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REFLECTION STUDY

Systematization of nursing care applied in street office teams

Sistematización de la atención de enfermería aplicada en equipos de oficina de calle

Sistematização da assistência de enfermagem aplicada nas equipes de consultórios de rua

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The social contrasts that mark large cities and generate exclusion by social class, skin color and behaviors not accepted by society are situations experienced in our daily lives and these different groups, with their different characteristics, still face great difficulties when accessing services offered by the Unified Health System (SUS)[1].

In Brazil, there is a considerable and growing number of homeless people, socially invisible Brazilians with difficult and constant access to benefits guaranteed by public policies and mainly by health resources due to the loss or lack of documentation[2].

The reinforcement of the invisibility of these individuals is established according to a study[3], when they seek the provision of care guaranteed by the State, since, due to the lack of documentation, usually characteristic of this population, they are unable to produce the SUS card and, therefore, access to Basic Units of Health and withdrawal of medicines, although they are not required to provide proof of address in accordance with Art. 19 of Ordinance No. 940[4].

The diversity of this group is marked by several health problems such as sexually transmitted diseases, tuberculosis, involvement with alcohol and other drugs, oral health problems, among others[5].

Adding to this, factors such as extreme poverty, prejudice, the rupture of family ties, issues involving mental health, lack of housing, work and income and the abuse of alcohol and other drugs, contribute to the occurrence of "street situation" phenomenon, with invisibility being one of the biggest causes for these individuals to have their rights curtailed[6].

Considering the limited supply of health care for these people, in 1999, in the city of Salvador, the first Street Clinics (CnaR) emerged, with the primary objective of providing care for the population that uses alcohol and other drugs. Only in 2009 did it join as a Public Policy through the Emergency Plan for Access to Treatment and Prevention of Alcohol and other Drugs in the SUS (PEAD) and, later in 2010, with the Integrated Plan to Combat Crack and other Drugs (PIEC)[7].

Through the National Policy on Primary Care (PNAB), Ordinance No. 2,488 of October 21, 2011, which characterizes primary care as a set of health promotion and protection actions, disease prevention, diagnosis, treatment, rehabilitation , harm reduction and its maintenance and, which aims to develop comprehensive health care and autonomy, both individual and collective, affirms that homeless people have the right to be assisted with completeness, universality and equity, trusting a greater scope of service offers[8].

In this sense, the Primary Health Care (PHC) constitutes a reference health equipment according to a study9, which gives the Street Clinic teams the objective of serving the integrated population according to the principles of the SUS, in addition to the assistance of the Center of Psychosocial Care (CAPS), when their work actions need sharing and interactions[10].

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The Street Clinics were recognized in 2009 by the Ministry of Health as an extension of care. The main objective was to assist homeless people in their total complexity, as well as the Family Health Strategies (ESF), and to act in conjunction with the Health Care Networks (RAS), having the PHC as the main point of attention[9].

Thus, as it is a heterogeneous group, composed of a population that has respiratory diseases in common, problems related to the use of alcohol and other drugs, psychological distress and mental disorders, rupture of family ties, among other characteristics, the work of the Street Clinic needs to be shared and integrated with other services covered by the SUS, such as Basic Health Units, Emergency Care Services, Psychosocial Care Centers so that, in this way, the user can have the possibility of rescuing your citizenship and get a treatment with equity and completeness[11].

The work of professionals from the offices on the street is itinerant and in loco, with specific facilities, within fixed Basic Health Units or in Mobile Units, using a set of singular and collective strategies aimed at people who use, abuse, or depend on drugs. Among these prevention strategies are, among others, the recommendation of not sharing instruments and the use of disposable materials, including for the use of industrial silicone and hormones among trans people. It is a gateway to Basic Health Units and other services covered by the SUS[12].

The following professionals may be part of the CnaR: Nurse, Psychologist, Social Worker, Occupational Therapist, Doctor, Social Agent, Technician or Nursing Assistant and the Oral Health Technician being separated into three modalities (modality 1, 2 and 3) that make up the CnaR teams[9].

In modality 1, the team of professionals must be composed of four professionals, two with higher education and two with secondary education. In modality 2, there must be six professionals in the team, three of them with higher education and three with medium level. In modality 3 there must be the six professionals of modality 2 and one more medical professional[12].

In the daily work of these health professionals, the unexpected is present every day. From a complex and dynamic street environment, in which the professional nurse's work process is carried out in an integral way, both individually and collectively, for individuals with extreme social vulnerability. Its activities cover family care, healthy or sick individuals, health maintenance and recovery, management, among other performances organized in a multidisciplinary and interdisciplinary manner[13].

Nurses working in CnaR teams use the work process to guide the comprehensive care of their patients, in which strategic planning, teamwork and the use of light technologies are essential for the development of their actions[13].

Among the various responsibilities of nurses, within their work context, the application of the SAE provides them with scientific knowledge, organization, and the individual's safety. In addition to assisting, you in an individual and complete way, it produces a greater flow of communication between patient and professional[14].

Given this context, this work seeks to show the feasibility of applying the SAE, as well as the relevance of the role of professional nurses within the Consultório na Rua (CnaR) program. The objective was to describe the activities performed by nurses in the Street Clinic.

The Systematization of Nursing Care

The support and comprehensive assistance to human beings began within nursing through the theory of Wanda de Aguiar Horta in which the basic human needs of the individual are assisted by professional nurses, who also include love, esteem, and security in these cares[14].

The safety of a nurse's care is essential for the care provided to the patient to be effective, as, with knowledge of their health-related risks, needs and comfort, the nurse prepares a care plan in which they can carry out the interventions of nursing following a process consisting of five steps: nursing history or data collection, nursing diagnosis, planning, implementation, and nursing assessment[15].

It is understood that these five guiding steps of the nursing process (NP) of which the NCS is constituted are following data and without the hypothesis of disharmony[16].

According to COFEN Resolution No. 358, the steps and their respective functions are: (1) Collection of Nursing data (or Nursing History) with the objective of information about the person, family or community, this process is systematic, continuous and carried out through the help of methodologies in order to resolve at some point in the health-disease process; (2) Nursing Diagnosis, which is the interpretation of the compilation of information obtained in the first stage, which will enable the nurse to make a decision about the nursing diagnosis and which also encompasses the selection of actions or interventions in which it is expected achieve the expected results; (3) Nursing Planning: Results determined according to the responses of people, family or community, identified in the Nursing Diagnosis stage in which nursing actions or interventions are performed; (4) Implementation: Execution of actions or interventions that were designated by the nurse through Nursing Planning; (5) Nursing Assessment: At any time in the health-disease process, there may be changes and, in view of this, the verification of these data is necessary in order to check whether the nursing actions and interventions produced the expected result, as well as how to perform modifications or adaptations in the steps of the nursing process.

For the development and execution of the NP, there are specific nomenclatures that are based on taxonomies, which are the theoretical and systematic studies of classifications, bases, principles, procedures, and rules, and also a way to standardize the SAE languages in which it uses North American Nursing Diagnosis Association NANDA for nursing diagnoses, (Nursing Intervention Classification) NIC for nursing interventions and (Nursing Outcomes Classification) NOC for nursing outcomes. carrying out all the steps so that it is possible to take decisions in which patient safety is prioritized[17].

The critical interpretation of the nurse, which involves the physical examination and clinical opinion, information from family members and the patient himself, gives the first stage of the SAE in which, in data collection, the NANDA taxonomy is applied to establish a classification of the nursing diagnoses that will guide nursing actions and, therefore, their interventions with the aim of, through the clinical judgment of the professional, offering subsidies for solving the problem of the patient they care for[18].

According to a study[19], between 2018 and 2020 there was an update in the NANDA taxonomy, resulting in 167 nursing diagnoses, which refer to the areas of functioning and behavior of the individual.

Therefore, the establishment of interventions for each diagnosis can be applied according to the NIC taxonomy, which guides its nomenclatures for the physiological, psychosocial, disease prevention and which also covers health promotion, with the purpose of restoring the patient[19].

In this way, the nursing results are obtained using the NOC taxonomy results classification language, which can also be used to classify the steps of nursing planning and evaluation, also being an organization of results and nursing interventions divided into three levels: domain, class, and result, in which it is possible to enunciate the patient's behavior, state oscillations and perceptions[18,19].

It appears that SAE is used in several countries such as Spain, Brazil, Canada, United States, Ethiopia and that its origin occurred between the 1950s and 1960s with the aim of providing care and contextualized as a process in which, in the 1970s, it was recognized as practices aimed at professional nurses[20].

In this scenario, the Federal Council of Nursing highlights, through its Resolution No. 358/2009, the SAE, as a precept of the work process, in public and private environments, and the recognition of nurses is evidenced in accordance with the Art. 4, inserted in Law No. 7,498, in which it privatizes its shares in the lead of executions in all its stages[21].

Use of lightweight technologies and harm reduction in the Street Clinic

There is a relationship between health care and health technologies that fall into three categories: hard technologies, defined in devices and machines in which the caregiver inserts its handling so that care can be provided; light-hard technologies, in which the health process encompasses structured technical knowledge; and light technologies, which can be producers of care through the caregiver's action and the acceptance of this care to the assisted individual for health care to be conceived[22].

It is necessary that nurses use active listening, embracement, and humanization among their patients, as the resistance of many of them to treatment adherence occurs due to various factors such as its social determinants, which include social stigmas, obstacles such as their clothes, poor hygiene conditions, the unpreparedness of UBS and ESF employees to deal with their characteristics, among other factors, which helps nurses to prioritize light technologies as support for their work process[23].

The provision of care in the street environment is made possible through the link between the health professional and applied in the form of harm reduction, in which the distribution of supplies related to the prevention of sexually transmitted infections (STIs) is present, in which you get the opportunity to present work proposals and treatment to users[1].

The situation of vulnerability of the groups that take part in the consultations at the Street Clinic make them more excluded and have difficulties in health care. A large portion of individuals use psychoactive substances, among other drugs, such as crack, which makes them dependent and results in great health damage, in addition to their poor health conditions, signaling to health professionals that, through the harm reduction tool, these individuals have information and access to care that is right, guided by the principles that govern the SUS: universality, equity and comprehensiveness[24,25].

The importance of nurses in the Street Office

The nurse is the professional who performs individual and specific actions within their work environment, being their fundamental presence in the health-disease-care process[25].

The therapeutic behaviors applied by nurses and their staff are based on patient-centered care to make them empowered in relation to their bodies and knowledgeable about their pathologies, granting them the right to their health and citizenship[26].

Nurses, within the context of the Street Clinic, in addition to teamwork and the centralization of the use of light technologies, use the care of their patients to guide the approaches and care within the context of the situation on the street. Promoting the right to health even in the face of adversity becomes a challenge. There is a lack of permanent investments and a lack of knowledge about the purpose of the work of homeless citizens, even within health care networks[13].

There are several professionals included in the Street Clinic team, such as Community Health Agents (CHA), physicians, psychologists, among others, however, the centralization of work is focused on the professional nurse because, due to their dynamism and coordination profile, they lead the whole the team provides and work harmony, in addition to out-of-office activities[27].

Invisibility of individuals who survive on the street

The first census aimed at the homeless population, was carried out in 2007 by the Federal Government, in 71 Brazilian municipalities, and listed several important information that mapped the situation of these individuals involving issues of ethnicity, gender, education, number of daily meals, possession of documentation, reasons for going out to the street, where they usually sleep, declaration of health problems, among other data, which helped to clarify the stigma that these individuals carry as being all beggars,

beggars, as according to the data obtained, 70.9% had some paid activity[27].

In the city of São Paulo, in 2015, a census identified that 82% of homeless people were male, 14.6% were female, 2.5% had up to 11 years of age. age and 4.7% were 60 years of age or older[28].

Conanda (National Council for the Rights of Children and Adolescents) demands a new count of the homeless population, with the most current estimate being 101,854 individuals collected in 2016 because, according to the IBGE, the matter is still missing. forecast, as the institute considers only permanent households in its surveys[29].

There was a growth of homeless people in the city of São Paulo between 2000 and 2015 (Figure 1), shown by the total number of homeless people, those who were sheltered and those who spend the night on the streets during this period.[28].

Figure 1. Increase in the number of homeless populations between the years 2000 and 2015. São Carlos, SP, Brazil, 2020

Source: FOUNDATION INSTITUTE OF ECONOMIC RESEARCH (FIPE, 2015).

Through this information, it is necessary to recognize this population to better assist them, how their relationships with the community and their difficulties in accessing health are exercised so that institutional partnerships are established with health teams and society provide data for the functioning of these identification mechanisms[27].

Family Health Strategy and Street Clinics

The teams of clinics on the street are devices for the integration and reorientation of homeless people (PSR) to the services offered by the SUS, such as the psychosocial care network (RAPS), in which, through their care, such as centers of psychosocial care in alcohol and drugs (CAPS-AD), bridge these individuals, integrating them into the APSA in which the FHS are inserted[9].

In the context of the Family Health Strategy, the teams that develop their activities seek a service that aims to organize the work process to meet the user's demands, dedicate themselves to disease prevention and health promotion actions, in addition to spontaneous demand and bureaucratic services, as well as prioritizing access to health services for the population, guaranteeing its principles of equality, and being the gateway to primary health[25].

It is understood that the idea of the ESF Strategy goes beyond the concept of care centered on procedures and, yes, it encompasses the care of the individual and the territory to which he belongs, transcending the health professional and user relationship, generating a bond between the team, the user, family, and community focused on health programs[1].

The work that is developed by the teams of street offices (CnaR), is related to the work developed within the ESF, providing a gateway to the (APS), but with different territorial approaches, where in the ESF, the work is carried out with territories delimited being that in the CnaR, the works are materialized according to the dynamics of the individuals and the territorial delimitation is more imprecise[9].

The array of treatments offered to CnaR also includes matrix support, made possible by the NASF (Expanded Family Health Center), which brings together the most complex cases, based on meetings between professionals working in other areas of knowledge, which implies a evolution in Public Policies by enabling the visibility of the homeless population[24].

Many people who live on the streets have already had the protection that a house and family life offer to an individual, with their advantages and disadvantages in their affective relationships. As they are living on the streets for various reasons, these individuals also share daily relationships in which their most frequent experiences are

shared, which is important for the construction of bonds between groups and in these people's lives, but as each new fact that occurs can undo these links in their experiences, which are usually itinerant and unexpected, the public assistance network should be consolidated to provide the necessary support to these groups, either individually or collectively[30].

Adding to this, most of the time, when the establishment of links between the teams working in the street offices and/or the individual(s), in the street, the very connections formed between professionals and patients become the best treatments and medications at that time, since the establishment of these bonds requires perseverance, but also generate insecurity on the part of professionals, as they challenge their capacity for acceptance and for shared coexistence[27].

In the context of caring for these people, there are difficulties in carrying out the various work techniques that are necessary in the street environment, such as sputum collection, bacilloscopy, attention to infectious diseases in which professionals provide care with great difficulty due to discontinuity of care, lack of adherence to treatment and mobility of this population[31].

Thus, there is a great need to adopt the SAE within the Street Clinic as an organizational tool, providing health services to the assisted population and documenting professional practices, in addition to consolidating the actions of nurses within their team, providing their autonomy, among other benefits, and its application is adaptable to each institution where it is implemented[21].

However, some studies also reported that there is a lack of specialized training of many nurses in naming the SAE as their main work tool, which clarifies that the nurse, a professional who interconnects the various health actions performed among the members working in the Street Office, needs tools that enable comprehensive care for the individual on the street, as he meets various demands such as patients in psychological distress, shelter for homeless pregnant women, orthopedic problems, diabetes mellitus, high blood pressure, in addition to health education and case discussions with the multidisciplinary team[31-33].

It is necessary to emphasize that there must be a realistic vision for the nursing team to have instruments in order to use the NP in its operational form, the NCS in all its stages and consolidate its implementation, as the difficulties encountered in health services such as the lack of physical and organizational structure, are not in line with the applicability of this work tool and, therefore, there is no way to confirm that the patient who has been assisted by it is able to achieve their independence in order to meet their basic human needs and, therefore, consolidate the stages in which the SAE is constituted[34].

Furthermore, it is important to discuss that there are nurses who do not have knowledge about the SAE or claim that this methodology is aimed at the level of tertiary health care (they provide high-complexity care). In addition to issues such as the lack of more attached forms of the NP in the medical records of patients assisted by the nursing staff, there is also a lack of encouragement for their insertion in institutions, which makes its implementation difficult, as the units that would benefit from this tool work, in order to meet the demands arising from the offices on the street, would also have to adapt to the necessary standards for the coverage of the service that this work tool proposes, with the objective of offering health actions with equity, organized and that provide the comprehensive user assistance[35].

In addition to the existing gap in the lack of practical theoretical knowledge about SAE, the various activities performed by nurses end up disconnecting them from care and from the focus of the patient's needs and, consequently, applying their knowledge in a technical way, which leads to the distancing of your functions[36].

All these evidences corroborate the study findings[36,37], in addition to pointing out that at graduation, the focus becomes the development of technical practices in which the future nurse is limited in learning technical procedures that lead to ignorance and devaluation of the SAE.

Final Considerations

People who are homeless are made up of individuals who are differentiated because they are floating and temporary groups, requiring special care and public policies that promote access to health care and reduce social inequalities for this population.

The immediacy of the care required by these groups leads us to reflect that, despite the Unified Health System guaranteeing in its principles the universality, integrality and equity of its care, these individuals still face many barriers to care due to compartmentalization and territorialization of services.

The realization of the exclusion of all rights and that the homeless population carries a stigma of social garbage and social invisibility, is a demand for a great effort by health professionals, such as those who are part of the street offices, to reduce the distance in the provision of basic care that is provided by the Health Care Networks to this population.

Another characteristic of providing care for these individuals is the difficulty in providing immediate responses to demands, due to the compartmentalization of services, in addition to bureaucratic barriers, which generates evasion, even after establishing links between the team, creating frustration and disruption of links already established for both sides.

Thus, the use of work tools used by the teams of offices on the street, need to adapt to the streets, from the form of language, flexible hours, reception space, possession or not of documents of users to build the management of these services.

One of the most important tools used by one of the components of the Street Clinic teams, the nurse, would be the SAE, which is very important within its context of care, due to the possibility of full monitoring of the individuals assisted by it, in addition to monitoring, evolution and records of health.

However, the implementation of this work tool, which already encounters difficulties in its routine due to the

lack of human resources, inputs, lack of support and both institutional and managerial negligence within public and private environments, and even due to the lack of knowledge of many professionals, proved to be an unfeasible tool within the Street Office context, because the nurse determines their functions according to the priorities found during the course of their appointments, as the scarcity and inadequate working conditions found within the street environment are also reinforced by the lack of a universal language related to the applicability of this tool among health services.

For the operationalization of the SAE to be used effectively, including in street offices, it would be necessary that all professional nurses, services, and institutions, build a relationship of perception and importance of their records on paper, nursing reports, monitoring of results, of its documentation and mainly its implementation be defended by the professional category.

Finally, there is a gap in the application of SAE in the work of nurses in the primary health care network, according to some authors and that, in this way, its use by nurses working in street offices would be unlikely since both services are in line with the objective of health care for the individual. On the other hand, this study can also serve as a stimulus for other authors to carry out other works on the applicability of SAE in street offices, articulated with primary care networks, as well as broadening the nurses' view regarding the appropriation of this tool. work, because when properly used, it provides the institution, professional and assisted individual, with work based on scientific methodology, providing comprehensive, individual, and resolute care as well as quality in care management.

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