THE NURSING PROCESS PRESENTED AS ROUTINE CARE ACTIONS: BUILDING ITS MEANING IN CLINICAL NURSES' PERSPECTIVE[1]

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This qualitative study aimed to understand the meanings attributed to the nursing process by clinical nurses at a Mexican hospital. Data were collected through semi-structured interviews, participant observation and document research. Symbolic Interactionism and Grounded Theory were the theoretical and methodological frameworks for data analysis, which permitted understanding the experience and meaning nurses attributed to the nursing process in their daily care practice, which was unveiled as routine care actions, performed differently from what they had learned in school.

DESCRIPTORS: nursing; nursing process; nursing care

EL PROCESO DE ENFERMERÍA COMO ACCIONES DE CUIDADO RUTINARIAS: CONSTRUYENDO SU SIGNIFICADO EN LA PERSPECTIVA DE LAS ENFERMERAS ASISTENCIALES

Este estudio de naturaleza cualitativa tuvo como objetivo comprender los significados atribuidos al proceso de enfermería por enfermeras de una unidad clínica de un hospital de México. La recolección de datos fue realizada por medio de entrevistas semiestructuradas, complementada con la observación participante y la consulta documental. Los datos fueron analizados bajo el marco teórico y metodológico del Interaccionismo Simbólico y la Teoría Fundamentada en los Datos, que posibilitaron la comprensión de la experiencia y significado atribuido por las enfermeras, al proceso de enfermería en su práctica cotidiana asistencial, que se desvela como acciones de cuidado rutinario, aplicados de forma diferente a lo enseñado y aprendido en la escuela.

DESCRIPTORES: enfermería; procesos de enfermería; atención de enfermería

O PROCESSO DE ENFERMAGEM COMO AÇÕES DE CUIDADO ROTINEIRO: CONSTRUINDO SEU SIGNIFICADO NA PERSPECTIVA DAS ENFERMEIRAS ASSISTENCIAS

Este estudo, de natureza qualitativa, teve como objetivo compreender os significados atribuídos ao processo de enfermagem por enfermeiras da unidade clínica em um hospital do México. A coleta dos dados foi realizada por meio de entrevistas semiestruturadas, complementada por observação participante e consulta documental. Os dados foram analisados tendo como referenciais teóricos e metodológicos o Interacionismo Simbólico e a Teoria Fundamentada nos Dados, possibilitando a compreensão da vivência e o significado atribuído pelas enfermeiras ao processo de enfermagem, na prática cotidiana assistencial, que se desvela como ações de cuidado rotineiro, aplicados de forma diferente daquilo que é ensinado e aprendido na escola.

DESCRITORES: enfermagem; processos de enfermagem; cuidados de enfermagem

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INTRODUCTION

The experience acquired as nurse teacher on the nursing process has generated frequent relations with care practice in the hospital context. Thus, it could be verified that the nursing activities performed in patients were focused on already established procedures and routines, with no reference to theoretical principles and how to put the nursing process into practice.

Feeling uneasy with reasons that contributed to this situation directed the author's attention to how professionals were experiencing and perceiving the use of the nursing process in the hospital context.

The nursing process is considered the appropriate method to explain the nursing essence, its scientific bases, technologies and humanist assumptions that encourage critical thinking and creativity, and permits solving problems in professional practice[1-2]. This method represents an attempt to evidence and understand nursing work focused on care as a reflective practice.

The development of the nursing process in Mexico was based on the work developed by the National Nursing Association in the 1970s. This work focused on gathering nurses in the country to reflect upon and expose strategies on new scenarios and changes in the profession. One of the strategies highlighted was training on teaching and nursing care based on this method[3].

Starting from this initiative, teaching and practice strategies were developed to provide tools to use the nursing process in the curricula of undergraduate programs and in health institutions. These strategies aimed to incorporate it as a nursing care method, focused on care and also to facilitate its integration in the construction movement of health care as a social and collective good.

Some scholars have recently shown the investments made to use the nursing process in care practice, providing information on what nurses know, believe and adopt in various situations and difficulties encountered in hospitals[4-8]. These studies indicate the potential of investments in its practice, by approaching nursing practice and health care, education and research.

Based on the above, we reaffirm the researchers' view that the nursing process is an action full of meaning that can be used by nurses in practice, as a method for care delivery, which represents challenges in education and in practice. The nursing process needs to be deepened in the hospital context, based on the perception of nurses working there, highlighting their doubts, uncertainties and questions about how to put it into operation.

In the attempt to address these questions, this study aimed to: understand the meaning attributed to the nursing process by nurses from a hospitalization unit in Mexico and describe actions they perform at this unit according to the meaning they attribute to the nursing process.

THEORETICAL AND METHODOLOGICAL FRAMEWORKS

This qualitative study is based on Symbolic Interactionism because it emphasizes the nature of social interaction, the dynamics and social activity involving actors, in the perspective that considers an active human being in his(er) environment as an organism that interacts with others and with the self. Interaction means that the actions of each human being are continually constructed, which in part depends on what others do, influencing each other. In acting and interacting, language is used that originates from intersubjectivity, basically operating in symbolic realities sustained in this intersubjective space[9]. Symbolic interactionism is a social science perspective designed to produce knowledge on collective human life and its conduct; focusing on the meaning events have for human beings and symbols used to attribute meaning to them. These symbols are socially developed during interaction and are agreed upon inside groups.

Symbolic interactionism is based on the following principles: human beings act in relation to objects based on meanings these have to them; the meaning attributed to objects/things originates from social interactions between human beings; meanings are manipulated and changed through an interpretative process, developed by human beings when they are faced with objects and themselves[10]. Human interaction is mediated by the use of symbols, interpretation and investigation of the meaning of others' actions.

Grounded Theory (GT) was the methodological framework of this study, which is rooted in Symbolic Interactionism and aims to generate theory as from obtained data, submitted to systematic and comparative analysis, organized in conceptual categories that explain the phenomenon under study.

GT is a method that maintains a close relation between systematic data collection, analysis and theory that emerge during investigation. The theory emerges from reality and is not a mere connection of concepts based on experience or assumptions on how things should be or work[11].

This methodological design demands ongoing data comparison, the researcher's theoretical sensitivity, theoretical sampling of empirical reality, notes that corroborate the process of open, axial and selective codification so as to assure the conceptual development and density. The result of this codification and integration of data contributes to the construction of theory.

Data collection, codification and analysis occur simultaneously in GT, which allows the researcher to understand the meanings in the participants' perspective.

METHOD

This study was carried out in the Internal Medicine Unit at the General Hospital No. 2 Family Medicine Unit of the Mexican Social Security Institute in Irapuato, Guanajuato-Mexico. This is a medium-size institution, linked to the health system and formal workers' social security. It has 110 operational and 52 extra beds with a staff of 327 nurses.

The Internal Medicine Unit has two wings (South and North) with a capacity for 25 beds and three designated to surgery. The nursing team consists of 36 nurses and nursing auxiliaries, and four head nurses. The average permanence in hospital ranges from four to nine days.

The research project was approved by the Bioethics Committee at the University of Guanajuato, School of Nursing and Midwifery at Celaya, and by the Research Committee at the General Hospital No. 2 Family Medicine Unit, of the Mexican Social Security Institute in Irapuato, Guanajuato. A free and informed consent term explaining the study objectives and methodological procedures was presented and signed by all professionals who agreed to participate in the study, following ethical principles in research and assuring anonymity.

Because this is a qualitative study based on GT, the number of participants was not predetermined. It was rather the result of a sampling process and theoretical saturation, which means that the number of participating nurses was determined according to the representativeness of concepts that emerged during data analysis.

Data collection strategies used were: semi-structured interview, participant observation and document research between March and September 2007. The semi-structured interview with open questions focusing on the object of interest was tape-recorded after nurses' authorization. The tapes' content was accurately transcribed and submitted to the interviewees for content validation.

Participant observation was performed by the researcher at the Internal Medicine Unit in the three shifts according to the participants' work schedule, in their daily routine, focusing on the work method, identifying actions, interactions, procedures and notations between August and September 2007. The researcher spent about eight hours with each participant in two different moments. Observations were recorded in the field diary afterwards.

Document research was carried out using official sources at the Nursing Department of the studied health institution, as well as records of nursing actions in forms defined by the Internal Medicine Unit where the interviewed and observed professionals work, after the authorities' consent.

Data analysis was carried out during collection, comparing information obtained in interviews, observations and document research based on central questions on the object of interest, considering ongoing comparison, which is a basic principle of the chosen method. After data transcription, a careful reading of interviews and observations was made so as to perform codification (open, axial and selective) and also theory delimitation[12].

Open codification was initiated as from the reading of interviews, carefully examining the text, decomposing it in fragments called incidents, which were examined and compared in the search for similarities and differences, generating codes. This procedure was repeated with the remaining interviews, one by one, in the attempt to define categories, deepen identified codes and group them so as to explain the meanings that emerged from data, reducing the number of codes, aiming for categorization.

The construction of categories, in terms of their priorities and dimensions, was carried out through detailed analysis of codes found in data, both

in interviews and observations. This process permitted to identify and list categories, specifying them in particular characteristics.

Axial codification implies deep and dense analysis of categories that emerged from the open codification process, includes the relation of categories and subcategories following the lines of their proprieties and dimensions. Categories and subcategories were related and grouped in this codification based on the codification paradigm, according to their components that include conditions, actions/interactions and consequences, orienting and helping the researcher to formulate questions, generate hypotheses and ongoing comparison, which is useful in theory construction[11].

In the selective codification, categories were integrated and refined so as to identify the central category and subcategories, in an interactive process between the researcher and data.

RESULTS

Sixteen nurses from three work shifts participated in the study, 14 women and two men, between 30 and 48 years of age. There were six nurses with a teaching diploma and ten with technical education only. The time of experience varied from 10 to 20 years at the institution and in nursing.

The analysis process permitted the construction of the central category the *nursing process as routine care actions*, representing the meaning attributed to the phenomenon studied by nurses in daily practice in the hospital context. This category is composed of the subcategories: *different from what have been learned with loss of continuity of actions; investigation of patients' needs and conditions based on medical treatment and perceptions of discomfort; performance of care actions/interactions based on the patients' needs, medical prescription and established routines, and records of care actions/interactions and medical prescriptions*, which permit to understand nurses' experience in the use of the nursing process.

The nurses at this internal medicine unit reported that the work they perform in daily routine is *different from what they have learned with loss of continuity of actions*, and compare it to undergraduate experiences, when they learned to have individual focus, on a few patients, to perform step-by-step procedures in chosen situations, which is different from what they currently experience. What has been taught at school is reported as knowledge that cannot be put in practice in their professional reality, and they idealize the transmitted theoretical knowledge that supported practice...

It's very different when you don't practice it, when we learn it at school, it has been more than 20 years since I graduated, as time goes by, you lose this continuity, we set aside things that are important, and don't manage it like when we're at school, with more detail because we're not with one patient or two, here we attend 13. (E10).

The meaning nurses attribute to the nursing process is present when they express elements that integrate it during care in the daily routine, as if it were a routine and mechanized activity, knowing beforehand what they are going to do, as follows.

...We use the nursing process but we don't even notice it, we have a work routine and don't realize it, we don't think we are putting it in practice, but it is done because we plan activities and perform actions, but it is like routine activities (E10).

Investigating patients' needs and conditions, based on medical treatment and perceptions of discomfort, is performed as daily care actions. Nurses report that they evaluate patients' needs and conditions through a process of information collection, at different moments during their shifts, and it is not systematic, with more or less details, does not follow an established standard and data from medical treatment are the priority and direct what aspects need to be evaluated and observed.

...when you get the shift, they say the patient's name, diagnosis, check if the venoclysis has all data, of no more than three days, and that the patient has his serum and that it corresponds to what has been prescribed (E13).

This investigation is also performed based on the perceptions and reports of patients' discomfort, which manifest nurses' potential autonomy in the search for information so as to direct their professional response to care demands.

...when I receive the shift I focus on observing the patient, checking again if his solution has to be repeated, if the venoclysis is ok, if there's some kind of drin, if it's dry, ask if there was any incident in the previous shift, if there's anything pending, this is my evaluation...(E8).

As from the investigation of patients' needs and conditions, nurses identify situations that require planning of nursing actions/interactions, giving priority to patients' critical conditions and medication administration. Prioritizing implies immediate care,

altering the sequence of their daily activities that demand interpretation of collected information based on their knowledge, clinical experience and values established by the hospital.

...As soon as I arrive in the morning I go to get to know the patients, see their medical diagnoses, what may be the characteristics in terms of symptoms or something bothering them....and based on this, I choose my priorities, in case there's some patient who needs more urgent care, so I pay more attention to this patient (E3).

Nurses give priority to medication administration during time available, according to the number of patients and medication prescriptions. This activity related to medical prescription is revealed as a central element in nurses' routine in the hospital context.

First I check how many patients I have and according to this I get my trolley, prepare my syringes with serum and then I go patient by patient because, if you don't do it this way, you lose time for administering medication (E1).

Also, the *performance of care actions/ interactions, based on patients' needs, medical prescription and established routines* sometimes follow care protocols nurses have internalized in their routine. Nursing autonomy at the institution is reflected in these actions/interactions that result from professional judgment, aiming to meet patients' needs, valuing their decision-making.

...we do not only perform care according to medical prescriptions, generally the physician visits the patient and we are the ones who are responsible to check if the patient has any changes, problems or needs, so we make decisions on what has to be done for the patient (E9).

Care actions/interactions also follow standardized routines and established functions in the hospital structure, working as guiding elements so as to discipline work.

...It's always the same, check signs, pass nursing records, continue with care prescribed by the physician responsible for each patient, following what is already established in the service (E7).

Records of care actions/interactions and medical prescriptions are considered a valuable tool in the profession; it is a tool for care and a legal requirement, however, nurses perceive it as something little important and undervalued by other professionals in the scope of their actions, alleging lack of time to perform it. Thus, records are vague with little detail, incomplete, repetitive and do not evidence their actions.

We don't take notes of everything we do because there's not much time, so there're places where I put the same thing from the other shift "all the same", I believe that we don't have time to do a detailed record of our actions (E13).

They establish differences, however, when records are related to medical prescriptions on which they spend a great part of their time, confronting and updating them at different moments during shifts, especially those regarding medication changes.

...we take care so that medical prescriptions coincide with nursing records, as I administer medications and check the prescriptions again to see if there's any change in the treatment or if prescriptions are the same (E2).

DISCUSSION

The nursing process as routine care actions represents the nurses' experience in care delivery based on the evaluation of patients' needs and conditions, planning of nursing actions/interactions, performing care actions/interactions with more and less autonomy, partially recording them. Most of the times, these prescriptive actions/interactions have an immediate resolution and come first in relation to pending conditions, needs and conditions of risk, with little time for attentive listening or for developing a close relation with patients.

Thus, nurses' routine actions/interactions predominate in the hospital's complex daily routine, where they try to respond for their ritualistic performance, incorporated into the institutional culture, as a normal, learned and adapted practice[12]. The nurses, in view of the organizational structure, become active organisms capable of modeling their line of action, based on what they consider important and significant[10], and perform the nursing process as routine care actions, executing habitual tasks established by the organization[7].

Nurses report that, most of the times, the nursing process goes by unnoticed in the hospital routine, as if it existed only in their imaginary because they perform it differently from what they have learned, which implies in loss of continuity of actions, it is not a viable, systematic and individualized action to all patients under their responsibility. The dichotomy between teaching and practice of this care method generates insecurity and disbelief in students and professionals who use it[13].

This situation is a challenge for the profession and generates questionings regarding the most adequate way to teach the nursing process, strategies to put it into operation in the teaching area and integrate it to academic programs, in addition to the ideology and value systems of faculty members. This way, the need for greater interaction between schools and services is evident, so as to link professional education to professional health practices[7-8]. The gap between nursing practice in the hospital routine and the proposal of nursing process teaching needs to be faced, so as to find viable strategies for its effective use in health services and to support nurses' care actions. Nurses' critical education should elect the dimension of applied science, knowledge and nursing practice as essential elements[14].

Nursing has currently faced an overload of tasks and lack of time. It is opportune to work on a more practical and reduced nursing process that focuses on patients' current needs, which is an issue nurses, faculty members and students need to reflect on in order to find viable paths for its practice[15].

In this perspective, nurses acknowledge that their care actions and use of the nursing process in the hospital context are being compromised, which results in evaluations focused on patients' signs, symptoms and needs, on their physical aspects and critical situations, mediated by acquired knowledge, interiorized values and meanings attributed to the care act.

The planning of care actions and interactions, which occupies an important part of nurses' time in their routine, is only perceived, oriented by protocols and routines established in the service, which have been interiorized and followed as a line of action, through an interpretation process.

Nurses, as social actors, interact with their peers, other health professionals, patients and family members in the hospital context, and formulate indications of conduct based on institutional standards, which orient their interaction with others, alienating themselves when the performance of tasks is defined by the health institution, a factor that determines their care actions/interactions, mainly based on medical prescriptions.

In addition, nurses execute care actions/ interactions focused on patients' needs, showing autonomous exercise, based on knowledge, critical rationale and decision-making that overcome the established normative model, strengthening their nature as agents[10]. This way, the nursing process permits autonomous action in the face of other health professionals[7].

Nurses experience autonomy when they comply with patients' care goals, using knowledge and abilities in the context of understanding and contributing to the care plan, evaluating their needs and conditions, expressing concerns and priorities, coordinating the multidisciplinary team's resources[16].

The nursing process is characterized as *routine* in a context of limited interactions to complete tasks, which is revealed as a mechanic activity, where the nursing prescription does not reflect patients' individual evaluation[4]. This context reflects the perspective of critical discussion of the work process, in the search for benefits the nursing process could introduce in the structure of team care practice, strengthening social interaction at work.

During observations and interviews, we verified that nurses' actions/interactions are mainly focused on patients' physical care, routine procedures and care protocols established at the unit, on following medical prescription, and also on receiving and passing the shift, medication administration, measurement of vital signs, nursing clinical records and referrals[17].

FINAL CONSIDERATIONS

The knowledge produced in this study, as already mentioned in literature, permitted to describe the social process clinical nurses experience with regard to the nursing process. They consider this process is integrated to their daily practice and is performed as routine and unnoticed care actions, different from what is learned at school, and incorporates care protocols established at the hospital, revealing a gap between what is recommended during formal education and what is performed in daily practice. It indicates the need to link theory and practice and the search for strategies that minimize this distance, incorporating continued education into the work process, a challenge that is presented to academic nurses and those working in the services, within the critical and reflexive paradigm.

We believe this study contributes to understand the meaning a group of nurses attribute to the nursing process in the hospital context, which can stimulate reflections and encourage proposals to change nursing education and practice.

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