

ORIGINAL ARTICLE

STRENGTHS-BASED NURSING AND HEALTHCARE: PERCEPTION OF WOMEN IN A USUAL RISK MATERNITY HOSPITAL

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ABSTRACT

Objective: to present the perception of women hospitalized in a maternity hospital regarding the nursing care received, with the theoretical reference Strengths-Based Nursing and Healthcare, by Laurie Gottlieb. **Method:** exploratory study with a qualitative approach. Twenty puerperal women hospitalized in the period from November to December 2019, in a usual risk maternity hospital in Curitiba-PR, Brazil, were interviewed. Data were transcribed and categorized, using MaxQDA®2020 software, and content analysis was performed, according to Creswell's steps. **Results:** two categories were established: "absence of elements of the theoretical framework"; and "presence of elements of the theoretical framework". **Conclusion:** the theoretical framework was perceived by women in the care they received; they benefited from this model, understanding their active role in the delivery process. Developing this theoretical framework in usual-risk maternity hospitals and in other care realities is a window of opportunity for the development of nurses' work.

DESCRIPTORS: Nursing; Nurse Midwives; Women's Health; Holistic Nursing; Nursing Theory.

HOW TO REFERENCE THIS ARTICLE:

Silva OBM da, Bernardin E, Encarnação P, Lima LS de, Silva OL dos S, Rorato C. Strengths-based nursing and healthcare: perception of women in a usual risk maternity hospital. *Cogitare Enferm.* [Internet]. 2022 [accessed "insert day, month and year"]; 27. Available from: <http://dx.doi.org/10.5380/ce.v27i0.78853>.

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INTRODUCTION

Nursing seeks to deepen its scientific, technological, and humanistic aspects, with health care of the human being at the center of its activities, searching in different theoretical references for support to substantiate its praxis⁽¹⁾. Since Peplau (1952), the theories confirm nursing care planning by means of the conceptual framework built about care phenomena, participate in the construction of the specific language, and guide nurses' thinking by identifying patient problems/deficits during the care experience. This practice is consolidated by the nursing process⁽²⁻³⁾.

Most practice scenarios are characterized by hospital-centered, fragmented and technicist care, whose professional actions are still strongly influenced by a traditional philosophy of science, based on the biomedical model, with emphasis on "doing"^(2,4). This model of care is the dominant thinking in the healthcare system and has been developed over the years to help professionals understand their patients' clinical problems, reach an accurate diagnosis, and find the best treatment⁽⁵⁾. Identifying, locating, and understanding symptoms is part of diagnosis, but when this process begins to be generalized to the person⁽⁵⁾ and the emphasis of the therapeutic plan is on identifying and treating the problem, there is little or no appreciation of the caregiver's own abilities and skills.

If the biomedical model is prevalent in care, in health training it is no different, specifically in nursing courses. The construction of this profession goes through the changes experienced in the historical path of health, focusing on the clinical model of fragmented practice, focused on the hospital area. The tendency of these professionals is to evaluate clinical cases through signs and symptoms of a particular pathology, diverting the focus from the person, focusing on symptomatology, on the deficit⁽⁶⁾.

However, currently, health policies and programs are focused on a totalitarian, humanized, and holistic vision of care, showing an apparent contradiction, in which on one side there is the presence of technicality and the focus on deficits, and on the other side there is the theoretical and legal framework focused on the participatory involvement of patients and on humanized care. In this context, the philosophy developed at McGill School of Nursing in Canada, Strengths-Based Nursing and Healthcare (SBNH), intends to rescue the practice, teaching, management, and leadership in nursing by prioritizing care according to the capacities, competences and resources of the person and his/her family, without, however, disregarding the problems⁽⁵⁾.

By using this perspective, the nurse seeks to identify the existing strengths within and around the individual and his family, positioning him in the center of care and providing the movement of empowerment, a social process of recognition, promotion, and improvement of people's ability to meet their own needs, solve their problems, and mobilize necessary resources, to feel in control of their lives. The term strength, in turn, is a comprehensive concept that includes both the internal qualities of the person or unit (family, community), and the external resources available to it; they are distinct qualities, aptitudes, skills, capacities and abilities that coexist with weaknesses, and may be of biological, psychological, and social nature⁽⁵⁾.

The SBNH is an approach that guides nurses in their daily practice, based on a set of assumptions about health, person, environment, and nursing care. It uses as main elements: patient/person/family/relationship-centered care; the empowerment movement in the patient/family; health promotion, disease prevention, and self-care; it considers the following underlying core values: health and healing; uniqueness of the person; holism and embodiment; objective, subjective reality, and construction of meaning; self-determination; person and environment are integrated; learning; preparation and timing; collaborative partnership in care.

The SBNH highlights the collaborative partnership relationship, which can be applied

in all lines of care, including obstetrics. This is a specialty with great potential for the development of different models of care, since it is directed to the specialized care of women of childbearing age throughout the physiological process of pregnancy, birth, and puerperium⁽⁷⁻¹¹⁾. If applied in this line of care, it can contribute to the women's feeling of empowerment to improve their performance for self-care, exert control over their own lives, confront the situation and build a more desirable future⁽⁵⁾, with potentialities beyond the process of parturition, even having influence on the care of their children and family.

This study aims to present the perception of women hospitalized in a maternity hospital regarding the nursing care received, based on the theoretical reference Strengths-Based Nursing and Healthcare, by Laurie Gottlieb.

METHOD

This is exploratory research of qualitative approach, conducted in a usual risk maternity hospital in Curitiba-PR, Brazil, with data collection in November and December 2019.

A group of nurses from the maternity ward participated in focus group meetings, in which they had the opportunity to get to know and reflect on the theoretical framework. After this period, the need to verify the perception of women regarding the nursing care received was identified, and the following guiding question was formulated: "Do women assisted in this usual risk maternity hospital perceive the differentiated nursing care positively?"

To this end, interviews were conducted with the women using a semi-structured instrument that was initially tested and adapted as needed. This instrument was composed of questions related to the characterization of the participants (age, gestation numbers, previous gestational history, and type of delivery performed in this hospitalization) and a main question "How was your experience in this institution in each care point (Emergency Room, Obstetric Center, Joint Nursing Unit, Neonatology Unit, and Outpatient Clinic)?"

Inclusion criteria were women over 18 years of age, hospitalized for a period of more than 24 hours, for clinical treatment, or who evolved to vaginal delivery, or who underwent a cesarean section. Women under 18 years of age, hospitalized for a curettage procedure or for an unwanted pregnancy termination, or for a period of less than 24 hours, were excluded. The definition of the inclusion and exclusion criteria sought to reduce possible biases related to the short time of contact between the women and the maternity ward nurses and related to situations of emotional fragility experienced by some women.

During the data collection period, the main researcher evaluated the daily census of hospitalizations at the maternity hospital and selected possible candidates for the interview, considering the reason and length of hospitalization. The selected women were approached individually and invited to participate in the project. The research was clarified, and the interview was only carried out after signing the Free and Informed Consent Form. The interviews were carried out in a reserved place, in the maternity ward, during the daytime, lasting approximately 15 minutes.

The right to confidentiality of information and anonymity was guaranteed, and an acronym (M) and a sequential cardinal number were used for identification. The interviews, audio-recorded and transcribed in full, were conducted by the main researcher, linked to the Discharge Management Service of the maternity hospital in the study. The MaxQDA®2020 program was used for data organization. Two a priori established categories were chosen: "absence of elements of the theoretical referential" and "presence of elements of the theoretical referential". Seven codes emerged from the analyzed segments corresponding to the eight SBNH values, as follows: absence of open-mindedness; attitude of judgment;

empowerment; self-determination; consideration of the uniqueness of the person; person and environment are integrated; learning, preparation, and timing; and collaborative partnership.

The categorization of the speech segments was carried out independently by two researchers; the categories and segments were compared, and in case of disagreement between the categories, a third researcher would perform the analysis and categorize the speech segment.

For data analysis, we followed the methodological framework of Creswell⁽¹²⁾, which is composed of six steps: I. organize and prepare the data for analysis; II. do the reading of the data to obtain a general sense of the information and reflect on it; III. start the detailed analysis with a coding process; IV. use the coding process to generate a description of the scenario or people, in addition to the categories or themes for analysis; V. predict how the description and themes will be represented in the qualitative narrative and make an interpretation or extract meaning from the data, highlighting the lessons learned; and VI. capture the essence of the idea⁽¹²⁾. The data were archived in a digital drive, used exclusively for content analysis, and later discarded.

Each care point was analyzed individually, respecting the path women walk in the maternity ward. The theoretical saturation criterion was used to end data collection⁽¹³⁾.

The research was approved by the Ethics Committee of the Clinics Hospital Complex of the Federal University of Paraná, under opinion number 2,703,011, dated June 8, 2018.

RESULTS

Twenty women who met the inclusion and exclusion criteria of the study participated. The age of the participants ranged from 18 to 37 years old, seven were primigravidae and 13 were multiparous. Regarding the type of delivery, five women progressed to cesarean section, 12 to vaginal delivery, and three were hospitalized for clinical treatment.

As a result of the content analysis, it was observed that the points of care have an influence on the perception of care. A total of 100 speech segments were categorized, 18 related to "absence of SBNH elements in nursing care" and 82 related to the category "perception of SBNH elements in nursing care". Examples of the speech segments and their respective categories are presented in Charts 1 and 2.

Chart 1 - Category: Absence of NHRS elements in nursing care. Curitiba, PR, Brazil, 2021 (continues)

Category	Assistance Point	Segments of Speeches
Lack of SBNH elements in nursing care	Emergency Care	<i>They didn't give much explanation, just for me to stay calm and that everything would be alright [...]. (M2)</i> <i>She was doubting, saying it couldn't be one minute, and in the morning, I was there and there wasn't even one dilation, and it was the same person, this was unpleasant [...]. (M15)</i>

	Obstetric Center	<p>They told me in the beginning that if there was an emergency, I would be taken care of, but then I would be the second, but they didn't say anything else, and I started to feel bad... it was just me and my husband and nobody came to talk to me, and time went by [...]. (M5)</p> <p>Actually, I was in doubt, because all the time they were putting me in IV drips and my first cesarean section I did, they did not put me in the IV drip... so I found it strange, for me, I thought they were trying to induce my labor [...]. (M12)</p>
	Joint accommodation	<p>The staff comes in and the staff leaves, I don't know if they are nurses, because they walk around there, not all of them introduce themselves [...]. (M6)</p> <p>The only thing that leaves us a little in doubt is about the baby, like the birth, because there are some who say that 36 weeks is still premature, that it's not time yet, and then someone comes along and says they won't release it, so this doubt remains... you never know what will happen [...]. (M3)</p> <p>I think that some of the nurses' care had to improve, the nurses' treatment, some of them, not all, there are some very good ones, but some had to improve [...]. (M9)</p>

Source: Authors (2021).

Chart 2 - Category: Perception of elements of the SBNH in nursing care. Curitiba, PR, Brazil, 2021

Category	Assistance Point	Segments of Speeches
Perception of SBC element	Emergency Care	They explained everything very well, they asked me if I understood what was happening. And then they prepared me to go to the hospitalization, I was with my husband [...]. (M13)
	Obstetric Center	<p>Because I found them very attentive, they explain things very well, we feel more confident here [...]. (M12)</p> <p>They treated me very well and gave me many options, the shower, the bath, the ball, they didn't leave me alone at any time [...]. (M2)</p> <p>I liked everything, but where you are going to win, I liked it more, because it is a moment when you are there nervous and, even so, I found that the service was very human, very different [...]. (M7)</p> <p>I think that if it wasn't for the incentive, I wouldn't have even managed, because I was already exhausted, already losing my strength, and they were encouraging me there, so it worked out [...]. (M19)</p>
	Joint accommodation	They introduce themselves, ask if they can come closer, arrive, talk, ask if everything is ok, if it can be now or later, we have the option to talk about everything [...]. (M7)
	Neonatology	It was difficult for him [the baby] to take the breast, but all the time the girls are always stimulating him to try to take it and do it the right way, there is always someone accompanying me, asking [...]. (M13)
	Ambulatory	About the 37-week consultation, it was very good, I did it with the nurses, they explained everything, how humanized childbirth is, I found it very interesting, I felt safe with the information, everything was well explained [...]. (M19)

Source: Authors (2021).

The “Perception of elements of the SBNH in nursing care” was identified in all points of care, highlighting the Obstetric Center. The women perceived the creation of a bond with the nurses and the construction of a collaborative partnership between the professional, the woman, and her companion, according to the examples presented in Chart 2.

DISCUSSION

Even with a significant evolution of the obstetric care line and a framework of public health policies and the supplementary network, maternal and childcare still suffers situations that compromise the quality and continuity of care. Hospital routines and professional practices are factors identified as hindering the institutional organization. The individual practice and posture are considered barriers that, together, hinder the implementation of the humanized model in labor and birth assistance⁽¹⁴⁾.

The situations of breaking the assistance bond are related to the devaluation of women’s complaints in the process of parturition, disregard of their uniqueness, and imposition in the learning process related to breastfeeding. These situations show the absence of fundamental elements of the SBNH, such as open-mindedness and non-judgmental attitude.

Open-mindedness concerns the ability to review one’s ideas and responses in light of different evidence, involving the ability to appreciate the perspectives and experiences of others. This essential quality allows the nurse to evaluate the person beyond the problem presented, look for possibilities and possible solutions, prevents hasty judgments and premature conclusions based on false assumptions, which can lead to poor clinical judgment and bad decisions⁽⁵⁾.

The nonjudgmental attitude means that one shows tolerance to the other person’s beliefs, values, behavior, or perspectives by not condemning or being critical. One must respect the choices of others, particularly when these choices differ from one’s own⁽⁵⁾.

From the SBNH perspective, nurses need to learn new ways of communicating and becoming socially involved, putting people at the center of care, focusing on uniqueness and strengths, and working in partnership. This requires nurses to acquire knowledge and develop therapeutic interaction and communication skills⁽⁵⁾. They need to know how to share responsibilities with patients, gaining the trust of strangers in a short period of time, need to apply interpersonal relationship skills to communicate with individuals and their families, gather meaningful and relevant information, and be able to effectively deal with their concerns and care needs⁽⁵⁾.

Professional communication is essential in care processes, including the process of parturition. The lack of active participation of women in communication processes performed in their presence characterizes an effect of the institutionalization of childbirth: the woman transformed into an object of study, characterizing a dehumanizing practice⁽¹⁵⁾. Regarding the devaluation of women’s complaints and the disregard of their uniqueness, two factors should be considered: the hierarchical culture, with the health professional as the only holder of knowledge, and the passivity of some women, who do not know or assert their rights, submitting themselves to the system and the health professional, especially at times surrounded by fears and fragilities such as pregnancy, childbirth and postpartum⁽¹⁶⁾.

The teaching-learning process of breastfeeding involves a socio-historical-cultural complexity, in which the health professional plays an important role by considering the woman’s knowledge and her own knowledge to enable a non-violent or disciplinary breastfeeding practice in the hospital context. This process is sometimes considered obligatory for hospital discharge, “qualifying” the mother to perform this function at home.

The disciplinary institutionalization of maternity and breastfeeding is an important warning of the absence of professionals' listening to women's wishes and non-wishes^(15,17-18).

For maternal health care to follow the precepts of humanization, numerous adjustments should be implemented, including changing the culture of health services, the appropriate environment, ensuring the active participation of women in this process, individualized care, and respect for the physiology of the parturition process⁽¹⁹⁾. The application of the SBNH tools, such as positive language, therapeutic communication, and the use of suggestive questions that help increase awareness, or that restructure a new meaning to the situation⁽⁵⁾, can compose the maternal health care in an integral and humanized manner.

Knowing what to say and when to say it can serve as a catalyst to help individuals restore themselves and continue in their transition process. A collaborative relationship, in which the nurse and the person make decisions and work together to find the most appropriate solutions to the health situation, increases self-awareness, promotes self-discovery, enhances recovery, and promotes development through the person's growth and transformation⁽⁵⁾.

In relation to the assistance point, the Joint Lodging presented an important dissonance in relation to the others, and the analysis of the women's speeches showed a limitation in the organization of work, welcoming, and professional care. This dissonance in the care between sectors of the same hospital leads us to reflect on the inseparability between management and work organization, between care and welcoming offered in technical and relational terms. Therefore, structural conditions, human resources, and work management are necessary for the teams to be able to offer resolute and humanized care, as advocated by the legal framework of this line of care⁽¹⁵⁾.

The content analysis of the speeches made it possible to identify numerous elements of the SBNH in the nurses' practice. Thus, it is perceived that the SBNH theoretical framework is naturally incorporated into the practice of maternity nurses, so that care is considered differentiated, providing safety for women and their families, resulting in health promotion and self-care, with the Obstetric Center as a care point where this perception was more pronounced.

The women's perception demonstrated the following elements of SBNH in care practice: empowerment; self-determination; consideration of the uniqueness of the person; person and environment are integrated; learning, preparation, and timing; and collaborative partnership. The professionals shared the decisions related to assistance, dividing, and clarifying the responsibilities related to care. Confirming this finding, studies point to the satisfaction of puerperal women assisted by obstetric nurses in the stages of the delivery process; the parturient women highlighted that the quality of care was above their expectations^(16,20).

The presence of a trained and experienced nurse in assisting the parturient woman gives security and confidence to women, which contributes to facing labor with tranquility, patience, and comfort⁽²¹⁾. In childbirth care, it is recommended that the professionals' tasks be planned exclusively with the participation of the woman to be assisted, and it is essential to master scientific knowledge, skills, intuition, critical thinking and creativity, and dialogue is indispensable⁽²²⁾.

Nursing professionals play an important role in the care of the parturient woman, providing guidance, clarifying doubts, welcoming, and assisting the patient during labor and delivery and in the puerperium. In this process, a bond of trust is built between the woman and the professional, sharing the feelings, planning and decisions of the care provided⁽²²⁻²³⁾. The possibility of assistance based on active listening, identifying the needs of each woman, in a welcoming environment with the presence of a companion of her choice, develops and strengthens the bond established between nurses and women in this process of parturition, contributing to a successful experience, in which the woman's safety and empowerment are evidenced⁽²⁴⁾.

Taking greater responsibility for one's own health is related to the SBNH principle and value, collaborative partnership. This concept identifies the person as active and co-responsible for their care. The role of the nurse is to encourage people to participate in decision making and to develop autonomy and self-efficacy by using their strengths and resources; the role of the person, in turn, is to be active. The relationship between professional and patient is balanced, reciprocal, and mutual. Goals are established together, and when the expected results are not achieved, there is no blame: goals are replanned⁽⁵⁾.

This study presented as limitations the application of the referential, for a determined period in a single maternity hospital, and the carrying out of the interview only with women of habitual gestational risk; men or companions of hospitalized women were not included as research participants.

FINAL CONSIDERATIONS

The theoretical framework was perceived by the women in the care they received, and they benefited from this model. This care provided a feeling of centrality and empowerment, which allowed them to succeed in this experience, including a more effective performance in the parturition process, in the care related to the postpartum period, in breastfeeding, in their self-care, and in the promotion of their health for the return to their routine, providing the understanding of their active role in the parturition process.

However, for the women who perceived the absence of SBNH elements in nursing care, the assistance provided generated a feeling of insecurity, due to the absence or fragility of the bond with the assistance team. This caused an unpleasant experience and a negative influence, producing a feeling of carelessness.

Developing this theoretical framework in usual risk maternity hospitals and in other care realities is a window of opportunity for the development of nurses' work. Applying an innovative theoretical framework in nursing practice can serve as a guide for assistance, demonstrating the specificity and scientific that nursing care requires, to be fully recognized by society as unique and differentiated.

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*Article extracted from doctoral thesis "Strengths-Based Care in usual risk maternity: rethinking practices and continuity of care". Federal University of Paraná, 2021.

Received: 12/01/2021

Approved: 17/09/2021

Associate editor: Tatiane Herreira Trigueiro

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ISSN 2176-9133



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