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Reconfiguration of palliative oncological nursing care: nursing contributions

Reconfiguração dos cuidados paliativos de enfermagem oncológica: contribuições da enfermagem

Reconfiguración del cuidado de enfermería oncológica paliativa: contribuciones de enfermería

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ABSTRACT

Objective: to analyze the strategies implemented by nurses to reconfigure palliative oncological care due to the hospital accreditation process in *Hospital do Câncer IV* (Hospital of Cancer IV). **Method:** qualitative research of historical-social approach, whose direct sources in use were written documents and four spoken accounts. **Results:** implemented strategies were: creation of the Nursing Division; nursing staff management; consolidation of Continuing Education sector; creation of Internal Nursing Bylaws through development of norms and routines; meetings; discussion of clinical cases; training and classes; creation of *Núcleo de Assistência de Enfermagem* (Nursing Assistance Core); creation of a tumoral and ostomy wound-dressing ambulatory; and organization of the 5th Vital Sign Forum. **Final considerations**: nurses, supported by an alliance with the institution directors, implemented effective strategies and reached significant advancement. As they took part in this endeavor, they became legitimate spokespeople of an authorized discourse in the field of oncological nursing care in Brazil.

Descriptors: Palliative Care; History of Nursing; Hospital Accreditation; Oncological Nursing; Quality Management.

RESUMO

Objetivo: analisar as estratégias empreendidas pelo enfermeiro para reconfigurar o cuidado paliativo oncológico frente ao processo de acreditação hospitalar no Hospital do Câncer IV. **Método:** pesquisa qualitativa, de abordagem histórico-social, cujas fontes diretas utilizadas foram documentos escritos e quatro depoimentos orais. **Resultados** as estratégias empreendidas evidenciadas foram: criação da Divisão de Enfermagem; gerenciamento de pessoal da enfermagem; consolidação do setor da Educação Continuada; criação do Regimento Interno de Enfermagem, com elaboração de normas e rotinas; reuniões; discussão de casos clínicos; treinamento e aulas; implantação do Núcleo de Assistência de Enfermagem; criação do ambulatório de curativos tumorais e ostomizados; organização do Fórum do 5º Sinal Vital. **Considerações finais:** os enfermeiros, apoiados por uma aliança pactuada com a direção da instituição, empreenderam eficazes estratégias e alcançaram significativos avanços, à medida que participavam desse investimento, se transformavam em porta-vozes legítimos de um discurso autorizado no campo da enfermagem oncológica no Brasil.

Descritores: Cuidados Paliativos; História da Enfermagem; Acreditação Hospitalar; Enfermagem Oncológica; Gestão da Qualidade.

RESUMEN

Objetivo: analizar las estrategias emprendidas por las enfermeras para reconfigurar los cuidados paliativos oncológicos frente al proceso de acreditación hospitalaria en lo *Hospital do Câncer IV* (Hospital del Cancer IV). **Método:** investigación cualitativa, con un enfoque histórico-social, cuyas fuentes directas utilizadas fueron documentos escritos y cuatro declaraciones orales. **Resultados** las estrategias emprendidas evidenciadas fueron: creación de la División de Enfermería; gestión del personal de enfermería; consolidación del sector de Educación Continua; creación del Reglamento Interno de Enfermería, con elaboración de normas y rutinas; reuniones; discusión de casos clínicos; entrenamiento y clases; implementación del *Núcleo de Assistência de Enfermagem* (Centro de Atención de Enfermería); creación de la clínica ambulatoria para apósitos de tumor y ostomía; organización del V Foro de Signo Vital. **Consideraciones finales:** las enfermeras, apoyadas por una alianza acordada con la gerencia de la institución, emprendieron estrategias efectivas e hicieron avances significativos mientras participaban en esta inversión, se convirtieron en portavoces legítimos de un discurso autorizado en el campo de la enfermería oncológica en Brasil.

Descriptores: Cuidados Paliativos; Historia de la Enfermería; Acreditación de Hospitales; Enfermería Oncológica; Gestión de la Calidad.

INTRODUCTION

Since the 1990's, in Brazil, there have been important alterations to oncological care, which aimed at promoting quality of life to patients and their families through comfort and pain relief measures, treatment of pain and of other problems of physical, psychosocial and spiritual nature, all of them able to bring forth conditions for understanding the finitude of patients' lives, decreasing the negative effects of the disease and planning life quality[1-2].

Due to that, care to patients with advanced cancer and without pharmacological answers was strengthened in 1990, with the first definition of a palliative care concept given by the World Health Organization (WHO)[1]. In the following year, in 1991, INCA (*Instituto Nacional do Cancer* – National Cancer Institute) officially opened the first Palliative Care service in Brazil[3].

In Brazil, accreditation was presented for the first time through the International Manual of Hospital Accreditation Standards. Throughout the 1990's, it was used by *Consórcio Brasileiro de Acreditação* (CBA – Brazilian Accreditation Consortium), the local partner of Joint Commission International (JCI), and the proposed process resulted in the concession of an international certification as an accredited institution. This certification allows hospital bylaws to be recognized by organizations of other countries[4].

It was in this context that, in 1998, palliative care was regulated in Brazil, according to Ordinance n. 3,535 of the Health Assistance Office, an organ within the Ministry of Health (MoH)[5]. In order to strengthen the palliative care movement in Brazil, in the same year, the construction of a new unit of INCA was finished, which was initially called Center of Therapeutic Oncological Support, and renamed in 2004 to *Hospital do Câncer IV* (HCIV – Hospital of Cancer IV)[3]. That way, the nomenclature of INCA hospitals was unified.

Consequently, given the perspective of a growing demand for palliative care in the country and the urgency for public policies of cancer control, important ordinances were sanctioned in the following decades to support and stimulate the creation and development of this service. In this context, following the national and international movement of palliative care, HCIV defined its mission in 2004, that is to promote and provide high quality oncological palliative care, with technical and humanitarian skill, focusing on obtaining the best quality of life to its patients and their families[3]. Such initiatives also aimed at obtaining the accreditation in palliative care, to certify the excellency of this unit in this type of care service.

Throughout 2004, HCIV began the reconfiguration of palliative oncological care and the reorganization of its health services, considering accreditation standards. Therefore, internal procedures had to be reviewed, regarding the management and quality assessment of health services therein provided, aiming at excellency at patient care and at staff working conditions.

The year of 2004 was, thus, marked by several alterations and by the path lead towards hospital accreditation of INCA units, including HCIV. Therefore, the hospital accreditation process started at the palliative care unit, according to international standards of care quality, with the objective of reviewing internal procedures in pursuit of care and working condition excellency. Operational alterations were carried out, normatizing and rationalizing processes, documenting care routines, organizing professional conducts, and establishing care and quality indicators. Moreover, the Humanization project was expanded to all areas. Facing this setting, the following question is presented: what were the challenges faced by nurses in the process of reconfiguration of palliative oncological nursing care, aiming at accreditation, in HCIV/INCA?

OBJECTIVE

This study aims to analyze the strategies implemented by nurses in order to reconfigure palliative oncological care within the process of hospital accreditation of HCIV.

METHODS

Ethical aspects

All ethical aspects were respected, according to the recommendations of Resolutions 466/12 and 510/16 of the Brazilian National Health Board (*Conselho Nacional de Saúde*). This paper was approved by the Research Ethics Committees of the proponent and coparticipant institutions.

Type of study

This is a historical-social study of qualitative approach, in the perspective of History of the Present, whose *corpus* contains direct historical sources, both written and spoken, and indirect sources used to support the discussion of results.

The timeframe comprises the year of 2004, when the reconfiguration of palliative nursing care in HCIV began, given the new institutional investments and new work axes. The accreditation axis lays among them, what required review of technical-scientific procedures, aiming at improving care activities in pursuit of service quality excellency, considering also the working conditions of hospital staff, in the city of Rio de Janeiro, Brazil.

Methodological procedures

Study setting

The setting is at HCIV, the exclusive palliative care and reference unit of INCA, in the city of Rio de Janeiro, state of Rio de Janeiro, Brazil.

Data sources

Written documents comprise INCA yearly management reports, books of meeting minutes (both from the Directors' Council and the Nursing Division), records from the Nursing Division related to planning and institutional activities directed towards the hospital accreditation process. Those documents are archived at HCIV/INCA. Four participants were also interviewed, and the following inclusion criteria were adopted in this study: professionals who had floor management positions, including a doctor who had a leadership position in hospital management, and who experienced the hospital accreditation process, whether they are currently active in

the setting-institution or not, with a work bond or not, expressing their consent to participate by signing a Free and Informed Consent Form, besides having availability and time to offer an interview. For recruitment, participants were identified by the staff in the institution and also by indication of other professionals who took part in the research. Indirect sources comprise articles in scientific journals that were published about the theme.

This study excluded professionals who had management positions but were on vacation or on leave during the data collection timeframe. During the master's degree dissertation development, the number of professionals who had a management position was 12. Out of them, 3 refused to participate, one was on medical leave, one was deceased, 7 took part in the research and 4 had excerpts of their interviews herein highlighted in direct contribution to the phenomena under study.

Data collection and organization

For written documents, their nature, availability and comprehensiveness were taken into consideration; i.e., all documents were scanned, categorized in named folders, and made available for consultation and copy. Thus, it was possible to confront them in order to identify possible divergences.

Interviews were carried out in the timeframe from February to June 2018, and they were guided by a semi-structured script with open questions about the theme under study, such as: What is your perception about the necessary changes for the accreditation of the unit? Comment on your participation in this process. Comment on the challenges that were faced. How was the nursing team prepared for those changes? How do you perceive the investment made by the staff and the institution?

The interviews were digitally recorded and, later on, transcribed and validated by the participants upon reading and providing written authorization for their use. That was preceded by the signature of a Free and Informed Consent Form (FICF), after ratification that there were no doubts about the research development and its respective objectives. Interview locations were defined by the participants. Average interview time was 65 minutes. In order to identify the spoken accounts, the initial letter of the interviewee's profession was used, followed by the Arabic number corresponding to the sequential order of the interviews: nurses (N1; N2; N3); doctor (D1).

Data analysis

In order to substantiate the data analysis in the research, the documental *corpus* considered internal and external criticism to eliminate any divergencies related to the content and the origin of the sources. Furthermore, the chronology of data collected in the investigated period was taken into consideration. The documental *corpus* was analyzed considering active procedures of document interrogation, with an independent stance from the official version and, therefore, making the historical phenomenon better evidenced. Result reliability was ensured with the valuation of the documental set instead of each isolated document, emerging from the following categories: Nursing Division, Nursing leadership, Continuing Education, and Strategical management. Data analysis was based in articles and books about the theme, i.e., the indirect sources.

RESULTS

The pursuit for excellency in service quality of a national reference palliative care hospital required great institutional investment, and specialized professionals in the field of palliative care. In that perspective, the nurses who worked at HCIV needed to adapt to a new management model. Therefore, it is made evident by the interview excerpts that there was a necessity for investment in the development of relevant nursing action for that unit, besides creating, developing and/or consolidating some services. It is also observed that there was an urgency to develop and spread norms and routines to the nursing sectors of that unit.

Nursing Division was created in HCIV as one of the strategies that were implemented for the reconfiguration of palliative oncological care, and it acted as a spokesperson of nurses in HCIV and in INCA as a whole. Therefore, the nursing Direction lead nurses' participation in institutional consolidation as a national reference in palliative care and in ratifying the role of INCA in the health field as a technical and executive instance of MoH, both in research development and in providing specialized care, directed exclusively to treatment in SUS (*Sistema Único de Saúde* – Brazilian Unified Health System). Nurse Fatima Vinhas was chosen by the directors of HCIV to take the position of Head Nurse, a leadership role for nurses, due to her volume of social and scientific capital.

> *Fatima was a candidate for the Nursing Division* [...] *we built this Nursing Division, it was during our management, too! And the nurses here didn't even have DAS to be head professionals* [brazilian salary bonus for head positions]. […] *INCA as a whole* [all the other units] *have a Nursing Division* […] *the only unit that didn't have a Division was HCIV* […] (D1)

> *It was then that Doctor Maurílio* [HCIV director] *saw my work, when I was Head Nurse at the ER* [Emergency Room]*, he saw it and he called me! That was in 2004, when he took office* [at HCIV direction]*, he has passed away now. He came to me and told me: I've been meaning to create a Nursing Division because the hospital doesn't have one. Would you go for it?* (N3)

The creation of the Division set HCIV nurses to face resistance from other nurses from Nurse Divisions in the other INCA units, justified by the alteration of the organizational structure of the institution. The HCIV Nurse Division, at that moment, was not a part of the administrative organization chart of Ary Frauzino Foundation (*Fundação Ary Frauzino*), the institution in charge of INCA administration. Thus, the organization chart defined by HCIV imposed, to the heads of Division in other units, the leadership of nurses who had equivalent positions in HCIV.

> *The nurses from Nurse Division of the other units said: no, we won't acknowledge your Nursing Division* [at HCIV] […] *no problem! To me, she [the nurse in charge of HCIV Nursing Division] is the Head Nurse! I consider her the Head Nurse, I said* […] *you may not even want to hear them!* […] *It's not in the organization chart. It's not allowed in HCIV! There's no DAS for them* […] *but I'm creating a Nursing Division.* […] (D1)

> *We had a lot of difficulties to get things, because the Division didn't exist* […] *those difficulties were normal because we didn't have a Division and the other units did* […]. *There was a routine in HCII, in HCIII, but there wasn't one in HCIV, there weren't even internal bylaws.* (N3)

With the Head of Nursing Division as a leader for all the nursing team in HCIV, it was possible to identify nursing staff management practices, an initiative that strengthened the strategic planning that was beginning, contributing to the organization and performance of activities, with objectives and action plans.

> *The first thing we did was the survey of all staff by category and checking where they'd work to improve* […] *of all the technicians […] at the time we had assistants* […] *it was necessary to know everything about the team that was working at the hospital* […] *we went and checked the profiles of who was good to stay at the nurses' station, who was good to be with emergencies* […] *who had a profile like they'd have more patience with families* […]. (N3)

The strategies implemented by the Division and by the nurses in the palliative care exclusive unit made the consolidation of some services evident, such as the Continuing Education sector, which was responsible for in-unit training for nursing professionals about care provided in HCIV.

> *We got to see where we could work our difficulties out* […] *a Continuing Education began taking shape, surveying all staff by category and we saw where we would act to improve even more* […] *such as the training of nursing technicians, we offered training with the support of Continuing Education* […] *Continuing Education was consolidated from the Nursing Division on.* (N3)

> [...] *there were some meetings and some trainings so we could know what was demanded, what would be scored, there were some trainings in that sense.* […] *we had a lot of classes promoted by the Continuing Education sector, I remember we often had classes on common themes of palliative care* […] *classes on sedation, on access, on lesions to instrumentalize* […] (N2)

With support from the Direction, the Division provided planning and actions for the nursing staff in HCIV, establishing competences and professional attributions. The creation of Internal Nursing Bylaws and the development and spread of norms and routines, regarding unit services, guided and unified nursing actions in that unit.

> [...] *later I created the whole HCIV Nursing Bylaws* [...] *because you have to have Bylaws* […] *the director helped with the bylaws* […]. *Some norms and routines we had already developed in our work, but they were recorded from 2004 onwards, at my time in the Nursing Division* […] *we gathered the heads of each sector and created these norms and routines with the Direction's assistance.* (N3)

Some strategies used by nurses, the Division, and the Direction included routine meetings; discussion of clinical cases among HCIV team members; training and classes. In those occasions, there was space for professionals' difficulties to be exposed, so together the staff could define the best way to respond to the needs of the unit:

> [...] *We worked with in-service training, with Education* [...] *we discussed cases* […] *they had classes* […] *we just directed to meet that demand* […] *we would control pain* […] *work on this new form for the pain matter* […] *We reviewed this matter of pain, reviewed the matters of assessment and records.* (N1)

Those investments did not happen to all nursing professionals in a unified way. Those who worked shifts had more difficulty to incorporate norms and routines created and made available in HCIV nursing service, necessary to its accreditation, which was the institutional motivation for the reconfiguration of nursing care and other services:

> [...] *I think the difficulty was to be better prepared* [...] *speak to more people* [...] *because the process wasn't cohesive with everybody and speaking the same language* [...] *I was prepared in the sense that I had already passed accreditation* [in another hospital where I worked] […] *we know they demand step-by-step action* [...] *the staff that worked the floors daily was organized in this aspect* [...] *but there could be something missing for the shift workers because there was no time to talk to everybody* [...]. (N2)

Other strategies recorded by the Nursing Division, with support from HCIV direction, were the creation of the Nursing Assistance Core (NAE – *Núcleo de Assistência de Enfermagem)* and of the tumor and ostomy wound-dressing ambulatory.

> *There was a wound-dressing commission* [...] *when we organized the ambulatory, we organized a specific space for nursing* [...]. *I thought: this nurse needs a bigger space to act with them* [patients], *because in the ambulatory she is the nurse who gets it done, she guided everyone with so much competence. Nursing staff needed a larger space* [...] *space to guide patients and caretakers* [...] *27% of them have tumoral wounds, they* [nurses] *can't just have a tiny room* [...] *we created a Nursing Assistance Core* (NAE) [...] *we hade the NAE in the ambulatory* [...] *it was theirs* [the nurses'] [...] *there were indicators and the special wound indicators* [...] *the organization of wound stages was constructed here [*in HCIV] *with them* [...] *they taught us that* [...] *it came from that NAE* [...] (D1)

> [...] *we opened the NAE within the ambulatory* [...] *there were the doctors' offices and there was our Core* [...] *there were two rooms* [...] *there were the procedure room and the consultation room* [...] *where we made nursing consultations and dressed the wounds* [...] *we showed indicators at the end of the month* [...] *and through those indicators we analyzed if we were controlling odor* [...] *we dressed wounds, maintained catheters, drew blood, gave guidance, changed fentanyl, or administered any medication that was needed* [...] *our unit also had someone who was part of the wound-dressing sub-commission* [...] *we had our wound-dressing commission and there was the bigger INCA one where participants from all units discussed the protocols* [...]. (N3)

In the same year, an important event happened on August 20, as recorded in the Nursing Division Management Report and in the INCA Management Report 2004 – the 5th Vital Sign Forum. This one-day event was offered by the HCIV Nursing Division to all INCA professionals, with a 6-hour program. This event happened in the Gama Filho auditorium of *Hospital do Câncer III* (HCIII – Hospital of Cancer III) and the following themes were broached:

pain relief in cancer patients; general principles of pain control; analgesic therapeutics; HCIV pain control group presentation; and workshops with discussion of clinical cases.

> *In 2004, under my management, when I created the Nursing Division, we were able to make the first 5th Vital Sign Forum* [...] *HCIV created it* [...]. *I organized everything* [...] *The first Hospital to promote a 5th Vital Sign Forum was HCIV* [...] *we created fifth vital sign stamps to be used on evolutions* [...] *we trained technicians on how to assess* [pain] *and record it* [...] *they were trained on how to make pain assessment* [...] *always training everybody.* (N3)

DISCUSSION

HCIV nurses implemented several strategies to reconfigure palliative oncological care to a process of hospital accreditation and, thus, to also answer to institutional investments. Consequently, they reinforced the importance of providing excellent care directed to such patients, their families and all other individuals involved in the process.

Regarding the reconfiguration of such care, one of the strategies was the creation of a Nursing Division and, to take the position of Head Nurse, nurses individually showed their availability to the job, so nurse Fatima Vinhas was chosen by HCIV direction due to her volume of social and scientific capital. The selection of that nurse was, therefore, a power granted by a doctor, counting with his approval.

Support of directors, of people who decide about the destiny of an organization, integrated to professional work, is of utmost importance for the advancement of care quality, the increase of patient safety, and the development of a stronger relationship of mutual exchange with the leader (e.g., nursing manager)[6]. It is relevant to consider that, so care can be provided with quality, and so goals and transformations to work organization can be reached, the nurse must be prepared, as a manager, to take the role of a leader[7].

It is relevant to consider, given those institutional changes, the experience and knowledge of that professional, besides characteristics such as agility, which also assist the development of organizations[8]. Nurses' autonomy is acknowledged by the team when they show themselves as leaders, consequently providing them with articulation power before other health professionals, greater commitment to patients and, therefore, professional valuation[9].

The Nursing Division didn't use to be a part of the Foundation's organizational chart, what made nurses from other INCA units refuse to recognize the authority of HCIV nurses, in spite of the fact the head position had been recorded by the unit director, granting one of them the representativity that did not exist until then. That situation proved itself to be one more challenge for the Head Nurse of the HCIV Nursing Division.

Palliative oncological nursing care became legitimized under the leadership of the Head of Nursing Division, and the strategies that were implemented for the reconfiguration of that care and for the consolidation of specialized knowledge, aiming at care excellency, contributed to the accreditation of the unit as a national reference in its specialty.

Strategic management focuses on the mission and vision of an institution, being performed by monitoring, analysis and systematic alignment of unit strategies, from a process developed through meetings, focused on decision-making, using strategic planning. Strategic Planning and thinking skill are essential tools for nursing leaders, since a management process comprises the formulation od strategic objectives for the service and action plans for its performance, all mensurable and consistent, based on the internal and external conditions of the institution, planning, therefore, its evolution[10-11].

It is extremely important to analyze the contribution and the role of team members, because they directly impact provided care, work force, and service quality. It is necessary to consider which skills are required to reach goals and which are essential to meet the needs of the patient profile under care. It is also important to consider work force data in order to make decisions about the organization and composition of a team[12].

Some participants also narrated the consolidation of some of the implemented strategies, among which there is Continuing Education, a sector that was created and developed in the unit, and which was responsible for institutional training. In that sense, that group's initiative – committed to the development of its activities as high-impact actions for care quality – represented a strategy that allowed all involved parties to gain scientific capital, as it increased and diversified knowledge, thus reflecting directly on integral care to patients, their families and all involved individuals, as well as on the quality of provided care.

A health institution that invests in nurses' Continuing Education acknowledges the contribution of those professionals in health care. Those investments train nurses, allowing them improved knowledge and skill practice, resulting from experience acquisition. Trained and updated professionals reflect directly upon the reconfiguration of health care practices, on support and on institutional systems, besides directly contributing to the dissemination of adequate care action and to the improvement of care quality[13].

Patient safety strategies contributed directly to care quality, favoring the new models of work axes in INCA unit IV. Thus, nursing staff took support on those strategies to develop their own new proposals, keeping their efforts and participation to consolidate HCIV as the national reference in palliative care. Moreover, it reaffirmed its role in the health field as a technical and executive instance of the Health Ministry, as a research body and as a specialized care provider, directed exclusively for SUS cases.

The importance of a nursing staff leader prioritizing the development of competences is highlighted, in order to achieve institutional and normative requirements, besides the ones from Joint Commission International (JCI). Thus, according to the Federal Nursing Council (*COFEN – Conselho Federal de Enfermagem)*, the internal bylaws establish the organizational structure, requisites, competences and attributions of the staff, and normatizations related to nursing practice. This document aims at easing professionals into knowing the norms, procedures and guidelines about work processes for all nursing team staff members. Furthermore, it must be approved by hospital Direction, whose responsibility is to provide means so the bylaws are followed[11].

The year of 2004 was rather intense, with plenty of changes to the nursing care and the reality of HCIV/INCA unit. The adaptation process was a vividly remembered factor for the research participants. Some difficulties were also mentioned about acceptance, insecurity and team resistance, whose attitudes influenced the progression of some processes.

Continuing Education also had an important role in order to overcome such resistance, because it arises from the needs and the reality of the work environment and it is developed from daily experienced situations, holding as objectives: discussing reality; improving staff development by stimulating critical reflection; and action based on constantly transforming knowledge[14]. Moreover, it may make practice more efficient and potentialize teamwork qualification, since it may add to the staff new perspectives about the way to care and to lead, providing new ways of sharing knowledge[15].

Continuing Education is an important contribution in a care context, since it is considered a support for factors such as increased motivation related to work and strengthened health unit and professional identity. Furthermore, it grants the nurses opportunities of professional development and strengthens leadership skills, allowing them a professional role at management level[16].

HCIV specialized nursing care grew stronger due to the creation of the tumoral and ostomy wound-dressing ambulatory. That initiative supported the actions of nursing staff within that INCA unit, since nurses started to provide care in a specific space. That way, a territory of nursing care is marked, therefore, it is an opportunity to make professional autonomy evident. On the other hand, that did not seem to be the most adequate of spaces, considering that ambulatory could be summed up in a room where many other nursing activities were carried out, such as: drawing blood; administering medication; and catheter maintenance; all besides wound dressing.

In order to develop specialized nursing care in HCIV, a different nursing care was necessary. The creation of NAE, however, was not up to standard requirements for hospital accreditation. That demanded some meetings involving the Head of Nursing Division and HCIV direction, in order to plan norms, routines and nursing protocols. In that year, a lack of computers was highlighted as an obstruction to NAE services, making nursing records harder to input in the pain control assessment and material use tool.

The involvement of nurses in 2004 was also shown through the 5th Vital Sign Forum. In that event, the relation of pain in palliative care was discussed and, furthermore, the unit intended to include pain as a fifth vital sign in routine records. Thus, they improved institutional protocols effectively in nursing care quality and broadened HCIV visibility, both to other INCA units and to other hospital institutions in the whole country.

The importance of pain identification and description is therefore made evident; it must be done through indispensable data such as service systemization, complaint detection, assessment and records so treatment can be carried out. In this context, the nursing team has an important position which may influence its control[17]. Thus, pain assessment tools hold great relevance to support and guide nurses' actions, besides serving as a basis for diagnosis, prescription and assessment of obtained effectiveness, whether it is pharmacological or not[18].

The year of 2004 was intense in the unit under study, with new work proposals and great investments made by the Direction and by nursing staff. On November 22, 23 and 24, the first stage of the hospital accreditation process happened, when an assessment of international standards of accreditation for continuing care was made, where HCIV recorded the general scores: 60% conformity, 16% partial conformity and 24% non-conformity to standard, thus generating an adequation plan[19].

Study limitations

Study limitations consist of the possibility of other historical documents being found in the future, despite the intense investment made in the search of such materials, what might allow adjustments to the historical version herein presented.

Contribution to the nursing field

The contributions of this study make evident the necessity for careful reflection upon the understanding of strategies in this care profile and upon the path of oncological health care practices in Brazil, which may be used by professionals in all levels of care. It contributes also by broadening the knowledge of those who work in the field, in order to promote greater possibility of understanding and mastery of strategies in the profile of palliative oncological care, aiming at quality in health care. Furthermore, this study is important as a resource for professionals who constantly face that user profile within all levels of care.

This study also serves as an important analytic tool to broaden the understanding of the path lead by nurses in this care modality in Brazil.

FINAL CONSIDERATIONS

Those strategies, which established the professional competences and attributions, furthered service systematization, contributing to the new shared management model and the proposed work axes, since they were able to redesign the workings of care activities and of nursing care itself. Moreover, the importance of standardization of norms, routines, and of internal nursing bylaws in order to reconfigure nursing care in HCIV is noticeable, because they reflected directly on the context where the unit was found as a hospital accreditation candidate pursuing the standards set by JCI, besides systematizing nursing attributions and care.

It is possible to make evident that, in 2004, HCIV invested in implementing new protocols and care routines. Furthermore, it became a fertile setting for the development of strategies by nurses, in order to evolve and reconfigure palliative nursing care facing the new challenges that came forth, as determined by the institutional proposals. So the unit could stand its ground as a national leader and to consolidate itself as a reference in palliative oncological care, it was necessary that nursing staff was specialized to act in a more qualified and more structured service.

The fact remains that, after the institutional investments and proposed axes began, the operationalization of an institutional strategic plan took off, so the need to also involve the nursing staff became evident, since that, besides the indispensability of creating or consolidating services that counted on the participation of such professionals, the development and spreading of norms and nursing routines in the unit was also required. It is relevant to highlight that the nurses used new strategies as a palliative care reconfiguration logic, in the name of quality of provided care. That promoted the update of their scientific capital and, as a consequence, it reconfigured their professional *habitus*, characterized by the innovation of specific knowledge in a perspective of palliative care, meeting the constant requirements in

the axes of work and of standards set in the International Manual of Hospital Accreditation Standards.

It is concluded that, in HCIV, nurses implemented effective strategies when faced with the challenge that arose in the name of palliative nursing care, what culminated in a better use of their positions within that field, transforming it and contributing to consolidate the unit as a reference in the Brazilian health setting, strengthening their area of professional practice. It is also relevant to highlight that nurses' effort and authority allowed the consolidation of their activities, with great possibilities to develop their professional potential and to create a setting of development of their knowledge in care processes, in teaching and in scientific production, strengthening excellency in HCIV care quality.

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