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REVISTA DE ENFERMAGEM DA UFSM

ISSN 2179-7692
Open access

Rev. Enferm. UFSM, v.12, e8, p.1-17, 2022 • https://doi.org/10.5902/2179769267045
Submission: 8/04/2021 • Acceptance: 11/08/2021 • Publication: 03/11/2022

Original Article

Work characteristics and attitudes of nurses in caring for families in primary health care*

Características laborais e atitudes de enfermeiros no cuidado às famílias na atenção primária à saúde

Características laborales y actitudes de los enfermeros en la atención familiar en la atención primaria de salud

Aurélia Danda Sampaio [I], Lílian Moura de Lima Spagnolo [I], Eda Schwartz [I], Fernanda Lise [I], Josiele de Lima Neves [I], Marinéia Albrecht Kickhöfel [I]

[I] Universidade Federal de Pelotas, Pelotas, Rio Grande do Sul, Brasil

***Extracted from the dissertation: "Nurses' Attitude in Family Care in the context of Primary Health Care", Postgraduate Program in Nursing, Federal University of Pelotas, 2020.**

Abstract

Objective: to identify the impact of work characteristics on supportive attitudes of nurses in family care in the context of primary health care. **Method:** cross-sectional study with 71 primary health care nurses. A form was used to characterize the participants and the Families' Importance in Nursing Care – Nurses' Attitudes scale was applied. Descriptive and analytical statistics were applied, stratifying the scale scores according to the characteristics of the nurses. **Results:** there was an attitude of support from nurses 80.9±7.8, with significant difference between nurses of the Family Health Strategy when compared to those of traditional units in the mean score in subscale 2, which evaluates the family as a resource for nursing care. **Conclusion:** the work characteristics of nurses affect the supportive attitude of professionals towards families, influenced by the work unit model, location, offer of professional training, and length of experience in Primary Health Care.

Descriptors: Primary Health Care; Nursing care; Family Health Nurses; Family Nursing; Family

Resumo

Objetivo: identificar a repercussão das características laborais nas atitudes de apoio dos enfermeiros no cuidado às famílias, no contexto da atenção primária à saúde. **Método:** estudo transversal, com 71 enfermeiros da Atenção Primária à Saúde. Utilizou-se um formulário para caracterizar os participantes e a escala Importância das Famílias nos Cuidados de Enfermagem – Atitude dos Enfermeiros. Aplicou-se estatística descritiva e analítica, estratificando os escores da escala pelas características dos enfermeiros. **Resultados:** verificou-se atitude de apoio dos

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enfermeiros 80,9±7,8, com significância estatística para a diferença de escore médio na subescala 2, que avalia a família como recurso dos cuidados de enfermagem, entre os da Estratégia Saúde da Família, quando comparados aos de unidades tradicionais. **Conclusão:** as características laborais dos enfermeiros repercutem na atitude de apoio dos profissionais em relação às famílias, influenciadas pelo modelo de unidade de trabalho, localização, oferta de capacitação profissional e tempo de atuação na Atenção Primária à Saúde.
Descritores: Atenção Primária à Saúde; Cuidados de Enfermagem; Enfermeiros de Saúde da Família; Enfermagem Familiar; Família

Resumen

Objetivo: identificar la repercusión de las características del trabajo en las actitudes de apoyo de los enfermeros en la atención familiar, en el contexto de la atención primaria de salud. **Método:** estudio transversal involucrando a 71 enfermeros de la Atención Primaria de Salud. Se utilizó un formulario para caracterizar a los participantes y la escala Importancia de las Familias en la Atención de Enfermería – Actitud de los Enfermeros. Se aplicaron estadísticas descriptivas y analíticas, estratificando las puntuaciones de la escala según las características de los enfermeros. **Resultados:** se notó una actitud de apoyo de los enfermeros de 80,9±7,8, con significación estadística para la diferencia de la puntuación media en la subescala 2, que evalúa la familia como recurso de la atención de la enfermería, entre los de la Estrategia de Salud Familiar, cuando se comparan con los de las unidades tradicionales. **Conclusión:** las características laborales de los enfermeros repercuten en la actitud de apoyo de los profesionales en relación con las familias, influenciadas por el modelo de unidad de trabajo, la localización, la oferta de capacitación profesional y el tiempo de permanencia en la Atención Primaria de Salud.
Descriptores: Atención Primaria de Salud; Atención de Enfermería; Enfermeras de Familia; Enfermería de la Familia; Familia

Introduction

Focusing on the composition of health care, Primary Health Care (PHC) is the ideal setting for the reorganization of professional practices, aiming at achieving effective care at all levels of the health system.[1-2] With the intention of expanding the coverage and access of the population, the Family Health Strategy (FHS) stands out as the model in accordance with the principles of the Unified Health System (SUS).[1] Nursing is widely inserted in the context of PHC/FHS and nurses are essential members of the basic multidisciplinary team. Nurses play a role of expanded leadership, being responsible for important activities in spheres such as management, care and administration of demands in order to meet the health needs of users and families.[3-4]

The family is the main focus of nursing care in the PHC/FHS. Thus, it is essential that nurses be willing to know, understand and respect the daily routine of family groups in order to develop strategies capable of cooperating with the recovery of the imbalance caused by the disease. By gaining knowledge about Family Nursing,

professionals are able to change their practice and develop family-centered care.[5] It is understood that involving family members and promoting actions that encourage care facilitates a cooperative interaction between nurses and families. Therefore, the attitudes of these professionals are decisive in this process.[6]

In order for PHC/FHS nurses to develop their activities, an adequate structure is necessary, one that provides minimum conditions for carrying out collaborative actions to achieve comprehensiveness health care, seeking to overcome the biomedical model. These conditions include administrative support, organizational and physical structure of services, and adequate workforce in number and qualification appropriate to the activities developed.[2] It is known that in the work process of the FHS, the work characteristics have implications for the satisfaction of professionals, directly influencing their attitudes towards users.[7]

The term attitude comes from the Latin *aptitude*, alluding to the way of acting, the way of proceeding, the way in which an intention is manifested. Thus, attitudes demonstrate the predisposition of each individual or his intention, materializing his emotional reactions in behaviors.[8] Therefore, the attitudes of nurses towards families directly influence care, and it is thus essential to identify whether the behaviors presented by the professionals are supportive or not when it comes to the presence of the family in the care process. Maintaining supportive attitudes can encourage and promote facilitating actions between family members and nurses, which is an important prerequisite for involving the family in nursing care.[5]

The Families' Importance in Nursing Care – Nurses' Attitudes (FINC-NA) scale was identified in the literature as an instrument to assess the attitudes of nurses towards families. This instrument was developed in Sweden in 2003 by a group of nurses who have the family as an important ally in nursing care, considering it a facilitator, both for the patients and for the nurses.[6] It is noteworthy that the attitudes of nurses constitute a relevant indicator of the quality of nursing care.[9] The scale was translated and used for the first time in Brazil by Angelo et al., applied at the hospital level, in the pediatric sector, in 2014, and since then, it has been used in several settings, but studies in PHC are few.[5]

Therefore, studying the impact of work characteristics on nurses' attitudes of support towards families provides a foundation for investments aimed at improving the relationship between professionals and the family group, enhancing supportive

behaviors that will help to achieve the principle of comprehensiveness of care. Based on the above, the present study aimed to identify the impact of work characteristics on nurses' supportive attitudes in family care in the context of primary health care in a medium-sized city in southern Brazil.

Method

Cross-sectional study. Data collection took place in the city of Pelotas, Rio Grande do Sul, between April and June 2020, with PHC nurses. Pelotas has a population of 329,435 inhabitants and has 52 basic health units, 38 of which are urban, 13 rural, and 1 is in the prison unit of the municipality. Forty-two units had FHS teams, covering 68.7% of the population.[10]

The study included all clinical nurses working in PHC in the city, corresponding to a total of 105 professionals. Exclusion criteria were nurses who were not active during the period of data collection, on vacation, sick and/or maternity leave or working remotely because they belonged to the risk group for Covid-19. There were four refusals to participate; 10 were considered a loss after three attempts; and 20 were excluded following the proposed criteria. A total of 71 nurses participated in the study.

The contact with the nurses was first made via e-mail. In order to make this contact possible, the electronic addresses were provided by the Municipal Health Department. Despite the attempt, there was no response. A telephone approach was then adopted, in which a student from the Nursing course got in touch with the city's basic health units, sensitizing professionals with the presentation of the research proposal. Subsequently, the forms were sent via WhatsApp, as the contacts were provided by the participants.

An electronic self-applicable form, built in the Google Forms tool, was used for data collection. The form included the Informed Consent Form (ICF), questions about the sociodemographic, educational and work characteristics of the nurses, and the FINC-NA scale.

The Portuguese version of the scale consists of 26 items, which comprise three

subscales: Subscale 1 - family as a conversational partner and coping resource (12 items); subscale 2 - family as a resource for nursing care (10 items); and subscale 3 - family as a burden (4 items). The answer options for each question are presented in a likert scale with 4 options (strongly disagree=1; I disagree=2; I agree=3; and strongly agree=4).[6]

After collection, an automatic database was generated in Google Forms, in Excel, and then transferred to the Stata 13.0 software. Descriptive statistics were used to analyze the characteristics of the interviewees, with distribution of relative and absolute frequencies and measures of central tendency and dispersion, namely, mean, median and standard deviation.

The variables analyzed were: sex (male/female), age, place of birth, university education (bachelor's degree/residence/specialization/master's/PhD/post PhD), education in a public or private institution, scientific initiation during training (yes/no), graduate degree in family nursing (yes/no), training course in family care (yes/no), time of experience at the Municipal Health Department (MHD) (in full years), employment bond (statutory/CLT,) type of work unit (traditional/FHS), zone (urban/rural), training to work with families (yes/no), if received training to work with families, who offered (did not receive/ sown initiative/ offered by the MHD/other), work overload (yes/no), adequate infrastructure to work with families (yes/no), you train your team to work with families (yes/no), you use genogram and ecomap in your practice (yes/ no/I don’t know this tool), you experience work overload (yes/no), you have a structure suitable for working with families (yes/no).

The FINC-NA scale scores were calculated by the mean of the nurses’ responses to the 26 items, ranging from 26 (minimum) to 104 (maximum). The attitude was classified as of little supportive, supportive, and very supportive.[11] The distribution of scores obtained by nurses between the quartiles was used for this purpose. Table 1 shows the scores obtained by quartile, with those in the first quartile considered to be little supportive, the interval between the first and third quartile, supportive, and scores above the third quartile, very supportive.

Table 1 – Mean score values of the FINC-NA scale, distributed by quartiles that represent the support attitude classification ranges.

FINC-NA scale	Below q1* Little supportive	Interval q1-q3* Supportive	Above q3* Very supportive
Scale total	65.0-74.9	75.0-88.0	88.1-97.0
Family: conversational partner and coping resource	30.0-35.9	36.0-45.0	45.1-48.0
Family: resource in nursing care	25.0-30.9	31.0-37.0	37.1-40.0
Family: burden	5.0-6.9	7.0-9.0	9.1-11.0

* Interquartile range

The nonparametric Mann-Whitney test was used to test statistical differences between subgroups. The *p-value* < 0.05 was adopted to assume the hypothesis that there was an association between the studied variables.

The study was approved by the Research Ethics Committee of the Faculty of Nursing at the Federal University of Pelotas, CAE 29818620.6.0000.5316, under number 3.936.716 of April 1, 2020, and complied with the ethical principles of Resolutions 466/2012 - 510/2016 - 580/2018, of the Ministry of Health, which standardize research with human beings.

Results

Among the 71 nurses surveyed, there was a predominance of females with 90.1% (64), aged between 31 and 50 years, with 76% (54). As for training, 38% (27) had *lato sensu* specialization as the highest academic degree, and 54.9% (39) had Specialization in Family Health. It was also found that 73.2% (52) of the participants graduated from public institutions.

Table 2 shows the nurses' work characteristics. It was observed that 84.5% (60) had a statutory employment bond, 76.1% (54) worked in the FHS, and 88.7% (63) were located in the urban area of the city. As for the time working in the PHC, the mean was 9.3 years (SD=8.0), and the median was 6 years, ranging from 0 to 32 years. When categorizing this variable, it was noticed that 46.5% (33) had worked for five years or less in PHC.

When asked about the offer of training to work with families, 60.6% (43) said they had not received it. Among those who had this training, 52.9% (18) reported having searched on their own. Regarding the question on training their team to work with

families, 64.8% (46) of nurses reported performing this practice. A lower percentage of nurses, 18.3% (13), reported using family assessment tools, genograms and ecomap in their care practice. It was evident that 50.7% (36) mentioned work overload and 57.8% (41) mentioned that the unit did not have an adequate structure to work with families.

Table 2 – Work characteristics of primary health care nurses in Pelotas/RS who answered the FINC-NA scale, 2020 (n=71).

Characteristics	N	%
Type of employment bond		
Statutory	60	84.5
CLT	11	15.5
Work unit model		
Traditional unit	17	23.9
FHS	54	76.1
Unit location		
Urban area	63	88.7
Rural area	8	11.3
Length of experience in primary health care (in years)		
0 to 5	33	46.5
6 to 10	16	22.5
11 to 15	5	7.0
16 to 20	9	12.7
> 20	8	11.3
Received training to work with families		
Yes	28	39.4
No	43	60.6
Training provided by		
Municipal Health Department	16	47.1
Own initiative	18	52.9
You carry out training with your nursing team to work with families		
Yes	46	64.8
No	25	35.2
You use genogram and ecomap in your care practice		
Yes	13	18.3
No	53	74.7
I don't know this tool	5	7.0
You experience work overload		
Yes	36	50.7
No	35	49.3
The unit has adequate infrastructure to work with families		
Yes	30	42.2
No	41	57.8

Source: database of the research "Nurses' attitudes in family care in Primary Care in Pelotas, 2020"

Table 3 shows the work characteristics of PHC nurses in Pelotas/RS stratified by

the total mean score obtained in the FINC-NA scale and the mean scores obtained in the subscales. The participating nurses had a total score of 80.9 (SD=7.8), which demonstrates a supportive attitude towards families and this means that these nurses see the family as a positive resource in nursing care.

Regarding the results obtained in subscale 1 - family as a conversational partner and coping resource, the total score was 39.9 (SD=4.7; q1=36 q3=45), and when stratified by work characteristics, there was no statistical significance in the data obtained. As for subscale 2 - the family as a resource for nursing care, the total score was 33.3 (SD=3.6; q1=31 q3=37) and showed a supportive attitude. In the distribution of the mean score of subscale 2 by type of work unit, nurses working in units with FHS had a mean score (33.7) significantly higher than among nurses working in traditional units (31.8), although both were situated in the interquartile range of q1-q3, which indicates a supportive attitude.

In subscale 3 - the family as a burden, the result was 7.8 (SD=1.3; q1=7.0 q3= 9.0). Although there is no statistical significance in the other distributions, it is noteworthy that among nurses who reported having received training to work with families, the mean total score and the scores in the subscales were lower than those of the group that did not receive training. Among the nurses who reported carrying out training with their teams, there was a mean score of 7.6in subscale 3, which indicates the presence of a supportive attitude, since the lower the value obtained in this subscale, the less the family it is seen as a burden in nursing work, thus denoting a greater supportive attitude.

Table 3 – Mean total scores obtained by nurses in the FINC-NA scale and mean scores in the subscales stratified by the work characteristics of Primary Health Care nurses in Pelotas, 2020 (n=71).

Characteristics	Scale total	*p* value	Subscale 1*	*p* value	Subscale 2†	*p* value	Subscale 3‡	*p* value
Mean Interquartile range (q1-q3)	80.9 (75-88)	-	39.9 (36-45)	-	33.3 (31-37)	-	7.8 (7-9)	-
Type of employment bond								
Statutory CLT	81.1 80.2	0.73	39.2 40.0	0.61	33.3 32.8	0.61	7.7 8.1	0.25
Type of work unit								
Traditional unit Family Health	78.9 81.5	0.30	38.8 40.2	0.26	31.8 33.7	0.04	8.4 7.6	0.06

Strategy								
Unit location								
Urban area	80.4	0.13	39.6	0.14	33.0	0.16	7.8	0.70
Rural area	85		42.1		34.9		8.0	
Length of experience in primary health care (in years)								
0 to 5	79.7		39.3		32.5		7.9	
6 to 10	84.2		41.6		35.1		7.5	
11 to 15	82.8	0.07	42.4	0.07	33.4	0.06	7.0	0.21
16 to 20	76.2		37.1		31.4		7.7	
>20	83.4		40.4		34.5		8.5	
Received training to work with families								
Yes	80.1	0.53	39.4	0.53	32.8	0.34	8.0	0.40
No	81.5		40.2		33.6		7.7	
Training provided by Municipal Health Department	81.6	0.62	40.4	0.43	33.2	0.90	8	0.63
Own initiative	80.3		39.2		33.3		7.8	
You carry out training with your nursing team to work with families								
Yes	80.8	0.98	39.9	0.97	33.3	0.69	7.6	0.16
No	81.1		39.8		33.1		8.2	
You use genogram and ecomap in your care practice								
Yes	80.3		39.6		32.8		7.8	
No	80.9	0.93	39.8	0.90	33.3	0.89	7.8	0.95
I don't know this tool	82.2		40.6		33.6		8.0	
You experience work overload								
Yes	80.6	0.93	39.8	0.89	33.2	0.99	7.7	0.71
No	81.2		39.9		33.3		7.9	
The unit has adequate infrastructure to work with families								
Yes	79.7	0.32	39.1	0.26	32.8	0.40	7.8	1.0
No	81.8		40.4		33.6		7.8	

Characteristics	Scale total	*p* value	Subscale 1*	*p* value	Subscale 2†	*p* value	Subscale 3‡	*p* value

*Subscale 1 - Family: conversational partner and coping resource. Number of items (score) 12 (12.0 to 48.0).
†Subscale 2 - Family: resource for nursing care. Number of items (score) 10 (10.0 to 40.0).
‡Subscale 3 - Family: burden. Number of items (score) 4 (4.0 to 16.0).

Discussion

The introduction of the family in health care requires that nurses incorporate attitudes of interaction and adopt an inclusive approach, seeing the family also as a partner and focus of care. Thus, it is considered that the nurses' attitudes towards the family demonstrate how they identify the relevance of involving family members in nursing care.[11-22] It is recognized that the composition, organization, and qualification of the health team allied to working conditions are factors that influence the role of nurses in relation to the family.[13]

The nurses participating in this study had 80.9 points (SD=7.8) in the total mean score of the FINC-NA scale, indicating attitudes of support to the family. This means that the participants accept the family as an ally in care. Similar results were found in the PHC of São Paulo/Brazil, together with Primary Health Care (PHC) of Porto/Portugal, in which mean scores of 86 and 82.1, respectively, were obtained. The score of supportive attitudes identified in this study indicates the receptivity of the PHC nurses in Pelotas to work with families.

As for the type of employment bond, 84.5% of the nurses who made up the workforce in PHC in the municipality studied have statutory bond. When verifying the supportive attitudes presented by this characteristic, the total scores and the scores in the subscales were in the range between q1-q3, characterizing supportive attitudes. This finding can be explained by the longer permanence of the server in the community, since statutory employees have guaranteed stability in their selection process, leading to lower turnover of professionals and greater continuity of care, facilitating the maintenance of the bond between professionals and the assisted population.

In 2019, the municipality of Pelotas had 68.7% of the population covered by the FHS, with 42 units and 68 FHS teams, which explains the result of 76.1% of nurses working in the FHS.[10] This figures resulted in supportive attitudes favorable to families in relation to nurses in traditional units, as verified in the results of the subscale 2, family: a resource for nursing care. There was a statistical difference between the support scores of nurses working in traditional units (31.8) and those in FHS units (33.7), although both had scores within the q1-q3 interval, representing a supportive attitude (p=0.04).

Nurses working in the rural area accounted for 11.3% (8) of the total number of participants. Supportive attitudes towards the family stood out among them, with a mean score of 85.0, which is higher than the mean obtained by nurses working in the urban area, with 80.4, although there was no statistical significance. This confirms that in rural PHC, there is a work dynamic that is differentiated by the strong connection of the health service with the community, governed by the characteristics of this space and its difficulties related to the living and health conditions of users, directly influencing the attitude of nurses.[16]

As for the length of work of the nurses in this study, there was a mean of 9.3 years (SD=8.0), a time shorter than that found in other studies that applied the FINC-NA scale. In Portugal, the time was 16.2 years, [15] in the United States, 10 years,[18] and in Spain, 20 years.[15] Among the interviewees, 46.5% (33) had worked for five years or less in PHC, which can be explained by the expansion of the number of FHS units and teams in the last 10 years in Brazil.[16]

As for the time working in PHC, the lowest mean score of 76.2 was seen among those who worked from 16 to 20 years in PHC, although still within the attitude of support. The length of experience in nursing in PHC can directly interfere with the attitude towards families, as nurses with more experience in the field focus on caring for the individual, without incorporating the families, possibly because they are not trained to do so. This result is in agreement with studies carried out in the hospital sector in which greater professional experience was an indicator of less support.[5,18]

When asked about the offer of training to work with families, 60.6% said they had not received it. Similar results were found in a Brazilian study.[19] It is noteworthy that 64.8% of nurses reported training their team to work with families. This result highlights the current challenge of the National Primary Care Policy (PNAB) in overcoming the fragmentation of the care model with the qualification of its practices.[20]

No significant difference was found when comparing the mean total score of the scale obtained between nurses who had received training and those who had not. Given the above, it was understood that nurses working in PHC in the city under study had insufficient theoretical knowledge to take care of families, either due to the lack of continuing education actions offered by the municipal administration or due to lack of

incorporation of content about family nursing in undergraduate and graduate courses. In this context, an investment by the municipal administration in the continuing education of public servants and in an incentive plan for them to invest in their qualification is thus necessary, since 52.9% of the nurses sought this training on their own, indicating the existence of interest and concern on the part of these professionals in qualifying for better work with families.

Corroborating the above statements, it was found that only 18.3% of nurses claimed to use the genogram and ecomap in their daily practice with family care and 7.0% reported not knowing these tools, although there was no statistical significance between the total mean scores obtained by nurses from different groups. It is noteworthy that the family is a dynamic and complex system and, for this reason, it is essential that health professionals have assessment and intervention tools to carry out the practice of care. The use of assessment instruments allows the diagnosis of the functional structure of families, providing the planning of interventions aimed at the real needs of this group.[21] Therefore, it is necessary to offer continuing education activities for these professionals focused on working with the family context, as this is the focus of the FHS, as it is only by training the eye that an excellent supportive attitude will be achieved.

To obtain an expanded view of the patterns and family relationships that involve the health-disease process, in recent decades, health care policies have undergone significant changes. New ways of thinking about health have also been formed, reflecting changes in practices of attention. Taking into account the model of comprehensive health care and considering the genogram as an auxiliary instrument in the assessment of families, the use of the genogram and ecomap as tools has been widely recommended as an aid in the practice of FHS professionals.[22] This guideline is present in the home care notebook in PHC.[23]

As for the perception of work overload, 50.7% of the nurses said to experience it. Furthermore, 57.8% reported that the units where they worked did not have an adequate structure to work with families. Although these results point to limitations faced by professionals, the total mean score obtained by them on the scale indicated a supportive attitude. These limitations confirm the main weaknesses related to

professional practices found in the comprehensive health care model, fostering the persistence of fragmentation of the biomedical paradigm. The study demonstrates the difficulty in the potential of the PNAB to consolidate changes in care practices as the main weakness, what demonstrates that practices remain predominantly centered on the physician, on the treatment and rehabilitation of diseases, and that there are failures in teamwork.[24]

When analyzing the mean scores of the subscales, the nurses obtained a score of 39.9 in the subscale 1 - family: conversational partner and coping resource -, which indicates that these professionals have a supportive attitude towards families. In this subscale, the need to perceive the family as a potential resource for the concreteness of care actions is considered. Therefore, it is necessary to rescue and value the dialogical, participatory and cooperative relationship between nurses and the family, in a reciprocal manner.

In the subscale 2 - family: resource for nursing care -, the mean score obtained was 33.3, which indicates a favorable attitude of support. The professionals perceive the family as an ally in nursing care. Statistical significance was observed in the distribution of the mean score of the subscale according to type of unit, with a higher (33.7) mean score among nurses working in units with FHS than among nurses working in traditional units (31.8). This result demonstrates supportive attitudes and greater openness to families by professionals working in the FHS, although both groups had scores within the interquartile range of q1-q3, which indicates a supportive attitude.

In the subscale 3 - family: burden -, the results obtained by the nurses showed a supportive attitude, situated in the q1-q3 interquartile range. It is noteworthy that considering the family as a burden is the same as alienating these family members from the nursing care actions and, thus, considering them as stressors and generators of difficulties in the health-disease process as a whole.[24]

Corroborating these findings, studies highlighted the need for strategies that support both the individual patient and the family as a unit in order to minimize their distressing experiences and focus on resources of family members to support their health and well-being.[25-26] From this perspective, by enabling, developing and improving nursing practices, interrelated to the family system, it is possible to encourage

empathetic understanding among all involved in this process, establish dialogue, strengthen bonds, and overcome challenges in nursing/health care actions.

Based on the analysis of the study, factors that directly and/or indirectly influence the attitude of nurses in caring for families in the context of PHC were evidenced. It can be inferred that embracement, dialogue, bonding, trust and valuing the active participation of the family enable the triggering of a positive attitude of the nurses in care actions.

This study had as a limitation the fact that the data collection was carried out entirely online, with no direct contact between the researcher and the nurses, due to the critical period of the Covid-19 pandemic, and this may explain the losses and refusals to participate. Another limitation is related to regional situation, due to the fact that the research took place in a specific city and state; different results may be found in other regions.

As a contribution, the study has implications for understanding the impact of work characteristics on the triggering of positive behaviors by nurses when they consider the family as an active and cooperative partner in the production of nursing/health. It is noteworthy that the municipal management needs to invest in promoting continuing education in health, creating spaces for dialogue and the active involvement of the family in care planning. This opens up the possibility for further research in the context of PHC, in view of the need of a supportive attitude from professionals in order to actively involve the family in care actions.

Conclusion

The present study identified that the work characteristics of nurses had an impact on the supportive attitudes of these professionals towards families in the context of PHC. Despite the evidence of supportive attitudes towards families in care provision, it was possible to observe that characteristics such as the unit model in which the professionals work interfere in their practice. The fact of being located in urban or rural areas, the scarcity of continuing education and the length of experience in the PHC may directly reflect on the supportive attitudes of these nurses regarding the participation of families in nursing care.

Therefore, the study of supportive attitudes within PHC, considered the gateway

to the health system, is a relevant indicator for a situational diagnosis and allows a view of how accessible the nursing teams are to family participation in this context of care. The supportive attitude identified in this study indicated that the nurses were willing to involve the family and saw it as a partner in nursing care for individuals. The high number of professionals working in PHC who have not been trained to work with families, as well as those who chose to seek knowledge on their own, promotes a reflection on the importance of encouraging specialization and the adoption of continuing education practices on the part of municipal management.

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Authorship Contributions

1 – Aurélia Danda Sampaio
Corresponding Author
Nurse, Master of Science - E-mail: aurelia.sampaio@hotmail.com
Conception or design of the study/research, data analysis and/or interpretation, final revision of the manuscript with critical and intellectual participation.

2 – Lílian Moura de Lima Spagnolo
Nurse, PhD in Sciences - E-mail: lima.lilian@gmail.com
Conception or design of the study/research, data analysis and/or interpretation, final revision with critical and intellectual participation in the manuscript.

3 – Eda Schwartz
Nurse, retired professor - E-mail: edaschwa@gmail.com
Conception or design of the study/research, final revision with critical and intellectual participation in the manuscript.

4 – Fernanda Lise
Nurse, PhD - E-mail: fernandalise@gmail.com
Final revision with critical and intellectual participation in the manuscript.

5 – Josiele de Lima Neves
Nurse, Master of Science - Email: josiele_neves@hotmail.com
Final revision with critical and intellectual participation in the manuscript.

6 – Marinéia Albrecht Kickhofel
Nurse, Master of Science - Email: marineiakickhofel@gmail.com
Final revision with critical and intellectual participation in the manuscript.

Scientific Chief Editor: Cristiane Cardoso de Paula
Associated Editor: Nara Marilene Oliveira Girardon-Perlini

How to cite this Article

Sampaio AD, Spagnolo LML, Schwartz E, Lise F, Neves JL, Kickhöfel MA. Work characteristics and attitudes of nurses in caring for families in primary health care. Rev. Enferm. UFSM. 2022 [Access in: Years Month Day]; vol.12 e8: 1-17. DOI: https://doi.org/10.5902/2179769267045