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Nursing consultation in Family Health Strategy, increasing the recognition of the distinct forms of action: an integrative review

Consulta de enfermagem na Estratégia Saúde da Família, ampliando o reconhecimento das distintas formas de ação: uma revisão integrativa

Consulta de enfermería en Estrategia de Salud de la Familia, ampliando el reconocimiento de las diferentes formas de acción: una revisión integradora

Ana Lúcia Abrahão[1], *Isabela Tavares Amaral*[2]

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ABSTRACT

Objective: To explore the publications in the health field in the last six years concerning nursing consultation in Family Health Strategy, in order to gather bibliographical evidences about the working processes that are part of this setting nowadays. **Method**: it is an exploratory research of qualitative approach. The chosen method was the Integrative Review. The articles selection was made on the Health Virtual Library (HVL) portal with no filter, between April and July 2014. The data were analyzed according to the thematic analysis of Bardin. **Results**: 61 articles were found in the LILACS, BDENF and ColecionaSUS databases . After excluding similar ones and evaluating the relevance of the content to this work, 30 articles were analyzed. **Conclusion**: the nursing consultation often sets a health care scenario in a verticalized and medicalized structure.
Descriptors: Family Health Strategy; Primary attention to health; Community Health Nursing

RESUMO

Objetivo: Explorar as publicações na área da saúde nos últimos seis anos sobre consulta de enfermagem na Estratégia Saúde da Família (ESF), de modo a compor evidências bibliográficas sobre os processos de trabalho que se configuram hoje nesse cenário. **Método**: Trata-se de um estudo exploratório de abordagem qualitativa. O método escolhido foi a revisão integrativa. A seleção dos artigos foi realizada no portal Biblioteca Virtual em Saúde (BVS), sem filtro por bases de abril-julho 2014. Os dados foram analisados segundo a análise temática de Bardin. **Resultados**: Foram gerados 61 artigos nas bases Literatura Latino-Americana e do Caribe em Ciências da Saúde (LILACS), Banco de Dados em Enfermagem (BDENF) e ColecionaSUS. Após exclusão dos semelhantes e avaliação da pertinência do conteúdo para este trabalho, foram analisados 30 artigos.
Conclusão: A consulta de enfermagem, muitas vezes, configura um cenário de atenção à saúde de forma verticalizada e medicalizada.
Descritores: Estratégia Saúde da Família, Enfermagem em Saúde Comunitária, Atenção Primária à Saúde.

[1] Bachelor in Nursing from the Fluminense Federal University (UFF) in 2011, Specialized in Family Health and Master in Health Care Sciences (UFF). Professor of the Estácio de Sá University, Niterói. Thematic: Public Health, Public Health Nursing.

[2] Professor at the Fluminense Federal University, School of Nursing. Graduated in Nursing from the Fluminense Federal University (1992), habilitation in Public Health from the Universidade Federal Fluminense (1993), residency in public health by the National School of Public Health / FIOCRUZ (1995), a graduate of the Federal University of Fluminense (1992) , a Master's degree in Collective Health from the State University of Campinas (1999), a PhD in Collective Health from the State University of Campinas (2004), and a PhD from the Institute of Social Medicine (UERJ). Thematic: Management and Subjectivity; Health Education; Micropolitics; Health Policy; Public Health Nursing; Care Production; Work Process in Health and Institutional Analysis.

RESUMEN

Objetivo: Explorar las publicaciones en el área de la salud en los últimos seis años sobre la consulta de Enfermería en la Estrategia de Salud de la Familia para componer evidencias bibliográficas sobre los procesos de trabajo que se configuran en este escenario de hoy. **Método**: Se trata de un estudio exploratorio de abordaje cualitativo. El método elegido fue la Revisión Integradora. La selección de los artículos se realizó en el portal BVS, sin filtro por Bases de abril a julio de 2014. Los datos fueron analizados mediante el análisis temático de Bardin. **Resultados**: Fueron generados 61 artículos en las bases LILACS, BDENF y ColecionaSUS. Tras la exclusión de los similares y evaluación de la pertinencia del contenido para este trabajo, se analizaron 30 estudios. **Conclusión**: La consulta de enfermería, a menudo, configura un escenario de atención a la salud de manera vertical y medicalizado.

Descriptores: Estrategia Salud de la Familia, Atención Primaria de la Salud, Enfermería en Salud Comunitária.

INTRODUCTION

The Health Policies in Brazil, in recent decades, have established different proposals to institutionalize the Unified Health System (UHS). Among them, there is the strengthening of Primary Care (PC), from the Family Health Strategy (FHS), which intends to break up with the current health care model and seeks to be characterized as a strategy that allows the integration and promotes the organization of activities in a defined territory, with the purpose of promoting the confrontation and resolution of problems identified in the population.[1]

The numerical expansion of PC teams focused on developing the FHS, especially since 1998, is outstanding. The accession of cities represents the expansion of the care coverage to a large portion of the population. In January 2002, according to the data provided by the Department of Primary Care of the Ministry of Health (MH), there were, in the country, 155.847 community health agents in 4.820 cities, 13.661 Family Health teams in 3.740 cities and 2.467 oral health teams in 1.396 cities.[2]

This increase in health accessibility impacts, differently, each city and each Brazilian state. As an example, we highlight the city of Rio de Janeiro that, between 2010 and 2011, presented a decrease in hospitalization and a significant reduction in urgent care demand, although not yet quantified.[3] This result may be explained by the strengthening of the FHS expansion in the city. Still, there are many challenges to overcome in order to change the way we provide and organize the health sector nowadays.

As the FHS is responding to several economic and social expectations, the MH has been developing procedures to facilitate its implementation in the entire country. Among its proposals, the nurse becomes important for his/her diversified role within the team. As part of his/her core activities, there are the provision of health care to individuals and families enrolled in all stages of human development, the execution of nursing consultations, referrals of individuals to other services, when necessary, participation in ongoing education activities of the nursing staff, community health promotion, supply management of the unit, evaluation of the community health agents' activities, implementation of program activities and attention to spontaneous demand.[4] Furthermore, the nurses' actions in the FHS also include home visits, participation and integration in key vertical programs of the MH, such as the National Immunization Program.

Nursing consultation uses scientific methods to identify situations of health/disease, with the objective of prescribing and implementing nursing measures that can contribute to the promotion, prevention, recovery and rehabilitation of the individual, family and community.[5] Therefore, the nursing consultation is compounded by the nursing history, physical examination, nursing diagnosis, prescription and nursing care implementation, and also nursing development.[5]

When we think of diagnoses and nursing prescriptions, we refer to the fields belonging to the nursing knowledge. The nursing diagnosis consists of a clinical trial regarding the individual, family or community response to their potential or actual health problems and, via nursing prescriptions, aims to achieve results in which nursing is required.[6]

> The professional recognition of the nursing diagnoses occurred in 1980, when the American Nursing Association (ANA) published *Nursing: A Social Policy Statement*, which stated that nursing is the diagnosis and treatment of human responses to actual or potential health problems.[6:143]

That is, the nurse's look must go beyond the current disease, and beyond the medicalization. In the art. 11 of Law 7498/86, which regularized the nursing consultation and established it as the nurse's private activity, it can be found as one of the activities that is compliant with these professionals, as part of the health team, the prescription of medications established in programs of public health and of routine approved by the health institution.[7]

The National Primary Care Policy mentions the nursing consultation as important for the health promotion and prevention. This document refers to the nursing consultation along with the drug prescription, the use of protocols or other established technical regulations and complementary exams. These assignments, though necessary to constitute the health care in the Strategy, leave doubts concerning the real focus of nursing consultation in the working process of Family Health teams.

Nowadays, we experience the steering of nursing actions towards a standard that is moving away from the focus on health promotion. This fact generates doubts regarding the working process in this scenario: are we experiencing a reproduction of the welfarism and curative biomedical model within the nursing offices of the FHS?

It is necessary to study the practice of this professional, considering his/her social importance in the FHS, especially regarding his/her influence on the individual and the community health-disease processes.[8]

There is a way of conducting the processes in health care organizations, determined by the micro-policy, which can be understood as the routine actions of the subjects.[9] These actions, in terms of nursing care, are most often configured within the nursing consultation space.

Therefore, the objective of this study is to explore the scientific production related to the nurses' procedures in the FHS, focused on the nursing consultation. It is intended to expand the recognition of the different forms of action encapsulated in the nurse's daily work in order to contribute to the process of understanding the nurse's expertise in the FHS practice fields.

The first part of the article is the description of the methodological procedures, followed by the presentation and analysis of the material and the conclusions of the study.

METHODS

This is an exploratory study of qualitative approach. The method used was the Integrative Review, which enables the research, critical evaluation and offers us a clear view of the current state of knowledge about the investigated issue, showing the available evidences in a synthesized mode.[10] Thus, we consider the synthesis of the results of different studies about nursing consultation, systematically and orderly.

The research question design emerged from the perception of studies that point to the fact that most of the nurses' working time in the Strategy is focused on management and support actions, instead of activities for health promotion and disease prevention.[11] It can be said that this support action is basically defined as nursing consultations, which currently tend to be based on curative actions and compliance with protocols corresponding to health care programs. Supporting this issue, an analysis of publications about the nursing consultation theme in Family Health in 2009 concluded that all studies discussed the nursing consultations linked to ministerial programs.[12]

Therefore, we start with the following guiding question: what are the focuses of the publications in the past five years on the nursing consultation in the FHS, in order to compose our understanding of the working process that is configured in this scenario nowadays?

The inclusion criteria were: original articles, including both field researches and review articles, published in Brazil, fully available, online and for free, in Portuguese, between 2009 and 2013, in order to obtain the latest national publications concerning the subject in question. No research filter was applied in the databases.

Theses were excluded, as well as dissertations and articles published in other countries and whose themes were different from our purpose.

The articles were selected using the Health Virtual Library (HVL) portal, in May 2013. We used three keyword combinations: "nursing consultation", with the search keywords "Family Health Program", "Primary Care" and "Family Health Strategy". The descriptor "Primary Health Care" was not considered in this study because of the insignificant number of different articles.

After successive readings of the works, the selected articles are those that directly discuss the nursing consultation, although expressed in specific biases, such as child care and prenatal care, for example, or care process in nursing, as long as it concerns to Family Health. The articles discussing the systematization of nursing care were also included, as long as they are related to FHS, because we believe this approach inevitably pervades the nursing consultation.

The material was analyzed via the thematic analysis of Bardin, which intends to go beyond the uncertainty and enrich, in some way, the collected data.[13] From the recognition of meaning units that were repeated throughout the reading of articles, we organized categories to facilitate the viewing and discussion of themes presented in this article. Therefore, the final selection resulted in twenty two publications described hereafter.

RESULTS AND DISCUSSION

After performing searches combining the mentioned descriptors in the HVL portal, the resulting bases were: LILACS - Latin American and Caribbean Health Sciences, BDENF – Nursing Databases and ColecionaSus, totaling 61 articles. After the reading, 49 articles were considered relevant to this research.

Among the 49 articles, 27 were found in more than one database, or repeated within the same database. Similar articles were excluded, totaling 22 articles that served as data source for this study.

We realize that most of the articles presented the nursing consultation (NC) as research background, and only five focused specifically on the nursing consultation.

After content analysis, three thematic categories emerged, described below, offering us a clear sense of the discussed issues about the nursing consultation in the FHS.

We grouped the content following three meaning units: a) the potential and limitations of the nursing consultation; b) reproduction of the biomedical mode ; and c) the impasse of the generalist nurse

a) **Potential and limitations of the nursing consultation**

The analyzed material focuses on the care production potential in nursing consultation. However, other authors discuss and explore its limitations. In order to fully explore the issue of consultation potential and limitations, we chose to divide this category into two others, completeness and resoluteness, pointing to the potential that makes nursing consultation an effective instrument of comprehensive care to the individual and its limitations. The sub-category resoluteness refers to it as one of the objectives to be achieved in nursing consultation. Below, the discussion produced in each subcategory is presented.

INVESTIGATING THE COMPLETENESS OF THE NURSING CONSULTATION (NC)

The NC is a strategy that enables the achievement of completeness in health care, and there was an increase in visibility after the implementation of the Family Health Program (FHP) .[14,15] Thus, one of the analyzed articles states that the use of NC as a generalist care strategy in the FHS increased the implementation of consultation by the nurse and the autonomy of this professional.[16]

Therefore, the NC is a strategy within another strategy, which highlights the potential of this instrument in the actions and the nurse working process. Reiterating this setting, some of the authors, whose works were analyzed in this study, indicate that the practice of nursing can be considered as one of the main axes of support for public health policies.[17]

This NC potential is explicit in its ability to recognize the real needs of the individual, and not only those translated in one's demands .[18] This occurs when the nurse assumes, in fact, the implementation of the NC, addressing both the promotion/ prevention and management of individual responses to health problems. On the other hand, some articles of this investigation indicate performances of nurses that, sometimes, only prioritize one approach or the other. Centered approaches on the "complaint-conduct" management lead, in a way, to the reduction of the NC degree, since they restrict a broader approach to the user's life process.

One of the analyzed articles points to the experience of a study conducted in Rio Grande do Sul, where it demonstrated that "the completeness of the intended actions in the FHP is not evident",[10] since the nurses strongly prioritized promotion/prevention actions at the expense of participation in clinical care demands, which led the team to a certain lack of knowledge regarding the possible actions of the NC, being no longer reference in the dynamics of the FHS, even for nursing technicians. Here, there is a evidence of the risk of focusing only on one aspect of the work. In this sense, the authors argue that:

> The basic unit must have its roles extended in order to fully assist the population health problems, performing, in addition to prevention and promotion actions, expanded clinical care, providing the necessary means to sustain life. Completeness must be a desire of professionals and not a users' solitary construction.[10:252]

Another factor responsible for the NC potential is the fact that it is an action focused on the life cycle of the individual, which considers the family in the query approach process. This issue was widely discussed in the articles raised during the investigation, which confirmed that the scope of completeness in assistance directly involves the family approach. This idea is still previous to the FHS, since it already appeared in maternal-child nursing.[19] After the idea of the mother/child dyad, it was considered the importance of the father's role in this pair, and then the extreme importance of studying the varied and possible family systems. This very article proved that many nurses acknowledge that they did not undertake any kind of activity with families. If, seeking to achieve comprehensive care, the Primary Care considers the individual in its uniqueness and socio-cultural integration,[4] how can this be possible without the approach of family dynamics in the process of attending to individuals?

INVESTIGATING THE RESOLUTENESS IN NC

One of the articles analyzed by this research shows that, in the health agenda, resoluteness is intended to implement the principle of completeness of the Unified Health System (UHS).[20]

According to the National Policy of Primary Care (PNAB – Política Nacional de Atenção Básica), it is one of the features that makes Family Health a strategy capable of expanding, qualifying and consolidating primary care, because the strategy has the capacity to increase the resoluteness and the impact on the health status of people and collectivities.[4] Therefore, we can say that being resolute is an essential prerequisite for the FHS nurse

However, we saw that some experiences from the articles presented a certain iniquity, pointing a serious assertiveness deviation of the strategy. This iniquity is reflected in the articles analyzed: the lack of family approach consultation with both the elderly and the bearer of chronic disease, which limits the extent of NC to the family,[21] attention focused on clinical demands and experiences denouncing the removal of the nurse's responsibility in the execution of prenatal and childcare - which will be discussed in the spontaneous demand topic.

This potential of NC can be reached from some actions that were repeated in the read articles, paramount to the achievement of resoluteness. We highlight the increase of the user's ability to cope with stressful situations,[22] the encouragement of the user's autonomy for decisions and actions regarding his/her life and health, favoring the assimilation of the guidance provided for the individual so that his/her choices are more lucid,[23] the nurse's ability of focusing on the user during the consultation and the joint responsibility of the family in the care process.

We also emphasize that two articles mention the need to systematize the nursing care in the FHS, in order to achieve more satisfactory results for the services and optimize the consultation time . In this sense, another study brings forth the idea of the various tasks that a NC requires, highlighting that these tasks have different natures, and usually compete with each other, with respect to the consultation time.[24] The Systematization of Nursing Care intends to organize procedures for the professional and, moreover, it helps to identify the problems and their interpretation.[14] These aspects strengthen the need for systematization of nursing care in a scenario with multiple roles, such as the FHS, in order to reach the resoluteness.

b) **Reproduction of the biomedical model**

We examined, in the the material obtained, the existence of many scenarios where there is the reproduction of the biomedical model, and we focused on two characteristics that emerged during the process of data analysis. For these characteristics, we created two subcategories to facilitate discussion. The first one discusses how to make health according to the articles, highlighting the medicalized and reduced aspect of vertical actions. The second one discusses the issue of spontaneous demand, considered in some Primary Care units, as an organization axis of the working process.

VERTICAL AND "MEDICALIZED" ATTENTION

From the 22 articles, 19 discussed the NC, linked to any ministerial program, confirming the results from other study[9]. It is controversial to think of vertical attention in a strategy linked to a care network whose role is, among others, coordinating care to the user, acting on a horizontal, continuous and integrated relationship.[4]

The predominance of the traditional way of attending the demand, along with verticalized programs, set up large barriers for implementing the FHS.[25] The analyzed articles point out that the elderly attended in the Hiperdia program, included in the Nurses' agenda for consultation, focused on monitoring diseases included in the program (hypertension and diabetes mellitus), which compromised the comprehensive care to the elderly by the nurse.[26] In addition, another article mentions the fact that hypertensive patients have reported that the NC is often reduced to following the prescription.[27]

Moreover, there are good experiences within the vertical mold of health care. An example is an article, which is not part of the results of this study, dealing with the nursing consultation for patients with Hansen's disease. In it, there is a recognition of the health needs of patients with Hansen's disease, not only physical, but also psychosocial, economic, emotional and cultural aspects, resulting in a nursing care with a view to what they called "focused comprehensiveness".[18:106] This term refers to the idea that it is possible to focus on a specific health problem, but contextualize this focus on the uniqueness of each individual.

Another article discuss the experience of the Program for the Children's Health Surveillance in their First Year of Life (Programa Prá-Nenê), in Porto Alegre, Rio Grande do Sul, intending to develop monitoring actions aimed at the children's health in their first year of life, aiming to facilitate the access to health services.[23] Although this program provides an excellent communication for better care of the children, the need for its existence makes us wonder if the dynamics of the FHS requires a program to fulfill these roles. After all, the role of any Health Unit Family is to follow-up the child's growth and development, ensuring the access to the service.

SPONTANEOUS DEMAND AND THE LABOR PROCESS

The issue of co-existence of spontaneous demand and scheduled activities in the FHS is placed on the National Policy for Primary Care. In two articles, this issue emerges as an obstacle in the progress of the working process at Basic Health Units.

We bring a text to the discussion, not resulting from the research presented, but very important since it reveals a worrying scenario: the nurses participating in the Primary Care study exempt themselves of the responsibility of accompanying the children in the childcare consultation, assuming certain " medicalized power" in child care, which only occurred in cases where the mother sought the services due to some specific demand.[24] The fact is characterized, according to the study, when the nurse checks the records made by Health Communitary Agents (HCA) of the child's weight, vaccination card, with the sole purpose of establishing the dosage of the medicine.

Such cases need to be problematized, once they reduce the capacity for action focused on health promotion arrangements and stimulates the popular culture of demand for services only in the presence of a disease, which strengthens the social imaginary dependence on prescriptive and medical acts. This distancing from the nurse's essencial care in the FHS is worrisome because, in addition to reducing the levels of quality in care, makes the FHS a reproduction of the biomedical model in a territorialized path, in actions derived from the "complaint-conduct" dynamics.

It is known that the more emergency doors open, more demand is generated. So the nurse that operates based only on the spontaneous demand runs the risk of ignoring the health needs of the users that are not immediate, such as follow-up actions, education and health promotion and prevention of injuries. It is important to meet spontaneous demand, but not consider it as the only way of care. Creating mechanisms to reverse this situation by incorporating approaches at the time of service that break with the model of "complaint-conduct", very frequent in the spontaneous demand, is of great interest.

Spontaneous demand should not be put, in any way, as a barrier to comply with any of nurses' roles in the strategy when they set up as a constitutive element of the work in primary care. However, we found in one of the items raised in the research, on adolescent care reception in nursing consultation that, generally, the teenager could not even reach the nurse, being stopped at the reception due to excessive demand.[28] We also verified, in another study on the role of nurses in Hiperdia, the difficulty most often cited by these professionals in the program's compliance is the excessive demand,[21] which leads us to question the mechanisms and management strategies able to cope with this demand, in accordance with the unique characteristics of each working process on each

team. Attending the spontaneous demands must be integrated into the everyday actions of the service, and not prioritized at their expense.

We infer, then, that the way we deal with spontaneous demand reflects in the working process of the Health Family teams, since we recognize certain bond-generating potential in the demand, because, in essence, it always consist in a search for the user meeting with the health professional. There must be a balance in the search for direction of scheduled and unscheduled actions.

c) **The impasse of the generalist nurse**

The proposal designed by the FHS requires a generalist professional, with the possibility to operate outside the compartmentalized model of the working process.

Again, with a view to facilitate the discussion, we divided this category into two subcategories, as follows. The first will focus on the "multi nurse" issue, responsible for performing various roles, often even simultaneously, and how it reflects in the care process, and those who receive this care. The second category deals with how the issue of vocational training is included in the conclusions of the analyzed articles, as the source of the issues that emerge in the nurse practice scenario.

THE MULTIPLICITY OF ROLES

Acting as a generalist means necessarily meeting the service demands [24], and this is reflected often negatively, both for professionals, because it leads to a service overload, and for users, who often fail to process the idea of a single professional attending his son, collecting his preventive exam and attending to his father's hypertension, for example. The results of another study of 2010, whose authors hypothesize that low childcare coverage in the Northeast and South of Brazil may have been due to the fact that mothers prefer specialized care for their children, since mothers consider that the FHS professionals are subject to a wide range of people's demands and, therefore, less suitable for the specific child's needs.[24] We identified the same argument when we look at another study, which found that 9% of the interviewed mothers requested that the children were directed to the pediatrician, which can certainly demonstrate how they are still focused on the traditional care model, centered on the figure of the doctor and often insecure with the nursing consultation.[29]

Studies confirm the fact, already mentioned at the beginning of this work by other authors, that the nurse spends most of his/her working time solving issues related to the care administration at the expense of the care itself. [14]

I In addition to the multitude of tasks of the nurse, there is also an important simultaneous character – the performance of several roles, as mentioned below:

> (...) The nursing professional is subjected to a working reality that requires different interventions according to the different situations presented. Such situations are characterized as a source of cognitive, physical and mental wear because in the daily work there is an service overload when attending to the unique needs of the users of this service.[…] Add to this the fact that, besides the overload arising from care demands, the nurse is responsible for the organization and operation of administrative activities […][24:40]

The PNAB reflects, in theory , and studies, in practice, that this multiplicity of roles can wear and compromise the quality of nurses' work. Among the duties of the nurse, we observe, in addition to general assistance, planning, management and evaluation of the activities of the HCA that, although these attributions should be developed together with other team members, ends up being relegated to the nurse, who acts as a supervisor, a manager of supplies for the operation of the unit and also conduct continuing education activities of nursing staff and other team members.

TRAINING AS A SCAPEGOAT

We point out that seven of the 22 read articles cite, somehow, graduation as the responsible for the low knowledge of professionals about the specific content discussed in the article. As stated by the authors of one of the articles analyzed, the specific preparation of the nurse to perform the nursing consultation is recent in graduation.[16] Now, we know the undisputed participation of vocational training in the capacitation of nurse professionals, but we also know that the graduation is not enough to teach everything a nurse needs for countless reasons. Among them, we highlight the fact that professional practice is quite different from internship during undergraduate courses and that the general education compels us to believe that we will become a "super professional" that will exert excellent assistance to any group of individuals. So we do not take into account the professional responsibility to pursue continuing education, training courses and graduation programs in order to provide better quality care to the individual.

On the other hand, the required specialization issue can be verified through studies that show the importance of expertise, specifically in the woman's care during pregnancy and childbirth.[30] According to this logic, each team should rely on an obstetric nurse, a specialist in child health, one in gerontology, one specializing in management, another in adolescent health, another in management with urgent/emergency situations, another with a master degree in alcohol and drugs management ... And there would be no shortage of specializations that could cope with the functions of the Family Health nurse!

There are even those nurses that withhold all the knowledge on how to perform their work with excellence due to the arising wear of the the aforementioned overlapping roles and contribute to poor care provision, as pointed out by many of the articles evaluated. An interesting

statement, recorded in one of the articles, shows that 100% of the nurses interviewed felt empowered to exercise the NC to the child, mentioning the 56 hours training given by the city's Municipal Health Department when they were hired.[21] Thus, capabilities enable both a unique approach and a place that promote safe work.

CONCLUSION

We can say that there are still practical scenarios in nursing offices in the FHS that fails to promote health and only care for ill patients, constituting a major setback for the Unified Health System, regarding the implementation of FHS as supervisor of the health network.

The nursing consultation brings great impact on ways of producing health, involvement of families in the individual's care process, and in the care granted. However, despite the nursing consultation proving to be of great value to the implementation of the FHS with a view to strengthening primary care, as shown by the raised articles, there is a great danger in mechanizing the service based on vertical care programs to the individual's health. These should guide clinical decisions during the consultation and not lead it, since the care must be centered upon the individual assisted, and not upon a protocol.

The issue of "multifunctional" nurses flows into professional's psychic and emotional wear, and stands as the villain of the quality of care provided to the user, and brings up some "poor training" of the professional.

It is worth mentioning the shy but important appearance in the articles of the need for systematization of nursing care in the FHS, for achieving better levels of service quality and greater resoluteness in the nurses' working process. Moreover, it is necessary that these professional pay attention to the management of their multiple roles, so that they do not exempt themselves from their caring role and ultimately assume purely administrative or medicalized roles. It is understood that these roles must coexist with the management of individual responses to health problems, and the ability of a specific socio-cultural approach of each individual should be understood within a familiar process. All these factors should act simultaneously in the exercise of nursing consultation.

In the end, and after exploring the scientific production related to the nurse's acting, with the central point at the nursing consultation, some questions for reflection emerged on different forms of action included in the daily work of nurses. Although ministerial programs often provide fragmented attention, it may be possible to make use of the "boxes" on a less formal basis, according to the user's health needs? Is it possible to make use of the verticalization of the programs and integrate them into a horizontal approach of the subject, which will allow us to achieve comprehensive and, at the same time, resolute care?

It is known that these are challenging issues when we look at the scale and, at the same time, the specificity of each aspect involving the nursing consultation in Primary Care Units.

Perhaps there lies the great potential of being a generalist nurse; the viability of many necessary "coexistences". "Coexistence" of functions, roles, social representations, management capacity and organization of simultaneous actions. But while this is justified by the need to service the current configuration of the UHS, this can often be detrimental to the provision of quality care to the population.

It can also be inferred that the management of spontaneous demand must be created and (re) created within the specificities of each territory, there is not a "recipe" that can be generically applied to all Primary Care Units. However, prioritization of this type of care alienate the nurses from the essentiality of their actions in the FHS, impoverishing the team work process and delaying the resoluteness of the heath needs of the registered users.

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Contact of the corresponding author:
Isabela Tavares Amaral
Rua Dr. Celestino, 74
Centro, Niterói, RJ
ZIP-code: 24020-091
E-mail: <isabela.t.amaral@gmail.com>