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Family approach and individualized therapeutic projects in Family Health Strategy: a case study with elderly patients

Abordagem familiar e projeto terapêutico singular na estratégia saúde da família: estudo de caso com idosos

Abordaje familiar y proyecto terapéutico singular en la estrategia salud de la familia: estudio de caso con ancianos

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It is a descriptive-narrative case study, guided by the Calgary model of family evaluation, and its aim was analyzing the implementation of the family approach in the family health strategy and the elaboration of the individualized therapeutic project. Home visits were carried out; six Community Health agents were interviewed and the indicators of the team, between June and August 2017, were analyzed. The case examined was that of a family of elderly people who care for other elders. Two categories were found: "the socio-epidemiological context of the territory" and "the family and the individualized therapeutic project". Were found: precarious personal hygiene and house cleaning, difficulties in the management of the drugs, fragile and conflictual ties with the extended family, lack of integration in community activities. Shared collective constructions guided the elaboration of the individualized therapeutic project. Family reunions, dialogues that generated commitment, panel with domestic activities, integration with the community group of gymnastic and bond creation with the health team were the discussed interventions. It was concluded that the reported case contributes to orienting inter-professional work with families for the provision of care in the Primary health care.
Descriptors: Family Health Strategy; Internship and Residency; Family relations; Aging.

Trata-se de estudo de caso único, descritivo-narrativo, orientado pelo Modelo Calgary de Avaliação Familiar que teve como objetivo analisar a implementação da abordagem familiar na estratégia saúde da família e elaboração do projeto terapêutico singular. Foram realizadas visitas domiciliares; entrevistados seis agentes comunitários de saúde e analisados indicadores da equipe - entre junho e agosto/2017. O caso analisado foi composto por uma família de idosos que cuidam de idosos. Evidenciou-se duas categorias: "O Contexto sócio epidemiológico do território" e "A Família e o Projeto Terapêutico Singular". Apresentou-se: higiene pessoal e limpeza da casa precárias, dificuldades no manejo do regime medicamentoso, vínculos frágeis e conflituosos com a família estendida, ausência de integração em atividades comunitárias. Construções compartilhadas em equipe orientaram a elaboração do Projeto Terapêutico Singular. Conferência familiar, diálogos que geraram compromissos, painel com atividades domésticas, integração ao grupo comunitário de ginásticas e estreitamento de vínculos com equipe de saúde compuseram intervenções. Conclui-se que o caso relatado contribui para orientar o trabalho interprofissional com famílias para produção de cuidados na atenção básica.
Descritores: Estratégia Saúde da Família; Internato e Residência; Relações familiares; Envelhecimento.

Se trata de un estudio de caso único, descriptivo-narrativo, orientado por el Modelo Calgary de Evaluación Familiar que tuvo como objetivo analizar la implementación del abordaje familiar en la estrategia salud de la familia y elaboración del proyecto terapéutico singular. Fueron realizadas visitas domiciliarias; entrevistados seis agentes comunitarios de salud y analizados indicadores del equipo – entre junio a agosto de 2017. El caso analizado fue compuesto por una familia de ancianos que cuidan a ancianos. Se evidenciaron dos categorías: "El contexto socio-epidemiológico del territorio" y "La Familia y el Proyecto Terapéutico Singular". Se presentó: higiene personal y limpieza de casas precarias, dificultades en el manejo del régimen medicamentoso, vínculos frágiles y conflictivos con la familia extendida, ausencia de integración en actividades comunitarias. Construcciones compartidas en equipo orientaron la elaboración del Proyecto Terapéutico Singular. Conferencia familiar, diálogos que generaron compromisos, panel con actividades domésticas, integración al grupo comunitario de gimnásticas y estrechamiento de vínculos con el equipo de salud, compusieron intervenciones. Se concluye que el caso relatado contribuye para orientar el trabajo interprofesional con familias para la producción de cuidados en la atención básica.
Descriptores: Estrategia de Salud Familiar; Internado y Residencia; Relaciones familiares; Envejecimiento.

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INTRODUCTION

The Basic Health Attention (BHA) consists of actions of the first Health level in local systems (municipal). And it should be linked to the service network in a way that ensures the implementation of the guiding principles of the Unified Health System (SUS)[1,2].

After more than 20 years of the SUS establishment, some challenges emerge in the national scenario for its implementation, in particular regarding the consolidation of BHA so that it can provide a positive transformation to the system. The challenges evidence the inefficiency of the public sector in the provision and financing of actions, the need to increase satisfaction of the population and the lack of guarantee of the quality of the services provided in face of the existence of inequalities. Another aspect to be overcome for the effectiveness of this system is in the organization of actions, for something beyond the procedure-centered model, based in a medical-hegemonic perspective[1-3].

In response to this situation, in 1994 the Ministry of Health, from successful experiences in municipalities in the northeast region — with the Community Health Agents — and the city of Campinas — for health promotion actions — launched the Family Health Program. In 2011, this program went through a reformulation in the National Policy of Primary Care — mentioning it as a strategy for strengthening the primary level of attention and reordering the procedure-centered model[2].

In particular, the HBA regulation happened in 2011, because in this context, the SUS started to seek its regionalized and standardized organization in health care networks, to ensure the composition of services of different complexities with higher degrees of problem-solving capabilities and adequate access levels to guarantee the safeguarding of lives. In September 2017, through law number 2436, the revision of guidelines for HBA was established. It discussed the recognition of other team formats, the inclusion of the Primary Care manager, as part of the team, the reduction of the population to be attended by each health team and the guarantee of the continuity of the use of the health information system by optimized modules[2,4].

Above all, the aim was for the HBA guided by the Family Health Strategy (FHS) assistance to be anchored in a working process that promoted amplified health care, the family (the dynamic relationships between the members that make it up) in its territorial context (a territory here understood as an organic epidemiological and socio-cultural process) being the primordial unit to be addressed[1,3].

To this end, the health teams must organize their work by establishing links with the dynamic territory. The professional performance at the BHA/FHS should consider complex and varied care technologies, guided by risk criteria and vulnerabilities of individuals, families and communities in their territories[1-4].

For the health area, in Brazil, where the state of social well-being has not yet been materialized in its full meaning, the family occupies a central role in the provision of well-being, especially throughout the years (with aging). However, the base conceptions of the family have been controversial, with interests and discourses that go in different directions[5,6].

As a result, it has been discussed how well politics have been able to cover all the diversification of existing family forms, and whether it favors a specific family model, marginalizing others. In turn, there are still few publications in Brazil that use the family approach, even though it is a performance guideline for PHC/FHS[5,6].

This is because, although the concept that family conditions interfere in the health-disease process is consistent among health professionals, there are few studies about the work of the PHC/FHS professionals with families that show how the family approach is seen in the everyday practice of these professionals[5-7].

In this context, the family constitutes the microstructure that would have the most important part in the representations and practices constitution of the subjects

regarding the health-disease-care process. The family sphere is a key reference in the determinations of morbimortality in different age groups and in the important dimensions of sociocultural structure, such as gender relations or social position, values, social conduct and mobilization patterns. For this reason, the family is given the status of a strategic analysis unit for the investigation of such process[7].

Faced with this reality, the following issue is raised: how to implement the family approach in the PHC/FHS setting? From this perspective, this study aimed to analyze the implementation of the family approach in the family health strategy and the elaboration of the individualized therapeutic project.

METHOD

This is a comparative descriptive case study. The case study approach proposes to examine contemporary events related to complex social phenomena. It is composed of commonly used techniques such as direct observation, systematic series of interviews and data analysis to answer research questions that permeate the 'how' or 'why' of a phenomenon[8].

Thus, one must consider the fact that the *locus* of the study is not the object itself. Instead of focusing in the limitation of the case, the approach of the comparative case study presents interactive follow-ups between a contingent of factors, actors, and features relevant to the understanding of the phenomenon. It aims to see the phenomenon in terms of people, situations, events, and the processes that connect them[8].

In June 2016, under a partnership agreement signed between the Municipal Health Department of Uberaba/Minas Gerais and the General Hospital of the Federal University of Triângulo Mineiro (UFTM), the establishment of a setting in which practices would be inserted with an emphasis on PHC/FHS for students in technical education, graduation, and post-graduation at UFTM, in a unit called Center of Integrated Health Care (CAIS), aimed at promoting the development of educational, extension, research and technological innovation projects, to ensure the role of the university, combined to that of the hospital, of giving back to the society the knowledge acquired in college, as part of their activities.

It is a new space for teaching-service integration, composed of a unit that supports six family health teams, with a territorial coverage of approximately 5,600 families, under different socio-epidemiological vulnerability conditions.

The operational design of the CAIS incorporates contemporary educational politics in the perspective of Health Promotion, centrality in primary care and the reorganization of the Family Health Strategy model, considering a performance in the integrated network health through the strengthening of a competent hospital discharge and a continuous and longitudinal care.

The context of the case was based on the working experience, at the CAIS, in the area of Elderly Health care of the *lato sensu* postgraduation program of multiprofessional integrated residence in health (RIMS) of the General Hospital of UFTM.

The multi-professional residency program started in 2010, with the proposal to train professionals: social workers, nurses, occupational therapists, physical therapists, nutritionists, psychologists, biomedical and physical education professionals.

The RIMS considers, in its political-pedagogical project, the promotion of attributes that enable the professional exercise with excellence in the areas of comprehensive care and compassionate health, involving people and communities, the management and organization of the work of education in health, aiming to improve the quality of life.

As a proposal of methodological reference, the study of a single case incorporated by multiple units of analysis was used and the phenomenon was: the family accompanied by the residents of RIMS. And, the subunits of analysis were related to the characterization of the family context and the therapeutic project elaborated through the family approach technique.

The Familiar Calgary Assessment model[9] was followed, allowing to assess the family in a multidimensional and ecosystemic perspective, considering the following dimensions: the family structure and the family development and its functionality, being this model the theoretical-methodological framework adopted.

In this model the family is understood as a system, being the family unit a retroactive *continuum* between stability and change, which allows transformations in its structure but maintains its organization and, leading to its own development as a natural consequence of its life cycle. The adoption of this model is indicated as beneficial for promoting interaction with the families and a better planning of the care[9].

For the composition of the comparative case study, the interviews were carried out during the visits and organized as guided by the Calgary model of family evaluation with the aim of generating engagement - building family ties; and family evaluation - for exploration and identification of health demands. The intervention: construction of the individualized therapeutic project (PTS) with a care plan constructed through the collective discussion of resident students and the supervisor of the program (professional with specialization in family care and practical experience in family approach).

The PTS is conceived by a plural perspective of valid knowledge and normativities of a non-technical nature[10]. It implies the adoption of cooperation between actors immersed in the context.

As a strategic tool, it opens a way for an interpretation less bound to a technological rationality, in face of the possibility of developing a solidary project — PTS. It is also understood as a permanent challenge for the horizontal interaction between the health team and the autonomy of the assisted families[10].

The family addressed was included in the study by identification of the demand presented to residents by one of the health care teams of the school health center, considered as a family of "difficult" management by its health team. Data collection was carried out by RIMS residents, through interviews at the home and region where the family resides, together with the Community Health agent responsible. Five home visits were carried out, lasting from 60 to 90 minutes, from June to August 2017. The interviews were recorded in a field journal. The results were presented in a discursive-narrative way, based in the description of the case.

In addition, open interviews with the Six Community Health Agents (ACs) of the FHS responsible for the family were incorporated as an analysis unit for understanding the socio-territorial context.

Questions on the lifestyle of the community were asked freely, and the answers were recorded in the interviewer's field journal, and this collection happened in a single moment during a Continuing Education meeting of the health team — previously agreed by the responsible nurse. It took place in July 2017 with a duration of 120 minutes. The results were presented in a discursive-narrative way, according to the reading of the records.

The indicators that characterized the territory and its social and epidemiological health aspects were collected through secondary data available in the Basic Attention Information System (e-SUS/SIAB) of the responsible health team.

The most recent data available in these systems were used in order to portray the health reality of the context of the family studied. These indicators are produced in the daily work of the family health team and describe the characteristics of the coverage area of their responsibility, in accordance with sociodemographic and epidemiological variables. These results were presented according to absolute and relative frequency, as a brief situational diagnosis.

As for the ethical aspects, the names of the members of the family were replaced by fictitious names to minimize constraints on exposure. Resolution CNS 466/2012 was respected, and the study received approval from the Research Ethics Committee of the Federal University of Triângulo Mineiro in

2017, under protocol number 2.427.323. The data were collected after signature of the free and informed consent form by the participants.

RESULTS

According to the protocol for the development of the case study, the results will be presented in the categories "The social and epidemiological context of the territory" and "The Family and the Individualized Therapeutic Project"

"The social and epidemiological context of the territory"

The territory where the family addressed lives is characterized by being an FHS area linked to the CAIS. The FHS coverage area has 3,555 people registered, with 1,002 families. As for the demographic profile, 52.9% of the population is female and 47.1% male. As for the elderly population, those with 60 years or more represent 25% of the residents.

According to the consolidated report of the Information System of Primary Care in 2016, it can be observed that the most prevalent diseases in the area are Hypertension with 20.5% and Diabetes Mellitus with 6.7%. There is a small number of children in the area, and only 0.96% of women are pregnant. Of the children between 7 and 14 years, 76.3% attend school and 93.9% of 15 years old or older ones are literate. Among the families, 25.5% of those registered are covered by health insurance, and only 0.6% receive financial assistance from the government.

As for the physical structure of the area, 80.1% of homes have water treatment and 19.7% have no water treatment. The water supply is provided by public institutions for 99.6% of houses. All houses are brick and mortar and 99.5% have electricity. The waste is destined for public collection and 99.9% of the houses have access to the sewers.

In the interview with the CHA, the key informants of the neighborhood, it was mentioned that the team consists of six Community Health Agents, one doctor, one nurse, one nursing technician, and one oral health assistant.

According to data from the interview about the general situation of the neighborhood, a significant number of elderly residents were reported. The main health problems reported were systemic arterial hypertension, diabetes mellitus, and depression. It was reported that there were no residents at social risk. On street signs are not sufficient for safety, according to the data, but the streets have regular paving. There are not many vacant lots in the region. The local health board is inactive because it has no representatives.

The CHA reported that there were no points for leisure, just a small and in bad shape square and the "forró" (a Brazilian type of music/dance/party) in the Urban Social Center with free entrance on Thursdays. They also mentioned many drug trafficking problems in the region, with bars being the main selling points. Few dependent patients were observed in the region.

They reported that most of the population stated to be Catholic, and a Catholic Church existed in the area of coverage. There is a large number of elderly people who attend the parish, but people of all age groups frequently go there.

However, there are more evangelical churches and spiritism centers. In general, the religious community, regardless of the type of religious practice exercised, carries out welfare activities for the poorest population in the coverage area, such as donations of clothes and food.

About other social facilities, the area of coverage has a single supermarket and only one pharmacy. During the interview, it was possible to realize that the neighborhood has severe safety problems, because the residents are exposed to situations of urban violence such as muggings and drug trafficking, according to the CHA.

Faced with the results, as the situational diagnostic showed, in the neighborhood there are more retired elderly people, and this reality is reflected in the family approached in the case chosen for this research. The macrocontext of the neighborhood where the family is inserted provided more subsidies to address the

family microcontext based in the real need and/or demand of the members of this family, through communicative and understanding care.

On the first visit, held on June 6, 2017, the team made up of social worker, nurse, nutritionist, and physical therapist, all members of RIMS, went to the family's home. The family consists of Rosa, Cravo, Margarida and Lírio.

Rosa and Cravo are married and first cousins, Rosa is 67 years old and takes care of the house. Cravo is 76 years old and retired. The couple had four children: two died, and Margarida, a woman who is 43 years old, receives welfare due to an intellectual disability, and lives with her parents. Anturio, the other son, male, is 50 years old. He is a bricklayer and lives in the back of part of his parents' house along with his daughters, the granddaughters of the couple, Violeta, 21, and Orquídea, 19. Lírio, Cravo's brother, also lives with them, he is 52 years old and works as a bricklayer's assistant.

Upon arriving at the family home, the CHA team was received by the couple's daughter, Margarida. Upon entering the residence, they noticed its poor hygiene conditions. The house has 3 bedrooms, a living room, kitchen, bathroom, garage and a yard with chickens. Lírio works and was not present during the visit.

Rosa and Cravo were lying in bed with limitations to walk, they were questioned about this setting and claimed that they had difficulty walking and were not motivated to move around the house. The two were also wearing disposable diapers and reported urinating in recipients during the day. Several recipients with urine and food waste were found in the rooms.

Due to these limitations, Cravo reported that the person responsible for receiving his and Margarida pensions is his trusted niece Iris, who transfers all the money monthly. Violeta, one of the granddaughters who lives in the back house, is responsible for buying the food monthly.

The brother Lírio is in charge of cleaning the house, preparing the meals, and Margarida gives the necessary drugs to her parents. When the CHA asked about the medications that the members of the house used, it was noted that both did not consumed them correctly and did not understand the purpose of each medication.

During the visit, Margarida was asked, in a separate room, about her relationship with her parents, as it was noted that Cravo was sometimes rude to her. However, she reported having a good relationship with her parents and initially no signs of abuse were shown. Cravo was asked if the hygiene conditions of the House bothered him and he claimed not to care.

During the conversation with Cravo, it was observed that he used a walker and/or cane as an auxiliary walking device, and he reported a fall when he left home to take a walk around the block and as a result injured his face and feet. Cravo also complained of pain and concerns for his daughter's situation after he passes, wondering who would transfer the welfare to Margarida. Cravo said he wanted to have a legal document made up so that his niece could continue to receive the money and pass it on to Margarida.

The second visit was in June 20, 2017, with the rest of the team: the social worker, nurse, nutritionist, and physical therapists. They were greeted by the daughter Margarida and remained in the room with Cravo. During the visit, it was noted that Cravo was still concerned with the question of his and Margarida's retirements. At that time, they talked about death, and his concern to sign or not the legal document that was already at hand, so that the niece could pass the money on to Margarida after Cravo's death. After a long period of discussion, Cravo also reported a lack of strength in the lower limbs. The physical therapists of the team taught him some home exercises to strengthen the members.

After that, attention was turned to Rosa. It was noted that she remains a lot of time in the room, lying on bed, and she does all her needs and activities of daily life within this room, including: brushing teeth, eating meals, physiological needs, and others. All objects

and food within are accumulated within the room. It was also found that the whole house has an unpleasant odor due to poor hygiene conditions. During the visit, one of the granddaughters left the back house, but did not have any contact with the grandparents or members of the team.

The visit was finished, and the researchers met with all the team members to discuss the case. Possible actions were brainstormed and considerations about them were made, constructing knowledge from the real and problematic experienced through discussions and direct supervision of teachers and experts in the context of RIMS. Shared collective constructions guided the elaboration of the individualized therapeutic project.

The family and the individualized therapeutic project

Initially, the team tried to contact one of the granddaughters, with no success. Thus, a third visit was made on July 18, 2017, with all members of the team and one of RIMS' tutors. Upon arriving at the house, the team was met by Cravo, and the whole family gathered in the living room. It was exposed to the family, from an open and direct dialogue, the proposal made by the team and the need for them to establish contracts that indicated their commitment, in a horizontal perspective, respecting the individuality and uniqueness of the subjects.

It is important to point out that such commitments are not inflexible. Adjustments and redefinitions are possible, and it is merely the main direction of the needs presented by the family. They were very receptive to the proposals.

The team suggested family conferences as a strategy for compliance with the plans, meetings prioritizing the collective dialogue for greater alignment of the planned actions. Such meetings are understood to enable the establishment of proposals from a shared perspective, through horizontal dialogue between the family and the team, enabling the expression of feelings, anxieties, and possibilities of acceptance of the previously discussed and proposed commitments.

At first, the organization, cleaning and hygiene of the house was a very important aspect discussed, and the team asked about the financial situation of the family. They were instructed to remove the waste, the food leftovers, and organize the house. The family was also oriented on the importance of making all meals on the kitchen table, not in the rooms, as was being done.

Boxes with partitions were given to them for the organization of the medicines they use, and each medication was separated correctly, according to the medical prescription. The team talked to each one about how the medicines should be taken.

One of the strategic actions that was also carried out was the identification of the existing relationships between the family and the social facilities present in the municipality, as well as their programmatic actions and policies. This strategy made it possible to acquire a greater knowledge about the family reality, as well as about the social resources available.

An appropriate access to the Health Network was made possible through references to the Basic Health Service, taking into account the diverse needs presented by the family, in order to guarantee integral and effective access to the public health system.

Considering the physical issues of this family, the limitations and difficulties to leave the house or even walk around the house, the importance of physical exercise for them was analyzed. Considering this, an invitation was extended for everyone to participate in the gymnastic activities that the team offered in the Spiritist Center, located four minutes from the House. At first, Cravo liked the idea, but asked for a time to organize.

During the fourth visit, held on July 25, 2017, the team was received by Margarida. The whole family gathered in the room and the house was more organized, but personal hygiene conditions and rooms were still in a precarious state. Rosa, Cravo and Margarida were in dirty clothes, their beds were disorganized, with lots of things on top, and dirty sheets.

A panel was made with the simplest domestic activities, to establish together the

responsibilities of each member of the family, related to cleaning and organizing the house, this being an idea well accepted by all.

The social worker of the team called Iris, and asked if she could be present in the next visit. She went to the family house as agreed, and during the visit, reaffirmed that the family receives only two minimum wages, and that she is working on Lírio's retirement. The brother Lírio, according to Iris, works with recycling, and is responsible for paying for the energy of the house, and according to the two of them, is mistreated by the family.

Iris just takes the money out of the bank, pays for the funeral plan and takes the rest to Cravo. She mentioned that there is no legal document, that she only has access to bank data and credit cards, and that they cannot afford to pay a maid, but pay Violeta, who often does not do her work. Iris tried to articulate Rosa's retirement, but Cravo becomes suspicious and does not leave the documents with her for long, and without the documents she cannot get through the procedures. The house has no scripture, and Iris is trying to organize the papers related to it.

Another important point is sharing the experiences with the responsible health team, to discuss actions and strategies and build a collective and shared knowledge, using the moment intended for the continuing education of the team for those discussions. In addition to sharing experiences, it is possible to give visibility to the work developed by the residents in a multi-professional and interdisciplinary work context.

It should be noted that for all stages there was specialized technical-scientific supervision, guided by discussions with the supervisor specialized in family approaches. To ensure the alignment of actions and the theoretical knowledge.

DISCUSSION

In accordance with what was found in the analysis of the case studied, it has been pointed out that the approach to a family allows the identification of conflicts, perception of the process of health and disease, and of the network of support resources (material and emotional), in addition to facilitating the recognition of the strengths of the family and the critical points that need be minimized, through an intervention plan[11,12].

As in this case study, it has been common in national productions to use the family approach to evaluate family support for chronic patients, or for families with elderly people in need of more intensive care. The experience of a series of personal and family changes is discussed, highlighting that depending on the severity of the disease, changes in the way of life of the family are required[11-14].

Other studies corroborate this research with regards to the fact that the family approached was indicated by the FHS team because they were difficult to handle[11-17]. The interviews in family approaches were motivated by family-related information provided by team members, that indicated interpersonal conflicts between family members or between family and health team[15-17].

Practices such as reflective listening, questioning and dialogue are instruments that mark the daily work with the families. The recognition of the health needs of the families, the commitment to them and the formation of bonds, encourage more integrated practices, marked by intersectionality and interdisciplinarity, signaling the potential for reconfiguring the model of care, and getting closer to an integral care[15,17,18].

In general, the experience reported aimed to present the implementation of initiatives to broaden the scope of the hegemonic biomedical model, which has been the predominant approach. This type of care is limited to the understanding of organic diseases, in which there is little concern for the social and family relations and for the territorial context, since they are not considered aspects of the processes of illness[11,18,19].

Above all, investing in actions for the reversal of hegemonic models corresponds to bringing health practices closer to the SUS

principle of integrality[11,19].

As far as the organization of daily work is concerned, Primary Care, guided by the Family Health Strategy, intends for assistance to be anchored in a work process that promotes expanded health care. The family, with its dynamic relations between individuals, and in its territorial context — the territory here considered as an epidemiological and sociocultural organic process — is the unit to be addressed[11, 19].

In another aspect, regarding the results presented, it is essential that health professionals understand the issues involving ageing, family functionality and the social context in which older people fit, in order to provide appropriate care strategies[19-22].

During the aging process, families undergo changes, face different situations that can affect family functionality, and impact on the harmony and balance of this relationship, leading to challenges in both family composition and the work of the health team[20,21].

As a strategy, this situation opens a path to an interpretation less tied to technical rationality of health care, aimed at the possibility of devising a supportive project — an individualized therapeutic project, understood as a permanent challenge of the horizontal interaction between the health care team and the autonomy of the families cared for[15,17,18].

This study shows the need to understand the family approach in aging families as a process that should involve the individuals themselves, the family unity, and society. From this perspective, the systemic dimension of care, provided by the theoretical frame of reference employed, made the recognition of the structure and context conditions of the territory itself possible, and they could support the family in overcoming their needs[19-22].

In this context, it is worth mentioning the commitment of the multidisciplinary team to seek integral care, involving all the participants in the act of care, including the elderly, the family that cares for them, the health team, and community resources, in arrangements that provide a protection micro-system[19-22].

As for the construction of the PTS, the importance of systematic meetings between the group of residents to align the actions can be highlighted. Health professionals are known to often find themselves immersed in a work routine that causes them not to realize the importance of devoting time to think about collective care practices and discuss them[23].

These meetings should be valued so that the team can try to find meanings in the work proposed, through critical reviews of the work itself. This composition — the critical reflection — is essential to the elaboration of a PTS, which permeates the problematization of the Health Practice in order to improve care management[23,24].

According to the case presented, the use of initiatives such as weekly family follow-up implies in closer bonds. The construction of bonds between family and team is a fact that makes it possible to achieve success in the actions proposed by the PTS, once this construction promotes the recognition of the singularities existing within the family. The recognition of the uniqueness of individuals and groups, associated with the use of light technologies in health, composes the dimensions of the PTS[23,24].

The specialist supervisor facilitated the discussion and development of strategies for the construction of the PTS, such as further theoretical discussions by the group of residents, with a greater potential for sharing experiences with the responsible family health team — with the objective of generating an exchange of knowledge.

The limitation of the study is related to the methodology used, because case studies are generalized to theoretical propositions, not to populations or universes, being analytical generalizations. Therefore, the case study aims to establish or clarify a set of decisions in relation to why they were adopted, how they were implemented and with what results.

However, this case study has potential and contributes to the increase of scientific production, as it evidences how the application of the family approach happened

in the daily practice of PHC/FHS. The analytical method may be reproduced in similar contexts.

CONCLUSION

The case presented is important because it reports an approach to a family in a dysfunctional situation — a family composed by elders who care for one another.

Faced with the challenges for the care of the elderly and considering population ageing, strategies such as those presented can be considered alternative technologies in promoting qualified care for the family of elderly people, in the primary health care, and can be reproduced in the PHC/FHS scenario.

Also, the family approach technique has been presented, in this study and in others, as a relevant intervention to be implemented in families considered difficult by the health teams. The adoption of the Calgary model is indicated as beneficial to promoting interaction with families and providing a better care planning.

It is crucial to implement strategies for the transfer of the evidence identified in this case study to the health team of the family, so the emotional support, to help with the changes and adaptations suggested, can be guaranteed.

The results presented contribute to the increase of scientific productions that discuss inter-professional training in order to dialogue with the complexity of the work at the PHC/FHS. Strategies for the transfer of the evidence identified in this case study to the health team responsible for the family also need to be implemented.

This study suggests that future researches should be made to evaluate the impact of this intervention on the family unit studied, and to verify how the analyzed family has organized itself, and its internal arrangements, together with the socio-territorial context for the support of the changes proposed in the intervention project.

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