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ORIGINAL ARTICLE

Nursing consultation in coping with COVID-19: experiences in primary health care

A consulta de enfermagem no enfrentamento da COVID-19: vivências na atenção primária à saúde

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ABSTRACT

Objective: to describe experiences in nursing consultations in Primary Health Care in the care of persons with symptoms of COVID-19. **Method:** this is a qualitative, descriptive, experience report study. Nursing consultations were held between May and November 2020 at a Basic Health Unit in a capital in the south of Brazil. **Results:** consultations took place in person and/or as teleconsultation. Through the theory of Basic Human Needs and care protocols, biopsychosocial needs were identified and nursing interventions were carried out. Nursing diagnoses were identified according to the International Classification for Nursing Practice. **Conclusion:** the use of care protocols supporting nursing consultations enabled greater professional autonomy, highlighting the role of the nurse in the user's access to the health system and in the resoluteness of the Primary Care in the pandemic context.

Descriptors: Primary Health Care; Community Health Nursing; Nursing Process; Coronavirus Infections.

RESUMO

Objetivo: descrever as experiências vividas na realização das consultas de enfermagem na Atenção Primária à Saúde no atendimento às pessoas com sintomas de COVID-19. **Método:** estudo qualitativo, descritivo, do tipo relato de experiência. As consultas de enfermagem foram realizadas entre maio e novembro de 2020 em uma Unidade Básica de Saúde de uma capital do Sul do Brasil. **Resultados:** as consultas ocorreram de forma presencial e/ou teleconsulta. Por meio da teoria das Necessidades Humanas Básicas e protocolos assistenciais identificarem-se necessidades biopsicossociais, e foram realizadas as intervenções de enfermagem. Identificou-se os diagnósticos de enfermagem conforme a Classificação Internacional para a Prática de Enfermagem. **Conclusão:** a presença de protocolos assistências dando suporte à consulta de enfermagem, possibilitaram maior autonomia profissional, destacando o protagonismo do enfermeiro no acesso do usuário ao sistema de saúde e na resolutividade da Atenção Primária no contexto pandêmico.

Descritores: Atenção Primária à Saúde; Enfermagem em Saúde Comunitária; Processo de Enfermagem; Infecções por Coronavírus.

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INTRODUCTION

The World Health Organization (WHO) declared the SARS-CoV-2 virus outbreak as an international public health emergency[1] and, subsequently, with the increase in the number of cases and its rapid spread around the world, as a pandemic in March 2020[2]. The clinical management protocol of COVID-19 (disease caused by SARS-CoV-2) in Primary Health Care (PHC), developed by the Ministry of Health of Brazil, demonstrates the role of nurses in combating the disease at this level of health care[3].

The PHC is responsible for the care of mild cases of the disease and it is the first care for severe cases, with the stabilization of the condition and referral to the tertiary sector[3]; in this context, it is the nurse who provides professional care to users with symptoms of COVID-19.

The theoretical density and structural complexity of the Brazilian PHC work process implies the need for collaborative health teams committed to maintaining the population's right to health, with nurses playing an essential role in the care and surveillance of the health of communities, and thus nursing consultations have become an important work tool as they qualify the professional practice from the systematization of the care[4].

In nursing consultations, clinical care protocols can be used as instruments to qualify care based on scientific evidence, which provides greater safety for users and professionals, prevents errors, optimizes resources, supports decision making, and collaborates with care coordination[5].

In the current Brazilian scenario, with legal support and facing an international movement that seeks to strengthen the visibility and appreciation of the profession, nurses, in the context of PHC, have stood out for carrying out the nursing consultation with persons with symptoms of COVID-19 in an autonomous, capable, and effective way and involving comprehensive care and health education that reinforce practices for the prevention of the spread of the virus.

In view of the above, this study has aimed to describe experiences in the performance of nursing consultations in PHC in the care of persons with symptoms of COVID-19.

METHOD

This is a qualitative, descriptive, experience report, which presents experiences in nursing consultations in PHC in the care of persons with symptoms of COVID-19. Nursing consultations were carried out between May 1 and November 30, 2020 in a Basic Health Unit (BHU) in the city of Florianópolis, Santa Catarina, Brazil. This BHU has three Family Health Strategy (FHS) teams and is responsible for the health care of an area with an average population of 7,500 persons.

Nursing consultations were carried out in the light of the theory of Basic Human Needs of Wanda Aguiar Horta[6] and Resolution No. 358 of 2009 of the Federal Nursing Council (COFEN)[7], being the philosophical and theoretical framework, respectively, adopted by the Municipal Health Department of Florianópolis.

COFEN explains that the nursing process, when performed in institutions providing outpatient health services, corresponds to the Nursing Consultation, and it is organized in the five following stages: 1st) nursing history, 2nd) nursing diagnosis, 3rd) nursing planning, 4th) implementation of nursing care, and 5th) evaluation[7].

The following care protocols were used as support for the professional conduct in the nursing consultations present in this report: "COVID-19 – Guide for health professionals in Primary Care, Florianópolis version"[8], "Attention to the spontaneous care demand in adults"[9], and "Attention to the care demand in children"[10].

In the nursing history, information was obtained about the user and their responses to the health and disease process[7]. The patient was encouraged to express their ideas, doubts, and expectations about their health situation and complaints in view of the pandemic scenario.

At that time, the nurse verified whether the user met the criteria for a suspected case of COVID-19 and evaluated the possibility of other infectious pathologies that presented fever. After the clinical interview, a physical examination was carried out focused on the patient's demands, investigating the warning/severity signs[8].

For the nursing diagnosis, the data collected in the nursing history were interpreted[7]. Nursing diagnoses were performed according to the International Classification for Nursing Practice (ICNP®)[11], a theoretical framework also adopted by the Municipal Health Department of Florianópolis. At that moment, the suspected cases of COVID-19 and contacts of positive cases were identified[8].

In the nursing planning stage, the results that were expected to be achieved in user care and the nursing interventions to be implemented were determined, and in the implementation stage, the interventions in the planning stage were carried out[7]. In the implementation stage, through the International Classification of Diseases (ICD) list, suspected cases of COVID-19 (ICD 10 B97.2) and contacts of positive COVID-19 cases (ICD 10 U07.9) were reported[8].

During the nursing evaluation, the user's responses (family member or caregiver, in the case of pediatric care) were verified in relation to the interventions, and it was possible to assess whether the expected result was achieved and, thus, make adaptations in the stages of the nursing process[7]. For cases in which ICD 10 B97.2 was notified, patients were contacted by teleconsultation three, seven, ten, and fourteen days after the onset of symptoms for evaluation[8].

A portfolio was made with notes about personal experiences during the exercise of the profession in caring for persons with symptoms of COVID-19, but no notes were made about the patient, such as name, telephone, contact, and any personal information. The report focused, in terms of ethical precepts, on the description of professional experience in the context of the nursing consultation. Thus, there was no need for the submission of the project to an Ethics Committee for Research with Human Beings as no associated research was carried out.

RESULTS

In order to provide a safe environment for both the health professional and the patient, it was necessary to pay attention to the organization of the place, named in the BHU as the "Symptomatic Respiratory Patient Care Room (SSR)", where exclusive care was given to persons with respiratory symptoms and/or in contact with a suspected and/or positive COVID-19 case, as well as training of the health and cleaning staff on concurrent and terminal disinfection routines.

Nursing consultations began daily after assessing that the SSR would provide patient safety, which included terminal disinfection by the cleaning team before the opening of the BHU. Spontaneous and scheduled appointments had a minimum duration of 15 minutes and a maximum duration of 40 minutes, depending on the demands brought by the patient. Patients who contacted one of the nurses of the PHU teams of the BHU by phone call, WhatsApp® message, or e-mail, who were identified as needing face-to-face care, had their appointments scheduled for the same shift or day.

During consultations, in the nursing history, communication techniques were used, such as: silence, emotional echo, summary, and non-verbal language demonstrating openness and understanding, so that the user could bring their experiences in the disease-health process.

Regarding biopsychosocial needs in service to users, the following items could be identified among the most common situations: concern about leaving work activities for fear of losing their jobs, and this situation was perceived more frequently among those without a formal contract; fear of death; fear of having COVID-19; fear of transmitting it to other persons (especially when they lived with children, pregnant women, and persons with chronic diseases); sadness and anxiety resulting from social distancing, home restriction, or home isolation, depending on each case; and, lack of a support network for the restriction or isolation at home.

To cope with the situations generated by the pandemic, some strategies used by users were perceived: faith in God; practice of meditation and yoga; video calls with family and friends; follow-up with a psychologist or psychiatrist by teleconsultation; and, pilates and other physical exercise practices through an online platform with a qualified professional (physical educator or physiotherapist). Limited financial resources resulted in fewer possibilities for managing stress and anxiety during the COVID-19 pandemic.

We highlight that some users who were in isolation at home were identified by members of the health team attending gym and other social spaces. This reality generated a feeling of professional hopelessness, when realizing that as a nurse, despite carrying out actions for the dissemination of information that promote learning on the topic in the community, citizens were still acting against the health efforts to face the pandemic. When the violation of home isolation was identified, the user was contacted to reassess the case, and the incident was communicated to the epidemiological surveillance as well.

During physical examination, focused on the patient's demands and investigating the warning/severity signs, the nurse could verify several symptoms that were present individually or concomitantly: fever; feelings of fever; shortness of breath; sore throat; runny nose; loss or changed sense of taste (ageusia) or smell (anosmia); myalgia; headache; and, diarrhea. The care of persons who had contact with a positive COVID-19 case was carried out mostly by teleconsultation.

When the patient presented data in the physical examination, such as mouth examination showing plaques or signs and symptoms caused by an uncontrolled chronic disease, which justified fever and other symptoms, the Family and Community Physician (FCP) was called in for an interconsultation/shared care. Other cases that needed shared care with a FCP involved the presence of warning/urgency signs or a user who could not have a teleconsultation and needed a doctor's note to present to the employer. The collaborative work with the FCP was of paramount importance to solve cases in which the evaluation of this professional was necessary.

Among the implemented actions, tests were requested to identify infection by SARS-CoV-2. In this sense, in cases where the symptoms had been present for less than eight days, the Reverse Transcription Polymerase Chain Reaction (RT-PCR) was requested to be performed between the third and seventh day of the symptoms. Until June 2020, when the symptoms had been present for more than eight days, and from June, after ten days or more, the antibody rapid test for the new coronavirus was performed from finger-prick whole blood sampling.

It was perceived that the belief that SARS-CoV-2 infection led to acquired immunity, thus eliminating the possibility of a new infection with this virus in the future, led some persons with mild respiratory symptoms to want to get the test to detect a positive SARS-CoV-2 infection.

The nursing diagnoses used in the consultations, according to the ICNP®[12], are described in Table 1.

Table 1. Nursing diagnoses, code, and definition according to CIPE® version 2017, Florianópolis, SC, Brazil, 2020.

Code	Diagnosis
10000477	Anxiety
10000703	Fear
10037834	Fear of Death
10000630	Diarrhea
10029433	Dyspnea
10023130	Pain
10000695	Fatigue
10022473	Lack of Family Support
10022753	Lack of Social Support
10021994	Lack of Knowledge about the Disease
10041539	Fever
10022880	Weakness
10022402	Mood, Depressed
10023032	Infection
10022528	Smell, Impaired
10022814	Taste, Impaired
10041895	Risk of Dehydration
10032386	Risk of Illness
10015133	Risk of Infection
10047143	Cough
10040662	Sadness

After the nursing diagnosis, the problem was explained to the patient, family member, or caregiver in easy-to-understand language using communication techniques to check their understanding. Then, nursing planning and implementation of nursing care was shared with users.

All cases identified as suspected or confirmed of the new coronavirus (ICD 10 B97.2), or as a contact of a positive COVID-19 case (ICD 10 U07.9), were compulsorily reported.

As for nursing prescriptions, the following were performed: medications for pain and fever relief (paracetamol or dipyrone); a spoon of honey whenever necessary for cough relief (as long as the patient did not have diabetes mellitus); ways to manage dehydration; oral rehydration salts when at risk of dehydration; health education about COVID-19; management strategies for anxiety, stress, sadness, and fear (including death); health education about social devices in the city of Florianópolis for support that favors the effectiveness of restriction and home isolation; management of diarrhea, pain, and fever; and, promotion of family support, seeking to list with the patient about family members who they could contact to contribute to the effectiveness of the restriction or home isolation.

Until the end of November 2020, during face-to-face visits, one patient with signs of COVID-19 was referred to hospital care and three patients were referred to the Emergency Care Unit (ECU) for evaluation.

With discussions in the media about the use of drugs such as ivermectin, azithromycin, and chloroquine as an early treatment for COVID-19, some patients requested the prescription of these drugs for fear of acquiring or presenting severe symptoms of the disease. When these requests occurred, the nurse first discussed what the current scientific literature brought about the treatment of COVID-19, and if the patient still wanted to use any of these drugs, the family physician was called for shared care.

It is worth mentioning that in rare situations, during these shared visits between the nurse and the family physician, the patient pointed out the use of the drugs previously mentioned as their right regardless of the physician's clinical judgment and non-prescription was interpreted as a refusal of care. The decision to prescribe the drug was the responsibility of the FCP.

The nursing protocols of the local government of Florianópolis entitled "Attention to the spontaneous care demand in adults" and "Attention to the care demand in children" were essential tools, and they were used in the professional routine during consultations in order to guide the physical health examination by the nurse, as well as the clinical conduct regarding findings.

At the end of the consultations, the nurse sought to establish the safety net by making it clear to the patient that, in case of doubts, they could contact the professional or the health team through the team's WhatsApp®, and that if the BHU was closed, they could call *Alô Saúde* of Florianópolis, but in case of shortness of breath or sudden difficulty breathing, they should call the Mobile Emergency Care Service (SAMU) at 192 or seek assistance from the emergency service.

At the BHU of this report, each FHS team has a cell phone. Thus, nursing evaluation was carried out through teleconsultations, via WhatsApp®, phone call, or video call, so that the patient could comply with the restriction or home isolation, depending on the case, and consequently, reduce the risk of transmission of the new coronavirus. The team questioned the patient about the symptoms they had, as well as their health complaints, improvements in clinical conditions, and results of the implemented care. The result of the PT-PCR test was reported to the patient, when it was carried out and available, care about home isolation was reinforced, and when appropriate, information was provided on the cure of the disease and the patient was released from home isolation.

The teleconsultation followed the steps of the nursing consultation, but with some limitations, such as restricted physical examination. In the nursing evaluation, the professional decided, together with the patient, which changes in care needs should be implemented in view of the new findings. Whenever coronavirus infection was ruled out or the patient was cured of the disease, the importance of preventive care against COVID-19 was reinforced. User satisfaction with the monitoring of the health-disease process by the nurses in the PHC could be perceived from the receiving of positive feedback, including messages and calls thanking and praising the care received.

DISCUSSION

The COVID-19 pandemic has had an important impact on health systems in several countries given their overloading at different levels of care. In Brazil, the PHC is often the first place sought for care when facing a health complaint. The strengthening of the problem-solving capacity of the care of persons with suspicion and/or confirmation of COVID-19 in PHC enables the appropriate use of highly complex resources at the tertiary level, thus ensuring the access of serious cases that need interventions requiring greater technological density[13].

The Ministry of Health of Brazil reinforces the importance of the PHC in the clinical management of COVID-19 and points out that, after screening, the user with flu symptoms should be referred to a nurse or physician for evaluation, but it is essential to carry out a medical consultation for severity stratification through anamnesis and physical examination[3]. It is noteworthy that, in the municipality where this report is described, management provides broad autonomy to nurses through the care protocol, which provides for the professional being responsible for the anamnesis, physical examination, request for exams, notification of the suspected and/or confirmed case of COVID-19, and prescription of drugs in the care of the user with flu symptoms, and interconsultation with a medical professional is carried out only in specific situations.

The Pan American Health Organization highlights the Advanced Practice Nursing (APN), which provides greater autonomy to nurses, as essential to achieve universal coverage of health services, and it supports Brazil in the consolidation of the APN in the country since 2015[14]. This report demonstrates the nurse's autonomy in caring for persons with mild symptoms of COVID-19 in PHC supported by municipal protocols, which ensures the access and problem-solving capacity of the service. This reality leads to the reflection of the importance of the clinical performance of nurses in the face of the population's health demands and in coping with COVID-19, as well as the efforts to expand and legalize nursing care practices in view of their role in health care, and these discussions are fundamental among the members of the Ministry of Health.

The nursing process in the current pandemic scenario has demonstrated the role of nurses in conducting the systematization of the nursing care, with legal support from a municipal protocol, as well as the implementation of collaborative practices between nurses and FCP. The protocols have strengthened the professional autonomy, and the scientific background intensifies the execution of good practices, the quality of the care, and assertive behaviors in user care, which opposes study findings[15] that reveals the inflexibility of nurses when health care protocols need to be followed.

Comprehensive care and the use of communication tools have favored the praxis process and have contributed to a trusting relationship between the parties, this way demystifying the empirical knowledge about the disease and corroborating studies carried out with persons with chronic diseases about the relevance of the nursing consultation[12,16].

Through clinical communication, nurses can also play their role as health educators, and they could address the care regarding social distance, isolation, and home restriction and other measures focusing on the prevention of COVID-19[8]. Professionals had to explain to patients that the treatment protocols for persons with symptoms of COVID-19 follow what is recommended by important current international scientific literature[17-19] and that, although many politicians continue to insist on the use of chloroquine/hydroxychloroquine for all patients with COVID-19[20], scientific findings demonstrate that these drugs are not effective in mild cases[21]. These drugs also do not reduce the severity of the disease[22], and they have been shown to be ineffective even in hospitalized patients[23-24], which denotes the need for further studies to implement their use in treatment protocols. In every process of education and health care, the user is autonomous in their decision-making process.

The clinical practice of health organizations in Brazil has undergone sudden changes during the pandemic and, to ensure precautionary measures, social isolation has been implemented, and thus teleconsultation was instituted by Ordinance No. 467[25]. In this study, telenursing as a work tool was used to ensure the transition of the care and the coordination and continuity of the care to users.

CONCLUSION

In the context of PHC, the role of the nurse is essential in providing health care and surveillance to individuals and communities, working as part of a team, and using instruments that facilitate this work process. In this scenario of health crisis imposed by the coronavirus pandemic, it is

evident the importance of strengthening the autonomy and working conditions of these professionals.

The nursing process with the support of care protocols has allowed professional autonomy and effective care of users with symptoms of COVID-19 in PHC in face of the pandemic caused by the coronavirus. The management of the care has improved its quality, coordination, and longitudinality. This report reinforces the importance of management and regulatory tools that ensure the autonomy of nurses in relation to public health problems.

We expect that this experience report will encourage researchers to carry out studies with different methodological approaches that address nursing care in PHC in view of the COVID-19 pandemic, in order to identify the practices of the profession, the advances of the expanded clinic, and the repercussions on the access to health services and the quality of care given to users.

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