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FROM PRESCRIBED WORK TO THE REAL WORK OF NURSING IN IN-PATIENT CARE UNITS OF FEDERAL UNIVERSITY HOSPITALS

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ABSTRACT

Objective: to identify similarities and differences found between the prescribed and real nursing work, from the perspective of nursing professionals of in-patient care units of federal university hospitals.

Method: qualitative research with a descriptive and transversal exploratory design. Data collection was based on floating observation of the service; interview with two managers and twenty-three nursing professionals; and shadowing a nurse and nursing technician during their work shift. The data were organized using the Atlas.ti software, using the Thematic Content Analysis, supported by the Health Work Process and the Ergological Approach theoretical framework.

Results: the results showed that there are similarities between the prescribed and the real nursing work which is determined by the division of work, which remains linked to the professional categories, and in relation to the team there is a multiprofessional work perspective. The differences are related to the management between the institutions and to the work pace. Both the similarities and the differences are connected to the one prescribed to the profession, being that there are movements of renormalizations, redefining the work organization, mainly with a view to integrative care, from the perspective of subjectivity.

Conclusion: it is necessary to reconsider work, as the practices can be modified by the nursing professionals when they acquire new knowledge that substantiates work reorganization.

DESCRIPTORS: University hospitals. Public hospitals. Organization and administration. Hospital management. Hospital units.

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DO TRABALHO PRESCRITO AO TRABALHO REAL DA ENFERMAGEM EM UNIDADES DE INTERNAÇÃO DE HOSPITAIS UNIVERSITÁRIOS FEDERAIS

RESUMO

Objetivo: identificar semelhanças e diferenças encontradas no trabalho da enfermagem, entre o prescrito e o real, a partir do ponto de vista dos profissionais de enfermagem de unidades de internação de hospitais universitários federais.

Método: pesquisa de natureza qualitativa com delineamento exploratório descritivo e transversal. A coleta de dados se deu a partir de observação flutuante do serviço; entrevista com dois gestores e vinte e três profissionais da enfermagem; e, acompanhamento de um turno de trabalho de enfermeiro e técnico de enfermagem. Os dados foram organizados com auxílio do *software* Atlas.ti, utilizando a Análise de Conteúdo Temática, sustentada pelo referencial teórico do Processo de Trabalho em Saúde e da abordagem Ergológica.

Resultados: os resultados evidenciaram que no trabalho da enfermagem há semelhanças entre o prescrito e o real determinados pela divisão do trabalho, que se mantém atrelada às categorias profissionais, e em relação à equipe há uma perspectiva de trabalho multiprofissional. Quanto às diferenças, estão relacionadas à gestão entre as instituições e ao ritmo de trabalho. Tanto as semelhanças quanto as diferenças estão articuladas ao prescrito à profissão, sendo que há movimentos de renormalizações, redefinindo a organização do trabalho, principalmente com vistas ao cuidado integral, a partir da perspectiva da subjetividade.

Conclusão: há que se pensar e repensar o trabalho, pois as práticas podem ser modificadas pelos trabalhadores de enfermagem, ao se apropriarem de novos conhecimentos que fundamentem a reorganização do trabalho.

DESCRITORES: Hospitais universitários. Hospitais públicos. Organização e administração. Gestão hospitalar. Unidades hospitalares.

DEL TRABAJO PRESCRITO AL TRABAJO REAL DE ENFERMERÍA EN UNIDADES DE INTERNACIÓN DE HOSPITALES UNIVERSITARIOS FEDERALES

RESUMEN

Objetivo: identificar las semejanzas y diferencias encontradas en el trabajo de enfermería, entre lo prescrito y lo real, a partir del punto de vista de los profesionales de enfermería en unidades de internación de hospitales universitarios federales.

Método: investigación de la naturaleza cualitativa con un delineamiento exploratorio, descriptivo y transversal. Se recolectó los datos a partir de la observación flotante del servicio; se entrevistaron a dos gestores y veintitrés profesionales de enfermería; y seguimiento de un turno de trabajo de enfermero y técnico de enfermería. Se organizaron los datos con la ayuda del *software* Atlas.ti, utilizando el Análisis de Contenido Temático, que se basa en el referencial teórico del Proceso de Trabajo en Salud y del abordaje Ergológico.

Resultados: los resultados demostraron que en el trabajo de enfermería existen semejanzas entre lo prescrito y lo real, determinados por la división del trabajo, que permanecen vinculadas a las categorías profesionales, y en relación al equipo hay una perspectiva de trabajo multiprofesional. Respecto a las diferencias, estas se relacionan a la gestión entre las instituciones y al ritmo de trabajo. Tanto las semejanzas como las diferencias se articulan con lo prescrito a la profesión, siendo que hay movimientos de renormalizaciones, redefiniendo la organización del trabajo, sobre todo con miras al cuidado integral, a partir de la perspectiva de la subjetividad.

Conclusión: debemos pensar y repensar el trabajo, dado que los trabajadores de enfermería pueden modificar las prácticas al apropiarse de nuevos conocimientos que fundamenten la reorganización del trabajo.

DESCRITORES: Hospitales universitarios. Hospitales públicos. Organización y administración. Gestión hospitalaria. Unidades hospitalarias.

INTRODUCTION

It is impossible to think about the historical evolution of humanity without thinking about work.¹ For many decades, the work organization established by Taylor, Fayol and Weber was dominant in the production process of goods and services in society. In the mid-twentieth century, these conceptions began to be questioned, with the hope of overcoming the fragmentation of work and construct participatory and innovative organizational practices.²

In the health area, these discussions on new models of work organization have also taken place, with multiprofessional work currently being the focus, since it is understood that it is developed by several professionals who are responsible for health care activities.³ The boundaries in the multiprofessional team are established by the specificity of knowledge, with the use of the domain of competencies for each professional category.

It is in this multiprofessional context that nursing work is inserted, which involves daily interrelations between the team itself and other professionals, and, it is through these connections that practices are improved, impacting the care provided to the users. The work organization involves planning and norms that establish the specific functions of the actors involved in the process. In the hospital setting, it is the nurse's responsibility to coordinate the work, and by managing the in-patient care units, they are responsible for the organization and maintenance of materials, personnel and infrastructure not only of the nursing professionals but for the health professionals.⁴

In the work organization process there are activities that are determined by norms, protocols, *i.e.*, they have some descriptive degree, an anticipated part, prescribed, since the applicability of norms is found in work situations.⁵ However, during the performance of work, not everything that is prescribed, anticipated; and this part which is not anticipated, is called the real work. The changes that are established in the work process, starting from the power relations in both the macro and the microspace, define changes in the prescribed norms, because even if they are precise, they are usually insufficient, due to the inevitable fact that not everything is anticipatory.⁶ This invisible dimension of work results in 'renormalizations', even if minimal.⁷

Norms are made from values, which means managing work, creating new rules in a given situation, which implies that the prescribed work normalizes the process of renormalization.⁸ Norms are part of human nature - since there is no person living without norms, and they are in agreement with the environment and fit the historical context.

When one reflects on work, especially the services sector, it is verified that these are normative, and have a history.⁹ Prescribed work includes the actions which must be performed by the workers, corresponding to the way of using the instruments and machines, the time granted for each task, the necessary method and the rules to be followed and respected.¹⁰ Upon doing the work, it is perceived that the prescription does not only contain the official, but also the unofficial content, the way to organize to do, or not do that which was prescribed. In this movement, real work can be understood as the "performed activity and also that which is evaluated in the uncertainty, discarded with regret or suffering, through the ever-present discussion on norms".^{11:722}

Nursing has an established space for each team member, however, (re)normalizing work is part of the human being. The current trend is to find ways to integrate collective work processes, which include planning, organizing, executing and evaluating the actions performed by the professionals involved in the work context. The nursing collective seeks ways to instrumentalize in order to better manage the processes under their responsibility, paying particular attention to efficiency and quality of work.

The activities of hospital institutions always take place collectively, *i.e.*, part of the individual work depends on the collective, other nursing workers and other professions, on work relationships,

aiming to handle the completed work. In an attempt to understand nursing work in this context of normalization and renormalization, this study aims to identify similarities and differences found between the prescribed and the real nursing work, from the perspective of nursing professionals from in-patient care units of federal university hospitals.

METHOD

A qualitative study, with a descriptive and transversal exploratory design, which reveals the dimensions, variations and importance of the phenomena of a researched reality.¹²

Cross-sectional studies in the work setting can be found in studies with an ergological approach, as studies with this approach analyze real work situations, *i.e.*, the action itself, its different possibilities, influenced by the macro-political and institutional context, and also, by the characteristics of the subjects involved in the work, including their choices.

This study used data from the macro-research entitled “Problems and challenges in the contemporary work of health professionals in teaching hospitals: a comparative study of Brazil, France and Algeria”, approved by the CNPq, Edital Universal 14/2013. The choice of exclusively Brazilian services and hospitals is due to the fact that the components of the macro-research are linked to the same services and hospitals.

Data collection was performed in in-patient care units in two University Hospitals (UHs): in a Medical In-patient Care Unit located in a hospital in the south of the country and a Surgical In-patient Care Unit (subdivided into two Units) located in the midwest region. Data were collected between January 2015 and December 2016, with the help of a team of researchers participating in the Multicentric Study who followed these steps: floating observation of the units; semi-structured individual interview with managers, nurses and nurse technicians; and, shadowing the nurse and the nursing technician.

Inclusion criteria: to be a nurse or nurse technician of the investigated in-patient care units, with at least six months of work experience in the unit.

Exclusion criteria: professionals who did not work exclusively in the investigated services.

Floating observation occurred in all work shifts, during a total of fifty-five hours and eight minutes (55h08min), recording a large area of all aspects of the work. Interviews were conducted with the two nurse managers, nine nurses, and fourteen nurse technicians covering all work shifts. In order to complement the floating observation, one nurse from each institution and only one nurse technician from the institution in the south of the country were shadowed during the daytime shift period. In this regard, the floating observation in the institution located in the Midwest region was used to make comparisons between the prescribed and the real work.

The analysis process was supported by the Atlas.ti¹³⁻¹⁴ software and was developed through data triangulation, based on one of the several modalities of Content Analysis, Thematic Analysis, which consists of three steps: (1) pre-analysis; (2) exploitation of material; and (3) treatment of results, inference and interpretation;¹⁵ and was guided by the Work Process theoretical reference and the Ergological Approach. The analytical categories were: division of work, staff, management and work pace.

Participants signed an Informed Consent Form (ICF), and their anonymity was guaranteed by using a sequential and alphanumeric code, consisting of: initials corresponding to the name of the profession (E for nurse, G for manager, T for nurse technician; O for Floating Observation or for Individual Shadowing, followed by the professional identification letter; Institutions: A for the hospital located in the south of the country and B for the hospital located in the midwest of the country; Units: I for in-patient care unit (followed by a cardinal number that expresses the order and number of the interview of a certain professional category). For example: EA11 (nurse, south, unit and first interview).

RESULTS

By analyzing the nursing work regarding the prescribed and real work, and basing this on the theoretical reference, the way the work is organized emerged in analytical categories (codes), which were identified by a significant number of quotations, which is demonstrated in Table 1.

With 54% of the quotations, the Division of work code highlighted some aspects, reinforcing the division of work between technicians and nurses and reaffirming the similarity between what was prescribed. In the two investigated institutions, the daily work of the nurse technicians is determined by the nurses, considering the number of patients, level of care complexity and daily bed rotation. They also follow the unit's schedule for the performance of daily tasks, such as nursing station organization, crash cart checks, among others.

The schedule is done by the nurse, usually the day before. [...] she looks at the last few days which patients I stayed with so that it doesn't become too repetitive with the same patients. She divides by rooms, then, number of patients to try to get each one with a similar number [...]. There is a schedule for the division of tasks, with the person responsible for the dressings room, the organization of the nursing station, restocking material, cleaning the counters, the control of the psychotropic medication, the linen [...] (TA11).

The division of work among nurses in the same work shift follows different characteristics in the two institutions. In the in-patient care unit (UIS) in the south the nurses carry out the activities collectively, dividing the tasks, making necessary decisions for the management of care and the sector. In the UIC, the nurse is responsible for managing the care of a number of patients, as well as responding to the management of the unit, as reported below.

The nurses have just done the patient rounds together, and discussed some cases when they arrive at the station, and only divide the necessary tasks between them (OAI).

Among us, nurses, to be didactic, we see the patients and divide. Let's suppose, there are ten patients, five for one, five for the other. It's not that we're exactly going to be alone with these patients. We do this to be practical, for us to solve the problems (EBI3).

In the Division of Work, the nurses at the UIC hold daily meetings at the time of patient admission, aiming to clarify the surgical procedures, nursing care and the multiprofessional dynamics of the unit.

At 4:00pm an admission meeting is held for the patients who are scheduled for surgery. The nurse takes the patients to the meeting room located inside the unit and gives detailed information on the routines of the unit and the surgical procedures; the nurse calls the patients individually in order to confirm the time of the procedure. There were about 12 patients and some were with companions today. At the end of the meeting, the nurse accompanies all the patients to their rooms. Today, there were no other members of the multiprofessional team (OBI).

Table 1 – Distribution of quotations (n) according to the Work Organization code, based on the data collected in in-patient care units in the South and Midwest regions of Brazil. 2017.

Codes	Quotations	
Work organization	n	%
Division of work	528	54
Pace	247	25,1
Team	105	10,6
Work management	103	10,3
Total	983	100%

In the UIS, the work organization adopted by the nurse technicians in the daytime follows the integrative care model, and at night the care model is functional. In the UIC, care in all the work shifts is performed according to the integrative care model. This work organization was verified both through observations as well as through the interviews.

Integrative care occurs during the day and at night (GB11).

The division is made by the number of patients, care is integrative. If I have six in the infirmary, I will do all the care for all six (TBI6).

Asked how they did the work at night, nurse technicians reported that they divided the work, where two were responsible for medications and fluid therapy and the others performed vital signs and care related to hygiene and comfort (OAI).

Shift handover occurs differently in the investigated institutions. In the UIS, the nurse is responsible for the shift handover that takes place in a specific room with all the nursing team members and members of the multiprofessional team. In the UIC, the shift handover is given in the unit hall, from nurse to nurse, and from nurse technician to nursing technician at the medication preparation station, according to the following data.

Shift handover in a specific room with the team seated at a central table. The nurse of the finishing shift is passing on the information, there are no other employees from her shift. One nurse and a nursing resident and some nursing technicians are recording the information being given. Also present in the room are: a physiotherapist, a pharmacist, two psychologists and a nutritionist [residents]. There is also a nursing student (OAI).

The shift handover is from nurse to nurse, from technician to technician. (GB11).

The UIC is assisted by a porter, who transports the patients to the surgical center; professionals from the pharmacy team, who dispense the individualized medications in the unit; and, the laundry service, who distribute the clothing kits in the rooms, as mentioned below.

The porter brings the patient in a wheelchair with their companion and a professional. Professionals from the laundry or cleaning department prepare the units for the reception of patients. Pharmacy professionals bring medication and delivery them to the nursing station; Professionals from the kitchen begin to distribute meals in the wards; cleaning professionals clean the beds (OBI).

When considered prescribed work, one can see similarity in the specific duties of the professionals, it is possible to see the commitment of the professional regarding their fulfillment of the prescribed work. In this regard, the nurse is responsible for the management of the team and the most complex procedures, while the nurse technician is responsible for the other procedures, as shown below:

My job is to prepare the medication, bathe the patient, change the patient's diapers, do the peripheral accesses, that's what we do. That's basically it (TBI3).

To supervise the care, provide the immediate care in situations that require the nurse, care related to the chemotherapy, insertion, withdrawal; patient evaluation, problems, history and nursing prescription for the new patients, writing the nursing notes from the shift, that is my responsibility, evaluate the nursing prescription each day according to the current situation of the patient, report the changes in the notes, give the shift handover, prepare the schedule for the following employee, seek shift cover in cases of work absences, when someone informs you that you that they will not be able to work, both nurse and technician coverage when needed. Call the team to assess when you have a patient with some particular need ... and there is everything else that we do and that is not exactly our responsibility, like bookkeeping, pharmacy, that kind of thing which nurses need to deal with (EAI1).

The Team code was evidenced in 10.6% of quotations. In these hospital services, care is given in a multidisciplinary way, usually the professional wants to speed up their own work and, sometimes, does not realize the importance of nursing care and other demands, generating certain conflicts that can be dealt with through effective communication between professionals.

Doctors are the ones who most interfere with the shift handover, [...] and I always tell the nurses for them to make it clear, to show them that handover is happening. I tell them to write down their question and that I will look at it later. Respect the shift handover, make sure that everyone around is aware that this is an important moment for the team (GB1).

The limitations related to communication and the use of social networks such as e-mail and WhatsApp messaging application between the nursing team itself and with the other professional appeared in the results of this research as an everyday communication tool.

Here, communication is an issue as well. [...] here I do not have a phone that I can use, I have to use my cell phone. WhatsApp became very popular here. Everything is about this WhatsApp (EB14).

Technology is very good now, but on the other hand, it is very bad for the manager, because they keep working at home, sending WhatsApp messages, sending e-mails, ... anyway. [...] I think it's getting harder and harder for you to separate things: personal life and work, because of technology (GA1).

The Management code appeared in 10.3% of quotations. The monthly service schedule is made by the nurse unit manager in the two investigated institutions. However, there are problems regarding staff shortages, a problem that differs in the two institutions. In the UIS reality, there is a shortage of personnel which directly interferes with the care given to the service users, making it difficult to manage and maintain the prescribed work.

Because the staff shortage is so bad, we have been working with exorbitant staff shortages for years, a very heavy workload, no one can stand it any longer, even with well-paid overtime (TA13).

Well, we do the monthly schedule. [...] we have a huge absenteeism rate in the institution, in the industry too [...] (GA1).

There were no human resources shortages in the UIC, in fact there is the possibility to reallocate personnel to cover other units using a relocation schedule, as follows:

We have a relocation roster, I also have one in the surgical clinic, in alphabetical order, for both nurse and technician. If I have an extra technician and the medical clinic needs a technician, I'll take mine and relocate them to the medical clinic. And I follow alphabetical order. Nurse, the same thing [...]. Since we have a group of supervisors, we discuss: I am in need of a nurse technician or a nurse (GB1).

In recent years, the UIC has undergone a change of management, with adherence to the Brazilian Hospital Services Company (EBSERH), which has shown to cause conflicts in the relationships between employees with statutory employment relationship and those linked to the Consolidation of Labor Laws (CLT). Quantitative targets are present in management, including deadlines in the implementation process and implementation of this new management model. A complete change process is observed, including continuous follow-up of CLT employees during their initial training period, using an evaluation protocol used to justify their stay in the institution.

Many new protocols came with the arrival of EBSERH Routines are now more established, there is more pressure too [...]. Today, we work together, including the surgical center, with the head of the surgical center. I have a group, which I participate in too, we are working on a safe surgery protocol. [...]. Now here, you follow the criteria: the surgeon, the nurse have their own demands, each with their own responsibility. [...] and there is also the nursing board, which meets every fifteen days (GB1).

Issues related to infrastructure, due to a lack of financial resources, interfere with the work organization, either due to a lack of resources/equipment, such as in the UIS, or in the UIC, where during the renovation of one of the units there was no provision for a staff bathroom or kitchen for the multiprofessional team, or a rest room for professionals working twelve-hour shifts, environments deemed necessary to ensure decent working conditions.

They renovated the hospital and did not put staff toilets [...] We have a tiny kitchen here on the third floor, a make-shift one, because the one on the second floor has already been demolished. [...] I work for six hours, [...] and the renovation did not include any space for employees to prepare their meals, but the patients, they receive breakfast, lunch and dinner, all while I'm here (EBI2).

The Work code represented 25.1% of quotations. An intense, exhausting and tiring work pace was observed in the UIS, as evidenced in the quotations of the professionals:

It feels like we can never do what needs to be done. We run, run to try to handle everything you need, but we end our day and feel like we could not finish what we had to do (GAI1).

The nurse's visit is affected by some interruptions: answering the telephone, guiding the technician and giving a lot of information to the health staff, patients and family members. The nurse makes notes on individual patient notes. Returns the medical records on the counter and organizes the crowded hallway, placing wheelchairs on one side, stretchers on another. Check the garbage and ask the cleaning lady to remove it (OEAI1).

The work pace in the UIC suffers due to some factors: rotation of nursing staff between the two hospitalization units; management changes and recent hiring of workers, who are still in adapting to the institution's new standards.

They are always different teams, different people commanding the work. [...] We are going through a transition period, several employees left and several new ones came in, because of EBSERH, who have the normal difficulties of those entering the industry (TBI9).

The results of this research show that, in the UIC reality, the work pace allows the professionals to perform their activities within the established time, *i.e.*, within what is prescribed.

Usually, there is a very high patient turnover. And so, I think it's fine, it's not much, it's not too heavy, no. [...] The workplace is fine, the staff is good. There is not much to complain about (EBI4).

We do our work in a pace that allows everyone to be attended to at the same time, so you try to allocate time for each patient [...] depending on the complexity of the case (TBI17).

The results presented here show similarities and differences in the sum of the real work of the two researched institutions.

DISCUSSION

There are many factors that interfere with the work of the nurse, especially those related to work organization, which are intrinsic to the profession, but also defined by the macrostructure of health services. Several of these factors have been referenced in the literature, such as the division of work, duties, teamwork and even the importance of management. The division of work reiterates social practices of its historical time. The ability to stand in the face of situations and make decisions leads to greater or lesser inequality between different professions. As teamwork is built in an intrinsic way, the possibilities for consensus on the purpose and on how to do the work increase.¹⁵ It is worth mentioning that, regardless of the location and management of the health care units, these data are manifested in some situations more clearly, and in others more subtly, and in some cases lead to the normalization or renormalization of nursing.

Since the 1970s, studies have highlighted the influence of the division of nursing work, highlighting the work processes: care and management, with a clear division between professional categories, reinforcing the prescribed work.^{3,16} In general, the nurse is responsible for managing the therapeutic unit and the actions performed by the nursing team, in addition to performing more complex care. The nurse technicians and nursing assistants are responsible for performing most of the direct care to users, under the supervision of the nurse.^{3,17} This way of organizing work, in which care and management are evident in the nursing process, especially the nurse, has been maintained over the years, despite studies indicating new methods of work organization¹⁷.

The nursing teams have defined roles in the performance of the specific activities of each professional category, according to what is provided for in the professional practice law, as well as in compliance with the provisions defined by the Federal Nursing Council (COFEN), regarding the duties, quantitative staffing and work organization.¹⁸⁻¹⁹ Thus, nursing contributes significantly to the increased quality of hospital care,¹⁸ in which nursing workers are responsible for a significant part of the care provided to patients cared for in hospitals.^{17,20-21}

The division of work and duties are reflected in the care model, and the findings of this research show trends towards adopting the comprehensive care model in both institutions, which is defended as one of the alternatives to overcome the fragmentation of care, since it involves the performance of all caring for one or more users, by a single professional, during a work shift, allowing a more global view of their needs and making the work potentially more creative. Even so, there is still a division between the intellectual work and the manual work, since the nurse plans the care that is provided by the other members of the nursing team.^{3,22} This division between the duties is manifested in the prescribed and in the real work, there is a contraposition of the nursing team in the search for a greater relationship between the different professional members, even with the adoption of integrative care. The division between doing and thinking is maintained, aspects that have also been studied since the 1970s, and remain present in nursing.

However, it must be considered that the worker, regardless of the professional category, by performing activities, uses technical knowledge, beliefs and life experiences, and the work is never just about performing, because in doing so, the worker makes “use of self”, referring to the position that each one adopts when faced with norms, exhibiting small changes, recombining values and criteria in the search for an adaptation to its practice, making each work task unique. In this aspect, the professional seeks knowledge about available resources, making their own decisions for the production of a particular task,²³ seeking to adapt the prescribed, but also renormalizing in the daily actions.

Reflecting on the way in which care has been provided, it can be seen that the two institutions have different paces in relation to their activities. The aspect with greater visibility that reflects on the pace of work is due to the quantitative staffing, followed by the management model, which directly interferes in the provision of the care.

The work pace of nursing professionals can be related to multiple aspects of individual characteristics, such as: knowledge, agility, initiative, creativity; and the characteristics of each institution, such as the management model, the material and structural conditions, the number of existing professionals to perform the necessary actions during the work shift, generating more or less wear and tear for the worker. It is worth mentioning that, even with the legislation that defines nurse staffing, discrepancies are still found in health institutions, often imposed by the macro-structure.

Regarding management, there are numerous difficulties related to health policies,²⁴ which have repercussions on UHs, and in order to address them, the government implements the Restructuring Program for University Hospitals and created the EBSEH. Seeking new paths in the face of difficulties and inquiries based on the discourse of inefficiency of public management and the high cost of federal hospitals, EBSEH appears as a new alternative for the management of all HUs, with the possibility to make changes.²⁵⁻²⁶

The two researched institutions experience management differently, where the governance of the HU/center-west, since 2013, remains under the command of EBSEH, adopting management regulations, personnel hiring and adopting a care model, according to agreement. In 2016, the HU/South in 2016, signed an initial adhesion contract to EBSEH.

Due to the adhesion to EBSEH, some changes have occurred in the HU / midwest in terms of management, personnel and care model. Regarding the quantitative nursing personnel, a resizing

process was carried out to meet the demands. Thus, following the EBSEH regulations, there was a need to hire nursing professionals, but the difference in management and relationships was strongly perceived among UIC nursing workers, which generated conflicts that are being dealt with in the daily context.

The UIC manager faces the challenge of assuming new perspectives from the existing management, seeking to transform a management that includes the effectiveness of the collective based on the prescribed work. However, these changes reflect a challenge that involves policy discussions, renormalizing work activities, building a new way of working and living together.²⁸

Thus, discussions on values and choices of the workers occur during the work activities, and represent the uses that influence the way of using the knowledge. Understanding 'use' in work activities as choices, negotiations, decisions, criteria and deliberations, while at the same, in the work actions 'use' is not only what is done, but also what each one makes of themselves.⁶

During course of this study, limitations were observed that interfere with care, such as shortages of personnel, materials and equipment, resulting in the the worker renormalizing, *i.e.*, "to make his the norm that anticipates and adjusts his action, in order to maintain, even if it is not enough, the origin of 'use of self', even if it conforms to the demand placed upon it."^{29:49} Thus, the rules do not remain suspended for a long time, and it is necessary to decide, to negotiate at a given moment, opting for the way to do certain action.²⁹ As a result, action forces the worker to choose a way to accomplish his activities so that, in this way, he rebuilds the existing norm, *i.e.*, renormalizing.

In this context, there is a collective action of nursing work, observed in the daily practices of the investigated institutions, maintaining much of what is prescribed for the profession. Changes and renormalizations, occur through individual initiatives, breaking with the prescribed, in search of a work that aims at creativity and which is enjoyable. Thus, it was observed, for example, that the changes occur depending on the established relationships, with a greater or less team articulation during work in favor of a quality assistance, based on the individual relationships of the workers. In this way, in the hospital services, the use of oneself and the use of oneself by others is present in the work activities,⁶ establishing relationships of commitments and responsibilities, judgements before the prescribed one, seeking to resolve the work demands¹⁷ in an individualized act, in favor of a collective action. Therefore, much still has to be developed in nursing.

In addition, individualized professional care implies competence, skill, ability, and values that are part of nursing professional training, which include resolute practices for the problems of users who seek health services.³⁰⁻³²

In recent years, with the management of EBSEH, a movement has been established to overcome individualized and fragmented care models, seeking to offer material, structural and organizational conditions in order to meet the needs of service users, reorganizing the care model.²⁵

At the UH/midwest, the care model is in the initial phase, as well as the use of the Computerized Nursing Process and the use of the electronic medical records by all members of the team. The UIC offers actions that are aimed at integrative care, this can be seen in the admission meetings for the service users, performed by the nurses who seek to include the other members of the multiprofessional team. Although fragile, but with the EBSEH administration in this institution, some gains for the care and for the worker begin to emerge, starting with the reorganization of the care services, selection and hiring of personnel and the implementation of a new organizational architecture.

The work process in the researched hospital units could be thought and organized based on the articulation of the care teams, since in these spaces the work takes place collectively. However, the specific actions performed by the members of the various professions, which are part of the multiprofessional team, do not always occur in a consensual way, interfering in the work of the other

professional teams. The limit of this impasse can only be given by the actors involved at the moment the problem occurs.

Communication has changed the working environments of nursing workers and the multiprofessional team. The use of social media, such as WhatsApp and e-mail, was evidenced in the daily activities of the work, and could extend into the rest period of the worker. In this way, the public space of work is progressively invading the personal space of the worker.

There is no doubt that health workers acquire new skills by using tools with technological innovations, both for personal use and at work, and, by socializing this knowledge, they generate technology transfers. "Any technical application is always a way of transferring technology, of recreation. There is always recreation, if only minimal".^{9,464} This demonstrates that real work activity is always an act of renormalization of prescribed work.⁹ Thus, by discussing human activity in general in the development of work activities between the local and the general, in order to transform into improvements of the conditions of work for the worker and for the user of the service, leads to constant renormalization of processes that will reconstruct history. However, the ongoing pursuit of new possibilities for group work must be constantly present in the workplace.

A study²⁸ highlights that work activities always require a discussion of existing norms and the inclusion of new ways of accomplishing them. Thus, "effectiveness is not neutral, but built from this discussion of norms, those choices that have a great consequences in professional life".^{28:210}

CONCLUSION

Similarities and differences in the work of nursing professionals in the investigated institutions in relation to work organization are observed. Regarding the similarities, the commitment of the professionals to comply with the determinations / norms of the prescribed work are highlighted. However, it is seen that nursing workers have to perform their daily activities in unfavorable working conditions, considering the inadequate physical facilities, which leads to renormalization, changing what is prescribed in daily work.

Considering the real work of nursing as a provided care, regardless of the care model adopted by the investigated institutions, nursing actions present aspects that are close, and others that distance themselves from the integrative care. The search for integrality of care involves the possibility of incorporating new work organization models, which make it possible to look at the user as a social being, integrated, with multiple dimensions. It entails multidisciplinary work, as well as the nursing work, that in a certain way is prescribed in the principles of the Unified Health System and in the reorganization Care Guidelines, still not very visible in the organization model of the researched institutions, with its incorporation remaining a challenge. However, it should be noted that the set of changes is usually slow and gradual and it is up to the workers, the managers, and even the users, to define the course that they want to follow.

The UHs are undergoing reorganization by changing their management models together with EBSERH, which appears as a possibility to strengthen the institutions, by means of gains expressed by the number of professionals and the beginning of the reorganization of the care services, with discussions on the implementation of the care guidelines, making integrality of care possible.

The present situation experienced by the HUs is certainly an excellent opportunity to discuss the work organization in hospital institutions, as the reorganization of the care model, focused on care practices based on the Health Care Network and on the Care Guidelines, which will also lead to a change in nursing work organization.

It is believed that this study may assist the UHs and their restructuring in this time of rethinking, seeking methods of work organization that contribute to the autonomy of nursing professionals and work with other professions.

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