



NURSING CONSULTATION FOR CHRONIC RENAL FAILURE PREVENTION IN A LIVING GROUP

A CONSULTA DE ENFERMAGEM NA PREVENÇÃO DE INSUFICIÊNCIA RENAL CRÔNICA EM UM GRUPO DE CONVIVÊNCIA

LA CONSULTA DE ENFERMERÍA EN LA PREVENCIÓN DE INSUFICIENCIA RENAL CRÓNICA EN UN GRUPO DE CONVIVENCIA

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ABSTRACT

Objective: to highlight the nursing consultation in the prevention of risk factors for the chronic renal failure (CRF) in hypertensive and diabetic people. **Method:** descriptive study with quantitative approach, performed in a Basic Health Unit in Natal/RN, which involved 23 adults and elderly people. The data was collected in June and July, 2011 during the nursing consultations through a semi structured form. The study was approved by the Committee of Ethics in Research upon Human Beings at the Universidade Federal do Rio Grande do Norte, protocol nº 229/2011 and CAAE nº 00620051000-11. **Results:** the characterization data pointed women predominance (82,6%), aged 65 years old or more (60,9%), married (56,5%), with incomplete high school (87%), and one to three minimum wages as a family income (52,2%). Concerning the risk factors for kidney damage, 87% were hypertensive and 8,7% diabetic, both of them with CRF family history. From these people, 78,3% were sedentary people and 52,2% had inadequate eating habits. 23 nursing consultations were done, and the following actions were developed: blood pressure verification, physical examination, requirement of extra exams, investigation of risk factors for cardiovascular and kidney diseases, educational practices in health, among others. **Conclusion:** the nursing consultation was highly important for the identification of users with a higher exposition to risk factors for renal complications due to arterial hypertension and diabetes Mellitus. It provides the nurse professional with the development of actions of extension and education in individual and group health. **Descriptors:** primary prevention; hypertension; diabetes mellitus; renal insufficiency, chronic; nursing care.

RESUMO

Objetivo: destacar a consulta de enfermagem na prevenção dos fatores de risco para insuficiência renal crônica (IRC) em hipertensos e diabéticos. **Método:** estudo descritivo de abordagem quantitativa, realizado em uma Unidade Básica de Saúde de Natal/RN, que envolveu 23 adultos e idosos. Os dados foram coletados nos meses de junho e julho de 2011, durante as consultas de enfermagem através de um formulário semiestruturado. O estudo foi aprovado pelo Comitê de Ética em Pesquisa em Seres Humanos da Universidade Federal do Rio Grande do Norte (CEP_UFRN) sob o nº 229/2011 e CAAE nº 00620051000-11. **Resultados:** os dados de caracterização evidenciaram predomínio de mulheres (82,6%), idade igual ou superior a 65 anos (60,9%), casados (56,5%), ensino fundamental incompleto (87%), e renda familiar de 1 a 3 salários-mínimos (52,2%). Quanto aos fatores de risco para lesão renal, 87% eram hipertensos e 8,7% diabéticos, ambos com história familiar de IRC. Destes, 78,3% eram sedentários e 52,2% tinham hábitos alimentares inadequados. Durante as 23 consultas de enfermagem (total), eram desenvolvidas as seguintes ações: verificação da pressão arterial, realização de exame físico, solicitação de exames complementares, investigação de fatores de risco para doenças cardiovasculares e renais, orientação para as práticas educativas em saúde, entre outras. **Conclusão:** verificou-se que a realização da consulta de enfermagem foi fundamental na identificação de usuários com maior exposição a fatores de risco para complicações renais decorrentes da Hipertensão Arterial e do Diabetes Mellitus, pois instrumentaliza o enfermeiro no desenvolvimento de ações para o cuidado de educação em saúde individual e coletiva. **Descritores:** prevenção primária; hipertensão; diabetes mellitus; insuficiência renal crônica; cuidados de enfermagem.

RESUMEN

Objetivo: destacar la consulta de enfermería en la prevención de los factores de riesgo para insuficiencia renal crónica (IRC) en hipertensos y diabéticos. **Método:** estudio descriptivo de abordaje cuantitativo, realizado en una Unidad Básica de Salud de Natal/RN, que involucró 23 adultos y ancianos. Los datos fueron recolectados en los meses de junio y julio de 2011, durante las consultas de enfermería a través de un formulario semiestructurado. El estudio fue aprobado por el Comité de Ética en Investigación en Seres Humanos de la Universidad Federal de Rio Grande do Norte bajo el nº 229/2011 y CAAE nº 00620051000-11. **Resultados:** los datos de caracterización evidenciaron predominio de mujeres (82,6%), edad igual o superior a 65 años (60,9%), casados (56,5%), enseñanza fundamental incompleta (87%), y renta familiar de 1 a 3 salarios-mínimos (52,2%). En cuanto a los factores de riesgo para lesión renal, un 87% era hipertenso y un 8,7% diabético, ambos con historia familiar de IRC. De estos, un 78,3% era sedentario y un 52,2% tenía hábitos alimentarios inadecuados. Fueron realizadas 23 consultas de enfermería, siendo desarrolladas las siguientes acciones: verificación de la presión arterial, realización de examen físico, solicitud de exámenes complementarios, investigación de factores de riesgo para enfermedades cardiovasculares y renales, prácticas educativas en salud, entre otras. **Conclusión:** la realización de la consulta de enfermería fue fundamental en la identificación de usuarios con mayor exposición a factores de riesgo para complicaciones renales decurrentes de la Hipertensión Arterial y del Diabetes Mellitus, pues instrumentaliza al enfermero en el desarrollo de acciones de extensión y educación en salud individual y colectiva. **Descritores:** prevención primaria; hipertensión; diabetes mellitus; insuficiencia renal crónica; atención de enfermeira.

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INTRODUCTION

When caring for people with Systemic Arterial Hypertension (SAH) and Diabetes Mellitus (DM), main risk factors for Chronic Renal Failure (CRF), the nurse performs an important function in the Basic healthcare (BH) scenario or Primary Healthcare to Health (PHC). At this care level, the living groups stand out through actions involving healthcare education and promotion and prevention in diseases and aggravation, in individual and collective context, by monitoring user's to enable a better approximation of their social context through using the service.¹⁻²

The number of renal patients is increasing worldwide and Brazil already represents the third largest hemodialysis market in the world where 10% of the Health Ministry's (HM) budget is spent on this type of treatment. Chronic Renal Disease (CRD) affects about 2 million Brazilians and of these 60% will not even be diagnosed.³

The National Healthcare Policy for Renal Disease Patients (2004) proposes, determinant and constraint identification for the main disorders that cause renal disease.⁴ Thus, when caring for people with SAH and DM, the nurse, among other attributions that he or she has in BC, the Nursing Consultation stands out, according to the Ordinance No. 2.488/GM from October 21st, 2011, that establishes the current National Policy of National Healthcare Policy (NHP).⁵

In this sense, according to the provisions of law No. 7.498/86, 8th Article, Decree No. 94.406/87 and Resolution No. 159/1993 of Federal Council on Nursing (COFEN), the nursing consultation is acknowledged as a nurse practice in the concretization perspective of the healthcare model that is adjusted to the individual and collective necessities of healthcare.⁶

The study justifies itself by understanding that the nursing consultation is a valuable instrument for nursing care as it enables the qualified listening investigation of health problems and creation of a care plan given the patient's demands and limitations so that they can have such a periodic monitoring. It is worth mentioning a few of the nurse's specific attributions, as the nurse is part of the BC staff, such as the solicitation of complementary exams, medication prescription and transcription, according to protocols established by the HM and legal provisions within the profession.

The relevance of the study is centered in

the high CRF prevalence in the worldwide and national context, as well as in the importance of the BC nurses work on risk factor prevention in this morbidity, helping control it, preventing and associated complications, contributing to mortality reduction and significant reduction in expenses that are incurred by the Nation Healthcare System (SUS).

Because of this, one may ask: What actions are performed by the nurse during the nursing consultation with the users regarding SAH and DM diagnosis in the basic care? What actions can contribute in risk factors prevention for CRF?

OBJETIVO

- To highlight the nursing consultation as a renal failure risk factor prevention instrument in a living group in primary healthcare.

METHOD

This is about an exploratory and descriptive study and quantitative approach developed in a Basic Healthcare Unit (BHU) in Natal/RN, by the monitoring of the nursing consultations performed by the hypertensive and diabetic patients included in the National Attention Program to Arterial Hypertension and Diabetes Mellitus.

The study was performed in a BHU which belongs to Sanitário Sul, an administrative, politic organization, founded in 1987 by the districtalization process. The BHU offers a multi-professional team and is managed by the Health Community Agents Strategy (HCAS), supervised by a Nurse.⁷

The nurses perform consultations through the HM programs and spontaneously, total care in the vital cycle, health education activities, disease and aggravation notification, supervision by community health agents and nursing technicians, investigation of diseases and aggravations, home visit and data feeding for the Basic Healthcare Information System (BHIS).

The participants were twenty-three adults and elderly who were part of "Amigos do Coração" (Friends of the Heart) living group, where they perform actions related to health education, in such a way promoting quality of life for diabetes and hypertension patient self-care.

The data were collected during June and July, 2011, during the nursing consultation at the group's Bi-monthly meetings with the poll participants. A semi-structured questionnaire

was used, made up of personal characterization data containing, sex, age, marital status, education and family's monthly income; data related to personal CRF risks factors, alcoholism, smoking, diet, use of ready spices, addition of cooking salt to ready-prepared foods, consumption of canned food and sausages, physical activities or sports, and adherence to treatment, in addition to data that refer to the family history that is inherent to CRF family history, like hypertension, diabetes and renal problems.

The study was approved by the Committee of Ethics in Research of Universidade Federal do Rio Grande do Norte (CER_UFRN) under No. 229/2011 and CAAE No. 00620051000-11, according to resolution No. 196/96 of Health Ministry for research with human beings.⁸

For the analysis, the results were typed on Microsoft Excel 2010 spreadsheet and shown in graphs and simple tables according to the

simple descriptive statistics and discussed by means of specialized literature.

RESULTS

The results focused on three main aspects: individual characterization, actions performed by the nurse during the consultation, and the nurse's actions in the consultation related to the CRF risk factor prevention.

• Users' characterization

Among the 23 adults who took part in the study, most of them were female (82,6%), their ages were over 65 (60,9%), 56,5% were married, with incomplete elementary school (87%) and family's income between 1 and 3 minimal salaries (52,2%), considering that the current salary was R\$ 545,00, during the period of data collection (Figure 1).

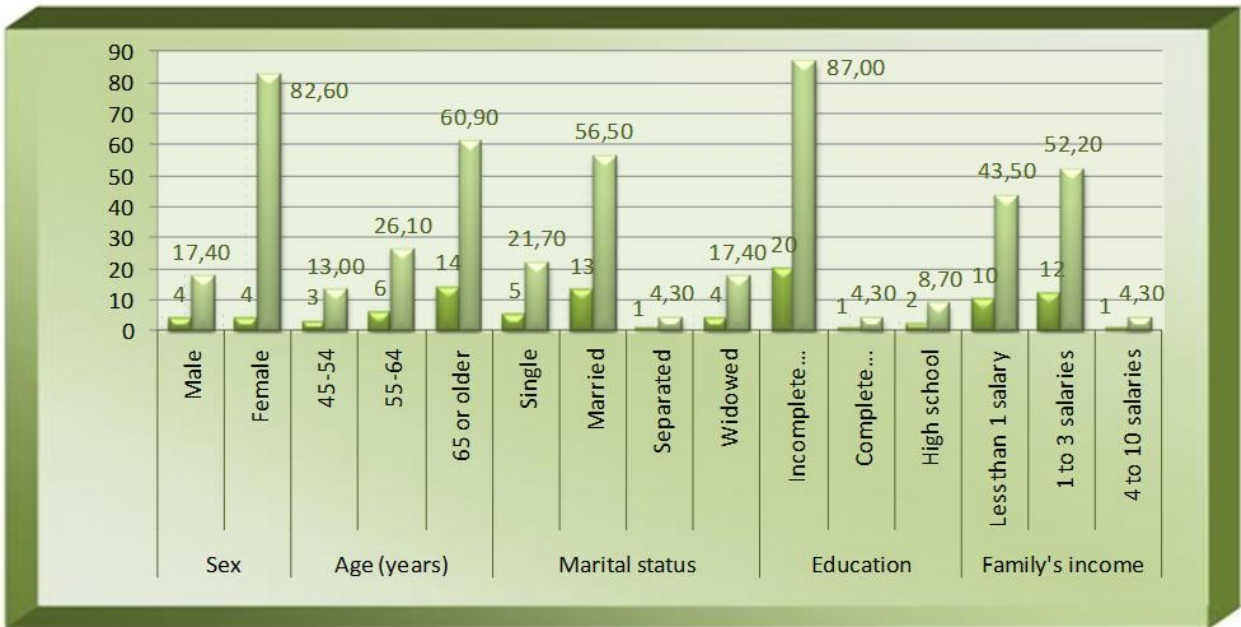


Figure 1. Characterization of the individuals as for the socio-demographic variables: sex, age (years), marital status, education, and family's income in adults and elderly interviewed. Natal/RN, 2011. Source: Poll data, 201

When considering the personal risk factors of for CRF, Figure 2 reveals that 17,4% were alcoholics or smokers, 73,9% were on diet and 56,5% used ready spices in their food.

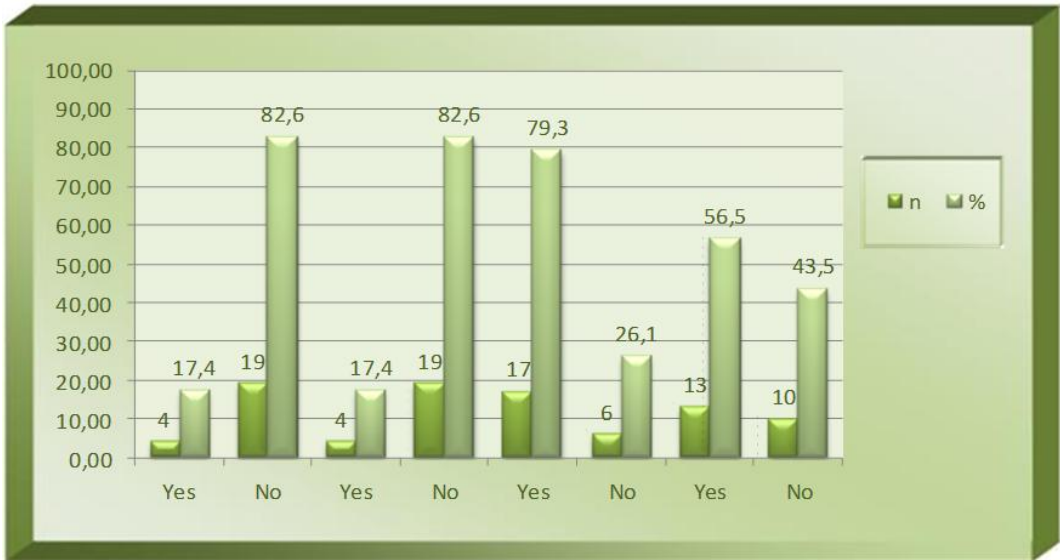
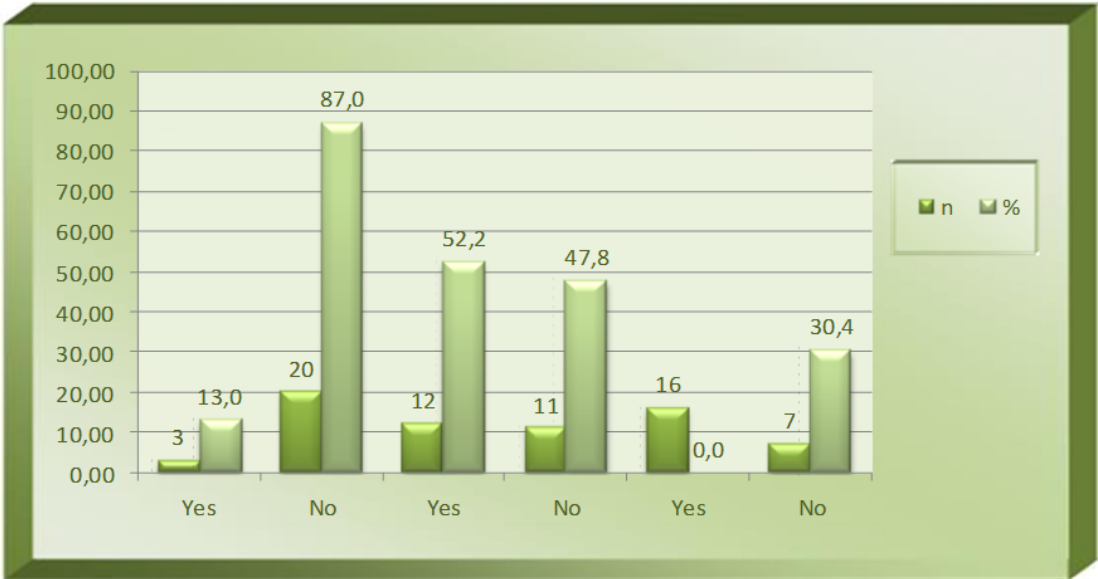


Figure 2. Characterization of factors of personal risks for chronic renal failure: alcoholism, smoking, diet and ready spices in adults and elderly interviewed. Natal/RN, 2011. Source: Poll data, 2011

It was shown that 69,6 affirmed they had received diet orientations at the Bi-monthly meetings of the living group and in the nursing consultations performed with the participants,

however, 13% said they added cooking salt to the ready prepared food and 52,2% said they consumed canned food and sausages together with their food (Figure 3).



Picture 3. Characterization of factors of personal risks for chronic renal failure: intake of cooking salt added to the food already ready on the plate, intake of canned food and sausages and fulfillment of the dietary orientations in adults and elderly interviewed. Natal/RN, 2011. **Source:** Poll data, 2011.

Among the participants, 78,3% revealed they did not perform any physical exercises, 86% had hypertension and 8,7% were diabetic.

Although these values were revealed, 86% stated that they rigorously complied with the time medication (Figure 4).

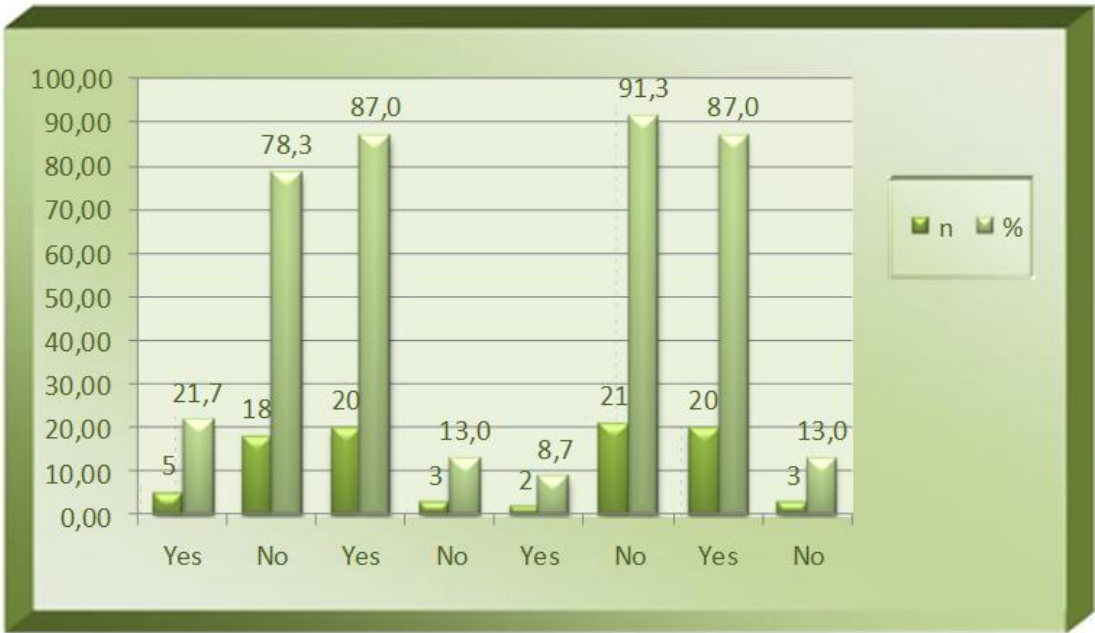


Figure 4. Characterization of factors of personal risks for chronic renal failure: physical exercises, hypertension, diabetes, fulfillment of diet and medication time in adults and elderly interviewed. Natal/RN, 2011. **Source:** Poll data, 2011

The characterization factor data of personal risks related to the family's CRF history show that 87% had a family's history of hypertension, diabetes (34,8%) and renal problems (34,8%). In this case, the relatives with the following degrees of kinship and consanguinity were considered, in a straight

line: parents and grandparents; and in lateral line: siblings. Hypertension development in individuals with a family history was a relevant discovery in the group interviewed as 87% had already been diagnosed as hypertensive (Figure 5).

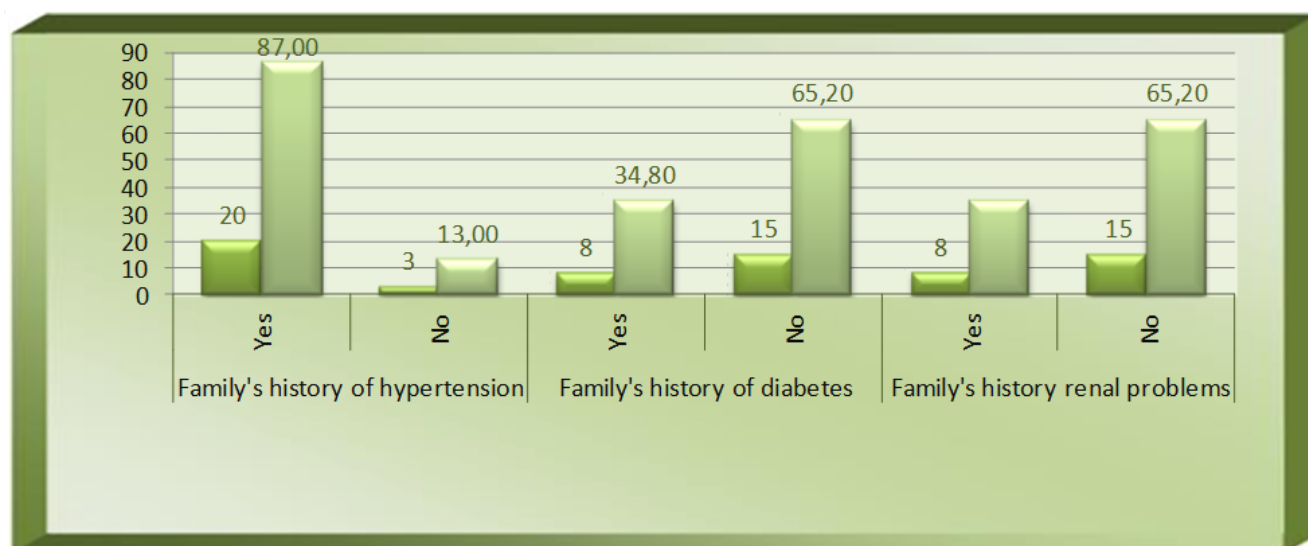


Figure 5. Characterization of risk factors related to the family's history of chronic renal failure in adults and elderly interviewed. Natal/RN, 2011. **Source:** Poll data, 2011

The nurse is believed to be an important part in the prevention and control of CRF development factors. The nursing consultation (Nursing History, Physical Exam, Nursing Diagnose, Prescription of Nursing Care, Evolution of Nursing Care and Nursing Report) becomes a tool for identification and intervention in the risk factors that make up this morbidity.

• Actions performed by the nurse during the consultation

It was observed that the nursing consultations were conducted because of the complaints by the users. In the clinical aspects investigation predominance was observed in pharmacologic treatment continuation, in the risk factor investigation for cardiovascular and renal diseases, in the observation of the user's normal state and checking of Arterial Pressure (AP).

The following items were also perceived: the reception; the establishment of a link; hearing; registry of patients not included in the National Healthcare Program for Arterial Hypertension and Diabetes Mellitus (Hiperdia); precocious identification of morbidities; and the approach of the importance of the family/caretaker in this process and as the extension of a domiciliary visit. We consider the nursing history from the characterization data of the above mentioned group members.

As for the physical exam used in all the consultations, the nurse observed the user's appearance, measured AP, body weight and sometimes they measured waist perimeter, evaluation of peripheral pulses (feet) and edema presence. The nurse prescribed and made a transcript of medications and the complementary exam solicitations.

• Nurse's actions in the consultation related to CRF risk factor prevention.

As for the actions that can contribute to CRF risk factor prevention, health education came as an extension at the basic care consultation.

Among the actions developed the following ones stood out: performing health educational practices in the living group, user sensitization of the change of life habits, mainly when referring to the changeable risk factors (smoking, alcohol, obesity and sedentariness). Moreover, actions were developed in order to help with DM and SAH control, in addition to strengthening the exchange of experience between hypertensive and diabetic patients through the living group.

DISCUSSION

As for the socio-demographic characteristics, they show that the living group was preferably formed by female individuals, older than 65, married, with incomplete elementary school and family income between 1 and 3 minimum salaries.

The high frequency of female participants coincide with the data from the Demographic census performed in 2010, whose analysis reflects a ratio of 96 men for each 100 women and this predominance follows the historical tendency in the composition per sex in the national population. In the Northeast Region of Brazil the relation is 95.3 men for each 100 women.⁹⁻¹⁰

The predominant age group was 65 years of age or older (60.9%), considered according to the Brazilian population age data analyzed in the National Poll per Sample of Homes (NPSH), which showed that 21 million people are 60 or older.¹¹

Through the Demographic Census, a widening on top of Brazilian age pyramid has been seen with the population growth which

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are as old as or older than 65, which represented 4.8% in 1991, 5.9% in 2000, reaching a percentage of 7.4% in 2010. In the Northeast Region, the elderly portion in this age group represented 5.1% in 1991, 5.8% in 2000, and 7.2% in 2010. It is worth emphasizing that 65 years of age is considered a bordering age for the elderly in developed countries, and 60 years of age for developing countries.⁹⁻¹⁰⁻¹ The Brazilian dialysis census performed in 2010 pointed out that the largest percentage of dialysis patients in the country are 65 years of age or older (30.7%).¹²

As for the participants' marital status, 55.6% were married; 21.7% single; and 16.4% widowed. The data corroborate with the data of another study performed with a similar population whose percentage rates are 66.2% (married), 23.5% (widowed) and 4.1% (single).¹³

As for family income, a higher percentage was obtained of individuals (52.2%) with 1 to 3 minimal salaries. In a study performed with elderly registered in Jequié City/BA, the same group profile was observed, regarding income, with a percentage of 53.85%.¹⁴

For the NPSH, 66% of the elderly in Brazil are retired, which represents a tendency, according to the data previously presented. Retirement gives the elderly a minimal income that can be used for their basic needs, though a great part is directed towards the medication and other treatment expenses. Furthermore, this population has actively contributed to family expenses and, in some situations, elderly income has become an integrate part of the family income.

Predominant education among the interviewees was incomplete elementary school, at 87%. This finding is according to the NPSH data, where Brazilians who are 65 or older have between 1 and 3 years of school and represent 20.1% of the country, while the Northeast Region presents 17.8%.¹¹

Investigating the socio-demographic characteristics during the nursing consultation brought forth knowledge of morbidities like SAH and DM which are only found in the clinic evaluation, but it is of great importance in acknowledging the health/disease process as socially determined, and this implies to understanding what are the producing and consuming ways within a society, since social group particularities, and the way they work and live characterize the way they get sick.

When referring to previously mentioned CRF personal risks factors, low indexes of alcoholism and smoking were observed among

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the group members. As for their diets, some divergence was observed in the affirmation of rigorously following the diet and the subsequent information of ready spices usage, canned food and sausage consumption and following the dietary orientations. The other fact that deserves attention is that, even stating that they follow the diet, there were participants that usually added cooking salt to prepared foods.

It was observed that a reduced percentage (17.4%) of elderly showed smoking habits and alcohol consumption. The phone survey for chronic disease risk factor monitoring (Vigitel) revealed data which are similar to this study when stating that the smoking prevalence in Brazil reduced from 35% to 17% between 1989 and 2009. Still according to the study, smoker frequency in Brazil was 15.1%, it was higher for men (17.9%) than for women (12.7%).¹⁵

Quitting smoking is considered a primary and secondary preventive step towards the development of cardiovascular, cerebrovascular and renal diseases. With more frequent health promotion actions through the Strategic Action Plan for Facing Non-Contagious Chronic Diseases in Brazil 2011-2022, it is expected to achieve, in 2022, a smoking prevalence Of only 10% and in 2040 lower than 5%.¹⁶⁻⁷

Because the alcohol consumption is a CRD predictor, as well as causes for AP level alterations, depending on quantity, a study shows that the alcohol consumption must be moderate, reducing it to 30 g per day for men and 15 g per day for women.¹⁸ In AP elevation, as the alcohol blood rates increase, they cause slow and progressive pressure elevation in the proportion of 2 mmHg for each 30 ml of ethyl alcohol consumed daily.¹⁹

During the consultation, the interviewed were informed about the harm from smoking and alcohol, the aim was to sensitize them about the importance of quitting the vice, and about the pressure elevation levels, the development of lung and coronary diseases, thrombosis, sexual impotence in men, among others.¹⁸

As for diet performance, 73.9% of the individuals affirmed they follow the orientations, which are understood as a restriction of some types of food that produce negative health effects. The diet consists of individual standards and can represent proportional food combinations with the objective of meeting the therapeutic needs.²⁰

A study performed with patients who had not yet been subjected to dialysis for CRD

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precocious detection points out that diets with high protein intake, among other factors, may determine an increase in plasmatic urea levels, while diets with few proteins added to the hepatic disease may result in reduction; it is worth pointing out that urea is considered an endogenous renal involvement factor.²¹

As for following the dietary orientations, an issue approached during the group meetings and in nursing consultations, the vast majority informed they followed the orientations. The World Health Organization recommends a daily intake of five fruits and vegetables.¹⁵ For the Health Ministry, daily healthy habits include healthy nutrition, salt restriction, sugar and alcohol free, reduction of meat intake with high lipid content and addition of daily portions of fruit, greens, vegetables and cereals.¹⁶

Ready spice usage in food was shown in 56.5% of the elderly and 52.2% said they ate canned food at least once per month. Studies have shown that developing countries permeate a nutritional transition, determined by the frequency of improper eating habits. The profile found that among the Brazilian families in obesity situations, hypertension and diabetes has shown an increased; general fat intake, animal origin fat and industrialized food rich in sugar and sodium, with reduction in cereals, vegetables, fruits and greens.²¹

As for the data, addition of sodium chloride or cooking salt to prepared foods, among the participants, they understood that salt works as an important non-pharmacologic AP factor.

At the time of investigation by the nurse facing the hypertensive patient, ingesting hypertensive substances, it is essential that emphasis be given when talking about salt intake, which is justified by a strong evidence of its impact in AP elevation. As it was clear that a 9-12g/day cooking salt reduction to the recommended quantity (5-6g/day) shows proven effects on health, like pressure level reduction, bodily water retention, like the left ventricle mass in people with primary SAH, risky obesity and development of renal diseases.^{1,22}

A study has pointed out the necessity of a reduction in sodium chloride intake for developed countries through a gradual reduction in the quantity of salt included in the industrialized food. While as for other countries, educative campaigns are recommended for deleting the effects of salt, it is mostly consumed when added to food during cooking.²²

As for regular physical activity, it was

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observed that 78.3% of the elderly did not perform any, which systematically contributes in the incidence and progression of chronic non-contagious diseases like CRD, whose etiology is multi-factorial.

For the World Health Organization, in elderly who are 65 or older, physical activity aims to improve their cardio respiratory, muscle and bone conditions, it reduces the risk of depression, cognitive deficit, type II diabetes, hypertension, cancer in uterine cervix, breast cancer and depression. They recommend 150 minutes weekly or 30 minutes daily.

Physical inactivity constitutes the fourth largest risk factor for the mortality rate in the world and it represents 6% of the world disorders. This problem is involved in the world public health, as it is caused by three tendencies: aging population, rapid urbanization and globalization.²³

It is worth pointing out that, though it has been mentioned by a great part of the investigated group the non-addition of sodium chloride to prepared foods, and 87% rigorously fulfilled the medication times, it became clear that hypertension was the most prevalent morbidity with 87%, while diabetes showed only 8.7%.

Hypertension is a precursor with high incidence for several pathologies, mainly because it is a silent disease and it is diagnosed upon late signals and symptoms. Such factors (sex, age, body mass index, eating habits, and salt intake, among others) significantly increase the possibility of acquiring diseases like CRF, acute myocardial infarction and brain strokes caused by renal, cardiac, and cerebral disorder. A study performed on BA programs, focusing on SAH and DM, showed that 65,8% of the individuals were hypertensive and 11% had diabetes.²⁴

According to the result of the last Brazilian dialysis census, the most frequent causes of primary renal failure were arterial hypertension (35%) and diabetes (28%). long time SAH and DM cause nephrosclerosis which occurs at renal artery level, generating a reduction of blood flow to the kidneys and necrosis in the renal parenchyma plate. Because this is the responsible structure for the working part of the kidneys, as time goes by as fibrosis begins and glomeruli are destroyed, this results in an irreversible loss of renal function.²⁵

As for the identification data for risk factors attributed to a family history of CRD, the majority of the participants revealed that

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they had a family history of hypertension (87%). In Felipe's and the collaborators' study, 18% of the hypertensive patients had a family's history of hypertension.¹ Some tendency can be noted in the association of arterial hypertension and the family's positive hypertension history.

The family history Diabetes analysis made it clear that 65.2% of the elderly did not have relatives with diabetes. In a multi-centric study in the south of Brazil, performed with diabetic patients, family history is admitted to be an important risk factor for the development of diabetes mellitus type 2, and it was reported that in general 76.6% of the patients have at least one affected first degree family member.²⁶

Finally, the data showed that 65.2% of the interviewed did not have a family history of renal problems, contrary to 34.8% who did. The studies show that the etiologies that were commonly observed in the nephropathies that determined CRD and Renal Disease in the Terminal Stage for those who have family tendencies.^{21,27}

It is necessary that health professionals inserted in the primary healthcare multi-disciplinary team to identify the individuals that have relatives with advanced CRD, as a way of starting therapy and delay disease progression. While the renal insufficiency genes have not been identified, it is reasonable to assume that history can be used as a risk factor for future renal disease.^{2,21,27}

When performing the consultation, the nurse creates a relationship with the user through the use of light technologies like the hearing, reception, links and responsibility.²⁸

At first, the identification of anti-hypertensive or hypoglycemic treatment in all nursing consultations shows care continuation, followed by the prescribed evaluation in advance (by a doctor or a nurse). In the sequence, the necessities mentioned by the user enabled the planning for the user their self and for the professional who previously treated them, so as to enable new strategies (in case it is necessary), overlooking the reach of the results expected in the control of diseases.¹

The AP investigation approach also implies in a way of monitoring and self monitoring, which should be encouraged for patients with SAH diagnosis.¹⁶ AP measurement is a fundamental procedure in the symptomatic evaluation of the cardiovascular system and it allows monitoring of anti-hypertensive treatment effectiveness.¹

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In the physical exam, studies made clear that it is limited to weight verification, PA measurement, with a brief reference to the evaluation of lower limbs, removing important aspects such as cardiopulmonar auscultation.²⁹ In fact, the physical exam should be performed with the proper education and general observation by the user, and the non-performance of some aspects present a semiotic theoretical and practical knowledge deficit, besides showing difficulty in the execution and depth of the physical nursing exam.¹

Following the clinical evaluation of hypertensive and diabetic patients, there was mention about the solicitation of complementary exams which include, hypertensive: urine type 1, potassium dosage, creatinine dosage, fasting glucose, hematocrit, total cholesterol, LDL, HDL, triglycerides and conventional electrocardiogram.³⁰ And for the diabetic: fasting glucose, glycated hemoglobin, total cholesterol, triglycerides, serum creatinine, urine exam (urine infection, proteinuria, ketone bodies, sediment), micro-albuminuria (diabetes type 2, if negative proteinuria) and electrocardiogram.³¹

Therefore, the consultation as a nurse's clinical practice in basic care stands out as a social practice as well, seen that it is performed based on individual social necessities that are formed and change into social relation dynamics. The nurse, when playing their caretaker role, overlooks care assistance expansion beyond the individual, such considering other factors that can be embedded in the health/disease process.²⁸

Thus, the nursing consultation becomes relevant for risk factor identification that can contribute to CRD prevention and proportion.²⁷ It is understood that the risk factors in the health field are the conditions or associated variables to the negative result occurrence possibility for individual or collective health.³²

As a prevention strategy for CRF risk factors, the nurse, as a caretaker and educator, uses health education through educational practices, aiming to strengthen the basic care service expense reduction, helping self-care and development of the patient's responsibility for the decisions that are related to his/her health.^{27,33}

It is worth noting that the health actions should be performed based on the user necessity, through biopsychosocial dimensions, and they should be considered health

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practices to articulate the social practice with the social totality.³⁴

Health education constitutes as a mechanism for the promotion for quality of life for individuals, families and communities, through the articulation of technical and popular skills, institutional and community resources, public and private initiatives, therefore interrupting the biomedical concept of health care, approaching the health-disease-care process social determinants.

For the educational practices performed in the living group, a puppet theater, chat circles, dialogued expositions, and theatrical play construction, among others. This is why some risk factors were focused: obesity, lack of regular physical activities, smoking, alcoholism, improper eating, excess sodium, preservatives and fat. Education in health performed in group reveals that each individual has their own importance and stands out in the group, making it more cohesive and effective.³³

Studies state that educational group practices help the formation of a basis that strengthens the relations and transforms individual experiences in learning. Because thinking about education in health is to understand the individual as a part of the process, which is creative, dialogic and has to be constructed.³³

CONCLUSION

The living group analysis, through the activities developed by the nurse during the consultation towards the hypertensive and diabetic patients, allowed us to notice that the risk factors for CRD development are prevailing, with emphasis on SAH, DM, addition of sodium chloride, physical inactivity, age, use of industrialized food, SAH family history presence and renal problems.

Because basic care is the subject of this research, it stands out as a proper scenario for the nursing consultation, as it provides the professionals and users with health actions for promotion, protection, recovery and maintenance. This is why the nursing consultation becomes fundamental in risk factor group identification for the prevention of Arterial Hypertension and Diabetes Mellitus of complications as well as other Chronic Renal Disease risk factors.

Therefore, it becomes relevant that nurses and other health professionals acknowledge the importance of the precocious CRD identification in basic care. With this objective, discussions about the results aimed

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to present the potential CRD risk factors and the need for improvement with health education actions and intersectoral policies, assuring that the nursing consultation towards risk groups has a qualified PCH monitoring.

Therefore, it is believed that much has to be researched on the current subject. In fact, it is expected to contribute a little more for the discussions on the nursing consultation in the prevention of CRD in living groups.

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Araújo AM, Mendonça AEO de, Menezes RMP de

Nursing consultation for chronic renal failure...

Sources of funding: No

Conflict of interest: No

Date of first submission: 2012/01/17

Last received: 2012/03/26

Accepted: 2012/03/26

Publishing: 2012/05/01

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