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Working process of nurses of the Family Health Strateg y

Processo de trabalho de enfermeiros da Estratégia Saúde da Família

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ABSTRACT

The work process of nurses in Family Health Strategy teams is analyzed. Current case study, foregrounded on qualitative approach and based on Symbolic Interactionism, was conducted with nine nurses. Data were collected between March and June 2016 by a semi-structured interview. Thematic content analysis was employed. Work object is identified by spontaneous demand, several activities have a scheduled agenda, besides management issues. Relational and hard technologies were acknowledged as working tools. The developed activities are still focused on the cure model, but an approach to health promotion and disease prevention is acknowledged. Facilitating factors comprised teamwork and Nursing Residence, whereas incomplete staffs made up the difficulties. Care reproduces the biomedical model and professionals acknowledge the need for change.

Keywords: Unified Health System. Primary Health Care. Family Health Strategy. Nursing.

RESUMO

Compreender o processo de trabalho dos enfermeiros que atuam em equipes da Estratégia Saúde da Família. Estudo de caso de abordagem qualitativa, fundamentada no interacionismo simbólico, realizado com nove enfermeiros. A coleta de dados ocorreu de março a junho de 2016 por meio de entrevista semiestruturada. Utilizou-se análise de conteúdo temática. O objeto de trabalho é identificado a partir da demanda espontânea, e algumas ações possuem agenda programada, além das questões gerenciais. Os enfermeiros reconheceram como instrumentos de trabalho as tecnologias relacionais e as duras. Sobre a finalidade do trabalho, destacaram que as ações ainda estão voltadas para o modelo curativo, porém apontaram uma aproximação com a promoção da saúde e prevenção de agravos. Fatores facilitadores foram o trabalho em equipe e a presença do residente de Enfermagem, e os dificultadores, a equipe incompleta. O cuidado reproduz o modelo biomédico e os profissionais indicaram a necessidade de mudança.

Palavras-chave: Sistema Único de Saúde. Atenção Primária à Saúde. Estratégia Saúde da Família. Enfermagem.

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INTRODUCTION

Primary Health Care (PHC) is defined by the National Primary Health Care Policy (PNAB) in Brazil as the structure for positive changes within public health, especially health promotion, protection, diagnosis, treatment and rehabilitation, health vigilance, integrated care and qualified administration by a multidisciplinary team aiming at care quality and the establishment of improvements in attendance to clients, families and communities[1]. The Family Health Strategy (FHS) updates PHC by new care production models, an organization that enhances the promotion of individual and collective assistance concretize the principles and guidelines of the Unified Health System (SUS).

Although FHS has a long history within SUS, the work process in PHC is still inarticulate and centered on cure and immediate methods – in fact, its focus is disease and patients´ health complaints – and interventions pervade normative and prescriptive procedures, and thus, an increase in spontaneous demands[2].

So that FHS professional teams are coherent with the principles, attributions and organization of the PNAB´s work processes[1], team planning and the effective participation of all are required to analyze practices and establish transforming strategies with the daily services to restructure the work process[3].

Consequently, it is highly relevant that the work process of FHS teams is well defined, with work object, tools, aim and agents working together. The work object is the worker´s activities characterized by the health work process triggered by human needs. On the other hand, tools, material and non-material, comprise the work object. Work agents give an objective to the work object which may be the same work instruments[4]. It must be underscored that work agents may be either the care professionals or the individuals and their family. In fact, attention is focused on the patient (object) and, at the same time, work is done so that the user is the agent of the work process and participates in the therapeutic plan to attain the well-being required[2].

However, the manner health workers perceive each factor of the work process is reflected in the way the professionals organize it, and consequently, in their manner of instituting the production of care as the purpose of the health work process[3]. Within the context of FHS, nurses have an increasingly consolidated role in care practice throughout the life cycle and team management. They are two axes carried out in their work process[5], still deeply permeated by the medicine-centered model[6-8].

Consequently, there is a great need for studies that discuss, within the context of local conditions, how the work process of nurses in the FHS is organized to provide subsidies for the approximation of a type of public health recommended in PNAB[1]. "The numberless weaknesses should be overcome so that the complete system could be improved; consequently, featuring a more comprehensive PHC as care coordinator and administrator of the Health Care Network"[9:13].

Owing to the paramount importance and centrality of nurses within a FHS team and its potential to work for the consolidation of PHC within the SUS, current paper investigates the organization of the work process of nurses integrated in Family Health Strategy teams.

METHODOLOGY

The analysis of current qualitative case study is based on Symbolic Interactionism. Case study is employed as a research strategy when one aims at contributing in pre-existing knowledge through the analysis of complex social phenomena. Research method is an investigation to present the holistic and significant characteristics of real-life events, among which may be mentioned organizational processes, the main object of current analysis[10].

Current study analyzes the organization of the FHS´s work process from the perception of nurses according to their social reality. It investigates how nurses interpret their role in the teams, the effects of their activities in daily routine and the way it is shared

with others. Thus, the qualitative approach is appropriate to respond to research issues since it focuses on a reality that investigates meanings, motives, values and attitudes[11].

Symbolic Interactionism foregrounds current research because it is a theoretical framework that describes human beings as active in their milieu. Further, behavior is defined by the significance and meaning that they attribute to things, to other individuals and also to the situations of everyday life. Social interaction, therefore, constructs individual and collective actions defined in the social context to which they belong. Consequently, symbolic interactionism investigates the manner people interpret the objects and the individual with whom they interact[12].

Current research was undertaken in the municipality of Divinópolis in the mid-western region of the state of Minas Gerais, Brazil, with approximately 238,000 inhabitants and 31 FHS teams, with only 44.9% of the population covered by PHC service[13]. It must be underscored that FHS teams of Divinópolis form health students of two government-run and two private universities, coupled to three multi-professional and health internments. The complex, used for the formation of health students and professionals, should be based on SUS´s principles and guidelines, with special reference to the system´s priorities and needs.

The municipality´s FHS teams are the focus of current study. They feature professional nurses with at least one-year activities in the health unit. This is the time limit established by the researchers to guarantee bonding between the team and the population of the region under analysis. The number of participating units was not defined *a priori*. A randomized draw of family health teams that met the inclusion criteria was undertaken. Nurses who worked in FHS teams were personally invited by one of the researchers to participate in the study. All nurses from FHS teams were invited to participate in the study, except those on vacation or sick leave. A single professional refused to participate after being informed on the research aims.

Data collection, performed between March and June 2016, was interrupted by data saturation. Saturation occurs when researchers were able to understand the internal logic of the study group[14] and could obtain the answer to their research. The sample comprised nine nurses (i.e., the scenario was composed of nine FHS teams).

Data were collected by a half-structured interview which facilitated approaching the interviewed person and flexibilization in discussions, warranting that interviewers´ hypotheses and presuppositions could be debated and making possible the absorption of new terms and issues brought by the interlocutor could be considered relevant[11].

Data comprised two sections, or rather, the first characterized the interviewee and the second comprised guiding issues that made possible participants to discuss perceptions in their FHS work, the work object, tools, aims and facilitating and impairing factors in the development of their activities. The schedule underwent a pilot test but no adjustments were required.

The interview was conducted in the FHS where the participant worked, after appointment and signing of the Free Consent Form. A private room was selected to preserve the interviewee's anonymity. The interview was conducted individually and recorded on smartphone for later full transcription by researchers. Contents was carefully transcribed by two researchers and ensured the information´s confidential nature. No return of the transcribed interview was possible to the respective participant for possible comments and/or corrections.

The interviewees' statements were used in parts to understand the object under study. Interviews were identified by the letter E with the respective interview number (Example: E1, E2, E3, etc.) to ensure the anonymity of the participants.

Data underwent content analysis in the thematic modality, appropriate for qualitative health investigations, which consists of three stages: pre-analysis, exploration of material and treatment, and interpretation of results[11].

The pre-analysis stage comprised flow reading of the material to make an in-depth analysis of the content of the interviews and investigate the topics

addressed matching them with aims initially proposed. The interviews in this phase were submitted to cutoffs according to the key themes identified by the researchers. Consequently, the recording units and the context units were produced[11].

Empirical categories were defined in the second stage. The contexts of units with similar themes were grouped to provide results on the issues researched[11]. In the result treatment stage, inferences and interpretations of data were provided and related to the theoretical contents in the literature to corroborate results from empirical data[11].

Information used in current research complied with ethical aspects of Resolution 466 published on 12/12/2012, on guidelines and norms on research with humans. Research was approved by the Committee for Ethics (CAAE 49972715.2.0000.5545; Approval 1.292.298. Current research was funded by the Institutional Program for Scientific Initiation Scholarships – PIBIC 2017/2018.

RESULTS

Out of the nine participating nurses, most (88.9%) were female; two did not have a postgraduate course (22.2%) and mean period in FHS team was 4 years and 2 months (minimum of 1.5 years and maximum of 10 years).

Empirical categories provided by thematic content analysis were: "Factors of the work process in the daily routine of FHS nurses" and "Potentialities and challenges in health work".

CATEGORY 1: FACTOR IN THE WORK PROCESS IN THE DAILY ROUTINE OF FHS NURSES

The health work process comprises the articulation of its factors (work object, tools, aim and agents), which in current analysis was composed of nurses. Within the context of the first factor, one has to analyze what the participants understood by FHS. Nurses defined FHS as one of the pillars of PHC in which a link with a specific population is developed with a small team and the support of the other professionals

> In my opinion, FHS is the entrance hall of primary care. It is a type, a unit by which one knows the patients very closely. It is the existing link. This link which one has is very important. The fact that one works with a limited population makes planning of the activities an easy task. (E1)

> It is a government program within primary care, takes care of a family group of a certain community, with a determined population, with professionals of a minimal team, doctor, nurse, nurse technician, health agent, may be supplemented by other professionals. That´s it! (E9)

The multiprofissional team develops activities involving health promotion, prevention of diseases, health treatment and maintenance.

> In my opinion, it is a different type of service. You do not merely deal with care. You are also concerned with health promotion, with the prevention of diseases, with the clients´ life quality. Full care, more integrated; the patient does not merely go for treatment so that the disease goes away; you take care of the family, you care for their health, you try to give them a better type of life style. This is health strategy. (E6)

The interviewees acknowledge that work process does not meet the aims of primary care. Although they understand the population´s profile and needs, they cannot plan strategies to control demand and build an agenda capable of organizing and predicting patients´ care in chronic conditions.

> The Family Health Strategy remained a big first care unit, a basic health unit, since the po-

pulation, unfortunately, thinks it is a machine for prescriptions, controlled prescriptions, many types of medicine; consequently, health promotion, prevention, information, family health, taking care of the whole family, we have to work more and more to improve that. (E4)

We have to dedicate more to care than to promote health. We have to work on the disease. You may perceive this fact by looking at the work schedule: ninety percent deal with prescriptions due to patients´ complaints. We have to work almost on disease and medications. Medication. The aim of most people who come here is to receive medicines. (E2)

The opinion of some nurses affects the way they perceive the FHS proposal, or rather, a service with a limited scope and includes the home as a space for care.

Family Health Strategy is the care that the health unit provides to the family and people of the area. This does not occur merely in the care unit but also at the home. (E2)

I perceive that it is a program that attends to a specific number of patients within a defined area. (E3)

Nurses perceive that it is necessary to know FHS activities to establish their work object.

We do not know the local conditions of FHS [Family Health Strategy] even though it has been here for the last four years [...]. I have been here for the last two years and I do not know either the entire population or their conditions, since we have not yet listed all the patients. (E1)

Since they lack such knowledge, the object may be characterized by individuals who seek the health unit in particular and painful circumstances; consequently, the work process develops as from spontaneous demand.

We try to organize the work process according to spontaneous demands. As I have said, since we do not know precisely the conditions of the area, our attendance is restricted to scheduled patients. Consequently, we try to follow up mainly people with hypertension and diabetes, nursing care, medical visits [...]. We have to attend free demands, but every day we attend to spontaneous demand. (E1)

In the morning, when I arrive at the health unit, the first step is attendance of spontaneous demand; we attend them, [...] we try to do this till 9 o´clock. Then I do the scheduled activities: puericulture, visits, first aid and also attend the vaccine section. (E2)

We try to schedule preventive and pre-natal puericulture. Most attendance is spontaneous demand [...] Since we are here, we have to attend all. Sometimes we have to take arterial pressure or attend to other conditions. However, the whole period is spent on spontaneous demands. (E7)

The statements above showed that the interviewees listed some demands for the construction of a programmed schedule, corroborated by interviewees 3 and 4.

Scheduled agenda are puericulture, preventive care, pre-natal care, home visits. I do that. One day per week. I have that scheduled so that people get accustomed [...]. Sometimes I have to administer vaccine, do a pre-consultation, attend the phone, go to the attendance desk, a nurse´s task and also other tasks. (E4)
For a nursing consultation, puericulture is scheduled, preven-

> tive care is scheduled, I do not manage to schedule a visit, [...] vaccines, supervision of the vaccine room I do that every day. [...] I have to take office work. Our coordinator is not always present. (E3)

Finally, nurses establish administrative tasks as the object of work.

> The administration section has to be taken care too: resources of medical material, requests, acquisition, verification of materials, the state of the room, organization, it´s part of the training, isn't it? All the training we learned we pass on to the team; then, we have meetings, every month. (E4)

> The nurse becomes a servant of bureaucratic demands required by the Municipal Health Secretary SEMUSA: vaccine, help in the vaccine room, coordination of community agents, meetings and their organization, we have to organize and participate in meetings, organize meetings with the team, capacitation, and all these things. (E5)

Only three out of the nine interviewees answered which tools they use daily. One of the nurses established light technology, verbal and nonverbal communication, as the main instrument.

> Speaking is the main tool [...] patients are needy. Looking, touching, a hug you give the patients, it helps a lot. (E5)

An interviewee listed the protocols and recommendations of the Ministry of Health as tools.

> We follow the guidelines of the government, the hand book, the book of basic care of the Ministry of Health, protocols, even protocols and resolutions of the municipality. (E8)

Robust technology is also mentioned as one of the main work tools.

> As tools we have the arterial pressure apparatus, the glycemia gauge, prevention material, folders, information material, handouts, small sketches, improvisations. Speech makes up more than 90%, chatting, pure guidance. (E4)

It has been observed among the interviewees that the nurses enhance health promotion, prevention, maintenance and recovery as main aims for the family and individuals in all life cycles.

> Our aim is to provide health attendance with quality and health promotion in our area. This comprises all life cycles, from the pregnant woman who comes to enroll for prenatal examination, prenatal follows up [...], and accompanying the newborn child, all activities of the fifth day and visits after birth. (E2)

> I suppose that the main aim is education in health, prevention, but we have to do other things as well. But the main one is this. (E8)

> My aim is to give attendance, provide attendance of quality to the point that the patient feels well within the general context and not merely within that particular issue. [...] the bond that makes us chat [...] and they go away satisfied because they felt well, they were listened to; so my job is not merely to take care of the sick, which is our condition, but the main aim, or rather, to give information that the patient takes care, information on self-care, prevention, promotion, I hope the patients go away feeling that they were well attended to. (E4)

Although several nurses underscored that assistance to the patient, family and community is the

aim of their work, the coordination of the work process was also listed as an aim within the FHS routine.

> I am the technician responsible for the nursing team and, as I understand my role, I am also accountable for directing the health agents´ work. I am not responsible for the other team members´ work. Since there is a great harmony between us, they respect me as if I were the chief nurse of the unit. They remark: You are the unit´s chief. I do not agree; I am accountable for the nursing service and the health agents, as a technician. I am always working with the others too within the team. (E3)

> My job is to supervise my team since [...] the nurse is the team´s supervisor. I am somewhat responsible for everything, from the inputs of the unit, personnel, vacations, send all documents of the unit, solicit service to SEMUSA (Municipal Health Secretary), give support to the whole team, nursing technician, share the physician´s attendance [...], discusses cases and with the health agent give him support too, guiding the activities he needs, working, training, capacitation [...] for the team, all this support, administrative which I have to do and give support as a member of the nurse team, approach the team, the family team, attend to people, receiving patients, nursing consultations, schedules consultations. (E2)

CATEGORY 2: POTENTIALITIES AND CHALLENGES FOR HEALTH WORK

The main facilitating principles identified by participants were team work and the presence of Nurse Residents.

In the case of the team work, participants mentioned that good relationships between FHS professionals facilitates decision-taking in routine work and the capacity of solving issues on service.

> The main facilitating aspect is the team; our team is very good, cohesive and united. I think that the main aspect is the team. If the team is not focused, speaking the same thing and have the same thoughts, nothing will be achieved. (E5)

The presence of the nurse residents is good since they encourage the broadening of space in PHC activities and help in the establishment of a link between theory and practice.

> There are many facilitators, the resident nurses facilitate things a lot [...] I always remark that we are working with the smallest possible team. If we want family health, we need more professionals. Jokingly, I say that we need two teams for the work [...]. But one more professional, the resident nurse, for example, another nurse, helps a lot. He even brings us knowledge and reminds us many things. In fact, they are close to knowledge than we are, they work a lot and share work. We may work more completely, undoubtedly. Without the resident nurse, I cannot work with the pregnant team, I will not be able to make visits, [...]. I would be restricted to the cure section, I would not be able to sit down quietly and apply a vaccine; patients are everywhere, sharing the work facilitates a lot. (E7)

An incomplete team, especially the lack of the community health agent, associated with the large coverage area, hinder the total coverage of the area, with overloading of the team.

> Our population, practically listed, consists of approximately ten thousand inhabitants [...]. We would need not merely two FHSs, but three. (E4)

> There are many people and they are dependent on the FHS, the area is enormous and the lack of personnel and health agents

> too. We could have five instead of three. There is always somebody on sick leave, another on vocation, this or that, so things are difficult, very difficult. (E5)

Geographic factors, such as the distance from the unit and the physical structure, impair the patients´ access to FHS; in addition, working hours of health units were identified by the interviewees as obstacles to the population´s bonding and adhesion.

> The FHS is not within the area; there is a certain resistance in the population to enroll in our unit. The Health Community Agent has also made a visit but there are people who refused to be enrolled in our FHS [...] [the population] is linked to the traditional one [...], their old reference. Most say that it is difficult to come here; many work downtown, and thus they also are downtown, their coming here for consultations is rather out of the way. Coming here and returning downtown is very difficult. Money, you know? (E2)

> The time schedule is also important; we work from 7 am to 5 pm and, sometimes, the patient cannot come during this period. The client works outside the area and timetables do not match. Rather difficult. (E2)

Permanent health education is shown as a possibility to re-signify the work process of FHS nurses.

> I suppose that permanent education may improve the work process. I sometimes think that something is missing. That there would be something that capacitates us to meet the issues according to the visible problems we have. (E1)

DISCUSSION

The first premise of Symbolic Interactionism establishes that the way people act is directly related to the meanings that concrete situations offer them[12]. Practicing health work goes beyond the knowledge of what is instituted and written[14]; one must permit renewal and go beyond the health-disease process. It is necessary to modify meanings through social interactions by new factors[12]. In this case, work aims at producing care, or rather, employing factors different from those already structured, such as instruments, objects and purposes[14].

In fact, FHS encompasses responsibilities, mentioned by the interviewees, which may be concretized in PHC, following the most recent PNAB[1], such as care coordination, preferential gateway to the health care network, prevention, integrality, enrolled population, and others. However, primary care, specifically FHS, has the primary role of bonding, continuity and care management. It establishes actions and interactions between professionals and patients and family, that would allow the complex process of health-disease. This is still a strong obstacle[6,15] in the practice of the interviewees. Breaking paradigms of health services and going beyond disease and clinical conditions are still a challenge for professionals, managers and patients. It is something that has to go beyond what is cultural[16]. Since Symbolic Interactionism explains that the meanings attributed by people come from existing social interaction, it is necessary to contact new elements to modify the process[12].

According to professionals of the FHS team, sharing knowledge and having multi-professional support is a differentiated and integrated practice, even if the FHS´s work process is characterized by activities foregrounded on the question: How are we going to tackle the disease? Integrality is beyond having the disease as the main focus. One has to reinvent the way of practicing health work beyond the walls of unity, in which those involved have the autonomy and freedom to develop activities that directly or indirectly refer the social determinants to health[6,15].

Moreover, in the interviewees´ opinion, one of the aims of health work was care continuity, continuous work with the patient and sharing information with other professionals. From the point of view of Symbolic Interactionism, the most appropriate term for this case would be "management continuity", due to the coordination of the assistance of different professionals who attend to that specific situation of the patient /family. Consequently, there is action-interaction between professionals with multidisciplinary views, and action-interaction between the network services[17].

Addressing social determinants of health, consolidating the practice of inter-sector work and strengthening FHS´s role do not merely constitute the conditions of current study and of all Brazilian municipalities. Countries with similar models as SUS and primary care also have difficulties to involve the clients in social activities that influence their health[8,18].

In Europe, the incorporation of health within public policies of other sectors are being met with by health system managers. Although there is a strong financial incentive in health care, little is invested in health promotion activities. The Health in all policies (HiAP) has been implemented to cover all sectors and make them fully or partially involved in public health[18].

In the case of lack of knowledge on the object of work in FHS, the nurses´ limited perception, illustrated by the phrase *"I understand that it is a program that serves a specific number of clients within a defined area of coverage"* (E3) impairs a broader view and strategy planning to go beyond primary care[19]. One cannot neglect the meaning of FHS attributed by the participants. From the Symbolic Interactionism´s perspective, it is a factor responsible for human behavior[12].

Primary care nurses have incorporated administrative or bureaucratic activities in their work process, overloading professionals. Bureaucratic work in health units mechanizes care and weakens care production, or rather, harms patients, since management is a "means" activity that causes care, whilst care characterizes aims[20]. However, the interviewees perceived that management is greatly demanding on nurses and constitutes their main purposes in the work process. The management of health service is the competence of this professional in the PHC in Brazil[19], with greater challenges to daily life. It does not merely overload professionals[21], but sometimes impairs the planning of several activities[15] which require structural and organizational changes to promote transformations in the organization and encourage adaptability[22].

On the other hand, with regard to nurses´ role, Brazilian conditions show several activities, or rather, competencies of different dimensions. Progressively, the range of functions of these professionals has been expanding during care through consultations, therapeutic projects, case management and monitoring of chronic conditions[21,23]. Consequently, the expansion of the nursing care function has a positive impact on patients (treatment adhesion, better access to the service) and on professionals (valorization and professional competence)[24].

Even though briefly mentioned by interviewee E4 ("training"), one of the nurses´ competencies is the continuous education of the team and all people involved. In fact, there is an exchange of experiences, knowledge, sharing of ideas and resignification of the purpose of their health or work. Continuous Health Education (CHE) was mentioned as a strategy to overcome the challenges and give a new meaning to the work process in PHCs.

CHE is a strategy for new learning and care production practices that contributes towards the organization of the work process. Consequently, for the consolidation of FHS, the organization of PHC work process by CHE is relevant to advance in care integrality and in the improvement of well-being and work itself. The expansion of knowledge core enables the development of policy and the management of work and care[19]. However, it is important to highlight that if the CHE remains on the symbolic plane and no concern is taken on the meaning of its factors, the analyzed behavior will be falsified[12].

Corroborating the interviewees' statements, a study with FHS nurses revealed that the work process is also defined from spontaneous demand. Such

organization of activities is a factor that triggers overload and impairs the performance of programmatic activities that make up the nurses' functions. They are rare moments when nurses are able to perform training with the team, elaboration of Standard Operational Procedures, programming with health agents, community preventive interventions and articulation with other professionals and services[25].

A study on accessibility, link and attendance to spontaneous demand in PHC[26] provided convergent results with interviews in current study, in which the impact of spontaneous demand *versus* continued care affects care continuity when chronic conditions are concerned. However, the literature highlights the importance of attendance, ensures care access and flexibility.

However, several authors insist that with the free access of spontaneous demand to FHS, the principles of care may be impaired since patients prefer spontaneous demand to elective consultations. Consequently, no planning of activities is available since spontaneous demand tends to increase. It also generates overload on the team, especially for the nurse who is responsible for the organization of the FHS work process[26].

Nurses' statements evidenced flimsy knowledge on health technologies. This fact is co-related with another analysis where lack of knowledge and superficiality about the concept of health technologies were highlighted. One may infer scanty understanding, although this is not a complicating factor for health practice. Even having superficial knowledge on the subject, it is possible to apply technologies according to the aims of the work process and social interaction with patients[27].

Nevertheless, the literature reports narratives and discussions on the theme[3,14], which proposes discussions on producing health through highlighting work and the possibilities of renewal coupled to protocols. When health is concerned, it is necessary to involve all technologies, without discarding any. Their correct usage according to each care station is important. The work process must list technologies proposed during patients´ care and professionals must have in-depth knowledge of these technologies[28]. Meanings are social products, or rather, they are re-elaborated within the process of human interaction[12].

As one interviewee remarked, light technology arises within the human connection between the professional and patient to concretize integral care. In a study with FHS workers, it has been demonstrated that professionals use hard technologies as "exchange currency" for light technologies, since in some situations the approach with other individuals may be obtained[23].

Technology is also inserted during the nursing process, through qualified listening and implementation of evidence-based interventions. The nursing process methodologically organizes the work of the professional, covering key factors of health practice and determines on which stage the process should be based [29]. Consequently, when nurses perform the nursing process on patients, they apply health technologies in each care station.

Participants mentioned teamwork as the main factor in the work process. In the interviews of current study, nurses´ statements with participants of FHS of Belo Horizonte, MG, Brazil, highlighted team work, the importance of interpersonal interactions, with similar objectives, planning and well-defined goals, which provide results coupled to a harmonious, satisfactory and productive environment[25].

The presence of the Nursing Resident should be enhanced. Besides encouraging the other nurses, he wanted to build FHS practices. Research showed that the resident nurse is a workforce to operate such changes and cope with the biomedical model, still adherent to daily health practice[30]. This occurs in spite of the numberless limitations for the development of their activities that impact the work process, such as: poor working conditions; lack of management experience; deviation of function, and difficulties in associating theoretical learning with the practices already common in the teams[31].

The above situation has a direct impact on health workers, particularly nurses, since, in addition to their leadership role within the team[5], they also

develop the role of preceptorship/supervision with resident nurses[31].

Although resident nurses bring a resignification for PHC, participants in current study also point out that the insufficiency of CHA impairs the entire team´s work process. Research has shown that when the team has the necessary number of CHAs within area, spontaneous demand tends to decrease. In fact, needs are already identified in home visits, and the CHA and other professionals have the ability to attend to patients and their families[2].

Participants also underscored that access may be a complicating factor for the implementation of the work process. The obstacles evidenced in current study for the use of health services suggest a limitation in PHC consolidation as the preferred gateway to the SUS and an obstacle to health rights[9].

In spite of the challenges pointed out by the interviewees, planning with other collaborators should be constructed and teamwork strengthened to achieve aims and find a balance between the individual and collective approaches to the approach of social determinants, as a literature review study revealed[7].

Current study describes nurses´ work process in the FHS in a medium-sized Brazilian municipality and presents subsidies to develop specific and indispensable skills and competencies for the practice of nursing in PHC services and to implementing the care model idealized in PNAB. It also enhances the role of the Nursing Resident in strengthening SUS and PHC.

A limitation inherent to current study lies in its investigation on data from a single municipality, although the situation may be very similar to that in many other Brazilian municipalities. Further studies with nurses and with other members of FHS teams are necessary to map situations that converge for high quality PHC, which is fundamental to achieve health to all.

CONCLUSIONS

FHS nurses have to cope with several work processes, with different and necessary objects, purposes and instruments. The interviews show that health professionals highlight care to promote health and management coordination as the main purposes through different work processes. Although the two axes are the protagonists of the nurses' activities, professionals do not have much clarity on their work object, aims and use of technologies. Further, methodology makes a difference in the development of the work process and in differentiating the operating agents.

Within the context of current study, the *modus operandi* is closer to the biomedical model than to health surveillance. Even when the interviewees acknowledge multiprofessional work, prevention and promotion activities and attendance at the patients´ home activities are focused on diseases, since the health team is limited to meeting the patients´ needs and cure their illnesses.

However, the nurses´ work process depends on the context of social interactions. This may be perceived through the activities and dynamics among individuals, as proposed by Symbolic Interactionism, in which the FHS nurses' performance depends exclusively on involvement and action-interaction with their team. Consequently, results are achieved by care continuity. It is a practice that depends on communication, bonding, interdisciplinarity, sharing of care management and the role of patients and their family within the work process.

Professionals acknowledge the need for change, but they still maintain daily activities without the transformations of symbolic orders. The Nursing Resident, an agent highlighted by the participants, increased the scope of FHS activities. It is actually a workforce capable of modifying the fragmentation of care and enhancing new relationships between the agents of the FHS team to reorient health practices and contribute towards the role of the FHS in restructuring of the current care model.

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