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NURSING DIAGNOSES IDENTIFIED IN A MEDICAL CLINIC UNIT: PROPOSAL OF RESULTS AND INTERVENTIONS

DIAGNÓSTICOS DE ENFERMAGEM IDENTIFICADOS EM UMA UNIDADE CLÍNICA MÉDICA: PROPOSTA DE RESULTADOS E INTERVENÇÕES

DIAGNÓSTICOS EN ENFERMERÍA EN UNA UNIDAD CLÍNICA MÉDICA: PROPUESTA DE RESULTADOS E INTERVENCIONES

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ABSTRACT

Objectives: to describe the nursing diagnoses in a medical clinic and propose nursing results and interventions for the five most frequent diagnoses. ***Method:*** this is a descriptive and retrospective study on the register of the main nursing diagnoses identified in patients' medical records in the first day of hospitalization in a medical clinic unit, which were analyzed on frequencies. The sample consisted of 17 medical records, corresponding to 35% of the hospitalizations on July 2010. The research was approved by the Research and Ethics Commission of Hospital Agamenon Magalhães (HAM), under the Protocol 88. ***Results:*** 274 nursing diagnoses were identified (49 diagnostic categories) in 10 domains of the taxonomy NANDA-I. The five most frequent diagnoses were: acute pain (88.2%), fatigue (88.2%), disturbed sleep pattern (82.4%), sedentary lifestyle (76.5%), and low situational self-esteem (64.7%). The respective proposals of results and nursing interventions were presented. ***Conclusion:*** the knowledge on the most frequent diagnoses can contribute to evaluations driven towards the identification of the results related to them and the performance of the interventions aiming to achieve them, something which favors caring in a holistic and individualized way, once it will meet the actual needs of these clientele. ***Descriptors:*** nursing; nursing care; nursing diagnosis.

RESUMO

Objetivos: descrever os diagnósticos de enfermagem em clínica médica e propor resultados e intervenções de enfermagem para os cinco diagnósticos mais frequentes. ***Método:*** estudo descritivo e retrospectivo de registro dos principais diagnósticos de enfermagem identificados em prontuários de pacientes no primeiro dia de internação em uma unidade de clínica médica, que foram analisados segundo frequências. A amostra foi composta por 17 prontuários, correspondendo a 35% das internações no mês de julho de 2010. A pesquisa foi aprovada pela Comissão de Ética e Pesquisa do Hospital Agamenon Magalhães (HAM), sob o Protocolo n. 88. ***Resultados:*** foram identificados 274 diagnósticos de enfermagem (49 categorias diagnósticas) em 10 domínios da taxonomia NANDA-I. Os cinco diagnósticos mais frequentes foram: dor aguda (88,2%), fadiga (88,2%), padrão de sono perturbado (82,4%), estilo de vida sedentário (76,5%) e baixa autoestima situacional (64,7%). Foram apresentadas as respectivas propostas de resultados e intervenções de enfermagem. ***Conclusão:*** o conhecimento dos diagnósticos mais frequentes pode contribuir para avaliações direcionadas à identificação dos resultados a eles relacionados e para a realização das intervenções visando a atingi-los, o que favorece o cuidar de forma holística e individualizada, uma vez que atenderá as reais necessidades dessa clientela. ***Descritores:*** enfermagem; cuidados de enfermagem; diagnóstico de enfermagem.

RESUMEN

Objetivos: describir los diagnósticos de enfermería en clínica médica y proponer resultados e intervenciones de enfermería para los cinco diagnósticos más frecuentes. ***Método***: estudio descriptivo y retrospectivo de registro de los principales diagnósticos de enfermería identificados en historiales de pacientes el primer día de internamiento en una unidad de clínica médica que fueron analizados según frecuencias. El muestreo se compuso de 17 historiales médicos, correspondiendo al 35% de los internamientos del mes de julio de 2010.La investigación fue aprobada por el Comité de Ética y Pesquisa del Hospital Agamenon Magalhães con protocolo nº 88. ***Resultados***: se identificaron 274 diagnósticos de enfermería (49 categorías diagnósticas) en 10 dominios de la taxonomía NANDA I. Los cinco diagnósticos más frecuentes fueron: dolor agudo (88,2%), fatiga (88,2%), rutina de sueño alterada (82,4%), estilo de vida sedentario (76,5%), baja autoestima situacional (64,7%) y presentadas las respectivas propuestas de resultados e intervenciones de enfermería. ***Conclusión***: el conocimiento de los diagnósticos más frecuentes puede enriquecer las evaluaciones dirigidas a la identificación de los resultados relacionados a éstos y para la realización de las intervenciones para alcanzarlos, fomentando el cuidado de la forma holística e individualizada, ya que se atenderán las reales necesidades de esta clientela. ***Descriptores***: enfermería; cuidados de enfermería; diagnóstico de enfermería

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INTRODUCTION

The nursing process is considered the base support of the Systematization of the Nursing Assistance (SAE) and can be defined as a method for organizing and performing the nursing care, applying the nursing theoretical structure to the practice. It is made up with phases or stages that involve the identification of health problems of the client, the delimitation of the nursing diagnosis, the institution of a care planning, the implementation of the planned actions and the evaluation. [1-3]

In Brazil, the theoretical limit for the nursing process is represented by Wanda de Aguiar Horta, who defined this method as the dynamic of systematized and inter-related actions, aiming the assistance to the human being.[1,4]

Therefore, Horta tried to start the development of the Theory of the Basic Human Needs, in which she tries to show the nursing as an applied science that goes from the empirical phase to the scientific one, developing its own theories, systematizing its knowledge, researching and becoming an independent science. For her studies development, the author was inspired by the theory of human motivation of Maslow, based on the basic human needs, which are psychobiological; psychosocial and psychospiritual, divided in categories and subcategories.[4]

The main function of SAE is to direct the practice, so, the applied method needs simplicity to ease the practice and be applied to reality, adapting to the needs of each patient. This method must allow a closer approach between nurse, patient and the family, enabling the assistance based on the specific knowledge.[5-9]

Studies aiming the identification of nursing diagnoses through the assistance practice have been developed since the 20th decade. The phase of the nursing diagnosis has been introduced in the nursing process in several nursing services in Brazil. Its insertion requires the nurses to establish a common language that favors the knowledge between their pairs about the clinical interest phenomenon, guiding the decisions about what to do for them. The nursing diagnosis contextualization in the nursing process can have positive effects on the definition of phenomena, in the nursing intervention proposal and the obtained results evaluation.[10, 11]

The NANDA (North American Nursing Diagnosis Association) aims to pattern the language of the nursing diagnoses; and this standardization will establish an agreement about the rules for using certain terms; the NANDA significantly contributes towards the improvement and refinement of the nursing diagnoses; developing a concept to classify the diagnosis in a taxonomy; and they represent a clinical focus for the science called Nursing.[12, 13]

The Nursing Interventions classification system (NIC) emerged in part from the work performed by NANDA, nowadays; the NIC presents 486 nursing interventions coming up with an activities total higher than twelve thousand. The NIC names and describes the performed interventions in the clinical practice in response to a Nursing Diagnosis.[14] These interventions performance influences the comprehensive results which are patterned by the nursing outcomes classification system (NOC).[14]

This way, caring demands the decisions about proposed interventions to be based on the evaluation of the individual health condition, through the adoption of diagnoses as a reference. Therefore, the knowledge of the nursing diagnoses is highly important for the proposition of nursing interventions and evaluation of the obtained results.

Considering the importance of the articulation between the diagnoses, interventions and results in order to refine the diagnoses use, this study aimed to describe the main nursing diagnoses in the light of the theory of the basic human needs, proposed by Wanda de Aguiar Horta, according to the NANDA-I taxonomy, as well as to propose interventions and results in accord with the NIC and NOC classification, for the five nursing diagnoses more frequently reported in a Medical Clinic Service of a University Hospital.

METHOD

It is a cross-sectional descriptive study, retrospective, which evaluated 17 patients' medical records who were hospitalized in the medical clinic unit of the Hospital Getúlio Vargas in Recife-PE, during July 2010, considering a convenience sample, of 35% of the hospitalizations in that month.

The first phase of the research started with the development of annotations through the literature about this theoretical model, we also searched studies that associated the Theory of Horta, as well as, data collection instruments applied to the medical clinic using this reference.

For the data collection it was used a form which included the main basic human needs affected in each patient. Afterwards, we organized a list with the most frequent and specific nursing diagnoses for the medical clinic. The researchers signed the Responsibility Term, fulfilling all the ethical principles and preserving the collected information secrecy.

The reported nursing diagnoses were created based on the data collection form and the nursing history, filled at the moment of the patient's admission to this unit.

For the data collection of each patient, the programs Epilnfo, version 6.04 and Word version 2007 were used; the descriptive statistical analysis was expressed in percentage. The interventions and results proposal was done based on the NOC and NIC.[14]

This research was conducted within the standards demanded by the Resolution 196/96 of the Ethic in Research National Commission – CONEP and the project was approved by the Ethic and Research Commission (CEP) of the Hospital Agamenon Magalhães/HAM, protocol 88.

RESULTS

274 nursing diagnoses were identified, distributed in 49 diagnostic categories in 10 domains of the NANDA-I Taxonomy. The most frequent diagnoses were: Acute pain (88,2%), Fatigue (88,2%), Disturbed sleep pattern (82,4%), Sedentary lifestyle (76,5%), Low situational self-esteem (64,7%). (Table 1).

Considering the absolute frequency of the nursing diagnoses, the most prevalent domains of the NANDA-I taxonomy were: activity/rest, represented by 90 diagnoses; security/protection, represented by 47 diagnoses. These two domains included 50% (137) of the reported nursing diagnoses. (Table 1).

According to Table 1, considering the frequency of each nursing diagnosis separately, in each domain of the NANDA-1 taxonomy, the diagnoses of Acute pain and Fatigue, belonging to the domains of Comfort and Activity and Rest respectively, were the most prevalent among all, both of them corresponding to 88,2% of the medical records selected for this study.

Table 1. Distribution of the most frequent nursing diagnoses according to the domains of the diagnostic classification of the NANDA-I of 17 hospitalized patients in the medical clinic unit of the Hospital Getúlio Vargas in July 2010, Recife-PE.

Domains	Diagnostic Category	N.	%
Activity/Rest	Fatigue	15	88,2
	Disturbed sleep pattern	14	82,4
	Sedentary lifestyle	13	76,5
	Impaired Ambulation	09	52,9
	Ineffective Tissue Perfusion	07	41,2
	Impaired Physical Mobility	06	35,3
	Dicreased Cardiac Output	06	35,3
	Ineffective breathing pattern	06	35,3
	Activity intolerance	05	29,4
	Self care déficit, dressing/grooming	03	17,6
	Self care deficit, feeding	02	11,8
	Self care déficit, bathing/hygiene	02	11,8
	Bowel incontinence	02	11,8
Subtotal		90	
Self- perception	Situational low self-esteem	11	35,3
	Risk for Situational low self-esteem	02	11,8
Subtotal		13	
Security/Protection	Hyperthermia	10	58,8
	Impaired skin integrity	07	41,2
	Risk of infection	05	29,4
	Risk for imbalanced body temperature	05	29,4
	Risk for trauma	04	23,5
	Risk for Impaired skin integrity	04	23,5
	Risk for falls	03	17,6
	Impaired oral mucous membrane	03	17,6
	Impaired tissue integrity	02	11,8
	Impaired bed mobility	02	11,8
	Risk for injury	02	11,8
Subtotal		47	
Conforto	Acute pain	15	88,2
	Nause	09	52,9
Subtotal		24	

Source: Hospital Getúlio Vargas, HGV, 2010.

Next, we present the intervention proposals for the five most frequent nursing diagnoses according to the Nursing Outcomes Classification (NOC) and the Nursing Interventions Classification (NIC), as well as their respective numerical codes.[14]

Table 2. Results and nursing interventions for the nursing diagnosis of acute pain in patients hospitalized in the medical clinic unit in the Hospital Getúlio Vargas in July 2010, Recife-PE.

Diagnostic Category	Results and Goals (Code NOC)	Interventions and Activities (Code NIC)
Acute pain	Pain control (1605) Goal: the patient must present satisfactory relief after an intervention evidenced by a verbal report or expression.	Pain control (1400) Activities: to gather the characteristics, place, beginning, intensity, frequency, quality, pain severity and preceding factors; to observe the non-verbal indicators of discomfort; to assure precise analgesia care; to evaluate the efficiency of the measures for pain control.

Source: HospitalGetúlio Vargas, HGV, 2010.

Table 3. Results and nursing interventions for the nursing diagnosis of fatigue in patients hospitalized in the medical clinic unit of the Hospital Getúlio Vargas em julho de 2010, Recife-PE.

Diagnostic Category	Resuls and Goals (Code NOC)	Interventions and Activities (Code NIC)
Fatigue	Endurance (0001)	Pain control (1400)
	Activity tolerance (0005)	Activities: to determine the physical limitations of the patient; to determine the perception that the patient/people has about the fatigue causes; to determine the fatigue causes; to monitor the nutritional intake to guarantee proper sources of energy; to monitor the cardiorespiratory response to the activity; to promote rest to the bed/limitation of activities; to encourage alternate periods of rest and activity; to avoid care activities during the programmed sleeping period; to help with the regular physical activities; to monitor the administration and effect of stimulants and depressive; to encourage the physical activity; to monitor the response of oxygen of the patient.
	Activity tolerance (0005)	
	Energy conservation (0002)	
	Goal: the individual must participate in the activities which stimulate and balance the physical, cognitive, affective and social domains.	

Source: Hospital Getúlio Vargas (HGV), 2010.

Table 4. Results and nursing interventions for the nursing diagnosis of disturbed sleep pattern in patients hospitalized in the medical clinic unit of the Hospital Getúlio Vargas in July 2010, Recife-PE.

Diagnostic Category	Results and Goals (Code NOC)	Interventions and Activities (Code NIC)
Disturbed Sleep pattern	Rest (0003) Sleep (0004) Goal: The patient must communicate an ideal balance between rest and activity.	Sleep enhancement (1850) Activities: To determine the sleep pattern/activity of the patient; to approximate the regular cycle of sleep/alert state of the patient in the care planning; to determine the medicine effects in the patient and the amount of sleep hours; to monitor the sleep pattern of the patient and observe the physical circumstances; to adapt the environment in order to encourage the sleep; to help to eliminate stressful situations before the sleep time; to monitor the intake of food and drink at the sleep time trying to use items that ease or interfere in the sleep; To help the patient to limit their diurnal sleep, providing activities that promote the alert state, when it is proper; to regulate the environment stimulus in a way they keep the normal cycles day/night.

Source: Hospital Getúlio Vargas (HGV), 2010.

Table 5. Results and nursing interventions for the nursing diagnostic of Sedentary lifestyle and situational low self-esteem (n=17), Recife-PE, 2010.

Diagnostic Category	Results and goals (Code NOC)	Interventions and Activities (Code NIC)
Sedentary lifestyle	Knowledge: Health behavior (1805) Goal: The patient will verbalize the intention of being involved in enhancing the physical activity.	Exercise promotion (0200) Activities: to evaluate the patient's health beliefs about the physical activities; to inform the patient about the health benefits and the psychological effects of the activity, about the proper activity for the health level, together with the physician and/or physiotherapist; about the techniques in order to avoid injuries while exercising; to monitor the patient's response to the exercises program.
Situational low self-esteem	Self-esteem (1205) Goal: The patient will have to Express a positive view of the future and resume the previous level of functioning.	Self-esteem enhancement (5400) Activities: To monitor the patient's declarations concerning self-esteem; to determine the environment of the patient; the trust the patient owns in their own judgment; to encourage the patient to identify their positive points; the eye-to-eye contact when communicating with others; to avoid negative criticism and provocations; to transmit confidence in the patient's ability to deal with the situations; to investigate the reasons of blame or self-criticism; to encourage the patient to accept new challenges and an environment and activities that enhance their self-esteem.

Source: Hospital Getúlio Vargas (HGV), 2010.

DISCUSSION

The five most frequent nursing diagnoses were described in this study: Acute Pain, Fatigue, Disturbed Sleep Pattern, Sedentary lifestyle, Situational low self-esteem.

It was observed that three from the five most frequent diagnoses belong to the Domain Activity/Rest. This domain is defined as the production, conservation, expenditure or energy sources balance.[8] The identified nursing diagnoses which belong to the Domain Security/Protection, were Fatigue, Disturbed Sleep Pattern and Sedentary lifestyle. It was established Outcomes (NOC) and nursing interventions (NIC) for these diagnoses.

The linking between the NANDA, NIC and NOC diagnoses relate one diagnosis to one or more nursing interventions so that we can obtain possible and desirable results for the patient. These connections ease the diagnostic base and the clinical decision-making by the nurse about the desirable results and interventions to reach them.[9]

The choice of the outcomes and interventions for each diagnosis also depends on the clinical abilities of the nurse, who must consider the peculiarities of each situation, the preferences of each patient in order to define the possible and desirable outcomes and then, the interventions to reach them.

The nursing interventions must precede the diagnoses elaboration, so that they are really suitable for the patient.[15]

The Acute pain diagnosis, the most frequent in this study, is an unpleasant sensory and emotional experience that comes from a real or potential tissue injury or described in terms of this injury (International Association for the Study of Pain); it has a sudden or slow beginning; light or intense intensity, with anticipated or predictable end and duration of less than six months.[8]

In a similar study 144 diagnoses were reported (31 diagnostic categories); an average of 4,8 diagnoses per patient (variation = 1-10) and the most frequent diagnosis was the Acute pain (66,7%).[9]

For this study, it was suggested as a nursing outcome, the Pain Control (1605), aiming as a main goal the satisfactory relief after an intervention. The suggested intervention for reaching this goal was the Pain Control (1400),

through the several activities proposed for that.

The diagnosis of Fatigue, according to the NANDA-I[8] is an oppressive feeling, supported with exhaustion and decreased capacity to perform physical and mental work in the habitual level. For this diagnosis, three outcomes were suggested: Endurance (0001); Activity tolerance (0005) and Energy conservation (0002). The proposed goals for these outcomes aim to encourage the individuals to participate in the activities that stimulate and balance the physical, cognitive, affective and social domains. The selected intervention for this diagnosis – Energy control (0180), as well as the attributed activities, tries to reach the expected outcomes.

The Disturbed Sleep Pattern (or insomnia) is a disorder related to the amount and the quality of sleep that disturbs the normal functioning of a person.[8] This study proposes the outcomes Rest (0003) and Sleep (0004). The established goal must communicate an ideal balance between rest and activity, being reached through the main intervention, in this specific case, Sleep enhancement (1850). The activities related to the intervention aims to determine a pattern of sleep/activity, as well as to approximate the regular cycle of sleep/alert state of the patient.

Sedentary lifestyle refers to a life habit that is characterized by a low level of physical activity.[8] For this diagnosis, it was chosen the outcome – Knowledge: Health Behavior (1805). The reaching of the outcome goal, through the intervention – Exercise Promotion (0200) and the proposed activities will allow the patient to verbalize some intention of commitment in order to increase the physical activity.

Situational low self-esteem according to NANDA-I refers to a prolonged self-evaluation/negative feelings about yourself or your own abilities.[8] The nursing outcome chosen self-esteem (1205), the intervention self-esteem enhancement (5400) and the activities, described in table 5, must conduct the patient to express a positive view of the future and return to the previous functioning level.

The diagnostic process is a fundamental phenomenon of the Nursing practice as the accuracy of this clinical judgment defines all the care planning, as well as the development of the other stages of the nursing process.[16,17]

In this context, the obtained outcomes in this study reflect the proposal of stimulating and preparing the nursing team to act together with the patient, besides encouraging the development and understanding of the nursing process stages, because the professional who develops an instrumetalized assistance, will be able to improve their cognitive and psychomotor abilities, associate and correlate multidisciplinary knowledge, better work relations, which are definite and concrete.

CONCLUSION

This study enabled the identification of 274 nursing diagnoses (49 diagnostic categories) in 10 domains of the NANDA-I Taxonomy. Concerning the five most frequent diagnoses, outcomes and nursing interventions were proposed, according to the affected basic human needs of each patient.

The obtained results in this study reflect the proposal of stimulating and preparing the nurses to perform together with the patient, besides making it possible to develop and understand the stages of the nursing process. The nursing professional who develops an instrumentalized assistance through the nursing process, in the light of a theoretical reference, will be able to enhance their cognitive and psychomotor abilities, associate and correlate multidisciplinary knowledge, better work relations, which are definite and concrete.

The results of this study are important for the teaching-learning process for nurse undergraduate students and nurses in relation to caring patients in specific areas. Being aware of the most frequent diagnoses, they can perform evaluations which are directed to identifying these diagnoses and the outcomes related to them, as well as implementing the interventions in order to reach them.

The use of the Systematization of the Nursing Attendance (SAE) provides clarity for the data collection performance, once it enables the identification of the nursing interventions individualized according to the need of attendance for the patient.

This way, the application of a SAE, based on the basic human needs directed towards the medical clinic clients, will contribute towards the attendance in a holistic and individualized way, as it will meet the needs of the patient and then, the Nursing will be effectively able to show in the records the important role they develop in the promotion, prevention and health recovery of these clients.

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