Nursing team overload and the risk of adverse events

RESUMO | Objetivo: Analisar os elementos relacionados a sobrecarga de trabalho da equipe de enfermagem que podem influenciar na ocorrência de eventos adversos e comprometer a segurança do paciente. Método: Estudo descritivo, quantitativo, realizado em um Hospital público do Distrito Federal, com aplicação de um questionário semiestruturado, com total de 92 participantes.Resultado: A maioria dos participantes eram técnicos de enfermagem do sexo feminino, com tempo de atuação superior a 10 anos, com carga horária semanal de 40 horas, e apenas 1 vínculo empregatício. O cooperativismo entre os colegas foi notório, e a grande maioria afirmou haver sobrecarga de serviço na unidade e que essa, por sua vez, afeta a segurança do paciente. Conclusão: A sobrecarga dos profissionais potencializada pela insuficiência de recursos humanos e materiais, alta demanda de pacientes e deficiência nos sistemas organizacionais institucionais, resultam em uma assistência deficiente com aumento do risco de eventos adversos.
Descritores: Cuidados de Enfermagem; Segurança do Paciente; Serviços Médicos de Emergência; Trabalho.

ABSTRACT | Objective: To analyze elements related to the workload of the nursing team that can influence the occurrence of adverse events and compromise patient safety. Method: Descriptive, quantitative study, carried out in a public hospital in the Federal District, with the application of a semi-structured questionnaire, with a total of 92 participants. years, with a weekly workload of 40 hours, and only 1 employment relationship. Cooperativism among colleagues was notorious, and the vast majority stated that there was a service overload in the unit and that this, in turn, affects patient safety. Conclusion: The overload of professionals, enhanced by insufficient human and material resources, high demand from patients and deficiencies in institutional organizational systems, result in poor assistance with an increased risk of adverse events.
Keywords: NursingCare; Patientsafety; Emergency Medical Services;Work.

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Palabras claves: Atención de Enfermería; Seguridaddel paciente; Servicios médicos de emergencia; Trabaja.

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INTRODUÇÃO

Patient safety is a relevant topic, and its principles, even if indirectly, were still applied in the Crimean War by Florence Nightingale Working conditions during the war aroused in Florence an interest in promoting security for soldiers, due to the current health problems. In 1990, the Institute of Medicine (IOM) published

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a study called Toerris human: building a safer health system (To err is Human: Building a safer Health System), disclosing the high mortality rates related to health care in American hospitals, in which reinforced the importance of the applicability of this theme [1].

Since then, the topic has gained notoriety and in 2004 the World Health Organization (WHO) launched the World Alliance for Patient Safety, with the aim of coordinating, accelerating, and disseminating improvements in the topic for the sake of patient and professional safety. The Ministry of Health (MS) established, through Ordinance MS/GM No. 529/2013, a set of basic protocols, defined by the WHO, to be implemented in all hospital sectors to minimize the risk of adverse events[2].

It is called adverse event, situations in which professional errors cause harm to the patient, whereas the incident is defined as the event or circumstance that could have resulted or resulted in unnecessary harm to the patient, when the incident does not reach the patient it is called near miss. These events, in addition to the psychological stress to the patient, increase the length of stay, mortality and hospital costs, directly linked to the assistance provided by health professionals[2-3].

Nursing is responsible for a large part of the care actions in all hospital sectors, approaching the context of urgency and emergency, these professionals are required to be agile and resolute in the tasks performed, speed in decision-making and extensive knowledge, as they are patients with high life risk. Such requirements, added to the lack of material resources, high turnover of professionals, damaged equipment, precarious working conditions and, above all, work overload, were cited as the main causes of adverse events [3-4-5].

With this, it is understood that nursing is directly linked to patient safety and, therefore, an important agent capable of minimizing adverse events.

In this way, this study is relevant, because when considering the global rise of the subject of patient safety, it became important to reflect on the contributions of nursing to the provision of safe care to the patient through the intense workday.

This research aims to analyze the elements related to the workload of the nursing team that can influence the occurrence of adverse events and compromise patient safety, to guide the research the following question was used: What are the factors that influence the workload of the nursing team and, consequently, the appearance of adverse events?

METHODOLOGY

This was a descriptive study of a quantitative nature. It was carried out in the emergency room of a medium-complexity public hospital located in the administrative region of Ceilândia, in Brasília - DF, from March to May 2022, with a population of 215 nursing professionals. The sample selection was for convenience in a simple random way, totaling 92 professionals, included in the study, nurses and nursing technicians working in the health institution during data collection, and those who were on sick leave at the time of recruitment were excluded.

Data collection was based on the validated questionnaire, Hospital Survey on Patient Safety Culture [6], which was adapted and restructured into three parts: sociodemographic data (age, gender, category and length of professional experience), work overload (workload weekly, number of employment relationships, interval between shifts and interprofessional relationship) and related to patient safety (knowledge and application of patient safety standards and their implications for practice) with a total of 22 questions.

The collected data were organized in a digital spreadsheet with the help of the Microsoft Office Excel 2016 program, divided into three main parts, as well as the questionnaire. Then, analyzed descriptively, in simple frequency and organized in tables to prepare the results, used to formulate the discussion and conclusion.

This research was approved by the Ethics and Research Committee of the Institution Fundação de Ensino e Pesquisa em Ciências da Saúde, whose favorable opinion number 5.180.554 and CAAE 52654321.5.0000.5553, after submission to Plataforma Brazil, according to the determinations of Resolution nº 466/12 of the National Health Council.

RESULTS:

Participants in this research totaled 92 professionals. It was observed that the majority 51.09% (n=47) of the professionals were between the ages of 36 and 45 years, with a predominance of females 79.35% (n=73). As for the professional category, the technical team represented 71.74% (n=66) of the participants. With regard to working time, 52.17% (n=48) had already worked in the range between 11 and 20 years, with 0 to 10 years working in the emergency room corresponding to the highest per-

Table 1: Sociodemographic characterization of study participants, Brasília-DF, 2022.

Age	(n)	%
26 to 35 years old	24	26,09%
36 to 45 years old	47	51,09%
46 to 55 years old	18	19,57%
over 56 years old	3	3,26%

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centage recorded, 72.83% (n=67), as shown in Table 1.

Regarding the weekly workload, 75% (n=69) of the participants worked 40 hours a week, and 53.26% (n=49) declared a minimum interval of 12 hours between shifts. As for the number of employment relationships, 72.83% (n=67) claimed to have only 1 relationship.

Table 2 shows data on interprofessional relationships and work overload. Despite the work overload imposed by the COVID-19 pandemic and reported by all participants, it is noteworthy that support between the category was predominant.

Regarding knowledge and application of patient safety standards, 94.57% (n=87) of the participants claimed to have knowledge about patient safety goals, but only 44.57% (n=41) stated that the institution in which they work follows the protocols for this. Table 3 shows a summary of the professionals' answers regarding patient safety.

GENDER	(n)	%
FEMALE	73	79,35%
MALE	19	20,65%
PROFESSIONAL CATEGORY	(n)	%
NURSE.	26	28,26%
NURSING TECHNICIAN	66	71,74%
PROFESSIONAL PERFORMANCE TIME	**(n)**	**%**
0 to 10 years old	38	41,30%
11 to 20 years old	48	52,17%
21 to 30 years old	5	5,43%
over 30 years old	1	1,09%
TIME OF PERFORMANCE IN THE EMERGENCY ROOM	**(n)**	**%**
0 to 10 years old	67	72,83%
11 to 20 years old	22	23,91%
21 to 30 years old	2	2,17%
over 30 years old	1	1,09%

Source: authors' data, 2022.

Table 2: Data related to work overload and interprofessional relationship, Brasília-DF, 2022.

IN THIS UNIT, DO THE PROFESSIONALS SUPPORT EACH OTHER?	(n)	%
Yes	81	88,04%
No	11	11,06%
WHEN THERE IS A LOT OF WORK TO BE DONE FAST, DOES THE TEAM WORK TOGETHER TO COMPLETE IT PROPERLY?	**(n)**	**%**
Yes	76	82,61%
No	16	17,39%
WHEN A PROFESSIONAL IN THIS UNIT IS OVERLOADED, DO THEY RECEIVE HELP FROM COLLEAGUES?	**(n)**	**%**
Yes	73	79,35%
No	19	20,65%
ARE THE WORKING PROFESSIONALS SUFFICIENT TO GET THE JOB DONE?	**(n)**	**%**
Yes	4	4,35%
No	**88**	**95,65%**

Source: authors' data, 2022.

Table 3: Data on knowledge and applicability of patient safety goals, Brasília-DF, 2022.

ARE THE PROTOCOLS, EQUIPMENT, AND SYSTEMS ADEQUATE TO PREVENT THE OCCURRENCE OF ADVERSE EVENTS?	Number	%
Yes	25	21,17%
No	67	72,83%
DO YOU BELIEVE THAT PATIENT SAFETY IS COMPROMISED AS A RESULT OF INCREASED AMOUNT OF WORK?	**Number**	**%**
Yes	88	95,65%
No	4	4,35%

DISCUSSION

Nursing is an essential profession within the scope of health in Brazil and in the world, it acts directly in the assistance provided to patients who need intensive care, in addition to coordinating and managing the health actions provided by technicians and nursing assistants. The profile of professionals corroborates with other studies, that is, it consists of a mostly female profession, associated with the fact that women have, in essence, the act of caring, due to their maternal nature[7-8-9].

Considered as a profession in rejuvenation, the data found in relation to the age of the professionals, agree with other researches, being the majority aged between 36 and 45 years old. The short time of work of professionals in the emergency room, less than 10 years, can be explained by their recent entry through public tenders, however it is important to highlight that the work overload

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ARE THE PROFESSIONALS INFORMED ABOUT THE ERRORS THAT OCCUR IN THIS UNIT?	Number	%
Yes	35	38,04%
No	57	61,96%
DOES THIS UNIT DISCUSS WAYS TO PREVENT ADVERSE EVENTS IN ORDER TO PREVENT THEM FROM REPEATING?	Number	%
Yes	33	35,87%
No	59	64,13%
DO PROFESSIONALS HAVE THE FREEDOM TO EXPRESS THEMSELVES WHEN THEY OBSERVE SOMETHING (EQUIPMENT, HUMAN RESOURCES, MANAGEMENT) THAT MAY NEGATIVELY AFFECT PATIENT CARE?	Number	%
Yes	64	69,57%
No	28	30,43%
DO YOU HAVE THE HABIT OF NOTIFYING ADVERSE EVENTS THAT YOU KNOW ABOUT?	Number	%
Yes	45	48,91%
No	47	51,09%
COULD PATIENT SAFETY HAVE BEEN NEGATIVELY AFFECTED DURING THE PANDEMIC?	Number	%
Yes	86	93,48%
No	6	6,52%

Source: authors' data, 2022.

in these units is one of the main factors that corroborate for the occurrence of errors and consequently affects the safety of patients and professionals[8,10].

In this context, a study carried out in Japan describes the existence of a positive relationship between maintaining an adequate workload and the balance between personal and professional life and the patient safety culture. While years of service in the hospital had a positive impact on patient safety culture, patient safety culture scores decreased when the number of years of interdepartmental experience was greater than 7 years.[11].

In the present study, the predominant weekly workload was 40 hours per week with a minimum interval of 12 hours between shifts, and only one bond, this is important, as it points out that professionals have a physical and mental rest time shifts, which can contribute to a state of alertness during the provision of care and in reducing the chances of errors The fact that the research site was a public health unit may have influenced this result, since there is a salary discrepancy between public and private institutions.[8,9 -12].

Therefore, caring for the safety of patients and health professionals is the duty of the State. The World Health Organization, published in 2006 the main goals of patient safety, are: identify the patient correctly; improve communication effectiveness; improve the safety of high-alert drugs; ensure surgeries with correct intervention site, correct procedure and correct patient; reduce the risk of healthcare-associated infections; reduce the risk of harm to the patient from falls. Most, 94.57% (n=87) of the professionals participating in this research claimed to be aware of these goals, corroborating with other studies, knowledge about patient safety becomes indispensable for quality care, preventing and minimizing risks of incidents[13-14].

However, patient safety and the reduction of incidents in the context of nursing care encompasses, in addition to knowledge, several factors such as the institutionalization of protocols, improvement of practices and procedures, appropriate material resources and adequate systems for such prevention.[13]. In the opinion of most participants, the health unit where the research was carried out does not follow patient safety protocols, and the provision of human and material resources are not adequate for the prevention of adverse events.

Regarding the availability of human resources, 95.65% (n=88) of the participants stated that there were not enough professionals. This factor contributes to the overload mentioned above, as the large number of patients per professional and the care demands imposed according to the profile of patients in an emergency room, and can lead to physical and mental illness of professionals. The study by Muniz et al [15], a literature review, ratifies the risks of adverse events when care is provided by sick professionals, reinforcing that these factors mentioned above have a direct impact on patient safety.

In addition, the lack of material resources also contributes to this overload, because in the absence of these inputs, for example, the sharing of monitors to check the vital signs of critically ill patients, their absence is common. In this sense, it is up to the unit's leaders to provide this equipment, as well as periodic maintenance, as a way to reduce the chances of adverse events. On the other hand, the recurrence of this type of problem impacts the psychological well-being of professionals, as they see themselves as conniving in the face of this reality[15].

All these issues associated with the great demand for services within public hospitals compromise the quality of care and consequently contribute to insecurity of care, and 95.65% (n=88) of the research participants agree that there is this commitment. An integrative literature review reinforces the negative impact of flawed organizational factors and overwork, since care weakened by lack of time impairs patient treatment

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and increases the risk of adverse events due to haste and fatigue[16].

With regard to patient safety, given the numerous difficulties imposed on professionals, it is up to leaders to adopt organizational practices that aim to reduce these impacts, among them the culture of reporting and learning based on errors. Regarding the errors that occurred during the provision of care, the professionals claimed that they are not informed of the errors and that ways of prevention are not discussed, this deficit in the communication of errors may be associated with the underreporting of adverse events, causing a false perception of quality of assistance[12,17].

The study by Tobias brings the recurrence of underreporting in health services, professionals often do not report for fear of punishments, administrative sanctions, dismissals, individual blame, or even lack of knowledge. However, the importance of notification is known to understand the etiology of the error and thus make adjustments to the care processes and prevent future failures, making care safer[13,17].

Corroborating with other studies, 51.09% (n=47) of the professionals stated that they did not have the habit of notifying errors that they were aware of, as previously mentioned, the main factor for this result could be the fear of punishment [13,17]. This punitive culture, which still exists within health units, distances and discourages professionals from reporting errors, making patient safety fragile and failing. It is known that, in order to improve the care provided, the notification of errors becomes necessary, as it is from these that adjustments are made in the institutions. With this, adjustments in the means of notification for a more confidential method, continuing education of professionals, effective communication with deconstruction of individual blame are means to improve the adherence of professionals to notifications[18].

On the other hand, professionals reported freedom to express opinions about processes that may affect patient safety, taking into account that the nursing team spends more time with the patient, their freedom of expression becomes essential for the quality of care . In order to achieve assistance with fewer errors, numerous factors are necessary, such as organizational and environmental systems, management, human resources, active participation of professionals, and especially interprofessional communication and between professionals and clients. The fact that the research institution accepts the opinion of professionals becomes positive, meaning a concern on the part of the health unit with the condition of the care provided[13,17].

The partnership and joint work between professionals was something notorious in the responses of participants in this research. The study by Rothebarthet al [19] carried out in a university hospital in the Midwest region confirms the importance of cooperation between teams in the nursing field for this quality of care, reinforcing that collaboration between teams goes beyond a personal relationship extra hospital. Therefore, support among colleagues in times of overload becomes indispensable to avoid the appearance of adverse events, since the patient will enjoy care such as medication at the correct time, changes in decubitus, changing dressings, enabling comprehensive quality care.

For managers, the challenge is to value behaviors that improve interpersonal, adaptive and deep relationships between teams and within professions, while modeling information sharing that leads to improvements in patient safety and quality of care[20].

It is evident that the pandemic caused by COVID19 significantly increased the demand for health care, with consequent overcrowding of the units. When asked about the subject, most of the professionals participating in the research, 93.48% (n=86), agreed that the pandemic negatively affected patient safety, possibly due to the high demand for services imposed in a short period of time. The innumerable structural weaknesses and deficits of material and human resources existing in the public health service, potentiated by the pandemic and associated with the exhaustion of professionals, substantially increased the risk of adverse events[21].

Regarding the limitations of the study, it was observed that the existence of only two alternatives for the answers (yes or no) may have contributed to not obtaining other relevant data for the research; in addition, there was a predominance of professionals who work the day shift with little participation of those who work the night shift.

CONCLUSION

The work overload imposed on nursing professionals, whether due to insufficient human or material resources, the high demand from patients, the numerous tasks given to nurses from assistance, organization and management of the health unit where they work, directly affect patient safety.

All these factors associated with the lack of institutional protocols and failures in the organizational arrangements related to patient safety, cause a shortage of time, resulting in a rush to carry out demands such as bathing, dressings, medication administration, changes in decubitus, which, added to fatigue, impair the patient's treatment and consequently significantly increase the risk of adverse events.

Thus, it is necessary to adapt organizational systems in health units in order to avoid work overload, providing qualified assistance and safer care. This study is expected to produce reflective thoughts on this topic, in addition to raising awareness of the importance and appreciation of the nursing team within health units.

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Referências

1. Nascimento JC, Draganov PB. História da qualidade em segurança do paciente. HistenfermRev eletrônica. 2015; 6(2): 299-309. Disponível em: http://here.abennacional.org.br/here/seguranca_do_paciente.pdf

2. Brasil. Ministério da Saúde (BR). Documento de referência para o Programa Nacional de Segurança do Paciente / Ministério da Saúde; Fundação Oswaldo Cruz; Agência Nacional de Vigilância Sanitária. – Brasília: Ministério da Saúde, 2014. Disponível em: https://bvsms.saude.gov.br/bvs/publicacoes/documento_referencia_programa_nacional_seguranca.pdf.

3. Duarte SCM, Stipp MAC, Silva MM, Oliveira FT. Eventos adversos e segurança na assistência de enfermagem. RevBrasEnferm. 2015; 68(1): 144-54. Disponível em: https://www.scielo.br/j/reben/a/mBxyRmzXxjVYbDQZfg7phyj/?format=pdf&lang=pt

4. Siman AG, Braga LM, Amaro LOF, Brito MJM. Desafios da prática na segurança do paciente. RevBras Enferm.2019; 72(6):1581-8. Disponível em: https://www.scielo.br/j/reben/a/xVGnxHjMmX8m5yty3BHTy3f/?lang=pt&format=pdf.

5. Miorin JD, Camponogara S, Pinno C, Beck CLC, Costa V, Freitas EO. Prazer e sofrimento de trabalhadores de enfermagem de um pronto-socorro. Texto Contexto Enferm. 2018; 27(2):1-9. Disponível em: https://www.scielo.br/j/tce/a/4NXfbYnVZKzGtBsbkBPGgMJ/?format=pdf&lang=pt

6. Andrade LEL, Melo LOM, Silva IG, Souza RM, Lima ALB, Freitas MR, et. al. Adaptação e validação do Hospital SurveyonPatientSafety Culture em versão brasileira eletrônica. Epidemiol. Serv. Saude.2017;26 (3):455-468. Disponível em: https://www.scielosp.org/article/ress/2017.v26n3/455-468/en/

7. Silva MCN, Machada MH. Sistema de Saúde e Trabalho: desafios para a Enfermagem no Brasil. Ciência & Saúde Coletiva. 2020;25(1):7-13. DOI: 10.1590/1413-81232020251.27572019

8. Alves IG, Santos ER, Bertolin DC, Santos LL, Sasso LS, Nunes LVSC, et al. Múltiplos vínculos empregatícios podem afetar a resiliência de profissionais de enfermagem de setores de emergência. Research, Society andDevelopment. 2022; 11(9): 1-12. DOI: http://dx.doi.org/10.33448/rsd-v11i9.31388

9. Fernandes JS, Miranzi SSC, Iwamoto HH, Tavares DMS, Santos CB. A relação dos aspectos profissionais na qualidade de vida dos enfermeiros das equipes Saúde da Família. RevEscEnferm USP. 2012; 46(2):404-12. Disponível em: https://www.scielo.br/j/reeusp/a/WFhYr9kGxjBz3nPHLsR8FFn/?lang=pt#:~:text=A%20duplicidade%20de%20v%C3%ADnculos%20empregat%C3%ADcios,que%20usualmente%20o%20enfermeiro%20consegue

10. Machado MH, Aguiar Filho W, Lacerda WF, Oliveira E, Lemos W, Wermelinger M, et al. Características gerais da enfermagem: o perfil sócio demográfico. Enferm. Foco 2015; 6 (1/4): 11-17. Disponível em: file:///C:/Users/franc/Downloads/686-1743-1-SM.PDF

11. Hata T, Murao H, Nakagami-Yamaguchi E, Yamaguchi Y, Eguchi H, Nishihara M. Fatores que mataram a cultura de segurança do paciente em um hospital universitário sob o sistema universal de seguro de saúde: um estudo transversal do Japão. Medicine. 2022; 101(45):pe31603. DOI: 10.1097/MD.0000000000031603

12. Trindade L, Lúcia Colomé Beck C, Ottes Vasconcelos R, Marion da Silva R. Sobrecarga de trabalho da enfermagem e o gerenciamento de atividades. SIEPE [Internet]. 3º de março de 2020 [citado 27º de setembro de 2022];9(2). Disponível em: https://periodicos.unipampa.edu.br/index.php/SIEPE/article/view/98798

13. Tobias GC, Bezerra ALQ, Moreira IA, Paranaguá TTB, Silva AEBC. Conhecimento dos enfermeiros sobre a cultura de segurança do paciente em hospital universitário. Revenferm UFPE online. 2016. 10(3):1071-9. Disponível em:https://periodicos.ufpe.br/revistas/revistaenfermagem/article/viewFile/11060/12481

14. Araújo EB, Silva FAB, Sobreira MVS, Braga AS, Santos EL, Fernandes GL. Conhecimentos e práticas de enfermeiros sobre segurança do paciente. 2019. 19(4): 95-115. Disponível em: http://temasemsaude.com/wp-content/uploads/2019/09/19407.pdf

15. Muniz DC, Andrade EGS, Santos WLS. A saúde do enfermeiro com a sobrecarga de trabalho. RevInicCient Ext. 2019; 2(Esp.2):274-9. Disponível em: https://revistasfacesa.senaaires.com.br/index.php/iniciacao-cientifica/article/view/275

16. Silva ET, Matsuda LM, Paulino GME, Camillo NRS, Simões AC, Ferreira AMD. Fatores que influenciam a segurana do paciente em serviços de urgência e emergência: revisão integrativa. Rev baiana de enferm. 2019; 33:e33408: 1-13. Disponível em: https://periodicos.ufba.br/index.php/enfermagem/article/view/33408

17. Viana KE, Matsuda LM, Pereira ACS, Oliveira JLC, Inoue KC, Cruz EDA. Cultura de segurança do paciente em hospitais públicos de ensino: estudo comparativo. Revenferm UERJ. 2020; 28:e51949:1-7. Disponível em: http://fi-admin.bvsalud.org/document/view/ng8rb

18. Ribeiro R, Servo ML, Silva Filho AM. Perfil da cultura de segurança do paciente em um hospital público. 2021;12(3):504-11. DOI: 10.21675/2357-707X.2021.v12.n2.4240

19. Rothebarth AP, Cesário JB, Lima LPS, Ribeiro MRR. O trabalho em equipe na enfermagem: da cooperação ao conflito. Revista Eletrônica Gestão & Saúde. 2016; 7(02): 521-34. Disponível em: https://dialnet.unirioja.es/descarga/articulo/5555895.pdf

20. Montgomery A, Lainidi O, Johnson J, Creese J, Baathe F, Baban A. Employeesilence in healthcare: Charting new avenues for leadershipand management. Health Care Management Review. 2023; 48(1): 52-60. DOI: 10.1097/HMR.0000000000000349

21. Caldas BN, Reis LGC. Qualidade do cuidado e segurança do paciente: desafios e contribuições diante da pandemia de covid-19. In: Portela MC, Reis LGC, Lima SML, eds. Covid-19: desafios para a organização e repercussões nos sistemas e serviços de saúde [online]. Rio de Janeiro: Observatório Covid-19 Fiocruz, Editora Fiocruz. 2022; 117-129. Disponível em: https://doi.org/10.7476/9786557081587.0007

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