Original Research Article
Disclosure as a tool for communication errors in healthcare

ABSTRACT

Introduction: Patient safety is currently the central focus of quality management, and patient care has evolved based on experiences, research and advances in the areas of education and healthcare. Among the countless tools that seek excellence in patient care and safety, Disclosure is the term that refers to the disclosure, revelation or sharing of information related to errors or adverse events with life-threatening consequences.
Aim: To understand the perceptions and experiences of healthcare professionals working in Brazilian hospitals in relation to the use of Disclosure.
Methods: This is a descriptive study with a qualitative approach. The participants were professionals who work in the Patient Safety Centers of general hospitals in Curitiba, Paraná, Brazil. Information was collected through semi-structured interviews.
Results: The participation rate in the research was 80%, totaling twelve professionals. Ideas that converged were extracted from the interviews and observations, indicating a categorical analysis approach to identify patterns and trends in participants' responses, from which five categories could be constructed, namely: (Mis)knowledge, Disclosure, Quality and Litigation , Professional Alignment, Work Process.
Conclusions: It was possible to observe a procedural gap between hospitals that implement Disclosure and those that do not, and the prevalence of hospitals with health accreditation seals is driving the increasing increase in compliance with these requirements, mainly through teaching and search.

Keywords: Medical errors; Adverse events; Patient safety; Disclosure; Education

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1. INTRODUCTION

In the current scenario, where patient safety is central to quality management and the care provided, the term Disclosure has emerged as a protocol adopted by institutions committed to patient safety. Its purpose is to share with patients and families the occurrence of errors in health care, providing an honest account of what happened, as well as the measures taken to minimize damage and preventive actions [1].
Patient safety is a critical measure for the quality of health services, aimed at preventing harm and injury resulting from the care provided. In most definitions, patient safety is not limited to the mere absence of errors, but is intrinsically linked to the absence of accidental injuries. From this perspective, experts argue that focusing on reducing the number of injuries is more pragmatic and productive than concentrating exclusively on the errors made during healthcare provision [2]. Annual estimates of the number of preventable adverse events vary substantially, ranging from 1.3 million to 15 million. This disparity is partly attributable to the complexity of conceptualizing these events and the variety of monitoring systems in place.

Globally, the regulation and implementation of safety practices are fundamental, and various measures are adopted on a daily basis to strengthen this commitment. In this regard, different countries are seeking to improve health care, particularly by highlighting the importance of Disclosure. This structured process of communicating with patients and their families in cases of serious unintentional harm is recognized by healthcare professionals as a fundamental practice for promoting transparency and trust in the care environment.
Although there is no specific legislation or precise definition for Disclosure, its effective practice requires ethical and moral reflection, with a respectful attitude that values patients' complaints [3]. This strategy is considered to be excellent for promoting patient well-being and reducing economic backlogs due to legal issues. In a survey carried out among healthcare professionals and patients/family members, it is mentioned that the Disclosure process does not receive enough attention in the scientific community or in healthcare institutions globally, with few countries adopting formalized and institutionalized practices through protocols or guidelines on this effective but primarily human communication technique [4].
Above all, disclosure stands as a fundamental foundation for building and maintaining trust in the provision of healthcare. Patients expect to receive complete and transparent information about the care process, including the risks, benefits and potential failures. The right to information is fundamental to the doctor-patient relationship. Hiding such failures only intensifies the suffering of patients and their families, preventing them from understanding what happened, seeking proper follow-up and even making crucial decisions for their health [5, 6].
Disclosure, therefore, transcends the mere communication of facts and becomes an essential element of the care process. Through transparency, patients become active agents in their own health, actively participating in decisions that impact their well-being [7].
It can therefore be said that Disclosure, as a process of revealing adverse events and errors to patients, is a practice that has been the subject of considerable reflection and research in the health field. Various ethical and legal aspects surround this process, influencing the quality of healthcare and the relationship between healthcare professionals and patients.
This global scenario, which is still under construction, motivated the search for in-depth knowledge of a specific context, considering that the researcher is a nurse who works with patient education and safety. We therefore set ourselves the objective of understanding the perceptions and experiences of healthcare professionals about Disclosure and its application in their respective institutions, an opportunity to discuss and add comprehensive ideas about how healthcare institutions work with Disclosure and also how they play their role in reporting adverse errors. This study also aims to contribute to the improvement of healthcare communication practices, promoting a transparent and ethical approach to disclosing information to patients and their families.

2. METHODS

In order to achieve the proposed objective, this study was carried out using descriptive research with a qualitative approach, which consists of a methodology aimed at exploring and understanding complex phenomena, behaviors, opinions and human experiences [8].
To carry out this study, the structure was divided into three phases: 1) pre-analysis, where a precise work scheme is established and the material to be analyzed is organized; 2) exploration of the material, involving floating reading, selection of documents, formulation of hypotheses and objectives, referencing of indices and development of indicators; and 3) treatment of the results, including collection, interpretation and condensation of information for analysis [9].
The participants were employees responsible for Patient Safety Centers or those designated for this role, identified through a search on the website of the National Health Surveillance Agency in Brazil. The aim of this initial survey was to identify healthcare establishments

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characterized as general hospitals that declared they had a registered Patient Safety Unit (PSU). After the initial collection of information, in which results were obtained from all over Brazil, it was necessary to delimit the sample with hospitals in the city of Curitiba, state of Paraná, Brazil and finally, an additional refinement was carried out to exclude hospitals that reported providing care exclusively in specific areas, such as maternity wards, pediatrics, cosmetic surgery, ophthalmology, nephrology and orthopedics. The final sample included public and private hospitals, with no distinction made between the size of the institution or the level of complexity of the care provided, in the city of Curitiba, and with a Patient Safety Center in place for six months or more.

The project was submitted for ethical appraisal and was approved under number 5.931.390.

The information was collected through semi-structured interviews with the following guiding questions: 1- What do you know about Disclosure, 2- What is your perception of Disclosure and the quality of care? 3- In the Patient Safety Center, how do you contribute to the development of the Disclosure process? 4- Is there a memorable fact for you related to Disclosure in this Institution and 5- What does the implementation of Disclosure change in the routine or work processes in the Institution? and finally, for the third and last part, the question was: in one word, how would you describe the Disclosure process?

The interviews were carried out between May and August 2023 after obtaining the consent of the participants, but it is worth noting that two nurses took part beforehand to validate the interview, which underwent minor adjustments.

Data collection ended when new information no longer provided additional ideas, reaching the densities and diversity needed to answer the research objective. This point of theoretical saturation indicates that the quantity and variety of data collected was sufficient to support the study's analysis and conclusions [10].

After the transcriptions were made, without the use of software, they were returned to the participants for their final consent.

3. RESULTS AND DISCUSSIONS

As we begin to present the results, it is important to note that the study design was based on the Eight Big Tent Criteria to support the research with excellence, using the COREQ qualitative checklist [11, 12].

Twelve professionals responsible for the NSP or Quality sectors actively participated in this research, providing a comprehensive analysis of the practices related to Disclosure in the institutions studied, achieving a representativeness of 80% in relation to the estimated audience.

During the process, we sought to understand healthcare professionals' perceptions and experiences of Disclosure. Of the data obtained and compiled, 41.7% of those interviewed said that they carry out Disclosure internally in their institutions, 25% carry it out partially, recognizing its importance but still unable to fully implement it, while 33.3% do not carry it out, as shown in Graph 01. In addition, the Table 01 also shows that the size of the institutions interviewed was six large (50%), four medium (33%) and two small (17%). As for the complexity of the care provided, ten were high and medium risk (83.3%) and two were low risk (18%).

Table 01. Hospitals with active Disclosure.

Hospital	Disclosure	Size	Complexity
H01	No	Large	High
H02	Yes	Large	Medium

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H03	Partial	Large	High
H04	Yes	Medium	High
H05	No	Small	Medium
H06	Partial	Small	Low
H07	Partial	Large	High
H08	Yes	Medium	Medium
H09	Yes	Large	High
H10	Yes	Large	High
H11	No	Medium	Medium
H12	No	Medium	Low

**Source: the authors*

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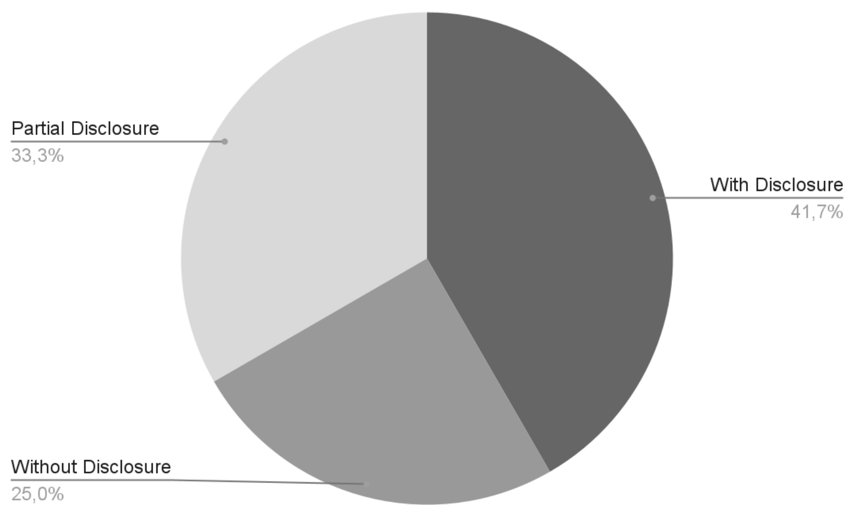
Graph 01: Percentage of hospitals with active Disclosure.



**Source: the authors*

The information obtained through the semi-structured interview was analyzed according to the theoretical framework and it was possible to didactically describe the content in five categories, which will be presented individually.

3.1 Category I - (Un)knowledge

When asked what they knew about Disclosure, some of the participants showed ease of comprehension, answering in an enlightening manner, as exemplified below:

> "It's a process for when we have an adverse event for the patient, from the moment we are sure that it was an adverse event, that there was a flaw in the process or a breach of conduct, which led or could have led to some damage, we need this transparency with the family, with an apology." (H11)

However, with regard to other participants, it was clear that they did not have in-depth knowledge of the subject, since their answers were brief or evasive:

> "The concept, but I understand that it's about working transparently both with the team and with the family." (H01)

> "We don't apply in hospital." (H05, 06 e 12)

In order to carry out Disclosure effectively, it is very important to know how to communicate the news to family members and the patient, but first you need to know its concept, recognize its causes and take an in-depth look at the fact. In this study, we observed that this is not always the case, because some professionals, although they already have a certain familiarity with the subject, don't know it properly. The professional responsible for carrying out the Disclosure must be aware that they are sharing information that is not always pleasant, and they need to approach it carefully in order to keep those involved comfortable during the conversation. Otherwise, there is a risk of causing greater trauma and jeopardizing the relationship of trust [13].

Disclosure aims to promote transparency, accountability and trust among stakeholders. However, it is important to note that the effectiveness of disclosure depends not only on the amount of information disclosed, but also on the clarity, accessibility and honesty with which it is presented. If the professionals involved don't know, don't reflect, don't improve on the subject, as was highlighted in some of the speeches, it is understood that disclosure will be hindered. Integrity and ethics play a fundamental role in conducting Disclosure at all levels and knowledge, sharing and dissemination of this practice is of great value if the goal of improving processes and quality of care is to be achieved [14].

3.2 Category II - Disclosure, quality and litigation

By recognizing and communicating errors, unnecessary litigation can be avoided, promoting organizational learning and ensuring that patients receive the support they need after adverse events occur. In addition, organizational learning is not restricted to simply informing patients about adverse events; it also involves analyzing these events to understand their causes and implement improvements. This learning process is vital for improving the quality of care, identifying risk areas and preventing future incidents. Quality in healthcare is a continuous process of improvement [15].

Below is an answer obtained in relation to an interviewee's view of the Disclosure process:

> ""A tool to share with them the cases that don't have a satisfactory outcome in their institution" (H04)

Disclosing information about safety incidents to patients and their families not only reinforces transparency, but is also a determining part of patient-centered care. This practice not only meets ethical requirements, but also contributes to maintaining trust by demonstrating a genuine commitment to patient well-being and safety [15]. The speeches reveal this extremely important issue, as can be seen:

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> "Having a family member at the meeting so that patients and/or their families can give ideas for improving activities is a way of building patient loyalty to the hospital." (H02)

Legal disputes in healthcare often arise from allegations of medical negligence, diagnostic errors, inadequate treatment, among other problems related to the quality of care. Proper disclosure of information and detailed documentation are crucial in cases of litigation [16]. In addition, health legislation, based on the National Health Council's Charter on the Rights of Health Users, guarantees people the right to adequate treatment, clear information about their state of health and respect in communication [17].

> "We communicated with the family, informed them of everything that had been done, and even so, after a while the lawsuit arrived." (H11)

> "We had a situation in which we were first notified by the event team, we began to investigate the process, and we had already taken it to the management, we had already brought in others involved, those responsible for the processes in the situation, and we had already come to the conclusion that we were going to have to talk to the family because of the failure that had occurred. Then, before we called the family in to talk, the family came in nervous..., quite armed and realized that we already knew about the situation and that we already had some options for resolving the problem for them, so the family calmed down, and the perception was that, as much as the fault was (...) a very serious flaw, something that there was no going back to fix, but we still managed to show the family that the measures had already been taken, so that it wouldn't happen to others.... that's the idea, it's exactly that we managed to put some options on what to do from then on with that family or another patient (...) so the family calmed down a bit and it didn't end up generating a legal case." (H07)

The interviews revealed that the Patient Safety or Patient Risk Management sector is an active arm of the Quality sector in the institutions surveyed. This integration facilitates the implementation of preventive measures and technical adjustments to the conduct needed to guarantee patient safety.

Without a doubt, Disclosure plays a critical and transformative role in promoting the quality of healthcare. Its essential contributions include creating an environment of trust, stimulating learning and reinforcing responsibility, providing significant benefits for patients, healthcare professionals and healthcare institutions as a whole [18]. By adopting Disclosure, healthcare institutions demonstrate a clear commitment to transparency and honesty. This open and frank approach builds trust with patients, who feel safer receiving care from professionals and institutions that recognize and report adverse events [19].

By taking responsibility for adverse events, healthcare institutions and professionals demonstrate a proactive stance towards transparency. This not only strengthens patient trust, but also reinforces ethical and professional responsibility in the provision of healthcare [19].

3.3 Category III: Professional alignment

The active involvement of the patient in decision-making about their care is recognized as an essential component for improving healthcare [20]. In addition, the effective participation of hospital staff in communicating Disclosure in situations of adverse events or medical errors is extremely important. The staff's transparent and ethical approach plays a fundamental role in managing these situations, contributing to building a relationship of trust between healthcare professionals and patients.

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The effective participation of hospital staff in communicating Disclosure is equally vital. Healthcare professionals, including doctors, nurses, psychologists, social workers and administrators, play specific roles in managing these situations. The team's transparent and ethical approach contributes to building a relationship of trust with patients.
Effective collaboration between these professionals is essential to ensure a comprehensive approach, taking into account different perspectives and needs [21]. Along these lines, a good comment from one of the participants:

> “Since the integration, we have talked about what Disclosure is and how we work with it within the Institution.” (H02)

Hospital staff play a crucial role in providing psychosocial support to patients and their families during the Disclosure process. Offering emotional support, clarifying doubts and making referrals to counseling services are important aspects of this support, especially when it is clear that professionals are aligned in their approach to healthcare [22].
The presence of a professional who has established a bond with the patient or family member during the Disclosure process is highlighted as effective. This professional, through the relationship built up, can provide additional support in clarifying doubts, contributing to a more humanized experience [23].
It is essential that hospital staff are instructed on how to prevent adverse events and, equally important, how to report them if they occur. Clear knowledge of the procedures to be followed provides an efficient response to adverse events, ensuring that communication is carried out properly and effectively [24].
In order for the team to be aligned and provide assistance in an equitable manner, we can say that the presence of established and systematized criteria is highlighted as a fundamental element. This implies having clear policies, well-defined procedures and systematized criteria that contribute to a more effective and ethical approach to Disclosure. These practices not only facilitate open communication with patients, but also promote organizational learning and the prevention of future adverse events [25].
Error analysis must go beyond individual accountability and seek to understand what went wrong in the system. This systemic approach is of great importance in identifying gaps in processes, system failures and areas for improvement. Healthcare professionals play a central role in identifying opportunities for improvement in processes and practices and engaging in continuous improvement initiatives contributes to a safer care environment [26].
An organization with an effective safety culture is characterized by openness and fairness when incidents occur. This implies not seeking immediate blame, but understanding the systemic factors that contributed to the adverse event. Healthcare professionals must feel motivated to notify or report errors when they occur. This is related to trust in the organization's approach to dealing with incidents constructively, without excessive penalties [27].

3.4 Category IV: Events

In this research, it was possible to observe that in all the institutions involved, there have been adverse events in recent years. Examples of participant reports follow:

> *“We had an elderly 80-year-old patient who had been discharged. The family was approached so that the patient could be discharged in accordance with the routine established by the hospital, which was to take a wheelchair to the exit and after checking he would be released, the family commented on the patient's stubbornness and that they wanted to guarantee his support, and at the end of the day he did what he wanted and almost as soon as he left the hospital there was a fall and consequently he died.” (H04)*

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“We had an exchange of urine results between an adult and a child, where when evaluating the response of the test, the presence of spermatozoa was noticed, where it was at first imagined possible violence to the minor, with this, when talking to the mother, the child spent part of the day with the father, this fact generated an uncomfortable suspicion about it, compliance and legal were involved to talk to the family and inform the failure that was the exchange of results in the laboratory sector of the Institution.” (H01)

Here, we only present two events that took place. However, during the interviews, we noticed that each individual had something to relate or exemplify. Most of the time, these experiences went beyond a single situation, thus highlighting the importance of a Disclosure process that is systematized, clear and ethical.
It is estimated that adverse events are among the top ten causes of health problems resulting in death or permanent injury, and it is even recognized that adverse events are significant concerns and that the notification and reporting of these incidents are essential to improving patient safety, as well as preventing future occurrences.
It is imperative that organizations establish a documented policy that clarifies to everyone the significance of the notification or reporting system. This policy should address the consequences associated with this, clarify the rights, privileges, protections and obligations that individuals can expect. Encouraging people to notify/report security incidents is key to building trust, based on the premise that information provided in good faith will not be used in a harmful way against the informants [28]. From these perspectives, the facts described demonstrate the importance of clear communication between the different team members and point to the need to establish protocols that everyone can follow effectively and effectively.

3.5 Category V: Work processes

The work process related to Disclosure begins with the identification of the adverse event or error. This process can be triggered through security monitoring, incident reporting, patient complaints, or other detection mechanisms. Once identified, the adverse event is reported and recorded, involving the completion of reporting forms and documentation of the circumstances of the event, as well as the collection of relevant information. Concomitantly, an internal investigation is conducted to understand the causes and circumstances of the adverse event or error [29].
This investigation process involves reviewing medical records, interviewing the team involved, and identifying any potential flaws in the process. The health team associated with the adverse event is informed and participates in the Disclosure process, including internal meetings to review the results of the investigation.After this stage, the health team prepares to communicate the adverse event to the patient and family in a sensitive and transparent manner. Where appropriate, remedial measures are discussed and implemented, such as additional treatment, psychological support, or financial assistance. Throughout this process, it is essential to provide support to the patient and family [30].
Finally, the healthcare team communicates how they can learn from the adverse event or error, highlighting the implementation of corrective measures to prevent similar errors in the future. This process is vital to ensure transparency, accountability, and continuous improvement in the quality and safety of patient care, and can be understood in the following speech:

“An easy practice, we have event notifications, there is an underreporting and sometimes we do active search, so events that reached the patient, those that have priority for Disclosure, events in patient safety that we take from the quality improvement report or we identify by active search (...) for example, I

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am there evaluating a case of infection and suddenly there is a hematoma that was not notified here by the report of quality." (H02)

The Disclosure, by addressing the open and transparent disclosure of adverse events or medical errors to patients and their families, is intrinsically linked to quality in patient safety. This practice aims to promote trust and effective communication between patients and healthcare professionals, contributing to the establishment of a culture of safety. Authenticity in communication during Disclosure is essential to ensure that patients receive safe and effective health care [28]. The practice of Disclosure not only builds trust but also plays a significant role in quality and safety improvement initiatives in the healthcare industry. By recognizing and reporting errors, unnecessary litigation can be avoided, promoting organizational learning, and ensuring that patients receive the necessary support after adverse events. In addition, organizational learning is not restricted to simply informing patients about adverse events; It also involves analyzing these events to understand their causes and implement improvements. This learning process is vital for improving the quality of care, identifying areas of risk, and preventing future incidents. Quality in health care delivery is a continuous process of improvement [15].

To complement the answer to the last question of the interview, a visual representation of the words provided by the interviewees was made, forming from a free evocation of words. Three of the institutions, as they do not have the Disclosure process active, refrained from conceptualizing. In this question, six words were mentioned, namely: Transparency (3 mentions), Responsibility (2), Challenge (1), Respect (1), Learning (1), and Essential (1), as you can see below:

*Source: the authors

The representation shows that transparency is essential for patient safety, however, it presents itself as a challenge to be overcome immediately. Time is pressing. The promotion of safe care must be boldly recognized in the contemporary scenario, outlining a strategy to improve the services offered and transform care practices. This allows for critical, reflective, purposeful, committed, and technically competent action [31].

4. CONCLUSIONS

It was possible to apprehend relevant and up-to-date facts, experiences and reports on Disclosure, a process that is not yet widely adopted in hospitals in Curitiba, Paraná State, Brazil. This gap reflects the need to consolidate this capability to facilitate the communication of adverse events or possible errors to patients and their families, not locally, but can be expressed to other healthcare settings globally.

Initially, it was observed that health professionals were unaware of the practice of disclosure, resulting from the lack of training aimed at professional training and discomfort in admitting or disclosing adverse events. In accredited institutions, however, there was a growing demand for compliance with this requirement, driving investments in continuing education programs. This not only strengthens patient safety but also improves the quality of care and promotes a fair culture in hospital institutions.

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Although still in incipient stages, some institutions already have systematized protocols for carrying out Disclosure, following pre-defined regulations. Others, however, did not pay due attention to this crucial point for the quality of care, evidencing the need for preparation and updating of professionals in the face of the evolution of the care process and the central role of the patient in health care.
It is essential that health institutions invest in continuing education programs to disseminate the culture of Disclosure among professionals, overcoming resistance and promoting transparency in relationships with patients. The implementation of clear protocols and the creation of an organizational culture that values patient safety are essential steps for the consolidation of this practice. In addition, it is necessary to encourage research on the subject, in order to identify the best practices and challenges to be overcome. The construction of a support network among health institutions can facilitate the exchange of experiences and the development of innovative solutions for the implementation of Disclosure.
We highlight, at the end, that organizational culture plays a fundamental role in the implementation of Disclosure. A culture of transparency and accountability is essential for building safer and more reliable health institutions. The implementation of Disclosure requires a profound cultural change, which involves all levels of the organization.
Although the shortcoming of this study is the fact that it was carried out in few health institutions, it is necessary to recognize that Disclosure is not only a legal requirement, but an ethical commitment to the quality and humanization of care. Therefore, we point to future opportunities regarding the implementation of disclosure, highlighting the role of managers and health professionals in promoting this practice.

REFERENCES

1. Pauferro MRV. The importance of the disclosure process for patient safety. Nexxto 2020. https://nexxto.com/a-importancia-do-processo-de-Disclosure-para-a-seguranca-do-paciente (accessed on October 30, 2022).
2. Fiocruz News Agency. Fiocruz News Agency 2008. https://agencia.fiocruz.br/pesquisador-apresenta-resultados-de-estudos-sobre-eventos-adversos-em-hospitais (accessed on November 2, 2022).
3. Façanha TR dos S, Machado IL de O, Garrafa V. The practice of disclosure as a strategy for patient safety in Brazil and its relevance for health care for the elderly. Cad Ibero-Am Direito Sanit 2022;11:91–110. https://doi.org/10.17566/ciads.v11i3.910.
4. Ribeiro ER, Bertoldo CLG, Kunz AC. The use of disclosure as a tool for quality management and patient safety: a systematic review. Res Soc Dev 2021;10:e67101316252. https://doi.org/10.33448/rsd-v10i13.16252 (accessed October 30, 2023).
5. Kalra J. Medical errors and patient safety: strategies to reduce and disclose medical errors and improve patient safety. Walter de Gruyter; 2011.
6. Blendon RJ. Views of practicing physicians and the public on medical errors. New England Journal of Medicine 2002;24:1933–40.
7. Gallagher TH. Patient and physician attitudes toward the disclosure of medical errors. Jama 2003:1001–7.
8. Godoy AS. Introduction to qualitative research and its possibilities. RAE 1995;35:57–63. https://doi.org/10.1590/s0034-75901995000200008.
9. Bardin L. Content Analysis. São Paulo: Almedina; 2011;70:229.
10. Minayo MC de S. The challenge of knowledge: qualitative research in health. São Paulo: Hucitec; 2010;12:261–297 (accessed October 10, 2023).

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11. Tracy SJ, Hinrichs MM. Big tent criteria for qualitative quality. The International Encyclopedia of Communication Research Methods 2017:1–10. https://doi.org/10.1002/9781118901731.iecrm0016.
12. Souza VR dos S, Marziale MHP, Silva GTR, Nascimento PL. Translation and validation into Portuguese and evaluation of the COREQ guide. Acta Paul Enferm 2021;34. https://doi.org/10.37689/acta-ape/2021ao02631 (accessed on October 30, 2023).
13. Branco J. Disclosure: a necessary protocol for patient safety. Medicina S/A 2023. https://medicinasa.com.br/Disclosure-protocolo (accessed on January 13, 2024)
14. Dantas P. When should an adverse event be reported to a patient or their family? - Disclosure. Jus.com.br 2022. https://jus.com.br/artigos/99535/em-que-momento-comunicar-ao-paciente-ou-sua-familia-evento-adverso-Disclosure (accessed on January 18, 2024).
15. Kim CW, Myung SJ, Eo EK, Chang Y. Improving disclosure of medical error through educational program as a first step toward patient safety. BMC Med Educ 2017;17:52. https://doi.org/10.1186/s12909-017-0880-9.
16. Bahia AA, Cunha NG. Challenges in implementing disclosure as a component of the healthcare safety process [undergraduate thesis]. Belo Horizonte: Universidade Federal de Minas Gerais; 2019 (accessed on January 20, 2024).
17. Albuquerque A. Disclosure of patient safety incidents from the perspective of Patient Rights. Cad Ibero-Am Direito Sanit 2022;11:70–90. https://doi.org/10.17566/ciads.v11i3.925 (accessed on March 15, 2024).
18. LEIASS. Quality in Care and Patient Safety: Education, Research and Management. vol. 8. 1st ed. 2021.
19. Conceição SH da, Dourado GB, Baqueiro AG, Freire S, Brito P das C. Determining factors in disclosure in Corporate Social Responsibility (CSR): a qualitative and quantitative study with companies listed on Bovespa. Gest Prod 2011;18:461–72. https://doi.org/10.1590/s0104-530x2011000300002 (accessed March 17, 2024).
20. Harrison R, Walton M, Kelly P, Manias E, Jorm C, Smith-Merry J, et al. Hospitalization from the patient perspective: a data linkage study of adults in Australia. Int J Qual Health Care 2018;30:358–65. https://doi.org/10.1093/intqhc/mzy024.
21. Siman AG, Brito MJM. Changing nursing practice to improve patient safety. Rev Gaucha Enferm 2016;37. https://doi.org/10.1590/1983-1447.2016.esp.68271 (accessed on March 17, 2024).
22. Galano E, De Marco MA, Succi RC de M, Silva MH da, Machado DM. Interview with family members: a fundamental instrument in planning the diagnostic disclosure of HIV/AIDS for children and adolescents. Cien Saude Colet 2012;17:2739–48. https://doi.org/10.1590/s1413-81232012001000022.
23. Brunello MEF, Ponce MAZ, Assis EG de, Andrade RL de P, Scatena LM, Palha PF, et al. O vínculo na atenção à saúde: revisão sistematizada na literatura, Brasil (1998-2007). Acta Paul Enferm 2010;23:131–5. https://doi.org/10.1590/s0103-21002010000100021 (acesso em 12 de março de 2023).
24. dos Santos MC, Grilo A, Andrade G, Guimarães T, Gomes A. Health communication and patient safety: problems and challenges. Rev Port Saúde Pública 2010;28:47-57 (accessed on June 1, 2024).
25. Cox S, Cox T. The structure of employee attitudes toward safety: a European example. Work & Stress 1991;5(2):93-106.
26. National Health Security Agency. Reference document for the National Patient Safety Program. Brasília: Editora MS; 2014 (accessed on February 3, 2024).
27. Belela ASC, Peterlini MAS, Pedreira M da LG. Disclosure of medication errors in a pediatric intensive care unit. Rev Bras Ter Intensiva 2010;22:257–63. https://doi.org/10.1590/s0103-507x2010000300007.

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28. 28. Dekker SWA, Breakey H. 'Just culture:' Improving safety by achieving substantive, procedural and restorative justice. Saf Sci 2016;85:187–93. https://doi.org/10.1016/j.ssci.2016.01.018.
29. National Health Surveillance Agency. Investigation of Adverse Events in Health Services. Brasília: Editora MS; 2013 (accessed on February 3, 2024).
30. Busetti F, Baffoni G, Tocco Tussardi I, Raniero D, Turrina S, De Leo D. Policies and practice in the disclosure of medical error: Insights from leading countries to address the issue in Italy. Med Sci Law 2021;61:88–91. https://doi.org/10.1177/0025802420979441.
31. Ministry of Health. Ordinance No. 529, of April 1, 2013. Institutes the National Patient Safety Program (PNSP). Official Gazette of the Union April 2, 2013 (accessed on March 14, 2023).

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