

KNOWLEDGE ABOUT PATIENT HOSPITAL CARE RECEIVED DURING YOUR ADMISSION

CONHECIMENTO DO PACIENTE SOBRE A ASSISTÊNCIA HOSPITALAR RECEBIDA DURANTE SUA INTERNAÇÃO

CONOCIMIENTO DEL PACIENTE SOBRE LA ATENCIÓN HOSPITALARIA DURANTE SU INTERNACIÓN

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ABSTRACT

This study aimed to identify the patient's knowledge about their health status and related hospital care during the hospital stay. There was a descriptive, cross-sectional, quantitative study conducted in two inpatient units of a public teaching hospital in the state of Paraná, Brazil. Data were collected in the period from June to August on a probability sample (n = 165) of eligible patients, using a specific form, previously evaluated and tested for extraction of self-reported patient knowledge about their health problem and assistance hospital waived, as well as documentary source records. The tabulated data, it proceeded descriptive statistical analysis in proportion measures. Most users know their medical diagnosis (73.94%); proposed treatment (82.42%); and knew which proceeded tests (87.84%). In contrast, unaware of the test results (70.91%); the maid drug therapy (80.14%), and indications and risks (51.52%). The doctor was professional legitimized with the highest proportion (40%) as a provider of information during hospitalization. It was concluded that the patient's knowledge in the hospital system is still a loss-making phenomenon, since it is limited only to the most basic aspects of their health problem, corroborating its passivity in attention, and possibly reducing its stake in caution.

Keywords: Communication; Patient Participation; Patient Care Team; Patient Safety; Nursing.

RESUMO

Objetivou-se identificar o conhecimento do paciente sobre a sua situação de saúde e assistência hospitalar correlata durante o período de internação. Fez-se estudo descritivo, transversal, quantitativo em duas unidades de internação de um hospital de ensino público do estado do Paraná, Brasil. Os dados foram coletados no período de junho a agosto sobre uma amostra probabilística (n=165) de pacientes elegíveis, utilizando-se formulário próprio, previamente avaliado e testado, para extração do conhecimento autorreferido do paciente acerca do seu problema de saúde e assistência hospitalar dispensada, bem como de fonte documental em prontuários. Quanto aos dados tabulados, procedeu-se à análise estatística descritiva em medidas de proporção. A maioria dos usuários conhecia seu diagnóstico médico (73,94%); tratamento proposto (82,42%); e sabia quais os exames procedidos (87,84%). Em contraponto, desconheciam os resultados dos exames (70,91%); a terapia medicamentosa empregada (80,14%), e a sua indicação e riscos (51,52%). O médico foi o profissional legitimado com maior proporção (40%) como fornecedor de informações durante a hospitalização. Concluiu-se que o conhecimento do paciente em regime hospitalar é, ainda, um fenômeno deficitário, uma vez que se limita apenas aos aspectos mais básicos de seu problema de saúde, corroborando a sua passividade na atenção e, possivelmente, reduzindo sua participação no cuidado.

Palavras-chave: Comunicação; Participação do Paciente; Equipe de Assistência ao Paciente; Segurança do Paciente; Enfermagem.

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RESUMEN

Este estudio tuvo como objetivo identificar el conocimiento del paciente sobre su estado de salud y la atención hospitalaria durante su internación. Se trata de un estudio descriptivo cuantitativo de corte transversal realizado en dos unidades de internación de un hospital escuela del estado de Paraná, Brasil. Los datos fueron recogidos entre junio y agosto en una muestra probabilística (n = 165) de los pacientes elegibles, a partir de un formulario específico previamente evaluado y probado para comprobar el conocimiento de los pacientes sobre su problema de salud y sobre la atención hospitalaria, así como de otros documentos. Después de tabular los datos se efectuó el análisis estadístico descriptivo en medidas de proporción. La mayoría de los usuarios conocía su diagnóstico médico (73,94%); el tratamiento propuesto (82,42%); y sabía qué pruebas le harían (87,84%). Por otro lado, no conocía el resultado de las pruebas (70,91%); la medicación utilizada (80,14%), ni su indicación y riesgos (51,52%). El médico fue el profesional más reconocido (40%) como proveedor de información durante la hospitalización. Se concluyó que el paciente tiene poco conocimiento sobre el sistema hospitalario que se limita únicamente a los aspectos más básicos de su problema de salud, lo que corrobora su pasividad en la atención y, posiblemente, reduce su participación en los cuidados.

Palabras clave: Comunicación; La Participación del Paciente; Equipo de Atención al Paciente; La Seguridad del Paciente; Enfermería.

INTRODUCTION

Health care affects the production and consumption between professionals and users/patients. By in a way being submitted to the decisions of the assistance team, these patients should have their rights diffused and guaranteed.

In this sense, the concern with the participation and guarantee of patients' rights has been registered since the 1960s in the United States of America, where health users were already recognized as having the right to security and information.¹

In Brazil, the concern to ensuring humanized and safe care has led the Ministry of Health to approve the Charter of the Rights of Health Users.² This document aims to ensure the user's right to receive clear, objective, respectful and understandable information, adapted to their cultural condition about their health situation. Also, depending on each case, the patient should be informed about the diagnoses, exams, objectives of the procedures, risks, and benefits of the proposed diagnostic and therapeutic measures, expected duration of treatment and possible evolution of the health problem.¹

When the patients have little knowledge about their health problem (s), they may demonstrate difficulties in understanding and accepting treatment and, in the case of hospital care, prolonging hospitalization and possibly increasing health risks.³ For this reason, it is necessary that health professionals exercise communication between the staff and the patients because this can facilitate the work process and mitigate the risks inherent to care, contributing to a safe care.⁴

Also, it is known that improving communication in health work is one of the main goals that give the patient's security for life.

In the context of nurses' work, communication is a managerial competence essential to the exercise of militant leadership, through the creation of favorable conditions for qualified service delivery.^{5,6} When applied to patients; such competence has the potential to empower them over their health situation and related treatment, contributing to a successful care.⁷

Based on the assumptions explained, it is extremely important to know how the communicative relationship between health team and patient happens, based on the user's knowledge. Improvements in this relationship may contribute greatly to the management of patient safety, possible by the communication. In this aspect, the scientific studies gain social relevance, since they can mean backed up direction for the decision making for interventions addressed to the possible flaws identified in this diagnostic process.

Regarding the justification elucidated to investigate this problem, this study was based on the following question: what does the patient know or about his or her health situation and hospital care? The objective to resolve this question was to identify the patient's knowledge about his or her health situation and related hospital care during the period of hospitalization.

MATERIAL AND METHOD

This is a descriptive, cross-sectional study with a quantitative approach. It was developed in two hospitalization units in a medical and surgical clinic of a public university hospital in the state of Paraná, Brazil, with an operational capacity of 195 beds exclusively for the Unified Health System (SUS).

The hospitalization units had 28 beds for general clinical and surgical care and cardiology; and 26 beds for orthopedics and clinical and surgical neurological care. These sectors were intentionally chosen since these patients would have more chances of presenting favorable clinical conditions to participate in the study, unlike the other hospitalization sectors for adults of the hospital, as an intensive care unit and emergency room, which usually hospitalize critically ill patients.

The study population consisted of all patients hospitalized at the units investigated. The sample was defined according to the following eligibility criteria: patients older than 18 years old or with caregiver/family member present at the hospital; admitted in the study fields for more than 24 hours; with clinical conditions favor-

able to participation, such as preserved level of consciousness and absence of complications that could eventually prevent the collection of data, a criterion that was evaluated by the researcher, resident nurse in Nursing Management in Medical and Surgical Clinic.

A probabilistic sampling was used to define the number of patients participating, with a calculation based on the occupation of 100% of the units. With a margin of error of 5%, as well as a confidence level of 95%, it was possible to estimate that the sample should be composed of at least 165 patients. Therefore, the data collection took place until the defined sample was reached in its entirety, and there was no stratification among the sectors on the understanding that the phenomenon under study should not interfere with the clinical specialty of the patients' hospitalization, that is, the knowledge of the patient should be diffused in any hospitalization sector.^{1,2}

Data collection took place in June and August 2015, based on the application of a semi-structured questionnaire, specially constructed for research purposes, based on the principles established by the Charter of the Rights of Health Users.¹ The questionnaire was previously evaluated by three Nursing Management professors, two with a doctorate and one with a Master's degree, and also by a specialist nurse responsible for the Quality Management service of the hospital. The pilot test was performed in May 2015 with six patients to verify the possible correction in the instrument, which was not necessary. It is worth noting that all of these procedures do not exclude the need for the questionnaire to be validated in the future by appropriate statistical procedures. However, due to the type of study (descriptive and of a diagnostic nature), it is believed that the effective application of the material was obtained.

Initially, the data collection was done through an interview with each eligible patient, through the application of the questionnaire containing eight objective questions that sought the extraction of dichotomous variables (yes and no) or trichotomous variables (not applied/do not know), referring to self-reported knowledge of the patients about their health condition and related hospital care: diagnosis and treatment intended for hospitalization; conducting examinations and obtaining results; and knowledge about the medications used, which and how many drugs/indications and risks. Also, there was an open question for notation of which professional (s) was passing information to patients according to their indication.

After collecting the data with the questionnaire, the patient's medical record was accessed to obtain the following data: hospitalization unit, bed, date of hospitalization, medical diagnosis, treatment, age, and education, as well as to verify if the information about their knowledge were consistent with the hospital documentation.

All the data collected were tabulated for better access and handling in the Microsoft Excel version 2010 software. Lat-

er, they were analyzed by descriptive statistics, in proportion measurements, using the same technological device. The information obtained in the patient's record was used to trace the sample profile. The data extracted from the questionnaires were used to analyze the participants' knowledge about the events related to their health situation and the care they had during the hospitalization period.

The study complied with all the ethical requirements for research with human beings established by the Resolution of the National Council of Health in the 466/2012 and received favorable opinion nº 1,049,793/2015 issued by the Committee of Ethics in Research of the State University of the West Paraná.

RESULTS

As established by the sample calculation, the study had 165 patients (100%) participating. Most of the sample (61.82%) was hospitalized in the unit of Clinical Medicine and General Surgery and Cardiology. The prevalent medical diagnoses were cholecystitis (33.33% - n=34) and hernias (22.55% - n=23), that is, a predominantly surgical profile. Table 1 summarizes the results of the profile of the participants, according to variables of education, age, and gender.

Table 1 - Sociodemographic profile of the patients (n=165). Cascavel, PR, Brazil, 2015

Variable	Category	n	%
Education	Complete elementary school	75	45
	Incomplete elementary school	20	12.12
	Complete high school	39	23.64
	Incomplete high school	22	13.33
	Incomplete Higher Education	3	1.82
	Non-literate	6	3.64
Age	12 to 18 years old	2	1.21
	19 to 59 years old	105	63.64
	60 years old or more	58	35.15
Gender	Male	86	52.12
	Female	79	47.88

The applied questionnaire began by asking whether the patient was aware of the health situation that led to his hospitalization and related treatment. Of them, 122 (73.94%) said yes, and the other 43 (26.06%) denied this knowledge. Also, 136 (82.42%) reported knowing the treatment proposed for their health problem, as opposed to 29 (17.58%) participants who were unaware of their treatment.

Table 2 shows the results obtained in the question that investigated the patient's knowledge regarding laboratory and imaging exams and their results.

Table 2 - Knowledge of the patients (n=165) on the performance of exams and results. Cascavel, PR, 2015

Question	Yes and they know about the exam		Yes and they do not know about the exam		No	
	n	%	n	%	n	%
Have you done any exam? If so, which one?	145	87.88	12	7.27	8	4.85

Question	Yes		No		They do not know		Not applied	
	n	%	n	%	n	%	n	%
Have the exam results been given to you?	40	24.24	97	58.79	20	12.12	8	4.85

Of the total sample (n=165), 146 (88.48%) patients reported being on medication during hospitalization and only 19 (11.52) denied this question.

Of the patients denying, four patients (21.05%) were taking medication according to the medical prescription of the medical record, increasing the patients that were unaware of pharmacological intervention.

Table 3 shows the results of patients who stated the use of medications (n=146) about which/how many drugs they used and their therapeutic indication and their risks.

In another question, the participants were asked if they had received information about their illness/health situation, treatments, examinations or other interventions during the period of hospitalization by the multi-professional health team. Thus, 140 (84.85%) said yes, that the team reported information about it, unlike the other 25 (15.15%) who denied it.

Based on the total (n=140) who said yes to the above question, patients were asked about which health care provided this information. In this way, Table 4 shows the frequency of each category or group of professionals cited by the participants.

DISCUSSION

Of the total (n=165) of interviewed patients, most of them (45%) had completed elementary school and only 3.64% of the individuals were not literate. This data is relevant for the hospital setting, because the difficulty of understanding, possi-

bly linked to the low level of education, may favor the misapprehension and/or incompleteness of important information about the clinical picture and continuity of treatment in the post-discharge period.⁸ Despite this, the sample studied can be characterized as having high education, which leads to the patient's ignorance, illustrated by several analyzed aspects, may be related to the work process of the health professionals, and not by the cognitive difficulty of understanding their patients.

Table 4 - Professional category responsible for passing information to inpatients (n=165). Cascavel, PR, Brazil, 2015

	n	%
Doctor	66	40.00
Doctor, nurse and nursing technician	45	27.27
Doctor, nurse, nursing technician and physiotherapist	4	2.42
Doctor and nurse	10	6.06
Doctor and nursing technician	5	3.03
Nurse	4	2.42
Nurse and nursing technician	2	1.21
Nurse, nursing, technician and physiotherapist	1	0.61
Nurse and physiotherapist	1	0.61
Nursing technician	2	1.21
Not applied*	25	15.15

*Patients who reported not having received information from any healthcare professional.

Table 3 - Patients' knowledge (n=146) about the medications used during the hospitalization period. Cascavel, PR, Brazil, 2015

Question	Partial		Complete		They do not know	
	n	%	n	%	n	%
Patients who answered yes and knew how many and which medicines they were using	22	15.07	7	4.79	117	80.14

Question	Yes		No		Do not applied	
	n	%	n	%	n	%
Do you know the indication and risks of the prescription drug (s)?	61	36.97	85	51.52	19	11.52

Question	Partial		Complete		They do not know	
	n	%	n	%	n	%
They said yes and they knew how to correctly inform the indication and risks of medicines	43	70.49	9	14.75	9	14.75

The interpretation is reinforced by the fact that regardless of the level of education since the health professional provides explanations to the patients in an understandable way, adapted to their social reality; the information is transmitted in an appropriate way, and the interaction between the patient/family member with the hospital staff is effective.¹

As seen in Table 1, the largest proportion of patients interviewed was classified between 19 and 59 years old. Although isolated, these data also reflect that the patient profile, unlike elderly people, could be able to receive information without much difficulty – as already consolidated, often linked to the common process of senility. Even though, equally, it is necessary to reaffirm that any patient, regardless of age, should be empowered with knowledge about their health situation or such information be provided to their relatives and/or their caregivers.^{1,2}

The study involved more than half of the male patients. This can be explained by men's distancing from their health care, and over the years, public programs that have been created have always been more focused on maternal and child health, leaving public policies to health of this patient in the background until recently.⁹

About knowledge of the health problem, most patients replied that they knew it. In turn, 26.06% who answered that they did not know the reason for the hospitalization could have more difficulties to participate in the decisions about their treatment or even to verify if the interventions proposed by the health team are in line with their real needs.²

Opposite to the previously discussed data, the sample minority (17.58%) did not know what treatment would be submitted. Thus, this reflects that the lack of effective communication by the team to reduce the patient's knowledge about their health situation, hindering to be an active element in their care, that is, the proposed treatment for the situation experienced.²

Based on the patient should participate in his/her care, it is lawful and necessary that he/she receive all the information on his/her state of health based on the decision making.³ In this aspect, it is imperative that the process of communication between the team and the patient is attentive, active and competent. This is because, if the patient participates in the treatment plans, he/she is co-responsible for his/her adherence.¹⁰

A positive point in the dialogue between patients and staff was the knowledge of the patients about the examinations carried out during hospitalization since most of the sample (Table 2) was able to answer the name of the examinations. This is important because this information can only be acquired through the communication of the health professional, since, it is known, this is the holder of the technical knowledge covering the diagnostic-therapeutic procedures, such as imaging and laboratory tests.

On obtaining, results for the exams performed, few individuals of the research (Table 2) answered that they knew the results.

This is a fact that contrasts with the result described above, that is, at the same time that health professionals seem to report on the conduct of examinations to the patients, they do not give the correct results of such interventions. Therefore, they limit the communicative process only to the accomplishment of tasks, contributing to the fragmentation of the care and the little active participation of the patient in the clinical decisions demanded.

Patients should be informed of all exam results, even those that do not have any changes.¹² This is because, once the patient is sure that he will know all the results of the exams performed, it can be a barrier of reliability for uninformed/registered findings, becoming a participatory agent in its care and treatment and contributing to safety in care.¹¹

When patients have unrealistic expectations about the benefits and risks of certain interventions, such as imaging tests that are often novel to patients and can influence their decisions, it contributes to increasing the use of patient interventions in an inadequate way and the costs of health care.¹² Therefore, it is suggested that knowledge about the exams and their results forms a dubious interface: of interest to the patient, within the reference of their safety and right; and the organization, in the context of the achievement of business goals common to the globalized world of health service providers.

Regarding the use of medications, as expected due to the research being performed in the hospital environment, a significant portion (88.48%) of the sample stated that they used some medication. In this aspect, there were compromising findings regarding the communication about the indication and risks of prescribed drugs and the completeness of how many and which drugs were being administered at hospital admission (Table 3).

Possibly, it is at the time of medication administration that nursing professionals are more prone to error, since it is known, to clinical practice, that this is a complex procedure that goes through many steps until reaching the patient. Thus, the timing of drug administration is the last opportunity to detect errors that have gone unnoticed in the dispensing or preparation of medication. Therefore, when patients are aware of their drug therapy, they can be a major barrier to avoid a possible error.¹³

In a research,¹⁴ it appears that about 90% of nursing professionals did not receive training on the preparation and administration of medications; and that there was a need to make feasible measures to reduce the risks to patient safety, including the development of training courses for the health team regarding medication administration.¹⁴ Despite the imperative relevance of the research experience cited, it is suggested that the training of the human capital about the medicines used in the hospital possibly does not guarantee their rational and safe use, since the knowledge of the patient is a factor that deserves more attention of the leaderships, as clearly shown in the results of the present study.

Medication errors are one of the most frequent adverse events in hospital institutions. However, taking some measures such as strategies for joining professionals to policies and procedures that aim at patient safety; participation of the patient in their care; use of technologies and environments that minimize the possibility of error; access to information; safety education; administrative support that ensures adequate contingent of professionals to care for patients, minimizing the occurrence of medication errors would be possible.²

The patient, family or legal caregiver should be aware of the risks and benefits of the drug therapy administered and may be collaborators in the prevention of errors.¹⁴ However, it was possible to identify that few patients (Table 3) knew about the pharmacological intervention during hospitalization. Therefore, they were very possibly unaware of their actual risks and expected benefits. Thus, this is certainly worrying, since not knowing the potential risk of drug therapy, perhaps the patient may have difficulty identifying any adverse event related to it, contributing to their insecurity in care and possible fear about the prognosis of the health situation.

It is necessary to promote a culture of patient safety to overcome this reality, including the promotion of non-punitive culture to errors, since this practice must be continuously exercised and stimulated by professionals so that the current organizational culture should be consolidated, which should be for active communication for safety.¹⁵

In the transfer of information by professionals, the sample of patients legitimized that the working class, in isolation, and responsible for the transmission of knowledge is the doctor (Table 4). This is consistent with the provisions of the Code of Medical Ethics¹⁶, which prohibits the physician from failing to inform the patient of the diagnosis, prognosis, risks and objectives of the treatment, except when direct communication can cause harm to him or her, and they should communicate to their legal representative.

Despite the information above, it is necessary to reflect on the general construct of results of this research, since 26.06% (n=43) of the sample reported not knowing their diagnosis and 17.58% (n=29) were not treatment offered during their hospitalization. That is, despite the low expressiveness of these data, it must be agreed that patients signal that some basic issues inherent in the physician's educational work may have been neglected.

It is also worth noting that to hold the doctor exclusively responsible for transmitting knowledge to the hospitalized patient is frivolous and counterproductive. Thus, the communicative ability is paramount for the development of nurses' work in the multi-professional team and represents a way of sustaining the care relationship for patients and their relatives/caregivers.^{4,5} Consequently, the communication process is intrinsic to the nursing actions, and it is up to the nurse to

understand the meaning of the messages that the patients emit and to transmit clear and complete information to the individual's understanding.¹⁷

The nurse was rarely mentioned as the main informant or transmitter of knowledge to the hospitalized patient (Table 4). This is worrying, once knowing that communication is fundamental competence for the success of the nurse as a leader, allowing him to approach to the patients as well as their staff and other professionals to understand the activities performed, share ideas and points of view, as well as create inter-dependencies for the development of work through multi-professional harmonic teams.

It is well known that the nursing team is the one who stays with the hospitalized patient for the most time, having care as his object of work. These professionals should seek to establish a bond with their patients to build relationships and know the other, contributing to ethical, legitimate and humanized care.¹⁸

Based on the literature consulted and on the results described, it is recommended that nurses acting on the empowerment of patients under their care, based on knowledge, can be a factor that contributes to the reaffirmation of this professional as care manager. This is because, through this practice, the nurse can link the manager action to the care. Therefore, it is believed that it is necessary for nurses to (re) plan their managerial activity, including the patient's participation in care as a fundamental premise for qualified and safe care.

CONCLUSIONS

With this study, it was possible to identify the (un) knowledge of the hospitalized patient about their health situation and related care. In this aspect, the following findings stand out: the expressive portion knows its diagnosis and proposed treatment; they know the intervening diagnostic tests, contrary to its results; they claim to use medications, but they have little knowledge about their therapeutic indication, and they legitimate the doctor as the main professional responsible for transmitting knowledge that involves hospital care.

Based on the results, it was concluded that the knowledge of the patient during the period of hospitalization is a multifaceted and deficient phenomenon and apparently, it is restricted to the domain of the most basic questions of the health problem, such as diagnosis, reinforcing the passivity that the user still has by the health professional.

It is true that there are limitations to this research, such as the absence of inferential statistics and the impossibility of generalizations, which reinforces the need for new studies with different methodological approaches, such as qualitative investigations aimed at revealing the taboos that still permeate the process of communication in hospital services.

Despite the above, it is believed that the study contributes greatly to patient safety management by reaffirming that communication between staff and users is a factor that deserves more attention from the leadership and there are aspects that should be monitored more rigorously by managers of care, so that the user has guaranteed the knowledge about his health situation and assistance dispensed, converging with the ethical and safe care.

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