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CARE FOR PEOPLE WITH DIABETES IN THE HIPERDIA PROGRAM: POTENTIALS AND LIMITS FROM THE PERSPECTIVE OF NURSES[1]

Aliny de Lima Santos[2], Elza Monteiro da Silva[3], Sonia Silva Marcon[4]

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[2] Ph.D. in Nursing. Collaborating professor, *Departamento de Enfermagem*, *Universidade Estadual de Maringá* (UEM). Maringá, Paraná, Brazil. E-mail: aliny.lima.santos@gmail.com

[3] Registered Nurse. Non-regular student, *Programa de Pós-Graduação em Enfermagem*, UEM. Maringá, Paraná, Brazil. E-mail: elzamonteirodasilva@gmail.com

[3] Ph.D. in Nursing Philosophy. Professor, *Departamento de Enfermagem* and *Programa de Pós-Graduação em Enfermagem*, UEM. Maringá, Paraná, Brazil. E-mail: soniasilva.marcon@gmail.com

ABSTRACT:

Objective: the aim of the study was to understand how nurses of the Family Health Strategy perceive the potentials and limitations of care for people with diabetes in primary healthcare of Maringá, Paraná.

Method: Qualitative case study conducted with 63 nurses. Data were collected between November 2013 and May 2014 through semi-structured interviews performed in health facilities, which were recorded and analyzed using SWOT.

Results: Adherence of the user to the services provided, bond with the team, involvement of the professionals and providing educational activities, were cited as potentials. In turn, the limitations mentioned were reduced treatment adherence, gaps in the work process of the team and lack of resources.

Conclussion: it was observed that the limitations were prevalent in the care for users with Diabetes which indicates the need for a close look at the implementation and evaluation of this service.

DESCRIPTORS: Health evaluation. Family health strategy. Primary healthcare. Diabetes Mellitus.

ASSISTÊNCIA ÀS PESSOAS COM DIABETES NO HIPERDIA: POTENCIALIDADES E LIMITES NA PERSPECTIVA DE ENFERMEIROS

RESUMO

Objetivo: apreender como os enfermeiros da Estratégia Saúde da Família percebem as potencialidades e limitações da assistência às pessoas com Diabetes na Atenção Básica do município de Maringá.

Método: estudo qualitativo do tipo estudo de caso, realizada com 63 enfermeiros, em Maringá, Paraná. Os dados foram coletados entre novembro de 2013 e maio de 2014, por meio de entrevistas semiestruturadas, gravadas, realizadas nas unidades de saúde, e analisados segundo matriz *SWOT*.

Resultados: adesão dos usuários aos serviços oferecidos, vínculo com a equipe, envolvimento dos profissionais e oferta de atividades educativas, foram citados como potencialidades. Por sua vez, as limitações foram: reduzida adesão ao tratamento, lacunas no processo de trabalho da equipe e reduzida disponibilidade de recursos.

Conclusão: observa-se que as limitações foram predominantes na assistência prestada aos usuários com Diabetes, o que sinaliza a necessidade de um olhar mais atento sobre a implementação e avaliação deste serviço.

DESCRITORES: Avaliação em saúde. Programa saúde da família. Atenção primária à saúde. Diabetes Mellitus.

ASISTENCIA PARA PERSONAS CON DIABETES EN CUIDADO PRIMARIO: CAPACIDADES Y LIMITA LA PERSPECTIVA DE ENFERMERAS

RESUMEN

Objetivo: el objetivo del estudio era entender como las enfermeras de la Estrategia Salud de la Familia se dan cuenta del potencial y las limitaciones de la atención para las personas con Diabetes en la atención primaria de Maringá, Paraná.

Método: realizado con 63 enfermeras. Los datos fueron recolectados entre noviembre 2013 y mayo 2014 a través de entrevistas semi-estructuradas, grabado, y se analizaron utilizando *SWOT*.

Resultados: servicios de adopción del usuario, que ofrece enlace com el equipo, la participación de profesionales y ofreciendo actividades educativas, fueron citados como potencial.

Conclusión: A su vez, las limitaciones se reducen la adherencia al tratamiento, las lagunas en el proceso de trabajo en equipo y la reducción de la disponibilidad de recursos. Se observa que las limitaciones eran frecuentes en la asistencia a los usuários com la Diabetes, que señala la necesidad de una mirada cercana de este servicio.

DESCRIPTORES: Evaluación de la salud. Programa de salud familiar. Atención primaria de salud. Diabetes Mellitus.

INTRODUCTION

Diabetes Mellitus (DM) is a chronic disease with a worldwide incidence, which has its increased prevalence concomitant with population aging.[1] It is still one of the main risk factors for cardiovascular diseases, being categorized as one of the chronic conditions most sensitive to primary health care (PHC), with it being possible to control and care for between 60 and 80% of the cases in this level of healthcare.[2] In an attempt to reduce the number of hospitalizations and achieve adequate monitoring and treatment in PHC, and in turn in the Family Health Strategy (FHS), several strategies and actions have been designed. Among them is the Reorganization Plan of Care for Hypertension and DM, created in 2001,[3] which aims to register users in the computerized system provided by DATASUS - HIPERDIA, as well as investigate risk factors for complications, monitor glycemic rates and other comorbidities, and provide medications when needed.[4]

In order to fulfill the objectives proposed by the program, the FHS teams are fundamental, as most of the actions of the program are still concentrated on the development of groups focused on educational actions in health and medical consultations.[4] In this scenario, the nurse stands out as one of the main professionals responsible for the care for users with DM, as well as contributing to the processes of planning, coordination, implementation and evaluation of this and other health programs.[5]

In this context, seeking improvement in the effects of the health services provided to the population, the importance of evaluation is emphasized as a way to verify the conditions under which health actions are developed.[6] Studies have highlighted the role of the evaluation of the performance of actions and health programs, with the aim of supporting decisions that meet the needs of the population, providing suitable alternatives for their better adaptation.[6-7] Among the different ways of evaluating the healthcare provided to people with DM, seeking the opinion of the nurses working in the FHS teams regarding these services is of great importance, taking into account their relevance and active participation in this context.[8] However, it should be pointed out that few studies have reported the perceptions of nurses regarding this issue, even though they are the main professional responsible for the performance of services in PHC and an essential part of the care process for people with DM.[9]

Nursing care makes it possible to evaluate the needs of the user with DM and the variables that interfere with their therapeutic adherence, favoring a more precise approach that is closer to reality. However, the quality of this care can be influenced by factors that include personal, structural and organizational difficulties.[10] This leads to the question: how is the care for the person with diabetes provided in the FHS from the perspective of the nurse? Which aspects act favoring or hindering the quality and effectiveness of this care?

The present study is therefore based on the prerogative that the evaluation of the care provided to people with diabetes, from the perspective of the nurses working in the FHS teams, is valuable for the organization and relevance of the services provided in the PHC, since their perceptions, values and projections regarding this care suggest the way it is performed and indicate the perspectives that guide it.[11] Thus, the aim of this study was to learn how nurses of the FHS perceive the potentials and limitations of the care for people with DM in the Primary Healthcare of the municipality of Maringá, Paraná.

METHODOLOGY

This was a descriptive qualitative study, of the case study type. The informants were 63 of the 66 nurses of the FHS teams working in the municipality of Maringá-PR. The inclusion criterion considered was to have been working as a nurse of the FHS team for at least six months, and the exclusion criteria were to be nurses of the rural team or to be on leave during the data collection period.

Data collection took place from November 2013 to May 2014, through semi-structured interviews conducted in the workplace of the FHS teams. The interviews had an average duration of 30 minutes and were previously scheduled by telephone contact. The script used during the interviews consisted of two parts: one dealing with characterization data, professional training and length of time working in the team and the other consisting of two guiding questions: tell me about the care for people with Diabetes provided by your team. What do you consider hinders or assists this care?

After obtaining the consent of the participants, the interviews were recorded on digital media and later transcribed in full. In the analysis, strategic planning assumptions were adopted, using a management tool for this: the SWOT Matrix. The name SWOT is an acronym of Strengths, Weaknesses, Opportunities and Threats, known in Brazil as the FOFA matrix, with it being configured as a tool that allows the internal and external conditions of a given situation to be analyzed.[12] This is one of the most common practices focused on strategic thinking and business organization. Through it, it is possible to have a clear and objective view on what these conditions are, as well as providing subsidies to potentialize the strengths and weaknesses in the internal environment and to correct or minimize the opportunities and threats in the external environment.[12]

The strengths, or strong points, are the internal variables that provide favorable conditions for the development and improvement of a service in relation to its environment, while the weaknesses are deficiencies that inhibit the capacity of performance. Both can be controlled by the actors involved. Opportunities, in turn, are external situations that can contribute to the achievement of the objectives of a given service and can create favorable conditions, provided that the conditions or interest to use them exist. In turn, threats are related to external situations that may hinder the execution of strategic objectives. Opportunities and threats, therefore, are factors of the external environment that directly impact on the service and cannot be controlled by the actors involved.[12]

The development of the study followed the ethical requirements of Resolution 466/12 of the National Health Council of Brazil; and its project was approved by the Permanent Ethics Committee for Research with Human Subjects of the State University of Maringá (Authorization No. 448,162/2013). The participants were asked to sign two copies of the consent form. The nurses are identified in the study with the letter E, followed by an number indicative of the sequence of the interviews, letters M and F, referring to males and females respectively, and the length of time in the service in years (e.g., E1-F, 10).

RESULTS

The 63 participants in the study ranged in age from 25 to 58 years, the majority were female (58) and six had two jobs. The time since graduation ranged from three to 33 years, six had postgraduate degrees and 57 some type of specialization, 27 of which were in family health, and six had *stricto sensu* postgraduate degrees.

The length of time working in the FHS ranged from six months to 14 years. In relation to the FHS teams, 43 of them had no oral health service and 28 were incomplete, with the health professionals most absent being the Community Health Agents (20 teams) and the Physicians (four teams).

The responses to the guiding questions allowed the identification, from the perspective of the nurse, of the potentials and limitations experienced by the FHS teams in the care/assistance for people with DM, which were classified as belonging to the internal and external environments of the team. Thus, a SWOT matrix adapted to the study was constructed as a way of demonstrating these conditions in a more didactic manner, subdividing them into the four aspects.

Potentials and limitations in the care for people with diabetes

In the construction of the matrix, more specifically from the internal environment aspect, all the conditions highlighted by the nurses as being favorable to the care of people with DM by the FHS team were considered as strengths, and those that inhibit or impede the efficiency and quality of the care as weaknesses, both of which are subject to governability. In the external environment, considering the conditions that cannot be controlled, those that

contribute to and favor the care were considered as opportunities and those which hamper or harm the care and have a direct impact on it and its respective outcomes were considered as threats, (Table 1).

Table 1 - *SWOT* matrix for the care for people with Diabetes monitored in the Family Health Strategy from the perspective of the nurse. Maringá, PR, Brazil, 2014

	Strengths	Weaknesses
Internal environment	- Performing the stratification of the Registered Users with Diabetes (UD), according to their risk for complications and form of adherence to treatment. - Provision of health education activities and walking/physical activity groups, specifically for UD*. - Establishment of the bond between the UD and professionals working in the FHS. - Performance of an active search for UD who do not attend the HIPERDIA meetings and/or who do not adhere to the treatment. - Provision of guidance regarding the disease to the family of the UD during home visits. Participation of the entire FHS and FHSC† team during the HIPERDIA groups. - Active participation of the CHA‡ in the home searches. - Satisfaction of the UD with the service provided.	- Absence of exclusive/specific education and health promotion activities for UD. - Little involvement of the team professionals in the planning, development and evaluation of actions with the UD. - Absence of medical consultations during HIPERDIA meetings. - Limitations of the UD in understanding the guidance received. - Duration time of HIPERDIA groups insufficient for screening and offering guidance about the disease. - HIPERDIA group mainly focused on dispensing medications. - Disbelief of the UD in the educational activities/talks. - Resistance of the UD in adhering to the use of insulin.
	Opportunities	**Threats**
External environment	- Frequency in the training in diabetes offered by the MHD§. - Sufficient amount of exams specific for the UD. - OAG□ located next to the PHU. - Availability of educational materials and supplies for the meetings. - Adherence of the UD to the groups and services provided. - Bond between the UD and the professionals of the FHS team. - Evaluation by the PIAQ¶. - Recognition of the importance of the FHS team by the UD. - Availability of Information Systems. - Availability of medicines, supplies and equipment.	- Reduced availability of work hours of the nurse to work exclusively in the FHS. - Reduced availability of physical, human and material resources. - Little adherence to the treatment by the UD, leading to frustration of the professionals. - Reduced availability of transportation for home visits. - Reduced FHSC participation in HIPERDIA groups. - Reduced family participation in the consultations and in the control of the disease. - High demand from users and services. - Reduced number of specialized consultations available. - Need to fulfill goals established by the MHD. - Poor understanding by the UD regarding the limitations of the service. - Overload of the nursing professional. - Overvaluation of the medical consultation by the UD. - HIPERDIA group mainly focused on dispensing medications. - Waste of oral antidiabetic drugs. - Disbelief in the educational activities/talks. - Reduced variety of antidiabetic drugs. - Need to exchange experiences among network professionals.

*User with Diabetes Mellitus; †Family Health Support Center; ‡Community Health Agent; §Municipal Health Department; □Older Adult Gymnasium. ¶National Program for Improving Access and Quality of Primary Care.

It should be pointed out that, in order to construct the matrix, the topics raised were allocated according to the indications of the nurses, with no inferences from the researchers, being delimited as potential and/or limitation according to the way the care was perceived (by the nurses of the study). In

addition, in order to illustrate the points identified in its construction, some sections of reports of the nurses were used, which were divided into thematic units, according to each branch of the matrix.

Strengths of the care

The availability of medications and supplies, the provision of health promotion activities, as well as the active search for users who do not adhere to the treatment and who miss the HIPERDIA meetings, were cited as strengths in the care provided by the team: *we manage to pick up one or another patient who is more rebellious* [...] *We can go to their house and do an active search when they do not come to the meeting, or else those who do not take the medicine correctly* [...] (E45-F 4); *We go to their homes and take advantage of it and talk to the family about the disease and everything. The CHA has the control of when they have to come back again, because there are patients who need this care to be replenishing the pills ... and medicine is not lacking. Neither medicine nor these basic things, you know?* (E8-F 1); *there are the 'talks' that we do only for the diabetic patients, especially the 'insulin'. There is the group of walking and stretching with the teacher of physical education of the city hall* (E18-F 6).

In addition, the participation of users in the HIPERDIA groups, the presence of a bond between them and the professionals working in the FHS teams and the effective participation of these professionals in the group meetings were also observed in the statements: *when you have been in the team for a long time you end up having the confidence of the population, knowing them by name and knowing what their problems are. Therefore, the user feels at home and knows that he can arrive here and meet us. So I think that even affects their adherence, I saw this* [...]. *They end up doing it properly not to disappoint us* (E15-F 8); *With the adherence in the group, we have no problem. They come to meetings and participate in everything we do. Of course there are those who do not adhere well, but at least they come to the meeting, this they don't miss. They know that in the group they will get guidance, they will get the medicine, the doctor, the girls from the FHSC* [...] (E53-F 3); *The physician, the whole team and even the FHSC as well. The CHAs, its rare for them not to be present, at least one or two are. There is also the psychologist of the unit, she is always present at the HIPERDIA meetings. This helps directs it better, you know? The involvement of the team. Not to mention that it helps to encourage them* [the UD] *to come too.* (E23-F 4).

Weaknesses of the care

Reduced involvement of the team with HIPERDIA activities, lack of medical consultations during the groups, insufficient duration of meetings and overload of the nurses were highlighted by the nurses: *HIPERDIA is complicated, there are a lot of people* [...] *And to make matters worse they argue because it takes time, they want to leave.* [...] *Then you put this together with the doctor who doesn't participate, because he already leaves the prescriptions ready and does not appear. Its all on top of me, I can't check blood glucose, weigh the patient, see their pressure and everything else, and still give guidance in such a short time, and alone.* [...] *We can't do everything* (E21-F 3); *The CHA is difficult! Look, almost 10 O´clock and they are still here* (in the PHU) *and if I go here and complain, then they really won't do anything. I've heard of times when they find the person on the street and ask for their signature* [SIAB form], *without even going to their house. They could be helping me, but they aren't, are they?* (E6-F 3).

Another weakness mentioned was the absence and/or disbelief in the educational activities by the professionals and the UD: *we are not even doing educational activities and talks, because there isn't time. And another thing, we've done a lot of talks and much more, but that does not really solve anything, they do not even come. They like to see the doctor, see the pressure, the blood glucose, get the medicine and leave quickly, then they are happy* (E26-M, 4).

Opportunities of the care

The availability of OAGs, the opportunity for training/updating, the realization of PIAQ evaluations, and especially the valorization of the staff and the services offered by the users, were present in the opportunities experienced in the care: *they call it "old stretching"* [laughs], *but this gym next door* [OAG] *helps a lot, because they like to stay there doing the exercises and even more so if one of us here goes there to see them. Sometimes the FHSC physical education girl goes there and stays with them a little and they love it* (E47-F 6); *there are lots of courses and training from the health department, so if they do not do it right it is because they don't want to, because we have the support and guidance. Another thing that helped was this PIAQ evaluation.* [...] *It made us rethink much of what we were doing and improve as well* (E60-F 7); *they come to everything that we do here. Because they know we're here for them, and they value it. Every once in a while someone comes with some homemade bread, with a pudding. They know they do not need to, but they like to please us. And I fight for them. I call the health department and I make sure*

nothing is missing, so that there is no lack of medicine or examination here. Thanks to God, I think they have nothing to complain about here (E12-F 11).

Threats to the quality of the care

The threats most often mentioned by the nurses were related to the overload, due to the reduced participation of the other FHS and FHSC staff members in the HIPERDIA activities and the accumulation of functions, since many nurses in addition to integrating the FHS team also dedicate four hours a day to carrying out general PHU activities: *this stratification is a very difficult thing* [...]. *Because it does not depend only on us of the nursing. The doctor has to want to do it as well, and you still have the issue of the exams that take time. Writing the rules is easy! I want to see them come here and see how much we struggle to take care of so much paperwork, work, patients, reports and still have to deal with the doctor who thinks that his job is just to come here, see the patient and leave without any commitment to the problems of the team* [...] (E58-F 12); *It's difficult to count on the FHSC because they insist that they only give support, but for them to come to give this support we have to put everything together, organize everything. They only come sometimes to talk in the meetings, and in some circumstances they make visits, but that's all, nothing else* [...] (E11-F 4); *Doing four hours of FHS and four hours of PHU is very difficult. How are we going to perform care more focused on groups if in the few hours we have in the FHS we still have to update the system, achieve goals and solve problems of the team? What this causes is a heavy overload for the nurse* [...] (E53-F 3).

The low adherence of users to the treatment, the number of specialized consultations, the availability of physical resources and materials and the limited variety of oral antidiabetic drugs, as well as their wastage, were also referred to as threats: *the problem is that they do not adhere to the treatment, there is no way! They come here, we talk and talk, but it seems they don't listen. Without a doubt our biggest problem here is their lack of their adherence.* [...] *It even makes us discouraged to do things, because we know that it will not achieve anything* (E26-F 3); *Without specialized consultations, it is difficult for us to control the diabetic patients. There are few physicians to attend the specialties, and so, there's this huge queue awaiting an endocrine consultation.* (E32-M 2); *You have to see that we need a greater variety of medication. There are only two. It would be nice to have more medication options for those patients who did not get along very well with either of the two. And we see that, they have a lot of resistance to using Metformin, because it gives diarrhea and pain in the stomach, therefore they stop taking it and do not tell us. There is that waste of medicine* (E42-M 1); *We even try to give guidance, but there is no space for this. There is this corridor here, where I get everyone sitting down and I'm talking, there's someone who needs to pass and I lose track of what I was talking about. TV, DVD, we have these things. But where will I put them?* (E18-F 6).

The insufficient participation of the family in the activities of HIPERDIA was also mentioned, because it is perceived as an indication that this also occurs in the daily care: *I realize that the family does not get involved and does not participate. What's the use of showing elderly people how to apply insulin if their children are going to do it? The family is critical to this adherence and they do not participate, and it ends up that the patients do not adhere because it is them doing it alone.* (E26-M 4).

DISCUSSION

From the perspective of nurses working in the FHS, positive and negative aspects influence the care provided to people with DM in the PHC of Maringá, Paraná. Among the negative aspects, the insufficient participation of other team members in the HIPERDIA activities was the most mentioned. This is a matter of concern, since the FHS has teamwork as one of the main organizational axes, coupled with the ascription of the clients, the establishment of bonds, the provision of quality care and the family as the focus of the attention, with a view to comprehensive actions of health promotion and disease prevention. This is also reinforced by the fact that the participation of the other team members, when effective, in the planning and development of the HIPERDIA groups, was mentioned as one of the aspects that favor the care.

Thus, the FHS work process is determined by, among other characteristics, cooperation in the interdisciplinary field, valorization of the different practices and areas of knowledge from the perspective of the integral and resolutive approach, and by the monitoring and systematic analysis of the implemented activities, aimed at providing the best possible care.[13] Thus, teamwork, in an engaged manner and focused on the well-being and best possible service to the user, is fundamental for the viability of the work process in the FHS.[14]

The non-participation of other professionals may be reflected in the care because, consequently, there will be an overload of activity for another professional, in this case the nurse. This overload can also lead to a deficiency in quality or even the

absence of health promotion activities, which in turn may impair adherence to treatment.[5] Unequal responsibility for the HIPERDIA activities is perceived as a problem that interferes with the result of what the nurses consider to be their specific work, particularly due to the overload of work that it causes.[9] This overload is due, in part, to the high demand of users, however, mainly to the multiple functions, since it is common in the municipality under study for the nurse to assume the duties of coordinator of the FHS team and of the nursing assistants, especially in the reception of the patients, as well as having the obligation to fulfill the goals agreed by the MHD, which interferes greatly with providing individualized and integral care.

The overlapping of tasks, coupled with the lack of recognition of their role by the management and the population, shows how much weight is still given to the model evaluated by the merit of production to the detriment of quality.[6] Furthermore, this also leads to difficulty in communication with the other members of the team, as explicitly mentioned by the nurses, causing, for example, failures in the supervision of the CHAs and the establishment of a sometimes conflicting and condescending relationship, regarding the schedule of programmed activities.

The differentiated social valorization among the healthcare workers leads to subordinate relations, which can cause failures in the work process, inadequacies in the organization and lack of definition of the roles of the professionals, as well as the valorization of the biomedical model.[14] This was observed when nurses highlighted the overvaluation of the medical consultations by users, to the detriment of the health promotion activities offered. In this context, the HIPERDIA meetings are reduced to the delivery of medications and the measurement of blood pressure and capillary blood glucose, which in turn triggers the discontinuity and fragmentation of the care.[15]

It is known that, among the aims of the HIPERDIA program, the provision of pharmacological treatment is one of the most important. However, the professionals of the FHS team need to identify risk factors and behaviors and empower people, not only for good adherence to this type of treatment, but also for self-care through guidance and information, aiming to qualify the coexistence with the disease and, thus, minimize their complications,[4] with the HIPERDIA meetings favoring this.

Nevertheless, in some discourses it was noticed that the distribution of medicines was considered to be the relevant factor for adherence to HIPERDIA, by stimulating participation in the meetings and, thus, ensuring continuity in the treatment. In general, a feeling of satisfaction was verified in having the medication to provide to the user, however, there was also dissatisfaction in having only two types of oral antidiabetic drugs. These often caused uncomfortable reactions, leading to treatment abandonment and even to the waste of the medications, because, in order not to be reprimanded by the professionals, the users took the same amount at every meeting, even if they still had medicines at home.

The low adherence to the treatment, as indicated by the majority of nurses interviewed, cannot be identified only from fulfillment of determinations of the health professionals. Some influential factors should be considered, among them: bodily responses, such as decreased episodes of hyperglycemia/hypoglycemia and glycemic levels, socioeconomic variables, cost-benefit of the treatment, medication effects and interactions, concepts and knowledge about the disease itself, family participation and interaction between health professionals and patients. Thus, the satisfaction of the user with the health services and, in turn, the bond with the working professionals are also important parts of this process.[17]

Regarding the participation of the FHSC, the presence of support professionals was considered an aspect that facilitates the adherence of the users to the meetings, favoring the bond and the development of health education practices during the HIPERDIA meetings. However, this same participation was considered inadequate by some nurses, because in some cases the professionals only lecture during the meetings without worrying about providing the subject matter and the necessary material, such as TV, DVD, printing and supplies, which have to be organized by the FHS team. The nurses, therefore, considered that the FHSC professionals should also act more directly with the users, including participating in home visits.

It is not uncommon for support professionals to take care of specific groups, compromising the integrality of the care. The strategy of strengthening the processes of co-participation of these professionals in a way more focused on the discussion of clinical cases, individual care, direct interventions with the participation of the team professionals and home visits, could qualify the PHC and increase its resolution without compromising the bond and the integrality.[13]

Another relevant aspect in the findings refers to the association between the care and the absence of physical, human and material resources. The absence of physicians and CHAs was reported by the nurses of some teams, as well as the lack of adequate spaces for nursing consultations, group and team meetings, and basic materials such as sphygmomanometers, tensiometers, scales, computers and even stretchers. The inexistence or inadequacy of the essential aspects of the structure, whether in terms of human, physical or material resources, may make it difficult to carry out the care process and, consequently, to achieve the results.[10] Thus, validity and influence of the availability of resources and inputs must be considered in the quality of the assistance provided, because the best structures and resources can be misused, while quality and effective care practices can occur, even in adverse conditions.[18]

For example, during the interviews, there were reports of good adherence to the health education practices, adherence to the treatment, and of the establishment of bonds and satisfaction of users with the care and the professionals in teams with reduced resources; as well as statements about the nonexistence of these aspects even in complete, well equipped teams located in large PHUs. The most important barrier to access to PHC is the availability and physical presence of services and human resources, which is a fundamental condition for the use and efficiency. However much access there is to the services, however much the healthcare is planned and organized, and however much the care models are implemented, the direct execution of care goes beyond the technique, that is, the synergy of the meeting between the professionals and the people seeking the service is one of the determinants of this process.[11]

Nevertheless, among the aspects that favor the care, a good interpersonal relationship between users and professionals has been reported as being associated with adherence by the person with DM to the groups and services provided by the team. In this way, it is understood that the satisfaction of the users with the service and with the working professionals, facilitated by good communication and the bond between them, makes the recognition of the importance of the team as a health institution possible and is positively related to treatment adherence and better control of the disease.[19]

Another relevant aspect was the provision of health promotion and self-care education activities, especially regarding the walking and stretching groups, reinforced by the availability of the OAGs next door to the PHUs, as well as talks and group discussions. The promotion of health aimed at self-care favors the treatment of the person with DM. Therefore, recognizing health promotion activities as a complement to the clinical care, as well as for their potential as facilitators of lifestyle changes, is a fundamental aspect for the implementation of these practices, since the motivation, enthusiasm and belief in them, on behalf of the professionals, can overcome the barriers and difficulties experienced in their implementation and performance.[20]

The availability and frequency with which Diabetes training is offered by MHD was also been highlighted as a promoter of the quality of the care. Continuing education, as well as training and improvement in the context of the FHS, are fundamental for a comprehension of the management of the healthcare, for the choice of appropriate instruments to intervene in the health needs of the individuals and also for good development of the teamwork.[13]

In turn, the importance of the participation of the family in the adherence to treatment by users with DM was mentioned by many nurses, either extolling their presence or lamenting their absence. The family plays an important role in the treatment and care process adopted by the person with DM, as they participate in a considerable part of their daily lives. In this sense, family support in the process of care for these individuals is an important resource in the control of the pathology.[21] However, even recognizing the importance of family support for better acceptance and adaptation to the disease and complaining of its absence in the care, the professionals did not include this resource in their care practice. Proof of this is that there were few reports of inclusion of family members in the HIPERDIA meetings or of discussions with the family about aspects related to the disease during the home visit.

Considering the perspective of the framework used, from the viewpoint of the nurses working in the FHS teams, it was observed that the weaknesses and threats were predominant in the care provided to the users with DM, when compared to the strengths and opportunities. This indicates the need for a close look at how this service is being implemented, developed and evaluated, either by the professionals working in the service or by the managers. The limitations of the service were mentioned, however, it is emphasized that the aspects highlighted as weaknesses could be easily solved through greater involvement of the professionals of the teams, as well as through better organization of the teamwork process.

It is important to emphasize that, in order to provide a quality service to the user with DM, even faced with limitations in the service, it is necessary to have a good relationship of respect between the professionals and the user, so that there is the best possible acceptance and care. This relationship of commitment, respect, understanding and listening makes the difference between the health practices. Thus, the acceptance, the support of specialists, and the support matrix can contribute to the organization of the work process of the FHS teams to meet the diverse health needs of the population and to increase the resiliency of the service.[11]

The study presents some limitations, namely: the treatment of the results through the construction of the SWOT Matrix only after completion of the data collection, without validation by the responding nurses, as well as it being constituted only from their perspective. However, identifying positive and negative aspects of the care for people with DM, from the perspective of one of the professionals most involved with it, highlights the relevance of the present study. In turn, developing mechanisms for assessing the capacity and performance of the FHS, especially from the perspective of those who construct it on a daily basis, is important both for the consolidation of the actions implemented and for encouraging the process of critical-reflexive discussion regarding the best proposal for organizing the care provided, making it increasingly efficient and effective.[13]

COMCLUSION

The results of the present study highlight several potentials and limitations in the care provided to people with diabetes from the perspective of nurses. A lot of gaps were perceived in the organization of the work process of the team, especially regarding the involvement of all the professionals in the planning and implementation of the HIPERDIA actions, as well as the weakness of the physical, material and human resources available for these actions. There was also the perception of a lack of involvement of the family members in the care of the disease, which for nurses is directly associated with the low adherence of users with DM to the treatment and control of the disease.

In turn, positive aspects such as the involvement and commitment of the professionals and the FHSC in the actions of the HIPERDIA program, the provision of health promotion activities, the active search for users who do not adhere to the treatment, as well as their bond and satisfaction with the professionals of the team, were also mentioned by some nurses as relevant aspects for the adherence of users with DM to the activities and services provided by the teams. Thus, the statements of the nurses show that the quality of the services provided to the users with DM, in general, is linked to the capacity of management, professional commitment, availability of resources, planning, organization, implementation and evaluation of the service. In this way, the development of quality work requires structure, resources and, above all, recognition of the potential of the FHS in this care, provided integrality and longitudinality are guaranteed, facilitating the access to the health services and technologies, directly affecting the quality of life of the people.

REFERENCES

1. Moraes SA, Freitas ICM, Gimeno SGA, Mondini L. Diabetes mellitus prevalence and associated factors in adults in Ribeirão Preto, São Paulo, Brazil, 2006: OBEDIARP Project. Cad Saúde Pública. 2010; 26(5):929-41.
2. Ministério da Saúde (BR). Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Coordenação Nacional de Hipertensão e Diabetes. Brasília (DF): Ministério da Saúde; 2011.
3. Carvalho ALM, Leopoldino RWD, Silva JEG, Cunha CP. Adherence to drug treatment among registered users in the "HIPERDIA" Program in Teresina in the State of Piauí. Cien Saude Coletiva. 2012; 17(7):1885-92.
4. Filha FSSC; Nogueira LT; Viana LMM. Hiperdia: Adesão e percepção de usuários acompanhados pela Estratégia de Saúde da Família. Rev Rene. 2011; 12(esp):930-6.
5. Spagnuolo RS, Juliani CMCM, Spiri WC, Bocchi SCM, Martins STF. O enfermeiro e a estratégia saúde da família: desafios em coordenar a equipe multiprofissional. Cienc Cuid Saude. 2012; 11(2):226-34
6. Araceli MM. Fontenele SMAA; Joseneide T. Câmara. Avaliação do programa nacional de atenção à hipertensão e Diabetes: satisfação dos usuários de uma unidade básica de saúde em Caxias-MA. Cad Pesq [Internet]. 2012 [cited 2014 Dec 05]; 19(1). Available from: http://www.periodicoseletronicos.ufma.br/index.php/cadernosdepesquisa/article/view/936/624
7. Reis RS, Coimbra LC, Silva AAM, Santos AM, Alves MTSSB, Lamy ZC, et al. Access to and use of the services of the family health strategy from the perspective of managers, professionals and users. Cienc Saude Coletiva. 2013; 18(11):3321-31.
8. Peduzzi M, Carvalho BG, Mandu ENT, Souza GC, Silva JAM. Trabalho em equipe na perspectiva da gerência de serviços de saúde: instrumentos para a construção da prática interprofissional. Physis. 2011; 21(2):629-46.

9. Souza MG, Mandu ENT, Elias NA. Percepções de enfermeiros sobre seu trabalho na estratégia saúde da família. Texto Contexto Enferm [Internet]. 2013 [cited 2014 Dec 05]; 22(3):772-9. Available from: http://dx.doi.org/10.1590/S0104-07072013000300025.
10. Silva ASB, Santos MA, Teixeira CRS, Damasceno MMC, Camilo J, Zanetti ML. Avaliação da atenção em Diabetes mellitus em uma unidade básica distrital de saúde. Texto Contexto Enferm. 2011; 20(3):512-8.
11. Barbosa SP, Elizeu TS, Penna CMM. The perspective of health professional on access to Primary Health Care. Cienc Saude Coletiva. 2013; 18(8):2347-57.
12. Souza LPS, Souza AMV, Pereira KG, Figueiredo T, Bretas TCS, Mendes MAF, et al. Matriz SWOT como ferramenta de gestão para melhoria da assistência de enfermagem: estudo de caso em um hospital de ensino. Rev Eletr Gestão Saúde [Internet]. 2013 [cited 2014 Dec 05]; 4(1):1911-21. Available from: http://periodicos.unb.br/index.php/rgs/article/view/23016/16538
13. Almeida PF, Fausto MCR, Giovanella L. Fortalecimento da atenção primária à saúde: estratégia para potencializar a coordenação dos cuidados. Rev Panam Salud Publica. 2011:29(2):84-95.
14. Silva LMS, Fernandes MC, Mendes EP, Evangelista NC, Torres RAM. Trabalho interdisciplinar na estratégia saúde da família: enfoque nas ações de cuidado e gerência. Rev Enferm UERJ. 2012; 20(esp.2):784-8.
15. Moretti-Pires RO, Campos DA. Equipe multiprofissional em saúde da família: do documental ao empírico no interior da Amazônia. Rev Bras Educ Med. 2010; 34(3):379-89.
16. Kell MCG, Shimizu HE. Existe trabalho em equipe no programa saúde da família? Cienc Saude Coletiva. 2010; 15(Supl. 1):1533-41.
17. Pontieri FM, Bachion MM. Beliefs of diabetic patients about nutritional therapy and its influence on their compliance with treatment. Cienc Saude Coletiva. 2010; 15(1):151-60.
18. Moura BLA, Cunha EC, Fonseca ACF, Aquino R, Medina MG, Vilasbôas ALQ, et al. Atenção primária à saúde: estrutura das unidades como componente da atenção à saúde. Rev Bras Saúde Mater Infant. 2010; 10(1):69-81.
19. Ribeiro KSQS, Farias DAA, Lucena EMF, Paes NA, Moraes RM. Avaliação da adesão e vínculo aos serviços de Saúde de hipertensos acometidos por acidente vascular cerebral em municípios da Paraíba. Rev Bras Ciênc Saude. 2012; 16(s2):25-34.
20. Santos L, Torres HC. Educational practices in diabetes mellitus: understanding the skills of health professionals. Texto Contexto Enferm. 2012 [cited 2014 Dec 05]; 21(3):574-80. http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-07072012000300012&lng=en&nrm=iso&tlng=en
21. Santos AL, Marcon SS. Como pessoas com Diabetes avaliam a participação familiar em seu processo de cuidado à saúde. Invest Educ Enferm. 2014; 32(2):260-9.

Correspondence: Aliny de Lima Santos
Rua Mario Clapier Urbinatti, 724. Bloco N apt 36
87020-260 - Jardim Universitário, Maringá, PR, Brazil
E-mail: aliny.lima.santos@gmail.com

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