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GOOD PRACTICES IN THE CARE PROCESS
AS THE CENTRALITY OF THE NURSING

RESEARCH

The care of nurses in the Family Health Strategy: practices and theoretical foundation

Cuidado do enfermeiro na Estratégia Saúde da Família: práticas e fundamentações teóricas

Cuidado del enfermero en la Estrategia de Salud Familiar: prácticas y fundaciones teóricas

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ABSTRACT

Objective: To analyze the practices of nurses working in the Family Health Strategy (FHS) in a city of Rio de Janeiro (RJ) and the theoretical foundations that guide them. **Method:** Qualitative research through semi-structured interviews with twelve nurses working in eleven FHS units between August and December 2014. Data were organized by hermeneutic-dialectical analysis. **Results:** The nurse is inserted in the municipal FHS as care coordinator and political agent; has practices aimed at welcoming, mobilizing social groups, making technical and monitoring of users through health programs. The practices remain in the confrontation of problems and are guided by technical manuals and coordination of health programs. **Final considerations:** Studies are needed to recognize the nurse's therapeutic objective at the FHS and to propose theoretical foundations, specific to Nursing or Collective Health that will instrumentalize their daily practice. **Descriptors:** Public Health Nursing; Community Health Nursing; Nursing Care; Public Health Practice; Primary Health Care.

RESUMO

Objetivo: Analisar as práticas dos enfermeiros que atuam na Estratégia de Saúde da Família (ESF) em um município do Rio de Janeiro (RJ) e os fundamentos teóricos que as orientam. **Método:** Pesquisa qualitativa através da entrevista semiestruturada com doze enfermeiros atuantes em onze unidades da ESF entre agosto e dezembro de 2014. Dados organizados pela análise hermenêutica-dialética. **Resultados:** O enfermeiro possui inserção na ESF municipal como coordenador do cuidado e agente político; possui práticas voltadas ao acolhimento, à mobilização de grupos sociais, ao fazer técnico e ao acompanhamento dos usuários através dos programas de saúde. As práticas permanecem no enfrentamento de problemas e são orientadas por manuais técnicos e coordenações dos programas de saúde. **Considerações finais:** Fazem-se necessários estudos para reconhecer o objetivo terapêutico do enfermeiro na ESF e propor fundamentos teóricos, próprios da Enfermagem ou da Saúde Coletiva, que instrumentalize o seu cotidiano de práticas. **Descritores:** Enfermagem em Saúde Pública; Enfermagem em Saúde Comunitária; Cuidados de Enfermagem; Prática de Saúde Pública; Atenção Primária à Saúde.

RESUMEN

Objetivo: Analizar las prácticas de los enfermeros que actúan en la Estrategia de Salud Familiar (ESF) en un municipio de Río de Janeiro (RJ) y los fundamentos teóricos que las orientan. **Método:** Investigación cualitativa a través de la entrevista semiestructurada con doce enfermeros actuantes en once unidades de la ESF entre agosto y diciembre de 2014. Datos organizados por el análisis hermenéutico-dialéctico. **Resultados:** El enfermero tiene inserción en la ESF municipal como coordinador del cuidado y agente político; tiene prácticas orientadas a la acogida, a la movilización de grupos sociales, al hacer técnico y al acompañamiento de los usuarios a través de los programas de salud. Las prácticas permanecen en el enfrentamiento de problemas y están orientadas por manuales técnicos y coordinaciones de los programas de salud. **Consideraciones finales:** Se hacen necesarios estudios para reconocer el objetivo terapéutico del enfermero en la ESF y proponer fundamentos teóricos, propios de la Enfermería o de la Salud Colectiva, que instrumentalize su cotidiano de prácticas. **Descriptores:** Enfermería en Salud Pública; Enfermería en Salud Comunitaria; Cuidados de Enfermería; Práctica de Salud Pública; Atención Primaria de Salud.

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INTRODUCTION

Studies on the practice of nurses in the Family Health Strategy (FHS) have pointed to the discussion about the role of this professional, in regard to the re-signification of care as the structuring axis of their practice[1], from an active stance towards reality[2] and that guarantees new modeling of care production[3]. It is necessary to look carefully at the relationship between Nursing care and the nurses' daily practice at the FHS, in addition to its theoretical basis in the consolidation of said strategy.

The FHS, as a ministerial proposal for the reorganization of the Health Care Network, presents itself as a possibility of producing care from the territory of the population's life and the recognition of their health needs. It is understood that in the Strategy, a disease-centered approach and its diseases have little to offer the population in their health needs. In this sense, there is the authors' apprehension regarding the need to rescue care and its production in the daily practice of Health Care[1-3].

The apprehension in redirecting nurses' practice in Primary Health Care (PHC), as a practice of social transformation in the defense of the health of the population is not specific to Brazilian authors, although is evidenced in studies in New Zealand[4], Australia[5] and Canada[6]. These point out the need to know how the practices of nurses working in this field of care and their impacts on the production of care are developed.

In Brazil, nurses' practice at the FHS is therefore a subject under construction[1-3]. While practicing socially committed to the lives of the people in its territory, it is urgent to discuss the role of this professional in the FHS in a way consistent with the construction of a project of society in the defense of health as a right of all.

It is understood the value of care guided by listening, welcoming and dialogue, however, the non-valuation of the socio-historical context of the person's life and the repercussions for the health of the population[1], reproduce practices that do not recognize the health- socially determined disease as a response of social classes, according to their insertion in the production system[7]. Thus, it is part of the understanding of the nurse's practice in the FHS as social and historically determined; which indicates values and conceptions related to the existing context. These, in turn, define the way in which nurses construct the practice of care in their daily lives.

Although studies present indications that the practices point to their qualification, such as the approach based on Nursing care[1,3], these practices continue to be anchored in knowledge based on protocols and technical manuals; non-participatory; individuals; and little transforming reality[2]. Thus, a challenge for Nursing is identified as a profession that mediates care practices and advocates the right to health to produce knowledge and practices that bring transformations in the Health Care Network from the FHS and not delegate thinking, its conceptual and methodological definitions.

In fact, two dimensions are important for the reflection of the role of nurses in the FHS: the first, related to the apprehension of the social determination of the health-disease process, as a dynamic response of the social classes that manifest themselves differently, according to their insertion in the production system, against social determinants[7]. The second is based on the positioning of Nursing in the field of Collective Health as a science focused on the care of human beings that intervene in the health-disease process, through the dynamic systematization of understanding and interpreting the health reality of a community, of intervene and thus reinterpret it - and again intervene on it[7-8].

In the context of nurses' practices at the FHS, such dimensions recover the social, political, ethical and subjective perspective of the health-disease process and the present care in the construction of the field of Collective Health[7], raise practices from the life territory of the population and collaborate in rethinking current practices. In this sense, it can be seen that the nurse's practice in the FHS cannot be based on a conventional structure of Health Care based only on protocols and technical manuals produced from the focus of the disease. These documents do not reflect, systematically and critically, nurses' practice of care.

Thus, it is believed that understanding nurses' practices in the FHS and the theoretical foundations that guide them collaborate in the identification of their role and contributes so that this professional does not delegate the thinking of their practices to other instances, such as the Ministry of Health (MoH- *Ministério da Saúde*) and Health Offices. These issues are related to the consolidation of the Nursing profession in the field of Collective Health and should be deepened in the perspective of building a new way of thinking, being and becoming a nurse in the FHS. It is hoped that this study can collaborate both to understand nurses' practices and to construct alternatives to those already existing.

OBJECTIVE

To analyze the practices of nurses working at the FHS in a city of Rio de Janeiro (RJ) and the theoretical foundations that guide them.

METHOD

Ethical aspects

The nurses expressed agreement on their participation through the Informed Consent Form, after clarifying the objectives; the methodology; and the risks and benefits of participating in a municipal FHS nurse meeting. In this meeting, there synergies with the professionals and there was permission to visit Family Health Units. The interviews were scheduled individually with each nurse.

This research, judged and approved by the examining board of the Research Ethics Committee of the UERJ Graduate and Research Sub-Rectory, is in accordance with the determinations of the National Health Council (*Conselho Nacional de Saúde*), through Resolution 466 of December 12, December 2012[9].

Theoretical-methodological framework and type of study

Qualitative descriptive research based on the theoretical-methodological framework of the Theory of Praxis Intervention of Nursing in Collective Health (TIPESC- *Teoria da Intervenção Práxica da Enfermagem em Saúde Coletiva*)[7].

TIPESC is based on the materialistic and dialectical worldview and proposes a Nursing in Collective Health methodology in response to the need for a new professional attitude related to the conception of the health-disease process, the assistance to Collective Health and Nursing. As theory, in Collective Health Nursing requires the application of five phases to be followed. The proposed phases are: *understanding and interpreting the objective*

reality; *construction of the intervention project*; *intervention in objective reality*; and *reinterpretation of objective reality*[7-8].

In order to respond to the objective proposed in this article, we used the first phase related to understanding the objective reality, which develops in three dimensions: structural, particular and singular[8]. In order to know the objective reality, it is necessary to understand the structural dimension: the health system in force as a whole and the form of attachment of the subject to it; in the singular dimension: the dynamics and historicity of survival and/or improvement of health, related to the health-disease process, physical environment, food, transportation, education, work, family and/or group relations, and biopsychic body; and as for the particular dimension, the insertion of the subject in a given social class stands out[7].

Thus, in order to understand the practice of care of the FHS nurses from a municipality in the state of Rio de Janeiro, from the deepening of their contradictory relationships in a certain historical context, it is necessary to recognize the dimensions proposed by TIPESC. First, in the structural dimension: attachment of nurses to the current health system; in the singular dimension: interpretation by the nurse of the dynamicity and historicity of the health-disease process of the community and the way in which it produces its practice of care; and finally, in the particular dimension: theoretical foundations guiding the practice of care.

So, the decision to use the phase of understanding the objective reality proposed by TIPESC helped this study to overcome a simplified view on the practice of nurses in the FHS by analyzing the contradictions present in their dimensions.

Methodological procedures

Study setting

The study was carried out in urban and rural areas of eleven Family Health Units (FHU) of a municipality in the state of Rio de Janeiro (RJ). The inclusion criterion for the selection of FHUs was to have a nurse linked to the Family Health Team for at least six months. The municipality has a population of 139,000 inhabitants. The PHC is composed of 18 Family Health Teams with coverage of 44% of the territory and 06 health units without FHS.

Data collection

A semi-structured interview was conducted with 12 FHS nurses. The inclusion criteria for the study participants were: nurses who worked more than six months in the FHU and who accepted to participate in the study, from August to December 2014. Exclusion criteria were established: nurses who act as managers of health programs, whether on vacation or health leave, at the time of research development.

The constitution of the data collection instrument covered three axes composed of open-ended questions regarding the insertion of the nurse in the municipal Health Care, the daily practice of nurses and the theoretical path that underlies the practice. The pilot of the interview, developed with two nurses who work in Family Health Teams in a municipality bordering on the research, did not obtain modification in the original script.

All the interviews were recorded with the permission of the interviewees and later transcribed in full. The participants' anonymity was guaranteed by identifying the letter "I" of Interview, followed by the transcription number. The interviews, conducted with FHU visits, with an average duration of 25 minutes, made it possible both to collect data on the subjective aspects of the subjects of the study and to allow them to reflect on their daily practice at the FHS - what they learn, what they experience and what they think.

Organization and data analysis

In the organization of the empirical data, the hermeneutic-dialectical analysis was used as a method capable of interpreting reality, since it presents the everyday conditions of life and clarifies its structures in the treatment of data[10-11].

Thus, by taking as concrete material the manifestations of social actors, the researcher elaborated analytical and empirical categories and turned to the theory foundations, in order to reflect on the initial concepts, casting doubt on the obvious ideas[10]. For this, the following interpretive trajectory[11] was used: First, the ordering of the data - through preliminary reading of the empirical material, the horizontal mapping was established; afterwards, the classification of the empirical data - exhaustive reading and clipping of each unit of analysis, which made it possible to conceive the synthesis of each central idea of the object of study and to find the nuclei of meaning; then, the confrontation of the nuclei of meaning - from the vertical synthesis, in order to find the general idea of each interviewee; then the confrontation of the horizontal synthesis - which made it possible to identify the convergences, divergences, complementarities and differences of the speeches of each interviewee; finally, the final analysis - which consists of the interpretation of the empirical material from the theoretical framework.

RESULTS

Of the 12 interviewees, all were female, only one of them ever worked at the FHS in another municipality. As for the working time in the FHU of the research municipality, a nurse has been working for less than a year; four participants are between one and four years old; and seven have been working for more than five years. In relation to age, two were between 21 and 30 years old; eight nurses, from 31 to 40 years old; and two, from 41 to 50 years. When questioned about the degree of specialization, 12 respondents stated that they had attended or were in the *lato sensu* specialization, and five of them had specialization in Family Health or Public Health.

The study showed a municipal daily practice focused on coordinating care, welcoming, doing technical and monitoring of users through health programs. Another practice mentioned by the interviewees was the practice of mobilizing social groups.

The results are presented in accordance with the categories established.

Category 1 - Structural Dimension: Nurse as care coordinator and political agent

Structural dimension determinants are characterized by the attachment of nurses to the Municipal Health System, based on a practice committed to the coordination of care and as a political agent. In this dimension, management and political practices of

nurse in the FHS, as well as in the life territory of the population, are listed. In the nurses' speeches, ideas that add planning actions in the daily practice of the Family Health Team stand out.

For the interviewees, the practice of care coordinator includes the planning of health education activities, the coordination of the unit's agenda, the monthly data registry to be sent to the Municipal Office Health and to the coordination of FHU inputs.

> *We are encouraged to participate, to interact with* [...] *lectures, guidelines - respecting the calendar of events - the fight against AIDS in December and in pink October.* (I 06)

> *In our agenda we have a planning from Monday to Friday.* (I 01)

> *We do the paperwork, production closure and consolidated programs, these things, so every end of the month, to send to the Office.* (I 04)

> *We manage the unit from the lack of material* [...] *everything that involves the process of working for the unit to be right.* (I 02)

Another important way of linking nurses to the health system, through their practice at the FHS, is as a political agent. It is characterized by the central ideas of the interviewees, which were identified under two aspects: the capacity to mobilize social groups; and the critical view of nurses as to their professional practice at the FHS.

> *I was talking to the director and we are going to set up a project to be acting directly at school, with activity there.* (I 08)

> *Because we are close to the community, we see these needs and can act; the neighborhood association also has this collaboration.* (I 01)

> *Sometimes that patient has to be referred somewhere, he cannot and we try to solve it some other way. I know it's wrong but I have to help.* (I 09)

In the FHS setting of the study municipality, the nurse develops practices that go beyond direct attention to the population. Its insertion presupposes the perception of the professional role as builder of new relationships between team and population, as well as the responsibility of managing the health unit for the implementation of public health policies.

Category 2 - Individual Dimension: Assistance role of nurses, understanding the health needs by the nurse and the role of educator in nurse's health.

The determinants of the singular dimension are characterized as practices of interpretation of the health-disease process in the daily life of the FHS. In this sense, the second category is organized by the central ideas related to the assistance role of the nurse, the understanding of individual health needs and the community, and the role of educator in nurses' health.

The assistance role of nurses is related to a set of care practices that permeate the reception, technical make-up and follow-up of the users through health programs. These are practices with intervention characteristics about individual illness processes, without the interpretation of the community health-disease process.

> *A simple blood glucose test that I made in the patient became a care. Because I saw the patient as a whole, what's his problem? Is it a family problem he's experiencing?* (I 10)

> *For example, the woman arrives here, I listen, I talk to her, I welcome her and then I enter the woman's health program, doing the preventive collection.* (I 12)

> *Ah, first we welcome the patient, then we collect the data and try to help in some way. Then we insert the patient in the program that suits him/her.* (I 05)

> *Working at the FHS helps me to be sensitive to perceiving patient's needs, the strategy helps me gain insight into what each user needs.* (I 02)

In this sense, the interviews analysis showed that the understanding of health needs occurs at the individual level. As to the needs of the community, this originates in the nurses' interpretation of the importance of articulating practices among FHS, community, schools, neighborhood associations and households. It is characterized by the possibility of being close to the reality of the community and, thus, recognize their health needs. In the speeches, work was found at the FHS as a facilitator to understand the community health needs and organize practices for resolution.

> *We have, with the neighborhood association, the work of monitoring families with social problems, with social conflicts.* (I01)

> *So when there is a problem that we deal with patient up front ... I go to the patient's house to see the environment he/she lives in.* (I 10)

> *I think the patient directs our work, the patient's health needs* [...] *I know I have to visit and schedule appointments, but if I could get some clothes, if I could get some food for him today,* [...] *Because this family doesn't have the document, let's run after and resolve the document case.* (I 09)

The role of health educator of the nurse was also evidenced. This is characterized as a practice of orientation to the population. It should be emphasized that the practices present specific themes, supported by the definition of the themes proposed by the MoH and others, originated from the health needs presented by the population.

> *I do a lot of health education in my own community. I have a schedule, like this: pink October, fight against AIDS for 2015.* (I 03)

> *We did HIV D-Day, made pink October and blue November.* (I 05)

> *We did this circle of meetings now that was great. We know the residents better, they all participated, they discussed, they suggested themes and they took doubts.* (I 02)

Category 3 - Particular dimension: Guiding principles of the nurse practice

The third category emphasizes the ideas that embrace the theoretical orientation of nurses in the FHS. These foundations permeate the support network built on the FHS, learning from the MoH manuals and the exchange of experiences with the health service user.

> *To get the information, we use coordination; It's a way for us to have a support.* (I 07)

> *What about the question of having background to perform the activities by the strategy? We must know the nursing manuals, have an understanding, because we have to always be updating.* (I 11)

> *What helps me? The manuals, which we go for, when in doubt.* (I 08)

The support network built at the FHS is characterized by the search for information from their professional relationships, in an experience of support and articulation with the coordinators of the health programs. The search for MoH manuals was highlighted as an important support for nurses to practice at the FHS.

It was also evidenced by the nurses that their practice has theoretical foundation in the search of knowledge from the experience in the FHS regarding the exchange of experience with the users of the services. The interviewees reported that, through the daily life of the strategy under consideration, learning occurs in a way shared with the population.

> *The day to day that every hour comes a new thing and you learn along with the population as well.* (I 04)

DISCUSSION

Through semi-structured interviews with the nurses of the FHS of a city in the state of Rio de Janeiro (RJ) it was possible to know their daily practices, as well as the theoretical foundations that guide them. Likewise, it was identified that the structural, singular and particular dimensions are present in these practices, being composed by the descriptions of the experiences and experiences of the interviewees.

It is interesting to note that the nuclei of meaning related to the coordination of care, the care role and the health educator of the nurse are present in the statements of all the interviewees. This fact helps to think about the complexity that involves the work of said professional. The complexity of nurses practices in PHC is also described in international studies[4,6] in the discussion about the role of nurses in this field of Health Care, based on the health needs of the population, through the production of a social, participatory and transforming practice of the reality of the population's life.

Another important aspect of the interview analysis was the role of coordinator of the nurse's care, where the planning of health education activities as a team was identified. It was noticed the potential of changes in these practices, regarding the capacity of mobilization of the health team and the production of new ways of acting in health. At the same time, it was observed the lack of participation of the users in the planning of educational practices, their contribution refers only to the suggestion of themes to be developed by the FHS teams.

Thus, despite the nurses' statements evidencing the planning of team health education practices, such practices remain without the participation of the population in its construction. A study on the practice of nurses in an urban area of a city in Southwestern of Bahia state, Brazil also showed that users did not participate in educational activities and pointed to the need for a practice that values the singularity of each user, their life history, beliefs and experiences[1].

Complementarity is evident in the description of health education activities. These practices are mentioned as lectures and orientations based on themes proposed by MoH, without the participation of the nurse as an incentive for practices that transform the daily life of the community. Thus, coordination of care permeates defined themes outside of its coverage area, rather than referencing local social and historical conditions. Studies also present health education practices geared to programmatic actions of specific groups and not to the territory of the community[2,12].

Regarding the nurse's role of assistance, we identified the meeting of care with the health service user and mobilization of skills such as listening and dialogue. However, the interventions developed remain focused on health programs and technical work. Thus, although the interviewees report the user's reception through listening and conversation, the contradiction is in the supply, which presupposes the programmatic actions and health needs of the community, which do not always have answers in the services offered in the unit.

The moment of meeting with the user and the continuity of care is also present in a study developed in Chile with nurses who work in family health centers, where it was evidenced that they consider their care as a meeting of subjectivities. However, they understand the need to program innovative practices, which can overcome traditional care aimed at a fragmented and biologistic practice[13]. It is important to emphasize the importance of a care practice that extrapolates the individual programmatic actions defined vertically at the central levels of management and defends the implementation of expanded responses to the health needs of the population[14].

Thus, as opposing poles of the same objective reality, nurses' practice of care reproduces the health system in force in a pole in which the care supply occurs from health programs and, in another pole, the health needs of the population are not recognized as a powerful social force for the production of innovative practices. It was noticed that the theoretical-practical rearrangement necessary in the field of Collective Health[7-8] - from the social and political approach in the defense of life; and with the participation of the population - remains timid in the practices described. There is no organization of its structural dimension, with mechanisms to strengthen groups of the population for social demands.

In the nurses' reports, practices were identified to mobilize social groups and to reflect on their own practice at the FHS. They are practices developed beyond the health unit - in the search for partnerships, to know better the attached area, and to be closer to the community, which shows the professional and personal commitment of the nurses regarding their care at the FHS. However, practices characterized by interventions that may bring about changes in the political and social issues of human health[15] were not noticed in

nurses' statements. It is understood that the political dimension is structural in the practice of nurses in Collective Health[7,15] and reveals the intentionality of their practice of care. However, studies do not describe the political dimension as a result of their research[3,12-13] or even identify it as a timid search by the nurses[2].

This little innovative scenario alerts to the need to rescue the political dimension[15] of nurses' care and their influence on the daily practice of the FHS. The convergence between the nurse as a political agent and the coordinator of care is present in the influence of the care model aimed at illness, which seems to be the guiding basis for care, although there is a persistence of practices and postures resistant to the model judged[12].

Another important aspect present in the interviewees' speeches was the nurses' practice, based on the need for individual health and the community. Participants express health needs as a tool to develop their care. However, it does not appear to be a systematization of these needs, because these are, when described, centered on the user, on the disease, on what is defined as a health problem. Practices remain in the face of perceived problems with the user, without an interpretation of how the community is organized for the production of life.

It is worth noting that, despite the nurse's identification of social needs - such as the lack of identification documents, food and clothes - such needs do not face the structural dimension that permeates health needs. There is no structuring of a care practice capable of intervening in the possible processes of economic, social and political development that produced them. However, they are interventions that approach solving the immediate problem - making the document, getting food and clothing. Thus, health needs are perceived as service needs rather than as expanded health needs[14].

In the present study, respondents valued health education as a guiding practice of care at the FHS. They are practices based on health orientation through lectures and meetings, with themes established by MoH. However, the analysis showed that the practice of the nurse as a health educator did not incorporate the political dimension[15] of education practices, the political action that involves the mobilization by social transformations, the right to health and the construction of public policies were not described.

It is highlighted that the interviewees reported practices of resistance to vertical care, using strategies such as the circle of conversation - and their commitment to approach the population -, however, these practices do not add to the social position of overcoming the hegemonic medical model, in the search for the collective, constituting of practices that focus on the determinants of the health-disease process[14].

It is important to situate the practice of the nurse practitioner in the context of the concerns that constitute the field of Collective Health through the transformation of health practices - in institutions and in society itself. The need for transformation of nurses' practices is observed in the theoretical bases that support professional knowledge and practice in the field of Collective Health, which demarcate the need for social, political and subjective transformation of nurses' practice. social determination of the health-disease process[7].

This need is also present in countries such as New Zealand, where the study emphasizes the imperative of nurses' practices based on the social context of people's lives, the structure of society and their social relations[4]. The challenges of the nurse in the consolidation of the FHS as a reorganization of the Network of Health Care in Brazil are highlighted, based on the displacement of practices focused on procedures and professionals for a practice centered on the user and its territory[14-15].

Regarding the guiding principles of nurses' practice, the reports showed that their practices are based on the support network built at the FHS, learning from the MoH manuals and the exchange of experiences with the health service user. It was not presented a theoretical reference of Nursing or other referential of the field of Collective Health that dialogue with its practice in the FHS.

In this sense, it is inferred that the interviewees' search for knowledge is based on the relational knowledge, represented by the nurses' knowledge exchange with the FHS coordinators and with the health service user. The theoretical basis of the nurse, based on the health manuals, refers to the delimitation of professional practice based on what is advocated by MoH. This fact demonstrates the perpetuation of practices with references outside the health needs of the community.

In the literature, there is a growing number of studies that examine the importance of thinking about nurses' practice in Collective Health[1-3,12-13]. However, such studies do not advance with respect to the application of models or theories that contribute to the structuring of the daily practices of this professional in the field of Health Care.

In a study carried out in the city of Vitória, Espirito Santo state, Brazil, aiming to characterize the nurses' practice in family health, it was shown that nurses perform all the actions minimally advocated by MoH, mainly directed towards curative and administrative actions[2]. In this sense, they do not perform a critical-reflexive practice on the determinants observed in the objective reality regarding the health-illness process of people, families and community.

The analysis developed in this research, by highlighting the contradictions present in the objective reality of the nurses' practice at the FHS of a municipality in the state of Rio de Janeiro (RJ), made it possible to present a critical reflection on the nurses' insertion in said strategy. Thus, the understanding that the production of care does not only occur from its singular dimension but is influenced by the structural and particular dimensions, broadens the professional view of the potentiality of its daily practice, and breaks with the process of naturalization and reception of norms and routines from health programs.

Study limitations

This research had limitations regarding the study in a municipality of the state of Rio de Janeiro (RJ), which makes it difficult to generalize the findings to other social contexts. In spite of finding potentiality in the applicability of the first phase proposed by TIPESC, in understanding and exploring the structural, particular and singular dimensions of the object studied, it did not present the development of the following phases because it did not contemplate the objective of this article.

Contributions to the sector of Nursing and Health

This study presents contributions to Nursing and to the field of Collective Health, recognizing the complexity that involves the practice of nurses in the FHS, based on the analysis of the

contradictions, convergences and divergences presented in the analysis of the collected material; by being attentive to the theoretical foundations that guide the nurse in his/her daily life; being alert to the need to reflect on the therapeutic objective of the nurse in Collective Health; and by strengthening the construction of knowledge in Collective Health Nursing by bringing to the debate the TIPESC and the reality of nurses practice at the FHS.

FINAL CONSIDERATIONS

The study showed that the nurse's practice of care in the FHS of the municipality in question has not expressed the intentionality of social transformation that points to the construction of life projects with the population. This fact is due to the perpetuation of practices that reproduce the focus on the disease from the programs proposed by MoH. Although these professionals resist these hegemonic practices when conquering practices closer to the subject of their Attention to Health, there is the appropriation, by this professional, of a referential of the Nursing or of the Field of Collective Health that supports, qualifies and instrumentalizes the care practices at the FHS.

In this research, the nurse's practice of care analysis is analyzed based on a critical attitude towards the objective reality resulting from the interviewees' speech, in such a way that it was possible to highlight the following contradictions, divergences and convergences: complexity of practices that involve the professional daily life at the FHS; little transforming care practice of social reality; role of political agent aimed at the mobilization of social groups; there is no critical reflection on the determinants of the health-disease process present in the territory assigned to the FHS; role of educator in health developed in its guiding sense; lack of systematization about needs perceived in the daily life of the community; guiding principles of care practices based on MoH determinations and municipal coordination of health programs.

In this way, attention is paid to the need for new studies to recognize the therapeutic objective of the nurse at the FHS. It means the appropriation of a critical posture against the context of the practice of care, based on studies that reveal the daily life of this professional and potentiate the critical-reflexive capacity for the health of the population. From these positions, the concern about the Nursing project in the field of Collective Health arises and the importance of reflecting on the theoretical foundations that guide the nurse in its practice.

Through this study, the need to break with the limitations of nurses' practices based on M technical manuals and the requirement of a care practice, in which the social determination of the health-disease process and its historicity were recognized. And, in this context, to concretize a social and political practice committed to the defense of health as a right of life for the population. Finally, it is necessary to move forward in new knowledge that helps nurses to reflect and act in this field of care.

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