Revista de Enfermagem e Atenção à Saúde
REAS

ORIGINAL ARTICLE
DOI: 10.18554/reas.v7i3.3061

DIFFICULTY FACTORS IN CARRYING OUT LIGHT TECHNOLOGIES IN NURSING IN PRIMARY CARE

FATORES DIFICULTADORES NA REALIZAÇÃO DAS TECNOLOGIAS LEVES NO CUIDADO DO ENFERMEIRO NA ATENÇÃO BÁSICA

FACTORES DIFICULTADES EN LA REALIZACIÓN DE LAS TECNOLOGÍAS LEVES EN EL CUIDADO DEL ENFERMERO EN LA ATENCIÓN BÁSICA

Joyce Wadna Rodrigues de Souza[1], Fabrícia Cristina Vidal Silva[2], Paloma Karen Holanda Brito[3], Rayara Cibelle Ribeiro da Silva[4], Bruna Alves[5], Marcelo Costa Fernandes[6]

ABSTRACT

Objective: To identify the obstacles found in the implementation of activities related to light technologies aimed at the care provided by nurses in Primary Care. **Method:** This is a descriptive study with a qualitative approach carried out with 15 nurses of the Family Health Strategies of the city of Cajazeiras, Paraíba, Brazil. A semi-structured interview was used for data collection, which took place between January and February 2016, after approval by the Ethics and Research Committee. **Results:** Some factors hinder the use of light care technologies, such as the reduced time to attend to the population, inadequate physical structure, immediacy of care, and the pressure of demand for work. **Conclusion:** It is essential that there is support from the managers through the provision of ongoing education actions to health professionals on the importance of using interactionist technologies in their everyday practices.

Descriptors: Nursing Care; Nursing; Primary Health Care.

RESUMO

Objetivo: identificar os obstáculos encontrados na execução de atividades relacionadas às tecnologias leves voltadas ao cuidado do enfermeiro na Atenção Básica. **Método:** Trata-se de um estudo descritivo com abordagem qualitativa realizado com 15 Enfermeiros das Estratégias de Saúde da Família do município de Cajazeiras, Paraíba. Foi utilizado para coleta de dados uma entrevista semiestruturada, que aconteceu entre os meses de janeiro e fevereiro de 2016, após a aprovação do Comitê de Ética e Pesquisa. **Resultados:** Percebeu-se a existência de alguns fatores que prejudicam a utilização das tecnologias leves do cuidado, dentre eles, o tempo reduzido para realizar o atendimento à população, estrutura física inadequada, imediatismo do atendimento, a pressão da demanda para o trabalho. **Conclusão:** É imprescindível que exista o apoio da gestão oferecendo ações de educação permanente para com os profissionais da saúde sobre a importância da utilização das tecnologias interacionistas em seus cotidianos de práticas.

Descritores: Cuidados de Enfermagem. Enfermagem. Atenção primária à saúde.

[1] Enfermeira, UFCG, Cajazeiras, PB – Brasil. Email: wadnajoyce@gmail.com
[2] Enfermeira, UFCG, Cajazeiras, PB – Brasil. Email: fabrícia.vidal23@gmail.com
[3] Enfermeira, UFCG, Cajazeiras, PB – Brasil. Email: pah.karen@hotmail.com
[4] Enfermeira, UFCG, Cajazeiras, PB – Brasil. Email: rayararibeiro@outlook.com
[5] Acadêmica de enfermagem, UFCG, Cajazeiras, PB – Brasil. Email: brunaalves0117@gmail.com

[6] Enfermeiro. Doutor pelo Programa de Pós-graduação Cuidados Clínicos em Enfermagem e Saúde pela UECE. Líder do Grupo de Pesquisa Laboratório de Tecnologias de Informação e Comunicação em Saúde – LATICS/ UFCG/ CNPq, Cajazeiras, PB – Brasil. Email: celo_cf@hotmail.com.

RESUMEN

Objetivo: identificar los obstáculos encontrados en la ejecución de actividades relacionadas con las tecnologías ligeras dirigidas al cuidado del enfermero en la Atención Básica. **Método:** Se trata de un estudio descriptivo con abordaje cualitativo realizado con 15 Enfermeros de las Estrategias de Salud de la Familia del municipio de Cajazeiras, Paraíba. Se utilizó para recolección de datos una entrevista semiestructurada, que ocurrió entre los meses de enero y febrero de 2016, tras la aprobación del Comité de Ética e Investigación. **Resultados:** Se percibió la existencia de algunos factores que perjudican la utilización de las tecnologías ligeras del cuidado, entre ellos, el tiempo reducido para realizar la atención a la población, estructura física inadecuada, inmediatez de la atención, la presión de la demanda para el trabajo. **Conclusión:** Es imprescindible que exista el apoyo de la gestión ofreciendo acciones de educación permanente para con los profesionales de la salud sobre la importancia de la utilización de las tecnologías interaccionistas en sus cotidianos de prácticas.

Palabras-clave: Atención de Enfermería. Enfermería. Estrategia de salud familiar.

INTRODUCTION

The dynamics of the nurses' work process is characterized by the diversity of actions they carry out, mainly by acting in diverse areas, such as care, management, research, teaching and political issues in this category, as well as in a wide range of subjects involving the health area.

Care is crucial in the work process of this category, because it involves interpersonal contact with the subject and their health needs. This care is determinant in assisting the human being in their needs and includes behaviors, attitudes and acts related to the social context of the user. In addition, providing care, in the light of sensitivity in nursing, comprises care actions that go beyond the biomedical model, thus encompassing subjective activities, such as contact, look into the eyes, the perception of afflictions and feelings.[1,2,3]

When the user is seen as a human being, a subject and a social actor, a more favorable scenario for care is built with the professional. This makes nursing care a social practice that is characterized by transversal action, that is, present in all care settings. However, it is worth mentioning its relevance in Primary Care (PC) since it is the main gateway to the Unified Health System (SUS) and because the care provided in this field of care determines the attendance of the user to the services and the strengthening of self-care.[4]

There has been discussion on the forms of organization of health actions. On

the one hand, we see the conceptual understanding of the expression "assistance model" and the practice of activities focused only on the disease; on the other, the characteristics of what could be a model guided by the principles and guidelines of SUS, that is, more comprehensive and based on the subjectivity of the user, use of light technologies and continuity of care. Despite efforts to promote increasingly humanized actions in health care, there is often a recurrence of practices based on the traditional care model, anchored on prescriptive and objective actions.[5]

In the practice of nursing care, the professional uses these technologies combined with the care practices that underpin the profession. In this way, care is seen as inherent to the human being, taking into account their needs, which assists in coping with the difficulties of the disease and promoting their health.[6] An alternative to reformulate the traditional model of assistance is the use of light technologies. Light technologies are used in human relations, such as forming of bonding, promotion of autonomy, and reception in the meeting between the professional and the user. It is through these technologies that positivity is built up and consolidated among the individuals involved in this process, as well as the meeting of the needs of individuals and the valorization (of workers and users) as a strategies to intervene in the concretization of the care.[7,8]

Therefore, the present study was based on the following guiding question: What are the difficult factors in performing the light technologies in the care provided by nurses in Primary Care?

This study is relevant for nursing, since it is necessary to emphasize the aspects that may hinder the practice of light care technologies in order to highlight the need for reconstruction of the care model, aiming at the formation of bond between the professional and the user, the promotion of autonomy and, consequently, the improvement of the quality of the services provided. Thus, the objective was to identify the obstacles encountered in the execution of activities related to light technologies focused on the care provided by nurses in Primary Care.

METHOD

The present research is descriptive with a qualitative approach. It was carried out in the Primary Health Care of the city of Cajazeiras, in the state of Paraíba, Brazil. This city is part of the 4th Macroregion of Health and the 9th

Regional Health Management of Paraíba, which is currently composed of 19 Family Health Units.

Research participants were 15 nurses that make up a total of 23 Family Health Teams, allocated in the 19 Primary Care Units of Cajazeiras. The inclusion criterion adopted was having been working for more than six months as a nurse in Primary Care, since we understood this as a minimum period to develop familiarity with the dynamics of this care scenario. The exclusion criteria were being on vacation, sick leave or away from work.

We used the semi-structured interview, which occurred between January and February of 2016, in a private place in the Basic Health Units where the nurses were worked. As a methodological process, the Collective Subject Discourse (CSD) was used to analyze the data, which is a method that favors the representation of the thought of a given group.

It is a methodological strategy for organization and tabulation of the qualitative data of verbal nature, obtained from testimonials. Basically, it consists in analyzing the collected verbal material to extract from it the Central Ideas (CI) and their corresponding Key Expressions (KE).[9] These statements make up the raw material in the form of one or several speech-syntheses in the first person singular, or rather, in the first (collective) person singular. This is because at the same time it shows the presence of an individual being in the discourse, it makes a collective reference, since this individual speaks in the name of a collective group.

The research began after the approval of the project by the Research Ethics Committee (REC) of the Federal University of Campina Grande, Cajazeiras campus, under process number 1,347,458. Participation in the study began with the signing of the Informed Consent Form (ICF), drawn up in two copies, signed by the research participant, as well as by the researcher in charge. Both copies contained the telephone contact of the persons responsible for the research and of the REC. The ethical and legal components are present at all stages of the investigation, in accordance with Resolution 466/12 of the National Health Council.

RESULTS

With regard to the activities carried out by the nurse and his/her team in the community, we noticed that some factors hinder the use of light care technologies. We identified four main categories that

will be exposed and analyzed with their respective CSD.

The first category was constructed based on the interviews of eight nurses, which addressed the weaknesses of performing the reception in the scenario of Primary Care, as shown below:

Category 01 - Reception in Primary Care: resistance and difficulties in its implementation:

CSD01: *At the Family Health Unit, there is not a good reception both from professionals and from patients, often due to the stress of everyday life, lack of knowledge of the professionals, since not all of them belong to the health area, or lack of training on how to better welcome the arriving patient. There are very deficient practices; it has not been applied. Unfortunately, the Primary Care is still too rigid; there is not much reception. There is no welcome, there is no humanization. Sometimes there is only a listening of an information that should be given and no, there is no such welcome. There is, sometimes, welcome on the part of some and not on the others. This is also not perceived by the community, this logic of the reception; they complain about the professional that sometimes fails to do it.*

The second category presents the vulnerabilities faced in the listening process. Six nurses participated in this category.

Category 02 - Experienced fragilities for the implementation of listening:

CSD02: *So, at least in my activities, I try to listen, I try to do the exercise of listening, whatever it is. But the population is usually very attached to the medical issue, it is that unending challenge for nursing. I think in health, in a general way, population is still much attached to the medical care, the consultation, the medicalization. They are much focused, still too focused to the previous method, to the previous health system. So, everything for them is an emergency, there is no time to wait here for us to attend, and they are not used to a consultation with listening, right? So many times, no matter how much you say, no matter how much you show the importance of practicing qualified listening, you have the weaknesses that not everyone has the ability to put in the other's shoes. Therefore, sometimes one does not put oneself in the other's shoes and it weakens the care also within the team.*

Promotion of autonomy is the theme for the third category, in which five nurses participated.

Category 03 - Promotion of autonomy: incipient knowledge and emphasis on outpatient practices

CSD03: *If promotion of autonomy means what I think it is, that is, giving autonomy and empowerment to this patient, I think we try but, as I said, there is no scientific basis There are frailties. I believe it is still under construction or to be built, even the very fact that they feel free to participate, right? I think that, from my daily practice, it is something to be built, to be improved, because it is still very… it is still very difficult. When we talk about empowerment it is very difficult, because who works in the Family Health Program, and who had already been in the Family Health Program, we see that we often have to offer something that is totally*

out of context to bring this patient. Even because we, professionals, have adopted this practice of doing outpatient care, and we are too much time inside the Unit, too much time inside the Family Health Program, and we do not try to leave, to exceed this limit and to leave, and to bring that user to us in that way. In addition, when the patient seeks the service and there is no service, they feel demeaned, they think that they are moving from place to place, think the service is still insufficient. There are also those that have some difficulty in feeling co-responsible they want the team, the managers, the world, to feel responsible. They are never responsible for anything; we have difficulty dealing with this.

Finally, the fourth category addresses the resistance that the population demonstrates when nurses try to use care technologies, in which seven nurses participated.

Category 04 - Care technologies: population's resistance to its implementation.

CSD04: *Another difficulty factor is the population itself, the issue of listening, of the bond. The way I think, I believe that, for the population, the issue of empowerment, it is not all of them that manage to really empower themselves. So, I think the population still has a closed mind for these changes in health care. The main thing is the lack of understanding of the population, the lack of understanding of the population about the importance of welcome and bond. We often make a longer consultation because we need to make a more qualified listening and the others complain, you know?! People do not want to understand, some of them, well, they have a hard time accepting it, right?*

DISCUSSION

CSD01 points to welcome as a crucial instrument for the successful work process in PC, but there is no effective implementation thereof, mainly due to the disarticulation among the members that make up the team.

A study[10] developed with PC health professionals from a city in the interior of the state of Rio Grande do Sul showed that welcome has been a segmented and non-systematic practice, so that service professionals end up implementing it according to individual understanding, which demonstrates the ignorance of the practice and its distancing from the principles of SUS.

There are many obstacles that hamper the development of a welcoming practice, such as reduced time to attend to the population, inadequate physical structure, immediacy of the consultation and the pressure of the demand for work, which lead to dissatisfaction on the part of professionals and population.[11,12]

In view of the difficulties encountered, there should be an incentive to the implementation of welcome, aiming to use it as a communication tool between health professionals and the population

and, mainly, to improve care and the resolvability of the identified problems.

In addition, CSD01 also evidences the transfer of the responsibility for the non-effectiveness of welcome to the community; however, this can be better explained by the lack of awareness of the population for such practice. It is extremely important to use educational actions in order to raise the awareness of the community about the relevance of interactionist technologies, which can contribute to greater acceptance, since welcome helps in the search for a longitudinal assistance, organization of the service demands, and promotes accessibility to health services and comprehensiveness of care.[13]

With regard to the training of professionals, managers should encourage continuing education, as well as strategies for the use of care technologies in PC in order to provide greater scientific improvement and adoption of the health model based on the logic of the extended clinic. This is relevant because the discourse of study participants shows differences between conceptualization and practice of welcome, both on the view of professionals and on that of the users (in the nurses' perspective), which is a reflection of the fragility of the team formatting and of the activities that are offered to the population.[14]

According to CSD02, the practice of active listening by professionals in PC is weakened, as the population is still reluctant to this "reformulation" of care and demonstrates a preference for medical care and for actions focused on medication prescriptions. This may be a consequence of the historical construction process of health care models, especially the biomedical model, centered in the hegemony of the physician and in the clinic with an emphasis on the disease, which is still very present in health services.[15]

Given this, this assistance paradigm influences both PC users and health professionals who, in the performance of their work process, do not show the population alternatives to care production beyond medical consultation, which results in individualistic actions to the patients. [16,17]

Nurses also highlighted the issue of the demand for immediate care in the Family Health Strategy (FHS) as one of the factors that make it difficult to implement listening. This demand is resulting from the fragility in the provision of guidance and information to the population on the adequate use of the health services. In view

of this, the service must be reorganized, with planning and performance of actions that inform and raise the population's awareness on the appropriate demand for care, as well as the importance of listening, aiming at improved care. [18]

Also, the overload of tasks and the dependence are obstacles to the conduction of these care practices through listening due to excessive bureaucracy and even the nurses themselves, who take conduction of many tasks for themselves. Converging with these findings, a study carried out with PC nurses in the city of Maracanaú, Ceará, identified that, because of the great demand and the scarce time for each patients, the actions that are based on the use of light care technologies, such as welcome, qualified listening and bonding, are now being neglected. Combined to this, there has been reluctance from the community, especially related to actions of health promotion and disease prevention.[19]

The CSD03 of revealed that an obstacle to the promotion of autonomy is the insufficiency of knowledge of these professionals, who lack of training to encourage the empowerment of people met in PC. In addition, the professionals highlighted the prioritization of outpatient actions with the scope of achieving goals, often due to the imposition of managers, which encourages distancing with the philosophy of this scenario of care.

It was noted, according to studies,[20,21] a trend in health professionals to devalue the construction of a dialogical relationship with users, which makes the promotion of autonomy difficult. They use hemodialistic outpatient practices to promote care, such as requesting tests and referrals for specialized consultations, when the needs could often be met at the Health Unit itself, from other care options.

Such conduct leads users to positively qualify outpatient actions, specific and effective practices in the short term, and devalue health promotion and disease prevention activities. These conditions of care production based on the hegemonic model do not generate a means for closer relations between health professionals and the community, and hinder the ability of these subjects to understand and act on themselves and their life and health contexts.

Care based on the expanded clinic is a potential tool to transform life contexts, since this action starts to be developed from the local reality and needs.[22] Thus, it represents a differentiated model of providing care, resulting in changes in the lives of individuals and the

gradual disruption of the traditional model of health services.

It is believed, therefore, that the promotion of autonomy of social actors will only be achieved once nurses realize the importance thereof in the process of producing care, that is, through the adequate use of technological devices together with users, ceasing this to be an one-sided practice by the nurse and becoming a mutual responsibility.

According to the aforementioned CSD04, we can note that nurses mentioned the reluctance of the population, also discussed in CSD02, on the implementation of light care technologies in PC. Obviously, there is reluctance; this is a fact, but the nurse, in certain situations, transfers all the "fault" to the user. However, this professional is also responsible in creating obstacles in the implementation of the light technologies as daily practice in this scenario.

Nurses face some difficulties in the construction of educational activities, such as those related to health promotion and disease prevention. This is due to the curativist culture that accompanies a large part of the users of health services.[23]

So that these activities are valued and accepted by the users and the multidisciplinary team, nurses should develop educational interventions that foster previous knowledge, aim at a liberating practice and involve all participants in the construction of knowledge.

Nurses must believe in these transformations and in the health benefits for the entire population so that users can understand the guidelines and work together with the team in the planning of actions. For this purpose, they must have an effective understanding of the shared knowledge in order to better understand the objective of the use of light care technologies and to stop focusing on the need to replicate practices centered on hard technologies.[23]

Finally, the adoption of educational actions allows social actors to develop their individual and collective capacities aimed at improving the quality of life and health in the search for more and more autonomy in the conduct of their lives. Thus, among the actions of PC, educational practices emerge as a primary tool to raise awareness and transform the perception of professionals and users on the objectives of this area of action and, more than that, to promote reflections that lead to changes in attitudes and behaviors of these individuals.

FINAL THOUGHTS

In the course of this study, we identified the main factors that hinder the implementation of light care technologies, namely welcome, listening, bonding and empowerment of the subjects seen in PC by the nurse.

The lack of knowledge coming from both the population and the professionals hampers the progress of continued care, the formation of the bond and the strengthening of the use of light technologies. The welcome must attend to the singularities of the subjects hosted in the PC, considering their social values, as well as socioeconomic, cultural, psychological and spiritual conditions.

However, for this to happen, it is necessary to structure the teamwork, mainly through permanent training, in order to guarantee the user's insertion and provide work based on comprehensiveness, considering the population's needs, the health determinants and conditioners, strengthening the bond and contributing to the existence of teamwork, which presupposes changes in interpersonal work and social relations.

The results obtained in this research have limitations, since it was developed in the PC of one city, so that we cannot generalize its considerations for all other services of national scope, since it depends on the context of health of each population and the dynamics of the work process of nurses of each reality.

We believe that revealing the particularities and weaknesses that permeate the implementation of the light care technologies will enable a better understanding of the reality of the nurses' work within the PC, which may allow more and more improvements in the actions in this area of activity.

Finally, there is a need for new researches, especially those of an interventionist nature, as well as managers' support in offering ongoing education for health professionals about the importance of the use of interactionist technologies in their daily practices in PC, thus aiming at transformations in this scenario.

REFERENCES

1. Waldow VR, Borges RF. Caring and humanization: relationships and meanings. Acta Paul Enferm. [Internet]. 2011 [citado em 17 fev 2018]; 24(3); 414-8. Disponível em: http://www2.unifesp.br/acta/pdf/v24/n3/v24n3a17_en.pdf
2. Queiroz BFB, Garanhani ML. Construindo significados do cuidado de enfermagem no processo de formação: uma pesquisa fenomenológica. Ciênc Cuid Saúde. [Internet]. out-dez 2012 [citado em 27 nov 2017]; 11(4):775-83. Disponível em:

http://ojs.uem.br/ojs/index.php/CiencCuidSaude/article/viewFile/21660/pdf
3. Souza MGD, Mandu ENT, Elias AN. Perceptions of nurses regarding their work in the family health strategy. Texto & Contexto Enferm. [Internet]. jul-set 2013 [citado em 05 out 2017]; 22(3):772-79. Disponível em: http://www.scielo.br/pdf/tce/v22n3/v22n3a25.pdf
4. 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 Saúde Colet. [Internet]. 2012 [citado em 13 jan 2018]; 17(1):223-30. Disponível em: http://www.scielo.br/pdf/csc/v17n1/a24v17n1.pdf
5. Fertonani HP, Pires DEP, Biff D, Scherer MDDA. The health care model: concepts and challenges for primary health care in Brazil. Ciênc Saúde Colet. [Internet]. 2015 [citado em 27 nov 2018]; 20(6):1869-78. Disponível em: http://www.scielo.br/pdf/csc/v20n6/en_1413-8123-csc-20-06-1869.pdf
6. Silva RC, Ferreira MA. The practice of intensive care nursing: alliance among technique, technology and humanization. Rev Esc Enferm USP [Internet]. 2013 [citado em 18 fev 2018]; 47(6):1324-31. Disponível em: http://www.scielo.br/pdf/reeusp/v47n6/en_0080-6234-reeusp-47-6-01325.pdf
7. Thofehrn MB, Montesinos MJL, Arrieira IC, Àvila VC, Vasques TCS, Farias ID. Processo de trabalho dos enfermeiros de um hospital da Espanha: ênfase nas tecnologias de cuidado. Cogitare Enferm. [Internet]. 2014 [citado em 15 jan 2018]; 19(1): 141-46. Disponível em: http://www.redalyc.org/html/4836/483647660021_2/
8. Merhy EE, Franco TB. Por uma composição técnica do trabalho em saúde centrada no campo relacional e nas tecnologias leves. Apontando mudanças para os modelos tecno-assistenciais. Saúde Debate [Internet]. set-dez 2003 [citado em 17 mar 2018]; 27(65):316-23. Disponível em: https://www.arca.fiocruz.br/bitstream/icict/712/3/Travassos_Viacava_Landmann_Alocacao%20equitativa_2003.pdf#page=141
9. Lefèvre F, Lefèvre AMC. O discurso do sujeito coletivo: um novo enfoque em pesquisa qualitativa (desdobramentos). Caxias do Sul, RS: EDUCS; 2003.
10. Borges JDM, Silva LAAO. Acolhimento na atenção básica à saúde: saberes e práticas. Rev Enferm UFPE on line [Internet]. maio 2015 [citado em 16 mar 2018]; 9(5):7887-94. Disponível em: https://periodicos.ufpe.br/revistas/revistaenfermagem/article/view/10538/11443
11. Santana JCB, Fortes NM, Andrade AV, Soares APF, Lima JRM. Acolhimento em um serviço da atenção básica à saúde de Minas Gerais. Rev Enferm Cent-Oeste Min. [Internet]. mai-ago 2012 [citado em 21 fev 2018]; 2(2):166-76. Disponível em: http://www.seer.ufsj.edu.br/index.php/recom/article/view/199
12. Nascimento MVN, Leite CCA, Rodrigues BS, Santos IA, Oliveira JOD, Bitú LSL. Integrated practices in health: a community therapy experience in basic care. Rev Enferm UFPE on line [Internet]. oct 2012 [citado em 10 fev 2018]; 6(10):2586-95. Disponível em: https://periodicos.ufpe.br/revistas/revistaenfermagem/article/view/7506
13. Penna CMM, Faria RSR, Rezende GP. Acolhimento: triagem ou estratégia para universalidade do acesso na atenção à saúde? Rev Min Enferm. [Internet]. 2014 [citado em 11 fev 2018]; 18(4):815-29. Disponível em: http://www.reme.org.br/artigo/detalhes/965
14. Kessler M, Lima SBS, Weiller TH, Lopes LFD, Ferraz L, Thumé E. Longitudinality in Primary Health Care: a comparison between care models. Rev Bras Enferm. [Internet]. maio 2018 [citado em 16 out 2018]; 71(3):1063-71. Disponível em: http://www.scielo.br/pdf/reben/v71n3/0034-7167-reben-71-03-1063.pdf

15. Santos AR, Carvalo MF, Santos RMM, Anjos SDS, Andrade CS. A produção do cuidado na atenção primária à saúde: uma compreensão teórico-filosófica. Ciênc Cuid Saúde. [Internet]. jul-set 2018 [citado em 27 out 2018]; 17(3). Disponível em: http://ojs.uem.br/ojs/index.php/CiencCuidSaude/article/view/39945/751375138365
16. Engela MHT, Rodarte AC, Rotondaro Júnior A, Seixas CT, Viegas SMF, Lanza FM. Uso das tecnologias em saúde na atenção básica às pessoas em condições de hipertensão arterial sistêmica. Rev Pesqui Cuid Fundam. [Internet]. jan/mar 2018 [citado em 15 nov 2018]; 10(1):75-84. Disponível em: http://www.seer.unirio.br/index.php/cuidadofundamental/article/view/5979/pdf_1
17. Pegoraro RF, Bastos LSN. Experiências de acolhimento segundo profissionais de um centro de atenção psicossocial. Rev Enferm Atenção Saúde [Internet]. jan-jun 2017 [citado em 17 abr 2018]; 6(1):3-17. Disponível em: http://seer.uftm.edu.br/revistaeletronica/index.php/enfer/article/view/1525
18. Puccini PT, Cornetta VK, Sahyom TZ, Fuentes ICP, Botta LMG, Puccini RF. Concepção de profissionais de saúde sobre o papel das unidades básicas nas redes de atenção do SUS/Brasil. Ciênc Saúde Colet. [Internet]. 2012 [citado em 19 mar 2018]; 17(11):2941-52. Disponível em: http://www.scielo.br/pdf/csc/v17n11/v17n11a10.pdf
19. Fernandes MC, Silva LMS, Moreira TMM, Silva MRF. Factors involved in the management of nursing care: a descriptive study. Online Braz J Nurs. [Internet]. 2013 [citado em 17 ago 2018]; 12(3):522-33. Disponível em: http://www.redalyc.org/pdf/3614/361433917011.pdf
20. Lima LL, Moreira TMM, Jorge MSB. Produção do cuidado a pessoas com hipertensão arterial: acolhimento, vínculo e corresponsabilização. Rev Bras Enferm. [Internet]. 2013 [citado em 15 jun 2018]; 66(4): 514-22. Disponível em: http://www.scielo.br/pdf/reben/v66n4/v66n4a08.pdf
21. Santos WJD, Giacomin KC, Firmo JOA. Avaliação da tecnologia das relações de cuidado nos services em saúde: percepção dos idosos inseridos na Estratégia Saúde da Família em Bambuí, Brasil. Ciênc Saúde Colet. [Internet]. 2014 [citado em 13 fev 2018]; 19(8):3441-50. Disponível em: http://www.scielo.br/pdf/csc/v19n8/1413-8123-csc-19-08-03441.pdf
22. Feuerwerker LCM. Micropolítica e saúde: produção do cuidado, gestão e formação [Internet]. Porto Alegre: Rede UNIDA; 2014 [citado em 09 ago 2018]. Disponível em: http://www.saude.sp.gov.br/resources/humanizacao/biblioteca/dissertacoes-e-teses/micropolitica_e_saude_laura_camargo.pdf
23. Roecker S, Budó MDLD, Marcon SS. The educational work of nurses in the Family Health Strategy: difficulties and perspectives on change. Rev Esc Enferm USP. [Internet]. 2012 [citado em 17 ago 2018]; 46(3):641-49. Disponível em: http://www.scielo.br/pdf/reeusp/v46n3/en_16.pdf

RECEIVED: 17/07/2018
APPROVED: 12/11/2018
PUBLISHED: 12/2018