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RESEARCH

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THE KNOW-HOW OF THE NURSING TECHNICIAN: A PERSPECTIVE ON CARE

O saber-fazer do técnico de enfermagem: uma perspectiva sobre o cuidar

El conocimiento del técnico de enfermería: una perspectiva en el cuidado

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ABSTRACT

Objective: to describe the nursing technician's work process in the hospital environment. **Method:** this is a descriptive, qualitative study, whose data were collected by simple observation, with notes in a field diary, and semi-structured interviews treated by content analysis. Nine nursing technicians from a public hospital located in the interior of the state of Rio de Janeiro participated. **Results:** it was identified that, when using health technologies with the user, the nursing technician produces his know-how articulated with the micropolitical dynamics of care. However, the power of the user-technician intercessor moment is little explored during the care process. **Conclusion:** the technical nursing professional, in their daily lives, little recognizes the moments of resignification of their practice as a therapeutic element in the care for the user.
DESCRIPTORS: Nursing technician; Nursing; hospitals; Working process; Health care.

RESUMO

Objetivo: descrever o processo de trabalho do técnico de enfermagem no ambiente hospitalar. **Método:** trata-se de estudo descritivo, qualitativo, cujos dados foram coletados por observação simples, com anotações em diário de campo, e entrevista semiestruturada tratadas por análise de conteúdo. Participaram nove técnicos de enfermagem de um hospital público localizado no interior do Estado do Rio de Janeiro. **Resultados:** identificou-se que, quando faz uso das tecnologias em saúde com o usuário, o técnico de enfermagem produz o seu saber-fazer articulado com a dinâmica micropolítica do cuidado. Entretanto, a potência do momento intercessor usuário-técnico é pouco explorada durante o processo de cuidado. **Conclusão:** o profissional técnico de enfermagem, no seu cotidiano, pouco reconhece os momentos de ressignificação de sua prática como elemento terapêutico no cuidado com o usuário.
DESCRITORES: Técnico de enfermagem; Enfermagem; Hospitais; Processo de trabalho; Cuidado em saúde.

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RESUMEN

Objetivo: describir el proceso de trabajo del técnico de enfermería en el entorno hospitalario. **Método:** este es un estudio descriptivo, cualitativo, cuyos datos fueron recolectados por observación simple, con notas en un diario de campo y entrevistas semiestructuradas tratadas por análisis de contenido. Participaron nueve técnicos de enfermería de un hospital público ubicado en el interior del estado de Rio de Janeiro. **Resultados:** se identificó que, al usar tecnologías de salud con el usuario, el técnico de enfermería produce su conocimiento articulado con la dinámica micropolítica de la atención. Sin embargo, el poder del momento intercesor técnico-usuario es poco explorado durante el proceso de atención. **Conclusión:** el profesional técnico de enfermería, en su vida diaria, reconoce poco los momentos de resignificación de su práctica como elemento terapéutico en el cuidado del usuario.

DESCRIPTORES: Técnico de enfermería; Enfermería; Hospitales; Proceso de trabajo; Cuidado en salud.

INTRODUCTION

This article has the field research of the production of health care in the work process of professional nursing technicians with Opinion Nº 345.635 of the Ethics Committee of Plataforma Brasil.

Work is a structuring activity inherent to human life that provides the interaction of man with nature,[1] and is configured as a set of procedures that man uses to obtain a certain product.[2] In this process, the raw material - the object - is transformed. In line with Marxist thought, the instruments used in the production process are a complex of things that the worker uses to perform his work.

Health work, specifically, is completed in the act of its execution, the result of which, which is not a material product, is inseparable from the process that produces it.[3] Its instruments are technologies that can be classified as: hard, related to technological equipment and organizational routines; soft-hard, which encompasses the knowledge structured in the health process; and soft, which refers to relationships, communication, and bonds.[4]

In this sense, to produce the work process in health is, in the relationship between the worker and the user who seeks health services, to build together the answers to the problems presented during the encounter. And it is at this moment that a product, the care, is produced.[5]

Thus, the work process in health is marked by the need for multiple ways of doing things, which are conducted by professionals. The nursing technician, in this scenario, assumes the role of a health team component, linked to and under the responsibility of the nurse, with reduced autonomy in his actions, since his acts and actions are hierarchically related to the nurse's actions.[6] His actions are subsumed in the middle of the work production of the nursing team, despite the fact that his activities are described in the legislation that supports his actions. And even under the aegis of legislation, this professional technician produces more through the creative process that is constituted in his practice of know-how, that is, in his practice, in his routine, the nursing technician produces intercessor relationships using soft technologies. It is in the relationship with the user, in the singular moment when the user brings in his/her knowledge and know-how, and in the encounter with the professional nursing technician that the creative process of know-how is produced.

To analyze the work process of the nursing technician, an articulation between two elements is necessary: doing, which is related to the technical procedures under the supervision of the nurse; and knowing, which is related to what the professional creates from doing. From this articulation, a given work process is configured, that is, a specific work.[5]

In view of the historically built technicist nature of nursing work, it is necessary to take even more care so that the work process is not established only on a protocol basis, especially due to the nature of the work, which presupposes the execution of standardized techniques, especially in the hospital environment.

In recent years, the scientific production in the area of nursing has revealed itself as a solid territory of knowledge, capable of refuting and (de)constructing the argument of non-scientificity attributed to this field of knowledge.[6] However, little research has been done on how the practice of nursing technicians has been processed before the perspectives of changes in the health production model.[7]

Considering this scenario, some questions structure this investigation: How is the work process of nursing technicians produced in their practice in the hospital environment? What are the tools and ways of producing health care that nursing technicians use in their daily work? How is the care relationship between the nursing technician and the hospitalized user constituted?

From this perspective, this study aims to describe the work process of the nursing technician in the hospital environment.

METHOD

This is a descriptive study with a qualitative approach because it answers very particular questions, being concerned with social sciences at a level of reality that cannot be quantified, that is, working with the universe of meanings, motives, aspirations, beliefs, values and attitudes, in a deeper space of relationships, processes and phenomena that cannot be reduced to the operationalization of variables.[8]

What differentiates the qualitative approach from the quantitative approach goes through the nature of each one. Therefore, the qualitative approach delves into the world of the meanings of human actions and relationships. Qualitative research is not opposed to quantitative research, and vice-versa; on the contrary, they complement each other, since the reality of each dynamically interacts, without any dichotomy.[8] Qualitative research manifests itself in several ways, and what always places it as a central concept for investigation is meaning.

The study setting was the Internal Medicine ward of a hospital in the interior of Rio de Janeiro state. To participate in the research, 21 nursing technicians who work in the ward were invited. Of these, nine met the proposed eligibility criteria: to provide direct care to the user admitted to the clinical medicine ward and to have worked on the ward team

for more than a year. Those on vacation or leave during the data collection period were excluded.

The data were collected through simple observation, with notes in a field diary, and semi-structured interviews, with questions about the tools used by the nursing technician in the production of work and the production of care with the user hospitalized in the ward. The interviews were recorded and transcribed in full. To ensure the participants' anonymity, they were coded by the term "TE" and a numerical sequence.

The data were treated by content analysis, which, according to Bardin,[9] foresees three chronological poles: 1) pre-analysis; 2) exploration of the material; and 3) treatment of results - inference and interpretation. From the process of message analysis, the following indexes emerged: the nursing technician's work process; the tools that the nursing technician uses in his/her work; and the definition of care in the nursing technician's work. From these indexes, the core of meaning was built: Production and practice of care.

All participants signed the Informed Consent Form, and the research protocol was approved by the Research Ethics Committee, under Opinion no. 345.635, dated August 2, 2013.

PRODUCTION AND PRACTICE OF CARE

In this core of meaning, the factors related to the dynamics of the work process of nursing technicians and its resultant: care are concentrated.

The nuclei of meaning make up "the communication and whose presence, or frequency of appearance, may mean something to the analytical objective".[9:135]

For content analysis, the nuclei of meaning are those that stand out with greater frequency, showing in the messages what makes connection, meaning, with the objectives proposed in the research, based on the indicators that are found in the semi-structured interviews.[8]

Index 1: The nursing technician's work process

regarding the work process, the routine of the nursing technician begins with visits to users in their beds. At this moment, the communicative process between the professional and the user is established and the needs of the inpatient are met, thus initiating assistance in the construction of care.

Still with regard to the development of the work, in the relationship that is being built between the nursing technician and the user, a third actor enters the scene, the companion, who can be a family member or another person indicated by the family. This actor assumes an important role in the development of the technicians' work process, since they help in the performance of activities such as the bed bath and the sprinkling bath.

The role of the patient's companion in the hospital environment was established with the implementation of the Unified Health System Law[10] in the 1990s, and with the implementation of the National Humanization Policy[11] in 2003, through which the hospitalized patient's companion has been recognized as an accelerating agent in the rehabilitation process. With the presence of the companion, it is possible to maintain the user's affective and social bond, helping in the dynamics of care. And, in this sense, there are discussions about the actions of the companion in the sense that his/her activities do not invade or harm the procedures involved in the work of the multidisciplinary team. As for the elderly, pregnant women, children, and individuals with special needs, they do not need special authorizations to have companions in the hospitals. For the adult user, in general, the granting of a companion is always negotiated in order to have this benefit.[12] In the case of the scenario of this research, this concession for the adult user is a routine practice in the ward, so that every user has a companion.

As an inherent actor in the care process, the companion also becomes the object of work and care by the nursing technician.

> *In truth, the companion ends up being as sensitive as the patient, even more so, because his life stops, there is no one from the team to be able to talk to the companion. We, besides being technicians, we have to be psychologists, we have to be nurses, we have to be everything.* (TE 06)

To deal with the complexity of health work, the worker has been building ways and instruments for work. These instruments and ways of working are called toolboxes, which, in health, have the meaning of "technological kits," which the health worker carries with him/her individually or collectively.[13]

The work developed by nursing technicians is produced by several tools, including their own body, which was not mentioned by them as a work tool. The use of their own body in their know-how is so intrinsic that they themselves do not realize that it is a valuable tool for their daily routine, for the production of care with the hospitalized user.

It is a body marked by tiredness and a heavy routine, but it holds other elements such as satisfaction with the work, especially when some improvement in the user's health condition is noticed.

> *For me, each day, each improvement is satisfactory because I do what I like, I do it with love, and I dedicate myself to my work. So, my greatest satisfaction is when I see a patient returning well to talk to us and each day that we arrive and that he is better, we are more satisfied.* (TE 03)

> *Satisfying and tiring because they are patients that require more attention. More debilitated patients, more care, and therefore it becomes tiring.* (TE 01)

Tiredness and turmoil are situations that appear associated mainly with improvisation, lack of material, incomplete team, and inadequate physical structure. Similar results were pointed out by a research carried out in the emergency department of a hospital in Pernambuco. This study found that, in the perception of the nurses, the team of nursing assistants was insufficient for the degree of complexity of care and the

frequency of care provided; and they emphasized the lack of equipment and the low quality of the materials acquired by the service as detrimental to the development of the work.[14]

When the nursing technician uses the tools that are available for the work, such as hospital materials, he brings in a technical knowledge mixed with his own knowledge; and another important tool is his own body in the health work process, producing living work.

In the production of the work of the nursing technician with the user, using the living work as well as the dead work, something unusual happens, unique, in the act, something new that is called "living work in act".[13] In this movement of acting, in the doing, in the know-how, in the meeting or reunion of the health professional with the user, micropolitics is what happens.[15]

Micropolitics, in general, can be understood as a construction based on the relations between subjects that make up the social field, understood as a territory in which these relations happen; it does not have the sense of something only large, of a society, but rather with meetings of smaller relations between subjects.

Index 2: Tools that the nursing technician uses in his work

by using the instruments (or tools), one begins to produce the technical procedures to start the institutional routine that includes, among other activities, personal hygiene and the administration of medications prescribed by doctors.

The worker has in his "toolbox" the machine-tools, such as the stethoscope, the syringe, and the thermometer, in addition to his technological knowledge and know-how. The latter are employed in the "clinical know-how", that is, they put into practice the procedures that are produced in their work, and, in this way, they build relationships with others that, in some way, consume the production of their work.

From the testimonies and observation, it can be seen that nursing technicians carry in their toolbox hard, soft and soft technologies. However, only the hard technologies prevail as they are clearly recognized by them, since, when asked about the instruments they use for the production of care, they basically mentioned the equipment used for the execution of nursing techniques, such as personal protection equipment (PPE), gloves, stethoscope, thermometer, infusion pump, sphygmomanometer, vacuum cleaner, pump for diets, heart monitor, adhesive tape, gauze, dressing material, nebulizer, ointments. Despite this, the observation of the field of study and the statements of some technicians allowed us to identify that this professional has other means of producing care, which he himself does not understand as a work tool, nor does he consider certain actions as care.

Active listening, for example, although understood by the technicians as an attitude that is not understood in their know-how, was also pointed out as being used on a daily basis, and that collaborates, in some way, to the well-being of the hospitalized user.

> *Look, listening to that emotional, for me, is a bit heavy, isn't it? We try not to have that emotional involvement, because if you absorb everything the patient goes through, you also delimit. So, we try to listen without getting involved, giving the necessary attention, but trying not to have emotional involvement to spare ourselves.* (TE 04)

In this context of listening, the soft technology can also be defined as the production between two subjects that occurs in the act of care between the health professional and the user.[16] And at this moment, the nursing technician also produces his know-how; it is the moment when, in addition to the technical applications, this professional produces knowledge that is shared with the hospitalized user.

In this line, one can bring the idea of "workmanship": "Workmanship functions as a bridge between the obligatory production of use values and the desires and interests of the workers".[17:134] The construction of "workmanship" can be in a singular and/or collective way. The work of the nursing technician is also the construction of a work because, at the moment he produces what is mandatory, he also produces something that is inherent to the relationship of desire as a worker, and even if he understands this fact as something outside his mandatory work, he dedicates time to produce something that he does not name technically, but produces during care.

Index 3: The micropolitical dimension of care in the work of the nursing technician.

The technicians' work routine also implies the development of other procedures based on their applicability under the supervision of the nurse, such as measuring blood pressure, checking body temperature, changing decubitus, performing dressings, and transporting users for exams.

> *We do the routine of the bath, if there are any pending issues we solve, like an expired access, handling a tracheostomy or macro, we have to clean, change. Then, around one o'clock in the afternoon we manage to finish this routine at the beginning of the shift. To orchestrate, to organize the sector, the patients. From one o'clock in the afternoon until the end of the shift is the maintenance according to the prescription for each patient, medication every 6 hours, every 4 hours, following that pattern.* (TE 07)

> *First, see the procedures of the patients. Prepare the baths. Check the vital signs. Check the medications, the serum changes during the day.* (TE 04)

The statements exposed point to a work process established in a mechanistic logic and structurally crystallized as, for example, when the term "macro" is mentioned, what it means is macronebulization, whose subjectivity is suppressed and the worker's autonomy is hindered, not allowing the production of new work processes.

The proposal of the Wheel Method[17] seeks to break with the tradition of creating in the worker the objectivity that is based on hegemonic managerial rationality, and tries to combine social commitment with freedom. And, in order to make this combination, the worker needs to express desires, interests, and needs that allow his or her own subjectivity.

This set of factors implies the technicians' difficulty in producing care, which was defined by them as: a whole, attention, comfort for the user to feel better. Also understood as priesthood, donation, medication to the user, hygiene, bath in bed, feeding at the right time (even when the user doesn't want to feed himself), love.

It can be observed that, from the technical applicability, a way of caring is given, but it is not enough to define care in its dimension. In general, care is generalized as something basic, incorporating it to the concept of treatment and use of medications, because to care is not to treat. In this expression, treatment is not conceivable as a definition of care.[18]

It should be noted, however, that the idea of care as the treatment of illnesses is grounded in a process of formation in which the health professions were sustained and, in some cases, still are. And in this conjuncture, the organization of the health work process remains centered on procedures with an offer of assistance based on the disease.[19]

In one of the statements, care was defined as:

You care and you are cared for. (TE 06)

The idea of care[16:2] states that "care is an intercessor productive event" that takes place in the moment, and that "contains in its constitutivity the logic of mutual production in a micropolitical act that supposes the production of one in the other. The micropolitical act takes place in the scenario in which it happens, in a singular way; the movement towards action.

In the use of the "toolbox," each work produced is not the same as the others already produced or to be produced, there is a certain uniqueness in each production of work that always differs one production from another. This uniqueness is built because each work is given by its specificity, its specific techniques, specific raw material, at different times with different consumers.[13]

Every work process, in health as in any other area, is built by works done in act, "live work," and works produced previously, "dead work. In this logic, the tools and instruments that the health worker carries in his/her "toolbox" constitute "dead labor," because they have already been produced at other times, when the raw material was transformed. In each step of the creation of each tool, there was its moment of "living work" production. After finishing the production of the tools that are used in health services, these finished tools are considered as dead labor.[13]

With the production of the tools for health work, their use is constituted in health technologies: hard, soft-hard, and soft technologies. The use of these three types of technologies in the production of care is constituted in a meeting space between the health professional and the user, this space is a scenario of micropolitics.

Micropolitics as a scenario of know-how

The micropolitics of the hospital scenario is full of complexities and singularities. Its professionals bring with them their individual projects built on a knowledge structured in the formation of each one. It is at this moment of putting their unique project in the care of those who seek the health service that the intertwining of health professionals with users begins, and, thus, the micropolitics takes place in the action of each one: professionals and users, in which each one produces their know-how through the demand that the user brings. From that moment on, there is a movement between what the health worker or workers bring and what the user brings in his or her baggage; it is in this exchange, in this flow, in this production of singularities, of subjectivities, that micropolitics takes place.[16]

The results of this research point to a nursing technician's work process that is still not very autonomous and rooted in the structural precepts of a health model whose object is the disease and whose health interventions are restricted to its treatment. On the other hand, the use of soft technologies is observed that allow the production of humanized care, shared between professional and user, which has positive impacts on the quality of life of the user. This is because health work is not controllable at all, since it is based on a relationship between people, regardless of the stages of its realization; and, therefore, it is always subject to the intentions of the worker in his or her autonomous space, of materialization of the practice.[20]

CONCLUSION

The process of health work is built in the dimension of small details in the daily routine of health workers, which are: each act, each action, each dynamic, the move, the go, each handling that the health worker produces in health services together with the user. It is by understanding these small details, the movements, the comings and goings, that the worker transforms nature, the raw material. It is in the relationship with the user, therefore, that the nursing technician produces and reproduces his know-how, and, at this moment, there is an act of transforming and being transformed.

The work of the nursing technician in the analyzed hospital environment is structured based on a well-defined routine of tasks which, to a certain extent, inhibits the autonomous development of new ways of producing care. However, the know-how is also produced in the micropolitical moment in which the nursing technician relates to the hospitalized user, producing care as an intercessor event in which life produces life, in which the production of care is re-signified in each encounter, in each scene. However, the professional nursing technician, in this daily routine, hardly recognizes the moments of re-signification of his practice as a therapeutic element in caring for the user.

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