



ARTERIAL HYPERTENSION AND DIABETES MELLITUS: HEALTH CARE IN A BASIC UNIT

HIPERTENSÃO ARTERIAL E DIABETES MELLITUS: ATENÇÃO À SAÚDE EM UMA UNIDADE BÁSICA

HIPERTENSIÓN ARTERIAL Y DIABETES MELLITUS: ATENCIÓN A LA SALUD EN UNA UNIDAD BÁSICA

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ABSTRACT

Objective: to report the experience of a university extension activity in a basic health unit (BHU), aiming to provide health care to people with diabetes mellitus (DM) and systemic arterial hypertension (SAH) through the development and application of a model for nursing consultation and home visit. **Method:** this is an experience report based on the execution of the university extension project "Health care to people with arterial hypertension and diabetes mellitus in the Lagoa da Conceição Basic Health Unit", in Florianópolis, Santa Catarina, Brazil. **Results:** 32 nursing consultations and 5 home visits to people with SAH and DM were carried out. The participants' average age was 61.18 years (SD: 12.21) and most of them were female (86.48%). **Conclusion:** the care to people with SAH and DM can be developed in a joint effort, with openness to dialogue, acknowledgement of experience, and connection of the health problem to the other domains of people's lives, with the possibility of a healthy living, even with a chronic disease. **Descriptors:** nursing; home visit; referral and consultation; hypertension; diabetes mellitus.

RESUMO

Objetivo: relatar a experiência de uma atividade de extensão universitária em uma unidade básica de saúde (UBS), com o intuito de prover atenção à saúde de pessoas com diabetes mellitus (DM) e hipertensão arterial sistêmica (HAS) através da elaboração e aplicação de um modelo de consulta de enfermagem e visita domiciliar. **Método:** trata-se de relato de experiência baseado na execução do projeto de extensão universitária "Atenção à saúde de pessoas com hipertensão arterial e diabetes mellitus na Unidade Básica de Saúde da Lagoa da Conceição", em Florianópolis-SC. **Resultados:** foram realizadas 32 consultas de enfermagem e 5 visitas domiciliares a pessoas com HAS e DM. A idade média dos participantes foi de 61,18 anos (DP: 12,21), sendo a maioria do sexo feminino (86,48%). **Conclusão:** o cuidado a pessoas com HAS e DM pode ser desenvolvido em parceria, com abertura ao diálogo, reconhecimento da experiência e associação do problema de saúde aos demais âmbitos da vida das pessoas, com a possibilidade de um viver saudável, mesmo com uma doença crônica. **Descritores:** enfermagem; visita domiciliar; referência e consulta; hipertensão; diabetes mellitus.

RESUMEN

Objetivo: referir la experiencia de una actividad de extensión universitaria en una unidad básica de salud (UBS), con el fin de proveer atención a la salud de personas con diabetes mellitus (DM) e hipertensión arterial sistémica (HAS) a través de la elaboración y aplicación de un modelo de consulta de enfermería y visita domiciliar. **Método:** esto es un relato de experiencia basado en la ejecución del proyecto de extensión universitaria "Atención a la salud de personas con hipertensión arterial y diabetes mellitus en la Unidad Básica de Salud de la Lagoa da Conceição", en Florianópolis, Santa Catarina, Brasil. **Resultados:** fueron llevadas a cabo 32 consultas de enfermería y 5 visitas domiciliarias a personas con HAS y DM. La edad media de los participantes fue de 61,18 años (DE: 12,21), la mayoría del sexo femenino (86,48%). **Conclusión:** la atención a personas con HAS y DM puede ser desarrollada en conjunto, con apertura al diálogo, reconocimiento de la experiencia y asociación del problema de salud a los demás ámbitos de la vida de las personas, con la posibilidad de un vivir saludable, aunque con una enfermedad crónica. **Descriptores:** enfermería; visita domiciliar; remisión y consulta; hipertensión; diabetes mellitus.

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INTRODUCTION

The epidemiological transition process experienced by the Brazilian population in the last decades triggers the influence of technological advances in health care, as well as in the living conditions, access to basic sanitation, food, and consumer goods. These factors contributed to the increase in life expectancy and, thus, a greater exposure to risk factors for developing non-communicable chronic diseases (NCCDs).¹

The health damages arising from NCCDs demand continuing care procedures that, for many people, are particularly complex; they require specialized health care, health education actions, emotional support, and social support, as well as specific assistance and treatment, focusing the increase in quality of life and decrease in damages.²

NCCDs are in the top positions among the causes of death in Brazil, and systemic arterial hypertension (SAH) is the most common cardiovascular disease and the main risk factor for more severe complications, such as stroke, acute myocardial infarction, and end-stage chronic renal disease.³

The onset of SAH occurs more frequently in adults, during the fifth decade of life, and poor adherence to treatment of this disease is commonly associated to its long asymptomatic course, as well as often neglected treatment.⁴⁻⁵

Other quite prevalent chronic disease is diabetes mellitus (DM), characterized by a set of metabolic and endocrine changes requiring constant attention to diet, physical exercise, glucose monitoring, and, in many cases, medication. It has an increasing incidence, with high morbimortality, being a major contributor to the development of renal failure, lower limbs amputation, blindness, and cardiovascular diseases.⁵

In Brazil, SAH and DM are the main causes of mortality and hospitalization, representing 62.1% of primary diagnoses in patients with chronic renal failure undergoing dialysis.⁵

Performance in health care and nursing becomes essential to improve the quality of life, understood as a subjective concept, inherent to each individual and her/his perceptions of society, culture, and values. Another important aspect is the promotion of health, which seeks to strengthen the knowledge, methods and procedures of caring, controlling, and living with the disease, in order to provide the individual with a healthy life despite of her/his chronic condition.⁶

The development of a university extension project with people with DM and SAH was founded on the experience and knowledge that the Center of Research, Nursing Care, and Health Care for People with Chronic Diseases (NUCRON) has been acquiring through its research, teaching, and extension activities in the last twenty years. NUCRON is a research group from the Nursing Department and the Graduate Program in Nursing of Universidade Federal de Santa Catarina (UFSC), focusing its studies on people with chronic diseases.

Thus, we present an experience report from the project aiming to provide health care to people with SAH and DM in the Basic Health Unit of Lagoa da Conceicao (BHU/LC), in Florianopolis, Santa Catarina, Brazil, focusing on the development of technologies for nursing and health care to people with chronic diseases treated in a primary care service, and to promote health to these people through nursing consultations and home visits, always considering the relation between teaching, research, and extension activities. Thus, the aim was to develop a model of nursing consultation and home visit to people with SAH and DM in BHU/LC.

METHOD

This is an experience report from the university extension activity developed from May 2009 to May 2010 in BHU/LC, which was selected due to the fact that it is a location where NUCRON carries out research and teaching activities.

This BHU has one health team from the Community Health Agents Program (CHAP) and two health teams from the Family Health Strategy (FHS), totaling 14 micro-areas; the community health agents (CHA) work in only 9 of these micro-areas. According to data from the Florianopolis city hall, the population of Lagoa da Conceicao is, in accordance with the 2010 Demographic Census from IBGE, 7,333 inhabitants.⁷ The Individual Outpatient Care Report/Collective Activities Outpatient Report (IOCR/CAOR) information system points out that in 2010 this BHU held an average of 1,300 treatments per month, including patients with diabetes and SAH.⁸

The methodology adopted aimed to strengthen ties between members of NUCRON, university students, and health professionals, involving the recognition of the BHU and community needs; development and implementation of a care plan for consultation and home visit; publicizing of the project within the community; implementation of a care agenda; and nursing consultations and home visits.

In the development of activities, a first draft of the model of nursing consultation and home visit was applied, prepared by NUCRON. This model was developed through the recognition that people have different ways of understanding their chronic condition; people perform their care and treatment through the understanding on them and on how their care and treatment are integrated (or not) to their daily lives. Besides, we had as a basis the recognition that the professional's knowledge is only a part of the knowledge on health and that the person in chronic condition is the one in charge of decision-making about self-care. The nursing actions carried out followed the premise that horizontal and dialogical relations, as well as those regarding the other's learning, may contribute to advances in the building of a healthier life of people with SAH and DM.

This model also highlights as relevant the recognition of feelings and ways of coping with the chronic disease; an understanding that people need to be empowered to perform their self-care autonomously; the importance of trading actions and establishing shared goals of care. In addition, the clinical aspects considered as relevant included general and specific physical evaluation for early identification of damages resulting from SAH and DM, which aims to identify signs and symptoms of changes in lower limbs.⁹⁻¹⁰ Thus, neurological, vascular, and functional evaluation of lower limbs has been recognized as essential, given the frequent presence of lesions that converge in irreversible impairment and consequent amputation of the structures compromised.⁹

The following concepts developed by members of NUCRON were taken as references: chronic conditions constitute health problems requiring ongoing management over a period of years or decades and changes in lifestyle. A common point they share is the persistence and the need for permanent care procedures, and they bring a personal, social, and economic impact. They cover different conditions, such as: non-communicable conditions, persistent communicable conditions, long-term mental disorders, and ongoing physical/structural disabilities; and health education as the process of promoting conditions that allow the person with a chronic condition to build her/his knowledge, develop skills to make decisions and choices aimed at healthy living. It involves teaching practices that can occur at any time of the interactions between the professionals, the person with a chronic condition, and her/his support network,

appreciating the different kinds of knowledge and aiming to provide people with autonomy to make informed decisions and choices that promote healthy living. It also favors the creation of spaces for reflection and learning from the perspective of taking individual and social responsibility, intervening in a favorable manner with the transformation of her/his reality.

The nursing consultation is a prerogative of the nurse who uses components of the scientific method to identify health/illness situations, prescribe and implement nursing measures that contribute to the health promotion, prevention, and protection, as well as recovery and rehabilitation of the individual, family, and community. It constitutes a process of nursing practice in order to complete an assistance model which is adequate to the health needs of the population.¹¹ In this case, it specifically addresses people with a chronic condition: DM and SAH, aiming to promote health and quality of life to these people.

A script for data collection was developed to obtain the nursing history, with four parts sequentially held, as follows: a) introductory topic, in order to identify the ways of care and control of the chronic disease, as well as to provide a space for the exposition of feelings and anxieties that are involved in the process of living/being healthy; b) physical examination; c) identification of issues and deficits of understanding in the care, treatment, and disease control; d) preparation of a joint care plan, as well as a proposal for recording the activities.

Through this script, elements that could hamper the chronic condition control and the healthy living of these people were identified. This process was carried out along with the nursing professional and the person with SAH and/or DM.

For the identification of the target public of the extension project, the registration data contained in the software INFO SAÚDE of the BHU/LC and those from participants of a community support group were accessed, allowing us to prepare a survey of people with SAH and/or DM: number of people, place of residence, length of follow-up at the BHU, among others.

To inform people with SAH and/or DM living in the community, a poster was designed to be displayed in the BHU, and people who participated in the support group, as well as those who sought to BHU were invited. Thus, it was possible to start scheduling weekly nursing home visits, with the participation of nurses from the BHU, the university student with a

scholarship, and male and female nurses who are members of NUCRON. Individuality and ethical principles were observed all the time during the care provided to these people.

RESULTS AND DISCUSSION

Thirty-two nursing consultations were performed, out of which five were follow-ups and five home visits. The average age of participants was 61.18 years (SD: 12.21), and most of them were women (86.48%). Fifteen people only with DM, six with ASH, and eleven with an association of both diseases were treated.

Initially, we had some difficulty to implement the scheduling of consultations, because the nursing consultation was not a routine in the BHU. We sought support from professionals and community agents to divulge it. Moreover, we contacted by phone the people enrolled in the service, especially those who were not often attending the BHU. During these calls, the existence of this service was reinforced, as well as the importance of participation for a better evaluation, disease control, and quality of life.

We observed that people who best responded to the phone call were those worried about interference from their life status with the chronic disease and those who were developing life and health care habits consistent with the therapeutic demands requiring specific adjustments.

The approach to people with SAH and DM was driven towards the recognition that there are multiple kinds of knowledge and experience of those living with a chronic condition, which should be considered as essential in the educational process. This approach favored the interaction with people with SAH and DM, the provision of comprehensive assistance, and the sharing of responsibilities for the implementation of care procedures.

The focus of consultations and home visits was, therefore, investigating the perception of people with SAH and DM with regard to their condition, how they saw the performance of the care and treatment and what might be interfering with the control of their chronic condition. From the vision they had of their reality we started to build new possibilities, negotiating goals. Each consultation arose new ways of performing the care and treatment. The professional's performance was based on the recognition that there was not an only way, but that this path had to be built in partnership. Flexibility and commitment were the references to the creation of these paths.

We emphasize that one of the main difficulties people considered as interfering with the control of blood pressure and glycaemia were the daily life problems, especially those related to family. They decreased motivation to carry out the diet and also promoted changes in these controls, even if the diet was observed and the drugs were used. The recognition that stress can be an element effectively promoting these changes sometimes led people to feel better understood, favoring a more open dialogue.

A connection between the professional and the client was established, providing an improved quality of the assistance delivered in the primary care, as evidenced by reports of a better understanding about the needed care procedures, that have been stressed in subsequent follow-up consultations.

The most obvious result obtained in the consultations and visits was the recognition that there were ways to improve the control of a chronic condition in a more realistic manner, i.e., considering the possibilities and limitations of each person. The ideal situation to control blood pressure and glycaemia exists only in the imagination of the health professional, so, this radical way of imposing some form of control has no positive impact on the health of these people. They continue to have interpretations of their own and make their own decisions, even when they state to follow the guidelines from health professionals.

With the development of these activities, it was possible to advance not only with regard to the welfare aspects, but to provide means for the training of professionals from the BHU and the nursing students involved in the care for people with DM and SAH.¹² This allowed the improvement of basic procedures (measurement of blood pressure, capillary glycaemia, etc.); the development of a practical and realistic vision of how a BHU works; the experience in implementing new assistance actions within the BHU; the observation and execution of nursing consultations/visits. It was also shown the importance of nursing care for people with SAH and/or DM, allowing a more comprehensive approach to the health-disease process.

FINAL REMARKS

The completion of the university extension project in the BHU/LC provided an approach to the health team, facilitating the project's execution and strengthening the relationship of this BHU with the community and the university. The project divulged scientific knowledge, contributing to change the care

and health promotion practices, and it allowed us to provide the community with a part of the scientific knowledge produced by NUCRON.

The model's application to nursing consultations and home visits allowed us to view the context in which people with SAH and/or DM live, emphasizing care as something that can be built in partnership. Different strategies can help people perform more effectively the care and treatment of their condition: openness to dialogue; recognition of people's experience as part of knowledge in health care; understanding of the health problem's connection to the other areas of people's lives; shared construction of specific ways of coping with obstacles to treatment adherence; and recognition of the possibility of a happy and healthy life despite having a chronic disease.

One recommends the continuing development of actions aimed at improving health care for people with SAH and/or DM, focusing on the active participation of the community along with the health services, triggering the performance of citizenship, the quest for a healthy living, a harmonious coexistence with the demands from chronic diseases, and the establishment of a connection between teaching, research, and extension.

The activity carried out, with the implementation of the nursing consultation and home visit model, provides support for the development of new technologies for caring for people with DM and SAH.

REFERENCES

1. Achutti A, Azambuja MIR. Doenças crônicas não-transmissíveis no Brasil: repercussões do modelo de atenção à saúde sobre a seguridade social. Cienc Saude Colet [Internet]. 2004 [cited 2010 Feb 14];9(4):833- 40. Available from: <http://www.scielo.br/pdf/csc/v9n4/a02v9n4.pdf>.
2. Edwards S, Gabbay M. Living and working with sickness: a qualitative study. Chronic Illness [Internet]. 2007; [cited 2010 Feb 14];3:155-66. Available from: <http://chi.sagepub.com/cgi/content/abstract/3/2/155>
3. Ministério da Saúde (Brasil). Diretrizes e recomendações para o cuidado integral de doenças crônicas não-transmissíveis: promoção da saúde, vigilância, prevenção e assistência [Internet]. Brasília: Ministério da Saúde. 2008 [cited 2010 Feb 14]. Available from: <http://portal.saude.gov.br/portal/arquivos/pdf/volume8livro.pdf>
4. Ministério da Saúde (Brasil). Cadernos de atenção básica: Hipertensão arterial sistêmica para o Sistema Único de Saúde. Brasília: Ministério da Saúde; 2006.
5. Ministério da Saúde (Brasil). Cadernos de atenção básica: Diabetes mellitus [Internet]. Brasília: Ministério da Saúde [cited 2011 Aug 12];2006. Available from: <http://www.scribd.com/doc/3381326/Caderno-de-Atencao-Basica-Diabetes-Mellitus>.
6. Meirelles BHS, Silva DMGV, Coelho MS, Francioni FF, Souza SS, Marchi CLA, et al. El soporte social en el cuidado y tratamiento de la enfermedad crónica. Rev Panamericana de Enfermería. Mexico (DF), 2006; 3(2):214-8.
7. Prefeitura Municipal de Florianópolis. Secretaria Municipal de Saúde. Distrito Sanitário Leste - População. Florianópolis: Prefeitura Municipal de Florianópolis; 2011. Available from: http://www.pmf.sc.gov.br/sistemas/saude/unidades_saude/populacao/uls_2010_index.php
8. Prefeitura Municipal de Florianópolis. Sistema de Informação da Atenção Básica. Florianópolis: Prefeitura Municipal de Florianópolis; 2010 [cited 2010 Dec 02]. Available from: <http://www.pmf.sc.gov.br/saude/index2.php?secretaria=siab>
9. Assumpção EC, Pitta GB, Macedo ACL, Mendonça GB, Albuquerque LCA, Lyra LCB, Timbó RM, Buarque TLL. Comparação dos fatores de risco para amputações maiores e menores em pacientes diabéticos de um Programa de Saúde da Família. J Vasc Bras [Internet]. 2009 [cited 2010 Apr 21];8(2):133-8. Available from: <http://www.scielo.br/pdf/jvb/v8n2/a06v8n2.pdf>
10. Sandoval RCB. Grupo multiprofissional de atendimento ao diabético/UFSC. Avaliação dos pés de pessoas com diabetes mellitus [Internet]. 2004. Available from: <http://www.hu.ufsc.br/~grumad/index.htm>
11. COFEN - Conselho Federal de Enfermagem. Resolução COFEN-159/1993 - Dispõem sobre a consulta de Enfermagem. Available from: portalcofen.gov.br/9tenovo/node/4241.
12. Alves KYA, Salvador PTCOS, Almeida TJA, Iglesias R, Dantas CN. Profile of hypertensive and diabetic patients enrolled in a basic health unit. J Nurs UFPE on line [Internet]. 2011 May [cited

Oct 5];5(3):[658-69]. Available from:
http://www.ufpe.br/revistaenfermagem/index.php/revista/article/view/1450/pdf_479.

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