Building the gerontological performance of nurses in Family Health Programs

CONSTRUINDO O FAZER GERONTOLÓGICO PELAS ENFERMEIRAS DAS UNIDADES DE ESTRATÉGIA SAÚDE DA FAMÍLIA

CONSTRUCCIÓN DEL QUEHACER GERONTOLÓGICO POR LAS ENFERMERAS DE LAS UNIDADES DE ESTRATEGIA SALUD DE LA FAMILIA

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ABSTRACT
The goal of this article is to analyze the development of gerontological nurses working in the Family Health Program in a municipal district in Belém, PA. Data have been collected through interviews with 14 nurses between 08/2009 and 02/2010 and have been analyzed using the content analysis method to generate topics. One such topic is the theme of this article: building gerontological work, and the sub-topics are the following: nursing consultation, home visits, family care, and seeking partnerships for integrated actions. According to the results, it may be inferred from nurses performing gerontological tasks that work is hampered primarily by urban violence, the inefficient functional structure of services and poor specific geriatric training. However, nurses have built a special "making of gerontology" by creating strategies of integrated actions according to each new situation that has been presented.

DESCRIPTORS
Aged
Family
Gerontological nursing
Family Health Program

RESUMO
Este artigo teve como objetivo descrever como as enfermeiras percebem a construção de seu fazer gerontológico no âmbito da Estratégia Saúde da Família em um distrito de Belém-PA. Os dados foram coletados entre ago/2009 a fev/2010, por meio de entrevista com catorze enfermeiras, e tratados pelo método de análise de conteúdo, gerando temas (entre eles a matéria do presente artigo – construindo o fazer gerontológico) e subtemas: consulta de enfermagem, visita domiciliar, atenção à família, parcerias para ações integradas e atuação em ações consolidadas. Do resultado infere-se que as vivências do fazer gerontológico das enfermeiras em seu cotidiano de trabalho são dificultadas principalmente pela insegurança no trabalho devido à violência urbana, pela deficitária estrutura funcional dos serviços e falta de capacitação específica em gerontogeriatria. Contudo, elas vêm construindo um *fazer gerontológico* peculiar, criando estratégias de ações integradas, possíveis em cada situação que se apresenta no processo do trabalho, com base em conhecimentos gerais de enfermagem que advêm de formação geral.

DESCRITORES
Idoso
Família
Enfermagem geriátrica
Programa Saúde da Família

RESUMEN
Se objetivó describir la percepción de las enfermeras sobre la construcción de su quehacer gerontológico en el ámbito de la Estrategia Salud de la Familia, en distrito de Belém-PA. Datos recolectados entre 08/2009 y 02/2010 mediante entrevista con 14 enfermeras, tratados según análisis de contenido, generando temas como la materia del presente artículo: construyendo el quehacer gerontológico y los subtemas: consulta de enfermería, visita domiciliaria, atención familiar, alianzas para acciones integradas y actuación en acciones consolidadas. Del resultado, se infiere que las experiencias del quehacer gerontológico de las enfermeras en su cotidiano son dificultadas por la inseguridad laboral debida a la violencia urbana, por la deficitaria estructura funcional de servicios y falta de capacitación específica en gerontogeriatría. No obstante, ellas vienen construyendo un *quehacer gerontológico* peculiar, creando estrategias de acciones integradas, posibles ante situaciones enfrentadas en el proceso laboral, basadas en conocimientos generales de enfermería adquiridos durante su formación general.

DESCRIPTORES
Anciano
Familia
Enfermería geriátrica
Programa de Salud Familiar

* Extracted from the thesis "Gerenciando o cuidado de enfermagem ao usuário idoso na Estratégia Saúde da Família", Postgraduate Program in Nursing of the Federal University of Santa Catarina, 2011.

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OnLine Português / Inglês
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Received: 10/28/2012
Approved: 05/17/2012

INTRODUCTION

The visibility of nursing as a healthcare profession is commonly shown by the development of care for people with deteriorating health. This vision of care is often focused on the curative actions of the nurses who have worked and still work under a biological focus alone. However, in primary care, especially in the Family Health Program (FHP), a nurse working in the community, together with the family, detects factors that may cause damage to the health of elderly persons and uses interactive and proactive as well as individual and collective actions that promote healthy living and aging. Under this scenario, gerontogeriatric nursing can develop as an emerging specialty by constructing and consolidating its actions collectively with elderly users and their families. A definition of their specific care actions, which are based on the changes that occur throughout the life cycle, is imposed here to contribute to the promotion of active and healthy aging and the best quality of life for patients, while considering their different sociocultural and circumstantial contexts of life and health[1].

Caring is a dynamic process that is based on the context of the user. In the context of gerontogeriatric nursing, care must be performed in a way that is integrated with other knowledge to accomplish integration of the multiple living dimensions of the elderly person[2], which is a perspective that is referred to as interdisciplinarity. It is evident that interdisciplinarity brings no ready answers nor is it the solution to all problems of professional practice in healthcare; however, the connections and correspondences established between the various disciplines and their respective professionals make interdisciplinarity an alternative and important contribution. The efforts of gerontogeriatric nursing in primary healthcare should be directed toward the specificities of the elderly person, toward establishing relationships and toward creating links with the elderly, the family and the community while always behaving ethically. The interactive, proactive, dialogic and shared attitude is the formula to solve health problems and improve the well-being and quality of life of the users. The fundamentals of the gerontological nursing practice are expected to be guided by its main principles, which are the following: promotion of healthy living; compensation for limitations and disabilities; provision of support and control in the course of aging; specific treatment and care; and facilitation of the care process. Achieving these goals requires fulfilling the integral care function for elderly users and their families[2].

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The promotion of healthy aging emphasizes educational measures that guide the elderly and other individuals in preserving their health and improving their functional abilities through adopting healthy lifestyles and avoiding unhealthy behavior. The promotion of healthy aging also includes education regarding care and the environmental risks that cause accidents (falls), which can compromise a person's functional capacity. Monitoring the health-disease status and continuous care during the process of aging and weakening are essential to maintain the elderly person within the family and community with the best possible quality of life[2]. The advent of the Family Health Program (FHP) in Brazil in 1994, which is currently known as the Family Health Strategy (FHS), as a point of entry of the Brazilian National Health System (SUS), represented a promising moment for the gerontogeriatric nursing specialty to increase the benefits of their specific care actions in cooperation with elderly users and their families, who are the caretakers of the elderly, who age and potentially become frail, sicken and die[3-4]. However, nurses currently employed in the FHP/FHS teams are most often not specialized or trained in care of the elderly, and users are almost always found within the families. There is recognition for the effort to consolidate the SUS, which use primary healthcare as the point of entry; however, a major impasse and challenge for the managers remains in attempting to ensure the integrity and quality of care to the users in all stages of the lifecycle. The FHP/FHS team, especially the nurses and the nursing staff, works with inadequate support with respect to trained human resources and structural features, among other aspects. Studies on the working conditions and quality of the actions undertaken by the FHP/FHS teams show, in general, an inability to care for the elderly either due to ignorance of the specific care required in old age or disarticulation in the work process[5-7].

Being aware of these difficulties in specific contexts and discovering implementations for the advancement of the *nursing action* defines the research question: How do the nurses working in FHP/FHS perceive the care they provide to elderly users and their families? What are the working conditions? These questions emerged from a doctoral thesis study conducted with nurses working in a FHS in a district on the outskirts of the municipality of Belém[8]. The goal of this article is to provide answers to the research questions by describing and analyzing how nurses perceive the construction of their gerontological action in the context of the FHS.

METHODS

The study was conducted in six Family Health units of the D'Agua district in the municipality of Belém, which is an urban area with a high concentration of low-income residents. This location was chosen because the

municipality is the capital of the northern region with a large population of elderly people, 7.6% of the general population, which is above the state average (7.0%). The population in this area shows a high poverty rate, multiple health problems and only 22% coverage by FHP/FHS units[9]. This explorative, descriptive and qualitative study used open interviews with a set of guiding questions, such as the following: Talk in detail about a typical day of your work in the FHS/FHP as you attend elderly users. While attending in the HIPERDIA program, which extra actions do you perform for the elderly? When making a home visit to a family with an elderly member, which actions do you perform? Talk about the aspects that are easy and the difficulties you encounter in your work routine when attending the elderly and their families.

The sample consisted of 14 nurses who were all working in the six Family Health units of the district in question at the time of data collection. The youngest nurse was 27 years of age and the oldest was 64; the majority of the nurses had completed a specialization course: eight in Public Health or Family Health and four in the hospital area. Twelve nurses began working in family healthcare in the 2000s and two in the 1990s. Ten nurses received their degrees in the 1990s and four in the 2000s. The interviews took place between 08/2009 and 02/2010 after each participant accepted and signed the Terms of Free Prior Informed Consent (TFPIC), with one copy retained by the principal investigator and another copy delivered to the participant, who was to maintain possession of the document. This document provided information about their participation in the project and ensured the confidentiality of their identity in the study. The project followed the recommendations of Resolution 196/96 of the National Health Council, which provides ethical standards for research with humans. The project was submitted to the Human Research Ethics Committee of the Federal University of Santa Catarina and was approved under protocol No. 036/09.

The content analysis method was used to process the data by using either the thematic or categorical analysis technique[10]. The preparation of the data occurred in three stages: *pre-analysis*; *exploration of the material*; and *treatment, inference and interpretation of the results*. All the transcribed material from the interviews was composed in the form of a framework that allowed, in the second stage, *free-floating reading*, which uses the research question as the reference to identify significant statements. The constitution of the corpus was elaborated, and the four rules to validate the qualitative research were applied: *exhaustivity* –identifying the meanings throughout the reading; *representativity* - verifying whether the significant extracted statements represented the whole; *homogeneity* – determining the extent that the choice of documents showed conformity; and *relevance* – examining whether the significant extracted statements correspond to the question and the aim of the study.

In the second phase, *exploration of the material*, the units of meaning were composed corresponding to similar significant statements, which created a framework of linked themes: *constructing the gerontological action, managing problems, defiance and violence and, as the central theme, managing the nursing care of the elderly in the FHP/FHS*[8]. During the data processing that resulted from the units, grouping by the similarity of meaning within each unit determined the respective subthemes that comprised a group.

This article represents an excerpt from a larger study on *constructing the gerontological action* of the nurses of the FHP/FHS working in a district on the periphery of the city of Belém, PA.

RESULTS

In the 1990s, the SUS and especially the FHP, which later became the FHS, was implemented as the point of entry of the SUS in which nurses occupied their space in primary care and the expanded labor market. From there, they began to develop more effective nursing care for the users, including the elderly and their families; therefore, nurses constructed their professional action. The statements from the nurses in this study led us to name the overall thematic category that emerged as *constructing the gerontological action* and its subthemes: performing the nursing consultation; making home visits; providing care to the family; seeking partnerships for integrated actions; and working on consolidated actions. Thus, *gerontological action* is embodied by the elderly user care performed by the nurses that adopt methods and techniques already known and commonly used in general nursing.

• *Performing the nursing consultation* - The care process that permeates the application of the nursing consultation emerges as a strong instrument for the nurse during the care of users and represents the main strategy in the practice of nursing functions. The consultation is performed so that the nurses interact with the users and systematize their care, which encourages the users to maintain their autonomy and independence and control their health, which prevents diseases.

> In the consultation, I do a physical examination, I listen to their complaints. (...) when beginning the physical examination, with the closeness, they start talking more, starting to talk about family problems (E2).

> With the elderly users we are more careful, more cautious, we try to listen more than talk. There are elderly people who cry, talk about their problems (...) (E7, E14).

> In the consultation, I give advice about walking, eating, the importance of the use of medication, (...) (E1, E4, E5).

> (...) if they have difficulty seeing, hearing, and walking alone, I advise the person to walk with a companion, thinking about preventing accidents (E5).

The statements of the nurses reveal that the nursing consultation focuses mainly on the risk factors of the elderly, which encourages them to adopt a safer lifestyle. At this point, some nurses perceive the need for the elderly to communicate or to talk. Therefore, their action is listening. The nurses listen more than they talk and adopt a human and welcoming touch; thus, more silent or secret feelings arise, which allows the elderly person to feel welcome in the healthcare facilities. However, this gerontological action is a construction of the nurses that is guided by intuition and by the general humanistic concept of nursing. This action does not result from specific training in elderly care.

The specialized guidance of geriatric nursing has not been absorbed by the FHP nurses who attended the elderly user in the same way as any other user without considering the particularities of their age. However, due to their training, which is focused on the comprehension of the integrality of the individual, their statements demonstrate that the social dimension is sometimes considered in their quotidian actions.

> We work little with group educational actions, only guidance. The elderly people come to us with health problems. We advise them to participate in group physical activities, social activities (E5, E11).

> I advise them to attend any church group, because there they will be more inspired, to participate in activities in the neighborhood. It becomes a loving relationship, because some create a bond with us (E5).

> I advise them to read, if they like to read, to watch TV, listen to music, meet with friends, not to isolate themselves from other people (E3).

> If the person is sedentary, I advise them about the importance of walking (E1, E6).

Some nurses were already advancing and addressing the social issues of the everyday world. During the consultation, the nurses include political and social practice and encourage, perhaps even mildly, and defend the rights of the citizen.

> We try to provide the elderly with dignified care, within our limitations (E13).

> Our elderly patients and families are resigned, passive people, I say it cannot be so, I put this into their minds: I go and fight for the rights, the lack of medicines, the delay in consultations with specialists, the lack of transport to take the elderly person to rehabilitation, (...) but I cannot do this much because if they say that I did this (...) I've already seen what will happen to me (E2).

In doing this, nurses sometimes face challenges when encouraging elderly users to exercise their citizenship rights and strive to minimize the suffering of population groups that live in conditions of social inequality.

• *Making home visits* - The home visit undoubtedly provides the nurse with a good opportunity to observe. At this time, the nurse can evaluate everyday environments, such as housing conditions, family dynamics and lifestyle, which demonstrate the family routine with more clarity and allows for the early detection of needs requiring intervention.

> It is during the visit that we observe whether the home has stairs, whether there is a handrail, we advise them to stay downstairs. If there is a carpet, we asked that it be removed because the patient could slip and fall (...) if it is the elderly person who cooks, we give guidance on the use of the knife being careful not cause injury (E3).

> We observe how the elderly person is treated in the family, whether they live alone or with someone. How the family looks after the elderly person, cares about their day to day, about their hygiene, their food (...) (E6).

> (...) those who have difficulty to come here, we go to their house, we perform the care there, we advise them on what is needed, when it is a serious case we stay in the house treating them until we manage to get a bed (E5, E3). I go to the house of the elderly people who cannot get around, (...) we take our material, pressure apparatus, glucometer tape (...) (E8, E9).

> (...) we make visits to those who are bedridden (...) we go to the houses of the physically or mentally disabled people (E10).

The home visit, which is one of the cornerstones of the work in the FHS, especially assists elderly users regarding health maintenance or recuperation, the prevention of injuries in addition to those who care for frail or sick elderly patients. The nurses agree with this statement; however, they encounter many obstacles.

> Home visits are made, not often, because our unit is located in the *red zone* - with a lot of urban violence - which makes our work in the homes difficult. Furthermore, a lot of demands are made of us, whether spontaneous or planned in the unit (E4, E6).

> (...) I have elderly people in my area who live alone, don't have children, we know that the monthly visits are a priority, but we do not always make the visit, it depends a lot on the other demands and on the violence in the area (E12).

• *Providing care to the family* - In the family section of this study, the primary caregiver and other caregivers are present and recognized by the nurses.

> The family (...) in general, the women are the caregivers. They always talk about the husband, the son, about concerns they have with the family (...) (E5).

> (...) it is usually the daughters who stay at home, they are always busy, they hardly talk with the elderly person. (...) They (the elderly) feel abandoned, we always try to invite the family to talk, to improve the relationship (E11).

Another noticeable aspect is low income, which leads all family members to work to support the family and often leaves the elderly person alone or accompanied by children or other disabled family members. The link between the nurses and the family enables detection of the true sociocultural situation and family dynamics and uncovers abuse and neglect.

> The ease is because we visit the families, we have access to the homes, we work with the registered families (...). You have to monitor all these elderly people, have the medical record, have all the history of these patients, know who the family are, all their reality, both social and cultural (E3, E7).

> They come accompanied; those who cannot, a family member comes with the prescription (...) I have the medical record, I talk to find out how he is, prescribe the medication, guide the family, perform the visit at the elderly person's home (E8).

> I try to advise the family regarding hygiene, eating, but often they do not have money, because they live on the water, have no sanitation, no quality of life (E9).

> The ease is the interaction with the community, to talk with the family members, obtaining collaborators for our work (E13).

However, there are many difficulties when attempting to reconcile the precepts of the FHS with reality. The nurses consider working with families to be easy due to the family's acceptance; however, acceptance may be limited due to poor living and sanitation conditions, and the violent environment, which continually threatens the security of everyone in the community. is a large obstacle to providing quality care to the users.

> One of the biggest obstacles is the violence in the area. We can only make visits in the early morning, up to 10 and with another community health agent, preferably a man. If people in the street are agitated I do not do the visit. The greatest difficulty, to go more often to the homes, is security (E1, E2, E3, E4, E5, E10, E11).

The fear of the violent environment, which is a constant risk in the daily work of the nurses, and the absence of support on the part of senior management, cause the nurses, along with their team, to ally themselves with precarious local resources to obtain support and protection to move within the community.

> We, the team, we had a meeting with the community. In this meeting, we invited the area coordinators, the people from the community center, the police. So what was decided between us, to be able to work without suffering aggression, was: the police arrive in the morning and leave the phone number of the police that are circulating in the car. Any suspicion and they are called (E10, E6, E7).

> (...) But this was not done by SESMA (Health Department of the Municipality); it did nothing to protect us, it was us who sought some protection (E10, E6, E7).

The risks and confrontations experienced by the healthcare team affect and worry them because these risks threaten their workplace safety and compromise their performance. The nurses try to carry out intersectoral articulation within their possible governance but never in the manner prescribed by the Policies of Healthcare for the Elderly.

• *Seeking partnerships for integrated actions* - The work in the FHP gives autonomy to nurses to act in the community, and it is with this work that the nurses gain the trust and respect of the population and develop cooperative relationships.

> During the vaccination campaign, we sought help from the community. We set up our stations within the area of coverage of the teams, in schools and community centers, so that all the elderly people could benefit (E6, E7).

> Sometimes we use the community center to do a campaign with the elderly, to check the pressure, to give a lecture in the associations of the neighborhood, requesting help (E11, E12).

> From the moment the elderly person arrives in the unit and becomes sick, we care for them while we wait for the ambulance: we carry out all the procedures that are possible within our unit (E6).

> If there is a need for a medical consultation with some urgency, I call the doctor, she comes and attends the patient straight away, here with me (...); if the elderly person has a problem, the CHA will go to the house to see how the patient is, if there is any improvement (E9).

> Although the health agents are not obligated to work so directly in the vaccination campaign (...), we ask them to mobilize the whole community (E9, E11).

• *Working in consolidated actions* - The HIPERDIA (Registration and Monitoring System for Hypertensives and Diabetics) and the National Immunization Program for the Elderly are the only programs undertaken by the municipality of the present study in which the elderly person is included and where the nurses demonstrate outstanding performance. The HIPERDIA system was indiscriminately developed in its original format for all hypertensive and diabetic users without any specific guidance regarding elderly users. Even so, the nurses show sensitivity to elderly users by caring intuitively and developing actions closer to actions that are preferable for the elderly.

> I talk to find out whether the elderly person takes their medication, if they have any complaints or other problems, if there is need for specialists (E5).

> If they are obese I try to get to know their eating habits, who helps in the preparation of the meal, I try to help (...) I make the referral to the service of reference. Upon his return he comes to us in the FHP unit and this gives continuity to the care (E6).

> If you notice other needs, these are dealt with through the reference and counter-reference sheet (...) for the central appointment service (E3, E9).

In this study, the nurses empower their team and, together with the Community Health Agents, technicians and auxiliary nurses, involve themselves in actions from planning, distribution and control of vaccines to the identification of the location of elderly absentees through an active search.

> I am involved in coordinating the campaign, (...) we apply the vaccine in the unit and in homes for those who cannot get around (E1, E3, E5, E7, E8, E10, E11, E12, E14).
>
> We work hard with this issue of vaccination (...), we try to find the elderly who are not vaccinated (E2, E3, E4, E5, E11).
>
> When the goal is not reached, the actions are intensified (...) delivering vaccines (E6).

During the vaccination campaign, the nurses rarely encounter adequate working conditions in which all of the necessary resources are made available for the development of the specific actions. Among the team members, the nurse is typically more committed to the success of the campaign.

DISCUSSION

The practice of nursing among the elderly in primary care should be focused on special life and health needs and seeking to establish bonds with the family and community. Interactive, proactive, dialogic and shared attitudes are the formula to seek resources, solve problems and implement certain improvements in the patient's health. From this perspective, nursing care for the elderly would be consolidated from specific knowledge and skills encountered in daily practice. Specifically, in the FHS, nurses working in the community together with the families have the opportunity to identify multiple factors that influence the health of elderly people and to develop actions that promote healthier aging[2-3]. Such ideas are far from being practiced by the nurses working in the FHP/FHS and participating in this study, as observed in the *gerontological actions*. This observation reveals the gap between the academic and practical field and demonstrates failures in the formation and specific training of the nurses throughout their initial training as well as in continuing education.

Among the various *actions* of the nurses in this study, the practice of the *nursing consultation* stands out as part of the methodology of the nursing care systematization. This instrument is integrated into their professional action because it has been some time since the nursing consultation was legitimized by the Law of Professional Exercise and regulated as the exclusive activity of the nurse[11]. The nursing consultation has also been favored to intervene in the social dimension because nursing, as a social practice, has expanded its action and makes connections between the social determinants and the health/disease process by considering the user as a participating subject within their social context. However, the incorporation of novel work concepts that are focused on the family in the context of FHP is a challenge in daily practice.

A study of care concepts found in the doctoral theses of a post-graduate program in nursing defended between 1995 and 2005 identified a prevalence of nursing actions based on technical performance and fewer proactive social intervention actions[12]. This evaluation confirms the findings of the present study in that nurses promote citizenship, especially among the elderly, by exploring concrete actions for the social issues encountered.

Although the nursing consultation has been used as an instrument by nurses in the FHP/FHS, it does not completely address the multidimensional needs of the users and the specificity of intervening actions with regard to elderly people and their families. In the context of a community, the nurses act much more intuitively rather than applying geriatric nursing knowledge and claiming that they lack training.

The *home visit* is already practiced and perceived by the nurses as an important instrument that allows nurses to establish a relationship with and be accepted by the family as well as to provide care for the families of the elderly people, without the specificity that gerontological care requires. This finding confirms that the home visit has been taught and practiced since nursing was recognized as a profession[13]. The nurses appeared to perform home visits with ease when following the dictates of the FHP/FHS[14-15], drawing on general knowledge and skills learned in academic courses. Another major difficulty reported by nurses when carrying out home visits of families with elderly members was the environment of urban violence that is prevalent in the poor peripheral neighborhoods of the city under study. This violence endangered the safety of all and restricted the freedom to come and go in the community. A similar situation was observed in a study performed at a primary care unit in a poor community of Rio Grande do Sul[14], which motivates the authors to emphasize the need for urgent political action with cooperative efforts to resolve the issues that prevent or impede the quotidian action of healthcare services being provided to families and to the community.

Amid these difficulties and others, the nurses are *making partnerships for integrated actions* using the precarious resources from the surrounding community and are developing cooperative relationships with members of the work team. A similar situation can be observed in several national studies concerning the work of the FHP/FHS units[7-8,16]. For example, in a study of the FHS in Belém, the nurses, because of the deficiencies of care and because they find themselves under pressure to care for an elderly user in a critical and urgent situation, rely on the *relationship of citizenship* using co-workers and workers from other units or services to make sure their *their* user is treated. The nurse, being an essential professional in the FHS team who is almost always present in the units established in the country, relies on the camaraderie with colleagues to treat users in the most critical situations, especially when encountering great difficulty, as in the situations presented in this study, or when unable to create formal partnerships.

In programs undertaken by the Municipality, nurses have already encountered rare working conditions when *working on consolidated actions,* such as the HIPERDIA program and the National Immunization Program for the Elderly's campaign against influenza, which is a timely action held over a limited period determined by the Health Ministry for which resources are widely available. In the HIPERDIA program, because it is a continuous system, the working conditions differ between the units according to the resources allocated. The nurses in this study demonstrated their action in the program with general care to the participants with little discrimination of the specific care required by the elderly. Regarding the vaccination campaign, the nurses work on a team leading the action against influenza in the elderly and are perceived as active members for excellence in the success of this vaccination campaign. Observations of the practice have demonstrated these results as have the findings of a study conducted in a municipality of São Paulo, which showed that nurses work in the administration by planning and executing actions[17]. This campaign, however, has received support from the Health Ministry[18] where the agenda for the mandatory annual performance in the month of April does not suit the regional climatic peculiarity of the North especially in Pará where, during the wettest period, which is between January and March, the elderly become more vulnerable to the flu.

CONCLUSION

In summary, the nurses of the Family Health Strategy Units in the district of Belém encounter difficulties in their work process, such as the following: a) incomplete functional infrastructure for the services; b) the lack of specific training and continuing education in gerontogeriatry; and c) insecurity to come and go to work due to the prevalence of urban violence in the attached territory.

Regarding the performance with the elderly users and their families, the nurses managed to achieve the following: a) show more competence when working in consolidated actions, such as HIPERDIA and the National Immunization Program for the Elderly, which demonstrates that, when resources and conditions are available, their work is performed with commitment and with relative success even without specific training and b) even with all the daily difficulties encountered, the nurses have constructed a specific *gerontological action* by providing nursing consultations and home visits, taking advantage of everyday experience and basic knowledge acquired in university courses. With the knowledge of social practice, the nurses articulated partnerships between the team, the users, the community and the services present in the described area, which created strategies in every situation for possible integrated actions that circumvent the prevalent fragmentation of care.

From the results, it appears that the experience of the gerontological actions of the nurses in Family Health Strategy Units highlights the need for a fairer allocation of trained human resources through continuing education as well as the provision of the minimum infrastructure necessary for proper functioning of the services. The efforts and political will of the municipal health managers should reevaluate the current operating system and negotiate the necessary agreements to provide and prioritize programs that the local population requires, including healthcare for the elderly.

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