NURSE LEADERSHIP PRACTICES IN PRIMARY HEALTH CARE: A GROUNDED THEORY[1]

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ABSTRACT: This is a qualitative study and its aim was to understand the meaning of nurse leadership exercised in the services of Primary Health Care in a municipality located in Southern Region of Brazil. Grounded Theory was used as methodological framework. Data collection was carried out with semi-structured interviews applied to 30 nurses who worked in Primary Health Care and nursing professors, divided into four groups, between 2011 and 2012. After the analysis process, nine categories emerged and sustained the phenomenon 'Revealing the nursing leadership practices in the complex context of Primary Health Care'. Leadership was understood as a resource in the process of caring/managing people and developing a team of leaders, intending the organization and qualification of health work. It is important to rescue the clinical work of nurses, in order to keep their investment in the health team and to strengthen the binomial leader/caregiver.
DESCRIPTORS: Leadership. Nursing. Public administration. Primary health care.

PRÁTICAS DE LIDERANÇA DO ENFERMEIRO NA ATENÇÃO BÁSICA À SAÚDE: UMA TEORIA FUNDAMENTADA NOS DADOS

RESUMO: Trata-se de uma pesquisa qualitativa com o objetivo de compreender as práticas de liderança exercidas por enfermeiros inseridos nos serviços de Atenção Primária à Saúde em um município na região sul do Brasil. Utilizou-se a Teoria Fundamentada nos Dados como referencial metodológico. A coleta dos dados ocorreu mediante entrevistas semiestruturadas com 30 enfermeiros vinculados à Atenção Primária à Saúde e professores universitários, distribuídos em quatro grupos amostrais, entre 2011 e 2012. Do processo de análise, emergiram nove categorias que sustentaram o fenômeno 'Revelando as práticas de liderança do enfermeiro no complexo contexto da Atenção Primária à Saúde'. A liderança foi entendida como recurso no processo de cuidar/gerenciar pessoas e de desenvolver uma equipe de líderes, visando à organização e à qualificação do trabalho em saúde. Indica-se o resgate da atuação clínica do enfermeiro, para a manutenção de suas contribuições na equipe de saúde e o fortalecimento do binômio líder/cuidador.
DESCRITORES: Liderança. Enfermagem. Administração pública. Atenção primária à saúde.

PRÁCTICAS DE LIDERAZGO DEL ENFERMERO EN LA ATENCIÓN PRIMARIA DE SALUD: UNA TEORÍA FUNDAMENTADA EN LOS DATOS

RESUMEN: Estudio cualitativo con el objetivo de comprender el significado del prácticas de liderazgo ejercido por los enfermeros que forman parte de los servicios de Atención Primaria de Salud en un municipio en el sur de Brasil. Se utilizó la Teoría Fundamentada en los Datos como marco metodológico. Los datos fueron recolectados a través de entrevistas semi-estructuradas con 30 enfermeros vinculados a la Atención Primaria de Salud y profesores universitarios, divididos en cuatro grupos, entre 2011 y 2012. Del proceso de análisis, surgieron nueve categorías, que sustentan el fenómeno: "Revelando las prácticas de liderazgo de enfermería en el complejo contexto de Atención Primaria de Salud". El liderazgo fue visto como un recurso en el cuidar/administrar personas y en el desarrollo de un equipo de líderes que vise la organización y calificación del trabajo en salud. Se recomienda el rescate del trabajo clínico de las enfermeras, a fin de mantener su inversión en el equipo de salud y fortalecer el binomio líder/cuidador.
DESCRIPTORES Liderazgo. Enfermería. Administración pública. Atención primaria de salud.

INTRODUCTION

The nurse is considered a distinguished professional in the services of Primary Health Care (PHC), due to possessing a unique set of skills, incorporating health promotion and disease prevention, as well as joint activities of several other health workers. However, disputes over leadership and confusion about the role of nurses in this scenario have hampered collaboration between professionals. To overcome these weaknesses, the strengthening of leadership as an opportunity to increase the visibility of nursing activities and build collaborative working relationships is recommended.[1]

In a large systematic review, it was found that nursing leadership styles and relational approaches were associated with reduced adverse events, complications and mortality, as well as increased patient satisfaction.[2] Yet another study found the positive relationship between transformational nurse leadership and the intention of nurses to remain in their place of work.[3] However, the findings of these studies and much of the research on nursing leadership, refer to the hospital context, since the comparison of data becomes facilitated by the similarity of the work process in these institutions. Thus, it is emphasized that this PHC theme still has little exploration.[4]

Each country organizes their health care networks and services to the population in a diversified way. In Brazil, the service to the population in the PHC occurs at the Local Unit of Health (LUH) as a priority entrance. In this service, the nurse should carry out prevention and treatment of diseases and health promotion, to persons of any age range to programmatic and/or spontaneous demands.[5] In this scenario, there is a significant concentration of power flow in nurses, which gives rise to the opportunity of unavoidable leadership, also caused by omission or accommodation of other professionals.[6]

This study considers leadership as an interpersonal influence in a given situation to achieve one or more objectives; health leaders were taken as agents of change that can create cohesion and positively influence organizational culture through their behavior and leadership practices.[2] Thus the need to know how Brazilian nurses experience and represent their leadership practices in PHC services is highlighted. Thus, the aim of this study was to understand the leadership practices exercised by nurses inserted in the PHC services.

METHOD

We used Grounded Theory (GT) as a methodological framework, for its potential to provide greater understanding of the phenomenon and provide an important action guide.[7] The setting chosen for the research was the Municipal Secretary of Health in city of about 400,000 inhabitants, located in Southern Brazil. Regarding the PHC, the municipality had 49 LUH, distributed in five health regions. The data were collected during the period September 2011 to June 2012.

The selection of participants was supported in the inclusion criteria and theoretical sampling, considering that this strategy is critical to identify participants who lived through the social experience, or rather , those who have information or knowledge about the phenomenon in question. Inclusion criteria included being a nurse from the Municipal Secretary of Health for at least two years and have worked in at least one of the following activities: Family Health Strategy team, coordination of LUH and administrative position at a management level; nurse with expertise in the subjects 'leadership in nursing' and 'PHC' and work in institutions of higher education and/or professional representative bodies.

For the formation of the first sample group, a nurse from the Family Health Strategy team of each of the five regional health was selected. During the process of collecting and analyzing the data, we realized the need to include other three sample groups. In total, we interviewed 30 nurses, as table 1 shows.

Table 1 - Presentation of sample groups according to the number and type of participants

Sample group	Participants	Numbers
1	Nurses from the Family Health Strategy team	6
2	Coordinating Nurses from the ULS/LHU and regional health	7
3	Nurses who worke in a central level Enfermeiros que atuam no nível central	10
4	Nurses with expertise in the theme – University Professors	7
Total		**30**

Recruitment of participants was done by making telephone calls to the workplaces, with presentation of the researchers and the research methodology, and a subsequent invitation to participate in the study. If positive feedback was received, a meeting was scheduled in order to perform the interview.

Data collection was performed with individual semi-structured interviews, using the following opening question: tell me how you exercise leadership practices. The delivery of the questions was directed by the researchers, starting from the responses of the participants. As the collection and analysis of data progressed, new sample groups were formed, aiming to get the details of concepts and a greater understanding of the phenomenon. The interviews were audio recorded and later were transcribed in their entirety. All information that identified the participants in the conference has been changed to protect their identities, and the use of encodings was employed, indicated by the letter P and an ordinal number corresponding to the sequence of interviews (P1 to P30).

Data analysis in GT occurs concurrently with data collection and provides constant comparison to the emergence of the phenomenon.[7] Thus, the data were analyzed manually, line by line, in order to identify each incident and name it with primary codes. The codes were gathered, considering their similarities and differences, for the preparation of conceptual codes. These, in turn, have been re-grouped, aiming to relate the different dimensions and properties of a particular concept for consolidation of categories and subcategories in order to get a clear and complete explanation of the phenomenon. To properly position each category and subcategory in an organizational scheme, the following questions to the data were made: how does this process develop? What influences the phenomenon? Where does the phenomenon happen and why does it change? This step helped to keep focus on the analysis and allowed the consolidation of the phenomenon studied based on the paradigmatic model (context, causal conditions, intervening conditions, strategies and consequences).[7] The saturation of data was reached with the repetition of information and consolidation of found categories. From the total of 30 interviews, nine categories were found, which interrelated, and made the phenomenon emerge.

The validation of the theoretical model was performed with a nurse linked to the institution of data collection who was nonparticipating in the study, and two nurse researchers with expertise in the method and the other an expert on the subject. Regarding validation, we sought to verify methodological consistency, thematic grip and abstraction possibilities of the developed theoretical model.

The research was submitted to the Ethics Committee in Research in the National Commission of Ethics in Research - Brazil Platform, and was approved by the Human Research Ethics Committee of the Universidade Federal de Santa Catarina, under CAAE N. 30360214.2.0000.0113, on April 22 2014. After acceptance to participate in the study, participants signed the consent form in order to perform the interview.

RESULTS

The categories organized into five components have emerged the phenomenon 'Revealing the nursing leadership practices in the complex context of Primary Health Care'.

Context

'The public management of primary health care is considered complex by the nurses' was the category that presented the context in which the phenomenon developed. Participants rescued the discussion of the PHC and its name in Brazil as primary health care, due to the term 'basic' being related to 'low technological complexity'. Although this relationship with the 'basic' term existed, participants classified PHC as extremely complex, being the users preferred entrance to the health system and to be able to make use of all network services. Thus, it emphasized the importance of professional qualification for that level of attention, because they worked with a diverse range of elements, from the newborn to the elderly, in the process of health-disease, acute and chronic, relational and social aspects: *the general nurse has to be very good in order to work in the conflicts of society. So let's say you receive a woman in your health clinic who had been hit by her partner [...] you have to make a plan of action... Being a general nurse in primary care requires higher quality and more complex skills. This is my vision* (P15).

Regarding the formal structure of the organization of health services and its programs, fragmentation by departments was made evident.

According to participants, they considered fragmentation and disarticulation of activities, by visualizing the number of health programs developed in the municipality, which responded to national guidelines as well as the resulting activities that overlapped and generated additional demands without an effective integration of information and health actions.

The movement of contradictions was present in the performance of nurses inserted in the PHC. Participants realized the intense manifestation of political party forces when the desirable was a qualified technical implementation. It was considered that public health management had a low standard of quality, which prevailed the traditional model linked to individual performance of people and exchanges of governments. Participants also pointed out that there were some substitution in the composition of managers or technical staff in order to include people with political party influence. This aspect was considered limiting, generating discontinuity of the proposed agenda, given that each management group prioritized actions as a guideline, just as the perceived workload, both for nurses at the central level, and for those who worked in Basic Health units.

Causal conditions

The phenomenon was generated by the category called: highlighting the many features of the leader nurse. This category showed leadership as a natural characteristic and/or developed during the training, especially during the nursing degree course. Thus, leadership, as an innate characteristic, was noticed in some nurses: *some people can exercise leadership naturally, they have the ability to influence people for a particular purpose. For those situations, people assume the leading position with the acceptance of the group and without imposing* (P28).

Participants understood that the nurse was invited to lead starting from inside the PHC until the hospital context and that this was recognized as leadership. In LUH when nurses did not occupy positions or formal coordination, they established partnerships, assuming managerial demands and solving many problems and conflicts that arose on a daily basis. The participants related the attitude to the dynamics/to this professional work process, who performed concomitant assistance activities to management actions. In this sense,

leadership was presented as a set of skills and attitudes that could be learned and perfected in higher education. The participants said that some nurses only led due to the influence from their training, that the interest in self developing started in the graduation course, in view of the need to coordinate the nursing staff, health facilities and coordination of care in PHC.

Intervening conditions

The categories, 'Perceiving complementarity between confidence and experience in order to generate links', 'Contrasting the dependence of nurses to the system and its autonomy in relationships, interactions and associations in Primary Health Care' and 'Limitations of working conditions and training of health professionals influencing the different demands of nurses' acted on the central phenomenon, in order to enhance or minimize its complexity.

In the category, 'Perceiving complementarity between confidence and experience in order to generate links', participants revealed the impact of trust and good relationship in the exercise of nurse leadership. To achieve harmonious teamwork, nurses tried to demonstrate that they believed in the health system in which they worked in and that they worked to transmit values, ie, cooperation, team spirit, patient recovery, while focusing on the action of the workers. Nurses linked their previous professional experience, both from the hospitals and in the PHC, to successful leadership and maintaining good relations. They said that every professional performance scenario required adaptations and potentiated their performance in the PHC: s*o,working in the hospital or in other units* [LUH] *inside, I was molding myself. So, I was able to take decisions based on different organizational models that I used here, when I arrived, for example* (P9). Yet, the fact that the nurse worked in various health services meant that the nurse was valued by others, because the nurse has differentiated knowledge.

In the category, 'Contrasting dependence of nurses to the system and their autonomy in relationships, interactions and associations in Primary Health Care', the participants discussed issues relating to the power struggle and the use of traditional work supervision of others. It was stressed that, in some situations, the nurse had reduced their leadership actions in the supervi-

sion of tasks, putting into practice the guidelines of public leadership and policies, and conducting an intense control over the other employees: *I see that the nurse has this historic role of leadership, sometimes, less than leadership, supervision over the other, right? In relation to community workers, nurses assume supervision, but it does not question their true contribution and they assume this role* (P25). In these circumstances, the participants realized that the nurse was in the middle of hierarchical layers, working with little autonomy and low capacity to innovate their practice.

'Limitations in working conditions and training of health professionals influencing the different demands of nurses' presented a relationship between the weaknesses of working conditions and the training of professionals that made up the health team and in the work of the nurse in the PHC . Due to the reform process and the expansion of the physical structure of the LUH, the participants evaluated the nursing work as potentiated considering the achievement and location for specific areas, such as, vaccine rooms, dressings, nursing offices and meeting rooms.

Another important challenge for nurses was the staff management, given that, in general, employees of LUH still had a very curative perspective, even with the difficulty of working with incomplete teams. In this scenario, the nurse took on different activities that were scheduled to meet the main needs of the users, which generated a mobility within the LUH discrediting the clinical work and determination as care coordinator between levels of care. With regard to the training for integrated work in the PHC, although the curriculums were updated and approximated to the content relating to the Unified Health System (SUS) and public health, gaps still existed relating to innovation in the service and the use of new co-management and humanization tools.

Strategies

Categories, 'Improving the practice of leadership through planning and support from managers', 'Using communication as a tool that gives dynamism to the interrelations between nurses, staff and community' and 'Enhancing skills, and individual and team potential, presented the strategies implemented by nurses to exercise leadership.

In the category 'Improving the practice of leadership through planning and manager's support', the importance of planning with a tool that required continuous adaptations and the involvement of the management group and the participation of all team members work was highlighted: *planning transforms this* [leadership practices] *to have a goal, motivation, and others, a thing with visibility and is able to be measured, and can be evaluated at the end of the process. Not as a straitjacket but a guide* (P18).

Dialogue was indicated as a leading strategy for building a common goal, feedback and motivation in the category 'Using communication as a tool which gives dynamism to the interrelations between nurses, staff and the community'. Participants revealed that dialogue brought fluidity to leadership by allowing constant exchanges between the individuals involved. In this sense, dialogue potentiated the management of conflicts, involving users, workers and managers: *for dialogue, I think I need to have common goals in the relationship* [...] *So through it, people feel part of the process for the construction of objectives to be pursued and permanently set* (P2).

In the category 'Perfecting skills and individual and team potential', participants realized that the theoretical and practical emplacements provided by graduate courses provided professional training for nurses and encouraged them to assume leadership positions in the Municipal Health Secretary or to instrumentalize during their duty as coordinators, for example.

With regard to teamwork, according to participants, nurses had ease in integrating professionals, and encouraging teamwork and individual responsibility to promote focused work in common goals and a harmonious atmosphere: *here at LUH, this division of tasks requires all professionals to be engaged in the leading role. Nurses, doctors and dentists have shared... the exercise of co-management. The nurse stands out because they assume many responsibilities* (P13).

Participants revealed that working with unmotivated staff was very difficult because it interferes in the organizational climate, generating impact on the professional performance and user dissatisfaction. Nurses believed the variation in the team motivation pattern was normal, considering constant stimuli necessary. Training on the issues of workers' interests, dynamic meetings, praise and gatherings were used by nurses to motivate employees.

Consequences

In the category 'Nurses sharing the lead as opposed to individualism', the participants showed that leadership was stimulated in the various health team professionals. In many LUH, sharing of decision-making, responsibility for achieving targets/specific objectives, and preparing for delegation of support for coordination activities was observed.

Participants realized that the decentralization of activities made the team more integrated, providing opportunities for collaboration spaces and peer and personal satisfaction. Thus, it was believed that good leaders created new leaders, or rather, instead of being led, working with a team of leaders: *so leadership builds new leaders, I think that's the definition of being a leader. Who is centralizing is not a leader, they only want power. If you give me a working structure and coordinate, my focus will be ready to leave a structure where people can walk alone. Structuring each sector, encourage each employee to exercise leadership and responsibility* (P6). In this sense, the participants concerned themselves with the maintenance of activities, despite employee turnover and the exchange of governments.

Another item identified by participants was the need for a national project for nursing, a leadership training program to allow reflection on the problems in practice. Thus, it envisions the development of instruments in which nurses don't get curbed by the institutions, and that they reach a highly qualified vocational training in specific domains of clinical and managerial issues concerning PHC. The nurses still had the challenge to advance the construction of a new reality, in which the nurse acts with more autonomy and greater visibility.

DISCUSSION

The Brazilian health system focuses PHC on a range of preventive, curative and promotional actions. Fragmentation of organizational structures in health programs, often designed independently and with disjointed goals requires nurses and professionals of the multidisciplinary team to be highly qualified. Aiming to overcome these barriers, the Health Care Network (Redes de Atenção à Saúde-RAS) has established a new dynamic, with services linked to each other with a single mission, common goals and a cooperative and interdependent action. However, profession-als still live with extremely bureaucratic routines and rules, which prevents the integrated and complex motion of care.[8]

Another element that integrates the complex scenario in health in Brazil is the political-party relations. Many politicians project expected electoral support from the staff of the Family Health Strategy, to gain visibility with the population and for self promotion.[9] It is noteworthy that internal forces of SUS, social and political, limit their ability to promote themselves, to break with misapplied procedures in which they are involved in.[10] Thus, the recognition and incorporation of these forces that are not in sight in the management and organization of health systems, as well as their inconsistencies, deviations and errors, point to a dialogic and complex action. Therefore, the participation of various sectors and organizations, performing multiple actions in a dynamic, flexible and interdisciplinary, that is, with the political will to share knowledge, can form complex networks of cooperation.[8]

Regarding the application of leading practices by nurses in this complex scenario of PHC, it was found that they emerge as a natural characteristic and/or developed in training. These findings corroborate study,[11] in which rural community nurses emphasize the importance of leadership as a personal skill and recommend the possibility of developing the same. Regarding the influence of leadership training, few significant changes in relation to the development of this competency[12] was already pointed out in a study in an Australian School of Nursing, which held a leadership pilot program for students in the fourth semester of the course and it was found that participants had expanded their influence skills, persuasion, motivation, communication and construction teamwork.[13] Thus, it appears that, when appropriate stimulus occurs from the educational institution for the development of skills, it is possible to achieve certain powers, among them leadership.

Regarding the intervening conditions for the exercise of leadership which was revealed in this study, they were identified as positive to the professional experience and for the trust between professionals and community. The study confirms the complementarity of this finding when it says that if the nurse does not develop a trusted relationship with his team, he may struggle to lead, as the distrust prevents the work to follow its normal

flow.[14] Furthermore, it is observed that when the bonds are present, they become the most significant work and increase the professional commitment to users.[9]

The elements mentioned by study participants that negatively influence the exercise of leadership, were inadequate working conditions, insufficient number of workers and the presence of professionals with different orientation from the recommended by public policies. In other regions of Brazil and the world, it appears that nurses productivity is negatively affected by unsatisfactory working conditions.[9,15]

Another factor that hinders the integration of professionals in health teams and does not guarantee the satisfaction of the population with regard to service, is the professional training guided by specialties and biomedic model.[9,16] Thus, it can be considered that certain attitudes of professionals are reflections of the weaknesses of the teaching and application of the integrity concept as a criteria to stipulate practices and generate new knowledge. The example was identified in a study conducted in the UK, the role of universities has been restricted to the theoretical support, with little involvement in the daily life of organizations, maintaining a distance from specific issues of public health and harming the development of contextualized and innovating practices.[17]

Participants of this study pointed out a reduction of the nurse leadership actions to the supervision of tasks, to execute orders without proper reflection and apply to public policies, with the focus to reach the institutional goals. It should be warned that the nursing leadership orientated to perform tasks presents less significant relationships in health outcomes of patients.[2] Attitudes characterized by the imposition and the punitive supervision do not reflect the best way to exercise leadership in the work environment, however, it indicates the need for the nurse leader to be open to work with an emphasis on motivation and dialogue.[14]

In this study, leadership strategies used by nurse leaders were planning actions, manager support, stimulating individual potential and self-organization of the group, through dialogue and motivation. All these strategies were presented by the participants in an interconnected way, to achieve the set goals, since health issues were considered complex and required different approaches, including nurse leadership. Studies claim that collectively working without an activity plan involving the team to the pursuit of quality of care and the lack of manager support can impair worker productivity.[9,18] In rural health clinics in Uganda, having managerial support makes the job easier, because it is possible to have infrastructure and professional training to carry out the activities of interest.[19]

While there are weaknesses in the teamwork of PHC, this is associated with better health practices, and nurses are considered experts in promoting teamwork. In this regard, a Canadian study shows that nurses working in public health are recognized for developing activities focused on building individual and group potential, providing educational support and leadership.[20] The initiatives to develop potential in other team members match with what the participants of the study envisioned as a phenomenon of the consequences 'Revealing the nursing leadership practices in the complex context of Primary Health Care'.

Still, the study findings indicate the organization of nurses to develop clinical and managerial leadership as a challenge to the profession. Corroborating these finding, the development of specific training is recommended[21] and inter-professional education in view to promote changes in individual and organizational levels, and focusing on leadership and activation of change, commencing with a group of experienced professionals to help develop skills, knowledge and confidence necessary for implementation of the integrated healthcare work.[22]

FINAL CONSIDERATIONS

Through the development of the phenomenon 'Revealing the nursing leadership practices in the complex context of Primary Health Care' and the integration of the categories found, we came to the proposed objective. Nurses are recognized as leaders by their natural characteristics, and by the vocational training, highlighting the strong influence of the complex Brazilian health system. The findings confirmed that inadequate working conditions, presence of professionals with curative and individual work guidance, and leadership oriented to tasks and supervision are hindering not only the leadership of the nurse practice, but

the integrated health team performance. Facilitating elements and strategies identified, namely professional experience, the use of planning, communication and stimulation of individual potential and the group led to the maintenance of quality service, by encouraging the role of the remaining multi professional team.

It is believed that the prospect of integrated professional practice and the encouragement of leadership in pairs has been one of the main contributions of this study to the practice of nursing, considering that the entirety of health care advocates multidisciplinary and interdisciplinary actions.

Although this study was conducted in the specific context of primary health care in Brazil, it holds similar characteristics with health systems implemented in other countries with regard to doctrinal and organizational principles. Thus, it is suggested as a topic for future research to study the characteristics and impact of nursing leadership in the various services in other countries, aimed at generating a wider body of knowledge and articulate their peculiarities.

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