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RESEARCH

The work of nurses in high-risk prenatal care from the perspective of basic human needs

O trabalho do enfermeiro no pré-natal de alto risco sob a ótica das necessidades humanas básicas

El trabajo del enfermero en el prenatal de alto riesgo bajo la óptica de las necesidades humanas básicas

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ABSTRACT

Objective: To analyze the work of nurses in high-risk prenatal care in secondary care, considering nursing problems and the basic human needs of pregnant women. **Method:** Cross-sectional and quantitative study, developed in a high-risk prenatal care clinic. Data were selected in the records of the nursing consultation. The studied variables were related to sociodemographic and obstetric characteristics, in addition to nursing problems. We performed the descriptive analysis of the data and the grouping of nursing problems within the levels of Basic Human Needs (BHN). **Results:** We evaluated 54 nursing consultations of pregnant women, mostly young, multiparous, and with nine or more years of study. Every pregnant woman reported, on average, 7.4 nursing problems. The psychobiological BHN prevailed in relation to psychosocial ones. **Conclusion:** In high-risk prenatal care, nurses can use the nursing consultation considering their mastery of light technologies to engage with hard and light-hard technologies.
Descriptors: High-Risk Pregnancy; Nursing; Prenatal Care; Nursing Process; Nursing Care.

RESUMO

Objetivo: Analisar o trabalho do enfermeiro no pré-natal de alto risco na atenção secundária, considerando os problemas de enfermagem e as necessidades humanas básicas das gestantes. **Método:** Estudo transversal, quantitativo, desenvolvido em um ambulatório de pré-natal de alto risco. Os dados foram selecionados nos registros das consultas de enfermagem. As variáveis estudadas estavam relacionadas com as características sociodemográficas, obstétricas e com os problemas de enfermagem. Realizou-se a análise descritiva dos dados e o agrupamento dos problemas de enfermagem nas classes de Necessidades Humanas Básicas (NHB). **Resultados:** Avaliaram-se 54 consultas de enfermagem de gestantes, em sua maioria jovens, multíparas e com nove ou mais anos de estudo. Cada gestante relatou em média 7,4 problemas de enfermagem. As NHB psicobiológicas prevaleceram em relação às psicossociais. **Conclusão:** No pré-natal de alto risco, o enfermeiro pode utilizar a consulta de enfermagem considerando seu domínio das tecnologias leves para dialogar com as tecnologias dura e leve-dura.
Descritores: Gravidez de Alto Risco; Enfermagem; Cuidado Pré-Natal; Processo de Enfermagem; Cuidados de Enfermagem.

RESUMEN

Objetivo: Analizar el trabajo del enfermero en el prenatal de alto riesgo en la atención secundaria, considerando los problemas de enfermería y las necesidades humanas básicas de las embarazadas. **Método:** Estudio transversal, cuantitativo, desarrollado en un ambulatorio de prenatal de alto riesgo. Los datos han sido seleccionados en los registros de las consultas de enfermería. Las variables estudiadas estaban relacionadas con las características sociodemográficas, obstétricas y con los problemas de enfermería. Se realizó el análisis descriptivo de los datos y la agrupación de los problemas de enfermería en las clases de Necesidades Humanas Básicas (NHB). **Resultados:** Se han evaluado 54 consultas de enfermería de embarazadas, en su gran parte a jóvenes, multíparas y con nueve o más años de estudio. Cada embarazada ha relatado en promedio 7,4 problemas de enfermería. Las NHB psicobiológicas

han prevalecido en relación a las psicosociales. **Conclusión:** En el prenatal de alto riesgo, el enfermero puede utilizar la consulta de enfermería considerando su dominio de las tecnologías leves para dialogar con las tecnologías dura y leve-dura.
Descriptores: Embarazo de Alto Riesco; Enfermería; Cuidado Prenatal; Proceso de Enfermería; Cuidados de Enfermería.

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INTRODUCTION

Pregnancy is a physiological process for human reproduction. However, it is a borderline situation, insofar as it may involve risks for both the pregnant woman and the fetus. Pregnancy is defined as high-risk when the probability of an adverse outcome for the woman or the fetus is greater than expected for the general population, and there are risk factors or determinants[1]. Most risks are related to preexisting conditions or complications of pregnancy by organic, biological, chemical, and occupational causes, but also to unfavorable social and demographic conditions[1-2]. In Brazil, the prevalence of high-risk pregnancies is inaccurate and, overall, they are associated with clinical conditions of high blood pressure, infections, and gestational diabetes[3]. These pregnancies account for the morbidity, maternal mortality, and most perinatal adverse outcomes[4].

In high-risk prenatal care (HRPC), the Ministry of Health recommends the maternal care by a multidisciplinary team, which includes nurses[5]. Among the actions of nurses in a multidisciplinary team, the nursing consultation[6] is highlighted, which, in the case of prenatal care, allows identifying actual and potential problems of pregnant women and, consequently, planning actions that are required for such care. The consultation is the moment in which the uniqueness of women is reassured and the process of sharing responsibilities and the achievement of goals starts.

The nursing process is a methodological instrument that systematizes the development of the nursing consultation and its documentation[7]. It can be understood as a logical model of decision-making, based on clinical judgment and critical thinking. During the consultation, the professionals identify nursing problems that, according to Horta[8], are "situations or conditions arising from imbalances of the basic needs of the individual, the family, and the community, which require nursing care." In its turn, Basic Human Needs (BHN) represent the clinical conditions arising from hemodynamic imbalances, in which conscious and unconscious tensions are registered. In this regard, Maslow[9] states that individuals have common needs and the pursuit of these needs motivates the human behavior. Such needs are interrelated, in a flexible and hierarchical way, and require different capacities of the organism to be achieved[9].

Although the care to pregnant women in HRPC is expected to be developed by a multidisciplinary team, we perceive that the work of nurses is not consistent with their technical skills. At the same time, this practice means, often, to work where there is the predominance of the use of hard and light-hard technologies. The first is represented by the propaedeutics and diagnostic and therapeutic procedures; and the second refers to the tension between consolidated scientific knowledge and the lightness required by the users for their care[10]. Considering this clinical condition, nurses tend to align their actions with those of processes involved with hard and light-hard technologies. However, this alignment is considered an impossibility to the extent that its best performance would be achieved using light technologies, those in which the relationship with the patient becomes a privileged locus for the immediate care[10]. Thus, we may state that the intervention capacity of the nurse in HRPC has been limited to interventions regarding collaborative problems, whose control and resolution are shared with specialists or other professionals[11].

Hence, the systematic knowledge of the needs of high-risk pregnant women with the identification of nursing problems, direct work done in the nursing consultation, can point to the broadening of the possibilities of the nurse as well as the quality of these actions.

OBJECTIVE

To analyze the work of nurses in HRPC in secondary care, considering the nursing problems and the basic human needs of pregnant women. It is noteworthy that the published scientific production is organized considering the actions of nurses in hospital environments, focusing on specific risks, although discussing issues concerning the autonomy of professional performance and pointing to aspects of multidisciplinary work in specific care fields[12]. Therefore, we expect that our study can contribute to review and restructure conceptual assumptions that are the basis for subject-related studies, within the most comprehensive vision of care to pregnant women at risk, from the BHN perspective[8]. As a result of these contributions, we intend to discuss the role of nurses, from a process of systematic work, with legal and scientific bases.

METHOD

Ethical aspects

The criteria recommended by Resolution 466/12 of the National Health Council were followed. The project was submitted to the Research Ethics Committee of Universidade Federal de Minas Gerais.

Study design, location, and period

This is a cross-sectional, descriptive, and quantitative study, developed in the outpatient clinic of Instituto Jenny de Andrade Faria (IJAF). IJAF is linked to the Hospital das Clínicas of Universidade Federal de Minas Gerais (HC/UFMG), located in the municipality of Belo Horizonte, MG, Brazil, which is a reference to the HRPC of the state. The service is a field of practice to the Residency Program in Obstetric Nursing of the School of Nursing/UFMG. Data regard nursing consultations carried out in the period from March 2014 to June 2015 and collected in medical records between May and June 2016.

Population or sample, inclusion and exclusion criteria

The study population was composed by pregnant women attended to at the nursing consultation. Inclusion criteria were: being pregnant women classified as high-risk and having the record of survey of nursing problems in the form of the nursing consultation. We excluded consultation of low-risk pregnant women and those whose records on the survey of nursing problems were absent.

Study protocol

Data collection was carried out from the medical records of pregnant women who attended nursing consultations with nurses and residents in obstetric nursing. The form for recording the nursing consultation comprised data on identification, previous history, current pregnancy, physical examination, problems, diagnoses, and nursing interventions.

Analysis of results and statistics

For the analysis we selected the following variables: age, education, marital status, religion, occupation, parity, gestational age, aggravation of pregnancy, and nursing problems. We performed the distribution of frequency and proportion of variables, in order to identify sociodemographic and obstetric characteristics of pregnant women as well as the predominant nursing problems. Nursing problems were grouped in classes of psychobiological, psychosocial and psychospiritual BHN. The psychobiological class includes needs derived from organic functioning. The psychosocial class corresponds to the demands linked to the processes of social coexistence and self-achievement. The psychospiritual class comprises needs deriving from the search for spiritual transcendence[8,13]. Data analysis was performed using the SPSS software.

RESULTS

We analyzed the records of 54 pregnant women attended in nursing consultations that met the inclusion criteria of our study. In Table 1 we present social and demographic characteristics, and the gestational history of the participants. Mostly, they lived in the city of Belo Horizonte, Minas Gerais state, Brazil. Age ranged between 16 and 44 years, with 40% of pregnant women aging 20-29 years. About 70% had nine or more years of study, 24.1% were unemployed, and 22.2% were housekeepers or worked in general services. In the group there was a predominance of multiparous and 29.6% reported having had an abortion.

The conditions for referral of pregnant women to HRPC have varied. The most prevalent ones were being bearer of the human immunodeficiency virus (20.4%), hypertensive disease (13.0%), and diabetes (9.3%) (Table 2).

Nursing problems were grouped into 27 categories, and each pregnant woman presented, on average, 7.4 problems. Most pregnant women had complaints or changes that could be grouped in problems/questions about childbirth, lack of physical activity, poor diet, and impaired sleep. However, other problems, such as pain, overweight, and medication use in pregnancy, were identified in about 40.0% of pregnant

Table 1 – Distribution of high-risk pregnant women attended in nursing consultations, according to sociodemographic characteristics and gestational history, Belo Horizonte, Minas Gerais, Brazil, 2014-2015

Sociodemographic characteristics	n	%
Origin		
Belo Horizonte	24	44.4
Metropolitan area	13	24.1
Ignored	17	31.5
Age		
Up to 19 years old	2	3.7
20 – 29 years old	22	40.7
30 – 39 years old	17	31.5
≥ 40 years old	4	7.4
Ignored	9	16.7
Education level		
Up to 8 years	9	16.7
9 to 11 years	27	50.0
≥ 12 years	11	20.3
Ignored	7	13.0
Occupation		
Unemployed	13	24.1
Housekeeper and general services	12	22.2
Market and rendering of services	10	18.5
Housewife	7	13.0
Others	4	7.3
Ignored	8	14.8
Gestational history		
Parity		
Primiparous	15	27.8
Multiparous	36	66.7
Ignored	3	5.5
Previous abortions		
No	35	64.8
Yes	16	29.6
Ignored	3	5.5

Table 2 – Distribution of high-risk pregnant women attended in nursing consultations, according to conditions to classify high-risk pregnancy, Belo Horizonte, Minas Gerais, Brazil, 2014-2015

Aggravation	Number of pregnant women	%
HIV seropositive	11	20.4
Hypertension	7	13.0
Diabetes	5	9.3
Multiple pregnancy	4	7.4
Isoimmunization	4	7.4
Anemia	4	7.4
Cardiopathy	4	7.4
Congenital malformation	3	5.5
Others	12	22.2
Total	54	100

Table 3 – Distribution of nursing problems among high-risk pregnant women attended in nursing consultations, Belo Horizonte, Minas Gerais, Brazil, 2014-2015

Nursing problems	Number of pregnant women	%*
Questions about childbirth	34	63.0
Lack of physical activity	34	63.0
Poor diet	31	57.4
Impaired sleep	29	53.7
Pain	23	42.6
Overweight	23	42.6
Medication use in pregnancy	23	42.6
Questions about puerperium and the newborn	20	37.0
Difficulty in family relationship	18	33.3
Concern about health problems	17	31.5
Difficulty in bowel elimination	16	29.6
Dissatisfaction with self-image	13	24.1
Fatigue	12	22.2
Pregnancy discomfort	12	22.2
Reduced self-esteem	11	20.4
Socioeconomic vulnerability	11	20.4
Urinary discomfort	10	18.5
Low water intake	9	16.7
Fear of the future of the newborn	8	14.8
Susceptibility to toxoplasmosis	8	14.8
Anxiety	7	13.0
Sexuality problems	6	11.1
Non-acceptance of pregnancy	5	9.3
Sadness	5	9.3
Partner violence and drugs	5	9.3
Elitist pregnant woman	3	5.6
Others	9	16.7
Total problems	402	100
Average problems for pregnant women	7.4	

*Note: *In relation to the total of 54 pregnant women*

women (Table 3).

Problems in the psychobiological BHN class (60.7%) prevailed in relation to psychosocial BHN (39.3%). In the psychobiological class, changes in the needs of diet, sleep and rest, exercises, and physical activities were the most frequent. Among the psychosocial needs, learning, safety, and gregarious needs were highlighted (Table 4).

DISCUSSION

The IJAF outpatient clinic is a reference center for the HRPC of the Rede Cegonha strategy[14], thus, the presence of pregnant women from other municipalities is expected. Such fact makes us reflect about two elements. The first refers to the reference and conter-reference[15-16] system, and the second refers to the execution of the access to health services. The reference and conter-reference system contributes to the maintenance of the bond between pregnant woman and the primary health care, ensuring the continuity of women's care during and after pregnancy[2]. However, we observed that the referral to the HRPC often represents a breach of the support and monitoring of pregnant women on the part of health care structures shared between the community and health services. It is believed that this process can lead to loneliness and anxiety, as identified in the nursing problems, considering that pregnant women and, sometimes, their family become part of another care locus and logic. In this respect, the changed gregarious need found in this study may be associated with this clinical condition, which was also evident in another study that found lack of support from the social network as a problem faced by pregnant women[17]. Therefore, we must be aware of this need, seeking means to promote the support of the family and the social network. On the other hand, even if pregnant women keep seeking health services in their health center, we evaluated that the alignment of the medical conducts between the

Table 4 – Distribution of nursing problems among high-risk pregnant women attended in nursing consultations according to the classes of Basic Human Needs, Belo Horizonte, Minas Gerais, Brazil, 2014-2015

Classes of Basic Human Needs	Problems	n	Percentage*
I. Psychobiological needs			
1. Oxygenation	Dyspnea and cough	3	0.7
2– Hydration	Low water intake	9	2.2
3. Diet	Poor diet and overweight	54	13.4
4. Elimination	Urinary discomfort and difficulty in bowel elimination	26	6.5
5. Sleep and rest	Fatigue and impaired sleep	41	10.2
6. Exercises and physical activity	Lack of physical activity	34	8.5
7. Sexuality	Sexuality problems and unprotected sex	6	1.5
12. Types of regulation: thermal, hormonal, neurological, sodium and water, electrolyte, immunological, cell growth, vascular	Pregnancy discomforts; unstable blood glucose; susceptibility to toxoplasmosis; presence of vaginal discharge and *Streptococcus* colonization	24	6.0
14. Types of perception: olfactory, visual, auditory, tactile, gustatory, pain	Pain	23	5.7
16. Therapeutics	Use of medication and non-adherence to treatment	24	6.0
	Subtotal	244	60.7

To be continued

Table 4 (concluded)

Classes of Basic Human Needs	Problems	n	Percentage*
II. Psychosocial needs			
1. Safety	Anxiety Fear of the future of the newborn Fear of the health problem Elitist pregnant woman Partner violence and drugs Socioeconomic vulnerability	51	12.7
6. Learning (health education)	Questions about childbirth, puerperium, and the newborn	54	13.4
7. Gregarious	Difficulties in family relationships	18	4.5
9. Leisure	Lack of leisure	1	0.2
12. Acceptance	Non-acceptance of pregnancy	5	1.2
13. Self-achievement	Reduced self-esteem Sadness	16	4.0
15. Self-image	Dissatisfaction with self-image	13	3.2
	Subtotal	158	39.3
Total		402	100

*Note: *% calculated in relation to total problems.*

two services is not always achieved. Hence, the structuring of an efficient reference and counter-reference system demands effective actions that balance the effects of distance and the different perspectives of care.

In this case, access is understood as a multidimensional concept that comprises interactions between health services, individuals, and communities[18-19]. The compliance of access, as the second element for reflection, refers to issues concerning socioeconomic conditions that facilitate or constrain the displacements to participate in all care actions[20]. Another component of access refers to the characteristics of the provided services, which favor or not the use and validation of such services by the users concerning the capacity to meet their health needs. In this respect, it is understood that in HRPC the complexity of relationships between access and use can subvert efforts to provide a qualified care. Overall, pregnant women find it difficult to go from their home to the health services, which is observed in the low frequency to group and educational activities and in the difficulty to grasp them for nursing consultations. Thus, we understand that the care towards high-risk pregnant women, in addition to ensuring specialized medical consultations, should be structured seeking the centrality of teamwork, whose contributions and dialogues can comprise the diversity of women's problems.

Social vulnerability of the studied pregnant women can be perceived from the conditions of unemployment and low-wage occupations. This vulnerability is one of the factors that may be associated with the social determinants of health (SDH), which are related to health inequities. This situation can increase the risk of adverse outcomes in pregnancy[21] and in the postpartum[22]. As a result, the analysis and the set of possible relations between the SDH and the situation of women's health can facilitate the identification of health risks and the establishment of assistance conducts, both for prevention and for treatment. However, services should not be aware only of situations that make women vulnerable, but also understand the protective role of age and education. We observed that women of our study were young and with an education level between eight and eleven years, which allows supposing that they possibly better understand the different equipment constituting the Brazilian Health System. This perspective is included in the discussion produced by the concept of "health literacy," defined as cognitive and social skills that determine both motivation and the ability of individuals to obtain access, understanding, and use of information that can assist them in promoting and maintaining their health[23]. Thus, we address a group of women that has better capacity for gathering the expected information and care, even before the aforementioned constraints. In addition, we should mention that one cannot do without the intersectoral actions delimited in order to better adapt social protection equipment to the demands and needs of each pregnant woman.

Therefore, the logic of assistance should be shifted from the univocal perspective of physiopathological risks and harms to health[24-25] to comprise other elements such as the effects of social vulnerability on health. In this regard, the organization of the proposed assistance to high-risk pregnant women should also reflect the collaborative quality of nursing problems, according to the findings of our research. These are the issues to which nursing interventions involve joint actions with other professionals[11]. The resolution of such problems or the care plan will involve, to a large extent, teamwork, with sharing of actions and effective negotiation regarding the care of pregnant women.

The predominance of the psychobiological BHN class was expected, to the extent that this class comprises needs that require the development of actions for prevention of acute exacerbations of chronic conditions as well as the adoption of strategies able to promote adherence to treatment. Mostly, the health behavior of pregnant women is under monitoring,

requiring the accurate technical competence of professionals[26] mastering hard and light-hard technologies[10]. Considering that the health care of high-risk pregnant women is a dimension in which hard technology often seems to prevail over the light care technologies, the work of nurses must seek a balance between hard, light-hard, and light technologies in interventions to respond to the uniqueness of the subject. The risk tied to the eminence of death, of the woman or the fetus, consumes both the subject and the professional, hindering the careful observation beyond the biological needs of high-risk pregnant women.

Within the psychosocial BHN class, we also perceive that the centrality of light technologies can occur in a relationship of compensation and complementarity with the hard and light-hard technologies. To intently listen, a constituent element of light technology, goes beyond meeting the needs of the patient, and aspires to the complex exercise of creating care plans aligned with the possibilities of women's self-care. In this case, health education structures the basis for any intervention aiming to achieve positive results. In fact, pregnancy produces physical, biological, and psychological changes, which require guidance and support for adapting to the process. Thus, prenatal care constitutes an appropriate moment for the development of actions regarding education and health promotion[27-30].

The diversity of emotions and the subjectivity of the high-risk situation is common for many women[12,25,31] and should constitute a precise guideline for nurses to develop their plans of action and care. There seems to be no inconsistency between the prevalence of the use of hard and light-hard technologies and a more intimate approach in favor of women, which can be competently developed by nurses. Thus, a favorable therapeutic environment is built, allowing to address different and specific approaches. This statement is supported in our findings, in which women exposed delicate and complicated situations involving violence and drug use in nursing consultations. We consider that the nurses, during the consultation, provided a privileged space for the narratives of pregnant women, with the creation of a protective environment – narratives which contribute to alleviate the suffering of these situations. However, the confrontation of this problem is still limited to interventions in crisis, which requires the incorporation of new components capable of dealing with the complexity of the problem during pregnancy. Interventions thus planned should focus on prevention, improvement in mental health, integration of the different actions and programs on harm reduction for the new generation in gestation[32].

On the other hand, we did not identified problems in the psychospiritual BHN class. This fact may be related to the instrument of the nursing consultation, which only identifies the religion of the pregnant woman, but does not address the linked issues. Thus, it may be useful to stimulate the narratives dealing with the experiences of spirituality, especially when addressing confronting strategies and those of tolerance to stress. Spirituality is important in the life of human beings, since it helps them in borderline situations such as in the case of chronic and terminal diseases[33]. Religion interferes both in the illness and in the healing processes[34].

Finally, the BHN are interconnected and the lack of perception of changes may hinder the solution of other changes. Data point to the multiplicity of changed basic human needs among pregnant women, with useful information to guide nurses in initiatives and actions that enhance the assistance and guide interventions. Furthermore, we highlight the importance of systematizing the nursing care in order for it to be effective alongside the pregnant woman, performed with scientific basis and professional autonomy[7].

Study limitations

The study presented as main limitation the incompleteness of some data in the instruments for recording the consultations. Illegible handwriting in some forms also hindered the reading and interpretation of nursing problems. Such issues can be minimized by permanent education, reinforcing the importance of correct and complete record of the data obtained in the consultations. We also suggest that nursing professors and students that work in the researched field carry out periodic evaluations of the instruments of the consultations, in such a way required changes and improvements can be achieved.

Contributions to the field of nursing, health, or public policies

The study contributes to the reflection about the work of nurses in the secondary high-risk prenatal care, an area in which such work can be extended to meet the basic human needs of pregnant women. We mention possibilities for the alignment of the care actions of nurses, which comprise the need of systematic work, from the consultation and the nursing process. In addition, it consists of the discussion on the use of technologies for this care. Moreover, we believe that the manuscript is a headway regarding nursing knowledge, since it addresses key aspects of the work of nurses, which can be extended to other population groups and sites of activity. We highlight that one of the implications for nursing education is the potential of the study to assist in guiding training and professional updating activities. Such aspect is especially related to the broadening of management and clinical perspective, in such a way to effectively implement related dimensions that characterize the light technologies of care.

CONCLUSION

The analysis of nursing problems and changed basic human needs of the studied high-risk pregnant women allowed identifying the work of nurses as a constituent part of a health care proposal for such patients. The initial hypothesis, in which we stated that the systematic knowledge of the needs of high-risk pregnant women could point to the work possibilities of nurses, as well as the quality of such practice, was confirmed. Therefore, the study brings visibility to the work of nurses in high-risk prenatal care, whose actions, systematically organized and based on scientific evidence, can overcome the pre-established assumption according to which the work of nurses is limited to spaces where there is the predominance of

hard and light-hard technologies. Thus, the HRPC consists in a space in which nurses can work as a team and with autonomous actions, and the compliance and efficiency of their work can dialogue with hard and light-hard technologies, through their mastery of light technologies.

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