



Nurse's actions in the interface with expanded services of Family Health and Primary Care Center

Ações do enfermeiro na interface com os núcleos ampliados de Saúde da Família e Atenção Básica

Las acciones de los enfermeros en su interacción con los núcleos ampliados de Salud Familiar y Cuidados Básicos

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ABSTRACT

Objective: To understand the actions of nurses from the perspective of the interface of performing with the Expanded Services of Family Health and Primary Care Center. **Method:** Qualitative participatory research based on the Freirean Itinerary, from the following steps: thematic research; encoding and decoding; and critical unveiling. The information was obtained through four Culture Circles, with nurses from Family Health teams, between April and June 2018. **Results:** A total of nine nurses participated in the study. Among the generative topics emerged, there is the "relationship between generalist teams and the health center: nurses as a reference and interprofessional bond". Nurses perceive themselves in this way because of generalist and managerial training. Shared activities as groups are among the practices developed collectively and that strengthen interprofessional work. **Conclusion:** By provoking reflections on autonomy and the work process in collaborative performance with the Centers, the study expanded the perception about the actions developed by nurses in the interaction with the multiprofessional team. It is suggested to carry out other studies on interprofessionality in the relationship between nursing and the extended services through the perspective of the Center professionals.

DESCRIPTORS

Primary Care Nursing; Patient Care Team; Healthcare Models; Integrality in Health.

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INTRODUCTION

Education is a collective and permanent process that makes it possible to reflect and act to change contexts. The importance of critical reflection on daily work in the health area lies in awareness and commitment to change, caused by the dialogue among its protagonists⁽¹⁻²⁾.

The Family Health teams (FHT) comprise the human capital of Primary Care (PC), composed of physicians, nurses, nursing assistants and/or technician and community health agents (CHA)⁽³⁾. It is assumed that this team is adequate to attend the attributes of integrality, longitudinality, in addition to contributing to the resolution of PHC. This can be enhanced by the general training of professionals, who develop actions, such as diagnosis of the territory, to plan interventions aimed at disease prevention, health promotion and clinical care⁽⁴⁾.

In order to expand the PC scope and intervene on health problems and needs in different territories, the Ministry of Health created the Family Health Support Centers, named, through the new National Primary Care Policy (NPCP), Expanded Services of Family Health and Primary Care Centers (PCC – in Portuguese Nasf)^(3,5).

The basic assignment of PCC is to offer support to the FHT through clinical and pedagogical support, in line with the concept of matrix support, a strategy aimed at sharing knowledge and practices of professionals with different knowledge with the FHT (generalist team). Matrixing occurs when demands emerge that require specific knowledge to plan interventions. Authors⁽⁶⁾ consider that this diversity of professions that can be integrated with generalists provide PCC the possibility to perform interprofessional activities, considering the knowledge of the specific centers of each profession and the field of knowledge of collective health. The concept of interprofessionality, combined with Interprofessional Education – IPE, converges with the perspective of coordination of care and longitudinality by incorporating actions such as teamwork, negotiation of decision-making processes, collective construction of knowledge, respect for differences and singularities⁽⁷⁾.

When acting as a bond among the municipal institution, the team and the community⁽⁸⁾, nurses from FHT perform individual and collective care for different population groups and include in their scope of actions the management of teams, prevention, promotion and care. Therefore, they have a training that prepares them for comprehensive care for human beings from the perspective of social determination of the health-disease process, focusing on the needs of people, groups and communities. This generalist, humanistic, critical and ethical-legal training, in different points of care, provides nurses the possibility of working with integrality and resolvability in the scope of PC⁽⁹⁾.

Considering the nursing work at the FHT, in interface with PCC, interprofessional practices emerge as a necessity for the success of this partnership. Studies⁽¹⁰⁻¹²⁾ point to a lack of interprofessional performance among PC professionals, precisely because of the difficulty of collaboration and interaction among knowledge centers. The authors problematize the lack of guidance on how PCC professionals should operate, whether in individual and collective clinical-care support or in technical-pedagogical support.

There are not many studies regarding the direct relationship between nurses and professionals at PCC, however, Vasconcelos and collaborators⁽¹³⁾ identify a marked capacity of nurses to act in the logic of matrix support because they have a profile that articulates interprofessional work and because this logic offers assistance rear in health services. The roles assumed by nurses in PC suggest that these professionals have relevant interference in the various points of care, both in bureaucratic issues and in work relationships, which largely determine whether the Centers will fulfill with the prerogatives of interprofessional team work or not, making matrix support effective⁽⁴⁾.

Investigations on the role of nurses in PC and their interprofessional practices with PCC are fundamental for understanding and consolidating actions that favor comprehensiveness and resolvability. Thus, this study aims to understand the actions of nurses from the perspective of the interface of performing with PCC.

METHOD

TYPE OF STUDY

Qualitative participatory research.

This is an excerpt from the research “Nursing care and management as knowledge in the field of primary care: propositions for good practices”, carried out in partnership with the Brazilian Nursing Association – Santa Catarina Section (ABEn/SC). As a methodological strategy, the Freirean Itinerary (FI) was used, which is based on a liberating pedagogical perspective, conducted through dialogue and horizontal relationships, which favors the understanding and visualization of what is hidden from social context, causing reflections among the participants, who instigate action proposals in the professional daily life^(1,14-16).

The FI involves three stages: (1) thematic research: it aims to discover the vocabulary universe of the participants, words and topics of their daily lives, giving rise to the generating themes (GT); (2) encoding and decoding: seeks the meanings of GT, allowing to expand knowledge and awareness; and (3) critical unveiling: it portrays the reflection of what was proposed in the objective encoding, in order to interpret the context and its possibilities of intervention, reducing the themes, that is, dividing them based on the participants' interest⁽¹⁶⁾. The stages of the FI were developed through the Culture Circle (CC), a place for learning and sharing knowledge, in which the researcher and participants dialogue about the context and collectively identify possibilities for intervention^(1,14-16).

SETTING

The study was carried out in the city of Chapecó, located in the western region of Santa Catarina, in Brazil, and it has 26 Family Health Centers (FHC) with a total of five teams from PCC, and 47 (forty-seven) FHT.

The inclusion criteria of the participants were the following: being a nurse at the FHT; having a relationship with PCC; and working in this role for at least three months. This minimum time was chosen considering the total number of participants,

possibly absents and on leave people. Those who were on leave for any reason during the period of data collection were excluded.

With authorization from the Health Secretariat, invitations for nurses to participate in the CC meetings were sent to the FHC e-mails, in addition to a summary of the research project. Telephone contact was made to reinforce the invitation and confirm their participation. Of 16 invited people, a total of nine nurses (women) accepted and participated in data collection.

DATA COLLECTION

The three stages of FI, by Paulo Freire, were permeated by the investigation of GT and occurred through four CCs, carried out at the University, between April and June 2018, with an approximate duration of two hours, with an average of five participants in each meeting and three researchers. The dynamics and flexibility of the CC allows them to be carried out with a small and irregular number of participants, respecting the approximation between the group and the limit situation⁽¹⁵⁾ (obstacles that interfere in the lives of individuals and that need to be overcome), so that it becomes a possibility of collective interest. Epistemological rigor is processed through constant dialogue and deep reflection on the context, critical awareness and the unveiling of limit situations⁽¹⁶⁾. Such performance was observed by the growing participation of nurses in the process, their critical stance and the ideas referenced as possibilities for daily intervention.

In the first CC, a total of 22 GT, which illustrate the role of nurses in the city, emerged from dialogue, such as: inter-professional relationships; role of nursing, etc. In the second meeting, the investigated GT were debated, initiating the stage of encoding and decoding. Through cards on a panel, the participants identified the order of priority for the discussion of GT, always considering the next meeting. From the dialogue, the participants understood that, of the identified GT, a total of 16 of them could be encoded and decoded, being the most representative of their context. In the last CC, in a continuous process of action-reflection on the context, the participants unveiled four main topics, one of which converged on the interface of the nurses' work with the PCC teams. These GT, problematized by using references from the field of collective health, allowed a new outlook at the phenomenon.

Notes about the meetings were made in a researcher's diary, and an audio recording was also carried out, guaranteeing the entire record of information. After each CC, complementary

meetings were held among the researchers to reflect on the topics and to discuss the conduct of the next meetings.

DATA ANALYSIS AND TREATMENTS

Due to the theoretical-methodological framework recommending a dialogical, critical and participatory process, the analysis occurred concurrently with the production of information. In all stages of the FI, the researchers transcribed the audio recordings and organized the material produced. They read them, seeking to systematize the information in order to obtain the thematic reduction and present, in an organized way, to the participants at the beginning of each new meeting⁽¹⁵⁾. The significant themes of each meeting were identified, relating them to the objective of the study. The highlighted themes guided the reflection in order to decode the identified GT. Decoding was made possible by re-reading each of the final GTs, in a collective practice of resuming the records that originated them and reflecting critically, in search of awareness about the experienced context. Among the final GT, this study focuses on the GT "nurses as a reference and interprofessional bond".

ETHICAL ASPECTS

The study was developed according to the guidelines of Resolution N. 466/12, of the National Health Council for research on human beings, with an approval by the Research Ethics Committee (2.380.748/2017). Also, in the first meeting, the topic and objectives of the study were exhibited and the Informed Consent Form (ICF) was presented. To guarantee anonymity, the participants were identified with names of creatures from Greek mythology, according to their choice, at the first meeting.

RESULTS

In this study, one of the GT that emerged from the research will be discussed: "Relationship between FHt and PCC: nurses as a reference and interprofessional bond". In order to value the Freirean Method as an educational and liberating action, the results that originated this theme will be presented in the context of its production during the CC. Chart 1 illustrates the results of the steps followed to reach the critical unveiling of GT. As can be seen, it consists in the conscious description of the context and its change possibilities.

Chart 1 – Itinerary for the preparation of GT: nurses as a reference and interprofessional bond – Chapecó, SC, Brazil, 2018.

Generator Theme (GT): nurses as a reference and interprofessional bond	
Encoding	Decoding
<ul style="list-style-type: none"> Nurses as a reference for the FHt and PCC; Dialogue as a conflict mediator; Users need an interprofessional look; Nurses can be resolute in PC; Nurses need to look at PCC as a team that enhances work in PHC. 	<ul style="list-style-type: none"> Nurses: professionals who discuss cases, organize the team and the physical structure to work with PCC, have general training and can act interprofessionally; Nurses develop a comprehensive look at the user and the community, which facilitates the identification of the individual/group that needs the PCC intervention; Nurses practice shared management with all FHt professionals, therefore, they need to value themselves as a professional.
<p>Critical unveiling</p> <ul style="list-style-type: none"> Nurses can foster in the FHt the habit of sharing with the PCC cases of the unit to think about interprofessional actions, strengthening the relationships between PCC and FHt and identifying potentialities and weaknesses in this process. 	

THEMATIC RESEARCH

The first stage of information production was essential for the study objectives to be achieved and ethical aspects to be fulfilled. In the first meeting, the objective was to get to know the nurses participating in the study, build bonds, trust and identify emerging issues that would give rise to GT. Therefore, it was necessary to enter its vocabulary universe through triggering questions: 1) what is the role of nursing in their working relationships with PCC professionals? 2) how to propose practices that favor interprofessionalism in the relationship with PCC? Among the speeches of the nurses who gave rise to GT, one highlights those that illustrate the prominent role of nursing in the context of the relationship established between FHt professionals and PCC professionals:

(...) it's the nursing staff that uses PCC the most (...) we always end up using them more than the physicians (...) (Aphrodite).

However, when the approximation with PCC does not work collaboratively, in the opinion of nurses, this can generate overload and make them distance themselves from their duties to help them, which means meeting demands which are PCC attributions, or even collaborative ones. Thus, they identify what would be necessary to change this context towards interprofessionalism:

(...) Who is Primary Care focused on? The nurses. Everything is the nurse. There are a lot of things left to do (...) normally, I help them (...) even though I can count on PCC, it's often us who have to lead groups and other services that should be led by them (Artemis).

Take consciousness. Because we have to perceive ourselves as a profession that has its duties - which aren't few - and we don't have to help them. So, we have to learn that (...) learn how to say no (...) to work "together" and not simply pass the problem on (Gaia).

Problems emerged from this relationship between nurses and PCC that, although the participants believe it is positive, it has eventual conflicts. However, they highlight dialogue as a tool for solving relational problems and the Human Development Group (HDG) (service created in the city that trains professionals to conduct Interactive Groups offered to PHC users) as a space that promotes processing and the proper handling of conflicts:

Sometimes we argue [conflicts occur], but then, as we do the HDG, we think: what's your part of it and what's my part of it? What's yours and what's mine in this relationship? What are we projecting on each other? And, then, we work on it until we understand what each one is trying to improve at that point (Artemis).

(...) the idea is talking about what is causing [conflicts] so we can solve it (Themis).

From these speeches, some initial themes emerged, such as: the nurse as a reference for the FHt and for PCC, and the dialogue as a mediator of conflicts. In the next meetings, they would give rise to the generator theme addressed in this study.

ENCODING AND DECODING

The second meeting was dedicated to the encoding of GT, during which nurses' considerations were resumed from a compilation built with the answers to the triggering questions.

The problems encountered during the meetings, extracted from the limiting situations, understood as challenges for the effectiveness of interprofessionalism in the context of nursing in interface with PCC, were transformed into GT and presented in cards distributed in the room for encoding. Nurses were instructed to choose two themes that they considered appropriate to be discussed. They considered the cards to be mirrors of their context, as they reflected the experienced strengths and weaknesses, and did not want to include other themes or unite them.

Then, they were encouraged to read the selected GT and express the reasons that led them to define it as indispensable for the study. At that moment, the most relevant issues from the previous meeting came to the conversation and the context was highlighted. The following speech is an example in which the nurse codifies the context and observes the challenge that is shown in the interprofessional work:

(...) This issue of the role of nursing in relationships with professionals from PCC is a challenge. What is our challenge? (...) keep going, establishing relationships to discover, little by little, what are our weaknesses, our potentialities and the achievements with PCC (Demeter).

The idea that nurses would behave as a kind of support, reference and leadership for PCC emerged, bringing this team closer to the FHt and working in a shared way:

(...) as nurses are usually the leaders, then, they end up being the reference: who will take the lead in a group? It's usually the nurses. Who will call the population? the nurses do it (Persephone).

We play this role of reference a lot, both for FHt professionals and for PCC professionals. I realize that we see the cases that can or should be referred to PCC more easily (Gaia).

Nurses, along with PCC professionals, discuss cases, among other activities that may involve interdisciplinary work, which characterize matrix support. They highlight the moments of knowledge sharing among professionals, as well as the comprehensive look at the user. The following speeches illustrate these findings:

Sometimes PCC comes and proposes something to us, and at other times, the conversation flows from both sides. Not with all professionals, but with some of them who are more participative (Persephone).

What we try to see is beyond the disease. The hypertensive patient, he is João, we try to see him as a whole and add everything we have from the mechanisms available in the unit to improve the care provided to that person. I think nursing has this ability to add and further enhance the service (Demeter).

The participants reflected on these situations and their role in that context, no longer naively, but critically to support awareness in order to become agents of change. From

the choice of GT, the most relevant situations were determined, which required further investigation.

In the third meeting, the themes were resumed, compiling them and giving rise to meaningful discussions, in order to change them into a more comprehensive GT. The propositional questions, presented in the first meeting, were transcribed in cards and used as a basis for dialogue. The researchers offered printed texts on the PCC Guidelines, the new NPCP and scientific articles, making available to the participants the reading of selected excerpts and free dialogue, in a circle, in order to discuss and continue the encoding and decoding process. With support in the theoretical material, nurses reflected on their practice, bringing daily situations to the group and thinking about strategies that could strengthen and even change some aspects of their relationship with PCC:

The importance of valuing the PCC professionals starts when we perceive them as potential and organize an adequate place for them, inside the unit. (...) it's really difficult for them. It seems they're everywhere, looking for a place in the unit to attend that will not disturb anyone (Gaia).

(...) it's time for us to stop, reflect and start doing our things and articulate with PCC in a different way (...) with my PCC, we have been talking through WhatsApp and other means of communication (Artemis).

When reflecting on the expression of their performance as a reference between FHt and PCC, nurses identify the reasons that lead them to become protagonists in this relationship. They decode the context, highlighting issues related to nursing training, which prepares them to work as a team:

Why do nurses are bonds? What is our training? What are our duties? (...) I think it comes from our training, from looking at others and seeing them as a whole so that we can manage. Nurses have to deal with everything that happens because we have this ability (...) this is our reality; we're prepared for that (Artemis).

CRITICAL UNVEILING

In the context's critical unveiling stage, held in the last meeting, phase of questioning or thematic reduction, awareness is developed through concepts. Thus, the analysis of the speeches meets the understanding of nurses on teamwork and interprofessional performance, which legitimizes the encoding and decoding made by the group, considering the role of nurses as a bond, for skills proper to the profession, among which is welcoming others:

When I work with Demeter, I'm more than Artemis, I'm Artemis and Demeter, that's what I am! This perception of having compassion, I don't know if I can express what I feel into words, but it's this movement, of us being able to welcome others in the work management process (...) in [name of FHC], there are forty more people to work with me, come on, let's welcome everyone (...), look at all of them, not just ourselves (Artemis).

(...) what calls my attention is the role of the receptive nurse, I think it's the profession that welcomes other professions. Nursing is a big mom, isn't it? (Demeter).

The speeches demonstrate the awareness process, which resulted from the procedural moments of dialogue and reflection. Regarding situations that overload or oppress nurses in the context of PC, they reflect on their autonomy and recognize the importance of delegating functions, in addition to the role of the university, highlighting the CC and the Professional Master's degree in Nursing at UDESC (Universidade do Estado de Santa Catarina) as places that enhance reflection about the practice:

(...) I believe in the division of things. I think we can do it, we just have to start little by little, talking to the other professionals. As we end up commanding the team, I think we can delegate some functions (Persephone).

And as the university is important in this process (...), if we didn't have this CC and the Master's degree, we would have limited our dialogue much more. So, how important is this movement that takes us out of the unit, care and daily routine, so that we can reflect and try to improve (Gaia).

From these analyzes, it is noted that, in the context experienced by nurses with PCC, there is a supportive relationship, which is like a bond, bringing together and favoring the performance between the teams of professionals of the FHt and PCC. Thus, nurses unveil some of their actions at the interface with the PCC. They perceive themselves as supporters of the Centers, especially due to their training, which includes managerial and leadership aspects and their vocation for comprehensive care. In addition, they recognize joint actions carried out in their daily work and how they contribute to this relationship to evolve towards interprofessionalism:

(...) they also learn from us. We work as multipliers. PCC professionals provide individual assistance, but we also provide assistance shared with them. We gather and assist a person, discuss the cases (...). (Artemis).

Sometimes I come across a situation. Before referring, I talk [with the PCC professional]: what do you think; do you think you can collaborate with something, or not? If it doesn't work out, I invite the person to a shared visit (Gaia).

When discussing on what are there in the literature about PCC's duties, the participants became aware of places in which clinical and pedagogical support between teams takes place and how much these tools contribute to daily work:

We found, here [in the literature], examples of support actions [that should guide the work of PCC]: discussion of cases, joint care or not, inter-consultation, joint construction of therapeutic projects, permanent education, interventions. Gaia spoke about shared consultation and these are moments of matrix support. (Hera).

It is noticed, from the collective reflections, that the perceptions about matrix support opened up and what, initially, was understood, in the nurses' universe, as a synonym of collective activity, becomes a broad technology that encompasses different activities, which permeate the matrix support of PCC to the FHt and, therefore, to nurses.

DISCUSSION

FHt nurses perceive themselves as influential in a relationship between PCC and FHT, in which they act as a reference and as a “bond”. The study reflects on the protagonism of nurses, as well as on their ability to carry out comprehensive approaches with a regard to the resolvability of PC. They perceive their condition to establish relationships of trust among themselves, FHt and PCC, recognizing themselves as a support for the Center in management and also in care. This aspect is related to leadership and generalist training, in addition to the managerial functions they occupy in PC spaces. Studies demonstrate⁽⁷⁾ that nurses, admittedly, have been leading the FHt, occupying the role of manager in more than 80% of Health centers in small cities in southern Brazil.

The nursing work process in PC has a perspective of performance based on the dimensions: care, management and education. Regarding the first dimension, the nursing care needs, direct health care and clinical practice of nurses are identified as an object of intervention. The management dimension, on the other hand, integrates the activities of work and personnel organization in nursing, which requires a participatory, communicative and integrated professional⁽¹⁷⁾. The educational dimension permeates the other two. Thus, the complexity of the manager's work in PC is clear, due to the need to articulate these dimensions, contrasting what is indicated by the new NPCP⁽³⁾, which highlights that the manager must ensure health planning, the organization of the work process, coordination and integration of actions and, therefore, preferably, should not be part of the teams linked to the Health Unit.

Interprofessionality, although it was not a concept that was deeply explored in the meetings of the CC, it emerges as a possibility to integrate knowledge from the different centers of the professionals who are part of the teams (generalists and specialists) through affection, when organizational and collective conditions are offered that include subjective aspects of these actors. Such care comes from nurses' reflections on welcoming others to work and promoting their well-being, in the case of PCC, through dialogue and sharing of cases, as well as in the organization of an appropriate place in the Health Center to carry out collective and individual activities relevant to the Centers. These designs are in line with the welcoming, an important component of care in PC, whose meaning attributed by the participants is the same pointed by authors⁽¹⁸⁾ and converges, among others, to the ambience and the expansion of accessibility to services.

The IPE aims to build knowledge in the collective through dialogue and respect for the inherent differences in a group of professionals, with regard to work and the knowledge of each one. The specific skills of the professions are considered, as well as those that are collaborative, for which tolerance and negotiation are imperative⁽¹⁹⁾. Thus, matrix support emerges as a possibility to collaborative practice among professionals. Shared consultations, case discussions and group activities are highlighted. The results reflect the

nurses' understanding that the support function does not underestimate the specialized clinic, an idea envisaged for matrix support by the precursor to the PCC proposal⁽²⁰⁾, problematized since the 1990s. Both (support to teams and specialized clinic) constitute matrix support and, thus, PCC occupies a place that performs the intersection between PC and secondary care, as it performs functions in these two points of the network^(4,6).

There is an understanding of the responsibility of each person in the shared place that permeates PC. This recognition causes situations to be solved through problematization, dialogue, considering the different worldviews, in order to build and deconstruct utopias, for the liberation and resolution of the problem⁽¹⁾. This prerogative converges with the guidelines that establish that PCC, along with FHt, must learn to solve problems through communication, so that the unique skills of each one are shared⁽³⁾. In this study, the relationship seems to move towards an interprofessional perspective, as it makes clear that there are moments, in the daily work routine, that stimulate the shared and interactive learning process from the perspective of the collaboration of those involved in which the nurse's autonomy stands out^(10,12,19).

Nurses have the ability to provide assistance in a different way, as they understand that the focus is in the users and their singularities, intrinsic to the history of life, culture and values, in a certain context⁽⁷⁾. However, difficulties are also highlighted in interprofessionality, as nurses are not always able to establish collaborative relationships with PCC professionals. Thus, they recognize the importance of expanding communication and dialogue strategies.

In seeking to guarantee universality of access, comprehensive care and the interdisciplinary approach, carried out by multiprofessional teams to attend users and families, regarding their individuality and complexity, the FHt is considered the most significant technological innovation in the scenario of PC⁽²⁰⁾. Therefore, the FHt, when implemented in Brazil, required changes in the work process of the teams, contributing to the significant increase in workloads and the consequent need to adapt to the teams. This is justified by the joviality of the proposal to accompany the teams in the country, which corroborates the literature that expresses that, with the emergence of a technological innovation, this process generally increases the workloads, because the beginning of a job requires new knowledge and skills⁽²¹⁾.

Another important skill in nursing management is that all subjects know how to participate in decisions, a consistent idea with the one of shared management in health. Thus, the interface between PCC and the nurses from the FHt produces effects that are related to the concept of co-production of health, anchored in the co-management of everyday processes, which allows a collective action, in which decisions are made and priorities are defined. The concept of co-production, supposing the professional performance of a subject under pressure from different reasons, is betting on changing⁽²²⁾.

The study participants mentioned the HDG, which collaborates with the development of individual professional skills and, according to nurses, is also a place for conflict resolution. This type of Interactive Group (IG) is inserted in social psychology and proposes reflection on the relationship between individuals and their environment, the way people think, affect and relate to each other. The IG are supported on a tripod, with complex thinking being one of the supports⁽²³⁾. Among the principles of complex thinking, organizational or systemic is that which links the knowledge of the parts to the whole knowledge. Thus, it refers to the importance of each one in the team, and of the team for each one of its members.

There is a need to consider that, in the design of this study, aimed at understanding a context with peculiar characteristics, there is a limitation in the generalization of the results and, although the option to consider the nurse's perspective, a dialectic analysis of the studied phenomenon was not offered, also considering the point of view of the professionals from PCC. Thus, one suggests further studies to be carried out on movements towards interprofessionality in the relationship between nursing and PCC, from the perspective of these professionals. In addition, it is important that nursing reflects and asserts its role, gaining appreciation in health institutions, with regard to the responsibilities assumed in the various places in which it operates.

RESUMO

Objetivo: Compreender as ações do enfermeiro na perspectiva da interface de atuação com o Núcleo Ampliado de Saúde da Família e Atenção Básica. **Método:** Pesquisa qualitativa de caráter participativo pautada no Itinerário Freireano, a partir das seguintes etapas: investigação temática; codificação e decodificação; e desvelamento crítico. As informações foram obtidas mediante quatro Círculos de Cultura, com enfermeiras de equipes da Saúde da Família, entre abril e junho de 2018. **Resultados:** Participaram nove enfermeiras. Entre os temas geradores desvelados, desponta a “relação entre equipes generalistas e os Núcleos: enfermeiros como referência e elo interprofissional”. As enfermeiras percebem-se dessa maneira por conta da formação generalista e gerencial. Atividades compartilhadas, como grupos, estão entre as práticas desenvolvidas coletivamente e que fortalecem o trabalho interprofissional. **Conclusão:** Ao provocar reflexões sobre a autonomia e o processo de trabalho na atuação colaborativa com os Núcleos, o estudo ampliou a percepção acerca das ações desenvolvidas pelas enfermeiras na interação com a equipe multiprofissional. Sugere-se a realização de outras pesquisas sobre a interprofissionalidade na relação entre a enfermagem e a equipe ampliada mediante a ótica dos profissionais do Núcleo.

DESCRITORES

Enfermagem de Atenção Primária; Equipe de Assistência ao Paciente; Modelo de Assistência à Saúde; Integralidade em Saúde.

RESUMEN

Objetivo: Entender las acciones del enfermero desde la perspectiva de la interacción con el Núcleo Ampliado de Salud Familiar y Cuidados Básicos. **Método:** Investigación cualitativa de carácter participativo basada en el Itinerario Freireano, a partir de las siguientes etapas: investigación temática, codificación y descodificación y revelación crítica. La información se obtuvo a través de cuatro Círculos de Cultura, con enfermeras de los equipos de Salud Familiar, entre abril y junio de 2018. **Resultados:** Participaron nueve enfermeras. Cabe destacar entre los temas generadores revelados, la “relación entre los equipos generalistas y los Núcleos: enfermeros como referencia y vínculo interprofesional”. Las enfermeras son percibidas de esta manera debido a la formación generalista y gerencial. Las actividades compartidas, como los grupos, figuran entre las prácticas desarrolladas colectivamente como reforzadoras de la labor interprofesional. **Conclusión:** Al provocar reflexiones sobre la autonomía y el proceso de trabajo de la acción colaborativa con los Núcleos, el estudio amplió la percepción sobre las acciones desarrolladas por las enfermeras en la interacción con el equipo multiprofesional. Se sugiere que se lleven a cabo otras investigaciones sobre la relación interprofesional entre la enfermería y el equipo ampliado, a través de la perspectiva de los profesionales del Núcleo.

DESCRIPTORES

Enfermería de Atención Primaria; Grupo de Atención al Paciente; Modelos de Atención de Salud; Integralidad en Salud.

REFERENCES

1. Freire P. Pedagogia do oprimido. 64ª ed. Rio de Janeiro: Paz e Terra; 2017.
2. Vendruscolo C, Ferraz F, Prado ML, Kleba ME, Reibnitz, KS. Teaching- service integration and its interface in the context of reorienting health education. *Interface (Botucatu)*. 2016;20(59):1015-25. DOI: <https://doi.org/10.1590/1807-57622015.0768>

CONCLUSION

The study made it possible to understand the nurses' actions at the interface with PCC. These professionals reflected on the limit situations related to the duties of PCC, FHT and, especially of their autonomy and duties in PC. Thus, they perceived themselves as mediators of the relationship among reference professionals for these teams, due to the generalist training, which prepares the nursing professional to work in a team, and the comprehensive look towards the user, regarding the comprehensiveness and resolvability of care.

The perspective that nurses behave as supporters of supporters is revealing. This fact puts them in the spotlight for the establishment of fruitful relationships and the practice of interprofessionality, since PCC has the task of working with generalist teams from PC, however, without being part of them. On the other hand, being part of them is essential to share knowledge.

The Freirean Itinerary, as it was conducted by the researchers, lead to the reconstruction of the nurses' praxis, as their speeches confirmed that the CC provided opportunities for dialogue and the creation of an environment of horizontal relationships that favored collective reflection through the sharing of experiences, awakening critical awareness and perception about the actions developed in the professional routine of PC.

3. Brasil. Ministério da Saúde. Portaria n. 2436, de 21 de setembro de 2017. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes para a organização da Atenção Básica, no âmbito do Sistema Único de Saúde (SUS) [Internet]. Brasília; 2017 [citado 2019 maio 25]. Disponível em: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2017/prt2436_22_09_2017.html
4. Vendruscolo C, Tesser CD, Trindade LL, Ferraz F. Núcleo Ampliado de Saúde da Família e Atenção Básica: espaço de interseção entre Atenção Primária e Secundária. *Texto Contexto Enferm*. 2019;28:e20170560. DOI: <https://doi.org/10.1590/1980-265x-tce-2017-0560>
5. Brasil. Ministério da Saúde. Portaria n. 154, de 24 de janeiro de 2008. Cria os Núcleos de Apoio à Saúde da Família – NASF [Internet]. Brasília; 2008 [citado 2019 maio 25]. Disponível em: http://189.28.128.100/dab/docs/legislacao/portaria154_24_01_08.pdf
6. Oliveira MM, Campos GWS. Matrix support and institutional support: analyzing their construction. *Ciênc Saúde Coletiva*. 2015;20(1):229-38. DOI: <https://doi.org/10.1590/1413-81232014201.21152013>
7. Araújo TAM, Vasconcelos ACCP, Pessoa TRRF, Forte FDS. Multiprofessionalism and interprofessionalism in a hospital residence: preceptors and residents' view. *Interface (Botucatu)*. 2017;21(62):601-13. DOI: <https://doi.org/10.1590/1807-57622016.0295>
8. Lanzoni GMM, Meirelles BHS, Erdmann AL, Thofehn MB, Dall'Agnol CM. Ações/interações motivadoras para liderança do enfermeiro no contexto da atenção básica à saúde. *Texto Contexto Enferm*. 2015;24(4):1121-9. DOI: <https://doi.org/10.590/0104-0707201500003740013>
9. Associação Brasileira de Enfermagem. Carta de Maceió para a Educação em Enfermagem. 14º Seminário Nacional de Diretrizes para a Educação em Enfermagem. *Rev Bras Enferm* [Internet]. 2014;67(4):646-8. Disponível em: DOI: <https://doi.org/10.1590/0034-7167.2014670422>
10. Brocardo D, Andrade CLT, Fausto MCR, Lima SML. Núcleo de Apoio à Saúde da Família (NASF): panorama nacional a partir de dados do PMAQ. *Saúde Debate*. 2018;42(1):130-44. DOI: <https://doi.org/10.1590/0103-11042018s109>
11. Ferro LF, Silva EC, Zimmermann AB, Castanharo RCT, Oliveira FRL. Interdisciplinaridade e intersetorialidade na Estratégia Saúde da Família e no Núcleo de Apoio à Saúde da Família: potencialidades e desafios. *Mundo Saúde*. 2014;38(2):129-38.
12. Barros NF, Spadacio C, Costa MV. Trabalho interprofissional e as práticas integrativas e complementares no contexto da Atenção Primária à Saúde: potenciais e desafios. *Saúde Debate*. 2018;42(n.esp.1):163-73. DOI: <https://doi.org/10.1590/0103-11042018s111>
13. Vasconcelos ER, Lucena KDT, Pereira AJ, Figueiredo DCM, Carício MR, Deininguer LSC, et al. Desvelando as funções do enfermeiro no apoio à Estratégia Saúde da Família. *Rev Enferm UFPE*. 2014;8(7):2069-75. DOI: 10.5205/reuol.5963-51246-1-RV.0807201431
14. Heidemann ITSB, Wosny AM, Boehs AE. Promoção da Saúde na Atenção Básica: estudo baseado no método de Paulo Freire. *Ciênc Saúde Coletiva*. 2014;19(8):3553-59. DOI: <https://doi.org/10.1590/1413-81232014198.11342013>
15. Durand MK, Heidemann ITSB. The promotion of women's autonomy during family health nursing consultations. *Rev Esc Enferm USP*. 2013;47(2):288-95. DOI: <https://doi.org/10.1590/S0080-62342013000200003>
16. Heidemann ITSB, Dalmolin IS, Rumor PCF, Cypriano CC, Costa MFB, Neves A, et al. Reflexões sobre o itinerário de pesquisa de Paulo Freire: contribuições para a saúde. *Texto Contexto Enferm* [Internet]. 2017;26(4):e0680017. DOI: <https://doi.org/10.1590/0104-07072017000680017>
17. Felli VEA, Peduzzi M, Leonello VM. Trabalho gerencial em enfermagem. In: Kurciant P, coordenadora. *Gerenciamento em enfermagem*. Rio de Janeiro: Guanabara Koogan; 2016. p. 1-13.
18. Franco TB, Bueno WS, Merhy EE. O acolhimento e os processos de trabalho em saúde: o caso de Betim. In: Merhy EE, organizador. *O trabalho em saúde: olhando e experienciando o SUS no cotidiano*. São Paulo: Hucitec; 2003. p. 37-54.
19. World Health Organization. Framework for action on interprofessional education & collaborative practice [Internet]. Geneva: WHO; 2010 [cited 2018 Dec 26]. Available from: http://www.who.int/hrh/resources/framework_action/en/index.html
20. Soratto J, Pires DEPP, Dornelles S, Lorenzetti J. Family Health Strategy: a technological innovation in health. *Texto Contexto Enferm*. 2015;24(2):584-92. DOI: <https://doi.org/10.1590/0104-07072015001572014>
21. Trindade LL, Pires DEPP. Implicações dos modelos assistenciais da atenção básica nas cargas de trabalho dos profissionais de saúde. *Texto Contexto Enferm*. 2013;22(1):36-42. DOI: <https://doi.org/10.1590/S0104-07072013000100005>
22. Campos GWS, Figueiredo MD, Pereira Júnior N, Castro CP. A aplicação da metodologia Paideia no apoio institucional, no apoio matricial e na clínica ampliada. *Interface (Botucatu)*. 2014;18(1):983-95. DOI: <https://doi.org/10.1590/1807-57622013.0324>
23. Morin E. *A cabeça bem-feita: repensar a reforma, reformar o pensamento*. Rio de Janeiro: Bertrand Brasil; 2014.