

Care of individuals with Diabetes mellitus: nursing consultation from the perspective of nurses

Cuidado de indivíduos com Diabetes *mellitus*: a consulta de enfermagem na perspectiva de enfermeiras

Atención de personas con Diabetes mellitus: consulta de enfermería desde la perspectiva de enfermeras

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Abstract: Objective: to know the perspective of nurses about the nursing consultation in the care of individuals with Diabetes mellitus. **Method:** exploratory, qualitative and descriptive study developed in a city of Santa Catarina, Brazil. It was attended by six nurses working in primary care units and in a reference service. The data were collected through semi-structured interviews, between June and August 2015. The analysis followed the Thematic Analysis technique. **Results:** when performed, the nursing consultation is incomplete, focused on complaints, repetitive and linked to the renewal of prescriptions, with a lack of professionals, high demand and concern in caring for quickly during assistance. **Conclusion:** the challenge of accomplishing the nursing consultation persists. Accordingly, the adequate staff sizing of the team is important, envisaging possible absences from work. Articulation of theory and practice and reorganization of the work process for integral care of individuals with Diabetes mellitus are essential for the nursing consultation to be used in the care.

Descriptors: Nursing care; Office nursing; Diabetes mellitus; Health centers; Primary health care

Resumo: Objetivo: conhecer a perspectiva de enfermeiras sobre a consulta de enfermagem no cuidado com indivíduos com Diabetes *mellitus*. **Método:** estudo exploratório descritivo qualitativo desenvolvido em município de Santa Catarina, Brasil. Participaram seis enfermeiras de unidades básicas e serviço de referência. Os dados foram coletados com entrevistas semiestruturadas, entre junho e agosto de 2015. A análise seguiu a técnica de Análise

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Temática. **Resultados:** quando feita, a consulta de enfermagem é incompleta, focalizada em queixas, repetitiva e vinculada à renovação de receitas, havendo falta de profissionais, alta demanda e preocupação em atender rapidamente durante a assistência. **Conclusão:** persiste o desafio da realização da consulta de enfermagem. Neste sentido, o dimensionamento adequado de pessoal da equipe é importante, prevendo possíveis faltas ao trabalho. Articulação teoria e prática e reorganização do processo de trabalho para atenção integral a indivíduos com Diabetes *mellitus* são essenciais para que a consulta de enfermagem seja utilizada no cuidado.

Descritores: Cuidados de enfermagem; Enfermagem no consultório; Diabetes mellitus; Centros de saúde; Atenção primária à saúde

Resumen: Objetivo: conocer la perspectiva de enfermeras sobre la consulta de enfermería en la atención de personas con Diabetes mellitus. **Método:** estudio descriptivo cualitativo exploratorio desarrollado en una ciudad de Santa Catarina, Brasil. Se incluyeron seis enfermeras de unidades básicas y servicio de referencia. Los datos se recolectaron mediante entrevistas semiestructuradas, entre junio y agosto de 2015. El análisis siguió la técnica de Análisis Temático. **Resultados:** cuando se realiza, la consulta de enfermería es incompleta, enfocada en quejas, repetitiva y vinculada a la renovación de recetas, con falta de profesionales, alta demanda y preocupación para atender rápidamente durante la asistencia. **Conclusión:** el reto de realizar la consulta de enfermería persiste. En este sentido, el dimensionamiento adecuado del personal del equipo es importante, previendo posibles ausencias del trabajo. La articulación de la teoría y la práctica y la reorganización del proceso de trabajo para la atención integral de las personas con Diabetes mellitus son esenciales para la consulta de enfermería que se utilizará en la atención.

Descriptor: Atención de enfermería; Enfermería de consulta; Diabetes mellitus; Centros de salud; Atención primaria de salud

Introduction

Diabetes mellitus (DM) is a chronic disease considered as a pandemic, with human, social and economic costs linked to early mortality and disabilities derived from its complications.¹ It is a metabolic disorder of multiple etiology, characterized by hyperglycemia and disorders of fat, protein and carbohydrate metabolisms, resulting from deficiency in secretion and or the action of insulin, which requires follow-up, treatment and care to prevent other illnesses caused by persistently high levels of glucose.²

In Brazil, considering the population over or equal to 18 years old, a study of surveillance of risk factors and protection in relation to chronic diseases held by means of telephone survey³ identified that 7.7% of those surveyed reported medical diagnosis for diabetes (8.1% of women; 7.1% of men) and, in both genders, the frequency of the chronic condition increased with age and

decreased among those with higher schooling levels. In Florianópolis, capital of the state of Santa Catarina, the frequency was 6.7%, ranging from 6.1% for males to 7.2% for females.⁴

As a Chronic Non-communicable Disease (NCD), DM interferes in the quality of life and health of the populations, as well as in the organization of the work processes of the teams in health care services. The burden of these diseases is growing in the world, which may be attributed to contemporary lifestyle, epidemiological and demographic changes, as well as to the globalization process itself.⁵

Aware of this and coherent with international initiatives, in 2011, the Strategic Action Plan to Combat NCD was launched in Brazil, with the objective of preparing the country to prevent and control such diseases between 2011 and 2022. To this end, it proposed the development and implementation of effective public policies aimed at reducing morbidity, mortality and disability caused by such diseases.⁶

The implementation of this Plan has demonstrated advances in surveillance, health promotion and integral care actions, following the example of the construction of the Chronic Disease Health Care Network proposed in 2012. Nevertheless, despite the observed progress, much remains to be done, especially regarding the training and work process of the teams for resolute assistance.⁷ The goals of this Plan are being met, but continuous follow-up is required to expand the actions already implemented, as well as review of the employed strategies.⁸

It is important to highlight that sedentariness, obesity and longevity can contribute to the growth of NCD and require strategies that include, in addition to drug treatment, the participation and regular behavioral adherence of the individual. In this context, it is essential to involve and establish links between the multiprofessional team and the individual experiencing NCD, with a view to achieving an effective control of the disease.⁹

In the context of care for the individual with DM, we should introduce the multiprofessional follow-up in primary health care (PHC), with emphasis on Family Health

Strategy (FHS), fertile field for the promotion of health and quality of life of individuals and communities. Accordingly, we should underline the importance of the nurse and other team members in the accomplishment of health education actions, enabling the individual to acquire autonomy over his/her care, becoming able to understand, evaluate and make decisions about his/her disease.⁹

Considering the perspective of integral care to DM, the nurse places himself/herself as an essential professional for the health care in all levels of care and components of an integrated network. However, the role of this professional stands out in PHC, due to the possibilities of disease prevention, early detection and follow-up and evaluation of those already affected. The work of nurses at this level of care is strategic and fundamental because of the potential to identify the health needs of individuals and perform risk stratification, which will subsidize the organization of network care.¹⁰

Accordingly, the National Policy of Primary Health Care (PNAB, as per its Portuguese acronym)¹¹ includes, among the attributions of this professional, the accomplishment of the nursing consultation and procedures, the request of complementary exams and the prescription of medications according to protocols, as well as clinical and therapeutic guidelines. Moreover, the risk stratification and the preparation of a care plan for those who, in the territory, live with chronic health conditions deserve to be highlighted.¹²

In the exercise of the profession, the nurse must operationalize his/her service by the implementation of the nursing process (NP), accomplishing it in a deliberate and systematic way, in any environment where professional nursing care takes place. In PHC, this instrument is usually called Nursing Consultation (NC) and has five steps: History of Nursing (acquisition of information from the individual and his/her family, as well as physical examination); Nursing Diagnosis (elaboration of diagnostic concepts about the health situation of the individual); Nursing Planning (interventions to be accomplished and expected results); Implementation

(accomplishment of the established interventions) and Nursing Evaluation (process that evaluates if the expected result has been achieved and if there is a need for changes in the interventions).¹²

As an important element of the know-how of nursing, NC is not a new theme. It has been considered for decades as an application of NP in the professional care to the “non-hospitalized and apparently healthy individual or the patient in outpatient treatment”.^{13:53} Currently, the nursing process (NP), which is expressed in the non-hospital care as NP, constitutes the nursing care systematization (NCS), as “the founding and structuring axis of the construction of knowledge and professional practice (teaching, care, research and management/management)” of nursing.^{14:5} As such, it requires different skills, abilities, study, flexibility, creativity and innovation, so that care is closer to the reality of life and the needs of people. Nevertheless, despite the current legislation and being a theme present in the investigations in the nursing area, it is still not consolidated in the scenarios where the care is developed.¹⁴

From the outlined context, the following research question emerged: what is the perspective of nurses about NC in the care of individuals with DM? In this framework, there is an urgent need to broaden the discussion about nursing care to individuals diagnosed with DM, with a view to improving health care. Thus, this article intends to know the perspective of nurses about NC in the care of individuals with DM.

Method

It is an exploratory and descriptive study with a qualitative approach, developed in three Primary Health Care Units (PHCU) and one Reference Center (RC) of the service network belonging to the Municipal Health Department of a mid-sized city located in the west of Santa Catarina (SC), Brazil. Such places were chosen because they are configured as spaces of assistance and care for individuals with DM and because they constitute environments of academic practice and project development for an extension course in nursing of a public university in Santa

Catarina. It is important to clarify that individuals with DM linked to PHCU are referred to RC for consultation with medical specialties where, in the same way, they are served by nurses.

We used the following criteria to include the participants: being an active nurse in one of the selected PHCU and RC, providing assistance for at least one year to individuals with DM. In PHCU and RC, there are a total of eight nurses, where six of them met the selection criteria, five working in PHCU and one in RC, who participated in the study. All nurses accepted to participate in it. The data collection took place with semi-structured interviews guided by a specific script with 14 questions about the time of training and work in Nursing, as well as the assistance to individuals with DM. The interviews were developed in the work environment of the participants, after prior scheduling, from June 18th to July 17th, 2015. The invitation to participate and the scheduling of interviews were made through telephone contact, when the study was presented.

Before the collection with the participants, we conducted two interviews with other nurses to check the adequacy of the script of questions and to prepare the interviewer. After each one of the interviews, the audio was heard so that the behavior of the interviewer was evaluated and improved. After that, the data collection took place.

In the meeting for the interviews with the participants that took place in PHCU and RC in a room that offered privacy, the study was presented again and, after clarification of doubts, the Free and Informed Consent Form was signed. The reports were recorded on a smartphone, stored on a computer and fully transcribed. Each meeting lasted an average of 40 minutes. The interviews were conducted by the first author of this article under the supervision and orientation of the second author. The data collection was interrupted when all six nurses had been interviewed. The text resulting from each transcription was validated with the interviewees, who read it and agreed with its content. Moreover, the Consolidated Criteria for Reporting Qualitative Research (COREQ) guided the preparation of this article as a way of ensuring the quality of the report.¹⁵

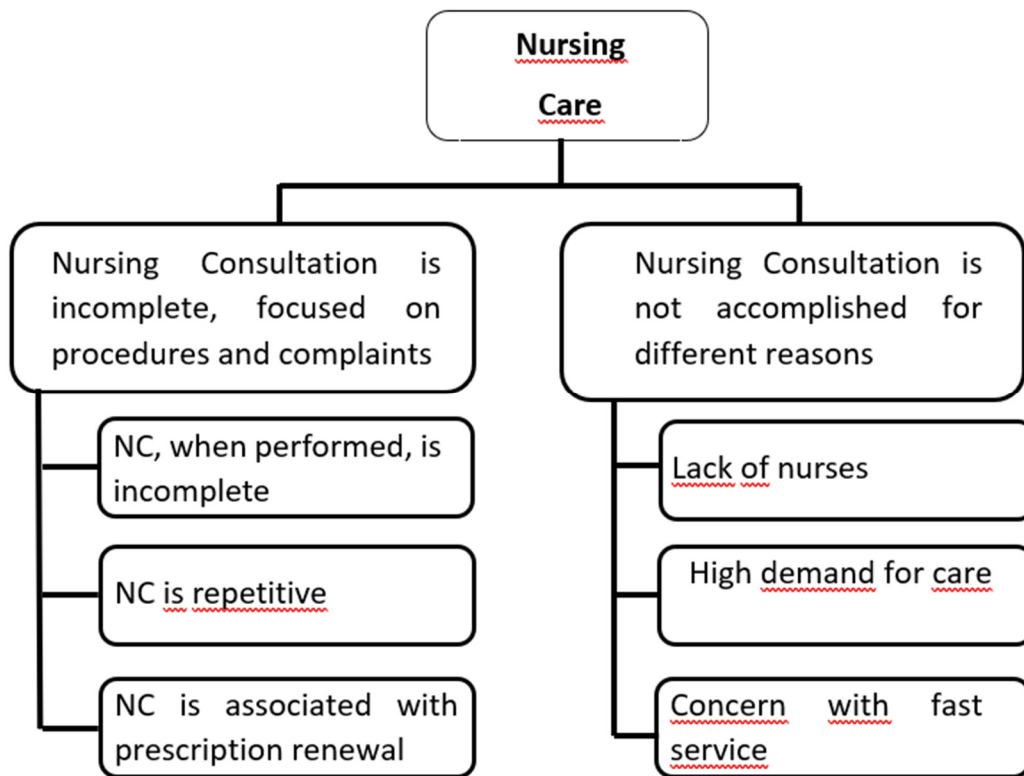
In order to analyze data, we complied with the guidelines of the thematic analysis modality with the following operational steps:¹⁶ a) pre-analysis, where a repeated floating reading was developed, with a view to recognizing the ideas present in the transcriptions and compose the research corpus; b) exploration of the material, with careful reading for classification and aggregation of data and definition of categories; c) treatment of the obtained results and interpretation with the establishment of relationships with literature. From this analytical process, the convergence of ideas resulted in the identification of the theme 'nursing care', with two categories and six subcategories, which are represented and discussed in the next section.

This study followed the recommendations of Resolution 466/2012 of the National Health Council and the data collection took place after the approval of the research protocol (CAAE nº 45125615.4.0000.5564) by the Research Ethics Committee, with opinion number 1101819, dated June 10th, 2015. In the presentation of results, the anonymity of the participants was preserved by the use of the letter E (interviewee in Portuguese language) followed by an Arabic number indicating the order of the interviews (Ex: E1).

Results and discussion

In this section, we will show the graphic representation of the categories and subcategories identified in the theme 'Nursing Care' (Figure 1).

Figure 1 – Graphic representation of the theme ‘nursing care’, its categories and subcategories. Santa Catarina, 2015.



As demonstrated in Figure 1, NC is not adopted as the daily practice of nurses when caring for individuals with DM, a circumstance that they attribute to different factors, such as the need to provide for the lack of a colleague and the desire to care for everyone quickly. NC is a central assistive technology in the performance of nurses in PHC and the expression ‘nursing consultation’ is synonymous with the nursing process when employed in primary care, outpatient clinics, homes, schools, as well as other non-hospital services.^{12,17}

As such, NC has specific legislation regulating it. Thus, according to the Resolution of the Federal Council of Nursing – COFEN 358/2009, NC is “[...] a methodological instrument that guides the professional nursing care and the documentation of professional practice”^{12:1}, besides an indispensable in NCS in any health institution.

The integral care to the health of the individual with a chronic condition from the perspective of the care network requires articulation and communication between the different

components/services and, above all, the professional performance of different nuclei of knowledge and practices,⁵ with a key role of PHC and nurses in this process. In PHC, NC is important for identification of health care needs of people with NCD, such as the case of DM. In this context, data are collected, nursing diagnoses are identified and behaviors are outlined, so that the care is resolute.

Incomplete Nursing Consultation, focused on procedures and complaints

The participants revealed that “NC, when performed, is incomplete”, which is related to different factors, such as the presence or not of complications:

There is a patient who complains of a foot injury. Thus, [the nurse] performs a physical examination and gives orientation about foot injury. He doesn't complain, he ends up being left behind and he often doesn't know the care he should take. (E3)

If he has a problem with his feet, some difficulty, his toenails, we always ask; if he has any complaints, we check, if he has no complaints, no. (E4)

When you perceive that the patient is a little pale, you go to the electronic record, investigate, check the latest exams. (E6)

As highlighted by the testimonies, the nurses link their behaviors to the care of complaints or signs presented by the user, which seems to reinforce the idea that the assistance prioritizes curative aspects and suggests a strong influence of the biomedical model in the performance of these professionals. At the same time, they highlight that the potential of NC to promote health and prevent complications of DM is not fully used.

NC involves different steps already described here, which places it as an important element of NCS.¹² It is an essential technology in nursing care, which enables us to direct assistance, make

decisions in the health care process and evaluate interventions.¹⁷ Moreover, NC is a private function of the nurse that increases his/her autonomy in this process, which allows this professional to evaluate different situations of health and disease by considering the concrete conditions of life of each individual, family and or community. As such, it requires specific knowledge, skills and competences.

Thus, we can say that the accomplishment of NC to individuals with DM makes possible an integral and resolute nursing care, favoring the promotion of health and the prevention of the development of complications, no longer having only a curative role. The care starts to be based on the needs identified in a careful evaluation in the nursing history, valuing the knowledge of the life conditions of that individual, as well as their complaints reported in the consultation, which can already signalize complications of DM. Nevertheless, the content of the presented testimonies suggests that NC has not been a basic instrument of work in the care of individuals with DM, even though it has been considered mandatory for the nurse since 2002.¹²

A study developed in Rio Grande do Sul, with the purpose of knowing how professionals conducted the process of caring for individuals with systemic arterial hypertension and DM in FHS, concluded that NC is not included in routine care and there was no identification of records in the medical charts of the investigated users.¹⁸ In addition, a health care practice developed in Criciúma/SC with people with NCD revealed that NC strengthened the bond of the nurse with them, making them feel welcomed, more confident and awakening their desire to participate in a therapeutic group, as well as broadening the possibility of adhering to treatment.¹⁹ In the same direction, a research with 20 PHC nurses from Florianópolis, SC, pointed out that NC is “considered as an instrument to strengthen the bond between the professional and the user, as well as a space for the development of professional autonomy and independence”, although many PHC nurses do not develop it.^{20:256}

Another research developed in the same city identified that the presence of chronic complications, often irreversible, represented a milestone in the follow-up of the individual with DM.²¹ Such results are in line with what was obtained in this study and demonstrated in the testimonials. We should underline that, in DM, the living conditions and the way of life are key elements to the health care process. This is why it is necessary to understand them, which is enabled by the individualized care²¹ provided by NC.

In this category, another aspect to be considered is “in NC, the guidelines are always the same”, as highlighted by the reports of the surveyed nurses:

In the second consultation, he already comes to the nurse. In this consultation, every time we address the care with food, medication, physical exercise. After that, we keep repeating, reinforcing. Every time [that the user comes] we perform hemoglucotest; once a year or more, we request exams to see how he is doing. (E4)

[...] in the routine consultation, we always focus more on food, medication, encourages women to undergo the preventive, that is, we also give some hints about these things. The consultation would be more or less like this, focusing on food, medication and physical exercise [...]. We repeat many times. (E5)

The reports reveal repetition of the same orientations at each new meeting with the user, which may be related to incomplete development or non-development of NC. The lack of anamnesis and physical examination (nursing history) means that the needs, difficulties and doubts of individuals with DM are not highlighted. Without acquiring this information and without evaluating the situation, the nurse passes on the same routine information to everyone, without particularities and singularities being valued. Thus, this professional adopts a prescriptive and unidirectional behavior of knowledge transmission, which does not contribute to the desired change in the health situation and to the resolvability of the care.

This way of acting reinforces the perception of a practice based on a biomedical model, with health education little instrumented and based on the transmission of knowledge and orientations.⁹ It is not a matter of devaluing the orientations made, but of arguing the need for them to be adequate to each one according to their reality of life and health, as a way of expanding the possibilities of integration of what is oriented in the daily health care of the individual.

Considering that the nurse is a health educator, it is expected that he/she perceives the needs of users so that he/she can play a mediating role in this education process.⁹ Accordingly, NC enables the knowledge and culture of those involved to be valued, so that the exchanges and shares established in this space are converted into health promotion.

The COFEN Resolution 358/2009¹² describes the objectives of the anamnesis or nursing history by detailing the techniques to be used in the physical examination, so that the survey of information about the health of the individual is careful. In other words, the legal orders of the profession standardize the nursing process as a basic instrument, a reflection of the scientific knowledge that underlies the discipline. When accomplished in its specificities, NC enables quality of care, because it provides a singular approach, appropriate to the peculiarities of each individual, bringing benefits to the team and to the user.¹⁰

In the testimonies, the practice of making “NC in the renewal of the prescription” is repeated. A new prescription is given when the individual seeks the health unit for this purpose or in a group meeting:

We take the opportunity to make the consultation when they return to renew the medication prescription. Nonetheless, it's not that consultation with all the steps! [...] we check the tests, if they are up to date or not, give advice on diet and renew the prescription. (E2)

We make the nursing consultations at the time the patient seeks the unit to renew the prescription. Therefore, in the screening, the technique checks the vital signs and, if the glycemic index is altered, we ask for a control and annual routine exams as well. Thus, I check the chart and see if it's late or

not. But, if it is not the first consultation, the diabetic doesn't want orientation; he wants just the prescription because he's hurried. Of course, we won't just deliver the prescription. We're always talking. (E3)

Look, we do a lot of things in the renewal of the prescription! We build the group every four months and we deliver the prescription there. Therefore, you check vital signs, weight, HGT and already guides what to do if there are changes. There is always a lecture with topics that we consider important for them. Some of them arrive there and say "could you give my prescription, then I'll leave, right? They don't want to participate. (E4)

Usually, they come to exchange prescriptions, so we already orient them about the medication and ask about the way they're using it. (E5)

NC is closely linked to the prescription renewal/repetition procedure, due to the fact that these prescriptions are valid for a limited time, which leads individuals to PHCU to renew them. Nevertheless, the attention of the nurse, and often the user, is focused on the prescription. As a result, NC is reduced to a quick conversation focused on medication, diet, and sometimes the request of routine exams. The testimony given by E4 suggests that, in the group meeting, the focus is on the delivery of a new prescription, despite the lecture and the collection of some data, such as vital signs and HGT. Moreover, the group seems to be a way of assisting more people at the same time.

In this same direction, a study identified that the care with diabetes performed in group was held as a way of assisting more people, optimizing the professional scheduling. Nevertheless, the results indicate that the main activity developed was the delivery of prescriptions and, sometimes, the request of laboratory tests without, most of the times, opportunity to discuss other themes. This situation suggests a lack of appreciation of the needs of individuals with DM, revealing a lack of welcoming and bonding, as well as a lack of systematic follow-up of those who have the disease, which could prevent and reduce complications.²¹

The testimonies presented here reveal that the NC scheduling, at least in the case of DM, is not the practice adopted by nurses. By linking NC to other procedures or activities, an

important tool for following-up individuals with DM is no longer used, which would contribute to the promotion of global health and the prevention of other diseases related to chronic complications. Accordingly, the non-scheduled NC interferes in the quality of care and in the integrality of the care, since the services are performed for free demand or taking advantage of occasions when the individual seeks the health institution for another reason.¹⁰

Nevertheless, we should recognize the value of group activities in sharing knowledge and exchanging experiences that are so important in health education, which requires articulated planning from the multidisciplinary team. In this regard, a research developed in the South Region of Brazil²⁰ reaffirmed that NC is an important tool for health education, because it strengthens the bond between professional and user, besides allowing autonomy and independence to the nurse. In the same direction, a study that compared the effectiveness of the nursing consultation and the group educational actions in the care of individuals with type 2 DM demonstrated that the individualized assistance provided by NC is recommended to clarify doubts and expand knowledge about the disease, reducing its impact on quality of life. The accomplishment of group health education activities together with NC favors greater adherence to self-care.²² Accordingly, it is a matter of developing both activities and not choosing one of them.

In the results of this study, it is important to highlight the use of the meeting with the individual with DM as an opportunity to offer information that arouses fear, in an attempt to motivate him/her to take care of his/her health and follow the orientations:

Sometimes, they will take care of themselves when they already have some impairment in kidneys, in eyes. I always try to scare. (E4)

[...] we talk about the vision, the foot, the healing. After that, we show a diabetic foot, wounds. This is to raise awareness and scare a little bit about the complications. If not, they don't even take care of themselves. (E3)

Acting in this way, the nurse places himself/herself in the position of behavior regulator, rather than as a key professional for the health education required for autonomous and conscious decision making by individuals with DM. This suggests a prescriptive, authoritative and coercive action, based on 'I said do it. If you don't do it, you'll have complications and it'll be your fault'. Perhaps, due to the lack of time and the repetitive character printed to the nursing orientations also highlighted by the participants, the dialogue between professional and individual with DM is not valued as an instrument of exchange of knowledge and shared construction of care. Dialogue presupposes "a horizontal relationship of respect, exchange, collaboration and openness to listening", which is necessary for the establishment of mutual trust and bond, both necessary for an effective communication.^{23:18}

As clinical work, NC is important for health promotion, especially when it is based on attentive listening and dialogue, in order to value other aspects of living beyond the biological. In this regard, we should underline that decisions about treatment cannot be exclusively technical, because the other, in the case of the individual with DM, brings with him/her his/her knowledge, vision about the condition and the care practices that he/she already adopts, all referenced in his/her concrete life conditions.²⁴ Therefore, we should remember the importance of bringing together, in dialogue, the knowledge and practices of the individual, in this case, with diabetes, with those of the professional, who, in this case, is the nurse.²⁵ Thus, the construction of a new knowledge and closer to the life of the population in general is mediated by dialogue, essential to communication, which demands, among other elements, trust, respect and sympathy in a horizontal interpersonal relationship.

The cultural knowledge and contents that the individual with DM brings are reflected in the way of living and in the health care process, interdicting some practices and stimulating others, for example, with regard to food. NC makes it possible to get to know and value them, so that, in the encounter with professional knowledge, care is jointly outlined and can be

incorporated into daily life. Listening attentively to the other is essential, and this is provided by NC, where the nurse turns to the other, dedicating more time to him/her than the attention directed to the possible complaints that he/she has.

The Nursing Consultation is not accomplished for different reasons

The “lack of nursing professionals” was indicated by those surveyed as one of the reasons for not accomplishing the procedures of NC. This situation is considered responsible for the decrease in quality of care highlighted by the impossibility of developing NC with all steps:

We coexist with situations where one colleague took a sick note, another is on vacation. It has already happened to me. Therefore, you provide assistance from three areas of FHS instead of one. Consequently, what happens? The quality of care falls, because you don't make an ideal nursing consultation, with that ideal physical examination that you could do if you had time available. (E1)

[...] it's hard to perform [NC] as we would like. Firstly, there is always a lack of nursing professionals. We're in two with three teams and we need to care for [...]. (E2)

Sometimes, it's a maternity leave, and then there is a lack of nurses. I already took over the coordination because there was no nurse for that. I have already covered the issues of assistance as well. (E5)

The lack of professionals does not mean that there are no other nurses linked to the service. The absences are due to medical certificates, vacations or leaves, situations that overburden the professional who continues acting, because there is no availability of another to meet the need during the period of absence. The absenteeism of team members overburdens the nurse, because many times it imposes him/her to abandon his/her activities to take over the ones that fit to the one who is absent. There is also the identification that the “high demand for care hinders the accomplishment of NC.

We have a lot of demand to pass all the information in nursing consultation. It depends on the day, we sometimes get it, but there are days on which we can't get it, because of the demand. (E3)

There are days when there are not many people and I assist more than 30 people. So, how will you do everything right? We manage to get it through practice. When it's the first consultation, where the person started the treatment for diabetes, you dedicate more time. After all, you just reinforce. (E4)

When it's calmer, I can even do it. Because here it's free demand. There are days when there are a lot of people; therefore, it surely doesn't work. We abbreviate. (E6)

Nevertheless, allied to the high demand and the daily rushes is the “concern to assist everyone quickly”, so that the individual does not stay too long waiting. In this context, NC, especially in relation to those users already known, is seen as a waste of time:

[...] in the first hour of the morning, I already had 10 patients. Thus, if you count the time to assist 10 patients means that those who arrived at 7:30 a.m., some left almost at 10 a.m. Thus, if a diabetic came in the third [user to be assisted], that you had seven more to assist later, you will not lose half an hour, an hour making a nursing consultation for a patient that you already know on a daily basis. If you have a new patient, the behavior changes a lot. (E3)

This testimony reveals a little of the influence that the organization of the work process of the nurse in PHCU has on the accomplishment of NC. The lack of professionals, the high demand of users and the concern in assisting quickly form, therefore, a triad of reasons that lead to the non-accomplishment of NC, making a higher quality care impossible. As a cascading effect, we should observe that the lack of professionals directs the high demand to the acting professional, who cares for the users in a quick way so that the others do not wait for a long time. In this setting, NC is considered as a consumer or as a waste of time.

A study developed in the South of Brazil observed that the absenteeism of members of the nursing team generates overburden to the nurse, who generally takes over the fulfillment of the activities, jeopardizing his/her performance and leading him/her to abandon those activities that are private to him/her. Add to that, we should mention the administrative functions that he/she develops and the lack of physical space as barriers to the development of the health care activities that fall to him, such as the case of NC.²⁰

The high demand and the lack of time available for the service are important factors that influence the accomplishment or not of NC, a practice that requires dedication of variable time according to the needs of a first consultation, follow-up and welcoming of the spontaneous demand.¹⁷ The role of the nurse in the follow-up of individuals with DM includes screening, prevention of complications, intensification of glycemic control and education activities, which requires technical-scientific skills and competences to perform it properly. Accordingly, the relevance of this professional training should be highlighted so that he/she has such skills and competences that enable him/her to act as a generalist in the management of care with chronic health conditions, paying attention to the integrality, equity and universality of care.⁹

The nurse develops bureaucratic activities that are sometimes excessive, which results in work overburden, creating difficulties for his/her involvement in assistance. However, this professional develops quality health care when performing clinical functions and, in addition, has preparation for “coordination functions with clinical and case management, managing care in the network”.^{26:5}

The testimonies also reveal that the non-accomplishment of NC as a scientific method for nursing care is related to the triad of reasons already presented. The participants mention an ideal consultation, learned during their training, but they are unable to put it into practice in their daily lives. Unable to apply the NC process in the way that they learned, they do not use it routinely in the care.

[...] that ideal nursing consultation that we learn in college is not always possible to put in daily life, in welfare practice. (E1)

I haven't followed that consultation pattern for a long time, because I think, at the health center, anywhere, you can't do that! Even because you have more experience and, just by looking at the patient, you already know how he behaves, what he does. I've been here for almost 8 years, so I know almost all the patients. (E4)

We check the skin, the places of insulin application, the feet. It's no longer that academic physical exam, open your mouth, look at the mucosa, but we check [...]. (E6)

The abandonment of the procedures of NC learned in the training process is also attributed to the experience gained by the nurse when caring for individuals with DM and other users, as revealed by participant E4. We should underline that the experience acquired in the work contributes to speed up health care and evaluation. However, care must be taken so that the proximity between professionals and users, made possible by FHS, does not lead to conclusions and actions that disregard the situation of the individual, without a careful evaluation of his/her health and life condition.

The identification of situations based solely on 'looking' at the 'already known' individual suggests a way of acting guided more by common sense than by science, which can lead to misinterpretation and neglect of attention. The NC learned during graduation follows the purposes of the broad and generalist education, being executed in ideal conditions and with time necessary for learning. The insertion of its exercise in the daily work in nursing in PHC, or in any other space, requires adaptations, but does not despise the collection of subjective and objective information of the individual to orient the integral and resolute care.

Nevertheless, the testimonies indicate a distance between the nursing education and the reality of health services. The correlation between theory and practice is important and, in this regard, a solid training is a necessary condition for nurses to have the basis and scientific knowledge to face the most diverse situations in the routines of work. When adopting NC as a care technology

for the professional practice of nursing, the nurse differentiates his/her performance and can, in individual and personalized care, direct his/her behaviors to the peculiarities and needs of each individual, increasing the quality of care, as well as identifying important aspects for a group approach.

At the end, the limit of this study is the fact that it did not include nurses working in the care of individuals with DM in all Primary Health Care Units of the city. This fact offers only a cutout of the reality of care, which could have achieved different results if a nurse from each PHCU had been interviewed.

Final considerations

The results found demonstrate that the implementation and operation of NC represents a challenge that faces obstacles to be overcome. One of them is the overburden of work of the nurse, who accumulates health care and management activities with the need to take over the activities of another colleague due to medical certificates, vacations, leaves and others. Accordingly, we believe that the staff sizing of the team deserves special attention of the managers.

NC is not included as an essential activity in the follow-up of the individual with DM. In this setting, it no longer fulfills its role as a care advisor and loses importance as an instrument for assistance focused on improving the health condition of the individual, whether for prevention, early detection and/or postponement of complications. Nurses have not mastered this technology that opens possibilities to outline the ways of caring for and innovating, even among so many protocols and rules already instituted in the care of individuals with DM. NC is not yet implemented as a meeting place, a place for links, exchanges, health education and empowerment.

As an element of NCS in PHC, the adoption of NC as a care technology enables the qualification of assistance to individuals with DM, increasing the autonomy and visibility of the performance of the nurse, which have long been on the agenda of the struggles of this profession.

The organization of the demand of assistance of individuals with DM could make care more effective, valuing the role of the nurse in the multiprofessional team. However, there is the possibility of new studies in this area, which still has much to explore in order to improve the team and the quality of assistance, since the role of the nurse still needs to be highlighted and discussed, with a view to having better appreciation and incentive to the category.

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