Original Article

TEXTO & CONTEXTO ENFERMAGEM
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STANDARDS OF KNOWLEDGE THAT FOUND NURSING PERFORMANCE IN HOME CARE

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ABSTRACT

Objective: to analyze the knowledge standards that found nursing practices in the home care setting.
Method: qualitative study using a single case study strategy, supported by the dialectical methodological framework. Thirteen nurses who work in home care services from two municipalities in Minas Gerais, Brazil, participated. The data were obtained in 266.5 hours of participant observation and 8 hours and 58 minutes of interview and submitted to Critical Discourse Analysis.
Results: empirical knowledge was revealed to be fundamental for clinical, managerial and educational care at home. The adaptations specific to this environment require aesthetic knowledge. The relational and educational actions, the decisions responsible for benefiting the individual and his family, the doubt and willingness to learn when dealing with unpredictable cases and the assessment of the socioeconomic conditions of the family, represent, respectively, personal, ethical, lack of knowledge and sociopolitical aspects present in the practice of nurses in home care.
Conclusion: the particularities of home care trigger different patterns of knowledge to ensure creative, sensitive, human and responsible care. Innovation and availability to learn are part of nurses' performance in home care. The need for differentiated training is reinforced in order to respond to the increasing complexity in this field.

DESCRIPTORS: Knowledge. Nursing care. Nursing. Home nursing. Home care. Home care services.

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PADRÕES DO CONHECIMENTO QUE FUNDAMENTAM A ATUAÇÃO DE ENFERMEIRAS NA ATENÇÃO DOMICILIAR

RESUMO

Objetivo: analisar os padrões de conhecimento que fundamentam as práticas de enfermeiras na atenção domiciliar.
Método: estudo qualitativo, na estratégia de Estudo de Caso único, sustentado no referencial metodológico da dialética. Participaram 13 enfermeiras que atuam em serviços de atenção domiciliar de dois munícipios de Minas Gerais, Brasil. Os dados foram obtidos em 266,5 horas de observação participante e 8 horas e 58 minutos de entrevista e submetidos à Análise de Discurso Crítica.
Resultados: o conhecimento empírico foi revelado como fundamental para o cuidado clínico, gerencial e educacional no domicílio. As adaptações próprias desse ambiente exigem o saber estético. As ações relacionais e educacionais, as decisões responsáveis por beneficiar o indivíduo e sua família, a dúvida e disposição para aprender perante a condução de casos imprevisíveis e a avaliação das condições socioeconômicas da família, representam, respectivamente, os conhecimentos pessoal, ético, desconhecimento e sociopolítico presentes na prática da enfermeira na atenção domiciliar.
Conclusão: as particularidades do cuidado domiciliar acionam diferentes padrões de conhecimento para garantir o cuidado criativo, sensível, humano e responsável. A inovação e a disponibilidade para aprender fazem parte da atuação das enfermeiras na atenção domiciliar. Reforça-se a necessidade de formação diferenciada para responder a uma complexidade crescente nesse campo.

DESCRITORES: Conhecimentos. Cuidados de enfermagem. Enfermagem. Enfermagem domiciliar. Assistência domiciliar. Serviços de assistência domiciliar.

NORMAS DE CONOCIMIENTO QUE FUNDARON EL DESEMPEÑO DE LAS ENFERMERAS EN EL CUIDADO DOMICILIARIO

RESUMEN

Objetivo: analizar los estándares de conocimiento que justifican las prácticas de las enfermeras en la atención domiciliaria.
Método: estudio cualitativo, en la estrategia única de Estudio de Caso, sustentado en el marco metodológico dialéctico. Participaron trece enfermeras que trabajan en los servicios de atención domiciliaria de dos municipios de Minas Gerais, Brasil. Los datos se obtuvieron en 266,5 horas de observación participante y 8 horas y 58 minutos de entrevista y se sometieron a Análisis Crítico del Discurso.
Resultados: Se reveló que el conocimiento empírico es fundamental para la atención clínica, gerencial y educativa en el hogar. Las adaptaciones propias de este entorno requieren conocimientos estéticos.Acciones relacionales y educativas, decisiones responsables de beneficiar al individuo y su familia, duda y voluntad de aprender ante casos impredecibles. y la valoración de las condiciones socioeconómicas de la familia, representan, respectivamente, los conocimientos personales, éticos, de ignorancia y sociopolíticos presentes en la práctica del enfermero en la atención domiciliaria.
Conclusión: las particularidades de la atención domiciliaria desencadenan diferentes estándares de conocimiento para asegurar un cuidado creativo, sensible, humano y responsable. La innovación y la disponibilidad para aprender son parte del desempeño de las enfermeras en la atención domiciliaria. Se refuerza la necesidad de una formación diferenciada para responder a una complejidad creciente en este campo.

DESCRIPTORES: Conocimiento. Cuidados de enfermería. Enfermería. Enfermería a domicilio. Cuidados en el hogar. Servicios de asistencia domiciliaria.

INTRODUCTION

Home care (HC) is configured as a type of health care in which the professional performs humanized care to the user and his family in the home environment.[1] The growing demand of people in need of this care modality has been an invitation to expand its offer and its worldwide expansion is evident.[1–2]In the HC setting, the work of the nurse is highlighted both for the essential participation in the multidisciplinary health team and for the potential to respond to the population's health needs, as it contributes to the integrality and continuity of care.[3–4] The role of the nurse is revealed in their autonomy as educator, manager and care provider.[3–7] Therefore, the nurse has a fundamental role in the production of home care[3,7] recognizing that this type of care requires the mobilization of specific knowledge[8] and qualified professional care.[6.8]

The specificity of home care requires the professional to have contextualized knowledge, which is able to differ from the standardized practices performed in other health services.[2,4,9] The singularities of the home context need to be recognized, as well as the dynamics of each of the families and the factors that interfere in them, such as income, beliefs, customs, values and knowledge.[10]Understanding the specificities inherent to the home context contributes to the production of knowledge and practices, and also has the potential to innovate care.[10] It is emphasized that the home environment challenges the professional to develop adaptations and inventions that arise due to the context of the HC, [9] which can be creative, intuitive, innovative and flexible when faced with the demands presented.[4,7,9,11] The lack of academic training of nurses working in HC is reinforced, reflecting a lack of knowledge which in turn affects home care.[9,12]

Concerning the work of nurses in HC, specific knowledge is required regarding the provision of care[8–9,13], especially in relation to therapeutic projects, interpersonal relationships with users, family members and the multidisciplinary team, as well as technical and scientific knowledge specific to the field.[8] It is necessary to recognize the peculiarity of the environment and, from that, plan, structure, implement and coordinate care actions effectively for the benefit of the user and their family members.[13] In this sense, nurses need to be prepared to act in the face of unpredictability and to use different knowledge[14] that need to be investigated, disseminated and systematized.[8]

As mentioned above, the different knowledge necessary for the performance of nurses in HC is evident, based on actions of assistance and relational nature,[4,8,15] with the capacity to combine scientific and popular knowledge, as well as technical and emotional knowledge.[15] In the context of HC, the nurse is invited, based on diversities and adversities, to link the different knowledge of the profession in order to perform their work.[15]

Knowledge can be described as one of the attributes that constitute competence[16] and also as an inherently human activity, which allows the professional to obtain information and use it with a defined purpose.[17] Thus, nurses need a body of knowledge in order to adequately perform their practices.[8] Knowledge is conceived by obtaining data, its understanding from a defined purpose and based on meanings and relevancies, contributing to deliberate actions, depending on the specific contexts in which they are produced.[17]

In 1978, upon analyzing the foundation of knowledge in nursing, Barbara Carper considered that the set of knowledge that guides nursing practices is configured by standards, which have forms, characteristics of external and internal expression reflecting the way these professionals think and base their work.[18] In this sense, the author describes four patterns of knowledge, according to the type of meaning: the empirical refers to the science of nursing; aesthetics to the art of nursing; the staff for the knowledge of themselves and others; and ethics allows the development of moral knowledge in nursing.[18]

Nursing knowledge standards are essential elements for the development of the practice and are expressed in an integrated manner. In view of its relevance, other standards have been added. Munhall, in 1993, included the pattern of lack of knowledge, which represents a state of readiness, of discovery.[19] In 1995, White added yet another pattern: socio-political knowledge, which refers to how and when to act in the context of care.[20]

The understanding of how knowledge is produced, applied and evaluated becomes relevant to nursing[17] and, in particular, to the role of nurses in HC.[21] Thus, the classification of knowledge standards proposed by Carper,[18] Munhall[19] and White[20] confers sensitivity, humanization, culture, moral precepts, scientific basis and interaction, being relevant to the nurse's care practice in HC.[21] Such standards anchored the analysis, and are adopted in this investigation.

It is believed that evaluations, based on these dimensions, can highlight the specificities and innovations of nursing practices in HC, given the complexity of these, when they are produced in a territory in the domain of the patient and his family and, in which, their real needs are manifested. The relevance of home care provided by nurses is proven. Thus, investigating the specific knowledge which underlies these practices may contribute to the process of training and improving the care of nurses in HC.[9] In this sense, the present research started from the following question: How do the patterns of knowledge found the nursing practices in Home Care? In this study, the objective was to analyze the patterns of knowledge that underlie the practices of nurses in home care.

METHOD

A qualitative single case study[22] with theoretical-methodological support from dialectics.[23] Dialectics, as a reference, enables the understanding that society is experiencing continuous and permanent movements of transformations and overcoming contradictions.[23]

Dialectics contemplates three principles: historical specificity, totality and the union of opposites. Historical specificity encompasses everything that goes beyond the individual to achieve social existence. The totality refers to phenomena in their self-correlation and heterorrelation, in their multiplicity and reciprocal conditioning by other phenomena or groups of phenomena. The union of opposites is present in several intertwining and conflict movements.[23]

The Case Study method aims to analyze a social unit, seeking to answer "how" and "why" the phenomena occur.[22] Single case studies analyze the phenomenon in a given context, and are valid and decisive when the case is revealing, allowing a specific situation to be explored.[22]

For the definition of the case, an integrative literature review[8] was taken into account, which made it possible to identify the complexity of the nurse´s performance in the HC, especially in specific actions, according to the profile of the patients' demands in the service, such as such as: parenteral nutrition, peritoneal dialysis, parenteral medication administration (subcutaneous, intramuscular and intravenous), oxygen therapy (including invasive and non-invasive mechanical ventilation), palliative care and care for complex wounds[8]. The case under study consists of "the nurse's role in highly complex Home Care", considering that the greater the complexity of care in HC, the greater the requirement for different knowledge to exercise nursing practices.[8] In the Brazilian context, such actions are included in the scope of Home Care Services (SAD) characterized by modalities AD2 and AD3.[24]

The study scenario then consisted of two municipalities, initials U and B, from Minas Gerais, Brazil, selected from the contact with the 22 municipalities that had (SAD) linked to the Unified Health System. The selection criteria for the municipalities considered the provision of highly complex care, the number of active nurses and the offer of invasive and/or non-invasive mechanical ventilation in the SAD, considering that patients on mechanical ventilation require complex continuous nursing care and long-term care in AD.[1]

The research participants were nurses working in the Multidisciplinary Home Care Teams (EMAD) in the chosen settings. The SADs of municipalities U and B had nine nurses in five EMADs and six nurses in four EMADs, respectively. During the data collection period, two nurses were on maternity leave and vacation, and were therefore not included in the study. Twelve women and one man participated. To preserve the identity of the participants, it was decided to standardize the female gender throughout the text, with a total of 13 nurses.

The production of the data took place from May to December 2016 and occurred in two moments: The first was the peripheral participant observation of the nurses' performance, guided by a guiding script recorded in a field diary and audio recording.[25] The observation was guided by questions regarding the description of the following aspects: subjects in the scene; actions performed by the nurse; instruments and technologies used; situations that express challenges at work; and the researcher's report/perception regarding what was observed. The entry into the homes was preceded by the authorization of the professionals who conducted the care practices, as well as of the users or guardians.

The observational phase was performed during the nurses' work in HC, especially during palliative care visits, death, discharge, admissions, medication administration, complex dressings, oxygen therapy and ventilation mechanics, paracentesis, evaluation and meeting the demands for unscheduled appointments. 272 visits were made to 186 patients, totaling 266 hours and 30 minutes of observation and the interruption criterion was the condition of response to the research objective. The field diary resulted in 277 pages of text and was coded with the following sequence of information: "Field diary (FD) - Place or number of the visit - Participant".

In the second moment, interviews were conducted which were guided by a semi-structured script, [23] whose questions were: Describe what enables the development of your actions in practice. How have you been handling uncertain or complex situations or those which you were not prepared? The interviews with the 13 nurses, with audio recordings and recordings in field notes which included the researcher´s impressions took place after all the observational part in each scenario. They were scheduled and performed individually, totaling 8 hours and 58 minutes of recording time which resulted in 169 pages of text after being transcribed in full. The transcript followed the conventions, models and guidelines proposed for the analysis, showing pauses and silence ("+"), intonation and emphasis ("capital letters") and vowel lengthening ("::"). The participants received an identification designated by an alphanumeric classification composed of the initial letter of the municipality (U and B) and the number from 01 to 09 for U and from 01 to 04 for B, which were randomly assigned. The production of the data sought to guarantee the aspects that give quality to qualitative research, namely: credibility, transferability and confirmability.[26]

The findings of this case study were supported by more than one source of evidence, allowing data triangulation[22,26], following what is indicated in the literature regarding the creation of a convergent line of investigation to allow greater exploration, expansion of reading and understanding the results obtained.[26] The data analysis was based on the theoretical frameworks of Carper,[18] Munhall[19] and White[20] for the interpretation of the category "Standards of Nursing Knowledge".

Thus, the triangulation between the observation and interview data reveals that the care provided by nurses at home requires the assimilation of empirical, aesthetic, personal, ethical and socio-political knowledge standards, in order to carry out diverse actions, as summarized in Chart 1.[18–20]

Chart 1 – Characterization of the appropriate knowledge standards in the work of nurses in HC

Empirical	- Scientific and theoretical knowledge: care which seeks to follow scientific principles; organization of the service and care plan; link with other services; training of patients and caregivers; performance of varied procedures (dressings, administration of medications, catheterizations, punctures, oxygen therapy); evaluation and clinical care.
Aesthetic	- Creative and intuitive knowledge in the process of interaction between nurse and patient/caregiver: orientations according to the resources available at home; adaptations of theoretical knowledge to the reality of each family; Resolutive and creative care. - Empathy in seeking to provide comfort to patients and family members.
Personal	- Know how to build an effective relationship with patients and family members: to be willing and receptive to others; establishment of bonds and relationship of trust with patient and family; respect, emotional support, dialogue, active listening; guidance to caregivers for continuity of care; guidelines in a playful way, understanding the need of the other. - Transformations in the ways of acting and being of nurses.
Ethical	- Notion of responsibility and decisions to benefit the individual and his family: respect for the legal precepts of the profession; adaptations responsibly; commitment to truth with family members; respect for family privacy.
Lack of knowledge	- Willingness to learn in each care situation: recognition of lack of knowledge in the face of the particularity of the home context and the unpredictability inherent to work in the; discoveries regarding the complexity of home care; search for knowledge to act in relation to individual differences in order to create a positive and resolutive result; the need to learn to adapt theoretical knowledge to the reality of each family, through the proper context of HC; learning with the patient, the team and the situation experienced; continuous learning in and for work; recognition of insufficient academic training and the need for continuing education.
Sociopolitical	- Knowing how to act in the social context: solidarity and activation of other services when performing and seeking donation for the family; recognition of the complexity of the home context and adequacy to the reality conferred by social differences.

Critical Discourse Analysis (CDA) was performed which allows the understanding of the social context of the object studied and the aspects that can complement it.[27] Through CDA, the analysis of discursive events, understood as part of a discursive practice, proceeded considering the dimensions of text, discursive practice and social practice in the socio-historical context and social transformations.[27]

This study met the ethical precepts of Resolution no. 466/2012 of the National Health Council. The project was approved by the Human Research Ethics Committee of the institution.

The presentation of the study results followed the recommendations for reports of qualitative research projects, using interviews available in the Consolidated criteria for Reporting Qualitative Research (COREQ).[28]

RESULTS

The triangulation of data reveals that the care provided by nurses at home requires knowledge to carry out diverse care actions in an educational and managerial nature. The deontic modality in the discourse ("must know") indicates that the nurse requires a lot of knowledge for the care performed in HC.

[...] *I have to know the right technique, dosage of antibiotics, interval between doses, everything, EVERYTHING, tube passage, everything, exam collection, you have to find the foot vein* [...]. (U05).

[...] *the managerial issue of the team itself, organization of the service, organization of medical records, organization of a care plan, patient training, active search, interface with other services, [...] I think that all these things the nurse has to know in order to be able to proceed with the program, you know*. (B03).

She (nurse) *reports, in the car, that the nurse has to know everything. [...]. According to her, the criteria for working in HC are: having a very open mind and being able to work in a team [...] you must know how to act by phone.* (FD - route - U01).

Evidence from observation and interviews reveals the responsibility to provide guidance to caregivers and patients to benefit the individual and their family according to their needs. The adequacy of language by the nurse is evidenced by the use of discursive metaphors, evidencing the orientations in a playful way.

[...] *there is a family member who has a low level of schooling, extremely low, there was a situation sinc*e [...] *we had a patient who had decompensated HF (heart failure)* [...], *and she went home and arrived at the house and everyone was illiterate* [...]. *And then she already had a catheter and the family were completely lost, they didn't know what they were doing. So, the nutritionist and I went there [...] we asked the daughter to make the food, and blend the, the, the soup there, for them to see the consistency because we could only do it, the only way they could understand was by demonstrating, because by explaining, they would not understand* (U03).

[...] *The patient's daughter explains "it is to change the serum, which has to run in three hours". He guides in a playful way on how to close the equipment: "big mouth is open mouth, and small mouth is closed mout*h". (FD - V132 - U01).

The specificity of the work performed in the HC marks the need for technical knowledge for the nurse's work according to the deontic modality and the evaluative statement present in the statement from U05. The normative and literary interdiscursivity present in the excerpt from U09 and in the field diary of V181 indicates that nurses have autonomy for actions that require knowledge of a clinical and technical nature in order to carry out care activities.

[...] *you must have technical knowledge because it is not always something you can do at home*. (U05).

[…] Nowadays, home care nurses have a lot of autonomy, they carry out all the procedures that are legally their responsibility, such as changing the nasogastric tube, changing gastrostomy, arterial puncture, urinary catheterization [...] (U09).

[...] (The nurse) *Mention that the care will be for a child to administer medication at home and [...] the whole process is different, the dose is different, the calculation is different, the puncture is different, the mother's presence is different* ". [...]. (FD - V181 - B02).

As can be seen from the above, the role of the nurse requires scientific knowledge for the various actions that are performed in the HC. Dialectically, the normative interdiscourse used by nurse U09 ("there are a lot of rules, norms, routines, laws, you know, about nursing") reveals that the rules established to normalize the practice of nurses in other contexts do not apply to the home context, and need to be flexible. The uniqueness of the nurse's work performed at home, is evidenced by the use of discursive assumption ("at home it is totally different, more resolutive", "creative") and also by what is exposed in the excerpt from V78 in the field diary

[...] *there are many rules, norms, routines, laws, you know, in nursing. This makes it a little more mechanical, and this autonomy in home care is totally different, more resolutive, creative, right, spontaneous. So, I think that the nurse's practice becomes softer, lighter, more important* [...]. (U09).

(visit for guidelines for gastrostomy) [...] *The nurse shows the catheter that will be used in the patient's daughter and demonstrates how it will b*e. [...] *The nurse informs that she will ask the patient to film the care she must give with the probe in order to show the patient's daughter, who cries and reports that it will be great to see the reality. The nurse welcomes the daughter's emotion*. [...] (FD - V78 - U06).

In a representational perspective, the U05 discourse reinforces the particularity of home care, initially unknown to the professional. The dialectical relationship between simplicity and complexity present in HC is noted.

[...] *I think that for me it was another view, totally different, nowadays I have another view of home care, we think it is simple, but it is much more complex than that: we imagine*. [...] (U05).

The speeches indicate that the practice in HC should be performed, according to the patient's reality, due to the characteristic that the home presents, this being a different space from other health services, which do not have a standardized physical structure for the nursing actions. The use of the deontic statement "you must" and the metaphor "find other ways" reinforces the need or obligation to adapt theoretical knowledge to the reality of each family, due to the context of HC, as well as the space in which care happens.

[...] *our DIFFERENTIAL here is that we are always in accordance with the patient's reality, [...] we have to adapt according to each reality*, [...] *you have to guide based on what the person has [...], so it's an adaptation,* [...] *you really have to be creative* [...] (U02).

[...] *so you end up adapting what you know in theory to the family's experience, righ*t. [...] *so you have to find other ways* (U03).

[...] (During the performance of relief catheterization for the collection of urine for examination) *the nurse mentions that "adaptation is necessary, because we don´t have everything in the homes, for example, there is no sterile field". He reinforces that "at home, you have to be very careful not to contaminate and you need to adapt". Uses the sterile gauze and glove wrapper itself as a sterile field*. (FD - V40 - U01).

With regard to the need and obligation to adapt at home, it stems from the speeches of intentionality in the nurses' work, when mentioning that they seek to carry out their actions in the best way for the patient. In this way, the adaptations are made in a responsible manner, seeking to adapt the knowledge, coming from the scientific evidence for the context of AD.

[...] *And then it's time to see what you will adapt and how it will work for the patient, that it will not cause any harm to him, and that you will be able to continue with your technique, be it sterile, or just clean.* (U04).

[...] *When performing the debridement, the nurse said: "here at home we don't have all the conditions, for example, we don't have a fenestrated field drape. But we do the correct technique using gauze and without contamination"*. [...] (FD - V05 - U02).

The participants mention that the provision of home care permeates the experience of situations of uncertainty in view of the unpredictability inherent to work in HC, as indicated by the evaluative statements "I don't know", "we are not the holder of all knowledge", "you never know". The intertextuality manifested in B04's speech indicates the nurse's voice in the face of the commitment to the truth with family members, in face of the imprecision in conducting care.

(+) *I think home care* [...] *each case is different, right? And I think that as much as you want to learn, you never know, because each situation is: sometimes it's the procedure itself, the pathology, sometimes it's the same. But as the cycle changes, so does everything.* (U04).

[...] *sometimes something comes to you, sometimes you have to say to the family: "Look, I don't know, I'll try to find out". Because it happens, we don't have all the knowledge* [...] *I really say*

this to the family, I say "Look, I don't know, I'll have to look and come back to be able to pass this on to you" (B04).

[...] (wound assessment) *The nurse is in doubt about the wound edges. She reports that "it has keratin on the edges, it looks like it". The nurse takes a picture and tells the patient that "she will ask the nurses at the SAD to see what to do". She reinforces "I'll see what I'm going to do with it, I'll see how I'm going to do it".* [...] (FD - V93 - U01).

The speeches also suggest poor academic training for the nurses, in relation to acting in different situations that stand out in HC. There is a lack of specific knowledge regarding the practice and the particularities of HC. In a dialectical combination, it is important to emphasize that, in the context of insufficient training, the deontic modality in the discourse indicates that the nurse needs to know "everything". In order to value the contradiction between the content needed to work in the home context and the one formed by the training, the participants use the metaphors "naked and raw" - "very raw" and "*you have to: wiggle*".

[...] *I think that it had to start in our training formation, right, because:: THERE IS NOTHING regarding home care*. [...]. *So:: the nurse when he goes to give home care, he GOES NAKED AND RAW*. [...] *So I think that:: this could be more invested in this question:::, about education, you know?* (U04).

[…] This nurse has worked at SAD for 3 years. [...] *She said that "she started very crudely at Melhor em Casa*" [...] (FD - path - U01).

[...] *the nurse has to know a little about everything, has to have technical knowledge because it is not something you can do at home*. [...] you have to: move around, right (U05)

Faced with the uniqueness of HC, the nurse gradually develops knowledge while working in HC. The discursive element "temporality" reinforces the willingness to learn, in each care situation, through experience with the team, patients and caregivers.

[...] *So:: that's why you are learning every day, right. You learn with the patient, right, with the situation, sometimes the team itself, right. You keep improving your knowledge* (U04).

The nurse mentioned that she studied a lot about wounds at home because she had many cases at SAD. And I trained in the service [...] (FD - route - U01).

[...] (after making a visit for palliative care) *In the car, the nurse said that she learned a lot about the palliative care approach from her team's doctor* [...] (FD - path - U03).

The deontic modality, present in the speeches, indicates that nurses need to know how to build an effective relationship based on the interaction between nurses and patients, family members and caregivers by establishing a relationship of respect, trust and emotional support, guided by dialogue, especially for the ability to listen.

Ah, I think the nurse has to know everything. [...] know how to deal with the emotional as well [...]. So, you have to know how to deal with the emotional. [...] to give advice, to explain, to calm down, to talk to the family. And it's like that in home care, it's you and them [...] (U07).

[...] (after dressing and caring for the patient). *The nurse goes to the kitchen for breakfast and talks to the patient's daughter about care.* [...] *In the car, the nurse reinforced that it is important to stop and talk to the daughter, because, at that moment, the family feels welcomed.* [...]. *He said that he learned to spend more time at breakfast* [...]. *According to her, this is important for building bonds and trust with the family.* (FD - route - U06).

Due to the complexity of HC work, nurses need to know how to adapt their actions to the reality conferred by social issues. In an attempt to provide the best care, nurses are required to know how to "deal with the social".

The nurse needs to know how to deal with others. (+) I think that here you have to know, [...] *how to deal with the situation, deal with the family::, deal with the social* [...] (U04).

[...] *The doctor prescribes clindamycin and the nurse mentions that she will look for a donation, as she considers that the medication is very expensive and inaccessible for the family*. [...] (FD - V136 - U04).

[...] *we have already organized food donations, we have already bought medicines, we buy mattresses, so the team does things, the team is very supportive to the patients* [...] *so we go, I ask for a loan of medication from the network* (B02).

As explained, the home is different from health institutions, as it is a private territory. When nurses enter this space in order to provide services, it becomes an open territory to potential actions and inactions, which requires knowledge of the specifics of the situations. In view of this, the deontic modality present in the speeches indicates that nurses need to have an ethical posture and develop a behavior that shows respect for family privacy.

[…] *Look, I think that home care requires* [...] *a very important ethical posture, right, because you are entering the home, in a reality that belongs to the patient and the family*, [...] *this specific issue of the home is this reality of dealing with the family, you know, with all its complexity* (B02).

[...] *the nurse excuses herself and asks if she can see the wound. The patient replies: "no". The nurse asks if it is only when she is alone* [...] *and asks for permission from the student and me* [...], *she says that the patient "does not let anyone see, for example, he did not let the physiotherapist se*e" (FD - V93 - U01).

The speeches indicate that some singular situations of HC cause changes in the nurses' performance in homes, as well as in their personal lives. The relationship with caregivers and patients and the experience of carrying out care in the face of the reality of patients and their families are situations that produce processes of change in the nurses' ways of acting and being, as represented by the metaphorical highlight "*I changed like this oh:: from water to wine"*.

[...] *many of the things we see, a lot of poverty, the lack of material things.* [...] *And then this question is always on my mind, you know?* [...] *And I wasn't much like that, I was: very material, very attached. And I detached a lot.* (U01).

So:: I stopped being very like that, impatient, and started to observe better, right, let's see what is happening here in this house [...] *changed me like this oh: from water to wine.* [...] *My concepts have changed a lot*. [...] (U06).

[...] The nurse, talking to me, informs me that she has been working HC for 3 years and that she likes what she does. She said that "*the service is easy and that the worst is for the head. We see a lot of difficult situations at the patient's house that makes us review a lot of things at work and in life" (*FD - Headquarters - U02).

DISCUSSION

Regarding HC work, the results indicate that different knowledge (technical and relational) is necessary with the complexity of this type of care being evident.

Empirical knowledge is present in the domain of theoretical, technical and scientific aspects in the role of nurses.[18] Historicity reveals itself in this pattern, which represents the hegemonic conception of knowledge and, in HC, it is relevant in supporting actions and enabling clarity and the mastery over the care provided. In view of this, theoretical knowledge is fundamental for the realization of clinical, managerial and educational care.[9,13]

Dialectically, it is emphasized that the empirical pattern is important in HC, but that it cannot stand alone.[21] The findings of a review study reverberate "that the nurse's performance at home is much more complex, and involves other activities of extreme relevance, which are not just technical procedures".[13: 1135]

Associated with scientific knowledge, the aesthetic pattern is expressed by the subjectivity and sensitivity present in the interaction process between nurse, patient and family. Aesthetic knowledge is expressive, subjective and exclusive. Aesthetics corresponds to the art of nursing, which become apparent in caring.[18] Considering the social context of HC, in the nurses' performance, the presence of a creative and intuitive process is noted in which "knowing how" includes planning and the performance of nursing interventions that emerge from particular situations in HC. The nature of aesthetic knowledge guides the nurse in her performance, in a way that adapts to the situation, according to the means, in order to achieve a desired result.[9]

It is worth mentioning that the adaptations have a dialectical conjugation, with regard to the absence/insufficiency of resources and, concomitantly, the guarantee of carrying out care. On the one hand, the act of adapting allows the recognition of the professional as a person involved in the search for the best for the patient and guarantees care. On the other hand, they represent the precariousness of working conditions and the absence of a critical attitude in the face of a macro-political context, produce uncertainty in relation to the implementation of scientific principles in the provision of care and can contribute to the perpetuation of such practices in professional action, while they can inhibit change.[29]

The data reveal that professionals should focus on the user, the family and the context of life. The reality of the family in HC causes the needs expressed by the user to be apprehended in an act, on a daily basis, by professionals and demand creativity and invention from them.[9] Creativity is considered a necessary attribute for the development of home care.[2,13] The development of creativity is fundamental for innovation and the conception of new practices, seeking to respond to advances in knowledge and to conceive innovations for the process of interaction and production of care for the user and the family in home care.[9,13]

The creative process and the potential for innovation/creation could be further developed if there was the supply of adequate and adapted materials to the home and if, in the training of nurses, the content necessary for the development of home care was done in a specific way.[9]

Personal knowledge refers to the way nurses perceive themselves and the client.[18] Knowing and recognizing another human being as a person occurs, through knowing oneself. Thus, relational and educational actions represent the personal knowledge present in the nurse's practice in HC. In its applicability at home, this knowledge is configured as fundamental in the home context, becoming necessary even in technical care[8], and also contributes to their professional competence and also as a person.[21]

The notion of responsibility present in the care provided by nurses and the search for the provision of better actions represent the ethical standard of knowledge. This refers to the moral code of nursing and is based on the commitment to serve and respect human life. This standard is guided by responsibility, judgment on what is beneficial or not, and it is up to the nurse to make the best choice and to determine what is appropriate in a given circumstance.[18]

The actions performed in HC by nurses are multiple, complex, time-consuming and involve great responsibility.[3] Furthermore, it is required that nurses know how to act in relation to individual differences in order to create a positive result, building a relationship of empathy in seeking to provide the best to patients and family members.[2]

The practice of nurses in the home setting is shown as a priority, due to the dynamics and unpredictability of HC, expressing the contradictory relationship between simplicity and complexity present in this care modality. The pattern regarding the lack of knowledge that is revealed in the work of nurses in HC represents a state of readiness and discovery.[18] The data indicate that nurses are willing to learn in each care situation, in a process of recognition in realizing that they do not know the world of on the other, its subjectivity and, therefore, is open to this learning. The doubt regarding

the handling of imprecise cases derived from the unpredictability present in the home setting is manifested in the nurses' daily action.[11] Nurses continue to constantly develop their practice of home care, through learning by reflective practice.[11]

With regard to the lack of knowledge, the statements highlight challenges inherent to the complexity of the nurse's performance in HC, through recognition of the insufficiency of academic training to work in this area. Studies indicate the invisibility of the context of HC in the training processes of nurses,[2,8] not being prepared to work in HC, with regard to its particularities.[2,8,12] Qualifications and sharing knowledge and experiences are necessary and the search for information aimed at understanding the particularities of HC.[13]

In HC, socio-political knowledge represents how and when to act in the context of care.[19,30] The findings indicate that this pattern of knowledge allows us to understand when and how to act in relation to home care that involves, in a perspective of dialectical totality, not only the practice of nurses, but also the spaces and contexts where people live. Therefore, health experiences should be considered, which are influenced by cultural, historical, economic, social and political aspects.[30] Thus, the nurse in the HC setting needs knowledge in order to assess the socioeconomic conditions of the family that can interfere in care.[3–5]

The findings of this research reveal that nurses are essential to home care, both because of the specific knowledge in relation to the therapeutic projects and because of their knowledge regarding the guidelines that are necessary for patient care. Thus, in the scope of the home care setting, it was possible to identify different necessary knowledge used by the nurse, as it is them who interacts with the patient and the family, employing technical and scientific, sociocultural, ethical and aesthetic knowledge and also intuitive knowledge in a unique way, being able to feel and perceive peculiar situations of home care, using them for a common good.[8]

This research is limited as it analyzed the practice of nurses in only two scenarios. The scarce literature of studies with a similar focus was also a restriction found at the time of the discussion. Given the complexity of this theme, the results of this work contribute to the recognition of the role of nurses in HC, as a professional involved in the search for best practices for the patient and for care.

It is recognized that there is a lack of studies, human resources and training that includes specific knowledge for work in the HC area. Thus, this research represents a contribution to the construction of knowledge for nurses in the home care setting and to provide reflections on nursing training for new health care requirements. It is reinforced that the evidence in this study does not represent the realization of all actions in all HC scenarios, since such activities are considered complex and particular, and thus, no generalizations are made.

CONCLUSION

The discursive and social practices of the nurses who participated in the study, pointed out that, in home care, they use the knowledge standards, necessary in each dimension (empirical, aesthetic, personal, ethical, lack of knowledge and socio-political), which are correlated and interdependent. It is observed that, in the management of care, assistance and health education for users, family and caregivers, nurses work, with mastery, technical and scientific knowledge. However, empirical knowledge does not stand alone in the home care setting, especially due to the gap resulting from academic and professional training and, especially, due to the characteristics of the home environment. Nurses' practices are mediated by relational, educational and technical procedures, and require different knowledge used by them in the home context. In view of the unpredictability inherent to home care, various expressions of creative, sensitive, human and responsible care become visible and require adaptations and availability to learn in and for the nurses' work, contributing to the production of knowledge by adopting, practicing and transforming knowledge resulting from the science of nursing.

Thus, the aesthetic, personal, ethical, lack of knowledge and socio-political standards stand out in the performance of care that dissolves in the act of acting spontaneously which is executed and learned moment by moment. This knowledge is even more complex due to the need to be used in the home setting, the patient's domain, in which the centrality of the user and families in the care process is enhanced. It is emphasized that the need to make adaptations is manifested throughout the nurses' work, in home care, in search of changes in reality. This knowledge becomes evident as a determinant in the face of unpredictability during practice. This implies the need for differentiated training to respond to an increasing complexity in the field of HC, which requires the mobilization of different areas of knowledge and elements of innovation.

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NOTES

ORIGIN OF THE ARTICLE

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AUTHOR CONTRIBUTION

Study design: Andrade AM, Silva KL.
Data collection: Andrade AM.
Analysis and interpretation of data: Andrade AM, Braga, PP, Lacerda MR, Duarte ED, Borges Junior LH, Silva KL.
Discussion of results: Andrade AM, Braga, PP, Lacerda MR, Duarte ED, Borges Junior LH, Silva KL.
Writing and / or critical review of the content: Andrade AM, Braga, PP, Lacerda MR, Duarte ED, Borges Junior LH, Silva KL.
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CONFLICT OF INTEREST

There is no conflict of interest.

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