



ELEMENTS THAT INFLUENCE THE HEALTH PRACTICES OF THE ELDERLY PERSON IN PRIMARY CARE

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ABSTRACT

Objectives: to analyze the practices held in the health of the elderly person in Primary Care. **Method:** qualitative study, performed through semi-structured interviews with health professionals from a Family Health Strategy in the city of Rio de Janeiro. The data collection instrument was a script of a semi-structured questionnaire and the data analysis took place through the methodological framework of content analysis proposed by Bardin. The research project was approved by the Research Ethics Committee of the University of Rio de Janeiro and by the Research Ethics Committee of the Municipal Health Department of Rio de Janeiro under the respective opinions 1.825.251 and 2.011.914. **Results:** nine professionals were interviewed, whose answers elucidated the elaboration of the category "Knowledge as a limiting factor in health promotion" and the following subcategories: "Lack of knowledge to meet and organize elderly care in ESF"; "Professional health promotion actions based on common sense"; and "Devaluation of nursing care". **Conclusion:** it was found that, in the Primary Health Care Unit in question, the lack of knowledge limits the implementation and execution of health promotion actions for the elderly population. As a Family Health unit, the integration of health promotion with care would be a real possibility. The work of the Family Health team needs to aim for maximum user autonomy in the face of their needs.

Keywords: Health of the Elderly. Health Promotion. Family Health Strategy. Nursing Care.

INTRODUCTION

The growing aging of the world population is a demographic phenomenon that directly interferes with both social and individual issues. Aging is a dynamic process, in such a way that it is not possible to detect its beginning and end, and presents as consequences changes in the biological, physical, psychological, environmental, cultural and social spheres, leading society to face the challenge of creating actions that can integrate, value and protect the elderly citizens⁽¹⁾.

Longevity is an advance for mankind, but the extra years of life require planning so that this aging process may provide quality of life by maintaining autonomy and functional capacity. Although it is still necessary to expand the knowledge about the human aging process, it is already established that, as they present specificities, the elderly patients require a multidisciplinary team⁽²⁾. It is important to emphasize that the focus of geriatric intervention is the maintenance and/or reestablishment of the person's functionality, and not only survival.

Besides the search for quality of life, health promotion for the elderly population aims at maintaining functional capacity, autonomy, as well as physical, mental and social functioning, with a view to preventing non-transmissible chronic diseases and disabilities; and, to this end, health education must be used. This practice is understood as an educational process for the elaboration of knowledge, which will contribute to the increase of collective and individual autonomy. As an emancipatory pedagogical method, health education creates conditions for the construction of intellectual autonomy, configuring itself as a fundamental strategy to favor the improvement of the quality of life and health of the elderly people⁽³⁾.

The National Health Promotion Policy (PNPS, as per its Portuguese acronym) defines health promotion as a set of ways and methods to generate health in both individual and collective spheres. It is characterized by intrasectoral and intersectoral articulation and participation, as well as by the creation of the Health Care Network, in order to involve other existing policies and technologies to guarantee

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equity and quality of life, with direct effect on the reduction of vulnerabilities and possible threats to health, arising from economic, social, cultural, environmental and political determinants⁽⁴⁾.

In order to offer an integral care to the elderly person, it is necessary that there is joint work among the health team, the elderly patient and his/her family. The user's first contact with the health systems takes place in Primary Care, i.e., it is the entry point of easy access of the user to the health services system. Accessibility makes it possible for people to reach the health services, thus acting as a necessary structural element for primary care^(4,5). Accordingly, in 1994, the Brazilian Ministry of Health (MS, as per its Portuguese acronym) elected Family Health as a priority strategy for the reorganization of primary care, aiming at implementing the principles and guidelines of the Unified Health System (SUS, as per its Portuguese acronym). The main focus of this strategy is to place the family as a unit of programmatic health action together with the individual.

The Family Health Strategy (ESF, as per its Portuguese acronym) does not wait for the user to become ill before intervening, i.e., there is an interaction with the population, where preventive action is taken, constituting a real instrument for the reorganization of the demand. Moreover, the conceptions of integration with the community and the focus on integral care should be reinforced, thus avoiding reductionist actions in the health area, focused only on biological and medical intervention⁽⁶⁾.

The increase in the elderly people's search for health services was proved by the study carried out by Cesário, where the demand for treatment in Primary Health Care decreased from 53.2%, in 2008, to 46.2%, in 2019; even so, remaining as the main service sought by this age group, as well as the increase in the search for public or private emergency care services, ranging from 4.6%, in the 2008 National Household Sample Survey (PNAD, as per its Portuguese acronym), to 14.6%, in the 2019 National Health Survey (PNS, as per its Portuguese acronym)⁽⁷⁾. In view of what was presented, the objective was to analyze the practices held in the health of the elderly person

in Primary Care, having as a research question: which practices are held in the health of the elderly person in Primary Care?

METHOD

A descriptive exploratory research was performed, with a qualitative approach, which had the purpose of portraying the local reality. Data were collected from April to May 2017, in a Family Health Unit, located in the South Zone of the city of Rio de Janeiro. The chosen unit has three family health teams composed of a manager, a technical manager, three nurses, three physicians, three nursing technicians and eighteen community health workers.

The criteria for inclusion of the participants were: to work directly in consultations with the elderly population in the unit for more than six months and to be a physician, nurse or nursing technician. Professionals who did not work directly in consultations with the elderly population were excluded.

Three nurses, three physicians and two nursing technicians took part in the study, who met the inclusion criteria and consented to participate in the research. A semi-structured questionnaire was constructed, with the following guiding question: what practices are held in the health of the elderly person in Primary Care? In addition, the participants were asked to make a direct observation of the medical and nursing consultations.

Before starting the interviews, the researcher made a prior contact with the unit manager and the professionals who would be interviewed to find out about the interest, availability and scheduling of the start of data collection. After the verbal invitation, where all information about the research was passed on, including risks, benefits, voluntary participation and the possibility of interrupting or withdrawing from the research at any time, only one nursing technician refused to take part in the study.

Every meeting was held at the place and time previously agreed with the individual, during the working day and on the premises of the health unit, with all interviews being audio-recorded after authorization and signing of the Free and Informed Consent Form (FICF), as determined by Resolution nº 466/12 of the National Health

Council⁽⁸⁾. Participants were named with their profession and sequential numbering.

The researcher followed only seven consultations, in the direct observation modality, as she found a barrier on the part of the unit's professionals to attend the consultations. Of this total, three medical appointments and four nursing appointments. The average time of the consultations ranged between 10 and 30 minutes. Five women and two men, with an average age of 69 years and without a companion, were served. The offices have a comfortable size, air conditioning and materials needed to accomplish a consultation.

In order to process the data, the participants' speeches were accurately transcribed, with a fluctuating reading and an exhaustive rereading of the transcripts. After assessing the information, there was an approximation with the findings of the statements, from which the relevant units for the study and establishment of significant categories were extracted.

The analysis of data obtained in the interviews was performed based on the methodological framework of Bardin's thematic content analysis, which consists of a set of methodological tools in continuous improvement, used in different types of speeches. Bardin organizes data analysis into three stages: pre-analysis; exploration of the material; and treatment of results and interpretations⁽⁹⁾.

The research project was approved by the Research Ethics Committee of the University of Rio de Janeiro and by the Research Ethics Committee of the Municipal Health Department of Rio de Janeiro (SMS/RJ, as per its Portuguese acronym) under the respective opinions 1.825.251 and 2.011.914.

RESULTS

Eight professionals were interviewed, being three nurses, three physicians and two nursing technicians who work directly with elderly users. Of the total number of interviewees, only one was male. The time of work in the unit ranged from 7 months to 6 years. The average age of the professionals was 40.5 years.

During the interviews, it was identified a concern of the nurses with monitoring the

commitment of the elderly patient to the action plan outlined during the previous nursing consultation, but the development of a singular therapeutic plan was not mentioned at any time. It was verified that these professionals perform the search in the electronic medical record to proceed to the new meeting, using the clinical information system to identify previous behaviors, record current ones and check if the personal factors that interfered with the health-promoting behavior remain the same or if there have been any changes in this area that could undermine commitment to the action plan.

It was also found that nurses were able to identify the users' feelings about the behavior and the barriers they had to adopt healthier habits. Nonetheless, even with support for decisions, the identification of influences and situations that would trigger health-promoting actions, supported self-care actions were not observed. For supported self-care to take place, it is necessary to collectively develop goals, care strategies, empowerment, health education and monitoring of actions, and not only identify problems without a targeted intervention⁽¹⁰⁾.

Furthermore, there was no evidence of a design for the service delivery system and community resources.

After analyzing the interviews with professionals, the category "Knowledge as a limiting factor in health promotion" emerged, with the following subcategories: "Lack of knowledge to meet and organize elderly care in ESF"; "Professional health promotion actions based on common sense"; and "Devaluation of nursing care".

Knowledge as a limiting factor in health promotion

Knowledge is understood as the technique for verifying a given object, where verification technique corresponds to any mechanism that allows one to describe, calculate, or predict an object in a controlled manner. The object refers to any fact, aspect, property or reality susceptible to such a process. The author further defines knowledge as the possession of a particular skill applied in a defined sphere⁽¹¹⁾.

Knowledge is summarized as "searching for answers or searching for causes to know

something or everything that is understood in terms of wisdom, which, in the primordial context of Hellenic culture, encompassed scientific knowledge and practical knowledge of the art”^(11:42).

In addition to the concept of knowledge, it is necessary to pay attention to knowledge management from a holistic perspective, considering that each individual has his or her “self”, which is composed of personality, knowledge, experiences, culture, science, religion, i.e., it is a set that results in the perception of a certain fact or phenomenon, generating knowledge from its management with the “self” group⁽¹²⁾.

Lack of knowledge to meet and organize elderly care in ESF

This subcategory reveals the lack of scientific knowledge. This type of knowledge is characterized by an ordered grouping of knowledge about an object achieved through observation, its own method and the experience of events⁽¹²⁾.

By answering the following questions: “How is the care provided to the elderly citizen in this health unit? Do you use any method or do you follow any protocol to provide care to the elderly patient?”, it was found, in the speeches of the research participants, that it is important that health actions are based on scientific knowledge, in addition to the care being based on the professional’s emotions and experiences. Nevertheless, in that health unit, there is no specific care protocol for the elderly population:

I don’t follow any protocol. I only follow the protocol if he has a chronic disease, a protocol for evaluating cardiovascular disease, only. But specific to the elderly, no. (**Nurse 1**)

How does it happen? In what direction? It occurs like any other, there is no established flow. The flow is to serve the population regardless of age, we don’t have any special flow, we serve like everyone else [...] the users hardly wait and come in; so, the elderly users, they don’t have any preference, let’s say, for being elderly, right?! If that’s what you want to know, then it’s a service to the public, a service to users of the territory; and, if they are children, pregnant women, elderly

or adults, they have the same flow of service. (**Physician 2**)

Professional health promotion actions based on common sense

This subcategory differs from the previous one, since research participants use common sense and not scientific knowledge.

Santos conceptualizes common sense as a “hierarchical distinction between scientific knowledge and common knowledge will tend to disappear and practice will be doing and saying will be practical philosophy”. The same author says that modern science was elaborated as being in opposition to common sense, considering it “superficial, illusory and false”, and that postmodern science appeared to legitimize the relevance of common sense, pointing to the power that it has to enhance the relationship of human beings with the world. Common sense also produces knowledge, even if it is “mystified and mystifying knowledge”, and this generated knowledge can be enhanced through dialogue with scientific knowledge⁽¹³⁾.

There needs to be an epistemological break contrary to that which happened in modern science, i.e., instead of moving away from common sense to reach a qualitative level for scientific research, it is necessary to bring this knowledge closer to the knowledge of common sense, since postmodern scientific knowledge only shows itself as such as it becomes common sense, and it cannot be denied that scientific knowledge arises from common knowledge⁽¹³⁾.

The first speech highlights the use of common sense by nurses when providing guidance to the family, while the second shows the use of common sense by professionals to serve the elderly population:

Thus, I have some things that I teach to families, that I ask them to observe, that I learned from everyday life, it wasn’t college that taught me, it was everyday life. (**Nurse 3**)

Our unit has a lot of elderly patients, we asked the NASF (Family Health Support Center) to even have a geriatrician, right?! [...] And, if there isn’t one at NASF, at least there (at CAP[Psychosocial Service Center]), I was the first to have this support, they (the unit’s doctors) are serving, going and learning according to their practical experience, you know?! (**Nurse 2**)

Devaluation of nursing care

By not valuing the nursing work, especially the knowledge of gerontological nursing, the research participants point to a lack of political knowledge in the field of ESF.

The first speech emphasizes the elderly care without respecting the specificities of this audience. The second portrays the devaluation of gerontological nursing care. In the third speech, the nursing technician recognizes the importance of the nursing consultation:

The elderly patient, if he has a chronic disease, he will follow a different protocol, like, if he's hypertensive, diabetic, yes, it could be every three months, four months, six months. If he doesn't have any chronic disease, doesn't have any specific health problem, the appointment is once a year. **(Nurse 1)**

Here? I think that here it could improve for us, it was for us to have a geriatrics NASF (Family Health Support Center), in order to perform matrix support with us, right [...] that guy who [...] is really a geriatrician, ok? Preferably, a specialist doctor, not a nurse [...] a geriatrician NASF (Family Health Support Center). **(Nurse 3)**

[...] most here want to see the doctor, they don't want to see the nurse during a consultation. Unfortunately, there is still this prejudice with nursing, which shouldn't be, right?! The nurse is as qualified as the doctor to be able to provide care. This is the main complaint, "but why the nurse? Can't it be with the doctor? I want with the doctor!". Then, it get's hard, right?! **(Nursing Technician 2)**

DISCUSSION

The study showed that professionals are aware of the predominance of chronic diseases and comorbidities among the majority of the elderly served in the unit in question. However, it was noted a gap in knowledge among the study participants about care models that would enable more objective, targeted and systematized service.

In this sense, the Chronic Care Model is a model that has been used in Primary Care to systematize care aimed at strengthening users' confidence and developing skills, so that they can manage their chronic condition. This

model reinforces the importance of developing a care plan for the user and carrying out frequent monitoring, in addition to offering adequate treatment for disease control, disease prevention and health promotion. The establishment of a bond between the user and the professional is essential for the success of any planning held⁽¹⁴⁾.

Another gap verified was the lack of any theory supporting the nursing consultations. This gap is worrisome, as the use of models and theories facilitates the understanding of the determinants of health problems and points out solutions capable of responding to the needs and interests of the people involved, besides the fact that they are a reference for all areas of nursing practice⁽¹⁵⁾.

One of the most used nursing theories in Primary Care is Nola Pender's health promotion model, which articulates nursing theories and behavioral theories. This model is intended to understand the main health determinants for behavioral counseling, with a view to promoting healthy lifestyles and thus achieving desired outcomes. Accordingly, the professional is able to assess, plan and intervene by using health promotion strategies as a basis for structuring protocols and nursing interventions⁽¹⁶⁾.

Regarding the fact that professional health promotion actions are based on common sense, it is necessary to discuss positive and negative aspects. Santos states that modern science was designed as an opposition to common sense, considering it "superficial, illusory and false", and that postmodern science appeared to legitimize the relevance of common sense, pointing out the power that it has to enhance the relationship of human beings with the world. Common sense also produces knowledge, even if it is "mystified and mystifying knowledge", and this generated knowledge can be enhanced through dialogue with scientific knowledge^(13: 88-89).

Postmodern science, when "fails to communicate", does not despise the knowledge that results in technology, but understands that, as knowledge must be transformed into self-knowledge, technological development must, in turn, become the wisdom of life^(13:91).

Approaching common sense with scientific knowledge can be risky, even though each individual's knowledge and experience are

unique. Nevertheless, it cannot be denied that both common sense and science are constituted in different contexts, but that they can also be complementary⁽¹⁷⁾.

With common sense as its own cultural good, scientific knowledge consists of a universal public good that enables interpersonal and social relationships, as well as the advent of new popular knowledge. Accordingly, it is possible to understand that the relationship between scientific knowledge and common sense is a two-way street⁽¹⁸⁾.

Thus, it is necessary that health professionals recognize the link between science and common sense, from a philosophical perspective, so that, using the two existing knowledge, it is possible to construct new knowledge and use it in their work routine. It is argued that “the hierarchical distinction between scientific knowledge and common knowledge will tend to disappear and practice will be doing and saying will be practical philosophy”^(13:20).

According to the speeches referring to the subcategory “Devaluation of nursing care”, nurses care for the elderly citizen in the same way they care for any other user, without taking into account the specificities of age and based only on the pathology, whether hypertension, diabetes or any other chronic condition.

The role of the nursing professional in the context of ESF is vast, since it covers the management of the nursing team and community health workers, managerial activities and user care. In the latter case, care is provided through home visits, nursing consultations and actions taken in the community, and this care must be focused on all stages of human development, which includes health care for the elderly person.

When nurses, who work in the context of ESF, act out together with the community and the family in the health of the elderly person, they are able to identify potential damage to the health of the elderly patient and, therefore, develop participatory and efficient actions, either collectively or individually, which promote a healthy life and aging process⁽¹⁹⁾.

In Primary Care, gerontogeriatric nurses direct their care towards the peculiarities of elderly patients, thus following an ethical behavior, being able to establish relationships

and generating bonds with the elderly citizens, their relatives and the community where they are inserted. The objective is to find resources to solve problems and, consequently, improve the well-being and quality of life of the elderly citizen, and this happens through an action that is interactive, proactive, based on conversation and knowledge sharing, developed by the professional with the user, with the environment in which he/she is inserted and his/her family nucleus⁽¹⁹⁾.

The function of gerontological nursing is to provide integral care to users and their relatives. In order to achieve this objective, its practice has as its main goals: to promote a healthy life; to compensate limits and incapacities; to support and control the course of aging; to offer specific treatments and care; and to facilitate the care process⁽¹⁹⁾.

Above all, the nurse, as a member of the health team, has the duty to know the reality of the families in the physical, mental, demographic and social areas, in order to guarantee continuous and integral care to all members. Thus, nurses can offer a social support network for the elderly patient based on humanized care with guidance, monitoring and home support, always respecting the local culture and the peculiarities of aging⁽⁶⁾.

FINAL CONSIDERATIONS

The results of this research highlighted that, at the Primary Health Care Unit (UBS, as per its Portuguese acronym) in question, knowledge gaps limit the implementation and execution of specific health promotion actions for the elderly population. As a unit of the ESF network, there would be a real possibility of integrating health promotion with care, since the health teams in Primary Care, especially Family Health teams, have important tools to provide humanized care. Regarding the elderly citizens, the work of the Family Health team must seek the maximum autonomy of these users regarding their needs. Nonetheless, the strong presence of the biomedical model in the practices of professionals in the studied unit makes it difficult to implement health promotion actions.

The objectives were achieved, but this study presented as a limitation the difficulty, imposed

by the limits of the research itself, by some participants, with respect to the direct observation of medical and nursing consultations. Another limitation of the research is that the authors' investigation design only allowed access to the perspective of the professionals interviewed in this unit located and presents, as a resolution of this issue, the expansion of the design to other units.

The health team acts reactively (and not proactively), with actions based on the biomedical model. This procedure undermines the creation of a bond with the user and, as a consequence, a commitment to the action plan is not established, as the user does not feel that he/she is a participant in this plan. Therefore, the

process that generates active and informed users does not take place completely. The expected result of this process is the stagnation or worsening of the clinical and functional status due to the fact that the user has not performed an active health-promoting behavior.

The research data show a difficulty in the system, especially in Primary Care, to perform its function as an orderer and coordinator of care, which represents a national problem. Given the above, there is a marked need to establish a continuing education program that addresses from the basic principles of SUS, through the importance of health promotion, to the specificities of care for the elderly population.

ELEMENTOS QUE INFLUENCIAM NAS PRÁTICAS EM SAÚDE DO IDOSO NA ATENÇÃO BÁSICA

RESUMO

Objetivos: analisar as práticas realizadas na saúde do idoso na Atenção Básica. **Método:** estudo qualitativo, realizado por meio de entrevista semiestruturada com profissionais de saúde de uma Estratégia Saúde da Família, no município do Rio de Janeiro. O instrumento de coleta de dados foi um roteiro de um questionário semiestruturado e a análise dos dados ocorreu mediante referencial metodológico da análise de conteúdo, proposta por Bardin. O projeto da pesquisa foi aprovado pelo Comitê de Ética em Pesquisa da Universidade do Rio de Janeiro e pelo Comitê de Ética em Pesquisa da Secretaria Municipal de Saúde do Rio de Janeiro sob os respectivos pareceres 1.825.251 e 2.011.914. **Resultados:** entrevistaram-se nove profissionais cujas respostas elucidaram a elaboração da categoria "O conhecimento como limitador da promoção da saúde" e das seguintes subcategorias: "Falta de conhecimento para atender e organizar o atendimento ao idoso na ESF"; "Ações profissionais de promoção da saúde pautadas no senso comum"; e "Desvalorização do cuidado de Enfermagem". **Conclusão:** evidenciou-se que, na Unidade Básica de Saúde em questão, a falta de conhecimento limita a implantação e a execução de ações de promoção da saúde à população idosa. Sendo uma unidade da Saúde da Família, seria uma possibilidade real a integração da promoção da saúde com o cuidado. O trabalho da equipe de Saúde da Família necessita objetivar o máximo de autonomia dos usuários perante suas necessidades.

Palavras-chave: Saúde do Idoso. Promoção da Saúde. Estratégia Saúde da Família. Cuidados de Enfermagem.

ELEMENTOS QUE INFLUYEN EN LAS PRÁCTICAS EN SALUD DEL ANCIANO EN LA ATENCIÓN BÁSICA

RESUMEN

Objetivos: analizar las prácticas realizadas en la salud del anciano en la Atención Básica. **Método:** estudio cualitativo, realizado por medio de entrevista semiestruturada con profesionales de salud de una Estrategia Salud de la Familia (ESF), en el municipio de Rio de Janeiro-Brasil. El instrumento de recolección de datos fue un guion de un cuestionario semiestruturado y el análisis de los datos ocurrió mediante referencial metodológico del análisis de contenido, propuesto por Bardin. El proyecto de investigación fue aprobado por el Comité de Ética en Investigación de la Universidad de Rio de Janeiro y por el Comité de Ética en Investigación de la Secretaría Municipal de Salud de Rio de Janeiro bajo los respectivos informes 1.825.251 y 2.011.914. **Resultados:** se entrevistaron nueve profesionales cuyas respuestas dilucidaron la elaboración de la categoría "El conocimiento como limitador de la promoción de la salud" y de las siguientes subcategorias: "Falta de conocimiento para atender y organizar la atención al anciano en la ESF"; "Acciones profesionales de promoción de la salud basadas en el sentido común"; y "Desdén por el cuidado de Enfermería". **Conclusión:** se evidenció que, en la Unidad Básica de Salud en cuestión, la falta de conocimiento limita la implantación y la ejecución de acciones de promoción de la salud a la población anciana. Siendo una unidad de la Salud de la Familia, sería una posibilidad real la integración de la promoción de la salud con el cuidado. El trabajo del equipo de Salud de la Familia necesita fomentar el máximo de autonomía de los usuarios ante sus necesidades.

Palabras clave: Salud del Anciano. Promoción de la Salud. Estrategia Salud de la Familia. Atención de Enfermería.

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