RESEARCH

# ANALYSIS OF YOUTUBE VIDEOS ABOUT ADVERSE HEALTH EVENTS

## *ANÁLISE DE VÍDEOS DO YOUTUBE SOBRE EVENTOS ADVERSOS EM SAÚDE*

## *ANÁLISIS DE VIDEOS DE YOUTUBE SOBRE EVENTOS ADVERSOS EN SALUD*

Pétala Tuani Candido de Oliveira Salvador [1]
Cláudia Cristiane Filgueira Martins [1]
Kisna Yasmin Andrade Alves [2]
Theo Duarte da Costa [3]
Viviane Euzébia Pereira Santos [4]

[1] RN. Doctoral student in Nursing Graduate Program, Professor at the Nursing School in Natal and member of the Research Group of the Care, Security, and Technology in Health and Nursing Research Laboratory, Federal University of Rio Grande do Norte – UFRN. Natal, RN – Brazil.
[2] RN. MsC in the Nursing Graduate Program, and member of the Research Group of the Care, Security, and Technology in Health and Nursing Research Laboratory – UFRN. Natal, RN – Brazil.
[3] RN. Doctoral student in the Nursing Graduate Program, and Member of the Research Group of the Care, Security, and Technology in Health and Nursing Research Laboratory – UFRN. Natal, RN – Brazil.
[4] RN. PhD in nursing. Adjunct Professor in the Nursing Department and Nursing Graduate School and leader of the Research Group of the Care, Security, and Technology in Health and Nursing Research Laboratory, UFRN. Natal, RN – Brazil.

Corresponding Author: Pétala Tuani Candido de Oliveira Salvador. E-mail: petalatuani@hotmail.com
Submitted on: 2014/01/20 Approved on: 2014/10/20

## ABSTRACT

This was an exploratory study with a quantitative approach carried out on the YouTube video sharing website. It aimed at analyzing videos from *YouTube* about adverse health events identifying the existence of relationships to patient safety. The search of videos was performed in December of 2013, on the *YouTube* website by combining "patient safety and adverse events". Thirteen videos were analyzed according to the indicators: duration; author; date of posting; total views; category; approach; focus; health professionals cited; type of adverse health event approached; causes; consequences; prevention strategies; and relationships with patient safety. Despite the incipient number of videos being elucidated, considering the actual relevance of the subject, they highlighted the relationship between patient safety and adverse health event, focusing on prevention strategies.
**Keywords:** Patient Safety; Medical Errors; Quality of Health Care; Nursing Care.

## RESUMO

*Pesquisa do tipo exploratória, com abordagem quantitativa, realizada no sítio de compartilhamento de vídeos YouTube. Objetivou-se analisar os vídeos do YouTube sobre eventos adversos em saúde, identificando a existência de relações com a segurança do paciente. A busca de vídeos foi realizada em dezembro de 2013 no sítio do YouTube, por meio da combinação "segurança do paciente e eventos adversos". Foram analisados 13 vídeos quanto aos indicadores: tempo de duração; autor; data da postagem; total de visibilizações; categoria; abordagem; enfoque; profissionais de saúde citados; tipo de evento adverso em saúde abordado; causas; consequências; estratégias de prevenção; e existência de relações com a segurança do paciente. Apesar de ser elucidado um número incipiente de vídeos frente à relevância da temática na atualidade, estes destacaram a relação entre a segurança do paciente e os eventos adversos em saúde, com enfoque nas estratégias de prevenção.*
***Palavras-chave:*** *Segurança do Paciente; Erros Médicos; Qualidade da Assistência à Saúde; Cuidados de Enfermagem.*

## RESUMEN

*Investigación cuantitativa exploratoria realizada en el sitio web de vídeos YouTube. Su objetivo fue analizar los vídeos sobre eventos adversos en salud para identificar su relación con la seguridad del paciente. La búsqueda de videos en el sitio de YouTube se realizó en diciembre de 2013 mediante la combinación de "seguridad del paciente y eventos adversos". Se analizaron 13 vídeos según los indicadores: tiempo de duración; autor; fecha de publicación; total de visualizaciones; categoría; enfoque; foco; profesionales de la salud citados; tipo de eventos adversos para la salud; causas; consecuencias; estrategias de prevención; y relación con la seguridad del paciente. A pesar de la poca cantidad de vídeos ante la importancia del tema en la actualidad, dichos vides destacan la relación entre la seguridad del paciente y los eventos adversos en salud y se centran en las estrategias de prevención.*
***Palabras clave****: Seguridad del Paciente; Errores Médicos; Calidad de la Atención de Salud; Atención de Enfermería.*

## INTRODUCTION

The advancement in research in the health care area has contributed to the improvement of care given to patients. However, even with this progress, people are still exposed to several risks, especially in the hospital environment.[1]

Research show that the estimated number of deaths will increase due to several flaws during the hospitalization process. Among them, are: medication prescription errors, communication problems, failures in discharge-processes, errors during the surgical procedure. Such issues are health care consequences causing 44 to 98 thousand adverse events annually in US hospitals.[2]

In this context, the World Health Organization (WHO) began to worry about patient safety and set goals for preventing errors that may cause some injury. The patient safety concept is related to reducing the risk of unnecessary damage, associated with healthcare to an acceptable minimum.[2] Thus, expressing this world concern for patient safety and improving the quality of health services, the *World Alliance for Patient Safety* was created in 2004 by the WHO.

The *Patient Safety Program*, composed of several countries, seeks to define priority issues for research on the patient safety area that is highly relevant for countries at all levels of development. The most important among them are: healthcare for mothers and newborns; healthcare for the elderly; adverse events related to medication errors; fragile security culture focused on the process of responsibility for the error; skills and inadequate skills among health professionals; infections associated with health care.[3]

Among other guidelines, this alliance sought to organize the taxonomic aspects related to the patient safety subject by defining an incident as any event or circumstance which could have resulted, or resulted, in unnecessary damage to the patient. These events can be considered adverse events in health, being conceptualized as unintentional injuries resulting from health care, not related to the natural evolution of the underlying disease, which cause measurable injuries in affected patients and/or prolongation of hospitalization and/or death.[4]

Therefore, it is important to support studies that seek to identify strategies for the prevention of adverse events related to healthcare. Meanwhile, the importance of the *YouTube* site is highlighted, which is today a worldwide information source, especially with regard to health problems. It is important, therefore, to pay attention to the fact that many of the videos posted on this site do not undergo any analytical treatment, not being of scientific nature, being therefore very important to pay attention to the quality of the material available on *YouTube*.

Nowadays, the Internet is an extremely important information area, which is unquestionably part of people´s everyday lives. TV shows, interviews, reviews, reports, home videos, everything can be seen and shared, anytime and anywhere.[5]

Thus, the expansion of interfaces through which users can interact and produce content is one of the characteristics associated with the called *web* 2.0,6 being relevant to consider the fact that any individual, for any purpose, can use sites like *YouTube* to have access to different information,5 in particular related to health aspects.

Rated by *Google* as a content distribution platform, *YouTube* provides opportunities to many users, to find, view, and share home or professionals videos.[7] Therefore, it is a site that serves as a bank of audiovisual products, an *online* video service that allows users to upload them, share them, produce them, and publish them in digital format, being considered the most popular site of this type, and therefore, an unquestionable valuable tool for the contemporary society.[8]

The video language, with its synthetic nature creating a superposition of codes and meanings and predominantly audiovisual, has a significant power of illustration,[7] making the information ubiquitous and universal, with a range of potential without discrimination – literate and illiterate.[9]

With such potential and unquestionable importance of videos available on the Internet in this contemporary time, it is imperative to pay attention to the quality of the material being used because when addressing issues related to healthcare, the information may result in erroneous actions and/or thoughts, even compromising patient safety regarding to adverse health events.

It is evident that *YouTube* videos can be a tool to help the population in the teaching-learning process if using it with careful planning, with goals to enjoy all its potencialities.[10] Aware of such assertive, some scholars have tried to analyze *YouTube* videos related to health aspects.[5,9,11,12]

When addressing adverse health events, it becomes even more important to analyze the videos on *YouTube* about the topic, as it captures the media impact that the problem has often been addressed in an appealing way and hardly enlightening about potential prevention strategies.

Thus, the answer to the following research questions is sought: what *YouTube* videos show about adverse health events? Do they bring up relationships with patient safety?

## OBJECTIVE

The objective of this study was to analyze *YouTube* videos about adverse health events, identifying the existence of relationships to patient safety.

## MATERIAL AND METHODS

This was an exploratory study with a quantitative approach, performed on the *YouTube* video sharing site, with a virtual address as: *www.YouTube.com*. The choice of *YouTube*

was due to currently being the most widespread video sharing site among Internet users.[8]

The study followed a research protocol composed of the elements: research topic; guiding questions; objective; research strategy; selection of studies; critical evaluation of studies; and presentation of results.

The research was performed in the *YouTube* search site in December of 2013 through the combination of the controlled keyword "patient safety" – extracted from Health Sciences Keywords (DeCS) – with the uncontrolled keyword "adverse events". The filter "type of result" offered by the site was used, choosing only "videos" as results.

Initially, the keywords combination was typed in the search field in the site, and then the filter offered by *YouTube* was applied. The *links* for the resulting videos in this initial search was saved for further analysis to not compromise the sample selection because the site is characterized by a continuous addition of new content. After this step, the research was conducted by visiting the selected *links*, without a defined location, because there is no restriction of access to videos visited in different sites, as it is the case in some other search sites. Thus, it was possible to visit them at different times, for the observation and analysis of pre-selected videos in an organized way.

Thus, the videos were analyzed individually, establishing as inclusion criteria: videos with direct reference to adverse health events; in verbal language – Portuguese – or non-verbal. Videos that did not answer the research question and/or did not relate to the topic were excluded, as well as duplicate videos.

After the initial selection of videos according to the inclusion and exclusion criteria, the selected sample was analyzed according to the following study indicators, which were synthesized in a *Microsoft Excel* 2010 worksheet:

- **duration:** shown in the *timeline* of the video (in minutes and seconds – nn'nn");
- **author:** responsible for posting the video – if from an individual, agency, or company;
- **date of posting:** indicated in the video description;
- **total number of views:** indicated under the video;
- **category (according to *YouTube* classification):** indicated in the video description;
- **video approach:** if theoretical, only with theoretical elements about adverse health events; practical, only with aspects related to care practices in adverse health events; or theoretical and practical, with both theoretical and practical elements;
- **focus:** to classify according to the general objective of the video – to educate, disseminate news, promote new products, or other (specify);
- **health professionals cited:** to report all professionals cited as involved in adverse healthcare events;
- **type of adverse health events addressed:** to indicate the type of reported adverse event;
- **causes for adverse health events reported:** if considering the causes of adverse health events, indicate which were cited;
- **consequences of adverse health events reported:** if considering the consequences of adverse health events, indicate which were cited;
- **prevention strategies for adverse health events addressed:** if presenting strategies for the prevention of adverse events in health, indicate which were cited;
- **existence of a relationship with patient safety:** Does the video relate adverse health events to patient safety? If so, which one?

The analysis of the indicators occurred through descriptive statistics. The approval of the ethics committee was not required because the research did not directly involve human beings, but used public domain material.

## RESULTS

The search for videos on *YouTube* by combining "patient safety and adverse events" showed 70 results, which filtered from the "type of result – video", totaled 40 videos. They were watched individually and analyzed based on inclusion and exclusion criteria, and indicators of data collection, resulting in a final sample of 13 videos, corresponding to 18.6% of the amount initially found.

The characterization of the research sample is shown in Table 1, where the indicators are described: duration, author, date of posting, category, approach, and focus.

Videos with intermediate length predominated: nine (69.2%) videos were four to 20 minutes long. The 13 videos together had an analyzed moving image time of 1 h 39 min 25 s, with an average of 7 min 63 s per video. The shortest video was 1 min 42 s long and depicted an advertising campaign about safe surgery, sponsored by the Anestesia Segura Company. The longest video was 17 min 42 s long and showed an interview with the Coordinator of the Sentinel Surveillance Services from the National Health Surveillance Agency (ANVISA) – Patrícia Fernanda Toledo – about the Sentinel Network, posted by TVNBR, the channel that disseminates the TV videos of the Federal Government.

Most of the videos were posted by agencies linked to public service – six (46.3%) highlighted TVNBR; two (15.4%) were previously cited; and the Patient Safety Proqualis – two (15.4%). This last one is a portal linked to the Institute of Communication and Scientific and Technologic Information (ICICT) from the Oswaldo Cruz Foundation entitled Collaborating Center for Quality of Care and Patient Safety (PROQUALIS), which aims to disseminate information about the quality of care and patient safety.

Table 1 - Characteristics of video components in the studied sample; 2013

| Indicator Analysis | n (N=13) | % |
|---|---|---|
| **Duration** | | |
| Short (less than 4') | 4 | 30,8 |
| Intermediate (between 4' and 20') | 9 | 69,2 |
| Long (more than 20') | 0 | 0,0 |
| **Author** | | |
| Individual | 4 | 30,8 |
| Agency | 6 | 46,2 |
| Company | 3 | 23,0 |
| **Date of posting** | | |
| 2011 | 2 | 15,4 |
| 2012 | 4 | 30,8 |
| 2013 | 8 | 53,8 |
| **Category** | | |
| Science and technology | 5 | 38,4 |
| Education | 4 | 30,8 |
| News and politics | 2 | 15,4 |
| Sports | 1 | 7,7 |
| People and *blogs* | 1 | 7,7 |
| **Approach** | | |
| Theoretical | 9 | 69,2 |
| Practical | 0 | 0,0 |
| Theoretical and practical | 4 | 30,8 |
| **Focus** | | |
| Journalistic | 4 | 30,8 |
| Educative | 9 | 69,2 |

The analyzed videos were recent, from the last three years, especially from 2013 – eight (53.8%). Adding the total number of views of all videos, there were 13,352 views, with an average of 1,027 views per video. An educational video posted by Proqualis Patient Safety stood out, which demonstrates the use of a surgical safety checklist, already viewed 8,745 times.

According to the categorization of videos followed by *YouTube*, which is defined by the author responsible for the posting, a higher quantity of Science and Technology videos was found – five (38.4%) – and Educational – four (30.8% ), which was confirmed by the analysis of the videos' approaches with a predominance of educational videos – nine (69.2%).

Most of the approaches were theoretical – nine (69.2%). Those who followed a theoretical and practical approach – four (30.8%) – used simulations of practical aspects of healthcare, especially for the videos demonstrating the use of tools for patient safety in surgical procedures – three (23.0%).

Regarding the cited health professionals, videos about multidisciplinary health teams in charge of prevention of adverse health events predominated – 11 (84.6%).

Unanimously, the videos showed adverse health events as predictable and preventable, highlighting the necessary surveillance and reporting of incidents as potential events as a way to prevent that such incidents turn into actual adverse events, which result in harm caused to patients. Figure 1 shows the adverse health events cited in the videos.

The fact that such situations can be prevented and avoided using appropriate surveillance before they cause damage and become adverse health events is highlighted.

Strategies to prevent adverse health events were generally observed in all analyzed videos, focusing on a larger view of patient safety, which overcomes the culture of punishment to promote the safety culture. Table 2 presents the prevention strategies cited in the videos.

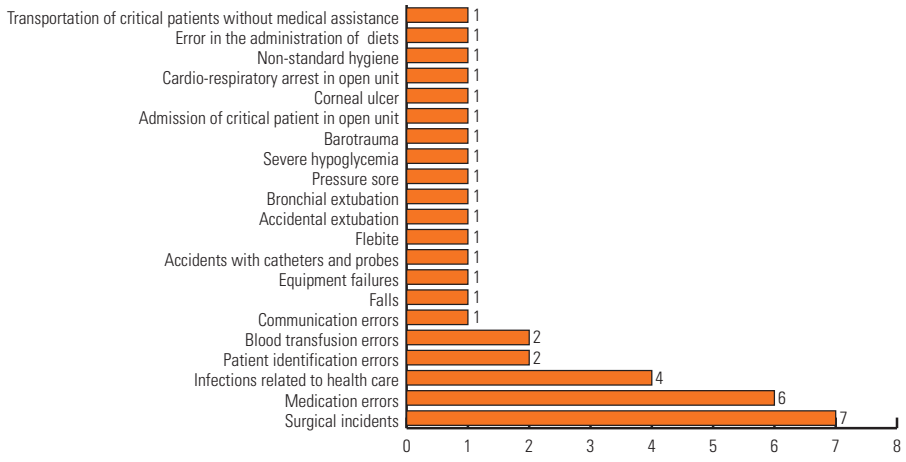


Figure 1 - Adverse health events cited in the analyzed videos; 2013. Source: research data.

Table 2 - Strategies to prevent adverse health events highlighted in the videos; 2013

| | |
|---|---|
| Programs follow up/ formalized protocols for monitoring patient safety | *World Alliance for Patient Safety*<br>National Program of Patient Safety<br>*Bundle* do *Institute for Health care Improvement*<br>Required Organizational Practices recommended by hospital accreditation |
| Use of tools to promote patient safety | Proper organization, adoption of protocols, adequacy of human resources, teamwork, training and ongoing training, joint surveillance, patient´s collaboration, communication, creation of Patient Safety Centers, notification, correct identification, hand hygiene, nursing process, use of surgical safety checklist, use of the 10 steps for safe anesthesia, more concern for professionals occupational health, risk management, time-out, management of high-risk medications, and use of the "sures" in the medication system |

## DISCUSSION

Similar to other studies,[5,11] the 13 videos analyzed focused on educational aspects related to adverse health events, potentially revealed as useful for the protection of population health.

It was also possible to observe the significant reach of the studied videos, which altogether were seen 13,352 times. It was observed that the most watched videos showed an evaluation for future users[7] since *YouTube* organizes the sequence of videos from the most viewed and evaluated. Thus, the most-watched and best-evaluated videos appear first in the search by users, and therefore, they should be carefully analyzed for quality of content, since they will be the primary source of information. In addition, these videos can represent training disseminators of knowledge about adverse health events.

The highlighted theoretical aspects addressed in the videos were: the concept; types; causes; consequences; and mechanisms for the prevention of adverse health events.

The videos addressed adverse health events as preventable incidents, although there is no standardization of concepts shown in each video, mostly informally reported, without reference to any specific definition. The lack of a standardized taxonomy to follow is cited in the literature as an aspect that hinders further analysis of the subject because in most cases each study follows a specific concept.[13]

Therefore, seeking to standardize definitions for the main concepts in the literature about patient safety, the WHO, through the *Patient Safety Program*, developed the Patient Safety International Classification (ICPS) in which an incident is defined as any event or circumstance that could have resulted, or resulted, in unnecessary harm to the patient; incidents with damage correspond to adverse health events.[13,14]

Generally, similar to the aspects shown in the literature, the videos brought the following items as intrinsic elements of the concept of adverse health events: they are preventable circumstances due to care and not associated with the disease, they cause injury or damage that result in disability or temporary or permanent dysfunction and/or extending the length of hospitalization or death, and they are important quality indicators as they measure the existing gap between given and optimal care.[4,14-16]

As for the most often addressed types of adverse health events, surgical incidents and medication errors were highlighted, topics that include the six goals of the *World Alliance for Patient Safety* that are also incorporated into strategic acting areas in the National Program for Patient Safety (PNSP) established in April 2012 by Ordinance 529.

Adverse health events related to surgical procedures are also highlighted in the literature. This is because the surgical center (SC) is recognized as one of the most favorable units for the occurrence of these events, due to the characteristics of its own work process, diversity of surgical and diagnostic procedures, and intense circulation of people from different professional categories.[17]

Thus, it is estimated that more than half of occurring adverse health events are estimated at about 4-16% of all hospitalized patients are related to surgical care.14 Each year, out of the 234 million surgeries worldwide, two million deaths and seven million incidents are estimated to occur, 50% of them being avoidable.16 In view of these alarming data, safe surgery is established as one of the global goals related to patient safety.

Errors related to medication systems are also highlighted as one of the most common types of adverse events related to hospitalization, affecting a significant number of people and increasing the costs of health system significantly.18 They are also the most conveyed by the media, mainly related to the nursing profession that acts directly or indirectly in all phases in the medication system.

The videos highlighted the following among causes of adverse health events: lack of human resources; fatigue; poor professional qualification; incorrect care plans; and lack or bad communication between health professionals. The last one was highlighted as the root cause of adverse health events.

It is emphasized that effective communication, in an interdisciplinary way, favors a single language, translated into a safe health care, and avoiding inaccurate information, which may predispose to an adverse health event.[19] A secure communication process must take place both among health professionals, and between them and patients, to avoid identification errors and failures arising from the neglect of important aspects of the care process that are not properly communicated.

In this sense, it is highlighted not only the spoken but also the writing language through records. Thus, the absence or inadequate documentation of information in the medical record can be related to the occurrence of adverse events, since it is from them that the necessary information for the specific and proper treatment of the patient is obtained.[20]

Therefore, the communication must be made both as a protective element to prevent the occurrence of the adverse event before it happens and as a learning element through the error, after the occurrence of adverse health events and based on the notification, an aspect highlighted in the sampled videos analyzed in this study.

The relevance of notifying adverse health events is to promote the identification of these events, providing a practical means of communication about these unexpected and unwanted facts, enabling the exploration of situations, building a risk and situations-problem database, enabling the implementation of necessary or appropriate changes in the care process, and contributing to management for planning safer work processes, allowing the prevention of future adverse events.[15] This process is synthesized in the videos as the "learning from errors" process.

However, it is emphasized in the literature that the phenomenon of underreporting adverse health events is still experienced mainly due to the non-incorporation of notification processes in routine work or professional insecurity due to the culture of punishment before an error that still exists in institutions, leading to the omission of facts and making it difficult for a realistic estimation of the problem.[15,16,18]

The analyzed videos also highlighted the consequences of adverse health events including: moral, physical, and/or psychological damages; high risk of complications; increase in the length of hospitalization; increase in care costs; disabilities; and death. The risk of law suits arising from the adverse events was also evidenced.

Studies show that the 1990s marked an increase in sensationalist approaches in the media about errors in health and growth of judicial disputes, both in number of cases as in financial value of damages. Health care has increasingly become a form of provision of services subjected to contract laws and their consequences in the civil and criminal areas.[18]

Currently, it is observed that the diagnosis of errors is recognized as a cause of more frequent and financially costly legal proceedings, occurring between 10 and 15% of all healthcare assistance.[16] Thus, one video highlighted discussions on a compensation system for victims of adverse events, which already exists in some European countries – Sweden, Finland, France – where there is a compensation system in an arbitration framework within the institution, extra judicially. It was observed, therefore, that further studies are needed to assess how such systems may promote the culture of patient safety.

The videos, unanimously in this study (13; 100%) as well as in the literature, highlighted an intrinsic relationship between patient safety and adverse health events, with a focus on prevention strategies, relating the continuous evaluation of health services to the quality and safety of the care process.

Thus, it was emphasized that the prevention of adverse health events must arise from a systemic view, exceeding the minimalist, individual, and punitive view of the problem. This systemic view is characterized by promoting patient safety culture, defined as the product of values, attitudes, skills, and individual and group behavior patterns, which determine the commitment, style, and proficiency of the administration of a healthy and safe organization.[3,4,16]

Scholars cite the understanding of the multifactorial character under security failures based on the theory of human error proposed by James Reason, Professor of Psychology at the University of Manchester, UK, named Swiss Cheese Theory. It infers that the source of the problem would often be triggered by multiple factors: as if the occurrence of adverse events was due to the alignment of several "holes" that could be structural or occasional failures, malpractice or neglect from health professionals, and unsafe or risky behavior by the patients.[3]

As a main element in promoting patient safety culture, the videos highlighted the patient as a key element in the process of prevention of adverse events who must take part of the safety precautions that will be beneficial to self. It is noteworthy that the patient involvement is recommended to ensure self-safety, becoming the last barrier for the interception of an incident and an important evaluator of the safety and quality of care received.[16]

The videos also highlighted a challenge that is experienced in the promotion of patient safety as a means of preventing the occurrence of adverse health events: the responsibility of professionals, managers, and patients – the protagonists of the health work process – for changes in the insecurity scenario that features health environments today.

## FINAL CONSIDERATIONS

Despite the great impact of the topic of adverse health events, the existence of videos that disclose aspects of the promotion of patient safety in relation to the prevention of adverse events in the *YouTube* sharing site is currently still incipient.

The analyzed videos were produced and posted recently, despite that adverse health events have been a subject discussed worldwide for a long time. However, a strong impact on patient safety is observed in recent years in the Brazilian scenario, especially in 2013, when the Patient Safety National Policy was established.

Therefore, it is observed that the technical quality of the videos is an essential aspect, not only of the quality of the im-

age in motion, but the concepts and approaches shown. It was evident, therefore, a lack of standardization in the concepts worked in the videos, an aspect that may hinder further analyses in the topic. The user who seeks to be updated watching videos will need to make a careful analysis on the quality of the transmitted technical information.

Given that *YouTube* is the most widespread site among Internet users and many use it as a source of research, the importance of analyzing the quality and reliability of the information posted is emphasized. In addition, it is understood that the selection and appropriate production of videos can create appropriate opportunities for their use in spaces of training and educational classes, favoring the fixation of the above content.

## REFERENCES


1. Raduenz AC, Hoffmann P, Raduz V, Dal Sasso GTM, Maliska ICA, Marck PB. Cuidados de enfermagem e segurança do paciente: visualizando a organização, acondicionamento e distribuição de medicamentos com método de pesquisa fotográfica. Rev Latinoam Enferm. 2010; 18(6):1045-54.
2. Wachter RM. Compreendendo a segurança do paciente. Porto Alegre: Artmed; 2010.
3. Reis CT, Martins M, Laguardia J. A segurança do paciente como dimensão da qualidade do cuidado de saúde: um olhar sobre a literatura. Ciênc Saúde Coletiva. 2013; 18(7):2029-36.
4. Gonçalves LA, Andolhe R, Oliveira EM, Barbosa RL, Faro ACM, Gallotti RMD, et al. Alocação da equipe de enfermagem e ocorrência de eventos adversos/incidentes em unidade de terapia intensiva. Rev Esc Enferm USP. 2012; 46(Esp):71-7.
5. Carvalho JA, Gurgel PKF, Lima KLN, Dantas CN, Martins CCF. Análise de vídeos do YouTube sobre aleitamento materno: importância e benefício. Rev Enferm UFPE on line. 2013; 7(Esp):1016-22. [Cited 2014 Jan. 13]. Available from: http://www.google.com.br/url?sa=t&rct=j&q=&esrc=s&source=web& cd=1&cad=rja&uact=8&ved=0CB8QFjAA&url=http%3A%2F%2Fwww.revista.ufpe.br%2Frevistaenfermagem%2Findex.php%2Frevista%2Farticle%2Fdownload%2F3530%2F5837&ei=cZ1XVO3vNsjTaKaVgoAH&usg=AFQjCNEXD6io36u5zX-GwbrqbgidpHJnWg&sig2=6Kf4Byer6gDSSM8z9BvIA&bvm=bv.78677474,d.d2s
6. Araújo JC, Costa RR. A fúria do Führer: um estudo das estratégias discursivo-pragmáticas presentes num "viral" do YouTube. Linguagem em (Dis)curso. 2011; 11(2):283-309.
7. Schneider CK, Caetano L, Ribeiro LOM. Análise de vídeos educacionais no YouTube: caracteres e legibilidade. Porto Alegre: CINTED-UFRGS; 2012.
8. Pellegrini DP, Reis DD, Monção PC, Oliveira R. YouTube: uma nova fonte de discursos. 2013. [Cited 2014 Jan. 09]. Available from: http://www.bocc.ubi.pt/pag/bocc-pelegrini-cibercultura.pdf.
9. Moraes AF. A diversidade cultural presente nos vídeos em saúde. Interface Comunic Saúde Educ. 2008; 12(27):811-22.
10. Lima MEM. O vídeo como instrumento didático educativo [monografia]. Especialização em Ensino de Ciências por Investigação. Belo Horizonte: Programa de Pós Graduação da Faculdade de Educação da UFMG; 2007.
11. Tourinho FSV, Medeiros KS, Salvador PTCO, Castro GLT, Santos VEP. Análise de vídeos do YouTube sobre suporte básico de vida e reanimação cardiopulmonar. Rev Col Bras Cir. 2012; 39(4):335-9.
12. Brendim MP, Rezende LA. Levantamento e análise de vídeos de prevenção e detecção precoce dos cânceres de cabeça e pescoço para educação de fonoaudiólogos. Ensino Saúde Ambiente. 2009; 2(1):52-71.
13. Mendes W, Pavão ALB, Martins M, Moura MLO, Travassos C. Características de eventos adversos evitáveis em hospitais do Rio de Janeiro. Rev Assoc Med Bras. 2013; 59(5):421-8.
14. Moura MLO, Mendes W. Avaliação de eventos adversos cirúrgicos em hospitais do Rio de Janeiro. Rev Bras Epidemiol. 2012; 15(3):523-35.
15. Paiva MCMS, Paiva SAR, Berti HW. Eventos adversos: análise de um instrumento de notificação utilizado no gerenciamento de enfermagem. Rev Esc Enferm USP. 2010; 44(2):287-94.
16. Paranaguá TTB, Bezerra ALQ, Silva AEBC, Azevedo Filho FM. Prevalência de incidentes sem dano e eventos adversos em uma clínica cirúrgica. Acta Paul Enferm. 2013; 26(3):256-62.
17. Souza LP, Bezerra ALQ, Silva AEBC, Carneiro FS, Paranaguá TTB, Lemos LF. Eventos adversos: instrumento de avaliação do desempenho em centro cirúrgico de um hospital universitário. Rev Enferm UERJ. 2011; 19(1):127-33.
18. Rosa MB, Perini E. Erros de medicação: quem foi? Rev Assoc Med Bras. 2003; 49(3):335-41.
19. Silva T, Wegner W, Pedro ENR. Segurança da criança hospitalizada na UTI: compreendendo os eventos adversos sob a ótica do acompanhante. Rev Eletr Enf. 2012; 14(2):337-44. [Cited 2014 Jan. 09]. Available from: http://www.fen.ufg.br/revista/v14/n2/v14n2a14.htm
20. Pavão ALB, Andrade D, Mendes W, Martins M, Travassos C. Estudo de incidência de eventos adversos hospitalares, Rio de Janeiro, Brasil: avaliação da qualidade do prontuário do paciente. Rev Bras Epidemiol. 2011; 14(4):651-61.