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ORIGINAL ARTICLE

Expansion of the interprofessional clinical practice of Primary Care nurses

Ampliação da prática clínica da enfermeira de Atenção Básica no trabalho interprofissional

Ampliación de la práctica clínica de la enfermería de Atención Básica en el trabajo interprofesional

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ABSTRACT

Objective: To analyze the clinical practice of nurses in the interprofessional context of the Family Health Strategy. **Method:** Case study in a basic health unit of the city of São Paulo with a professional team of the Family Health Strategy and of the Family Health Support Center. Direct observation and interviews with thematic analysis and triangulation were conducted. **Results:** Four empirical categories were identified: interprofessional actions guided by the logic of the user's health needs; interprofessional actions guided by the logic of expediting service; interprofessional actions with a biomedical approach and interprofessional actions with an integral/holistic approach. Six interprofessional actions that indicated the expansion of the clinical practice of the Family Health Strategy's nurses were also identified. **Conclusion:** The results express the world trend of interprofessional practice and expansion of the scope of practice of different professions, particularly that of nurses, which requires consolidation based on the population's health needs.

Descriptors: Patient Care Team; Primary Health Care; Nursing; Interprofessional Relations; Work.

RESUMO

Objetivo: Analisar a ampliação da prática clínica da enfermeira no contexto interprofissional da Estratégia Saúde da Família. **Método:** Estudo de caso em unidade básica de saúde do município de São Paulo com profissionais de uma equipe da Estratégia Saúde da Família e do Núcleo de Apoio à Saúde da Família. Realizaram-se observação direta e entrevista com análise temática e triangulação. **Resultados:** Foram identificadas quatro categorias empíricas: ações interprofissionais orientadas pela lógica das necessidades de saúde do usuário; ações interprofissionais orientadas pela lógica de agilizar o atendimento; ações interprofissional com abordagem biomédica e ações interprofissionais com abordagem integral/holística. Também foram identificadas seis ações interprofissionais nas quais a enfermeira participa, que evidenciaram a ampliação da prática clínica da enfermeira da Estratégia Saúde da Família. **Conclusão:** Os resultados expressam a tendência mundial de trabalho interprofissional e de ampliação do escopo de prática das profissões, em especial, da prática clínica da enfermeira, que requer a consolidação a partir das necessidades de saúde da população.

Descritores: Equipe de Assistência ao Paciente; Atenção Primária à Saúde; Enfermagem; Relações Interprofissionais; Trabalho.

RESUMEN

Objetivo: Analizar la ampliación de la práctica clínica de la enfermera en el contexto interprofesional de la Estrategia de Salud de la Familia. **Método:** Estudio de caso en una unidad básica de salud de la ciudad de São Paulo con un equipo de profesionales de la estrategia de salud de la familia y el núcleo de apoyo a la salud de la familia. Se realizaron observación directa y entrevista con análisis temáticos y triangulación. **Resultados:** Se identificaron cuatro categorías empíricas: acciones interprofesionales orientadas por la lógica de las necesidades de salud del usuario; acciones interprofesionales orientadas por la lógica de agilizar la atención; acciones interprofesionales con enfoque biomédico, y acciones interprofesionales con enfoque integral/holístico. También se identificaron seis acciones interprofesionales en las que la enfermera participa, que evidenciaron la ampliación de la práctica clínica de la enfermera de la Estrategia de Salud de la Familia. **Conclusión:** Los resultados expresan la tendencia mundial de trabajo interprofesional y de ampliación del alcance de la práctica de las profesiones, en especial, de la práctica clínica de la enfermera, que requiere la consolidación a partir de las necesidades de salud de la población.

Descriptores: Grupo de Atención al Paciente; Atención Primaria de Salud; Enfermería; Relaciones Interprofesionales; Trabajo.

INTRODUCTION

This study investigates the participation and contribution of the Family Health Strategy's (ESF) nurses in the interprofessional practice that occurs between professionals of the Family Health Team (EqSF) and of the Family Health Support Center (NASF), particularly the expansion of their clinical practice.

Nurses offer relevant contributions to the strengthening of teamwork and collaborative interprofessional practice, due to their way of communicating with other health professionals, promoting synergy among the team's members and facilitating decision making, with impacts on the quality of care[1].

The key characteristic of collaborative interprofessional practice resides in being effectively patient-centered, and nursing theories discuss two aspects that encourage the development of this practice by nurses: a holistic approach to patients, as well as focusing on them as the central feature of the interaction between nurse and patient. However, the author warns of the risk of nurses shifting the focus to their own performance, making patients spectators, and not protagonists of care. This risk may be related to their training and to the practitioners' socialization process[2].

Hart[3] indicates factors that occur concomitantly with practice and that may facilitate or impede the nurses' engagement in the interprofessional team: the commitment of various professionals to patient-centered interprofessional practice and the existence of tensions related to the perception of unequal power relations between the different professional categories. The study also highlights that these tensions can be especially significant to nursing, as it represents the largest professional group that has also the most direct contact with patients in the hospital.

In this sense, research regarding the contribution of nurses in collaborative interprofessional practice and teamwork is justified, especially considering the extension of their clinical practice object of this study, particularly within the context of the Brazilian Unified Health System's (SUS) Primary Care (PC). Interprofessional practice is recommended both at a global[4-5] and national level, and particularly within the context of SUS's PC[6], due to its impact on the realms of quality and universal access to health care.

In Brazil, SUS assigns to PC the ability to promote the healthcare of users, families and population more effectively, in particular since the implementation of ESF in the 1990s, as a strategy for the reorganization of PC[6].

In the city of São Paulo, the implementation of ESF took place in the early 2000s after the municipality's adherence to SUS and its partnership with the Social Health Organizations (OSS). Hospital care in the municipality has always been fairly developed and a reference in the national scenario, which also applies to PC in smaller proportions, both having been organized by the state government.

ESF develops actions of care and management aimed at users, families and population of defined territories, based on teamwork and on the integrity and continuity of care[6]. Its team is comprised by a dental surgeon, a nurse, a doctor, nursing auxiliary/nursing technicians, oral health technician/assistants and community health agents, working in an integrated manner[6].

To broaden the scope of EqSF and PC, NASF was created in 2008, consisting of teams that support the ESF teams in the analysis and intervention regarding health needs, through shared accountability between EqSF and NASF[7].

The theoretical framework in the field of Public Health adopted, is the approach to health practices and the health work process[8-9], as well as the framework of Nursing in Public Health, and specifically the nursing work process[9]. The authors analyze cooperation in the process of collective work in health based on the Marxist referential, noting that "the foundation of cooperation is the development of the joint work of subjects in an organized manner. (...) In summary, cooperation is the grouping of individual capacities potentiated by the encounter with others, forging a collective capacity"[10]. From this perspective, cooperation stems from the technical and social division of labor which, on the one hand, produces division, fragmentation and the unequal value of work and workers/practitioners from different areas and, on the other, maintains in various degrees and levels the need for reuniting the actions that refer to the same end product.

The increasing complexity of health practices and the changes in the population's demographic and epidemiological profile result in the increasing need for integration of actions and collaboration between professionals from different areas, as well as between professionals and users, families and community. Since the 2000s, teamwork is associated in the literature with interprofessional collaboration.

Another reference adopted by this study was the literature on teamwork and collaborative practice which highlights a set of features, such as: interdependence of actions of different professionals, acknowledgment of the work of others, sharing of team identity, goals, values and responsibilities in the process of care given to users, families and communities – focusing on the users[2,4-5,11-12].

The national literature on the nursing work process also highlights its double dimension: management and care, present both in primary and specialized care[13-14]. The changes in the practices of PC nurses, in the last two decades, with the implementation of ESF, indicate the expansion of direct care to users, families and community, while keeping their managerial work; however, both are guided by the traditional care and management models, in which the Taylorist/post-Fordist and biomedical approach prevail[14].

OBJECTIVE

To analyze the interprofessional actions implying nurses' participation, particularly those relating to the expansion of their clinical practice in the context of the interprofessional work developed at ESF.

METHOD

Ethical aspects

The research was approved by the Research Ethics Committee of the University of São Paulo's School of Nursing, and by the Research Ethics Committee of the Municipal Health Secretariat of São Paulo. The project was presented to the participants, and those who agreed to participate in it signed an informed consent form.

Type of study

This is a qualitative research with exploratory character using a case study strategy, researching a contemporary phenomenon in real-life context, with limits that are not clearly defined by the context[15]. The choice for an instrumental case study was made based on the fact it may be used to gather in-depth knowledge about a topic or object of interest[16].

Methodological procedures

Two field research methods were used. As a first step, direct observation was performed to monitor the everyday work of the teams, their actions, interfaces and connections, as well as the interaction between professionals and the participation of nurses in interprofessional actions[17]. Then, non-structured interviews were carried out[16], which will be described in the presentation of data collection.

Study setting

Health management in the municipality of São Paulo is organized into six regional coordination offices (CRS); each of them is divided into Technical Health Supervisory Bodies (STS), which combine administrative districts.

A EqSF team and a NASF team were studied, belonging to one of the STS of one of the six existing CRS, in a Basic Health Unit (BHU) with ESF. The CRS in this study has 123 BHU, representing 27.3% of the total of PC in the municipality, which corresponds to 56% of the total supply of health services[18]. The STS chosen for this study covered about 270 thousand people in 2013.

The case's selection – EqSF qualified with Oral Health and NASF team of the studied unit – was conducted with successive approximation, through interviews with key informants: coordinator of the region's NASF, nursing supervisor and managers of the indicated BHU. The selection criteria included: NASF with at least one year at the BHU, regular meetings between NASF and ESF and active participation of nurses in the meetings.

Based on these criteria, the study chose the BHU that featured the lowest staff turnover, in particular of doctors, as well as the longest time of joint practice between the EqSF and NASF professionals. The unit studied works exclusively with Family Health since 2003, and had six ESF teams at the time of the study.

Data source

Sixteen health professionals attended the interview, ten from EqSF: a nurse, a doctor, two nursing assistants, four community health agents, a dental surgeon and an oral health technician; and six from NASF: a physical educator, a nutritionist, an occupational therapist, a physical therapist, a social worker and a speech therapist.

Data collection and organization

Data collection began with the direct observation of a specific aspect of the studied team's daily work: the interaction and integration between the EqSf and NASF professionals, with emphasis on the nurses' performance. The following topics were addressed during the observation: the professionals' activities; meetings between the EqSF and NASF teams; workflow and interactions between professionals. The observation was carried out from February to June 2013, with a total of thirteen visits to the BHU and 37 hours of observation which were recorded in a field diary.

Sixteen professionals from the teams followed during the stage of direct observation were also interviewed, to investigate the meanings and experiences that they attributed to the object of study – the participation of nurses in interprofessional actions, in particularly in the interfaces between EqSF and NASF. In the interviews, the critical incident technique was applied, considered useful for elucidation of practice-related behaviors[19], based on a questionnaire composed of the respondent's identification and two issues investigated: situations in which he/she observed the nurse engaging in interprofessional relationships and others in which he/she noted that the nurse could have engaged in interprofessional links, but did not do so. In both cases, the interviewee was asked to describe what happened before and immediately after the situation. Six hours of interviews were held in total, with an average of 20 minutes each, recorded and transcribed in full.

Data analysis

Content analysis[20] contemplated the stages: pre-analysis, exploration of the material and processing, inference and interpretation of the results. The empirical material of the observations and interviews was analyzed separately to understand its peculiarities in relation to the purpose of the study, as well as for codification purposes. The thematic analysis of all records contributed to the construction of the empirical categories[17]. The comparison between the results of the analysis of the observations and interviews was then carried out, to identify convergences and divergences and to achieve greater consistency. In the presentation of the results, the source of the excerpts will be indicated: observation as "O" and interviews as "I", followed by the professional's category.

RESULTS

The analysis of the observations and interviews allowed identifying four empirical categories: interprofessional actions guided by the logic of the users' health needs; interprofessional actions guided by the logic of expediting the process of care; interprofessional actions with a biomedical approach and interprofessional actions with a comprehensive /holistic approach.

In the interprofessional actions guided by the logic of the users' health needs, the professionals investigate and respond to these needs and also take into account, in the decision-making process, the views of users about their health conditions.

> *Then I saw the nurse engaging, when she called the patient and a relative to be there with her, she made a genogram of the patient, talked to the agent* [Community Health Agent – ACS] *about all children who are available to accompany her* [...]. *One of the daughters was located, we've talked once with the NASF team, we'll talk to them again.* (I – doctor)

In the logic of expediting the process of care, characterized by the attempt to rationalize the time employed in health care, the professional-patient interaction is monological, with users only answering the professionals' questions.

> *The user brought the exams' results, the nurse analyzes the result of the Pap smear and the doctor evaluates the results of the laboratory tests. While the doctor transcribes the results in the chart, the nurse explains the results of the Pap smear, then the doctor explains the results of the laboratory tests.* (O)

Both logics can have a biomedical approach, in which the central focus is the disease, and any intervention is carried out based on this.

> *The nurse was in a non-routine nursing consultation with an 81-year-old lady with diabetes, dyslipidemia, glaucoma and hypertension, she stops the consultation and walks to the EqSF doctor's office and discusses with her the results of the blood tests and electrocardiogram* [ECG] *which are abnormal. The doctor checks them and states that the abnormal ECG results are normal for her age and do not pose a risk. The nurse asks whether it is necessary to introduce a medication for dyslipidemia, the doctor says that she needs to use simvastatin, but the nurse reports that the user got sick from this medication.* (O)

The professionals' action may also have a comprehensive/holistic approach, when in addition to performing the health recovery actions, they seek information and focus their actions on the prevention of diseases and promotion of health, seen from a comprehensive perspective .

> *Then, the nurse comes in to discuss the case of a 9-year old who suffered sexual abuse when visiting the father's family. She reports that the mother opposed to making the complaint and taking the child to be examined at a proper location, and asks the doctor what she thinks can be done. The doctor talks with the nurse and tells her that, as the mother does not want to be involved, it is important to discuss the case with the BHU's violence committee. The doctor also states that NASF's social worker is the best person to help in these cases.* (O)

The analysis of the empirical material showed that actions guided by interprofessional health needs are carried out predominantly with a comprehensive approach, and actions intended to speed up the service have a predominantly biomedical approach. However, the results showed that the actions that predominated were those in which the professionals sought at the same time, to recognize and respond to the health needs of the users and also to the pressures associated with the need of an expedite service flow.

With regard to activities shared between professionals from different areas of expertise, the results identified six interprofessional actions in which the nurse participates: shared consultation; nursing consultation that unfolds in shared consultation; trading spaces/discussion of doubts; shared service (groups and home visit); coordination of care; and referral.

Among the interprofessional actions identified, there was a predominance of consultations shared between a EqSF doctor and NASF professionals, as well as of nursing consultations that unfold in shared consultations with the team's doctor or the doctor currently on duty.

The results show that in shared consultations, in which the purpose of expediting service predominates (next excerpt), the professionals – nurse and doctor – also use the comprehensive care approach to carry out health promotion and prevention actions, inviting the user to participate in food reeducation groups conducted by the nutritionist.

> *The nurse initiates the physical examination and the doctor continues talking to the patient, asks about the follow-up with the rheumatologist, the patient says he is attending the consultations, an exam was requested and no medication was prescribed for pain; he also complains of a lot of pain on his hands. The doctor says the blood tests are fine, the patient reports he told the nurse he drank a lot of pineapple and eggplant juice and even lost some weight, the nurse offers him nutritional advice and talks about the importance of attending the dietary re-education group to maintain his weight.* (O)

The nurses use formal and informal spaces to discuss priority cases with other health professionals, as seen in the following excerpt. The articulation is triggered by the interprofessional action of the nurse, who acknowledges the others' work from the perspective of her expertise, while also demonstrating her acknowledgement of the dental surgeon's abilities to sensitize the user so he may start the dental treatment.

> *we also try to solve the problems of those who are bedridden, I think that's an example of care. Another example is this gentleman, he was afraid of hospital consultations and even the nurse gave me his name. She felt he was avoiding them. So I went to his house on a home visit, talked with him and his wife, then I brought him here as a joke and now he's undergoing treatment, and then...* (E – dental surgeon)

Among the interprofessional actions, referrals were also identified, especially from the nurse to other health professionals of the EqSF or NASF teams, which shows that she recognizes the work of other professionals, as well as the care protocols agreed upon in the unit.

> *The mother brings a letter from the school requesting an evaluation with a psychologist for her son. The nurse tells her that these cases are discussed with NASF's speech therapist and then the professional to whom she is referred sees them.* (O)

The nurse also works in the coordination of care, since she promotes the articulation of interprofessional and intersectoral actions, as well as among the health care network. The interprofessional coordination work of the nurse is related to her ability to receive and distribute information, constituting a communication channel between the unit's professionals and between the unit and other health services.

> *She is the one who directs everything, the one between doctors and the ACS, so each has a part of the information and the nurse is the one person who can put it all together, to organize the care provided to that patient. We detect the problem and evaluate approximately how each one can help, then we talk and discuss the case. The role of the nurse at NASF is sharing all the information available to provide the care the person needs.* (E – nurse)

DISCUSSION

The results show that PC nurses participate in several interprofessional actions in which they share care with professionals from other areas.

However, this study shows that the predominant involvement of nurses in interprofessional actions occurs in shared consultations and in nursing consultations that unfold in shared consultations. A recent study confirms that the predominant activities of PC nurses include: nursing consultations, health promotion groups and home visits. Both consultations and visits are spaces of care that include clinical practice[21]. This can be attributed, in part, to the characteristics of the case study, provided that in these specific region and unit studied, nurses spend 55% of their weekly work in nursing consultations. On the other hand, it also demonstrates the changes that have been taking place in the practice of PC nurses since the deployment of SUS and in particular of ESF, since it extends their experience in the direct care to users, families and community, including clinical care[6,21-22].

The results of this study also show that interprofessional actions are developed following two distinct logics: the logic of health needs and the logic of expediting the service flow, which can be concomitant, and comprise two approaches: comprehensive/holistic care and biomedical care. The professionals aim to use the two logics in an articulated manner in their work, on the one hand tending to the needs of users and families and, on the other, following production indicators defined as goals in the OSS's contract with the Municipal Health Secretariat. This aim can be a permanent source of tension depending on the kind of work management model that is employed.

The discussion of the aforementioned tension should be based on the recognition that the PC nurse already develops a wide range of "care and management actions simultaneously, and is often understood as a jack-of-all-trades in the team."[21] This results in work overload and distress, which requires the consideration of the macrosocial, economic and political contexts in which the work of PC nurses is developed – now accompanied by the enlargement of their clinical practice.

In the context of outsourcing and job insecurity and financialization of capital, a study about work in health with a focus on nursing states that these professionals are inserted in the post-Fordist model, under the paradigm of reactivity to demand, i.e., they are reactive to the number of users and to the demands of care[23]. It is understood that this new rationalization of work concerns the performance of nurses in different practical settings, with scant possibilities of questioning and resistance.

The author also states that nurses are permanently under pressure between the demands for agility and the intense demands associated with the logic of care, requiring attention and dedication in the interaction with users. In the disproportionate ratio between the number of workers and users, the practitioners internalize this pressure and blame themselves for the difficulties in meeting the demands of users and families. Thus, the author identifies two forms of exploitation of nurses: work overload and intensification[23]. In another study, the job insecurity associated with the work developed by nurses is reiterated[24].

It should be emphasized that the expansion of the clinical practice of PC nurses in the post-Fordist scenario occurs, which also impacts the interprofessional work analyzed in this study. This highlights the fact that the interprofessional movement while seeking to recognize the contribution of professionals from all areas of health and promoting collaboration, also brings in its midst the tension between improving the quality of care and reducing the *per capita* cost[25].

According to the literature, collaboration occurs within teams, between different teams of a same service and between different services within a network and therefore is diluted in networking. Teamwork, on the other hand, is a form of interprofessional work in which there is less distance among health professionals because they share the care of the same users and families. With respect to the characteristics of teamwork, this study shows that there is acknowledgement of the interdependence between the actions and work of each professional, as well as of the focus on the users' health needs and on effective communication[2,4-5,11-12].

In addition to the challenges of integration of professionals in the practice of health and interprofessional education, interprofessional work also concerns the regulation of professional practices, particularly the extension of the scope of practice of the various professions in the health field. This movement is observed in the global and national contexts and is related to both the post-Fordist organization of labor, driven by the strong demand for services, and to the need to create conditions for the performance of each profession with the maximum of skills provided by training.

A study highlights the efforts of regulatory agencies to loosen professional boundaries, since the overlapping of tasks and competencies allows teams to respond more effectively to changes in the profile of the population's health needs[26]. This effort becomes strategic in relation to the increasing demand for health services and to the need of ensuring universal access to PC services, in a context of changes in the demographic and epidemiological profile of the population, which requires their continuity.

The results of this study suggest that a new step is underway in the process of division of labor, particularly between PC nurses and physicians. In the aforementioned nursing consultation that unfolds in a shared consultation, the nurse showed clinical knowledge through her recognition of the abnormal results of the exams, the need for medicine to correct these results and for new tests to request a clinical re-evaluation, whereas the doctor discussed with the nurse the changes in drug prescription, showing the flexibility of the professional limits of both as they focus on the user's needs.

There was no conflict of roles between the nurse and the doctor in the situation described, although this may occur in teamwork. Contrariwise, the search for understanding and cooperation that, according to the literature, characterizes teamwork[12] was discussed during an intense nationwide legal conflict in 2017, about the prohibition of requests for exams by SUS's PC nurses, judged by the Brazilian Federal Council of Medicine. This demonstrates that one of the main barriers to interprofessional practice resides in the disputes between corporations, especially in the defense of segmented interests of each professional category, at the expense of the common interest of professionals, managers, users and the population, regarding ensuring universal access to high-quality health services[27]. This shows that the proposal and search for teamwork and collaborative practices coexist with corporate practices and conflicts in power relations[28].

Power relations, their conflicts and the possible relationships of command and subservience, which relate to the social interactions of health teams, occur both between professionals from different categories, as in the group of nursing workers itself, between nurses and nursing assistants/technicians, and also with ESF's ACS[28].

In a context of strong professional fields' disputes, an intense debate also occurs globally regarding the experiences of advanced nursing practices (ANP) which, according to the International Council of Nurses (ICN), encompasses the practice of nurses with specialized knowledge, complex decision-making skills and clinical skills for expanded practice, whose characteristics are shaped by the context and/or country where they are licensed to work. A master's degree is recommended for the entry level[29]. This debate is based on studies about the actions of ANP in PC, which indicate outcomes such as: increase of access, health promotion, disease prevention, quality of care and management of chronic diseases (heart disease, hypertension and diabetes)[30], as well as their association with greater patient satisfaction, lower mortality and lower hospital admission rates[31-33].

The debate on ANP in PC also occurs in Brazil, and takes into account the expansion of the clinical practice of nurses in PC, identified in this and other studies[21-22]. It should be remembered that ESF's implementation, with a nurse in each team, allowed the expansion of the dimension of care in their work process[8-10,23], including clinical care[6,21-22,33].

The expansion of direct care starts a movement of resignification of nurses in PC, in particular of the senses of their clinical practice, which can be based on a well known model of "medical consultation, in which they reproduce the hegemonic model"[22], which the nurses call "pseudo-medical consultation", or, alternatively, on the professionals' self-perception as "care clinicians", as they extend their attention to the user's family and life context: "The extended clinic indicates team building and the need for revision and resignification of the lines that demarcate the territories of professional performance as a method of care"[22].

In this study, it was identified that interprofessional actions are performed based on the logic of health needs, with a predominant comprehensive approach, and on the logic of expediting the service flow, associated mainly with the biomedical approach. It was observed that the EqSF and NASF professionals have a strong involvement in interprofessional work, evidenced by their interactions based on respect, trust and mutual acknowledgment in the actions of care developed during shared consultations.

It should also be emphasized that PC nurses are agents of convergence and distribution of information and they communicate in order to improve the decision-making processes, by searching for information from different sources, constant updating of the information and sharing of information verified in relation to its veracity. Thus, nurses optimize the spaces of exchange and discussion of doubts and promote the coordination of care, operating mediations between users and health professionals and between professionals from different areas and services within the healthcare network[1].

The role of nurses in the effective communication[28] and interaction between team members and with other services that make up the healthcare network shows their significant contribution for the development of an interprofessional work that is especially focused on the health needs of users, families and community.

Study limitations

Limitations of the research include: being a study of a EqSF and a NASF team in a BCU; as well as the use of the critical incident technique, which proved to be limited, as it did not allow an in-depth reflection of the respondents about the object of study.

Contributions to the fields of nursing, health or public policy

The study advances in the understanding of the actions developed by PC/ESF nurses in the context of collaborative interprofessional practice, particularly derived from the expansion of their clinical practice. It helps to clarify their role regarding healthcare to users and families. It also contributes to the debate of public policies concerning the expansion of the clinical practice of these professionals in the SUS's PC, to ensure universal access to and better quality of health care.

FINAL CONSIDERATIONS

The study showed that the expansion of the clinical practice of PC nurses in the interprofessional scenario is related to: the enlargement of the scope of practice, taking place in various professions and expressing the changes in the population's profile; the expansion of the work process and the healthcare models; and the clinical practice of nurses, which can be guided by the logic of health needs and/or expediting service flows, using a comprehensive or a strictly biomedical approach. This process occurs in the context of development of an interprofessional work focused on the user, families and community.

The results also reveal tensions and contradictions present in the daily work life, since the search for collaboration between the different professionals and their synergy suffers tensions from the disproportionate ratio between the number of workers and the demands for service, which EqSF and NASF professionals try to meet, even in situations in which working conditions are far from the minimum required.

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