interface
comunicação, saúde, educação
https://www.interface.org.br
eISSN 1807-5762

Articles

The use of the analyzer flowchart to describe the movements of living networks of a user with dementia

A utilização do fluxograma analisador para descrever os movimentos de redes vivas de um usuário com demência (abstract: p. 17)

Análisis con diagrama del flujo para describir los movimientos de las redes vivas de un usuario con demencia (resumen: p. 17)

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Dementia is an emerging public health issue resulting from population aging and epidemiological transition. Therefore, this research aimed to analyze the living networks woven by a user with dementia and her family in the path of seeking health care and support, through the existential connections established in their journey, from the perspective of a guiding team. To achieve this, a qualitative cartographic approach was applied using techniques such as focus groups, analyzer flowchart, and field diary. The analysis of the results allowed identifying home visits as a tool of soft technology in the movement of living networks and the need for ongoing education to ensure the comprehensive care of users with dementia syndromes. It is concluded that there is a need to better articulate care technologies in order to make actions more effective.

Keywords: Aged. Dementia. Community networks. Delivery of health care. Education, continuing.

Lopes FMVM, Espírito Santo TB, Caldas CP, Nicoli EM. The use of the analyzer flowchart to describe the movements of living networks of a user with dementia. Interface (Botucatu). 2025; 29: e240507
https://doi.org/10.1590/interface.240507

Introduction

Brazil is experiencing a fast demographic and epidemiological transition[1]. It is projected that, in just over two decades, the elderlies will account for around a third of the national population[1]. The changes resulting from these processes have led to an increase in the prevalence of chronic non-communicable diseases, such as dementias[1].

Dementias are chronic and mental health conditions that are growing in number and importance, becoming a publichealth problem[2]. Their prevalence increases with age, affecting one in five elderly people (>80 years)[2], and impose a heavy burden on users, their families and society[3]. With the ageing of the population, there is a need for the qualification of health professionals for the elderly, as well as public policies that promote healthy ageing, focusing on autonomy and independence[4].

The Family Health Strategy (FHS) is an essential Brazilian policy for the organization of primary health care in municipalities, and is the main gateway to care for elderly people with dementia[5]. Despite its ethical, social and cultural foundations and its purpose of promoting health and quality of life, in practice, users often find it difficult to make referrals and seek resources on their own due to lack of knowledge or difficulty in accessing FHS services[6].

In the process of searching for multiple ways of satisfying their health needs[7], users create living networks, constituting a transforming protagonism[8]. These networks are made up of existential connections that go beyond formal networks and institutions. Informal and dynamic, these networks function in an understandable way that can improve health care[8], which is why this study poses the following question: “What is the path taken by a person with dementia who uses the Brazilian National Health System (SUS) in search of care, from the perspective of the health team at a family clinic?”

In order to answer this question, the aim was to observe and record the living networks woven by a user with dementia and their family in their search for health care and care, through the existential connections they establish in their journey, from the perspective of a guiding team.

Methodology

A qualitative methodological approach was carried out, using a cartographic approach, based on the schizoanalysis of Deleuze, Guattari[9] and Baremblitt[10], currents of institutional analysis, based on the actions of professionals who direct care strategies based on singular practical realities[9,10]. The main tenet in this current is the implication of collective thinking and the singularity of the networks of relationships formed by the contradictions between the instituted and the instituting[9,10]. When using the cartographic approach, the narratives of encounters about the production of care are more valued than the synthesis of discourses, as they allow for the expression of intensities[11,12].

The cartographic choice is justified by the ability to access the relational plane of the micro-politics of health work, where the researcher affects and is affected by the research field, in reciprocal interference, in view of the implication in the intense production of encounters and affections[13]. From the perspective of institutional analysis, this approach was carried out with professionals from a health team (guide team). Inspired by the concept of the guiding user[14], the study includes the team as the guide of the investigative process, with the researcher accompanying them in the process of producing care for a user, identifying visible and invisible modes and lines of care. The researcher-guide team encounter, in its daily and reflective practice, guides the paths of the study and the data produced, including the researcher's affections, recorded in the field diary.

The ethnographic field diary contributes significantly to data collection in health research, recording multiple rationalities in the social world[13]. This record includes objective facts and the narrative of the relationship between the researcher and the researched world, interfering in the organizations of this world and elaborating a narrative of the affections of the interactions between observer and observed[13]. Thus, the tool aims to record the cartographic journey from the researcher's perspective, becoming a document that aids in the formation of discursive plans[13].

The cartographic process aimed to identify problems, conflicts, tensions and potentials, as well as the interactions between the subjects involved in care, mapping each everyday situation. This process was materialized by the collective elaboration of the Analyzer Flowchart (AF) through a focus group. This group, made up of a guiding team, aimed to collect the workers' narratives about the production of care for a user, identifying critical nodes and strengths of the encounters that produced or did not produce care.

The main researcher, a nurse and PhD student in Nursing, led the group and was, at the time, the manager of the unit that was the setting for the study. It should be noted that this place in the team was the object of reflection, since cartography, due to its micro-political and relational characteristics, is a process of interference in the world being researched, giving up the researcher's place of exemption and analyzing it critically[13]. Cartography doesn't just collect data, it produces it in the act, by way of collecting what emerges and making others emerge through research in a space of investigation and interference[13].

In this sense, being the manager of the unit can provide, in the research process, reflections on this hierarchical position that were collectively elaborated during the course of the groups, not presenting itself as an impediment to the development of the research process[15]. In addition, being a member of the team made it easier to get to know the workers, the service users, the territory and the routine of the health services through the network of relationships already established[15].

An assistant researcher was responsible for observing the collective dynamics and recording the data that emerged, as well as her impressions, which were also recorded in the Field Diary.

The Analyzer Flowchart (AF), built collectively in the Focus Group, is a qualitative tool for analyzing healthcare models, graphically representing the stages of the work with three symbols: ellipse (input/output), rhombus (breakpoints) and rectangle (intervention/action). During its construction, the narratives collected generate new reflections, returning to the flowchart as part of the process and result of the research[16]. By identifying strengths and points for reflection in the team's work, the AF allows for a better perception of institutional micro-politics in care practice, as well as helping in the planning and reorganization of work[16].

The study was carried out in a Family Clinic (FC) located in a territory with more than 20,000 registered citizens[17], organized into five family health teams, each with responsibility for around 4,000 users in four micro-areas. The data was produced by one of the Clinic's teams, chosen because it was complete in terms of professional categories, with 12 people: a doctor, a nurse, a nursing technician, five CHWs, a dentist, an oral health assistant, a pharmacist and a psychologist.

The territory of the team studied has more than 3,000 registered people[17], including two communities with high social vulnerability, dominated by drug trafficking. The majority of the population is young and beneficiaries of government cash transfer programs.

After agreeing to take part in the research, the team's workers were invited to the focus group. The group of professionals was asked to reflect on the paths taken by elderly users with dementia through the healthcare networks. The following trigger questions were then asked: "An elderly user diagnosed with dementia moves to your area of coverage. How does she get care and integrate into the health service?" and 'What paths does she take through the health care networks?'.

It was suggested that the answers be based on the choice of a real, complex case monitored by the team. As the questions were discussed and reflected on, the team collectively drew up a diagram of the user's flow on a sheet of paper. The focus group was audio-recorded and later transcribed, lasting approximately 60 minutes. The notes taken in the field diary, the product of the workers' collective construction and the recording of the meeting were added to the analysis of institutional documents, thus making up the study's documentary corpus. The focus group was held in the FC itself, at a reserved time, so as not to affect the flow of appointments. The 12 members of staff mentioned above took part in the focus group.

The process used to draw up the categories was in line with the assumptions of the AF methodology, which identifies the points of reflection, their progress and obstacles in the process of collective construction. These are elaborated and re-signified by the group of researchers, giving rise to the categories of analysis.

The case chosen by the team was a 76-year-old single woman who lived in the area. Her son acted as her main caregiver, but received support from a community network made up of neighbors who organized themselves to help with care. Her main diagnosis was Alzheimer's and her comorbidities were hypertension, diabetes and motor deficits. In this study, the pseudonym Aparecida will be used for the user.

The research was cleared by the Research Ethics Committee, and received Certificate of Submission for Ethical Appraisal No. 3637820.8.3001.5279.

Results

The results are presented in the form of narratives from the meetings established between professionals, family members and the user through the care networks, represented by an AF constructed by the team about the user's trajectory. The narratives include information obtained in the focus group and recorded in the field diary, as well as information obtained from the medical records.

In the focus group, the doctor, nurse and one CHW participated most, while the others observed most of the time. For this reason, although the CHWs were in higher numbers, this was not a bias in the research.

Analyzer Flowchart

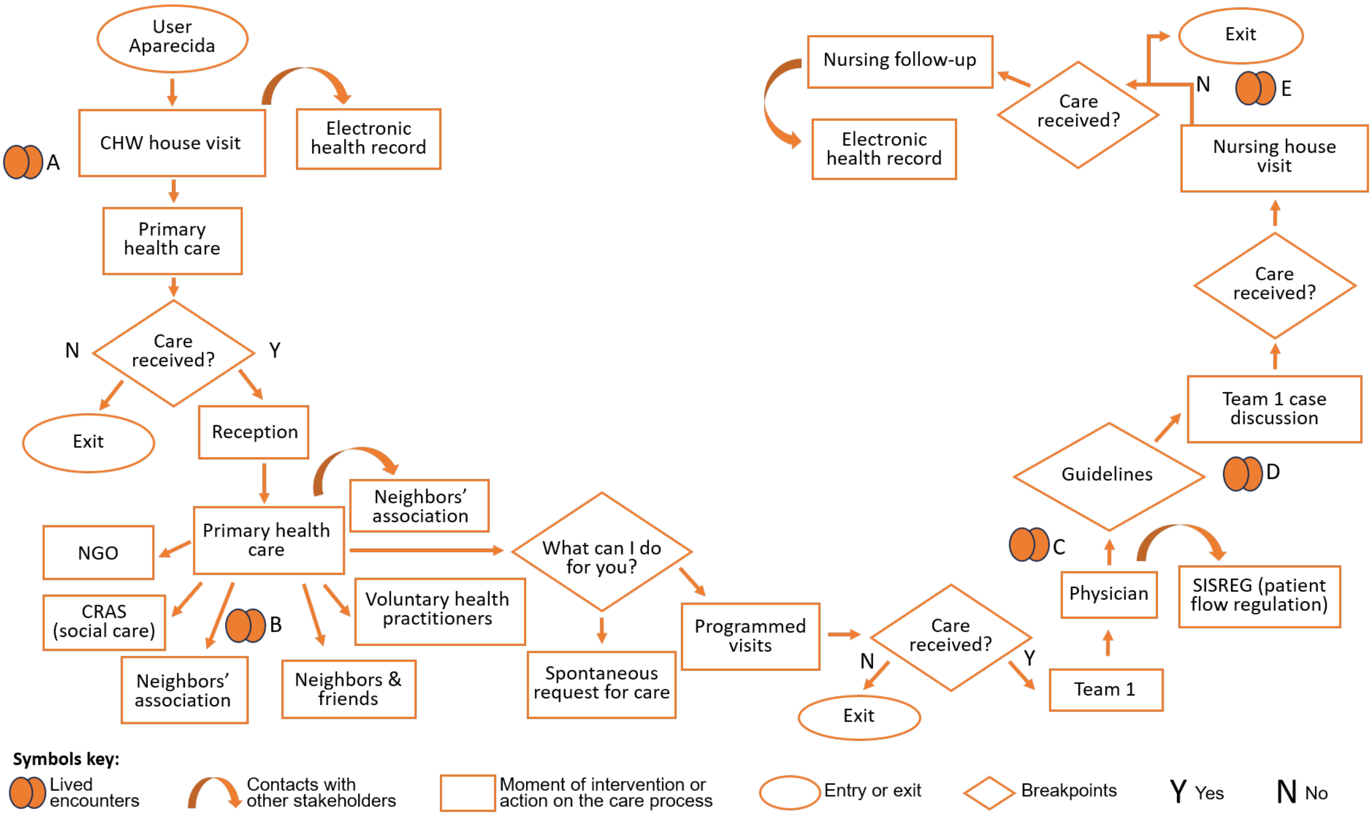

Figure 1. Flowchart of the path of the user diagnosed with dementia. Rio de Janeiro, 2023.

Source: The authors

A - First entry point

The user Aparecida accessed the service through her registration during a house visit to her home (HV) carried out by the CHW. The CHW reported that she observed the organization of the home and that Aparecida was accompanied by her son (38 years old) who, although he didn't live with his mother, offered support and was very interested in registering and being monitored by the SUS (information obtained from the focus group).

Aparecida was confused. She said that she lived in another municipality and that her son was too young to deal with these health issues. The son reported that his mother had been diagnosed with Alzheimer's for five years and that he relied on the help of relatives, neighbors and friends to take care of him, as he was an only child. The CHW showed a lot of interest and took the case to the team for discussion, highlighting the family's organization and coordination of care (information obtained from the focus group).

On consulting the electronic medical records, it was found that the CHW did not describe in detail the care and experience she had at Aparecida's house. However, during the focus group, the HV was presented in detail by her (information obtained from the field diary).

B - Second entry point

Two days after registering, Aparecida arrived at the FC accompanied by a neighbor, reporting blurred vision and a headache. She was taken to the observation room, where she received medical care and was diagnosed with high blood pressure, nausea and vomiting, and medicated for hypertensive urgency (information obtained from the focus group).

The neighbor reported that the community where they lived was very organized and that they took very good care of all the elderly, with a support network that included other neighbors providing daily meals and cleaning. The mobilization resulted in a schedule in which three people took turns to accompany and care for Aparecida on a daily basis (information obtained from the focus group).

An NGO in the community provided a wheelchair, diapers and food. This NGO was organized by local residents who worked on a voluntary basis, receiving donations from adjacent neighborhoods. All the donations were registered by the volunteers and organized so that they could be sent to the families as needed. The Social Care Reference Center (CRAS) monitored the case in order to expedite social benefits. This was done with the president of the association (information obtained from the focus group).

An occupational therapist living in the area provided daily cognitive stimulation services and a physical educator led collective activities in the community's main square. Both were volunteers. Aparecida was picked up from home for the activities. The neighbor reported that Aparecida was very well cared for and that her son always helped out in any way he could, especially with buying medicines (information obtained from the focus group).

After two hours in the FC, Aparecida was released with a prescription for medication and a doctor's appointment scheduled. The nursing technician informed the CHW in the area about the support network created by the user and her family (information obtained from the focus group).

The CHW then went to the area and surveyed all the possibilities of support for other similar cases, including the president of the residents' association. He was very receptive, referring with affection and dedication to Aparecida's care, and emphasizing that she was a very important person in the community, very supportive, having helped everyone (information obtained from the focus group).

We are thus introduced to the living networks that support the creation of other networks, shared between health professionals and users living in the territory (information obtained from the field diary).

C - Breakpoints and orientations

On the scheduled day, Aparecida went to the doctor's appointment with her neighbor, who was responsible for her care. The doctor examined her and prescribed laboratory tests, imaging tests and started treatment for hypertension. During the focus group, the doctor verbalized the difficulty of dealing with elderly people with dementia and referred Aparecida to a neurologist via the Patients' Flow Regulation System (SISREG), deciding to keep the prescription of the previous neurologist from the private network, who had treated her three years earlier (information obtained from the focus group and field diary).

On consulting SISREG, the doctor's entry was observed, with all the exams carefully described so that it wouldn't be refused by the person allocating the slots for visits (called SISREG regulator). The classification in the system had a yellow code, indicating the need for priority scheduling within 90 days (information obtained from the field diary).

D - Discussion and guidelines

The case was discussed again at the team meeting, where the nurse highlighted the need to carry out a multidimensional assessment, cognitive and functional tests to identify geriatric syndromes. The team, surprised by the nurse's knowledge, asked for ongoing education to improve everyone's knowledge of gerontology (information obtained from the focus group).

He instructed them to read the manuals on the care pathway for the elderly in primary care beforehand for further discussion. A second meeting would discuss geriatric syndromes, functional capacity and Alzheimer's (information obtained from the focus group).

The team agreed that permanent education and the discussion of cases are essential for qualified care for the elderly with dementia, and decided that all the elderly should be assessed to screen for signs and symptoms that compromised their independence and autonomy (information obtained from the field diary).

E - Breakpoints and orientations

The team scheduled a home visit by the team's nurse and doctor. During this visit, a global analysis of the elderly woman was carried out, with a functional assessment using tests and checks for impaired autonomy and independence in activities of daily living. The tests indicated impaired cognition and symptoms of depression, as well as a risk of falls and the need for caregiver training. A singular therapeutic plan was drawn up with weekly monitoring and assessment of the user's support network, taking into account all those (professionals or not) who helped with her care (information obtained from the focus group).

The case led to developments and served as a topic for discussion at a continuing education meeting at the unit, suggesting greater coordination with the residents' association to register complex cases in need of help. Also noteworthy was the creation of a WhatsApp® group with all the volunteers who made up the support network and some FHS professionals, especially those from the referral team (information obtained from the focus group).

Consulting the medical records revealed insufficient records, which did not reflect the complexity of the case, showing that the instrument does not favor the recording of complex cases, as it is not suited to multidimensional care for the elderly.

Discussion

Home visits to elderly people with dementia as a soft technology tool in the living networks movement

The FHS is crucial in reducing morbidity and mortality in Brazil, controlling illnesses and monitoring chronic diseases such as dementia syndromes, as well as carrying out health promotion and prevention actions through HVs, especially those carried out by CHWs[18]. According to the national program for Primary Care (PNAB), CHWs are responsible for carrying out HVs and updating the registration of all the people in their micro-area, providing moments for the inclusion of the user and family in the health system, but also identifying and recording the difficulties and dilemmas of that family nucleus, starting to build bonds[18].

House Visits, therefore, are powerful tools that allow professionals to get closer to the user's real world[18]. However, for this to happen effectively and for a bond to be created between the parties, it is necessary for the professional to recognize the user as the protagonist in the construction of their care network[18]. In practice, it is evident that the CHW is the category that is most involved in building the living network outlined by the user, probably because they live in the area and already know the difficulties and potential that the place offers[18].

In their search for care, health service users look beyond the available services for different ways of meeting their health needs and/or problems, creating living networks from within[8]. Living networks are thus configured from existential connections that go beyond formal networks and institutions, with the interpenetration of informal and dynamic networks[8]. This understanding can contribute to more qualified health care that is closer to users' needs[8]. This movement highlights their role as protagonists of their therapeutic projects, regardless of what is or isn't done by the health teams[8]. This fact in itself is transformative, both for the user and for the team that allows itself to be crossed by this agency[8]. The construction of living networks allows the various services, organizations, bonds and affections in the territories to be connected, producing an encounter between workers and users[8]. In this way, it is possible to draw up more qualified singular therapeutic projects that go beyond structuring the physical network and what has been established[8].

In the case of Aparecida, the CHW, by identifying and validating the living network, was a central figure and facilitator in the process of expanding the support network, which although it already existed, did not cover all the health care needs. The directions given by the team, in turn, accompanied the CHW's mobilization and went beyond the institutional walls because, when they came across the network created by the family and community itself, it awakened the professionals to the complexity of caring for this type of user, bringing what was already being mobilized by the existential territory into the logic of the production of instituted care.

When considering the production of care, the complexity of the field and the confluence of interventions that make it up must be recalled, based on the health technologies used, namely: hard technologies, based on procedures and instruments/materials; soft-hard technology, based on structured, epistemological knowledge and its application; and soft technology, which validates the encounter, welcoming, bonding, sensitive listening and creativity[19]. The shared construction of the care plan and the possible emergence of conflicts depends on the use of these technologies and the recognition and mutual respect of the actors, thus contributing to improving care for the users[19]. Hard and soft technologies are necessary; however, the production of care for the elderly with dementia only occurs when soft technology is the basis of the process[19]. Family health care cannot do without the elements of soft technology, as they are what favor dialogic communication and comprehensive care[16].

Therefore, the findings of this study corroborate previous research that points to the home visit as a differentiated opportunity for care, because by entering the environment where the user lives, relationships can be established through qualified listening, bonding and welcoming, favoring the empowerment of this family as the protagonist of care[20].

It can therefore be seen that HVs are activities carried out by teams outside the unit that can be used as a powerful tool for incorporating soft technologies into care, increasing the user's protagonism and positioning them as a valid interlocutor of their existence, by making it possible to validate their living network. It is understood that this care should be multidisciplinary, including their caregivers (formal or not), allowing them to get closer to the challenges presented by family dynamics[21].

This approach is important because dementia syndromes are considered to be degenerative diseases that affect the degree of dependence of the individual, and the diagnosis is an impacting moment for the family, as it reveals the need to face a family reorganization[22]. In addition, the way home care is managed has a direct impact on the comfort and safety of the user, as well as on the level of stress in the caregiver[22,23].

The creation of Health Care Networks (HCN) in a regionalized and integrated way has developed since the 1988 Federal Constitution[24]. However, the actions proposed are based on a rigid structure and biomedical rationality, which is insufficient to meet health needs[8]. Thus, the possibility of users setting up their own networks in an unconstituted territory is not taken into account[8]. And because these living networks aren't taken into account, they don't dialog with the established network, due to the fact that health professionals don't know the individual as a whole and don't think it's important[8].

Considering the users as the drivers of their own health care process will allow their actions to be valued in favor of a more effective HCN. An example of this is the story of Aparecida, who set up her care network together with her son, producing care that was complemented and qualified with each relationship with the professionals who helped her. It's interesting to note that even with a protocol-based look at the biomedical logic, the professionals didn't erase the possibility of interlocution with this living network built by the family, since the team allowed itself to be crossed by the instituting.

We believe that this team was permeable to the crossing of the living network because the CHW showed an interest in learning about the organization of the agencies woven by the user, considering that these movements that produced support and care would also be pertinent and valuable for other residents of the territory. Thus, the instituted and the instituting met when the team considered this experience relevant and invited the volunteer professionals to share in the care of Aparecida and other users who needed support.

Within these living networks, users produce care by building connections in their lives. They are living networks that are able to move through territories that are often not perceived by health professionals[25].

Despite these rich experiences described by the team, it is notoriously difficult to validate the records as instruments of care, because when they are consulted, they do not reflect the experiences lived and reported during the focus group, and are considered to be a cold and protocol instrument. In this way, we can consider that this is a "barrier" to care, because if the care needs are not clearly described, there is no way for all team members to be aware of the case. Thus, without a reliable record, it is not possible to guarantee an adequate therapeutic plan and the resolution of the proposed actions.

The need for permanent education to ensure comprehensive care for users with dementia syndromes

Family health teams are well aware of the need to train professionals who deal with elderly people with dementia, as lack of knowledge can lead to unnecessary referrals to the care network. Malta's study[26], which analyzed the practice of doctors and nurses working in PHC teams, showed that these professionals are expected to take a preventive approach and intervene early to detect cognitive disorders, impaired functionality and their complications.

These professionals must therefore be qualified to care for elderly people with dementia and their caregivers. Strategies to qualify them should include permanent in-service education, guaranteed by specialized professionals through matrix support, which was not observed in this team.

In this regard, matrix support stands out as a working methodology that offers assistance and pedagogical support to family health teams[27]. Matrix support has the power to favor the direction of health promotion actions, with strategies of commitment and co-responsibility of the professionals of the reference team and the matrix team, the user and their family and the community[27]. Users who benefit from a matrix support service will not cease to be users of their reference team[27]. There are no referrals, but rather therapeutic projects to be jointly carried out[27].

Having a multidisciplinary team that offers this matrix support in the FHS is important due to the positive results that are achieved with this work methodology, both for the user, family members and workers and for the health system itself, which reduces spending on specialized care and unnecessary hospitalizations[27].

The study's findings show that it would be essential for this team to have the support of these matrix professionals to help them deal with the living networks set up by users and their families, as Aparecida's family did in such an organized way. This is about the need for PHC professionals to go beyond the limits of what is established and protocolized in the formal healthcare networks and allow the user to play a leading role.

In PHC, the primary care manuals related to Ageing and Elderly Health[28] are guiding documents. These manuals present procedures for assessing functional and cognitive capacity, which are essential technologies for diagnosing and planning the necessary interventions for this population. This care must involve the family and the elderly person's social support network[28].

Permanent education has been adopted in Brazil as a human development policy for the SUS[29]. Using problematizing education as its pedagogical trend, continuing education is based on a concept of learning that aims to produce meaning and provide for the transformation of professional activities through critical reflection[29].

Ceccim[30] adds that continuing education is a fundamental device for reformulating management, training and social control practices, given that the learning process is participatory.

However, despite all the guidelines pointing out that permanent education in PHC is functional and necessary for improving professional practices, we realize that it is often not established as an institutional policy due to the overload of tasks. The actions carried out are still insufficient in the face of what is expected for the desired transformations in the health sphere. When it is carried out, we see that the education format is done in a punctual and fragmented way, using traditional and vertical methodologies, with little or no connection to the local reality.

Scientific evidence has shown the need for a multidimensional assessment of the elderly, in order to acquire a global understanding of all the needs of the elderly, to contribute to more appropriate and personalized interventions, with a consequent improvement in the resolution of identified problems and the prevention of comorbidities[29]. These tests are suitable for implementation in primary health care, but due to the long time it takes to apply them and the high demand for care, they should only be considered for users with a higher risk of disability[31]. Thus, the use of instruments to detect possible dementia syndromes is necessary in PHC, since dementia has been underdiagnosed worldwide and the diagnosis is usually made at an advanced stage of the disease[2].

Thus, we emphasize the need to recognize the importance of multidimensional assessment in the elderly in order to identify the specific needs of the aging process, whether in promotion, protection, recovery or rehabilitation, and, based on this recognition, increase the possibilities for more assertive and qualified care.

Final considerations

The study's limitations include the fact that it was carried out in just one Family Health Team using one case, which reduces its possibility of generalization. However, it was possible to conclude that FC practitioners direct their health actions based on a biomedical model that assures them of an established, protocol-based world. However, sometimes the micro-politics of their work process is invaded by users who express their voices, undoing this established world. In undoing this institution and in search of access to their care, they trace their own networks, which are sometimes unknown to professionals and not valued.

The establishment of symmetry, in recognizing the other as a valid interlocutor, made it possible for the user to play a leading role in the movement of living networks, through meetings between the actors involved in care. It is believed that the actions offered by health professionals should be done through a living work in act and relational, in order to produce bonding and acceptance.

In this way, there is a need to articulate care technologies in order to make the care provided by PHC teams to elderly people with dementia more effective, especially the incorporation of more soft technologies, which materialize in relational practices. In this sense, home visits stand out as a facilitating device for establishing these relationships.

There is also a clear need to invest in training through permanent education for these workers and managers, with a view to integrality, welcoming and humanizing health practices, which consider the user as the protagonist of their care, especially among elderly people with geriatric syndromes.

In view of the emotional and incapacitating impact of dementia, continuing education for primary care professionals requires the creation of collective spaces with the aim of leading health professionals to reflect on and evaluate the actions they take on a daily basis, in order to seek the transformation of health practices, thus providing more qualified care for this clientele.

Authors' contribution

All authors actively participated in all stages of preparing the manuscript.

Funding

Esther Mourão Nicoli - CAPES Scholarship, process number: 88887.968238/2024-00.

Conflict of interest

The authors have no conflict of interest to declare.

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Editor
Tiago Rocha Pinto
Associated editor
Lina Rodrigues de Faria

Translator
Félix Héctor Rigoli Caceres

Submitted on
02/16/24
Approved on
09/16/24

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A demência é um problema de Saúde Pública emergente, consequente ao envelhecimento populacional e à transição epidemiológica. Assim sendo, a pesquisa teve como objetivo analisar as redes vivas tecidas por um usuário com demência e sua família no percurso em busca de Atenção à Saúde e cuidado, por meio das conexões existenciais que vão estabelecendo em sua trajetória sob a ótica de uma equipe-guia. Para tal, aplicou-se a metodologia qualitativa de abordagem cartográfica com base nas técnicas de grupo focal, no fluxograma analisador e no diário de campo. A análise dos resultados possibilitou identificar a visita domiciliar como instrumento de tecnologia leve no movimento de redes vivas, e a necessidade de Educação Permanente para garantir a integralidade do cuidado dos usuários com síndromes demenciais. Conclui-se que há necessidade de melhor articular tecnologias do cuidado para tornar as ações mais efetivas.

Palavras-chave: Idoso. Demência. Redes comunitárias. Atenção à saúde. Educação continuada.

La demencia es un problema de salud pública emergente, consecuencia del envejecimiento poblacional y de la transición epidemiológica. Por esa razón, la investigación tuvo el objetivo de analizar las redes vivas tejidas por un usuario con demencia y su familia, en la jornada de la búsqueda de atención de la salud y el cuidado, desde el punto de vista de un equipo guía. Para ello, se aplicó la metodología cualitativa de abordaje cartográfico, a partir de las técnicas de grupo focal, diagrama de flujo analizador y diario de campo. El análisis de los resultados posibilitó la identificación de la visita a domicilio como instrumento de tecnología leve en el movimiento de redes vivas y la necesidad de educación permanente para asegurar la integralidad del cuidado de los usuarios con síndromes demenciales. Se concluyó que existe la necesidad de articular mejor las tecnologías del cuidado para que las acciones sean más efectivas.

Palabras clave: Anciano, demencia. Redes comunitarias. Atención a la salud. Educación continuada. Salud mental.