

ORIGINAL ARTICLE

NURSING PROTOCOLS IN PRIMARY HEALTH CARE: INSTRUMENT FOR QUALITY OF CARE*

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ABSTRACT

Objective: to analyze the nursing protocols as a possible instrument for the quality for the nurse's practice in Primary Health Care.

Method: a descriptive and qualitative study, carried out by means of documentary analysis and semi-structured interviews, with 14 nurses from Metropolitan Regions I and II in the state of Rio de Janeiro. Bardin's thematic content analysis was used for data treatment.

Results: the category analyzed in this article was the "place of care", which addresses the quality of care in nurses' actions and its importance for the profession.

Conclusion: collective and dialogical constructions are motivating factors for the elaboration of local protocols. In addition to being a permanent education strategy, nurses recognized the protocols as tools for decision-making, providing them with technical and ethical support, which greatly contributes to the construction of knowledge and to the development of good nursing practices.


DESCRIPTORS: Primary Health Care; Nursing care; Nursing Evaluation; Office Nursing; Professional Practice.


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PROTOSCOLOS DE ENFERMAGEM NA ATENÇÃO PRIMÁRIA À SAÚDE: INSTRUMENTO PARA QUALIDADE DO CUIDADO

RESUMO

Objetivo: analisar os protocolos de enfermagem como um possível instrumento para a qualidade da prática do enfermeiro na Atenção Primária à Saúde.

Método: estudo descritivo e qualitativo, realizado por meio de análise documental e entrevistas semiestruturadas, com 14 enfermeiros das Regiões Metropolitanas I e II do estado do Rio de Janeiro. Para o tratamento dos dados, foi utilizada a análise temática de conteúdo de Bardin.

Resultados: a categoria analisada neste artigo foi o "lugar do cuidado", a qual aborda a qualidade do cuidado nas ações dos enfermeiros e a importância desta para a profissão.

Conclusão: a construção coletiva e dialogada são fatores motivadores para elaboração de protocolos locais. Além de ser uma estratégia de educação permanente, os enfermeiros reconheceram os protocolos como ferramentas para tomada de decisão, proporcionando-lhes apoio técnico e respaldo ético, o que contribui sobremaneira para a construção de conhecimento e o desenvolvimento de boas práticas em enfermagem.

DESCRITORES: Atenção Primária à Saúde; Cuidados de Enfermagem; Avaliação em Enfermagem; Enfermagem no Consultório; Prática Profissional.

PROTOSCOLOS DE ENFERMERÍA EN LA ATENCIÓN PRIMARIA DE LA SALUD: INSTRUMENTO PARA LA CALIDAD DE LA ATENCIÓN

RESUMEN:

Objetivo: analizar los protocolos de Enfermería como posible instrumento para la calidad de la práctica del enfermero en la Atención Primaria de la Salud.

Método: estudio descriptivo y cualitativo, realizado por medio de análisis documental y entrevistas semiestructuradas, con 14 enfermeros de las Regiones Metropolitanas I y II del estado de Río de Janeiro. Para el tratamiento de los datos se empleó el análisis temático de contenido de Bardin.

Resultados: la categoría analizada en este artículo fue el "lugar de la atención", que aborda la calidad de la atención en las acciones de los enfermeros y su importancia para la profesión.

Conclusión: la construcción colectiva y dialogada es un factor motivador para elaborar protocolos locales. Además de ser una estrategia de educación permanente, los enfermeros reconocieron a los protocolos como herramientas para tomar decisiones, que les proporcionan apoyo técnico y respaldo ético, lo que contribuye para construir conocimientos y desarrollar buenas prácticas en Enfermería.

DESCRIPTORES: Atención Primaria de la Salud; Atención de Enfermería; Evaluación en Enfermería; Enfermería en el Consultorio; Práctica Profesional.

INTRODUCTION

Protocols are systematization instruments that assist nurses in planning actions and making clinical decisions, supporting ethical and professional conflicts, and collaborating in legitimizing practices and difficulties in the professional practice in PHC⁽¹⁻³⁾. Incorporating the use of protocols in the care practice aims to facilitate the work of nurses and benefit the user⁽¹⁾.

In the daily practice of nurses, a “tension in the caregiver field” is established, between structured action, centered on vertical programs, and performance with poorly structured actions, with the possibility of advancing in the construction of another model of health action. There is a dichotomy between valuing the needs of the users versus the construction of their practices, which go beyond the established biomedical knowledge. Therefore, there is a logic of technological and communicative actions in the work process⁽⁴⁾. In a study conducted with nurses in PHC in the city of Rio de Janeiro, a similar perception was identified by the nurses. At the same time that they valued the protocol as a mean to guarantee autonomy and legal security while exercising their clinical practices, they questioned the organization mode and the construction of these instruments, as they still reflected an organization structure by lines of care (programmatic), not often responding to the needs felt and expressed by users who sought the Health Units (HUs)⁽²⁾.

Thus, it is possible to note that building up health practices focusing on comprehensive care and on the health needs of the population is a challenge, as this requires reflection and collective learning on the part of nurses and managers, requiring investment in processes of joint construction of the health practices, which was proposed to those involved in the elaboration of the protocols⁽⁵⁾.

Historically, nursing care in the field of public health has been constituted with a focus on curative actions, although this field privileges preventive guidelines. Recent studies on the practices of nurses in Primary Care Units (PCUs) demonstrate that, in their care activities, individual care predominates, with a focus on the attention of priority groups stratified by biological risk, such as hypertension and diabetes, and by life cycle, such as preschool children, with diversity in these practices^(6,7). Thus, the valorization of the programmatic actions in the organization of the health services in Brazil instituted practices that focus on the processes of illness of the collectives, which reinforced the dichotomy between individual clinic and epidemiology, promoting the organization of access and reception in the PCUs by means of activities aimed at the risk of falling ill, instead of a clinical practice focused on the need of the subject⁽⁵⁾.

In this context, the aim of this article is to analyze the nursing protocols as a possible instrument for the quality of the nurse’s practice in PHC.

This article is part of the results of a study that emerged from the partnership between the Technical Chamber of Nursing Management and Assistance of the Regional Nursing Council of Rio de Janeiro (*Câmara Técnica de Gestão e Assistência de Enfermagem do Conselho Regional de Enfermagem do Rio de Janeiro, CTGAE/COREN-RJ*) and the Superintendence of Primary Care of the State Health Secretariat of Rio de Janeiro (*Superintendência de Atenção Básica da Secretaria Estadual de Saúde do Rio de Janeiro, SAB/SES-RJ*). This initiative resulted in the shared construction of care protocols anchored in the daily experience of nurses involved in the care and management of Primary Health Care (PHC) in Metropolitan Regions I and II of the state of Rio de Janeiro (RJ).

METHOD

A descriptive research study, with a qualitative approach, whose objective was to analyze nursing protocols as a possible instrument for the quality of nurses' practice in PHC. To better apprehend the reality of the object under study, bringing the actions of the social subjects closer to their realities, documentary analysis and semi-structured interviews were used for data collection, with the following triggering question: How was your participation process in the construction of the nursing protocol and how did you experience the implementation of the protocols in PHC?

This study was developed from August to October 2016, with 14 nurses working in Health Units (HUs) and/or in the management of Metropolitan Regions I and II of the state of Rio de Janeiro (RJ). Considering the context of jointly carrying out a protocol between the Regional Nursing Council of Rio de Janeiro (*Conselho Regional de Enfermagem do Rio de Janeiro*, Coren-RJ) and the Municipal Health Secretariat (*Secretaria Municipal de Saúde*, SMS), the research participants were the nurses involved in the proposal for the shared construction of the nursing protocols from Metropolitan Regions I and II of RJ (which took place from 2012 to 2014) and a key informant.

Among the study participants, the following were included: nurse counselors from Coren-RJ who were members of the CTGAE; supporters of state management, linked to the municipalities of Metropolitan Regions I and II under the responsibility of the SAB/SES-RJ; and municipal management professionals and Family Health teams who worked in Metropolitan Regions I and II.

As inclusion criteria, nurses were considered who participated in the process of constructing the regional protocols of Metropolitan Regions I and II; who followed most of this process, having attended to at least five of the eight regional meetings held; and who agreed to participate in the research. Nurses who participated in less than five meetings to build these protocols were excluded. The interviews were previously scheduled with the subjects according to the interviewees' availability.

Another instrument used was the search for documentary sources, based on documents filed by the CTGAE. Such documents were organized by subject matter and recorded in a form previously prepared by the author.

For data treatment, Bardin's thematic content analysis⁽⁸⁾ was used, which is characterized by the organization of information in phases or stages, leading to a structured and organized result of the content⁽⁸⁾. First, the exploration of the material was carried out, where the object of study and the research objectives were resumed and the codification of the Registration Units (RUs) was initiated. After identification, the 913 RUs important for the object under study were grouped, resulting in 21 Signification Units (SUs) or themes.

The SUs were subsequently quantified and regrouped, making up four categories of content analysis, as follows: The path taken in the construction and agreement of the protocols: The path taken in "doing together"; Care protocols and professional practice: the role of protocols in the nurses' practice; Repercussions of the process of construction of the protocols; and The place of care: the essence of care that permeates nursing care. The "The place of care" category was discussed in this article.

In order to preserve the anonymity of the study participants, nurses were identified by the word "Interviewee", followed by sequential Arabic numbering, according to the participation order.

This research was approved by the Ethics and Research Committee, as established by Resolution No. 466/2012, under opinion No. 1,508,499.

RESULTS

Due to the need for care and minimization of conflicts related to nurse autonomy in PHC, it also became necessary to analyze the repercussions of the process of collective construction of the nursing protocols in the care practices of these professionals in PHC.

From this analysis, the "The place of care" category emerged, constituted by 153 registration units (RUs), corresponding to 1% of the total RUs in the study, and constructed from four themes/signification units (SUs): the nursing assistance in the lines of care in PHC, the protocols as mobilizers of the technical-scientific knowledge, the concern with the professional qualification, and the quality of the care provided to the users.

The nursing assistance in the lines of care corresponded to 10.7% of the SUs and was present in the speeches of 75% of the participants. The concern of the interviewees in relation to the care provided to the users within the care lines and the development of a quality care practice emerged, but not limited to monitoring the health situations, drug-related prescriptions or requests for exams.

Within my municipality, there was a concern to study beyond prescriptions and requests [for exams]. It was a moment to review all our assistance, we had to study a lot at that second moment... (Interviewee 4)

We are very focused on the medical assistance part, only we have to broaden our look when we talk about family, territory... and it was an opportunity that we had with other professionals to increase even more the nursing assistance, to improve that look, so it was something where we could work a lot. (Interviewee 1)

The need to perceive the emotions and feelings of the people cared for in the experienced situations is verified in the speeches, reviewing, in such a way, nursing assistance in the lines of care.

The protocols have an effect of mobilizing the scientific knowledge for the base of the know-how-to-do, because they help in noting deficiencies of the professionals in their performance in the PHC services, helping them to identify the necessity of greater theoretical support. The need for scientific knowledge, as being important for the care practice, was evidenced in the testimonials:

Once prescribed, it is there in the protocol, that I can do this or that I can do that. I need to have a lot of technical-scientific knowledge of what I am applying. So, if I'm asking for an hemogram, I have to know how to read it, at least, all the white series and the stages of an hemogram. Is the nurse qualified to know what changes they have? (Interviewee 3)

So... for us to widen our look, when we enter the person's house, we have to look not only at the clinical part... but the child gives signs, and we need to see them. When the protocols come, it is to sensitize the nurse to have a very wide look, to look at the family. (Interviewee 1)

In this sense, the protocol was pointed out by the interviewees as an instrument of qualification for the professionals who work in PHC to improve assistance to the population:

... the qualification, which I think is fundamental, is one of the great challenges of the SUS [...], but there is there... among the several difficulties, there is one for me which is the challenge of qualifying the professionals so that they work in a way that they have confidence and that they take better care of their user, so I think this is already something that always motivates me. This is a challenge. The idea of building, of participating in the construction of a protocol, to think about the qualification of this care, to better assist the user and also to give more security to the professional, I think it is fundamental. [...] it is to work on the qualification of the professional, to support the professional in this care. (Interviewee 5)

For me, the role of the protocols is to give quality to the assistance and to give security to the professionals in their performance. (Interviewee 7)

... when we establish protocols and qualify the network, because it's no use having the protocol and not qualifying the network over the behaviors of the protocol, you are looking for quality in the assistance, give support to this nurse in their conduct and knowledge. Because the protocol also brings this, this knowledge about what is mine as a nurse in PHC, makes them make decisions in their day to day that will greatly improve the assistance provided to the population. (Interviewee 4)

Furthermore, the qualification of the nurse was pointed out, correlating it with professional autonomy.

It is important for this, to give security to the nurse, to value professional qualification, and make the service network work. Not only focused on the medical professional. It increases the autonomy of the nursing professionals and gives them more security at the time of setting directions in the network. As well as the assistance provided to the user is improved. (Interviewee 3)

DISCUSSION

The practice guided by the Flexnerian or biomedical model has advanced in the technological area, which has led to the overvaluation of hard technologies and the consequent devaluation of care, the strengthening of specific professional knowledge, the reduction of the subjects' social and collective view of the health-disease process, resulting in authoritarian assistance, centered on procedures and reducing the users' autonomy over themselves and their treatment^(9,10). It is also observed that the devaluation of care is part of a process of alienation and loss of nurses' autonomy, which historically has care as the essence of their practice. That said, Nursing can only acquire full autonomy if care is reasserted as its central action sphere, both from a scientific and practical point of view⁽¹¹⁾.

Thus, the analysis of the nursing protocols, as a possible instrument for qualifying the practice of nurses in Primary Health Care (PHC), returns to the centrality of care and to the importance of the protocols being instruments to support the care practices in PHC and not the central element of these practices.

It is worth noting that PHC operates significant learning processes where the workers themselves have the opportunity to analyze their work, generating knowledge about this doing, identifying potentials and gaps that, then, mobilize the search for new knowledge. In this sense, it is necessary to distinguish "knowing-how-to-do" from "knowing-how-to-act", with the first referring to the skills of the professional, and the second to "going beyond what is prescribed", which constitutes in competent action, so that knowledge is incorporated into the development of techniques and is essential to the practice of doing and acting efficiently and effectively⁽¹²⁾.

In view of this, the meeting between nurse and user can be powerful for expanding the clinical view beyond the referred complaint, being a therapeutic meeting with the opportunity to identify, in addition to the health needs, the social and family context of the users⁽¹³⁾. Since the implementation of the Unified Health System (*Sistema Único de Saúde*, SUS), there has been a new meaning in the work of nurses in primary care regarding their duties, not only in the management and organization of the health services, but also in the clinical actions on direct care to the user. However, what is perceived is that the nursing practices have been predominantly focused on emergency care and on the production of procedures⁽¹⁴⁾. Thus, the authors^(14,15) corroborate that the nurse's clinical practice needs to be revised with a view to comprehensiveness and resoluteness, to centrality in the user, considering the uniqueness of the users and respecting the autonomy of the subject who needs care.

International studies indicate that the expansion of the nurses' clinical practice in

PHC improves access and is configured as a gateway to the health system^(16,17). They also suggest good health outcomes and user satisfaction^(18,19).

When the nurse has a good quality performance in the clinical dimension and the management of the work process in the team, there are positive repercussions in the organization of the actions in PHC, which is one of the strengths of their action, contributing to consolidating the principles of the Family Health Strategy (FHS). Therefore, there is a need for investment and adaptation in critical, collective and creative improvement, in order to strengthen the social practice of the profession⁽²⁰⁾. This means qualifying the clinical dimension of the nurse's practice in PHC, without abducting the political facet of knowledge, which feeds the nurse's autonomous actions. Therefore, knowledge involves both the clinical and political dimensions, without which the professional practice of nurses can be vulnerable to the manipulation of the interests of others, be it professionals, managers, market representatives or government officials, within the health policy⁽²⁰⁾.

Regarding the relevance of the study, the process of shared construction for the protocols allowed for interaction and reflection, and qualified not only the product of the experience but its own participants. There was an opportunity for nurses to learn from each other through sharing experiences. In relation to the limitations of this study, the need to create mechanisms for monitoring and evaluating new technologies inserted in nurses' care practices was perceived, so that this monitoring provides objective elements for decision-making in the longitudinal improvement of the professionals and constant updating of the protocol as support for good care practices.

FINAL CONSIDERATIONS

Data analysis showed that the process of collective construction and dialog, as well as the adaptation of the protocols to the local reality, were motivators for the construction process and constituted an important exercise of permanent education and deepening of the technical-scientific knowledge of the nurses, with the active participation of the various actors in the learning process.

Nurses recognize the protocols as guidelines for care, without configuring them as the totality of their care, but as subsidiaries of decision-making, providing support and professional ethical support.

Confidence in the "know-how-to-do" was expressed as the professional's security in offering the users the best procedures to solve their health problems, qualifying the care provided.

The study showed that the protocols provide security in doing, as they support professionals in their "not knowing", since they point out gaps in their knowledge and, at the same time, assist in the conduct and decision-making, enabling the daily construction of ways for caring.

The shared construction of the protocols also proved to be a facilitator for the systematization of care, an important tool for the improvement of care processes and for the construction of scientific knowledge, contributing to the improvement of the quality of professional care. The collective, dialogical and interactive process stimulated learning and allowed for the deepening of the technical and scientific knowledge necessary for quality of care. The participating nurses reflected on the use of THE protocols for the qualification of lines of care, understanding that they are an important component of the work process; however, they may not have the necessary coverage, considering the singularities of the users and their health needs, the sensitivity and creativity of the professional being essential for the act of caring.

There is a need for a “broadening of the nurse’s perspective” for comprehensive care, centered on the needs of the subjects and respecting the users’ autonomy and life history. The protocols may come to contribute to constructing the clinical practice, which is an assistance dimension of the nurse and is built up in daily life, where care must be the central sphere of their practice, both from a scientific and practical point of view.

This study brings as a contribution to the area the importance of articulating technical and scientific knowledge with a clinical practice supported by nursing protocols adapted to local specificities. And that these may come to guide care and the good clinical practices, in order to increase the likelihood of quality care results, as well as guarantee professional autonomy and user safety.

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