Original Article

Judicial deployment of nursing error

Desdobramentos judiciais do erro na enfermagem

Despliegue judicial de errores en enfermería

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Abstract
Objective: To characterize lawsuits with judicial decisions by errors involving nursing professionals.
Methods: A documentary study, with cases judged and concluded that dealt with error involving nursing professionals. The survey was carried out in May and June 2018, on the online website of the Court of Justice of Paraná State. The information of interest was place of occurrence, professionals involved, characteristics of victims, error and outcome of the investigation. For analysis, the data were submitted to descriptive statistics.
Results: There were 31 cases judged, most of which occurred in a hospital (90.32%) and with adults (64.71%). In eight cases, the victim died; in half, the victims had temporary disability (17.50%); seven people had permanent disability. The most frequent error involved medication administration (38.71%), followed by delivery error (19.35%). In more than half of the cases, police report card was registered by the victim (58.06%) and only one medical expert was consulted during the lawsuit (61.29%). In 22 cases, the professional was convicted. Of these, 20 were civil and two criminal convictions. On average, civil lawsuits generated reimbursement of about 10,654 US dollars. In criminal cases, the average length of imprisonment converted into community services was 18 months.
Conclusion: Lawsuits culminated in convictions. In addition, they point to the need for better structure and support for professionals who undergo legal experience.

Resumo
Objetivo: Caracterizar processos com decisões judiciais por erros envolvendo profissionais de enfermagem.
Métodos: Estudo documental, com os casos julgados e concluídos, que versavam sobre erro envolvendo profissionais de enfermagem. O levantamento foi realizado nos meses de maio e junho de 2018, no sítio *online* do Tribunal de Justiça do Paraná. As informações de interesse foram: local da ocorrência, profissionais envolvidos, características das vítimas, do erro e o desfecho da investigação. Para análise os dados foram submetidos à estatística descritiva.
Resultados: Foram identificados 31 casos julgados, cuja maioria ocorreu em ambiente hospitalar (90,32%), com indivíduos adultos (64,71%). Em oito casos a vítima foi a óbito, em metade deles apresentou incapacidade temporária (17=50%) e sete pessoas apresentaram incapacidade permanente. O erro mais frequente envolveu a administração de medicamentos (38,71%), seguido por erro de assistência ao parto (19,35%). Em mais da metade dos casos o boletim de ocorrência foi registrado pela própria vítima (58,06%) e somente um perito médico foi consultado durante o processo (61,29%). Em 22 casos o profissional foi condenado. Destes, 20 foram condenações cíveis e duas criminais. Em média, os processos cíveis geraram ressarcimento de R$ 42.614,30 reais e nos processos criminais, a média de tempo de reclusão, convertidos em serviços comunitários foi de 18 meses.
Conclusão: Os processos judiciais culminaram em condenações. Além disso, apontam à necessidade de melhor estrutura e apoio aos profissionais que passam pela experiência jurídica.

Resumen
Objetivo: Caracterizar procesos con decisiones judiciales por errores donde hubo profesionales de enfermería involucrados.
Métodos: Estudio documental con los casos juzgados y concluidos, referentes a errores donde hubo profesionales de enfermería involucrados. El análisis fue realizado en los meses de mayo y junio de 2018, en el sitio web del Tribunal de Justicia de Paraná. La información de interés obtenida fue: lugar del caso, profesionales involucrados, características de las víctimas y del error y desenlace de la investigación. Los datos fueron sometidos a la estadística descriptiva para su análisis.
Resultados: Se identificaron 31 casos juzgados, cuya mayoría ocurrió en ambiente hospitalario (90,32%), con individuos adultos (64,71%). En 8 casos la víctima falleció, en la mitad de los casos la persona presentó incapacidad temporaria (17=50%) y 7 personas presentaron incapacidad permanente. El error más frecuente se relacionó con la administración de medicamentos (38,71%), seguido por error de atención en el parto (19,35%). En más de la mitad de los casos, la denuncia fue registrada por la propia víctima (58,06%) y se consultó solo a un perito médico durante el proceso (61,29%). En 22 casos el profesional fue condenado, de los cuales 20 fueron sentencias civiles y dos criminales. En promedio, los procesos civiles generaron indemnizaciones de R$ 42.614,30 y en los procesos criminales, el promedio de tiempo de reclusión, convertidos en servicios comunitarios, fue de 18 meses.
Conclusión: Los procesos judiciales terminaron en sentencias. Además, señalan la necesidad de una mejor estructura y apoyo a los profesionales que pasan por la experiencia jurídica.

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Introduction

Health error is characterized as failure to perform the intended action or in applying a plan incorrectly.[1] In short, its occurrence is unintentional and originated by violations resulting from failure to comply with the planning, standards or established standards.[1]

Errors or violations increases the risk associated with health care and can lead to judicial penalties for professionals and institutions involved. The analysis of such events by the judicial system can be supported by the Civil Law,[2] Criminal,[3] or Consumer Protection Code.[4]

Civil liability related to health care failures has as its main objective to promote damage repair and/or compensation.[2] In this sense, error or violation analysis is based on the phatic connection between the agent's conduct (action or omission) and the harmful result.[5] In the case of criminal lawsuits, investigation seeks to determine guilt or fraud, which may lead to personal or property restrictions.[3] In turn, the Consumer Protection Code implies that the individual is guilty and can be applied to the health institution if the error is attributed to the professional with a proven link.[4]

Although legal penalties for error occurrence are recognized, there are few discussions about its implications in nursing whose staff has the largest contingent of health professionals in Brazil and participates in most of care lawsuits.[6]

Considering that studies on lawsuits and outcomes involving nursing error can subsidize decisions and actions of managers, workers and educators in the promotion of safe care, this study is anchored in the following question: What are the judicial deployments of nursing error? For this purpose, this study aimed to characterize lawsuits with judicial decisions for errors involving nursing professionals.

Methods

This is a documentary, quantitative study, based on cases judged by the Court of Justice of Paraná State, with no start date, until April 2018, available online and involving nursing professionals. It was considered as a res judicata the event with judicial decision and no longer subject to appeal.

The data were collected in May and June 2018, in the electronic database of the Court of Justice of Paraná State (www.tjpr.jus.br). In the search, the terms "Nursing error" and "Medical error" were used. The latter was used because in law language, it is the term adopted to determine error committed by any health professional category.

A total of 2,605 lawsuits were identified that, after reading the notes, summary presentation of each case, those that were related to errors involving nursing professionals were selected for analysis in full. Figure 1 shows the flow of selection of the lawsuits contemplated.

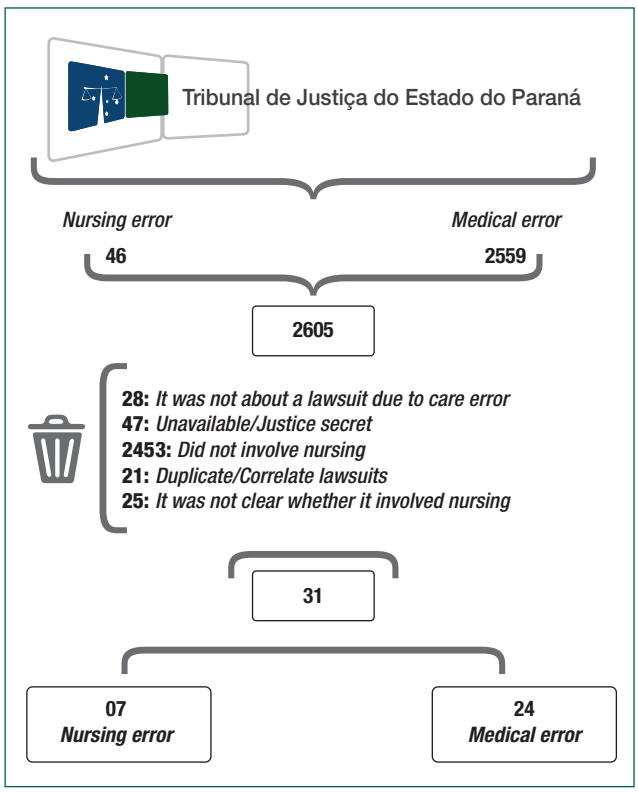

Figure 1. Flow of selection of lawsuits

For the data collection, a spreadsheet/form containing six chuncks was elaborated: a) Lawsuit identification (number, year, related lawsuits and menu, synthesis); b) Place of occurrence characterization (region, municipality, and type of institution); c) Professionals involved category (nursing and oth-

er areas); d) Victims characterization (number, age group and outcome); e) Error characterization (type and third-party involvement); and f) Investigation characterization (police report registration, investigative and consulted body, professional support and legal outcome). Data were tabulated in electronic spreadsheets and analyzed using descriptive statistics techniques. All ethical precepts involving research with human beings have been respected and the proposal for this research is registered under the CAAE (*Certificado de Apresentação para Apreciação Ética* - Certificate of Presentation for Ethical Consideration) 79998817.3.0000.0104.

Results

Thirty-one lawsuits were analyzed, which lasted 8.27 years on average (standard deviation (SD) ± 3.49, minimum=1, maximum=17), from error occurrence to the end of the case's trial (Table 1).

Table 1. Lawsuits cgaracterization due to nursing error. Place of occurrence, professionals involved and victims (n=31)

Variables		n(%)
Occurrence data		
State region (Geographical)	South	13(41.94)
	North	12(38.71)
	West	4(12.9)
	Southwest	1(3.23)
	Southeast	1(3.23)
Place	Hospital	28(90.32)
	Emergency Care Unit (ECU)	2(6.45)
	Primary Care	1(3.23)
Type of institution	Private	21(67.74)
	Public	10(32.26)
Member of the nursing staff involved	Nurse	12(38.71)
	Nursing technician	3(9.68)
	Nursing assistant	6(19.35)
	Nursing staff*	9(29.23)
	Middle-level intern	1(3.23)
Other professionals**	Physician	20(64.52)
Victims data		
Age group	Newborn	4(11.76)
	Child	3(8.82)
	Adolescent	4(11.76)
	Adult	22(64.71)
	Elder	1(2.94)
Outcome	Temporary disability	17(50)
	Permanent disability	9(26.47)
	Death	8(23.53)

*The nursing team was used in cases where the accusation of error did not identify individual or category, since the defendant was the institution. **Another professional category involved in the event

The 31 cases culminated in 34 victims, since in three cases there were two victims, which resulted in an average of 1.10 person per lawsuit (SD ± 0.17, minimum=1, maximum=2) (Table 2).

Table 2. Nursing errors classification by type (n=31)

Type of error	n(%)
Medication (n=12; 38.71%)	
Administration	6(19.35)
Identification (patient exchange)	2(6.45)
Preparation/dilution	2(6.45)
Route of administration	1(3.23)
Dose	1(3.23)
Surgery (n=5; 16.13%)	
Cautery positioning (burn)	3(9.68)
Material count (gauze in the cavity)	1(3.23)
Post-operative care neglect	1(3.23)
Identification (n=1; 3.23%)	
Identification (newborn)	1(3.23)
Fall (n=1; 3.23%)	
Bed fall	1(3.23)
Delivery care (n=6; 19.35%)	
Delivery with dystonia performed by a nursing assistant	2(6.45)
Delivery with dystocia performed by a nurse	2(6.45)
Postpartum care neglect	1(3.23)
Brachial plexus injury by positioning at delivery	1(3.23)
Others (n=6; 19.35%)	
Risk classification error	2(6.45)
Registration incompatible with the clinical picture of the patient	1(3.23)
Containment fracture	1(3.23)
Hot compress burn	1(3.23)
Discharge (allegedly) given by nursing	1(3.23)

There were 22 judicial convictions, of which 20 were civil and two criminal. On average, civil claims generated reimbursement of about 10,654 US dollars (SD ± about 5,559,00 US dollars, minimum=2,000.00 US dollars, maximum=30,000.00 US dollars,). Regarding criminal cases, the average length of imprisonment converted into community services was 18 months (SD ± 2, minimum=16, maximum=20) (Table 3).

Table 3. Lawsuit characterization, professional support and legal outcome (n=31)

Investigation data	n(%)
Police report	
Victim	18(58.06)
Family	11(35.48)
Not included	2(6.45)
Investigation	
Civil	29(93.55)
Criminal	2(6.45)

Continue...

Continuation.

Investigation data	n(%)
Expert consulted*	
Physician	19(61.29)
Nurse	1(3.23)
Not specified	5(16.13)
Not consulted	7(22.58)
Nursing professional support**	
High institutional management	18(58.06)
Immediate boss	3(9.68)
Testimony of physician/nurse in the service	2(6.45)
Not included	9(29.03)
Outcome	
Civil conviction of the professional	3(9.68)
Criminal conviction of the professional	2(6.45)
Related searches	17(54.84)
Unfounded	9(29.03)
Conclusion	
Negligence	13(41.94)
Imperfection	6(19.35)
Imprudence	2(6.45)
Innocence	9(29.03)
Not included	1(3.23)

*Consulted more than one expert (physician and nurse). **Witness immediate supervisor and physician/nurse service

Discussion

The use of judicial services in health institutions can be interpreted as a form of manifestation of the exercise of citizenship by individuals,[7] supported in Brazil by the Organic Law of Health and Federal Constitution[8,9]. This demonstrates the State's recognition of the rights and duties of health service users and their workers.

The data indicate that in the South (41.94%) and North (38.71%) of Paraná, they obtained the highest number of lawsuits (Table 1). This is possibly justified by the fact that they constitute State's regions with the greatest economic development.[10] Therefore, this provides better access to technologies and health, which, together with the dissemination of knowledge about the cause and the progression of diseases, generate greater expectations of the patients/users in relation to the performance of health professionals.[11,12] Consequently, it is natural that there should be a greater number of lawsuits for those who feel injured in the healthcare process.

It should be noted that the data found evidence the tension already exposed in the literature about the discrepancy between legal equality and socioeconomic inequalities. This research indicates that economic difficulties may present as barriers to access to the courts, where the rights of economically disadvantaged people may be purely apparent.[13]

Private (61.74%) and public (32.26%) hospitals (90.32%) were the most sued types of health institutions (Table 1). This result may be related to the higher technological density that permeates tertiary care, institutions usually responsible for specialized care and invasive procedures that generate greater risk to patient safety. Corroborating this statement, a study[14] that analyzed reports of medication errors in nursing published by the Brazilian television media found that all errors (n=14) occurred at the tertiary care and were reported in order to show the professionals' blame, reinforcing in the social imaginary the sense of insecurity associated with health services. However, the existence of care failure should not be attributed exclusively to the health service, but it may also be associated with individual factors of care professionals.

The lack of knowledge of the applicants about healthcare processes seems to contribute to the difficulty of identifying exactly the professional responsible or involved in the adverse event that encouraged suing. This fact may justify the number of lawsuits directed to the nursing team (29.03%) without identification of the professional or the filing of lawsuits against a nursing professional and a physician, as shown in 20 of the 31 cases investigated (Table 1). This demonstrates the invisibility provoked by the social and technical division of labor in nursing.

Lawsuits involving physicians are discussed in the literature and pointed out as one of the causes of stress, decrease of career satisfaction and exercise of defensive medicine to avoid litigious processes.[15] In addition, physicians commonly work autonomously, differentiating themselves from other health professionals who, in general, have institutional support due to the employment relationship.

It is hoped that the institutions can use the experience of physicians with the judicialization of their practice as a way of creating barriers to the prevention of errors by raising awareness about the need to guarantee legal support during the practice of care. As an example, a French investigation that analyzed judicial proceedings for lack of information to the

patient identified that out of 201 physicians prosecuted, 127 were convicted, with surgeons being the most prone to lawsuits risks.[16]

The results of the present investigation reinforce the need to include complete information in the medical records since the registry incompatible with the clinical picture of the patient generated conviction of nursing professionals (Table 2). In this regard, it should be noted that nursing records are indicators of quality of care provided. However, the literature points to a practice that demonstrates the poor quality of care documentation,[17] even in relation to the nursing process,[18] whose instrument subsidizes Nursing Consultation.

As for victims, adults (64.71%) were the most affected and had as main errors those involving medication (38.71%), delivery (19.35%) or surgery (16.13%), which resulted in temporary disability (50%), permanent disability (26.47%) or death (23.53%).

Regarding the age group, the data of the present study do not correspond to the results of an investigation that focused on the errors of medication with nursing involvement in Brazil published in television media, since a greater number of victims were observed in the extremes of life (children or elderly) who died.[14]

The *Lei do Exercício Profissional da Enfermagem* (US' Nurse Practice Act)[19] allows nurses to perform normal delivery without distraction, but the main error found in relation to childbirth care was the performance of a nursing professional during childbirth with dystocia, justified by physician absence (Table 2). Although knowledge of the profession's legal bases is essential to its exercise, it is also necessary to analyze the context in which the nursing work is carried out, in order to identify situations of risk to the health and safety of patients, due to the unavailability of (human and/or material) resources and appropriate conditions for care to be safe.

A study with the objective of knowing the perceptions and experiences of obstetric nursing residents found difficulties related to material resources and infrastructure and to teamwork, including the non-recognition of other professionals about the nursing role in delivery care.[20] These factors can certainly favor the occurrence of errors during care.

The main error related to the surgery was related to cautery positioning, which caused burns in the victims (9.68%). It is noticed that risks run through the entire perioperative period, and cautery use constitutes one of these factors. To minimize risks, it must be assumed that the safe use of equipment, as well as constant monitoring and immediate investigation of complaints should be the responsibility of the entire health team[21], not exclusively from the nursing team. Thus, there must be the inclusion of cautery positioning check in the safe surgery checklist, as a barrier to the occurrence of the adverse event.

The errors identified culminated in 22 convictions of nursing professionals, most of them civil, with an average reimbursement of 10,500 US dollars. Studies on the valuation of indemnities are still incipient, even in the international literature, which restricts the comparison between lawsuits with isolated involvement of nursing professionals. However, this type of analysis has been carried out in the medical field in Taiwan, for example, where physicians also work autonomously, the average value in court convictions for medical error was around 83 thousand US dollars.[15]

In Brazil, most of the time, the nursing team acts under an employment relationship with a health institution, which denotes the service of joint responsibility, for being responsible for ensuring the quality of the services offered.[4] Thus, it is justified that, from the total of civil convictions, 17 culminated in convictions of the health institution by the practice of nursing professionals, concomitantly with the manifestation of high institutional management in defense of the mistake committed by its professional (58.06%) (Table 3).

Institution involvement may illustrate the need to defend the individual interests of the service, which points to the fact that in none of the lawsuits is the participation/performance of the Brazilian Regional Nursing Board (*Conselho Regional de Enfermagem*). Although ethical processes occur in parallel and independently to judicial processes, it is important to note that the category body is not

cited in the lawsuit, and the medical professional is the expert consulted most of the time (61.29%) (Table 3).

Expert consultation bases the judicial decision and can sometimes prevent injustices. The Civil Code describes rules for appointing such experts in which, it points to the direct consultation of the Class Councils, Universities, Public Prosecutor's Office, Public Defender's Office and Bar Association.[11] In this perspective, most of the lawsuits involving a physician as an expert may have limited the profitable analysis on nursing practices.

Physicians tend to have more autonomy over their actions and sometimes regulate the work of other health professionals, weakening multidisciplinary relationships and preventing effective integration with the team.[22] In this context, recognition by the legal system of the medical professional as a single expert, not consulting other professionals, even when other categories are involved in legal proceedings, reinforces the hierarchy present in the social imaginary and possibly compromises judgment.

A study that analyzed the constitution of responsibility in the work of health professionals in a pediatric intensive care unit emphasizes that practices in this environment are regulated by laws, truths derived from medical and legal knowledge and values of Christianity that goes back to a scenario in which responsibility is converted into feelings of guilt, suffering and conflicts among professionals.[22] This may occur in other institutions and professionals. To minimize this, there must be formation of a mental health support network of the nursing professional who tends to be subjugated in their work practice.

The present study focused on the judicial deployment of nursing error. However, the possibility of psychological, economic and social developments in the lives of people and families that have been victimized by errors committed by nursing and health professionals stands out, which denotes the limitation of this research and the need for future research related to the topic addressed.

Conclusion

Lawsuits culminated in civil convictions for errors committed in hospitals. The highest number of convictions involved institutions, which justifies the participation/support of the high institutional management, which suggests a search for self-preservation. Experts in the research were medical professionals instead of the Class Council board. Therefore, their role as part of the indispensable support network is questioned, to overcome/solve the legal experience by mistake.

Collaborations

Souza VS, Inoue KC, Oliveira JLC, Freitas GF, Barlem JGT, Marcon SS, Oliveira MLF and Matsuda LM contributed to the study design, data analysis and interpretation, article writing, critical review of intellectual content and version approval end to be published.

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