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ORIGINAL ARTICLE

HEALTH CARE FOR HYPERTENSIVE AND DIABETIC PEOPLE: NURSES' PERCEPTION

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ABSTRACT

Objective: to know the nurses' perception in relation to care for people with hypertension and/or diabetes in Primary Health Care (PHC). **Method:** this is a qualitative, descriptive and exploratory research, developed with 14 nurses linked to municipalities of a regional health of Paraná/ BR. Data collection took place in September 2021 through the participatory technique entitled Integrated Panel, from four guiding questions, mediated by three teachers and four students. The data were transcribed and submitted to interpretative analysis. **Results:** six topics of interest were identified: Care strategies; Organization of nursing consultations; Challenges for conducting nursing consultation; Potential for conducting nursing consultation; Challenges of the Care Network the Chronic Conditions; and Potentialities of the Care Network the Chronic Conditions. **Final thoughts:** nurses' perception about the care of hypertensive and diabetic people is given by programmed and spontaneous actions aimed at glycemic and blood pressure control. Nursing consultations usually occur prior to medical consultation and without systematization. Moreover, nurses recognize their importance in this context, but routine and high demand are challenges to be overcome to improve the practice.

Keywords: Hypertension. Diabetes mellitus. Nursing care. Primary health care.

INTRODUCTION

Chronic diseases with higher incidence and morbidity and mortality rates in the country are Diabetes Mellitus (DM) and Systemic Arterial Hypertension (SAH). The progressive increase of these diseases is related to social, economic and technological factors, such as increased life expectancy, change in life habits and access to diagnostic and treatment services. Chronic diseases affect all age groups, but this occurs more expressively in the elderly, and cause a high number of deaths, injuries and complications, influencing the demands of health services[1].

The evolution of chronic diseases can be controlled and complications minimized if the health system is organized for the care of this public, with primary health care (PHC) being the primary *locus* for this care[1]. However, for greater resolution, users and professionals need support services, organized through care networks for chronic diseases, in order to expand care, and ensure its integrality and longitudinality of care at different levels of care[1].

Such a model of care is essential for the reduction/improvement of indicators, but its implementation requires financial and political support from all entities, as well as a trained and

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engaged multidisciplinary team to build the process of change[2]. Despite the advances in PHC services, the organization of care is still fragmented and fragile in the integration with the different levels of care, being ineffective in the care of people with hypertension and diabetes, who need continuous, proactive and integrated monitoring [3].

Thus, the systematized care to patients with chronic conditions is essential to control the disease, prevent injuries and promote the health of UHS users, and nurses play an essential role in this process. Thus, the research was based on the following guiding question: How does the care of people with chronic conditions in PHC occur, according to nurses? Thus, the study aimed to know the nurses' perception in relation to care for people with systemic arterial hypertension and diabetes in PHC.

METHOD

Descriptive and exploratory research, with a qualitative approach, developed with 14 nurses working in the PHC of municipalities belonging to a regional health in the northwest of the state of Paraná/BR. The convenience sampling was chosen: 65 nurses working in a regional health were invited to participate in the study, but only 14 expressed interest. The invitation was sent by email and in groups of messaging applications. The inclusion criterion was: to work for more than six months in PHC, and exclusion, not to perform care actions for patients with chronic conditions.

Data were collected through the participatory technique entitled Integrated Panel[4], which enables reflection, interaction and autonomy of participants. A workshop was held in September 2021, lasting two hours. The discussions were based on four guiding questions, namely: 1. How are hypertensive and diabetic patients treated in your UBS? 2. What are the challenges and potential of the care network for chronic conditions in its reality? 3. How do nursing consultations occur in your UBS? 4. What are the challenges and potential of nursing consultation in your reality? Craft paper posters with about 80cmX100cm were used, as well as colored pens. The workshop was organized and mediated by three nursing professors and four students.

According to the technique used[4], the activities occurred in four stages. In the first, there was the organization of 14 nurses and six members of the research team, in four groups, each with five people. In the second stage, each group received a poster, which contained a guiding question, then all participants were encouraged to share their perceptions and experiences[4] about the issue, and record the group's discussions in the poster. After about ten minutes, the groups exchanged the posters, until all discussed the four guiding questions, thus the participants received the posters with the records of the previous groups, allowing understanding the conceptions of the other groups.

In the third stage, the group had to organize all the information presented in a written form on the poster, synthesizing group understanding about the theme. In the fourth stage, each group presented and discussed critically and reflexively the answers on the last guiding question they received. The research team member who did not participate in the groups organized the activity and mediated the final presentation. The other team members integrated the groups and assisted in the activity, without interfering with the responses. Furthermore, this step was used to analyze interpretatively[5] and validate by the participants themselves the answers to each guiding question, which were recorded in topics in order to facilitate the understanding of the topics discussed, and are presented in chart.

The records of the groups were transcribed and submitted to interpretative analysis[5], elaborated based on the most significant and representative information to the study objectives, seized by the group. Due to the data collection technique, it is possible to analyze group perceptions, not individual ones. The technique followed was the Consolidated Criteria for Reporting Qualitative Research (COREQ) to organize the study.

The research is part of a larger project, entitled: Telemonitoring in the Care Network for Chronic Conditions as a resource to support self-management of the disease by people with diabetes mellitus and hypertension, which was approved by the Human Research Ethics Committee of the signatory institution (Opinion n. 4,518,312), and followed all the ethical

precepts of resolutions n. 466/2012 and n. 510/2016 of the National Health Council, by signing the informed consent form by the participants and researchers. To ensure the anonymity of the participants, the data are presented in general, without individual identification.

RESULTS

The participants were 14 nurses, 12 female and two male, most are married and aged between 27 and 54 years (mean 35 years), belonging to six municipalities linked to the regional health of the state of Paraná/BR. Concerning professional performance, all have specialization and one has a master's degree, are graduated between 6 and 28 years (average 10 years) and work on average for seven years in basic unit.

The attention to users with chronic conditions in PHC occurs in an articulated way with the care network possessing potentialities and challenges, being the professional nurse essential in this process, according to the perspective of the participants of this study, which synthesized their perceptions in topics of interest related to health care for chronic patients (Chart 1).

Chart 1. Nurses' perspective regarding care for patients with chronic conditions in PHC and in the care network. Paranavaí, Paraná, Brazil, 2021.

Guiding Question	Topics of interest in the care of patients with chronic conditions from the perspective of nurses
Strategies of care for hypertensive and diabetic patients in the Basic Health Unit	*Appointment scheduling for people with diabetes and hypertension;* *Global cardiovascular risk stratification;* *Request for follow-up exams;* *Evaluation of the therapeutic response;* *Assessment by the nurse of the foot of the user with diabetes;* *Monitoring of users, if necessary;* *Home consultation (carried out by a higher education professional);* *Home visits to control blood pressure and blood glucose (carried out by nursing technicians and community health agents);* *Hiperdia meetings [Group of hypertensive and diabetic patients];* *Educational actions for the prevention of complications;* *Nursing and medical consultation;* *On-demand service, especially for acute cases.*
Organization of nursing consultations in the basic health unit	*Free demand in the morning and scheduled in the afternoon for specific groups.* *In scheduled service for priority groups.* *In the triage (in an informal way) where the anamnesis takes place, the user's history, the complaints presented and vital signs are collected.* *During the application of the stratification instruments, through physical examinations and guidance in relation to complaints and habits.* *Routine adaptation for sorting and classification according to operational availability.*
Challenges for carrying out the nursing consultation in your reality	*Continuity of follow-up.* *Biomedical health model;* *Patient adherence to treatment;* *Deconstruction of the 'myths' apprehended through the media;* *Duality of roles: unit management and assistance;* *Routine/Time;* *Adequacy of the number of teams for population demand;* *Operational capacity.*
Potential for carrying out the nursing consultation in your reality	*Reduction of risk of injuries;* *Improved quality of life.* *Health promotion;* *Systematized care planning;* *Capacity of persuasion and creativity of the professional.* *It provides the formation of bonds;* *Recognition of the population profile and its needs;* *Optimize the use of resources;* *Provides popular health education.*

Challenges of the Chronic Conditions Care Network in its reality	*Resources;* *Professional turnover;* *Qualified professional;* *Idiosyncrasy;* *Time;* *suitable location;* *Health literacy;* *Adherence to treatment;* *Communication.*
Potential of the Chronic Conditions Care Network in its reality	*Referral to specialties;* *Access to technologies for care and communication;* *Routing of stratifications;* *Care centered on the coverage area;* *home visits;* *Educational actions through conversation circles;* *Nursing consultation and autonomy;* *Professional qualification.*

Source: created by the authors (2021).

The care of patients with chronic conditions in the health unit, according to the nurses, occurs in a programmed way, through scheduling of medical and nursing consultations, performing actions such as risk stratification, evaluation, groups, monitoring and control of blood glucose and blood pressure. Such actions are carried out both in the health unit and in the individual's home, as well as the spontaneous demands. It should be noted that the services are performed by all members of the primary care team, especially by members of the nursing team.

Regarding nursing consultations, the study nurses reported that they are not systematized and usually occur associated with screening for medical consultation, because patients do not always have interest in scheduling consultation with the professional nurse, participants take advantage of contact with the patient for screening and perform the consultation. During the consultation is performed stratification of the user, anamnesis and physical examination. This type of care is usually performed in the afternoon, and organized for specific groups according to disease or life cycle: elderly, pregnant women, children, users with chronic conditions, among others.

Furthermore, nurses recognize consultations as an effective strategy for the prevention and health promotion of the hypertensive or diabetic individual, through the systematization of care, the promotion of health education and self-care. It also enables the optimization of resources, expansion of access and creation of links, affecting the care provided and health conditions of people living in the area of coverage of the team, through detailed knowledge of the reality and the needs of residents.

However, the participants point out several challenges for the consultations, especially related to the organization of work, such as the routine that combines management and assistance actions and high population demand, which weakens the continuity of care and frequent monitoring. Another challenge is user-related factors, such as low adherence to prescriptions and recommendations, and non-recognition of nursing consultation as a care strategy, both by patients, other staff members and managers; which comprise the consultation centered on the medical professional.

For the longitudinality and completeness of care for people with hypertension and/or DM, they sometimes need to access health services from other levels of care, so the network of care for chronic conditions is essential. In this sense, the nurses participating in the study reported that they have autonomy for the referral of users with chronic conditions for care with a multiprofessional team after performing the stratifications.

They also highlighted as potential for care the realization of educational actions with users, the possibility of home visits, monitoring of residents in the area covered by the unit, and the use of technologies such as communication and information applications. This fact operationalizes and puts into practice the care network, ensuring integrality and resolution of care.

Finally, it is emphasized that the use of a participatory technique as the integrated panel proved effective to identify the perceptions of nurses in relation to care for chronic conditions, by stimulating the sharing of attitudes and realities, as well as exchange of ideas, values and experiences; still stimulates autonomy and motivates the participation of those involved.

DISCUSSION

Users with chronic conditions need adequate management of the underlying disease, which in turn depends on the articulation of various activities, such as educational actions, in order to empower the user in relation to their health condition (diagnosis) and respective treatment, as well as performing risk stratification for the underlying disease and its comorbidities, multiprofessional care and articulation of PHC with the Health Care Networks[6,7].

For the proper articulation of these actions, professionals need constant qualification through actions of continuing and permanent health education, in order to bring the different levels of care and the broad understanding of the flow and care to the specificities of people with chronic conditions[6,7].

The specific and frequent demands and complaints of users in health services can hide a more complex need for care, especially in those with chronic diseases. This is because the individual demands involve several biopsychosocial issues, which can only be perceived and understood by the health professional who has a link with the user and a broader view of the health-process which can be apprehended through home visits and monitoring of indicators in the coverage area[6].

Another strategy for comprehensive care is the nursing consultation, which is an effective health intervention, simple method, easy to apply and low cost, not compromising the budget and physical resources of health institutions. In this scenario, it is important to highlight that the consultation is part of the nursing process, which, through a structure and systematic sequence, is composed of: nursing history, physical examination, survey of nursing diagnoses, preparation of the care plan and its evaluation[9].

The integral and longitudinal care provided by the nursing consultation ensures the professional nurse better monitoring the evolution of patients, assisting in their decision-making over time, which will ensure health promotion, prevention of diseases and rehabilitation of the user[9].

However, for its execution, it is necessary that the professional have scientific knowledge, technical preparation, critical thinking, holistic look and cognitive abilities, interpersonal and psychomotor skills, as well as time for such activity. Thus, consultations are consistent with the principles of the UHS and allow the identification of the real health needs of the individual and their community[8].

Thus, the nursing consultation is an important instrument for the nurse's work process, since it allows access to indispensable information about the patient, besides representing opportunity for the user to clarify doubts. From these data, a care plan for maintenance and control of chronic disease can be developed, ensuring individualized and quality care[10,11].

In this scenario, it is important to highlight that the nursing consultation focused on chronic conditions in PHC is a support tool for FHS teams, as it contributes to the management and control of the disease, prevention of diseases and knowledge about the disease. Such actions promote the development of self-care, co-responsibility for one's own health, increased longevity and quality of life of individuals with chronic disease[8].

Thus, the nursing consultation to the individual diagnosed with chronic conditions such as hypertension and/or DM is a fundamental tool for achieving positive results and controlling the disease. Such action generates benefits to the individual, due to the control and management of the disease by health professionals, reducing the rates of complications, hospitalizations and health expenditures, and increasing the quality of life[8,11].

Despite the numerous challenges that permeate the implementation of nursing consultation, its effectiveness is duty and ethical and legal responsibility of the nurse, being certified by formal registration of data. Complete annotations provide quality and safety in patient

care, as well as validate the provision of care[12].

Therefore, the nursing consultation becomes a stage for access to the care network for chronic conditions in the regional health. However, nurses pointed out difficulties for its implementation, due to: communication failures, low patient adherence and still organizational difficulties, such as: lack of resources, high turnover of professionals and unavailability of time[12].

Nevertheless, the care network is conceptualized as "organizational arrangements of actions and health services of different technological densities that, integrated through technical, logistical and management support systems, seek to ensure the integrality of care"[13]. In this sense, the care network must operate in a polyarchic, cooperative and interdependent manner, constantly ensuring the reference and counter-reference of its users, without hierarchy between the points of health care and focusing on integral care, preventive, problem-solving and longitudinal[14].

Among the difficulties in implementing health care networks[2] study conducted in a health region of the Northwest in the state of Paraná described the confrontations experienced by managers during the implementation of the Model of Care for Chronic Conditions in the state of Paraná/Brazil[2]. This research pointed out the following needs: collaboration and encouragement of local managers, permanent health education and awareness of the professionals involved in all stages of the process. It also highlights that the implementation demands the provision of hospital care, in order to ensure continuity of care and health care at the levels of greater complexity[2].

Thus, in order to effectively implement the care network in the context of chronic conditions, it is necessary to change the work process of health professionals with regard to care planning and organization of the care network[2]. The work process should be designed, organized and structured based on the health needs of the target population, systematizing data such as the incidence and prevalence of chronic cases in order to ensure comprehensive, problem-solving and humanized care[1-3].

This research has as a limitation the time of data collection, and more contacts with participants can enable a broader and deeper understanding of the problem. Studies need to be developed in order to strengthen nursing consultations, their intensified teaching in the context of the training of professional nurses, as well as their dissemination in order to expand the recognition of their importance and impact on the health of individuals, as well as the qualification of the care network for chronic conditions.

FINAL CONSIDERATIONS

The care for users with chronic conditions in the health unit occurs both in scheduled and spontaneous actions, is performed by all members of the PHC team, and is based on stratifications and control of glycemic and blood pressure levels.

Nursing consultations are not systematized and occur combined with screening for medical consultation. However, nurses recognize them as a relevant strategy for prevention and health promotion, with routine, high demand and non-recognition of it as challenges for its implementation.

In the scope of PHC, the need to create a bond between professionals and individuals and the effective practice of health communication, as well as the reference and counter-reference between services, is also highlighted. Such actions can ensure the effective participation of the parties involved in the process of care and continuity of health care in a longitudinal way, seeking to solve the challenges of implementing the care network.

Concerning the care network, an important strategy for comprehensive care for people with hypertension and/or diabetes, nurses report difficulties related to communication between levels of care, patient and organizational adherence, regarding the flow of care. On the other hand, they pointed out as potentialities for its effectiveness the autonomy of nurses for referral to the care network, risk stratifications, qualification of professionals, service by specialists and multidisciplinary team.

ATENDIMENTO DE SAÚDE À PESSOAS HIPERTENSAS E DIABÉTICAS: PERCEPÇÃO DE ENFERMEIROS

RESUMO

Objetivo: conhecer a percepção de enfermeiros em relação à atenção às pessoas com hipertensão e/ou diabetes na Atenção Primária a Saúde (APS). **Método:** trata-se de pesquisa qualitativa, descritiva e exploratória, desenvolvida com 14 enfermeiros vinculados a municípios de uma regional de saúde do Paraná/BR. A coleta dos dados ocorreu no mês de setembro de 2021 por meio da técnica participativa intitulada Painel Integrado, a partir de quatro questões norteadoras, mediadas por três docentes e quatro discentes. Os dados foram transcritos e submetidos a análise interpretativa. **Resultados:** foram identificados seis tópicos de interesse: Estratégias de atendimento; Organização das consultas de enfermagem; Desafios para a realização da consulta de enfermagem; Potencialidades para a realização da consulta de enfermagem; Desafios da Rede de Atenção as Condições Crônicas; e Potencialidades da Rede de Atenção as Condições Crônicas. **Considerações finais:** a percepção dos enfermeiros sobre o atendimento às pessoas hipertensas e diabéticas se dá por ações programadas e espontâneas que visam ao controle glicêmico e pressórico. As consultas de enfermagem usualmente ocorrem previamente à consulta médica e sem sistematização. Desvelou-se também que os enfermeiros reconhecem sua importância nesse contexto, porém a rotina e a alta demanda se constituem como desafios a serem vencidos a sim de melhorar a prática exercida.

Palavras-chave: Hipertensão. Diabetes mellitus. Cuidados de enfermagem. Atenção primária à saúde.

ATENCIÓN DE SALUD A PERSONAS HIPERTENSAS Y DIABÉTICAS: PERCEPCIÓN DE ENFERMEROS

RESUMEN

Objetivo: conocer la percepción de enfermeros con relación a la atención a las personas con hipertensión y/o diabetes en la Atención Primaria de Salud (APS). **Método**: se trata de investigación cualitativa, descriptiva y exploratoria, desarrollada con 14 enfermeros vinculados a municipios de una regional de salud de Paraná/Brasil. La recolección de los datos ocurrió en el mes de septiembre de 2021 por medio de la técnica participativa titulada Panel Integrado, a partir de cuatro cuestiones orientadoras, mediadas por tres docentes y cuatro discentes. Los datos fueron transcriptos y sometidos al análisis interpretativo. **Resultados**: se identificaron seis tópicos de interés: Estrategias de atención; Organización de las consultas de enfermería; Desafíos para la realización de la consulta de enfermería; Potencialidades para la realización de la consulta de enfermería; Desafíos de la Red de Atención a las Condiciones Crónicas; y Potencialidades de la Red de Atención a las Condiciones Crónicas. **Consideraciones finales**: la percepción de los enfermeros sobre la atención a las personas hipertensas y diabéticas se da por acciones programadas y espontáneas que tienen como objetivo el control glucémico y presórico. Las consultas de enfermería generalmente ocurren previamente a la consulta médica y sin sistematización. Se reveló también que los enfermeros reconocen su importancia en ese contexto, pero la rutina y la alta demanda se constituyen como desafíos a vencer a fin de mejorar la práctica ejercida.

Palabras clave: Hipertensión. Diabetes mellitus. Atención de Enfermería. Atención Primaria de Salud.

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