

DAILY ACTIVITIES OF NURSING AUXILIARIES AND TECHNICIANS IN RELATION TO ETHICAL EVENTS

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This study aimed to know and understand the actions of nursing auxiliaries and technicians who work in the intensive care unit of the school hospital at the University of São Paulo in relation to ethical events. Data were collected through interviews with eight nursing auxiliaries and technicians (NAs and NTs), with experience with ethical events, and were analyzed according to sociological phenomenology. Participants' experiences permitted to uncover the following concrete categories of meaning: minimization of the risk in these events for patients, openness/dialog within the nursing team, nurses' guidance and supervision of activities performed by NAs and NTs, valuing justice in interpersonal relationships, and respecting the right of patients to be informed about such events. The actions of NAs and NTs in ethical events revealed their intention to ensure delivery of safe care to patients.

DESCRIPTORS: ethics; nursing care; malpractice; imprudence

ACTIVIDADES COTIDIANAS DE AUXILIARES Y TÉCNICOS DE ENFERMERÍA FRENTE A ACONTECIMIENTOS ÉTICOS

El estudio tuvo como objetivo conocer y comprender las acciones de auxiliares y técnicos de enfermería, que trabajan en la Unidad de Terapia Intensiva del Hospital Universitario de la Universidad de San Pablo, frente a acontecimientos éticos. Los datos fueron obtenidos por medio de entrevistas con ocho auxiliares y técnicos de enfermería (AEs y TEs) que experimentaron el fenómeno, siendo analizados bajo el marco teórico de la fenomenología sociológica. Las experiencias de los colaboradores permitieron revelar las siguientes categorías concretas del significado experimentado, minimizar los riesgos al paciente en esas situaciones; mantener el diálogo entre los miembros del equipo de enfermería; orientación y supervisión de las actividades de los AEs y TEs por los enfermeros; valorización de la justicia en las relaciones interpersonales, así como el respeto al derecho del paciente a ser informado sobre tales situaciones. Las acciones de los AEs y TEs, en los acontecimientos éticos, revelaron la intención de asegurar una asistencia que ofrezca seguridad al paciente.

DESCRIPTORES: ética; atención de enfermería; mala praxis; imprudencia

ATIVIDADES COTIDIANAS DE AUXILIARES E TÉCNICOS DE ENFERMAGEM FACE ÀS OCORRÊNCIAS ÉTICAS

O estudo objetivou conhecer e compreender as ações de auxiliares e técnicos de enfermagem, que trabalham na Unidade de Terapia Intensiva do Hospital Universitário da Universidade de São Paulo, frente às ocorrências éticas. Os dados foram obtidos por meio de entrevista com oito auxiliares e técnicos de enfermagem (AEs e TEs) que vivenciaram o fenômeno, sendo analisados segundo o referencial da fenomenologia sociológica. As experiências dos colaboradores permitiram desvelar as seguintes categorias concretas de significado vivido, pois eles buscam a minimização dos riscos dessas ocorrências ao paciente, a abertura e diálogo entre os membros da equipe de enfermagem, orientação e supervisão das atividades dos AEs e TEs pelos enfermeiros, valorização da justiça nas relações interpessoais, bem como respeito ao direito do paciente de ser informado sobre tais ocorrências. As ações dos AEs e TEs, nas ocorrências éticas, revelaram a intenção de assegurar assistência segura ao paciente.

DESCRIPTORES: ética; cuidados de enfermagem; imperícia; imprudência

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INITIAL CONSIDERATIONS

Because patients/clients should have guaranteed delivery of nursing free of worry concerning risks or harms caused by malpractice, negligence, imprudence or inexperience committed by nursing professionals, we should aim to better understand the actions of these professionals so as to understand the phenomenon of ethical events from the experiences of nursing auxiliaries and technicians in an Intensive Care Unit (ICU).

We also need to consider that an ICU is a complex and dynamic unit that gathers professionals and is also a place where decision-making has to be ready and precise, thus, adequate personnel and material structures for the delivery of safe care to critical patients⁽¹⁻²⁾ are expected. Hence, this study helps to understand the actions of nursing professionals in relation to ethical events and contributes to the improvement of nursing care through the minimization of risks to patients, health institutions and nursing professionals involved in the process.

Ethical events are harmful events caused by nursing professionals during their practice and which are related to inadequate behavior toward co-workers, clients or the institutions where they work. These events can cause injury or damage to clients or to the involved professionals themselves whether by lack of attention, ability, knowledge or zeal. They can also be caused by omission, that is, when professionals do not act or do something they were supposed to, thus, injuring or posing risk to others⁽³⁾.

When errors involving nursing professionals occur, greater emphasis is placed on punishing the guilty than on the analysis and improvement of processes that include such events. Thus, professionals become afraid of communicating errors for fear of punishment and, consequently, opportunities to learn from one's own failure are lost⁽⁴⁾.

The phenomenon of nursing ethical events is the object of this study, which is based on the experience of nursing auxiliaries and technicians working at the ICU of the school hospital at the University of São Paulo. The objectives of this study were defined as: to know and understand the meaning of actions of nursing auxiliaries (NAs) and technicians (NTs) in relation to ethical events at the ICU mentioned above.

The problematization of the study object leads to the question: How do NAs and NTs working at the

school hospital at the University of São Paulo act in view of ethical events in the ICU? What do they expect from the nursing team and professionals directly involved with such events?

THEORETICAL PHILOSOPHICAL APPROACH IN THE STUDY CONTEXT

The sociological phenomenology framework⁽⁴⁾ was chosen to broaden the understanding of ethical events involving NAs and NTs because it permits one to know and understand the meaning of nursing professionals' actions regarding the studied phenomenon in the context of their daily experience at an ICU.

Sociological phenomenology does not focus on single acts or individual behavior centered in one's self, but rather permits the understanding of what constitutes a given social group living in a typical situation. Hence, daily life is not an individual universe; it is an intersubjective world common to everyone in which people share with their equals⁽⁵⁾.

Intersubjectivity under the sociological phenomenology perspective also refers to *human action*, which can be purely interior (thought) or externalized through body movements, i.e., changing something in the world. Human behavior is focused on a project people propose to achieve⁽⁶⁻⁸⁾.

People act based on motives directed to goals that would shape the future. Motives consist of a desired state of things, the goal one intends to achieve with action. When one takes action, there are motives for such actions. These motives are rooted in experiences, in the personality one develops over life⁽⁶⁾.

We considered the hypothesis that when NAs and NTs take action in relation to ethical events, they cause changes in practice. These changes permeate interpersonal relations and actions related to patients' care, influencing or guiding new actions⁽⁹⁾.

METHODOLOGICAL TRAJECTORY

The following inclusion criteria were established: participants should be nursing auxiliaries or technicians at the ICU and have experienced ethical events in the unit, also involving nursing personnel.

The setting chosen to carry out the study was the school hospital at the University of São Paulo, which is an institution that focuses on teaching, research and community services. The choice of an ICU is justified by the fact this is a unit where procedures of high technical complexity are performed on patients who are, in general, more vulnerable and are oftentimes subject to a series of risks arising from professionals actions, which can lead to harmful ethical events. The choice of NAs and NTs is justified by the fact that most of time they are those who deliver care and are also those who are charged for failures in the care process.

The study was initiated after permission was obtained from the institution's Ethics Research Committee and participants were provided a free and informed consent agreement. Then, a closer relationship was established with each participant. The number of participants was not pre-determined and interviews ceased when reasons that led NAs and NTs to act in relation to ethical events they have experienced in the ICU were understood. In this way, data collection was carried out with the voluntary participation of eight individuals among nursing auxiliaries and technicians.

It is worth mentioning that the area of study was not limited to the ICU physical space because according to phenomenology scholars, the idea of area of inquiry is much more broad and is focused on the researchers' universe of inquiries or questioning regarding the phenomenon under study⁽¹⁰⁻¹¹⁾.

To establish rapport with the participants, the following questions were asked: *tell me about your professional activity at the Intensive Care Unit; tell me about your actions in relation to ethical events involving nursing professionals at the Intensive Care Unit; what do you expect from your actions?*

Participants are not identified in order to ensure their anonymity, thus, initials of their function followed by the interview number are used (NA1, NT1...).

EMERGENT CONCRETE CATEGORIES AND THE EXPERIENCED TYPE

The organization and categorization of results allowed the construction of the concept *experienced type*, which constitutes a typical characteristic of a given social group, which is

experienced given the social situation of experienced behavior⁽⁷⁾. To organize and discuss results, the researcher followed models assumed by other nursing researchers who have used Alfred Schütz's Sociological Phenomenology as the theoretical framework in their research⁽¹²⁻¹³⁾.

The following steps were followed: a) reading of discourse to comprehend the individuals' motivated experience b) identification of concrete categories that include individuals' acts in relation to nursing ethical events; c) grouping excerpts of reports, that is, related aspects that are significant for actions in relation to the phenomenon of ethical events involving nursing professionals; d) establishment of meanings of social acts in relation to these events from the typical discourse to develop the typology of participants' experiences.

NAs' and NTs' "motives to" in relation to ethical events at the ICU revealed emergent propositions and concrete categories from their experiences in relation to the studied phenomenon, presented below:

Proposition: to deliver nursing care with minimum risk to patients – Category: minimization of risk

The study participants revealed that their concern to ensure the delivery of care with minimum risk or harm to patients originated from professionals' malpractice or lack of attention or prudence in the ICU, taking into account the patients' greater vulnerability and severity of the patient condition as noted in the following reports.

I hope nothing happens to patients, that nothing has changed...I hope that nothing worsens the situation due to a failure of nursing. I hope that people pay more attention to what they are going to do, though this is a highly stressful place [referring to the ICU], you can never be too careful.

We make mistakes, but when you assume you'd made a mistake, you have the opportunity to learn with that. You can improve yourself so as not to make any more mistakes. Dealing with lives is something very complicated, because the ideal is never to make mistakes (NA).

Regarding "motives to" action of participants in relation to ethical events at the ICU, the categories *openness and dialog, guidance and supervision, justice and information to patient* emerged in the reports of NAs and NTs when they refer to expectations regarding their actions and of nurses in relation to ethical events as presented below:

Proposition: to allow the participation of nursing auxiliaries/technicians in actions related to ethical events – Category: openness and dialog

What we expect is that the nurse who is present during an event, an error, is a balanced professional, a balanced person, who talks, not as if punishing, because it causes you not to communicate the error, which makes things extremely grave (NT2).

I hope he's a person open to dialog, because this way the professional himself can talk to the nurse and acknowledge his fault... (NA2).

We expect an understanding behavior from nurses; they have to see the employee's perspective and conditions of work and the moment of the event. What happened? Why punish so severely if there was no injury to the patient or nothing to harm him? (NT3).

Proposition: the promotion of guidance and supervision, avoiding punishing the professional involved in the ethical event – Category: guidance/supervision

Another remarkable aspect in the participants' reports is related to nurses' guidance and supervision, pointed out by NAs and NTs as important elements so as to avoid punishing professionals involved in the ethical event. They value nurses' follow-up, the guidance and supervision of nursing procedures, supporting and encouraging safe practice in relation to the delivery of nursing care to clients in ICUs.

I expect less punishment, even if the professional has made a mistake. But, if there's a situation where the patient is harmed, in this case, I'm in favor of punishment. The professional himself has to acknowledge his fault, but not to be fired, no (NT3).

I expect nurses, in the case of such events, errors, etc., to have a different perspective. I expect them to talk to the employee and explain things clearly, because I guess that nurses and auxiliaries and technicians don't need to be enemies... Nurses should guide professionals, because the professionals, sometimes, act without the orientation they'd need to do a good job and not to make mistakes (NA1).

Proposition: act with justice in relation to ethical events involving nursing auxiliaries/technicians – Category: justice

NAs and NTs expect and consider justice to be a significant element when ethical events occur. They expect nurses to be fair and not to punish, but

instead, guide professionals and take into account their work conditions, which can lead professionals to involuntarily commit errors harmful to patients.

I expect nurses to act with justice in relation to professionals' mistakes. What nurses have to do is to talk with the patient and professionals when his team makes mistakes (NA1).

... and justice would be for nurses to value people who work right and accept critiques. It is not about privileging one over another in schedules, work shifts, allowing one to take two weekends off in a row while other people have only one weekend off (NT1).

If you who have an adequate number of employees and mistakes still occur, the nurse's role is to guide the professionals because such mistakes should not occur (NA2).

Proposition: to inform the patient and/or responsible people about mistakes made by nursing professionals – Category: provide information to patients

Participants highlighted the need of nurses to inform patients about ethical events committed by nursing professionals in the ICU. This information should include what measures will be implemented to minimize consequences and should be provided in clear, understandable and accessible language to patients and/or legally responsible people, as shown by the following reports.

I also expect that the nurse take the initiative and inform the patient about what happened when there are mistakes involving the team; inform of the type of nursing error and explain what measures will be taken to correct the error and that he's going to do his best for that not to happen again. If the patient falls off the bed, for instance, the nurse should orient the team and the patient to avoid that in the future; expressing this in a clear and understandable way for those who matter: the patient or his responsible party (NA1).

In case the event is not very grave, for instance, you should have given a Capoten of 12.5 but gave one of 50, the patient hasn't died, is stable. In this case, in my opinion, you wouldn't need to communicate with the family, but the nurse responsible for the unit needs to know. Now, if the error severely harms the patient, I guess the patient and family have to be told. I guess that the head nurse is the one who should be responsible for communicating the error to the patient's family (NA2).

COMPREHENSIVE ANALYSIS

The categories "minimization of risk, openness and dialog, guidance and supervision, justice

and information to patient" gathered, most of time, the "motives to" action in relation to ethical events in the ICU in the reports of both NAs and NTs.

The category "information to patient" consisted of an important "motive to" for NAs' and NTs' actions in relation to ethical events in the ICU. These professionals revealed their desire that clients acquire or maintain trust in the nursing team who deliver care to them, justifying, in this way, their concern to inform patients about the event, especially when it poses a risk to patients' safety or lives.

On the one hand, professional ethics aims to study duties, rights and responsibilities of a given professional category. On the other hand, patients/clients should be considered subjects of rights and duties. Thus, the right of being informed regarding professionals' actions, as well as potential risks, costs and benefits are highlighted so that patients can consent, after being appropriately informed of or receiving clarification regarding the service/care that will be delivered⁽¹⁴⁻¹⁶⁾. Hence, *right to information* constitutes a measure of *justice*, revealing itself as a value that can be defined and can integrate a lasting belief in a specific model of behavior or state of existence, which is personally or socially adopted and based on pre-existent behavior⁽¹⁷⁻¹⁸⁾.

The category "justice" revealed the participants' desire or expectation to face the fear of punishment when errors or failures occur during care delivery, especially when such mistakes cause physical or moral harm to patients. Participants also expressed their desire to overcome fear through *guidance* and *supervision* of the nursing team's actions as part of the nurses' role.

In this perspective, NAs and NTs revealed their expectation that these actions would contribute to avoid or lessen the stigma of punishment when errors occur. This expectation is consistent with other studies that point to the fear of punishment of professionals involved in these events, which sometimes lead them not to register or communicate events of this nature and consequently, do not take the opportunity to learn from their own mistakes^(4,14).

The category "guidance and supervision" revealed to be inherently interwoven with the educational process because the NAs and NTs expressed their intention to work through nurses' orientation so as to get everyone committed to the educative and preventive objectives in relation to ethical events. This guidance should be supported by

communication and reflection by professionals involved in situations of failure or error, whether in their care giving or in interpersonal dimensions.

Reports reveal that NAs and NTs hold similar perspectives regarding their actions. Hence, some NAs and NTs expressed their expectation that nurses be able to guide and supervise their actions, acting with justice and informing patients regarding the occurrence of events with language compatible to their understanding. NAs and NTs also expect the nursing team to be open to dialog in situations involving ethical events, which can allow better understanding of the set of factors leading to errors such as work conditions and individual factors. In this way, participants expressed their interest in minimizing the risk of the reoccurrence of events of this nature in addition to respecting patients' right to be informed about nursing professionals' errors.

CONSTRUCTION OF THE EXPERIENCED TYPE

In sociological phenomenology, the idealized "experienced types" are interpretative schemes of the social world that are part of human beings' collection of knowledge regarding the world, have a signification value and their elements are always taken in interpersonal relationships^(5,9).

The study shows that there is a common experienced type, which is understandable because these individuals are inserted in the same social group and have experienced similar "motives to" based on the same context of meanings of these experiences.

Hence, actions related to ethical events in the ICU revealed the participants' intention to minimize risks of ethical events. For that, they believed a relationship that favored openness and dialog within the nursing team as well as nurses' guidance and supervision of nursing activities to be necessary.

FINAL CONSIDERATIONS

Minimizing the risk of ethical events occurring in the ICU represented important "motives to" actions for NAs and NTs while dialog and openness were presented as instruments of the nursing team to discuss ethical events in the ICU. Under this perspective, the study also points to the need to

overcome the fear of punishment that involves ethical events, revealing the need to place a priority on educative actions focused on guidance/supervision. NAs and NTs expect nurses to inform patients in the case of failures during care delivery involving the nursing team and also to speed up measures to minimize the risk of harmful events.

Based on the results, we can conclude that nursing professionals should feel able to deal with ethical events in their daily practice in an ICU. For that, ongoing training is required so they can discuss their own daily experiences related to this phenomenon. In the author's point of view, this training should be initiated during professional education, revealing the importance of continued

education, updating and training programs, with a view to minimize ethical events.

It is worth highlighting that the phenomenological approach permitted obtaining positive answers to the initial questions because meanings regarding professionals' actions were revealed, namely: minimization of risks posed to patients due to errors or failures; the need of nurses to be open, dialog, guide and supervise the nursing team's activities in the ICU. Hence, the "motives to" actions of NAs and NTs are contextualized in the practice of these professionals and indicate the important need to invest in educative actions so as to guarantee the delivery of nursing free of risk of harmful events to patients.

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