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Muda o modelo assistencial, muda o trabalho da enfermeira na Atenção Básica?

Does the nurses' work change when the Primary Health Care change?

¿Cambia el modelo asistencial, cambia el trabajo de la enfermera en la Atención Primaria de Salud?

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RESUMO: Este estudo teve por objetivo identificar as atividades desenvolvidas pelas enfermeiras que atuam em Unidades Básicas de Saúde, incluindo unidades que ainda seguem o modelo assistencial orientado pela biomedicina e unidades que atuam com o modelo da Estratégia Saúde da Família. Pesquisa de abordagem qualitativa, com a utilização de triangulação para a coleta e análise dos dados obtidos por meio de entrevista e observação. Foram entrevistadas vinte enfermeiras de onze Unidades Básicas de Saúde, de quatro municípios da região Sul do Brasil, entre março a maio de 2013. Os achados mostram que o trabalho das enfermeiras, nas unidades investigadas, são semelhantes nos dois modelos assistenciais. Houve predomínio de práticas de cuidado, destacando-se a realização de consultas, ações curativas e atividades prescritas em programas formulados pelo Ministério da Saúde. As entrevistas e observações realizadas revelaram diferentes realidades nas UBS pesquisadas, especialmente no que tange as condições de trabalho. Conclui-se que houve similaridade no trabalho das enfermeiras em ambos os modelos, com predomínio de ações fragmentadas. Ressalta-se que estudo foi realizado em um momento e região do país em que houve grande expansão da ESF, o que parece ter influenciado o resultado de pouca diferenciação no trabalho das enfermeiras que atuam nos dois modelos assistenciais. A replicação em outras regiões

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do país pode evidenciar resultados diferentes.
Palavras-chave: Atenção Primária à Saúde. Saúde da Família. Papel Profissional.

ABSTRACT: *This study aimed to identify the activities developed by nurses in Basic Health Units, including units that are still under the care model guided by biomedicine as well as units that use the Family Health Strategy model. Research using qualitative approach, applying triangulation for the collection and analysis of data obtained through interviews and observation. Twenty nurses from eleven Basic Health Units in four municipalities in the southern region of Brazil were interviewed between March and May 2013. The findings show that nurses work in the two care model units under study are similar. There was a predominance of care practices, especially consultations, curative actions and activities in programs following directives by the Ministry of Health. Interviews and observations revealed different realities in the BHUs researched, especially regarding working conditions. It was concluded that there was similarity in the nurses' work in both models, with a predominance of fragmented actions. It is noteworthy that the study was carried out at a time and region of the country where there was a great expansion of the FHS, which seems to have influenced the results showing little differentiation in the work of the nurses under the two care models. Replication in other regions of the country may show different results.*
Keywords: *Primary Health Care. Family Health. Professional Role.*

RESUMEN: *Este estudio tuvo por objetivo identificar las actividades desarrolladas por las enfermeras que actúan en Unidades Básicas de Salud, incluyendo unidades que aún siguen el modelo asistencial orientado por la biomedicina y unidades que actúan con el modelo de la Estrategia Salud de la Familia. Investigación de abordaje cualitativo, con la utilización de triangulación para la recolección y análisis de los datos obtenidos por medio de entrevista y observación. Se entrevistó a veinte enfermeras de once Unidades Básicas de Salud, de cuatro municipios de la región Sur de Brasil, entre marzo y mayo de 2013. Los hallazgos muestran que el trabajo de las enfermeras, en las unidades investigadas, son similares en los dos modelos asistenciales. Se observó un predominio de prácticas de cuidado, destacándose la realización de consultas, acciones curativas y actividades prescritas en programas formulados por el Ministerio de Salud. Las entrevistas y observaciones realizadas revelaron diferentes realidades en las UBS investigadas, especialmente en lo que se refiere a las condiciones de trabajo. Se concluye que hubo similitud en el trabajo de las enfermeras en ambos modelos, con predominio de acciones fragmentadas. Se resalta que un estudio se realizó en un momento y región del país en que hubo gran expansión de la ESF, lo que parece haber influenciado el resultado de poca diferenciación en el trabajo de las enfermeras que actúan en los dos modelos asistenciales. La replicación en otras regiones del país puede evidenciar resultados diferentes.*
Palabras clave: *Atención Primaria de Salud. Salud de la Familia. Rol Profesional.*

INTRODUCTION

The health care guided by the biomedical model has played an important role in the organization of health services throughout the past hundred years. This model is characterized by the Cartesian epistemology, technicality, specialization, focus on the alterations of the human body and the disease, giving a reductive view of the patient and the process of health-illness, and it is still hegemonic nowadays[1].

In Brazil during the 80's the Health Reform Movement provided an intensification of criticism regarding the biomedical model, fostering debates about the nature of diseases and healthcare models. The ensuing debate process and the political arguments resulted in the launching of the SUS (Unified Health System), which was set in the Constitution of 1988 and implemented through Laws 8080 and 8142 in 1990. The new system adopted a broad conception of health, guided by the social definitions of health and illness, in which the people must have their health care needs attended in their communities, in a family context and under a perspective of comprehensiveness[1].

The BCNP (Basic Care National Policy), implanted in Brazil since 2008, incorporated concepts established by the World Health Organization for the Primary Health Care and defined the FH (Family Health) as the priority strategy for the promotion of this new view on health and the ways of providing care[2].

One of the common responsibilities of all government spheres is the incentive of the adoption of the Family Health Strategy (FHS) by the municipal health services, putting priority in the consolidation and improvement of the Basic (Primary) Care services. However, there are discrepancies in relation to the implantation of the FHS around the country. There are different takes related to the rupture with the biomedical model, the deficit of work conditions and structures of the Basic Health Units (BHU), as well as the insufficient or inadequate education and training to work with the FHS as a way to promote a disruption with the biomedical model, as well as related to the difficulties to implement the comprehensiveness of care[1].

The Ministry of Health stipulates that BHUs must guarantee the principles and guidelines of the Primary Health Care, which means acting on the promotion, prevention, recovery and maintenance of health in the community. The BHUs with FHS teams must attend a maximum of 12 thousand residents, while the BHU without the FHS teams must attend a maximum of 18 thousand residents, both in their delimited areas[3].

As of 2012 there were 32.970 FH teams spread across the entire national territory, and the prescribed minimum composition of each team includes doctors, nurses, nursing technicians, nursing assistants and Community Health Agents (CHA). In 2016, the Basic Care Department of

the Ministry of Health registered 41.523 FH teams, covering approximately 88% of the country population[4].

Amongst the members of health teams in both care models, there is a prominent presence of nursing professionals. These professionals include nursing technicians and assistants working under the supervision of nurses, as required by the Law 7.498/86[5]. In this context, nurses are strategic professionals in the provision of healthcare and the practicability of the prescribed in the care programs and in the Basic Care National Policy, justifying the studies about their work.

The nurses are professionals who have knowledge and technical skills allowing them to advocate for the patients of health services and to act in collaboration with other healthcare professionals. Therefore, nurses are responsible as fundamental providers in the care of SUS[6] patients. The nurses who work in FHS use different technologies, including technical-healthcare dimensions such as scientific technical procedures, educational pamphlets, planning, as well as technical-relational dimensions, including the interactions between patients and families and the social- collective dynamic of the people involved in the work process[7].

The Basic (Primary) Care proposes common attributions to all the professionals on the teams, without differentiation of care models. Some of these attributions are: participation in the process of mapping the health territory ; updating the families registrations; performing healthcare actions; participating in the first contact activities for reception and welcome users; doing active search and notifications of diseases and injuries; to be held accountable for the population under their responsibility and perform care to families, communities and social groups; participating in team meetings to monitor and perform assessment of the implemented actions; to carry out interdisciplinary and teamwork actions of health education; implementing permanent education of the teams and mobilizing the community; identifying partners and resources in the community; as well as creating other activities according to the local demands[2].

The nurses attributions for the Primary Health Care are stipulated in the Basic Care National Policy (BCNP)[2] without differentiation of care models. Among the specific attributions, the following stand out: the supervision of nursing teams; nursing consultations; procedures; group activities; programmed activities; respond to spontaneous demand; planning, management and evaluation of the actions developed by the CHAs; activities of permanent education, and management of consumables. The following are also described: requesting complementary tests, prescription of medications and patients referral to other services, as prescribed in the provisions of the Professional Nursing Practice Law[2].

Considering the above mentioned background and the prescriptions of the Basic Care National Policy, the present study sought to identify the activities developed by the nurses who work in

Basic Health Units, including the ones that are still under the care model guided by biomedicine as well as those units following the Family Health Strategy model.

METHODS

This was an exploratory descriptive study with qualitative approach. The participants were nurses of 11 BHUs belonging to four districts of the Grande Florianópolis region, located in Santa Catarina, southern Brazil. The districts and the participants were intentionally selected, guided by the following inclusion criteria: units which were better characterized by the use of the FHS model and BHUs where the FHS model was not implanted yet; both units were pointed out by the Health's Secretary of each district as good examples of providing care to their population; and nurses who had been working with Basic (Primary) Care for more than a year. The criteria for exclusion of participants were: being on vacation or away from work for any reason (health, work related accident or leave of absence), completing education or traveling for work.

We used triangulation for the collection and analysis of the data obtained through semi-structured interviews and observation[8] conducted between March and May of 2013. In the 20 interviews with different nurses, we sought to identify their activities as they were practiced in both care models and to elicit in which way those models influenced the activities. The composition of the research sample respected the criteria of intentionality, parity of nurses from both care models and agreement to participate in the study. The sample was considered sufficient by the criterion of data saturation.

The interviews were recorded, transcribed and coded by the letter E, followed by the letter which identified the care models (E for FHS and T for the traditional model) and lastly by the cardinal number in the order in which they were made.

The observations were written in a field diary and later transcribed to a digital file with a total duration of 22 hours. The observation script was organized to identify the nurses' activities related to the patients, their bosses and team colleagues, and the relation of these activities with the care model. For the data organization it was used the *Atlas.ti*, software used for studies of qualitative nature, which contributed with the codification and construction of categories that emerged from the interviews and observations. The classification of the items was guided by the Content Analysis proposed by Bardin[9]. The data systematization for the characterization of the nurse's work in the BHU teams was organized in 3 categories: common activities in both care models; activities done only in the traditional model; and activities done only in FHSs.

The participants signed a Free and Informed Consent Term written in two copies and the data was collected only after obtaining the approval by the Ethics Committee on Research with Human Beings (CEPSH) of the Federal University of Santa Catarina, under the No. 207.307, observing all

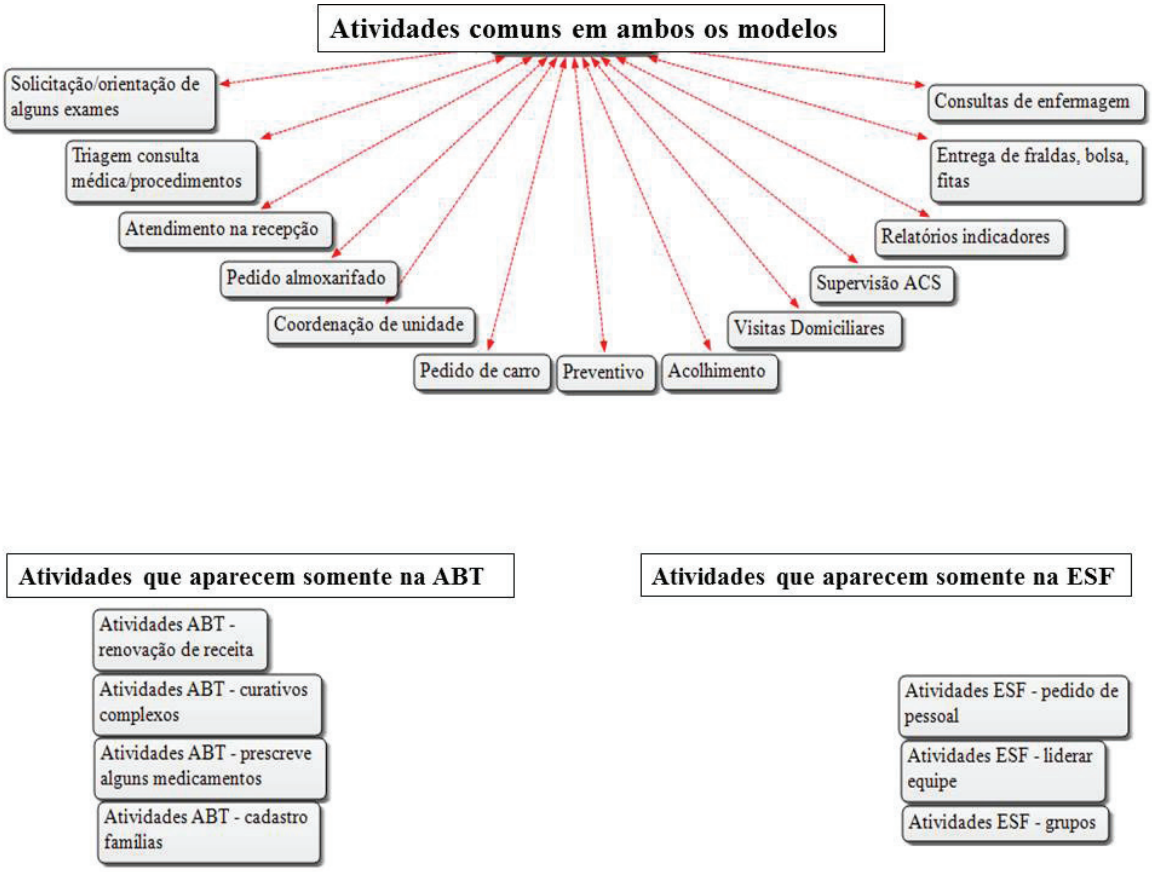
the recommendations of the Resolution No. 466/12 of the National Health Council[10]. Therefore, we guaranteed participants' anonymity and their right to quit the study at any stage, as well as to be informed about the study and its development.

RESULTS

The results of this study about the characterization of the nurses' work in Primary Health Care following both the so called "traditional" and FHS care models show that the activities performed are very similar, which was confirmed by the nurses' descriptions as well as the field observations.

The activities performed by the nurses in their daily work, as quoted in this study, range from assistance to management and health education, a total of 20 different activities performed by nurses in the Basic (Primary) Care, being four of them done only in the traditional care model while three are exclusive to the FHS model.

Picture 1. Activities performed by nurses in the Basic (Primary) Care. Florianópolis, 2013.



Among the care activities, the nursing consultation and home visit are relevant in both care models. The nursing consultations were generally mentioned in the nurses' interviews and it was considered a strategy that promotes the implementation of health actions as prescribed by programs that integrate basic healthcare. Some examples are women's health, including colpocitological exams (preventive) and prenatal; children health, including childcare; the care for chronic diseases such as hiperdia (hypertension + diabetes) as well as the care of patients with stomas.

> [...] prenatal consultations and everything else that comes up, which we can do. (ET1).

> [...] we attend scheduled appointments, all kinds of consultation, diabetics, hypertensive patients, ostomy patients, pregnant women, childcare [...]. (EE6).

The nurses highlight the execution of Pap tests, an activity present in both care models, but they criticize the excessive number of collection of samples in certain periods of the day. It was possible to verify through observation the difficulty to perform this kind of procedure, especially in the traditional BHU's, because of the lack of structure in the units and the excessive amount of daily activities performed by the nurses.

In both models, home visiting was an activity mentioned by the nurses, but considered as a not so frequent procedure in the traditional model. The nurses said the home visits are usually done by doctors or that it is an attribution of nursing technicians who are responsible for daily assistance activities. Nurses only perform the home visits when they involve situations with patients who are bedridden, depending on other people to do procedures such as put dressings and give vaccines.

> I do home visits too, actually we do a lot of nursing technician activities, I go on a routine visit and end up checking an elderly man's blood pressure, caring for bedridden patients, assistance jobs like that (ET6).

> We do visits too, only for the bedridden patients who need supplies and vaccines (ET7).

> [...] I do some home visits, it's not very frequent, the doctors are requested more, I visit the bedridden patients who have pressure ulcers. (EE9).

> On Tuesdays, I go on home visits in the morning and in the afternoon I do the first reception of patients. On Thursdays and Fridays I do the first reception of patients and other things. (EE1)

The first contact and reception of patients is significantly quoted by the nurses of the FHS, while in the traditional model it is mentioned only once.

> [...] so what I do is first reception of patients, people who come in in need of orientation. (EE7).

> [...] we start the day by doing first reception of patients in the ER wings. (EE8).

> What I do is first reception of patients, people who come in needing orientation, with pain, the patients look a lot for the doctors, then I do the evaluation and send them to the doctor. We get a bit of everything, gynaecological complaints, flu, diarrhea, vomit, pain, everything. All queries pass through me and I do the evaluation, I count a lot with my team to help, but my job is not with appointments, I work 8 hours a day attending everyone that comes. (EE3).

Some activities were only pointed out by nurses who work in the units with the traditional model, like renewing prescriptions and medicines, complex dressings and family registrations.

> We renew prescriptions here, of course we take into consideration the date the patient had their consultation for the last time and depending on the case we send them back to the doctor to do a screening before renewing the prescription. (ET3)

Other activities performed by the nurses in both care models of Primary Health Care are the delivery of diapers, colostomy bags and blood glucose tapes;

> [...] some markers like ostomy patients, oxygen therapy patients; I monitor the tapes of patients with Hiperdia. (EE5).

Amongst the management activities executed by the nurses in the two care models, the health indicators reports and the CHA supervision are also part of the nurses' daily work.

> [...] put the information on SIAB, on the prenatal SIS, all that part we are the ones who do it. (ET4)

> [...] besides finishing the reports [...]. (EE10)

> [...] we supervise the work of technicians and CHA. (ET2).

The following activities were also mentioned as common to both care models: unit coordination and stockroom requests. Other activities were also pointed out on a smaller scale during the interviews: car requests for the visits; working in the reception; orientation/solicitation of some exams and the screening for medical appointments and exams.

In the units organized by the FHS, some management activities were mentioned, such as staff request and leading teams. In the activities of health education and promotion, gathering groups

of patients was highly pointed out as an important device in an specific way by nurses of five BHU with FHS care models.

The activities of the promotion and health education are done during the consultations and in some groups of hiperdia and smoking. (OBSESF1).

The activities for prevention and health promotion are done during consultations and in groups of hiperdia, PSE [...]. (OBSESF2).

In the BHU, regardless of the care model, the nurses talked about the difficulties found in the work conditions for the development of their duties, including scarcity of human and material resources, which caused dissatisfaction.

> We don't have enough human resources, it's all outdated. (ET8).

> The lack of staff, because many workers are redistributed, there is no administrative staff, many areas don't have CHA and staff is used in other functions. (ET10).

> One of the reasons for my dissatisfaction with my work is the lack of human and material resources. (EE4).

About the home visits, the nurses pointed out that one of the limitations for the execution is the lack of cars. In emergency situations, the professional has to use their own car or be taken by the families into their homes.

> We do home visits, but we haven't had a car in two months, so it's been two months since we don't do visits, when it's an emergency, the family comes and picks us up. (EE2).

DISCUSSION

The interviews and observations revealed different realities in the BHUs where the study was made, especially in relation to the work conditions. However, the activities executed by the nurses on both care models were very similar, although these activities exist across the board in the production of healthcare, at times closer to the traditional model, while at other times, near to the FHS model.

It is important to highlight that this study consists in presenting the activities that were described by the nurses who were part of the study and the ones we were able to observe, and it does not include all the activities performed by them.

The nurses pointed out a different number of activities as part of their daily work and they can be classified according to the dimension of the nursing job as follows: healthcare activities, management activities at the BHU and health education activities[11].

The results showed a predominance of healthcare work performed by the nurses on both models, being predominant the nursing consultations, as well as the care actions carried out in the home visits and other care actions, related to government program goals, such as the sample collection for Pap tests and the activities of first contact for reception and welcome users.

According to the BCNP, nursing consultation is a specific attribution of a nurse and it is described by the Law No. 7.498/1986 as a privative action, and it must be executed in a systematic way, including clinical reasoning and registration[2,12].

Of the four districts studied, only one of them has service protocols stipulating the guidelines and procedures oriented to specific regions.

The medicine prescriptions appeared in the nurses' reports of the traditional model, and this happened exactly in the districts whitout service protocols. The districts with service protocols and also part of the FHS model let the nurses prescribe some medications, although they did not mention this activity. Some examples are: contraceptive cases (emergency contraceptives, oral and injectable, IUD); they can prescribe folic acid and ferrous sulphate for the low risk pregnant women; they are responsible for the prescription of products derivative of silver, hydrocolloid and fatty acids for the wounded, as well as products to cover the wounds[13,14].

The medicine prescriptions made by nurses have been object of international debates, especially because of population ageing and the prevalence of chronic diseases. In this scenario there are other health professionals besides doctors that have their responsibilities broadened to attend to the population demand[15].

The renewals of medical prescriptions described by the participants of the traditional model are related to the activities during the first contact with the user. In that moment, the nurse evaluates the need for a renewal of the medical prescription and fills out a new prescription so that *a posteriori*, the team doctor may sign and stamp. In legal terms[5], considering the existence of approved protocols in the health institutions, the nurse would be able to renew a number of prescriptions as long as she does it with her own license, assuming her technical responsibility in doing so. The justification for this practise is that it speeds up the consultation, being convenient both for the professionals and for the patients. However, it is valid to question the ethics, legal and technical implications of this decision, regarding both the violation of professional normative and the patient's security.

The home visits are provided in the BCNP as an attribution common to all professionals of Primary Health Care teams[2]. This assistance activity gives the health team the opportunity to have contact with the patients' environment and family relations, and also to assist beyond physical problems as well as to try to promote actions that attend to the patients' real needs[16].

In some BHU, the home visits are made difficult by the deficit of automobiles available in the districts. One of the nurses interviewed said some visits were possible when they used their own cars or were transported by the families to their homes.

The swab collection for the Pap test (preventive for cervix cancer) is done by the nurses of the Primary Health Care and it is the major strategy to detect early lesions, before symptoms appear. This activity was predominant in both care models and it is made in a fragmented way to comply with government policies. The importance of this activity in care is indisputable, for it allows individual and educational orientation[17]. In all the studied cases, there is a defined schedule for the sample collections, in a specific period/day of the week devoted to the execution of the process. This goes against the recommendation of the Ministry of Health that specifies that the teams' work process should avoid the division of schedules according to different criteria such as health issues, life cycles, sex and pathologies, because this division can hamper the patients access [2].

The first contact for reception and welcome users is prescribed in the BCNP as one of the characteristics of the work process of the Primary Health Care teams. It must be performed by all the members of the team, putting in practice listening, risk classification, evaluation of health and vulnerability necessities, with a view of solving the spontaneous demand and the first emergency consultations[2]. The first contact for reception and welcome users reported in the studied BHS refer to the consultation of spontaneous demands (without appointment) and it is performed only by nurses, who try briefly to attend to the patients' needs or send them to the urgency consultations with the team doctor.

The activities related to management dimensions present in both care models were the work coordination of CHA and the typical administrative actions of the bureaucratic clerical work.

The supervision of CHA described by the participants is written in the BCNP for both care models. As well as the healthcare attributions and the management common to every nurse, such as planning, coordination, and evaluation of the tasks developed by the CHA. The Community Health Agents strategy is cited as a possibility to reorganize the BHU with no Family Health, with the purpose of promoting the gradual implantation of the FHS and integrating the CHA to other ways of the Primary Health Care organization[2].

The participants pointed out activities that are specific for nurses. However, other professionals

normally perform several of the many activities mentioned. The nurses find difficulty executing their specific attributions because of other demands, such as administrative work, which are the result of human and material resources deficit. Another study found similar results of this one. The findings showed the strong influence of the work conditions in the nurses work performance, especially due to the deficit of work force and material supplies[19].

Among the specific attributions described in the BCNP, the only one that was not pointed out by the participants of the study even though it does not mean it is not performed, is the activity of permanent education of the nursing team and other members. According to the BCNP, the nurses must contribute, participate and perform such activities.

The family registrations must be done by the CHA. However, due to the deficit of workers, the nurses of the traditional care model can also accumulate this job, which creates an overload of work especially because all BHUs under the traditional model included in this study did not have a digital system. The nurses of the FHS model also pointed out the deficit in the staff when they mentioned the staff request as one of their performed activities.

Actions which refer to an educational dimension were cited only by the FHS nurses, and the predominant activities were the group health education. The activities for the promotion of health are considered main axes for the FHS teams work as well as an efficient intervention within the community for the prevention of disease and health awareness, being necessary to overcome the difficulties faced by the teams, which prevent the consolidation of this care model[19]. The main difficulties faced by the groups lie in the interdisciplinary way of working, the lack of infrastructure in the BHU and the deficit of professionals in the daily work in the FHS.

The health education activities, especially the groups, must be "dialogic and recognize the historic character of the social, political and economic determinants of the health-illness process, breaking the standard model and articulating the individual and collective dimensions of the educational process" [20].

The results presented in this study corroborate the findings of Costa, Couto and Silva[21] in a study about the revision of nurses' clinical practices in the Primary Health Care. In this study they verified a tension between a procedural - based clinic – in this case, the traditional model – and a extended clinic (FHS), concluding that the work has gradually evolved towards the perspective of the extended clinic, sustained by the assumptions of the FHS/SUS inside the practice of the hegemonic model.

In light of the concrete situations exposed by the nurses, some activities could be performed more often and/or more efficiently, which it does not happen because of the lack of structure in

the BHU, independent of its care model. The logic of the basic care organization is already present in the nurses' daily work, but the districts' management creates difficulties to make it real, which causes a lot of frustration and consequent suffering[22]. This suffering can grow by the impediment of activities and the failure present when there is a desire to do, but the circumstances do not allow to do it.

FINAL CONSIDERATIONS

The activities executed by the nurses of the Basic (Primary) Care of both care models are oriented by the framework in the BCNP as well as what is prescribed in the professional legislation, with local specificities related to the political and logistical context. This group of factors influenced the expression of the work with the predominance of some activities and deficit or absence of others. The political-institutional background and especially the work conditions interfere in a crucial way in assisting the population.

The study findings pointed out three situations: the home visit as a privileged space for full-time assistance; the execution of fragmented actions; and the limitations imposed by the working conditions.

With both care models in the activities performed by the nurses there was a predominance of healthcare and management dimensions, while the nurses from the traditional model did not even mention any activity of educational dimension.

From the nurses' testimonies about their daily work activities, it is possible to realize that these professionals are agents modifying the reality and trying to build new chances of action using the proposal of innovation of the healthcare in SUS, even when they work in a BHU whitout FHS.

The problems described in this study were found in both care models, which allow us to assert that, regardless of the model, the policies for health management and the work conditions contribute to the way and quality of the nursing assistance in the Basic (Primary) Care. These findings indicate the importance of the promotion of the expansion of the FHS, seeing as the model has contributed with the expansion of universal health access as well as it enabled the nurses to work in an environment of teamwork and interdisciplinarity.

It should be noted that this study did not take into account the opinion of the other members of the teams about the nurses' work, a point of view that may have unveiled further relevant aspects for the better understanding of the characterization of the work of these professionals in Basic (Primary) Care.

It is also important to highlight the time and region of the country in which this study was conducted. The context was one of a great expansion of the FHS, seemingly influencing in the scarce differentiation between the nurses who work under the two different care models. The replication of this study in other regions of the country may show different results, and even a more clear distinction between both care models.

REFERENCES

1. Fertonani HP,Pires DEP, Biff D, Scherer MDA. Modelo assistencial em saúde: conceitos e desafios para a atenção básica brasileira. Ciênc. saúde coletiva [Internet]. 2015 June [cited 2017 May 19]; 20(6):1869-78. Doi: http://dx.doi.org/10.1590/1413-81232015206.13272014.

2. Ministério da Saúde (BR). Política Nacional de Atenção Básica. Brasília: Ministério da Saúde; 2012.

3. Ministério da Saúde (BR). Números de equipes que atuam em Atenção Básica. Brasília: Ministério da Saúde; 2012.

4. Ministério da Saúde (BR). Portal da Saúde. Histórico de Cobertura da Saúde da Família. [Internet]. 2016.[cited 2017 May 19]; Available from: http://dab.saude.gov.br/portaldab/historico_cobertura_sf.php

5. Lei do Exercício Profisissional de enfermagem – 7.498/1986. In: Conselho Regional de Enfermagem de Santa Catarina. Consolidação da legislação e ética profissional. 2ª ed. Florianópolis: Quorum; 2013.

6. Ventura CAA, Mello DF, Andrade RD, Mendes IAC. Aliança da enfermagem com o usuário na defesa do SUS. Rev. bras. enferm. [Internet]. 2012 Dec[cited 2017 May 19];65(6):893-8. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0034-71672012000600002&lng=en.

7. Backes DS, Backes MS, Erdmann AL, Büscher A. O papel profissional do enfermeiro no Sistema Único de Saúde: da saúde comunitária à estratégia de saúde da família. Ciênc. saúdecoletiva [Internet]. 2012 Jan [cited 2017 May 19];17(1):223-30. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232012000100024&lng=en. http://dx.doi.org/10.1590/S1413-81232012000100024.

8. Marcondes NAV, Brisola EMA. Análise por triangulação de métodos: um referencial para

pesquisas qualitativas. Rev. Univap. 2014; 20(35): 201-8.

9. BardinL. Análise de conteúdo. Lisboa: Edições 70; 2011.

10. Conselho Nacional de Saúde (BR). Resolução n. 466, de 12 de dezembro de 2012. Brasília; 2012. [Internet]. Disponível em: http://www.conselho.saude.gov.br/web_comissoes/conep/index.html.

11. Dutra CD, MC Soares, Meincke SMK, Matos CG. Processo de trabalho da enfermagem na Atenção Primária à Saúde: revisão integrativa.Online braz j nurs. [Internet]. 2016Apr. [cited 2017 Ago 31]; 10(3):1523-34. Available from: https://periodicos.ufpe.br/revistas/revistaenfermagem/article/view/11094/12549

12. Gasparino RF, Simonetti JP, ToneteVLP. Consulta de enfermagem pediátrica na perspectiva de enfermeiros da estratégiaSaúde da família. Rev Rene. 2013; 14(6):1112-22

13. Secretaria Municipal de Saúde - Florianópolis. Vigilância em Saúde. Protocolo de cuidados de feridas. Florianópolis: IOESC; 2007.

14. Secretaria Municipal de Saúde - Florianópolis. Programa Saúde da Mulher. Protocolo de atenção integral a saúde da mulher. Tubarão: Copiart; 2010.

15. Schwartzman H. Menos médicos. Folha de S. Paulo[Internet]. 17 Ago 2013.

16. Lionello CDL, Duro CLM, Silva AM, Witt RR. O fazer das enfermeiras da estratégia de saúde da família na atenção domiciliária. Rev. GaúchaEnferm. [Internet]. 2012 Dec [cited 2017 May 19]; 33(4):103-10. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1983-14472012000400013&lng=en. http://dx.doi.org/10.1590/S1983-14472012000400013.

17. Melo,MCSC, Vilela F, Salimena AMO, Souza IEO. O Enfermeiro na prevenção do câncer do colo do útero: o cotidiano da Atenção Primária. Rev. bras. cancerol. 58(3):389-98, 2012.

18. Moreno CA, Ferraz LR, Rodrigues TS, Lopes AOS. Atribuições dos profissionais de enfermagem na estratégia em saúde da família, uma revisão das normas e práticas. Rev bras ciencsaúde [internet]. 2015 [cited 2017 Set 01]; 19(3):233-40. Available from: http://dx.doi.org/10.4034/RBCS.2015.19.03.10

19. Caçador BS, Brito MJM, Moreira DA, Rezende LC, Vilela GS. Ser enfermeiro na

estratégia de saúde da família: desafios e possibilidades. REME rev. min. enferm [internet]. 2015 jul./set [cited 2017 Set 01]; 19(3):612-9. Available from: http://www.dx.doi.org/10.5935/1415-2762.20150047

20. Friedrich TL, Petermann, XB, Miolo SB, Pivetta, HMF. Motivações para práticas coletivas na Atenção Básica: percepção de usuários e profissionais. Interface (Botucatu) [Internet]. 2017 Ago [cited 2017 Set 01]; ahead 0-0. Available from: http://dx.doi.org/10.1590/1807-57622016.0833

21. Costa RHS, Couto CRO, Silva RAR. Prática clínica do enfermeiro na Estratégia de Saúde da Família. Saúde Santa Maria [Internet]. 2015 Jul./Dez [cited 2017 Ago 31];41(2):09-18. Available from: https://periodicos.ufsm.br/revistasaude/article/view/10841/pdf

22. Lhuilier D. Filiações teóricas das clínicas do trabalho. In:Bendassolli PF,Soboll LA. Clínicas do trabalho. São Paulo: Atlas; 2011.

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