

Wounds Treatment: nursing assistance in the 24-hours Primary Care units

Tratamento de Feridas: assistência de Enfermagem nas unidades 24 horas de Atenção Primária*

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Abstract

The aim was to identify how nursing teams of 24-hours Basic Health Units of a municipality on the coast of Rio Grande do Sul act on wounds evaluation. Exploratory study with a qualitative approach developed in the 24 hours of basic units a coastal municipality of Rio Grande do Sul. The data were collected through semi-structured individual interviews and the thematic analysis was used. Study participants were nursing professionals operating directly in the care of patients with wounds. The assessment step is at the discretion of who performs the initial service. It is noticed that there are no established conduct for guidelines/information and evidence that the way records are made by nursing professionals is insufficient. So, were understand the need of creating an instrument to record the aspects involved in the evaluation and wounds treatment and the importance of creating an integrated online operating system for implementation and consultation of nursing records. The study has identified that the performance of nursing professionals in the evaluation of patients with wound is carried out in a particular way, without any previously established routine.

Keywords: Nursing Care; Wounds and Injuries; Healing; Knowledge; Primary Health Care.

Resumo

O objetivo foi identificar como as equipes de enfermagem das Unidades Básicas de Saúde 24 horas de um município do litoral do Rio Grande do Sul atuam na avaliação de feridas. Estudo exploratório com abordagem qualitativa, desenvolvido nas Unidades Básicas 24 horas de um município litorâneo do Rio Grande do Sul. A coleta de dados foi realizada por meio de entrevistas individuais semiestruturadas e a análise utilizada foi a temática. Os participantes do estudo foram profissionais de enfermagem que atuavam diretamente no cuidado aos pacientes com feridas. A etapa de avaliação fica a critério de quem realiza o atendimento inicial. Nota-se que não há uma conduta instituída para a fonte de orientações/informações apreendidas e evidencia-se que a forma como os registros são realizados pelos profissionais de enfermagem é insuficiente. Assim, compreende-se a necessidade da criação de um instrumento para registrar os aspectos envolvidos na avaliação e tratamento de feridas e a importância da criação de um sistema operacional *online* integrado para realização e consulta dos registros de enfermagem. O estudo permitiu identificar que a atuação dos profissionais de enfermagem na avaliação dos pacientes com ferida é realizada de modo particular, sem qualquer rotina previamente instituída.

Palavras-chave: Cuidados de Enfermagem; Ferimentos e Lesões; Cicatrização; Conhecimento; Atenção Primária à Saúde.

Introduction

The patients' care with wounds is a specialty that everyday requires more knowledge and versatility in acting, sparking interest among nurses in expanding their knowledge in the wounds treatment area⁽¹⁾. The nurse should be able to follow the evolution of the injury, guide the necessary care and run the bandage, is the professional who holds major technical field of this practice and, therefore, to act in the wounds treatment, is it necessary to have a vision the scenario⁽²⁾.

The basis for the health care practice in this area, when it comes to the fundamentals of nursing, need to be worked on since the formation, both in technical vocational education, and higher education⁽²⁾.

Early diagnosis and management of skin lesions should be coordinated, and consistent, with clear objectives, accurate and standardized in all health services. Therefore, the need to make the actions of the professionals and systematize the care to be provided to the patient with injuries⁽³⁾.

The assessment of the wound should be considered phases of the healing process. It is important to observe the presence of exudate and their characteristics, as in chronic wounds, the exudate can become a barrier to healing. In addition, should be inspected aspects of edge and skin around the wound and tissue types involved⁽⁴⁾. All such information shall be collected during the evaluation process that matches since the withdrawal of the previous dressing, during the dressing and until the time the wound is clean⁽⁵⁾.

However, in the quest for comprehensive care, it is necessary to overcome the routine and mechanistic vision of dealing with all the injuries the same way and just look at the wound, leaving the person in the background⁽²⁾. The identification of important elements to determine the causes of the wound, and for your time determine the nursing diagnoses, is obtained through the nursing history (anamnesis and physical examination).

The structure of these instruments should contain sociocultural aspects dealing with the conditions of life and work, beliefs, level of physical activity, demographics, use of medicines, history of present illness and history, family history, among

others. It is also important, where possible, the professional has access to laboratory tests, including the most important, as: CBC, metabolic profile with electrolyte indicators, indicators of kidney, liver and Glycemic function⁽⁶⁾.

It is the responsibility of the nurse to perform patient assessment considering the factors that can influence wound healing. He must have a critical view with regard to the treatment of a wound, because the role of a trader is not implementing the dressings, but assess and intervene with autonomy and quality at every stage of the healing process⁽⁷⁾.

Study⁽²⁾ held in Recife/Pernambuco found that 1.05% of the population presents chronic wounds that need healing achievement in health units, being the treatment of wounds, according to this study, a public health issue. This study also found that anyone who performs most of the dressings in health units is the nursing technician, and the products available to such procedure does not correspond to the current technological development. Also pointed out that there is almost wound care studies in Brazil, showing the relevance of studies that address this subject.

It is understood that evaluate the patient with wound consists of a complex process, being necessary to identify data that relate to the injury itself, as well as the information relating to clinical conditions, socioeconomic and cultural that patient, so This interweaving of information offer subsidies that guided a good nursing practice.

Thus, it is hoped that this study will contribute to the strengthening of the participation of nurses of primary health care in the implementation of systematization in the daily life of work and collaborate to consolidate your perception as a key agent of care.

The aim of this study was to identify how nursing teams of the 24-hours Basic Health Units of a municipality on the coast of Rio Grande do Sul act on evaluation of wounds.

Method

Descriptive study of a qualitative approach, carried out in three Basic Health Units (BHUs), which work 24 hours, located in four boroughs of a coastal city of Rio Grande do Sul.

Of the total, were working in the three BHUs, 18 nurses, 25 technicians and 15 nursing assistants. All were invited to participate in the study. Inclusion criteria were: nursing professionals with direct performance in the treatment and care of patients with wounds during the data collection period. Exclusion criteria were adopted as the nursing professional who was away for health reasons or on vacation at the time of collection and you were working for less than six months in the 24-hours BHUs. After application of the inclusion and exclusion criteria, participated in this study eight nurses, 11 nursing technicians and four nursing assistants.

In order to ensure the anonymity of the subjects, they were identified in the research through the "RN" to nurses, "TEC" for nursing technicians and "ASS" for nursing assistants, followed by the number corresponding to the order of the data collection.

The data were collected in September 2015 through semi-structured interview with questions about the assessment and conduct the wounds and also on the records of the assistance provided, and subsequently were analyzed by analysis of theme type content⁽⁸⁾. Such analysis allows the researcher to group the data by themes and examines all cases in the study to make sure that all manifestations of each theme were included and compared. In this sense, the analysis was performed by following the steps of pre-analysis (reading material), exploration of the material and the interpretation of these results⁽⁸⁾.

The project was approved by the Committee of Ethics in Research in the Health Area of the Federal University of Rio Grande (CEPAS/FURG) under opinion No. 84/2015, and also the Core of Permanent Education in Health (NUMESC) under opinion No. 14/2015, of the Municipal Health of the city of Rio Grande. All the participants of this study have consented your participation through the

signature of Free and Informed Consent Term (FICT).

Results and Discussion

Three categories were identified in the thematic analysis: Wound evaluation, Conduct in relation to the wounds treatment and Records of customer assistance with wounds.

Wound evaluation

This category deals with the professional evaluation of patients with wounds, how and what sources of guidance that the trader gets to take care of patients with wounds. As for the question about how the patient's evaluation occurs with wounds:

"We are ourselves, technicians and auxiliaries. We evaluate the whole picture, we observe the healing, [...] how is the tissue, if he's in recovery or not. And depending on the case, we call the nurse or physician to evaluate together [...]" (ASS2).

"If the wound is infected, I ask the clinician's evaluation, otherwise, I can start nursing make the dressing and guide the care" (RN1).

"At first I try to get a record, when it was, how long has [...] If you have the issue of self-care, [...] the presence of the phlogistic signs. I also see the point of work, home, nutrition, if you're eating right, if you are diabetic or not, if there's any pathology that might worsen that initial state, made the use of medicine and if didn't. Actually, I start with the history and at the same time making that assessment of the wound specifically" (RN2).

"Who does the assessment is the professional who is serving, or technical assistant [...]. Evaluate as a whole if you have psychic, physical conditions to carry out the guidelines, [...] If you're having a good prognosis or not" (RN5).

The results of the study show that the assessment step is at the discretion of who performs the initial service, which corresponds mostly to technicians and nursing assistants, and as your own understanding, the need, request

assistance from a nurse or a physician on duty practitioner.

All the different subjects of the nursing staff working directly for the treatment of wounds, however, the professional nursing law does not discriminate in specific way what are the assignments for each one of the professionals in referred care with wounds. However, the nurse is the legal guardian of nursing activity, and so, it is up to him to make the care process, coordinate and conduct the actions of nursing staff under your supervision⁽⁹⁾.

Being the treatment to the patient complex and dynamic, the evaluation must be judicious and thorough. Thus, it is essential that the team is prepared to perform their duties in an agile and efficient, and the nurse performing the initial assessment and the first patient care⁽¹⁰⁾.

Evaluate the patient with wounds far beyond observing the wound itself. It is necessary to perform an evaluation that considers the local systemic factors and which affect the external appearance of the wound or interfere with the healing process, and above all, develop the ability to view clinic that connect the dots important influencing this process⁽⁷⁾.

In the assessment and treatment of complex wounds is necessary to get the source of the injuries for which the appropriate follow-up occurs effectively. It is necessary to qualify the nurses, by means of permanent education and develop protocols to make your work better. On the contrary, the knowledge deficit associated with improper practices, can collaborate for the emergence or worsening of wounds⁽¹¹⁾.

In this study, it was observed that the evaluation is performed individually, without any routine, and there is no instrument to guide how this assessment should be carried out. In this way, it is believed that assistance can be weakened by the lack of important data that must be collected during the evaluation, and that can be ignored or unappreciated.

The evaluation of a wound involves factors such as: location, size, color of the tissue in the wound bed, quantity and characteristic of exudate, the presence of odor and aspect of your skin, so that in this way is indicated the ideal coverage. In addition, they must observe the aspects related to

the general user, such as: nutritional status, concomitant chronic diseases, immunity, physical activity, socioeconomic conditions, among others⁽¹⁰⁾.

In a study⁽¹²⁾ conducted with nurses who investigated the know about indication of coverage in care with wounds, it was found that most presented insufficient knowledge regarding the indication of the covers. He noted that commonly used products such as Hydrogel and essential fatty acids (EFA), reached a high level of error, which reflects the difficulty of the evaluation process itself. The results of a study⁽¹³⁾ held in a public teaching hospital support with these findings and indicate that 92.7% presented regular or inadequate knowledge on the topic.

The present study reiterates the need to better exploit the knowledge related to the stage of wound assessment and the own responsibility of patient assessment, facing the complexity that involves. In this sense, it is also the organs of class to discuss and legislate on the theme that, arguably, permeates the everyday professional practice of nursing.

This study shows that few professionals express performing a clinical evaluation of the patient in your entirety, in particular, the auxiliary and technical nursing professionals. As the nurses, though present greater area on the aspects to be covered in this evaluation, identifies a character evaluation of completeness.

The provision of quality care is related to the promotion of conditions of work or for the number of staff, the qualification of professionals or the provision of resources to provide nursing care qualified⁽¹¹⁾.

Furthermore, the systematic and continuous assessment, qualifies and highlights the work of nursing. In this light, it is believed that the implementation of protocols for assessment and treatment of wounds can make the process more efficient, effective and integrated to the local reality, producing positive responses on assistance.

Conduct in relation to the wounds treatment

When asked respondents if they receive guidance on how the dressing must be carried out, the answers were diverse.

"The guidelines that I have are the ones I'm looking for, I'm always looking for let me know" (ASS1).

"Always on-call nurse, all sorts of guidance [...] about the contamination, [...] handwashing" (ASS2).

"[...]who does is as learned in the course" (TEC2).

"[...]the physician is present at the moment or the nurse" (TEC4).

"In fact, they (technical and nursing assistants) are the bandages and the people is who else they call to assess, to guide. And to be guided, when we need something, ask for help to the doctors" (RN4).

Note that there are no established conduct for guidelines/information seized. While some refer to not receive orientation or seeking individually by a source of particular orientation, still others are guided solely by the knowledge built during the training process. It is observed that in some cases the nurse is who directs technicians and nursing assistants and, in others, the guidelines are of doctor who are on duty.

A study⁽¹⁴⁾ conducted with nursing students of a public University, has identified good theoretical foundation about risk factors, type of injury, wound healing and types of treatment of skin lesions. However, most of these students do not know how to proceed with the clinical evaluation of wound, suggesting that the subjects of the course focus on more injuries, healing and treatment, to the detriment of a more complete clinical evaluation.

The Ethics Code of the Profession establishes as a duty of the nursing professional, improve their technical, scientific and cultural knowledge that give sustenance to your practice, as well as establishes the responsibility of the nurse, stimulate, promote and create conditions for the technical, scientific and cultural improvement of nursing professionals, under your guidance and supervision⁽¹⁴⁾.

It is understood that within the responsibility of the nursing staff nurse responsibility about the orientation of conduits, so this must be the professional reference for the rest of the team. Without disregard the knowledge and experience of other team members, it is important to note that, in this context, the nurse should put in center position of the educational process so that the ducts are conducted in a uniform manner.

This finding leads to reflect on the review of responsibilities and training of these professionals about the individualized care and efficient, and on it, on the need to rescue the allocation of supervision on the part of nurses, in addition to the establishment of parameters of action, through protocols⁽²⁾. The nurse has fundamental importance in the implementation of preventive and therapeutic measures of various types of wounds and is therefore a responsible task of guidance⁽⁷⁾.

Furthermore, the effectiveness of the treatment of the wounds also depends on the education and guidance of the client, causing him to become an active participant in the healing process, and it is important that your performance directly in the prevention of wounds. In this sense, the training of nursing to promote self care results in efficiency and speed in the treatment. For both, professional guides must have the technical and scientific knowledge domain, thus providing proper guidance, for every situation⁽¹⁵⁾.

The nurse must also worry about investing in your own development, spreading the importance of improvement and professional development, stimulating the development of people according to their potential. Noting that the act of managing, in chance, can distance themselves from the act of caring, as there is a significant gap in these two functions that it is exclusively to the nurse professional⁽¹⁶⁾.

Certainly the knowledge acquired during the training process is a fundamental basis for a good professional practice. But today, with the work process of nursing professionals, permeated by rapid advances in technology, it is imperative that these professionals are up to date on the subject, since the treatment of wounds appear evidence that make it increasingly complex.

It is believed that the lack of standardization regarding the reference sources of guidance, as has been observed, desfavoreça continuity of assistance. Thus, the importance of systematization of assistance through the elaboration of instruments that guide, and normatizem pipes to establish a standard of patient care with wounds, contributing to patient safety as for the quality of care in nursing⁽¹⁷⁾.

Records of customer assistance with wounds

The registry of clinical findings and actions taken must be done in detail, including notes from the assessment, orientation and conducts, as well as the application of products, in order to document the evolution of the lesions⁽¹⁸⁾. As the subject of this study, in General, nursing records are conducted in a fairly succinct and not systematized. However, even if they don't, some professionals recognize the importance of electing more information you consider relevant in these records.

"Today I just put: dressing in upper limb in SIA/SUS. I think it's important, but I don't do and is my mistake [...]" (ASS1).

"I usually record the location I'm doing, I usually write down which aspect of secretion and I used that. We have no charts at night, so the bandages are registered in the SAI/SUS. I think it could be more detailed record, as aspects of skin, complaints of patient [...]" (TEC9).

"The records, they are very superficial [...] we know that it would have to come a determination to which this record was a little better, I think people would do since it was standardized" (RN2).

It evidenced that the way records are made by nursing professionals is inadequate and, therefore, does not meet legal standards of the Council that governs the profession. Professionals recognize the importance of the record to the monitoring of the evolution of the patient, however, recognize that they don't fully. Another important observation is that in no time, any

professional referred to that record as a document which gives legal support of the actions taken.

According to the code of ethics of nursing in Nursing Council (COREN) decision⁽¹⁹⁾, the registry of nursing is the foundation that underpins the actions taken, being the only way to demonstrate the work performed by nursing professionals and the legal proof of the care provided. The record should contain true and complete information, should be clear, objective, accurate, and legible with no erasures, containing subsidies to enable planning continuity of nursing care in different phases and for planning assistance⁽¹⁹⁾.

It was found that the record of nursing actions is performed in an Outpatient Information System servicing the Unified Health System (SAI/SUS), usually referred to as SAI/SUS, which was deployed by the Ministry of Health (MH) throughout the country in 1995. At the time, for being standardized system nationwide, was on instrumental at federal, State and municipal management of SUS⁽²⁰⁾.

Since your deployment aims to record the calls/procedures/treatments performed in each health establishment in the framework, for the purposes of financial allocation⁽²⁰⁾. Thus, the SAI/SUS is a tool of productivity information that aims to feed a national system for statistical purposes and epidemiological profile, enabling the regional budget forecast for each dimension of the Government, enabling the distribution of funding and resources as needed for each State and municipality.

The nursing record is an important tool in the practice of nursing, ethical and legal scenario. When scarce and inadequate compromises safety and patient care perspective and makes the measurement of results from this practice⁽¹⁷⁾.

In litigation, the chart, as a legal instrument, serves as a review by translating the relationship between patient and staff. Experts and judges crop subsidies for judicial decision, and health institutions, the duty of maintenance and custody of the chart and make it available for judicial elections, to wit the provoked, serving as an indispensable element of expert testimony⁽¹⁷⁾.

In fact, the fill plug, SAI/SUS, is not appropriate for such a document registry, since your purpose is the generation of statistical data,

and yet enables records present a character continuity. Similarly, it is understood that the implementation of these records with free care demand BHUs, is infeasible operating point of view. However, being the plug SAI/SUS the only document available to be filled with the information service, it is necessary that these records are more detailed.

As legislation is allowed that the imposition of health set your own format of evidentiary documentation of nursing actions, since she is committed to ethical and legal standards without hurting any article of this decision. In this sense, it is understood that the institution must have active participation in creating education and awareness strategies for these records to be made containing the necessary information, as well as facilitate the tracking records regarding patients who perform continuous care⁽¹⁹⁾.

Before the findings of the study, we understand the need of creating an instrument to record the aspects involved in the evaluation and treatment of injuries to the patients in the BHUs. It is believed to be possible the deployment of a portfolio of patients with wounds, as well as existing monitoring programmes of diabetic and hypertensive patients, in that is documented, since the historic, with the patient's biopsychosocial aspects that have relationship with the wound, as well as the steps of assessment, nursing diagnosis, prescription of care and also the developments, so that you can track the progress of treatment. Were understood how important still is the creation of an integrated online operating system in which the professionals perform and records of nursing believes that any patients seen by SUS.

The results of this study point to the need for permanent education in health so that these professionals are abused on the assessment of wounds. Whereas, the step of evaluation submits all the other steps in the conduct with the patient, it is understood that the quality of this phase is crucial to the quality of assistance to individuals and collective.

It is believed that the nurse must rescue your role as a centralizer nursing care in the assessment of wounds with the support needed for institutions, so that it is possible to prevent your appearance, optimize the time of healing,

contribute to the reduction of hospitalizations and prolonged psychological disorders and to reduce the patients, their families and public health system.

Conclusion

The study has identified that the performance of nursing professionals in the evaluation of patients with wound on 24-hours BHUs is performed in a particular way, without any previously established routine. In this context, the evaluation stage is at the discretion of whoever receives the patient, which is predominantly technical and nursing assistants.

It is evidenced that the minority of professionals performs a clinical evaluation that consider the patient in your entirety, and among them, the nurses were the professionals mentioned an assessment to consider the biopsychosocial aspects. However, these professionals are not always the reference to the guidelines on the conduct relating to sores, on the other hand, it was observed that there is no clarity on what should be the source of guidance within the service.

Front of the complexity that the treatment of these patients involves, identifies that the assignment of the evaluation of the patient with wounds, as well as the guidance of professionals should be institutionally established. In this sense, the rescue of the tasks and the importance of the role of the nurse within the teams not only as administrative manager but also as assistance and health educator.

About the nursing records, identified that there is no systematic documentation of nursing care and the professionals perform only in attendance form comes SAI/SUS fairly succinct. Stresses that, given this, it is not possible to carry out the monitoring of the progression of the lesion and thus weakens the nursing care given to the patient. In addition, professionals do not point the nursing records as a document that subsidize legal backing his actions. It is understandable that nursing professionals face daily difficulties in basic network services, and the institution should be provided with instruments that allow both the monitoring of the treatment of the patient with

wound, but also, ensure legal support to these professionals.

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