Esc Anna Nery 2023;27:e20220404

Care dimensions of nurses' work in primary care

Dimensões assistenciais do trabalho do enfermeiro na atenção primária

Dimensiones asistenciales del trabajo de las enfermeras en atención primaria

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Abstract

Objective: to analyze the development of care practices of nurses working in Primary Health Care. **Method**: A cross-sectional and quantitative study was carried out with 216 nurses from 97 municipalities in two Health Macroregions of the state of Santa Catarina, who answered a survey-type questionnaire in 2019. The data were submitted to analytical and inferential descriptive statistics. **Results**: Among the care practices, there was a prevalence of welcoming and Nursing consultation, strengthening their autonomy and Primary Care resoluteness, followed by Nursing procedures. Home visits stand out for the periodicity of up to three times a week, and the educational activities were concentrated on fortnightly periodicity. Health education activities are mainly targeted at users with chronic pathologies. Nurses favor individual care approaches to the detriment of group educational actions. **Conclusion and implications for the practice**: There is a need to strengthen the educational dimension in nurses' work, which has repercussions on care and management activities in Primary Health Care, especially those aimed at groups.

Keywords: Primary Health Care; Educational Activities; Primary Nursing Care; Nurse; Family Health Strategy.

Resumo

Objetivo: analisar o desenvolvimento de práticas assistenciais de enfermeiros que atuam na Atenção Primária à Saúde. **Método**: estudo quantitativo e transversal, realizado com 216 enfermeiros de 97 municípios integrantes de duas Macrorregiões de Saúde do Estado de Santa Catarina, os quais responderam um questionário do tipo *survey*, no ano de 2019. Os dados passaram por estatística descritiva analítica e inferencial. **Resultados**: entre as práticas assistenciais observou-se prevalência do acolhimento e da consulta do enfermeiro, o que fortalece a sua autonomia e a resolutividade da Atenção Primária, seguidos dos procedimentos de enfermagem. As visitas domiciliares sobressaem-se para a periodicidade de até três vezes por semana e as atividades educativas concentraram-se na periodicidade quinzenal. As atividades de educação em saúde voltam-se majoritariamente aos usuários portadores de patologias crônicas. Os enfermeiros privilegiam as abordagens assistenciais individuais, em detrimento às ações educativas em grupo. **Conclusão e implicações para a prática**: há necessidade do fortalecimento da dimensão educativa, no trabalho do enfermeiro, que tangencie atividades assistenciais e gerenciais na Atenção Primária à Saúde, em especial, voltadas para grupos.

Palavras-chave: Atenção Primária em Saúde; Atividades Educativas; Cuidados Primários em Enfermagem; Enfermeiro; Estratégia Saúde da Família.

Resumen

Objetivo: analizar el desarrollo de las prácticas asistenciales de los enfermeros que actúan en Atención Primaria de la Salud. **Método**: estudio cuantitativo y transversal, realizado con 216 enfermeros de 97 municipios de dos Macrorregiones de Salud del estado de Santa Catarina, que respondieron un cuestionario tipo encuesta en el año 2019. Los datos fueron sometidos a estadística descriptiva analítica e inferencial. **Resultados**: entre las prácticas de atención predominaron la acogida y la consulta de Enfermería, lo que fortalece su autonomía y la capacidad resolutiva de la Atención Básica, seguida por procedimientos de Enfermería. Se destacan las visitas domiciliarias por su periodicidad de hasta tres veces por semana y las actividades educativas se concentraron en la periodicidad quincenal. Las actividades de educación para la salud están dirigidas principalmente a usuarios con patologías crónicas. Los enfermeros privilegian enfoques de atención individual en detrimento de acciones educativas grupales. **Conclusión e implicaciones para la práctica**: es necesario fortalecer la dimensión educativa en el trabajo de los enfermeros, lo que repercute en las actividades de atención y gestión en Atención Primaria de la Salud, especialmente aquellas dirigidas a grupos.

Palabras-clave: Atención primaria de salud; Actividades educativas; Atención Primaria de Enfermería. Enfermero; Estrategia Salud de la Familia.

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Submitted on 12/07/2023.
Accepted on 09/13/2023.

DOI:https://doi.org/10.1590/2177-9465-EAN-2022-0404en

INTRODUCTION

In Brazil, Primary Health Care (PHC), also known as Primary Care (PC), operates as the organizer of the Health Care Network (HCN) and is characterized by a "set of individual, family and collective health actions involving promotion, prevention, protection, diagnosis, treatment, rehabilitation, harm reduction, palliative care and health surveillance".[1:2] With this configuration, among other things, PHC presents two different and interdependent aspects: the possibility of organizing health systems and a model for changing health professionals' clinical and care practices.

Consolidated in the mid-2000s in Brazil, the Family Health Strategy (FHS) stands out as one of the possibilities for organizing and modeling the clinical and care practice, which has achieved important indicators, including a reduction in the infant mortality rate, mortality due cardiovascular diseases and hospitalizations due to PHC-sensitive causes. Thus, it is anchored in the PHC attributes and the intersectoriality, social participation and multidisciplinarity dimensions, linked to the doctrinal principles of the Unified Health System (*Sistema Único de Saúde*, SUS), which are integrality, universality and equality.[2]

The implementation of the FHS in municipalities has led to a significant increase in the number of nurses working in PHC, making it possible to direct Nursing actions towards the health needs of users, families and communities through a wide range of tasks, from care and health education to managerial organization of activities.[3] In this context, nurses are the professionals with the due technical skills and competencies to care for health service users, in collaboration with other professionals in the field. The dimensions of their work are assistance, research, education and management and, as a result, they are responsible for and stand out as fundamental professionals in monitoring SUS users.[4,5] Nurses working in the FHS use different technologies, which include both the technical-care dimension, such as technical-scientific knowledge and procedures, and the technical-relational dimension, such as interactions between users and families and the collective-social dynamics of the work process.[5]

Nurses' work contributes to improving quality and effectiveness of the health systems[6] and, specifically in Brazil, to consolidating the SUS.[7] It is recommended that the nurses' work process in PHC converge with the proposed care model centered on comprehensive user care and the promotion of universal access to health. In fact, nurses working in PHC experience the dichotomy between managerial and educational/assistance activities, as the vast majority of professionals end up performing all these functions, becoming polyvalent. These accumulated activities constitute a limiting factor for the definitions between managerial and educational/care practices, as they fail to confer a clear perspective of their work process. This implies the nurses' practices linked to the team, the service, planning and the assistance to be provided to the users.[8] It is worth highlighting nurses' responsibility in management and assistance, as these professionals do not fail to corroborate with practices to strengthen the service through intersectoral actions, always seeking to strengthen care resoluteness.[9]

Given the aforementioned, the objective of this study is to analyze the development of care and educational practices of nurses working in Primary Health Care. This recognition is considered necessary to instigate reflections on the role played by nurses in the different dimensions of their work, through effective professional practices in the care of people, families and communities, in the Macro-regions studied.

METHOD

This is a cross-sectional and quantitative study conducted with nurses working in the Family Health teams (FHts) of 97 (74.04%) of the 131 municipalities from two Health Macro-regions in the state of Santa Catarina: Large West and Midwest. For sample calculation, the population of 440 nurses working in the FHts of these Macro-regions was considered, using 50% proportion, 5% error margin and 95% confidence interval, with 205 estimated participants.

The inclusion criterion defined stipulated that the nurses should have been working in the FHt of the municipality for a minimum of one year, considering this period important to apprehend their work process. The exclusion criterion considered was as follows: nurses who were on leave or away from the service for any reason during the data collection period. After inviting all the professionals that met the research criteria, 216 (49%) nurses took part in the study.

Data collection was carried out from May to August 2019 using a survey-type questionnaire structured in *Google Forms*®, which was emailed to the nurses in partnership with the Brazilian Nursing Association – Santa Catarina Section (*Associação Brasileira de Enfermagem*, ABEn/SC) and the Regional Health Departments. The Free and Informed Consent Form was included in the email content, assuming that accessing and answering the survey represented formal acceptance to voluntary participation in the research. The instrument has nearly 30 closed questions that address nurses' practices in all dimensions of their work in PHC. This study presents and discusses part of the results.

To identify a trend among the practices developed by the nurses who took part in the research, a periodicity score was elaborated for the care activities (n=201) and the collective/group educational activities (n=78). For the care activities score, five questions were considered, which involved the frequency of the following: nurse consultations; welcoming; home visits; procedure at homes; and procedures at the BHU. The score for the educational activities took into account the six questions involving collective/group activities with the following themes: chronic pathologies, development (pregnant women, childcare and adolescents, among others), workers' health, mental health, licit drugs and groups of family members.

The possible frequency answers to these questions were the following: Every day (Value=4); Three times a week (Value=3); Fortnightly (Value=2); Sporadically (Value=1); and None (Value=0). The participants who answered not performing any of the activities (Value=0) were not included in the score calculations. The score for the care activities could vary from 5 to 20 and a mean of

15.21 was obtained (Standard Deviation of 2.92), showing a mean value closer to the upper limit. The Cronbach's alpha coefficient for this set of questions was 0.64. In turn, the score for the collective/group educational activities could vary from 6 to 24 points, obtaining a mean of 12.51 (Standard Deviation of 5.43) and a Cronbach's alpha value of 0.87.

For the other sets of activities, the values corresponding to each question were added up and subsequently divided into a scale comprised by five classes (based on its possible variation range): "Very high"; "High"; "Average"; "Low"; and "Very low".

Data analysis was performed with the aid of the *Statistical Package for the Social Sciences* (SPSS) software, version 21.0. The findings were expressed as absolute numbers, absolute and relative frequencies, interquartile range, mean value and standard deviation.

The study observed the ethical aspects recommended by resolutions No. 466/12 and No. 510/2016 of the National Health Council and was approved by the Committee of Ethics in Research with Human Beings (Opinion No. 2,380,748/2017).

RESULTS

The sociodemographic variables of the 216 nurses participating in the study presented a mean age of 36 years old (standard deviation of 7.06); 94% (n=203) were female; 80.6% (n=174) had specialized in the field of Collective Health; median time working in PHC of 8.5 years (Interquartile Range: 4-13); and median working time in the current FHt of 4.5 years (Interquartile Range: 2-9).

Table 1 presents the variables and periodicity of the care practices developed by the nurses.

Table 2 and Figure 1 are focused on the analysis of the types of health education groups held and on their respective frequency.

Table 3 and Figure 2 classify the periodicity scores corresponding to the development of the care practices.

Table 1. Periodicity corresponding to nurses carrying out care activities in PHC services from the SC Large West and Midwest macro-regions, 2019.

Care and Educational Activities	None		Sporadically		Fortnightly		Up to three times a week		Daily		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Nursing Consultation	6	2.8	21	9.7	0	0.0	38	17.6	151	69.9	216	100
Welcoming	3	1.4	7	3.2	1	0.5	6	2.8	199	92.1	216	100
Home Visit	6	2.8	45	20.8	51	23.6	104	48.1	10	4.6	216	100
Procedures at the home	10	4.6	101	46.8	25	11.6	59	27.3	21	9.7	216	100
Procedures at the BHU	4	1.9	28	13.0	3	1.4	36	16.7	145	67.1	216	100
Collective/ Group activities	11	5.1	72	33.3	85	39.4	33	15.3	15	6.9	216	100
Health education	11	5.1	100	46.3	46	21.3	19	8.8	40	18.5	216	100

Source: Prepared by the authors (2022).

Table 2. Periodicity corresponding to nurses holding group according to the nature of the PHC services from the SC Large West and Midwest macro-regions, 2019.

Nature of the groups	None		Sporadically		Once a month		Up to three times a week		Daily		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Chronic pathologies	20	9.3	47	21.8	100	46.3	10	4.6	39	18.1	216	100
Development and growth	19	8.8	52	24.1	93	43.1	18	8.3	34	15.7	216	100
Mental health	64	29.6	61	28.2	40	18.5	19	8.8	32	14.8	216	100
Family members	116	53.7	58	26.9	16	7.4	11	5.1	15	6.9	216	100
Workers	98	45.4	70	32.4	21	9.7	9	4.2	18	8.3	216	100
Fight against smoking and/ or alcoholism	54	25.0	88	40.7	30	13.9	16	7.4	28	13.0	216	100

Source: The authors (2022).

Table 3. Periodicity corresponding to the scores of the care and collective/group educational activities in the PHC services from the SC Large West and Midwest macro-regions, 2019.

Frequency	Score for the care activities	Score for the collective/group educational activities
Very low	5 (2.5%)	31 (39.7%)
Low	8 (4.0%)	19 (24.4%)
Average	26 (12.9%)	12 (15.4%)
High	112 (55.7%)	8 (10.3%)
Very high	50 (24.9%)	8 (10.3%)
Total	201 (100%)	78 (100%)

Source: The authors (2022).

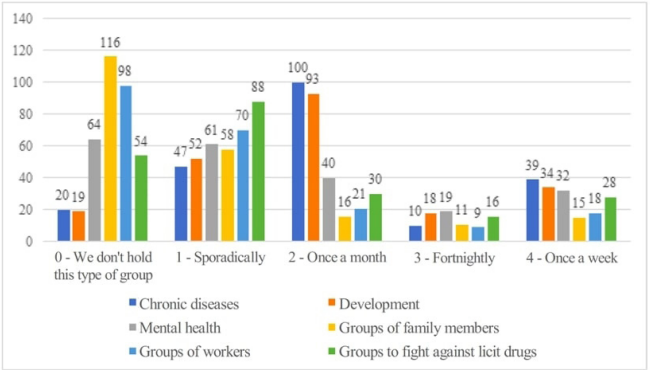

Figure 1. Periodicity corresponding to nurses holding the different types of educational groups in the PHC services from the SC Large West and Midwest macro-regions, 2019. (n=216).
Source: The authors (2022).

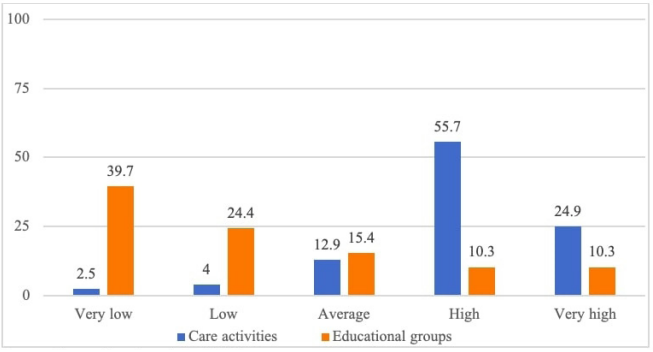

Figure 2. Periodicity scores corresponding to nurses developing care activities and health education groups in the PHC services from the SC Large West and Midwest macro-regions, 2019.
Source: The authors (2022).

DISCUSSION

In the characterization of the participants in this research, it is observed that most of the professionals interviewed are women, mostly aged 36 years old. Some researchers[10] assert that Nursing is one of the careers in which the professional framework is mostly developed by the female gender because women were recognized as pioneers and protagonists in the creation and systematization of the profession, inspired by Florence Nightingale, the pioneer in this category.

As for the training of nurses working in PHC, this study evidences that the majority have a specialization in the field of Collective Health, which is in line with the assertion[11] that the more experience they have in their work area, combined with a specialization, the easier it will be for them to perform their duties. This is also the case when collaborating with the team and management, as the team depends on a leader that ensures improvements in the work process.

Regarding the median time working in PHC, it is noticed that most of the participants had been active for a mean of 8.5 years, with 4.5 in FHS. The longitudinal and effective bond between FHt professionals and the population enhances PHC care, recognized as an essential attribute and permeated by others such as first contact, comprehensive assistance and care coordination.[12]

In Brazil, health promotion, disease prevention and clinical care are still the three main tasks or missions of PHC/FHS teams in their routine. Nursing plays a fundamental role in this sense: (1) clinical care (Nurse Consultation) and coordination of this care; (2) disease prevention, especially through educational actions and guidance to the population; (3) health promotion, which permeates the previous ones, with specific actions and a more participatory, sometimes collective, empowering and politicizing character.[13] In this sense, the findings are consistent with the importance of nurses and teams devoting more time to health promotion activities for specific groups, more centered on chronic diseases.[14] In the Macro-regions studied, the FHts have dedicated themselves to group practices in the PHC context, especially targeted at mental health.

With regard to the Systematization of Nursing Care (SNC) and the Nursing Process, in this study it can be seen that nurses carry out consultations in PHC, contributing to effectiveness and resoluteness of the service. When carrying out SNC, nurses establish the organization of the work process, focused on the demands that emerge, not directing the user to their professional practices alone but to all members of the Nursing team, backed by the law of professional practice.[15] In Brazil, the Law on the Professional Nursing Practice No. 7,498/86[16] and its regulatory Decree No. 94,406/87[17] describe carrying out consultations as a nurse's private activity, which includes requesting tests and the possibility of prescribing some medications, provided that this is covered by institutional protocols. The National Primary Care Policy (*Política Nacional de Atenção Básica*, PNAB)[18] also assigns nurses the specific duties of their work process, such as carrying out consultations, procedures, requesting complementary tests, prescribing medications by protocols, clinical and therapeutic

guidelines or other regulations, in compliance with the legal provisions of the profession. Regarding Nurse Consultations, it should be noted that, in the West Macro-region and due to the presence of Universities with Nursing courses, including *stricto sensu* ones, there is greater adherence to this practice thanks to the teaching-service integration actions.

Another activity that stood out was welcoming by PHC nurses, which enables qualified listening, implying advanced access and resolute practices in PHC. The objective of welcoming emerges from discussions about reorganization of the assistance provided, highlighting this method as a supporter in qualification of the SUS, as it corroborates the users' needs by allowing access to expanded and comprehensive care, based on their needs.[19] Nurses are professionals who stand out in the job market because of their ability to understand and interpret human needs in all their dimensions.[20] In the FHS *praxis*, nurses' role as welcoming people reinforces the relationship between professionals and users by linking practical knowledge to empirical knowledge, listing the needs of the population. In this sense, welcoming is considered as a relational technology used by PHC nurses, and it is important to maintain this tool in the teams' work process.[21]

The practices that stand out in this study also include the development of group activities in PHC to foster health promotion practices, encouraging better individual and collective habits. As already discussed, one of the PHC objectives is health promotion, which focuses on quality of life, reducing vulnerabilities and risks associated with the social determination of health,[22] which makes it possible for professionals to act on lifestyles and, to some extent, on the local environment. However, it is worth noting that working conditions, income and formal education are elements that demand more encompassing public policies.[13,19]

In the context of the education practices, we were able to notice certain disparity between care and educational activities, where the former ones are more frequent. Again, this draws the attention to nurses' work organization. The educational dimension of their work[4,5] can be present in the others, namely: care and managerial. Health education is understood as a knowledge-building strategy and has worked to promote health at all levels, as it allows the target population to adhere to a given topic, with a possible change in behavior. It is a set of knowledge items focused on the *praxis*, and which contributes to the individual and collective autonomy process, with the involvement of both professionals and managers to meet local and regional needs. This knowledge also contributes to the population's quality of life.[23] Therefore, what seems most feasible to us is for nurses to take on the clinical/assistance dimension of their work, focusing on qualified Nurse Consultations, with health education as a tangential practice in these appointments. It can (and should) permeate other processes, such as group activities and home visits, among others.

In this context, it is interesting to mention and reflect on the best Nursing practices, whose discussion emerges in Brazil with the purpose of strengthening PHC and, consequently, the SUS. The concept of "best practices" points to the techniques or methodologies anchored in reliability, experience or research and that present proven effective results. These methodologies require functional knowledge and practice in specific contexts, with a view to achieving expected results and with the possibility of being replicated in other contexts. In synthesis, best practices consist of the research, experience and reliability triad.[24]

One of the possibilities for the applicability of best practices is centered on Advanced Practice Nursing; however, in the Brazilian context, the legislation or even the training of Advanced Practice Nurses is not recognized. In international realities, this modality includes more accurate clinical care, from evaluations and diagnoses to prescribing medications, taking into account the appropriate regulations established by the Federal Nursing Council, by government bodies and in the various practice settings.[13,25]

However, what can be observed is that carrying out clinical practices based on evidence and guidelines or protocols, even though it is not an entirely regulated practice in Brazil, has already caused discussions about the Nursing *praxis*, especially in PHC. This is because, on the one hand, there is a view that the role of advanced practices implemented in Latin America might make a difference in care access and resoluteness for users of public health services.[26] On the other hand, although they favor an increase in nurses' autonomy, taking on advanced practices, for some, it would imply a greater overload for these professionals; besides, in Brazil there is precariousness in training and other discouraging situations for this adaptation.[13] According to the International Council of Nurses (ICN), Advanced Practice Nursing requires specialized knowledge, the ability to make complex decisions and clinical competencies for an expanded practice of the profession, including skills such as organizational leadership. For this reason, MSc courses are recommended in the professionals' training to work in this modality.[27,28]

Although it was not the object of this study, it is known that PHC nurses are predominantly involved in the coordination and administration of health services, in line with the managerial dimension of their work. This has exerted negative impacts on care provision by PHC nurses in Brazil, given the different work demands.[29]

FINAL CONSIDERATIONS AND IMPLICATIONS FOR THE PRACTICE

In the context of the PHC under study, strengthening of health education actions as an implemented practice can be observed, with slightly more than one-third of the professionals carrying out actions of this nature, contributing to care and managerial activities.

As far as the nurses' work process is concerned, it is in included in the PHC context, which is still markedly influenced by the biomedical model, with actions centered on clinical care and hardly on prevention or health promotion, with health units as the privileged places for their practices. This feature is in line with what is expected in relation to the comprehensive care

model and assistance to users targeted at promoting universal access to health. However, one of the study limitations lies in its exclusively quantitative approach to the topic, with the due relevance of conducting qualitative studies that observe nurses' professional practices in a longitudinal way.

As for nurses' autonomy, it has been facilitated by the legal backing for consultations and other actions; however, these professionals still need to reflect on their proactivity and organization of their work process, using the method of sharing duties for reorganizing the service in which they are inserted and herein referred to, namely: PHC.

Another important issue is sensitizing managers and other members of the team towards strengthening health education, whose interprofessional dimension is unavoidable. In disease prevention and health promotion, even during the clinical practice and in group actions, education is tangential and contributes short-, medium- and long-term results, both individually and collectively.

This study met its objectives, evidencing nurses' professional practices in the region researched, which are still very much centered on assistance but are gradually evolving towards the clinical practice, represented by Nurse Consultations. It was noticed that the education practices permeate all their actions, with emphasis on group activities and on welcoming the users. However, there are still some reservations to be considered on the part of the work process, such as Advanced Practice Nursing not being recognized by the Brazilian legislation, the fear of professional overload if this is implemented, and the need for better professional qualification.

ACKNOWLEDGMENTS

To *Universidade do Estado de Santa Catarina* (UDESC) and to *ABEn*-SC for their cooperation with student scholarships and for contacting the municipalities, respectively.

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