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Punitive culture perceived by health professionals in intensive care units: integrative review

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Cultura punitiva percibida por los profesionales de la salud en unidades de cuidados intensivos: revisión integrativa
Cultura punitiva percebida por profissionais de saúde atuantes em unidades de terapia intensiva: revisão integrativa

ABSTRACT
Objective: To analyze in the literature health professionals' perception of punitive culture in Intensive Care Units. Method: integrative literature review, based on articles published between 2010 and 2020 on the dimension of culture "Non-punitive responses to error" of the Hospital Survey on Patient Safety Culture questionnaire. Data collection occurred in August 2020 at the databases: LILACS and MEDLINE. Units with punitive culture were considered when the score of positive responses was ≤ 50 %. Results: 281 studies were found, of which 11 were considered eligible. There was a prevalence of studies conducted in units for adult care (45,45%). All studies presented fragility of the dimension "Non-punitive responses to error", ranging from 17.50% to 49.34% of positive responses. Conclusion: the punitive culture is strongly present in the perception of professionals from critical units, which demands actions to reverse this perception and migrate to fair culture.
DESCRIPTORS: Organizational culture; Punishment; Intensive care units; Patient safety; Nursing.

RESUMEN
Objetivo: Analizar en la literatura la percepción de los profesionales de la salud sobre la cultura punitiva en Unidades de Cuidados Intensivos. Método: revisión bibliográfica integradora, basada en artículos publicados entre 2010 y 2020 sobre la dimensión de la cultura "Respuestas no punitivas al error" del cuestionario Hospital Survey on Patient Safety Culture. Los datos fueron recogidos en agosto de 2020 en las bases de datos: LILACS y MEDLINE. Se consideraron unidades con cultura punitiva cuando la puntuación de las respuestas positivas fue ≤ 50 %. Resultados: Se encontraron 281 estudios, de los cuales 11 fueron considerados elegibles. Hubo una prevalencia de estudios realizados en unidades para el cuidado de adultos (45,45%). Todos los estudios presentaron fragilidad de la dimensión "Respuestas no punitivas al error", que van desde el 17,50% hasta el 49,34% de las respuestas positivas. Conclusión: la cultura punitiva se presenta fuertemente en la percepción de los profesionales de unidades críticas, lo que exige acciones para revertir esta percepción y migración a una cultura justa.
DESCRIPTORES: Cultura organizacional; Castigo; Unidades de cuidados intensivos; Seguridad del paciente; Enfermería.

RESUMO
Objetivo: Analisar na literatura a percepção dos profissionais de saúde acerca da cultura punitiva em Unidades de Terapia Intensiva. Método: revisão integrativa de literatura, com base em artigos publicados entre 2010 e 2020 acerca da dimensão de cultura "Respostas não-punitivas ao erro" do questionário Hospital Survey on Patient Safety Culture. A coleta de dados ocorreu no mês de agosto de 2020 nas bases de dados: LILACS e MEDLINE. Consideraram-se unidades com cultura punitiva quando o escore de respostas positivas foi ≤ 50%. Resultados: foram encontrados 281 estudos, dos quais 11 foram considerados elegíveis. Houve prevalência de pesquisas conduzidas em unidades para atendimento adulto (45,45%). Todos os estudos apresentaram fragilidade da dimensão "Respostas não-punitivas ao erro", com variação de 17,50% a 49,34% de respostas positivas. Conclusão: a cultura punitiva apresenta-se fortemente na percepção dos profissionais de unidades críticas, o que demanda ações para reversão dessa percepção e migração para cultura justa.
DESCRITORES: Cultura organizacional; Punição; Unidades de terapia intensiva; Segurança do paciente; Enfermagem.

Stephany Aparecida Rambo Grimm Toledo
Nurse. Graduated from the Santa Cruz University Center of Curitiba
ORCID: 0000-0002-8858-6127

Josemar Batista
Nurse. Master in Nursing. Professor at the Santa Cruz University Center in Curitiba.
ORCID: 0000-0001-9838-1232

Andressa dos Santos
Nursing Student at the Santa Cruz University Center in Curitiba.
ORCID: 0000-0003-1648-9499

Fabieli Borges
Nurse. Master in Nursing. Collaborating professor at the State University of West Paraná.
ORCID: 0000-0002-0835-5311

Suellen da Rocha Lage Moraes
Nurse. Master in Nursing. Professor at the Santa Cruz University Center in Curitiba.
ORCID: 0000-0002-2468-9784

Bruna Eloise Lenhani
Nurse. PhD in Nursing. Professor at the Santa Cruz University Center in Curitiba.
ORCID: 0000-0002-6009-3400

INTRODUCTION

Patient safety is one of the main goals pursued by healthcare institutions in order to ensure quality care to patients. In recent decades, this topic has been much discussed due to the occurrence of errors and the relevance of actions to offer safe care, [1] with emphasis on the context of Intensive Care Units (ICUs).

The adverse event (AE) is defined by the World Health Organization (WHO) as an incident that has resulted in harm to the patient. [2] The adverse event (AE) is defined by the World Health Organization (WHO) as an incident that has resulted in harm to the patient.

A cohort and retrospective study conducted in 30 ICUs in Canada showed that 12.549 (25%) patients had more than one AE among the 49.447 cases analyzed. The prevalent AEs were those of respiratory origin (10%) and those related to infection (9%), and were associated with patients with ≥2 comorbidities. These AE increased the length of stay by 5,4 days in the ICU, 18,2 days in the hospital and represented a greater chance of mortality compared to patients without AE. [3]

In a bibliometric study whose objective was to investigate the scientific production about AEs occurring in adult and neonatal ICUs, it was identified that AEs related to medication errors and hospital infection were prevalent and intensified by the workload of the health team. [4] These data portray the magnitude of the problem in this care context and encourage the need to list actions to reduce them, such as investigating cultural and systematic approaches, which contribute to mitigating human error. [5]

The product of individual and collective values, attitudes, perceptions, competences and patterns of behavior that determine an organization's style, proficiency and commitment to quality and institutional safety make up the concept of patient safety culture. [2,6]

This, when considered positive, is identified as a protective factor to prevent the occurrence of errors [7-8] and its construction is recommended by the National Patient Safety Program (Programa Nacional de Segurança do Paciente) - PNSP. [9] This program configures the safety culture based on five characteristics operationalized by the organization's safety management. Among them, we highlight the culture that encourages and rewards professionals to identify, notify and participate in the resolution of problems related to safety, and the culture that, based on the occurrence of incidents, promotes organizational learning. [9]

The adoption of a non-punitive culture in health services is necessary and opportune to implement these two characteristics, as well as to promote safe and quality care.

It is known that the implementation of tools in favor of care safety and the opening of communication to report and notify AE are limited in punitive environments, as professionals feel frightened about punishment in the event of an error. These circumstances are incompatible to reduce care risk and positively build the composites of organizational safety culture. [10]

A fair culture consists of identifying and addressing system problems that lead professionals to engage in unsafe behavior, maintaining individual responsibility and establishing zero tolerance for reckless behavior. [11] Given the encouragement of national and international bodies to develop actions that collaborate with health institutions to reverse the punitive culture, with a view to advancing safe practices and structuring organizations for highly reliable care, this research contributes to the knowledge of health and nursing professionals on the subject, in addition to serving as a subsidy for hospital administrators and care managers in the list of effective interventions to mature the culture of patient safety. Thus, the objective of this research was to analyze in the literature the perception of health professionals about the punitive culture in Intensive Care Units.

METHOD

This is an integrative literature review

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consisting of six steps. [12] In step 1, the research question was elaborated: What is the perception of health professionals about the punitive culture in Intensive Care Units? In step 2, the following inclusion criteria were adopted: (a) original articles in Portuguese, English and Spanish and available electronically in full; (b) that address the culture of patient safety and that have the dimension "Non-punitive responses to error" measured by the Hospital Survey on Patient Safety Culture (HSOPSC) instrument and applied to health professionals working in adult, pediatric and/or neonatal ICUs; (c) and which were published between 2010 and July 2020.

The time frame was chosen because it considered relevant and relevant to the investigations conducted after the publication, in 2009, of the Conceptual Framework of the International Classification of Patient Safety, which standardizes key concepts related to the area, including safety culture and fair culture. 2 The following were excluded: (a) review articles; (b) editorials, case reports and opinion reports. The survey of the studies was carried out in August 2020. The databases were the Latin American and Caribbean Literature on Health Sciences (LILACS) and the Medical Literature Analysis and Retrieval System Online (MEDLINE), via the Portal of the Virtual Health Library (VHL). For the search and selection of articles, the Boolean operator AND was used, using the Health Sciences Descriptors (DeCS) and the Medical Subject Headings (MeSH): "organizational culture", "patient safety" and "intensive care unit".

For data extraction (Step 3), they were initially analyzed by reading the titles and abstracts in order to identify whether they had the potential to answer the question established in the previous step. After this refinement, the articles were read in full and for those who met the inclusion criteria, the information was extracted according to a validated instrument [13] and adapted to the context of this research, namely: authors, year of publication, country, type of study and level of evidence, [14] characteristics of the population/sample, type of ICU and results of the dimension "Non-punitive responses to error". This dimension assesses how professionals feel about their mistakes, if they think that the mistakes made by them can be used against them and kept in their functional files. [15]

The search, selection and analysis of the articles were performed by two indepen-dent examiners (double-blind mode), and, in case of divergences, a third examiner was invited to participate in the consensus meeting regarding the selection of studies. After recurrent readings, the articles that made up the final sample were organized in a Microsoft Office Excel® spreadsheet, version 2016, and the variables were descriptively presented in a table, proceeding with interpretations and comparisons between similar and conflicting results of the selected studies (Steps 4 and 5).

For the result variable, the Agency for Healthcare Research and Quality (AHRQ) recommendation was adopted, which classifies the dimensions of culture according to the index achieved in strong areas ≥75%, neutral areas ≥51% and ≤74% and negative areas ≤50% positive responses. [16]
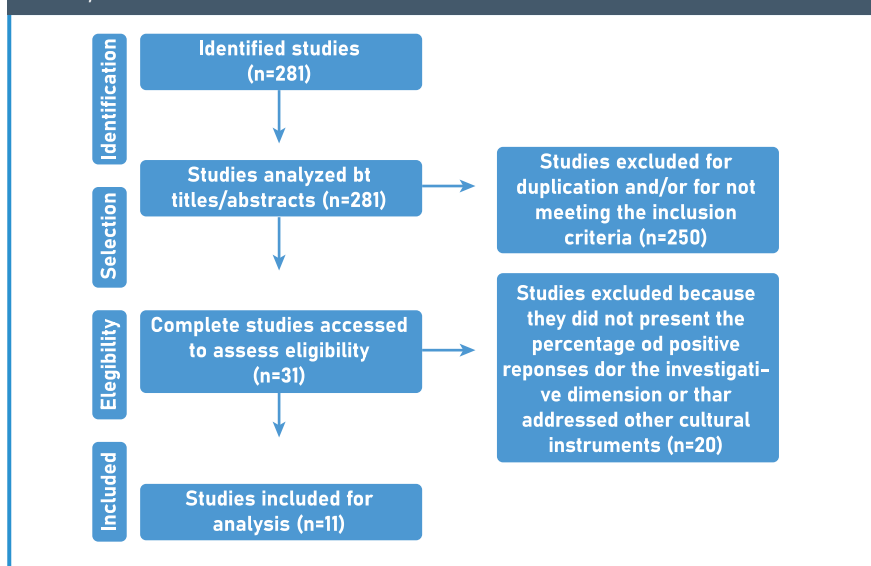
Step 6 consisted of the presentation of the review/synthesis of the evidence found, enabling the reader to apply the integrative review designed for teaching, research and management in health and nursing, whose purpose is to advance the concepts and practices aimed at the area of safety of the patient in critical care settings.

RESULTS

Of the 281 studies found in the databases, 11 were considered eligible. Of these, four (36,36%) were indexed in the LILACS database and seven (63,64%) in MEDLINE. The steps used to select the articles were guided by the recommendations of the Preferred Reporting Items for Systematic Reviews and MetaAnalyses (PRISMA), 17 and are shown in Figure 1.

There were publications from 2010 to 2019, with a prevalence of studies conducted in Brazil (45,45%) and with a cross-sectional methodological design (63,63%). As for the population/sample, this ranged from 61 to 2.073 health professionals. Among the studies listed, six (54,54%) were conducted with the nursing team, and 45,45% (n=5) of the surveys were applied exclusively with health professionals working in adult ICUs.

FIGURE 1: Study selection flowchart for integrative review. Curitiba, PR, Brazil, 2020

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The percentage of positive responses for the dimension "Non-punitive responses to error" ranged from 17,50% to 49,34% (Chart 1).

DISCUSSION

Studies show that the dimension "Non-punitive responses to error" was considered a fragile area according to the AHRQ, which recommends a percentage of positive responses ≥75% to be considered favorable areas for patient safety. [16]

This result points to a perception of punitive culture among health professionals in the investigated ICUs, which deserves attention by managers to advance actions aimed at promoting safe practices for critically ill patients, especially when considering the relationship between the organizational safety culture and the implementation of continuous improvement processes. [29]

Chart 1: Summary of studies included for integrative review. Curitiba, PR, Brazil, 2020				
AUTHORS, YEAR, COUNTRY	**STUDY TYPE/LEVEL OF EVIDENCE**	**TYPE OF ICU**	**POPULATION AND/OR SAMPLE**	**RESULTS OF THE DIMENSION "NON-PUNITIVE RESPONSES TO ERROR"**
Armellino et al[18], 2010, Estados Unidos da América	Descriptive and correlational/VI	ICU-A	102 nurses	Positive answers: 21,09%
Mello et al[19], 2013, Brasil	Survey, Cross-sectional and comparative, with a quantitative approach/VI	Two ICU-A of public hospitals.	97 professionals (69 nursing technicians, 21 nurses and 7 nursing assistants)	Positive answers: 18%
Santiago et al[20], 2015, Brasil	Cross-sectional/ VI	Three ICUs (01 ICU-A; 01 ICU-P; ICU-N) of a public teaching hospital	88 healthcare and administrative professionals.	Positive answers: ICU-A: 25,0% ICU-P: 32,5% ICU-N: 31,1% Overall: 29,6%
Tomazoni et al[21], 2015, Brasil	Quantitative descriptive-exploratory, cross-sectional survey/ VI	Four type II ICU-N of four public hospitals	141 professionals from the nursing and medical team (58 nursing technicians, 48 doctors, 23 nurses and 12 nursing assistants)	Positive answers: 18% Neutral answers: 22% Negative answers: 58%
Profit et al[22], 2016, Estados Unidos da América	Cross-sectional/VI	44 UTI-N that make up the California Perinatal Quality Care Collaborative (CPQCC) state network	2.073 professionals (235 doctors, 1.499 nurses, 286 physiotherapists; 32 ignored)	Positive answers: 49,34%
Ling et al[23], 2016, China	Prospective controlled/ III	Two ICU-A of two public hospitals	95 participants (78 nurses, 11 patient care assistants; 6 physicians)	Positive answers: 19%
Collier et al[24], 2016, Estados Unidos da América	Descriptive/ VI	26 ICU (not described specification) of 11 hospitals	98 nurses	Positive answers: 34%
Mello et al[25], 2017, Brasil	Survey and cross-sectional/ VI	Two ICU-A of Public Hospitals	86 nursing professionals	Positive answers: 17,5%
Farzi et al[26], 2017, Irã	Cross-sectional and descriptive/ VI	ICU (not described specification) of nine teaching hospitals	367 nurses	Positive answers: 24,7%
Amiri et al[27], 2018, Irã	Randomized clinical trial/II	Six ICU-A of a general hospital	61 participants (48 nurses and 13 supervisors of nursing services)	Positive answers: 21,66%

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Notaro et al[28], 2019, Brasil	Survey and cross-sectional/ VI	Three ICU-N of large public hospitals	514 health professionals (223 nursing technicians; 121 nurses; 79 physicians; 91 participants distributed among speech therapists, physiotherapists, occupational therapists, social workers and psychologists)	Positive answers: 18,9% Neutral Answers: 25,6% Negative answers: 55,4%

Caption: ICU – Intensive Care Unit; ICU-A - Adult Intensive Care Unit; ICU-P - Pediatric Intensive Care Unit; ICU-N - Neonatal Intensive Care Unit

It should be noted that the behavior and organizational identity related to attitudes and values can be different in different administrative natures, which, in turn, contribute to diversified approaches to the occurrence of errors, [30] and positive perceptions, or not, in relation to the punitive culture. A guilt-free environment, in which health professionals can report errors or near misses without fear of reprimand or punishment, is necessary to reduce unsafe behaviors, in addition to contributing to the positive construction of the organizational safety culture. [11]

It was observed, among the studies that made up this integrative review, that the best culture score was found in investigations in the United States of America (USA) with 34% [24] and 49,34% [22] of positive responses in the dimension "Non-punitive responses to error". Although it is still considered a weak score to promote a safe care environment, there is a relevant difference in comparison with Brazilian surveys that presented positive response scores below 20%, regardless of the specific characteristics and peculiarities existing between the neonatal ICU and the Adult care ICU. [19,21,25,28]

A possible explanation for more favorable results for neonatal ICUs in the USA may be primarily the fact that the HSOP-SC was previously constructed and validated by researchers from that country, making it possible to measure the previous safety culture in other countries, including Brazil. And, secondly, that the 44 neonatal ICUs [22] make up a state network which has a committee of specialists in quality improvement composed of neonatologist physicians and nurses. It is believed that

this fact may have collaborated to identify fragile areas and, thus, adopt actions that promote patient safety. This inference, therefore, contributes to reducing the team's perception of individual blaming and punitive culture in the US prior to other countries; however, it needs to be further explored in subsequent studies.

The culture of the individual's guilt in health care hinders progress in other dimensions that make up the safety culture. [11] Furthermore, it causes distortions in the use of quality and safety tools when these are used for punitive purposes and not for organizational learning. [10] In this context, reversing the punitive perception of the health team in the context of critical care units is challenging, as it remains rooted in different hospital settings, [10,30] and that raises the theme of fair culture and the culture of non-blame.[20] The investigations analyzed here were mostly conducted in public hospitals,[19-21,23,25,28] which partly explains the similar percentages between the surveys analyzed here, given that most hospitals are managed or financed by the public sector. Furthermore, it refers to the idea of a deficit in patient safety research in private institutions.

It should be noted that researchers from Brazil [31-32] and from Peru [33] revealed that there are differences in the perception of health professionals about punishment in view of the occurrence of errors between public and private hospitals. This fact possibly indicates that the administration and the management model adopted institutionally impact on the construction of subcultures, with different behaviors, beliefs and values, which influence the transition from the perception of a punitive and blame culture to a fair and learning

culture between professionals and managers in different health settings.

Thus, leaders, especially in nursing and medicine, need to be trained and encouraged to promote a fair culture in the work environment. The non-punitive approach to errors must be worked on continuously in continuing education and during the interprofessional training process. Participatory management, effective communication and the development of actions involving the entire health organization to aim for a culture of notification, non-punitive and organizational learning are necessary to strengthen the institutional safety culture and, consequently, revert this punitive perception. [34]

On the other hand, a randomized clinical trial developed in Iran revealed that the dimensions "Non-punitive response to errors" and "Frequency of reported events" did not significantly improve even after the implementation of an educational program on patient safety, [27] which is corroborated by another prospective study conducted by researchers in China. [23] It is noteworthy that, in the two aforementioned studies, the educational program contributed positively to the improvement in several domains of the culture of patient safety in the ICU, but had little impact on the migration from punitive to fair culture, which encourages changes in specific strategies for this composite of organizational culture. Furthermore, it becomes evident that improvement approaches must include both organizational measures and care actions that influence the provision of safe care in ethnically diverse teams. [35]

The fact that educational programs have not contributed to reversing the punitive culture reinforces the need for

discussions to identify the specific and necessary skills of the management and corporate team to conduct training/training aimed at training other health professionals in the area of safety of the patient. Likewise, it corroborates the growing need to include the theme from the initial training of these professionals, with emphasis on nurses and physicians, with a view to developing managerial skills aimed at providing excellent care, such as communication and planning centered on safety. [36]

Given the multifaceted aspects that contribute to the perception of guilt and punishment, it is important to recognize the need for more research, including covering subjective issues in order to understand the threatening elements for the communication of errors in care and the punitive culture in institutions , as it is a little explored topic with many gaps. [21,25] The literature recommends penalizing the employee only in extreme cases, carrying out non-punitive assessments and adopting strategies so that the professional communicates the error, and that it is corrected in a non-punitive manner, are pointed out as factors relevant to the advancement in this important aspect of the culture of patient safety. [19] It is known that time is a determining factor for changes in this important cultural aspect to occur and satisfactorily reflect on clinical practice outcome indicators. Thus, one of the steps to improve this composite of safety culture is the importance attributed by the management in not treating errors in a punitive way. [34,37]

The limitation of this integrative review is related to the scarce number of eligible primary studies. The incipience in exploring and discussing the dimension of non-punitive responses to errors by researchers in these studies adds to the limitations.

CONCLUSION

The articles analyzed in this integrative review highlight, through their results, a weakness in the dimension "Non-punitive responses to error", which denotes that the punitive culture about errors is present and rooted in the context of ICUs. It is believed that this factor, associated with failures in communication by health professionals, may be strongly related to the deficiency in the frequency of reports of mistakes made, accentuated by the fear of individual guilt and not in a systemic way.

A work environment open to communication, with the adoption of strategies aimed at a fair and non-punitive culture, can contribute to the promotion of safe practices. It is necessary to address the issue in technical and higher education, with the development of more studies related to the non-punitive culture, with a view to implementing continuous actions aimed at patient safety and in favor of improving the quality of care. ■

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