RESEARCH | PESQUISA

Nursing care practices in intensive care: An analysis according to ethics of responsibility

Práticas de cuidado de enfermagem na terapia intensiva: Análise segundo a ética da responsabilidade

Atención de enfermería en la terapia intensiva: Análisis desde la perspectiva de la ética de la responsabilidad

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Abstract

Objectives: To identify and analyze nursing care practices that affect ethical and professional values in intensive care. **Methods:** A qualitative and descriptive study was conducted in 2011 with 21 nurses from the Intensive Care Unit of a public hospital in the city of Rio de Janeiro, based on the Hans Jonas's ethic of responsibility framework. The observation of practices was carried out during 150 hours, followed by extensive description, and 21 individual interviews, in which thematic content analysis was applied. **Results:** The distancing of nurses from direct care and their preference for providing care to sedated patients due to their low demand for attention and presence were found. **Conclusion:** The distancing from patients and direct care affects the ethical and responsible behavior of nurses and their ethical and professional values, resulting in negligence of the concept of person that forms the basis of the nursing metaparadigm.

Keywords: Nursing; Nursing Care; Biomedical Technology; Intensive Care Units; Nursing Ethics.

Resumo

Objetivos: Identificar e analisar as práticas de cuidar da enfermagem que comprometam os valores ético-profissionais na terapia intensiva. **Métodos:** Pesquisa qualitativa e descritiva, realizada em 2011 com 21 enfermeiros da Unidade de Terapia Intensiva de um hospital público do município do Rio de Janeiro. O referencial é o da ética da responsabilidade de Hans Jonas. Realizou-se 150 horas de observação das práticas, seguidas de descrição densa, e 21 entrevistas individuais nas quais se aplicou a análise de conteúdo temática. **Resultados:** Evidenciou-se afastamento do enfermeiro no cuidado direto e preferências por cuidar de clientes sedados, por sua baixa demanda de atenção e presença. **Conclusão:** O afastamento do cliente e do cuidado direto compromete o agir ético-responsável do enfermeiro e os valores ético-profissionais, havendo negligência ao conceito de pessoa que forma o metaparadigma da enfermagem.

Palavras-chave: Enfermagem; Cuidados de enfermagem; Tecnologia biomédica; Unidades de Terapia Intensiva; Ética de enfermagem.

Resumen

Objetivos: Identificar y analizar las prácticas de cuidar de enfermería que comprometan los valores ético-profesionales en terapia intensiva. **Métodos:** Investigación cualitativa, descriptiva, realizada en 2011 con 21 enfermeros de la Unidad de Terapia Intensiva de hospital público del municipio de Rio de Janeiro. Referencia de la ética de la responsabilidad, de Hans Jonas. Se efectuaron 150 horas de observación de prácticas, seguidas de su descripción densa, y 21 entrevistas individuales aplicándose análisis de contenido temático. **Resultados:** Se evidenció alejamiento del enfermero en cuidados directos y preferencia por cuidar pacientes sedados, por su baja demanda de atención y presencia. **Conclusión:** El alejamiento del paciente y del cuidado directo compromete la actuación ético-responsable del enfermero y los valores ético-profesionales, existiendo negligencia sobre el concepto de persona, que integra el metaparadigma de la enfermería.

Palabras clave: Enfermería; Atención de Enfermería; Tecnología Biomédica; Unidades de Cuidados Intensivos; Ética en Enfermería.

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INTRODUCTION

Nursing care provided to human beings has ethical, political, historical and philosophical dimensions. In this study, the dimension of ethical care is highlighted, which is founded on the relationship between nurses and their patients and based on respect for human dignity.

Nursing, as a social practice, is guided by ethical and moral values, and its purpose is to guide the process of health care and nursing care in a proper manner[1]. Professional practice is regulated by laws, codes, standards and resolutions based on ethics. Therefore, nursing care, as an art and science, cannot do without ethics[2] and as such, the protection of patients' rights, their integrity, and safety are part of nurses' responsibilities.

The current knowledge concerning ethics in nursing care area in Intensive Care Units (ICU) points to two important concerns; the first is about the use of technology. This points to the need for a moral examination in the technological context in the ICU, because in using technology for clinical interpretation and evaluation, the nurses assume a position of power that distance them from patients[3-6].

Reflections on fostering a human e environment in the ICU calls for the discussion of the use of technology and its role in the abandonment of patients[7].

The second concern is about risks inherent to nursing care, since errors in the practice of such care is seen as something that affects human dignity and totality[8-10].

These errors in care were found in a study carried out in an ICU with 36 professionals of the nursing team. They were considered active failures under the human error theory, especially errors in the administration of medications and not elevating the bed rails, which affect a patient's recovery[9]. One of the matters to consider about these errors is the admission of newcomers, and the influence that certification in the specialty exerts on the clinical ability of ICU nurses and on patient safety[6].

The analysis, in terms of depth of this study, indicated that in the professional performance in ICUs, the balance between expressive and technical/instrumental elements is not always seen. This might be expressive of disrespect for nursing values. In practice, this is demonstrated by the increase in judicial complaints against health professionals, indicating the population's dissatisfaction with the occurrence of harm.

These faults and risks give rise to questions about the essence of the art of nursing[11], and this matter confirm the discussion on the application of ethical and professional values in care. Assumptions about traditional ethics do not meet contemporary problems, especially concerning the use oftechnology[12].

This is because innovations that result from technology and science impact contemporary man, making him change his ways of behavior with other humans and the extra-human world. Therefore, there is a role reversal, where human beings lose their role as individuals, and technological processes start to dictate rules and standards on how they should proceed[13].

Based on the idea that there is an ethical emptiness, Hans Jonas proposed the principle of responsibility to guide actions and establish an ethical basis for the technological age[12]. According to this theorist, the moral responsibility of all actions that are influenced by technology and science must be analyzed to give them an ethical meaning[14].

Responsibility is an ethical principle which can face the challenges in acting collectively in a technological civilization, ensuring human existence and other life forms[13]. It is based on the magnitude of the being, and is characterized by intentional acts conducted during the present time with responsibility for future generations[15].

The ethics of responsibility aims to overcome precepts of traditional ethics based on immediacy and individualism, and move towards the imperative of acting collectively for the public good. Such an ethical theory is organized by the articulation of categories such as the heuristics of fear, purpose and value, the good and the duty be, and the paternal, political and total responsibility that was the basis of the analysis of this study[15].

The analysis of the ethical and professional values in the technological care performed by ICU nurses contributes to the discussion of the ethical repercussions of such care, aimed at raising its quality.

The objective of this study was to identify and analyze the practices of nursing care that affect ethical and professional values in the intensive care unit.

METHODS

A descriptive and qualitative study was conducted in the ICU of a federal hospital in the city of Rio de Janeiro. Of the total 24 nurses in the unit, 21 participated in the study, composed of 17 women and four men who met the following inclusion criteria: had to be working in the ICU; be involved directly in patient care during the period of data production. Three nurses were excluded for being on work leave or involved in managing activities.

The data were produced from January to June 2011, by means of two techniques; field observation[16] and individual interviews. Initially, the researcher entered the sector to obtain first impressions, get acquainted with the environment and approach the nurses. Later, the researcher invited the nurses to participate in the study, explaining the techniques of data production to be applied, which were observation of their practices and interviews.

The observation phase of the nurse concerned began after obtaining individual consent. In the field observation, a semi-structured guide aimed at capturing the dynamics of nurses' practices of care was used. The objective was to learn about the values, perceptions, and meanings of behaviors observed in these practices. Data originated from the observation compiled in the field diary, totaling 150 hours of records.

The records in this field diary were made according to the principles of an extensive description[14]. Initially, care practices were described with depth and in detail, enabling

the interpretation of their meaning with density, based on their reading and analysis by the researcher. The apprehension of these meanings made it possible to translate and explain them, and based on this, to identify the ethical aspects that deserved attention in the study.

This led to the second stage, which was the interpretation of the researched about the data analyzed by the researcher. For this purpose, the in depth interviews were also applied as a technique for data production. The aspects identified in the preliminary reading and the analysis of the observation's records enabled the organization of a semi-structured guide to help conduct the interviews.

The interviews were undertaken in the afternoon period with employees who were on duty on the day of the research, in a private room, with the help of a recorder and with an average duration of one hour and thirty minutes. The questions in the guide were divided into two parts: in the first part, the questions had to do with the record of the situations during care practice, requesting participants to talk about them, with the purpose of tracking the logic of their actions and comparing them with the researcher's interpretations.

Based on the responses, the approach to this practice was based on an ethical point of view, with questions referring to points previously highlighted, such as professional responsibility, patients' rights and ethical principles.

Content analysis with thematic categorization was applied to the corpus of the interviews, which made it possible to understand the reasons for behaviors and their association with ethics as established by the participants. This was possible based on the marking in the corpus of the interviews, of units of record composed of themes that would describe the discussion of ethical and professional values.

Based on the mapping of the interviews with this point of view, the grouping of a set of themes with a core of meaning was undertaken, with the aim of giving density to the results. The analysis of such cores in both quantitative and qualitative terms was the basis for the organization of the thematic categories.

One of the cores addressed the feature of the ethical and professional values in the nurses' style of providing care, around which 10 units of record were grouped, whose meaning referred to professional behaviors in the face of demands for care by ICU patients. 13 units of record described the type of care prioritized by professionals. The other core described the respect for the singularity of the individual in the ICU, in which 15 units of record were grouped. This described the preference of the nurses for a certain type of patient, who in this case were sedated. Patients' rights were a theme presented in eight units of record.

The content produced by the observation of the team's daily practice was analyzed and compared with that which emerged from the interviews, and the results were presented in the study.

The project was approved by the research ethics committee of the hospital where the research was conducted, under protocol number 35/10, in accordance with Resolution Nº 196, October 10th 1996, of National council of Health, that addresses research with human beings. The participants signed an informed consent form and the anonymity was ensured by the identification through the code Nurse and numerical order in which the observation was made.

RESULTS

Mark of ethical and professional values in the nurses' method of providing care

Data researched on nurses' practices evidenced characteristics that distinguished their way of providing care to ICU patients, and they also enabled the analysis of the values involved in the actions of these professionals.

A scene described in the field diary on the practice of care by nurse 3, based on his behavior in the face of the clinical situation experienced by the patient of bed 2, expressed one of these ways of care.

In box number 2, two nursing technicians provided care to an elderly patient hospitalized in the ICU, who was under mechanical ventilation and with a decreased level of consciousness. One of them asked:

> *Who is here?[referring to the nurse on duty responsible for this bed]. Then, somebody answers: _Nurse 3. The technician directs him: Nurse 3, she is vomiting [this nurse does not move toward the patient. Not long after, the technician alerts him again]:Hey, she is vomiting a lot, it even got out through the tracheotomy![At this time, the patient presents with a drop in oxygen level and blood pressure, and understanding the situation, nurse 4 proposes to call a doctor. The nursing technician complains]:You know, worst of all is that nurse 3 is seeing everything and he is on the telephone! (Extract from the field diary, afternoon shift)*

After nurse 4 called a doctor, the team initiated interventions for the reversal of the clinical condition. The nursing technician's comment, in turn, indicated dissatisfaction with the absence of involvement of nurse 3 in these interventions, since he remained on the telephone and did not get involved in the situation. Therefore, she questioned his behavior regarding the lack of attention given to this situation that needs interventions, which may indicate negligence concerning the lack of commitment on the part of nurse3 to the protection and health recovery of the human being.

The aspects that characterize the ways of care identified in the observation, such as the one exemplified above, were also addressed in the interviews of the nurses. The analysis of these interviews generated the unit of meaning, which dealt with the professional behavior in the face of intensive care demands, and which comprised 10 units of record. In this unit, professionals' actions were revealed, whose performance showed whether life, dignity, and the rights of human beings were values respected by nurses in the care they provide. This extract about endotracheal aspiration indicated low commitment to these values.

The biggest example of involvement inside the intensive care is the concern about airways aspiration, which is an intervention where there is no professional requirement. The aspiration is a situation of patients' need that can emerge from any situation [...] when you see somebody nearby, who does not make this aspiration because it is not her function or the patient is not scheduled for her shift. (Nurse 7)

The patient has a lot of secretion:" _I have already aspired it, I have just aspired it! "You did it, but you have to do it again! It became a routine exchange" He has a lot of secretion", "I have just aspired it!" (Nurse 4)

In the dynamics established during the practice of care, other important ethical matters stand out, such as autonomy and ability in the development of attributions. This is because the performance of bureaucratic activities has relevance in the daily work of nurses, especially those regarding the administration of drug therapy, as is verified in this more general field record undertaken by the researcher.

Nurses organize their daily care routine circumscribed by medical prescriptions, occupying their time with the management of this prescription. They delegate more complex actions of direct care to the technician team, who provide care for the assistance of biological needs. (Extract from the field diary, morning and afternoon shifts)

This observation's data are also confirmed in the interviews. In this thematic unit, 13 units of record describe one of the characteristics that allowed distinguished ways of providing care in an intensive care unit: The type of care that is prioritized by professionals, classify them as bureaucratic and assistance. Such classification leads to reflection on the place given to patients, and whether they are considered in a central position in the definition of care behaviors.

There are nurses who take care, but they deal a lot with paper, bureaucracy [...]there are others who get more involved with the patients, they are more supportive, they like to pick up the patient, follow, bath [...]. There are also professionals who are not supportive, they have a relationship with the patient, but they do not get close, it is not that they do not get close to the patient, they get close when it is necessary, in case of complications. (Nurse 9)

There are colleagues who deal more with work leadership, checking what is happening, and others don't, they provide different care, they go to the bed to look, assess, touch, and this is the difference. There are colleagues who sometimes don't want to get near the bed, they don't want to see the patient, and sometimes they don't like to do it. (Nurse 3)

In situations where patients are not in the center of action, professional errors might occur, many on them caused by inadequate delegation of tasks by nurses. Therefore, there is a professional responsibility in ensuring care free from harm. During the observation of a member of the team who was moving a patient, a respirator triggered an audible alarm, which promptly generated a comment on alarms, in which a need for reassessing the value of this responsibility is addressed.

When I hear the respirator's noise, I feel like this (worried). One of these days, I was performing trichotomy in the patient and I ended up reaching the endotracheal tube's cuff [...]I prayed to God to help with the intubation, to not let him die at that moment. (General note of the field diary, morning and afternoon shifts)

The respect for the individual's singularity in intensive care

Because bureaucratic activities took up a lot of a nurse's time, it was difficult to generate a clinical knowledge based on the articulation of the patients' dataset, which in turn directed to protocol actions, as highlighted in the record of nurse 19.

There are bureaucratic and administrative parts. You leave one of them uncovered, or you don't give quality in any of these two parts to try to share time. You end up not giving attention to the patient's clinical evaluation, being with him, talking, evaluating. (Nurse 2)

Nurses perform equally, as if they were taking care of another patient, and only following those protocols, care, and they forget to collect data, to even use the data provided, both in observation and examination, and implement them in care, and transform in a prescription. (Nurse 19)

This supports the critics regarding the respect for patients' individuality, since in the professional field, the relationship between nurses and patients is highlighted. Therefore, by acting equally, non-individualized care was found, which contrasts with ethical and professional values. People must be seen as individuals with rights, autonomous, able to respond with actions in accordance with individual values, customs and beliefs.

In the distribution of the daily work in the ICU, a trend for choosing patients who are sedated or intubated was found, and, consequently, with lesser interactive demand. When approaching the unit's dynamics, one of the nurses interviewed provided the information that nurses subdivided their daily work according to patients' severity. However, she states:

The majority asks for being with patients sedated, who do not interact, they prefer critically ill patients. There are people who don't like patients who talk. (Extract from the field diary, morning and afternoon shifts)

Nurse 9 resumed this field record in her narrative, highlighting the preferences of nurses for patients who were sedated because of the assumption of lesser requests from them as compared with those who were awake. In the organization of empirical categories, such a theme obtained 15 units of record.

> *Being more awake, theoretically, patients will ask more, talk about what they are feeling, their needs, but many times this bothers professionals, and maybe because they think that the ICU is for critically ill patients, so they don't have to talk. (Nurse 9)*

Consequently, nurses rely on technology, which produces, by means of clinical codes, an objective image of the patients' bodies and determines care actions. Its use explains the absence of nurses from patient care, allowing them to spend more time with bureaucratic activities. Technology supplies information to nurses at a distance, without necessitating the need for talking to patients.

> *Most people are already used to the technology, is difficult to say this, but I listened to it many times, many, not few times:" _patients talking have to leave the ICU, because in the ICU you have to be sedated! The ICU is more than this, patients may be talking, and they might be indicating other things; in general, people become more accommodated to believing in what the machine is saying. (Nurse 19)*

Finally, patients' rights emerge as a theme in eight units of record, which refers to providing assurance to patients as an expression of a professional value.

> *Not be allowed to be dressed, to feel exposed, to have to respect our schedule, not be able to make their schedule. The bath is in the morning. So, if he does not have the habit of taking a bath in the morning, or if he has the habit of sleeping until late in the morning, he has this right violated. (Nurse 2)*

DISCUSSION

The results present in the first category of analysis show practices of care that are related to the discussion of ethical values underlying professional actions from the perspective of responsibility, such as the scenes that bring situations of absence of care.

Some of the principles of the ethics of responsibility are the concepts of Good, Duty and Being. The Good is something specific that is part of the reality of Being and may become a Duty from the moment there is an intention to transform it into action. Therefore, there is a duty related to the preservation of life and with the future existence that depends on people's responsibility. By assuming this responsibility, the right to be in the world by means of actions that do good must be ensured[15].

In the present study, individual behaviors were affected by values that might compromise this continuity of Being, as is seen in the interview of nurse 7 who reported that some professionals saw the need for aspirating the patient, but they did not do so.

When comparing this result with that of other studies, it was observed that nursing practice in intensive care has been the object of discussions from an ethical point of view[11]. In research conducted with nurses of Portuguese hospitals as to which ethical matters are perceived by them in their daily practice in intensive care, decisions on end of life, privacy, teamwork, interaction, and access to care stood out. They sought to solve these questions by their own or the team's resources[17].

One of the concerns found in the studies was about ethical dilemmas experienced by ICU nurses and the values that guided their behaviors and decisions. This concern is justified, since obstacles in the decision making of nurses were observed, which were associated with unpreparedness, lack of knowledge, lack of reflection, and distancing. The ethical dilemmas that were highlighted in the study were about terminality, use of material resources and blood transfusion[18].

The difficult ethical situations in the practice of intensive care present in studies and observed in research show evidence regarding questions in the field of nursing knowledge and its can-do, and in pedagogical practice, bringing attention to the relevance of professional behaviors[11].

In this context, it was concluded that the ethics of responsibility is directed to a "duty-do", in which the responsibility for the future is assumed. It is implied that the consequences from one's actions should not interrupt the possibility of life continuing to be manifested in all its expressions[12]. The application of this prerogative in nursing care, especially by nurses in intensive care, shows that these professionals must have such an understanding of duty, and express it through actions that value human life, and consequently, ensure its maintenance. This is in contrast to the scenes and interviews described in the research.

The aspect of professional responsibility and the matter of adverse events showed in the results are becoming increasingly problematic in intensive care under the approach of patient safety and ethics[5]. This was found in two studies that highlighted errors in ICU nursing care.

In the first study, the records of nurses concerning their behavior when faced with an error, revealed that responsibility involved, recognizing the error as an expression of human vulnerability and taking responsibility for it, in order to conduct ethical behavior with the others involved[19].

In the second study, researchers affirmed that ethics depends on people's practice and choices they make in what they call aesthetic of existence. The aestheticization of ethics is built from an art of living based on choices of practices, overstepping moral rules and managing their own freedom[5].

The concern with ethical responsibility also deals with the privacy of patients in ICUs[20]. In interviews with 22 ICU professionals, it was found that even in the team which valued respect and dialogue with patients, there was still negligence, forgetfulness and breach of privacy during care[20].

Fear is configured in the first obligation of an ethics of responsibility and serves as a guide for the analysis of ICU nursing practices and studies used in this discussion. The heuristic of fear, also understood as precaution and prudence, works as a guiding principle for actions, as long as such fear leads to reflection on the future of men and is aimed at preventing things from becoming worse. It is not about a paralyzing or pathological fear, but one that leads to thinking and to acting, in contrast to an individuals' lack of responsibility[12].

The category, heuristic of fear, in the theory of responsibility is a criterion used to evaluate risks present in the technique. In it, the term heuristics is understood as an elaboration of good questions, resulting from fear or the possibility of making someone vulnerable[12]. It means to investigate or try to know the effects or possibility of effects resulting from a particular action[12].

The interviews reveal a distancing of care for patients due to the prioritization of managing activities, whereas fear is a principle of responsibility, it must be used for the benefit of human beings, whereby patients and their needs are the central concern. This is in contrast to the concern for managing dynamics.

Consequently, the anticipatory dimension of fear in predicting effects that the delegation of interventions to other members of the nursing team may cause in the protection and safety of human beings means to adopt principles of ethics in the context of care, in which safety and quality of care are essential[21].

The second unit of analysis also highlights situations that reflect a distance from ethical values of nursing. When nurse 2 said, "leave one of them uncovered", conflicts that emerge from reflection on her actions are revealed, but at the same time, it characterizes a practice that is opposed to the theoretical and philosophical nursing framework. This is because, "the uncovered part" is exactly the recognition of patients in a singular way, with respect to their autonomy, individuality and their rights as human beings.

It is worth mentioning that the teaching of Ethics in Health has not kept up with the demands of society. This affirmation is supported by a study that proposed to find out the perceptions of nurses on how they experience the main ethical problems at work, and if their professional training was adequate to face them., Weaknesses in professional training concerning ethics were found, especially in the theoretical and practical fragmentation of the ethics of care dimension, which indicates the need for reappraising the teaching/learning of ethics[22].

The teaching of ethics in a nurse's education, according to conceptions of teachers who have established connections with professional skills and an ethical profile, can develop a reflective ability in students on the relationship between themselves and others, so that they have an ethical commitment in the future[23].

Therefore, to prevent professionals from being focused on technical procedures, contradictions of pedagogical practice must be overcome. For this purpose, the access to laws of art is a strategy, since to become an interpreter of the expression of art, it is necessary to emphasize their meaning in the artist's role[11].

The option to provide care for sedated patients observed in the data disregards communication as basic instrument of nursing. This result in particular, corroborates another one in which there is a preference for unconscious patients, since they have their emotional demands silenced by sedation/coma. The lack of time to assist with communication needs is alleged[24].

In intensive care, studies that deal with communication and its interface with the use of technology highlight this discussion[25-27]. Interaction is demanded by ICU patients, as is shown in experiences of critically ill patients under mechanical ventilation[25], However, since there is a devaluation of situations that involve deep interaction[26], patients' experiences, difficulties and needs are little known. On the other hand, there is confidence in the objective data originating from technology, which guide the control of clinical events[27].

These studies that underline the discussion and the presented empirical data take on significance in Hans Jonas theory regarding the meaning of Purpose and Value. The theory states that the Purpose is part of the Being, it is that for which an action is undertaken[11]. Regarding the artifacts, the purpose integrates their concepts, precedes their existence, and is the cause of their creation. This, however, does not presume their Value in use, which refers to the real need related to an object. Therefore, he shows concern with the major technological inventions regarding their purposes, which demand an ethical discussion in society[15].

The purpose of nature is the maintenance of continuity of existence, which in this ethical theory means that life is an object of responsibility. Such a responsibility of human beings to other similar beings, who are also individuals with responsibilities, is total and not partial in situations. The object must be considered in its historicity, articulating the present with the future in a temporal dimension of responsibility[15].

Under this point of view, the distancing from patients who demand care is not characteristic of responsible care, because whether they request care verbally or not, patients need to be fully cared for by means of effective communication. Taking responsibility for patients' care and treatment also entails knowing how the situation that is being experienced in the present is related to the individuals' existence, to what happened before, and to understanding its possible repercussions.

Therefore, in a situation of total responsibility, dialogue is an instrument of exchange of knowledge and accountability in health or illness. Ethical conduct in the search for its implementation is a responsibility for nurses.

The use of technological devices by nurses as source of substitute information to that obtained directly from the contact with patients calls into question the application of such technologies for achieving the purpose of nature, which is the maintenance of life by responsible individuals.

CONCLUSIONS AND IMPLICATIONS FOR PRACTICE

In conclusion, there were difficulties for nurses in reflecting and expressing ethical and professional values in their conduct. These difficulties which were more strongly apparent in the field observations, for passing over their ways of providing care in ICUs, and priorities established in their daily practice.

The distance of nurses from direct care for patients emerged, justified by the prioritization of bureaucratic activities, which are common in managing activities of nursing care. The non-performance of certain procedures of care, which were identified as daily requirements, represents the lack of accomplishment of responsibility and professional commitment, inherent in the ethical actions of nurses. This was also demonstrated bytheir preference for providing care to sedated patients who were not able to communicate verbally, thus reducing demands for their attention and presence.

Practices that oppose ethical values in nursing are found when priorities are not focused on patients as the first recipients of attention, with negligence for the concept of the individual that forms the basis of the paradigm of nursing.

Based on concepts that guided the analysis, the responsibility of nursing care in the performance of actions in line with this principle is reiterated. This means ensuring the range of the being, and at the same time, complying with professional values.

Continuing education based on the approach of ethical competence and comprehension of individuals' integrality may contribute to a change to this reality. Creating spaces for the exercise of self-reflection and a redefinition of individual values in the interface with professionals was a possibility presented.

Academic education concerning ethical and professional values is another focus of intervention that is outlined based on the results. To incorporate and improve such values in professional practice enables nurses to assume an ethical position in the face of the sociocultural context where they are placed, and to value solidarity and responsibility. Therefore, the teaching of ethics must be transversal in undergraduate courses, with practice labs that provide the opportunity for reflection on ethical acting according to the professional performance at the time.

Patient safety free from risks and adverse events is an ethical commitment of nursing professionals that must be defined in their education. When this commitment is not well articulated, nursing credibility and knowledge might be questioned, knowledge, affecting the established principles of care. Therefore, efforts are concentrated in the maintenance of such principles.

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