CLINICAL PROTOCOLS IN ADVICE TO CHRONIC PATIENTS

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ABSTRACT: Qualitative study, undertaken in three phases between 2012 and January 2014 to verify the use of clinical protocols when giving advice to chronic patients. The initial data collection took place upon discharge from the hospital, the second at home after 12 months and the third after 24 months. The sample consisted of 20 hypertensive and/or diabetic adults hospitalized at a teaching hospital in Curitiba, Brazil. Based on the data analysis, three categories were constituted: "Knowledge about the disease", "Care with regard to the disease" and "Barriers for treatment adherence". It was identified that the advice, through the use of clinical protocols, furthered the knowledge about the disease and the care the participants developed. In conclusion, the use of the protocols is a health education strategy for chronic patients. They make the care feasible and reveal the progress made and difficulties found.
DESCRIPTORS: Nursing; Chronic illness; Clinical protocols; Health education.

PROTOCOLOS CLÍNICOS NA ORIENTAÇÃO DE PESSOAS COM DOENÇA CRÔNICA

RESUMO: Estudo qualitativo, realizado em três etapas no período de 2012 a janeiro de 2014, com o objetivo de verificar a utilização dos protocolos clínicos na orientação das pessoas com doenças crônicas. A primeira coleta foi na alta hospitalar, a segunda no domicílio com 12 meses e a terceira com 24 meses. A amostra foi de 20 adultos hipertensos e/ou diabéticos internados em Hospital de Ensino de Curitiba, Brasil. A análise dos dados permitiu a formação de três categorias: "Conhecimento sobre a doença", "Cuidados em relação à doença" e "Barreiras para a adesão ao tratamento". Identificou-se que as orientações, mediante uso dos protocolos clínicos, propiciaram a melhora do conhecimento da doença e dos cuidados desenvolvidos pelos participantes. Conclui-se que o uso dos protocolos é uma estratégia de educação em saúde para as pessoas com doenças crônicas, eles viabilizam o cuidado sendo possível visualizar o progresso e as dificuldades encontradas.
DESCRITORES: Enfermagem; Doença crônica; Protocolos clínicos; Educação em saúde.

PROTOCOLOS CLÍNICOS EN LA ORIENTACIÓN DE PERSONAS CON ENFERMEDAD CRÓNICA

RESUMEN: Estudio cualitativo, realizado en tres etapas en el periodo de 2012 a enero de 2014, con objetivo de verificar la utilización de los protocolos clínicos en la orientación de las personas con enfermedades crónicas. Los datos fueron obtenidos primeramente en la alta hospitalar, después en el domicilio con 12 meses y, enseguinda, con 24 meses. La muestra fue de 20 adultos hipertensos y/o diabéticos internados en Hospital de Enseñanza de Curitiba, Brasil. El análisis de los datos posibilitó la formación de tres categorías: "Conocimiento sobre la enfermedad", "Cuidados referentes a la enfermedad" y "Obstáculos para la adhesión al tratamiento". Se identificó que las orientaciones, por meio del uso de los protocolos clínicos, propiciaron la mejoría del conocimiento de la enfermedad y de los cuidados desarrollados por los participantes. Se concluye que el uso de los protocolos es una estrategia de educación en salud para las personas con enfermedades crónicas, pues ellos hacen viables el cuidado siendo posible mirar el progreso y las dificultades encontradas.
DESCRIPTORES: Enfermería; Enfermedad crónica; Protocolos clínicos; Educación en salud.

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INTRODUCTION

Non-Transmissible Chronic Illnesses (NTCI) represent a great problem in Brazil, being responsible for 70% of deaths in the country, and mainly affect vulnerable population groups, such as the low income population with low education levels. Among the chronic illnesses, two stand out in the country: Systemic Arterial Hypertension (SAH) and Diabetes Mellitus (DM), which constitute the primary cause of hospitalizations in the Brazilian public health system[1].

The large number of hospitalizations due to the complications of NTCI entail high medical and socioeconomic costs. A significant association exists between these hospitalizations and non-adherence to the treatment, whether involving medication or not[2-3].

In that sense, the encouragement towards treatment compliance requires an agreement between the professional and the SAH patient, so that they make appropriate choices to conduct the treatment, considering that the effectiveness of the treatment requires knowledge related to their disease, with a view to granting them an active voice in their care process, with conditions to choose after assessing the consequences of the treatment regimens proposed[4].

Hence, when they know the treatment possibilities, SAH patients can agree upon easy compliance actions together with the professional, which can make them adhere effectively to the treatment. The use of the clinical protocols, which aim to improve the care and facilitate the health education process, guide the care towards the established action, optimize resources and offer efficient and high-quality care[5].

The protocols are considered to be auxiliary tools in the health education process, in case management and in the self-management of chronic illnesses, which can reduce the appearance of complications and the number of hospitalizations these diseases cause[6].

To make this possible, a change is needed in the hegemonic health model, which is currently disease-centered, with a supply-and-demand network structure and communicating and articulating points for the purpose of integral health actions and services, providing continuing, high-quality and responsible care[7].

Therefore, a project was elaborated for the management of care for chronic patients, in which the researchers constructed clinical protocols based on the Brazilian Hypertension and Diabetes Guidelines, which were used for discharge advice and monitoring at home. Thus, the objective in this study was to verify the use of clinical protocols for advice to chronic patients.

METHOD

A descriptive and qualitative study with a longitudinal approach was undertaken in three phases, between January 2012 and January 2014. The data were collected by nursing undergraduates who served as grantees in the post-training project, and took place at a teaching hospital and at the home of 20 participants chosen by convenience who complied with the following inclusion criteria: adults between 18 and 60 incomplete years of age, living in Curitiba or the metropolitan region, SAH and/or DM patients, hospitalized in emergency care at the research hospital for at least two days. Before the data collection, the entire team was trained on how to conduct the interview and use the protocols and the orientation guide.

The first step was developed at the hospital, during the hospitalization period, through a semistructured interview, when the identification data, age, marital status, education, family income, occupation, risk factors, history of the disease and care actions were collected. In addition, questions were asked about the participants' knowledge of the disease, doubts or need for further information.

The collected information permitted individual orientations using clinical protocols (Figure 1), elaborated by the authors, which consist of organization charts based on the National Hypertension and Diabetes Guidelines[8]. After the orientations, actions were established together with the participants, written down in a guide, and the next visit was scheduled at home or by telephone.

The second step was developed 12 months after the discharge, which consisted in monitoring the actions taken during the hospital stay, through an interview with open questions, aimed at verifying the effect of applying the protocols on the treatment compliance and the participants' knowledge about their disease. This monitoring took place through home visits to 15 participants and telephone contact with five, as the latter alleged they could not receive the researchers.

In the third phase, 24 months after the discharge, contact was again made by telephone

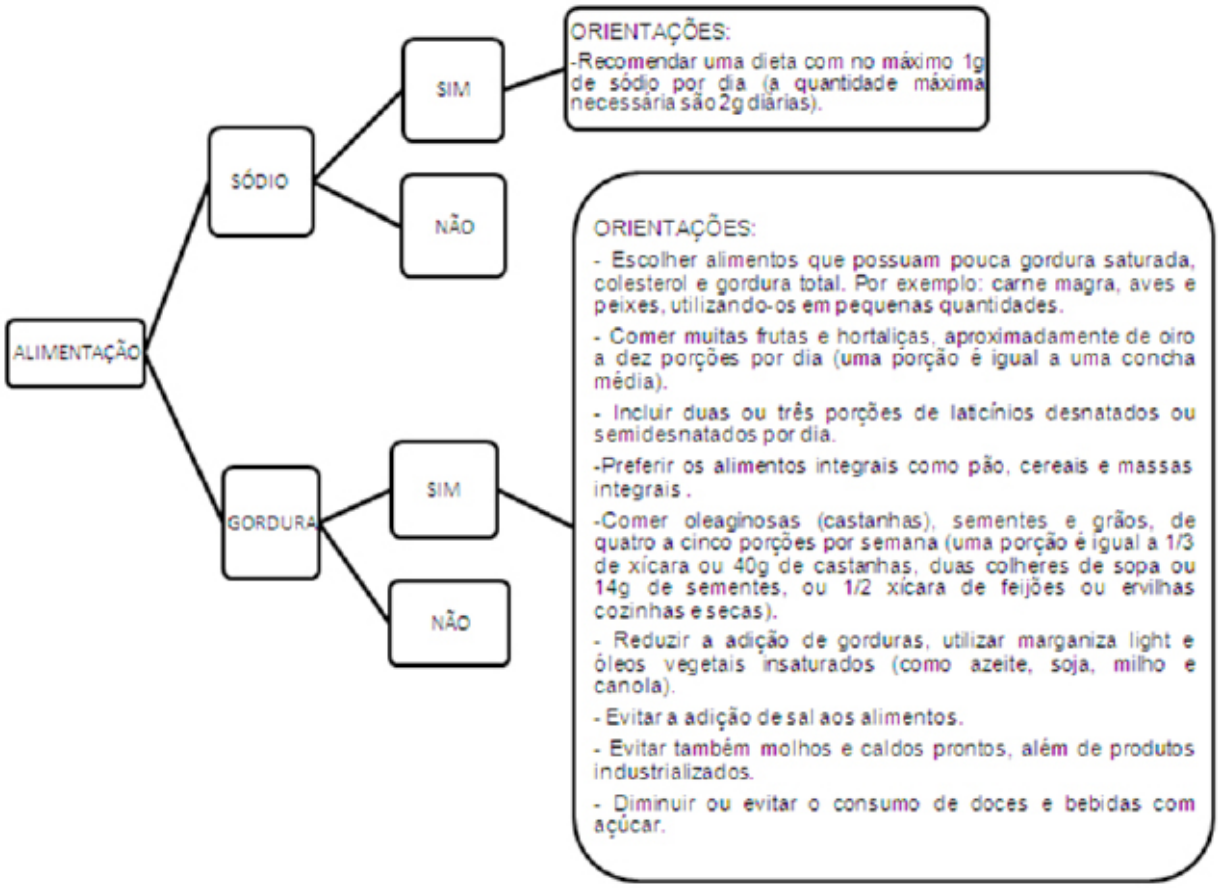

Figure 1- Example of protocol used for advice to hypertension and diabetes patients. Curitiba, 2015

to verify the compliance with the actions agreed upon with the help of the protocol, which were emphasized during the first contact with the participants after the discharge. Three were not part of the sample due to death.

In all phases, the interviews were recorded, fully transcribed and the content was analyzed according to Bardin[9], who proposes three phases: pre-analysis, exploration of the material and treatment of the results. This resulted in three categories: "Knowledge about the disease", "Care in relation to the disease" and "Barriers for treatment compliance". In the first two categories, the discourse before and after the orientations was highlighted.

As regards the ethical aspects, approval for the project was obtained from the Research Ethics Committee of the Health Science Sector at Universidade Federal do Paraná under protocol CEP/SD 1227.152.11.09. Out of respect for the participants' anonymity, they were identified by the vowel "E", followed by increasing algarisms (e.g. E 01, E 02, etc.).

RESULTS

Among the 20 interviewees, nine were female and 11 male, between 25 and 59 years older, with 49.5 years as the average age. Eleven were married, five single, two widowed and two divorced. As for education, 12 had up to eight years and eight more than eight years of study.

Concerning the diagnosis, 10 were SAH patients, five DM and five had both diseases at the same time. Three participants were smokers, eight former smokers and nine had never smoked. Two used alcoholic beverages, two were former drinkers and 16 affirmed they had never drunk alcohol. With regard to physical exercise, seven regularly exercised.

What the Body Mass Index (BMI) is concerned, one participant suffered from morbid obesity (BMI over 40 Kg/m2), five class I obesity (BMI between 30.0 and 34.9), four class II obesity (BMI between 35.0 and 39.9), five overweight (BMI between 25.0 and 29.0) and five normal weight (BMI between 18.6 and 24.9). Regarding the family history, 16 had a first-degree relative who suffered from a chronic disease.

All participants presented comorbidities and some complications, such as: cerebrovascular accident, profound venous thrombosis, phlebitis and thrombophlebitis, chronic kidney failure, hypothyroidism, chronic cardiac disease, congestive heart failure, portal hypertension and hepatic steatosis.

Concerning the reasons for hospitalization, 12 participants were admitted due to a hypertensive crisis and/or complications related to SAH, such as angina, tachycardia, arrhythmia, dyspnea, chronic kidney failure and suspected thrombosis.

The thematic analysis of the data permitted the elaboration of the following categories: the first, "Knowledge on the disease" reflects the patients' notion of the changes the disease causes in their organism.

Before the advice

I know it [DM] hampers several things. (E06)

The high pressure causes headache and back pain. (E07)

After the advice

It [DM] can cause kidney and heart problems. (E06)

The high pressure can cause a stroke, heart attack. (E07)

The second category, called "Care related to the disease" demonstrates the the care actions the patients developed before and after the orientations.

Before the advice

I cut down on the salt, sweets and I take the medication. (E01)

I act normally, when the pressure rises I take care with the diet. (E18)

I don't take care of myself, I don't take the medication correctly [...] I smoke about 20 cigarettes per day [...] I drink one or two bottles per day [Patient refers to beer]. (E10)

I take it healthily, we don't take care of ourselves that well. (E16)

After the advice

I run on the treadmill [...] I do that twice or three times per week. I haven't used sugar for a long time, only sweetener [...] I take that full-fat soy milk instead of normal milk. I have the blood pressure and diabetes measuring device, I measure it twice or thrice a week. I eat more fish and chicken, beef I am trying to cut down on. It's good to know, getting the right monitoring helps a lot, I observed a lot of difference between then and now. (E01)

I cut the salt, fat, sugar, I don't eat that much fried food, I am maintaining my weight... I am taking my medicines correctly. (E18)

Unfortunately I smoke [...] I managed to reduce it a little as we had talked about, I am smoking about 5 cigarettes per day [...] I ended up smoking a pack of cigarettes per day and I have got a project to quit smoking completely. (E10)

It's like they taught me. I am not eating a lot of salt, a lot of sugar, little fat [...] I measure my blood pressure at the service, I always go there. It has changed for me, I feel more certain that, when I follow the correct treatment I will live longer, I used to feel insecure, concerned, I know I've been diabetic for a long time, but I used to feel apprehensive, very scared, now I have started to understand it better, accept that I got like this, despaired and drinking. Then I quit drinking and got calmer, because the alcohol used to have negative effects, now it seems like one less burden. Now I do it more correctly. (E16)

And the third category "Barriers for treatment compliance" refers to the obstacles the participants face when trying to follow the treatment. In that category, the lack of family comprehension, the patients' limitations and excess medication were identified as barriers for compliance.

Lack of family understanding:

They get so mad [the children] and then they complain, say like: - Ah mom, that food without salt is bad. (E20)

[...] my father is 80 years old and he cooks, he makes food with plenty of spices and salt, and then I have to eat it. (E14)

[...] my stepmother makes those "big tables" and then I have to eat. (E02)

Physical limitations:

[...] I cannot walk anymore, I go to the kitchen from here and I get back tired, and from there to here it's just the bed and nothing else. (E04)

I am watching her here, suddenly I don't see her anymore, you know? He keep on varying all day [the eye] [...] It's difficult to see the names of the medicines [...] sometimes I forget to take the medicines, my mind is not very good, I don't know what is happening. (E05)

It has been two days that I don't take them [the medicine], because I am unable to go and get them, then I ask my father to get them for me at the service. (E14)

Too much medication:

It's so much medication that we get lost. (E16)

[...] I end up forgetting, because there are many [medicines]. (E15)

Then I take prednisone, [...] it is difficult to recall all of them [...]. (E07)

During the third contact with the participants, the compliance with the actions agreed upon was observed, no repeated hospitalization and three deaths due to comorbidities that started before the application of the protocol.

DISCUSSION

The study participants were all adults with a mean age of 49.5 years, and SAH and/or DM patients, in line with a study developed in Goiânia-GO, which demonstrates a positive association between the prevalence of SAH and increased age. The prevalence corresponded to 14% in the age range from 30 till 39 years, increasing to 34.6% from 40 till 49 years and 63.1% in individuals aged 60 years or older[10].

Concerning physical exercise, 13 reported not exercising regularly. It is known that regular exercise reduces the pressure levels, including patients under medication treatment, and improves the metabolic control, reducing the need for hypoglycemic agents. In addition, exercising reduces the risk of cardiovascular disease, promotes weight loss and contributes to the quality of life[10].

As regards the patients' classification through the BMI, it was verified that 15 were classified as obese, in line with a study developed in Aracajú-SE, in which approximately 67% of the group assessed presented overweight and 80% metabolic risk, based on the waist circumference, representing a risk factor for the development of chronic illnesses[11].

All study participants presented comorbidities and complications associated with SAH and/or DM. The cardiac complications entail important implications in terms of the management of therapeutic actions, which are necessary to control these chronic conditions, whose treatment requires perseverance, motivation and continuing education[12].

As for the category "Knowledge about the disease", before the advice, the participants indicated signs and symptoms attributed to the disease, demonstrating partial knowledge, considering that the disease is asymptomatic. Next, it was verified that they were able to name the complications the chronic disease process entails, as observed in the statements by E06 and E07.

Participants from another study mentioned the reference to signs, symptoms and complications as educational needs[13]. The participants' knowledge about the disease and treatment contributes to enhance the disease control and participation in the decision processes of the health team and society. The health education of SAH patients makes them feel greater control and responsibility for their disease, encouraging them to adopt an active posture in the management of their disease[14].

When assessing the effect of the educative action on type 2 diabetes patients, increased knowledge was perceived, which allowed them to feel co-responsible for their health. Thus, the nurse's educative action can be the base for preventive and health promotion interventions[15].

Hence, health education for chronic patients should be a strategy the professionals need to use continuously, so that hypertensive patients feel secure and co-accountable for their care, furthering their conditions of wellbeing and, thus, their compliance with medication and non-medication treatment, besides permitting the reduction of complications[16-17].

In the second category, entitled "Care related to the disease", it was perceived that the participants practiced some care, as they affirmed. After the advice, the discourse was of action and co-participation, aiming to reduce the risk factors for complications of the disease.

Acceptance and compliance with the treatment plan the health professionals recommend are not always easy, leading to weak adherence and difficulties to manage the proposed regimen. The difficulties both the SAH patients and their family feel refer to the acceptance of the disease and ability to manage the treatment effectively, resulting in the worsening of the condition and individual, social and economic repercussions[18].

It was perceived that the protocols supported the participants' understanding and involvement

in the treatment, a fact certified in the discourse of E1, E10, E16 and E18 after the advice. This finding is in line with the literature, which discusses the benefits of using the protocols in practice, as they guide the health professionals' decision making, help the SAH patients to develop their targets, can improve the treatment compliance and further clarifications about the disease, besides facilitating the ongoing assessment and monitoring of the changes made, with a view to compliance with pre-set actions[19-20].

The third category, entitled "Barriers for treatment compliance", demonstrated actual obstacles in SAH patients' lives, such as physical limitations, excessive medication and lack of family understanding, which hamper and can even impede the effective adherence to the treatment. During the interviews, it was observed that the family members face difficulties to understand the needs for changes in the life habits and the most mentioned problem was related to the resistance in the daily incorporation of the low-salt diet.

The literature shows that the most common changes the family members face refer to the adaptation and participation in activities, such as taking care of the medication treatment and adapting to the dietary and exercise routine[13-21]. The family's role in the inclusion and maintenance of the dietary habits can act as a positive factor in the dietary treatment compliance, considering that family support is one of the elements that grants security for SAH patients to move on within this new perspective of life[22].

With the support of relatives and friends, it is easier for SAH patients to comply with the treatment than for people without support. They affirm that family support encourages the hypertensive patients to effectively comply with the treatment, who feel secure in their disease experience[23].

Another obstacle the participants mentioned with related to the physical limitations the SAH and/or DM causes, such as fatigue and visual acuity problems, which prevents them from adhering to the treatment at certain times. Similar to these results, in a study developed in Rio Grande do Sul, the goal was to identify the factors due to which the participants did not comply with the medical prescription, and appointed that the difficulties to the physical limitations, such as reduced visual acuity, negatively influence the medication treatment compliance[24].

The treatment of NTCI commonly demands a multidrug scheme over long periods. These factors, in combination with the adverse effects of the drugs, can play a determinant role in the premature abandonment of the medication treatment[25].

In line with this study, in their testimonies, the participants demonstrated that the excess of medicines is one of the factors that interfere in the continuity of treatment, as it becomes difficult to recall the times and identify which drug to take.

The treatment compliance involves countless factors that are related in a broad and complex sense, without influence from a single variable. The biological, psychological, cultural and behavioral factors are interrelated, supporting the individual's attitude to use or practice what was recommended[26].

During the year the participants were monitored by telephone or home visit, there were no renewed hospitalizations due to SAH and/or DM and associated complications. In line with the importance of a planned and systemized discharge and monitoring at home and by telephone, to provide SAH and/or DM patients and their families with clarifications in order to contribute to the reduction of re-hospitalizations and avoid or postpone the emergence of complications[6-27].

As study limitations, during the inclusion period of the participants, a strike by the public servants at the research hospital caused a reduction in the number of hospitalizations, a fact that influenced the total number of subjects, besides the participants' lack of availability to receive the researchers in the second and third research phase, as most of them had a paid job during office hours.

CONCLUSION

The protocols used were a health education strategy to support, assess and monitor the participants. It was perceived that these permit health care and shared monitoring, showing the progress achieved and difficulties faced and encouraging the search for new ways to achieve the actions agreed upon.

It was identified that the advice by means of the clinical protocols led to better knowledge on the disease and the limitations that influence the treatment, as well as better care by the participants.

Nevertheless, it can be affirmed that the

protocols can only be implemented at the health services if there is care continuity and links between the hospital and the primary care services to monitor and manage the treatment, with a view to reducing the complications these diseases cause.

Based on these conclusions, advice for discharge, care monitoring and the need to effectively include the family in the orientations for discharge are considered important, using the health education strategies, cheap technologies that can be applied throughout the health system. Through patient-centered care, responding to the patients' expectations and needs through the establishment of targets, the appearance of complications and re-hospitalizations can be postponed and the cost of the treatments can be reduced, improving the patients' quality of life.

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REFERENCES

1. Ministério da Saúde (BR). Secretaria de Vigilância em Saúde. Departamento de Análise de Situação de Saúde. Plano de ações estratégicas para o enfrentamento das doenças crônicas não transmissíveis (DCNT) no Brasil 2011-2022. [Internet] Brasília: Ministério da Saúde; 2011 [acesso em 16 fev 2015]. Disponível: http://bvsms.saude.gov.br/bvs/publicacoes/plano_acoes_enfrent_dcnt_2011.pdf.

2. Santos SS, Vasconcelos DFSA. Hospitalizações por hipertensão arterial essencial em caráter de urgência no Brasil, 2008-2012. Rev. Ciênc. Méd. Biol. [Internet] 2013; 12(n.esp) [acesso em 24 abr 2014]. Disponível: http://www.portalseer.ufba.br/index.php/cmbio/article/viewFile/9191/6758.

3. Barretos MS, Marcon SS. Hospitalização por agravos da hipertensão arterial em pacientes da atenção primária. Acta paul. enferm. [Internet] 2013; 26(4) [acesso em 13 abr 2014]. Disponível: http://dx.doi.org/10.1590/S0103-21002013000400003.

4. Mantovani MF, Mendes FRP. A condição crônica de saúde: do diagnóstico a gestão cotidiana da situação. In: Trentini M, Paim L, Guerreiro D, organizadores. Condições crônicas e cuidados inovadores em saúde. São Paulo: Atheneu; 2014. p.11-26.

5. Mcwen M, Wills EM. Bases teóricas para enfermagem. 2ª ed. Porto Alegre: Artmed; 2009.

6. Mattei AT, Arthur JP, Mantovani MF, Ulbrich EM, Cruz IML. Elaboração de protocolos para a alta de pacientes hipertensos e diabéticos: relato de experiência. Ciênc Cuid Saúde. [Internet] 2014; 13(1) [acesso em 13 abr 2014]. Disponível: http://periodicos.uem.br/ojs/index.php/CiencCuidSaude/article/view/20064.

7. Mendes EV. O cuidado das condições crônicas na atenção primária à saúde: o imperativo da consolidação da estratégia da saúde da família. [Internet] Brasília; Organização Pan-Americana da Saúde; 2012 [acesso em 13 abr 2014] Disponível: http://bvsms.saude.gov.br/bvs/publicacoes/cuidado_condicoes_atencao_primaria_saude.pdf.

8. Sociedade Brasileira de Diabetes (SBD). Diretrizes da Sociedade Brasileira de Diabetes: 2013-2014. São Paulo: AC Farmacêutica; 2014.

9. Bardin L. Análise de conteúdo. 1ª ed. São Paulo: Edições 70; 2011.

10. Nascente FMN, Jardim PCBV, Peixoto MRG, Monego ET, Barroso WKS, Moreira HG, et al. Hipertensão arterial e sua associação com índices antropométricos em adultos de uma cidade de pequeno porte no interior do Brasil. Rev. Assoc. Med. Bras. [Internet] 2009; 55(6) [acesso em 15 abr 2014]. Disponível: http://dx.doi.org/10.1590/S0104-42302009000600017.

11. Teixeira PDS, Reis BZ, Vieira DAS, Costa D, Costa JO, Raposo OFF, et al. Intervenção nutricional educativa como ferramenta eficaz para mudança de hábitos alimentares e peso corporal entre praticantes de atividade física. Ciênc. saúde coletiva. [Internet] 2013; 18(2) [acesso em 13 mai 2014]. Disponível: http://dx.doi.org/10.1590/S1413-81232013000200006.

12. Organização Pan-Americana da Saúde (PAHO). Linhas de cuidado: hipertensão arterial e diabetes. Brasília: Organização Pan-Americana da Saúde; 2010.

13. Ulbrich EM, Maftum MA, Labronici LM, Mantovani MF. Atividades educativas para portadores de doença crônica: subsídios para a enfermagem. Rev. Gaúcha Enferm. [Internet] 2012; 33(2) [acesso em 13 mai 2014]. Disponível: http://dx.doi.org/10.1590/S1983-14472012000200005.

14. Novais E, Conceição AP, Domingos J, Duque V. O saber da pessoa com doença crônica no autocuidado. Rev HCPA. [Internet] 2009; 29(1) [acesso em 22 jan 2015]. Disponível: http://seer.ufrgs.br/hcpa/article/view/7376.

15. Pereira DA, Costa NMSC, Sousa ALL, Jardim PCBV, Zanini CRO. Efeito de intervenção educativa sobre o conhecimento da doença em pacientes com diabetes mellitus. Rev. Latino-Am. Enfermagem. [Internet] 2012; 20(3) [acesso em 22 jan 2015]. Disponível: http://dx.doi.org/10.1590/S0104-11692012000300008.

16. Ulbrich EM, Mantovani MF. Descobrindo-se portador de doença crônica: repercussão de uma pesquisa-ação. Ciênc Cuid Saúde. [Internet] 2014; 13(2) [acesso em 05 jun 2015]. Disponível: http://periodicos.uem.br/ojs/index.php/CiencCuidSaude/article/view/19126.

17. Candido JSA, Milagres CS, Siman AG, Carvalho CA, Amaro MOF. Hipertensão Arterial em Pacientes em Tratamento Hemodialítico e Fatores Associados. Cogitare Enferm. [Internet] 2015; 20(2) [acesso em 05 jun 2015]. Disponível: http://dx.doi.org/10.5380/ce.v20i2.39848.

18. Pinto APPP, José HMG. Hypertension and adherence to the therapeutic regímen in primary health care. Rev enferm UFPE [Internet] 2012; 6(7) [acesso em 30 ago 2015]. Disponível: http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/viewArticle/3057.

19. Bosworth HB, Almirall D, Weiner BJ, Maciejewski M, Kaufman MA, Powers BJ, et al. The implementation of a translational study involving a primary care based behavioral program to improve blood pressure control: the HTN-IMPROVE study protocol. Implement Sci. [Internet] 2010; 5(54) [acesso em 30 ago 2015]. Disponível: https://dx.doi.org/10.1186/1748-5908-5-54.

20. Figueiredo NN, Asakura L. Adesão ao tratamento anti-hipertensivo: dificuldades relatadas por indivíduos hipertensos. Acta paul. enferm. [Internet] 2010; 23(6) [acesso em 30 ago 2015]. Disponível: http://dx.doi.org/10.1590/S0103-21002010000600011.

21. Lopes MCL, Marcon SS. A Hipertensão Arterial e a família: a necessidade do cuidado familiar. Rev. esc. enferm. USP. [Internet] 2009; 43(2) [acesso em 12 ago 2014]. Disponível: http://dx.doi.org/10.1590/S0080-62342009000200013.

22. Verrengia EC, Sousa AA. A dieta hipossódica na percepção de indivíduos hipertensos hospitalizados. Demetra. [Internet] 2012; 7(3) [acesso em 12 ago 2014]. Disponível: http://www.e-publicacoes.uerj.br/index.php/demetra/article/viewFile/3590/3843.

23. Oliveira RG, Frota NM, Martins ABT, Silva CJA, Santos ZMSA. Accession of user interface and treatment hypertensive relationship with the family. Rev Enferm UFPI. [Internet] 2013; 2(4) [acesso em 15 ago 2014]. Disponível: http://www.ojs.ufpi.br/index.php/reufpi/article/view/1302/0.

24. Marques EIW, Petuco VM, Gonçalves CBC. Motivos da não adesão ao tratamento médico prescrito entre os idosos de uma unidade de saúde da família do município de Passo Fundo - RS. RBCEH. [Internet] 2010; 7(2) [acesso em 20 ago 2014]. Disponível: http://www.upf.br/seer/index.php/rbceh/article/viewFile/865/pdf.

25. Cabral MV, Silva PA. Adesão á Terapêutica em Portugal: atitudes e comportamentos da população portuguesa perante as prescrições médicas. Lisboa: Imprensa de Ciências Sociais; 2010.

26. Mourão-Júnior CA, Souza AB. Adesão ao uso de medicamentos: algumas considerações. Estudos Interdisciplinares em Psicologia. [Internet] 2010; 1(1) [acesso em 12 ago 2014]. Disponível em: http://dx.doi.org/10.5433/2236-6407.2010v1n1p96.

27. Mussi CM, Ruschel K, Souza EN, Lopes ANM, Trojahn MM, Paraboni CC, et al. Visita domiciliar melhora conhecimento, autocuidado e adesão na insuficiência cardíaca: ensaio clínico randomizado HELEN-I. Rev. Latino-Am. Enfermagem. [Internet] 2013; 21(n.esp) [acesso em 12 ago 2014]. Disponível: http://dx.doi.org/10.1590/S0104-11692013000700004.