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RESEARCH

ORGANIZATIONAL CULTURE IN NURSING WORK: INFLUENCES IN ADHERENCE TO QUALITY AND SAFETY PRACTICES

CULTURA ORGANIZACIONAL NO TRABALHO DA ENFERMAGEM: INFLUÊNCIAS NA ADESÃO ÀS PRÁTICAS DE QUALIDADE E SEGURANÇA

CULTURA ORGANIZACIONAL EN EL TRABAJO DE ENFERMERÍA: INFLUENCIAS EN LA ADHESIÓN A PRÁCTICAS DE CALIDAD Y SEGURIDAD

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ABSTRACT

Objective: to analyze the influence of organizational culture on the Nursing team's adherence to the model of quality management and patient safety in a university hospital. ***Method:*** a single case study, with a qualitative approach, using the theoretical framework of Fleury and Fischer, in the internal medicine units. Eleven nurses and 11 Nursing technicians participated. The data was collected through observation, documentary consultation and interviews, being subjected to thematic content analysis. ***Results:*** the symbolic elements of the organizational culture were identified: the power of the teacher and the power of the doctor, strength of the university culture, stability of statutory professionals, myth of the seventh floor of the medical ward, public service work process, work overload and insufficient number of staff. These elements guide actions and determine behaviors in the face of institutional routines, rules and proposals. ***Conclusion:*** Nursing experiences conflicts, leadership difficulties and inefficiency of regulatory mechanisms, creating an environment in which authorities, roles and responsibilities are not recognized. It maintains in its practices the symbolic elements of culture and mechanisms of resistance in a structure in which the power of the teacher and the doctor determines decisions of the units.

Keywords: Organizational Culture; Quality Management; Hospitals, University; Nursing.

RESUMO

Objetivo: *analisar a influência da cultura organizacional na adesão da equipe de Enfermagem ao modelo de gestão da qualidade e segurança do paciente em um hospital universitário.* ***Método:*** *estudo de caso único, de abordagem qualitativa, utilizando-se o referencial teórico de Fleury e Fischer, nas unidades de clínica médica. Participaram 11 enfermeiros e 11 técnicos de Enfermagem. Os dados foram coletados por meio de observação, consulta documental e entrevistas, sendo submetidos à análise de conteúdo temática.* ***Resultados:*** *foram identificados os elementos simbólicos da cultura organizacional: o poder do professor e poder do médico, força da cultura da universidade, estabilidade dos profissionais estatutários, mito do sétimo andar da clínica médica, processo de trabalho do serviço público, sobrecarga de trabalho e quantitativo de pessoal insuficiente. Esses elementos orientam ações e determinam os comportamentos perante as rotinas, normas e propostas institucionais.* ***Conclusão:*** *a Enfermagem vivencia conflitos, dificuldades de liderança e ineficiência dos mecanismos regulatórios, criando um ambiente no qual autoridades, atribuições e responsabilidades não são reconhecidas. Mantém em suas práticas os elementos simbólicos da cultura e mecanismos de resistências em uma estrutura na qual o poder do professor e do médico determina decisões das unidades.*

Palavras-chave: *Cultura Organizacional; Gestão da Qualidade; Hospitais Universitários; Enfermagem.*

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RESUMEN

Objetivo: *analizar la influencia de la cultura organizacional en la adherencia del equipo de enfermería al modelo de gestión de la calidad y seguridad del paciente en un hospital universitario.* ***Método:*** *estudio de caso único, con enfoque cualitativo, utilizando el marco teórico de Fleury y Fischer, en las unidades de medicina clínica. Participaron once enfermeros y 11 técnicos de enfermería. Los datos fueron recogidos mediante observación, consulta documental y entrevistas y sometidos a análisis de contenido.* ***Resultados:*** *se identificaron los elementos simbólicos de la cultura organizacional: el poder del docente y el poder del médico, fortaleza de la cultura universitaria, estabilidad de los profesionales estatutarios, mito del séptimo piso de la clínica médica, proceso de trabajo del servicio público, sobrecarga de trabajo y número insuficiente de personal. Estos elementos orientan acciones y determinan comportamientos ante rutinas, reglas y propuestas institucionales.* ***Conclusión:*** *Enfermería vive conflictos, dificultades de liderazgo e ineficiencia de los mecanismos regulatorios, generando un entorno en el que no se reconocen autoridades, roles y responsabilidades. Mantiene en sus prácticas los elementos simbólicos de la cultura y los mecanismos de resistencia en una estructura en la que el poder del profesor y del médico determina las decisiones de las unidades.*

Palabras clave*: Cultura Organizacional; Gestión de la Calidad; Hospitales Universitarios; Enfermería.*

INTRODUCTION

Organizational culture is the basis on which people's behaviors and actions in organizations are based. Proposals for change must consider it in order to be successful, as culture and its elements will influence the acceptance and adherence to assistance/managerial projects.In hospitals, the adherence to quality management and patient safety by Nursing is influenced by the nature of the work, which implies the relationship with patients and family members within 24 hours, as well as dealing with the organizational processes for assistance. Thus, nurses and Nursing technicians are inserted in the organizational culture as important actors in processes of change.

This study aims at the organizational culture in the work of the Nursing team with quality management and patient safety in a university hospital, considering that the understanding of the organizational culture is preponderant for the successful implementation of health management programs able to promote assistance improvement and safety.

The university hospital is a complex system, making it necessary to consider the interactions between the assistance, administrative, as well as teaching and research areas, in order to implement quality management and patient safety projects that promote reduction of assistance fragmentation and improvement of the processes. Quality management projects can enable comprehensive and safe care, helping to reshape the scenario of insecurities in health institutions.[1]

Thus, the cultural perspective of organizations must be approached, initially, with broad reflection that change has become necessary. In recent years, there has been, in health, technological incorporation and technical training, but little change in work relations and in the formation of a culture of quality and safety.[2]

Organizational culture reflects the way in which individuals experience everyday reality. It is in the cultural arena that the capacity for adaptation is developed, which influences the decision to comply with collective rules.[2] Culture is an element that governs people's actions, consolidating behaviors expected by the group, for the creation of a cultural identity and a sense of belonging.[2] This multifaceted complexity involves the approach of political-cultural patterns.[3]

Still, the organizational culture constitutes a set of basic values and assumptions expressed by symbolic elements that, in their ability to order, assign meanings and build organizational identity, both act as an element of communication and consensus and hide and instrumentalize the relations of dominion.[3,22]

Symbolic elements are social constructions capable of attributing meanings to individual and collective actions and, at the same time, building power relations in organizations in a movement of communication and consensus that creates the group's identity.[3] Such elements are created and maintained in daily life work in a unique symbolic universe, own and with multiple facets, capable of maintaining the status and repelling unwanted changes by the groups, without in practice identifying the reason for the failure of the proposals.[3]

The symbolic elements are, in the daily work, the feeling of collaboration between employees, the myth of the team as a large family, the feeling of social recognition and love for the institution and the affection among employees. The striking historical facts told and passed on by the subjects, such as directors or coordinators who made improvements in the work process and valorization of employees, also complete the picture of the symbolic elements.[3]

In this perspective, to approach the management of quality and patient safety in hospitals is to enter the symbolic universe of culture, considering that it is people in daily life who interact and shape the organizational culture.[3] The implementation of quality and patient safety projects involves changes in the units, professional practices and relationships between groups. However, these projects sometimes assume models incompatible with the organization's culture, so the implementation and maintenance of these projects must be supported by the organizational culture for people to recognize their benefits.[4]

Nurses must understand the quality management inserted in the organizational culture as decisive actors in processes of change, for promoting articulation among professionals, thus enabling the interdisciplinarity and comprehensiveness proposed by the quality management methodologies.[5]

Based on the above, the following research problem has arisen: how does organizational culture influence the Nursing team's adherence to quality management and patient safety practices in a university hospital?

The study is relevant because it addresses symbolic elements of the organizational culture in Nursing work with the management of quality and patient safety since these elements can influence the team's adherence to quality and safety practices. And, yet, it can contribute to the reflection of Nursing professionals due to their participation in quality programs in hospitals. Issues related to organizational culture can influence the achievement of the objectives of these programs, considering the subjective issues and the meanings attributed by the subjects to practical actions in their daily work.

The objective of this research was to analyze the influence of the organizational culture in the adhesion of the Nursing team to the model of quality management and patient safety in a university hospital.

METHOD

Single, qualitative case study, using the theoretical framework of Fleury and Fischer[3], whose scenarios were the internal medicineunits of the *Hospital das Clínicas* of the *Universidade Federal de Minas Gerais* (HC-UFMG), which have 87 beds, 24 of which on the 3rd floor and 63 on the 7th floor. The criteria for choosing the hospital were: introduction of the quality management system 10 years ago with partial results; historical importance and reference of the Brazilian Unified Health System (*Sistema Único de Saúde* - SUS) for high complexity; and the entry of the Brazilian Hospital Services Company (*Empresa Brasileira de Serviços Hospitalares* - EBSERH).

Participants were 11 nurses and 11 Nursing technicians who met the inclusion criteria of working in internal medicine units for over a year. Among the participants there were professionals with UFMG and EBSERH bonds. Exclusion criteria were working in the Nursing sector of the wound committee and clinical laboratory and being away from work at the time of data collection. The number of professionals was not defined *a priori*. The collection was interrupted when the collected data did not add new information to the researchers' evaluation.[6] There was no refusal to participate.

Initially, contacts were made with the chief of the internal medicine unit and of the Nursing coordination to present the project and the Nursing work schedule was requested. Based on this schedule, a drawing of professionals was carried out. After the draw, the professionals were contacted to verify if they agreed to participate in the research and if they met the inclusion criteria; given the consent, the interview (time and date) was scheduled according to their availability.

Data were collected from May to September 2018 through individual interviews, with a semi-structured script, previously submitted to pilot testing, observation and documentary consultation. The semi-structured script addressed issues directed to the planning of Nursing assistance, the process of quality management and patient safety in the units, the entry of EBSERH in hospital management and the training routine.

The interviews were conducted by a single researcher at previously scheduled times, in a private environment in rooms available at the unit, with an average duration of 40 minutes. They were recorded on media player device and later transcribed in full, being coded with the acronyms N =nurse and T=Nursing technician, followed by sequential numbering.

Observations were carried out in the Nursing team's work environment, in meetings of collegiate managers, of quality, of the Center for Patient Safety (CPS), of the Nursing Division and during the conduct of the interviews, being recorded in a field diary.

The documents were consulted: 90 years of care and celebration of life - commemorative catalog (D1)[7]; People Management Policy (D2)[8]; People Management Plan (D3)[9]; Proposed dimensioning of beds by degree of complexity on the 7th floor of the Medical Ward, Post-CCU/Cardiology Unit, Respiratory Precaution Unit (D4)[10]; internal report of the patient safety culture evaluation survey - Hospital Survey on Patient Safety Culture (HSOPSC) - 2016 (D5)[11]; and internal report of the patient safety culture assessment survey - Hospital Survey on Patient Safety Culture (HSOPSC) - 2017 (D6).[12] The last five documents are for internal use, and their use in the research is authorized.

The interviews were transcribed and analyzed by means of thematic content analysis, following the stages of pre-analysis, exploration of the material, treatment and interpretation of the data.[13] The documents were analyzed for the description of the biography and hierarchical, functional and construction structure of the quality management system and patient safety of the university hospital, supporting the apprehension of the origin of the symbolic elements of the organizational culture. The observations were used to understand the reality and enrich the analysis of cultural phenomena. The data from the interviews and the field diary were organized with the aid of the MAXQDA software, version 2018.2.

The project was approved by the UFMG Ethics and Research Committee under Opinion Nr. 2,585,139/2017 and CAAE Nr. 84969818.2.0000.5149, in compliance with Resolution 466/2012 guidelines. The Teaching and Research Management of HC-UFMG requires that the institution be cited in publications. After clarifying the research, the participants signed the Free and Informed Consent Form (ICF).

RESULTS

The hospital's culture did not change with the switch in management with the entry of EBSERH in 2013, with the symbolic elements being passed on to trainee workers keeping the daily work practices of the Nursing team unchanged.

The symbolic elements were identified: the power of theteacherand the power of the doctor, strength of the university culture, stability of statutory professionals, myth of the seventh floor of the medical ward, work process of the public service, work overload and insufficient number of staff. These have an influence on the Nursing work, showing the complexity of the culture of a university hospital.

HC-UFMG was founded in 1928 and linked to the Faculty of Medicine, in which the full professor was the chair of the specialty. This model lasted until 1968, giving rise to the symbolic element power of the doctor and the teacher.

In 2004, HC became a special unit of UFMG (D1) historically inserted in its context, constituting the symbolic strength of the university's culture.

The stability of UFMG professionals admitted by public contest is ensured by the Unified Legal Regime (*Regime Jurídico Único*-RJU) described in the HC-UFMG policy (D2) and in the personnel management plan (D3), establishing the symbolic element of stability of statutory professionals.

This symbolic element, historically established, contributes to the delegitimization of the adjustment instruments, such as the personnel record card, performance evaluation, managers' feedback, verbal and written warning, suspension and administrative process. These become dysfunctional in the daily life of the hospital, being little used and their flows little known by workers and leaders, although foreseen in institutional documents.

> *The performance evaluation is also not done truthfully, because in the hospital there is a culture that has a standard to do, but it is not fulfilled. For example, one sector says I will give 100 to everyone. You don't do a reliable evaluation there* (N2).

> *It is not a very rigid, very strict thing, I think it runs a little loose here. For you to make a warning, there is a whole bureaucracy of which we ourselves do not know the exact line to follow, we have no guidance. We were never told how to warn an employee* (N7).

The Nursing team of the internal medicine unit, for its most part, has an EBSERH bond, both on the 3rd and 7th floors. The "7th East" receives complex patients and is called "East Timor", constituting the symbolic myth of the 7th East of the medical ward.

> *And the seventh floor is that thing, everything comes here, on the third you cannot receive critically ill patients because they do not have an airway aspirator, they do not have O_2. We are working in an ICU without recourse, which does not fit in the ICU comes here* (N7).

Conflicts in Nursing frequently occur due to the difference in bonds and rights of professionals from EBSERH and UFMG, as well as by the organization of the work process, as verified in the observations and reports of the interviewees. The EBSERH contest sought professional experts, generating a feeling of loss of values and the identity of the university, resistance and conflicts with the entrance of those who were offered by EBSERH, given that the hospital management would pass to the management of a company that, in its creation, brought the market discourse and the proposal to increase efficiency. This, in the interviewees' perception, contrasts with the management and assistance models proposed by the university.

> *EBSERH professinals do nothave the commitment to the organization that UFMG professionals have. When UFMG professionals are apporved in the public exam, they are are proud and I do not see it in EBSERHprofessionals. I think it's more of a financial issue* (N10).

> *Hospital das Clínicas did not want EBSERH, which generated conflict. UFMG thought we were coming in to take their places. But we show our value by improving the indicators* (N3).

Conflicts related to the work process still occur because nurses do not directly monitor Nursing technicians and do not always evaluate all patients. In the shift change, the technicians are asked to provide data to complete the change of shift record.

> *Is the nurse able to do skin evaluation? Looking at the insertion site of a parenteral nutrition catheter? He does notsee, and the 24-hour chemotherapy patient must control the pump* (N1).

> *I think that, many times, it is the colleague* [nurse] *who does not get close to* (N11).

> *There is a nurse over there, a Nursing technician over here, there is a separation, no matter how much it is saidit is a team. Some people have a hard time accepting orders. So, this can cause divergence* (T4).

Official means of communication, such as intranet e-mail, computer screens, visible management boards and the institutional website, are not sufficient and are routinely used, being a messaging applicative used that contributes to increasing conflicts in the process of work.

> *I no longer participate in WhatsApp®. I did not do the ISBAR program, I did not have an official communication, it was communicated by the applicative and I do not participate in the group. I amnot getting informed because I don't participate in WhatsApp® in the sector* (N4).

There is not much communication, I think only what is necessary via WhatsApp® (T1).

The UFMG School of Nursing (*Escola de Enfermagem* - EEUFMG) developed a conflict management project on the 7th floor that improved relationships. There is more proximity with the teachers than with the Nursing Division, which translates the power of the teacher as a symbolic element.

The teacher did and enforces several things, nobody says to her "we are not going to do it", you know that thing about respect because she is the teacher (N1).

I think the relationship with the Nursing Division is a long way off. I should be closer to whoever is on the edge, participating, listening, contributing (N8).

The Nursing Division is a long way from the technician's reality (T9).

The Nursing Care Systematization (NCS) is not always done by nurses, although it is mandatory in the hospital. The reports show little adherence to the rules and the warning flows are unknown due to the stability of the statutory and the public service work process (symbolic elements).

We have serious problems and things do not happen, I do not know if the public service work process and bureaucracy is slow. People do not fully assume their roles. In the private sector, you assume your role and not here, they think that it belongs to no one (N1).

I did notwitness a warning either with me or with a colleague (T7).

The teacher reported that she is sorry for not having used the time of excitement, of the new, of the workers who joined EBSERH at the institution. Today they have entered the logic of the public service (Observation Note 06/15/2018).

There is resistance to the proposals for changes even among the new professionals at EBSERH, and the work overload discourse (symbolic element) is the same in both bonds.

The proposal is made on the day shift and then taken to the night, the information is passed on little by little and there is the question of acceptance, resistance to change (N2).

Everything new causes turmoil. So, people go against it, it is not like that, they will have to change, and it has changed. There is a fight over that (T2).

At first, people always tend to resist change (N9).

A team sizing study in 2018 (D4), carried out by Nursing on the 7th floor with the EEUFMG, demonstrated that 43.39% of patients on the 7th floor south ward and 75.92% on the 7th floor east ward are of minimal care, but there are semi-intensive, intensive and highly dependent patients (D4).

In the past, team sizing had a calculation that averaged two nurses for the entire ward of the internal medicine unit. For each Nursing technician it was from five to six patients, it was overloaded. Then there was the contest, the team practically doubled and, really, we do not see that the assistance has improved (N6).

Nurses articulate the work of the multiprofessional team, assuming demands that are not typical of Nursing, such as the custody and control of highly supervised medications. In the unit's routine, it was observed that this control generates security problems and is another source of conflicts in the team.

The relationship with the medical team is distant and with the team of non-medical professionals is closer. The situation is accentuated in the night shift, in which the doctor on call is only called in case of emergency. The physiotherapist is in the Intensive Care Unit (ICU) and has difficulty meeting the demands of the unit.

There is a lot of resident doctors, in fact, I do notknow, and I do not want to know. Several pass by the day, I do not risk wanting to know the name (T3).

Little contact. Usually when we have a problem, first we pass it on to the nurse and he to the doctor (T8).

We, from the night shift, have no relationship with physiotherapy, speech therapy, nutrition, they do not have these professionals at night. Physiotherapy only at the ICU in an emergency and with doctors we do not have much contact, only when we really need it (N10).

It was reported that the hospital works differently on day and night shifts. Night shift professionals find it difficult to participate in meetings, decisions and training, as these occur during the day. On the 3rd floor there are nights without a nurse and coverage is provided by a nurse from another unit.

The hospital has been working on quality issues, according to the requirements of the international patient safety goals of Join

Commission International (JCI), but without control of the activities and communication flow to maintain the actions. At the time of the audit, there is more demand.

> *I am pessimistic, I think it works in theory, little in practice to achieve JCI standard* (E4).

> *When we have accreditations, we are more charged. But other than that* (T6).

> *We are in a public hospital and sometimes it is a long time before we can really work with quality and patient safety. It gets in the way of our work* (T5).

> *It is no use thinking only about the day you are auditing* [...] *I think this is silly* (T11).

Adverse events (AE) are not reported by the team with the argument of insufficient staff (symbolic element). The reports reveal that the notified AE indicator, registered in *VIGIHOSP* (Risk Management and Patient Safety software), does not reflect the reality of the unit.

> *The notification of AE in VIGIHOSP by Nursing technicians is rare, they do not have this custom, but they are aware that they can do it. But it is the nurse who does it* (N10).

> *The Joint Commission made a diagnosis and agreed on the AE notifications, we have a lot of adverse events here* (N6).

The Management for Quality in Health (Gesqualis), in the years 2016 and 2017, applied the questionnaire Hospital Survey on Patient Safety Culture (HSOPSC) (D5,D6), which showed improvements, but the safety culture is not yet consolidated.

The fragmentation of the assistance provided was mentioned, the professionals work in isolation and the autonomy of the professionals is limited by the medical power (symbolic element) with distance between professionals.

> *The nurse rounds and sees the demand for Nursing. The doctor rounds. But the part of sitting and discussing the case in a team, it does not happen between doctors and Nursing* (N5).

> *We are still in that phase where the doctor demanded, and the Nursing technician and the nurse obeyed. It does not have to be that way, we can talk. I think that at the daily crossing in the corridor, Nursing and the doctor can greet each other and comment on a certain patient. I see that they are more closed in their knowledge and do not like to expand* (T7).

DISCUSSION

Federal Universities have always played an important role in the country's social and political scene as a place for discussion and an opinion-forming center. At the time of the dictatorship, it was a place of resistance against a regime of arbitrariness imposed on society. The *Universidade de Brasília* (UnB) and UFMG stand out as active participants in the search for freedom, autonomy and egalitarian relations in the complex relationships between the authoritarian State and the academic elite, which were permeated by resistance, accommodation and adhesion with profound impacts on these institutions, with teachers persecuted, imprisoned, tortured and killed.[14]

With the democratic opening, the mechanisms that ensured equal relations and rights were instituted by the Brazilian Constitution of 1988, which, in its article 41, ensured the stability of the nominated civil servants who render public contest.[14] The regulation of this stability took place through the Law 8,112, in 1990, which instituted the RJU to which university professionals are submitted.[14]

On the other hand, over the years, stability has become dysfunctional in practice, as regulatory mechanisms foreseen in institutional documents and in legislation such as feedbacks from managers, warnings, performance evaluation and administrative processes are little used. Regulatory mechanisms built historically, but ineffective, embody the symbolic element "stability of statutory professionals". Thus, stability in the public sector tends to discourage hospital staff from engaging in actions aimed at improving work.[15] Lack of recognition should be considered as a factor that can interfere with the work and productivity of public employees, as the professionals' commitment is associated with the work environment.[15]

HC-UFMG was created related to the Faculty of Medicine, inheriting its values, myths, rites and the symbolic elements of organizational culture. Beliefs and values are crystallized in the symbolic elements of the group, focusing on the collective constructions that express the elaboration of identity, cohesion and belonging to the group, which, contradictorily, unveil the relations of domination in labor relations.[3] However, for shaping convergence with existing cultural norms, people assume models of behavior expected by the group.[2]

Thus, every construction and proposal for change is faced with the values of a culture rooted in the hospital and university. The institutional proposals to be implemented need to overcome resistance and go through discussions until reaching consensus in the hospital's deliberative instances, in which the university has active participation and decision-making power. In this context, discussions on management models and expanded solutions are necessary, aiming at more employee involvement with the search for improving the quality of assistance.[15]

The entry of EBSERH, in 2013, caused a cultural shock and friction between professionals with different hiring regimes and lack of equality, resulting from the different bonds.[16] EBSERH is a new structure, introduced nationally as a solution for university hospitals, having in view that direct administration by universities was and still is seen as a management difficulty. It is a company model that seeks results, achievement of goals, control and little participation of employees in decisions about work.[16] The creation of EBSERH is part of the historical scenario of the State reform and precarious labor relations, with a logic of market and private company, with a proposal to bring efficiency to federal university hospitals.[17]

However, the maintenance of work practices in the institution can be seen, with repetition of the rites and rituals that give meaning to the symbolic element "strength of the university's culture", revealing that the university's identity remains present and strong. And yet, the EBSERH employees were trained by UFMG statutory officers, perpetuating the culture.

Organizational culture is transmitted through the socialization process of new students in a movement to confirm and adapt culture and established power relations.[3] Socialization is a powerful tool for sharing concepts with its various interpretations, and for newcomers the organization reveals itself as a complex object with many facets, that is, what it sees, what the training says and what the senior workers see.[3]

Thus, the practices and discourses are not linear, evolving in denial, conflict, acceptance and adaptation, in a dynamic construction of the organizational culture, since the perception of belonging to the group is the main element for its maintenance.[2-3]

Thus, the internal medicine unit is inserted, notably on the 7th floor, due to the performance of the quality management system recognized in the institution, as it was the location for the implementation of several institutional pilot projects, mainly the JCI projects.

The 7th floor is recognized for the care of complex patients and employees call it "East Timor", in analogy to the conflicts in the Democratic Republic of East Timor. For the institution, it has a trained Nursing team, material and equipment, which is not always recognized by interviewees, who complain about working conditions to care for critically ill patients. The symbolic element "the myth of the 7th East of the medical ward" is present in everyday life and influences the number of professionals and relocations. The internal medicine on the 3rd floor has an inadequate infrastructure and some shifts are covered by nurses from other units, generating in the medical team the perception that Nursing care is worse. Working conditions influence the organization of the service, making it difficult or easier to guarantee patient safety.[5]

The different bonds between Nursing professionals and the difficulties in working relationships, in the fulfillment of routines and in the performance of private nurses' activities increase conflicts. Nursing leadership and insufficient regulatory mechanisms create an environment of tension in which authorities, roles and responsibilities are not always clear to the team. A movement of cultural adaptation of the various members of the team is perceived, considering that some bring with them ways of making roots and others are still in the process of adaptation.

In this sense, for the Nursing team to work harmoniously, respecting the limits of each assignment, it is necessary that the Nursing leadership has a representative role for the team. Nursing leadership is responsible for improving the quality of patient assistance and reflects on the quality of work relationships and organizational culture.[15,18] The challenges for these processes include difficulties in managing people in the hospital environment.[15]

In the face of conflict situations in the Nursing team, EEUFMG developed a conflict management project in the Unit, which brought improvements in relationships. Thus, the symbolic element "teacher power" was essential to conduct conflicts in a positive way, considering that they impact patient care, according to the satisfaction of the Nursing team and its performance. In this case, it is emphasized that the intervention of teachers has a specific focus, per project, which is different from the management of the team in 24 hours.

Despite the interviewees reporting distance from the Nursing Division, it was possible to observe that there are efforts by the latter in order to plan actions, with the participation of intermediate Nursing chiefs, aimed at improving the work process and strengthening communication between teams and between them with the Division. In this sense, nurses in the exercise of intermediate leadership are responsible for the unit's team, have more proximity to employees and must propose solutions to identified problems, in addition to assisting the Nursing Division in sectoral planning. The chief of the Nursing Division is responsible for strategic actions and guidelines for Nursing work throughout the hospital. It is also important to consider that the work of the Nursing Division became more complex with the entry of EBSERH and its hiring process, which brought the challenge of managing statutory and hired workers working together on institutional projects.

Nursing, in the face of the power of the doctor and the teacher, realizes in reality a structure that is not very favorable to its practice, which embodies the symbolic elements, work overload and insufficient staff, assuming, in addition to Nursing care, attributions that are not specific to the category.

Furthermore, interdisciplinarity in the hospital as a condition for coexistence between different areas, creating the feeling of belonging, essential in organizational culture[2,3] in practice, is weakened by work relationships. It was possible to perceive care centered on the doctor (symbolic element) and fragmentation of assistance.

It is noteworthy that the construction of interdisciplinarity is a challenge for health organizations. It is necessary to break with the

logic of fragmented and doctor-centered assistance, in a movement that seeks to contemplate the multiple dimensions present in health issues and contribute to the changes. Interdisciplinarity, when considering an expanded concept of health, enables the work process articulated in different teams of professionals and improvements in the professional/patient relationship and institutional results.[19] However, interdisciplinarity, in practice, requires horizontalization of relationships and has adherence to the existing organizational culture.

In the hospital, resistance becomes a survival mechanism that maintains the myths, rites and rituals that constitutes culture and expressed in symbolic elements that until today have been successful in maintaining the status of power. Thus, the discourses and practices are maintained even if the situation shows to be different, considering that they are reinforced by symbolic elements. Daily practices are beyond the knowledge of the actions outlined in the rules and work routines.[20] These result in implicit and explicit practices, establishing behaviors and the organization of work.

Thus, quality management is inserted, which, despite being valued by the interviewees, is weakened by the maintenance of actions. It may be related to the continuity of actions, inefficient communication, the importance of permanent training and adherence of the multiprofessional team to issues of quality and patient safety.Certification, although perceived as important, still depends on institutional issues that are not resolved by management, for example, delays in the delivery of the duty schedule, conflicts, few team meetings with wide participation and interdisciplinary work.

To these issues is added the low notification of AE, which is associated with work overload, due to the insufficient number of staff that is often used to justify the low notification and little adherence to the quality management proposals. However, AE notifications are a valuable tool that helps to identify risks, enabling learning from incidents and the implementation of preventive measures.[21]

The nurse, as the chief of the Nursing team, is a key element with the competence to coordinate and manage all phases of care and perform organizational management, enabling credibility and involvement of the team with the quality and patient safety program.[22] It is subject to the forces arising from the organizational culture of the hospital and the university that, to a large extent, influences their actions.

FINAL CONSIDERATIONS

The power of the teacher and the doctor, strength of the university culture, stability of statutory professionals, myth of the seventh floor of the medical ward, public service work process, work overload and insufficient number of staff were identified as symbolic elements of organizational culture. These elements give meaning to the actions that worked and express the identity and feeling of belonging to the group, but they also reveal power relations. EBSERH's management brought conflicts and generated resistance, but the hospital's work process and culture were maintained, reinforcing the university's culture.

Nursing strives to take its place in the hospital's power structure, dominated by doctors and teachers. However, it maintains rites and rituals in its practices, strengthening the symbolic elements of the organizational culture. As a contribution to the practice in health and Nursing, the research reveals the need for the hospital to encourage participatory management by encouraging workers to assume roles as protagonists in the management of quality in health and in Nursing.

The result of this research is not subject to generalization, as it is a qualitative study, carried out in a specific scenario. However, it advances in the construction of knowledge when addressing the analysis of the symbolic elements of the organizational culture that influence the Nursing team's adherence to the practices of quality management and patient safety in a university hospital. They are relevant aspects because it is a federal university hospital whose culture reflects university values that have not been studied in Brazil.

New studies are suggested, including different units and professionals, considering the complexity of the university hospital and the existing subcultures that may influence the work of Nursing in quality management. Studies comparing the organizational culture of different university hospitals are also important.

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