Necessary skills for the Family Health Units manager: a clipping of the nurse's practice

Competências necessárias ao gestor de Unidade de Saúde da Família: um recorte da prática do enfermeiro

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ABSTRACT Exploratory descriptive qualitative study with the objective of analyzing and discussing the necessary competencies for the Primary Health Care (PHC) manager. The scenario was the Family Health Units of Angra dos Reis and as participants of the research there were 10 statutory nurses who had been working as managers for over a year. Data were produced through focus group and weighted based on Bardin content analysis. Three categories emerged from the study: Leadership management skills; Managerial skills relating to resource management and care; Managerial skills related to the mobilization of cognitive and affective resources. The findings indicate that the competences described by the participants are in line with the narratives in other studies and highlight the need to invest in a training that allows reflecting and seeking development of managerial skills for PHC managers, as the category is under construction, requiring improvement and formal recognition beyond ministerial ordinances. These findings are related to Paulo Freire's thought as a basis for Permanent Education, a strategy for changing the reality found.

KEYWORDS Primary Health Care. Family Health Strategy. Professional competence. Organization and administration. Health services administration.

RESUMO *Estudo qualitativo descritivo exploratório com objetivo de analisar e discutir as competências necessárias ao gerente de Atenção Primária à Saúde (APS). Teve como cenário as Unidades de Saúde da Família de Angra dos Reis e como participantes da pesquisa dez enfermeiros estatutários que exerciam a função de gerente havia mais de um ano. Os dados foram produzidos por meio de grupo focal e ponderados com base na análise de conteúdo de Bardin. Do estudo, emergiram três categorias: Competências gerenciais relativas à liderança; Competências gerenciais relativas à gestão de recursos e do cuidado; Competências gerenciais relativas à mobilização de recursos cognitivos e afetivos. Os achados apontam que as competências descritas pelos participantes se alinham às narradas em outros estudos e evidenciam a necessidade de investir em uma formação que permita refletir e buscar desenvolvimento de competências gerenciais para os gerentes de APS, pois a categoria mostra-se em construção, necessitando de aprimoramento e reconhecimento formal que ultrapassem portarias ministeriais. A esses achados, relaciona-se o pensamento de Paulo Freire como embasamento para a Educação Permanente, estratégia de mudança da realidade encontrada.*

PALAVRAS-CHAVE *Atenção Primária à Saúde. Estratégia Saúde da Família. Competência profissional. Organização e administração. Administração de serviços de saúde.*

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Introduction

Health services have particularities that raise unique demands in terms of organization and management, as they meet complex and variable needs that have biopsychosocial dimensions, whose definition varies according to social class and the respective representations of health, disease, death, the clientele and the type of problem. The Basic Health Units (BHU) bring an even more abstruse panorama, as it is in them that health problems are largely identified, attended or referred to other levels of care, since Primary Health Care (PHC) is the preferred gateway to the health care network and the care coordinator in the Unified Health System (SUS)[1-5].

A key actor for the operationalization of PHC services is the manager, who, literally, has as assignments planning health according to the needs of the territory and the community, the organization of the work process, the coordination and the integration of actions. It demands much more than political will and common sense, it requires a knowledge base in the areas of health and administration, an overview of the context in which social commitment to the community is inserted, and a solid knowledge of the fundamentals that underlie the systems of health services[1-10].

In such way, it is indispensable for the manager to have a range of managerial skills in order to optimize and maximize existing resources, to lead and add value, to increase the potential of his/her team and to combine efforts to use financial, technological, material and human resources in order to increase the service's resolution, minimize conflicts, overcome the limitations that the service presents and provide assistance based on the principles of SUS[6-10].

Managerial skills are one of the main pillars of an organization. Competence is defined as the set of characteristics perceived in people that involve knowledge, skills and attitudes that lead to superior performance. The components required for competences involve knowledge, acquired 'learning'; attitudes, which are linked to personality; and the skills, the 'know-how', that is, the know-how put into practice, hence the ability to mobilize resources. That is, the behavioral capacity to act appropriately, using previously acquired knowledge[9-11].

Considering the current health work landscape, in which the new National Primary Healthcare Policy (PNAB) inserts the manager in the Family Health Team; and, among professionals working in the health area, nurses, in their daily practice, usually assume the management functions, betting on the need to analyze and discuss the skills recognized by nurses as necessary for their management practice in Family Health Units (FHU). For this, Paulo Freire's thought is used that education releases through reflections and emancipatory actions as a theoretical framework.

Material and methods

This is a clipping of the research 'Permanent Health Education: strategy for strengthening managerial skills of nurses of Basic Health Units' from the professional master's degree in Health Education at the Fluminense Federal University. It has a qualitative approach of exploratory descriptive type that had as scenario the FHU of Angra dos Reis.

At the time of the study, the municipality had 47 FHU, which represented population coverage for family health greater than 75%. The managerial function was not instituted and was performed in almost all units by the nurse, which was divided between unit administration and care.

The research participants were the nurse managers of the FHU who were submitted to the inclusion criteria (statutory professional for more than one year acting as manager because it is believed that after this period, the nurse has knowledge of the assigned area and is familiar with the flows

of primary care) and exclusion (professional not submitted to public tender and removed from unit management at the time of data collection). To maintain confidentiality, participants were coded using an alphanumeric index as their responses returned. At the time of collection, there were 16 nurses meeting the inclusion and exclusion criteria; and 10 of them proposed to participate in the survey, corresponding to 62.5% of the guests.

For data collection, it was used a focus group that was recorded in an android application and transcribed removing language addictions. The speech was recorded so that no information was lost during the focus group, which allowed a better interpretation of the dialogue, ensured the reliability of the information and enriched the data collection. The researcher in charge had the role of moderator/coordinator of the focus group, being responsible for the preparation and instrumentation in all phases of the process. The focus group was guided and problematized by the following question: 'What are the necessary managerial skills for a BHU/FHU manager?'.

Data were weighted by researchers based on content analysis following Bardin principles and thematic analysis. To reach the categories, some methodological movements were adopted. After the transcription, reading and analysis of the speeches, occurred the definition and accounting of the Registration Units (RU), from them were constructed the Meaning Units (MU). The grouping of the MU in a logical-semantic way, following the ideas absorbed by the subjects' speeches and their similarities, gave rise to the categories.

The project followed the ethical guidelines of Resolution nº 466/2012 and was approved by the Municipal Secretary of Health with the signing of a letter of consent and interest, being approved by the Research Ethics Committee of the Fluminense Federal University with CAAE 596121116.3.0000.5243 and opinion issued by number 1.764.754. There was no financial support for the execution of the research.

Results and discussion

As for the participants' profile, there was a predominance of females (80%). Age ranged from 29 years to 58 years with a mean age of 35 years. All participants received the same base salary, varying only the bonuses. All had postgraduate degrees: six had specialization in family health; four in management; one attended residence; two also hold master's degrees. In addition, 100% reported management experience for more than seven years, none of them had exclusive dedication to management and performed all the duties of the FHU nurse described by the PNAB.

The search for specialization courses suggests that professionals are open to new knowledge and interested in qualifying. The search for specialization in family health indicates that professionals realize the complexity of care demand at this level of care and deconstructs the idea that professionals who work at FHU do not specialize. Sales[7] mentions that having a *lato sensu* postgraduate course indicates a greater concern in training and updating their knowledge. The low turnover of professionals becomes relevant because it allows effective contacts with the community, knowledge of their needs and greater possibility of continuing the projects initiated in the establishment. All this engagement occurs without the trivial interference of change, when new governments take over, especially in the case of partisan alternation[12]. A study by Barbosa and Bosi[13] specifies the semantic variances used in the literature to define bonding. Among them, the best employability in this study are the conceptualizations of bonding under the perspectives of: increasing the resolution of services; reduce staff turnover;

promote humanization, accountability for care, trust between professionals and users; favor learning and professional practice.

The discussions led to the occurrence of three categories: Managerial competencies related to leadership (25.75%); Managerial competencies related to resource management and care (28.78%); Managerial competences related to the mobilization of cognitive and affective resources (39.4%). In order to bring the reader closer to the discussions, below is a synthesized scheme of the composition of the categories:

Chart 1. Units of registry, meaning and categories

Unit of Registry	**Unit of Meaning**	**Category**
Leadership Manage conflict/deal Delegate roles Stimulate the team Recognize skills in others Know how to work in teams Negotiation Ability	Leadership	Managerial skills regarding leadership
Run/manage inputs and materials Administrative capacity Manage human resources	Management: unit organization	Managerial skills related to resource and care management
Know the flow Know the network Knowledge of the coverage area Knowledge of indicators Know the situational diagnosis Articulation ability	Clinical management in care networks	
Proper use of information Plan actions Coordinate actions Evaluate actions	Care management	
Technical-scientific knowledge Knowledge of laws Dexterity Decision making Administrative training Know how to argue Knowledge of administrative and management concepts	Cognitive skills	Managerial skills related to the mobilization of cognitive and affective resources
Resilience Suitability Coping Ability Flexibility Creativity	Empirical skills	
Autonomy Impartiality Neutrality	Values	

Source: Own elaboration.

The first category had as occurrences: leadership, mediating conflicts, delegating roles, stimulating the team, recognizing skills in others, knowing how to work in teams and negotiating skills. The second category had the most referred competence to manage inputs and materials. In the third category, scientific technical knowledge, resilience, autonomy, flexibility and creativity stood out, respectively.

First category – Managerial skills regarding leadership

Leadership was emphasized by participants as a competency that can influence and propel other team members. The following lines connote the statement:

> *I need leadership so that community workers can subsidize me with the data I need to know...* (N.7).

> *The first thing I thought about was leadership ability.* (N.3).

Leadership is conceptualized as the combination of different leader behaviors, applied in a process of influencing people to achieve their goals. Some authors suggest that leadership drives teamwork, cooperation, communication mechanisms[6,8,9].

Jonas[8] states that the health services manager, as a leader, needs to know how to work with his/her team in order to expand the group's knowledge and skills, aiming to generate synergy and continuous development of the community, as well as the ability to deal with adversities, conflicts and instabilities in your daily work.

Alignment of ideas with the author was observed since delegation of functions, the process of teamwork and conflict management were considered as necessary managerial competences as seen in the statements:

> *I see as competence also delegate functions, team stimulus, recognize skills, strengths in each person...* (N.2).

> *Recognize strong bonds, see what others like to do and encourage them.* (N.1).

In this study, delegating functions is understood as the transfer of decision power to perform specific tasks, is to recognize in the other capacity and ability. Sales[7] and Montezelli[9] state that managers should not only delegate, but should know and live the dynamics of the process of caring for and knowing the people who are involved in this process and the environment for management to take place in accordance with human, material, technological and available financial resources.

Conflict management was another competence mentioned in the research:

> *I see as competency managing conflicts.* (N.1).

> *Another skill as the colleague said is dealing with conflicts in the team.* (N.3).

> *Particularly I understand management as an activity related to conflict management.* (N.6).

One of the reasons for the frequent appearance of this competence may be the fact, as described by Carvalho and collaborators[14], of the conflict being an intrinsic characteristic and impossible to eradicate from organizational life, especially in institutions where work processes are mediated, immediately, by social interaction, as is the case with health organizations.

Conflict management was seen by participants as inherent to work in health services, involving both the team-to-team relationship, the users themselves, central management and the team. However, the conflict between the team was considered the most exhausting, the one that spends the most time for resolution and that often ends up poorly resolved, since those involved have great coexistence, about

40 hours per week, and find each other worn out by the daily problems.

It was also pointed out that conflict confrontation is always 'tense', and that there is no systematized way to deal with them, although they occur daily, as noted in the statements:

> *another skill as the colleague said is dealing with team conflicts and this is also a major difficulty, since we work with the same team for years.* (N.7).

> *Additionally it is important to consider that there are at least 3 different interests in dispute when discussing a particular point of management that may conflict with each other, namely: that of the contractor/manager; that of the employee/manager; the user/patient.* (N.5).

Conflict is then part of relationships, and having the ability to negotiate, to divide, to listen, to delegate, and to communicate is a premise for teamwork. In the context of primary care, negotiation is a fundamental instrument of adjustment, generating consensus, capable of sustaining and enabling proposals for joint action.

The ability to work in teams was another competence pointed out in the discussion. There was consensus regarding this competence; the speech below reflects the group's thinking:

> *The nurse must develop the ability to work in a team, establishing partnerships and effective relationships between professionals of the multidisciplinary team, since we are considered coordinators, managers.* (N.3).

Primary care and its structuring axis, the Family Health Strategy, only materialize from the multidisciplinary knowledge: family health is not done with only one professional category; knowledge and actions are interdependent and complementary; there is no supreme knowledge nor should there be medical sovereignty; family health is done with a careful and differentiated look of each team member, with the multiprofessional integration. The manager must ensure and value the communication process and the effectiveness of multiprofessional work. Must lead, direct employees to achieve goals, but recognize that the success of work depends on each of the team members[1,5-14].

Teamwork is seen as a possibility of expanded care, as it favors health professionals to expose their knowledge, perform risk and priority assessment, articulate care, in order to seek continuity, intersectoriality and integrality, through the collective construction of this approach's staff[15].

Leadership competency relates to the ability to manage conflict, the ability to work in teams, delegate roles, stimulate staff, recognize skills in others, and negotiate; and the articulation of all of them is extremely important for nurses to manage the clinic and care[14,15].

For Paulo Freire[16(171)], "the path of leadership must be the dialogical one, that of communication [...]". Antidialogical action – oppressive, domineering – seeks conquest, division as a means of maintaining oppression, manipulation and cultural invasion. Leadership presupposes participation, convincing. Respect for people provides the opportunity for dialogue and conflict resolution inherent in the different cultures and histories of each human being. If conflict is inherent in human relations, tolerance for the 'man unfinished' is the way to overcome this tension[17].

Second Category – Managerial skills related to resource and care management

Administering/managing resources/inputs and materials was cited as competence by four participants, however, there was agreement among all. Perhaps this may be justified by the notes of the National Curriculum Guidelines (DCN) of the 2001 nursing course that include

the contents of administration among those considered essential to the development of skills. The three statements illustrate the event:

> *I see it as a competency managing inputs.* (N.1).

> *I agree, I also think managing inputs, I need to know what my patient needs...* (N.4).

> *I also see the ability to manage inputs and materials.* (N.8).

The nurse is a professional who has in his/her training an emphasis on the administrative area. In the DCN established by the Ministry of Education (MEC), nurse practitioners must be able to take initiative and manage and administer the workforce, physical, material and information resources, as well as be fit for entrepreneurship, managers , employers or leaders in the health team[7].

Considering that primary care is the basis, organizer and coordinator of the health care network, the participants understand as managerial competence the knowledge of the network and the flows, a situation marked by the following discourses:

> *We need to know the flows... We need to know the network...* (N.3).

> *We need the flows, we need to know them, without them we cannot continue the process.* (N.8).

In addition to the network and the flows, nurses express their competence as management *"to know the coverage area and to know the situational diagnosis"* (N.1). One participant complements the speech:

> *The administration's specific work process is composed of a set of own and interrelated activities, with a view to the comprehensiveness of user care and meeting their health needs.* (N.6).

Articulation ability was also mentioned as competency for FHU management, as shown in the following elocutions:

> *The nurse in the context of the FHS should participate in the elaboration, coordination and articulation of health unit planning. The nurse can identify the resources and demographic and epidemiological profile of the assigned population related to the planning of the FHS.* (N.9).

> *I see as competence also the ability of articulation, articulation in the sense of weaving the care network with all spheres of attention and care, health, education and social action.* (N.7).

Planning, monitoring and evaluation stand out as important organizational technologies, which allow the realization of local diagnoses and, consequently, the readjustment of work processes to reality, considering the needs, difficulties and possibilities in primary care. Through planning, it is possible to organize and qualify the work in order to share goals and commitments. When planning, workers can reflect on action proposals, in order to intervene on a particular problem, individual or collective need[18].

It was also legitimized as managerial competence to know indicators. The speech of N.7, described below, leads us to believe that professionals know the real importance of using information as a negotiation instrument and fundamental transformation for work in primary care, however, they do not know where to look for it.

> *Knowledge of indicators, because how will I know how much material I need if I don't know my population, how will I know how much medicine if I don't know my number of hypertensive people...* (N.7).

Indicators should act as a compass guiding the path of services in order to improve the management and quality of care provided. They need to be connected to a goal, without

which they lose their meaning, since they are only useful when one knows what one wants to achieve[19].

Fernandes and collaborators[10] analyze that knowing the indicators implies that the manager knows how to deal with hard technologies, that is, know how to use information systems, manipulate and analyze databases, and this does not always happen. Once this situation is over, the information needs to be up-to-date, traceable and accessible.

The evaluation, on the other hand, involves reflection on the path being taken, enables adjustments when necessary, strategic changes or even total interruption of the plan[20].

All these pathways can be recognized as a technical-administrative strategy, as they aim to assist decision making within health services, and are key elements for management.

When the articulation and integration between care and management actions happens, nurses develop their best professional practice, called care management. At this moment, the intertwining and complementarity of care (direct care) and management (indirect care) are perceived, forming a dialectic and non-dichotomous relationship of these actions, resulting, with that, in the integrality of nurses' activities[21].

The speech of N.5, presented below, brings us to the thought of care dissociation and the practice of managing. Moreover, it leads us to infer that the activities that nurses perform in primary care exceeded the responsibility for activities related to the nursing team and Community Health Workers, assuming, in the absence of a local manager, their duties, occurring, thus, an overload of tasks to be developed by the nurse. This way of acting generated a distance from the professional nurse between managing and caring in their daily work, and it was observed in the statements that there was difficulty in articulating these two dimensions. The speech of N.5 reflects the fact:

> *The many attributions of nurses ultimately result in the precarious work of the professional nurse who performs this managerial activity, in addition to their predicted attributions.* (N.5).

Hausmann and Peduzzi[23] consider care as the hallmark and core of nursing work and understand that the managerial actions of nurses should present the quality of care as their purpose. The split between the dimensions care and manage compromises the quality and causes conflicts in the work of nurses, whether the professional with their own practice, or in their relationship with the nursing team and the health team.

Thus, it can be said, based on the current research and the research by Fernandes e Silva[23], that, within the work process developed by nurses in BHU, the tension between care and management appears as poles of opposition, not as intercessory and intercomplementary actions, making management implementation difficult.

It is important to remember that the managerial activity is a means for the work, because the end activity is the assistance and care based on a given quality standard, recognized by the service as desirable. However, the management of these processes should be shared (co-management), enabling the construction of objectives and projects in a more participatory manner, so as not to overload the work of nurses[5-8].

Regarding planning, Bazzo-Romagnolli et al.[24] point out that it is the most important skill for management and that, in the daily work of managers, there are difficulties to accomplish it, but they consider that it happens and is embedded in management processes, and that evaluation is as important as planning.

The term management (or democratic management) is not frequent in Paulo Freire's work. It appears in the books 'Politics and Education' (1993) and 'In the Shadow of Mango Tree' (1995). It is interesting to note the addition of the adjective 'democratic' to the term management used in these works. For

Freire[25,26], democratic management indicates civil society participation in the command of public affairs. To manage, therefore, is to be willing to dialogue. Planning and seeking knowledge, as in indicators, through dialogue with people generates awareness and transformation. It is this awareness that allows care to be done generously, and not as an extra assignment that makes management difficult.

Third Category: Managerial skills related to the mobilization of cognitive and affective resources

As a skill, there was also the technical-scientific knowledge, knowledge and administrative training, as we observed in these statements: *"I think it is also part of the skills to have technical knowledge"* (N.6). *"... and abilities I think you have to have dexterity..."* (N.7) and

> *Ability to defend opinion, here even more because of the lack of manager with knowledge and because of politics, defend opinion with scientific knowledge, with knowledge of cause. If we are unable to defend our opinion with arguments, we cannot convince anyone of our capability.* (N.3).

It has been mentioned that a good set of knowledge improves analytical skills, critical-reflective thinking skills, and action ability, by improving practices that lead to good results.

As much as the processes are shared with the team, it is the manager who initiates and finalizes the planning and evaluation of actions, it is this professional who speaks to central management and points out the points that need to be reviewed; it is also for him/her that political demands and ombudsmen arise, and there is no way to answer and address all these questions without a solid academic background, without the constant search, appropriation and acquisition of knowledge that become management tools[7,8,10,18-22].

Scientific knowledge permeates the set of theoretical knowledge necessary to understand the phenomenon care and management, its objects – the individual, the family, the community –, the specific situations and unique constituents of personal interactions, organizations and health institutions, of work processes, organizational culture, products and equipment in use, strategies, structures, procedures, protocols, among other components, updated and evidence-based, aiming at the consolidation of best practices in human attention[9-11,17-21].

Knowledge directly implies another competence referred to by the group, decision making, as observed in the following speech:

> *[...] quick decision making, because sometimes you are unsupported and need to act quickly in an emergency, take action and base it, I've learned it...* (N.7).

Every manager needs knowledge, up-to-date, reliable and complete information to make decisions about the operations and performance of the unit's actions under his/her responsibility, because during the process of facing problems, it is essential to rethink the management practice at FHU, aiming at improving care for the population, cooperating for the development of effective health services and capable of performing actions compatible with the proposals of the SUS[27-29].

For Tanaka and Tamaki[27], decision making can be considered as the function that characterizes management performance, however, regardless of the decision aspect; it must be the result of a systematic process, which involves the study of the problem, starting from obtaining data, producing information, then establishing proposals for solutions, choosing the most appropriate decision, enabling and implementing the decision and analyzing the results obtained.

Participants noted that they, often, need

to readjust, give new meanings, new uses to work tools, reinvent assistance and reconfigure management with what they have to work with. In this way, they elected resilience as an indispensable skill for the FHU manager. Related to it are the skills aptitude, coping, being flexible and creativity; which can be observed in the following statements.

> *Today we all have to have coping skills and resilience because all the time we have to adapt and think about how to accomplish something without having the necessary equipment to not compromise the quality of service.* (N.2).

> *[...] we have to be flexible to adapt to the conditions what is right and what we have...* (N.7).

For Barlach and collaborators[28], resilience can be defined as the construction of creative solutions in the face of the adversities present in the working and business conditions of today's society, resulting in a double effect: the response to the problem in question and the renewal of skills and vital *elan* of individuals. Thus being resilience linked to creativity.

Caveião[29], in his study, states that some authors present the importance of creativity and innovation in health services, distinguishing these concepts as creative behavior, which is the improvement of a known element or action, while innovation means finding new alternatives. Creativity is one of the easiest skills to find in people's behavior in organizations, being mentioned as creative behavior, or to do better what was already being done.

Autonomy, similarly, was given as managerial competence, the statements *"I believe that the manager would have to have autonomy..."* (N.4) and *"The manager needs autonomy to perform his job better"* (N.6) bring this representation.

Jonas[8] corroborates the study by stating that the process of autonomy assumes that the professional nurse can interfere in the process of defining care priorities. Autonomy is based on the individual's will for action, based on social and cultural influences.

The management of care requires from the nurse a vision that integrates and welcomes different values and logic, imprinted on the needs of users, not manifest or recognized until some time ago, being necessary, by this professional, an involvement of interrelations, in their creativity and autonomy, in order to meet the needs of the work process, since autonomy is necessary for the definition of priority actions for health care, within the scope of the FHU[3].

Thus, responsible autonomy and coherent with the principles of SUS is essential to the development of managerial action, since its absence makes it impossible to organize and control the work process.

One of the participants also pointed out as skill being competent, impartial and neutral:

> *So I think the most necessary skills are to be honest, impartial, religiously and politically neutral... I really want to be neutral, to be impartial, because I am there to be a health professional not to be political.* (N.7).

Impartiality, neutrality are managerial competencies described as values, involve the scope of knowing how to separate their beliefs, their culture, their political position from their workplace. This is difficult because the manager imprints his/her brand on the job, whether or not he/she drives the team through his/her own work, that is, he/she becomes a model, a reference due to his/her attitude towards the game of forces that influence the daily life of the service[6]. From this perspective, it is assumed that the manager of a FHU should have a broader view of health, be able to properly prioritize community problems and needs, and implement the model of comprehensive care and participatory management requires the latter to have the skills to do so. Some competency studies indicate that the core competencies present in organizations

are those that are difficult to imitate and are favored by the personal and interpersonal skills expressed by the manager. These include teamwork, ability to inform, systemic thinking, ability to work with information and technology, creativity in problem solving, communication skills, self-confidence and self-esteem[1,3,26].

Resistance, in Freire's thinking, reflects the possibility of recognizing the ability to change a given reality. Having the ability to 'bend over' to the opposing forces, but to recover and adapt – a concept of resilience – is a form of resistance; which, in turn, is directly related to liberating autonomy, which antagonizes the fatalistic, immobilizing ideology that animates neoliberal discourse in the world[30].

Conclusions

The skills described in this study are in line with other research on the subject, the DCN of the Nursing Course and the new PNAB. The emphasis given to the ability to manage inputs/materials and manage conflicts points to the need to create spaces that allow reflection and pursue the development of managerial competencies beyond the Taylorist administration aspects.

The testimonies of the participants reveal discomfort and disquiet before the double mission of nurses in the FHU, many authors agree that nurses are health professionals more prepared to assume management, a fact justified by their training in the disciplines; however, by taking over the administration of the unit, the time devoted to work processes and care is considerably reduced, often hindering comprehensive user assistance.

Even describing nursing graduation as a facility for management, the respondents question the training because they do not feel truly prepared to move between the dimensions of care, management and education required by health work, highlighting the need for continuity of the training process.

Thus, in addition, permanent education is used as a tool capable of generating changes in working conditions and resolution of technical barriers to reach and governability of the manager. In this sense, Paulo Freire's thought is extremely current. His ideas provide broad support for problematizing managers' practices and building dialogue in everyday life. There is never one who knows the other who does not know, but rather different knowledge. Therefore, if the discussion of the necessary competencies for managers goes through Permanent Health Education, there is also a clear gain in the use of Paulo Freire's thinking in this strategy.

Further research is suggested in the area of basic unit management, as managerial practice is in the process of being built, requiring improvement, change and formal recognition.

Collaborators

Fernandes JC (0000-0001-7913-9264)*, Cordeiro BC (0000-0001-6387-511X)* and Freitas DS (0000-0002-5482-0376)* also contributed to the drafting of the manuscript. Rezende AC (0000-0003-4404-4753)* contributed to the drafting and critical review. ■

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