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RESEARCH

THE CONSTRUCTION OF ASSISTANCE PROTOCOLS IN NURSING WORK

A CONSTRUÇÃO DE PROTOCOLOS ASSISTENCIAIS NO TRABALHO EM ENFERMAGEM

LA CONSTRUCCIÓN DE PROTOCOLOS ASISTENCIALES EN LOS SERVICIOS DE ENFERMERÍA

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ABSTRACT

Objective: to analyze how the construction and discussion of care protocols takes place in a high complexity public hospital. **Method:** a qualitative study conducted through focus groups with 16 professionals: nurses, nursing technicians and members of the Permanent Education Committee, whose information was submitted to the thematic analysis. The study is based on the Freirean premise, with regard to change or transformation, problematization, dialogue, and autonomy. **Results:** three categories emerged: the protocols in the midst of the complexity of the organizational context, protocols in the midst of gaining nursing work and lifelong education as strategy for the construction of protocols. **Conclusion:** the demands of the hospital context and the organization of nursing work need to be (re) thought of in order to alleviate the obstacles that hamper the elaboration of protocols. Continuing Education promotes dialogue, problematization of reality and the constitution of new ways of doing health care.

Keywords: Health Management; Nursing Process; Education, Nursing.

RESUMO

Objetivo: *analisar como ocorre a construção e discussão sobre os protocolos assistenciais em um hospital público de alta complexidade.* ***Método:*** *estudo qualitativo realizado por meio de grupos focais com 16 profissionais: enfermeiros, técnicos de enfermagem e membros da Comissão de Educação Permanente, cujas informações foram submetidas à análise temática. O estudo fundamenta-se na premissa freireana no que diz respeito à mudança ou transformação, problematização, diálogo e autonomia.* ***Resultados:*** *emergiram três categorias: os protocolos em meio à complexidade do contexto organizacional, os protocolos em meio à organização do trabalho em enfermagem e a educação permanente como estratégia para construção dos protocolos.* ***Conclusão:*** *as demandas do contexto hospitalar e a organização do trabalho de enfermagem necessitam ser repensadas numa perspectiva de minorar os entraves que dificultam a elaboração de protocolos. A educação permanente propicia o diálogo, a problematização da realidade e a constituição de novas formas de fazer o cuidado em saúde.*

Palavras-chave: *Gestão em Saúde; Processo de Enfermagem; Educação em Enfermagem.*

RESUMEN

Objetivo: *analizar cómo se da la construcción y discusión sobre los protocolos asistenciales en un hospital público de alta complejidad.* ***Método:*** *estudio cualitativo realizado por medio de grupos focales con 16 profesionales: enfermeros, técnicos de enfermería y miembros de la Comisión de Educación Permanente, cuyas informaciones fueron sometidas al análisis temático. El estudio se fundamenta en la teoría de Paulo Freire, en lo que se refiere a cambio o transformación, problematización, diálogo y autonomía.* ***Resultados:*** *surgieron tres categorías: los protocolos entre la complejidad del contexto organizacional, los protocolos entre la organización de los servicios de enfermería y la educación permanente como estrategia para la construcción de protocolos.* ***Conclusión:*** *las demandas del contexto hospitalario y la organización de los servicios de enfermería necesitan ser (re) pensadas desde la perspectiva de mitigar los obstáculos que dificultan la elaboración de protocolos. La educación permanente propicia el diálogo, la problematización de la realidad y el establecimiento de nuevas formas de dispensar cuidados de salud.*

Palabras clave*: Gestión en Salud; Proceso de Enfermería; Educación en Enfermería.*

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INTRODUCTION

Assistance protocols are technologies that are part of the organization of nursing work and constitute an important instrument of health management. Currently, taking advantage of these technologies is the prerogative of health institutions that value the excellence of services and seek to guarantee the safety of professionals and patients.[1] In this sense, the adoption of protocols for care is pertinent and provides support to organize and manage the nursing work.[2]

Some institutions use the protocols to organize the service, optimize the work and standardize behaviors, incorporating them into the practice of care and getting the resources available. Also, it is not uncommon to find protocols in the drawers of the care units or in computer files that are rarely accessed by teams. Thus, the non-use of regulations can lead to the lack of standardization of actions and diversity in the ways of doing, culminating in misunderstandings in the accomplishment of the assistance actions.

Although this form of organization is widely disseminated in health institutions, there are often situations in which professionals do not know the protocols or know about their existence, but do not apply them in practice. It also occurs that professionals develop their actions, often without being aware of the object to be modified.[3]

In health work, the actions developed are completed at the time of their performance and they can be identified and characterized in the sphere of non-material production.[5] It is understood that the product of health work in most cases does not materialize, making evaluation impossible or concrete comparison of what was produced. This circumstance may generate discrepancies through health care. Thus, it is essential to use a technology, such as the assistance protocols, to guide the organization of work within the health services.

This study was based on the works of Paulo Freire and anchored in four key concepts: change or transformation, problematization, dialogue, and autonomy. Change or transformation is understood as inherent in the development of the consciousness of society, awakened through education,[4] and the educational activity is an act of knowledge and awareness, mediated by the singular dialogue between the subjects. Change also assumes the character of process, because a critical, self-conscious subject is grounded on the present and then projects ideas for the future.[5]

In the dialectical and emancipatory perspective, recognizing the importance of standardization and the application of service organization protocols seems to be contradictory since the determination of norms and standards is closely linked to a hierarchical management model, composed of division of labor and task-centered. In this direction, Freire mentions that problematizing education is the "demand to overcome the contradiction between educator-learners, made by subjects who know their context. Without this, the dialogical relation, indispensable to the cognoscibility of cognitive subjects, is not possible around the same knowable object".[4:39]

However, problematizing the reality of work in a conflicting context is inherent in human interactions, and the presence of dissent seems salutary when viewed through the lens of dialectic. This manuscript is justified because it is believed that it can trigger new knowledge and new practices, transforming reality from individual and collective initiatives

The organization of work depends on the clear definition of norms, protocols, rules, and flows, which must be socialized and respected by all professionals, so the actions together meet the objectives for which a health service is proposed. In this sense, the question of research emerged: how does the process of constructing the assistance protocols in the daily routine of nursing work occur in the hospital context? Thus, the purpose of this study was to analyze how the construction and discussion of care protocols takes place in a high-complexity public hospital.

METHOD

The study follows the qualitative aspect and was carried out with 16 professionals, including nurses, nursing technicians and members of the Permanent Education Commission of a public hospital of high complexity of the South region of the country, that seeks to become accredited to become a teaching hospital. Data collection took place between January and May 2016, through focus groups. In the meetings coordinated by the researcher doctoral student, we had the assistance of a research assistant, a doctor, with experience in the development of this technique, who exercised the role of non-participant observer. The groups were conceived as:

Focal group 1 comprised of nursing assistants, unit coordinating nurses and nursing techniques, from four adult care units. The selection of the participants for this group occurred through the technique of snowball among the nursing professionals of the afternoon shift. Thus, initially, the nurse responsible for continuing education were invited, considering the importance of this scope in the discussion of the protocols, which indicated a nurse from the hospitalization units and she suggested another until completing the module of four nurses; the last nurse indicated a nurse technician who, in turn, recommended another, and so on, until completing the module also of four participants of this professional category. Two meetings were held with this group of nine participants, counting the nurse of the Continuing Education Committee.

Focus group 2 formed by members of the Standing Education Commission, personally invited by the researcher. In the same way as the previous group, two meetings have succeeded this group. The main purpose was to discuss the construction of assistance protocols. Five of the 15 committee members at-

tended the first meeting and seven in the second meeting, with three participants from the first meeting and four new members.

Given the partial results of these stages, there was an integrating moment between the focus group participants 1 and 2, nominated as focal group 3. The purpose of the meeting was to reformulate strategies to follow the implementation of care protocols at the study site. A total of 16 professionals participated in the study, nine of them from FG 1 and seven from FG2, as shown in Table 1.

Table 1 - Research participants

Participants	Meeting dates	No Participants
*FG1 - coordinating and nursing nurses + nursing techniques	2016/01/27 (1º)	9
	2016/02/03 (2º)	8
†FG2 - members of the Standing Education Committee	2016/03/10 (1º)	5
	2016/03/15 (2º)	7
‡FG3 – 5 members FG1 + 6 members of FG2	2016/05/09 (Integrative meeting)	11

* Focal group 1 † Focal group 2 ‡ Focal group 3.

The inclusion criterion of the participants in the focus groups consisted in having interest in discussing the proposed theme. The exclusion criteria established were not available to attend the dates and times of the meetings.

As they were different groups, the discussion in group 1 were to argue about the knowledge of the protocols used in the care units and to know the participation of the group in the construction of these protocols. These two themes were discussed at both meetings. In group 2, the most important topic was about how the protocols were being built and under what circumstances decisions were taken. In group 3, the themes were socialized and strategies were established for improvements in the implementation of care protocols.

The information was submitted to the thematic analysis, whose purpose was to discover the nuclei of meaning that make up the communication and with meaning and relevance for the study.[7] Operationally, the software was used Nvivo10 to organize the information, but the analysis was done manually. The research complied with the recommendations contained in Resolution CNS 466/128 and processed in the Brazil Platform under the CAEE number 50337315.6.0000.5347. It was approved by the Research Ethics Committee of the Federal University of Rio Grande do Sul under number 1,348,999. Participants signed a Free and Informed Consent Form, keeping one document and the other with the researchers.

RESULTS AND DISCUSSION

The results were grouped into three thematic categories: the protocols in the midst of the complexity of the organizational context, the protocols in the midst of the work organization in nursing and the permanent education as strategy for the construction of the protocols.

THE PROTOCOLS IN THE MIDST OF THE COMPLEXITY OF THE ORGANIZATIONAL CONTEXT

The hospital initially focused on the creation of standard operating procedures to organize the nursing service, which are common instruments in Nursing and contain the step-by-step actions necessary for the development of a technical activity or procedure. Subsequently, these professionals were dedicated to the construction of protocols, debating in small groups, and updating and implementing them according to the service they demanded the most or, as some participants mentioned, "*those who most needed it*". The following dialog illustrates this condition:

> *– I think the construction of the protocols was by the users 'demand and the professionals' needs, so the situations that we were experiencing and started by the protocol of skin lesions and the PCR, then we had to accelerate a little the construction of the others by the safety issue (creation of the Patient Safety Nucleus) and now all are being adapted by the new model so it is indeed a protocol* (E1, FG 1, Meeting 1, 2016/01/27).

> *- Then, for each protocol, a group of professionals responsible for the elaboration was stipulated, for example: for the protocol of safe surgery an attending nurse and was assigned two more professionals to elaborate it. And so, several commissions of work were formed for this purpose. This is in progress* (E2, FG 1, Encounter 2, 2016/02/03).

The participants highlighted the protocol for attending to cardiorespiratory arrest (CRP) among all the protocols built, the first to be implemented in 2012 and that occurred according to the conception of practice that they consider appropriate: it was written by a commission of professionals of the service of that time and later, socialized and discussed through the theoretical study and simulations made in the own unit of work. Besides to this, participants mentioned protocols for prevention and treatment of skin lesions, aspiration of the airways, transplants and organ donation and Manchester System of risk classification. It was commented by the group:

> *[...] this PCR protocol, I think it was the best because it was put into practice. Simulations were first made on the units with the doll. It was always scheduled, organized with the sector. I think that the last training they did was*

> *much more real, you have to do it. For example: where did the material put pressure on the team as if it were real, in the family as well* (E4, FG 1, Meeting 1, 2016/01/27).

The focus group discussion is the dialectical relationship between concrete and theoretical contexts. By exposing the path and the modus operandi, the debate about the different perspectives of the same context opens up, revealing reality with its contradictions and incompleteness, as is living in society. However, this movement seeks to achieve the best practice and can promote the transformation of the way of caring towards better living conditions and health of the people.[9] In this regard, the established dialogue among professionals is a triggering factor for the changes that may occur in the context of the work.

Again, the protocol for the care of the PCR was highlighted. However, a caveat regarding the period of time to which the participants refer, since not all members of the focus groups worked in the institution when the process of protocol construction began. Therefore, at times, they alluded to what was done and at other times to what was to come, as illustrated in this excerpt from GF 2:

> *The most successful protocol was PCR because we went out of the logic of just bringing information and training. People got involved in the very construction and implementation. I think it was a big win. We realized how much the teams produce knowledge. I think that at the time they participated around 20 people, it was in loco, in the sectors* (MCEP7, FG 2, meeting 2, 2016/03/15).

This process can be understood as a given action that is something that cannot be changed, whose characteristic is the constant movement.[4] Although the PCR protocol was cited as the most outstanding and effective experience among participants, this was not immediately grasped by all the professionals. The explanation for this is that in the hospital work organization, there is not enough time to study for the appropriation of the protocols, requiring health professionals to study outside the working hours and work environment. Also, the service does not have the appropriate number of workers, as indicated in the lines:

> *[...] professionals go into shock, become apprehensive, or know what to do first. [...] in fact, in my sector, it was done once, until I told the girls to take the material home, to study it. [...] when fetching the defibrillator, bring the cart as well* (E1, FG 1, Meeting 1, 2016/01/27).

> *[...] it is the lack of time and make the connections between flows of all sectors to write a normative. In the implementation of the protocols, it is the time, the issue of employee schedules, it does not have enough employees* (E3, GF 1, Meeting 2, 2016/02/03).

It is important to emphasize that, despite the problems attributed to the lack of professionals in the context of the study, there is no systematic application of instruments to assess the degree of dependence of the patients in the nursing care and the consequent non-accomplishment of personnel sizing.[10] Intervening in this complex context is possible if the process of change is dialogic and if there is a relationship between subjects who aim at solving problems, defining common goals, without interfering in the autonomy of each and every one.

By distinguishing the different knowledge from each professional that makes the practice, it faces a complex scenario in which to respect the knowledge of each one and the life trajectories are determining conditions for the critical reflection of reality.[4] In this way, they confront subjectivities, similarities and dissimilarities are identified, opening up a possibility of establishing common projects in the midst of differences. Furthermore, the importance of dialogue as one of the pillars that supports the elaboration and implementation of the protocols is emphasized.

Nursing professionals evaluate the results of some practices by completing forms. They refer to the way of doing, revealing the immediate concern of the team in meeting the needs of the patient, in the act of their production. However, they are not yet systematized to the point of being presented as a management tool, as portrayed in the comments:

> *[...] we have a form that evaluates the outcome of the care. By this care, the team is evaluated and given the feedback of the data. For example, it is known that the pyramidal mattress with cover is not effective, then the cover was removed* (E3, Source: FG 1, Meeting 1, 2016/01/27).

> *Yes, we even have some evaluation data, ah [...] this has improved a bit, but then until you get into management, how are you going to say that? Sometimes, it exposes the weaknesses of nursing* (MCEP7, FG 2, Meeting 2, 2016/03/15).

The ultimate goal of practice assessment is to provide patient care[11]. Such care involves a number of aspects that must be reviewed in practice through daily guidance from the nurse to the team. However, besides to day-to-day orientation, it is envisaged to broaden the focus on lifelong education.[12] Even if it is a difficult and complex challenge, quality must be prioritized by health institutions and their professionals.

The dialogues established in the groups show the imminent need to evaluate the situation at the time of its pro-

duction, that is, to do correctly those actions that had been thought and discussed by the teams, which culminated in the execution of a protocol. Nevertheless, in addition to the urgency to obtain the result, professionals are also valued to change their practice, improve interpersonal relationships and obtain better results for patients.[13] This movement of reflection and action, even which timidly occurs when subjects are in transition from a naive consciousness to a critical consciousness.[4]

The protocols in the midst of work organization in nursing

When highlighting the organization of work as a theme that generated uneasiness in the dialogue of groups, it is important that professionals reflect on the continuity of the act, problematizing the contexts where work occurs.

The care protocols aim to guide the health care provided by nursing. The absence of protocols that standardize health activities and services hinder to organize care practices.[9]

In nursing, managing and administration in such complexity, besides being a private activity of the nurse, requires knowledge, skills and attitudes whose development is possible when they realize that these dimensions are inseparable and are embedded in regular training, in the institutional structure model, in the technologies available and in the characteristics and involvement of professionals with the organization of the service.[14] These characteristics converge to a flexible and dialogical way of being and make ideal for a health institution that lives up to its mission.

In this direction, it is pertinent to clarify that the hospital structure is formal, complex, composed of several departments and, for the most part, used communication through manuals, job descriptions, organizational charts, rules, and regulations. This modality is predominant today,[15] so the context referred in the literature is similar to this study.

When discussing the organization of work in general, internal difficulties were revealed, which refer to the reception of nursing professionals and the lack of time to manage the unit and perform care to the patient simultaneously. In the reception, the difficulties of the institution were evident in accompanying and orienting the new professional until its adaptation to the work and appropriation of the organizational culture. This was demonstrated by the emphasis on nurses' heads, coordinators and nursing technicians who spoke at the meetings:

> *[...] first, it is explained the operation of the hospital, what is currently the integration, in which some people explain their sectors, to those who are newly admitted, but sometimes happens to go straight to the sector, I think which is not enough to give a sense of the hospital* (E1, FF 1, Meeting 1, 2016/01/27).

> *I already got two female employees at the same time and I gave things easier for them that day, so as not to delay my service and not frighten. One has to shake hands with the other. And at the end of the week, there is only one nurse on the floor, how is she going to welcome the employee, provide assistance and management, does not give* (TE2, FG 1, Meeting 2, 2016/02/03).

When entering as a hospital employee, the health professional needs to be welcomed since he often faces a complex and adverse scenario and unaware of the institution's culture, its flows, physical area and people. In this sense, the reception of the professional by the institution is not detached from the reception given to patients.[16] The presentation is among the ways of welcoming the new professionals, in a dialogical way, of the protocols that the institution possesses so through the operation of this technology, they feel more integrated and secure with the organizational aspects of the service.

In the midst of the hospital environment, there is a consensus and dissension about the issue of people management, illustrated in the focus group discussions:

> *In the past six months, I believe about five nurses and three technicians have left my sector.*

> *[...] Usually we do not present them, we do not have the time. I think they should be presented before sending the employee to the sector. Explain some routines, the new person is there, is accompanied by the technicians for 2 or 3 days, the girls are very collaborative* (E1, FG 1, Meeting 1, 2016/01/27).

One aspect mentioned as an obstacle to the construction and implementation of the protocols was the high turnover of professionals in the hospital sectors, unlike other areas of knowledge and the labor market, where staff turnover can be seen as an important dynamics of oxygenation of the organizations. In nursing, this fact may reflect the discontinuity of the services, interfering in the interpersonal relationship and in the organization of the teams.[17]

Besides the high turnover of workers in the health sectors, the lack of time due to the high workload was perceived by professionals as an obstacle to the construction of protocols. The excessive workload that translates into lack of time to perform the functions of management and care is a deadlock for nurses.[18] In daily practice, the nurse simultaneously exercises care and management, which causes overload of work of the nursing team, compromising the quality of the care.[19] It is inferred that part of the problem attributed to the lack of time in the context of the study stems from the multiple functions

that the nurse develops, such as care practice, human and material resources management, leadership, assistance planning, staff training, and evaluation of nursing care actions. The following statement makes explicit the assertions:

> – *[...] yes, the lack of time and make the connections between flows of all sectors to write a normative. In the implementation of protocols is the time, the issue of employee schedules, it does not have enough employees, take it out of the units is complicated* (E3, FG 1, Meeting 2, 2016/02/03).

Also, many nurses judge the actions of managing and caring as different and value care when it is provided by the patient.[20] Among the explanations for such perception, the conceptions of nursing management and care management from the proposed model by Florence Nightingale emerge, and also of administrative theories, which have strongly influenced nursing as a profession.[20]

Intervening in this complex scenario is possible if the process of change is dialogic and if there is a relationship between subjects who seek to solve problems, defining common goals without interfering in the autonomy of each and every one. In this regard, education at work is an important strategy for understanding the context and intervening in it with knowledge and responsibility.

Continuing education as a strategy for the construction of protocols

One aspect considered as a strategy for the construction of care protocols was the permanent education developed by the hospital. The investment in vocational training has been a current topic of discussion, given the speed of technological development and deficiencies in Brazilian education, which directly affect nursing practice and health. Training needs to be continued because the development of managerial skills and competencies of nurses can not only focus on undergraduate work but also have continuity in professional life as a personal responsibility, as well as of training institutions and employers, forming a permanent network of updating and production of knowledge.[21]

Work education as a means to build and implement the protocols emerged due to difficulties in vocational training, which were repeatedly debated and characterized by focus group participants as an institutional problem. These deficiencies occur at the technical level and also at the undergraduate level, which worries managers. And it is urgent to establish training strategies at work, as it was verbalized:

> – *[...] I think that what is being said, the deficiency of technical-scientific knowledge, the clinical part and the performance, I realize in recent years that it is evolving very fast. The demand increases, the complexity of care also, however, develop that capacity in knowledge, in the skills to deal with things. People's skills do not go along. This is happening now and to make education within it all is more complex still* (MCEP 7, FG 2, Meeting 1, 2016/03/10).

> – *[...] another great difficulty is the technical training, I am in the ICU, I hope to receive a technician who knows at least what is an adrenaline, but he arrives here without knowing what a dipyrone is, that is our greatest difficulty. So we're drying ice, we're running after it and the demand is there, but you do not have the right professional. This is a training problem and you have to repeat the orientation until you match the employee. Yes, too, but at the higher level the disability is more particular, you observe one or another student who has disability, is not general [...]* (MCEP9, FG 2, Meeting 2, 2016/03/15).

Also, in the focus group discussions, lifelong education emerged as a strategy to re-signify the nursing care practice, aiming to implement the protocols with more effectiveness and contribute to the professional improvement, enabling the organizational learning, including the other hospital areas. The dialogue on this theme was pointed out by the participants in the integrative meeting:

> – *[...] I defend this idea of lifelong education, as an important possibility to improve our education. We can already see the universities that are in here, working in this direction* (E3, FG 3, Integrative Meeting, 2016/05/09).

> – *[...] for me, this is the biggest node, being able to structure the education sector within this demand of the hospital and the universities, the complexity, the increase in the number of people, and the expansion of the service network. We had a moment of urgencies and emergencies, so there are many adaptation movements happening at the same time and structuring the permanent education is a challenge and the protocols are very related to this* (MCEP 10, Source: FG 3, Integrative Meeting, 2016/05/09).

In this way, raising awareness to understand the environment and taking responsibility for best practice seems to be a motivation for transforming the context. Considering the process of awareness, it begins in the unveiling of reality, but it is not enough to know and reflect on reality for the transformation to occur.4 In addition to reflection, it is necessary to intervene in the context, in a constant movement of learning and dialogue, establishing feedback, in order to build and rebuild practices.

Continuing education can also be perceived as learning at work and occurs through problematization and active methodologies, with the aim of transforming practices into something significant for the organization and for the professionals.[22,23] It has as its starting point the reality of the workers, without highlighting of the health needs of the community and the objectives of the organization.

Nurses´ autonomy in the development of practices emerged in the debate because the nurses participating in the focus group believe that they have more autonomy over the nursing team, given that they have knowledge about the scope and responsibility of team coordination. Regarding the work with the other teams, the autonomy is relative, since each professional has different responsibilities in the acts of assistance that are shared.

Also, the purpose of the practice of PE is to generate the autonomy of nurses in the development of competencies for their care practices. In the elaboration of assistance protocols, one must go beyond a normative proposition, often embedded. It seeks to build a flexible technology to the innovations and demands in the health area. In this logic, it would be necessary for nurses to develop autonomy by deconstructing their instruments of work, as they become aware of the context in which they work, identify consensus and dissent, respect differences and are free to act in accordance with the precepts ethical and legal issues that govern society.

CONCLUSION

The complexity of the nursing work in the hospital environment demands to understand general aspects of administration and the organization of work in health, as well as to increase the skills, abilities, and attitudes to develop a safe practice. The construction of protocols is one of the activities carried out by professionals, among other demands, but it is extremely important, especially for patient safety. The elaboration of this work technology occurs through theoretical studies, peer dialogues, and practices, as simulations of its implementation in health care. Among the obstacles to the construction and appropriation of protocols by professionals, there is the lack of time due to the high demand for care that the hospital receives. Also, the organization of the work of the hospital service does not corroborate the elaboration and effective implementation of the protocols, since there is high personnel turnover and inadequate reception of the new workers in the sectors.

At first, the anchoring in Freire's assumptions was controversial, since the determination of norms and standards is strongly linked to a hierarchical management model, composed of the division of labor and centered on the task. This hierarchical mode has greatly influenced work organizations, including health services, with repercussions also in the field where the study took place.

However, in the dialectical and emancipatory perspective, recognizing the contradictory and deliberating on conflicting issues seems to be adequate to the complex scope of a hospital institution. The adoption of this theoretical reference mobilized the professionals to express their opinion about their work scenario and about the difficulties found and also to reveal the successful experiences that occur in the daily work.

The problems emerged in the discussions stem from staffing, management, high demand and lack of time to manage and care. Without ever exempting the institution's responsibilities regarding the training of professionals, it should be noted that the individual contribution to the success of the implementation of the protocols has never been discussed, which may lead one to believe that problem solving is the responsibility of only the management, the manager or both.

The permanent education was presented as a potential aspect of the professional formation and reaffirmation of the internal processes and technical conducts. The changes in the health area signal the permanent education to adapt the formation of the worker to the reality and the use of products and services, such as the introduction and implementation of assistance protocols.

Regarding the limitations of the research, the focus of the approach in nursing professionals and in the Permanent Education Commission of the hospital is pointed out. In the face of the literature gaps, this study is a trigger for future research, in which the focus of the discussions can be broadened, encouraging the adherence of other health workers, especially those who are part of the multi-professional team and who, directly or indirectly, involved in the construction and implementation of care protocols.

It is considered that the results of this research are an important source of reflection for nursing professionals, health professionals, and managers, understanding that the moment by which the institution passes is unique to establish new flows, new behaviors and foster the development of culture through the implementation of assistance protocols. It is important to emphasize the importance of studies that enable to reflect on nursing work, as well as the use of technologies that allow professional autonomy and legitimacy of actions.

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REFERENCES

1. Quadrado ERS, Tronchin, DMR. Evaluation of the identification protocol for newborns in a private hospital. Rev Latino-Am Enferm. 2012[cited 2017 Jan 16];20(4):659-67. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-11692012000400005
2. Cruz FOAM, Ferreira EB, Vasques CI, Mata LRF, Reis PED. Validation of an educative manual for patients with head and neck cancer submitted to radiation therapy. Rev Latino-Am Enferm. 2016[cited 2016 Dec 15];24:e2706. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-11692016000100337
3. Ferraz F. Contexto e processo de desenvolvimento das comissões permanentes de integração ensino serviço: perspectiva dos sujeitos sociais pautada na concepção dialógica de Freire. Interface. 2012[cited 2017 Feb 05];16(42):847-51.Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1414-32832012000300021
4. Freire P. Pedagogia do oprimido. Rio de janeiro: Paz e Terra; 1987. [cited 2016 Dec 12]. Available from: http://www.dhnet.org.br/direitos/militantes/paulofreire/paulo_freire_pedagogia_do_oprimido.pdf
5. Franco TB, Merhy EE. Cartografias do trabalho e cuidado em saúde. Tempus Actas Saúde Coletiva. 2012[cited 2017 Jan 16];6(2):151-63. Available from: http://www.tempus.unb.br/index.php/tempus/article/view/1120/1034
6. Carvalho BG, Peduzzi M, Mandú ENT. Work and Inter-subjectivity: a theoretical reflection on its dialectics in the field of health and nursing. Rev Latino-Am Enferm. 2014[cited 2017 Jan 16];20(1):19-26. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-11692012000100004
7. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 14ª ed. São Paulo: Hucitec; 2014.
8. Ministério da Saúde (BR). Conselho Nacional de Saúde. Resolução 466/12**.** Aprova as diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos. Brasília: MS; 2012. [cited 2017 Jan 16]. Available from: http://conselho.saude.gov.br/resolucoes/2012/Reso466.pdf
9. Erdtmann ALE, Mello ALSF, Andrade SR, Drago LC. Organization of care practices in the health network. OBJN. 2011[cited 2017 Jan 02];10(1). Available from: http://www.objnursing.uff.br/index.php/nursing/article/view/j.1676-4285.2011.3220.1
10. Lorenzini E, Deckmann LR, Costa TC, Silva EF. Dimensioning of nursing staff: an integrative review. Ciênc Cuid Saúde. 2014[cited 2017 Jan 02];13(1):66-72. Available from: http://periodicos.uem.br/ojs/index.php/CiencCuidSaude/article/view/15959
11. Caldana G, Gabriel CS, Rocha FL R, Bernardes A, Françolin L, Costa DB. Evaluating the quality of nursing care at a private hospital. Rev Eletrônica Enferm. 2013[cited 2017 Jan 02];15(4):915-22. Available from: https://www.fen.ufg.br/fen_revista/v15/n4/v15n4a08.htm
12. Carraro TE, Gelbcke FL, Sebold LF, Kempfer SS, Zapelini MC, Waterkemper R. A biossegurança e segurança do paciente na visão de acadêmicos de enfermagem. Rev Gaúcha Enferm. 2012[cited 2017 Jan 16];33(3):14-9. Available from: http://www.scielo.br/pdf/rgenf/v33n3/02.pdf
13. Campos GWS. A mediação entre conhecimento e práticas sociais: a racionalidade da tecnologia leve, da práxi e da arte. Ciênc Saúde Coletiva. 2011[cited 2017 Jan 02];16(7):3033-40. Available from: http://www.scielo.br/pdf/csc/v16n7/02.pdf
14. Rothbarth S, Wolff LDG, Peres AM**.** Developing nursing managerial competencies from the perspective of nursing administration professor. Texto Contexto Enferm. 2009[cited 2017 Jan 16];18(2):321-9. Available from: http://www.scielo.br/pdf/tce/v18n2/16.pdf
15. Lorenzetti J, Oro J, Matos E, Gelbcke FL. Work organization in hospital nursing: literature review approach. Texto Contexto Enferm. 2014[cited 2017 Jan 02];23(4):1104-12. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-07072014000401104
16. Nóbrega JAS, Assis CML, Farias ES, Grimberg SKCR. Entraves no acolhimento por enfermeiros de um hospital público. Rev Bras Ciênc Saúde. 2015[cited 2017 Jan 02];19(4):299-306. Available from: http://periodicos.ufpb.br/index.php/rbcs/article/viewFile/19857/15105
17. Pagno MS, Faveri F. Rotatividade da equipe de enfermagem: análise dos fatores relacionados. Rev Adm Hosp Inov Saúde. 2014[cited 2017 Jan 02];11(2):136-42. Available from: http://revistas.face.ufmg.br/index.php/rahis/article/view/2061/1360
18. Dall'agnol CM, Moura GMSS, Magalhães AMM, Falk MR, Riboldi CO, Oliveira OP. Motivations, contradictions and ambiguities in the leadership of nurses in managerial positions in a university hospital. Rev Latino-Am Enferm. 2013[cited 2017 Jan 02];21(5). Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-11692013000501172
19. Silva EC, Silva KL, Collet N, Nobrega MML, Marques DKA. Management of the time of nursing actions in hospitalized child and adolescent care. J Nurs UFPE online. 2014[cited 2017 Jan 02];8(11):3920-8. Available from: http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/view/5871/pdf_6545
20. Santos JLG, Pestana A, Guerreiro P, Meireles BSH, Erdamnn AL. Práticas de enfermeiros na gerência do cuidado em enfermagem e saúde: revisão integrativa. Rev Bras Enferm. 2013[cited 2017 Jan 16];66(2):257-63. Available from: http://search.proquest.com/openview/216a1e83dfa94f02d5975e61460ff90f/1?pq-origsite=gscholar&cbl=2032618
21. Sade PMC, Peres AM, Wolff LDG. The formation of the managerial competencies of nurses: an integrative review. J Nurs UFPE online. 2014[cited 2017 Jan 02];8(6):1739-45. Available from: https://periodicos.ufpe.br/revistas/revistaenfermagem/article/view/13649
22. Vendruscolo C, Trindade L, Krauzer IM, Prado ML. The insertion of the university in the quadrilateral of the permanent education in health: report of experience. Texto Contexto Enferm. 2016[cited 2017 Jan 02];25(1):1-7. Available from: http://www.scielo.br/pdf/tce/v25n1/0104-0707-tce-25-01-2530013.pdf
23. Fagundes NC, Rangel AGC, Carneiro TM. Educação permanente em saúde no contexto do trabalho da enfermeira. Rev Enferm UERJ. 2016[cited 2017 Jan 02];24(1):1-6. Available from: http://www.epublicacoes.uerj.br/index.php/enfermagemuerj/article/view/11349