

Health actions and the use of clinical protocols by nurses in the Family Health Strategy

Ações de saúde e o uso de protocolos clínicos pelo enfermeiro na Estratégia Saúde da Família

Acciones en salud y uso de protocolos clínicos por parte de enfermeras en la Estrategia de Salud Familiar

ABSTRACT

Objective: To analyze the health actions performed by nurses and their use of clinical protocols and therapeutic guidelines in the current context of the Family Health Strategy in the city of Rio de Janeiro. **Method:** This is a cross-sectional study with a quantitative approach. **Results:** The actions recommended by the National Primary Care Policy (n = 232) were significant for people's health care (213 – 91.81); appointments with nurses (215 – 92.67%); attention to spontaneous demand (216 – 93.10%) and planning, management and evaluations (173 – 74.57%). The most consulted protocols were child health care (94 – 62.25%); women's health (89 – 57.05%); men's health and family planning (85 – 56.07%). **Conclusion:** Nurses who work in family health believe that clinical protocols and therapeutic guidelines represent tools that support the performance of their health actions and facilitate the clinical approach.

Descriptors: Family Health Strategy; Family Health Nurses; Clinical Protocols; Nursing Care; Nursing.

RESUMO

Objetivo: Analisar as ações de saúde realizadas pelos enfermeiros e o uso de protocolos clínicos e de diretrizes terapêuticas no contexto atual da Estratégia Saúde da Família, no município do Rio de Janeiro. **Método:** Estudo transversal de abordagem quantitativa. **Resultados:** As ações preconizadas pela Política Nacional da Atenção Básica (n = 232) foram expressivas para: atenção à saúde dos indivíduos (213 – 91,81); consulta de enfermagem (215 – 92,67%); atenção à demanda espontânea (216 – 93,10%), planejamento, gerência e avaliações (173 – 74,57%). Os protocolos mais consultados foram: atenção à saúde da criança (94 – 62,25%); à saúde da mulher (89 – 57,05%); à saúde do homem e ao planejamento familiar (85 – 56,07). **Conclusão:** Os enfermeiros que atuam na saúde da família acreditam que os protocolos clínicos e as diretrizes terapêuticas correspondem a ferramentas que apoiam à realização de suas ações de saúde e facilitam a abordagem clínica.

Descritores: Estratégia Saúde da Família; Enfermeiras de Saúde da Família; Protocolos clínicos; Cuidados de Enfermagem; Enfermagem.

RESUMEN

Objetivo: Analizar las acciones en salud realizadas por enfermeras y el uso de protocolos clínicos y guías terapéuticas en el contexto actual de la Estrategia de Salud Familiar en la ciudad de Río de Janeiro. **Método:** Estudio transversal con enfoque cuantitativo. **Resultados:** Las acciones recomendadas por la Política Nacional de Atención Primaria (n = 232) fueron significativas para: atención de salud a las personas (213 – 91,81%); consulta de enfermería (215 – 92,67%); atención a la demanda espontánea (216 – 93,10%) y planificación, gestión y evaluaciones (173 – 74,57%). Los protocolos más consultados fueron los siguientes: atención a la salud infantil (94 – 62,25%); salud de la mujer (89 – 57,05%); salud masculina y planificación familiar (85 – 56,07%). **Conclusión:** Las enfermeras que trabajan en salud familiar creen que los protocolos clínicos y las guías terapéuticas representan herramientas que apoyan el desempeño de sus acciones en salud y facilitan el abordaje clínico.

Descriptor: Estrategia de Salud Familiar; Enfermeras de Familia; Protocolos Clínicos; Atención de Enfermería; Enfermería.

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INTRODUCTION

Primary Health Care plays an important role in the Unified Health System (*Sistema Único de Saúde*, SUS), as it allows consolidating the bond between the user and the health team, in addition to ensuring comprehensive assistance, monitoring of the families, and case follow-up⁽¹⁾.

In this sense, the importance of new health actions is emphasized, encompassing both the individual clinical approach and the collective approach, through comprehensive and continuous assistance to all members of the families enrolled in the health unit. Care must be equitable and directed to each phase of their life cycle, with the construction of bonds between families, nurses and the community. The bond can provide a systemic and comprehensive view of people in their own family and social context, where nurses can develop actions for health promotion, protection and recovery, prevention and limitation of harms, and rehabilitation⁽²⁾.

However, the lack of clinical basis in the professional nurses working in Family Health Units, a strategy considered a priority gateway to Primary Health Care, can become a barrier to decision-making in the choice of clinical interventions in therapeutic implementation, in the integrality of assistance, in the maintenance of the bond and in the longitudinality of the care provided to the assisted families. In this sense, the professionals' competences must be based on the importance of technical-scientific knowledge⁽³⁾.

To strengthen the statement presented, it is emphasized that the Clinical Protocols and Therapeutic Guidelines, when used as technical-scientific support tools by nurses, can contribute to safety and ethical commitment, allowing the professionals to act with autonomy and seek to provide quality, directive and practical care to users of the SUS. In addition to offering support and safety in the care provided to the user, the technical-scientific foundation may reduce possible variations in the ways of doing, with inadequate practices and avoidable errors⁽⁴⁾.

Consequently, the research question for this paper is as follows: Which are the health actions, clinical protocols and therapeutic guidelines used by the nurses who work in the Family Health teams from the municipality of Rio de Janeiro?

The objective of this paper was to analyze the health actions performed by nurses and the use of clinical protocols and therapeutic

guidelines in the current context of the Family Health Strategy (FHS), in the municipality of Rio Janeiro.

METHOD

A cross-sectional study with a quantitative approach, designed based on the recommendations for observational studies included in the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) checklist. The data were collected in a five-month period, from June to October 2016.

The research fields selected were the basic health units with Family Health teams from the municipality of Rio de Janeiro.

It should be clarified that, according to the portfolio of services in force, in the city of Rio de Janeiro, by definition there are two types of units: Type A, whose territory is covered by Family Health teams, and Type B, characterized as mixed, whose territory is partially covered by Family Health teams.

The survey of all the basic health units was concluded in December 2015. All the units registered in the National Registry of Health Institutions (*Cadastro Nacional de Estabelecimentos de Saúde*, CNES) were identified. This survey provided the real determination of the number of units and their coverage areas, in order to coherently establish the corresponding settings and the research participants.

The research settings that include the study population are as follows: 139 (68.81%) Type A units, with 712 (72.14%) Family Health teams; and 63 (31.19%) Type B units, with 275 (27.86%) Family Health teams, totaling 202 units and 987 teams implemented and active in the Planning Areas of the municipality of Rio de Janeiro.

The study population consisted of nurses working in Family Health teams in basic health units registered as active and operational in the municipality of Rio de Janeiro. A previous survey was carried out with the CNES and, only in June 2016 authorization was obtained from the Superintendent of the Subsecretariat of Primary Care, Surveillance and Health Promotion (*Subsecretaria de Atenção Primária, Vigilância e Promoção da Saúde*, SUBPAV) for the research in the entire city of Rio de Janeiro. As required by the secretariat responsible for the SUBPAV database, the availability of the list with the

identification and email address of the nurses working in the Basic Health Units occurred after approval by the research ethics committees of the State University of Rio de Janeiro (*Universidade do Estado do Rio de Janeiro*, UERJ) - in April 2016 - and the Municipal Health Secretariat of the municipality of Rio de Janeiro (*Secretaria Municipal de Saúde-Rio de Janeiro*, SMS/RJ), at the end of May 2016.

Initially, the intention was to carry out the study with a probabilistic sampling; however, immediately after introducing the electronic addresses in the system, there was an initial loss due to an error in the constitution of the addresses.

Subsequently, from the beginning of data collection, it was verified that, of the email addresses sent, only part was viewed and opened by the respondents. Consequently, the adoption of inclusion and exclusion criteria was defined, therefore characterizing non-probabilistic sampling, for convenience. The inclusion criteria were the electronic addresses that were contained in the list provided in the database of the City Hall, which belonged to units registered and active in the CNES and electronic addresses with instruments answered by the respondents. The exclusion criteria were electronic addresses with constitution errors, inactive email addresses, email addresses sent and not opened by the respondents, email addresses visualized with instruments not answered by the respondents, and email addresses of respondents who did not accept to participate in the research.

For the research data collection phase, an instrument was constructed by the researcher containing questions about sociodemographic data, as well as information/content from three notebooks, that is, information/content of Nursing Protocols in Primary Health Care⁽⁵⁾, in the Portfolio of Services⁽⁶⁾ and in the data obtained from the Secretariat of Primary Care, Surveillance and Health Promotion⁽⁷⁾ with Nursing actions that could or could not be performed by the nurses who participated in the research. Thus, the variables of interest were the sociodemographic data, employment characteristics and performance frequency of the Nursing actions recommended in the protocols for assistance to women's health, to older adults' health, and to people with chronic diseases and mental disorders. The sociodemographic variables were measured by means of descriptive statistics (absolute frequency and percentage) and the

variables related to the nurses' actions were measured in an ordinal qualitative way (always, almost always, sometimes, rarely, never) based on their absolute frequency. The instrument consisted of a structured self-administered online questionnaire, through the SurveyMonkey® software, an online questionnaire software program, which makes it easier to create research studies, surveys and questionnaires to obtain information.

The 219 respondents who participated in the research opened and answered the instrument. The data were collected between June and October 2016, and 10 (5%) respondents did not accept to participate in the research. It was noticed that the initial invitation was the most effective for attracting participants and, subsequently, the respondents progressively reduced their participation, including partially filling out the instrument. The largest number of respondents was mainly from the Planning 3.0 (83 – 37.90%) and Planning 5.0 (45 – 21.92%) areas, that is, areas with the highest number of active Family Health teams. Despite the losses presented, the sample was considered representative based on the relevance of the study and on the nature of the data analyzed.

Pilot tests or pre-tests were carried out for semantic validation and adequacy of the online instrument with Nursing students from the *lato sensu* graduate course in Family Health Management. The researchers made all efforts possible to avoid any risk of bias such as conducting a pilot test, an important sample “n” and impartiality in data analysis.

The data were tabulated in Microsoft Office Excel® spreadsheets and were used for the variables of interest and descriptive statistics with absolute and relative frequency. In addition to that, data analysis took place with the aid of the SurveyMonkey® Software, which offers a specific advanced program that directly connects the data collected online with the Statistical Package for Social Science (SPSS) software, the latest version made available by the SurveyMonkey® software (2016). It should be clarified that the database built was restructured and debugged using the Microsoft Office Excel® program. For the variables of interest, the sequential procedure of data coding, tabulation, organization and statistical treatment was followed, based on descriptive statistics.

With this research, commitment to comply with the guidelines contained in Resolution

No.466/12 of the Ministry of Health was assumed, and the research was approved by the Research Ethics Committees (*Comitês de Ética em Pesquisa*, CEPs), through consubstantiated opinion number 1,208,179 and number 1,558,217, issued by the CEPs of the home institution and the co-participating institution, respectively.

RESULTS

Regarding the sociodemographic data of the participating nurses, predominance of 147 women (84.97%) was identified; and the proportionality found between females and males was six to one, that is, for every six working female nurses, there is one male nurse. Regarding the age group, the highest frequency values (87.36%) varied between 18 – 29 years old (70 – 40.23%) and 30 – 41 years old (82 – 47.13%). Regarding self-reported skin color, the highest percentages of professionals were white-skinned (76 – 44.19%) and brown-skinned (64 – 37.21%), and a lower number of nurses self-declared as black-skinned (32 – 18.60%).

Regarding nationality, only one nurse stated being foreign; the rest reported being Brazilian nationals. In relation to the experience in family health, the results reveal that most of the nurses have worked between 1 and 6 years in Family Health teams (116 – 67.44%). In addition to that, most had a temporary contract (127 – 74.71%), followed by residents (29 – 16.96%), statutory regime (05 – 2.92%) and scholarship holders (01 – 00.58%).

According to the context of employment contracts, 127 (74.49%) reported having only one. However, there is still a percentage of professionals who have more than two employment contracts, 32 (20.51%), totaling 60 or 70 hours of work per week, 48 (28.40%).

Regarding marital status, the percentages were identical both for married and for single nurses, with 41.04% (71) each. As for the place of residence, most of the nurses live close to the workplace, that is, 83.33% (145) in the city of Rio de Janeiro, traveling by car (48.85% – 85) or bus (53.45% – 93), taking less than an hour to reach the unit where they work (53.76% – 93).

The time elapsed since the completion of the undergraduate course in Nursing was more expressive among those who reported having between four and six years of graduates, with 64 (80%) nurses, and also with more than six

years of graduates, 61 (76.25%) nurses. The number of recent graduates also seems significant: 45 (56.45%) nurses with less than three years of having concluded their training. The origin of the educational institutions in the training of nurses is highlighted, with 91 (52.91%) nurses trained by private institutions, while 78 (45.35%) were trained by public institutions.

As for the schooling level, the highest frequency was for *lato sensu* post-graduation, specialization (93 – 65.03%). The highest numbers were expressed in specializations focused on the performance area (60 – 41.96%), being distributed as follows: Specialization in Public Health Nursing, 9 (6.29%); Specialization in Family Health Management, 12 (8.39%); and Specialization in Family Health, 39 (27.27%). Another important data refers to the residents in Family Health, who total 25 nurses (17.48%). There are also nurses with *stricto sensu* post-graduate courses: academic master's, 13 (9.09%); professional master's degree, 01 (0.70%); and PhD, 01 (0.70%)

Responding to the objective of the study, with regard to the health actions performed by nurses in the FHS, the following stand out: health care for individuals and families registered in the teams and, when indicated or necessary, at home and/or in other community spaces (schools, associations, etc.), in all stages of human development (childhood, adolescence, adulthood and old age); Nursing consultation; procedures, group activities and, according to protocols or other technical regulations established by the federal, state, municipal or Federal District manager, in compliance with the legal provisions of the profession; request for additional exams; prescription of medications; and referrals, when necessary; programmed activities and attention to spontaneous demand; planning, management and evaluation of actions developed by Community Health Agents together with other team members.

In this sense, it is worth emphasizing that the “always” answers to the actions recommended by the National Policy on Primary Care were expressive for: health care for individuals (213 – 91.81%); Nursing consultation (215 – 92.67%); attention to spontaneous demand (216 – 93.10%) and planning, management and evaluation of the actions (173 – 74.57%).

The actions performed by nurses related to

communicable diseases such as tuberculosis (188 – 85.84%), dengue (172 – 79.26%), monitoring of STDs and HIV (169 – 77.52%), leprosy (116 – 52.97%) and intestinal parasites represent the highest frequency in the “always” answers (112 – 51.61%). However, a fact that draws the attention refers to the nurses who reported never having taken actions for the management of leprosy (32 – 4.61%), unlike the other actions, which had little frequency for the “never” answers (except for work-related diseases).

Regarding the non-communicable chronic diseases, the results also indicate a strong trend

of actions aimed at Systemic Arterial Hypertension (190 – 86.76%), being the approach most performed by the nurses participating in the research. Following this line of analysis, the nurses' performance stands out, aimed at screening diabetes mellitus (182 – 83.49%); prevention, identification and treatment of non-communicable chronic diseases (158 – 72.48%); screening for dyslipidemia in adults (150 – 68.49%); and management of cardiovascular diseases (117 – 53.42%) that contribute to the prevention and early diagnosis of these pathologies.

Table 1 - Periodicity of the actions performed by FHS nurses targeted at diseases and health problems in adults/older adults, Rio de Janeiro, RJ, Brazil

Diseases and health problems in Adults/Older adults	%	ALWAYS	ALMOST ALWAYS	SOMETIMES	RARELY	NEVER	n
Systemic Arterial Hypertension screening	86.76	190	25	2	2	0	219
Management of tuberculosis	85.84	188	16	11	3	1	219
Diabetes Mellitus screening	83.49	182	30	3	2	1	218
Management of dengue	79.26	172	23	19	3	0	217
Prevention, identification and follow-up of STDs and HIV	77.52	169	35	11	3	0	218
Prevention, identification and treatment of non-communicable chronic diseases	72.48	158	47	11	1	1	218
Dyslipidemia screening in adults	68.49	150	42	20	6	1	219
Management of cardiovascular diseases	53.42	117	69	28	3	2	219
Management of leprosy	52.97	116	26	22	23	32	219
Management of intestinal parasitosis	51.61	112	50	34	19	2	217
Management of chronic respiratory diseases	50.23	109	60	32	15	1	217
Screening and counseling for the smoking habit	49.77	109	62	33	14	1	219
Approach to acute viral Hepatitis	44.50	97	52	46	18	5	218
Screening and counseling for alcoholism	32.57	71	67	50	27	3	218
Identification and follow-up of work-related diseases	26.03	57	51	53	45	13	219

Source:: Own elaboration

Regarding the actions related to family planning and to women's and men's health, the main actions performed by the nurses are first and foremost directed to reducing maternal and child mortality. Of all the numbers presented, the highest percentage of “always” answers was linked to the following, in descending order of

frequency: prenatal and postpartum care (212 – 96.36%), cervical cancer screening (210 – 95.89%), breast cancer screening (207 – 94.52%), promoting and supporting breastfeeding (204 – 96.68%), weighing and evaluating the child's development (204 – 96.68%); mother-infant care after hospital discharge (191 – 90.52%),

are tools that contribute to their practice and facilitate the clinical approach. On the other hand, the protocols less accessed by the respondents are made evident, whose themes were mainly focused on care for the homeless population (12 – 60%).

DISCUSSION

The sociodemographic data related to the nurses allowed observing that there is predominance of the female gender (147 – 84.97%), of the age groups from 18 – 29 years old (70 – 40.23%) to 30 – 41 years old (82 – 47.13%), white skin color (76 – 44.19%), single (71 – 41.04%), and living in Rio de Janeiro (145 – 83.33%).

These sociodemographic results are consistent with a survey recently carried out entitled “The State of Nursing in Brazil, which built the Professional Profile of more than 1 million Nursing workers⁽⁸⁾.

Regarding the characteristics of training and experience time, it is worth noting that the majority had *lato sensu* postgraduate schooling level, specialization (93 – 65.03%), with experience between 1 and 6 years in the family health teams (116 – 67.44%), having a single employment contract (124 – 74.49%) and bond by temporary contract (127 – 74.71%).

When considering that the Present Health Program in the municipality of Rio de Janeiro began in 2009, with the expansion of family clinics in their different work processes⁽⁹⁾, it is noticed that the time of professional experience occurred during the expansion of the program.

Regarding the number of jobs, it should be noted that most were young professionals, starting their careers, justifying a single employment contract; this result differs from a study that shows that most nurses have more than one employment contract⁽¹⁰⁾. It is relevant to highlight that, in the type of contract variable, as the result obtained was predominance of the health professionals with a temporary contract. Most of the health professionals working in family health teams are linked, through an outsourced contract by Social Health Organizations (SHOs) with a legal regime provided for in the Consolidation of Labor Laws (*Consolidação das Leis do Trabalho*, CLT) and, under a work regime of 40 hours per week, distributed in a work schedule to be established by the Manager. The SHOs are non-profit private sector institutions

that work in formal partnership with the State and collaborate, in a complementary way, for the consolidation of the SUS. Analyzing ordinance number 1886/GM, of December 18th, 1997, in isolation, the impression is that the organizational principles of the SUS are being fully complied with, especially with regard to regionalization and hierarchization. However, what is configured is the outsourcing of the work contracts, even though the FHS is a Federal Government program.

To discuss the data, it is highlighted that 80% of the causes of death of Rio residents between 2000 and 2012 correspond to six groups, namely: cardiovascular diseases; neoplasms; endocrine-metabolic diseases; diseases of the respiratory system; poorly defined signs and symptoms (poorly defined causes) and external causes. However, it is worth emphasizing that the participation of these groups has been changing in the last few years in the municipality. There are also other groups of causes of death considered not so relevant, proportionally, but strategic for the development of integrated public policies, such as: Infectious Parasitic Diseases – tuberculosis and AIDS (Human Immunodeficiency Syndrome); and Mental and Behavioral Disorders – senile dementias and Alzheimer's disease⁽¹¹⁾.

In this context, great interest is also perceived in the specific protocols aimed at pathologies with incidence or prevalence in the city, such as: Sexually Transmitted Diseases, Diabetes Mellitus, Systemic Arterial Hypertension, Chronic Obstructive Pulmonary Disease, and breast and cervical cancer.

Given this context, it is highlighted that, in this research, the use by nurses of protocols that addressed the performance of actions aimed at cardiovascular diseases, endocrine-metabolic diseases and respiratory diseases, among others, was significantly identified, allowing for the identification of dedication to meeting the health and/or disease needs of the population in Rio de Janeiro.

Furthermore, in recent years, there has been a reduction in child mortality and this is mainly due to adequate care for newborns up to the sixth day of life and to the development of appropriate diagnostic and treatment actions. Thus, these actions developed by nurses contributed to the decline in the number of deaths in the first year of life in the city⁽¹¹⁾. However, maternal death persists as a serious health problem in the municipality, and the

actions to prevent it must be prioritized.

It is believed that the reduction in maternal-child mortality in the national scope is related to the health actions recommended by the municipality of Rio de Janeiro. Therefore, this fact arouses greater interest in updates on the subject matter on the part of the nurses who work in family health teams. Nevertheless, the high rates of cesarean sections in Brazil can be related to the increase in maternal mortality⁽¹²⁾.

Regarding the nurses' health actions aimed at older adults' health and at mental health, these did not show significant expression in the data collected. It is noticed that less than half of the nurses report dealing with the actions targeted at the aforementioned themes.

This data is worrying, as the demographic transition and the growing aging trend of the population in the city also bring important and numerous challenges to the health services. This reality should be a concern for most health professionals, especially those from the teams that deal directly with the real problems of the families in different territories. This finding has important impacts on the health of the population, requiring an approach based on health promotion and comprehensive care throughout the families' life cycle, including older adults' health and mental health^(11,13).

Furthermore, limitations were identified regarding the actions recommended for health promotion and surveillance; it is highlighted that, in this context, the actions performed by nurses were aimed only at disease prevention. However, health surveillance is more comprehensive. It aims at permanently observing and analyzing the health situation of the population, articulating a set of actions designed to control determinants, risks and harms to the health of populations living in certain territories, ensuring comprehensiveness of care, which includes both the individual and collective approach to health problems⁽¹¹⁾. In this paper, the results showed certain limitation regarding the nurses' actions in this context.

The concept of health surveillance also comprises the surveillance and control of communicable diseases; surveillance of non-communicable diseases and health problems; surveillance of the health situation, environmental health surveillance, workers' health surveillance and sanitary surveillance⁽¹¹⁾. Therefore, health surveillance work cannot be restricted to a single problem; it is necessary to pay attention to actions within its context, such as: relevant

geographic objects – the occupation characteristics of the place: roads and streets, paths, sewage and water systems, vacant land lots, garbage dumps, housing centers – residence, new settlements and occupations – and their ecological and geomorphological conditions – forest and deforested areas, fauna, flora, relief, hydrography and climate. Therefore, health surveillance actions should not be limited to or emphasize a single area of action, but rather carry out a social analysis in the territory, so that it can contribute to the identification of information, in order to operationalize decision-making and definitions of action strategies in their different contexts⁽¹²⁾.

Regarding the outpatient procedures, the most prevalent actions performed by the nurses are verification of blood pressure and capillary blood glucose and collection of material for cytopathological examination (pap smear).

In addition to that, with regard to the actions developed by the nurses in the management of urgent and emergency situations, hypertensive crises, respiratory infections in children, joint pain, myalgia, headache, otitis, angina/acute myocardial infarction, severe allergic reactions, convulsive crisis and cardiopulmonary resuscitation stand out, among others.

From this perspective, regarding the use of clinical protocols and therapeutic guidelines by nurses, most of them reported using them as a form of consultation, updating and/or contribution to the performance of their health actions. The adoption of clinical protocols aims at developing best practices in the health work processes; however, there are certain criticisms of the use of such technologies as they reinforce policies aimed at managed care. It would therefore be necessary to recover their potential to add quality to the health practices as a rationalizing, pedagogical, evaluative and inducing device for research in health care. However, in addition to the technical-scientific evaluation, centered on standards established by the scientific community, and on elements of the health process, the view of the users and other social actors must be incorporated in order to improve care and increase population satisfaction.

The quality of primary care must be evaluated considering, therefore, all dimensions, the dimension of implementation of guidelines based on scientific evidence; the dimension of the needs, values and priorities of each user; the family and community dimension involved in the

user's care and support process; and that of health services in which access and equality become essential criteria⁽¹⁴⁻¹⁶⁾. Excessive attention to a single aspect could harm the quality of the others, or even the scope of the system's quality as a whole⁽¹⁴⁾.

It is concluded that there have been many advances made by the FHS in the municipality; however, it seems that there is a need to overcome the sanitary care model, with a curative focus mainly aimed at the diagnosis of prevalent diseases. In their discussions, other studies^(1-2,14) also confirm the influence of the biomedical, curativist and individual hegemonic model on the actions performed in the Family Health scope. The authors⁽¹⁾ argue that, although official documents state that the FHS is based on the family theme, in search of a transition from the care model, based on collective health, there are still weaknesses in the execution of the model. The scarcity of content aimed at the family and the emphasis on technical contents aimed at the disease still prevail in the health services, making it difficult to implement the guiding principles of the FHD⁽¹⁴⁾.

The opportunity of overcoming towards a health care practice focused on the family presented by the FHS is unique. By living with the families, the team professionals can perceive demands, anxieties, distresses and potentials that would have been ignored before. With the establishment of a context based on theoretical references and instruments that enable the professionals to effectively address issues related to the family dynamics, the FHS overcoming potential approaches its realization⁽¹⁾.

As a limitation, the lack of clinical associations and correlations is highlighted, with only descriptive and cross-sectional data analysis.

This study makes an important contribution to nursing, health and public policy, as it highlights important points such as the use of guidelines by nurses and their positive impact on Nursing care in the FHS. In addition to that, it points to reflection in the context of public health to encourage health and policies to maintain primary care and especially the FHS.

CONCLUSION

Regarding the actions developed by nurses in the FHS, care for non-communicable chronic diseases stands out as prevalent, with a strong tendency towards actions aimed at Systemic Arterial Hypertension (190 – 86.76%).

Another important indicator in this study were the actions performed on the newborn, prevalent by most of the nurses, ensuring quality care to this clientele and improving the indicators. In addition to that, it is worth noting that, among other factors, the reduction in child mortality is due to adequate care for the newborn until the sixth day of life, corroborating the results of this study. Consequently, the actions developed by the nurses in the Family Health context seem to have contributed to the reduction in the number of deaths in the first year of life in the city. However, maternal death persists as a serious health problem in the city and the actions to prevent it must still be prioritized. It is emphasized that these actions, in the results of this research, did not obtain the “never” answer, that is, all the nurses surveyed performed actions aimed at reducing maternal mortality, with different frequencies of care.

Thus, most nurses performed their actions based on clinical protocols and focused mainly on child care and on care for communicable and non-communicable chronic diseases, which directly reflects on the effectiveness of these programs and on the improvements of the health indicators in these populations.

As a contribution to collective health nursing, based on the results of this study, the need is pointed out for greater attention to the policies of the older adults, expansion of the health surveillance actions and assistance to the homeless to ensure universality of health care and improvement of indicators in these contexts.

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