REVISTA ONLINE DE PESQUISA

CUIDADO É FUNDAMENTAL

Universidade Federal do Estado do Rio de Janeiro • Escola de Enfermagem Alfredo Pinto

RESEARCH

DOI: 10.9789/2175-5361.rpcfo.v13.8250

NURSES CONSULTATION IN THE FAMILY HEALTH STRATEGY: A CUT-OFF IN RIO DE JANEIRO

A consulta do enfermeiro na estratégia saúde da família: um recorte do Rio de Janeiro

La consulta del enfermero en la estrategia salud de la familia: un recorte del Rio de Janeiro

Isabela Barboza da Silva Tavares Amaral[1], Ana Lúcia Abrahão da Silva[2]

How to cite this article:
Amaral IBST, Silva ALA. Nurses consultation in the family health strategy: a cut-off in Rio de Janeiro. 2021 jan/dez; 13:227-233. DOI: http://dx.doi.org/0.9789/2175-5361.rpcfo.v13.8250.

ABSTRACT

Objetctive: This article aims to describe the work process of the Nurse during the nursing consultation in the Strategy in Family Health. **Method:** It is a descriptive study of qualitative approach and its data were obtained from field research in four Basic level medical units in the city of Rio de Janeiro. Semi-structured interviews and plain observation were used to carry it out. **Results:** The results show that vertical approaches tend to be applied to the subjects focusing on programs of the Ministry of Health and in the *Biomedical* Model of attention. Besides, there were many interruptions throughout the Nurses' consultations breaking the nurse-and-patients. **Conclusion:** A reorganization of the nurses' work process allowing the patients to hold main role is required. The fact that the overlap in the appointments seriously damages the consultation in the office and delegitimizes the nurses' work must be highlighted.
Descriptors: Public healthcare; Office nursing; Primary health care.

RESUMO

Objetivo: Este artigo objetiva descrever as características do trabalho da Enfermeira durante a consulta de enfermagem na Estratégia Saúde da Família. **Método:** Trata-se de uma pesquisa descritiva de abordagem qualitativa cujos dados foram colhidos através de trabalho de campo em quatro unidades básicas de saúde na cidade do Rio de Janeiro, sendo utilizados para tal, os seguintes instrumentos: entrevista semi-estruturada e observação simples. **Resultados:** Os resultados obtidos apontam para uma tendência à realização de abordagens verticais ao indivíduo, com foco nos programas do ministério da saúde, e no modelo biomédico- flexineriano de atenção, além de revelar repetição contínua de interrupções ao longo das consultas, fragmentando os encontros Enfermeiro-paciente. **Conclusões:** Defende-se uma reorganização do processo de trabalho de modo que o enfermeiro permita o protagonismo do usuário. Reafirma-se que a sobreposição de atendimentos traz graves prejuízos a qualidade do serviço prestado ao indivíduo no consultório, e deslegitima o trabalho do enfermeiro.
Descritores: Saúde pública; Enfermagem no consultório; Política de saúde; Atenção Primária à saúde.

1 1Nurse, Master's Degree in Health Care Sciences, Assistant Professor of Nursing and Midwifery at the Federal University of Rio de Janeiro - Macaé campus. Macaé- Rio de Janeiro-Brazil.

2 Nurse, PhD in Collective Health, Full Professor, Director of the Aurora de Afonso Costa Nursing School, Universidade Federal Fluminense/EEAAC/UFF. Niterói- Rio de Janeiro- Brazil.

RESUMEN

Objetivo: Este artículo objetiva describir las características del trabajo de la Enfermera durante la consulta de enfermería en la Estrategia Salud de la Familia. **Método:** Se trata de una investigación descriptiva de abordaje cualitativo cuyos datos fueron recolectados a través de trabajo de campo en cuatro unidades básicas de salud en la ciudad de Río de Janeiro, siendo utilizados para ello, los siguientes instrumentos: entrevista semiestructurada y la observación sencillo. **Resultados:** Los resultados obtenidos apuntan a una tendencia a la realización de enfoques verticales al individuo, centrándose en los programas del ministerio de salud, y en el modelo biomédico-flexineriano de atención, además de revelar repetición continua de interrupciones a lo largo de las consultas, fragmentando los encuentros Enfermero-paciente. **Conclusiones:** Se defiende una reorganización del proceso de trabajo de modo que el enfermero permita el protagonismo del usuario. Se reafirma que la superposición de atenciones trae graves perjuicios a la calidad del servicio prestado al individuo en el consultorio, y deslegitima el trabajo del enfermero.

Descriptores: Salud pública; Enfermería de consulta; Atención Primaria de Salud.

INTRODUCTION

The health policies have been advancing in recent decades in Brazil, to achieve the consolidation of a health care network that promotes more egalitarian, resolutive, and comprehensive care. In this perspective, the strengthening of Primary Care was fostered to break the paradigm of the biomedical-flexinerian model of health care.

In this context, the nurse has occupied a prominent position as a professional working directly or indirectly in the process of care, management and implementation of the Unified Health System(SUS).[1]

The nursing consultation is among the attributions of this professional category as a private activity of the nurse. According to paragraph 2 of Article 1 of the Resolution of the Federal Nursing Council number 358/2009, the so-called Nursing Process is the nursing consultation, when it is performed in an outpatient health unit, or other environments such as homes, schools, and others. This Resolution organizes the Nursing Process in five stages also appliedto the systematic organization of what the Nursing consultation should be: data collection, nursing diagnosis, nursing care planning, nursing implementation, and evaluation.[2]

The National Primary Care Policy mentions the nursing consultation together with the functions of prescribing medications, requesting tests and performing procedures.[3]

It is also important that the documents of the Ministry of Health that register the actions in primary care are the same for doctors and nurses and almost all direct the consultations to follow a well-defined complaint-conduct model. Thus, the management of the complexity of health problems as they appear in practice is compromised. The consultations of the nurse and the individual attended to end up being "framed" within some health program that will define through protocols, the conduct, and actions to be performed.

This paper aims to describe the characteristics of the nurse's work during the nursing consultation in the Family Health Strategy (FHS) in a certain area of the city of Rio de Janeiro. We intended to generate a movement to [re] think health care practices, as this movement aims to improve the quality of the service developed and reduce the mechanism of the intended actions.

We used the following guiding questions: How is the nurses' work process in the FHS Nursing offices in the city of Rio de Janeiro? What factors interfere in this process? How has it been sought to produce health in these care spaces (the nursing offices)?

The elaborated discussion dialogues with other realities experienced in the country. Although the FHS acquires local characteristics that reflect the specificities of its territory, SUS has unique guidelines.

METHODS

This research has a qualitative approach and is configured in descriptive research, as the researcher is concerned with practical performance.[4] The practice in this study is limited in the performance of the Family Health Nurse during the Nursing consultation, that it is the phenomenon to be analyzed.

The choice of the field is fundamental to the investigation process and must consider several aspects, including the researcher's interest, the object, and the objectives proposed for the study. The municipality is divided regionally into Planning areas to organize the local management of the health care network. In this way, a single programmatic area was selected and the units were chosen to contemplate different profiles of the units with a Family health strategy.

This study had four primary care units as a research field that worked with the Family Health Strategy in the city of Rio de Janeiro within a certain Planning Area of the city, facilitating the researcher's displacement during the collection period data and at the same time contemplating differentiated unit profiles. Therefore, a Family Clinic, a Municipal Health Center (CMS), a School Health Center, and a CMS that works within an Integrated Health Unit participated in the study.

In that city, the FHS coverage in the complete teams went from 3.5% of the population in December 2008 to 65% in December 2016, representing a very significant growth.[5]

The data collection period of this research was in April and May 2015. Each Nurse was observed for a shift of consultations, and the interviews were applied in the same shift; at the beginning or the end of it, at the discretion of the

possibility presented by the research participant, notaffecting his work routine.

The choice of participants was based on the following criteria: 1) Nurses who were active in family health teams in the city of Rio de Janeiro for at least 3 months in the same unit 2) Nurses who were not on vacation or sick leave/ maternity leave in the period of data collection 3) Nurses who agreed to participate in the research by signing the Informed Consent Form.

Ten nurses were selected from four different basic units. The participants were named with the letter 'N' followed by a number that was successively from one to ten, maintaining their anonymity.

As for data collection techniques, simple observation recorded in a field diary was used, where the researcher described his observation and the reflections generated from the observation. The semi-structured interviews carried out were recorded and transcribed in full.

The simple observation was configured as an initial approach to the daily work of the health of the selected teams. Its main objective was to analyze how the nurse's consultation takes place in practice, as well as the interaction with the patient, the dynamics of the consultation, and the work processes instituted in these spaces. In this stage, the researcher produced records of everything that was observed in the field diary.

The semi-structured interview was the second technique used in the production of data to obtain information about the nurses' conceptions regarding the consultation, relational aspects, their view of the work process developed, and the challenges and potential of the nursing consultation in the FHS.

The hermeneutics-dialectics technique was used for data analysis. The hermeneutics searches for understanding, implying the possibility of interpreting, drawing conclusions and establishing relationships, and the dialectics establishes a critical attitude, emphasizing contrast and the rupture of meaning.[6]

When usingthe hermeneutics for data analysis, the overlap between the subject and the object occurs through language, considering the meaning of the individual' speeches including their consensus and dissent, and also using coherent analytical resources for content analysis.[7]

Therefore, this method promotes the possibility of critical analysis, through the understanding of the studied phenomenon; however, without dismantling the facts of the historical context where they are inserted and the possible contradictions that cross it.

After an exhaustive reading of the material produced, some units of meaning were highlighted, emerging as characteristics of the work process that were repeated more often during the observations and present in the interviews. Therefore, each unit of analysis was defined by fragments of interviews and field diary records.

This research was submitted to the Ethics Committee of the Faculty of Medicine of Universidade Federal Fluminense, under the number 996,698, and also to the Ethics Committee of the Municipal Health Secretariat of Rio de Janeiro SMS/RJ, under the number 1.021.164. The participating individuals had their entry into the research by signing the Informed Consent Form.

RESULTS

The age range of the participants was quite diverse, from 26 to 55 years old. More than 50% of these nurses have a training time of up to 05 years, and reserve up to 05 weekly shifts on their agenda for nursing consultation.

Only one of the ten participating nurses is male, which reinforces the historical majority of women in the profession.

The Units of analysis raised as characteristics of the nurses' work process during consultations are presented below, divided into three topics: The Integralityapproach character, the educational-prescriptive character (seen as a single characteristic) and the multiple, simultaneous and fragmentedcharacter, totaling five characteristics observed during data collection.

DISCUSSION

As an organization of the reflections on the findings of the characterization of the nursing consultation, we organized the five characteristics found in three topics to deepen the discussions in this work:

- Integralityapproach character
- Educational-prescriptive character
- Multiple, simultaneous and fragmented character

Integrality approach character

There is a movement approachwith the practice of Integrality in most of the consultations observed. At these times, questions were asked about family members of the patients assisted, questions about family life, questions about the territory where the patientlived, the daily routines of their families. We also approached the need of other family members in prenatal and childcare consultations to involve them in the care process for pregnant women and children respectively. Also, the articulation with other members of the multi-professional team was clear in several situations observed.

These facts show an approximation of the professional with the reality of the patients' lives, greatly contributing to the transition of care modes and to address the health-disease process within the Unified Health System.

We sought an approach with the patient's way of life, consequently a reduction of the focus on the behavior complaint axis, and a reallocation of that patient as a center.

This integral character that emerges as a characteristic of the work performed by Nurses in the offices corroborates with other studies in Brazil. For example, a study in São Paulo identified actions of FHS Nurses in the perspective of integrality, with interventions aimed at family and community context, and the identification of this category as an articulator in the multi-professional team and the health care network, promoting the access of individuals to comprehensive care.[7]

However, this research defined theintegrality character as an approach because the real concretization of integrality should involve a total break in the vertical ways of approaching the individual. However, the conduct of the procedures, the clinical reasoning framed in the "boxes" of the vertical programs is still a strong character in the nursing offices.

This situation was so evident at certain times that the interviewed nurse's approach of how care is delivered is done in the use of a term that refers entirely to a mechanistic work process, as pointed out in the following interview excerpt:

> *[...] Difficulty in the unit, you know, the reality we live is a lack of time, you know? the rush of busy schedules together with the demands, the other diverse demands that we have [...] There is a queue outside waiting, and we have to 'dispatch' the main complaint.* (N 10)

Dispatching is the action of resolving, which has its meaning described in "putting in a state of undertaking a journey or leaving". In other words, "dispatching" is closer to a sense of "getting rid" of the other, than to accept their demand for the construction of a solution that is indeed resolving.

This need to direct the nurse's consultation within this doctor-centered, mechanistic and prescriptive model hinders the integrality approach character to emerge as a performance of the integrality.

Educational-prescriptive character

We noticed that the entire academic education process of the Nurse is permeated by the objective of training a professional who not only is an educator but is also capable of organizing health actions and services and who theoretically holds a "broader" view of the care process of the individuals. The Nurse's self-reference as an educator is evident in the following excerpts from the interview:

> *[...] you take care, you guide, they follow, right ...* (N 8)

> *The main purpose of the consultation would be Health Education.* (N 1)

Education is a mediating tool for care. However, it is worth asking what kind of education the nurse can do inside the offices? Is this verb "to follow" the guidelines that best defines a good result of a health education process? Or do we call education the prescriptive acts dictated in offices?

Most of the consultations observed constitute spaces of "prescriptive education", although there is a concern with the use of language understandable by the individual.

Another striking characteristic still within the scope of the Nurse as an educator in her work process is that this professional has two tools that instrumentalize the act of education during the consultation.The first of these tools is the explanation of the guidelines. In most of the consultations observed, after each guidance is given, a justification as to "why" and "for what", was verbalized.

The language used by the nurses always seemed to be used in an attempt to get as close as possible to the patient's understanding of establishing effective communication for a more adequate and contextualized orientation.

The second tool used in this educational process was the act of repeating the guidelines at the end of the consultation as if a "summary of the care plan" reinforces the patient's understanding.

During the observations, we verified that in addition to doing, the nurse is concerned with explaining what he is doing. In addition to prescribing, the nurse is concerned with whether the patient understands the prescription. In this sense, another study that deals specifically with the prenatal nursing consultation point out that there is a recognition of pregnant women in the nurse's work in the practice of health education during the consultation.[8]

In addition to guiding, the nurse is concerned with understanding whether the patient understands the importance of guidance. However, there is a more prescriptive character than necessarily an educator since there was no space for the patient to make self-care suggestions.

In the observations, we identifiedspeeches in several moments such as: "You can't", "It kills", "You have to do it". Perhaps we can historically locate this educating character in the heritage of the hygienist model, a sanitary practice that follows the Oswaldo Cruz era in the history of Nursing in Brazil.

This posture ends up generating frustration in the nurse when the patient chooses to follow a different path from the one indicated by the Nurse, making the professional responsibilitythat must be shared with the patient as shown in the following fragment of the interview:

> *It's not because you don't… I don't feel incapable, you know? But you wonder ... could I do more? And how to do more if you have a workload that ... you saw it, right [...]. Because educate it is you sometimes have to be there all day talking, talking, talking, talking ... and that's what makes me sad, because sometimes, even you guide, even... some right, because some accept it, right there are both sides of the coin.* (N 8)

This conception of what health education is, in addition to being mistaken, generates frustration because the idea of what is the best care must be built collectively. Otherwise, the nurse's work will pass from educator to "medical police".

We need to ask the individual what he wants. Education in true health should enable changes in people's lives, instructing them to make decisions and not represent attempts to standardize, control, or, many times, to medicalize their own lives. Regarding the transformative power of the true health education, in other studies, the educational process must consider popular interests and knowledge, so that the content addressed by the health professional is indeed significant for individuals and meets their needs.[9-10]

Multiple, simultaneous and fragmented character

Another characteristic that goes through the nurse's work process during nursing consultations is that this professional performs multiple tasks at the same time, giving multiple and simultaneous character work during the consultation.

The consultations usually are overlapping; while starting a new appointment, registering a previous appointment, receiving a demand for a call from the CHA, or taking the case to the door of the office, or even entering the office in the middle of consultation to share something about another case.

During the observation shifts, the nurse's consultation was interrupted several times in all units - reaching 10 times in a single consultation that lasted about 40 minutes.

The overlapping occurs due to the attendance that is the nurse's responsibility, but also due to the attendance of medical demands. The nurse is activated as a "bridge" between the patient and the doctor for example for the renewal of a controlled prescription, eliminating the characteristics of nursing work. Other times, the demands are administrative, such as replenishment of stock in a vaccine room.

We noticed an extreme demand in the figure of the professional nurse as if they were always failing to do something. Maybe in fact they are always failing to do it, but it is important to reflect on the "how many things" are demanded to be done by these professionals. In this sense, an integrative review on nursing consultation shows that the multiple roles of nurses within the Family Health Strategy can cause psychological and emotional wear of these professionals, directly interfering with the quality of care provided during consultations.[11]

The following statement shows certain anxiety of the nurse professional when describing his greatest difficulty in conducting the nursing consultation:

> *We have a very high demand and it makes us a little nervous, because ... not nervous; incapable because we want to welcome everyone, and we try. I try to welcome everyone but we are not superwomen or supermen, and that leaves me with my hand ... with my hands tied.* (N 2)

This simultaneity of actions generates a highly fragmented work process within the nursing offices, making it very difficult to continue a consultation after the beginning of it, without interrupting it.

Also, during the observations,we noticed that several times, the nurse once interrupted forgot "where she left off" in the consultation. Several times, the nurses observed verbally expressed the result of the following interruptions: "Where did I stop?", "Where were we?", "Did I forget something?". In one of the observations, in about an hour of consultation, the nurse had been interrupted twelve times (on average, one interruption every five minutes).

Although it is not the objective of this study, to measure the workload of nurses in the Family Health Strategy, and the data collected about their work process during the act of the nurse's appointment points to a service overload that in addition to compromising the health of the worker, may compromise the quality of care.

This concern is reflected in the following interviewee's statement:

> *The CHA knocks on the door all the time, a phone that keeps ringing, so this is one of the things that ... sometimes the patient is there in the greatest difficulty of passing on information. Then the phone rings. Ended. Until you get back to that [...] And I think it should happen in any unit, right. Interruptions ... it's terrible.* (N 7)

This comment at the end of the interviewee's speech saying that interruptions should happen in any unit points to a process of naturalization of interruptions.

This overlapping of attendances and simultaneity of actions are understood throughout the observation period and appeared quite clearly in the interviews, as shown in two excerpts from the interviews below:

> *So, I think it is a hurry, not only in nursing but in the whole world, right? The whole world is in a hurry for something [...] So, the tests are fast, the evaluation is fast, the information is fast [...]. In the past, there was no such thing, so the accelerated work process and the very large demand-supply, by the way; very high demand and low supply capacity.* (N3).

> *Difficulty in the unit, right, in the reality that we live,the lack of time, right? the rush of busy schedules together with the demands, the other diverse demands that we have. The Nurse, who is not just attending patients.*

Reports, organizing the team, organizing the flow, knowing everything that happens in the unit. It would be more about the multiplicity of functions, you know? (N 10)

There is an immediacy by the professionals and patients, which is also a social paradigm of the modern world, where it seems that nothing can wait. In one of the consultations, a patient who had arrived due to a prescription renewal is not satisfied with waiting outside the office, and enters in the middle of an appointment and waits for the nurse to perform the prescription next to her desk, while the scheduled patient waits while sitting in the office to continue her interrupted consultation.

This characterization of the nurse's work process in the doctor's office highlights to two possible aspects: There are more demands than the nurse's response capacity, who ends up being frustrated by not being able to perform her role; or, the work process of this professional is not organized, who, letting himself be captured, most of his time, by the protocol directed by the manuals, by the high demand and by the social immediacy, fragment, reduce and "de-potentialize" the consultation of nursing as a care tool.

The excess of demands isseen as a major producer of increased workload for FHS nurses in other studies as well.[11-12-13] However, we need to think about ways of reorganizing processes and reframing work priorities in FHS.

CONCLUSION

The possibility of performing the work in the office in a way not captured by the only biomedical model of care is possible if there is a possibility for the planning of the work process to occur so that the nurse allows the role of the patient.

Although the data were collected before the publication of the new National Primary Care Policy, which dropped from four thousand to three thousand five hundred that the maximum recommended several registered per team, there is no establishment of social vulnerability criteria.[3] In this sense, rethinking the numbers of patients monitored is a solution since the excessive number of patients added to the high degree of social vulnerability in the communities directly interferes with the quality of the nurse's work, also bringing exhaustion and frustration. We highlight the need to develop other studies that better evaluate this numerical dimensioning of family health teams.

Also, the FHS nurse should appropriate the clinic and the drug treatment protocols but not making them the axes of the main conduction of nursing consultations to de-characterize them as a private activity of the nurse who requires specific skills to do so.

Weshould emphasize once again that the challenge of overcoming social immediacy, which also captures the live work of nurses is another important point to configure the quality care in the office environment. We need to reflect on how nurses have allowed being led in their work process by an immediate, normalizing "dictatorship of modernity", hindering the possibility of health production of the nurses and patients in the meetingsat the doctor's offices.

We reaffirm that the overlapping of attendances brings serious losses to the quality of the service provided to the individual in the office, and delegitimizes the nurse's work.

REFERENCES

1. Santos FPA, Acioli S, Rodrigues VP, Machado JC, Souza MS, Couto TA. Nurse care practice in the family health strategy. Rev. bras. enferm. (Online). [Internet] 2016 nov-dez. [cited 2018 mar 10]; 69(6):1124-61. Avaiable from: www.scielo.br/scielo.php?script=sci_arttext&pid=S0034-71672016000601124&lng=en&nrm=iso&tlng=en
2. Brasil. Resolução do Conselho Federal de Enfermagem de número 358/2009. Dispõe sobre a Sistematização da Assistência de Enfermagem e a implementação do Processo de Enfermagem em ambientes, públicos ou privados, em que ocorre o cuidado profissional de Enfermagem, e dá outras providências. Diário Oficial da União. 23 out 2009.
3. Ministério da Saúde (BR). Política Nacional de Atenção Básica: Operacionalização. Brasília (DF): MS; 2017.
4. Gil CRR. Atenção primária, atenção básica e saúde da família: sinergias e singularidades do contexto brasileiro. Cad. Saúde Pública (Online). [Internet] 2006 jun [cited 2018 mar 18]; 22(6):1171-1181. Avaiable from: http://www.scielosp.org/pdf/csp/v22n6/06.pdf.
5. Pinto LF, Rocha CMF, Lapão LV. Comparative health systems: primary health care in the cities of lisbon and rio de janeiro. Ciênc. Saúde Colet. [Internet]. 2017 [cited 2018 mar 29]; 22(3):676-677. Avaiable from: http://www.scielo.br/pdf/csc/v22n3/en_1413-8123-csc-22-03-0676.pdf
6. Taquette SR. Análise de dados de pesquisa qualitativa em saúde. Rev. Atas- Investigação qualitativa em saúde [Internet] 2016 [cited 2018 apr 10]; v.2. Avaiable from: *https://proceedings.ciaiq.org/index.php/ciaiq2016/article/download/790/777*
7. Furtado MCC, Mello DF, Pina JC, Vicente JB, Lima PR, Rezende VD. Ações e articulações do Enfermeiro no cuidado da criança da Atenção Básica. Texto & contexto enferm. [Internet] 2018 [cited 2018 apr 15]; 27 (1). Avaiable from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-07072018000100309&lng=pt&tlng=pt#B31
8. Silva CS, Souza KV , Alves VH, Cabrita BAC, Silva LR. Nurse's perfomance in prenatal consultation: limits and capabilities. Rev. Pesqui. (Univ. Fed. Estado Rio J., Online). [Internet] 2016. abr./jun. [cited 2018 apr 15]; 8(2):4087-4098. Avaiable from: http://www.seer.unirio.br/index.php/cuidadofundamental/article/view/2009/pdf_1839
9. Santili, PGJ, Tonhom SFR, Marin MJS. Educação em saúde: algumas reflexões sobre sua implementação pelas equipes da estratégia saúde da família. Rev. bras. promoç. Saúde (Online). [Internet] 2016. [cited 2018 apr 22]; 29. Avaiable from: http://periodicos.unifor.br/RBPS/article/view/6411
10. Amthauer C. A educação popular e a fusão dos diferentes saberes nas práticas educativas em saúde. Rev. Enferm. UFPE on line. [Internet]. 2017 jan. [cited 2018 apr 22]; 11(1 suplement 1): 438-441. Avaiable from: https://periodicos.ufpe.br/revistas/revistaenfermagem/article/view/13573/16369
11. Amaral IT, Abrahão AL. Nursing consultation in Family Health Strategy, increasing the recognition of the distinct forms of action: an integrative review. Rev. Pesqui. (Univ. Fed. Estado Rio J., Online). [Internet]. 2017. out./nov. [cited 2018 abr 20]; 9(4): 899-906. Avaiable from: http://www.seer.unirio.br/index.php/cuidadofundamental/article/view/4539/pdf

12. Amaral IT, Abrahão AL, Pina FR. Spontaneous demand in the Family Health Strategy: an integrative review. Rev. Enferm. UFPE on line. [Internet]. 2015 ago [cited 2018 apr 20]; 9(Supl.7):9086-94. Avaiable from: https://periodicos.ufpe.br/revistas/revistaenfermagem/article/view/10701/11771

13. Pires DEP, Machado RR, Soratto J, Schere MA, Gonçalves ASR, Trindade LL. Nursing workloads in family health: implications for universal access. Rev. latinoam. enferm. (Online). [Internet]. 2016 [cited 2018 apr 22]; 24:e 2677. Avaiable from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-11692016000100313

Received in: 26/10/2018
Required revisions: 28/03/2019
Approved in: 18/05/2019
Published in: 15/03/2021

Corresponding author
Isabela Barboza da Silva Tavares Amaral
Address: Rua Aloísio da Silva Gomes, 50
Macaé/RJ, Brazil
Zip code: 27930-560
Email address: isabela.t.amaral@gmail.com
Telephone numbers: +55 (22) 2796-2500/ 2141-4010

Disclosure: The authors claim to have no conflict of interest.