priority of the direction. The PS must be worked on by everyone in the institution, but it fundamentally depends on the way in which the direction and managers conduct the institutional policy, from the hiring of personnel, professional development policy, choice of products and materials, in short, a multitude of conditions interfere directly on patient safety [1].

The professionals reported that it was common to lose information during the shift change (57%), that it was unpleasant to work with professionals from other units (41.6%) and that there were frequent problems in the exchange of information between the units (47.2%). Similar data were found in a research carried out at a university hospital in Rio de Janeiro, which showed a low percentage of positive responses in the three dimensions, 40.71%, 46% and 37.23%, respectively [26].

Changing shifts is one of the propitious moments for AEs to occur, since, during this period, information about patient care is lost. It is noticed how communication is still flawed in the services, as well as changes in the service routine are poorly seen and interpreted as problematic. Likewise, it is essential that the shift change occurs in a noise-free place, to avoid misunderstood information [28].

A considerable part of the professionals agreed that “the hospital management only seems interested in PS when an AE occurs”. In view of this data, it was found in the literature that 52% of professionals stated that management was only interested when an AE occurred. This can be explained by the fact that PS is still left aside in some institutions, and better attention is only given when an error occurs and puts patients' lives at risk [12].

As for the hospital units working well together to provide the best care to patients, professionals agreed (59.7%). Regarding shift changes being problematic for patients, 55.5% of professionals disagreed. However, in another study carried out in Paraná, it was evidenced that 60.3% of professionals considered shift changes to be problematic for patients [14], as well as a percentage of negative responses regarding joint work between units in a study of Florianópolis (42%) [12].

Communication is a fundamental element in the shift change; correct information must be passed on about the continuity of care, thus reducing the chances of unsafe care [18]. The perception of a culture unfavorable to PS in intermediate care units is also shown, due to the low percentage of positive responses.

This demonstrates faulty communication between the team. In a survey that evaluated PS in public and private hospitals in Peru, only 35% of professionals gave a positive assessment regarding the degree of open communication, as well as whether professionals thought they could question superiors, when they saw something that could affect the patient negatively [24].

In view of this data, it is demonstrated that changes must be made in health services, so that professionals can talk freely about possible care failures, especially those that can negatively affect the PS. They must be free to report mistakes, when made, without fear of punishment. Thus, it is possible to intervene where care is insecure [8].

It is noteworthy that in the last 12 months, the majority did not report AE (55.6%). A study carried out in Belo Horizonte showed even greater value in terms of this statement, with 75.4% of professionals not reporting in the last 12 months, with the nurse being the professional who most carried out the notifications [22]. It is believed that the work overload in the ICU and the inadequate dimensioning of the health teams can influence the lack of time to carry out the notifications correctly. Also, the lack of interest and fear of punishment arising from the notification of errors did not really demonstrate the real problem encountered [15].

It is known that errors, when committed, are underreported, which suggests that most errors that do not affect the patient or are noticed before they happen are probably not reported [16], which was not demonstrated in this study.

It is also considered that the expansion of knowledge and the training of professionals contribute to the improvement of PS. Some strategies are also used in health services, such as Permanent Health Education (PHE) and training of professionals, contributing to the implementation of a positive safety culture and the recognition and identification of errors [29].

The classification of PS, according to the perceptions of health professionals, was “very good” (50%). In a study carried out in 2019 at the NICU, the “regular” grade prevailed (48%). It was found in the literature that nurses, as they constitute the head of nursing, are the professionals who most consider patient safety as “weak”. Thus, it is believed that other categories are unaware of the process and have different perceptions about safety [22]. It should be noted that each institution has a different culture, from the perspective of professionals, and discussion, feedback and ECS/permanent are ideal for identifying the weaknesses of the service [1].

CONCLUSIONS

The study identified that two categories achieved favorable responses regarding the safety culture in the ICU. Aspects of the safety culture were evidenced in need of interventions, considering the desired evaluative levels. The results showed conditions for guidance in relation to the identification of problems in the PS of the institutions surveyed and possible strategies to be carried out.

Health service managers, as well as professionals who are in direct contact with patients, should be directly involved in the search for conditions that favor SP as a priority for the development of safer care.

As a limitation of the study, the sample size was considered, a fact that may be related to the pandemic period, in which professionals find themselves with a high workload in the ICU and little availability to answer the questionnaires. Finally, we suggest the development of new research in the area, with different instruments, so that managers and professionals of health services can develop actions that enable quality care.

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