THE FREQUENCY OF NURSING DIAGNOSES IN PATIENTS WITH WOUND

ANÁLISE DA FREQUÊNCIA DOS DIAGNÓSTICOS DE ENFERMAGEM EM PACIENTES COM FERIDAS

Isis de Carvalho Oliveira, Regina Célia Sales Santos Veríssimo, Maria Lysete de Assis Bastos, Ingrid Martins Leite Lúcio

ABSTRACT

Objective: to identify the frequency of nursing diagnosis based on the CIPE® version 2011 of patients with wounds. Method: a descriptive study with quantitative approach. The records were subtracted from the interviews form applied to 12 patients with wounds. The research was approved by the Research Ethics Committee of the Federal University of Alagoas, under the opinion of the process nº 023507/2011-43. Results: predominantly male; half are elderly; marital status with stable union; incomplete elementary education; family income between 1 to 2 minimum wages; mostly retired. There were identified 41 nursing diagnoses. The most common: wound present edema in the peripheral region; absence of odors; current hypertension; severe pain in the wound; wound erythema present in the peripheral region. Conclusion: the frequency assessment helps to determine specific care for the wounds problematic, favoring an efficient and quality service. Descriptors: Nursing Diagnosis; Nursing Process; Wound; Wound Healing.

RESUMO


RESUMEN

Objetivo: identificar la frecuencia de los diagnósticos de enfermería basado en la CIPE® versión 2011 de los pacientes con heridas. Método: se realizó un estudio descriptivo con enfoque cuantitativo. Los registros se sacaron de formularios de entrevistas aplicadas a 12 pacientes con heridas. El estudio fue aprobado por el Comité de Ética de Investigación de la Universidad Federal de Alagoas, a juicio de la Causa nº. 023507/2011-43. Resultados: predominantemente hombres; la mitad son de edad avanzada; están casados; de educación primaria incompleta; entre 1 y 2 salarios mínimos; en su mayoría jubilados. Se identificaron 41 diagnósticos de enfermería. Los más comunes: edema herida presente en la región periférica; olor ausente, hipertensión corriente, dolor intenso en la herida, la herida eritema presente en la región periférica. Conclusión: la evaluación de la frecuencia ayuda a determinar el cuidado específico para heridas problemáticas, lo que favorece un servicio eficiente y de calidad. Descriptores: Diagnóstico de Enfermería; Proceso de Enfermería; Herida; Cicatrización de Heridas.
The registration of clinical patient data is the primary means of communication for professionals in the health care team, because it ensures the continuity of care, and it is a written evidence of the given care.\(^1\) Also, the Nursing Process (NP) is the main resource that nurses have to consolidate their professional practice.\(^2\)

Because it is a method of organization of nursing practice, the NP is the basis for sustaining the Care System Nursing (CSN) and involves interdependent phases or stages. So, it is possible to identify health problems of the client, the delineation of Nursing Diagnoses (ND), the establishment of a plan of care, implementation of planned actions and ultimately, a review of actions.\(^3\)\(^4\) It is worth mentioning that ND provide measurable criteria to evaluate the assistance, provide support and direction to care, facilitate research and teaching, demarcating the independent functions of nursing and encourage the client to participate in their treatment and the therapeutic plan.\(^4\)

The inclusion of the ND requires that nurses have a common language. Nursing has been using a language represented by clinical terms that integrate theoretical and practical context of the profession. The study of the concepts of these terms may allow improvement of professional communication. Due to the above, there are currently several classification systems, and these systems are constantly evolving.\(^5\)

Among various classification systems developed from the different phases of NP, we highlight the North American Nursing Diagnosis Association (NANDA); Nursing Interventions Classification - (CIN); Nursing Outcomes Classification (NOC) and International Classification for Nursing Practice (ICNP ®).\(^5\)\(^6\) However, the International Classification for Nursing Practice (ICNP ®) stood out among the other systems classification, given its ability to adapt to the global language, considering the culture and the particularities of each region or area of work in the use of technical terms.\(^1\)

In this research, the ICNP ® was chosen as an instrument because it is consolidating as a worldwide trend towards the standardization of communication and information exchange among nurses, aiming at the representation of nursing practice in Information Systems in Health.\(^7\) Likewise, through its use, it has the ability to communicate and compare nursing data across different contexts, countries and languages.\(^8\)

In compliance to the growing demand of patients with wounds, nursing stands out as the care to this client group, particularly patients with chronic wounds. That professional has more contact with the patient, monitors the evolution of the lesion, directs and executes the bandage and holds greater area of the technique. Nevertheless, it is difficult to obtain statistical indicators, since the records of these services are scarce, thus demonstrating the deficiency relating to existing statistical data.\(^9\)

It is essential that nurses perform nursing consultation in customer service with wounds, whether acute or chronic, establishing a methodology for the assistance to these clients.\(^10\) So, it is essential to highlight the assistance performed by nurses, being necessary increase the use of ICNP® among these workers.

Nursing professionals base the importance of this work on systematic nursing care to patients using an outpatient clinic for treatment of their wounds. So the patient and his family going to the clinic to perform the dressing was an opportunity to collect data and clinical assessment of the wound during the service. Consequently, it is essential to know the socioeconomic and cultural conditions affect the daily lives of patients surveyed.

Furthermore, inserting the ND in patient care wound is an important contribution to an ongoing evaluation of the treatment, as this stage of the NP will direct the practice of care, following the evolution of the wound and the patient’s response to the treatment.

This study aims to:
- Identify the frequency of nursing diagnoses based on the ICNP® Version 2011 of patients with wound.

### METHODOLOGY

Article elaborated from the monograph "Frequency of nursing diagnoses in patients with wounds" submitted to the Nursing and Pharmacy School, Federal University of Alagoas/UFAL, Maceió-AL, Brazil, in 2012.

This is a descriptive study with a quantitative approach and cross section. It was developed in curative area at the outpatient clinic of medium complexity in the city of Maceió - AL. Patients with acute or chronic wounds pursuing this sector to the achievement of their healing were invited to participate in the study. Thus, the definition of the subjects was proportional to the spontaneous demand in that service.
The instrument used for data collection aimed to gather information to make the characterization and assessment of the socioeconomic conditions of the patients and their wounds, thereby highlighting the various factors that affect the healing process.

The records were subtracted from the interviews form applied to 12 patients with wounds who attended the curative sector during the period May-June 2012. For tabulation and data analysis, we used Microsoft Excel®, and from them, tables were elaborated.

For the preparation of ND, they were taken under the ICNP® Version 2011, which includes a description of the characteristics pertaining to anamnesis, physical examination and clinical assessment of wounds. At the end of this process, the value of the absolute number (N) was assigned and calculated the percentage (%) of the frequency of ND.

The research was conducted within the standards required by Resolution 196/96,11 being approved by the Ethics Committee in Research (CEP) of UFAL, based on the opinion of the Case No. 023507/2011-43.

RESULTS AND DISCUSSION

♦ Socioeconomic Characterization

The results highlight that the socioeconomic characteristics of patients with wounds of that unit are represented by predominantly male (83.3%). Half are elderly (age> 60 years); presenting mostly with stable marital union (58.3%) and 58.3% of the participants have until uncompleted elementary school. As family income, 83.3%

receive one to two minimum wages; although most were qualified to do the job market, many reported not practicing their profession, because 58.3% are retired.

♦ Frequency of Nursing Diagnoses

From the elaborated diagnoses 41 different ND were identified, distributed in a total of 128 diagnostic statements, with an average of approximately 10.6 diagnoses per client. The ten most frequent were identified in 50% or more of the cases, which are wound with current edema peripheral region; odor absent; current hypertension; severe pain in the wound; current wound erythema peripheral region; small wound; integrity of tissue disrupted in extent of muscle tissue; compromised vascular process; current wound necrosis in the peripheral region and secretions low. 69 diagnostic statements were the total, corresponding to 53.9% of total diagnoses identified.

♦ Base Illness Association

To achieve the actual quality of care provided to the wounds, the initial step is the evaluation of the patient and nursing planning to the appropriate choice of treatment. With the presence of underlying diseases in patients with established wound therapy, the main objectives are the elimination of the causes of the disease, improving the quality of life of patients and elimination of symptoms associated with the disease.12

Table 1. Frequency of base illness

<table>
<thead>
<tr>
<th>Nursing diagnosis</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current hypertension</td>
<td>7</td>
<td>58.3%</td>
</tr>
<tr>
<td>Compromised vascular process</td>
<td>6</td>
<td>50%</td>
</tr>
<tr>
<td>Current diabetes</td>
<td>3</td>
<td>25%</td>
</tr>
<tr>
<td>Compromised joint contracture</td>
<td>1</td>
<td>8.3%</td>
</tr>
</tbody>
</table>

Thus, in relation to the associated diseases (Table 1), in addition to patients being affected by the interruption of their tissue integrity, concurrent to this factor, are still mostly physiologically compromised by interference from underlying diseases such as hypertension (58.3%) vascular involvement (50%) and diabetes mellitus (25%).

Diabetes mellitus and hypertension interfere with the healing process of the injury due to impaired blood circulation, producing a poor healing of wounds. In addition, diabetes may favor infections.13

Thus, the identification of such diagnostic guides a differentiated behavior of nurses across the tissue involvement on the basis of association with these diseases. As the circulation in the affected limb becomes altered, this condition leads to the susceptibility of the patients had venous stasis ulcers, which are mainly associated with hypertension.14

The Ministry of Health has adopted various strategies and actions to reduce the burden of cardiovascular disease in the Brazilian population, which culminate in the appearance of vascular lesions such as ulcers. Thus, the policies of promotion and prevention measures used are smoke-free, healthy food and care actions at public health to hypertension and diabetes, providing basic medicines through the public network, and
like this make the monthly control of these chronic diseases. The sensitive, emotional and cultural aspects also make this perception a subjective and personal experience.

Thus, the same stimulus can be unbearable to a patient and tolerable to another. Nevertheless, the implementation of pain management is of extreme value. Aiming to treat the patient in a more humane way, the United States Agency for Research and Quality in Public Health and the American Pain Society introduced the assessment of pain as the fifth vital sign, such behavior should be part of nursing care along with other vital signs: temperature, pulse, respiration and blood pressure.

**Presence of Pain/Discomfort**

Pain is defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of the injury. There is not a unique relationship between pain and tissue damage. Added to the injury, there are other factors that imply the proper healing, it is paramount to achieving the CSN in the care of lesions and evaluation of the patient as a whole. Thus, the nursing professional must know the patient’s history, from the possible pathologies, psychological aspects, to the socio-economic, familial and cultural condition of the client to possibly take appropriate decisions and optimize their recovery.

**Table 2. Frequency of presence of pain/discomfort**

<table>
<thead>
<tr>
<th>Nursing Diagnosis</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe pain in the wound</td>
<td>7</td>
<td>58.3%</td>
</tr>
<tr>
<td>Absent pain in compromised body region</td>
<td>5</td>
<td>41.6%</td>
</tr>
<tr>
<td>Pain in the mild wound</td>
<td>4</td>
<td>33.3%</td>
</tr>
<tr>
<td>Severe pain in affected body region</td>
<td>3</td>
<td>25%</td>
</tr>
<tr>
<td>Mild pain in the affected body region</td>
<td>2</td>
<td>16.6%</td>
</tr>
<tr>
<td>Moderate pain in affected body region</td>
<td>2</td>
<td>16.6%</td>
</tr>
<tr>
<td>Pain in the missing wound</td>
<td>1</td>
<td>8.3%</td>
</tr>
</tbody>
</table>

Given the above, the ICNP® describes the wound pain as: sensation of pain caused by the wound and surrounding area. Given the proposed statements, we notice the extreme prevalence of ND (Table 2), in which 58.3 % reported having severe pain in the wound and 8.3% reported pain in the missing wound.

Pain is one of the main complaints of those who have an continuing injury in the skin. In a literature found, the perception of pain was assessed on a wound, noting that patients with venous ulcers of the lower limbs reported pain as the main complaint, unlike patients with diabetic foot, in which this lesion is painless. This is due to impairment caused by diabetic mellitus neuropathy. The explanation for most present with severe pain in the wound is due to the fact that participants are also mostly patients with venous ulcers, compared to patients with diabetic foot.

When referring to a location separate from the painful event (Table 2), as reported by participants, the ND ‘absent pain in body region’ showed a frequency of 41.6% of the diagnoses identified; while the diagnosis “severe pain in body region” was present in 25%, not performing as often as before.

It is worth mentioning that the pain is related to the physiological process; when unchecked results in respiratory, hemodynamic and metabolic changes that predispose the patient to cardiovascular, higher energy and protein intake, walking difficulty, thus favoring the appearance of deep venous thrombosis mainly in the elderly instability. Among these factors, sleep is also impaired, resulting in increased physical stress, fatigue and lower motivation to cooperate with treatment.

These sensations of different intensities of ND reflect the purpose of encouraging and preparing the nursing staff to work with the patient on the expression of pain. Armed with this knowledge, the nurse should investigate the painful response of the individual against the involvement of their tissue integrity.

As a strategy to control the pain, it is necessary to evaluate its intensity. As a resource, healthcare professionals can use the pain scale to increase this review. Another way to minimize this discomfort is to reduce the anxiety of this type of patient, simply by providing with explanations about the procedure established and preparing him for the expected level of pain.

**Etiology, Time of Onset and Recurrence of Injury**

The wound is any injury that results in interruption of the skin. It may have different etiologies such as mechanical trauma, physical or chemical; can be intentional, as in the case of surgery; due to tissue ischemia, such as the arterial leg ulcer; or be caused by pressure, what happens in bedsores.
Therefore, the ND identified describe which is the actual condition of the lesions found among those surveyed. Regarding the occurrence of the etiology of the wounds were found in the majority of cases, venous ulcers (50%), followed by diabetic foot (25%) of a case where the appearance of the lesion was caused by burning (8.3%), another of traumatic origin (8.3%) and initiated an injury due to infection (8.3%).

Wounds can be classified as acute or chronic. When close spontaneously within three weeks, the wound is defined as acute; when they can heal after three weeks, are chronic. Some authors advocate that only after three or four months of no resolution, the wounds would be considered chronic.22

With respect to the time elapsed since the appearance of the injury until healing were classified as acute or chronic, and, at the time of data collection, acute (41.6%) began within three months and chronic (58.3%) more than three months. Cases in which lesions remain for more than ten years (16.6%) were also evident. As for recurrence, 25% healed and opened again; only once, and 8.3% of respondents, the same happened three times or more.

Among the most frequent diagnoses, the ND are repeated as ‘current acute venous ulcer’, ‘chronic venous ulcers often present’ and ‘chronic diabetic wound present in the foot’, representing 16.6% each. These ND reflect how the client is diverse. Thus, the assistance provided to them should also be differentiated, since patients were found with wounds that were into different classifications.

Many years living with a chronic wound causes a number of difficulties to be faced, and may cause some problems later in life, both physical and emotional.

The time elapsed since the appearance of the wound until total healing, and the possibility of recurrence, influenced also the adopted therapy for treatment.13 The treatment consists of cleaning the wound daily and the choice of an appropriate stage of healing product that is injury. This situation burdens the public health system because, besides the high cost of the material used in wound dressing, the limitations imposed by the injury contribute to the removal of patients, often still in their productive years of their work activities; as this time can fluctuate from months to years, depending on the therapy instituted.23

For this, the nurse will identify the direct influence of the “history of the wound”, performing the inspection, to determine the most appropriate procedure to that injury. Still, it is necessary to clinical evaluation as to the characteristics of the wound bed, which will be detected the type of injury that can be classified by origin or by the causative agent; extension; the degree of involvement, depth of the lesion and the presence or absence of infection. This step is an important step for the development of ND, so that subsequently may be possible to choose the treatment.24

♦ Condition of surrounding skin

It is defined as surrounding skin that one involving or around the lesion with dependent extensions.25 It is important to notice, the surrounding region provides information regarding the conditions of the etiology and the healing process.14

Some changes in the surrounding area are highlighted in Table 3, as follows: desquamation (maceration commonly resulting from the action of excess exudate), pruritus (caused evidenced by the action of scratching the surrounding region) and erythema (which can be perceived as a reddening the region), and may be accompanied by other signs of infection such as redness and warmth.

Edema or swelling corresponds to the increase in volume, causing deformity of the tissue due to fluid accumulation. It becomes harmful when limited cellular metabolism, because it hinders the diffusion of oxygen supply available during communication with the cells of the capillaries, producing hypoxia in the tissue. Edema can also come accompanied by signs of inflammation: redness, pain and heat.26

When injury to adjacent tissue ischemia suffer a time, there arises an area of necrosis due to cell death, which is characterized by the formation of a black or brown crust color.14

<table>
<thead>
<tr>
<th>Table 3. Frequency of the conditions surrounding skin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing diagnosis</td>
</tr>
<tr>
<td>Current wound edema in peripheral region</td>
</tr>
<tr>
<td>Wound erythema present in the peripheral region</td>
</tr>
<tr>
<td>Current wound necrosis in the peripheral region</td>
</tr>
<tr>
<td>Current wound maceration in the peripheral region</td>
</tr>
<tr>
<td>Current wound with itching in the peripheral region</td>
</tr>
<tr>
<td>Wound with integrity current peripheral skin</td>
</tr>
<tr>
<td>Current wound with dry skin in the peripheral region</td>
</tr>
</tbody>
</table>
Among the ND regarding the conditions of the surrounding skin, Table 3 highlights as the most common: the presence of peripheral edema in the current region (66.6%), wound erythema present in the peripheral region (58.3%) and wound current necrosis in the peripheral region (50%).

Due to altered circulatory conditions in the lower limbs, especially the high venous and capillary pressures extravasation of fluid from the capillaries into the interstitium occurs. This event, in turn, prevents adequate diffusion of nutrients from the capillaries to skin and muscle cells, thereby contributing to the nutritional deficit in the local state, evidenced by muscular weakness and ischemic tissue changes.27 The associations may indicate that, in most cases, the wounds are experiencing difficulty in the epithelialization process and favor the emergence of new lesions.

◆ Amount of exudate

The presence of exudate in the wound bed is present in the inflammatory phase, due to plasma leakage due to vasodilation of small vessels physiological process. Such expansion is caused by trauma.14

Given that understanding the physiology of the skin leads to understanding of the healing process, it is worth highlighting that the exudate is produced by increased vascular permeability, resulting from own reactions of the healing process. Therefore, the inflammatory phase is characterized by the increase in proteins in the wound bed. After tissue injury, chemical mediators that increase vascular permeability will be released; thus these mechanisms will provide tissue repair.26

The amount of exudate should be controlled in order to keep the moisture in the wound bed, but this amount cannot be exceeded to the point of compromising the integrity of the skin adjacent region by its leakage. Otherwise, the result of this action causes maceration of the skin, bruising, redness and pain.25

Thus, a very exudative wound may be an infection or prolonged inflammatory phase. The presence of large amounts of exudate may be evident in the later stages of inflammation. This fact becomes detrimental to the injury, delaying the healing process.28

Table 4. Frequency amount of exudate

<table>
<thead>
<tr>
<th>Nursing diagnosis</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secretions at low level</td>
<td>6</td>
<td>50%</td>
</tr>
<tr>
<td>Secretions in the expected level</td>
<td>4</td>
<td>33,3%</td>
</tr>
<tr>
<td>Secretions at high level</td>
<td>1</td>
<td>8,3%</td>
</tr>
<tr>
<td>Absent secretion</td>
<td>1</td>
<td>8,3%</td>
</tr>
</tbody>
</table>

To prepare those ND, the amount of exudate was measured by the number of gauzes used for cleaning of the lesion. According to ICNP®, there are not terms classifying types of exudate. Therefore, this classification is not part of ND. However, with regard to the amount of exudate in the wound bed (Table 4) was observed more frequently as the wound secretions with low (50%).

However, it is important to note that the characteristics of exudate may vary during the healing process. For this reason, during the reassessment of the wound by the nursing professional is important to control both quantitative as qualitative released this exudate.

Odor

The odor is a subjective experience and its judgment may be influenced by the frequency with which a person experiences it. The record of the odor exhaled by the wounds is part of the assessment of the state where the injury is, because the unpleasant odors may indicate the presence of infection or necrotic tissue. Due to the above, the ICNP® brings the focus of 'foul odor' in their nomenclature and defines how aggressive the sense of smell.18

The foul odor coming from the wound is an embarrassing situation for the patient, interfering with their work and social relationships, because society discriminates who has a wound, especially if exhalas unpleasant odor. So, people affected by this feature are excluded because they feel shy, or are excluded from the social environment, not to meet the standards of this prejudiced society.19

Among those surveyed, it was identified a prevalent of ND in 'absent foul odor' (66.6%), while the diagnosis 'severe foul smell' was present in 8.3% of cases. To evaluate the presence and intensity of the odor exhaled, another study shows similarity, indicating that 9% had foul-smelling exudate and 91% identified lack of odor.28
Besides the large amount of exudation, the foul odor also configures as one of the clinical signs with potential indicator that microorganisms are colonizing the wound bed. Thus, it is essential to classify the presence of odor in wounds, as this generates subsidies for review, with the patient, the nursing professional develop strategies coping that nasty factor.

- **Degree of Tissue Involvement**

The skin function is to protect the human body against the action of external agents eliminating excreta, participate in the metabolism, regulate body temperature and promote sensory stimulus. Being a cladding organ, it is likely to suffer any kind of aggression. It is worth noting that tissue involvement may impair the operation of these functions in the body.\textsuperscript{24} The loss of integument is represented not only by disruption of the skin and subcutaneous tissue, but also, in some cases, may reach muscles, tendons and bones.\textsuperscript{29} Thus, the degree of tissue damage is able to classify the wound: grade I (epidermis); grade II (dermis); grade III (subcutaneous) and grade IV (muscle), where the epidermis and dermis are the most superficial layers of the skin and subcutaneous tissue and muscle are deeper.

Table 5 shows that among the lesions found, there was a predominance of deeper tissue involvement, in which the ND ‘integrity of body tissue disrupted in muscle tissue extension’ is a frequency of 58.3%, while the diagnosis “integrity of tissue interrupted extension in the subcutaneous tissue” was present in 25% of participants; where impaired diagnosis presents more surface is described as ‘integrity of body tissue suspended in extension of the skin’, occurring in 16.6% of cases.

It is known that restoration of the skin, i.e. healing process occurs via a dynamic, continuous, complex and interdependent process comprises a number of overlapping phases, such as inflammation, reconstruction, and epithelialization maturation.\textsuperscript{28}

Although the treatment of skin wounds and be a dynamic process dependent on the evolution of the phases of healing, nursing professionals need to have available the best option of dressing to thereby provide a better and more efficient patient prognosis. However, the outpatient clinics of the public health service does not always offer product diversity, making the nurses use the dressing available, considering the conditions of the lesion of each patient and always adapting to the nearest ideal.

- **Wound Size**

The size and shape of the wound change during the healing process. Monitoring the evolution of the wound becomes relevant to assist in choosing the proper coverage to the healing stage.\textsuperscript{14} A very useful tool for chronological monitoring of each lesion is the measuring depth, exudate, size, inflammation/inflection; granulation tissue and necrotic tissue; thus, it is possible to compare whether the injury is progressing or regressing.\textsuperscript{30}

Continuous measurement should be performed in order to compare the measurement with a previously established standard. The quantitative measurement is simple and can be performed by rulers. It consists in measuring the distance between the edges of injury.\textsuperscript{25} This study, with the aid of a caliper simple linear measurement was performed from the measurement of the vertical and horizontal extent of injury, resulting in its area in cm\textsuperscript{2}, classifying it into small (<50 cm\textsuperscript{2}); medium (50 - 100 cm\textsuperscript{2}); and large (> 100 cm\textsuperscript{2}).

By highlighting the subsequent measures, in order to monitor the evolution of the lesion, these should preferably be conducted by the same person on a regular basis between two to four weeks. If performed prior to that time, it is likely that little change is observed.\textsuperscript{18}

As expressed in the wounds of this study corresponds to the measurement performed at the first visit. Despite the wounds presented, mostly with the highest degree of tissue involvement, it was found a lesser extent. Fact observed on the ND ‘small wound’ has reached 58.3% frequency. In two patients (16.6%) in which the wounds were assessed as large, we observed more than one injury in a single member, then with an average area of 115.46 cm\textsuperscript{2}. Consequently, documentation of measurement allows higher fidelity evaluate the evolution of the healing process.
Moreover, this feature is easily within the reach of nursing. These factors demonstrate how important it is performing this assessment before the clientele highlighted.

CONCLUSION

In the present study, we sought to characterize the socioeconomic status of patients with wounds, and through the data to anamnesis, physical examination and clinical assessment of the wound, it was possible to identify the nursing diagnoses targeted to this population as well as their frequency.

For nursing get a better performance and more recognized, it is necessary to use the NP to organize and provide quality its assistance activities, making the job of systematic and continuous nursing, because this tool allows the evaluation of professional practice. It is noted also that as the ICNP® allows a universal language, its use in daily nursing promotes the grounds of their activities and thus promote nursing records, generating grant for research.

On the results, it can be seen that the investigated population faces a great social insecurity, it is mostly made up of seniors, with a low level of education, poor family income. Despite having qualification for the labor market, many reported not practicing their profession due to disabilities caused by injuries.

In addition to the suffering caused by impairments and losses caused by the wound, these patients are still weakened by the social environment, since, in disrepair, are more difficult to achieve a satisfactory response during the course of the wound.

Given the more frequent ND, there is presence of interferences that prevent normal healing process of the injury, proving the fact that these lesions have a long stay, recurrence and difficulties in the process of epithelialization due to changes in their surrounding tissues. This demonstrates that the systematic monitoring of patient injury is important to establish not only the treatment of the wound, but also the control and prevention of future complications caused by several factors that interfere with the healing process.

This study shows important implications for nursing practice, and evaluation helps to determine specific problematic for wound care. Therefore, the use of these diagnoses can facilitate effective and quality care.

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