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Convoy model to family support by nurses in primary health care: the descriptive study

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ABSTRACT

Aim: investigate the exchange of related support health care between the family, inserted in the center of the convoy model, and nurses of primary care. **Method:** descriptive study, conducted with 30 users of Primary Care of Maracanaú/CE in July 2014. Appealed to the Collective Subject Discourse to organize the data and the convoy model for visualization of the support exercised by the nurse. **Results:** the nurse is a secondary source of support to families; their actions are restricted to health facilities, demonstrating the mistaken role of their duties, and have focused on the orientation activities. **Discussion:** There are nurse's detachment regarding the assisted families, as well as influences of the hegemonic medical model, which distances the nurse from the carrying out of their real duties. **Conclusion:** nurses are undervalued and pointed as a secondary reference in relation to families solving health problems.

Descriptors: Public Health Nursing; Nursing Care; Social Support.

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INTRODUCTION

The professional nurse, essential for the viability of actions and health care network services, has a significant role in the Primary Health Care (AB), especially for articulating knowledge, skills and attitudes in order to solve the problems of social actors who seek this first level of care.

AB is characterized in the context of health, for a range of actions, developed individually and collectively, involving health promotion and protection and preventing aggravations, diagnosis, treatment, rehabilitation, harm reduction and maintenance of health. These actions are carried out in order to encourage full attention, from which it is possible to influence the health status and autonomy of the population and the determinants and health conditioners of communities[1].

Thus, it is in AB that the family becomes the center of attention and understood in full. In this regard, it is necessary that nurses appreciate the diverse knowledge and practices from the perspective of an approach with high resolving potential, which enables the creation of support where there is the formation of bonds of trust with ethics, commitment and respect.

Therefore, the relationship between the nurse and family in AB enables the strengthening of the trusted link, bond and emotional support, providing a longitudinal follow-up to improve the quality of life and health of the population[2].

The support framework for this research, called the convoy model, considers that the subject develops himself by interacting with other people in their social environment, occupying a specific role as a member of groups such as friends, professionals and/or a particular organization. Exercising this role the person experiences events as part of a group[3].

Thus, this research aims to investigate the support of exchange related to healthcare in health among the family, inserted in the center of the convoy model, and the professional nurse of AB.

METHOD

This is a descriptive study with a qualitative approach carried out with 30 users, whose families were assisted under three Basic Health Units (UBS) in the municipality of Maracanaú/CE. We used a semi-structured interview as data collection technique as well as an instrument based on the conception of the convoy model.

The convoy model aims to identify the roles and positions of the subjects in their significant personal network, so it only works with the important and key people for that individual-focus. Each person entered in this network has a different relationship with the investigated person[4].

The convoy has three concentric circles, surrounding the subject. Each circle signifies a different level of closeness to the subject in focus. Therefore, members of the inner circle are understood as the most essential to provide support. The subjects located in the second circle have a greater level of interaction than the realization of demanding roles, but are more distant than the initial circle. The individuals of the third circle interact via paper prescriptions[4].

The interviews took place from July 2014, in a reserved place of UBS itself. At this point, a diagram formed by three concentric circles was presented. Inside the smaller circle in

the center was written "Family". In the outer circle, the interviewee indicated the health professionals who were close and important enough to be in the reference circle for the family. In the second circle, he mentioned the professionals who were not completely close, but important for the family. In the inner circle, he pointed professionals taken as a reference, the first to be sought to solve the health problems presented by the family.

After the participants of this research point in concentric circles, the reference professional for the family, was carried out semi-structured interviews in order to understand how they perceived the relationship of the UBS nurse with the families, from the speeches of the same.

To proceed with the ordination and organization of empirical data produced in semi-structured interviews, we used the methodological process of the Collective Subject Discourse (DSC), which is a tool that enables the representation of thought of a particular group. It is a methodology that proposes the sum of ideas in a non-numerical way, but rather through operationalizing in a methodological way, the expression of collective thought through speech[5].

The DSC is therefore an expedient or methodological resource to make it more clear and expressive the social representations, allowing that a particular social group can be seen as an author and issuer of common discourse, sharing among its members. With the collective subject, the speeches do not cancel or reduce to a common category unifier, as what seeks to do is precisely the opposite - to rebuild, with pieces of individual speeches, as in a puzzle, so many synthesis speeches how it is considered necessary to express a given "figure", a given thought or social representation of a phenomenon [5].

As inclusion criteria, it adopted the idea that the family must have at least one year of follow-up conducted by the family health team of AB. It was excluded those that did not have a nurse as a team member accompanied in the AB. The suspension of data collection occurred from the moment the theoretical saturation was identified.

The research started after the project was approved by the Ethics Committee in Research of the State University of Ceará/UECE under n°124,454. The ethical and legal components were present at all stages of the research, in accordance with Resolution 466/12 of the National Health Council.

RESULTS

As the questioning about the professionals that the users seek to support the family, from the convoy model, it was divided into three groups which are presented in Figure 1.

Each group is composed by the respective professionals appointed as reference to the family, each circle is presented in descending order in which it was mentioned. Group A, the outermost, is composed of the hospital doctor, cited by twenty users, the doctor of the health unit, mentioned four times and the nurse of the health unit, stated by one user. Group B, intermediate, it consists of the hospital doctor cited by fourteen study subjects, the nurse of the health unit, remembered seven times, the doctor of health unit mentioned by three times, and a hospital nurse mentioned by two users. And Group C, the innermost, consists of the doctor of the health unit, cited 17 times, the nurse of the health unit, informed by four participants and the hospital nurse, reported by two.

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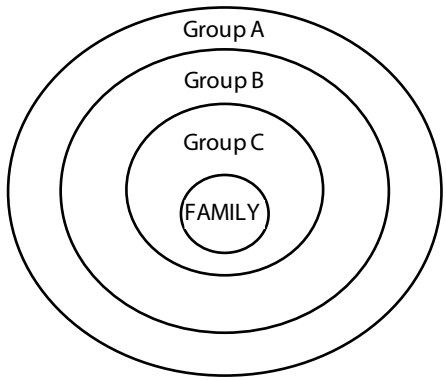
In the context of the nurse's relationship with the family in AB, will be shown below the IC and its DSC of users reports on this matter.

Figure 1 - Representation of support system that families seek in health and disease care, as represented in the familiar convoy circles. Maracanaú, 2014.



Source: research data, 2014.

The first IC about the place where the professional nurse support occurs, originated from an interview with eight users generating the following DSC:

IC 01: Nursing support restricted to the health unit

> DSC 01: The nursing care is done more in the healthcare clinic. She does not know all the members of my family. I am the one who comes to the clinic when needed. It's hard to go to my house. Even a community agent struggles to come to my house, as well as the nurse. But, when a senior citizen, someone who has difficulty walking or has a disease that them leaves bedridden, she goes to the person's home. I only know that she never came to my house. My son is two years old and had no consultation at home. The relationship is only nurse-patient himself, nothing more.

The second IC was built from the user reports about the narrow and misguided view of the role of nurses. Its DSC of this IC emerged from four interviews:

IC 02: Nursing support mistaken view in Primary Health Care

> DSC 02: The relationship with the nurse is a good relationship because return to her to renew the prescription of medications I need. So it can help and replace the doctor when he is not present. It's good. I come here to test glycemia and ask for an appointment to take the medications, that's all. The nurse is important because it helps the doctor and this relationship is very good. Regarding the nurse here in the unit with my family, it really helps the doctor (physician) when he is not present, the nurse can replace a few things, right?! Such as giving medication.

About the construction of the DSC of the third IC participated eight users who approached the main support performed by nurses as guidelines for better care of their health, which will be addressed in the following DSC:

IC 03: Nurse support through guidance

> DSC 03: The relationship with the nurse is very good because she takes away the doubts and is interested. She answers everything you ask her, explaining properly and guiding the care to be taken, in addition to requesting the necessary tests. It is a good support, these guidelines. She gets rid of your

> doubts, requests exams, examines and asks if I'm okay. She forwards already directing what action should be taken. It's a good relationship, it guides us how to take care of our child. That we should breastfeed for six months, we should be careful about the health of the child. I find it very good.

DISCUSSION

Families are developed inserted in the convoy, i.e., incorporated into a network of social relationships that provides social support in their life cycle. In this research, the concentric circles are linked to the support that health professionals provide to the families of their service territory. Thus, the characteristics of the inner circle represent the professionals considered as a reference point, and who are preferably sought over those in the intermediate and outer circles[4]. So we chose the inner circle by understanding that this better represents the support available by the relationships that take place in this circle.

In the inner circle, composed of health professionals who are perceived as the main references for support with health problems presented by the family, there is a predominance of references to medical professional as main support. In turn, the nurse of AB slightly is remembering as well as a reference professional for families.

Similar data were found in a survey of users of AB in São Paulo, who considered as a key element of support to address their health needs the presence of the doctors in the unit[6].

It is understood that the proposal of AB differs radically from that model that, for many years, prevailed in the Brazilian reality. He could not meet the real health needs of the population, as it had as characteristics the individual care, centered on the complaint, on the biological elements, in the care stratification, and, as the main scenario of care, the hospital[7].

However, this hegemonic medical model is still strongly present in Brazilian reality, as we observe in the data of this research, which shows certain dependence of the population to this professional category, something culturally and historically rooted in society.

Therefore, it is essential that nurses establish a closer relationship with users, so that their work is visible to the families in AB, enabling them to realize the importance of the actions of this professional as a member of the family health team[8] and therefore responsible for longitudinal care, integral, human, and ethical to this population, providing them with solutions to the demands presented.

The DSC 01 depicts, according to users, that the nurse's relationship with the family is restricted to the health unit, which shows that professional detachment to the actual current conditions in which this population is inserted. This hinders the formation of bonds and the construction of adequate care actions to the specifics of these social actors.

In the inner circle are provided care more closely to the families[3], but there is distance contact of AB nurses with the population under their responsibility, as observed in this research. According to the convoy model, these professionals are not understood as support reference by the families. They are considered secondary professionals in this field of attention.

It is understood that the centralization of actions within the health unit is often condi-

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tioned to the reproduction of the traditional care model with emphasis on medicative treatment, technicalities and biologicist. This situation complicates the use of other care production possibilities, such as the host, link, active listening and empowerment of social actors.

In this sense, there is also the need for nurses to take ownership of the support as a function of the social network, beeing care production a specific type of support to be effected with the family throughout the life cycle, which can foster a closer approach and interaction with these social actors[3].

Moreover, with the effectiveness of the approach of the nurse with the community in its attached territory, may emerge the various situations of vulnerability in which this population exists. These circumstances require specific skills, interdisciplinary and intersectoral action, elements in which nurses can still have limitations upon acting as a diverse field of knowledge necessary for a production with quality in primary health care[9].

In the DSC 02 note is a mistaken view of the nurse's role in AB - pictured as a replacement for when the doctor is not in the health unit.

The AB work process requires specific skills of health professionals and consequently of a nurse. In this first level, there is no division of responsibilities in this category. This may have originated in the work of the professionals themselves, who have not yet appropriated the main purpose of their everyday work of AB, adding tasks and functions that are not their own, but also because of functions that are hybrid in this action scenario such as consultations, test requests, and prescriptions, among others, which can lead to ambiguities of its role by the users[10], as noted in this DSC.

The vagueness of the actual functions as well as those that are possible to be shared among nurses and other members of the healthcare team in primary care, is not restricted to Brazilian scenario. This issue is also highlighted in Canada[11], Australia[12], Bahrain[13] and Ireland[14], where there is still no definition of the role of nurses in this scenario of action, which undermines the social and professional recognition of this category.

It is understood that there is a need for professional identity specification of nurses in AB, since it is confusing to users, which compromises the recognition of the value of your practice; beyond the attainment of autonomy at work and relations of cooperation and collaboration, either with other health professionals or social actors who seek health services in this area of attention.

Finally the DSC 03 addresses the nurses' support to the family, from the users view, is realized by guidelines, which aim to address the questions about the best care in their daily lives to maintain adequate health, but also to perform exams.

It can be inferred that these guidelines should transcend the pragmatic and normative actions, which are still commonplace in this scenario of operation, thus expanding the understanding of the health, illness and family care.

Therefore it is important that these guidelines may be directed towards the production of care focused on users and their families, involving, besides the disease, the subject in context, fostering the development of autonomy of people in dealing with their problems through the predominant use of interactionists technologies and dialogued construction between the social actors involved in this process[15]. As well as the utilization

of proper tools to work with families as close to nursing practice.

The convoy model was an important revealer of the AB nurse's detachment from the assisted families, because most family representatives users cited the support of this professional as secondary to other first priority searches, such as medical care in the health logic linked to disease, prescription and medicalization.

CONCLUSION

This research has identified, as perceived from the perspective of users, that support is performed by the nurse for the family in the AB, based on the convoy model of social relations.

These results demonstrate a greater appreciation of the doctor, considered as the main reference for the families in solving health problems. The professional was named in the convoy most frequently in the inner circle. In contrast, the nurse of the health unit was remembered just a little, making visible their fragility in enabling adequate support to the family.

It also identified that the nurse focuses its activities within the unit's physical structure, whether on the deficiency in dealing with complex situations present in the territory or by the action of continuity in prescriptive and technologic actions, just using the creative potential that carries.

These situations may contribute to the mistaken perception of the nurse's role in the AB, i.e., as a medical substitute, since it still did not take their specific competencies at this level of attention.

It is understood, finally, that the nurse should transcend the traditional model of health care that reverberates in their daily practice, and adopt an attitude whose orientation may have as a foundation, interactionist technologies to foster the reception, link, active listening and consequently the empowerment of social actors under their responsibility.

It is necessary to emphasize that the results obtained have limitations because it was developed in the AB of a municipality, so that we cannot generalize them to other nationwide services, since it would requires the health reality of the population and the process dynamics of the professionals' work in each territory.

Furthermore, this research aims to not saturate the concerns presented and discussed in this investigation, but instigate further discussions about nurse's professional support to family in the AB, mainly emphasizing the expanded clinic, enabling an ethical, humane and comprehensive care.

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