



EVALUATION OF THE KNOWLEDGE OF CHRONIC RENAL PATIENTS IN CONSERVATIVE TREATMENT ABOUT DIALYTIC MODALITIES

AValiação DO CONHECIMENTO DO PACIENTE RENAL CRÔNICO EM TRATAMENTO CONSERVADOR SOBRE MODALIDADES DIALÍTICAS

EVALUACIÓN DEL CONOCIMIENTO DEL PACIENTE RENAL CRÓNICO EN TRATAMIENTO CONSERVADOR SOBRE MODALIDADES DIALÍTICAS

Renata Laís Gouveia Santos¹, Diego Rafael Ferreira de Oliveira², Marília Gabrielle Santos Nunes³, Rodrigo Moraes Pereira Barbosa⁴, Viviane de Araujo Gouveia⁵

ABSTRACT

Objective: to evaluate the knowledge of patient chronic kidney in treatment about dialytic modalities and substituted therapies. **Method:** descriptive and cross-sectional study performed in an outpatient clinic of Nephrology of a hospital in Recife/PE, with 80 patients submitted to conservative treatment. The data collection was held in the period of July and August 2013. The data were analyzed in SPSS 18.0 software. The research was approved by the Ethics Committee in Research, CAAE number 17403113.8.0000.5200. **Results:** there was a predominance of 52.5% with restricted and insufficient knowledge about the disease; 32.5% responded correctly about conservative treatment; and 41.25% know that chronic kidney disease is a disease without a cure. **Conclusion:** the results showed insufficient knowledge by most participants, requiring the expertise of health professionals promoting the interdisciplinary approach encompassing health education measures. **Descriptors:** Knowledge; Dialysis; Kidney Diseases; Therapy.

RESUMO

Objetivo: avaliar o conhecimento do paciente renal crônico em tratamento sobre as modalidades dialíticas e terapias substitutivas. **Método:** estudo descritivo, transversal, realizado em um ambulatório de nefrologia de um hospital do Recife/PE com 80 pacientes submetidos ao tratamento conservador. A coleta foi realizada no período de julho e agosto de 2013. Os dados foram analisados no software SPSS 18.0. A pesquisa foi aprovada pelo Comitê de Ética em Pesquisa, CAAE nº 17403113.8.0000.5200. **Resultados:** houve predominância de 52,5% com nível de conhecimento restrito e insuficiente quanto aos saberes sobre a doença; 32,5% responderam corretamente sobre o tratamento conservador; e 41,25% sabiam que a doença renal crônica é uma doença sem cura. **Conclusão:** os resultados mostraram conhecimento insuficiente pela maior parte dos participantes, sendo necessária a atuação do profissional da saúde promovendo a abordagem interdisciplinar englobando medidas de educação em saúde. **Descritores:** Conhecimento; Diálise; Nefropatias; Terapêutica.

RESUMEN

Objetivo: evaluar el conocimiento del paciente renal crónico en tratamiento sobre las modalidades dialíticas y terapias sustitutivas. **Método:** estudio descriptivo transversal realizado en un ambulatorio de nefrología de un hospital de Recife/PE, con 80 pacientes sometidos al tratamiento conservador. La recolección de datos fue realizada en el período de julio y agosto de 2013. Os datos fueron analizados en el software SPSS 18.0. La investigación fue aprobada por el Comité de Ética en Investigación, CAAE: 17403113.8.0000.5200. **Resultados:** hubo predominancia de 52,5% con nivel de conocimiento restrito e insuficiente sobre la enfermedad; 32,5% respondieron correctamente sobre el tratamiento conservador; 41,25% saben que la enfermedad renal crónica es una enfermedad sin cura. **Conclusión:** los resultados mostraron conocimiento insuficiente por la mayor parte de los participantes, siendo necesaria la actuación del profesional de la salud promoviendo el enfoque interdisciplinar englobando medidas de educación en salud. **Descriptores:** Conocimiento; Diálisis; Nefropatías; Terapéutica.

¹Nurse, Federal University of Pernambuco, Academic Center of Vitória/UFPE/CAV. Vitória de Santo Antão (PE), Brazil. E-mail: renatinhalais@hotmail.com; ²Student, Nursing Course, Federal University of Pernambuco, Academic Center of Vitória/UFPE/CAV. Vitória de Santo Antão (PE), Brazil. E-mail: bio_diegorafael@hotmail.com; ³Nurse, Master degree student, Integrated Graduate Program in Collective Health/PPGISC, Federal University of Pernambuco/UFPE. Recife (PE), Brazil. E-mail: marilia_gabrielle170@hotmail.com; ⁴Nurse, Master degree in Health Science, School of Medical Sciences / Institute of Biological Sciences, University of Pernambuco/FCM/ICB. Recife (PE), Brazil. E-mail: rudrigompb@hotmail.com; ⁵Nurse, Professor, Nursing Graduation Course, Federal University of Pernambuco, Academic Center of Vitória/UFPE/CAV. Ph.D. student, Graduate Program in Therapeutic Innovation/UFPE. Recife (PE), Brazil. E-mail: vivi_gouveia@yahoo.com.br

INTRODUCTION

Chronic kidney disease (CKD) is considered a progressive and irreversible syndrome of endocrine functions, glomerular and tubular of kidneys and has as main characteristic the decrease in glomerular filtrate ($>60\text{ml/min/1,73m}^2$) during a period of three months or more. From then on, the kidneys become unable to maintain their water-electrolyte and metabolic balance. In the initial phase, asymptomatic appeared, due to an adaptation of the organism, but in late phases, the symptoms become persistent and intense.¹

Among the causes of CKD there are primary renal diseases, which are the glomerulonephritis, obstructive diseases and systemic diseases (diabetes mellitus, hypertension, gout, autoimmune diseases), hereditary diseases and congenital malformations.²

CKD is considered currently a high morbidity and mortality disease, with progressive increase of incidence and prevalence in the population. These rates vary depending on the degree of development of the regions, as the socio-economic, demographic and environmental conditions influence the determination of these variables.³ In Brazil, there is an alert to the persistent increase in prevalence and incidence rates in recent years of patients on substituted renal therapy (SRT).⁴ However, there is no relevant national publications regarding the epidemiological data of patients with CKD in pre-dialytic period, which highlights an underreporting of the actual data and of deaths, mainly in less developed regions.² This is proven because the incidence of new patients on dialysis treatment growing about 8% per year.⁵

Epidemiological research have pointed the terminal diabetes mellitus (DM) (27.1%) and nephrosclerosis (22.3%) as the main causes of CKD.⁵ Its prevalence is increasing worldwide and the factors for this growth have been the increasing of cases of diabetes mellitus and hypertension.⁶

The DM and hypertension are highlighted as modern diseases that affect mainly young and middle-aged adults who can live for some time without the clinical symptoms, although there is the risk of some organs. These diseases are of concern to health professionals in Nephrology under the prevention and control of CKD, because the lack of information and inadequate treatment is part of the reality of the population.⁷

The treatment of CKD will depend on how the disease will evolve and may be conservative with the use of medications, dietary or water restriction. When this treatment becomes insufficient to keep the electrolytic and metabolic levels, it is necessary to start dialysis replacing in part, the function of the kidneys or renal transplantation.¹ The conservative treatment (CT) aims to assist in reducing the rate of progression of renal disease using dietary guidelines in order to promote an adequate nutritional status, control of uremic symptoms and metabolic disorders.⁸ The medication treatment aims at controlling chronic diseases installed, as well as the correction of metabolic and uremic disorders. The water restriction may be necessary for those patients that during reduction phase in glomerular filtration rate have decreased urine output volume produced.⁹ With the beginning of the CT or SRT, the signs and symptoms tend to diminish or disappear.¹

The CT and the SRT are based on improvement of quality of life of patients, rescuing of physical well-being, cognitive ability, in addition to maintaining the insertion in the social context. However, it brings changes of daily life with the dialysis treatment, in the performance of their social roles and psychological aspects arising from the situation of the sick person. Advances in dialytic procedures and the standardization of clinical routines and techniques for the treatment of patients with CKD have improved therapy and prolonged survival of patients.¹⁰

Early diagnosis, immediate forwarding and imposition of measures to decrease the progression of CKD are among the key strategies to improve disease outcomes. The interdisciplinary care model, when providing the necessary care, comprehensively and organized, seems to be the best way to treat CKD¹¹ as contributing to a better physical, clinical, social and psychological condition of the patient.¹²

The individual with CKD experience many changes in his life, feeling discouraged and many times because of this or because of a lack of guidance, he abandons the treatment leaving to care for the constant care for his quality of life. In this way, it becomes imperative that the importance of a holistic view of the patient and the professional guidance and support, encouraging him and allowing him to adapt positively to his new lifestyle and take control of his treatment.¹²

The nurse's work as an educator of the patient with CKD is indispensable, as it is responsible for guidelines on self-care, notions

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about the disease and its treatments, making him an active member in the health-disease process. In this educational process, it is essential that the individual is respected in his entirety, i.e. holistically within the biopsychosocial complex, since the patient with a better knowledge about his disease, better follows his treatment rescuing his emotional and physical wellbeing.¹³

In this context, research on epidemiological data and personal opinions of patients with CKD in conservative treatment represent a valuable contribution to the nursing care, because the results obtained may contribute to the adoption of strategies that prioritize patients' adherence to treatment and the elaboration of guidelines on the CKD, conservative treatment, dialysis and kidney transplant.⁶

Given the above, the objective of this study is to evaluate the knowledge of chronic kidney patients in treatment about dialytic modalities and substituted therapies.

METHOD

Descriptive, cross-sectional study, with a quantitative approach. The research was conducted in the Nephrology outpatient clinic of a teaching hospital in the city of Recife/PE with 80 patients enrolled in outpatient for chronic renal conservative treatment. The inclusion criteria were: patients with chronic kidney disease in more than three months of conservative treatment, older than 18 years old and have signed an informed consent term (TCLE). The data collection was held in the period of July and August 2013.

For data collection, the instrument was a questionnaire, structured script type, individualized and anonymous and the questions referred to the socioeconomic demographic and clinical profile of patients (name, age, address, income, education, time undergoing treatment for chronic kidney disease, what was the disease about and the types of substitute treatments). The data were obtained in a single moment through the review and interview with filling out of questionnaire for demographic characterization and clinical knowledge. The parameters were evaluated: gender, age, household income, type of residence, address, education, marital status, occupation, religion, main disease, what was the chronic kidney disease, conservative treatment, arteriovenous fistula, intraperitoneal catheter, substituted therapies and where was held each one.

The patient's knowledge evaluation was carried out by previously tested instrument that contained thirteen questions. The dimensions worked in this questionnaire were grouped into two categories: socio-economic and demographic data and specific data to renal disease. Definitions of knowledge level were assigned randomly as follows: full knowledge (11 hits), Middle Knowledge (five to ten hits), restricted Knowledge (two to four hits) and insufficient Knowledge (zero to one hit). For the statistical calculation a (full/middle knowledge) and two (restricted/insufficient knowledge) were considered.

During the data collection, a clear and standardized language was used in order to avoid the biases of information, of response and of the observer. For tabulation and data analysis, statistical package SPSS 18.0 was used. The data obtained were tabulated manually and represented in tables through Excel spreadsheet 2007 using of absolute and relative frequency and described using Word 2007. For significance testing, the Fisher exact was conducted based on $p<0.05$ and for that epidemiological calculator StatCalc 1.06 was used. With the aim to characterize the sample studied, tables with relative (%) and absolute (N) frequencies of the classes of each variable were shown.

The study had approved the research project by the Ethics Committee in Research of the Hospital Otávio de Freitas (HOF), under certificate of introduction to Ethics Assessment CAAE number 17403113.8.0000.5200 and Opinion number 337.117, in line with the Resolution 466/2012 of the National Health Council (CNS), classifying it at minimal risk.

RESULTS

The sample was composed of 80 patients in conservative treatment for chronic renal disease. The data presented in Table 1 are relevant information about the sample researched, observing relative characteristics to some demographic variables. It was verified the predominance of patient aged 36 to 59 years old (40%). When assessing specifically the gender, women performed in highest percentage (51.25%). It is observed that (62.5%) were browns, (41.25%) married, (48.75%) studied between five to seven years, (77.5%) are Catholic and mostly reside outside the metropolitan region of Recife (75%).

Table 1. Socio-demographic profile of patients, Recife/PE, 2013.

Variables	Patients	
	n	%
Age group		
21 to 35	23	28,75
36 to 59	32	40,0
≥ 60	25	31,25
Total	80	100,0
Gender		
Female	41	51,25
Male	39	48,75
Total	80	100,0
Ethnicity		
Brown	50	62,5
Black	15	18,75
White	15	18,75
Total	80	100,0
Marital Status		
Single	19	23,75
Married	33	41,25
Widow	17	21,25
Stable union	11	13,75
Total	80	100,0
Education (years)		
Analfabeto	3	3,75
≤ 4	34	42,5
5 to 7	39	48,75
≥ 8	4	5,0
Total	80	100,0
Religion		
Catholic	62	77,5
Evangelic	18	22,5
Total	80	100,0
Address		
MRR*	20	25,0
OMRR**	60	75,0
Total	80	100,0

*MRR: Metropolitan Region of Recife.
**OMRR: Out of Metropolitan Region of Recife.

In table 2, we observed a predominance of 52.5% with restricted and insufficient knowledge as to the knowledge about the disease. However, the comparative analysis of

knowledge on these groups did not differ with regard to socio-demographic characteristics and the level of knowledge about chronic kidney disease (p>0.05).

Table 2. Correlation of socio-demographic variables and the level of knowledge about chronic kidney disease. Recife/PE, 2013.

Variables	Knowledge				P
	Full and average		Restricted and without knowledge		
	n	%	n	%	
Gender					
Female	18	47,4	23	54,8	0,50
Male	20	52,6	19	45,2	
Total	38	100,0	42	100,0	
Ethnicity					
White	8	21,1	7	16,7	0,61
No White	30	78,9	35	83,3	
Total	38	100,0	42	100,0	
Marital Status					
With partner	23	60,5	21	50,0	0,53
Without partner	15	39,5	21	50,0	
Total	38	100,0	42	100,0	
Education (years)					
Illiterate	2	5,3	1	2,4	0,60
≤ 4	12	31,6	22	52,4	0,16
5 to 7	20	52,6	19	45,2	
≥ 8	4	10,5	0	0,0	0,06
Total	38	100,0	42	100,0	
Religion					
Catholic	31	81,6	31	73,8	0,40
Evangelic	7	18,4	11	26,2	
Total	38	100,0	42	100,0	
Occupation					
Housewife	4	10,5	6	14,3	0,43
Retired	21	55,3	18	42,9	
Grantee	13	34,2	18	42,9	0,32
Total	38	100,0	42	100,0	
Address					
MRR*	13	34,2	7	16,7	0,07
FRMR**	25	65,8	35	83,3	
Total	38	100,0	42	100,0	
Familyincome (SM***)					
< 1	6	15,8	7	16,7	0,95
1 to 3	29	76,3	35	83,3	
4 to 6	3	7,9	0	0,0	0,06
Total	38	100,0	42	100,0	

*MRR: Metropolitan Region of Recife.
**OMRR: Out of Metropolitan Region of Recife.
***Minimum wage.

In tables 3 and 4, patients are distributed according to the level of knowledge about the CKD. The minority of the patients (32.5%) answered correctly that the CT is water and dietary restriction to decrease renal injury. As regards the treatment time, 32.5% of the patients began the CT for more than a year, 25% in one to two years, 13.75% in two to three years and 28.75% over four years. Only 41.25% knew that the CKD is a kidney disease

without a cure and 33.75% knew that the forms of treatment are hemodialysis, peritoneal dialysis and renal transplantation. Regarding the importance of CT, 45% believed they would be cured. The majority (77.5%) felt that hemodialysis is the treatment for CKD where a machine filters the blood, removing toxic substances to the body and 81.25% recognized that this procedure is performed in hospitals.

Table 3. Distribution of patients according to the level of knowledge about chronic kidney disease. Recife/PE, 2013.

Variables	Patients	
	n	%
What is conservative treatment?		
Treatment for terminal chronic kidney disease	39	48,75
Water and dietary restriction to decrease renal injury	26	32,5
I don't know	15	18,75
Total	80	100,0
How long have you been in conservative treatment?		
> 1	26	32,5
1 to 2	20	25,0
2 to 3	11	13,75
≥ 4	23	28,75
Total	80	100,0
For you, what is chronic kidney disease?		
Kidney disease without cure	33	41,25
Kidney disease with a cure	45	56,25
I don't know	2	2,5
Total	80	100,0
What are the ways of treatment?		
Hemodialysis	35	43,75
Peritoneal Dialysis	2	2,5
Kidney Transplant	1	1,25
All the answers above	27	33,75
I don't know	15	18,75
Total	80	100,0
What is the importance of treatment?		
Prolong my life time by decreasing my pain	39	48,75
Will be my cure	36	45,0
I don't know	5	6,25
Total	80	100,0
What is hemodialysis?		
Treatment for CKD where a machine filters the blood, removing toxic substances to the body	62	77,5
Medication treatment	6	7,5
I don't know	12	15,0
Total	80	100,0
Where is hemodialysis performed?		
At home	3	3,75
In the hospital	65	81,25
I don't know	12	15,0
Total	80	100,0

As for peritoneal dialysis, 45% do not know its meaning and 47.5% noted that this type of CT is performed at home. Regarding the kidney transplant, 27.5% early identified a third kidney blood filtering and 26.25% demonstrated lack of meaning. It is noted that

62.5% do not know the meaning of arteriovenous fistula, as well as 68.75% do not know intraperitoneal catheter meaning. In relation to the professional who taught about the disease and ways of treatment, only 15% have described receiving nursing orientation.

Table 4. Distribution of patients according to the level of knowledge about chronic kidney disease. Recife/PE, 2013.

Variables	Patients	
	n	%
What is peritoneal dialysis?		
Treatment that filters blood through a membrane located in the belly	34	42,5
Medication treatment	10	12,5
I don´t know	36	45,0
Total	80	100,0
Where is peritoneal dialysis performed?		
At home	38	47,5
In the hospital	10	12,5
I don´t know	32	40,0
Total	80	100,0
What is renal transplantation?		
Is a third kidney to filter my blood	22	27,5
Is the removal of my old and reposition with a new kidney	37	46,25
I don´t know	21	26,25
Total	80	100,0
What is the arteriovenous fistula?		
Venous access for hemodialysis, providing blood flow suitable for filtration	26	32,5
Venous access for introduction of medication	4	5,0
I don´t know	50	62,5
Total	80	100,0
What is intraperitoneal catheter?		
Peritoneal dialysis access, allowing for blood filtration	20	25,0
Hemodialysis Access	5	6,25
I don´t know	55	68,75
Total	80	100,0
Which professional taught me about the disease and ways of treatment?		
Nurse	12	15,0
Doctor	68	85,0
Total	80	100,0

DISCUSSION

One of the factors studied in recent literature is the socioeconomic status. Low socioeconomic status is a risk factor for chronic diseases, but some studies have shown an inverse relationship with the incidence of CKD.^{5,6} Among the possible explanations for these associations between low socioeconomic status and the CKD, there are the difficulties of access to basic health systems and inadequate control of endemic diseases like hypertension and diabetes.¹⁴

Most of the studies published in the literature show that there is a predominance of males in treatment for CKD.^{2,5,15-7} It is interesting to make a comparison of values obtained in this study with further research, since in this study the conservative treatment consists of more women than men. In line with this finding, study aiming to assess the demographic profile of patients undergoing peritoneal dialysis developed into a Nephrology Clinic State of Sergipe revealed that, for this type of CT, the female is also the majority.¹⁸ To explain the observed, it is known that women care more about their clinical situation than men. They eat better, they smoke less, drink less, seek more medical services for preventive examinations and follow more medical recommendations

relating to existing diseases, while most men consider themselves immune to disease, prioritizing the pleasures of life in detriment to health.^{10,8} This is a known information of many health professionals.

It is noteworthy that the age range of chronic renal patients is mostly between 36 to 59 years old,^{4,13,5} which corroborates with the data of this research.

Other relevant data is that most patients reside in neighboring towns. This can demonstrate that there is a deficit in the treatment of basic diseases aggravating the symptoms, causing them a chronic renal disease and be forwarded to referral hospitals. Moreover, those who are in more advanced stages are submitted to conservative treatment without possessing knowledge of the disease, which makes difficult the beginning and treatment adherence.^{2,14}

There are studies that confirm the association of CKD with ethnic and socioeconomic factors.⁶ However, this study did not obtain statistical significance among levels of knowledge and socio-demographic variables, being considered by the limitations of the sample.

Although some studies affirm that the knowledge of patients about their disease and

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treatment does not necessarily improve their adherence to the treatment¹⁹, in others, it shows that the accession behavior of patients to treatments, especially chronic diseases, suffers the influence knowledge of the patient, health service facilitation and interaction by the professionals.¹⁴⁻⁵ The adequate knowledge of the patient about the disease has been discussed and the treatment might work as a facilitating factor of adherence.¹⁹

In the evaluation of knowledge, the results showed that patients in general are unaware of the permanent character of the disease, because they believed that the treatment would cure the kidney failure, in addition to not being aware that the conservative treatment aims to reduce or maintain renal injury without progression to postpone the necessity of substitute dialytic therapy.²

The results of a qualitative study conducted with adults in conservative treatment for CKD showed that only with time patients began to understand that the disease is forever and none of the treatments would cure, nor even, the kidney transplant. They believed that, if the correct information was given earlier, there would have been greater motivation to involve them actively in self-care.¹⁵ This was evidenced when less than half of the studied know what was chronic kidney disease and what ways of treatment, and most of them had less than a year of treatment.

Self-care of patients with CKD should be continuously stimulated, encouraging the look around yourself, of everyday life, from day to day, gestures, words, attitudes, in an attempt to identify specific problems of their own existence. The person with chronic kidney disease goes through limitations that require rehabilitation in his life due to the progressive evolution of the disease, causing physical, psychological, social and economic problems.¹³ This care is also influenced according to socio-economic class to which people belong.⁷

Health promotion is understood as a relationship between technical and popular knowledge and the mobilization of financial resources for coping and solution of improvement of quality of life of a population.²⁰ Health promotion actions, different from the prevention, aimed at better conditions of life and work, in addition to the problems related to illness, and nursing has an important educational activity in chronic renal failure.¹²

The nurse can act on health promotion for people with CKD in accordance with the needs of the population, in order to detect high-risk

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groups, mentor and shows the way for coping and adaptation to new lifestyle and their health condition. Health education activities can be undertaken jointly and constructively since the primary attention to the tertiary level of health. The nurse has important role of caretaker and educator, responsible for systematizing and encourage care of themselves. Thus, we need to develop health promotion activities in order to reduce the incidence of CKD and improves the quality of life of the population.¹⁴

It is understood that people in treatment for CKD go through various physical, social and emotional limitations, in addition to the loss of renal function, being necessary to evaluate the daily life, in order to show the occupational performance, special diets, restrictions and family dynamics,⁸ once the daily life of the patients with CKD changes according to the evolution of the disease, in which feelings of disbelief are common, and the staging of the progression of kidney disease is one factor that contributes to increasing the self-esteem of these people.²⁰

The educational approach aims to clarify the disease and adoption of practices of self-management of the disease, in an accessible and dialogic way, with the participation of the patient. The carrier of the disease needs to understand and know the ways of care without imposing methods or difficulties, being an active in their treatment. It is relevant to the patient assign the agent profile and active participant in the educational program, assisting in the recovery and adaptation imposed by the CKD.¹²

The nurse, when taking care of people with CKD, must be attentive to the complications of the disease and the stresses and anxieties surrounding this condition. Promoting and encouraging the care of themselves through health education is one of the steps for care, with a view to reduce the low self-esteem related to the evolution of the treatment, since it is proven the need of knowledge of the patient about their illness to improve their treatment and clinical condition.

Although is not explicit in tables, when the patients were questioned about the diseases that affect them besides CKD, 7.5% have lupus, 93.8% SAH, 73.8% diabetes, no patient suffers from polycystic kidney, only 3.8% have glomerulonephritis, this same percentage was affected by nephritic and nephrotic syndrome.

Hypertension and renal function are closely related, and hypertension can be both the cause as the result of kidney disease. Chronic hypertension or malignant can determine a framework of renal injury in the general

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population, being identified as the second most common cause after the diabetic nephropathy of patients starting treatment for CKD, annually, according to data from the Ministry of Health.⁷ In the studied population, there was more prevalent SAH as underlying disease than diabetes. Given this, it is believed that there are not enough guidance measures only for blood pressure control, it also need to confirm and follow the diagnosis of hypertension and chronic kidney disease, and develop strategies that help the patient during his conservative treatment to a good result.

CONCLUSION

It was noted in this study, insufficient knowledge by most participants, mainly among the young and middle-aged adults and with a shorter length of stay in the program. This suggests the need for re-evaluation of strategies used in educational activities making them more appropriate for age and cognitive development of each patient. There is a need for proposals for activities that involve the active participation of patients and family members contributing to make them constructors of knowledge and, consequently, get them the best treatment adherence.

The user needs proper care requires from multidisciplinary team the ability to identify the needs of care, allied to technical-scientific actions relating to physical, technical and emotional care, providing the requirements for the effectiveness of the process of care. In this context, it is possible to realize that nursing has a key role as educator, offering these individuals the opportunity to learn more about their disease, treatment and therapies instead which may be adopted in the future, contributing to the patient suits their conditions during the dialysis treatment.

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Corresponding Address

Viviane de Araújo Gouveia
Universidade Federal de Pernambuco
Centro Acadêmico de Vitória
Rua Alto do Reservatório, S/N
Bairro Bela Vista
CEP 55608-680 – Vitória de Santo Antão (PE),
Brazil