



## Nurses' perception about interprofessional collaborative practices concerning primary care in Palmas, TO

*Percepção de enfermeiros sobre as práticas colaborativas interprofissionais na atenção básica em Palmas, TO*

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### ABSTRACT

In order to evidence the perception of nurses about interprofessional collaborative practices in Primary Care in the city of Palmas, TO, this qualitative study was conducted in 34 Basic Health Units where collaborative practices are experienced. Data were analyzed using the Collective Subject Discourse technique, based on the Social Representation Theory. The collaborative practices reported were: team meetings, work groups, shared care, joint activities in the community, case discussions, integrated therapeutic plans and conversation circles. They mentioned interprofessional communication as facilitators; team profile; partnership, trust and respect; flexible schedule for meetings and collaborative leadership. In the participants' perception, collaborative practices favor greater effectiveness in solving complex problems and intensify professional bonds between team members. They emphasized that collaborative practices are of great relevance in the scope of Primary Health Care, improving the ambience, job satisfaction and the quality of the service.

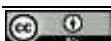
**Keywords:** Interprofessional relations. Primary Health Care. Patient care team.

### RESUMO

Com objetivo de evidenciar a percepção de enfermeiros(as) sobre as práticas colaborativas interprofissionais na Atenção Básica no município de Palmas (TO), foi realizado este estudo de abordagem qualitativa, conduzido em 34 Unidades Básicas de Saúde sobre onde as práticas colaborativas são vivenciadas. Os dados foram analisados pela técnica do Discurso do Sujeito Coletivo com base na Teoria da Representação Social. As práticas colaborativas relatadas foram: reuniões de equipe, grupos de trabalho, atendimento compartilhado, atividades em conjunto na comunidade, discussão de casos, planos terapêuticos integrados e rodas de conversa. Referiram como facilitadores: comunicação interprofissional; perfil da equipe; parceria, confiança e respeito; flexibilização da agenda para os encontros; e uma liderança colaborativa. Na percepção dos participantes, as práticas colaborativas favorecem maior eficácia na resolução de problemas complexos e intensificam os vínculos profissionais entre os membros da equipe. Ressaltaram que as práticas colaborativas são de grande relevância no âmbito da Atenção Primária à Saúde melhorando a ambiência, a satisfação no trabalho e a qualidade do serviço.

**Palavras-chave:** Relações interprofissionais. Atenção Primária à Saúde. Equipe de assistência ao paciente.

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## INTRODUCTION

The right to health, based on values such as equality, equity, and universality, requires a broad range of health services that are not only curative, but also answer to the health needs of society through health promotion and prevention, focusing on treating alterations in health states and rehabilitation<sup>1, 2</sup>.

With that in mind, the elaboration and implementation of the Single Health System (SUS)<sup>3</sup> brought several innovations to Brazilian society, being an important strategy of State reform created due to the mobilization of many social sectors. Regulated by the Organic Laws of Health (Laws No. 8.080/90 and 8.142/90), it is based on principles and values that were then innovations, aimed at providing universal access to health services and integral care through intersectoral actions<sup>3</sup>.

The National Policy for Primary Care (PNAB), put into effect in 2006<sup>4</sup>, was recently updated via Decree No.2.436/2017<sup>5</sup>, establishing that the directives for the organization of Basic Care (BC) or Primary Health Care (APS) should be reviewed. In the scope of SUS, this was done to increase the coverage of services due to emergent health needs and demands. This new health care model is based on the principles of universality, accessibility, bonds, continuous and integral care, accountability, humanization, equity, and social participation<sup>4,5</sup>.

In this context, the Centers for the Support of Family Health (NASF), created in 2008 by the Ministry of Health (MS) through Decree No. 154/2008, are a strategy to improve PHC in Brazil, aiming to increase its resolution powers and the scope of the reference teams of health care units receiving support from larger bodies<sup>6</sup>.

With the new update of PNAB, the NASF became the Expanded Center for Family health and Primary Care (NASF-AB), formed by health teams with professionals from many categories (expertises) in the field of health, who must work together to provide clinical, sanitary, and pedagogical training to the Family Health Team (ESF) workers. This team is expected to be an organic part of the APS, to have an integral experience of day-to-day life in the UBSs and work as peers of the other professionals, so care is longitudinal and provided directly to the population<sup>5</sup>.

The collective APS work aims to share knowledge and decision making, which may lead to overcoming professional barriers or limits, requiring common and complementary competences between the different professional fields. General competences are those that can be carried out by all health workers or at least in many of them, leading to similar worker behavior in certain sectors. Specific competences, in turn, are the unique traits of a professional, which can hardly be transferred to another. Collaborative competences, finally, are those that can be shared between the

professions/agents involved in a work activity<sup>7</sup>.

Formative actions of Interprofessional Education prepare workers for collaborative practices recognized by the World Health Organization<sup>8</sup>, who proposes ideas to aid both in the formative process and in collaborative practices, recognizing the fragmentation and difficulties of managing the several world health systems and the health demands that go unanswered. Interprofessional Education is an opportunity for joint education and for the development of shared knowledge, with two or more professions learning one from the other<sup>8,9</sup>.

Collaborative interprofessional practices contribute for the quality of health care outcomes, since failure in communication and professional interaction may lead to issues in patient care and in health services. Interprofessional collaboration is a process where different professional groups work together, demanding the desire to cooperate/contribute with the work carried out by the other both in the context of internal teams and in that of the community as a whole. It involves an agreement between professionals that values the expertise and contributions of each one, favoring the dialog in the team and with users, families, and social groups in the territory<sup>10, 11, 12, 13</sup>.

Collaboration is paramount in any collective interaction, being essential when one must implement the best health care

possible. A research carried out in Primary Care in three cities in the state of Paraná found that interprofessional collaboration took place through home visits, and in the planning and execution of collective activities carried out in and between sectors. The study highlighted collaborative practices as a condition for Primary Health Care to provide integral attention to the territory covered, articulating actions of health promotion or even recovery<sup>14</sup>.

When health work is articulated between different professionals, it allows not only for actions to be carried out in partnership, but also for the establishment of an interdisciplinary process where specific knowledge increasingly enrich common competences, enhancing the capacity of all team members to provide care<sup>4</sup>.

Considering the centrality of the role of nurses in the ESF and its teams, this investigation sought to shed a light on the perception of nurses about interprofesional collaborative practices in Primary Care in the city of Palmas, Tocantins, Brazil.

## **METHODOLOGY**

### **DESIGN, PERIOD, AND PLACE OF STUDY**

The study developed here is cross-sectional, descriptive, and exploratory, with a qualitative approach, and a sample of 24 nurses. Inclusion criteria were: being an active nurse working for the Municipal Secretariat of Health from Palmas, in the

state of Tocantins, with more than three years of experience in the ESF working with the APS. Nurses who were residents or were part of the program *Palmas para Todos* were not included.

Palmas is the largest city and the capital of the state of Tocantins, a state in the North of Brazil. It is the newest state capital of Brazil, with an estimated population of 299,127 people. The municipality of Palmas includes 8 regional territories with 34 Community Health Centers (CSC), 74 health teams, and 15 NASF professionals. From these, 89 are nurses - 52 active, 21 residents, and 16 in the program *Palmas para Todos*<sup>15</sup>.

#### ETHICAL ASPECTS

The semistructured interview script used as a qualitative collection instrument was elaborated and used to establish a dialog with workers and explore the topics of interest for the research. Individual researches were previously scheduled in their workplace, and participants, who signed the Free and Informed Consent Form, had their privacy guaranteed. In accordance with the ethical precepts for research with human beings established by Resolution 466/12, from the National Council of Health<sup>16</sup>, which guides all rights and duties of researchers and participants involved in research, this investigation was sent to the Research Ethics Committee, being approved under Approval Opinion No.3.178.593, on 02/28/2019.

Data collection took place from June to September 2019, and the mean length of the interviews as of 10 minutes. The materials were recorded, transcribed into spreadsheets, and organized in protocols where all questions from the script were grouped, as well as sociodemographic data.

Data were analyzed by the technique Discourse of the Collective Subject (DCS), based on the Social Representation Theory<sup>17,18</sup>. The DCS technique is based on the organization of discursive data, which enables recovering the social representations stored about a specific topic in a certain universe of people who, since they experience the same reality, are influenced by beliefs, costumes, and values, but also influence the practices that are consolidated in that context<sup>18,19</sup>.

The software "DSCsoft", which favors this type of analysis was used to facilitate the researcher's work and allow for the visualization of this analysis in graphics and tables, so the results could be better understood, and the collective character of the group could be defined quantitatively<sup>20</sup>.

#### RESULTS

Interviews were carried out from June to September 2019 at the work environment of nurses from the Primary Care of Palmas, TO, and the discourse of the 24 nurses who participated brought important elements to the debate on the role of interprofessional collaboration in the workplace.

79.17% (n=24) of participants were female and 20.83% male. Most were from 25 to 30 years old, with 4.18% older than 51. Regarding their educational level, most nurses interviewed (79.9%) had finished a post-graduation, as Table 1 shows.

#### INTERPROFESSIONAL COLLABORATION PRACTICES AND THE WORK ENVIRONMENT

The first question the nurses were asked was about whether interprofessional collaboration interfere in the work environment. In general, it was found that collaborative practices are highly relevant in BC, improving the environment, work satisfaction, and the quality of the service.

Nurses highlighted, regarding this first question, that quality interpersonal relations in a team always improve the work environment as a whole. In their discourses, it became clear that these practices can lead to a healthcare network where professionals are articulated to improve the quality of the service. Collaborative practices promote a dynamic of resolution as the Family Health Strategy deals with the complex challenges that need to be resolved. They also enable Interdisciplinary Planning, even considering that it is difficult to gather all members of the team whenever necessary. The interviewees state how much collaborative practices are essential in the workplace, providing better attention to patient and community.

#### INTERPROFESSIONAL COLLABORATIVE PRACTICES: TYPOLOGY AND DEVELOPMENT

The second aspect addressed was related with the types of collaborative practices carried out in the workplace and their functioning, according with the discourse of the participants.

The conversation between DCS interviewees built using Key-Expressions (KEs) is related with the context where their activities are executed in the units mentioned and guided by collaborative practices of continued or permanent education, which are weekly and bi-weekly meetings and work groups. There are also case discussions, integrated therapeutic plans, rounds of conversations, joint activities in the community, and attention together with the NASF team.

Support from head offices, mentioned by the nurses interviewed as a potential of the collaborative practices, enables joint work, which separates itself from traditional forms of health care and assistance organization.

#### FACILITATORS AND OBSTACLES OF INTERPROFESSIONAL COLLABORATIVE PRACTICES

The third question uncovered the opinion of participants regarding the issues that facilitate or difficult the development of collaborative practices by interprofessional teams. The result of the discourse analysis

about this issue led to three Central Ideas (CIs), according with Table 2.

The facilitators of collaborative practices in the workplace that were highlighted were adequate communication, team interaction, and institutional support. For this collaborative process, it is important for workers to have free time in their schedules for joint meetings.

The discourse of nurses regarding facilitator aspects highlighted that a positive and collaborative leadership is important in the Health Unit, as well as support from the Municipal Health Secretariat. The nurses highlighted how relevant it is to find a team that is willing, open, and sensible partners to share knowledge, act with mutual respect, and trust the work of the other. It is also important for each worker to understand their role in the team. This factor should be considered to facilitate collaborative practices among them.

Factors that difficult collaborative practices at work are, firstly, the lack of involvement of workers and schedule openings to do so, in addition to physical space and materials needed for these group

meetings. The work overload in the ESF routine and the extensive area under their coverage make it difficult to put into effect collaborative practices.

In addition to these obstacles, nurses in the city of Palmas, TO, also mentioned the issue of high turnover in the unit or even the lack of human resources, in addition to the fact that the profile and sensibilities of certain professionals are not ideal for work in the Family Health Strategy. They believe that knowledge, learning, and actions do not need to be shared. According with the nurses, individualism, excessive competition, doubting the colleagues work, the lack of flexibility in one's work schedule due to joint considerations, the lack of interaction caused by the fact that they do not understand that workers depend on each other to provide integral health care, starting with the lack of availability from management, in some cases. Still according to the nurses interviewed, in some units, collaboration is, unfortunately, informal and occasional, not representing an intentional planning of activities.

**Table 1.** Characterization of nurse participants in the research according with the variables: sex, age, and educational level (n=24), Palmas, TO, 2020

Variable	n (%)	%
SEX		
Male	05	20.83
Female	19	79.17
AGE		
25 to 30	14	58.33
31 to 35	2	8.33
36 to 40	3	12.5
41 to 45	2	8.33
46 to 50	2	8.33
51 to 60	1	4.18
EDUCATIONAL LEVEL		
Complete Higher Education	5	20.83
Post-Graduation	19	79.17

This research highlights the leadership role of the nurse in the health team. Nurses usually encourage articulation between different professionals as a way to gather, organize, and plan joint actions. As such, they become the connective tissue between the members of the team and the families. As leaders, they can often ask for the participation of other group members and the NASF. Their role is paramount and is the base of the interprofessional team, which means they are the ones who carry collaborative practices forward. The nurse is largely the one who establishes a bond with the community, as they understand better local contexts and coordinate the services of primary health units. They also

supervise and train community health agents and technicians in general.

At first, the interview aimed to ask for an affirmative or negative answer to questions about whether interprofessional collaboration can change the work environment: *Interprofessional collaborative practices can change the work environment, isn't that right? What collaborative practices are carried out in your day to day life? How do they take place? Talk a little about that.* (Question 1).

The CI A emerged from the result of the analysis of participant discourse, synthesizing the key expressions in their statements, thus, dismembering the first question.

**Table 2.** Representation of the Central Ideas (CIs) of the first question

Central Ideas - CI	Collective Subject Discourse - CSD
<i>CSDIA - n-24</i>	<b>CSD</b>
- Collaborative practices improve work environment, service quality, and promote satisfaction at work	Yes, undoubtedly, collaborative practices are fundamental to change the work environment. The more you create an interprofessional and interpersonal relationship with the members of the team, the better the work environment is. Collaborative practices among workers from several fields that work at SUS can form a health care network through the articulation between workers, improving the quality of the services where these professionals are. These practices help the family health team solve the issues they are faced with.

Source: Research data, Palmas, TO, 2020.

The continuation of the initial question asked the interviewees to identify interprofessional collaborative practices

carried out in their daily lives as health workers.

**Table 3.** Representation of the Central Ideas (CIs) of the first question

Central Ideas - CI	Collective Subject Discourse - CSD
<b>CSDIA - n-13</b>	<b>CSD</b>
ICA - Team meetings, work groups, and providing care jointly with NASF workers.	The collaborative practices applied in my work environment are those of care, care for the elderly, care for the chronically diseased, and care with the psychosocial network. These lines of care take place inside the unit even when they are supported by the NASF. We have head office discussions every month at the NASF, where clinical cases are discussed, and we work in the elaboration of the TP (individual therapeutic plans). NASF meetings are scheduled weekly or bi-weekly, according with the needs of each team. We work with meetings, consultations, work group, case discussions, integrated therapeutic plans, rounds of conversation, referrals, and all these practices require interpersonal interaction.
<b>CSDIB – n-4</b> CIB - Continued education activities among team professionals	The practices developed by the multiprofessional team are health education. We have meetings that take place during service, we receive guidance regarding attention flow in the health care network, receive guidance about self-care, guidance, and practice health promotion and prevention of diseases, all this integrated with the multiprofessional team (NASF).
<b>CSDIC – n- 4</b> CIC - Activities in the community with NASF participation	We have weekly meetings to trace the profile of our users, so we can determine the main demands of this population. The practices involve interprofessional communication, care focused on the user, family, and community. So today I think that it was an improvement, because earlier this was very distant, but today it is very close. We also provide personal therapeutic projects, home visits, and as the demands appear, they are discussed, so I think that the NASF is here to provide this support.
<b>CSDID – n- 3</b> CID - Collaborative practices are not entirely implemented	In the unit where I work this type of work of and activity is very scarce. Today we count on the NASF in our unit, but is very limited due to the fact we do not see effectiveness in regard to that work. The practices are informal, a meeting, a pedagogic gathering, a meeting to learn something.

Source: Research data, Palmas, TO, 2020.

The interview, then, asked about facilitators and obstacles to interprofessional collaborative practices in the workplace, and the main ideas presented by the nurse participants can be found in Table 4.

*In your opinion, what factors can facilitate or make more difficult the development of these practices by the interprofessional team? (Question 2).*



**Table 4.** Representation of the Central Ideas (CIs) in the second question

Central Ideas - CI	Collective Subject Discourse - CSD
<p><b>CSDIA - n-13</b>  <b>Adequate communication, team interaction, and institutional support facilitate, while excessive competitiveness is an obstacle</b></p>	<p><b>CSD</b>                      Teamwork really flows best when there are collaborative practices. Positive leadership in the Health Center, work ethics, good will and good communication between workers, partnership and health team integration are factors that can facilitate the development of collaborative practices in the workplace.                      Other factors, such as individualism, excess competitiveness, not trusting the work of the colleagues, not sharing learning activities, not willing to open a space in your schedule to work in this type of action, sometimes due to egoism; these things are notable obstacles.</p>
<p><b>CSDIB n-7</b>  <b>CIB - B- Facilitators: Schedule with time available for meetings</b>  <b>Difficulties - Lack of physical space and lack of involving all workers in the meetings</b></p>	<p>An organized network with a better bond with the community, reduced barriers in the access to services, workers available to help and present in the health unit, professionals willing to open time in their schedules, time in schedules open for different professional categories to be able to sit and discuss, each giving contributions from their field of work, these factors are contributions.                      Obstacles are the lack of interaction of a worker with the team, since this is a collective work, and if there is no interaction, this will interfere in the action, since one depends on the other. We also have trouble meeting all workers at once, because there is no specific scheduled day for all of them to be present, because the unit is small and we cannot meet everyone at once, so you cannot speak with a specific professional in that specific day. The work schedule also makes the meeting between workers more difficult.</p>
<p><b>CSDIC - n- 4</b>  <b>CIC - The area under coverage is too large and the excessive work makes collaborative practices more difficult.</b></p>	<p>Among the factors that difficult these practices is the fact that the medical schedule itself is too focused on an outpatient clinic, so, scheduling a meeting is harder, you have to cancel the patients scheduled for the physician to participate. Another obstacle would be the work overload of this professional, who is responsible for an area of coverage that is too large, this making it more difficult for the patient to continue to be treated due to the lack of structure of the units, due to work overload. There are other issues, like the lack of human resources, unbalanced interpersonal relations, competition, and lack of support from the management itself.</p>

Source: Research data, Palmas, TO, 2020.

**DISCUSSION**

The analysis of the data, based on the Theory of Social Representations, subsidized the discussion of research results, improving the interpretation of the discursive content in the local and international context.

In the characterization of the nurses researched, feminization was a strong feature in the sector of nursing, currently representing more than 70% of the workers in the profession. In some profession, this

feminization This is the case of the nursing team, which is almost entirely formed by women<sup>21</sup>.

**INTERPROFESSIONAL COLLABORATION PRACTICES AND THE WORK ENVIRONMENT**

The process of change to adopt interprofessional cooperation in the services involve understanding how complex this phenomenon is. This complexity is not only related with

organizational issues, but also with the integration of several elements that determine the phenomenon, such as relations between professionals, work processes, and the conditions of the social and economic structure that several organizations share<sup>12,22</sup>.

The perspectives from the several different professions that form the Family health Teams may facilitate the collaborative practice in health care networks through an integral approach to individuals and families, while also favoring interdisciplinary action<sup>12,22</sup>.

#### INTERPROFESSIONAL COLLABORATIVE PRACTICES: TYPOLOGY AND DEVELOPMENT

The NASF is formed by an organizational arrangement that is part of the primary care and formed by different occupations (professions and specialties), acting in articulation to give clinical, sanitary, and pedagogical support to the workers in the primary/family health care ("referral teams", for the users). The participants highlighted that, in the team, one can hear many different professional characteristics and contribute with suggestions of strategies to aid users, always seeking to improve the health outcome of the patient through the sharing of knowledge, practices, management of care in a network, and receiving their main theoretical-methodological frameworks from institutional support in dialog with the others, such as in the case of basic care,

attention networks, health care, permanent education, and collective management<sup>23</sup>.

Institutional support is the grouping of several tools (under certain forms) in favor of a broader and shared clinic. In the Individual Therapeutic Projects, the identification of health needs, the repercussion of extended diagnostics (or problem identification) and the definition of a plan of care are all shared, allowing for the members of the team to communicate more between themselves, increasing the chances of improving the efficacy in dealing with issues, be these clinical or otherwise. Through this project, bonds can be established, and the degree of co-accountability can be increased, thus enhancing the work of the NASF in the territory<sup>23</sup>.

Research highlights that teamwork is a network of relations between people, knowledge, affections, interests, and desires, and that it is possible to identify and reach solutions in group. Interprofessional collaboration favors information and knowledge exchanges by subsidizing team practices, while also encouraging cooperation in activities, co-accountability when attending to health needs to construct projects for therapies and health promotion, collective activities in the territory, and the set of affective bonds that strengthens the team even further<sup>24</sup>.

## FACILITATORS OF INTERPROFESSIONAL COLLABORATIVE PRACTICES

Some difficulties from the context of ESF were reported by the nurses, together with the multiprofessional team, as they carried out educational work. They face issues in bringing their work into effect in regard to management, since the management has a strong influence on day-to-day actions, such as the lack of physical, material, or financial resources or their inadequate distribution. There are also difficulties in health education, in the inadequate physical structures, and in the insufficient material resources. Furthermore, the nurses in the ESF mentioned the accessibility as another issue, both for the team to have access to the entire area of coverage of the Family Health Unit (USF) - which is relatively large and mostly rural - and for the users to have access to the place where the educational actions take place<sup>25,26</sup>.

The integration stands out from the perspective of new interactions regarding interprofessional teamwork, with the exchange of experiences and knowledge, as well as with a posture of respect to diversity, enabling cooperation in the direction of transformative practices that can contribute to the construction of projects and to the permanent exercise of dialog<sup>11</sup>.

Recognizing the role and the work of the members of the team implies, basically, in knowing the activities and responsibilities of each member, and the

way in which this knowledge can be acquired in the day-to-day at work, that is, whether there are resources and time to do so. This process includes recognizing what separates the fields of knowledge and what they have in common<sup>21</sup>.

As professionals focus on the user and their health needs throughout the work process, creating patient-focused attention during their practice of care, they also change their perspective, focusing on a broader horizon that goes beyond their own professional role, which is restricted to their profession and expertise. This change is targeted at a shared practice with workers from other fields<sup>26</sup>.

The ESF is a priority health care model aimed at reorganizing Primary Care in the country, according with the precepts of SUS. It is considered to be a strategy to expand, qualify, and consolidate Primary Care as it favors a reorientation of the work process. The team that is part of the strategy must be formed by, at least: physician, preferably expert in Family and Community Medicine; nurse, preferably expert in Family Health; nursing auxiliary and/or technician; and community health agent (CHA). The team may also include endemic confrontation agents (ECA) and oral health professionals: dental surgeon, preferably expert in Family Health, and oral health auxiliary or technician. The number of CHAs per team should be determined according with population size and demographic, epidemiological, and socioeconomic criteria, to be evaluated locally. In risk areas and in those where the

territory to be covered is large or socially vulnerable, population should receive 100% coverage, with a maximum number of 750 people per CHA<sup>5,6</sup>.

As a result, health education in the ESF incorporates and reinforces the basic principles of SUS - universal, decentralized, integral care, and participation of the community -, being based on three great pillars: family, territory, and accountability, which are carried out with the aid of teamwork<sup>27</sup>.

The nurses from the ESF face obstacles, the most challenging of which are resistance to change and the lack of acceptance of the new assistance model. These reactions are also connected to the acceptance and adherence of educational activities, which in turn is related with the degree of understanding of users regarding the guidance they receive, and with workers whose profile does not fit the work at the ESF, not to mention the lack of human resources in the ESFs.

There are operational difficulties to actualize the educational work at the ESF, and management also has a strong influence on the work, as a study carried out with nurses in the 34 health units from Palmas, TO, has recently shown.

#### THE ROLE OF THE NURSE IN THE DEVELOPMENT OF INTERPROFESSIONAL COLLABORATIVE PRACTICES

In a primary care unit, especially in Family Health Units (USF), nurses have many roles. The interaction involving this

professional and the family is very important to enable mutual trust, so the bond between them is increasingly strong. As a result, the respect families and community have for this professional increases accordingly. Establishing this bond, while also a result of the interaction between nurses, families, and community, is an essential condition for the nursing consultation to be successful and have positive repercussions on the outcomes of care<sup>28</sup>.

In this context, when the nurse believes in the worth of interprofessional education, has the space to rethink their attitudes and interact with the community, considering the educational needs of the teams and the values of the population.

The contributions from permanent education to professional practices is made clear by the attitudes of the professionals as they provide care. The commitment they make with themselves due to their motivation to search self-knowledge, self-improvement, and self-actualization, promotes the improvement of the management of the care provided to the clients, to the community, and to the team<sup>29</sup>.

#### CONCLUSION

The results of the analysis of the discourses show that collaborative practices improve the work environment, the satisfaction of the workers, and maximize the quality of the services and their capacity of dealing with the situations presented to them. Collaborative practices carried out in

the context of the ESF, with support from the NASF, were characterized by the workers as broader clinics, shared provision of care, case discussion, rounds of conversation, joint activities in the community, individual therapeutic projects with periodical meetings, and work groups proposed by the team. These activities include the sharing of knowledge and practices to, progressively, reach a better capability of solving the issues of the patients.

In the context of the research, obstacles were mentioned, such as the territory, long work hours, full schedules of patient care, schedules with excessive demands, poor physical structure, inadequate workspaces, health workers uncommitted to collaborative practices, and management that does not share its power with the demands of the service. Another issue is the absence of workers who, in addition to having the expertise necessary, have a profile that fits the need for teamwork to deal with complex situations while showing mutual trust and support.

The facilities conquered by collaborative practices were teamwork, collaborative leadership, mutual respect and confidence between peers, an organized network for services with partners, and effective communication between team members, creating an patient-and-community focused attention. The presence of the NASF in the Center of Community and Health facilitates this collaboration and the making of decisions.

Corroborating this research, the nursing professional, present in the service, is a unique member of interprofesional education, working with autonomy, leadership, and creating bonds with patient and community. They work in the planning of actions, especially the development of innovative practices aimed at providing care and strengthen the health services.

During this investigation, some conflicts were unveiled, among which the turnover of nurses in the ESF, the transfer of some of the workers who participated to other workplaces, refusals to participate, and the high number of commissioned and resident nurses, who worked in the service but were not in accordance with our inclusion criteria.

The study highlighted the relevance of joint actions to break paradigms of actions proposed by the nursing professional, so collaborative practices are carried out with the presence of other professionals and the team works proactively. It also stands out that overcoming the difficulties mentioned, discussed, and reflected on in the service, towards a more shared management, should be carried out in a more regulated manner, since the professionals are not interested in informal or accidental collaborations. We expect future collaborative practices in health to be planned jointly and more purposefully.

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