Brazilian registered nurses' perceptions and attitudes towards adverse events in nursing care: a phenomenological study

GENIVAL FERNANDES DE FREITAS RN, PhD[1], LUIZA AKIKO KOMURA HOGA RN, PhD[2], MARIA DE FÁTIMA PRADO FERNANDES RN, PhD[1], JOSÉ SILES GONZÁLEZ RN, PhD[3], MARÍA CARMEN SOLANO RUIZ RN, PhD[3] and BÁRBARA BARRIONUEVO BONINI RN[4]

[1]Doctor Professor *and* [2]Associate Professor, *School of Nursing, University of Sao Paulo, Sao Paulo, Brazil*, [3]Titular Professor, *School of Nursing, University of Alicante, Alicante, Spain and* [4]Student of Post Graduate, *School of Nursing, University of Sao Paulo, Sao Paulo, Brazil*

Correspondence
Genival Fernandes de Freitas
School of Nursing
University of São Paulo
Av. Dr. Enéas de Carvalho Aguiar,
419 São Paulo,
SP. CEP:
05403-000
Brazil
E-mail: genivalf@usp.br

DE FREITAS G.F., HOGA L.A.K., FERNANDES M.F.P., GONZÁLEZ J.S., RUIZ M.C.S. & BONINI B.B. (2011) *Journal of Nursing Management* **19**, 331–338

Brazilian registered nurses' perceptions and attitudes towards adverse events in nursing care: a phenomenological study

Aim To describe the perceptions and attitudes of registered nurses (RNs) towards adverse events (AEs) in nursing care.
Background The professionals' subjective perspectives should be taken into account for the prevention of AEs in care settings.
Method Schütz's social phenomenology was developed. Interviews were conducted with nine Intensive Care Unit RNs.
Results The following five descriptive categories emerged: (1) the occurrence of AEs is inherent to the human condition but provokes a feeling of insecurity, (2) the occurrence of AEs indicates the existence of failures in health care systematization, (3) the professionals' attitudes towards AEs should be permeated by ethical principles; (4) the priority regarding AEs should be the mitigation of harm to patients, and (5) decisions regarding the communication of AEs were determined by the severity of the error.
Conclusions The various subjective perspectives related to the occurrence of AEs requires a health care systematization with a focus on prevention. Ethical behaviour is essential for the patients' safety.
Implications for nursing management Activities aimed at the prevention of AEs should be integrated jointly with both the professionals and the health care institution. A culture of safety, not punishment, and improvement in the quality of care provided to patients should be priorities.

Keywords: accident prevention, adverse events, delivery of health care, intensive care, nursing care management, safety

Accepted for publication: 20 October 2010

Introduction

When a person becomes ill, the desire is to receive safe treatment and return home in better health. However, some patients do not achieve this goal because they are victims of adverse events (AEs) in the health care system. AE refers to the occurrence of failures in nursing care that have the potential to cause harm to patients. An AE is defined as 'any occurrence leading to iatrogenic injury' (Wakefield *et al.* 2005).

A systematic review of the assessment of AEs has shown an incidence rate of between 2.0% and 16.6% in

DOI: 10.1111/j.1365-2834.2011.01208.x

Brazilian hospitals (Mendes *et al.* 2005). The incidence of AEs among hospitalizations is between 2.5% and 3.7% in the United States (Brennan *et al.* 1991, Thomas *et al.* 2000), 10.8% in the United Kingdom (Vincent *et al.* 2001),and 16.8% in Australia (Wilson *et al.* 1995). In Canada, is estimated that an AE occurs in 7.5% of all hospitalizations (Baker *et al.* 2004). A 4.6% incidence of AEs was reported in a study conducted in Colombia (Gaitán-Duarte *et al.* 2008). To our knowledge, no study that focuses on rates of AEs in a representative sample has been conducted in Brazil.

Patient safety is recognized globally as a health care priority (World Health Organization 2006). Direct intervention by professionals and exposure of patients to unnecessary or potentially harmful risks are factors that can compromise the integrity of health care (Moullin 2002). An improvement in patient safety is considered an ethical imperative (Terry & Kaplan 2007, Wlody 2007, Chen *et al.* 2007) and constitutes one of the main preoccupations of health service managers (Moullin 2002).

Acceptance of the presupposition that AEs are inevitable is the main philosophical aspect in this issue (Armitage 2001). The occurrence of AEs involves many factors, and studies that aim to achieve a deep and comprehensive understanding of this issue are required (Wlody 2007). This recommendation makes sense for the health care institution, a complex adaptive system in which individuals are able to make decisions and take actions based largely on their own values and beliefs (Chen *et al.* 2007). Thus, the social, subjective and contextual underpinnings should be taken into account for an understanding and description of AEs in the health care process (Mayo & Duncan 2004, Hoff & Sutcliffe 2006).

The present study was conducted considering the need for clarification and answers to the following questions: What are the perceptions of RNs towards AEs in nursing care? What are the expectations of RNs regarding the attitudes toward AEs in nursing care? AEs in this study were considered to be harm caused to an individual while he or she was a patient (Moullin 2002).

An understanding of nurses' perceptions and expectations regarding AEs is essential for the implementation of appropriate strategies to manage nursing care. In this sense, registered nurses' (RNs') beliefs and values as well as the organizational culture are important aspects to be considered (Cassiani 2000).

Aim of the research

The present study aimed to explore the perceptions and attitudes of RNs towards AEs in nursing care.

Theoretical background

Schütz's theory of motivation was the study's theoretical background. Human action is considered a product of intersubjectivity. Each person shares life experiences with other members of his or her social group. People act as a function of their motivations related to the future. In this way, these are 'in-order-to motives'. Human actions are rooted in life experiences and in the personality type developed during their life, i.e. their 'because motives'. Personal action originates in the conscious mind, is voluntary and is directed towards the future (Schütz 1972, Capalbo 1998).

Social phenomenology is not oriented towards single acts or individual behaviours, nor is it restricted to the self-consciousness. Rather, it is oriented towards the understanding of what constitutes a determined social group that experiences a typical situation. Thus, the daily world is not individual but intersubjective, and this one common world is what we share with our peers (Capalbo 1998). Intersubjectivity reveals itself in the reciprocity of motives and perspectives. Thus, the reaction of one individual provokes the reaction of another in view of a given situation in which one experiences the common situation from the perspective of the other and vice versa. This 'we-relation' emerges by capturing the other person's existence in face-to-face interactions (Schütz 1972).

In the present study, the exploration of professionals' perceptions and attitudes towards AEs, a complex phenomenon encountered in the daily work setting, is based on Schütz's theory of motivation. It was utilized in this study because the impulses that lead RNs to act in the way they do can be better understood within this background (Schütz 1974).

Methods

Research approach

An investigation of the actions and motivations of RNs facing the phenomenon of AEs requires a qualitative approach. Schütz's (1974) social phenomenology, which permits an understanding of the decisions taken by members of a social group living in a typical situation, was the methodological approach of this research.

Within this study, there was no attempt to predict or control RNs' behaviours because the research priorities involved the search, interpretation, and illumination of meaning of what was happening, being done, being understood or being interpreted by RNs. This study was conducted in consideration of the importance of better

understanding the perceptions and background supporting the attitudes towards AEs in nursing care from the perspectives of RNs.

Schütz's theory of motivation was used to analyse the impulses that led the RNs to act in the way they did. According to Schütz, actions are a function of human motivation. Human actions are guided by past experiences and the personality type developed during life, i.e. their 'because motives'. The conscious mind is the origin of the individual's actions. Human or social action is a behaviour directed to the realization of a specific action or act and can only be interpreted subjectively.

Ethical considerations

The research project was presented and approved by an ethics committee authorized by the Brazilian National Research Ethics Committee. Written informed consent explaining the purpose, intent and nature of participation as a guarantee of the preservation of personal data and authorization for the use of data for scientific purposes was obtained and signed by all research participants. Participation was entirely voluntary, and no attempts were made to coerce participants to become involved. Personal data were obtained and registered before the beginning of the interviews. To protect the participants' confidentiality, the number corresponding to the RN who has expressed the experience is presented after each quotation. This practice provides a way to preserve the personal perspective of the experience.

Setting

RNs working in the Intensive Care Unit (ICU) of the University Hospital of the University of São Paulo, located in southwest Brazil, participated in the present study. The ICU nurses were elected as the focus of this investigation because they work in a setting that involves critically ill patients.

The nursing staff of this ICU is composed of 23 RNs and 43 auxiliary nurses. The inclusion criteria included the following: at least 5 years experience in an ICU as a RN, experience with AEs in the ICU setting involving nursing staff and an interest in discussing this issue. Five years was considered a sufficient time to experience the phenomena of interest (Oguisso & Schmidt 2007). The names of all RNs who met the inclusion criteria were put in a small box and drawn consecutively.

Permission to hold an interview was requested, and none declined the interview. When asked about their preferences as to the place, time and date for the interviews, all chose their own work setting. The individual interviews were held in a private room in the hospital.

Data collection

In-depth interviews were conducted and an open-ended introductory question was used (Kvale 1996). The researchers focused on personal expectations to understand the plans and actions of the RNs, i.e. their 'in-order-to motives' (Schütz 1974).

Nurses were asked to describe their experiences related to AEs while working in the ICU and the decisions made after the occurrence of AEs. When appropriate, additional questions were asked to obtain a deeper understanding of the experiences. An active listening behaviour was maintained to preserve the spontaneous nature of the narratives (Kvale 1996).

The criterion adopted to end the inclusion of new participants was theoretical saturation. The number of participants was not determined in advance. Continuous data repetition was perceived by the seventh interview. The interviews were stopped when we perceived repetitiveness of the motives that reflected the subjects' perceptions and attitudes regarding AEs. In total, nine RNs were interviewed to guarantee the occurrence of saturation (Morse *et al.* 2001). The interviews were conducted by the first author of this manuscript between July and August 2008 and lasted between 20 and 60 minutes each. At the time, the interviewer was a faculty member and not a member of the hospital staff.

Data analysis

The audio tape-recorded interviews were fully transcribed verbatim. The study findings were analysed according to Schütz's phenomenological approach. An understanding of the RNs' 'because motives' was attempted to place their actions into context.

During the comprehensive analysis of the interviews, which was the first phase of the interpretation process, each narrative was read in an attentive and detailed manner to identify the whole meaning of the experience. This reading required an open-minded attitude. In the second phase, the structural analysis, the text was divided into meanings units, i.e. a sentence or several sentences that had a similar meaning were grouped considering the aims of the study.

A code manual, which included the identification of the name of the code and the definition of what it concerns, was done. After this step, the reliability of the codes or the relationship between the codes and the raw

information was verified. During this phase, the initial themes were identified and summarized. When meaningful units of the narratives were identified, we applied the template of codes, and additional coding was performed (Fereday & Muir-Cochrane 2006).

The formulated categories or meanings were then related to each other, reflected upon and organized into five descriptive categories. The categories were expressed in the deepest, most comprehensive and most trustworthy way possible, the RNs' meanings related to their experiences.

In the present study, the content and meaning of the descriptive categories are illustrated by short quotes. The clearest and most meaningful example was quoted to represent the lived experience. Numerals are used to identify RNs who had expressed similar experiences.

Rigour

A colleague who was not involved in the research guaranteed a rigorous data analysis process. She read all the interviews and the contents of the five descriptive categories. She was satisfied with the final product of the data analysis.

Findings

Brief personal and professional characterization of the RNs

The RNs were between 30 and 45 years of age, with between 5 and 15 years of experience as a nurse in the ICU setting; all of the RNs were specialists in intensive care nursing.

Descriptive categories and their components

Table 1 shows a summary of the descriptive categories and their components.

1. The occurrence of AEs is inherent to the human condition but provokes a feeling of insecurity

The occurrence of AEs was reported as an unavoidable event, an event inherent in the human condition, because no professional commits an AE intentionally.

> Nobody makes mistakes with the intention of causing harm (1); We are humans and are prone to making mistakes (5).

The occurrence of an AE causes feelings of discomfort and insecurity. Therefore, guilt and distress permeated the feelings of the professionals who made mistakes.

> The experience of failure is traumatic and causes discomfort and insecurity (1, 4, 9).

2. The occurrence of AEs indicates the existence of failures in health care systematization

The occurrence of an AE should not be seen as an isolated event because it indicates the existence of trouble in care systematization. Therefore, we analysed the possible factors leading to the occurrence of an AE. This comprehensive assessment was considered essential to enable the identification of potential problems.

> An error cannot be seen as an isolated event because it is a consequence of troubles (4); The error

Table 1
Descriptive categories and its components

1. The occurrence of AEs is inherent to the human condition but provokes a feeling
It is not provoked intentionally
The occurrence provokes a feeling of insecurity to the professional
2. The occurrence of AEs indicates the existence of failures in health care systematization
It is not an isolated occurrence
Its occurrence is an alert
The reflection about the occurrence is essential for the comprehensive understanding of the factors involved
Its comprehensive understanding is essential for the identification of the failures in health care
The identification of the failures in health care is essential to avoid its recurrence
3. The professionals' attitudes toward AEs should be permeated by ethical principles
The personal values incorporated over life should be respected
The ethical values learned from family members and professors should be respected
Peace of mind is essential for the professional
4. The priority regarding AEs should be the mitigation of harm to patients
Adoption of measures to diminish the negative repercussions
No omission is essential for the adoption of immediate measures
Immediate measures are essential to avoid major damages
5. Decisions regarding the communication of AEs were determined by the severity of the error
Communication to professionals aimed at the adoption of necessary measures to mitigate damages or in the case of fatal errors
Communication to patients and their family members in case of damage to health and fatal errors

AE, adverse advent.

> is a kind of warning indicating that the trouble needs to be identified and corrected (2, 5).

The comprehensive analysis of an AE was performed with the intent of finding opportunities for change and action. The most appropriate strategy was adopted according to the aspects involved in each situation.

> The possible causes of errors are analysed with other members of the nursing team. Together we see the possible ways that these errors can be prevented in the future (1, 4, 6, 9).

The occurrence of an AE was followed by deep reflection. The main expectations of the RNs were related to the identification of the causes of AEs, evaluation of the consequences and the identification of measures aimed at preventing harm to patients.

> I hope the team members reflect on the error to identify its causes, evaluate the consequences, and avoid further harm to the patient (3, 7).

Establishing a dialogue with the professional responsible for the occurrence of a mistake was one of the measures taken. The main issues addressed in this dialogue were the analysis of the situation and the adoption of measures to avoid its recurrence.

> I talk about the mistake with the nursing team in order to prevent its recurrence (4); I talk about the AE, analyze the situation, and give suggestions (3, 4, 5, 6, 8, 9); I take measures to prevent a recurrence of the error (3, 8).

The existence of any personal trouble that could interfere with professional performance was determined when an AE occurred in nursing care.

> I verify whether the professional who committed the mistake has any ongoing personal troubles (4).

Some institutional measures were taken to prevent the occurrence of AEs. The training of the professionals and the provision of adequate human and material resources were the main measures adopted.

> The prevention of an error requires continuing education based on dialogue and institutional arrangements related to human resources and materials. These measures are essential for the prevention of failures (8, 9).

3. The professionals' attitudes towards AEs should be permeated by ethical principles

The attitudes toward AEs were based on ethical principles.

> My own ethical values are the bases of my attitudes toward errors (2).

The coherence among their own values, the other people involved and the decisions made were essential aspects of RNs' behaviours.

> The consistency between my own ethical values and respect for the perspectives of other people involved is what guides my behavior (5); My personal values are the basis for my actions, the peace with my conscience guides my beliefs regarding the error (5).

The main expectation of RNs was non-collusion with the error.

> I hope that professionals do not collude with the error because this attitude is in opposition to the commitment (3); The professional behavior toward AEs should be based on ethical principles (1).

4. The priority regarding AEs should be the mitigation of harm to patients

The main concern of RNs was the mitigation of the negative effects on the patients' health conditions.

> My actions are aimed at reducing negative impacts on the patient (1); I take measures aimed at mitigating the consequences of AEs on the nursing team and patient (1, 2).

Non-omission of errors was an expectation of the RNs. This attitude was considered vital for the adoption of necessary measures.

> One mistake should not be omitted because actions aimed at mitigating harm need to be taken (4); The omission of a mistake is a new error (2).

5. Decisions regarding the communication of AEs were determined by the severity of the error

The decisions regarding the communication of AEs to other members of the professional staff, the patients and their family members were based on an evaluation of the situation and consideration of the possible harm to the patients' health conditions.

Avoiding further severe injury was the main factor considered when the decision was made regarding communicating the error to the professional staff.

> The error should be reported in order to permit the immediate adoption of measures (1, 4).

The manager was the first person to be informed about the occurrence of AEs.

> When an AE occurs, the first person I tell is my boss (2).

Communication of the error to the patients and their family members was carried out only when the possibility of some harm was identified.

> I evaluate the impact of an error on the patient. The patient and his family are told about the AE only when there is the possibility of harm (1, 2, 3, 6, 9).

When the absence of harm was guaranteed, the patient and family members were not informed. This measure was taken to avoid losing the patients' confidence. The loss of confidence can cause interferences in the relationship between the patient and the professional and may worsen the situation.

> If the error does not affect the patient, I do not communicate it so as not to lose the confidence of the patient (5).

When the AE resulted in a patient's death, the decision regarding communication of the AE to the family members was made with consensus after a comprehensive analysis of the situation. These analyses were conducted with the participation of the RN, the nursing staff manager and the physician.

> In the case of fatal errors, I must inform the head nurse and the doctor, and together we decide whether or not to communicate the error to the patient's family (4).

Discussion

The RNs' perceptions and actions, characterized by continuous interactions and exchanges, were permeated with meanings and motivations emerging from their own beliefs and values. These findings confirmed Schütz's (1972) presupposition that human actions result from their own intentionalities, occur in daily life and are loaded with subjective meanings.

AEs are considered an attribute of the human condition. The premise has been confirmed that an error is intrinsically related to human failure (Armitage & Flanagan 2001). The occurrence of an error is an opportunity to learn and make changes in health care systematization that are aimed at improving patient safety (Armitage & Flanagan 2001). Professional action in this manner promotes the recognition of weaknesses and incompetencies, and the professionals' abilities and potential may be discovered. Personal and professional development can be promoted because the learning is acquired from one's own experiences (Freitas & Oguisso 2010).

An error can be considered a misconception of reality. The establishment of a clear distinction between errors resulting from a misconception of reality and errors resulting from a complete lack of knowledge is considered essential (Gonçalves 2007, Oguisso & Schmidt 2010). The Code of Ethics for Nurses determines that all nursing professionals should be responsible for the implementation of safety health care actions (International Council of Nurses 2006).

AEs were considered signs of the existence of failure in nursing care systematization. In a complex adaptive system, several factors involving the occurrence of AE must be considered (Chen *et al.* 2007). Offering equitable social and economic working conditions for the nursing staff as well as developing and monitoring the environmental safety in the care setting are considered essential aspects of nursing care (International Council of Nurses 2006).

Promoting a non-punitive environment in health care institutions is required. This requirement does not imply a lack of measures in relation to the professional who caused the AE. Recognizing the institutional responsibility related to an AE provoked by one professional is essential. The possibility that social factors induce the occurrence or recurrence of AEs must be considered (Cassiani 2000). In this sense, the present study's findings suggest the importance of non-punitive actions regarding AEs because educative attitudes seem to be wiser and more effective actions in management practice related to these phenomena.

Precarious working conditions, an overload of activities, professional fatigue or stress and a lack of training and continuous education are the main social factors associated with the occurrence of AEs (Freitas & Oguisso 2010). Health institutions must provide sufficient human and material resources to ensure nursing care to patients without harming them (Lisson 1987, Stolley *et al.* 1991, Morray 1995, Kelly 1997, Bueno *et al.* 1998, Mendes & Caldas-Junior 1999, Carvalho & Cassiani 2000, Kohn *et al.* 2000, Quinn 2000, Elder *et al.* 2003, Freitas *et al.* 2006).

The aspects related to ethos were the fundamental actions toward AEs. Ethical principles are manifested in the 'ways of being and acting' of professionals toward AEs. The attitudes of RNs were based on personal principles and ethics. The nursing identity, shared by members of this profession, is integrated into these issues (Reale 2002, Boff 2003, Vásquez 2003, Pessini & Barchifontaine 2004).

One of the main ethical aspects guiding the actions of RNs was non-connivance with the error. This behaviour required transparency in relation to the error. An orientation regarding the importance of communicating committed failures was considered a priority in nursing education (Vermoch 2000, Gundogmus *et al.* 2004, Mayo & Duncan 2004, Preston 2005, Fakih *et al.* 2009). Dialogue about non-connivance is important for preventing AE recurrence (Lisson 1987, Stolley *et al.* 1991, Morray 1995, Kelly 1997, Bueno *et al.* 1998, Baumann 1999, Mendes & Caldas-Junior 1999, Carvalho & Cassiani 2000, Kroll 2000, Quinn 2000, Elder *et al.* 2003, Freitas *et al.* 2006).

The patients must be also oriented to the benefits, risks and consequences of an action. Although RNs have recognized patient rights in relation to an AE, some research findings have shown that the decisions related to the communication of an AE to patients are made exclusively by the professionals. The culture of non-punishment should be built in at health care institutions (Freitas *et al.* 2006) because most professionals do not report errors, fearing punishment or accusations of negligence (Mayo & Duncan 2004). Instead of punishment, strategies aimed at preventing AE occurrence and recurrence should be adopted (Vermoch 2000, Freitas *et al.* 2006).

Limitations of the study

As a result of the subjective nature of this research, the interviewed RNs may have omitted strong experiences involving AEs in nursing care to preserve their own reputations or the reputations of other members of the professional staff. The interviews were stopped at the ninth interview when we perceived the repetitiveness of the motives that reflected RNs' perceptions and attitudes regarding AEs. Therefore, the data revealed by the RNs may be incomplete. The findings were not checked with participants because the phenomenology method does not require this procedure.

Implications for nursing managers

A deep and comprehensive understanding of AEs requires a good ethical structure and an excellent ethical climate in the health care organization. Health care institutions must develop strategies to address organizational ethical issues so that questions can be addressed at both the unit and organizational levels. Addressing this growing need requires formalized strategies with operational plans, policies and procedures. Although organizations may have mechanisms in place, the mechanisms tend not to be cohesive, comprehensive or known to most of the health care staff. This reality indicates the need for an organizational assessment and cataloguing of current ethical mechanisms existing in the care settings (Wlody 2007).

The results of the present study underscore the importance of the understanding the experiences of RNs regarding AEs. The human factor was the element that prevailed in the four dimensions involved in this issue: the patient, the professional, the family and the health care institution.

Action should be taken to involve the multidisciplinary staff and aim for the identification and adoption of strategies related to the prevention of the AEs. Educational activities must be held continuously and should be integrated with the goals of both the professionals and the health care institution. A culture of safety, a culture of non-punishment and improvement in the quality of care provided to patients should be the priorities of nursing care managers.

The present study's findings gave us a closer look at the experiences lived and depicted by the subjects of social action. Our results indicated the need to eliminate the fear of punishment for reporting AEs. This recommendation was given by Freitas *et al.* (2006), who described that the RNs felt a fear of punishment regarding the occurrence of AEs in nursing care. Our study's participants expected and aimed for the goals of nursing services and health care institutions to contemplate and allow for the construction of a participatory, dialogue-based and supportive process based on reflection and the responsibility of the professional who may have been involved in an ethically complex event. In this sense, the educative and management actions proposed in relation to the problematic occurrences should be meaningful for the professionals. Safe and efficient nursing care, free from foreseeable risks, should be the main purpose of institutional policy and should also guide the RNs' and nurse managers' actions.

References

Armitage M. & Flanagan D. (2001) Improving quality measures in the emergency services. *Journal of the Royal Society of Medicine* **94** (Suppl. 39), 9–12.

Baker G.R., Norton P.G., Flintoft V. *et al.* (2004) The Canadian adverse events study: the incidence of adverse events among hospital patients in Canada. *Canadian Medical Association Journal* **170** (11), 1678–1686.

Baumann Z. (1999) *Modernity and Ambivalence*. Zahar Editora, Rio de Janeiro.

Boff L. (2003) *Ethics and Moral: the Search of Backgrounds*. Vozes, Petrópolis.

Brennan T.A., Hebert L.E., Laird N.M. *et al.* (1991) Hospital characteristics associated with adverse and substandard care. *Journal of the American Medical Association* **265** (24), 3265–3269.

Bueno E., Cassiani S.H.B. & Miquelim J.D.L. (1998) Errors in administration of medications: risk factors and measures employed. *Revista Baiana de Enfermagem* **11** (1), 101–119.

Capalbo C. (1998) *Methodology of Social Sciences: the Alfred Schütz'* Phenomenology. UEL Editora, Londrina.

Carvalho V.T. & Cassiani S.H.B. (2000) Medication errors and consequences for nursing professionals and clients: an exploratory study. *Revista Latino-Americana de Enfermagem* **10** (4), 523–529.

Cassiani S.H.B. (2000) Errors in medication: preventive strategies. *Revista Brasileira de Enfermagem* **53** (3), 424–430.

Chen D.T., Werhane P.H. & Mills A.E. (2007) Role of organization ethics in critical care medicine. *Critical Care Medicine* **35** (Suppl. 2), 11–17.

Elder R., Prince J. & Williams G. (2003) Differences in ethical attitudes between registered nurses and medical students. *Nursing Ethics* **10** (2), 149–164.

Fakih F.T., Freitas G.F. & Secoli S.R. (2009) Medications: ethical and legal aspects of nursing care. *Revista Brasileira de Enfermagem* **62** (1), 132–134.

Freitas G.F. & Oguisso T. (2010) *Ethics in the Context of Nursing Practice*. Medbook, Rio de Janeiro.

Freitas G.F., Oguisso T. & Merighi M.A.B. (2006) Ethical events in nursing: daily activities of nurse managers and nursing ethics committee members. *Revista Latino-Americana de Enfermagem* **14** (4), 497–502.

Gaitán-Duarte H., Eslava-Schmalbach J., Rodríguez-Malagon N., Forero-Supelano V., Santofimio-Sierra D. & Altahona H. (2008) Incidence and preventability of adverse events in patients hospitalised in three Colombian hospitals during 2006. *Revista de Salud Publica – Bogota* **10** (2), 215–226.

Gonçalves C.R. (2007) *Civil Law, Laws of Obligations*. Editora Saraiva, São Paulo.

Gundogmus U.N., Oskara E. & Mete S. (2004) Nursing and midwifery malpractice in Turkey based on the Higher Health Council records. *Nursing Ethics* **11** (5), 489–499.

Hoff T. & Sutcliffe K. (2006) Studying patient safety in health care organizations: valuing a range of approaches. *Joint Commission Journal on Quality and Safety* **32** (1), 5–15.

International Council of Nurses (2006) *The ICN Code of Ethics for Nurses*. International Council of Nurses, Geneva.

Kelly J. (1997) Prescribed drugs and iatrogenic disease. *Journal of Professional Nursing* **12** (11), 827–828.

Kohn L.T., Corrigan J.M. & Donaldson M.S. (eds) (2000) *To Err is Human: Building a Safer Health Care System*. National Academy Press, Washington, DC.

Kroll B.N. (2000) Medication errors: problem process not a problem nurse. *Minnesota Nursing Accent* **72** (8), 9–15.

Kvale S. (1996) *Interviews: an Introduction to Qualitative Research Interviewing*, Sage Publications, London.

Lisson E.L. (1987) Ethical issues related to pain control. *Nursing Clinics of North America* **22** (3), 649–659.

Mayo A.M. & Duncan D. (2004) Nurse perceptions of medication errors: what we need to know for patient safety. *Journal of Nursing Care Quality* **19** (3), 209–217.

Mendes H.W.B. & Caldas-Junior A.L. (1999) Ethical infractions involving the nursing personnel from a university hospital. *Revista Latino Americana de Enfermagem* **7** (5), 5–13.

Mendes W., Travassos C., Martins M. & Noronha J.C. (2005) Review of studies on the assessment of adverse events in hospitals. *Revista Brasileira de Epidemiologia* **8** (4), 393–406.

Morray B. (1995) Pain medication for the patient following treatment withdrawal. *Dimensions of Critical Care Nursing* **14** (2), 92–98.

Morse J.M., Swanson J.M. & Kuzel A.J. (2001) *The Nature of Qualitative Evidence*. Sage Publications, Thousand Oaks, CA.

Moullin M. (2002) *Delivering Excellence in Health and Social Care*. McGraw Hill, California, CA.

Oguisso T. & Schmidt M.J. (2007) *The Practice of Nursing: an Ethical-legal Approach*. Guanabara Koogan, Rio de Janeiro.

Oguisso T. & Schmidt M.J. (2010) *The Practice of Nursing: an Ethical-legal Approach*. Guanabara Koogan, Rio de Janeiro, RJ.

Pessini L. & Barchifontaine L. (2004) *Humanization and Palliative Care*. Edições Loyola, São Paulo.

Preston R.M. (2005) Aseptic technique: evidence-based approach for patient safety. *British Journal of Nursing* **14** (10), 540–542, 544–546.

Quinn C. (2000) Infusion devices: risks, functions and management. *Nursing Standard* **14** (26), 35–41.

Reale M. (2002) *Philosophy of Law*. Saraiva, São Paulo.

Schütz A. (1972) *Phenomenology of Social World*. Paidos, Buenos Aires.

Schütz A. (1974) *Studies on Social Theory*. Amorrortu, Buenos Aires.

Stolley J.M., Buckwalter K.C., Fjordbak B. & Buch S. (1991) Iatrogenesis in the elderly – drug-related problems. *Journal of Gerontological Nursing* **17** (9), 12–17.

Terry S. & Kaplan L.J. (2007) Ethical imperatives in staffing and managing a trauma in intensive care unit. *Critical Care Medicine* **35** (2), 24–28.

Thomas E.J., Studdert D.M., Burstin H.R. *et al.* (2000) Incidence and types of adverse events and negligent care in Utah and Colorado. *Medical Care* **38** (3), 261–271.

Vásquez A.S. (2003) *Ethics*. Civilização Brasileira, Rio de Janeiro.

Vermoch K.L. (2000) Should medical laboratorians admit mistakes? *Clinical Leadership Management Review* **14** (5), 219–224.

Vincent C., Neale G. & Woloshynowych M. (2001) Adverse events in British hospitals: preliminary retrospective record review. *British Medical Journal* **322**, 517–519.

Wakefield A., Attree M., Braidman I., Carlisle C., Johnson M. & Cooke H. (2005) Patient safety: do nursing and medical curricula address this theme? *Nurse Education Today* **25** (4), 333–340.

Wilson R.M., Runciman W.B., Gibberd R.W., Harrison B.T., Newby L. & Hamilton J.D. (1995) The quality in Australian health care study. *Medical Journal of Australia* **163** (9), 458–471.

Wlody G.S. (2007) Nursing management and organizational ethics in intensive care unit. *Critical Care Medicine* **35** (2), 29–35.

World Health Organization (2006) *The World Health Report 2006 – Working Together for Health*. World Health Organization Press, Geneva.

