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# THE NURSE AS THE PROTAGONIST OF CARE MANAGEMENT IN THE *ESTRATÉGIA SAÚDE DA FAMÍLIA*: DIFFERENT ANALYSIS PERSPECTIVES[1]

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**ABSTRACT**

**Objective**: discuss how the social subjects (health team, nursing team, managers and users) visualize the care management practices of the nurse in the *Estratégia Saúde da Família*.

**Method**: a qualitative study was undertaken, in which the data were collected through semistructured interviews (102 persons) and practical observation (11 family health services) and analyzed through thematic content analysis and an analysis flowchart.

**Results**: the study reveals that the care management is marked by the nurse's protagonist role, who takes charge of problem solving and, therefore, develops care strategies based on program actions and health education. This reality evidences the nurse's multiple actions and suggests the creation of possibilities to expand the autonomy with co-accountability.

**Conclusion**: the care management practice involves multiple actions, demanding shared activities between the health and nursing teams, based on qualified listening to the users' needs.

**DESCRIPTORS:** Patient care management. Nursing care. Community health nursing. Public health nursing. Unified health system. Family health strategy.

# ENFERMEIRA COMO PROTAGONISTA DO GERENCIAMENTO DO CUIDADO NA ESTRATÉGIA SAÚDE DA FAMÍLIA: DIFERENTES OLHARES ANALISADORES

**RESUMO**

**Objetivo**: discutir como os sujeitos sociais (equipe de saúde, de enfermagem, dirigentes e usuários) visualizam as práticas de gerenciamento do cuidado da enfermeira na Estratégia Saúde da Família.

**Método**: estudo qualitativo, com dados obtidos por meio da entrevista semiestruturada (102 pessoas) e observação da prática (11 unidades de saúde da família) e analisados através da análise temática de conteúdo e fluxograma analisador.

**Resultados**: o estudo revelou que o gerenciamento do cuidado é marcado pelo protagonismo da enfermeira, que assume a resolução dos problemas e, para isso, desenvolve estratégias de cuidado baseadas em ações programáticas e educação em saúde. Tal realidade evidencia as múltiplas ações da enfermeira e sugere a abertura de possibilidades de ampliação da autonomia com corresponsabilidade.

**Conclusão**: a prática de gerenciamento do cuidado envolve múltiplas ações, o que exige atuações compartilhadas entre a equipe de saúde e de enfermagem, a partir da escuta qualificada das necessidades dos usuários.

**DESCRITORES:** Administração dos cuidados ao paciente. Cuidados de enfermagem. Enfermagem em saúde comunitária. Enfermagem em saúde pública. Serviços de Saúde. Sistema Único de Saúde. Estratégia Saúde da Família.

# ENFERMERA COMO PROTAGONISTA DEL GERENCIAMENTO DEL CUIDADO EN LA ESTRATÉGIA SAÚDE DA FAMÍLIA: DIFERENTES MIRADAS ANALIZADORES

**RESUMEN**

**Objetivo**: analizar cómo los sujetos sociales (equipo de salud, enfermeras, administradores y usuarios) visualizan las prácticas de gestión de la atención de enfermería en la *Estratégia Saúde da Família*.

**Método**: se trata de un estudio cualitativo, en el que los datos se obtuvieron por medio de entrevistas semiestructuradas (102 personas) y observación de la práctica (unidades de salud 11 de la familia) y se analizaron mediante análisis de contenido temático diagramas de flujo.

**Resultados**: el estudio muestra que un manejo cuidadoso está marcado por el papel de la enfermera, que asume los problemas y, por lo tanto, desarrolla estrategias de atención con base en las actividades del programa y la educación sanitaria. Esta realidad resalta las múltiples acciones de enfermería y sugiere la apertura de posibilidades para la expansión de la autonomía con responsabilidad.

**Conclusión:** la práctica de la gestión del cuidado implica múltiples acciones, lo que requiere acciones compartidas entre la salud y el personal de enfermería, de la escucha calificado para las necesidades de los usuarios.

**DESCRIPTORES**: Gestión de la atención al paciente. Cuidados de enfermería. Enfermería en salud comunitaria. Enfermería de salud pública. Servicios de salud. Sistema único de Salud. Estrategia de Salud Familiar.

## INTRODUCTION

Health care practice in Brazil takes the form of care actions to the disease processes, marked by curative and individual actions and health promotion actions, including preventive interventions guided by program-based thematic lines.[1] Hence, practices based on the production of integral care are constituted in line with the principles of universality and equity, in the composition of a Unified Health System (SUS, *Sistema Único de Saúde*). These arguments are in line with the "image-objective"[2] of integrative and interdisciplinary practices expected for a good organization of the services in the Family Health Strategy (*Estratégia Saúde da Família* - ESF), indicating problem-solving and high-quality health care. It is highlighted that care is the result of these comprehensive practices, which directly influence people's health situation and autonomy, as well as the determining and conditioning factors of groups' health.[2] The movement is therefore guided by the need to disseminate the expanded health concept based on primary care, social organization and health production in articulation with the popular struggles for change. Family Health, as a guiding strategy of Primary Health Care (PHC) is devised and constructed to defend the need to organize the systems based on the main health problems of each nation. In that context, the involvement of the health actions in the individual and collective spheres is advocated, offering services of different technological densities, in teams focused on the population within a defined territory. Thus, Family Health proposes comprehensive practices that build on care for people and (democratic and participatory) management, translated as teamwork, putting the user at the center of the care process.[3]

The nursing practices, in turn, seek interfaces with other practices, even if the main intervention object is guided by nursing management. Nevertheless, more creative alternatives are needed that go beyond the "hegemonic management rationality".[4:2338] In that sense, the nurse's work process can reveal a reality with broad possibilities for invention, constructed daily in practice, translated into "live work".[5] It refers to the power of daily practice to do and think health and its high degree of governability in view of the care production. Hence, it can serve as a device for the constitution of connective flows through different territories and can gain multiple and heterogeneous characteristics. Nevertheless, due to its capacity to create vanishing point and work with very peculiar logics, it is able to find new territories of meanings.[5]

The challenges derive from the search for an attitude that enhances the welcoming and bonding, attributing a new meaning to the daily practice of the care process, through shared interventions among the team, user and family, based on the understanding of PHC as the preferred entry door of the care network.[6]

International studies[7-9] discuss the care management, emphasizing the hospital sphere, presenting analyses focused on the organization of care and self-care instructions, in a context of global epidemiological and demographic transition. These studies suggest the need for change in the care model, from the perspective of more complex and prolonged care provision, valuing the users and families' autonomy. The nurse's activities would need to guide the constant search to develop strategies that overcome the challenges of bureaucratic care management in order to enhance co-accountable work through self-care.[9]

Brazilian and recent studies on nurse management are also scarce, mainly in the PHC context. Such research is mostly focused on hospital management, emphasizing emergency care,[10-12] or how conflicts are manifested in teamwork and the importance of the nurse's management practice in hospital.[13]

Thus, the objective in this study is to discuss how the social subjects (health team, nursing team, managers and users) visualize the nurse's care management practices in the ESF. Thus, the goal is to present the different analysis perspectives on the nurse's practice in the ESF. We believe this knowledge can contribute to reflect on and seek alternatives for a more comprehensive and interdisciplinary practice, attending to the users and families' needs.

## METHOD

Qualitative study, developed through semistructured interviews and systematic observations of practice. The empirical field consisted of 11 Family Health Units (FHUs) in two Brazilian cities, located in the State of Bahia: seven in city 1 and four FHUs in city 2. The population in the first city consisted of 556,642 inhabitants, with 86 FHS teams; in the second city, there are 90,985 inhabitants and 20 FHS teams. The population coverage rate corresponds to 52.23% and 77.84%, respectively.[14]

The research participants were divided in four representative groups: 34 members of the health team (physicians, dentists, community health agents – CHA, oral health auxiliaries and receptionists), 15 nursing team members (nurses, nursing technicians, auxiliary nurses), 16 PHC managers (municipal health secretary, basic network coordinator, PHC and FHS coordinators, supervisors and technical references) and 37 users. The nursing team was analyzed separately from the health team. This option served to outline the meaning attributed to care management, as the nurse's main intervention object, despite considering that the nursing team is part of the health team. The data were collected between October 2012 and January 2013.

The inclusion criteria were: health professionals and managers with more than six months of experience in the FHS or on the job; users over 18 years of age who lived within the unit's territory; and FHS with oral health team in function. The number of research subjects was defined by the repetition of common elements in the discourse, based on the criteria of exhaustiveness, as represented by the empirical data apprehended in the data collection and ordering process.

Scripts were used with guiding themes for semistructured interviews and for the systematic observation of practice. For the interviews, three types of scripts were used, containing shared (access to the health services and articulations among managers, workers and users) and specific questions (care flow and health and nursing practices). In the group consisting of the SUS managers, the specific questions addressed the care system, forwarding to other services involving institutional decision making and the care flow, among others, composing 11 guiding themes. For the health and nursing team, the following specific themes were used: team and nursing practices concerning the internal demand for care in different care lines, accomplishment of health promotion and disease prevention procedures and practices, problem solving depending on other services in the care network, among others, totaling 18 themes.

A third script was used for the SUS users, complemented by specific themes: communication access, forms of access and social participation, among others, composing 13 questions, including common and specific items. For the systematic observation, the script consisted of 23 items, related to the health service access, care flows, access to health and nursing team practices and articulations among the social subjects. The interviews with the teams were held based on intentional sampling. For the users, random sampling was applied during the observation at the reception desk of the FHU, when they were awaiting care by the health team. The users were chosen for an interview, independently of what type of care they would receive or any background knowledge of the demand/need. The length of the interviews varied between three minutes and one hour. For the observation, an analysis flowchart was adopted, represented in figure 3, inspired on another production,[5] with a view to facilitating the apprehension of the subjective elements that cross the production of practice, present at different moments in the users' flow through the service. The interviews were stored on a portable recorder and filed on CDs. None of the interviews held was disposed of.

For the analysis of the empirical material, thematic content analysis was also used.[15] In the ordering, skimming was applied to get into the content of the field material and vertically summarize each analysis unit. Next, in the data classification, the

"relevant structures"[15] were identified in relation to the different study participants' perspectives. First, the thematic units were selected, arranged in analytical frameworks and organized individually per group, interviewee and city. Next, to better apprehend the essential content, horizontal syntheses were elaborated of the interviews per interviewed groups, in relation with the intervention cores, separated per city to refine the empirical material. In the horizontal synthesis, the convergences and complementarities among the different representations were outlined. The information from the systematic observation, in turn, was crossed with the syntheses of the groups in each city. In the final analysis, the data were interpreted and articulated with the theoretical framework of the study.

Approval for the research was obtained from the Research Ethics Committee at Universidade Estadual de Feira de Santana-BA (Brazil) (opinion 73485/12 and CAAE 05549512.2.0000.0053) and the cities' Municipal Health Departments granted their authorization.

## RESULTS

The analytical syntheses are displayed in figures 1, 2 and 3. The empirical data evidence convergences (Figure 1) in the interviewees' discourse and indicate that the care management the nurse develops includes actions that depart from the solution of problems, the implementation of care strategies and health education, further revealing the Higher Education Institutions' (HEIs) participation as partners in these strategies.

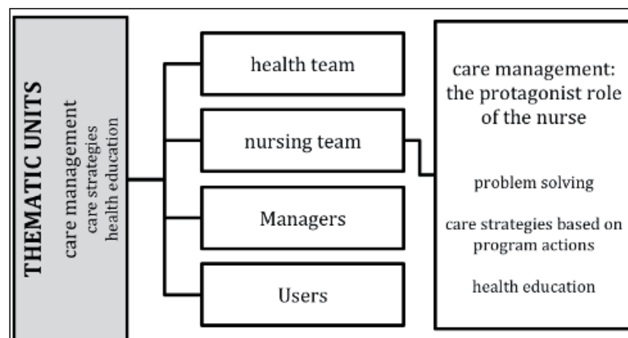


**Figure 1 - Analytic synthesis (thematic units) of the convergences among the interviews in the representation of the health and nursing team, managers and users in two cities in Bahia, Brazil, 2012–2013**

The complementary data (Figure 2), in turn, reveal that the health team consider the management as the orientation of new members incorporated into the teamwork practice (physicians, nurses, community health agents, among others), the assessment of the family grant and the elaboration of reports. It is highlighted that, among the 11 FHUs investigated, the sharing of the service management actions with a dentist happens at only one FHU, located in city 2.

The nursing team appoints that, beyond the elaboration of the reports, it requests attendance quota from the municipal health departments, plans actions, offers individual and group instructions to the users, supervises CHA, solves problems in the community, among others. The managers, in turn, agree with the health and nursing team on the fact that the nurses elaborate reports in the unit management, monitor demands and assess the teams' actions. The users, on the other hand, refer that the nurses' actions consist of individual and group orientations and appoint that they no longer make home visits due to the unavailability of transportation. This information, according to them, comes from health team members (CHA and receptionists) and the nursing team.

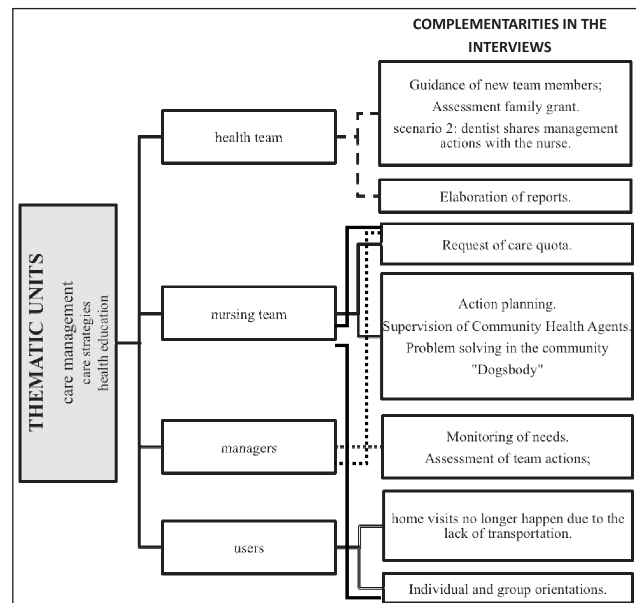


**Figure 2 - Analytic synthesis (thematic units) of the complementarities among the interviews in the representation of the health and nursing team, managers and users in two cities in Bahia, Brazil, 2012–2013**

The observations of the spaces the users pass through (Figure 3) showed that the units are accessible from the geographical perspective and that care is offered upon spontaneous or organized

demand. The existence of administrative, structural and temporal barriers is highlighted. The team members lead the reception, some of whom are unprepared and discouraged. These groups are lead by nurses, who set the attendance criteria, the priority actions, the services offered, the internal and external forwarding and the information supply. In this space, health education strategies also take place and sometimes welcoming, manifested in the interviewees' converging discourse as actions that respond to the users' demands, whose problems are identified by the team, mainly nurses and nursing technicians. At five units in the two cities, "qualified screening" was observed, which consists of interested listening. Nevertheless, the nursing team and the users' statements also converged on welcoming as an operational guideline with a welcoming relationship with listening and positive responses to the population's demands/needs[1]. And, as from this moment, the user already accepts the reception's requisites to follow the flow within the service. Next, the user who already knows the services offered (Figure 3) once again needs to decide on whether or not to incorporate the route the service proposes or to give up the attendance. The user leaves in different manners: a) through the solution of his demand within the service; b) leaving without instructions and guidance; c) by forwarding to other services in the SUS network; and d) by seeking care in the private network.

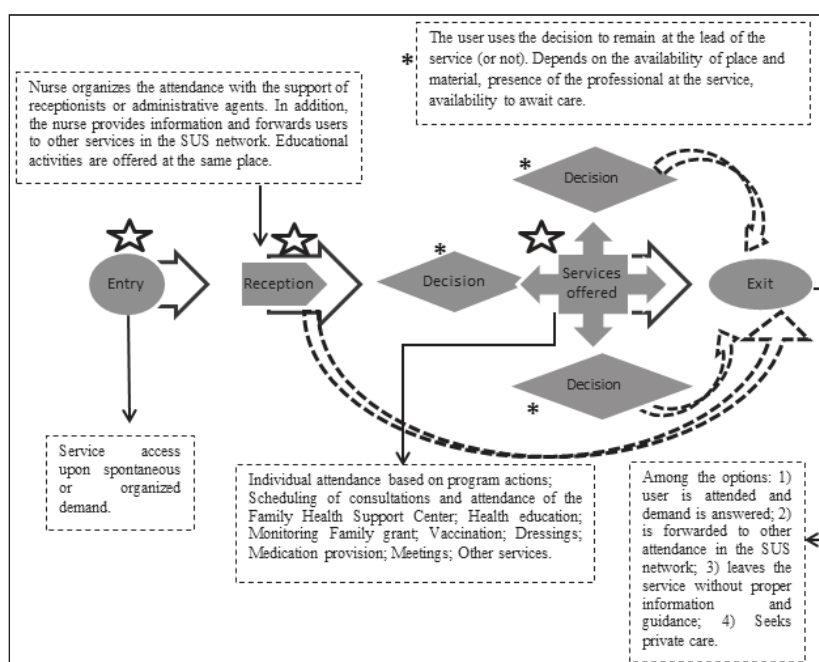


**Figure 3 – Flowchart representing the observations of the spaces the users pass through in the health services of the two cities in Bahia, Brazil, 2012-2013.**

In view of the aspects observed, the starting point adopted is that the management is a core and predominant practice in nurses' work.[16-18] The challenges for comprehensive practices consist in the possibilities to link thinking and doing health, "outlined by the politics, management, technical procedures and collective interaction in the care production act"[19:337] and, in that sense, the nursing practices should operate based on knowledge that constructs the relationships and intersubjectivity as part of the world of the users' needs.[19]

It is highlighted that, in city 2, exceptionally at a health service, the nurse and the dentist share the management actions. This reality remits to advances in the management processes, based on the decentralization of decisions and the approximation among the team members.[19]

The presence of the nurses was verified in the different FHU sectors, that is: reception, immunization room, individual care room, pharmacy and procedure room. In addition, these professionals also take part in the development of different activities, in view of the demands assumed in daily work (Figure 3). Nevertheless, it is highlighted that they are clearly present in all place and articulate these in activities related to the coordination, supervision and control,[17] besides the use of light technologies,[5] involving gatherings among nurses, users and fami-

lies, granting meanings to these gatherings, held in practice, turning them into protagonists in the construction of networks of affection, interactions and subjectivities.

These professionals are responsible for solving the team and/or community's problems, in the attempt to guarantee the proper functioning of the service. The practices comprise the following strategies: organization, articulation in the work process and with the team, dialogue and negotiation.[9,11] Nevertheless, it is important to highlight that health team (and nursing team) management skills are needed and that the users' expectations need to be attended to, with ongoing training to maintain the balance and discernment (with a view to minimizing existing conflicts). In other words, nurses would need skills to overcome the service's limitations and to act within the fundamentals of the SUS.[5]

Nevertheless, the question is raised: can other members of the health team be involved? How is multidisciplinary, interdisciplinary and comprehensive work possible? Different subject's participation requires the collective desire for relational, institutional and organizational changes.[19] The responsibility should be shared and connected by all stakeholders in the daily family health practice. The protagonist role of the nurse in actions such as health education, problem solving (Figure 1), user welcoming, dialogue about the demands, among others, could be shared among the other stakeholders: workers, managers and users. In other words, a more horizontal and shared management presupposes teamwork, involving the social subjects around a collective project. The work cannot be centered on a single subject or on specific subjects. The challenge would relate to how to manage the different interests and desires of a group or a subject, in order to construct solidary and democratic sociability.[4]

The investigated cities are also marked by conventional disease and procedure-centered care practices, which compromise the logic of change in the model. Nevertheless, some institutional incentives are identified, such as the creation of reference groups with institutional supports, which do not even assume new and creative practices. The entire team, including the nursing team, develops care practices based on program actions (Figures 2 and 3), that is, they establish priority actions concentrated on certain population groups and problems, a fact that limits the achievement and problem-solving ability of the FHS.[6,16] This limitation negatively influences the access and breaks with the perspective of including PHC as the preferred entry door.

The individual (nursing) consultations is part of the care strategy and, as the research data in both cities appoint, the nurse's tasks are in line with the definitions of the Federal Nursing Council (COFEn, *Conselho Federal de Enfermagem*), which deals with the systemization of nursing care.[20] Nevertheless, care needs to be enhanced beyond the individual consultation by holding all team members accountable and involving the users and families. The care production process "centered on the health professional" may mean an imprisonment of the worker, especially in nursing. The fragmentation of the work needs to be coped with, as well as the need to operate in a comprehensive and interdisciplinary manner in practice. The procedure-centered activities need to be overcome.[17] A care practice needs to be devised that puts the "user at the center of the process",[5] sharing an innovative therapeutic project.

The data revealed that the interviewees agree on the fact that the nurses play a protagonist role in the health and in-service education actions (Figures 1, 2 and 3), despite the contribution of CHAs and HEI students and faculty. Education gains a participatory management role in work, as it indicates possibilities for changes in the work reality, based on the involvement of managing, caring, educating and, furthermore, using critical reflection to reflect and take a new stand towards the needs identified and the situations experienced in interaction with the people and social groups.[16] Thus, one can acknowledge that people have needs, but also desires, knowledge and powers that should be valued, in order to understand the singularities of each person's experience processes and to construct a care plan that involves individual and collective actions. Efforts should be established in the daily dialogue among workers and in the teamwork modes (health team and nursing team), besides the user's participation, signaling possibilities for collective constructions.[17] Furthermore, it is highlighted that the HEIs' presence in these spaces underlines the importance of reflecting on the education process of the new health professionals (including nursing professionals) from the perspective of the construction of renewed/expanded care practices.[6]

Transversely, it was evidenced in the research that the different health workers' work, including the nurse, is marked by the overlapping of actions, taking the form of mechanical work with little room for creativity and articulation of knowledge and practices. In view of this aspect, it was also revealed

in the interviews that the nurses are responsible for monitoring the demands (Figures 2 and 3), including the organization of material, staff and functional infrastructure, with a view to guaranteeing care and aiming to produce comprehensive and effective care.[8]

The data revealed in the study can be observed in other studies,[18,21] whose analyses appointed that components needed for the professional competences are related to the knowledge, attitudes, behaviors and skills. In that sense, the knowledge/action put in practice indicates competency and the mobilization of resources.[21] Links can be made with the nurses' work, observed in the empirical field, in which the attributions are in line with the legal devices[20] and with other theoretical productions,[18,21] as they realize the planning of actions, elaborate reports, supervise CHAs, request attendance quota from the municipal health departments and assess the teams' actions.

The constitution of the nurse's protagonist role in the production of care in the FHS has been enhanced as an important territory, permeated by individual actions and not always consensus-based articulations with other professionals, permeated by difficulties and challenges, and it is in the territory of the caregiving actions that leaderships emerge. Nursing is part of this context, also because care management has been a fundamental nursing practice and a space for the emergence of leaderships.[11,19] In other words, the practice of leadership interacts with decision making and communication, which are important attributes in the care production process.[8]

The complementarities the health team revealed in the interviews (Figure 2) included the assessment of the Family Grant Program. The National Policy on Food and Nutrition defines the responsibilities of the health teams in the FGP for health: prenatal monitoring, return for postpartum appointment, dietary advice, child growth and development monitoring, among others.

Furthermore, through half-yearly monitoring, problem-solving health actions can be achieve, with the teams' committed and citizen guarantee that the families' living conditions will progressively improve.[22] Thus, for the interviewees, this practice took place between the CHA and the nurse, strengthening the discussion about the insufficiency of teamwork, concentrating the actions on some workers.

Also concerning the complementarities in the discourse, particularly among the users, they also indicate that the home visits no longer happened due to the lack of transportation. This problem reveals that gaps exist in the activity management, as the insufficient resources can curtail the singularity of care (home visit), according to the identified needs and available resources.[19] It is highlighted that the visit, at home or in other community spaces, needs to be high-quality, constructive and focused on specific problems, with a view to identifying risks and vulnerability, favoring bonding between the team and the community and the construction of more humanized and co-participatory therapeutic projects.[18]

It is noteworthy that Nursing cannot practice care disjointed from the information and communication technologies that guide the management practices[23] of care and of the organizational context of the health system, at all technological density levels of the SUS network.[19]

In short, the care management demands rich and dynamic interactions with the teams from the nurse, guided by technological and therapeutic rationalities. In other words, communication, information, intersubjective interactions, technical competency and sensitivity need to be valued in order to cope with people's demands/needs.

## CONCLUSION

In its theoretical field, care management is considered to be a collective process, whose implementation requires joint action by the nursing and health teams, based on qualified listening to the users' demands/needs.

In view of the study data, it is valid to consider that, despite significant discussion on the care process in current scientific productions, in the health practices, difficulties are observed to relate the demands with the techno-scientific apparatus involved in the health field. The nurse's management practice involves multiple actions, such as attention related to the direct care in different intervention lines and the educational processes, through knowledge construction and the articulation among services in search of high-quality care. In other words, the nurse plays a protagonist role in the care delivered in the ESF. Nevertheless, investments are still needed in integrative and integrated work with the team.

In the Brazilian reality, access to the services and technologies is difficult for most of the population, the results of the actions are frequently frustrating; the relations among the health professionals are based on individual practices, emphasizing procedures and "professionals centered" on the daily real-

ity of the investigated spaces. These aspects weaken the sharing of care among the teams, in addition to these professionals' limited involvement in health planning, management and education aspects. In that sense, innovative and interactive forms of management need to be constructed in nursing, which seek to cross the institutionalized limits of traditional care. Thus, the strengthening of continuing education actions in health can contribute to encourage critical reflections related to health actions. In addition, the discussion of management strategies in nurses' education based on the real context is a powerful space for the development of innovation. Therefore, articulating the theoretical constructs with the intervention spaces is important, involving the management and production of care and the symbolic processes that permeate these articulations.

As verified, the changes targeted at the health services can be facilitated by the discussion among the different social subjects, in the incessant search for dialogue among these subjects. The noise in the system would be captured and rationalized, permitting the construction of renewed ways of practicing health. This strategy would also permit attending to the managers, workers and users' expectations.

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