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Original Article

Care in the hospital routine: perspectives of professional managers and nursing assistants

O cuidado no cotidiano hospitalar: perspectivas de profissionais gerentes e assistenciais de enfermagem

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ABSTRACT

Objective: to understand the meanings of care in the hospital routine for nursing professionals working in management and care. **Methods:** qualitative study that adopted the Human Care Theory as a reference. 38 nursing professionals participated, including service coordinators, directors, nurse assistants and nursing technicians. Data collection took place through semi-structured interviews recorded, transcribed and submitted to Content Analysis, Thematic modality. **Results:** three categories emerged: possible and necessary: the rescue of meaning and subjective values of care; scientific and human potential as a determinant of care; and difficulties involved in care. **Conclusion:** care in the hospital routine was perceived by nursing managers and care professionals as an event monitored and influenced by operational aspects, of a more objective nature, as institutional barriers for bonding, but mainly due to subjective aspects, linked to the way of being of the heath professional which shape humanistic care.

Descriptors: Nursing Care; Nursing, Team; Empathy; Health Management.

RESUMO

Objetivo: compreender os significados do cuidado no cotidiano hospitalar para profissionais de enfermagem atuantes na gestão e assistência. **Métodos**: estudo qualitativo que adotou como referencial a Teoria do Cuidado Humano. Participaram 38 profissionais de enfermagem, destes, coordenadores de serviço, diretores, enfermeiros assistenciais e técnicos de enfermagem. A coleta de dados ocorreu por meio de entrevistas semiestruturadas gravadas, transcritas e submetidas à Análise de Conteúdo, modalidade Temática. **Resultados**: emergiram três categorias: Possível e necessário: o resgate de sentido e valores subjetivos do cuidar; Potencial científico e humano como determinante do cuidado; e Dificuldades intervenientes no cuidado. **Conclusão**: o cuidado no cotidiano hospitalar foi percebido por profissionais de enfermagem gerentes e assistenciais como evento acompanhado e influenciado por aspectos operacionais, de cunho mais objetivo, como barreiras institucionais para formação de vínculos, mas, principalmente, por aspectos subjetivos, atrelados ao modo de ser do profissional e que moldam o cuidado humanístico.

Descritores: Cuidados de Enfermagem; Equipe de Enfermagem; Empatia; Gestão em Saúde.

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Introduction

Care is what differentiates human beings from other living beings. The concept of human care is an essential characteristic of nursing, with the aim of promoting the well-being of individuals, families and communities. It is understood, therefore, that, regardless of the position, the nurse's work contemplates several dimensions: care and assistance, teaching and education, research and management/administration, to a greater or lesser extent, which makes it complex[1].

Nurses in management positions, like nursing directors, perform activities with the objective of achieving quality care and the success of the institution. To this end, daily actions emphasize the coordination and organization of the institution, service units, staff, and decision making. In turn, the coordinating nurses work in the direct administration of the unit, considering the provision of physical, material and human resources for care management[2]. Assistants respond directly for improvements related to care, managerial activity, coordination of the nursing team and enabling the care process[3], being a reference for nursing services, which can influence team members in the way they perform care[4].

In this context, the performance of the nurse's functions in the practice of care can have different meanings, depending on who performs it, receives it and the environment in which it occurs. For a group of women with breast cancer, for example, nursing care must be based on the communication process, from which they can expose their physical, emotional and spiritual needs, and they consider it essential that the professional understands, from the patient, the impact caused by falling ill[5].

From the perspective of a group of nursing professionals from a pediatric inpatient unit, care was translated as the expression of affection for children, and the art of promoting a safe and affectionate environment for them[6]. It is noticed that, although researched in different contexts, for professionals, the meanings of care have similarities in their meanings. Thus, when reflecting on care, it is understood that the attitudes of nursing professionals need to be constantly reassessed.

Thus, considering the experiences of caring, the hospital routine and the premise that the identification of characteristics and fundamental elements for care can help in the recognition of what is really important and that makes a difference in the care routine, in addition, the perceptions about care, the different components of the nursing team (directors, in charge of the divisions of hospitalization and care, sector supervisors, nursing assistants and nursing technicians) can effectively contribute to the construction of reflection and conception about holistic/integral care, a fact often neglected by institutions, due to difficulties in providing moments of interaction between hierarchical instances.

Therefore, this study aimed to understand the meanings of care in the hospital routine for nursing professionals working in management and care.

Methods

This is a qualitative research that used the Theory of Human Care as a theoretical framework for data interpretation[7]. The informants in the study were nursing professionals from a General Teaching Hospital in the Northwest of Paraná, Brazil. At the time of data collection, 109 nurses worked (78 statutory, 30 accredited and one employee) and 186 nursing technicians (163 statutory, 22 accredited and one employee). In the first moment, 15 professionals who held managerial positions were included in the study: director of nursing, nurses in charge of the inpatient and care divisions and sector coordinators. Subsequently, nurses and nursing technicians, active in direct care for patients, included as a reference of care in the unit and hospital were included.

The indications were made through the follo-

wing request: Indicate a nurse and a nursing technician in your sector and a hospital nurse that you consider as a reference for care. It is noteworthy that three nurses who were in charge of the sector received two or more referrals of care in the hospital and, for this reason, were interviewed again. Thus, 41 interviews were carried out with 38 participants, all statutory, whose number was defined by exhaustion.

Data were collected from December 2015 to July 2016, through previously scheduled interviews, which took place in a private room, in the sector itself, outside working hours or at rest. It appears that a participant appointed by the head was interviewed at home, as she was on maternity leave. The professionals in charge of leadership and the nominees accepted to participate in the study.

During the interviews, a semi-structured script was used, consisting of questions that addressed sociodemographic and professional characteristics, as well as the following guiding questions: how do you perceive the care offered in your work/hospital sector? For managers: tell me how you take care. For professionals indicated as a care reference: mention some care situations that you provided. The interviews were conducted by the first author, lasted an average of 40 minutes and were recorded on digital media, after authorization. For analysis, they were transcribed in full, preferably on the same day of the performance and submitted to Content Analysis, Thematic modality, obeying the proposed steps: pre-analysis, data treatment and data interpretation[8].

The project was approved by the Research Ethics Committee of the signatory institution (Opinion 1,868,933/2015). The participants signed the Free and Informed Consent Form and, to guarantee their anonymity, the extracts of the reports were designated: for nurses in charge of leadership (LN), care reference nurse (CRN) and care reference technician nurse (CRTN), followed by the indicative number of working time in nursing.

Results

38 professionals of the nursing team participated in the study, 15 nurses who held a management position (nursing director, head of the inpatient and care division and the unit coordinators) and 23 professionals appointed by them as a direct care reference (12 nurses and 11 technicians). The participants were aged from 28 to 56 years old and 35 were female. Regarding education, the eleven nursing technicians participating in the study had some degree (seven in nursing), nine of them were specialists and a doctoral student. Among the nurses in charge of leadership, six were specialists and nine masters. Of the nurses indicated as a care reference, eight were masters, two doctoral students, a doctor and a specialist. From the analysis of the reports, three categories emerged: possible and necessary: the rescue of meaning and subjective values of care; scientific and human potential as a determinant of care; and difficulties involved in care.

Possible and necessary: the rescue of meaning and subjective values of care

This category emerged exclusively from the reports of the professionals who were indicated by the superiors as being a reference of care and add the objective and subjective elements, considered by them, important to perform such task. *Before being a good professional, I try to be a good human being, I don't believe that having a lot of knowledge is enough if you are not willing to be a good human being, if you don't put it into practice* (CRN, 22y). *There are times when I hold the patient's hand, ... he is even strange, I was hospitalized for so long, this is the first time someone has held my hand, ... these are simple things, which are not available in the arsenal, you know* (CRTN, 17y).

The difficulty in creating the bond of trust between professional and patient was pointed out by the nursing chiefs as one of the main elements that makes quality care difficult. However, the reference nurses of care highlighted that the bond is an integral part of the daily care. *There are a lot*

of patients who leave the Intensive Care Unit here, that I will visit [silence], outside the Intensive Care Unit they saw another patient [laughs] it is very good, they welcome us well, this exchange with them is very good. (CRT, 17y). *It's very good, they leave the surgical clinic, come back to follow up at the clinic, ... come here, talk, laugh, demonstrate our importance and feel important too.* (CRT, 16y). *You arrive at the room and say: - Look, I'm the night nurse, trust me, whatever you need (because we are so fragile in the hospital). So this relationship of trust for me is a care, knowing who to turn to ...* (CRN, 25y).

The relationship of trust can occur from the first contact or develop over the period of hospitalization, and may extend to family members. *It is quite difficult, sometimes, here in the Pediatric Intensive Care Unit, to deal with the mother, the family, but I am safe, because I realize that they see us taking care with love* [silence] *they are more confident and safe* (CRT, 33y). *I dedicate myself so that the care is individualized, and here in the Pediatric Intensive Care Unit, it has to be very directed towards the mother, mainly, who sometimes even show some aggressive behavior towards the professionals, but over time, I managed to understand that that behavior, it was not for me, for us [silence], I had to gain the mother's trust [silence], after I understood this, things started to flow much better* (CRN, 26y).

In this sense, some reports have shown that human values and professional attitudes are mixed, configuring a web of meanings specific to each moment of care. *You have to put the other person's shoes on, if that mother has changed behavior, you have to understand that she needs attention, care and understanding, because everything that is happening at that moment, all the difficulties of breastfeeding, does not mean that she it is always like this* (CRN, 26y). *No matter their story [silence], we don't know what he went through, what led him to do what he did ... I treat all patients the same, within their difference ... with affection, care, attention [silence]. And, for the family, I give confidence, security, I'm always talking to someone in the family* (CRT, 17y). *I take care of it like this, as if each patient were my father, my mother* (CRT, 22y).

It was noticed in the reports that the care provided by the professionals indicated as a reference was impregnated with values and attitudes, such as love for others, a bond based on trust, in addition to altruism, respect, empathy and otherness. Furthermore, care was directed to patients, families, staff and even the institution.

Scientific and human potential as a determinant of care

This category was configured from the reports that demonstrated the importance given to scientific knowledge and investment in the qualification of human capital. *Our* [emphasis] *here we take care and take care in excess. We have a nurse responsible for clinical research, patient safety commission, nursing support services, epidemiological surveillance and adverse reactions to medications, blood products, orthoses and prostheses. We are a reference for the country in the treatment of wounds; we have an international breastfeeding consultant* (LN, 24y).

Furthermore, regardless of training, they highlighted the importance of valuing the knowledge of each professional. *We have autonomy, we can do the nursing prescription, and we go to congresses and bring knowledge to the team. I have nursing technicians trained in Informatics, Social Work, with wounds in wounds, or in intensive care, I value the knowledge of each one of them, to spread the care, improve and monitor the care* (LN_{2}, 22y).

It is observed that the professionals appointed by the managers also value scientific knowledge, whether due to the search for training or because of the importance they attach to the knowledge of the subjectivity of the human being when caring. *Sometimes, I see that the child improves much more because of the way you treat him, than the treatment itself, having a good relationship with the mother and the child too, this helps a lot* (CRT, 25y). *Working in an intensive care unit is good because we always have to study, a lot ... I always try to take care with love, affection, because the family is more calm and confident and makes all the difference* (CRT, 33y). *Respect, call by name, put yourself in the other's place, ... how would I feel if it were me?* (CRT, 11y).

The subjectivities of care were also pointed out by nurses in charge of leadership, when recognizing the individuality/collectivity of employees and how it affects the care process. *We realize during all these years of assistance, that care depends a lot on who cares, there is a professional who is more committed, and this is his line of thought* [silence] *and, sometimes, he is more altered, with the higher voice, this affects the sector ...* (LN1, 17y).

Care professionals also perceived their subjectivities and their influence, positive or negative, on the collectivity and care delivery. *It was supposed to be a simple procedure, but due to pure stress we lost the Mean Arterial Pressure, the Nasoenteral Probe, we were very upset. It was the rush, some problem with us, and it happens. You have to police yourself* (CRT, 17y). *There was a girl who worked here, what a wonderful, calm, calm person, always with a word of support, it was so good to work with her. She was able to calm the sector* (CRT, 16y).

The professionals working in the assistance observed that the effectiveness of the work depended on the actions

and commitment of each one and the recognition of the role of each one within the team. *We work a lot here, we do hope, a colleague's return, to help you ... yes, some team spirit is missing, I miss the relationship between the team and the service, and there is a lack of bond* (CRN, 17y). *Our work schedule always has three technicians, but, lately, there is always a certificate or two, or absence, ... it is very difficult to take care of 15 children and their mothers with two technicians, but we are always running, trying to do our best* (CRT, 25y). Such reports are in line with what was mentioned by the professionals involved with management, when they pointed out that, with commitment, bond and respect, it is possible to achieve an environment of individual and collective growth: *I do not believe that we have reached a level of excellence in care, we have a very old team together, we have at least more than ten years of living together, we help each other, we grow, we mature together. We realize the importance of care, this good, quality care.* (LN, 26y). *We have been together for over 20 years, this creates bond and trust between the team members, ..., if one does not know, calls the other, we are very easy to cover absences, ..., employees help each other , there is no overworked employee* (LN, 22y).

The weaknesses existing in the units were many and distinct. However, the reports highlighted that professionals believed that the attitude of commitment to the institution, co-workers, patients and care can help to overcome them, resulting in better quality care for the patient.

Difficulties involved in care

The nurse managers were the first interviewed, and when asked (how do you perceive the care offered in your work sector/hospital?), They highlighted weaknesses specific to health services and that were directly related to care, among these, the considerable number of professionals in the pre-retirement phase, due to the characteristics of the current work scenario. *There is an already well-aged staff, they have already dedicated themselves a lot, they are tired, and the vast majority does a job that is very heavy for their age, many are working at night, exercise good care, but they are very tired and overload the employees, others are neglecting themselves* (LN, 16y).

They also pointed out the reduced number of professionals resulting from the non-substitution by competition in the cases of retirement and even death, and the precarious hiring of temporary professionals. *There was an expansion of rooms and services and you have to hire, because in fact you already had a shortage of staff, and today the volume of procedures is much higher* (LN, 21y). *Here, we have the statutory, the employee and the accredited. Each with a different workload ..., [silence] and the professional turnover is still high, because they win contracts or end up leaving* (LN, 20y).

Furthermore, they demonstrated that due to the turnover of employees in the sectors, the establishment of a bond with patients, co-workers and even with the institution itself is impaired. *Here in the sector, there are 71 employees. Of the 23 nurses, six are statutory, the rest are hired and accredited and 48 nursing technicians, less than half are statutory, and there are also teaching staff, which is seven. People come and go; it is difficult to establish a bond* (LN1, 17y). *There are a lot of selective test employees, accredited, outsourced, service provider; it becomes even more difficult for him to make the connection with the sector, with co-workers and patients. And, in the majority, they have another job, they already arrive on duty tired* (LN2, 17y).

The association of these difficulties culminates in another condition pointed out by the managers: the difficulty of exercising leadership. *I am a little square, from the time of the right clothes, the rigor, the demands, and the right uniform. The use of the cell phone bothers me a lot during work hours, then you go, call in a meeting, talk about complaints, but it doesn't seem to do any good, I don't know, how will this be rescued. The technician no longer has that security of working with the nurse, because there is no affinity between them, there are conflicts, before it was not like that* (LN, 13y). *There are people that we talk to, speak to, hold a meeting, guide, make an internal communication and nothing, the person does not change ... it's very difficult because we depend on their work. I get very worried ... it is an issue that affects the patient* (LN, 20y).

It was observed that professionals working in direct patient care also described situations of difficulties in interpersonal relationships and leadership by the managers. *I think that if I had a firm, stronger, even tougher leadership, I could find a way. You see that there is a lot that goes on without being talked about, talked about, charged, most employees really need to be charged* (CRT, 22y). *It is very important to work as a team; we have to think the same thing, for the good of the patient. We, statutory, have been together for a long time, but there are the employees and the accredited and this bond is not always achieved at work, sometimes it is very difficult* (CRN, 24y).

This category reinforces factors that make it impossible to perform effective and efficient care, since the personal dimensioning of nursing, the leadership model and the difficulty of interpersonal relationships are points that directly affect the quality of care offered.

Discussion

As a limitation of the study, the indication of the care professionals by the management stands out, since different results could be obtained if they had been selected randomly among the professionals of the institution. In addition, the participation of only statutory professionals may also have interfered with the perceived care identified, as they have been part of the institution's model of care for many years and often in the same sector, which makes the concepts aligned with the philosophy of care of the service. It is also necessary to consider that their perception can also be differentiated due to the greater training opportunities available and performed by them. Finally, it is also pointed out as a possible restriction the fact that the interviews were conducted in the workplace, which may have restricted the freedom of expression of the participants.

In any case, the results obtained are valid, as they can subsidize and favor reflection on the practice of care. It is emphasized that because they are statutory professionals, with many years of experience in the institution, they are able to bring a valid perception of the reality of care closer, as they use their daily experiences to reflect on the care they offer, highlighting the importance of the bond in different contexts as a facilitating factor of care, as guided by the Theory of Human Care, therefore relating practice to theory.

In the perception of nursing professionals, care is related to the assistance, managerial, relational, education and human values, different from the evidence that points out that the nurse's care is based on a technical practice[9]. It is pointed out that, sometimes, the nurse's hard work routine and the multiple tasks performed affect the quality of the care provided[1], a fact that requires continuous reflection among the team members, in order to list strategies to get around them.

Most of the professionals appointed by the boss had worked in nursing for about 20 years, and yet, or for that very reason, they performed care whose characteristics made them a reference among their professional colleagues. This finding contradicted the observation of nurse managers, who pointed out that the pre-retirement staff was one of the internal problems of public institutions. However, it corroborates the difficulties identified by the limited replacement of personnel, employees with restrictions on work efforts and intergenerational differences[10]. It was noted that only statutory professionals were appointed, which allows inferring about the importance of the employment relationship for the quality of care, to the point of being a reference for the others.

Still related to the staff, the double link was pointed out as another factor that influences the quality and continuity of care, as it is common for professionals to be late or leave early, in addition to not being able to do the job with the same disposition and physical condition, due to the consecutive shifts. This aspect also affects the worker's life in several ways, such as bad sleep, body pain, memory lapses, difficulty concentrating, irritability, sadness, mood disorder and professional exhaustion[9], which can result in absenteeism or sick leave, which overloads the team.

It is observed that, sometimes, the nurse's work routine, especially in the hospital context, is arduous and affects the physical and mental condition, as it is constantly forced to go beyond its own limits, a fact that also affects the quality of care provided[4,11-12]. In this sense, another study pointed out that the professional gradually becomes individualistic and, thus, starts to perform only the care activities under his responsibility and which he considers to be priorities[9]. This acts as a passive reaction to all obligations.

It is also evident that the duplicity of employment bonds is more common among accredited professionals, which, in a way, hinders interpersonal relationships and leadership by nurses in the sector and managers, precisely because they do not have stability in institution. This is because a weak employment relationship can create difficulties and insecurity for the professional to exercise leadership in the team. On

the other hand, as noted, statutory professionals find it difficult to recognize accredited or hired workers as team leaders. Thus, the work and care relationship continues to be impaired[4,10], causing moral distress[12].

In contrast, a study carried out with 84 nurse managers of hospital services in southeastern Brazil, showed a negative correlation between length of care and employment with the leadership based on incentive and professional motivation[13]. Results of this investigation are in line with the findings of this study, especially in relation to the difficulties in dealing with the team, ways of dressing, postures and behaviors. It is pointed out that the fact that the nurse says, "draw attention", takes criticism to the team meeting, is not sufficient or effective, given the low capacity to lead, raise awareness and integrate the team[13].

It is also considered that, sometimes, technical unpreparedness, as well as difficulties in communicating with co-workers, as mentioned, make it even more difficult to carry out effective care. In this sense, a study with 15 nursing professionals pointed out that this care requires articulation and engagement between team members, in order to enable the discussion of needs and decision making that favor decentralized execution[14].

There was a consensus among the participants, regarding the importance of scientific and technical knowledge of those who care, mainly on the part of the nurse, as well as the disposition of the technological potential in the service. Knowledge was identified as a way of transmitting safety to the patient and the team's professionals[11-12]. A study carried out at this same institution found that the main causes of moral distress in nursing technicians were related to the construct "working with nurses/doctors who do not have the competence to work"[12:1058].

In addition to knowledge, the commitment to the activities inherent to the performance of the nursing team also proved to be an important aspect, which seems to be related to the safety transmitted to the team and patients in the execution of care. Thus, it is highlighted that promoting a culture of safety in relation to care is the responsibility of nurses.

Some subjectivity of those involved in the care process was identified as an important element that impact on the execution of care. The differential in the care of the indicated professionals is related to the attitudes, based on human relationships, which are shown by the production of a new way of caring, based on the recognition of the patients' needs and the professionals' work possibilities[7,14-15].

It is noteworthy that communication is a way for the professional to approach and interact with those being cared for, as it is in this process that it becomes possible to know the individual, establish relationships, bond and identify the needs for care[7,15]. The concept of therapeutic communication - empathy, respect and receptive listening - has been widely used when analyzing the relationship between nurse and patient, as technical and objective knowledge does not cover all possibilities and needs for nursing care. Subjective elements emerge in therapeutic communication, which, in turn, acts as an intervention to recover the patient's health[7,16]. The nurses studied also observed that implementing a therapeutic relationship produces observable results in the comfort and improvement of the patients' health status. In addition, they pointed out the relevance of informing and creating bonds with family members and even including them in care, since communication is able to alleviate the suffering of patients and their loved ones[15,17].

These considerations point to the need to reflect on the moment of caring, from the perception of the caregiver, the complexity of the act and the environment in which it takes place. Still, the dynamism in which it occurs, embedded humanitarian values and the need to identify oneself as a person of care[7,18]. Thus, care, as pointed out by nurses participating in the study, must be based on human attitudes and values, essential elements for quality of care.

However, it is evident the distance between some objectivity pointed out by the chiefs and the appreciation of humanitarian and subjective aspects

brought by the professionals indicated by them as references in care. The existence of possible dualities regarding the concept of nursing care is considered, which can bias the understanding of it. A study carried out with professionals working in an oncology ward in Rio de Janeiro, Brazil, for example, addressed the duality between the expected care and that which is actually implemented by the professionals (the real one), so that the distance between them consists of the which is conceptualized as practical intelligence, in which the "know-how" of the professional reigns, focusing on the skills of speaking and listening and promoting comfort. Such skills sometimes go unnoticed in the face of the means applied, with a view to assessing care, usually directed to managerial purposes[19].

The "invisible" aspects of the care process emerged, even without being directly related to care contexts in which these aspects are, more often, highlighted as fundamental. In the context of care for people with chronic conditions, it is common for family members to value care based on interaction and that takes into account patients' beliefs, values, possibilities and limitations, while in caring for brain-dead and potential donor patients - a condition contrary to the purpose maintenance of life - the team demands a posture of zeal and care, envisioning the possibility of a new existence from organ donation[20].

Understanding the perceptions of the different categories of nursing team professionals about care enables reflection on the importance of each element within the team and the role that each plays. Therefore, it is imperative to seek integration between the different perceptions of care and forms of care, in order to make the care practice an interconnected process, with a view to further benefiting the patient and his family and, consequently, the very way to structure this care within the institutions, with repercussions on benefits also for the team and the institution. Despite the countless tasks in daily life, nursing must prioritize human care, which is characterized by being systematized and having a therapeutic intention, which, in turn, requires knowledge, technical competence, skill, empathy, attention and ethics by part of those who propose to care[7,10].

Conclusion

The care in the hospital routine was perceived by nursing professionals working in management and assistance as an event monitored and influenced by operational aspects, of a more objective nature, as institutional barriers for the formation of bonds, but mainly by subjective aspects, linked to the way of being of the health professional which shape humanistic care.

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Collaborations

Costa JR and Marquette VF collaborated with the conception and design, analysis and interpretation of data and writing of the article. Marcon SS, Testón EF, Arruda GO, Peruzzo HE and Cecilio HPM contributed to the writing of the article, relevant critical review of the intellectual content and approval of the final version to be published.

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