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ORIGINAL ARTICLE

PERCEPTION OF ASSISTANCE NURSES ABOUT THE HEALTH EDUCATION PROCESS[1]

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ABSTRACT

Objective: To apprehend the perception of assistance nurses about the process of health education for the family and user victim of stroke during hospitalization. **Method**: Descriptive and exploratory study with a qualitative approach, carried out in the first half of 2021, through a semi-structured interview with 18 assistance nurses working in medical clinic units of three university hospitals in southern Brazil, recruited with the aid of the non-probabilistic sampling technique – Snowball – and use of Content Analysis to interpret the findings. **Results:** The facilitators for the development of the educational process pointed out were: the presence of a multidisciplinary team; the very characteristic of institutions such as university hospitals; the presence of protocols and monthly meetings; and family members interested in learning. The difficulties involved: the lack of integration and communication between the members of the multidisciplinary team; didactic materials and adequate space; work overload; excessive bureaucracy; overcrowding of the unit; and deficit of workers. **Final considerations:** The facilitators and difficulties pointed out allow us to think about strategies that may contribute to health education in the context of hospitalization, considering work activities in medical clinic units.

Keywords: Health Education. Nursing. Hospitals. Stroke.

INTRODUCTION

The actions of health education aim to develop the process of autonomy and responsibilities in the individual and/or family that are part of a group/community, and are based on horizontal relationships in the dialogicity between professionals of the multidisciplinary team, patients and family, in search of behavior change, co-responsibility and improvement of the conditions of health problems[1]. However, not all educational approaches to health use the same educational theory or methodology for its realization. The educational practice of nurses often meets the concept of traditional education, where professionals use vertical teaching methods, reinforcing prescriptive behaviors and controlling positions, as opposed to a problematizing methodology that would be suitable for the teaching-learning process of the patients and family, as these have, in their essence, the change of behavior through awareness[2].

The educational practice developed in hospital spaces becomes a challenge because, as a reference for tertiary care, they are seen as places of rehabilitation and not disease prevention, such as primary care, to which health education studies are mostly associated. The biomedical model of care focuses on curing diseases, to the detriment of health education processes, necessary to prevent new diseases and learnings from users and family

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members about care aimed at the conditions imposed by the diseases[3].

From this perspective, it is understood that it is necessary to develop a health education based on the search for critical awareness, through a problematizing and dialogical education between nurses and patient/family, in order to break with the verticalization of the relations of traditional education[4]. Thus, health education actions should be developed by nurses and nursing staff with the support of the multidisciplinary team, with a view to the autonomy of the person, in a horizontal way, in the search for more critical, reflective individuals and, mainly, protagonists of the management of their health/disease process[5].

Hospital teams are fundamental for the care of people with Stroke and their families, especially the nursing team, which directly provides nursing care. Annually, in the United States, almost 800,000 people suffer a stroke, 87% of which are ischemic in nature and 13% hemorrhagic. It is estimated that 50% of survivors remain with some disability, especially those related to mobility[6].

According to the World Stroke Organization's 2022 Annual Report, this disease is the second leading cause of death in the world. One in four people over the age of 25 will experience a lifelong stroke and 90% of all strokes are linked to 10 modifiable risk factors. In addition, 101 million people are living with the consequences of stroke[7].

Regarding the nursing care developed in the hospital, during the hospitalization period of the stroke patients, a methodological study carried out in southern Brazil, which sought to build a nursing care protocol with educational interventions for caregivers of post-stroke patients, pointed out, among the needs of approaches in the protocol, the administration, storage, adverse effects on the use of medications, and also demonstrated the need for health education for caregivers/family members regarding positioning, transfer, activities of daily living such as bathing, dressing, and the reduction of the risk of pressure injuries[8].

In this perspective, the practice of nurses stands out, which encompasses managerial, administrative, investigative and health education functions in the most different contexts of action, however, studies on health education are predominantly associated with a practice of Primary Health Care (PHC)[9]. However, health education activities are fundamental for the recovery and readaptation of patients and this should also be present in the contexts of hospitalization[8].

Thus, it is necessary that the health education actions developed by nurses aimed at the users and family to face the possible limitations imposed by stroke start at hospital admission, either at the bedside or in collective spaces in the units, and that they guarantee listening to the wishes of users and family, mediated by horizontal relationships permeated by cooperation, trust and responsibility, in order to prepare them for home care[10].

In addition to the role of nurses in educational practices, the role of the multidisciplinary team in the hospital context is paramount in health education actions, through practices with dialogical and emancipatory approaches that reinforce the autonomy of patients, family and caregivers and provide a preparation for hospital discharge capable of minimizing the desires and difficulties of post-discharge care[11].

Based on these assumptions, the guiding questions were: What is the perception of assistance nurses about the process of health education for the family and users victims of stroke during hospitalization? What are the facilitators and difficulties for the development of this process?

Therefore, the objective was to apprehend the perception of assistance nurses about the process of health education for the family and users victims of stroke during hospitalization.

METHODOLOGY

A qualitative, descriptive and exploratory study was carried out in three University Hospitals (UHs) in Rio Grande do Sul, which have a current contract with the Brazilian Hospital Services Company. The UH located in the city of Santa Maria has two medical clinic units, totaling 118 beds and 20 nurses. Pelotas has a medical clinic unit with 30 beds and 15 nurses; and the UH of Rio Grande has 49

medical clinic beds and 16 active nurses. In total, there are 197 beds and 51 nurses.

Data were collected through semi-structured interviews with nurses in clinical units. The first search strategy of the participants was by e-mail invitation sent to the 51 nurses, however, due to the low adherence we opted for the recruitment of the participants through the Snowball technique, which uses a network of references[12]. This is a form of non-probabilistic sampling used in social research, in which the initial participants of the study indicate new participants who, in turn, indicate other participants and, thus, successively, until the number of predicted components and/or data saturation is completed.

Thus, the second search strategy for the participants was by invitation by telephone, with the nurse who was on duty at the medical clinic of each hospital, on the days and times of the calls, and/or those who had answered the e-mail. Thus, the first nurses of the medical clinic units of each hospital who agreed to participate in the research after telephone contact were considered the seeds of the study. Subsequently, these indicated the next participants, called fruits. Thus, one seed and five fruits from each hospital were considered, that is, six nurses from each hospital, totaling 18 participants in the research. The request for indication of each participant followed the inclusion criterion: to exercise the profession of care nurse in these units for at least six months; and the exclusion criterion: to be on vacation and/or away from care activities.

The semi-structured interviews were conducted in the first half of 2021. Due to the global scenario of restrictions imposed by the Coronavirus-19 pandemic, during the research period, it was decided to develop the entire data collection stage virtually. Professionals who agreed to participate in the research were scheduled to be interviewed, according to the availability of each participant, via video call. Of the 18 participants, only one chose to do the interview through the Google Meet platform and the others preferred the video call of the WhatsApp application. There was no refusal to participate by the nurses who were indicated.

During the interviews, a script built specifically for this study was used, containing closed questions related to sociodemographic and functional data and open questions, which were recorded and later transcribed. The guiding questions of the study were: What is the perception of assistance nurses about the process of health education for the family and users victim of stroke during hospitalization? What are the facilitators and difficulties for the development of this process? Thus, the open questions of the interview included questions about the difficulties and facilitators found by nurses to develop the educational process for the family and the users victims of stroke during hospitalization.

For data reliability, pilot tests were carried out, using the interview script, initially, with an assistant nurse and member of the research group. And, subsequently, the first two interviews with the participants were considered pilot tests. However, as there was no need for *corpus* changes, they were included in the study.

After transcribing the interviews, the data were submitted to Content Analysis [13], which comprises three phases. In the pre-analysis, we sought to make the process operational and systematize the initial ideas, through floating reading, with the choice of documents, allowing the constitution of the *corpus* and the formulation of assumptions and objectives. The exploration of the material made it possible to encode the data, through previously established rule functions. And the treatment of the results provided the opportunity to transform the raw data into expressive data appropriate for the analysis. At this stage, the coding was carried out, where the raw data were transformed into units, which allowed an accurate description of the relevant contents.

Resolutions number 466/12 and 510/16 of CONEP/MH and their precepts regarding ethics in research involving human beings were respected, and data collection began after release from the Teaching and Research Managements (TRMs) of the selected hospitals and approval of the project by the Research Ethics Committee of the Federal University of Rio Grande, under CAAE number: 39733320.6.0000.5324.

The participants received and virtually signed the Informed Consent Form, which was

delivered in two copies, conditioning their voluntary participation and the confidentiality of the information. The identification by codes guaranteed the confidentiality of the participants: letter N for nurse, followed by the initial of each city where the UH is located (S for Santa Maria; P for Pelotas and R for Rio Grande), followed by cardinal numbers, according to the order of each interview (NP1; NS3; NR2...).

RESULTS

The 18 nurses participating in the research had a mean age of 45 years. Of these, 15 (83.3%) were female; 12 (66.6%) had less than three years of experience in a medical clinic. As for the time since graduation, 11 (61.1%) had between nine and 15 years of graduation and eight (44.4%) had attended some type of *Latu Sensu* specialization.

The data analyzed allowed the construction of two categories, described below.

Facilitators for the development of the educational process

Regarding the facilitators found to carry out health education, the data point to the presence of a multidisciplinary team as a facilitating aspect of the educational process and the very characteristic of institutions such as University Hospitals. They also have protocols and meetings that help in the educational process. In addition, the disposition of the nursing team also emerges as an important element.

> The support of the multidisciplinary team is essential, because nursing alone does not achieve anything [...] The multiprofessional team is one of the richest things you have there to be able to develop the activities. (NS1)

> A facilitator is precisely in relation to the multidisciplinary team, if the physician makes a request to the psychologist, I will quickly have access to the psychologist [...] there is the multidisciplinary residence [...] they are a very positive point there, as they give a great help. (NR4)

> [...] we have other professionals and residents, they are also in this teaching-learning process, they are learning, at the same time they are educating [...] everyone is involved in this atmosphere, of passing, guiding, teaching, learning [...] (NR3)

> There are our protocols to follow according to the pathology [...] We have meetings with the team every month and one of the agendas we have is about health education with the patient. (NR1)

> I see a facilitator in the nursing team, they are a very willing team, they help [...] (NP2)

Another aspect that favors the health education process is the interest of users and family members. According to the interviewees, most of the time, they are interested and willing to learn about a certain procedure/care or about the evolution of the patient's health status.

> Regarding the facilitator, I see the interaction that the family and the patients have in seeking to know, interact, with the nurses, it is great [...] the staff is lacking information, so when you talk, they really cooperate with you, interact a lot. This I see as a positive factor. (NR5)

> The family is a facilitator, because there are patients who stay for a very considerable time, and the family always as an adjunct to this process [...] the family is much more a positive point, participatory, questioning, interested. (NR6)

Difficulties in the development of the educational process

Aspects that tend to hinder the success of educational actions in the hospital context are related to the lack of integration and communication among workers in the multidisciplinary team.

> Regarding the multidisciplinary team, I see that integration is lacking. There is no interaction, it is each one acting on their own [...] this is a great difficulty, it is all fragmented. (NP2)

> [...] the lack of communication, communication is not effective with the multidisciplinary team, which I believe is the biggest problem [...] (NR3)

> The difficulty is the failure in communication, one does not tell the other what he did, or does not take notes, in the evolutions. Or I say

> something and the other professional says something else, I think, this lack of cohesion in the information, this makes it difficult [...] (NS2)

> There are difficulties in relation to the nursing team, because here we are very robotic, arriving, administering the medication, doing the things and talking little, sometimes we do not allocate more time to do HE (health education) [...] (NP4)

Other reports point to the form of "robotized" nursing action as a difficulty to carry out health education.

> I see a great difficulty with the nursing technical team, the team there is very robotic, it is very difficult, it is just the basics and they do not want to be part of this process [...] (NP6)

In addition, nurses pointed out as difficulties to carry out the educational process the lack of didactic materials and adequate and specific space for these activities.

> The difficulties I see, we do not have any type of teaching material to do health education [...] the lack of a suitable place to do this [...] (NR1)

> [...] maybe if we had a classroom in the unit, if it was a small room, even for us to guide some care... instead of saying everything in front of the patient [...] so, a difficulty is the lack of space for this [...] (NS1)

Other difficulties brought by the participants refer to the lack of time related to work overload, excessive bureaucracy and overcrowding in the units, and a deficit of workers.

> How difficult I see the lack of time, the overload. (NR1)

> [...] the dimensioning of nurses is a difficulty; it is a unit that has many patients, overcrowding [...] (NR3)

> [...] when the professional is overloads, it already leaves him unable to do some things and, in this case, health education is one of them. (NR5)

> Another difficulty is bureaucracy; it's not that it isn't necessary, but everything could be easier. [...] (NP1)

DISCUSSION

The multidisciplinary team was considered by most participants to be a fundamental link in health care. In the hospital context, its performance, when well structured, is able to provide a unique understanding of the users and family, assuring a humanized care, based on horizontal relationships and effective connections that help in the recovery and promotion of health[14].

In addition, the multidisciplinary team was mentioned by the participants as a facilitating factor for health education in the hospital environment. It is verified that, when the educational process is successful in the care practice, it cooperates for a positive relationship between patients and multiprofessional team. However, it is necessary to understand that, for its feasibility in practice, organizational aspects of the hospital service are necessary, not depending only on the team and patients[15].

A study that aimed to analyze the integrated practice of the physical therapist, as a member of the multidisciplinary team in the Intensive Care Unit, verified that the main impacts from the multidisciplinary integration were: improvement in communication, effectiveness of care and reduction of complications[16]. Similarly, the research participants reported that the support of the multiprofessional team is configured in exchanges of knowledge between professionals.

In this segment, it is understood that health education carried out collaboratively and maintaining horizontal relationships between the multidisciplinary team, patients and family members is capable of overcoming the weaknesses that prevail in the biomedical model of care and conditioning a problematizing educational process, which awakens the critical sense for more conscious decision-making about self-care and post-discharge rehabilitation.[4]

As reported by the participants of this research, although the work of the multidisciplinary team generally adds positively to the care provided by nurses, some also mentioned gaps that hindered their work with the multidisciplinary team.

Integrative review research that investigated the importance of the multidisciplinary team in

patient safety meets the data pointed out by the participants, as the results showed that, among the difficulties encountered in the performance of the team, is the fragmentation of care influenced by ineffective communication between the team, in addition to the hierarchy between the professions that, consequently, interferes with the quality of care provided to the users and family[17].

The participants pointed out that the existence of communication failures among the multidisciplinary team is one of the points of difficulty to develop health education. This aspect, in addition to health education, can end up interfering with the quality of care and patient safety, as they depend on effective communication between team professionals, as well as with patients and their families[18].

The results reveal that the presence of a willing and integrated multidisciplinary team facilitates the development of the educational process, because if the multidisciplinary team is not integrated, does not communicate and is overloaded, educational processes are unlikely to take place. From this perspective, it is noteworthy that the teaching-learning process on health education is inherent to care and should be inserted in the research, and not only worked in professional training. However, for this process to occur properly in undergraduate nursing, it is important for teachers to understand how to work in a dialogical way to develop students' competencies and skills for health education[19]. By addressing these aspects since graduation in Nursing, it is expected that future nurses, members of multiprofessional teams, will be more present and willing for this integration.

The participants emphasized the importance of the presence of the family members in the hospital context of stroke patients and considered it as facilitators to develop the health education process, because, in their perception, they are questioners and interested during the procedure. International research legitimizes the data obtained in this study, by pointing out similar results in investigations carried out in China with family members of users affected by stroke on health education for family caregivers, and by demonstrating that the family is interested and participatory, with regard to learning to care for their families after hospital discharge[20].

Corroborating this, a qualitative research carried out with nurses in the countryside of São Paulo pointed out that the presence of the family member during hospitalization favors the patient's recovery and allows the nurse to develop health education actions that will contribute to the recovery and continuity of care at home[21].

On the other hand, some nurses reported the lack of interest of family members regarding health education to develop care, pointing to it as a difficulty in carrying out the educational process, and this factor may be related to the denial arising from the new health condition of the user.

In addition, nurses considered work overload, associated with excessive bureaucracy and lack of human resources as difficulties for health education in the hospital context. In this same context, hospital infrastructure was also mentioned by the participants as a factor hindering health education. Corroborating this, a research with nurses from a public hospital in São Paulo found that the precariousness of hospital infrastructure, as well as the scarcity of physical resources, hinders the work of nurses[22].

The difficulties encountered may be reflections of a training and practice still based on the biomedical/curative model, based on the Cartesian view that fragments the body and mind, disregarding social, psychological and environmental aspects that are also involved in the process of becoming ill. Thus, thinking about the training and practice of nurses for the process of health education for the family and user victim of stroke during hospitalization is to reflect on the predominance of this hegemonic model of training and how to move forward to overcome such limitations.

It is essential that nurses have knowledge and technical-scientific practices to carry out nursing care in view of the implications of stroke for victims and their families. However, it is necessary to advance in the practice that values effective and sensitive communication; integration between teams, users and families; less robotic and more humane performance;

space for creativity and construction of teaching materials that help educational processes; adequate sizing of teams so as not to overload work; as well as the reduction of bureaucracy in activities.

In this sense, it is worth highlighting that the "Paulo Freire Method" brings possibilities for thinking about the educational process, including in the hospital context, for stroke victims and their families, but requires nurses to understand that it is necessary to talk with people and not to people. Furthermore, it is necessary to overcome the idea that learning is a fixed factor and consider it as transitory, learning and relearning, creating and recreating from interactions between the multidisciplinary team, family members and stroke victims, considering their particularities and life contexts, which requires availability to be together and with each other.

As for the limitations of the study, it is noteworthy that, due to the COVID-19 pandemic, the interviews had to take place virtually and the intention, initially, was that they would take place in person, being able to provide greater proximity to the participants and their work contexts.

FINAL CONSIDERATIONS

It was possible to describe the facilitators and difficulties found by nurses regarding the performance of health education in the context of hospitalization, considering their work activities in medical clinic units, and discuss them nationally and internationally with authors who achieved similar or different results. Even working in different university hospitals, the difficulties and facilitators for health education were similar.

Among the facilitators found, multiprofessional work stands out. When this happens in an integrated way and with good communication, it favors the exchange and sharing of knowledge, which directly reflects on the rehabilitation process of patients and the possibility of developing a more horizontal and dialogical health education among all those involved in this process.

Regarding the difficulties encountered, it is suggested that hospital institutions seek to improve the integration and communication of workers in multiprofessional teams. In addition, provide spaces and teaching materials to strengthen health education. It is suggested that the permanent education centers of these institutions offer nurses and multidisciplinary staff conditions to develop the educational dimension, making it possible to reflect on their way of thinking and acting as educators and understand that teaching does not rest on the action of knowledge transfer, but on the construction of knowledge that enables awareness, legitimizing an emancipatory and transformative health education.

PERCEPÇÃO DE ENFERMEIROS ASSISTENCIAIS SOBRE O PROCESSO DE EDUCAÇÃO EM SAÚDE

RESUMO

Objetivo: Apreender a percepção de enfermeiros assistenciais sobre o processo de educação em saúde para a família e usuário vítima de acidente vascular cerebral durante a internação hospitalar. **Método**: Estudo descritivo e exploratório com abordagem qualitativa, realizado no primeiro semestre de 2021, mediante entrevista semiestruturada com 18 enfermeiros assistenciais atuantes em unidades de clínica médica de três hospitais universitários do Sul do Brasil, recrutados com auxílio da técnica de amostragem não probabilística – *Snowball* – e utilização da Análise de Conteúdo para interpretação dos achados. **Resultados:** As facilidades para o desenvolvimento do processo educativo apontadas foram: presença de equipe multiprofissional; a própria característica das instituições como hospitais universitários; a presença de protocolos e reuniões mensais; e familiares interessados em aprender. Já as dificuldades envolveram: a falta de integração e comunicação entre os membros da equipe multiprofissional; de materiais didáticos e espaço adequado; sobrecarga de trabalho; excesso de burocracia; superlotação da unidade; e déficit de trabalhadores. **Considerações finais:** As facilidades e dificuldades apontadas permitem pensar estratégias que poderão contribuir na educação em saúde no contexto de internação hospitalar, considerando as atividades laborais em unidades de clínica médica.

Palavras-chave: Educação em Saúde. Enfermagem. Hospitais. Acidente Vascular Cerebral.

PERCEPCIÓN DE LOS ENFERMEROS ASISTENCIALES SOBRE EL PROCESO DE EDUCACIÓN EN SALUD EN CONTEXTO HOSPITALARIO

RESUMEN

Objetivo: comprender la percepción de enfermeros asistenciales sobre el proceso de educación en salud para la familia y usuario víctima de accidente cerebrovascular durante la hospitalización. **Método**: estudio descriptivo y exploratorio con enfoque cualitativo, realizado en el primer semestre de 2021, mediante entrevista semiestructurada con 18 enfermeros asistenciales que trabajan en unidades de clínica médica de tres hospitales universitarios del Sur de Brasil, elegidos con la ayuda de la técnica de muestreo no probabilístico - *Snowball* - y utilización del Análisis de Contenido para interpretar los hallazgos. **Resultados**: las facilidades para el desarrollo del proceso educativo señaladas fueron: presencia de equipo multiprofesional; la propia característica de instituciones como hospitales universitarios; la presencia de protocolos y reuniones mensuales; y familiares interesados en aprender. Las dificultades involucraron: la falta de integración y comunicación entre los miembros del equipo multiprofesional; falta de materiales didácticos y espacio adecuado; sobrecarga de trabajo; exceso de burocracia; la superpoblación en la unidad; y déficit de trabajadores. **Consideraciones finales**: las facilidades y dificultades señaladas permiten pensar estrategias que podrán contribuir en la educación en salud en el contexto de ingreso hospitalario, considerando las actividades laborales en unidades de clínica médica.

Palabras clave: Educación en Salud. Enfermería. Hospitales. Accidente Cerebrovascular.

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