

Reflecting on the practices of nurses in approaching the person with a chronic illness

O refletir das práticas dos enfermeiros na abordagem à pessoa com doença crónica
Reflexionar sobre las prácticas de los enfermeros en el tratamiento de la persona con enfermedad crónica

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Abstract

Theoretical framework: The changes that have been seen in health, namely the increase in chronic illness, have resulted in challenges to health professionals.

Objectives: The aim of this study is to reflect on the Nursing practices used in approaching the person with a chronic illness.

Methodology: We conducted a qualitative study, using the technique of spoken reflection, with 35 primary health care nurses from the North of Portugal.

Results: The nurses acknowledged that their practice is influenced by the biomedical model, centred mainly on disease and its control. They found it difficult to work with people with a chronic illness, related to aspects inherent to the client, organisational factors, the practice of care itself and relationship factors within the team.

Conclusion: The analysis, reflected in the practices in use, represents the first step so that nurses become aware of the need to change, in order to bring the current model closer to this model.

Keywords: nursing care; adherence to the therapeutic regime; chronic illness; nursing

Resumo

Enquadramento: As mudanças que têm vindo a verificar-se na saúde das populações, nomeadamente o aumento das doenças crónicas, colocam desafios aos profissionais de saúde.

Objetivos: Este estudo pretende refletir sobre as práticas de Enfermagem em uso na abordagem à pessoa com doença crónica.

Metodologia: Desenvolveu-se um estudo qualitativo, utilizando a técnica da reflexão falada, com 35 enfermeiros dos cuidados de saúde primários da região Norte de Portugal.

Resultados: Os enfermeiros reconheceram que a sua prática é influenciada pelo modelo biomédico, centrando-se maioritariamente na doença e seu controlo. Constataram dificuldades em trabalhar com a pessoa com doença crónica, relacionadas com aspetos inerentes ao cliente, a fatores organizacionais, à própria prática de cuidados e a fatores relacionais entre a equipa.

Conclusão: A análise refletida sobre as práticas em uso representa o primeiro passo para que os enfermeiros se consciencializem sobre a necessidade de mudar, com vista a aproximar o modelo em uso do modelo exposto.

Palavras-chave: cuidados de enfermagem; adesão ao regime terapêutico; doença crónica; enfermagem.

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Resumen

Marco contextual: Los cambios que se han observado en la salud de las poblaciones, en particular, el aumento de las enfermedades crónicas, suponen un desafío para los profesionales de la salud.

Objetivos: Este estudio busca reflexionar sobre las prácticas de enfermería en uso en el tratamiento a la persona con enfermedad crónica.

Metodología: Se desarrolló un estudio cualitativo, utilizando la técnica de la reflexión hablada, con 35 enfermeros de atención primaria de la región Norte de Portugal.

Resultados: Los enfermeros reconocieron que su práctica se ve influida por el modelo biomédico, aunque se centra principalmente en la enfermedad y su control. Se constataron dificultades al trabajar con personas con enfermedades crónicas, relacionadas con aspectos inherentes al cliente, a factores organizativos, a la propia práctica de los cuidados y a factores de relación entre el equipo.

Conclusión: El análisis sobre el que se ha reflexionado en relación a las prácticas en uso representa el primer paso para que los enfermeros tengan consciencia de la necesidad de cambiar con el objetivo de acercar el modelo en uso al modelo expuesto.

Palabras clave: atención de enfermería; adhesión al régimen terapéutico; enfermedad crónica; enfermería.

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Introduction

The constant demographic changes associated with the ageing of the population and increased chronic illness, as well as the current socio-economic and political context, envision that nursing care will evolve to respond to the new health needs of clients. By providing person-centred care, the nurse helps patients to recognise, verbalise and find a way to respond to their health situation and to make an active commitment to managing their illness.

Although the development of Nursing as a profession and discipline is well known, there still seems to be some difficulty in prioritising, in practice, an approach centred on the person and on their potential, since the current paradigm still overrates the curative aspect (Organização Mundial de Saúde, 2008). Indeed, and according to Silva (2007), the biomedical paradigm still seems to predominate since “there are difficulties ... in introducing aspects that are characteristic of the models given here that emerge from the disciplinary development of Nursing, in the models in use in professional practices” (p. 11).

This study emerges from the express desire of a group of nurses to rethink their care, with a view towards helping people with a chronic illness to effectively integrate the therapeutic regime into their daily life. Focusing on the problem of managing chronic illness, the aim is to progress to more advanced Nursing, where the models in use in the professional context move closer to the models set forth in the discipline.

Thus, the aim is to analyse Nursing practices used in approaching people with chronic illness, identifying factors that facilitate/inhibit client-centred care.

Background

The onset of a chronic illness is considered a stressful event that often requires people to redefine meanings, adapt to new behaviours, change lifestyles and deal with new emotions, which may give rise to profound changes in their health and life plans (Meleis, Sawyer, Im, Messias, & Schumacher, 2010). Taking as the object of the study the processes of transition that people experience throughout their life cycle, and that are related to the processes of health, it is important to evolve from a model centred

only on the management of illness and the control of its signs and symptoms, to models that emphasise the human responses to transitions (Pereira, 2009; Silva, 2007).

The World Health Organization (2008) recognises the inadequacy of health services to treat people with these conditions, assuming as a challenge the need to provide innovative care, which implies a change of paradigm. Professionals are still focused on a model centred mainly on the illness, which often translates in to unsuitable care (Organização Mundial de Saúde, 2008).

Reflecting on the reality will constitute a first step to enable modification. Boterf (2006) notes that distancing or reflexivity is one of the dimensions that translates into competence or professionalism. Distancing is the condition needed to be able to improve professional practices which, in the specific context of this study, means improving nursing care. Analysing the practices consists in distancing oneself to become aware of them, with the objective of implementing or conceptualising them (in the form of discourse) or giving them another form (schemes). The reflexivity does not end in the description of the development of the activity performed, but also covers the explicitness of the reasons inherent to this practice, a process commonly known as the «operative scheme». Professionals do not limit themselves merely to describing how they act, but also explain the reasons for that action (Boterf, 2006).

The work set forth here is part of a research project and deals with its diagnostic phase, describing the progress made by a group of nurses aimed at bringing about modifications in their professional action, evolving to more advanced Nursing, i.e., to *Nursing with more Nursing*. Centred on a more conceptual logic and carried out by personal inter-relationships, it involves increasing abilities for decision making and performance, sustained on the theories of the discipline itself (Silva, 2007).

Research question

In order to provide greater reflection and induce practices that are more consistent and adapted to people's real needs, we asked: What are the facilitating and inhibiting factors of a client-centred approach that nurses encounter in their professional practice?

Methodology

We developed a qualitative exploratory study. As criteria for inclusion in the study each health centre in the former Health Sub-Region of Vila Real had to be represented by at least two nurses: one with supervisory functions and one who provided care directly to patients with chronic illness. Thirty-five nurses took part: 2 supervisory nurses, 13 head nurses and 20 direct care nurses. To achieve the stated objective, we used spoken reflection, a technique that allows us to access the cognitive processes that people use in resolving a certain problem (Somerén, Barnard, & Sandberg, 1994). In our case, we specifically used the technique of retrospection. In this technique, the participants are questioned on the thought processes used in resolving certain problems or tasks. The professionals reflect and explain about the *praxis*, representing an exercise which, in itself, allows exposure of the variables/factors that led them to take certain options regarding the care provided. Thus, awareness is promoted about the decision-making process.

The study was approved by the Health Sub-Region. Initially the objectives were defined and clarified by the main researcher and told they could withdraw at any time. It was also clarified that the entire content of the information under analysis relating to the professional exercise would only be used for study purposes, and that it would not interfere in any way with their performance evaluation. Initially a guide was provided with the topics and the main issues that would be the basis for analysis and discussion. These focused on the difficulties experienced in approaching people with chronic illness, on the main focus of attention and Nursing diagnostics, as well as the most frequently implemented interventions. For a better exploration of the contents to be investigated, the nurses were divided into four groups. After analysing the issues, everyone gathered in a plenary session, where a spokesperson from each group shared the main aspects that had emerged from the analysis. The role of moderator was assumed by two members (the main researcher and the research advisor). At the end of each meeting (five in all, making up 35 hours of work) the moderators gave a summary, highlighting the main points. Thus, since these sessions were not recorded in audio format, they validated the main ideas that emerged from the

reflection with the participants. The sessions were also documented by a member responsible for this. The documents produced by this member, by the nurses and by the field notes taken by the researcher, constitute the analysis material. Without previously defined categories, we proceeded initially with a complete reading of the information gathered. Next, we proceeded to examine sentences or paragraphs, focusing our attention on discovering thoughts, ideas and concepts. In the process of open codification we identified the categories (or topics) and the subcategories (attributes), evolving later to axial codification, where we established the relationships among them (Strauss & Corbin, 2008).

Results and discussion

The nurses said that they felt it difficult to provide care to people with chronic illness and mentioned various aspects, in their daily practice, that had made it difficult to monitor these individuals. These barriers were grouped into four categories: *The person, the illness and the surrounding environment*; *Organisation of care*; *The Practice of Nursing*; and *Relationships in the health team*.

(1) *The person, the illness and the surrounding environment*. The psycho-social factors have been widely referenced in the literature as aspects that influence self-care behaviours (Levesque & Pahal, 2012). The factors related to the person include socio-demographic variables such as age, gender, sociocultural level and economic resources. Although the socio-demographic factors may interfere with the self-care behaviours, the truth is that this influence has not achieved consensus among the research produced. However, a large number of the nurses consider that generally women and younger and more literate clients are more committed to health care. A good socio-cultural and economic level was also associated with greater adherence. Literacy, related to a low level of schooling and a lack of knowledge about the illness, has contributed to the minimal care given to its management (Tanqueiro, 2013). This situation, in the nurses' opinion, is still driven by difficulties in learning due to problems in comprehension and memorisation of the information transmitted. The nurses highlighted the aspects related to the reasons for the action, namely cognition (knowledge about the

illness), learning (literacy, the ability to learn), beliefs, willpower (motivation), decision making (initiative), awareness and also adaptation (acceptance and adaptation of the health status), considering them relevant in behaviours of self-care of their clients. The volitional aspects, adaptation and beliefs were considered as the most challenging focus of attention for the intervention of these nurses. The truth is that these foci are in the genesis of attitudes and behaviours and thus present themselves as fundamental when the goal is to help people integrate the illness into their lives (Meleis et al., 2010). The nurses have noted that the lack of awareness, of acceptance of the state of health and adaptation to the illness, have made adherence difficult, since people tend to *not feel ill*, devaluing their situation, showing unavailability to take care of themselves and to listen to the advice of health technicians. It has also been found that the experiential knowledge that people have constructed, resulting from their own experiences or what has happened to those close to them, has interfered with the care they dedicate to their health. Literature has alerted us to the need for nurses to access the client's experiences, allowing them to understand how the client acts in light of their illness. A health professional may encourage them to reflect on past events, in the sense of promoting learning (Meleis et al., 2010). There has also emerged the influence of the aspects related to the perception of illness and treatment: the nurses noted that beliefs about the seriousness, perceived vulnerability, complications of the illness, the existence of comorbidities, the adverse effects of the treatment and the complexity of the regime have interfered in the way their clients become involved in self-management. Thus, they understand the influence that health beliefs have on the way people manage their therapeutic regime (Pourghazneina, Ghaffarib, Hasanzadehc, & Chamanzarid, 2013). This set of conditions that are intrinsic to the client, according to Meleis et al. (2010), must be equated in the understanding of the phenomena of transition and therapeutic approaches.

The factors related to the surrounding environment, specifically with family support were also described as being essential in managing the therapeutic regime. The nurses emphasised the benefits of direct or indirect involvement by the family in managing the illness. The importance of family support has been widely accepted in the literature (Levesque & Pahal,

2012). However, the team noted the scarce presence of family members at the consultation, making it necessary to find strategies to increase the level of involvement of the significant persons in planning and managing the therapeutic regime.

Therapeutic interaction was another aspect mentioned as very relevant for the production of health gains. The nature of the quality and intensity of the interaction of the client with the nurse is a decisive aspect in the success of the transitions (Meleis et al., 2010). The nurses recognised that the way they transmit information, the strategies used, the capacity for negotiation and the positive reinforcements, are primordial in establishing a relationship of trust. According to this group, it is necessary to invest in the development of competences to negotiate with the client. The truth is that the focus on the illness, and not on the person who has the illness, has limited the development of a therapeutic relationship (Organização Mundial de Saúde, 2008). Also, the reduced autonomy of the client to improve their health has made the nurses' work more difficult, mainly when they are dealing with people whose management styles are negligent, independent or formally guided (Bastos, 2012). The nurses in this study recognise these difficulties, especially when they provide care for older clients, those who are less literate and less motivated.

(2) *Organisation of care*. Regarding the organisational aspects related to the care, the nurses noted that the work method adopted has interfered negatively in the care provided to people with a chronic illness. Some health units have still not implemented the work method according to the model recommended by the family nurse, using the distribution of the work of Nursing by task. This method, besides compromising patient follow-up, prevents the establishment of a true therapeutic relationship. The current hiring of nurses, with short-term work contracts, has resulted in a greater turnover in the team. The World Health Organization (2008) emphasises the need for a customary and trusted provider, cultivating a stable, personal and long-lasting relationship. This therapeutic process, which has beneficial effects for both, could take between two to five years to produce results, i.e., to establish a relationship of empathy, respect, understanding and trust between the health team and the client (World Health Organization, 2008). The short time destined for the Nursing consultation, which lasts approximately 15 minutes,

was also considered by the group as a limiting aspect. According to these professionals, the consultation times established by the institutions continue to be weighted based on acutely ill patients, where the nurse only has time to focus on the pathology and monitoring the signs and complications. Always safeguarding the nature of the care, the recommendations of the Portuguese Nursing Board (2011) suggest 30 minutes for a Nursing consultation/interview and 60 minutes for a home visit. Lack of awareness of the family's socio-economic and cultural context has also contributed to the difficulties nurses feel in promoting behaviours of adherence. They recognise that populational dispersion, characteristic of some communities of this region, has limited contact with the client's family. Territorial dispersion, the scarcity of material resources, such as the lack of sufficient vehicles, associated with few human resources, have made home visits difficult. Staffing is often based on interventions of a biomedical nature and the allocation of financial resources may favour specialised or hospital care. The need for more development of primary health care requires us to redefine allocation of resources, to provide health care that is nearby and centred on the citizens (Deloitte, 2011).

Health indicators were also mentioned as a factor that has interfered with care, guiding nurses to areas predominately focused on illness. The use of indicators in different contexts should promote and support best practices in the provision of health care (Administração Central do Sistema de Saúde, 2010). However, limiting professional activity to complying with the indicators may de-centre the health care of the citizens (Melo & Sousa, 2011). The truth is that currently the indicators are more centred on the process than the results, not specifically representing health gains, but rather process data and some intermediate results (Escola Nacional de Saúde Pública, 2010; Melo & Sousa, 2011). The need for us to evolve to the use of indicators that are finer and more sensitive to Nursing care, in a logic of complementing normal health indicators, is also emphasised and noted by Pereira (2009). The emphasis placed on process indicators, especially Nursing care, could contribute to some discouragement in nurses who see their work very much reduced to the frequency with which they perform certain interventions, as opposed to gains in health.

(3) *The Practice of Nursing*. Some problems related to aspects of the practice of Nursing have also made working with this type of clients difficult. Nurses mention difficulties in diagnostic evaluation, in interventions to be implemented, in the motivational approach and in the definition of objectives with and for the patients. They also recognised that since they outline the objectives of the therapeutic plan, this could call into question the enforceability of these same objectives, and even demotivate the clients. This paternalistic type of approach is, from our perspective, not very favourable to making clients responsible and autonomous for their health.

Because of the complexity of the therapeutic regimes, nurses have encountered multiple focuses of attention which contributes to the difficulty in proceeding with a deeper evaluation of the real needs of patients and joint preparation of an adapted care plan. This is a decisive aspect in the quality of care. The nurses' training models seem to contribute to the difficulties that are experienced. For example, some of the senior professionals, say that their training was oriented to managing signs and symptoms of the illness and collaborating with the doctor in the treatment of pathologies. Furthermore, there are the difficulties various nurses report in the use of information systems as well as their lack of experience with the International Classification for Nursing Practice (ICNP). As a result, there has been a deficit in documentation, which could jeopardise the continuity of care and the generation of indicators sensitive to Nursing care (Pereira, 2009; Silva, 2006). Silva (2006) states that the activity of documenting Nursing care is not seen as very exciting, although they are aware of the need to document, and of their legal obligation to do so. In light of the reflection we made with the nurses we dare to suggest the possibility that the problem is located upstream, related to the difficulty in the decision making process. Indeed, the approach to people with a chronic illness is challenging. Moving in situations of great complexity, where the care is so individualised, and as such, complex, nurses see themselves confronted with the need to develop their critical thinking in Nursing, clearly related to a certain underlying conceptual model (Silva, 2006). Thus, in light of the model that guides their practice, i.e., according to the model in use, nurses seek the data considered most relevant to plan the care. If this model is close to the biomedical model, it is natural

that the professional is more centred on aspects related to the illness, if the focus is more on adaptive practices, then probably the focus of attention will fall on people (Silva, 2011).

An important aspect of nurses' discourse centres on recognising some deficit in preparation in areas regarding the problem of managing and adhering to the therapeutic regime, such as the motivational approach to the patients, the beliefs in health and the meanings and emotions associated with the illness and its control. As already mentioned, the models of practice directed to the treatment of acute illness still prevail (Organização Mundial de Saúde, 2008), limiting the development of tools and techniques by health professionals to help clients in self-managing illness. Thus, nurses do not develop competences that allow them to work with the clients, in the sense of promoting their autonomy and empowerment.

(4) *Relationships in the health team.* The professional credentials and the way information is shared has,

from the perspective of this group, constituted an obstacle to an effective relationship of professional cooperation. The incipient sharing of the definition of objectives and strategies among the health team has been seen to have little consistency with the promotion of adherence to the therapeutic regime. Neves (2012) stresses the need to invest in team work, based on the respect for the role of each one, the clearness of the objectives and the commitment and systematic participation of all the professionals. From this perspective, this dissonance, often hidden within the multidisciplinary team, may reflect negatively on the quality of care. The existence of intervention planning among the various professionals, taking advantages of their different contributions, could improve the care and satisfaction of the clients.

Figure 1 summarises the factors (categories and subcategories) which we have been discussing and which interfere with the way nurses provide care to people with chronic illness.

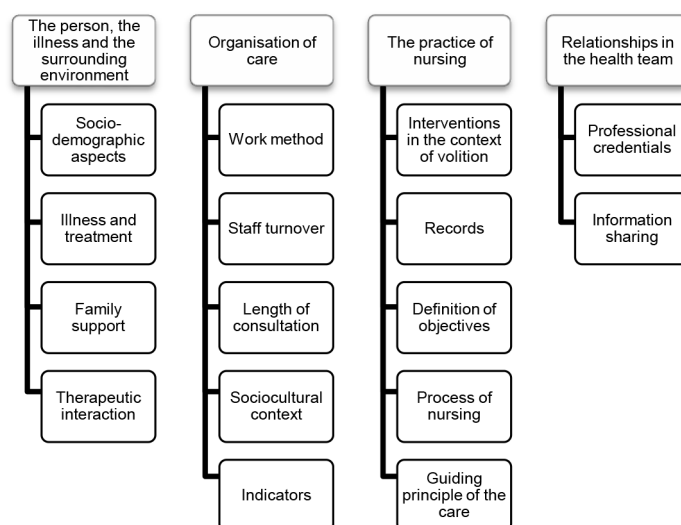


Figure 1. Factors that influence the practices of nurses in approaching people with a chronic illness.

The nurses also reflected on the structure and the normal content of Nursing consultations. The nurses spoke of welcoming clients with an interview where they collect data that will allow them to identify the main health needs and perform interventions in the context of monitoring (monitoring parameters such as blood pressure, heart rate, weight, body mass index, abdominal perimeter, capillary blood glucose) and Vigilance (vigilance of the foot, in cases of clients

with diabetes). They identify Nursing diagnosis and implement the respective interventions. These rest on teaching (about the complications of the illness, the risk factors, the therapeutic regime) and instructing/training in self-vigilance, providing clients with knowledge and skills. The nurses encourage and praise adherence as well as the results obtained and assist people with difficulties in adhering. When asked to enumerate the *main focuses of attention*

on which they invest in the consultation with people with diabetes/high blood pressure, they highlighted the focuses: Adherence to the therapeutic regime; Managing the therapeutic regime; Self-monitoring; Tissue, perfusion; Acceptance of the health status; Energy metabolism and High blood pressure. We verified that, overall, the focuses habitually worked in these consultations were related with bodily processes (tissue perfusion; energy metabolism, high blood pressure, obesity), the reasons for the action (acceptance of the health status, self-control: infection) and the action performed by the people themselves (adherence to the therapeutic regime, management of the therapeutic regime, self-vigilance, safety precautions: diabetic foot). Similar results were found by Pereira (2009), where clinical contents of the Nursing Minimum data set regarding the dimensions of *self-care* and *adherence* arise with greater frequency in the documentation produced by the nurses in the context of primary health care, especially in risk groups. When the author analysed the distribution of the cases arising from these consultations by dimensions, he saw that the *adaptation* and *learning* the abilities of the clients, by the small percentage compared with the *adherence* and *the cognitive learning* of the client, constituted “aspects of care situated in the territories of the exposed” (Pereira, 2009, p. 327). As for interventions that are usually carried out in the consultations, the most frequent types that emerge are *Observing* (monitoring, watching); *Informing* (instructing, training) and *Attending* (assisting, praising) (Pereira, 2009). A study developed by Ferrito (2010) demonstrated that the interventions that gathered consensus to be implemented in the type 2 diabetes Nursing consultation were: checking blood pressure and heart rate; monitoring weight, height, abdominal perimeter, blood glucose and glycated haemoglobin; observing and looking for any alterations in the feet; and teaching about self-management of the illness. However, the author also found that, at least in this area, the nurses valued education for self-management of illness, thus aligning with the standards of clinical guidelines (Ferrito, 2010). As we can infer, the emphasis was placed on *vigilance*, complemented with *teachings*, that arose in a logic of providing information and, it seems, little involvement with the clients themselves. We run the risk of these being the *teaching-types*

referenced by Silva (2011), since they seem to show a standard of approach focused in the illness, in which the initial data on the clients does not appear to be fundamental for making the information transmitted suitable (Silva, 2011). The *teachings* related by the nurses in this research, for example in the context of the diabetes consultation, included self-evaluation of capillary blood glucose and information on physical exercise, diet and foot care. This could mean that teaching is based on the *transmission of information Through information*, instead of being a strategy to promote the qualification and development of clients as people, with a unique life experience.

Since this study is part of a research project, the findings emerge from a group of professionals in a specific context, and thus it is not to be expected that they can be generalised. However, we think they can contribute to a better understanding of the factors that influence the practice of the nurses in approaching people with chronic illness. Awareness of these aspects by the nurses is the first step in the process of change, that aims to provide nursing care that is more centred on people and therefore, more significant for the clients.

Conclusion

Our goal has been to build a space for reflection that allows nurses to clarify their practice, analysing it in light of their conceptions, guiding models, motivations and the surrounding social system. We found that the approach to clients adopted by nurses depends on various factors that may be related to the clients themselves, with the organisation of care, with the relationship between the health team and aspects inherent to the practice itself. These variables that interact in different ways may facilitate a client-centred care. The nurses concluded that the approach to people with a chronic illness has been based essentially on the biomedical model. They recognise that this model does not respond to the clients' effective needs and does not reflect what the most recent scientific evidence suggests. It thus seems to us that these nurses find themselves faced with a certain dichotomy regarding what they perceive to be the object of Nursing (exposed model) and what they practice in the work context (model in use). The nurses identified the obstacles to a client-centred

approach. They showed difficulties in working focused on the context of the reasons for the action and in naming Nursing diagnostics using the ICNP. They point to the need for more systematic use of the process of Nursing as a problem solving method, for training in the process of clinical decision and diagnostic identification. They consider it essential to invest in training professionals in the factors that influence health behaviours. Also, from these nurses' perspective, comes the need to resort to the use of intervention models that guide the practice of Nursing to more significant care, in the sense of supporting people in mobilising the skills that allow them to take informed decisions, and making them autonomous in the process of managing their health.

Since there are various factors that influence the approach to people with chronic illness, this study suggests that the existence of a shared vision of change among the different actors who intervene in the care process is vital. Although the nurses recognise that there are constraints to this change, some outside their direct sphere of action, they believe that many of the alterations operate in the professionals who work in the context of the practice and that these "small great changes" are the genesis to improve health care.

References

- Administração Central do Sistema de Saúde. (2010). *Cálculo de indicadores de desempenho: Critérios a observar na sua implementação*. Retrieved from <http://www.acss.min-saude.pt/Portals/0/C/C3%AlculoIndicadoresDesempenho.pdf>
- Bastos, F. (2012). *A pessoa com doença crónica: Uma teoria explicativa sobre a problemática da gestão da doença e do regime terapêutico* (Tese de doutoramento não publicada). Universidade Católica Portuguesa, Porto, Portugal.
- Boterf, G. (2006). *Três dimensões a explorar: Avaliar a competência de um profissional*. Retrieved from <http://www.guyleboterf-conseil.com/Article%20evaluation%20version%20directe%20Pessoal.pdf>
- Deloitte (2011). *Saúde em análise: Uma visão para o futuro*. Retrieved from http://www2.deloitte.com/content/dam/Deloitte/pt/Documents/life-sciences-health-care/pt%28pt%29_lshc_saudeemanalise_04022011.pdf
- Escola Nacional de Saúde Pública. (2010). *Contratualização em cuidados de saúde primários: Horizonte 2015/20.: Fase 5: Relatório Final*. Retrieved from http://www.acss.min-saude.pt/Portals/0/Fase%205_Relatorio%20Final.pdf
- Ferrito, C. (2010). *Intervenções de enfermagem à pessoa com diabetes tipo 2 em cuidados de saúde primários: Contributos para uma prática baseada em evidência* (Tese de doutoramento não publicada). Universidade Católica Portuguesa, Portugal.
- Levesque, A., Li, H., & Pahal, J. (2012). Factors related to patients' adherence to medication and lifestyle change recommendations: Data from Canada. *International Journal of Psychological Studies*, 4(2), 42-55. DOI:10.5539/ijps.v4n2p42.
- Meleis, A., Sawyer, L., Im, E., Messias, D., & Schumacher, K. (2010). Experiencing transitions: An emerging middle-range theory. In A. Meleis (Ed.), *Transitions theory: Middle-range and situation-specific theories in nursing research and practice* (pp. 52-72). New York, USA: Springer Publishing Company.
- Melo, M., & Sousa, J. (2011). Os indicadores de desempenho contratualizados com as USF: Um ponto da situação no atual momento da Reforma. *Revista Portuguesa de Clínica Geral*, 27, 28-34.
- Neves, M. (2012). O papel dos enfermeiros na equipa multidisciplinar em cuidados de saúde primários: Revisão sistemática da literatura. *Revista de Enfermagem Referência*, 3(8), 125-134.
- Ordem dos enfermeiros. (2011). *Guia de recomendações para o cálculo da dotação de enfermeiros no serviço nacional de saúde: Indicadores e valores de referência: Proposta do grupo de trabalho*. Retrieved from <http://www.ordemenfermeiros.pt/comunicacao/Paginas/RecomendacoesDotacoesEnfermeirosAplicaveisUnidades.aspx>
- Organização Mundial da Saúde. (2008). *Cuidados de saúde primários: Agora mais que nunca: Relatório mundial de saúde 2008*. Retrieved from http://www.who.int/whr/2008/whr08_pr.pdf
- Pereira, F. (2009). *Informação e qualidade do exercício profissional dos enfermeiros: Estudo empírico sobre um resumo mínimo de dados de enfermagem* (Tese de doutoramento não publicada). Universidade do Porto, Instituto de Ciências Biomédicas Abel Salazar, Portugal.
- Pourghazneina, T., Ghaffarib, F., Hasanzadehc, F., & Chamanzarid, H. (2013). The relationship between health beliefs and medication adherence in patients with type 2 diabetes: A correlation-cross sectional study. *Life Science Journal*, 10(4s), 38-46.
- Silva, A. P. (2006). *Sistemas de informação em enfermagem: Uma teoria explicativa da mudança*. Coimbra, Portugal: Formasau; Porto, Portugal: Escola Superior de Enfermagem de São João.
- Silva, A. (2007). Enfermagem avançada: Um sentido para o desenvolvimento da profissão e da disciplina. *Servir*, 55(1-2), 11-20.

- Silva, A. (2011). *Intenções dominantes nas concepções de enfermagem: Estudo a partir de uma amostra de estudantes finalistas* (Tese de doutoramento não publicada). Universidade Católica Portuguesa, Porto, Portugal.
- Somerén, M., Barnard, Y., & Sandberg, J. (1994). *The think aloud method: A practical guide to modelling cognitive processes*. London, England: Academic Press. Retrieved from http://echo.iat.sfu.ca/library/vanSomerén_94_think_aloud_method.pdf
- Strauss, A., & Corbin, J. (2008). *Pesquisa qualitativa: Técnicas e procedimentos para o desenvolvimento de teoria fundamentada* (2ª ed.). Porto Alegre, Brasil: Artmed.
- Tanqueiro, M. (2013). A gestão do autocuidado nos idosos com diabetes: Revisão sistemática da literatura. *Revista de Enfermagem Referência* 3(9), 151-160.

