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OS DESEMPENHOS DA ENFERMEIRA NA SAÚDE DA FAMÍLIA – CONSTRUINDO COMPETÊNCIA PARA O CUIDADO

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THE PERFORMANCES OF THE NURSE IN FAMILY HEALTH – BUILDING COMPETENCE FOR CARE[1]

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ABSTRACT: The aim in this qualitative, exploratory and descriptive study was to identify and analyze performances in nurses' individual and collective care actions in the Family Health Strategy. After approval by the Ethics Committee, the data were collected through participant observation of a typical workweek of the nurses at five Family Health Units in Ribeirão Preto, São Paulo, Brazil, totaling 200 hours. Thematic content analysis was applied. The results show the performances in: nursing visits, home visits, evaluation with risk rating, monitoring and evaluation of vaccines and adverse reaction to vaccines, educational care groups for vulnerable individuals and epidemiological surveillance. In conclusion, the nurses' work is developed with a focus on the biological, with initiatives to use tools that enable the expansion of clinical care and welcoming.

DESCRIPTORS: Professional competence. Primary health care nursing. Primary health care. Family health program.

OS DESEMPENHOS DA ENFERMEIRA NA SAÚDE DA FAMÍLIA – CONSTRUINDO COMPETÊNCIA PARA O CUIDADO

RESUMO: Estudo qualitativo, exploratório-descritivo, com objetivo de identificar e analisar os desempenhos nas ações da enfermeira para o cuidado individual e coletivo na Estratégia Saúde da Família. Após aprovação do Comitê de Ética, os dados foram coletados, através da observação participante de uma semana típica de trabalho das enfermeiras, em cinco Unidades de Saúde da Família de Ribeirão Preto, São Paulo, Brasil, totalizando 200 horas. Foi realizada análise de conteúdo, usando a análise temática. Os resultados mostram os desempenhos nas ações em: consulta de enfermagem, visita domiciliar, avaliação com classificação de risco, monitoramento e avaliação de vacina e reação adversa à vacina, atendimento para grupos educativos com indivíduos vulneráveis, e vigilância epidemiológica. Concluímos que o trabalho da enfermeira é desenvolvido com foco no biológico, com iniciativas de uso de ferramentas que possibilitam a ampliação da clínica e o acolhimento.

DESCRITORES: Competência profissional. Enfermagem de atenção primária. Atenção primária à saúde. Programa saúde da família.

LOS DESEMPEÑOS DE LA ENFERMERA EN SALUD DE LA FAMILIA – CONSTRUYENDO COMPETENCIA PARA EL CUIDADO

RESUMEN: Estudio cualitativo exploratorio-descriptivo con objetivo de identificar y analizar los desempeños en las acciones de la enfermera para el cuidado individual y colectivo en la Estrategia de Salud de la Familia. Después de la aprobación del Comité de Ética, los datos fueron colectados por medio de la observación participante de una semana de trabajo de las enfermeras en cinco Unidades de salud de la Familia de Ribeirão Preto, São Paulo, Brasil, totalizando 200 horas. Se empleó el análisis de contenido, utilizando la técnica de análisis temático. Los resultados muestran los desempeños en las acciones: consulta de enfermería, visita domiciliar, evaluación con clasificación de riesgo, seguimiento y evaluación de vacuna/reacción adversa a la vacuna, atención para grupos educativos con individuos vulnerables, y vigilancia epidemiológica. Concluimos que el trabajo de la enfermera se desarrolla con foco en el biológico, con iniciativas para utilizar herramientas que permiten la expansión de la clínica y el acogimiento.

DESCRIPTORES: Competencia profesional. Enfermería de atención primaria. Atención primaria de salud. Programa de salud familiar.

INTRODUCTION

In the current implementation context of the Unified Health System (SUS), research that is aimed at identifying and analyzing health workers' work process is focused on understanding how it has been developed in the daily reality of health services, as well as the potentials and difficulties in its transformation.

Departing from the understanding that health work and nursing work are a social practice,[1] this study was focused on the nursing work process in Primary Health Care, particularly in the Family Health Strategy (FHS), considering that research needs have been indicated in the literature,[2] so as to explore nursing "know-how" in the FHS. Authors who have studied the work process in health are guided by the understanding that it results from the combination among the object, instruments and product of the work, responding to the goals set for its development.[1,3-4]

Generically, the work object will always be the raw material for transformation, while the work means/instruments are the tools, represented by the operating knowledge, that is, the "know-how", translated as the knowledge, skills, equipment used to operate the transformation and/or attend to the present needs that trigger the work process. This includes the workers and their knowledge, with their work force employed in this dimension of the transformation process, as agents who can mobilize actions. The product constitutes the end result of the process that will attend to the needs that trigger the work process.[1,3]

Thus, the development of this research was based on the following guiding question: how do nurses perform in the development of individual and collective care actions in the FHS?

It is important to highlight that, in this research, performance is understood based on the theoretical reference framework of Dialogical Competence, which works with the development of skills or attributes combined with the context and local work culture where the action takes place, in view of the values and ethics in the development of the practice.[5] It is in the construction of this framework that one can relate the job world with education with a view to the development of practices. Competence is the ability to mobilize a complex network of attributes in the action, in different manners, with a view to pertinently and successfully solving a range of situations in professional practice.[5] It is not observed directly, but inferred through performance, which comprises a combination of attributes (knowledge, skills and attitudes) that support the accomplishment of professional tasks.[6] It is emphasizes that performance derives from reflections about: the production conditions, the means conceived to execute the activity, the goals of the action, the organization of the work.[5]

The movement pursued in this research permitted further approximation with the daily reality of nurses in the FHS and further understanding of the care production strategies and of the use of technologies in care actions, that is, soft (relations and mediating processes), soft-hard (technical knowledge, the set of knowledge that permits health work) and hard (equipment) technologies in primary health care.[3]

We believe that the study results can be of help in the construction of political-pedagogical projects aimed at preparing nurses with knowledge, skills and attitudes to work in the implementation of the SUS, as the construction of these projects can be made feasible based on discussions about the transformations in daily work.

In this study, we depart from the premise that, in primary health care, care delivery joins disease, vulnerability and risk situations. Workers are expected to perform in such manner that the care delivered stimulates the creation of the users' autonomy within the social and cultural context. When focusing on health care, we consider it as live work on the spot, that is, deriving from the establishment of a mediating space, a space of listening and intervention, aiming to respond to health needs.[3]

Nursing care can be understood as a process that involves and develops actions, attitudes and behaviors based on scientific, technical, cultural, social, economic, political and psychospiritual knowledge, aiming for the promotion, maintenance and/or recovery of human health and dignity.[7] It is also important to highlight that the collective can be understood as the group of men who relate in life in society.[8] In that sense, it is more than the mere sum of individuals, with some actions considered as collective exerting particular effects on individuals. It is emphasized that collective care actions cannot be "separated from clinical care. They can be powerful to question the daily reality of health work and can also permit the renewed binding between promotion and prevention and care actions".[9:581]

In view of the above picture, the aim in this study was to identify and analyze the performances present in nurses' individual and collective care actions in the FHS.

METHOD

This qualitative, exploratory and descriptive research was developed with theoretical support from the health work process and was accomplished in Ribeirão Preto, a city in the Northeast of São Paulo State, Brazil.

As regards the health system, at the Primary Health Care level, Ribeirão Preto is divided in five districts and 47 primary care institutions, including: 5 District Primary Health Services (UBDs), 13 Family Health Services (USFs) with 21 FHS teams, and 21 traditional Primary Health Services (UBSs) with 26 Community Health Agent teams (EACs).

To select the research scenario, the city's definition of teaching districts was considered. The University of São Paulo (USP) is responsible for the Western District. Therefore, five USFs from the Western District were considered as the research scenario.

It should be highlighted that this research as part of a larger study about the analysis of nurses' competences in the FHS, within a time continuum, aimed at monitoring the installation of FHS teams in the city. The first data collection phase took place in the second semester of 2006, at four USFs affiliated with the USP. Then, considering that nurses' performances in the FHS should be analyzed in view of these professionals' different activity contexts in Ribeirão Preto, that is, considering the USF affiliated with the USP as well as an USF under municipal administration, the second data collection phase was developed in the second semester of 2010. In order to continue with this phase, without impairing the analysis of the FHS context in the city, the data collection was complemented at another service in the same health district, but under municipal administration. Thus, the data were collected at an USF under municipal administration, chosen after discussion with the Nursing Division of the Municipal Health Secretary. One USF was selected with the physical structure of a traditional service, that is, a service with a nursing consultation room, vaccination room, wound dressing room, medication room and aerosol.

Based on the selection of USFs in the research context, the following inclusion criteria were used: nurses working in the FHS and at the USF for more than one year, indicating some accumulated work experience in the FHS. This criterion was necessary as three FHS worked at one of the USFs.

For data collection, the work of each of the five nurses was analyzed during a typical workweek, that is, a week without any motive or situation to interfere in the nurse's work, like a holiday for example, through participant observation. Two hundred hours of observation were accomplished, during which the following were observed: the actions done, the way they were developed, the criteria and resources used, the interaction (with the users and team), the type (verbal, non-verbal) and the communication mode used (centralized, dialogued), the decision making mode to develop an action, among others.

At the same time as the observation, records were kept in a field diary, which described the daily situations as reliably as possible, making notes about the nurses' actions, the start and end time and manifestations (verbal, non-verbal, attitudes) to develop the activity. It should be highlighted that, to register the observations, specifically the nurses' verbal and non-verbal manifestations during the daily situations, the researcher needed training to cope with the difficulties deriving from this form of capturing the empirical.

Although four years passed between the first and the second data collection phase, when complementary data were collected from the USF under municipal administration, no noteworthy differences were identified as a result of the time and even the institutional affiliation in the nurses' work process, given that the services belong to the same health district. In addition, the four USFs where data were collected in the first phase served as references for the USF where the data were collected in the second research phase.

Initially, to treat the material collected through the observations, various readings were done for the sake of further approximation. Then, the material was separated into fragments systemized into a matrix, which was constructed based on aspects linked with the theoretical matrix of the health work process. Hence, for analytic purposes, we used the matrix, considering: what does the nurse do? How is it done? Why is the action developed? Based on these questions and the floating reading of the material, the cores of meaning were identified, which were then organized into the themes addressed in this discussion.[10]

The research project received approval from the Research Ethics Committee at the Teaching Health Center of the University of São Paulo at Ribeirão Preto Medical School under protocol 0192. The nurses signed the Informed Consent Form and were identified using colors, so as to guarantee their anonymity.

RESULTS AND DISCUSSION

In the analysis of the empirical material, six themes were identified, which have been presented separately, but this division is only possible as an analytic abstraction as, in the reality of the health services, they are articulated in the nurses' performances, that is, in the way knowledge, skills and attitudes are expressed in their actions in the FHS.

The nursing consultation in the different lifecycles

Although the Nursing Consultation (NC) is developed in the FHS for the different lifecycles, NCs more frequently involve women and children. As the nurse's exclusive activity, the NC is a strategy in which components of the scientific method are used to identify health and disease situations, prescribe and implement actions to prevent illnesses, and promote, protect and rehabilitate the health of individuals, families and communities.[11]

So, he hit his head. If it had been during the week, I would have brought him here. So I observed if he fell asleep, if he threw up, they said you cannot (Child's mother); *Sleep. Sometimes, the child cries and gets tired, then he sleeps. But you should really observe vomiting. You just need to watch for drowsiness* [...] (White Nurse).

In the dialogue between the nurse and the mother in the above situation, it is highlighted that the nurse does not investigate other care possibilities based on the mother's discourse about the fall, apparently not using clinical and critical reasoning.

As observed, most of the nurses did not accomplish a full physical examination during the NC. Nevertheless, punctually, the physical examination was not limited to the verification of weight, height and vital signs. The Blue Nurse weighs the child, auscultates the cardiac frequency and abdomen, verifies the body temperature, measures the head circumference, touches the fontanel, examines the mouth and observes a scar in the back: *[...] and your husband, has he understood already that he's a normal child?* [child was born with urethral stenosis] [...] (Blue Nurse); [...] *he's got a cold. He's got a cough, mainly when he lies down. His lungs are clean* [talking to the physician after auscultating the lungs] (Blue Nurse).

In the above fragment, it is highlighted that the physical examination included auscultation, clinical assessment and detection of the problem. The nurse decides to transfer the case to the physician, possibly due to professional limitations (medication prescription). It is noteworthy that the nurse is familiar with the child's history, which enables her to demonstrate skills for the monitoring of the family and family relationships, putting care longitudinality in practice, a primary care attributed defined as care delivery/monitoring over time.[12]

We identified that, during the NC in the FHS, the nurses are frequently confronted with social situations that demand the development of essential skills (such as listening, bonding, communication and interaction) to manage the cases.

Can you make fresh juice? [...] *do you know at what time?* (Blue Nurse); *No* (Mother); *When Xuxa's on television* (Blue Nurse); *The television has burned* (Mother); *And now, how will we know how late it is?* [...] (Blue Nurse); *Through the radio* (Mother); [Other daughter plays and almost falls] *Damn you!* (Mother); *Why are you cursing her? If you use bad words your daughter will learn* [...]. *So, the fruits. Do you think you can buy them?* [...] *you can buy her fruit with one real per week. An apple is good for three days. A banana is good for three days. Buy the nanica, which is cheaper. Do I need to write that down? And who's gonna read it?* [...] (Blue Nurse).

As observed, the nurse's clinical practice is somewhat expanded, that is, she seeks "to transform individual and collective care, so that other aspects of the subject than the biological can be understood and addressed [...]".[13:12] In that perspective, the nurse's actions are in line with what was identified in another research[14] as the care clinic, that is, the clinic that makes room to listen to people's needs, without remaining limited to the individual, but also looking towards the family and the life context, which can also be observed in the following excerpt, collected during a nursing consultation to collect a pap smear.

Are you in a crisis? (Blue Nurse); *I am about to get depressed* (User); *What do you feel?* (Blue Nurse); *I just want to cry* [...] (User); *Do you want to talk*

about it? (Blue Nurse); [...] *it was a bad fight* (User); *What do you think we can help you with?* [...] *do you hear voices?* [...] *have you considered killing yourself?* (Blue Nurse); *I have* [...] (User); [...] *I remember when you lost the father of your daughter* [...] *he died, and you gradually got over it* [...]. *If you think you need medicines, we call the physician* [...] (Blue Nurse); *Don't tell the doctor* [...] (User); *I'll tell him that you* [...] *haven't slept, have considered suicide. I won't talk about the boyfriend. But there's also treatment without medication,* [...] *learning to breathe, close your eyes and think of something good* (Blue Nurse).

The situation described seems to support the results from another study[15] in which, when confronted with mental health situations, the nurses assume the function of listening, welcoming, articulating care for people who are suffering. The welcoming raises the possibility for workers to mobilize all technologies in their toolbox to receive, listen to and solve health problems the users bring along.[16]

In view of the above, regarding the action "accomplishes NC in the different life cycles", we identified that the research subjects mobilize a set of knowledge, skills and attitudes to characterize the performances: collects data. Knows the user's history Seeks information from other family members and in the patient file. Among the physical examination activities, the professional only weighs and measures, and possesses skills to interact with the user and use language that is understandable. On some occasions, auscultation is included during the physical investigation, with clinical assessment and problem detection. The use of critical and clinical reasoning does not always appear clearly, without any further investigation on care possibilities. Attitudes include the elaboration of a diet script in writing and the use of the opportunity to dialogue about the family's condition. Has technical-scientific knowledge to monitor: growth and development, contraceptive methods, physical investigation, diet and equipment available at the service. Makes the decision to transmit the case to the physician, possibly due to professional limitations. Identifies health needs, not only the users' but also the families'. Formulates a problem and practices care focused on the biological.

The home visit as a care strategy

The empirical data indicate that the Home Visit (HV) does not take place frequently, as some nurses had not made any HV during the week when the work was observed. Experts unanimously affirm that HV are accomplished to assess both the users and family members' demands and the environment and context they live in, with a view to establishing a care plan and/or supporting interventions in the health-disease process of individuals and families.[17-20] In the present study, we can also observe this end, as expressed. [The Green Nurse looks at the medical prescription] *'there's potassium chloride at the station* [...]. *Are you looking after him?* [referring to the elderly] *there are four open of this one* [drug]. *You need to look how much there is, before buying, otherwise your retirement won't be enough. For some things the family needs to be there* [...]. *The social worker herself can see it* [...]. *How can that be solved? Negotiating. We come here to provide orientations* [...]' (Nurse Green).

After a HV, the Green Nurse says to the researcher: '[...] *it's almost 11:00h and there's no food moving whatsoever* [...]. *I think that's negligence. You can notify it* [...] *the HV pilfers. The HV denounces* [...]' (Nurse Green).

The descriptive fragment indicates the nurse's relatively broader look during the HV. Her discourse after the activity shows that she heeded other aspects of the VD, like the identification of the family's organizational context for care delivery to the elderly, in the attempt to investigates the entire conjuncture present in the case. We also observed situations in which the VD was triggered by the goal of accomplishing the procedure, with care actions focused on the biological.

The Blue Nurse organizes materials for HV to a user who underwent a femoral fracture surgery. During the HV, the auxiliary nurse asks whether it's time already to take out the stitches. The Blue Nurse says that it has been 13 days since the surgery and observes the stitches and says: 'it's dry [...]' (Nurse Blue).

The Blue Nurse opens the material and the auxiliary nurse asks if there are no scissors. 'There is no [kit to] *remove of stitches. I had to take a dressing. But I brought a scalpel. There is the toothed clamp to hold the ends* [...]' (Nurse Blue)*; 'It's dark* [the house is a shed in the slums]' (Auxiliary Nurse).

In the excerpt presented, we were able to capture the accomplishment of actions and the mobilization of attributes focused on the biological, in response to one of the user's needs and present in the analysis of the situations that have most demanded HV, that is, care delivery to post-surgical patients.[4] It is highlighted, however, that

the accomplishment of this HV granted the nurse knowledge about the concreteness of the reality the user experiences,[4] in this case the shack in the slums.

Thus, for the action "performs HV as a care strategy", we identified the performance: plans the activity, organizes materials to perform HV. Demonstrates knowledge about: services (medication dispensing), human resources, medicines available in the health network, resources available at the unit (notification), ethical principles, history of the user and family and socioeconomic context. Data are collected dynamically from users and other family members and from the medical prescriptions. Is able to perform a broader assessment, addressing the family's socioeconomic aspects and proposed joint work with other team members. Demonstrates knowledge about professional limits, materials needed to accomplish the procedure, function of each material, clinical and pharmacological assessment tools. Calls the physician to transmit and discuss the case. Performs inspection (part of the physical examination) and procedures. Investigates risks. Observes the environment. Supervises the auxiliary nurse. Identifies materials needed in the home visit kit. Possesses communication skills, uses language that is easy to understand, in order to accomplish and provide orientations about technical-scientific aspects, so as to create conditions for the user to practice care.

Assessment with risk classification

The services that are part of the primary health care network on a daily basis receive users' demands without previously scheduled appointments. This spontaneous demand has been constant at these services and, to organize and order care delivery, the Ministry of Health has elaborated the welcoming strategy with risk classification,[21] as well as protocols in this respect.[22-23] The data indicate that the nurse has also been responsible for receiving the users' spontaneous demand, assessing the health-disease situation and organizing the flow at the health service in the FHS.

[...] *pain, bodily pain, diarrhea* [...] (User); *And the joints?* [...] *did it hurt around the eye? When did this all start? Did you take some medicine?* (Yellow Nurse); [Yellow Nurse checks temperature, weighs and measures the user] *how many times did you evacuate?* [...] *are you drinking fluid?* [...] *It's at the end of the intestine that you absorb water and potassium. Lack of potassium causes weakness, and potassium is found in saline solution and coconut water. Dengue serology negative. Let's see the hematocrit* [...] *49.* [Looks at the protocol on the wall]: *that's high. Above 45 is suspicious* (Yellow Nurse). *The Yellow Nurse notifies the suspected case of dengue fever and collects blood for NS1.*

In the above situation, it is noteworthy that the nurse does not collect data on collective aspects, like the situation of the residence (including the identification of possible foci/breeding sites with the presence of the vector) and dengue cases in the family and neighbors. In addition, no orientations were observed on environmental actions related to epidemiology and disease prevention. Hence, during the welcoming, interventions were made focused on the sick patient-centered model, indicating the need to reconsider the practices, if these do not take place during the planning of team actions.

Based on the collected data, for the action "performs assessment with risk classification", we identified the performance: collects data (interview, verification of vital signs, weight and height and observation of user's body language – inspection). Identifies: signs and symptoms, period of referred condition and medicines used. Attempts to reach a diagnosis; adopts the attitude of putting in practice specific procedures for a certain pathology, according to the protocol established in the city, demonstrating knowledge and technical-scientific skills. Uses language that is easy to understand for explanations and orientations to users and companions. Notifies suspected cases of the disease, indicating knowledge about the importance of specific epidemiological surveillance actions for the problem. Demonstrates interaction with team members to conduct the case. Manifests concern with the family's condition to forward the case. Makes nursing notes using technical language. Uses the occasion to research on other morbidities present and to observe the user's attendance at the service. Demonstrates skills to call attention in case of absence from scheduled appointments, highlighting the importance of attending follow-up consultations.

In this care process, one can identify, even without the strictness of systemized protocols, the development of attitudes to mobilize and articulate different resources, with a predominance of biological knowledge, including concerns to specifically forward each user who receives care. However, there is a need to invest in unveiling

needs and vulnerabilities to "enhance the possibilities of coping with the presented problems and forwarding patients with responsibility and articulated with the services indicated in each situation"[23:2] have not been incorporated into the nurses' practice. The interventions adopted within a problem-solving perspective imply that the nurse needs to possess and use her knowledge and professional autonomy, not considering patients who demand health services only in their disease-related complaints, but adopting a practice that incorporates the dimension of health promotion,[24] besides focusing on the collective dimension of the health disease process.

Monitoring and assessment of vaccines and adverse reactions

It is highlighted that the FHS represents a public policy strategy in the field of immunization actions, considering different aspects, such as: vaccine administration, orientation and monitoring of vaccination situation and adverse events, maintenance of cold network and health education.

The Green Nurse observes the reaction site: *have you brought the vaccination card?* (Green Nurse); *No* (Child's mother); [Green Nurse seeks information in the Hygia System] *She hasn't registered it on the computer* [...]. [Green Nurse calls the Epidemiological Surveillance Service]*: I've got a child here who received the second reinforcement dose of the dual vaccine. He's got a local reaction. I don't have the lot here. It's red* [...]. [Green Nurse puts down the phone]: *I've talked to the person responsible for supervising the vaccination room. She's going to fill out a form. And check if that was the only case or if it was a lot problem. Bring him tomorrow for me to check* [...]. *The vaccine is diluted in aluminum hydroxide, that's why it hurts more. It may cause cellulitis here. You need to apply it by deep intramuscular route* [talking to the auxiliary nurse] (Green Nurse).

The nurse demonstrates concern with collective care by indicating that she did not have information about whether it was a "lot problem or just affected the child". The nurse did not provide the mother with orientations about care in case of other possible reactions, like fever and local pain.

Finally, for the action "monitoring and assessment of vaccines and adverse reactions", we identified the performance: data collection from the child's mother, in the city's information system. Transmits information. Observes/inspects the vaccine reaction site for assessment. Formulates a problem. Adopts the attitude: contacting the Epidemiological Surveillance (ES) Service in the area to present the case and find out about the conduct taken, schedule return to the service for monitoring, making notes in the file. Advises the mother to visit the vaccination room at the referral service and explains the process, using language that is easy to understand. Possesses knowledge about: vaccination calendar, vaccination reaction, vaccination administration (technique, route, dilution), documents needed for notification, flow among services, service network, information system available in the city, and about the child's and the family's history.

The historical and social construction of nursing work can be identified more clearly,[1] as nurses and nursing teams have accomplished and are practicing public health actions and actions to control diseases susceptible to vaccination, demanding an articulated set of knowledge.[25]

Attendance to educative groups with vulnerable individuals

The data indicate the nurses' performance in the preparation of educative groups. To hold groups, workers need knowledge about the group structure, which can be based on some essential elements to determine the strategy's functioning, including: type of participant, prevention level, physical variables and theoretical orientation.[26] Besides knowledge, the development of group activities demands planning, founded on the selection of participants.[9,26]

[...] *the main goal in the conversation is to explain what it is* [...]. *There are eight meetings* [...]. *How do you see yourself in view of the possibility to participate in dietary reeducation? If you had to attribute a score, how would you score the importance of losing weight?* [...] *how would you score your confidence in losing weight?* (Pink Nurse); *About eight* (User); *Reeducation works with the idea of reducing excesses. The main goal is not to lose weight, but you do* [...]. *Lifestyle change* [...] (Pink Nurse); [...] *it's good because we pass it to the family* (User); *That's nice* [...] *you change the family's habits too* (Pink Nurse).

The groups can be developed based on different objectives, including: offering support, accomplishing tasks, socializing, apprehending behavioral changes, offering therapeutic support and training human relations.[26] In the above

fragment, the nurse's discourse clearly reveals that the proposal to hold the group represents a behavioral change.

In view of the collected material for the action "attends to educative groups with vulnerable individuals", we identified the performance: collects data about participation in earlier groups, availability of times, medication use and consumption of alcoholic beverages. Explains the goal and functioning of the group. Possesses knowledge about diet and nutrition. Has skills to question the user about expectations when participating in the group, to suggest a weight control model and explain positive aspects of the user's attitude.

While observing the nurses' work in the FHS, we did not identify any groups the nurses organized at the services, but only the reported situation about preparing for the organization of a specific group. These aspects should be focused on in further research, as the FHS establishes individual and group educative activities in the community. In a study on nurses' participation in primary care groups, it is shown that they plan and prepare group activities, delegating the accomplishment to other team members.[9] Furthermore, the need to reconsider and discuss the most relevant theoretical and methodological frameworks is indicated, within an educative practice that is committed to the intended changes in the FHS.[27]

Epidemiological surveillance actions

Departing from the understanding that epidemiology sustains not only the specific work areas like ES, health, vector control, but is also part of different dimensions of daily nursing actions in the FHS, like for example: work at the clinic, in the territory, in prevention actions and in cases of diseases of compulsory notice. Many times, however, it is focused on singular aspects.

[...] *I'll show you the foot* [...] (User); *I don't know if it looks like scabies. If it's scabies, it will pass* [...]. *Haven't you noticed whether anyone at the school has it?* [...] *we've already attended to two children with scabies. We even thought of calling the school, but the whole family had scabies* [...] (Pink Nurse); *Although there's no consultation room, can you attend to the case?* [...] *it looks like scabies. And she works at the same school as the children who were here* [...]. *It has affected the body extremities. There's not need for a consultation room* [...] [talking to a sixth-year medical student] (Pink Nurse).

The nurse possesses knowledge about epidemiological data in the area. In a research on epidemiology for nursing work,[25] it is considered that, in routine nursing practice, collected data are used which, if related to the population attended at the service and submitted to epidemiological analysis, can identify both health problems the service already attends and others the service does not attend yet and which should to be considered. Hence, in the situation described, nurses' actions are in accordance with the study cited,[25] as the worker explicitly mentions the identification of scabies data at the service and, by referring to possible contact with the school, demonstrates concern with other cases that may emerge or may even exist without receiving care. It is highlighted that the observation data indicate that ES actions are more centered on the control of diseases and problems.

In view of the above, for the action "performs ES actions", we identified the performance: possesses knowledge on transmissible diseases, epidemiological data about the disease in the area and family history. Assesses the risk of contagion. Provides orientations to patient and team. Nurses' activities in the development of ES actions can effectively contribute to move beyond the focus on the pathological in the accomplishment of these actions, keeping in mind that the FHS was implemented to modify health practices.

FINAL CONSIDERATIONS

Based on the theoretical perspective of dialogical competence in the nursing work process in the FHS and on the premise that competence cannot be verified directly, but only inferred through professional performances, permitted the identification and analysis of nurses' performances for care delivery in the FHS. The analysis of the empirical material indicated the performances that are part of these workers' practice in a specific context, that is, Ribeirão Preto, São Paulo, Brazil, showing a work process that is still developed with a predominantly biological focus.

Nevertheless, the performances translated into the set of knowledge, skills and attitudes mobilized to develop the actions also indicate initiatives to expand the clinic beyond the biological individual excerpt, with nurses focusing on the families and the context the users are part of, within a longitudinal care perspective. Also, the use of important tools could be identified (such as listening, bonding, welcoming)

so as to put the FHS in practice with a view to the development of a care model that considers man as a social and not just biological being, and which can gradually focus on the subject instead of the illness.

It is highlighted that the analysis of nurses' performances permits new inquiries and analyses, whose reflections can contribute to identify the determinants of the work process in that city.

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