The construction of Nursing practices: training in healthcare for diabetics in a community context

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Abstract:
In recent decades we have witnessed social and technical changes in all the sciences. Nursing is no exception, and to keep up to date one has to develop skills and practices that should derive from the training administered. In this background it is essential to question the professional practices, centring them on training in the workplace, based on the assumption that training implies the social actors in their entirety. The population selected was diabetics in the community context, researching the problem in their natural environment, which calls for integrated responses. We analyse the training dynamics that occur in the diabetes healthcare project, where the socialisation process is intertwined with health training. The methodology used was a case study. The unit of analysis was the health centre in which the project was carried out. To collect the empirical information we used participant observation, semi-structured interviews with diabetics and nurses and to complement the data we undertook a document analysis. Through this research we intend to contribute to the understanding and development of Nursing practices through an approach centred on people and their contexts.

Key words:
Informal learning, Nursing healthcare, Diabetics healthcare, Professional training.

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INTRODUCTION

This article is the culmination of an ongoing research project as part of a Masters' Degree in Education Sciences — area of specialisation in Adult Training. The dissertation (Cosme, 2004) analyses the wide-ranging and profound changes we have witnessed over recent decades in the area of health, resulting from the evolution of social construction of healthcare. This construction is no longer focused on the ailments and techniques but has evolved towards prevention and transformation of the relationship between healthcare professionals and the environment and their patients; the rapid scientific and technical evolution, as in other professional fields, calls for training designed as a catalyst for change.

In today's process of social and scientific change, Nursing is a profession that is evolving, both as regards policies and philosophies, and the relations with the healthcare benefactor. Today's problems call for the development of skills that should flow from the training process and integrate all the parties involved in the caring process, so as to promote the construction of the healthcare.

In the last decade Nursing has been the object of several studies focussing on wide-ranging aspects and leading to the obtaining of much data, with special emphasis on understanding the production of healthcare for certain patients, whereby the process of socialisation and nurse training is intertwined, enabling the development of modes of construction of healthcare and training in the workplace (Abreu, 2001; Costa, 2000).

The main topic of this research is the construction of Nursing practices in a community context. The object under study is related to the interactive training processes and Nursing practice in caring for diabetics, where much emphasis is placed on the work environment and the interactions that occur therein. We select a specific workplace, the community context, and the unit of the Lourinhã Health Centre, where a healthcare project for diabetics is run. The community was the context selected because of its high degree of complexity, thus allowing the analysis of professional practices from the professionals themselves and the patients, contextualising the different life and health situations in the socio-cultural environment. This context induces a diverse representation of Nursing healthcare: "not healthcare organised through the structure of the health centre and limited to the doctors' surgeries or treatment rooms, but rather healthcare articulated with and in the community" (Abreu, 2001, p. 211).

We selected Lourinhã Health Centre because it is running a diabetics healthcare project which is informally classified as innovative, both by the health professionals and by the diabetics, with whom we had the opportunity to contact, on a professional level, in the initial phase of the study. We chose this project because we believe that to understand the training contexts it is essential to analyse the interactions in a healthcare environment where

there are several actors who critically express and examine the practices.

We focused on a specific population — diabetics — because they are a growing group as a proportion of the population, and, according to forecasts from several bodies (WHO, INE [Portuguese National Statistics Office], DGS [Portuguese National Health Board]), this trend is likely to continue over the coming decades. These patients are heavy healthcare consumers owing to the vulnerability inherent to their physical, emotional and social problems, which has made it difficult to find answers to these problems, which do not fit into the global solutions of our health system.

As regards the social aspect the analysis of the diabetes issue becomes important owing to the dimension it has acquired in our society, the high prevalence and incidence of the diagnosis and complications, encompassing not only the diabetics, but also their families, the community and the health system itself. Taking into account all these issues, health professionals, especially those who work in the community, have to accept the challenge of the construction of integrated solutions through mechanisms of community support which respond to the diabetics' problems, built on humanised and integrated approaches

The central question of this study is as follows: What are the training dynamics that occur in the diabetics' healthcare project where Nursing practices are exercised? In studying the construction process of Nursing practices in the workplace we attempt to find out how the practices are carried out and analysed and how these are viewed by the patients.

FROM TRAINING TO CONSTRUCTION OF HEALTHCARE IN THE COMMUNITY

At the theoretical level the development of the framework of references was subdivided into two large blocks. In the first we analyse training in the workplace, more specifically the relation between training and the production of knowledge in the workplace; in a second block we reflect on the healthcare practices and their interconnection with diabetics as the main actor of this healthcare.

Training: from design to production of knowledge in the workplace

To analyse the relationship between training and the production of knowledge we focussed on the notion that training should not be limited to the most common professional training practices, teaching and learning techniques, but rather these should give way to practices that develop the learning capacities of people, groups and institutions. Failure to do so will mean the training is no more than reinforcing the predominant biomedical model, and keep the significance of health limited to the absence of disease (Honoré, 2002).

In questioning the adult training one has to overcome the schooling models and include the practices in a socialisation process, in which the individuals are simultaneously objects, subjects and agents (Lesne, 1987).

As such, the production of professional practices leads, essentially, to the process of professional socialisation, as experienced in the workplace. It is not through the accumulation of courses, knowledge or techniques that one constructs learning, but through reflection, by individuals, on their practices and an ongoing construction of their personal identity (Nóvoa, 1991).

For adults to accept the training it has to provide a concrete response to their everyday problems.

Questioning the construction of the professional practice helps us understand that training and learning is based on the notion that experience is one of the sources of knowledge that adults tap in to. According to Dominicé (1990, p. 150) it is important "(…) to return experience to the place that it deserves in acquiring the knowledge needed for existence". Therefore, the learning process has experience as its starting point for the construction of the practices.

Training contributes to the construction of professional skills, emphasising the real problems of the practice, relating them to the quality of the healthcare, in order to provide possible changes at institutional level. We question professional practice that does not reflect only isolated or abstract actions, insofar as we consider that the nurses' answer in the workplace does not involve only individual factors, but also the interactions that are established with the workplace.

To study the training of nurses in the workplace we should therefore adopt a wide-ranging perspective in order to understand its different aspects. We start with the assumption that the training of nurses views them in their entirety as social actors, where patients and professionals cross paths. We believe the concept of training defines the nature of a training path that has diffused limits, space and time in which the learning is not restricted to the instrumental logic. In other words, through informal training in context, the individual constructs him/herself professionality (Abreu, 2001).

The diabetic: from the social problem to the construction of Nursing healthcare in the community

In the second block we specifically analyse the practices of Nursing healthcare and its interconnection with the diabetic as the main target of the care. These practices are understood as a complex system of interactions, not only of repeated action, but which involves regulated and reflected action (Shön, 1996), where different actors interact every day: those that administer care (nurses), those that are cared for (patients), the workplace and all other professionals that take part in the healthcare.

In the health field it is essential that the practices are shared with the professionals' partners, who are the patients, whose expression should be encouraged and who should be listened to carefully (Honoré, 2002).

In Nursing healthcare, specifically in the community context, the interactions among the actors are important, and debate and reflection should be encouraged to formulate the aims and prepare the actions that should be implemented to achieve them, relating them to the global health mission. Hence, each person will be invited to express their particular conception of health and contribute towards the drawing up of a common path. As such the diabetic has to be a major participant in the whole process of adaptation to the disease.

To analyse the construction of Nursing practices in the healthcare of these patients it is important to have an integrating vision of the diabetic, which has to adapt to several constraints, both physical and social, to control their ailment and not to develop irreversible complications.

In 1998 in the Diabetes Dossier, the Portuguese National Health Board (DGS) defined the functions of nurses in general:

> Nurses, in addition to exercising healthcare, must provide individualised technical Nursing care, take part actively in programmes on health monitoring, promotion and education, undertaking activities that are inherent to their scientific training, geared towards vulnerable and high-risk groups (n.pag.).

These international guidelines for the treatment of diabetics emphasise the importance of action adapted to the patients' problems. The main goal of caring for a diabetes sufferer is to advise about the prevention of complications by promoting health, i.e. carry out activities to increase the health potential of these people in order to prevent serious and incapacitating complications, where caring is "helping to live" (Collière, 1989, p. 177).

METHODOLOGICAL OPTIONS: FROM THE OBJECTIVE TO THE ANALYSIS AND PROCESSING OF THE DATA

The objective of this study is focused on an attempt to understand the training dynamics that occur in the diabetic healthcare project where Nursing practices are undertaken.

The following questions were defined as guidelines: What is the role of the training devices in developing healthcare for diabetics? What is the link between experience, the workplace and construction of skills in healthcare for the diabetics? What influence do the interactions among the actors have in the development of this healthcare? What role in the healthcare project is attributed to the diabetics in the construction of the Nursing practices? What professional Nursing practices are specific to the care of these patients? What is the significance of the Nursing care practices for the diabetics? How are the training dynamics in the healthcare viewed by the diabetics?

As regards the methodological strategy, the problem devised around guiding questions points to the use of a case study, through a qualitative approach, so as to allow direct contact with the situation

and practices in the workplace which fit into a particular reality. It was our aim to understand, in depth and through direct contact, the situation and the context involved in the research and the behaviour of the actors.

The unit of analysis was a Health Centre that was undertaking a project of personalised care for diabetics. We positioned this study close to the interpretative paradigm owing to our desire to understand the social world as it is, in relation to subjective experience (Bogdan & Biklen, 1994). To understand the health problems, specifically Nursing problems, we adopted a micro approach whereby the individual was the unit. We also attempted to grasp the meaning the events and interactions took on for the common person in certain situations (Bogdan & Biklen, 1994).

To collect the empirical information we used nuclear techniques of observation of the participant and interviews. Observation took place throughout the three months for two to three hours a day, at different times of the day and also different days of the week. We observed and took part in the community appointments and actions. We finished this period when we ascertained that our presence in the field would bring no new relevant data to the research. After the first month of the period of observation we drew up the data collection tools, the interview questions, in line with the information collected in the field. Semi-structured interviews were carried out with three nurses, surveying all the nurses involved in the project, and the five diabetics, the latter constituting our intentional, non-representative sample. To select them we defined qualitative criteria: participation in the project for at least two years; interest in the prevention of the complications not restricted to the curative treatment of diabetes; physical and psychic capacities that enable communication; availability of time to hold the interview. As a complementary technique we analysed documents pertaining to the project and the Health Centre. The data analysis and processing were carried out through analysis of the content.

The implementation of the research strategies and data collection techniques required permanent reflection by the researcher, which enabled in the course of the study the demarcating and clarification of the structure through the development of the relationship with people and the context itself. This dynamic allowed the constant discovery of information that led to readjustment in the research process, by permanently comparing and analysing the data.

THE CONSTRUCTION OF NURSING PRACTICES

Throughout the undertaking of the research there was a process of (re)formulation that we intended, subsequently, to analyse in order to discover the specificities of the diabetics' healthcare, the interactions among the actors and the construction of the healthcare for diabetics.

The specificities of healthcare for diabetics

Healthcare for diabetics requires a global health approach, which is not broken down into a sum of problems, as this makes it difficult to situate each one of them. A transcultural approach to health must therefore be carried out, taking into consideration the problems of the population and their surrounding environment. The empirical data analysis allows us to see that in the healthcare administered to diabetics in the community, the nurse is in an ideal position, having access to an overall vision of the individual in his/her social context, which makes it easier to adapt the intervention to the problems of the patient.

Nurses are the people who have the most direct and constant action on the patient, and hence are authentic vehicles of educational action (Couto & Camarneiro, 2002).

By analysing the empirical data we see that there is a positive perception by diabetics regarding Nursing healthcare, which influences the image they have of these professionals and enables the building of a trustworthy relationship, so as to work in partnership in the construction of the healthcare practices. We also see that there are certain aspects of care that are important for the diabetics, the most highly valued being the relational and communicational facets. The technical healthcare was less valued by the diabetics because in the case of these patients it is not always the carrying out of an active, physical act with the hands that is of greater help for the diabetic, but rather the maintenance of a positive approach and attitude (See table 1).

Table 1
ASPECTS OF NURSING HEALTHCARE VALUED BY THE DIABETICS

NURSING HEALTHCARE	CHARACTERISTICS	EXCERPTS OF EMPIRICAL DATA
Relational	Occurs in the interactions between the nurse and the patient, in the understanding and empathy created, with the emphasis on warmth.	"A good nurse is one who makes an effort to help us, who gives his/her all!" (Interview with diabetic A)
Communicational	Arises in the interaction between the nurse and the patient based on verbal and non--verbal communication, with the emphasis on simplification and adaptation of the message and language, and use of repetition.	"In my opinion being a good nurse is giving good advice to the patient, what you should do and should not do, what you should take care with, for me that's it." (Interview with diabetic B)
Technical	Based essentially on the action of the professionals in carrying out their technical procedures.	"I think it's important to look at my feet, measure my blood pressure, the finger prick, but what's most important is to talk to me, not so much doing these tasks." (Interview with diabetic E)

The results obtained as regards the healthcare administered to the diabetics are in accordance with the results obtained by Abreu (2001), in his study on the professional identity of nurses in the community context, when he concluded that at the centre of the debate on training and assistance is always the relationship, which is referred to as the essence of primary healthcare assistance.

Based on the empirical data we see that the diabetics realise the importance of their participation in the healthcare and that it really does happen in the context of this study. These patients are informed about the healthcare and want to be well informed about its status. As stated by Honoré (2002), the patients now want to get themselves involved in the decision-making processes concerning them and the choice of treatments and measures to be undertaken. Indeed, this is a right and duty of any patient. However, at a given moment diabetics often decide not to carry out preventive healthcare, often owing to their difficulty in accepting the illness. The first thing that emerges in the mind of the diabetic is the uncertainty in relation to the future and the feeling of impotence to deal with new situations. This leads to rejection of the undertaking of healthcare. Facing up to diabetes is difficult and although not ignoring the sequence of emotional states that may simultaneously occur (shock, denial, depression, adaptation and reorganisation), it is considered that adaptation, because of the lasting effects, is the most complicated phase (Couto & Camarneiro, 2002).

In the course of the healthcare administered to diabetics, analysis and definition of the problem takes place that leads to new learning, even if not intentional or conscious by the actors — the so--called informal learning. The most valued aspect by the diabetics during the healthcare is essentially the preventive measures concerning diet, physical exercise and care of the feet. This informal learning may occur every day, at any time, when the diabetics meet and talk about health, which implies the undertaking of preventive care. Through this day-to-day learning a link is established between health and training.

These practices reinforce a holistic approach to the healthcare rather than the biomedical model. The whole experience of a health initiative opens up to its actors the possibility of exercising, in the place where they live, a health training action, thus enabling the construction of community health practices (Honoré, 2002).

Healthcare for diabetics: interaction among the actors

Healthcare for diabetics is highly complex because it induces a diverse representation of the Nursing healthcare that is not restricted to the Nursing action itself, but calls for interaction among nurses and other professionals and the patients themselves. In this

perspective, the healthcare administered in the Health Centre today demands ongoing interaction among all the actors and the surrounding environment, in order to encourage change, which will lead to the development of new ways of training in the workplace. Hence, all life contexts are considered training possibilities, in order to encourage the discovery of health, integrate the practices, involve all the partners and establish their relation to the life context.

In analysing the empirical data we see that the main goal of the interaction between nurses and diabetics focuses on the relationship of help, where there is negotiation among these actors in order to encourage articulation between the prevention of complications and the promotion of health, so as to help diabetics reorganise their lives and increase their potential for health.

According to Boavida (2001), the purpose of the interaction between the nurse and the diabetic is focused on the perspective that the patient is a unique individual that has to live with a contingency — diabetes — and therefore the patient is accompanied to teach him/her to live in a healthy manner.

The interactions in the Nursing group encapsulate potential for training of the practices, insofar as the group formalises itself in the relations established, in the rules defined, constructing knowledge in this context. To understand the interaction among the nurses in the construction of healthcare for diabetics in a community context, it is obviously important to debate and reflect on the formulation of the aims, the way in with the actions should be prepared to achieve them, relating them to the organisation's mission. This group dynamic engenders attitudes of reflection and accountability for the healthcare that allows us to question the experiences of day-to-day healthcare and certain routines. The dynamics of the group relations, as well as their cohesion, function as catalysts in the evolution of the healthcare.

As Crozier and Friedeberg (1977) state, to train is also to learn to minimise the imbalance deriving from the exercising of power through collective learning with a view to developing a collective conscious action, alternating the rules of the game and the areas of uncertainty.

Health organisations, which includes the Health Centre, are places in which groups with different statutes interact, and where a struggle for power may be taking place to strengthen the existing positions. In the healthcare administered to the diabetics this struggle is polarised in the group of nurses and doctors. In the interaction among these groups the power is present in all the activities of the action, in the form of exchanges and negotiations, where the capacity of each professional to structure the negotiation processes in their favour is shown, in order to achieve their aims; to do so, the constraints and the opportunities of the differing situations are explored, to impose the terms of negotiation favourable to their interests. Increasingly, the Health Centre nurses take on a major role with growing independence, given that there is an increase in their responsibilities, in new chronic disease situations like diabetes. The social representation of nurses is changing, which encourages a training dynamic that allows the development of Nursing Healthcare. Therefore we consider that for nurses the Health Centre represents the place with the best potential for training, given that it is "a space where they can undertake their professional project with greater independence" (Abreu, 2001, p. 212).

The construction of healthcare for diabetics

Caring for a specific population, such as diabetics in the community context, tends to constitute an emerging field of reflection. New intervention roles and healthcare practices call for innovative ways of acting, which have an influence on the lives of the actors, but also at the organisational level. In this context the undertaking of healthcare inherent to the transformation that occurs in the workplace requires knowledge that is not centred on isolated actions, but on the process of organisational production.

In the field of healthcare practices for diabetics we see that a collective dimension emerges, where the exercising of the work brings benefits akin to qualifications. In this background each individual forms and develops knowledge, influenced by his/her social space of interaction and by the practices experienced, reflected upon and shared, which have a high training and socialising potential.

This process corresponds to a collective dimension that some label organisational learning, through which a group of actors construct and mobilise, in a shared manner, theories of organisational action and frameworks of collective action (Charue, 1992).

In the healthcare administered to diabetics we ascertained that the training potential of the workplace is influenced by the relations and by the communication established among the different professionals, as a means of encouraging dialogue and reflection on the practices which in turn leads to learning. In the community context analysed, the informal and formal communication networks among nurses themselves and between the nurses and other professionals (doctors and psychologists) came to the fore, which play an important role in solving problems related to healthcare for diabetics and which allow a dynamic and creative work organisation, driving forward new organisational knowledge. Informal networks are those that are attributed most value and are most common in the healthcare, and are centred essentially on personal contact when the nurses identify the most suitable way to solve problems.

In the context of care for diabetics new ways of thinking and organising work processes arise, which call for new kinds of knowledge: teamwork, thinking on the organisational scale as a whole, acting strategically based on anticipation. Through a global, participatory and interactive training strategy, it is possible to construct a shared and consensual vision of the future of the organisation, its purposes, the means of action and the underlying values (Canário, 2000).

After analysing the empirical material we saw that training devices and dynamics arise that, in the workplace, lead to the conditions needed to enable the nurses and the diabetics to transform experience into learning. We identified a set of formal, non-formal and informal devices that allow the construction of healthcare for the diabetics (see

Table 2

CHARACTERISTICS OF THE TRAINING DEVICES THAT OCCUR IN HEALTHCARE FOR DIABETICS

TRAINING DEVICES	CHARACTERISTICS	EXCERPTS FROM EMPIRICAL DATA
Informal	Dynamics occurring in the context of healthcare administered to diabetics that have training potential, even if not conscious or intentional by the actors. They are unstructured and unorganised situations, which open up areas for analysis of healthcare practices.	"Whenever the three of us get together there is always conversation about the diabetics, either because somebody read something new in a magazine, or because of a practical case. The other day a patient appeared with hyperglycaemia, which we couldn't understand because he was taking insulin. We asked a colleague what she thought could have happened. We're always talking because sometimes it just needs a useful tip (…)" (Interview with nurse C)
Non-formal	These devices are initiatives organised with flexible content, timetables and locations. They are generally based on voluntary work which strives to build educational situations to tackle the problems of the actors. In the healthcare for diabetics these devices include: health education initiatives and periodic Nursing meetings.	We subsequently talked about the health education sessions, which the nurses were going to hold in January and which were being planned: Nurse A. — "These sessions are essentially for the patients who have been recently diagnosed with diabetes. They would not be attended only by the patient, but also the (…) person they are closest to and who will help them in their day-to-day activities (…) so we want to share their fears and concerns, which we only manage to do in a protective and highly trustworthy environment." (Participant's comment — report no. 6)
Formal	Initiatives programmed in advance, based on the teacher-student asymmetry, the existence of assessment processes and certification, and which are carried out outside the workplace.	Nurse B. — "(...) there is a programme that we think will be useful and then we go there and in the end it is completely different." (Interview with nurse B)

Table 2). This healthcare tends to be constituted in a global and articulated process in order to develop, in the actors, reflection that makes it easy to analyse the professional practices and their evolution.

The training devices tend to develop the whole process of production of knowledge, where the informal and non-formal moments are considered the most valuable by the nurses and the diabetics, with significant effects in the development of individual and collective practices. As stated by Pain (1990), the work situations have educational effects, i.e. they produce changes in behaviours of individuals or groups, are the result of individual and collective experiences and the acquisition of knowledge in action, and are not necessarily produced consciously.

In the field of Nursing practices and specifically healthcare for diabetics in the community, as in other fields of action, experience is viewed as the fundamental basis for the development of learning processes. The construction of knowledge in healthcare for diabetics is underpinned by reflection, which allows it to be reconstructed, in such a way as to question the practices and organisation of the work. The reflective experience in the context of healthcare for diabetics occurs at the individual level by the nurse, or at the collective level, centred on the interaction between nurses and diabetics, and the Nursing group. The experiences of nurses in the workplace enable them to learn. The actors learn better when the knowledge to be acquired refers to practical situations they are familiar with (Dominicé, 1990; Pineau, 1991).

In the healthcare administered to diabetics, the production of professional skills corresponds to a simultaneously individual and collective process. The skills emerging from the healthcare contexts are the fruit of a combination of individual knowledge that runs through the complexity of the workplace and the experiences of the group and the organisation.

To analyse the skills of the nurses in administering healthcare for diabetics, we used indicators identified by Costa (2000), in his study on the geriatric skills of nurses, which allow systematisation of the construction of skills in a professional path in relation to the global problem of healthcare and training in geriatric Nursing. These indicators allow interconnections to be made between what is done (Action) and what happens in the course of the action (Relation), and encompasses the reflective and implicative ability of being (To be). In healthcare for diabetics the skills related to the *To Be* dimension were highly valued by the diabetics, where the importance of the nurse being able to show a reflective ability in situations that require a relationship of help in the healthcare is seen. The skills related to the *Relation* dimension were the competences that most came to the surface, mentioned both by the nurses and the diabetics throughout the data collection process, which is linked to the fact that the Nursing is intimately a profession which should involve empathetic relations and communication with others. The skills related to the *Action* dimension were not highly valued because Nursing healthcare in the community is focussed essentially on relational aspects, where curative healthcare is not so highly valued, such as the techniques implemented (see Table 3).

Table 3

CHARACTERISTICS OF THE SKILLS THAT ARISE OUT OF THE HEALTHCARE ADMINISTERED TO DIABETICS

SKILLS	CHARACTERISTICS	EXCERPTS FROM THE EMPIRICAL MATERIAL
To be dimension	Derives from an intimate approach, less analysed, constructed through the nurse reflecting by him/herself, with other professionals, diabetics and with the surrounding environment.	D. N. — "You can see that all the nurses like what they do very much, they know how to do it and as such are a real help." (Participant's comment — report no. 12)
Relation dimension	Occurs in coming face to face with diabetics, listening to, talking to and understanding them and creating empathy.	"A good nurse makes one feel comfortable when speaking, when we feel loved." (Interview with diabetic C)
Action dimension	Arises out of what the nurse does during the interaction with the diabetic.	"A good nurse is one who measures your blood pressure." (Interview with diabetic A)

The results obtained in the context of healthcare to diabetics are in accordance with those found by Abreu (2001) in his study on the professional identity of nurses in the community context. He concluded that primary healthcare was understood as a set of activities containing a facet of assistance, a facet of a strategy or a philosophy, where the set of skills that nurses chiefly develop are relationship skills, which in itself is an indication of the nature of the work undertaken in and with the community.

OVERALL CONCLUSIONS

The main conclusions we arrived at are as follows:

- The construction of healthcare for diabetics at the community level is based on the development of a set of informal, non-formal and formal devices that are intertwined into a whole that has training potential.
- The production of professional skills in healthcare for diabetics corresponds to a process of simultaneously individual and collective reflection on experience. The skills that arise out of the healthcare context are the fruit of the combination of individual knowledge that runs through the complexity of the workplace and converges into three indicators: *To be*, *Relation* and *Action*.
- In the healthcare to administered to diabetics' groups interact that have different statuses: patients, nurses and doctors, where power is an ever-present aspect, whereby each actor shows ability to structure the negotiation processes in their favour, to achieve their aims and where the constraints and opportunities of the different situations are explored.
- The healthcare project implies the nurses and the diabetics working in partnership: targets, aims, strategies and assessment processes are defined, which make the mechanism innovative, allowing one to respond to the problems of the population in their socio-cultural context and helping the practices to evolve.
- The Nursing practices in the healthcare administered to the diabetics require a holistic vision of the patient, and therefore a transcultural approach to health is adopted, taking into account the problems of the particular population and their surrounding environment.
- In the healthcare administered to diabetics, the Nursing care is viewed in a positive light by the patients, which leads to the development of a trustworthy relationship. The most highly valued aspects of the healthcare are the relational and communicational facets, which encourage participation.
- In the healthcare administered to diabetics, dynamics occur that involve the patients in their social context and the nurses, which lead to areas of analysis and framing of problems that allow the undertaking of informal learning.

Through the line of research we followed in this article we hope to have made another contribution to understanding the healthcare practices of Nursing, allowing analysis of the ways of constructing healthcare and training in the workplace. As such, the engendering of reflections in this environment can only lead to the development and visibility of these same practices. This was the conviction that led to the writing of this text.

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