Research Article
Artigo de Pesquisa
Artículo de Investigación

DOI: http://dx.doi.org/10.12957/reuerj.2022.70117

Tools used by nurses in the lines of care management during the COVID-19 pandemic

Ferramentas utilizadas por enfermeiros na gestão das linhas de cuidado durante a pandemia de COVID-19

Herramientas utilizadas por enfermeros en la gestión de líneas de atención durante la pandemia de COVID-19

Amanda Rodrigues de Souza[I]; *Sonia Acioli*[I]

[I]*Universidade do Estado do Rio de Janeiro, Rio de Janeiro, Brazil*

ABSTRACT

Objective: to carachterize the strategies and tools used to manage lines of care by nurses during COVID-19 pandemic. **Method:** study with qualitative approach, carried out with seven primary care nurses in the city of Rio de Janeiro, between December 2021 and March 2022. Data were obtained from filling out an online form, submitted to the content analysis technique. Research protocol approved by the Research Ethics Committee. **Results:** the participants pointed to the use of reports extracted from the electronic medical record, preparation of their own spreadsheets and teleconsultation to continue monitoring users of the care lines during critical periods of social isolation. **Conclusion:** from the identified tools, the team can list the users who need priority in their follow-up, define strategies and deadlines to capture these individuals and offer the health care they need. **Descriptors:** COVID-19; Primary Health Care; Nursing Care; Remote Consultation.

RESUMO

Objetivo: caracterizar as estratégias e ferramentas utilizadas para gestão das linhas de cuidado por enfermeiros durante a pandemia da COVID-19. **Método:** estudo de abordagem qualitativa, realizado com sete enfermeiros da atenção primária de um município do Rio de Janeiro, entre dezembro de 2021 e março de 2022. Os dados foram obtidos a partir do preenchimento de formulário on-line, submetidos à técnica de análise de conteúdo. Protocolo de pesquisa aprovado pelo Comitê de Ética em Pesquisa. **Resultados:** os participantes apontaram o uso de relatórios extraídos do prontuário eletrônico, elaboração de planilhas próprias e teleconsulta para dar continuidade ao monitoramento de usuários das linhas de cuidados durante os períodos críticos de isolamento social. **Conclusão:** a partir das ferramentas identificadas, a equipe pode elencar os usuários que precisam de prioridade em seu acompanhamento, definir estratégias e prazos para captar esses indivíduos e ofertar a assistência em saúde de que necessita.
Descritores: COVID-19; Atenção Primária à Saúde; Cuidados de Enfermagem; Consulta Remota.

RESUMEN

Objetivo: caracterizar las estrategias y herramientas utilizadas para la gestión de las líneas de atención por parte de los enfermeros durante la pandemia del COVID-19. **Método**: el estudio tiene un abordaje cualitativo, se realizó junto a siete enfermeros de la atención primaria de salud de una ciudad del estado de Rio de Janeiro, entre diciembre de 2021 y marzo de 2022. Los datos se obtuvieron mediante el llenado de un formulario en línea y se sometieron a la técnica de análisis de contenido. El Comité de Ética en Investigación aprobó el protocolo de investigación. **Resultado:** los participantes de la investigación señalaron el uso de informes extraídos de la historia clínica electrónica, la elaboración de hojas de cálculo propias y la consulta remota para continuar con el seguimiento de los usuarios de las líneas de atención durante los períodos críticos de aislamiento social. **Conclusión:** con base en estas herramientas, el equipo puede enumerar los usuarios que necesitan ser priorizados, definir estrategias y plazos para capturar a estos individuos y ofrecerles la atención en salud que necesitan.
Descriptores: COVID-19; Atención Primaria de Salud; Cuidados de Enfermería; Consulta Remota.

INTRODUCTION

Care Lines (CLs) are a way of remodeling the assistance provided to the user and trigger certain rethinking the health-disease process in terms of its determining and conditioning factors, in addition to guiding care coordination through agreement/signing of contracts and connectivity of tasks performed by different health care levels, from health promotion to rehabilitation[1]. It presupposes a global response by the health professionals involved in care, overcoming fragmentation practices and generating care from the perspective of integrality.

Therefore, it is fundamental for Nursing to deepen on the theme of care lines, becoming aware of its skills and of possibilities of practice and clinical management of these users, mainly in view of the COVID-19 pandemic. The pandemic imposed an increased demand on health professionals, who had to reinvent themselves and adapt their practices to maintain proper monitoring of individuals and their families.

Corresponding author: Amanda Rodrigues de Souza. E-mail: rodriguesa.2014@gmail.com
Editor in chief: Cristiane Helena Gallasch; Associate Editor: Magda Guimarães de Araujo Faria

Received: Sep 12th 2022 – Accepted: Dec 30th 2022

DOI: http://dx.doi.org/10.12957/reuerj.2022.70117

It is relevant to contextualize the COVID-19 pandemic scenario. The first reported cases of the novel coronavirus (SARS-CoV-2), the causative agent of COVID-19, occurred in Wuhan, China, on December 31st, 2019, and the World Health Organization (WHO) confirmed circulation of the virus on January 9th, 2020. The first case in the United States was recorded on January 21st and, in the same month, other countries such as Canada and Australia have confirmed imported cases. Up to January 27th, 2,798 cases have been reported in the world[2].

From January 30th, 2020, the WHO declared a Public Health Emergency of International Importance (PHEII) due to the spread of SARS-CoV-2. On February 3rd, 2020, the Ministry of Health (*Ministério da Saúde*, MS) declared a Public Health Emergency of National Importance (PHENI) as a result of human infections by COVID-19[3].

In Brazil and through a post in the MS website, the first case diagnosed in the country was notified on February 26th, 2020, in the state of São Paulo. Concomitantly, more than 20 suspected cases were monitored in another seven states of the country, including Rio de Janeiro[3].

In the city of Maricá, locus of this study, 26,886 COVID-19 cases and 818 deaths due to the disease were confirmed up to April 6th, 2022. In turn, regarding hospitalizations, 2.5% occupancy of the COVID-19 exclusive beds in the city was confirmed[6].

Due to virus aggressiveness and its rapid spread, nonexistence of specific vaccines and medications, interventions such as lockdown and mandatory wearing of a face mask were necessary. Measures such as social isolation, population mobility control and closure of schools, universities, non-essential trade and public leisure areas were also implemented, as well as other actions[4]. They were abrupt changes in people's lives and generated social, political, cultural and economic impacts, especially in the vulnerable social groups.

These strategies had important and different social consequences in a country characterized by inequalities like Brazil; thus, for many Brazilians, social isolation meant losing their job, experiencing increased domestic violence, and confining entire families to small and unhealthy houses[5]. This reality indicated the urgency of implementing social protection and financial support measures, with priority to the even more vulnerable social sectors at that moment of crisis[4].

Initially, the investments in a sanitary response to the pandemic in Brazil were focused on hospital services, with concerns such as increasing the number of beds, hiring human resources, purchasing lung ventilators, building field hospitals and purchasing Personal Protective Equipment (PPE), among other measures.

However, it becomes necessary to pay attention to Primary Health Care, as it receives more than 80% of the mild and moderate cases of the disease[7]. To that end, this health care level also needed to abruptly modify its operating routines and care flows, requiring skills, adaptability and resilience from the professionals to act in this scenario of uncertainties and dynamic transformations.

Health departments had to deal with the pandemic using their own human and material resources and their own experiences, some routines and internal flows of PHC units were dismantled, and other procedures were restructured to adapt to the new reality. Among them, the monitoring of users belonging to Care Lines, consisting of vulnerable individuals who had a specific routine of home consultations or visits by the health team, precisely for being people and families requiring more attentive care due to their health condition. However, given the pandemic, they had their care provision and contact with the health teams abruptly restricted.

In this context, the objective of this study was to characterize the strategies and tools used by nurses to manage the care lines during the COVID-19 pandemic.

METHOD

A study with a qualitative approach, which works with the universe of meanings and has the following characteristics: objectivation the phenomenon; hierarchization of the actions of describing, understanding and explaining; precision of the relationship between global and local in a given phenomenon; search for the most reliable results possible; and opposition to the assumption which advocates that there is a unique research model for all sciences[8,9].

Data collection was conducted with seven Primary Health Care nurses from the municipality of Maricá (RJ). The inclusion criteria were nurses who accepted to participate in the research by signing the Informed Consent Form and who had been working the Municipal Health Center or Family Clinic for at least six months. The exclusion criteria corresponded to temporary workers, statutory ones, and those who were away, on holiday or on medical leave during the data collection period.

DOI: http://dx.doi.org/10.12957/reuerj.2022.70117

The interviews were conducted between December 2021 and March 2022 by means of a form available in online format. The time to answer the form varied from 10 to 20 minutes.

Subsequently, the data obtained from the forms filled-in were treated, reading the answers as a first step. After reading, the data were analyzed using the content analysis method, a technique to analyze communications that allows inferring knowledge related to a given subject matter. The analysis was made based on the answers to each question in the form, considering that those related to the same theme were grouped, assembling a category. Subsequently, the similar phrases were analyzed, separated by color, which generated the registration units.

The research protocols was approved by the Research Ethics Committee of the institution involved, according to resolutions No. 466/2012 and No. 510/2016 of the National Health Council. A copy of the answers and of the consent form was immediately sent to each participant after filling-in.

RESULTS AND DISCUSSION

Regarding gender, all the participants were female, with a mean age of 45.4 years old. The predominance of women in Nursing is remarkable and confirmed by a research study conducted by the Federal Nursing Council and the Oswaldo Cruz Foundation, which indicated that 84.6% of the Brazilian nurses were female[10]. This number may also be justified by the Nightingalean model, historically marked in Brazil by feminization of the profession[11].

As for training and experience in Primary Care, the nurses had a mean of 13.4 years of performance in PHC and, with regard to specialization, 71.4% had some specific specialization in the area, including Collective Health, Family Health or Public Health. This result represented a search indicator for qualification and improvement, as it shows the search for knowledge in order to improve health care provision due to the complexity PHC work, which requires these professionals to have a repertoire of specific competencies, in which they should be capable of making Nursing diagnoses, developing and executing care plans, and investigating health determining and conditioning factors of a given population. The professionals' training is essential for good quality of the assistance provided and, consequently, to improve the organizational results[12].

Finally, it was possible to observe that nearly 57% of the professionals had been working for less than one year at the current health unit, 14.2% from one and two years, and 28.6% for more than three years. Therefore, the issue of health professionals' turnover in PHC can be raised. The reasons for this are multifactorial and are influenced by economic, social and political aspects. Some of these factors include the following: distance of the house, availability of materials and devices, interpersonal relationship and training, among others. This turnover can be negative to allow effective assistance, bonds with the users, monitoring and management of care lines, and organization of the team[13].

The data obtained were compiled and organized in full and logically, following the Content Analysis method guideline. In this space, the results of the analytical categories were presented, emerging from 25 thematic units and 107 registration units (RUs), thus originating the category called “Nurses' performance in Cares Lines and management tools”.

This category originates from nine thematic units and 16 RUs and refers to questions 13, 14, 15 and 16 of the form, which seek to understand what the participants understand as Care Lines (CLs), which their practices to deal with CL users are, how the team manages CLs, and the tools they use for that purpose.

The literature indicates that the nurses' practice has been increasingly more directed to service organization procedures and to supervision of activities developed by Community Health Agents (CHAs) and of the care provided by the Nursing team members[14].

Other authors also raise the topic where the administrative focus gains relevance in its activities, as pointed out by the participants. They are functions marked by a high degree of bureaucratic work associated with managerial activities with an emphasis on health care management, planning and team supervision; where caring and managing are complementary activities and management is a knowledge production space[15].

> *Managing the CHAs and Nursing technicians [...] (P1)*
>
> *[...] health service and Nursing team management activities (P2)*

Health care management encompasses health technologies, considering each person's singularities and aiming at their well-being, safety and autonomy. In Nursing, this concept is applied to two dimensions: managerial and assistance. The managerial dimension includes actions targeted at the work process and at human resources in order to ensure means for assistance to be provided adequately. However, the assistance dimension deals with the purpose of meeting the users' health needs, ensuring comprehensive care[16].

DOI: http://dx.doi.org/10.12957/reuerj.2022.70117

FHS operates with an assigned population and well-defined population groups and, according to the testimonies below, the teams organize their actions in the health care demand and provision including care lines directed to at-risk groups, according to Basic Care Notebooks and municipal protocols.

> *[...] by resorting to priority groups, we standardize Nursing consultations. The practices are specific evaluations and exam requests for each care line, with Interconsultations if necessary. (P4)*
>
> *[...] communication between the teams, services and users of a Health Care Network, with a focus on standardization of actions, thus organizing a care continuum. (P1)*
>
> *The care lines are care flows, which design the steps the users will follow throughout their path in PHC. (P2)*

The participants addressed health promotion, prevention and rehabilitation developed by professionals during care provision from the point of view of the individuals' training, mainly of those with chronic diseases. With regard to self-care, knowledge about the health-disease process and strategies to deal with risk factors such as smoking, physical inactivity and inadequate diet tend to bring autonomy to these people and self-responsibility regarding their own health.

Strategies such as counseling, monitoring and motivation for physical activities, healthy diet and smoking control contribute to improving adherence to the treatment, reducing medication use and achieving better disease control, in addition to reducing costs for the system, due to the lower rate of referrals to more complex health care levels. Forwarding and monitoring the demands to more complex levels in the care network also emerged as functions of PHC nurses.

> *[...] contemplating diverse information regarding the promotion, prevention, treatment and rehabilitation actions and activities to be developed by a multidisciplinary team in each health service. (P1)*
>
> *[...] providing access to all technological resources required by users, from simple home visits by the Family Health Strategy team to high-complexity hospital resources, among others. (P3)*
>
> *The core of health promotion and prevention in Basic Care is where we can start providing universal care and promote the SUS guidelines in Family Health. (P5)*

In general, individuals with chronic diseases presented better results in disease management and control with the development of self-care actions supported by nurses, due to the implementation of health promotion strategies, mainly those related to healthy diet and practice of physical activity[17].

When asked about who is in charge of the care lines in the team, 71.7% (five) of the participants stated that they were developed together with the team's physician. Findings from a recent study[18] warn about the need for the team to implement shared process management, in order to preserve the intervention object of nurses' work, so that it is not dominated by bureaucratic activities.

Other authors[19] draw the attention to the need for nurses to meet the demands related to operation of the health service, as well as to comply with the established goals, agreements and indicators. Such fact generates work overload due to the accumulation of several activities and distancing of nurses from direct care, in which the burden imposed on these professionals is not directly proportional to the conditions they have to properly respond to the family health prerogatives and the users' needs. Consequently, it collaborates to a feeling of frustration and doubt regarding their role in PHC, once again noting the need for shared management by the team.

In relation to the tools used to assist in management of the CLs, 71.4% resort to the monitoring reports generated by the electronic medical chart and self-prepared spreadsheets. In turn, 14.2% only used the medical chart reports and another 14.2% only employed the self-prepared spreadsheets.

Electronic patient records (EPRs), a type of Information and Communication Technology in Health (ICTH), are one of the main tools used by health professionals both at the outpatient and hospital scopes. This tool aims at allowing for health care quality, data storage and processing, clarity of reports, and support for organizational and managerial tasks so as to ensure health care continuity[20].

> *We use the VITA CARE system, which allows generating reports for monitoring. At the beginning of each month, I take the reports and give them to the CHAs at the team meeting for the searches. We update continually during the week. (P1)*
>
> *The reports from electronic medical charts are the most used, but I have monitoring spreadsheets for pregnant women and children. (P2)*

The medical chart used in the health units where the participants of this research work is *Vita Care*. It enables selecting the user's health condition or life cycle and creating spreadsheets that assist in health monitoring by the

DOI: http://dx.doi.org/10.12957/reuerj.2022.70117

team (pregnancy, hypertension, diabetes, tuberculosis, HIV, leprosy and children's monitoring, among others).

In addition to identification of the individuals, these spreadsheets contain important data such as date of the last appointment with the physician and the nurse, last CHA visit and tests performed, which help the team identify the users who require further attention or active search for a new evaluation with the team's nurse or physician, as well as planning home visits and health education groups. It would also be important that this tool included a specific space to quantify the Nursing actions in each care line or life cycle, so that a way to target care provision and record the assistance provided by Nursing professionals can be devised.

Based on these tools, the team can analyze and list users who need to be prioritized, define the best strategies and deadlines to attract these individuals and provide the health care they need. And this care can be provided through home visits, health education groups or customized consultations with physicians or nurses.

Since the beginning of the pandemic, the work process of PHC nurses has undergone changes in order to adapt to the care demand of patients with respiratory symptoms, as well as of tests for COVID-19 detection and vaccination against this disease.

> *The users with respiratory symptoms [...] are treated based on free demand [...] and, when necessary, a COVID-19 detection test is required [...] Right now, all my mornings are devoted exclusively to COVID-19 testing. (P1)*
>
> *We haven't been able to care for the patients the same way we did before, our opening hours for appointments have been reduced, because we have to include the care of patients with flue syndrome and performance of tests in our current care practice and, with that, the schedule was reduced to prevent exposure of the other users. (P1)*
>
> *[...] the increased care demand for patients with Flue syndrome hampered monitoring of these users, with constant schedules in testing and vaccination, the number of scheduled appointments was reduced, impairing monitoring of the users. (P3)*
>
> *With regard to care effectiveness, the users' access was limited, even by social distance itself, populations' fear and lack of information. (P4)*

Three women researchers include this PHC adaptation in a bibliographic search which revealed that, in many health units, elective appointments were interrupted and immediate screening was conducted when the individuals arrived at the health services, in order to organize the activities in terms of scheduling so as to reduce crowding and promote early identification of respiratory symptomatic cases, allowing for their isolation as soon as possible[21].

There was a reduction in the number of most routine health tests, due to low demand and to risk of contamination by COVID-19. The appointments related to Children's Growth and Development Programs and to puerperal women care were canceled, only Family Planning was maintained, and contraceptive methods were provided by the Nursing team (RIOS et al, 2020).

> *Nurses' lack of contact with the patients may have generated deterioration of the diseases (P5)*

This entire change in the team's agenda, and mainly in the nurses', hindered care continuity and monitoring of the CL users. The main negative consequences of these changes include the following: reduced number of childcare appointments and, consequently, deficient control of the vaccination schedule, low women's demand for preventive screening tests and contraceptive methods, worsening of symptoms in patients with chronic diseases, and treatment discontinuity and/or abandonment among users with HIV, tuberculosis and leprosy. Given the above, the health units adopted various strategies to mitigate these impacts.

The participants underwent different experiences in relation to maintaining care and monitoring of the CL users. Some units maintained care provision only for some at-risk groups, such as patients with hypertension and diabetes, children under 2 years old, pregnant women and cases with acute complaints.

> *After the medical or nursing consultation and the exams, we only schedule return visits in the cases where there are changes Priority is for severe hypertensive patients, diabetics, children aged <2 years old and pregnant women. (P3)*
>
> *Right now we schedule pregnant women, children under 6 years old, severely-ill chronic patients and spontaneous demand for acute cases. (P5)*
>
> *We're prioritizing childcare and pregnancy consultation, and all the other cases are served in case of deterioration, spontaneous demand and home visits for the more severely-ill patients. (P4)*

Other care alternatives are consultations and monitoring of the risk groups and of chronic diseases via the Internet by means of video calls or phone calls. However, the reality experienced by PHC professionals is permeated by difficulties regarding infrastructure of the health units, such as lack of high-speed Internet and filming cameras.

DOI: http://dx.doi.org/10.12957/reuerj.2022.70117

The same happens with the population treated, who also faces lack of skills in terms of technological resources. These and other challenges impair the conduction of teleconsultations, limiting performance in evaluating the patients at a distance[17].

CONCLUSION

Through the testimonies made by the participants of this study, it was possible to notice how CL management was conducted during the period in question. The units organized themselves differently: the priority was to maintain the care provided to pregnant women, children under two years old, hypertensive patients and diabetics with acute complains. In some cases, the users attended the unit or the team went to the homes in specific situations; even conducting teleconsultations as a means to ensure care.

The difficulty monitoring these users can result in repressed care demand, patients with chronic diseases experiencing deterioration and acute complaints, low rate of vaccine coverage and monitoring of children's growth and development, lack of adherence to drug treatment and impacts on the prenatal care routine, thus affecting the quality of care indicators.

Ensuring team planning and organization is fundamental for quality and performance of health actions, as they are the grounds supporting the care management strategies involving care, managerial and educational processes directed to the users. In its turn, care management promotes improvements in care provision in terms of access, quality and care continuity, adding services and actions across several health system levels.

Therefore, Primary Care demands professionals with knowledge and characteristics that go beyond technical competencies, requiring them to also develop skills related to the implementation of policies and new tools, thus assuming the role of self-managers of the care spaces.

REFERENCES

1. Malta DC, Cecílio LCO, Merhy EE, Franco TB, Jorge AO, Costa MA. Perspectivas de regulação na saúde suplementar diante dos modelos assistenciais. Ciênc. saúde coletiva. 2004 [cited 2020 Nov 12]; 9(2):433–44. DOI: https://doi.org/10.1590/S1413-81232004000200019.
2. Ministério da Saúde (Br). Secretaria de Vigilância em Saúde. Infecção humana pelo novo coronavírus (2019-nCoV). Boletim Epidemiológico 2020. Brasília: Ministério da Saúde, 2020 [cited 2020 Nov 12]. Available from: http://www.saude.gov.br/images/pdf/2020/janeiro/28/Boletim-epidemiologico-SVS-28jan20.pdf.
3. Secretaria Estadual de Saúde (RJ). Primeiro caso no novo coronavírus é confirmado no Estado do Rio. Rio de Janeiro, 2020. [cited 2020 Nov 12]. Available from: https://www.saude.rj.gov.br/noticias/2020/03/primeiro-caso-do-novo-coronavirus-e-confirmado-no-estado-do-rio.
4. Bezerra ACV, Silva CEM, Soares FRG, Silva JAM. Factors associated with people's behavior in social isolation during the COVID-19 pandemic. Ciênc. saúde coletiva. 2020 [cited 2020 Nov 12]; 25:2411-21, Rio de Janeiro. DOI: https://doi.org/10.1590/1413-81232020256.1.10792020.
5. LimaCRM, Sánchez-Tarragó, Moraes D, Grings L, Maia MR. Emergência de saúde pública global por pandemia de COVID-19: desinformação, assimetria de informações e validação discursiva. Folha de Rosto. 2020 [cited 2020 Nov 12]; 6(2):5-21. DOI: https://doi.org/10.46902/2020n2p5-21.
6. Secretaria Municipal de Saúde de Maricá. Boletim 341: ações de prevenção ao coronavírus. Prefeitura de Maricá. [cited 2020 Nov 12] Available from: https://www.marica.rj.gov.br/2021/02/20/boletim-341-da-covid-20-02/.
7. Sarti TD, Lazarini WS, Fontenelle LF, Almeida APSC. Qual o papel da Atenção Primária à Saúde diante da pandemia provocada pela COVID-19? Epidemiol. Serv. Saúde. 2020 [cited 2020 Nov 12]; 29(2):e2020166. DOI: https://doi.org/10.5123/S1679-49742020000200024.
8. Minayo MCS. Pesquisa Social: teoria, método e criatividade. Rio de Janeiro. Editora Petrópolis: Vozes; 2002.
9. Gerhardt TE, Silveira DT (Org.). Métodos de pesquisa. Porto Alegre. Editora da UFRGS; 2009.
10. Machado MH, Aguiar Filho W, Lacerda WF, Olibeira E, Lemos W, Wermelinger M, et al. Características gerais da enfermagem: o perfil sócio demográfico. Enferm. Foco. 2015 [cited 2020 Nov 12]; 6(1/4):11-17. DOI: https://doi.org/10.21675/2357-707X.2016.v7.nESP.686.
11. Oguisso T, Campos PFS. Why to study History of Nursing and what is it for? Enferm Foco. 2013 [cited 2020 Nov 12]. 4(1):49-53. DOI: https://doi.org/10.21675/2357-707X.2013.v4.n1.503.
12. Celestino et al. Capacitação profissional da Estratégia de Saúde da Família: percepção dos enfermeiros. Rev Eletr Acer Saude. 2020 [cited 2022 Feb 20]; 12(9):e3751. DOI: https://doi.org/10.25248/reas.e3751.2020.
13. Tonelli BQ, Leal APdosR, Tonelli WFQ, Veloso DCMD, Gonçalves DP, Tonelli SC. Rotatividade de profissionais da estratégia de saúde da família no município de Montes Claros, Minas Gerais, Brasil. RFO UPF. 2018 [cited 2020 Nov 12]; 23(2):180-185. DOI: https://doi.org/10.5335/rfo.v23i2.8314.
14. FERREIRA SRS, PÉRICO LAD, DIAS VRFG. The complexity of the work of nurses in Primary Health Care. Rev BrasEnferm. 2018 [cited 2020 Nov 12]; 71(Supl 1):704-9. DOI: http://dx.doi.org/10.1590/0034-7167-2017-0471.
15. BARROS RC et al. Atuação do enfermeiro na atenção primária à saúde no município do Rio de Janeiro. Saúde em Redes. 2022 [cited 2020 Nov 12]; 6(3):157-71. DOI: https://doi.org/10.18310/2446-4813.2020v6n3p157-171.

DOI: http://dx.doi.org/10.12957/reuerj.2022.70117

16. Rosa AP, Zocche DAA, Zanote SS. Management of care to women in primary care: strategies for effectiveness of the nursing process. Enferm. Foco. 2020 [cited 2020 Nov 12]; 11(1):93-8. DOI https://doi.org/10.21675/2357-707X.2020.v11.n1.2670.
17. Lima BFC, Costa FS, Rabelo EM, Torres LM, Almeida SP. As dimensões do cuidado no processo de trabalho dos enfermeiros na Atenção Primária à Saúde. BEPA, Bol. epidemiol. paul. 2020 [cited 2022 Abr 12]; 17(202):1-20. Available from: http://fi-admin.bvsalud.org/document/view/g6u82.
18. Gárdia LL. Linhas de cuidados de atenção integral à saúde: dispositivo de gestão no Sistema único de Saúde: revisão narrativa [trabalho de conclusão de curso]. Goiás: Pontifícia Universidade Católica de Goiás; 2021.
19. Ferreira SRS, Périco LAD, Dias VRFG. The complexity of the work of nurses in Primary Health Care. Rev Bras Enferm. 2018 [cited 2022 Jun 12]; 71(Supl 1):704-9. DOI: https://doi.org/10.1590/0034-7167-2017-0471.
20. Monteiro EKR, Santos JAM, Santos, AAP. Electronic Medical Charts For Care Management In Family Health Teams. Revista de Saúde Dom Alberto. 2019 [cited 2022 Mar 30]; 4(1):77-90. DOI: https://doi.org/10.5380/ce.v27i0.79641.
21. Marques LSS, Santos TS, Braz, LC. Impactos da pandemia da COVID-19 nas atribuições da equipe de enfermagem na Atenção Primária à Saúde: revisão integrativa. Práticas e Cuidado: Revista de Saúde Coletiva. 2021 [cited 2021 Nov 10]; 2:e12011. Available from: https://www.revistas.uneb.br/index.php/saudecoletiva/article/view/12011.