



Workloads in the Family Health Strategy: interfaces with the exhaustion of nursing professionals*

Cargas de trabalho na Estratégia Saúde da Família: interfaces com o desgaste dos profissionais de enfermagem

Cargas de trabajo en la Estrategia de Salud Familiar: interfaces con el desgaste de los profesionales de la enfermería

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ABSTRACT

Objective: To identify the workloads of nursing teams working in the Family Health Strategy in the five regions of Brazil and their interfaces with their feelings of exhaustion. **Method:** Qualitative study with nursing professionals from 20 Family Health Units, from eight cities in the five regions of the country. Data were collected through interviews, observation and analyzed according to the precepts of thematic analysis and the theoretical framework of workloads. **Results:** A total of 79 professionals participated in the study. Workloads were related to structural and managerial problems. Workloads that stood out were psychological workload, due to excessive demands and staff shortages; physiological workload, due to the overload of activities that generate physical pain and exhaustion; physical and mechanical workload, due to inadequacies in the work environment and equipment; biological workload, due to the presence of microorganisms; and chemical workload, due to exposure to dust and smoke. **Conclusion:** The sources that increase workloads are similar in the five regions, indicating that there is a strong influence of psychological and physiological loads on exhaustion among workers. However, workloads are reduced by dividing and planning team actions and by the affinity with the assistance model.

DESCRIPTORS

Primary Care Nursing; Workload; Nursing; Team; Occupational Health; Family Health Strategy.

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INTRODUCTION

In Brazil, Primary Health Care (PHC) is operated by the Family Health Strategy (FHS). This mode of assistance is described in the National Primary Care Policy (PNAB – *Política Nacional de Atenção Básica*)⁽¹⁾ as a fundamental strategy for improving health care and, since the implementation of the Family Health (FH) teams, there has been important improvements in access to health services and in health indicators, such as reduction in the rate of child morbidity and mortality and reduction in potentially avoidable hospital admissions, among others⁽²⁾.

In the FHS, work is carried out by FH teams composed of at least one doctor and one nurse, preferably specialists in family health, a nursing technician or assistant and community health agents (CHAs), and each team is responsible for 2,000 to 3,500 people⁽¹⁾. Nursing professionals have a central role in PHC, as they contribute to improve the social determinants of health and illness, especially when assisting people in situations of vulnerability and promoting access to health services⁽³⁻⁷⁾.

Nursing work is complex and involves several aspects of practice that are common to the profession, which can generate high workloads. In the context of PHC, there are several challenges related to the care model, which require nursing professionals to develop a creative work, focused on solving problems and providing comprehensive care, individual and collective assistance beyond the walls of the health care facilities, which adds complexity and diversity to their workload and promotes universal access to healthcare⁽⁸⁾.

To understand the nursing work process in the FHS and the existing workloads, it is necessary to understand its technical and social dimensions and how body processes can reflect the relationship between worker, institution and division of labor⁽⁹⁾. Workloads interact with each other and with the body of the person doing the work; these factors are not isolated, but in combination with each other. They determine the conditions through which the worker deals with the global logic of the work process, characterized by physical, chemical, biological, mechanical, physiological and psychological loads⁽⁹⁾.

In this sense, this study aims to identify the workload of the nursing team and its interface with the exhaustion of professionals who work in the FH team in different regions of Brazil, in order to answer the following questions: to which workloads nursing professionals are exposed to in FH in the five regions of Brazil? What are the interfaces between workloads and illness among these professionals?

METHOD

TYPE OF STUDY

Qualitative study with data obtained through triangulation of instruments, semi-structured interviews and observation, and guided by Laurell and Noriega's workload theory⁽⁹⁾.

Researchers from six Brazilian universities in the five regions of the country were involved in the study and participated in periodic seminars in the South region to define the theoretical and methodological framework of the study.

SCENARIO

The scenario chosen followed the inclusion criteria: Basic Health Units (UBS – *Unidade Básica de Saúde*) that worked only with the FHS assistance model and that had teams with the minimum composition established in the National Primary Care Policy (PNAB); teams considered to be of good quality, according to managers and professional leaderships in each region and associating data published in the National Program for Access and Quality Improvement in Primary Care (PMAQ-AB – *Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica*)⁽¹⁰⁾; at least one city per region of the country.

Criteria of intentionality and convenience were used to select the participating cities, considering the possibility of access to the different geographic regions of the country. The cities selected were: Araranguá and Florianópolis (South); Brasília (Center-West); Rio de Janeiro (Southeast); Manaus, Belém and Nova Olinda do Norte (North); and Natal (Northeast). A total of 21 UBS were included, of which seven were in the South; five in the Center-West; two in the Southeast; three in the North; and four in the Northeast.

The inclusion criteria used for the selection of the population were being a nursing professional and having worked for at least one year in the FHS. Exclusion criterion was being absent for any reason at the time of data collection.

The study population was composed of 79 participants, of which 45 were nurses, 30 were nursing technicians and 4 were nursing assistants. The number of professionals and teams involved was considered enough by the criteria of data saturation, which is when new explanations, interpretations or descriptions of the studied phenomenon are no longer found. This criterion was collectively evaluated in the methodological seminars with the researchers who coordinated the data collection process in the five regions of the country.

DATA COLLECTION

For data collection, interviews with participants were conducted to identify/characterize information related to the nursing work in the FHS; the organization and division of the team's work; characterization of the assistance model of the FHS, as well as its influence on the category's workload. Interviews were conducted at the participant's workplace according to a previous appointment, and were recorded and later transcribed in full.

Observations of at least one working day were also conducted in each region/city/UBS, using a script, and the data were recorded in a field journal. The purpose of the observation was to apprehend the forms of division, organization and work management in nursing and in the FHS.

The interview and observation scripts were developed during national seminars, with the objective of standardizing content and procedures in data collection and analysis. The scripts were tested, and the necessary adjustments were made before data collection.

To achieve the objective of the study and enable a deeper understanding of the studied phenomenon, the inclusion of different regions of Brazil was associated with instrument triangulation. Thus, in order to make data collection feasible in a country with continental dimensions such as Brazil, it was necessary to build a database with data obtained from 2013 to 2018.

DATA ANALYSIS

The Atlas.ti 7.0 software (Qualitative Research and Solutions) and the precepts of Thematic Content Analysis were used for the analysis. Findings were interpreted based on the chosen theoretical framework.

In pre-analysis, a storage unit (Hermeneutic Unit) was created in the software, and data obtained in the interviews and observations (Primary Documents) were inserted in this unit. In the data exploration phase, units of meaning (Quotations) were selected and assigned with Codes, which were subsequently grouped into Families that could be viewed in Networks. In the interpretation process, quotations, codes and families were articulated, enabling the organization of themes and the elaboration of categories of analysis. In this process, the most used resource was

visualization in Networks, which can be extracted from the software and presented in the results.

ETHICAL ASPECTS

All ethical precepts of research involving human beings and regulations established in Resolution no. 466/2012 of the National Health Council were respected, and the research was approved by the Research Ethics Committee of the Universidade do Estado de Santa Catarina (protocol 366.844/2010 and no. 1.933.348/2017). Participants received information about ethical procedures and signed an Informed Consent Form. Secrecy and anonymity were guaranteed by assigning codes to the participants, using initial letters from each category: letter NU (Nurse), NT (Nursing Technician), NA (Nursing Assistant); followed by the letter(s) that identify each region, S (South), CO (Midwest), N (North), SE (Southeast), NE (Northeast); and the sequential number (For example: NU1, NU2, NTS3, NTCO4, successively). The observation excerpts were presented with the acronym OBS, followed by the region.

RESULTS

SOCIAL AND WORK PROFILE OF THE NURSING STAFF IN THE SURVEYED FH TEAMS

The social and work profile of the participants is found in Table 1.

Table 1 – Distribution of participants regarding the social and work profile – Florianópolis, SC, Brazil, 2018.

Variables	Description of variables	Number of Nurses	Number of Nursing Technicians	Number of Nursing Assistants	Total
Gender	Female	41	27	4	72
	Male	4	3	-	7
Age	< 20 years old	-	-	-	-
	20 to 40 years old	26	16	-	42
	41 to 50 years old	10	9	1	20
	51 to 60	8	4	2	14
	> 60 years old	1	1	1	3
Level of education	High School	-	28	4	32
	Undergraduate degree	3	2	-	5
	Specialization/residency	37	-	-	37
	Master's Degree	5	-	-	5
Time of Professional Experience	1 to 5 years	8	11	-	19
	>5 years	37	19	4	60
Time of Experience in the FHS	1 year	-	2	-	2
	1 to 5 years	18	17	-	35
	>5 years	27	11	4	42
Employment bond	Permanent/State	29	15	3	47
	Temporary and CLT	16	15	1	32
Working hours (weekly)	< 40 hours	4	1	-	5
	40 hours	26	21	3	50
	>40 hours	15	8	1	24
Another job	Yes	14	9	1	24
	No	31	21	3	55

WORKLOADS IN THE NURSING WORK PROCESS IN THE FH TEAMS

This analysis category presents the aspects/elements of the nursing work process in the FHS that are sources of increased workloads that can lead to exhaustion or illness.

Loads can act in isolation or be interrelated, and an aspect/element present in the work process can generate more than one type of load. Chart 1 shows the types of load, sources of increase and the evidence identified in the interviews and observations.

Chart 1 – Types of load and sources of increased workloads in the nursing team of the FHS – Florianópolis, SC, Brazil, 2018.

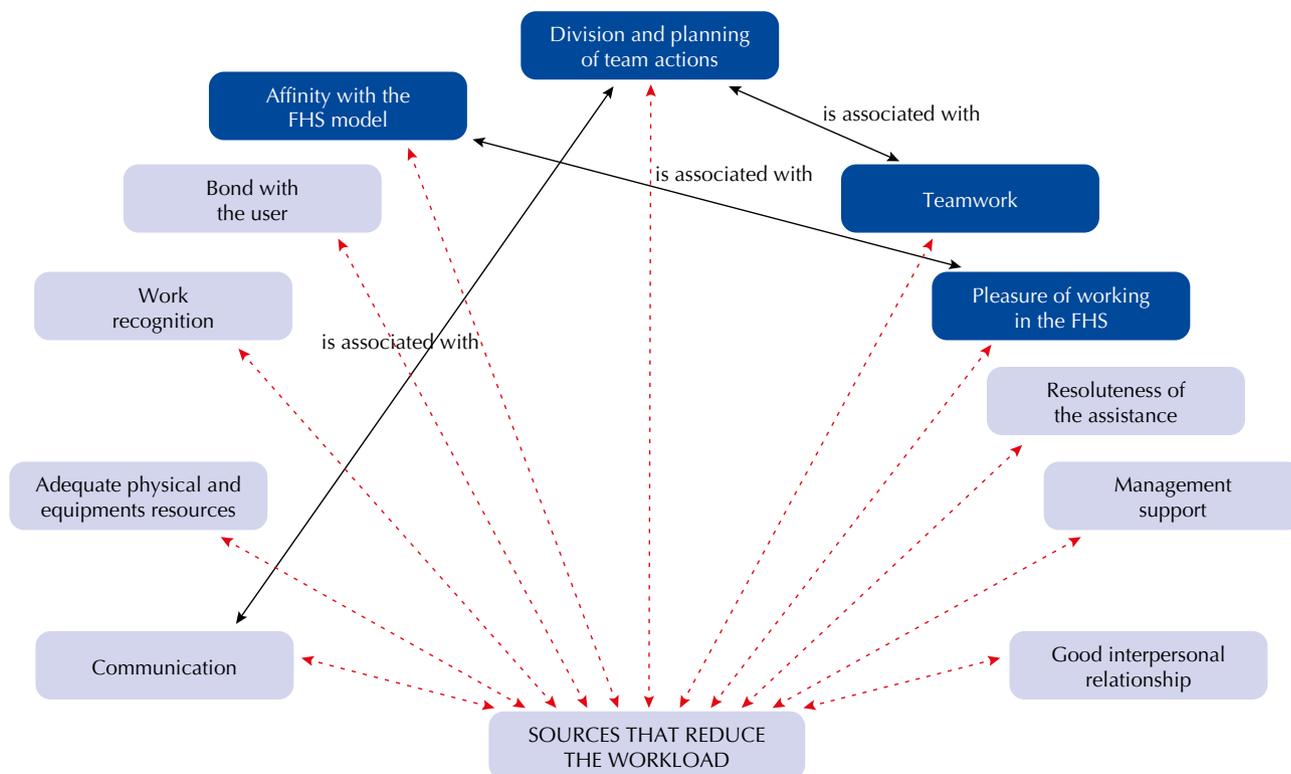
Type of workload	Sources of increased workload	Excerpts from speeches and observations that demonstrate the workload
Psychological loads	Excessive scheduled and spontaneous demands.	<i>The demand is very high, because we don't have enough professionals in the network. We have nine thousand inhabitants in my area, it is very far from what is recommended (NUS3). The psychological pressure related to the number of people to be attended, waiting for care, can be noticed by the anxiety presented by the professionals at the time of the interview (OBS SOUTHEAST).</i>
	Deficit of employees, with insufficient numbers to serve users; sick leaves and/or absences.	<i>I think it can improve, but for that you need material resources, human resources too, because we work with very few professionals and there are absences (...) there is always a lack of professionals and one professional has to cover another and gets overloaded (NUCO5).</i>
	User dissatisfaction.	<i>We have a lot of paperwork that makes you waste time (...) Sometimes the person stays in the hallway and I only hear complaints (...) they do not know that it is a bureaucratic issue, it is a lot to write down, it makes the service take longer (NANE1).</i>
	Overload of activities.	<i>So, the technician has many duties (NTSE3). We, technicians, are not only technicians, we are porters, telephone operators, typists, pharmacists (NTN6).</i>
Physiological Loads	Excessive scheduled and spontaneous demands.	<i>Having to carry out 98 home visits, for a technician, I have to be in the dressing room, in the medication room, in medication dispensing, in patient triage, scheduling appointments, making medication, so, the professional who knows he does a well done job, like me, leaves work very tired, so I don't think about having another job, I can't do other activities, when I get home I'm already tired (NTCO5). There is a large number of people here, it is unusual for me to be here talking to you because I don't even have time to go to the bathroom (...) (NTS2).</i>
	Overload of activities.	<i>Work overload is very harmful to our health, I have seen many people getting sick, the doctor herself. And there is also injuries, one of these days, I couldn't even raise my arms. I couldn't move my hand (...) work overload has hurt me a lot, sometimes I'm deprived of drinking water, going to the bathroom, sitting for a few minutes to rest (NTCO5).</i>
	Deficit of employees, with insufficient numbers to serve users; sick leaves and/or absences.	<i>I think the work overload is due to the lack of professionals. We stress a lot (NTCO1). We are just two nursing technicians in our team (...). One employee just for the pharmacy [would reduce] this overload (...), then I could be helping the community more, I could be making more visits (NTCO3).</i>
	Excessive working hours.	<i>(...) we don't even have the right of having lunch here (...) we buy lunch, there is no rest, nothing. If it was at least 30 hours, as we are trying to, maybe it would improve (NTNE1).</i>
Biological loads	Exposure to biological agents, such as bacteria and viruses, by handling immunobiological products and carrying out procedures involving contamination; contact with infectious diseases; and presence of yeasts (mold) due to inadequate physical structure.	<i>I know a nurse who got Hepatitis A, two CHAs who got tuberculosis and a technician who had an accident with sharp material (NUN2). There is a room without minimum standards, there is no sink inside that room, there is no descarpack for proper dispensing of sharp material. A can of "powdered milk" is being used for the disposal of needles (OBS CENTER-WEST).</i>
Physical loads	Exposure to intense heat or cold and humidity is closely linked to the environmental conditions and physical structure of the UBS.	<i>This is a rented house, adapted (...) we had a very serious problem with a lot of infiltration, a lot of mold, a lot of leaks and when it rained we couldn't stay at the Unit (NUNE6). (...) no air conditioning, no window, no ventilation, so we end up feeling bad (...) my blood pressure drops, I get irritated (NTSE3).</i>
Mechanical loads	Equipment inappropriate for use in the service (without maintenance), lack of and/or inappropriate furniture.	<i>The infiltrations, it gets wet when it rains, we can slip and fall, we have no safety. There are also the stairs, because we keep going up and down, we may even fall, and the entrance of the unit is difficult, because the ditch is open and we do not have a sewer pipe (NUN2). There is no equipment in good shape for health care. Instruments and equipment essential for assistance in terrible conditions, such as: cabinets supported by rocks, rusty iron chairs that do not meet ergonomic standards (OBS NORTHEAST).</i>
Chemical loads	Exposure to dust and smoke	<i>In this region of the UBS], the air is very heavy, due to the cement factories that are installed here, this affects the respiratory health of some colleagues (NUCO9).</i>

Psychological workloads are present in the daily routine of nursing workers in the FHS. These are the most significant loads, and the sources that increase them are strongly related to excessive demands and management failures. Similarly, the sources of physiological workloads are the accumulation of administrative and care activities for nurses and overload of activities for other nursing categories. In biological workloads, contact with microorganisms predominates among nursing technicians and assistants. The chemical loads were related to the external environment of the unit. Physical and mechanical workloads were associated with the work environment and were identified, predominantly, by nursing technicians.

There was no difference between the regions regarding the sources of increased workloads and types of loads, except for chemical loads, which were mentioned only in the Center-West region. Therefore, it can be inferred that the difficulties and challenges are very similar.

SOURCES FOR REDUCING NURSING WORKLOADS IN THE FH TEAMS

This category points out the aspects/elements of the nursing work process in the FHS which are sources of reduction of workloads and protective factors in relation to exhaustion and illness, as shown in Figure 1.



Subtitle: dark blue, most mentioned by participants.

Figure 1 – Sources that reduce the workload of the nursing staff in the FHS – Florianópolis, SC, Brazil, 2018.

The division and planning of team actions is the main source of reduction of nursing workloads in the FHS and is associated with teamwork and good communication between team members.

The difference for the operation of the Unit is the whole team (...) if everyone speaks the same language there can be 10,000 inhabitants and it will still work (...) This is what makes the difference, when the team works together, even if they don't have what is necessary (NTS4).

Affinity with the FHS model is related to the pleasure of working in the Strategy and is an important factor for the reduction of workloads.

(...) the person who works as a nurse, as a coordinator of a Family Health team, has to have an (...) inner motivation (...)

Something that makes you want to do your daily work, even when something is missing (...) that motivates you to receive a patient, to talk, to get to know the community (NUCO9).

The bond with the user was identified as a recommendation of the PNAB that, if implemented, would contribute to improve the care provided.

At the Unit, everyone is welcoming, and attentive listening cannot be provided only by one person at a certain time (...) everyone has the ability to listen, to look for a solution within the possibilities of each one. I see this as a very positive quality in my unit. This search for empathy, humanization (ENE7).

In addition, when valued and recognized by the managers, the professionals feel supported and feel that their needs are validated. This fact was mentioned mainly by nurses.

(...) *I have the support of my team, I have support from management. Management is always like this, they understand and they also try to resolve any dissatisfaction* (NUN5).

For the nursing staff, the availability of adequate physical resources expands the service and the resolution potential of the FH team.

I have possibilities for acting and expanding my resolution potential as a health professional, much more than in other health units in Brazil (...). Many units do not even have electronic medical records, I have a computerized system, I can do ultrasounds, X-rays, blood tests. I have a series of opportunities that expand my resolution potential (NUSE4).

DISCUSSION

Regarding the profile of nursing professionals, the results in the PHC scenario studied were similar to those described in studies conducted in Brazil⁽¹¹⁾ and internationally⁽¹²⁾. There was a predominance of female workers and a work week of 40 hours or more, and 30.37% of the participants had a second job.

Regarding their level of education, it was identified that most of the nurses had a graduate degree, whether a specialization or a master's degree. Studies carried out in the hospital area show that the qualification of the nursing staff has a positive impact on the quality of care⁽¹³⁾.

Regarding the employment bond, it was observed that 50% of nursing technicians are temporary employees or are hired through the Consolidation of Labor Laws (CLT – *Consolidação das Leis do Trabalho*) system, especially in the Southeast and South regions. Researchers^(7,12,14) indicate the importance of stable employment relationships, which favor investments in the qualification of professionals, reduce turnover and strengthen the bond between professionals and users. This raises more concern regarding the approval of the Outsourcing Law, no. 13.429/2017, which expands the possibilities of outsourced contracts and especial workload regimens.

Understanding the global logic of the nursing work process in the FHS, it became evident that the different types of workloads are present in all regions, with the exception of chemical loads. Workloads impact the body of the workers, leading to exhaustion or illness. It is also worth considering that workloads interact with each other and with the worker's body, and that the reproduction of alienating and fragmented processes that limit the abilities of the workers affects their biopsychological processes⁽⁹⁾.

Psychological loads are prevalent in the nursing team and are related to problems in physical structure and in management. Excessive demands, staff shortages and work overload are the main sources of this type of load. It is worth noting that structural problems, inadequate staffing to provide safe care and problems in the organization of work and management in PHC have an impact on the exhaustion of workers⁽¹⁵⁻¹⁹⁾. Excessive demands hinder the workflow and the routines in the UBS, the follow-up of priority groups and the planning of teams⁽¹⁹⁾.

The other factors that increase psychological workloads are related to users' dissatisfaction due to the complexity of their needs and the lack of knowledge about the FHS/PHC model, which often leads to the search for typical biomedical

and healing behaviors. This situation generates dissatisfaction among users, as their desires for quick and curative care are not achieved. Promotion and prevention actions, bonding and longitudinally are difficult to implement and can have a negative effect on the relationships between users and professionals⁽¹²⁾. Dissatisfied users pressure and/or offend professionals, causing psychological distress, demotivation and stress⁽¹⁹⁾. In the other perspective⁽²⁰⁾, one emphasizes the importance of expanding the clinical practice of nurses in PHC, which results in better access to services. Longer consultations and more efficient communication contribute to improved treatment adherence. For the nurses, clinical practice contributes to a greater autonomy and recognition, as well as to the expansion of the body of knowledge of their profession⁽²⁰⁾.

Psychological workloads were equally mentioned by nurses, nursing technicians and nursing assistants in the five regions. However, the overload in nurses' activities was more related to the accumulation of educational, assistance and managerial activities⁽¹⁶⁾, while for nursing technicians and assistants, it was related to the necessity to carry out various activities simultaneously, as the lack of professionals made them have to take over the work of colleagues. This reality can lead to exhaustion, as mentioned in other studies^(18,21), decreasing the quality of the care provided and, consequently, the resolution potential of health services and access to the services⁽²²⁾.

It was demonstrated that physiological workloads result from managerial problems such as excessive demands, insufficient number of employees and excessive working hours, resulting in physical exhaustion, sometimes leading to tiredness, obesity, systemic arterial hypertension, physical pain, among others. Uncomfortable positions, repetitive movements and physical efforts result from overburden due to staff shortages⁽²³⁾ and are most mentioned by nursing technicians and assistants, who are in direct contact with the user.

It was demonstrated that the physical structure was inadequate, which increases the biological load, with factors such as humidity, which favors the appearance of yeast (mold) and insects, poor ventilation and poor lighting. Nursing assistants and technicians are more exposed to this type of load, as they are in closer contact with the user and have to carry out technical procedures^(18,24).

Because they are external to the worker's body, physical, mechanical and chemical workloads can be observed more easily⁽⁹⁾ and are strongly related to the work environment and structural problems, such as lack of or insufficient size of spaces to serve the user, inadequate equipment, unhealthy structure and exposure to humidity, noise and heat due to lack of air conditioning.

As for the sources of reduction of nursing workloads, division and planning of team actions was the most significant factor. This factor is characterized by cooperation and co-responsibility among the nursing team in decision-making and care processes. A good relationship within the team contributes to a more pleasant and less stressful work. This requires the support of managers and other team members, who must value collective decisions, strengthening the organization of interprofessional work⁽⁷⁾.

Affinity with the attributes of the FHS/PHC assistance model, such as teamwork, prevention, longitudinally of care

and therapeutic bond with the user, achieved through listening and empathy, is an important factor⁽²⁵⁾ that contributes to reducing the workload of those who work in this scenario. Knowing the reality of the users, their life story and their social context can have a positive effect on the professionals, reducing their workload and favoring the longitudinality of care and the creation of collective and individual strategies adapted to the reality of the territory.

The recognition of their work, the availability of physical and material resources and adequate staffing increases the resolution potential of care and reduces workloads of nursing professionals.

Other authors⁽²⁵⁻²⁶⁾ argue that it is necessary to invest in improving evaluation and monitoring of work in organizations, with the objective of achieving excellence in care. Therefore, it is necessary to focus on the qualification of professionals and the analysis of the social, political, economic and health context.

Nursing professionals are responsible for several activities in the FHS, and performing them in good conditions and appropriate environments can contribute to expanding access and increasing the resolution potential of care. Positive and favorable scenarios reduce the workloads of professionals and promote the satisfaction of professionals and users.

A limitation of the study is the temporality of data collection, which, although necessary for conducting an in-depth study in a vast territory, makes it difficult to analyze

the practical implications of macro-political changes, which could be apprehended in longitudinal studies.

CONCLUSION

A study with nursing professionals from the Family Health Team identified, in different scenarios around the country, that the psychological workloads are the most responsible for the exhaustion of these workers, demonstrated through body processes such as insomnia, anxiety, and others. The other loads also affect the nursing team as a whole and interact with each other and with the worker's body, increasing physical and psychological exhaustion. Chemical loads were rarely recognized by professionals in the researched scenarios.

The study was intentionally defined to analyze the phenomenon in scenarios recognized as being of good quality. However, the results show that nursing workers in FHS in Brazil are exposed to workloads that are generated mainly by structural problems related to precarious working conditions and overload. The results depict a more dramatic reality, which can be evidenced in other studies, and present a challenge for managers, scholars, health workers and legislators that must face the problems identified.

To reduce workloads, it is necessary to turn the attention to the nursing staff, investing in the valorization of the work developed by these professionals and in the provision of means that allow a resolution-oriented and less stressful assistance.

RESUMO

Objetivo: Identificar as cargas de trabalho de equipes de enfermagem que atuam na Estratégia Saúde da Família nas cinco regiões do Brasil e as interfaces com o desgaste desses profissionais. **Método:** Estudo qualitativo com profissionais de enfermagem de 20 Unidades de Saúde da Família, de oito municípios das cinco regiões do país. Os dados foram coletados por meio de entrevistas e observação, sendo analisados segundo preceitos da análise temática e do referencial teórico de cargas de trabalho. **Resultados:** Participaram 79 profissionais. As cargas de trabalho foram relacionadas a problemas estruturais e gerenciais, destacando-se as psíquicas devido ao excesso de demanda e à falta de profissionais, as fisiológicas pela sobrecarga de atividades que geram dores físicas e exaustão, as físicas e mecânicas em função das inadequações no ambiente de trabalho e equipamentos, as biológicas pela presença de micro-organismos e as químicas devido à exposição a poeiras e fumaças. **Conclusão:** As fontes que elevam as cargas de trabalho são semelhantes nas cinco regiões, indicando forte influência das cargas psíquicas e fisiológicas nos padrões de desgaste da enfermagem. Entretanto, divisão e planejamento das ações em equipe e afinidade com o modelo assistencial reduzem as cargas de trabalho.

DESCRITORES

Enfermagem de Atenção Primária; Carga de Trabalho; Equipe de Enfermagem; Saúde do Trabalhador; Estratégia Saúde da Família.

RESUMEN

Objetivo: Identificar las cargas de trabajo de los equipos de enfermería de la Estrategia de Salud Familiar en las cinco regiones de Brasil y las interfaces con el desgaste de estos profesionales. **Método:** Se trata de un estudio cualitativo realizado entre 79 profesionales de enfermería de veinte Unidades de Salud Familiar, en ocho municipios de las cinco regiones del país. Los datos se recogieron mediante entrevistas y observación y se analizaron de acuerdo con los preceptos del análisis temático y de la referencia teórica de las cargas de trabajo. **Resultados:** Las cargas de trabajo estaban relacionadas con problemas estructurales y de gestión, destacándose las psíquicas por el exceso de demanda y la falta de profesionales; las fisiológicas por la sobrecarga de actividades que generan dolor físico y agotamiento; las físicas y mecánicas por las inadecuaciones en el ambiente de trabajo y los equipos; las biológicas por la presencia de microorganismos y las químicas por la exposición al polvo y al humo. **Conclusión:** Las fuentes que aumentan las cargas de trabajo son similares en las cinco regiones, lo que indica una gran influencia de las cargas psíquicas y fisiológicas en los patrones de desgaste de la enfermería. Sin embargo, la división y la planificación de las acciones en equipo y la afinidad con el modelo de atención reducen las cargas de trabajo.

DESCRIPTORES

Enfermería de Atención Primaria; Carga de Trabajo; Grupo de Enfermería; Salud Laboral; Estrategia de Salud Familiar.

REFERENCES

1. Brasil. Ministério da Saúde. Portaria n. 2.436. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes para a organização da Atenção Básica, no âmbito do Sistema Único de Saúde [Internet]. Brasília; 2017 [citado 2018 mar. 13]. Disponível em: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2017/prt2436_22_09_2017.html

2. Malta DC, Santos MAS, Stopa SR, Vieira JEB, Melo EA, Reis AAC. Family Health Strategy Coverage in Brazil, according to the National Health Survey, 2013. *Ciênc Saúde Coletiva*. 2016;21(2):327-38. DOI: 10.1590/1413-81232015212.23602015.
3. Thum E, Fehn AC, Acioli S, Fassa MEG. Formação e prática de enfermeiros para a Atenção Primária à Saúde – avanços, desafios e estratégias para fortalecimento do Sistema Único de Saúde. *Saúde Debate*. 2018;42(1):275-88. DOI: 10.1590/0103-11042018s118
4. Swan M, Ferguson S, Chang A, Larson E, Smaldone A. Quality of primary care by advanced practice nurses: a systematic review. *Int J Qual Health Care*. 2015;27(5):396-404. DOI: 10.1093/intqhc/mzv054
5. Cassiani SHB. Strategy for universal access to health and universal health coverage and the contribution of the International Nursing Networks. *Rev Latino Am Enfermagem*. 2014;22(6):891-2. DOI: 10.1590/0104-1169.0000.2502.
6. Grant J, Lines L, Darbyshire P, Parry Y. How do nurse practitioners work in primary health care settings? A scoping review. *Int J Nurs Stud*. 2017;75:51-7. DOI: 10.1016/j.ijnurstu.2017.06.011.
7. Ammi M, Ambrose S, Hogg B, Wong S. The influence of registered nurses and nurse practitioners on patient experience with primary care: results from the Canadian QUALICO-PC study. *Health Policy*. 2017;121(12):1215-24. DOI: 10.1016/j.healthpol.2017.09.019
8. GBD 2016 Healthcare Access and Quality Collaborators. Measuring performance on the Healthcare Access and Quality Index for 195 countries and territories and selected subnational locations: a systematic analysis from the Global Burden of Disease Study 2016. *Lancet*. 2018;391:2236–71. DOI: 10.1016/S0140-6736(18)30994-2.
9. Laurell AC, Noriega M. Processo de produção e saúde: trabalho e desgaste operário. São Paulo: Hucitec; 1989.
10. Brasil. Ministério da Saúde. Portaria nº 1.645, de 2 de outubro de 2015. Dispõe sobre o Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica (PMAQ-AB) [Internet]. Brasília; 2015 [citado 2018 mar. 13]. Disponível em: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2015/prt1645_01_10_2015.html
11. Machado MH, Filho WA, Lacerda WF, Oliveira E, Lemos W, Wermelinger M, et al. Características gerais da enfermagem: o perfil sócio demográfico. *Enferm Foco*. 2016;6(1-4):11-7. DOI: 10.21675/2357-707X.2016.v7.nESP.686.
12. Faraz A. Novice nurse practitioner workforce transition and turnover intention in primary care. *J Am Assoc Nurse Pract*. 2017;29(1):26-34. DOI 10.1002/2327-6924.12381.
13. Aiken LH, Sloane DM, Bruyneel L, Van den Heede K, Griffiths P, Busse R, et al. Nurse staffing and education and hospital mortality in nine European countries: a retrospective observational study. *Lancet*. 2014;24;383(9931):1824-30. DOI: 10.1016/S0140-6736(13)62631-8.
14. Vilela EN, Mafra LA. Estratégia Saúde da Família: contratação temporária e precarização nas relações de trabalho. *Cad Estudos Interdisc [Internet]*. 2015 [citado 2018 mar. 25]. Disponível em: <https://publicacoes.unifal-mg.edu.br/re-vistas/index.php/cei/article/view/410/pdf>.
15. Biff D, Pires DEP, Machado FL, Oliveira JSA, Souza DF. Workloads of nurses in the Family Health in Brazil: what the literature says. *Int Arch Med*. 2016;9. DOI: <http://dx.doi.org/10.3823/2187>
16. Ferreira SRS, Perico LAD, Dias VRF. The complexity of the work of nurses in Primary Health Care. *Rev Bras Enferm*. 2018;71 Suppl 1:704-709. DOI: 10.1590/0034-7167-2017-0471.
17. Facchini LA, Tomasi E, Diélio AS. Quality of Primary Health Care in Brazil: advances, challenges and perspectives. *Saúde Debate*. 2018;42(1):208-223. DOI: 10.1590/0103-11042018S114
18. Scherer MDA, Oliveira NA, Pires DEP, Trindade LL, Gonçalves ASR, Vieira M. Increased workloads for nurse technicians in primary health care in Brazil. *Trab Educ Saúde*. 2016;14 Suppl 1:89-104. DOI: 10.1590/1981-7746-sol00030
19. Trifunovic N, Jatic Z, Kulenovic AD. Identification of causes of the occupational stress for health providers at different levels of health care. *Med Arch*. 2017;71(3):169-72. DOI: 10.5455/medarh.2017.71.169-172
20. Toso BRGO, Filippin J, Giovanella L. Nurses' performance on primary care in the National Health Service in England. *Rev Bras Enferm*. 2016;69(1):182-91. DOI: 10.1590/0034-7167.2016690124i
21. Soratto J, Pires DEP, Trindade LL, Oliveira JSA, Forte ECN, Melo TP. Job dissatisfaction among health professionals working in the family health strategy. *Texto Contexto Enferm*. 2017;26(3):1-11. DOI: 10.1590/0104-07072017002500016.
22. Pires DEP, Machado RR, Soratto J, Scherer MA, Gonçalves ASR, Trindade LL. Nursing workloads in family health: implications for universal access. *Rev Latino Am Enfermagem*. 2016;24:e2682. DOI: 10.1590/1518-8345.0992.2682.
23. Felli VEA, Costa TF, Baptista PCP, Guimarães ALO, Anginoni BM. Exposure of nursing workers to workloads and their consequences. *Rev Esc Enferm USP*. 2015;49(n.spe2):98-105. DOI: 10.1590/S0080-623420150000800014.
24. Freire MN, Costa ER. Qualidade de vida dos profissionais de enfermagem no ambiente de trabalho. *Rev Enferm Cont*. 2016;5(1):151-8. DOI: 10.17267/2317-3378rec.v5i1.871.
25. Costa C, Laimer VR, Piovesan RTC, Coelho EA. Competências gerenciais importantes em uma organização hospitalar. *RAIMED - Revista de Administração IMED*. 2016;6:45-55. DOI: 10.18256/2237-7956/raimed.v6n1p45-55
26. Camelo SHH, Soares MI, Chaves LDP, Rocha FLR, Silva VLS. Nurse managers at a teaching hospital: training, responsibilities and challenges. *Rev Enferm UERJ*. 2016;24:1-6. DOI: 10.12957/reuerj.2016.11637.

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