



Interprofessional collaborative practice and nursing care

Prática colaborativa interprofissional e assistência em enfermagem

Práctica colaborativa interprofesional y atención en enfermería

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ABSTRACT

Objective: To reflect upon the elements that improve understanding of nurses' practice, considering collaborative practice and seeking potential links between the substantial elements of nursing care and interprofessional collaborative practice.

Method: Theoretical and reflexive study based on the aspects of nursing care. **Results:** The elements supporting autonomous and collaborative practice were identified in the new diagnostic structure proposed by NANDA-I and in the interventions proposed by the Nursing Interventions Classification. This discussion categorizes three reflexive theoretical points: Interprofessional Collaborative Practice: Convergence of Views; Nursing Diagnoses: Autonomy and Points of Intersection; and Nursing Interventions: Autonomy and Points of Intersection. **Conclusion and implications for practice:** Discussing nursing practice by taking into account nurses' assistive role and collaborative practice enables understanding what is unique and particular to nursing, while allowing nursing practice to interact with other types of knowledge, making a connection with discussions that challenge interprofessional collaboration in health.

Keywords: Nursing Process; Nursing Diagnosis; Nursing Care; Education, Nursing.

RESUMO

Objetivo: Refletir sobre os argumentos que ampliam a compreensão da atuação do enfermeiro, considerando a prática colaborativa e buscando possíveis nexos entre os elementos substantivos da assistência em enfermagem e a prática colaborativa interprofissional. **Método:** Estudo teórico-reflexivo, baseado nos aspectos da assistência em enfermagem. **Resultados:** Elementos que corroboraram a prática autônoma e a colaborativa foram identificados na nova estrutura diagnóstica proposta pela NANDA-I e nas intervenções da Classificação das Intervenções de Enfermagem. Essa discussão categorizou três pontos teóricos reflexivos: Prática Colaborativa Interprofissional: Convergência de Olhares; Diagnósticos de Enfermagem: Autonomia e Pontos de Interseção; e Intervenções de Enfermagem: Autonomia e Pontos de Interseção. **Conclusão e implicação para a prática:** A discussão da prática do enfermeiro, considerando o assistir e o fazer colaborativo, permite compreender o que lhe é próprio e particular à enfermagem, mas tal prática dialoga com outros saberes, fazendo nexo com as discussões que desafiam a atuação interprofissional em saúde.

Palavras-chave: Processo de Enfermagem; Diagnóstico de Enfermagem; Cuidados de Enfermagem; Educação em Enfermagem.

RESUMEN

Objetivo: Reflexionar sobre los argumentos que amplían la comprensión de la actuación del enfermero, considerando la práctica colaborativa y buscando posibles asociaciones entre los elementos substantivos de la atención en enfermería y de la práctica colaborativa interprofesional. **Método:** Estudio teórico-reflexivo, basado en los aspectos de la atención en enfermería. **Resultados:** Elementos que corroboran la práctica autónoma y la colaborativa fueron identificados en la nueva estructura diagnóstica propuesta por NANDA-I y en las intervenciones de la Clasificación de Intervenciones de Enfermería. Esa discusión categorizó tres puntos teóricos y reflexivos: Práctica Colaborativa Interprofesional: Convergencia de Miradas; Diagnósticos de Enfermería: Autonomía y Puntos de Intersección; e Intervenciones de Enfermería: Autonomía y Puntos de Intersección. **Conclusión e implicación para la práctica:** La discusión de la práctica del enfermero, considerando el acto de asistir y hacerse colaborativo, permite comprender lo que es propio y particular a la enfermería, pero esa práctica dialoga con otros saberes, haciendo una asociación con las discusiones que desafían la actuación interprofesional en salud.

Palabras clave: Proceso de Enfermería; Diagnóstico de Enfermería; Atención de Enfermería; Educación en Enfermería.

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INTRODUCTION

This reflection is based on the substantive aspects that represent nursing care according to Nursing Diagnoses (NDx) from NANDA-I¹ and Nursing Interventions (NI) in light of Nursing Interventions Classification (NIC),² considering that there are elements in both taxonomies that point to collaborative practice without disregarding what might be termed art and what is science in nursing, characterized by an autonomous and particular practice when the needs of patients are verified.

In 2017, the Brazilian Federal Council of Nursing (Cofen) updated the Code of Ethics for Nursing Professionals, establishing that nurses should organize their actions and interventions autonomously or in collaboration with other workers in the field.³ Therefore, two dimensions of nursing practice emerge in the care delivery routine: the autonomous and the collaborative – the latter symbolizes the cooperation and teamwork nurses and staff implement as members of the health team.

In the same way, NANDA-I's last issue was updated with diagnostic indicators presenting new elements that compose NDx and the diagnostic structure. The understanding is that there are diagnostic indicators that are useful in the development of NDx, but which are not resolved by NI in an independent manner. Ideally, NI should focus on the cause of human responses, that is, related factors.¹ Such factors, related in the diagnostic structure of previous issues, were often not modifiable by independent actions or interventions prescribed by nurses.¹ In general, they hindered the selection of interventions and the focus of disciplinary care, considering that diseases were seldom listed as related factors, findings that went beyond the scope of nurses' autonomous practice. A review of the NDx structure and presentation of the new elements Risk Populations and Associated Conditions, especially the latter, has implications for the education of students, considering that professors usually faced difficulties when nursing students were encouraged to exercise critical thinking and diagnostic reasoning in addition to therapeutic reasoning when they faced related factors that were not autonomously addressed by nurses, for instance, diseases.

Likewise, when using NIC, nurses frequently initiate treatments in response to NDx, configuring an autonomous action. They also implement treatments based on the prescriptions of other health providers,² a time when the collaborative aspect of their practice emerges. When exercising their autonomy, nurses organize their actions using the Nursing Process (NP), a methodological tool that guides nursing professional care and documentation of professional practice. The NP is composed of five elements – Nursing History, NDx, Nursing Planning (Expected Outcomes and NI), Implementation, and Assessment.⁴ Clinical diagnostic reasoning and therapeutic reasoning is required for this tool to be properly used.

Nursing care should be represented by phenomena that provide an independent response and are sufficiently sensitive to be modified by NI, establishing a relationship between the phenomenon identified (NDx) and actions prescribed (NI), while delimiting the disciplinary scope when these issues are taken into account.

Nursing is a “practical human science, the knowledge of which is the outcome of practical-reflective reasoning resulting from clinical practice, and when systematized it constitutes its own disciplinary knowledge.”^{5:143} While reflecting and producing knowledge, nursing delimitates its disciplinary scope in such a way that it is unique and singular, with attributes that structure what nursing is and how it is characterized as a relevant social practice to the health staff in the “social and daily practice of providing care, managing, teaching, educating and researching”.³

In the daily practice of nursing care, nurses and the nursing staff address health needs that are under the scope of nursing. Nonetheless, only one perspective of disciplinary care should suffice if people are to be seen in their wholeness, which by itself requires the various types of knowledge to interact. Collaborative practice considers “care that is shared among the members of health teams performing integrated and interpersonal work, connecting actions and technical scientific knowledge to common objectives focused on the needs of patients.”^{6:23}

Collaborative practice carries with it great challenges, with an emphasis on the hegemonic model still in force, and relational asymmetries existing between the different professions from which the health staff derives – which often operates from a one-profession and specialized perspective, mainly a physician-centered model. This view leads nurses to delimit their contribution to NDx and NI; that is, what they occupy themselves with and how they treat the needs of patients, which justifies the existence of a nursing science.

Dialoguing with other types of knowledge is essential considering that the protagonist of the process, who does not belong to a single discipline, is the recipient of care. Whatever language is applied to health needs to be minimally understood beyond its disciplinary field, considering that records are also a form of implementing dialogued care, so that it needs be accessible to all, symbolically and objectively.

Thus the question that emerges is: Are there elements in NANDA-I's NDx and NIC's NI that lead to interprofessional collaborative practice (ICP)? This study's objective was to reflect upon the arguments that expand understanding of nurses' practice, considering collaborative practice and seeking the links between the substantive elements of nursing care and interprofessional collaborative practice.

METHOD

This theoretical-reflective essay is based on substantive aspects of nursing care. We aimed to review the new diagnostic structure of NANDA-I, comparing it with the previous structure. Thus, elements such as risk populations and associated conditions that supported the development of the NDx category Autonomy and Intersection Points were identified. The same was done when reading the NIC, in which different types of interventions were identified to ground the NI category Autonomy and Intersection Points. The objective was to analyze these elements from an inter-professional perspective, supporting these questions regarding the category Interprofessional Collaborative Practice: Convergence of Views.

Inter-professional collaborative practice: convergence of views

Contemporary health needs are presented as “complex problems requiring that the expertise of different professionals be combined to seek the best care results focusing on the health needs of patients”.^{6:43} Coupled with these is demographic and epidemiological transition.⁶ In this sense, workers need arrangements that go beyond the multidisciplinary perspective and advance towards an interpersonal perspective, emphasizing joint care projects in which all views converge on patients, focusing on care needs, rather than diseases, requiring joint efforts and a common project, opposing the practice focused on (one) profession.

Since the 1980s, when the importance of multiprofessional education was acknowledged as an essential element of health care, the World Health Organization (WHO) has highlighted a concern over the need for different professions to be in dialogue, later proposing the term “multiprofessional” to be replaced by “interprofessional” to emphasize the need for changes in the learning structure if shared knowledge is to be achieved – “with, for and about” the different professions.⁶ This promotes collaboration to connect professionals who compose the health teams.

The WHO has encouraged Collaborative Practice (CP) since 2010, defining it as “when health workers from different fields provide services based on the integrality of health, involving patients and their families, caregivers and communities to provide high quality health care at all levels of the service network.”^{7:13} CP is possible when workers are trained with an interprofessional perspective, through interprofessional education, which occurs “when two or more professions learn about each other and with each other to effectively collaborate and improve health outcomes”.^{7:13}

The training of human resources in Brazil has been a concern and the object of the development of policies with this purpose. In 2004, the National Policy for Permanent Education in Health (PNEPS) was developed. As a way to advance the PNEPS, new approaches to the training of human resources have been proposed, among which, Interprofessional Education has been considered a device to reorient the training processes of health workers. Among other actions, Interprofessional Education was formally incorporated by the *Secretaria de Gestão do Trabalho e da Educação na Saúde* (SGTES) [Secretariat of Labor Management and Health Education] with this purpose⁸. Our understanding is that these actions enhance the implementation of the principles and guidelines established by the Brazilian Unified Health System through collaborative practice performed by workers in the various care settings.

ICP can be understood as “a process in which professionals from different fields work together, in integrated teams, with common objectives to promote the quality of healthcare.”^{6:43} ICP leads each worker to focus attention on patients. Patients, rather than a single profession, become relevant, presupposing horizontal relationships and communication among the various workers. Focus is on the health need, to which everyone can and should contribute by implementing assertive and dialogued

actions – including the participation of patients – in client-centered care.

Such a perspective enables converging views and actions so that each worker provides his/her discipline-based contribution, composing a whole by seeking to implement integral care, embodied in a common project guided by a common interprofessional care plan, in which all members of the health team know exactly the therapeutic objective of each professional.

Nursing diagnosis: autonomy and intersection points

NDx concerns phenomena identified and treated by nurses, characterizing their autonomous area of practice. NDx can focus on the problem, risk or health promotion,¹ exhibiting a given structure for each type, which guides the focus of NI. NDx constitutes a “critical assessment of a human response to health conditions/life processes, or a vulnerability to such a response.”^{1:38} It can be also characterized as a “problem, potential or risk identified in an individual, family, group or community.”^{1:39} Ideally, NDx should be resolved through NI, which are treatments nurses employ when prescribing care.

NANDA-I¹ employed an NDx structure focused on the problem. Such a structure was composed of a diagnostic label, related factors and defining characteristics. There were risk factors for risk diagnoses and a diagnostic label, while NDx concerning health promotion exhibited a diagnostic label and defining characteristics, which could have related factors or not. When nurses considered related factors, that is, “etiologies, circumstances, facts or influences that have a certain type of relationship with a given nursing diagnosis,”^{1:39} or the cause of a diagnosis, nurses often reported difficulties selecting interventions and prescribing care for the NDx identified because various related factors were not independently treated by nurses.

NANDA-I¹ revised the diagnostic structure and relocated some related factors and risk factors, proposing two other elements that now compose NDx and serve nurses’ clinical reasoning without necessarily being the focus of an independent nursing intervention. This change reaffirms collaborative practice, that is, risk populations and associated conditions. Risk populations would be groups of people who share some characteristics that render each member susceptible to a given human response, such as demographic characteristics, health or family history, growth/development stages or exposure to certain events/experiences.¹ For associated conditions, there are medical diagnoses, injuries, procedures, medical devices or pharmaceutical agents.¹

This new diagnostic structure contributes to the training of nursing and care practice because it clarifies the real contribution of nurses to clinical practice and their roles as diagnosticians and prescribers of nursing care. It also clarifies the phenomena to which they independently respond. Moreover, it presents phenomena in which nurses work in collaboration with other workers, as is the case in medical diagnoses. Figure 1 shows the previous structure (10th issue) of a problem-focused NDx (actual), in which (11th issue) at least 11 related factors were relocated as risk populations and associated conditions.

Domain 11. Safety/protection Class 2. Physical injury Impaired Skin Integrity	Domain 11. Safety/protection Class 2. Physical injury Impaired Skin Integrity
Definition Damage to mucous membrane, cornea, cutaneous tissue, muscle fascia, muscle, tendon, bone, cartilage, joint capsule and/or ligament.	Definition Damage to mucous membrane, cornea, cutaneous tissue, muscle fascia, muscle, tendon, bone, cartilage, joint capsule and/or ligament.
Defining characteristics Destroyed tissue Injured tissue	Defining characteristics Localized site warm to touch Tissue damage Acute pain Hematoma Bleeding Destroyed tissue Redness
Related factors Chemical injury agent (e.g., burn, capsaicin, methylene chloride, mustard agent) Insufficient knowledge concerning maintenance of skin integrity Insufficient knowledge concerning protection of skin integrity Imbalanced nutritional state (e.g., obesity or malnutrition) Mechanical factor Humidity Insufficient fluid volume Excessive fluid volume Extremes of age Extremes of environmental temperature High voltage power source Pharmacological agent Altered sensitivity Altered metabolism Impaired circulation Impaired mobility Peripheral neuropathy Surgical procedure Radiation therapy	Related factors Chemical injury agent Insufficient knowledge concerning maintenance of skin integrity Insufficient knowledge concerning protection of skin integrity Imbalanced nutritional state Humidity Insufficient fluid volume Excessive fluid volume Risk Populations Exposure to high voltage electrical network Extremes of age Extremes of environment temperature Associated conditions Pharmaceutical agent Altered sensitivity Altered metabolism Impaired circulation Impaired mobility Peripheral neuropathy Surgical procedure Arterial puncture Radiation therapy Vascular Trauma

Figure 1. Structure of a Nursing Diagnosis focusing on the problem according to the 10th and 11th issues of NANDA-I.

Source: adapted from NANDA-I^{9:377}; NANDA-I^{1:387}

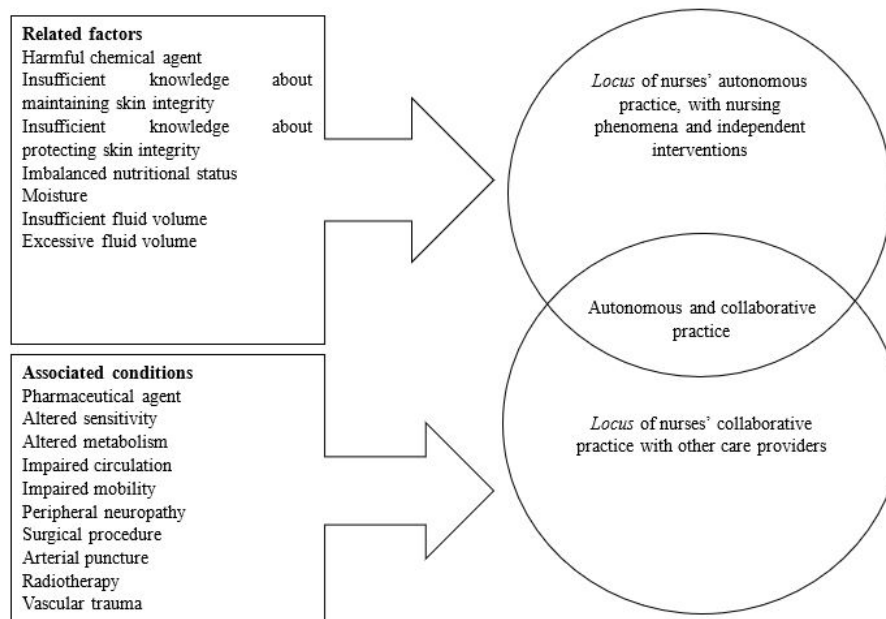


Figure 2. Explanatory model addressing autonomous and collaborative practice between nurses and the other members of the health team.

Source: adapted from NANDA-I^{9:377}; NANDA-I^{1:387}

Figure 2 presents two current elements, related factors and associated conditions, which compose the NDx according to NANDA-I. Considering NANDA-I's review, current related factors present the *locus* of nurses' autonomous practice, with phenomena that respond to independently prescribed NI and that enable positive health outcomes to be achieved, clarifying the "locus of nurses' autonomous practice, with nursing phenomena and independent interventions."

Associated conditions are elements that support diagnostic accuracy and precise formulation of an NDx but do not respond to intervention, or are not yet within the scope of disciplinary practice, when we consider nursing interventions/prescriptions. In this sense, associated conditions unfold in the "locus of nurses' collaborative practice together with other health providers." The intersection of these two *loci* would be responsible for bringing out the autonomous and collaborative practice of nurses and of the health team in a third *locus*, the "locus of nurses' collaborative practice together with other care providers."

Nursing interventions: autonomy and intersection points

The NI discussed here are theoretically grounded on NIC. They are structured based on a title and its respective definition, as well as a list of activities needed to implement the intervention. They should be clinically useful and present from general characteristics, such as hygiene and comfort care, to other specialized characteristics,² such as wound care.

Based on clinical-therapeutic assessment, NI refers to treatments, which once implemented, are intended to improve a patient's outcomes. NI are divided into direct, indirect and

community (or public health) care interventions and allow for two types of treatments: those initiated by a nurse in response to an NDx and those initiated by other healthcare providers,² but which nurses take part in the implementation or in monitoring the outcomes. An intervention intended to respond to an NDx represents the scope of nurses' autonomous practice, while implementing an intervention prescribed by another care provider represents collaborative practice.

Figure 3 presents NI for the NDx Impaired Skin Integrity, a priority and primary human response among patients with vasculogenic ulcers. These NI should guide the planning and implementation of care.¹⁰ Even though these are defined by the NIC as NI, these interventions have characteristics that place them on two interconnected extremities: independent and collaborative interventions.

It is inferred that there are links between nursing care's substantive elements and ICP, considering that the NIC includes both independent and collaborative interventions.² The practical challenge is in consuming knowledge produced in care settings for the "nature of nursing" to be clarified,^{2:432} i.e., its contribution and disciplinary boundaries.

Interventions were selected based on the NDx Impaired Skin Integrity¹ to present the autonomous and collaborative aspects of nursing care. Considering the NDx presented, the NI wound care has been identified as the most commonly selected intervention,¹¹ representing treatments nurses implement autonomously. Nutritional therapy is one example of intervention in which nurses collaborate, as it requires "determining, together with a nutritionist, the number of calories and types of nutrients necessary to meet

nutritional requirements",^{2:407} when considering the nutritional aspects involved in the approach to vasculogenic lesions.

Infections often appear when vasculogenic lesions become chronic and treatment frequently implies the use of antibiotic therapy and the need for nurses to establish a partnership with a physician due to the need to prescribe antibiotics in order to curb infectious processes. In this context, the role of a physician is to prescribe medication and the role of nurses and the nursing staff is to administer the medication, using the NI Medication Administration.²

FINAL CONSIDERATIONS AND IMPLICATIONS FOR PRACTICE

This study clarifies the autonomous practice of nurses based on NDx and its new structure in light of NANDA-I, which incorporated two new elements: associated conditions and risk populations. This study also focused on the NIC's NI. Discussing the limitations and possibilities, as well as the intersection between autonomous and collaborative practice in nursing care, contributed to uncovering the links existing among the substantive elements of nursing care and ICP. Meanwhile, this study reinforces the need to train human resources in the health field using qualified methods and techniques for shared learning, focusing on interprofessional education. In this sense, we highlight active methodologies, among which stands out realistic simulation, which privileges the development of simulated care settings and allows the inclusion of various professions learning from their interlocution.

This study's innovation is in seeking the links between the substantive elements of nursing care and ICP, considering that

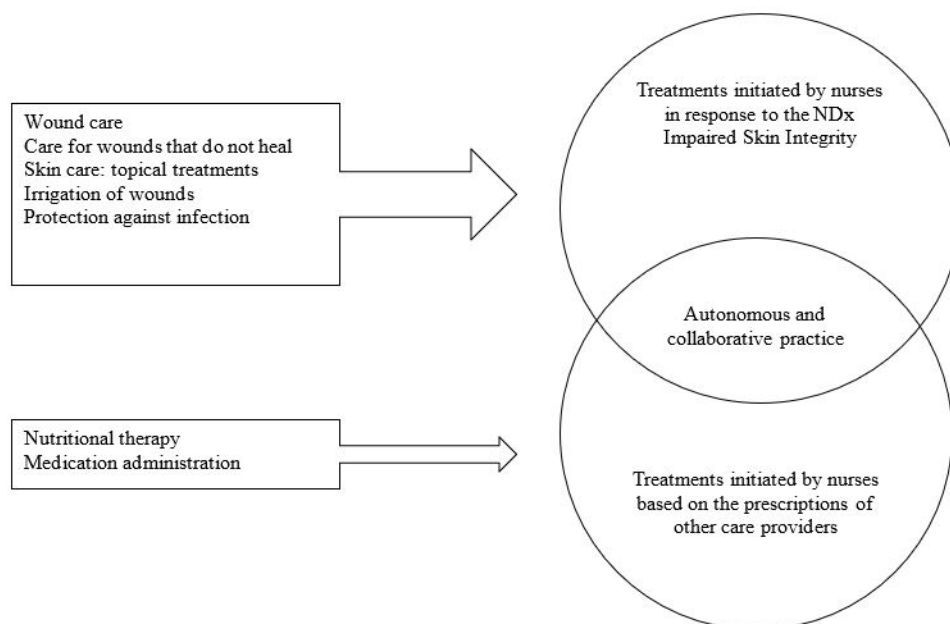


Figure 3. Explanatory model addressing autonomous and collaborative Nursing Interventions for the Diagnosis Impaired Skin Integrity.

Source: adapted from Bulechek et al.²; NDx: Nursing Diagnosis

we were able to unveil the intersections that can clarify points of contact between the autonomous and collaborative practice of nurses and other care providers.

AUTHOR'S CONTRIBUTIONS

Reflection study design. Technical support. Analysis and interpretation in light of the theoretical framework. Writing and critical review. Final version's approval. Responsible for the paper's content and ethical aspects. George Luiz Alves Santos. Glaucia Valente Valadares. Sheilane da Silva Santos

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