Revista Brasileira de Enfermagem
REBEn

THEMATIC ISSUE:
CONTRIBUTIONS AND CHALLENGES OF NURSING PRACTICES IN COLLECTIVE HEALTH

RESEARCH

Primary health care: the experience of nurses

El cuidado en la Atención Primaria de Salud: vivencia de las enfermeras

O cuidado na Atenção Primária à Saúde: a vivência de enfermeiras

Marcela García Vera[I], Miriam Aparecida Barbosa Merighi[II], Claudete Aparecida Conz[II], Marcelo Henrique da Silva[II], Maria Cristina Pinto de Jesus[II], Luz Angélica Muñoz González[I]

[I] Universidad Andres Bello, School of Nursing, Postgraduate Program in Nursing. Santiago, Chile.
[II] Universidade de São Paulo, School of Nursing, Postgraduate Program in Nursing. São Paulo, Brazil.

How to cite this article:
García-Vera M, Merighi MAB, Conz CA, Silva MH, Jesus MCP, Muñoz-González LA. Primary health care: the experience of nurses. Rev Bras Enferm [Internet]. 2018;71(Suppl 1):531-7. [Thematic Issue: Contributions and challenges of nursing practices in collective health] DOI: http://dx.doi.org/10.1590/0034-7167-2016-0244

Submission: 07-14-2016 **Approval:** 08-09-2017

ABSTRACT

Objective: to understand the meaning of nursing care in primary health care from the perspective of Chilean nurses. **Method**: this was a qualitative study based on the social phenomenology of Alfred Schutz. Data was collected between January and April 2013, through interviews with 13 primary health care nurses in Chile. **Results:** the nurses perceived primary care as a gratifying experience, considering it an encounter of subjectivities. However, they felt burdened with multiple functions and by the hierarchical pressure to achieve targets. They strived to implement innovative care, expressed by the desire to go beyond traditional care practices, and improve the efficiency of management at the various levels of health care. **Conclusion**: it is important to discuss the results of the present study in the context of health care and especially nursing education, with the goal of better preparing nurses who will deliver care at the primary health care level.

Descriptors: Primary Health Care; Nursing Care; Qualitative Research; Practical Nursing; Family Nurse Practitioners.

RESUMEN

Objetivo: comprender el significado de realizar cuidados de enfermería en la Atención Primaria de Salud desde la perspectiva de las enfermeras chilenas. **Método**: investigación cualitativa con enfoque desde la fenomenología social de Alfred Schütz. La recolección de datos fue realizada entre enero y abril del 2013, a través de entrevista con 13 enfermeras de Atención Primaria en Chile. **Resultados:** las enfermeras perciben el cuidado como una experiencia gratificante considerando un encuentro de subjetividades. Sin embargo, se sienten sobrecargadas por múltiples funciones a realizar y por presiones jerárquicas en el logro de las metas. Aspiran implementar cuidados innovadores manifiestados por el deseo de superar el cuidado tradicional y la eficiencia de la gestión de los diversos niveles de atención de la salud. **Conclusión**: es importante discutir estos resultados en el contexto de la asistencia y especialmente en la formación, con el fin de preparar mejor a las enfermeras que brindarán cuidados en este nivel de atención.

Descriptores: Atención Primaria de Salud; Atención de Enfermería; Investigación Cualitativa; Enfermería Práctica; Enfermeras de Familia.

RESUMO

Objetivo: compreender o significado atribuído aos cuidados de enfermagem na Atenção Básica de Saúde por enfermeiras chilenas. **Método**: pesquisa qualitativa baseada na fenomenologia social de Alfred Schutz. Os dados foram coletados entre janeiro e abril de 2013, por meio de entrevistas com 13 enfermeiras de unidades de Atenção Básica em uma cidade do Chile. **Resultados:** as enfermeiras percebem o cuidado prestado como uma experiência gratificante, considerando-o um encontro de subjetividades. No entanto, elas se sentem sobrecarregadas pelas múltiplas funções que realizam e pelas pressões hierárquicas para cumprir metas. Elas se esforçam para implementar cuidados inovadores que possam superar o cuidado tradicional e aumentar a eficiência da gestão nos vários níveis de atenção à saúde. **Conclusão**: é importante discutir estes resultados no contexto da assistência e especialmente na formação, com o objetivo de melhorar a preparação de enfermeiros trabalhando nesse nível de atenção.

Descritores: Atenção Básica na Saúde; Cuidado de Enfermagem; Pesquisa Qualitativa; Enfermagem Prática; Enfermeiras de Saúde da Família.

CORRESPONDING AUTHOR **Claudete Aparecida Conz** E-mail: clauenf@uol.com.br

CC BY

INTRODUCTION

Primary health care (PHC) has been responsible for the implementation of the family health care model, a transformation in which nurses, with their distinct roles, play a fundamental part. At this level of care, the contribution of nurses is undeniable and has been made increasingly evident, not only in terms of performance in direct care based on the nurse-specific knowledge, but also by managing different health programs, which address each of the stages of the life cycle[1].

In the United States, a study conducted in public and private PHC institutions, including hospitals and health centers, investigated the performance of nursing in episodic and preventive care, chronic illness case management, and practice operations. The results showed that nurses contributed to improving the quality and efficiency of care delivery, and decreased cost for the healthcare system[2].

In Brazil, nurses have stood out as professionals who are directly or indirectly involved in managing and implementing the Unified Health System (SUS), with emphasis to PHC, working as members of multiprofessional teams in the Family Health Strategy (FHS). In this context, the care provided to service users is defined by practices of embracement, rapport, patient autonomy, and attentive listening. This form of care establishes a greater dialogue with users and allows nurses to identify individual and family expectations about the care provided[3].

Studies about PHC nursing have highlighted the importance of a comprehensive approach to human health, through actions that promote, protect, and recover health, emphasizing biopsychosocial aspects. Thus, interpersonal relationships should be based on caring attitudes. In this direction, when planning its interventions, nurses must include the knowledge of other health sciences that can contribute to improving care quality[4].

In the context of PHC, care is at the essence of daily nursing practice and requires the appropriation of ethical, humanitarian, solidary and citizen values. The goal is to develop new ways of practicing and delivering comprehensive health care that values users[3]. However, a study conducted in Rio de Janeiro, Brazil, showed that PHC nursing practices were mostly directed at technical-biological issues, while expressive/sensitive care was lacking. This reflects negatively on the delivery of comprehensive health care[5].

Thus, it is necessary to create models of care that can coordinate technology and the relationship between caregiver and individuals receiving care in PHC, with the aim of shifting away from the traditional biologistic and fragmented model of care to a broader approach of human beings, considering subjective and social themes. Care must be comprehensive and personal, overcoming the fragmentation of the work process and strengthening the performance of nurses, who can function as agents of social change[6].

In Chile, nursing has an important role in PHC, developing health promotion and disease prevention actions and restorative care, throughout the population's entire lifespan, including the child, adolescent, adult, and older adult population. Based on the assumption that PHC must value relational aspects, which include biopsychosocial needs, and the humanization of health care and comprehensiveness of health practices, the following research questions were posited: "What is the care delivered by Chilean PHC nurses like?", "What do they expect from the care delivered?" These questions determined the objective of the present study: to understand the meaning of nursing care in primary health care from the perspective of Chilean nurses.

Understanding the phenomenon "nurses and primary health care" will support the necessary changes both at the level of academic education and daily nursing practices, in addition to encouraging further studies on the topic.

METHOD

Ethical aspects

The Ethics Committee of the Andrés Bello University School of Nursing approved this study through protocol L1/CECENF/71.

Type of study and theoretical-methodological framework

This was a qualitative study based on the social phenomenology of Alfred Schütz[7]. This framework was chosen because it allows researchers to unveil the "meaning of human action." In the context of this study, the action in question was the care provided by a group of Chilean nurses at the PHC level. These nurses' actions in PHC intentionality are directed towards building affective relationships with users and their families to achieve mutual satisfaction. Their position at this level of care allows them to visualize care alternatives, while trying to overcome the limitations of the work context defined by the current health system.

The present study used the conceptual assumptions of intentionality, intersubjectivity, stock of knowledge and "in-order-to" and "because motives" of human action[7]. According to the social phenomenology of Alfred Schütz, humans experience the intersubjective world in the biographical situation that is defined by the stock of knowledge they experience throughout their lives[7]. The interests of people originate from the motivational relevance of specific moments and situations. People act according to motivations aimed at objectives that point to the future, known as "in-order-to motives." Furthermore, the reasons for people's actions are also rooted in past experiences and the personality they developed over time, known as "because-motives"[7].

Study location

The present study was carried out at Family Primary Health Care Centers in the city of Antofagasta, Chile. Forty-five nurses work for the municipality's PHC system, distributed among the city's six family healthcare centers.

Source of data

Participants were approached during the monthly PHC nurse meeting. The researchers informed them of the study objectives and invited them to participate.

The inclusion criterion was: nurses working in PHC since before 2005. This was important to ensure participants were familiar with both the new and the old model.

The nurses who expressed interest in participating and met the selection criteria were contacted by telephone to schedule the interview at the time and place of their convenience.

Data collection and organization

The phenomenological interview was used to register the nurses' discourse. The number of participants was not previously defined. The best place to carry out the interviews was chosen together with the nurses; however, they preferred to be interviewed at their workplace. The interviews were conducted between January and April 2013, recorded with the nurses' consent, and lasted an average of 40 minutes, being both conducted and transcribed by the researcher.

The interviews were guided by the following questions: What is it like for you to work in PHC? How do you perceive the care you deliver? What do you expect from the nursing care you provide? Interviews were identified with the letter N (nurse), followed by the number of the order of the interview (N1 to N13).

Data collection was concluded when the research questions were answered and the objectives of the study reached. Theoretical saturation[8] occurred at the thirteenth interview, after which no new meaning emerged. Thus, 13 nurses volunteered to participate in the study and met the selection criteria, providing their signed consent.

Data analysis

The material was classified, categorized, and analyzed according to the steps recommended by social phenomenology researchers[9]. The interviews were analyzed through careful reading and re-reading of the transcripts, seeking to understand the essence of the experience of Chilean nurses in PHC. Significant aspects extracted from the interviews were grouped based on thematic convergences, with the goal of apprehending the meaning of delivering PHC. Next, the categories were analyzed to understand the "in-order-to motives" and "because motives" for care actions by PHC nurses. Finally, the results were discussed in light of social phenomenology and other theoretical frameworks involving the study object.

RESULTS

The participants were all women, with a mean age of 42 years (33-58), mean time since graduation of 21 years (9 to 33) and mean time working with PHC of 17.5 years (7-31). Two nurses held a degree in public health, specialized in family health. The other nurses had generalist degrees.

After carefully reading the transcripts of each of the PHC nurses' interviews and conducting a comprehensive analysis of their discourse, the researchers obtained categories that corresponded to the "because motives," which are based on the daily lives, life history and social actions of PHC nurses. The nurses expressed satisfaction with the care they provided, as it enabled them to establish bonds, commitments, and co-responsibility with the community.

Category 1: Working in primary health care is gratifying

> *It's gratifying because I like to be with people. I couldn't imagine myself in a hospital, because it's so impersonal. PHC allows us to build relationships with people, their families, and all those around them.* (N2)

> [...] *Through promotion and prevention work, you become familiar with people and are more intimate about their problems, getting to know them better.* (N4)

> [...] *It's the most gratifying experience you can have with another person,* [...] *because here, my practice requires all I have regarding my personal experiences and professional background, acquired in university, especially in terms of public health care and human development.* (N7)

> *The work fascinates me, it's where I can most progress as a professional. I worked in the private sector for a couple of years and the difference was abysmal, I went from being just a task-doer to being able to think, plan, assess and solve problems here at PHC.* (N11)

The nurses strived to deliver care tailored to the needs of individuals, who they refused to see as objects, establishing close relationships fostered by their ability to listen and empathize. This gave them greater credibility with their patients and, thus, transformed the act of caring into a form of interaction.

Category 2: An encounter of subjectivities

> *In merely technical care, we lose the essential, the present moment. This moment will never come back, and I could have given it to my patient and we just lose the human element.* (N1)

> *I have good relationships with my patients, we go beyond the office relationship, these people are eager, all you have to do is listen and you can empathize with them* (N5)

> *I get really personal about it, I get involved in the emotional part of people.* [...] *I notice that the person who comes in is burdened, and even though sometimes they have to wait, when they leave, they feel better, satisfied, and when they come back they know what to expect and feel at ease.* (N7)

> [...] *When caring for a patient, I want them to leave as well as possible in terms of the care I can provide* [...] *a bond of trust, so that they know that they can count on me, that I can provide them with information, that they can come to me as many times as needed.* (N9)

In addition to describing their care delivery, the nurses reported work overload caused by the many different tasks they had to carry out and not knowing how to place effective limits. They recognized that they were frustrated and felt a lack of motivation because of the pressure to meet work targets.

Category 3: Work overload

> [...] *Negative points include time, schedules, too many people waiting, but I believe that, essentially, I could give more of myself, I wish I could, but I see myself pressured by the numbers and the paperwork, and that's what bothers me most of all.* (N1)

> [...] *You're inside these four walls, working, working, you never lift your head. I feel very pressured, very tired,*

overwhelmed, but even so, I stay here because I like taking care of people. (N6)

[...] *This system we are a part of wears us down mentally more than physically.* (N10)

The following categories extracted from the interviews refer to the participants' desires and expectations for their daily activities. The subjective meaning of "in-order-to motives" involves someone's experience while developing a given activity. These motives give meaning to actions and underline the intention to obtain a predetermined purpose.

The nurses wished to deliver quality and satisfactory care to service users. At the same time, to complement the care received until then, they mention different strategies and forms of care, including alternative therapies that focus on other human dimensions, thus providing more comprehensive care.

Category 4: Going beyond traditional care

[...] *I want to develop alternative medicine practices, I've never studied them, but I wish to learn and use them with our patients*. (N1)

I wish I could study alternative medicine, next year I'm going to study acupuncture so that I can complement the knowledge I already have and benefit our users. (N4)

My goal is to help people change their lives, [...] *not because of any imposition or out of fear; I think the best way to influence someone is by touching on their understanding, so they can change their behaviors, because they decided to change their attitude*. (N5)

I would like to positively impact people's health, to be able to exercise change in nursing care. (N9)

Institutional bureaucracy and the demand for meeting priority targets greatly interfered with the work of nurses who wished to provide users with better PHC management.

Category 5: Efficiency and effectiveness of technical and administrative management

I would like to spend time with my patients. One of the things I question here at PHC is that we are very bureaucratic, and it bothers me, because instead of taking full advantage of being with my patient in that instant, and being able to deliver everything I know, my time is spent filling out paperwork. (N1)

There is always something that can improve. I hope that those who are in management have knowledge about what they are doing and make good decisions, because it is important for people to have knowledge so that they can manage resources, and thus provide a quality structure within the system. (E4)

Some management teams and sector leaderships do not have the necessary skills, nor capacities. There is no effective change, and there are too many human resources, we are six nurses in such a small CESFAM. At every level, management is poor. There is so much neglect involving us [...] *we need skillful leaders, who know how to administrate, who know how to manage*. (N10)

Poor management is seen at every level. I wish we had leadership with clear guidelines. (N13)

DISCUSSION

The results of the present study shine a light on how the nurses understood the current model of PHC. In this context (in-order-to motives), the nurses perceived their work as gratifying, because it allows for the encounter of subjectivities. However, they felt burdened with the multiple tasks assigned to them and the hierarchical pressure to meet institutional targets.

A study conducted in the United States within the context of the private PHC system showed that the generation of innovative actions was indicative of professional satisfaction, knowledge employed in daily practices, and procedures based on therapeutic care and patient-centered comprehensive and decisive actions[10]. Some of these actions were also reported by the nurses in the present study as reasons to work in PHC, as well as the positive impact perceived in the lives of their patients.

Another element that generated satisfaction were the relationships built with users and family members. According to the nurses, the essence of care lies in the encounter of subjectivities, i.e., the contact that is established with users and how they perceive this bond. In line with these findings, a study conducted in Minas Gerais, Brazil, showed that professionals felt responsible for the population assisted by the family health program, not only for a given time, but throughout the patients' and their families' entire life cycle. Thus, they developed ongoing actions that went beyond the traditionally proposed health care model, creating mechanisms to deliver comprehensive and personalized care. Furthermore, they established bonds, made commitments and shared responsibility with the community under their care[11].

In this context, a study conducted in Córdoba, Spain, assessed the effectiveness of the motivational interview to improve medication adherence in patients being treated with polypharmacy in public PHC services. The findings showed that the patients who spent face-to-face time with nurses presented greater adherence to the drug treatment. Furthermore, nurses were shown to be the most indicated and competent professionals to establish actions that result in greater adherence to the established treatment[12].

Even though they felt grateful for their work, the nurses in the present study also felt work overload. Along these lines, a study conducted in the United Kingdom concluded that the public primary care services were saturated, and the professionals, overloaded. A workload reassessment was recommended along with an urgent change in primary care provision internationally. The authors emphasized that these increased numbers, in addition to administrative pressure and low professional recognition, contribute to stress generated from work overload, and impact the appeal of this career choice[13].

The interviews in the present study showed that the work of the nurses can be exhausting and that the impositions made by the health system do not usually provide adequate conditions for developing care according to the actual user needs. Similarly, a Brazilian study that assessed 17,482 family health strategy units and other primary care models associated with the National Program for Access and Quality Improvement in Primary Care (PMAC), in 3,972 participating municipalities across all Brazilian states, showed that PHC nurses developed several activities in their daily practice. In addition to delivering care, they also performed administrative and bureaucratic tasks in addition to interdisciplinary and intersectorial work. These multiple roles can overload professionals, hindering their care practice[6].

The PHC family health centers in Chile focus strongly on disease prevention and health promotion, protection, and recovery. Furthermore, nurses must carry out many administrative activities, such as heading technical programs and sectors among which health teams are distributed in the centers. Therefore, nurses are in charge of support units as well as immunization, treatment, epidemiology, emergency services, and subprograms like tuberculosis and early childhood stimulation. Considering the number of activities developed by nurses, it is important to consider PHC staff size in order to achieve efficiency of human resources and effectiveness of care plans.

A study conducted in Brazil highlighted the importance of PHC nurse staff size as a management tool, enabling not only care delivery to the population, tailored to the reality of each municipality, but also to establish the ideal and necessary number of professionals that facilitate the provision of effective health care[14]. Another study conducted a longitudinal investigation into the time used by Dutch nursing staff in long-term institutional care. By using the time-motion technique, they assessed time spent on interventions, the study recommended the implementation of adequate staff size with ongoing training as a form of optimizing available resources and the quality of the services provided[15].

In the present study, the nurses referred to the stress generated by pressure to meet targets. Even though the goal of the health targets established by PHC management is to improve the epidemiological profile of communities, they do not always favor the work process of health teams. A literature review about the nursing work process in family health showed that when work organization and division is based on nurse productivity, repeated demands, and extreme rationalization, it can lead to physical, psychic, and cognitive wear[16].

The targets required by the PHC need to be defined at the local level, as they should be based on more precise knowledge of professionals about the reality of the territory in which they work, their capacities, and existing needs. However, reality shows that this negotiation process is still far from being democratic and participative. Mostly, local teams do not have space to be heard or to discuss these issues, and they are usually considered as those who put plans into motion, without being informed about the real impact of their actions[17].

Based on personal existential motives, people usually interpret different actions from the point of view of their own subjectivity[7]. As mentioned above, the "because motives" of the Chilean PHC nurses reflected their life history and stock of knowledge in this context, which places them as being responsible for and providers of care. Special mention goes to the duality between providing care – which is gratifying because of the encounter of subjectivities between nurses and users – and the work overload to which they are submitted because of administrative tasks, important to the work process at this level of care. Thus, the motives related to expectations (in-order-to motives) were expressed as the desire to surpass traditional care, which is centered on the biomedical model, and improves the efficiency of the management at the different levels of health coordination.

The interviews showed their desire to be even closer to patients, providing them with more comprehensive care and alternative practices that go beyond the biomedical health model. An integrative literature review discussing comprehensiveness and health care and nursing, and the relationship between comprehensiveness and PHC, showed that this relationship is the key point for healthcare production, which considers the actual needs of people. This requires shifting away from the still predominant biomedical model to the social, psychological, and biological aspects of individuals. Even though the health care provided by the nurses was not completely recognized and defined as comprehensive, they strived for comprehensiveness when developing their PHC activities[18].

Regarding alternative and complementary practices, an integrative review showed that PHC nurses face many challenges when implementing such actions in their daily routine. The study showed that these treatments are important to users and their practice should be incentivized. Managers should invest in the introduction of programs that implement alternative and complementary treatments, in addition to training and qualifying human resources in the area[19].

Another study about the attitudes and practices of nurses in Burkina, Africa, showed that PHC nurses were responsible for managing and evaluating continuity of patient care. In addition to conventional treatment, their actions also included simple and decisive alternative and complementary practices at the primary care level[20].

By proposing complementary and alternative care techniques, the nurses in the present study referred to the attributed meaning of PHC, which is developed within an interpersonal professional/user relationship. This meaning provides them with the social sense that characterizes this group of nurses[7].

Furthermore, the nurses wished for care management that was not only patient-centered, but also based on the professional-user dyad.

In the United States, studies have shown that private PHC services have been evolving to provide answers to the population's health needs. Improved availability and access to patient-centered care have contributed to increasing the demand for this type of care[2].

Another study conducted in France recommended that policies must provide resources for health teams to develop successful practices and public management that includes patients in health care decision making. These changes should allow for alternative practices that meet the needs of people in a context where professionals are prepared to work as the patients' allies[21].

Studies have shown that in order to develop and apply health care, governments must establish policies that strengthen the weak points of the health system, whether public or private. At the same time, such policies must empower professionals as agents of change and the population as receivers of care[2,21].

These findings are in line with the discourse of the nurses in the present study when they referred to effective and efficient service management. A study conducted in France emphasized the need to prioritize health policies, especially in PHC. The authors discussed that the health system (universal for residents), needs to evolve in terms of adopting new procedures and sources of funding, in addition to reviewing old habits and proposing more dignified care for PHC users[21].

A study conducted with nine PHC nurses in London found that more time spent on establishing more efficient communication with users led to increased treatment adherence and expanded clinical practice. The participants gained greater professional recognition when they were allowed to spend more time in consultations[22]. These findings are in consonance with the expectations expressed by the Chilean nurses in the present study.

Face-to-face social relationships help build community relationships in which people are aware of one another[7]. In this direction, the participants expressed their desire to focus care actions directly on users, which would make administrative activities complementary to care delivery.

An investigation developed in the United States proposed the reformulation of the private nurse-designed PHC models and focused on empowering both professionals and citizens as the anchors of change. The study concluded that when nursing performance was in line with models that allow for good care outcomes, they were able to develop, expand and innovate practices and programs related to community health programs, in addition to coordinate the actions of groups working with communities[23].

Study limitations

Only one group of PHC nurses was investigated in a specific country in Latin America. Even though the findings show the meaning attributed by nurses to PHC, they are limited to the specificities of the study context. Further studies in other realities and with other participants are needed to expand the evidence, which together with the results of this study could contribute to improving patient care and nursing education.

Contribution to the nursing, health, and public policy areas

The knowledge obtained in this study provides important information that can guide actions at different care levels. Among PHC nurses, it can foster reflection among the professional group about its own practices and expectations, which they must take on as a united front and reach a consensus about decisions for future actions that lend nursing care greater visibility.

On one side, institutional authorities must make decisions to implement the family health model in its totality. Thus, resources must be allocated in a form that privileges clear and decisive actions that advance the model's development and consolidation, as required to carry out comprehensive community care. On the other side, selected leaderships must have certified managerial skills, so their decisions can facilitate care delivery.

In terms of academia, the present study provides knowledge for reflection about and innovation in nursing education. Undergraduate and graduate students can incorporate tools and dimensions of disciplinary knowledge that enable adequate PHC, including professional autonomy, comprehensive care anchored in values such as excellence and solidarity, effective communication, social responsibility that promotes equity and solidarity in the context of quality of life and safe environments, and interaction with interdisciplinary teams. Thus, ethics, care management, research and family and community health would be addressed transversely across the entire nursing program.

CONCLUSION

Social phenomenology showed that a group of Chilean nurses working in the current model of care perceived PHC as a gratifying line of work, as it allows for interactions with patients, bonds of trust, and commitments with shared responsibility. However, they were overloaded with multiple tasks. The nurses expressed the desire to provide quality care and practice alternative techniques tailored to the needs of users and thus, go beyond the traditional biomedical of care. To this end, they hoped to have efficient management at all health coordination levels, who would invest in programs that allow for more expansive and comprehensive community care.

These results must be discussed within the scope of health care and education, especially to better prepare nurses to work at this level of care.

REFERENCES

1. Marilaf CM, Alarcón MAM, Illesca PM. Rol del enfermero/a rural en la Región de La Araucanía, Chile: percepción de usuarios y enfermeros. Cienc Enferm [Internet]. 2011 [cited 2016 May 06];XVII(2):111-18. Available from: http://www.scielo.cl/pdf/cienf/v17n2/art_12.pdf
2. Smolowitz J, Speakman E, Wojnar D, Whelan Ellen-Marie, Ulrich S, Hayes C, et al. Role of the registered nurse in primary health care: meeting health care needs in the 21st century. Nurs Outlook [Internet]. 2015 [cited 2016 May 06];63(2):130-6. Available from: http://dx.doi.org/10.1016/j.outlook.2014.08.004
3. Santos FPA, Acioli S, Rodrigues VP, Machado JC, Souza MS, Couto TA. Nurse care practices in the Family Health Strategy. Rev Bras Enferm[Internet]. 2016 [cited 2017 Jul 19];69(6):1124-31. Available from: http://www.scielo.br/pdf/reben/v69n6/en_0034-7167-reben-69-06-1124.pdf

4. Salviano MEM, Nascimento PCFS, Paula MA, Vieira CS, Frison SS, Maia MA, et al. Epistemology of nursing care: a reflection on its foundations. Rev Bras Enferm[Internet]. 2016 [cited 2017 Jul 19];69(6):1240-5. Available from: http://www.scielo.br/pdf/reben/v69n6/en_0034-7167-reben-69-06-1240.pdf

5. Acioli S, Kebian LVA, Faria MGA, Ferraccioli P, Correa VAF. Care practices: the role of nurses in primary health care. Rev Enferm UERJ [Internet]. 2014 [cited 2017 Jul 19];22(5):637-42. Available from: http://www.e-publicacoes.uerj.br/index.php/enfermagemuerj/article/view/12338

6. Galavote HS, Zandonade E, Garcia ACP, Freitas PSS, Seidl H, Contarato PC, et al. The nurse's work in primary health care. Esc Anna Nery Rev Enferm [Internet]. 2016 [cited 2016 May 06];20(1):90-8. Available from: http://dx.doi.org/10.5935/1414-8145.20160013

7. Schütz A. Sobre fenomenologia e relações sociais. Petrópolis: Vozes; 2012.

8. Fontanella BJB, Luchesi BM, Saidel MGB, Ricas J, Turato EB, Melo DG. Amostragem em pesquisas qualitativas: proposta de procedimentos para constatar saturação teórica. Cad Saúde Pública [Internet]. 2011 [cited 2017 Feb 24];27(2):388-94. Available from: http://www.scielo.br/pdf/csp/v27n2/20.pdf

9. Jesus MCP, Capalbo C, Merighi MAB, Oliveira DM, Tocantins FR, Rodrigues BMRD, et al. The social phenomenology of Alfred Schütz and its contribution for the nursing. Rev Esc Enferm USP [Internet]. 2013 [cited 2016 May 16];47(3):736-41. Available from: http://dx.doi.org/10.1590/S0080-623420130000300030

10. DesRoches CM, Buerhaus P, Dittus RS, Donelan K. Primary care workforce shortages and career recommendations from practicing clinicians. Acad Med [Internet]. 2015 [cited 2016 May 10];90(5):671-77. Available from: http://dx.doi.org/10.1097/ACM.0000000000000591

11. Cardoso CML, Brito MJM, Pereira MO, Moreira DA, Tibães HBB, Ramos FRS. A vivência do sofrimento moral na estratégia de saúde da família: realidade expressa em cenas do cotidiano. Invest Qual Saúde [Internet]. 2015 [cited 2016 May 10];1:547-52. Available from: http://proceedings.ciaiq.org/index.php/ciaiq2015/article/view/125/121

12. Moral RR, Torres LAP, Ortega LP, Larumbe MC, Villalobos AR, García JAF, et al. Effectiveness of motivational interviewing to improve therapeutic adherence in patients over 65 years old with chronic diseases: a cluster randomized clinical trial in primary care. Patient Educ Couns [Internet]. 2015 [cited 2016 May 10];98:977-83. Available from: http://dx.doi.org/10.1016/j.pec.2015.03.008

13. Hobbs RFD, Bankhead C, Mukhtar T, Stevens S, Perera-Salazar R, Holt T, et al. Clinical workload in UK primary care: a retrospective analysis of 100 million consultations in England, 2007-2014. Lancet [Internet]. 2016 [cited 2016 May 16];387(10035):2323-30. Available from: http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(16)00620-6.pdf

14. Bonfim D, Fugulin FMT, Laus AM, Peduzzi M, Gaidzinski RR. Padrões de tempo médio das intervenções de enfermagem na Estratégia de Saúde da Família: um estudo observacional. Rev Esc Enferm USP [Internet]. 2016 [cited 2017 Feb 25]50(1):118-26. Available from: http://dx.doi.org/10.1590/S0080-623420160000100016

15. Tuinman A, Greef MHG, Krijnen WP, Nieweg RMB, Roodbol PF. Examining time use of Dutch nursing staff in long-term institutional care: a time-motion study. JAMDA [Internet]. 2016 [cited 2017 Feb 25];17:148-54. Available from: http://dx.doi.org/10.1016/j.jamda.2015.09.002

16. Souza Gomes LT, Silva Jr SI. Processo de trabalho em enfermagem na saúde da família: revisão da literatura. Rev APS [Internet]. 2015[cited 2016 Sep 22];18(3):390-7. Available from: https://aps.ufjf.emnuvens.com.br/aps/article/view/2123/902

17. Cubas MR. Challenges for nursing at the reach of primary health care goals. Rev Esc Enferm USP [Internet]. 2011[cited 2016 Sep 22];45(spe2):1758-62. Available from: http://www.scielo.br/pdf/reeusp/v45nspe2/en_21.pdf

18. Silva TCS, Silva SS, Gama MVA, Araujo BI. Integralidade e suas interfaces com a produção do cuidado. Rev Cuid [Internet]. 2014 [cited 2015 Sep 19];5(2):731-8. Available from: http://dx.doi.org/10.15649/cuidarte.v5i2.85

19. Araújo AKL, Araujo Filho ACA, Ibiapina LG, Nery IS, Rocha SS. Difficulties faced by nurses on the applicability of phytotherapy in the basic attention: an integrative review. Rev Pesqu Cuid Fundam [Internet]. 2015 [cited 2016 May 16];7(3):2826-34. Available from: http://dx.doi.org/10.9789/2175-5361.2015.v7i3.2826-2834

20. Diendéré J, Sawadogo A, Millogo A, Ilboudo A, Napon C, Méda N, et al. Connaissances, attitudes et pratiques des infirmiers des centres de santé primaires concernant les troubles de la déglutition chez les patients hémiplégiques dans les districts sanitaires urbains de la région des Hauts-Bassins au Burkina Faso. Nutr Clin Metab [Internet]. 2015 [cited 2016 May 16];29:253-62. Available from: http://www.em-consulte.com/en/article/1012214

21. Czernichow P. Un système de santé plus intégré pour mieux prendre en charge les maladies chroniques. Sante Publique [Internet]. 2015 [cited 2016 May 03];27(1-Suppl):7-8. Available from: http://www.cairn.info/revue-sante-publique-2015-HS-page-7.htm

22. Toso BRGO, Filippon J, Giovanella L. Nurses' performance on primary care in the National Health Service in England. Rev Bras Enferm [Internet] 2016 [cited 2016 May 16];69(1):169-77. Available from: http://dx.doi.org/10.1590/0034-7167.2016690124i

23. Martsolf GR, Gordon T, Warren May L, Mason D, Sullivan C, Villarruel A. Innovative nursing care models and culture of health: early evidence. Nurs Outlook [Internet]. 2016 [cited 2017 Jul 19];64(4):367-76. Available from: http://www.nursingoutlook.org/article/S0029-6554(16)30004-5/abstract