



PERCEPTIONS OF NURSES IN A PRIVATE HOSPITAL ABOUT ADVERSE EVENTS IN NURSING CARE

PERCEPÇÕES DE ENFERMEIROS DE UM HOSPITAL PRIVADO SOBRE EVENTOS ADVERSOS NA ASSISTÊNCIA DE ENFERMAGEM

PERCEPCIONES DE ENFERMEROS DE UN HOSPITAL PRIVADO SOBRE EVENTOS ADVERSOS EN LA ASISTENCIA DE ENFERMERÍA

Fabiele Aozane¹, Diogo Jardel Cigana², Eliane Raquel Rieth Benetti³, Gerli Elenise Gehrke Herr⁴, Adriane Cristina Bernat Kolankiewicz⁵, Máira Fátima Pizolotto⁶

ABSTRACT

Objective: to know perceptions of nurses in a private hospital on Adverse Events in nursing care. **Method:** qualitative, descriptive study conducted with eight nurses, between January and February 2014, with a sociodemographic characterization questionnaire and open questions, after the research project approved by the Research Ethics Committee, CAAE No. 24501413.3.0000.5350. **Results:** the nurses have knowledge of Adverse Events and their occurrence in the workplace, identifying the need for protocols directed to nursing actions and realizing the importance of permanent training. **Conclusion:** to know the perceptions of nurses helping to identify weaknesses and potential of the work processes, support the team instrumentalization in order to identify sources of Adverse Events, working with their prevention and minimization, making the assistance more effective and safer to patients. **Descriptors:** Nursing; Security Management; Quality of Health Care; Safety.

RESUMO

Objetivo: conhecer percepções de enfermeiros de um hospital privado sobre Eventos Adversos na assistência de enfermagem. **Método:** estudo qualitativo, descritivo, realizado com oito enfermeiras, entre janeiro e fevereiro de 2014, com um questionário de caracterização sociodemográfica e questões abertas, logo após o projeto de pesquisa ter sido aprovado pelo Comitê de Ética em Pesquisa, CAAE nº 24501413.3.0000.5350. **Resultados:** os enfermeiros têm conhecimento sobre os Eventos Adversos e suas ocorrências no ambiente de trabalho, identificam a necessidade de protocolos direcionados às ações de enfermagem e percebem a importância de capacitações permanentes. **Conclusão:** conhecer as percepções dos enfermeiros possibilita identificar fragilidades e potencialidades dos processos de trabalho, subsidiar a instrumentalização da equipe com vistas a identificar origens dos Eventos Adversos, trabalhar com a prevenção e minimização destes, tornando a assistência ao paciente mais eficaz e segura. **Descritores:** Enfermagem; Gerenciamento de Segurança; Qualidade da Assistência à Saúde; Segurança.

RESUMEN

Objetivo: conocer percepciones de enfermeros de un hospital privado sobre Eventos Adversos en la asistencia de enfermería. **Método:** estudio cualitativo, descriptivo, realizado con ocho enfermeras, entre enero y febrero de 2014, con un cuestionario de caracterización sociodemográfica y preguntas abiertas, luego del proyecto de investigación haber sido aprobado por el Comité de Ética en Investigación, CAAE nº 24501413.3.0000.5350. **Resultados:** los enfermeros tienen conocimiento sobre los Eventos Adversos y sus ocurrencias en el ambiente de trabajo, identifican la necesidad de protocolos dirigidos a las acciones de enfermería y perciben la importancia de capacitaciones permanentes. **Conclusión:** conocer las percepciones de los enfermeros posibilita identificar fragilidades y potencialidades de los procesos de trabajo, subsidiar la instrumentalización del equipo para identificar orígenes de los Eventos Adversos, trabajar con la prevención y minimización de los mismos, tornando la asistencia al paciente más eficaz y segura. **Descriptor:** Enfermería; Gerenciamento de Seguridad; Calidad de la Asistencia a la Salud; Seguridad.

¹Enfermeira, Especialista em Enfermagem em Terapia Intensiva e Gestão de Pessoas, Hospital Unimed Noroeste/RS. Ijuí (RS), Brasil. E-mail: aozane@hotmail.com; ²Enfermeiro, Especialista em Urgência, Emergência e Trauma, Hospital de Caridade de Ijuí/RS. Ijuí (RS), Brasil. E-mail: diogocigana@hotmail.com; ³Enfermeira, Hospital Universitário de Santa Maria/RS, Doutoranda em Enfermagem, Programa de Pós-Graduação em Enfermagem, Universidade Federal de Santa Maria/PPGENF/UFSM. Santa Maria (RS), Brasil. E-mail: elianeraquelr@yahoo.com.br; ⁴Enfermeira, Hospital Unimed Noroeste/RS, Mestranda, Programa de Pós-Graduação Strictu Sensu em Atenção Integral à Saúde UNICRUZ/UNIJUI. Ijuí (RS), Brasil. Email: gerli.herr@yahoo.com.br; ⁵Enfermeira, Doutora em Ciências, Docente do Departamento de Ciências da Vida da UNIJUI. Ijuí (RS), Brasil. Email: adri.saudecoletiva@gmail.com; ⁶Administradora, Mestre em Administração. Docente do curso de Administração da Universidade Regional do Noroeste do Estado do Rio Grande do Sul (UNIJUI). Ijuí (RS), Brasil. E-mail: mairap@unijui.edu.br

INTRODUCTION

Adverse events are incidents occurring during the provision of health care that result in harm to the patient, being physical, social and/or psychological, including injury, suffering, disability or death.¹ The occurrence of these events may increase hospitalization and costs related to care, causing complications in the patient's condition and even contributing to death.²⁻³ Therefore, this topic has been highlighted worldwide, either because of the events described in the literature as the empirical reports of health professional experiences, being a challenge for the improvement of health care quality.

There is a significant number of adverse events occurring and could have been avoided with action planning in prevention. In this regard, a study that evaluated the incidence of adverse events in three Brazilian hospitals found that, among 1,103 hospitalized patients, 7.6% had suffered any adverse event and 66.7% of those events could have been avoided.³

Thus, nurses need to know in order to prevent, assist with quality and justify their actions. It necessary to empower nurses about the concept and measures for prevention and control of Adverse Events in order to ensure assistance with minimum risk, safe and quality.⁴ In this context, nursing professionals show their concern to the occurrence of non-conformities in nursing care, especially in patient's care and care management, since these events may compromise the results and quality of service.

The recognition and understanding of Adverse Events, its management, control and risk factors, allow the team to the implementation of preventive measures and effective treatment.⁵ In this searching for quality and excellence in care prevention, Adverse Event appears as a challenge and one of the goals to be achieved by professionals working in the health sector. Thus, studies related to the topic are relevant for allowing evaluation of the service, in addition to supporting the actions of healthcare professionals in care planning, in order to prevent the occurrence of adverse events and maintain quality of service and patient safety.

Meanwhile, actions aimed at preventing the occurrence of unwanted situations for the assistance provided in pursuit of awareness of the culture of patient safety are needed. The recognition and identification of non-conformities are considered essential for this development and the possibility of having errors as a source of teaching.⁶ Thus, the

relevance of working with Adverse Events in nursing is to raise awareness and provide tools for nurses to develop actions for a safe care.

In order to answer the main question of this study (What are the perceptions of a private hospital nurses on adverse events in nursing care?), this study aims to:

- Know perceptions of nurses in a private hospital on adverse events in nursing care.

METHOD

Descriptive study with qualitative approach, carried out in January and February 2014 at a mid-sized private hospital from Rio Grande do Sul Northwest, Brazil.

Study participants were randomized in a total of 15 nurses in different hospital units (Emergency Department, Intensive Care Unit and Clinical and Surgical Inpatient Unit) and different work shifts (morning, afternoon and evening) and the inclusion criteria was to work in the institution for more than six months in the hospital. Study participants were eight nurses.

Data collection was conducted through a questionnaire, consisted of two parts: the first one, with socio-demographic and professional data (age, gender, marital status, time operating as a nurse and hospital) and the second part with descriptive questions, such as: Knowledge, frequency, reasons for the occurrence of adverse events in nursing and how is the notification of these events, suggesting actions to prevent and promote patient safety. Data collection questionnaire was given to each nurse, agreeing to return it in a week in sealed box, in the nursing coordination room, preserving the identity of the participants.

Data and reports of participants were transcribed into a Microsoft Word document to form the corpus of analysis and were identified by the letter N (nurse), followed by a cardinal number (N1, N2, N3...). As the questionnaires were returning, data analysis was performed. Data were described and analyzed from the reference of content analysis, followed by the pre-analysis, material exploration, treatment of results, inference and interpretation.⁷ The discussion was held by deepening, comparison and inferences informed on evidence scientific about adverse events and patient safety.

The project followed the recommendations of Resolution 466/12 of the National Health Council and the data collection was started after approval by the Ethics Committee in Research of the Northwest Regional University of Rio Grande do Sul State under Opinion

Aozane F, Cigana DJ, Benetti ERR et al.

511,141 of 16 January 2014, CAAE 24501413.3.0000.5350, approval of the hospital administration and by signing the Informed Consent Form.

RESULTS

All study participants were women, most unmarried and aged 23-34 years old. Referring to the time of work as a nurse, the operating time of six to ten years prevailed.

There were 25 Registration Units studied in the nurses’ reports, described in the following category.

◆ Category 1 - Knowledge of nurses about adverse events

Nurses were asked about their knowledge, perception of Adverse Events in nursing work process. All participants answered this question and found that they are aware of the meaning and recognize their occurrence in nursing care.

The nurses pointed out that the consequences of non-conformities can cause harm to patients and compromise their safety, as shown in the following report.

I understand that adverse events in my care practice is all non-conformity act, unintentional that will result in harm to the patient, compromising their safety. (N2)

Nurses associate non-conformities in nursing care for negligent practices that may occur in daily life, the lack of attention and care, and errors in the work process.

I think that those are negligent practices having the potential to cause harm to patients. (N1)

Adverse events are mistakes, regardless of the reason, during the process of work as well as the errors in the work process, which result in unsafe acts. (N4)

All nurses concluded that adverse events occur most of the time by inattention at the time of the procedure and the non-compliance with Standard Operating Procedures (SOPs), as quoted below.

I realize that adverse events happen because there is little concentration when performing the procedures. (N1)

An event happen by inattention, failure to comply with what has been described in SOPs and inefficient supervision. (N2)

The statement revealed that the Adverse Events may occur with any worker, but the lack of training, work overload, double shifts, physical and emotional stress that health professionals are subjected may influence the occurrence of such events.

All activities performed by people are at risk for errors, however inattention, work overload and fatigue influence them. (N4)

Perceptions of nurses in a private hospital...

Sometimes the error occurs by the lack of professional training, because they do not know. (N7)

The work overload, excessive hours, lack of attention and commitment can lead to the employee error. (N8)

◆ Category 2 - Adverse events identified in the workplace

By analyzing which Adverse Events have occurred in the workplace, non-conformities related to medication administration were mentioned. The nurses highlighted that errors can occur in this process, as the cited reports.

I realize that sometimes we have errors of late prescription, for example, the patient receives 6/6h medications, but is prescribed 8/8 hours, after reviewing the prescription that is corrected. (N1)

Errors in dilution and redilution of medications can happen if the professional does not follow the drug dilution guide. The lack of information can also lead to administration of incompatible drugs in the same way, sometimes medications with the same purpose, if the prescription is not reviewed carefully, can be prescribe for the same time. (N3)

Among the Adverse Events related to medication based on the statements, non-conformities that occur most are related to dose and at the right time.

Errors related to medication administration occur, but the most common are related to the correct dose and prescribed time. (N4)

Some medications are given before or after the schedule time. (N6)

The error of the five rights happens even before administering the drug, because in some cases the prescription is not conferred with medication record. (N7)

Only two nurses cited the fall of patients as non-conformities in the nursing assistance and one reported non-conformities related to the safe surgery protocol, as described below.

(...) I have observed that the fall of patients have happened in recent days, which is a problem that can be avoided, I believe that we should work more on prevention and guidance to patients and families. (N6)

The fall of the patients have happened, interfered in the process of recovery and prolonged hospital stay. (N7)

Non-conformities were already identified in compliance with the safe surgery protocol, for example, the patient was referred to the surgical center without any further examination, which were essential to the procedure as well as using accessories such as prostheses and alliances. (N4)

As for the reporting of Adverse Events, most of them state that are notified. The

most common forms of communication of reported adverse events were the description of the event that occurred, but differences among nurses were found, as described in the following reports.

Adverse events are not always reported in the hospital. (N1)

We always notify errors related to medications through existing standard form in the institution. (N2)

It happens when a nonconformity drug is described in an internal memo to the nursing coordination and also forwarded to the pharmacy error form. (N3)

In some situations, such as before the fall of the patient, only communicate the attending physician. (E6)

Given the above, it is clear that there are several mechanisms of non-conformities notifications in assistance and that there is an established routine, which is the knowledge of all participants in this study.

♦ Category 3 - Actions to prevent or reduce adverse events and promote patient's safety

The implementation of protocols can make the actions of all professionals who work directly and indirectly in safer care, with prevention and guidance activities. It was observed that the nurses realize this need.

It is necessary to implement protocols aimed at patient safety, including all sectors of the institution, that is, from the time of admission until discharge. And, for that it is important to team training and awareness related to the topic. (N8)

The implementation of a central dilution of drugs is proposed. In this way, the medication would be dispensed in a diluted form for nursing administration. In addition, the professional carries the suggestion of a new routine medication administration.

To improve the security regarding medications, one option would be to use the duplicate of the prescription as well: the technical nursing would go to the patient's bed with a copy of the prescription and the original prescription would be in the patient's medical record. Thus, it enables the organization and additions of drugs by doctors, as it could also improve the quality of the information passed on to the patient. Furthermore, it would be interesting proposal that the hospital had a medicine dilution center. (N5)

As for the proposals to improve patient safety, the participants suggested:

To meet patient safety, the work process should improve (aligned sectors) and promote more health education to better qualify the professionals. (N2)

Strictly follow the prescription, observe dilution, medication and route, as well as

compatibility of medications, for example: Antibiotic sedation and antibiotic parenteral nutrition. We should inspect more medicines, check appointments to avoid errors. (N3)

DISCUSSION

From the analysis of the results, it was observed that nurses have knowledge of Adverse Events. In this sense, the elucidation of these concepts can be an activity carried out by the leadership of the service and the Patient Safety Center. It is important an approximation of all professionals working in the service of content and taxonomy of Patient Safety, with a universal language used, so that everyone understands each other at the time of carrying out the communication of incidents, errors.⁸

By the magnitude of the problem involving the occurrence of Adverse Events and its consequences, the empowerment of the patient safety culture in all health services is needed, focusing on quality, safety and excellence.⁹ To strengthen this culture, the first step is to recognize and identify errors and, from there take educational measures. Therefore, it is essential to deconstruct the notion that failure is individual and expand the focus of the team/community as co-responsible for the nonconformities in nursing care.⁶ In this respect, permanent education in health is one of the viable alternatives changes in space work, due to contemplate different ways to educate and learn, instigating active professional participation in the process as well as the development of their critical and creative capacity.¹⁰

The study participants also indicated the relationship of Adverse Events with non-conformities in the nursing work process. It is known that in the hospital, the work is divided horizontally among several professionals and it is executed collectively, and with cooperation. Thus, searching for organization, lower costs, prevention and minimization of errors and results that benefit patients, are set flow charts, procedures and routines.¹¹ In this context, the purpose of the nursing work process, in addition to meeting the health needs of patients, is articulate, integrate and coordinate the team, in order to provide safe care.¹²

The number and complexity of activities performed may affect the routine work and communication, which favors the occurrence of Adverse Events related to the work process. Furthermore, it must consider the double shift that many nursing workers are submitted, which can interfere negatively in attention, productivity and quality of service. The study

showed that the greater the difference between the available and required hours of nursing care for patients in nursing allocations, the lower the frequency of undesirable events.¹²

Among the Adverse Event identified, nurses highlighted the errors related to the administration of medications, risk and occurrence of falls and non-conformities in the safe surgery checklist. It is noteworthy that these results may be related to the experiences of these nurses in care practice, and they reported the events that take place every day, as other events that may occur in the hospital scenario, such as phlebitis; inadvertent removal of probes, drains and catheters; pressure ulcers; nonconformity and adverse reactions to the infusion of blood products among others, have not been described.

IN the errors related to the administration of medications, a study that evaluated the incidents reported in a large hospital in southern Brazil, showed that 16.7% of the incidents were related to medications, which corresponds to the second Adverse Event more frequent.¹³ Regarding the analysis of intravenous medication preparation in a guard hospital network, there were more frequent events errors of omission and dose, wrong time and the wrong route of medicine administration found.¹⁴ In the findings of other research, the error with medication were 62.7%.¹⁵

The occurrence of these events may reflect the process of the drug chain as a whole and the involvement of various professionals and should not be attributed only to those who finish the administration of medications. Thus, it is important the instrumentalization of all involved, which should include guidelines related to prescription (written prescriptions legibly complete without abbreviations and using the generic name of drugs), the dispensation (placing in separate locations and different and storage in alphabetical order), administration (double-check of the medication).¹⁵

In the reports, there was the need to have aligned processes from the time a medication is prescribed by the doctor, followed by the release of the medication by the pharmacy and finally the management of the nursing process. It can be said that it is necessary that these three processes (prescription, dispensing and administration of medication) are organized and the professionals involved are trained on its operation. In this regard, it is relevant to more traditional practices of continuing education on the topic for the

nursing staff and other professionals. The care medication administration involves multidisciplinary team and these professionals must be constantly updated in order to become effective barriers to prevent a Material Adverse Event.

It is desirable that reporting of adverse events happen quickly, enabling prompt management action.¹¹ Thus, it is considered that an electronic notification system can quicken the process of communication and to build a database. This favors a control indicator of the incidence of adverse events and possible preventive measures directed to each unit, which contributes to minimize these events and provide patient's safety.

The falls of patients as reported by nurses is one of assistance non-conformities that occur in the hospital scenario. Risk factors that favor this event are cited, such as age greater than 60 years old, use of medications that alter the central nervous system, walking difficulty, neurological disorder, confusion, agitation, disorientation, presence devices, deficit sensory, bowel and urinary urgency, previous history of falls and pediatric patients.¹⁶

With regard to the environmental conditions favoring the falls, the presence of obstructions or lack of support are considered the most frequent. It is understood that falls may be associated with environmental factors such as no family room, absence of non-slip material and environment with excess furniture. Although these factors do not directly influence the increased risk of the bed falls, they are cited as contributing to the occurrence of falls.¹⁷

One of the observations on the patient's falls is that in everyday practice, there has been the tendency of patients not call nursing to help them perform daily living activities, such as going to the bathroom. This situation may worsen at night when fewer staff are in the unit, a condition that can contribute to higher frequency of falls.¹⁷

The prevention of falls should be strengthened through measures to ensure patient compliance, and accompanying staff to preventive actions, notification of events and measures with an environmental focus.¹⁶ Study suggests test achievement with non-slip product for floors, installation of lights with occupancy sensors in bathrooms, review of educational material for the prevention of falls, training for healthcare networks and development and adherence to the protocol for the prevention of falls.¹⁶ It is considered that these tools are important and provide

improve quality of care and promote patient's safety.

Non-conformities directed to safe surgery are mentioned in this study. This practice should be done through the checklist protocol "safe surgery", released by the World Health Organization and directed the establishment of a work culture focused on patient safety. It is known that the guarantee of surgical treatment depends on the assistance of integral, individualized and specific way for every moment of the perioperative period in order to provide the patient an effective and fast recovery.¹⁸ Discussions about the origins of errors in health care should be part of the hospital routine. This is a process of constant vigilance, which helps identify causes, detect potential errors and direct efforts in order to incorporate in clinical practice evidence-based strategies.¹⁹

Before all aspects discussed, it is emphasized that in order to strengthen actions for Patient Safety and the involvement of professionals, Ordinance MS/GM Number 529/2013 establishes a set of basic protocols, defined by the World Health Organisation (WHO), which guide the program implementation, such as: hand hygiene practice in health facilities, safe surgery, Security in prescribing, use and administration of medication, identification of patients, communication in health establishments of the environment, prevention falls, pressure ulcers, transfer of patients between care units and safe use of equipment and materials.²⁰

In this respect, it should be noted that nurses must take ownership of these nuances, and encourage and motivate the nursing staff periodically reduce existing constraints and boost the safe care practice and quality.²¹ It is essential that health institutions prioritize the safety culture, with incentives for prevention of adverse events rather than punitive measures to professionals. Discussions about patient safety must overcome theoretical barriers and be implemented in Patient Safety Centers in collaboration with healthcare professionals, managers and patients, who are part of the organizational culture of health services.²²

Thus, to work on these issues is a challenge for institutions that provide health care services, either by changing the safety culture, but also by the accession of professionals working with actions that minimize the occurrence of adverse events.

CONCLUSION

It was found that nurses who participated in the study understand about Adverse Events and they happen at the workplace. The drug delivery-related events and then the patient falls and non-conformities related to safe surgery were highlighted with more emphasis. It was found that non-conformities related to hand hygiene, patient identification devices loss and changes in infusion of blood products were not noticed.

It was observed that it is necessary to improve the reporting system and control of non-conformities in the hospital and that it is relevant to have protocols to be used before an adverse event. In this sense, it is inferred that it is necessary to notify Adverse Events in order to identify the gaps that need to be addressed by the service, in order to improve the quality of nursing care and multi that is provided to the patient and family/caregivers.

Knowing the perceptions of nurses helps identify weaknesses and potential of the work processes, support the team instrumentalization in order to identify sources of Adverse Events, working with their prevention and minimization, making the assistance more effective and safer to patients.

REFERENCES

1. World Health Organization (WHO). More than words. Conceptual framework for the International Classification for Patient Safety (ICPS). Technical report. Geneva: World Health Organization; 2009. Available from: http://www.who.int/patientsafety/implementation/taxonomy/icps_technical_report_en.pdf
2. Rozenfeld S, Chaves SMC, Reis LGC, Martins M, Travassos C, Mendes Wet al . Efeitos adversos a medicamentos em hospital público: estudo piloto. Rev Saude Publica [Internet]. 2009 [cited 2015 July 06];43(5):887-90. Available from: <http://www.scielo.br/pdf/rsp/v43n5/1101.pdf>
3. Mendes W, Martins M, Rosenfeld S, Travassos P. The assessment of adverse events in hospitals in Brazil. Int J Qual Health Care [Internet]. 2009 [cited 2015 July 08];21(4):279-84. Available from: <http://intqhc.oxfordjournals.org/content/intqhc/21/4/279.full.pdf>
4. Queiroz Bezerra AL, Queiroz E, Weber J, Paranagua TTB. Eventos adversos: indicadores de resultados segundo a percepção de enfermeiros de um hospital sentinela. Enferm

global [Internet]. 2012 [cited 2015 July 08];11(27):186-97. Available from: http://scielo.isciii.es/pdf/eg/v11n27/pt_administracion2.pdf

5. Carneiro FS, Bezerra ALQ, Silva AEBC, Souza LP, Paranaíba TTB, Branquinho NCSS. Eventos adversos na clínica cirúrgica de um hospital universitário: instrumento de avaliação da qualidade. Rev Enferm UERJ [Internet]. 2011 [cited 2015 July 24];19(2):204-11. Available from: <http://www.facenf.uerj.br/v19n2/v19n2a06.pdf>

6. Wegner W, Pedro ENR. Patient safety in care circumstances: prevention of adverse events in children's hospital. Rev Latino-Am Enferm [Internet]. 2012 [cited 2015 July 08];20(3):427-34. Available from: <http://www.scielo.br/pdf/rlae/v20n3/a02v20n3.pdf>

7. Bardin L. Análise de conteúdo. Lisboa: Edições 70; 2010.

8. Leitão IMTA, Oliveira RM, Leite SS, Sobral MC, Figueiredo SV, Cadete MC. Análise da comunicação de eventos adversos na perspectiva de enfermeiros assistenciais. Rev Rene [Internet]. 2013 [cited 2015 July 10];14(6):1073-83. Available from: <http://www.revistarene.ufc.br/revista/index.php/revista/article/view/1193/pdf>

9. Ramírez OJG, Gámez AS, Gutiérrez AA, Salamanca JG, Veja AG, Galeano EM. Una mirada actual de la cultura de seguridad del paciente. Av Enferm [Internet]. 2011 [cited 2015 July 10];29(2):363-74. Available from: <http://www.scielo.org.co/pdf/aven/v29n2/v29n2a15.pdf>

10. Silva AEBC, Reis AMM, Miaso AI, Santos JO, Cassiani SHB. Adverse drug events in a sentinel hospital in the state of Goiás, Brazil. Rev Latino-Am Enferm [Internet]. 2011 [cited 2015 July 24];19(2):378-86. Available from: <http://www.scielo.br/pdf/rlae/v19n2/21.pdf>

11. Paiva MCMS, Paiva SAR, Berti HW. Adverse events: analysis of a notification instrument used in nursing management. Rev Esc Enferm USP [Internet]. 2010 [cited 2015 July 10];44(2):287-94. Available from: http://www.scielo.br/pdf/reeusp/v44n2/en_07.pdf

12. Gonçalves LA, Andolhe R, Oliveira EM, Barbosa RL, Faro ACM, Gallotti RMD, et al. Allocation of the nursing team and the occurrence of adverse events/incidents in intensive care unit. Rev Esc Enferm USP [Internet]. 2012 [cited 2015 July 10];46(spe):71-7. Available from: http://www.scielo.br/pdf/reeusp/v46nspe/en_11.pdf

13. Lorenzina E, Santib JAR, Báoc ACP. Patient safety: analysis of incidents reported in a hospital in southern Brazil. Rev Gaúcha Enferm [Internet]. 2014 [cited 2015 July 14];35(2):121-7. Available from: http://www.scielo.br/pdf/rgenf/v35n2/pt_1983-1447-rgenf-35-02-00121.pdf

14. Camerini GF, Silva DL. Segurança do paciente: análise do preparo de medicação intravenosa em hospital da rede sentinela. Texto Contexto Enferm [Internet]. 2011 [cited 2015 July 24];20(1):41-9. Available from: <http://www.scielo.br/pdf/tce/v20n1/05.pdf>

15. Ministério da Saúde (BR). Protocolo de segurança na prescrição, uso e administração de medicamentos. Protocolo integrante do Programa Nacional de Segurança do Paciente. Brasília: Ministério da Saúde; 2013. Available from: <http://proqualis.net/sites/proqualis.net/files/000002490IQmwD8.pdf>

16. Correa AD, Marques IAB, Martinez MC, Laurino PS, Leão ER, Chimentão DNM et al. Implementation of a protocol for hospital in falls management: results of four years of follow up. Rev Esc Enferm USP [Internet]. 2012 [cited 2015 July 24];46(1):67-74. Available from: http://www.scielo.br/pdf/reeusp/v46n1/en_v46n1a09.pdf

17. Paiva MCMS, Paiva SAR, Berti HW, Campana ÁO. Characterization of patient falls second notification in adverse event reports. Rev Esc Enferm USP [Internet]. 2010 [cited 2015 July 24];44(1):134-8. Available from: http://www.scielo.br/pdf/reeusp/v44n1/en_a19v44n1.pdf

18. Grittem L, Meier MJ, Peres AM. Sistematization of perioperative care - a qualitative research. Online Braz J Nurs [Internet]. 2009 [cited 2015 July 24];8(3). Available from: <http://www.objnursing.uff.br/index.php/nursing/article/view/j.1676-4285.2009.2588/576>

19. Grigoletto ARL, Gimenes FRE, Avelar MCQ. Segurança do cliente e as ações frente ao procedimento cirúrgico. Rev Eletr Enf [Internet]. 2011 [cited 2015 July 24];13(2):347-54. Available from: Disponível em: <http://www.fen.ufg.br/revista/v13/n2/pdf/v13n2a22.pdf>.

20. Brasil. Ministério da Saúde. Portaria nº 529, de 1º de abril de 2013. Institui o Programa Nacional de Segurança do Paciente (PNSP). Diário Oficial da União, Brasília, DF, 2 abr. 2013. Seção 1, p. 43. Available from: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2013/prt0529_01_04_2013.html

Aozane F, Cigana DJ, Benetti ERR et al.

Perceptions of nurses in a private hospital...

21. Barros AA, Oliveira RM, Pinheiro AC, Leitão IMTA, Vale AP, Silva LMS. Motivation practices to promote safety culture by nursing leaders according to assisting nurses. J Nurs UFPE on line [Internet]. 2014 [cited 2015 July 6];8(12):4330-6. Available from: http://www.revista.ufpe.br/revistaenfermage/index.php/revista/article/view/6753/pdf_6759

22. Lima RRS, Matos JC, Rodrigues MCS. The process of patient's identification and organizational culture: a reflective analysis. J Nurs UFPE on line [Internet]. 2015 [cited 2015 July 24];9(Suppl. 5):8468-73. Available from: http://www.revista.ufpe.br/revistaenfermage/index.php/revista/article/view/7701/pdf_8127

Submission: 2015/07/27

Accepted: 2015/08/06

Publishing: 2016/02/01

Corresponding Address

Fabiele Aozane
Rua Osório Pedro Ilgenfritz, 700
Bairro Assis Brasil
CEP 98700-000 – Ijuí (RS), Brazil