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Nurses' role in consolidating longitudinal care for people with coronary artery disease

Atuação do enfermeiro na consolidação do cuidado longitudinal à pessoa com doença arterial coronariana

Rol del enfermero en la consolidación de la atención longitudinal de las personas con enfermedad arterial coronaria

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Abstract: Aim: to understand how primary health care nurses experience the care of people with coronary artery disease in a longitudinal perspective. **Method:** qualitative study using semi-structured interviews to collect data and thematic analysis to handle them. It was attended by 16 nurses in the period between January and April 2016. **Results:** we raised the main category "Nurses' role in consolidating longitudinal care for people with CAD", underpinned by two subcategories addressing nurses' actions and factors interfering with the follow-up of the person with coronary artery disease. **Final considerations:** the follow-up of people with coronary artery disease in primary health care is based on welcoming, follow-up and conscious referral to other services of the health care network, as well as the effective communication among services of different technological densities, which can significantly contribute to the continuity and longitudinality of care.
Descriptors: Nursing; Coronary Disease; Primary Health Care; Continuity of Patient Care

Resumo: Objetivo: compreender como enfermeiros da atenção primária à saúde vivenciam o cuidado da pessoa com doença arterial coronariana em uma perspectiva longitudinal. **Método:** estudo qualitativo o qual utilizou entrevista semiestruturada para coleta e análise temática para tratamento dos dados. Participaram 16 enfermeiros no

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período entre janeiro e abril de 2016. **Resultados:** encontrou-se a categoria "Atuação do enfermeiro na consolidação do cuidado longitudinal à pessoa com doença arterial coronariana" sustentada por duas subcategorias que abordam ações do enfermeiro e fatores que interferem no acompanhamento da pessoa com doença arterial coronariana. **Considerações finais:** o acompanhamento da pessoa com doença arterial coronariana na atenção primária à saúde tem como base o acolhimento, monitoramento e encaminhamento consciente desta a outros níveis de complexidade da rede de atenção à saúde, assim como a comunicação efetiva entre os serviços de diferentes densidades tecnológicas podendo contribuir de maneira significativa para a continuidade e longitudinalidade do cuidado.
Descritores: Enfermagem; Doença das Coronárias; Atenção Primária à Saúde; Continuidade da Assistência ao Paciente

Resumen: **Objetivo:** comprender cómo los enfermeros de la atención primaria de salud experimentan la atención de las personas con enfermedad arterial coronaria desde una perspectiva longitudinal. **Método:** estudio cualitativo que utilizó entrevistas semiestructuradas para recopilar y análisis temático para tratar los datos. Participaron 16 enfermeros en el período entre enero y abril de 2016. **Resultados:** se encontró la categoría "Rol del enfermero en la consolidación de la atención longitudinal de las personas con enfermedad arterial coronaria", basada en dos subcategorías que abordan acciones del enfermero y factores que interfieren con el monitoreo de la persona con enfermedad arterial coronaria. **Consideraciones finales:** el monitoreo de las personas con enfermedad arterial coronaria en la atención primaria de salud se basa en darles la bienvenida, monitorearlas y derivarlas conscientemente a otros niveles de complejidad de la red de atención sanitaria, así como la comunicación efectiva entre servicios de diferentes densidades tecnológicas, lo que puede contribuir significativamente a la continuidad y longitudinalidad de la atención.
Descriptores: Enfermería; Enfermedad Coronaria; Atención Primaria de Salud; Continuidad de la Atención al Paciente

Introduction

Coronary Artery Disease (CAD) is part of a set of diseases that affect the circulatory system and prevails with a significant impact in terms of morbidity and mortality, either in the national or in the international setting. In addition to generating a high number of premature deaths, they cause loss of quality of life and important economic consequences for families and the State.[1] CAD can appear in a chronic form, as in the case of stable angina, or as an acute coronary syndrome (ACS) that includes unstable angina and acute myocardial infarction (AMI), where the latter is the main cause of death among diseases that undermine the circulatory system.[1]

The clinical outcomes related to CAD serve as a warning that, after diagnosis, the person with CAD receives information and is followed-up throughout the care network, in order to

reduce anxiety about the new life condition and ensure integrality throughout his/her health-disease process.[2] Specifically in Brazil, the Ministry of Health developed and disseminated the Strategic Action Plan to Cope with Non-Communicable Chronic Diseases (NCD) in 2011, which aims to prioritize actions and fundamental investments for the reduction of the morbidity and mortality caused by these diseases by means of preventive and health promotion actions.[3]

Primary Health Care (PHC) has an active role in this process, since it is characterized as the preferred gateway to the Brazilian Unified Health System (SUS, as per its Portuguese acronym), having the role of organizing care in the longitudinal follow-up of users. In the face of chronic diseases, longitudinality or longitudinal care, recognizing PHC as a regular source of care over time, gains prominence, as it consolidates itself as a therapeutic relationship, which reinforces the accountability of the team for the care of the user and contributes to the construction of the autonomy of the person with chronic disease.[4]

The treatment of the person with CAD can range from the medicine approach to medium and high complexity interventions.[1] Accordingly, it requires that health professionals have mastery of the reference system for services with different technological densities in the Health Care Network (HCN). In this sense, in several countries, regulation is considered an organizational tool used for user reference and comprises two fundamental aspects for the health sector: the quality and the safety of the health service provided.[5] In Brazil, however, we can note that there is no depletion of resources in PHC before the referral to other levels of care in HCN, which ends up restricting the health access and the follow-up of people with CAD, due to overload in the medium and high complexity services.[6]

In order to expand the follow-up of people with CAD within the PHC scope and offer greater resolution in this setting, the nurses' role is essential, together with the multidisciplinary team, in the development of care plans and enhancement of the bond with the service,[7] this through qualified listening and welcoming. The contribution of this professional is

important for the development of care and managerial practices that ensure actions of resolutive, safe and continuous care.

The emphasis on professional performance, especially on the strategies developed and the challenges faced by nurses in PHC, allows us to establish a closer portrait of the health system, considering that it is characterized as a connection point between users and other professionals – technicians and managers. Thus, we should emphasize the importance of performing studies on the nurses' role in caring for people with CAD in PHC, so that technologies are implemented and incorporated, allowing longitudinal care.

Accordingly, we raised the following research question: how do Primary Health Care nurses experience the care of people with Coronary Artery Disease in a longitudinal perspective? Thus, the study aims to understand how nurses in Primary Health Care experience the care of people with Coronary Artery Disease in a longitudinal perspective.

Method

This is a study with a qualitative approach that used thematic analysis to deal with the data, aiming to extract meanings from words, phrases or incidents attributed by a person or community to a certain topic.[8]

The study setting were the Primary Health Care Units (PHCU) in a town located on the coast of the South Region of Brazil. The PHC network of the studied town is composed of 49 PHCU distributed in five health districts: Center, Continent, East, North and South, where the Family Health Strategy (FHS) teams develop their actions.

Data were collected from January to April 2016. The participants were selected intentionally using the snowball technique, in an attempt to contemplate the five health districts through the indication of names among the nurses who took part in the study. Although the network has approximately 234 registered nurses, we used as an inclusion

criterion: being a nurse with one year of experience in PHCU in the studied town and being active during the data collection period. Regarding the exclusion criteria, we considered professionals on vacation or away for another reason.

The first contact with nurses was made by telephone, seeking to schedule a time to invite them to participate in the research and introduce the methodological proposal in person. Thus, 30 nurses were contacted and 14 refusals were obtained. The reason informed by the professionals was the lack of time to participate in the interview. Accordingly, 16 nurses linked to PHC participated in the study, 12 nurses from FHS and 04 coordinators from PHCU, working in 11 different health units, each representing the different health districts. We should underline that data saturation was achieved when repetition of information regarding the searched phenomena and the absence of new elements relevant to the study was noticed.

In order to collect data, we performed individual semi-structured interviews in the work environment and shift, in a private room that ensured privacy. The interviews were registered by digital voice recording after introducing the research and signing the Free and Informed Consent Form (FICF) and lasted approximately 40 minutes. These interviews were based on the guiding question: How do you, PHC nurse, experience the care of the person with Coronary Artery Disease in a longitudinal perspective? From this question, others were introduced.

Data collection and analysis took place simultaneously, being operationalized in three stages: Pre-analysis; Material Exploration; Treatment and Interpretation of the obtained results.[8]

Pre-analysis is characterized as a moment of approach and organization of the material, as well as the formulation and reformulation of hypotheses and objectives. The interviews were transcribed in full, generating the raw data. The second stage, Material Exploration, contemplated the classification of data, in such a way as to allow the essential understanding of the interview and the creation of analytical codes.

Thus, the raw data were coded, reducing the text to meaningful words or expressions, aiming, subsequently, to formulate the analytical categories, grouping the data according to the theme. In the third stage, we performed the treatment and the interpretation of the obtained results, raising the main categories.

The research complied with the ethical aspects of Resolution nº 466/12 of the National Health Council. The study was submitted to and approved by the Ethics Committee on Research with Human Beings of the Federal University of Santa Catarina (CEPSH/UFSC), under protocol number 03616612.6.0000.0121. In order to ensure the anonymity of the participants, we used the letter E followed by the number corresponding to the sequence order of the interviews (E1, E2, E3 ...) to designate them.

Results

From the analysis of the collected data, we raised the category entitled **Nurses' role in consolidating longitudinal care for people with CAD**. This category was underpinned by two subcategories: "**Nurses' actions in following-up people with CAD in PHC**" and "**Factors interfering with the follow-up of people with CAD by the nurses in PHC**". The subcategories portray the interventions performed by nurses in PHC related to the provision of care to people with CAD, focusing on the referral and counter-referral process.

In the first subcategory "**Nurses' actions in following-up people with CAD in PHC**", the welcoming held by nurses in this setting is signalized as a facilitator of access and bond between these patients and the health professionals.

> *The follow-up of the cardiac patient happens through [medical and nursing] consultations, mainly, individual or with its relatives, due to spontaneous demand or programmatic consultations. In the case of the cardiac patient, programmatic consultations are more focused on the medical and nursing aspects in relation to the guidelines and care where nursing may be working. (E07)*

According to the participants, the nurse welcomes the patient at the PHCU where he/she collects the necessary information to compose the health history and situation, as well as complaints and clinical signs. After this interaction, the nurse passes the collected information to the general practitioner of FHS, who evaluates the patient and, as he identifies the need, calls for the accomplishment of tests to define/confirm the diagnosis and possible referral to medium or high complexity to be evaluated by the cardiologist of HCN.

From this moment, the nurse's performance is considered fundamental, since he/she will continue to follow-up the person with suspected CAD, performing the control of patients who are on the waiting list, for exams and/or consultations with specialists, through of a spreadsheet prepared by professionals from PHCU, aiming to maintain the constant follow-up of these patients:

> *We have a spreadsheet of patients who are waiting for regulatory schedules that we are controlling, so these patients end up entering this spreadsheet where we control whether or not the surgery or specialist scheduling has already done. (E10)*

Nurses reveal that case discussions are carried out by coverage area, in monthly meetings of the health team. Thus, with the exchange of information among professionals working in FHS, the best care plan for these patients is established.

According to the participants, the community health workers, through home visits, perform an active search, aiming to identify patients at risk, such as those who have already undergone cardiac surgery, or those who have risk factors or comorbidities associated with CAD, such as, for example, people affected by high blood pressure and diabetes mellitus. These cases are communicated to the nurse, who is responsible for the management of the team and the information related to the patient and, depending on the patient's situation, decides the behavior to be adopted.

> *The nurse's schedule is not as busy as the doctor's [schedule], so the nurse always ends up being the gateway to the family health team. We always have a free schedule for these patients, we go, talk, schedule a consultation, follow-up, visit [home], so they can have support at the health unit. (E15)*

Nurses affirm that, when performing the follow-up in health in PHC through nursing consultations, patients have easy access and the opportunity to clarify doubts about their health condition and treatment, which also allows early identification of situations of anxiety or clinical change, and there may be rapid intervention by the health team. From the nursing consultation, the nurse has the possibility to develop an appropriate care plan aiming at the patient's well-being and improving the quality of life, with guidance on food and the practice of regular physical activities.

> *After the cardiovascular event, besides the consultations with the physician, the patient also undergoes nursing consultations to analyze his health situation and deal with questions and complaints. (E04)*

The participants highlight that, from the nursing consultation, patients can be referred to other professionals of the multiprofessional team, such as psychologists, physiotherapists and social workers, offering a care network that seeks to address the biopsychosocial needs of this patient. In this sense, the referral of people with CAD to the support groups offered at the PHCU, such as groups of hypertensive and diabetic individuals and of physical activity practices, is a common strategy held by the nurses working in FHS, aiming to follow-up and encourage a change in lifestyle.

> *We have the NASF (Family Health Support Centers) that offers the service of a physical educator, there is a psychologist and a social worker, a nutritionist, so we can easily refer [the patient].* (E02)

Accordingly, the nurse as a care manager for this specific patient in PHC is able to identify the main needs by means of actions capable of favoring planned and continuous care.

In the second subcategory "**Factors interfering with the follow-up of people with CAD by the nurses in PHC**", we addressed aspects that affect the care of the person with CAD in PHC. After the referral of the patient to the specialist, few return to PHC for follow-up because they understand that they already have clinical support in the medium or even in the high complexity. Due to the failure in communication among the HCN points, as well as between the patient and the FHS team, nurses end up unaware of the evolution of the patient's case and, consequently, fail to recognize his/her care needs, which hinders the follow-up in health.

> *Once referred to the cardiologist, many of them prefer to continue the treatment only with the specialist, there are few followed-up there [cardiologist] and return with the family doctor too, so you can count on the fingers the number of patients with this double follow-up, most go and do not return. (E13)*

Nevertheless, we noted weaknesses that directly affect the productivity in relation to the follow-up of patients with suspected CAD by nurses in PHC. Among these, the limitation of physical space that affects the performance of nurses' activities, since they need to share the service room with other professionals, restricting their operation time.

> *Due to the physical space, we have a room for five nurses, so we have to share this room and we are unable to effectively follow-up these patients. (E10)*

In addition, another fact reported by nurses had a dual meaning, since, at the same time that they develop actions for the person with CAD, there is no specific and targeted follow-up, and this follow-up is normally performed like any other morbidity. In view of this, nurses expect adequate training from the municipality, so that they become able to perform the necessary care and interventions for patients who are in these conditions, considering their general training without a focus on the cardiovascular specialty, as portrayed by the following statement:

> *I realize that we have no investment in training, in programs, specific things for this field [cardiovascular]. At least where I work, which is primary care, we have things focused on children, pregnant women,*

> *diabetics and hypertensive patients. However, for cardiac ones, I never saw anything, we never had any training. (E03)*

An important challenge found by nurses for the continuity of care for people with CAD is the communication among services with different technological densities in HCN. Nurses emphasize the lack of communication, especially between PHC and high complexity, as one of the main obstacles to the effectiveness of the referral and counter-referral process and the consequent follow-up in health of the person with CAD.

We should underline that there is no sharing of clinical information between PHC and high complexity, since there is no integration between the municipal and the state information systems, or unification of the electronic medical record, resulting in the discontinuity of the follow-up of the person with CAD by the PHC professionals after his/her referral. Thus, the counter-reference is weakened by considering that few patients receive discharge reports and are instructed to return to PHC.

> *As long as we do not have a unified medical record, it complicates this communication. Nevertheless, we do what can be done in the reference, having the counter-reference is what fails, so we end up not having this return and it makes the things difficult for the nursing professional. (E10)*
> *There is no institutional counter-reference, it depends a lot on the professional who cares for, there is a professional who gives a discharge summary, for example, and we know everything that has been done; there are professionals who do not, and then the patient comes with nothing, just with the exams that were delivered, it's very relative. (E04)*

For the nurses in this study, information regarding the care process at other levels of health care is essential for the preparation of the care plan, since any complication affects the intervention to be performed with the patient. When the patient brings the complete discharge report, including exam results, the nurse becomes able to check the patient's situation broadly and develop a longitudinal care plan.

Discussion

The findings of this study reveal that, among the actions developed by nurses in PHC to the person with CAD, the welcoming is shown as a facilitator of access to the health team and through which they seek to resolve the patient's health/disease demands. The welcoming in the nurse's work process is revealed as part of the systematization of care, where it is possible to perform a qualified listening and establish a bond, in addition to organizing the demand for medical consultations.[9]

This study found that nurses manage the referral of PHC patients to other levels of care through their own instrument. When the importance of following-up the referral of these patients by the nurse becomes evident, two points of discussion are raised. Firstly, this initiative on the part of the nurse demonstrates an attitude of commitment to the patients' need in view of the difficulty of accessing certain exams and specialists due to the high demand for referrals. Conversely, the amount of unnecessary referrals constitutes a curativist model of health care, generating waste of resources, waiting lines and low resolution, lacking reflections.[4]

Despite the conduct of referral, without exhausting the resources available in PHC, there are actions that seek to fully address the patient's needs, taking into account the case discussions with the multidisciplinary team. The participants highlighted that the case discussions with the team are fundamental for the strengthening of the link between the patient and the FHS professionals.

In this perspective, actions taken jointly by professionals to strengthen the principles of health prevention and promotion, such as community interventions, for example, aim to cope with CVD focusing on the risk they bring, with a view to changing the care model through integrated and intersectoral actions.[10] In Canada, a study indicates that clinical case management reduces psychological stress, increases the patient's and caregiver's safety and

proves that it is a promising way to improve health outcomes among users who frequently use the health unity with complex needs.[11]

A study that sought to check the treatment adherence of patients with heart failure undergoing home care by nurses after hospital discharge found that educational interventions at home significantly improve treatment adherence among these patients. [12] It also highlights the importance of home visits by nurses, being an opportunity to manage these cases, guided by protocols of care and drug treatment, guidelines for changes in lifestyle and individual follow-up.[13]

Due to their permanent condition, patients with chronic diseases may be resistant to health care services and to the guidance, requiring differentiated assistance. Thus, the longitudinal follow-up in PHC for these patients has its own complexity, since it implies the integrality of the welcoming and the temporality of care. This requires that each case be considered in a singular way with the assurance of continuous attention to the health situation.[14]

For this purpose, through the nursing consultation, the nurse accomplishes the follow-up of the patient and has the opportunity to listen to the demands and evaluates his/her health conditions, thereby being able to provide appropriate guidance for each situation, as well as share information with the multiprofessional team. In this regard, a strategy for the management of complex cases, widely used in patients with chronic diseases, is the Singular Therapeutic Project, which aims to promote care through the co-production and co-management of individual and collective care, where the patient and the family are the focus of action planning.[15]

In this context, the accomplishment of nursing consultations can be facilitated by the provision of a suitable room, i.e., an individual room for each nurse. In this study, limited physical space was considered an obstacle to the follow-up provided by the nurse to the person with CAD. Corroborating it, a study on the expansion of access in PHC showed that the

readjustment of physical space in primary health care units allowed nurses to have their own offices and reorganize patient flows, favoring access.[16]

Still through nursing consultations, nurses find space to perform their care, managerial and educational skills. They carry out health education activities in PHC, whose aim is to guide the population and provide strategies for the prevention of CAD, with a focus on reducing risk factors and recurrence of heart problems through self-care. FHS has a space that allows such actions, with the nurse's work aimed at the educational aspects of care. Thus, although there is a lack of specific training for the care of people with CAD in PHC, nurses assume roles and characteristics in their practice that enables integral patient care.[17]

A study found that there is no specific role of nurses when it comes to rehabilitation for patients with heart diseases. Nevertheless, we should emphasize the importance of the presence and the significant participation of nurses in their field of operation, mainly in the sense of offering safety and better quality of life to the health and disease process of the person with CAD.[18] The triad of adequate food, drug treatment and physical activity represents a possibility for the maintenance of the health of individuals affected by CAD or revascularized, being a space for the nurses to act, which has the potential to substantially contribute to the continuity of care.[19]

According to the interviewees, the ideal for the adequate follow-up of the patient is that PHC becomes the gateway to HCN, but they point out numerous difficulties in this process. In this sense, a study performed in the United Kingdom highlights the importance of establishing a bond between the health professional and the patient to help us to reduce gaps that may be faced during health care, many of them due to the lack of communication among the HCN points. The continuity of care with a professional where the bond is already established ensures that patients do not deviate from PHC and helps us to reduce the excessive use of highly complex services.[20]

We should underline that, sometimes, due to the lack of bond and resolution in PHC, referral of the patient after discharge to PHC does not happen.[21] Patients seek rehabilitation services in an autonomous manner, when they do. On the other hand, access to PHC is restricted to renewing medical prescriptions, distributing medicines and measuring blood pressure, not characterizing a service for referral and follow-up of health promotion and prevention.[21-22] In addition, the testimonies showed that patients diagnosed with CAD after contact with the environment of medium complexity prioritize the act of giving continuity of care in this location, instead of PHC.

In this regard, a study performed in Barcelona, Spain, showed the interaction between primary and secondary care doctors, where the definition of duties and the sharing of responsibilities between clinician and specialist favored the diagnosis and plans for the patient's treatment.[23] Moreover, technologies such as *Telessaúde* may avoid referrals to medium complexity, in addition to being characterized as a resource of assistance support, strengthening the integration among health services, expanding resolution and establishing a cost-effectiveness of public health processes. We should also mention that it enhances family health teams through continuing education.[24]

Nevertheless, when dealing with access to information in the hospital environment, the participants brought the difficulty of sharing information between PHC and the hospital environment as a barrier for the longitudinal follow-up of patients in HCN. Accordingly, the benefit regarding the shared medical record is the enhancement of the performance of the FHS team towards patient care, enabling integral and optimized care.[22]

In addition, the advantages of shared electronic records reinforce the safety of information storage, promptness and, especially, the facilitation in relation to patient care at any point in the scope of HCN.[21] However, as in this study, the State and the municipality governments use different and non-integrated systems, where the only source of information in

relation to the patient takes place through the discharge form, which the patient can take to PHC to give continuity to the follow-up in health.

Final considerations

The PHC nurse involved in following-up the person with CAD performs actions such as welcoming, management of referrals for exams and consultation with specialists, discussion of cases with the multiprofessional team, management of home visits and nursing consultation. Nevertheless, it also experiences challenges with regard to the consolidation of longitudinal care, such as the poor return of the patient to PHC after referral to medium and high complexity, the limitation of physical space for nursing consultations, the lack of specific follow-up in health of the person with CAD, as well as the lack of communication and exchange of information among HCN points.

We should highlight that the effective follow-up of the person with CAD in PHC is based on the welcoming, monitoring and conscious referral of the patient to other levels of complexity in HCN, as well as the effective communication among services of different technological densities, which can significantly contribute to the continuity and longitudinality of care.

As an implication for the practice itself, we should highlight the importance of the nurses' performance for the feasibility of longitudinal care for people with CAD, besides the need to improve the strategies developed by them to follow-up the flow of users and manage cases that include professionals from different HCN points, as well as users, in order to favor the bond and the self-care.

The study has as a limitation the fact that it was performed only with nursing professionals, thereby suggesting studies addressing the viewpoint of FHS and its multiprofessional team, with a view to broadening the vision and discussion about the consolidation of longitudinal care for people with CAD.

References

1.Vieira EC, Cardoso ACC, Macêdo LB, Dias CMCC. Ocorrência de internações hospitalares por doenças do aparelho circulatório no estado da Bahia. Rev Pesqui Fisioter [Internet]. 2016 [acesso em 2017 jun 29];6(2):115-23. Disponível em: https://www5.bahiana.edu.br/index.php/fisioterapia/article/view/920/607

2. Badar AA, Perez-Moreno AC, Hawkins NM, Jhund PS, Brunton AP, Anand IS, et al. Clinical characteristics and outcomes of patients with coronary artery disease and angina: analysis of the irbesartan in patients with heart failure and preserved systolic function trial. Circ Heart Fail [Internet]. 2015 [acesso em 2017 jun 29];8(4):717-24. Disponível em: https://www.ncbi.nlm.nih.gov/pubmed/26067854

3. Ministério da Saúde (BR). Plano de ações estratégicas para o enfrentamento das doenças crônicas não transmissíveis (DCNT) no Brasil 2011-2022 [Internet]. Brasília (DF): Ministério da Saúde; 2011 [acesso em 2017 jun 29]. Disponível em: http://bvsms.saude.gov.br/bvs/publicacoes/plano_acoes_enfrent_dcnt_2011.pdf

4. Santos ROM, Romano VF, Engstrom EM. Vínculo longitudinal na Saúde da Família: construção fundamentada no modelo de atenção, práticas interpessoais e organização dos serviços. Physis (Rio J) [Internet]. 2018 [acesso em 2017 jun 29];28(2):e280206. Disponível em: https://doi.org/10.1590/S0103-73312018280206

5. Anjos JN. Regulação no setor da saúde: análise de Direito Comparado: Portugal, Reino Unido, França e Espanha [Internet]. Coimbra (Portugal): CEDIPRE; 2015 [acesso em 2017 jun 29]. Disponível em: https://www.fd.uc.pt/cedipre/wp-content/uploads/pdfs/co/public_26.pdf

6. Gawryszewski ARB, Oliveira DC, Gomes AMT. Acesso ao SUS: representações e práticas de profissionais desenvolvidas nas Centrais de Regulação. Physis (Rio J) [Internet]. 2012 [acesso em 2017 jun 29];2(1):119-40. Disponível em: http://www.scielo.br/pdf/physis/v22n1/v22n1a07.pdf

7. Oksman E, Linna M, Hörhammer I, Lammintakanen J, Talja M. Cost-effectiveness analysis for a tele-based health coaching program for chronic disease in primary care. BMC Health Serv Res. [Internet]. 2017 [acesso em 2017 jun 29];17(1):138. Disponível em: https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-017-2088-4

8. Minayo MC. O desafio do conhecimento: pesquisa qualitativa em saúde. São Paulo (SP): Hucitec; 2013.

9. Ferreira MLSM, Ferreira RMVBP, Marin MJS, Pinto AAM, Mazetto FMC, Meneguin S. Welcoming in the work process of the primary care nurse: qualitative study. Nursing (São Paulo) [Internet]. 2017 [acesso em 2018 ago 04];20(226):1623-7. Disponível em: bvsalud.org/portal/resource/pt/biblio-869197

10. Ribeiro AG, Cotta RMM, Ribeiro SMR. A promoção da saúde e a prevenção integrada dos fatores de risco para doenças cardiovasculares. Ciênc Saude Colet [Internet]. 2012 [acesso em 2017 jun 29];17(1):7-17. Disponível em: http://www.scielo.br/pdf/csc/v17n1/a02v17n1.pdf

11. Hudon C, Chouinard MC, Aubrey-Bassler A, Burge F, Doucet S, Ramsden VR, et al. Case management in primary care for frequent users of healthcare services with chronic diseases and complex care needs: an implementation and realist evaluation protocol. BMJ Open [Internet] 2018 [acesso em 2019 nov 15];16(3):e026433. Disponível em: https://bmjopen.bmj.com/content/8/11/e026433

12. Mantovani VM, Ruschel KB, Souza EN, Mussi C, Rabelo-Silva ER. Adesão ao tratamento de pacientes com insuficiência cardíaca em acompanhamento domiciliar por enfermeiros. Acta Paul Enferm [Internet]. 2015 [acesso em 2018 ago 25];28(1):41-7. Disponível em: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0103-21002015000100041&lng=en

13. Toso BRGO, Filippon J, Giovanella L. Nurses' performance on primary care in the National Health Service in England. Rev Bras Enferm [Internet]. 2016 [acesso em 2018 ago 25];69(1):182-91. Disponível em: http://www.scielo.br/pdf/reben/v69n1/en_0034-7167-reben-69-01-0182.pdf

14. Junges JR, Fernandes RBP, Herbert NDR, Tomasini F, Werle L, Pereira C, et al. The difficult longitudinal care of a female patient in a severe chronic situation: analysis of an emblematic case. Interface (Botucatu) [Internet]. 2017 [acesso em 2018 ago 25];21(62):651-9. Disponível em: http://www.scielo.br/scielo.php?pid=S1414-32832017000300651&script=sci_arttext&tlng=en

15. Silva AI, Loccioni MFL, Orlandini RF, Rodrigues J, Peres GM, Maftum MA. Projeto terapêutico singular para profissionais da estratégia de saúde da família. Cogitare Enferm [Internet]. 2016 [acesso em 2018 ago 25];21(3):01-08. Disponível em: https://revistas.ufpr.br/cogitare/article/view/45437

16. Lowen IMV, Peres AM, Ros C, Poli Neto P, Faoro NT. Inovação na prática assistencial do enfermeiro: ampliação do acesso na atenção primária. Rev Bras Enferm [Internet]. 2017 [acesso em 2018 ago 26];70(5):898-903. Disponível em: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0034-71672017000500898&lng=en

17. Silva KM, Santos SMA. A consulta de enfermagem na estratégia de saúde da família: realidade de um distrito sanitário. Rev Enferm UFSM [Internet]. 2016 [acesso em 2018 ago 26];6(2):248-58. Disponível em: https://periodicos.ufsm.br/reufsm/article/view/18079/pdf_1

18. Gonçalves ES, Torres RM, Peixinho TC, Borges CCL. Fatores de risco para doença arterial coronária em motorista de ônibus. Rev Baiana Enferm [Internet]. 2014 [acesso em 2017 jun 29];28(3):252-9. Disponível em: https://portalseer.ufba.br/index.php/enfermagem/article/viewFile/11399/8987

19. Callegaro GD, Koerich C, Lanzoni GMM, Baggio MA, Erdmann AL. Significando o processo de viver a cirurgia de revascularização miocárdica: mudanças no estilo de vida. Rev Gaúch Enferm [Internet] 2012 [acesso em 2018 ago 26];33(4):149-56. Disponível em: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1983-14472012000400019

20. Tarrant C, Windridge K, Baker R, Freeman G, Boulton M. 'Falling through gaps': primary care patients' accounts of breakdowns in experienced continuity of care. Fam Pract [Internet]. 2014 [acesso em 2017 jun 29];32(1):82-7. Disponível em: https://academic.oup.com/fampra/article-lookup/doi/10.1093/fampra/cmu077

21. Erdmann AL, Lanzoni GMM, Callegaro GD, Baggio MA, Koerich C. Compreendendo o processo de viver significado por pacientes submetidos à cirurgia de revascularização do miocárdio. Rev Latinoam Enferm [Internet]. 2013 [acesso em 2017 jun 29];21(1):[cerca de 8 p.]. Disponível em: http://www.scielo.br/pdf/rlae/v21n1/pt_v21n1a07

22. Bousquat A, Giovanella L, Campos EMS, Almeida PF, Martins CL, Mota PHS, et al. Atenção primária à saúde e coordenação do cuidado nas regiões de saúde: perspectiva de gestores e usuários. Ciênc Saúde Colet [Internet]. 2017 [acesso em 2017 jun 29];22(4):1141-54. Disponível em: http://www.scielo.br/pdf/csc/v22n4/1413-8123-csc-22-04-1141.pdf

23. Waibel S, Vargas I, Aller MB, Coderch J, Farré J, Vázquez ML. Continuity of clinical management and information across care levels: perceptions of users of different healthcare areas in the Catalan National Health System. **BMC Health** Serv Res [Internet]. 2016 [acesso em 2017 jun 29];16(1):466. Disponível em: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5010665/

24. Piropo TGM, Amaral HOS. Telessaúde, contextos e implicações no cenário baiano. Saúde Debate [Internet]. 2015 [acesso em 2018 jun 29];39(104):279-87. Disponível em: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0103-11042015000100279

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