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ICNP® as care strategy in nursing for a patient with multiple pathologies

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ABSTRACT. Current study analyzes an integral care plan for a person with multiple pathologies, using the International Classification for Nursing Practice (ICNP®). The descriptive and observational study, clinical case type, was developed during a home visit to an individual residing in the city of João Pessoa, Paraíba State, Brazil. Eleven nursing diagnosis / results and their respective interventions were outlined following the terms in the ICNP®. Results show that the nurse's role in this context is a practice grounded on the systematization of nursing with the intention of an easy early identification and prevention of damages related to the patient, during nursing visits.

Keywords: nursing. nursing processes. classification.

Utilização da CIPE® como estratégia do cuidar em enfermagem para um paciente com múltiplas patologias

RESUMO. O objetivo deste estudo foi fomentar um plano de cuidado integral a um indivíduo com múltiplas patologias, utilizando a Classificação Internacional para a Prática de Enfermagem (CIPE®). Trata-se de um estudo descritivo e observacional, do tipo estudo de caso clínico, desenvolvido durante uma assistência domiciliar, a um indivíduo residente no município de João Pessoa, Estado da Paraíba, Brasil. Foram traçados onze diagnósticos de enfermagem e respectivos resultados esperados e intervenções propostas de acordo com os termos encontrados na CIPE®. Conclui-se que o papel do enfermeiro, nesse contexto, possibilita uma prática embasada na sistematização de enfermagem com o intuito de fácil identificação precoce e a prevenção de danos relacionados ao paciente durante as consultas de enfermagem.

Palavras-chave: enfermagem. processos de enfermagem. classificação.

Introduction

The systematization of nursing care (SNC) is a practice used for care planning, implementation and evaluation, which is highly relevant in the nursing profession (CHAVES, 2009). This systematization is a current practice in everyday nursing practice. Discussed daily, it demonstrates the nurses´ interest in extending the implementation of the methodology in hospitals and in several care specialties in public health (ZANARDO et al., 2011).

Nursing is a profession focused on caring and professionals must use their theoretical knowledge and associate it to real practice to provide appropriate assistance to patients. This requires a broad knowledge of nursing theories to use the most appropriate theoretical model for the implementation of the nursing process for the specific individual under care (SMELTZER; BARE, 2011).

Professional nurses work on care planning to have the necessary tools to take the right decisions related to health and disease. This entails informing, discussing, sharing and negotiating with the patient and family the aspects of the diagnosis that interfere in the health process and in the actions and strategies that may contribute to reverse, when necessary, the situation as it was first encountered (LOPES; MARCON, 2012).

Although theoretical and methodological knowledge is not enough for changes in the work process, it is crucial that health professionals acquire such knowledge and transform it into the very foundations of their profession within the work environment. This may be their biggest challenge, compounded by deficient academic formation and limited to the biomedical model of health care (ALVES et al., 2013).

The nursing process is an essential tool for the systematization of assistance. Through the ICNP®,

nurses share a specific language with other professionals in the health care team and enhance their autonomy to plan actions for patients´ care. ICNP® employs practical methods for diagnosis/results and interventions, facilitates the implementation of the nursing process and includes aspects that are not covered by other diagnosis classifications (PRIMO et al., 2010).

The International Classification for Nursing Practice (ICNP®), introduced by the International Council of Nurses (ICN), is a perfect tool that provides nurses with a scientific and unified language, common to the nursing world community. ICNP® enables the planning of interventions by nursing professionals according to the needs of the person, according to their needs, and takes into account the disabilities to cope with (ICN, 2011).

Nursing may be presented as an important strategy in the maintenance of a humanized, individualized and systemized service. Under this perspective, systematic assistance, based on previously planned actions, may be the turning point in the quality of life of an individual. This is especially true for patients whose pathological process involves multiple pathologies, and therefore, require the need for more comprehensive care.

In the case described below, the motivation for the implementation of nursing care systematization (NCS) and its justification are equivalent due to the complexity of existing diseases in an individual requiring care in an orderly manner for the maintenance of life. Thus, based on the underlying disease of Lupus erythematosus, which already requires specific care due to immunosuppression and to opportunistic diseases, the patient´s conditions were worsened by cancer. Since intestinal stoma and enterocutaneous fistula were mandatory, the case became highly complex. Consequently, nursing had to intervene in the planning of care, education and empowerment of the patient and her caregiver for a better management of the patient´s condition.

Current study underscores a wholesome care plan for an individual with multiple pathologies, employing the International Classification for Nursing Practice (ICNP®).

Material and methods

A descriptive and observational study of a clinical case was developed during home visits to a woman suffering from several diseases (Systemic Lupus Erythematosis, Colon Cancer and Ileostomy) who resided in João Pessoa, Paraíba State, Brazil. The study followed requirements in Resolution 466/12 of the National Health Council on research involving human beings (BRASIL, 2012). The project was appreciated by the Committee for Ethics and received a favorable opinion (Protocol 269/2010). Furthermore, the patient´s consent to participate in the study was requested, assuring her that her identity would not be disclosed. It should be noted that current research is an integral part of a larger project called "Building evidence about skin problems in ostomized patients".

The case was selected due to the complexity of the pathologies involved, to care priority, and to the patient being a professional in healthcare which favored the teaching / education process. The patient was identified during attendance in secondary service for ostomized people, specifically at the section of dispensing material, where estomoterapeutic service is also provided to develop a healthier life by training and empowering patients in self-care.

The service and home visits were requested by the patient herself since she was unable to adapt the collection bag. The issue was identified and the need for a systematic approach and qualified assistance was raised. Visits were carried out over a period of thirty days, primarily with regard to procedures on the stoma and data collection (physical examination and anamnesis), permitted by the Term of Consent. The visits were made initially every four days which coincided with the change of apparatus and thereafter once a week.

Data were collected by a structured tool, adapted and developed by the surgical clinic of the University Hospital Lauro Wanderley in João Pessoa, Paraíba State, Brazil, focusing on the Basic Human Needs described by Horta (1979). Based on these data, the nursing diagnoses were identified by ICNP® 2.0 through the establishment of expected results and nursing interventions.

To generate diagnosis, outcomes and nursing interventions, the ICN recommends the 7-Axes Model of ICNP® version 2.0. One term of the focus axis and one term of the judgment axis are mandatory for the elaboration of the nursing diagnosis / results by ICNP®. Additional terms may be included according to the needs of focus and judgment axes, and other axes. For the composition of the nursing interventions by ICNP®, one must use one term from the action axis and, at least, one target term, which may be a term from any axis,

except the judgment axis. At the end, results were provided through descriptive tables.

Results and discussion

Following the proposed aims and methodological criteria, the diagnosis and nursing results described below were prepared. They were based on the information collected through anamnesis and nursing history

Nursing History

R.P.P., 40 years old, female, single, Catholic religion, was born in the state of Paraiba, Brazil, and currently resides in João Pessoa, Paraíba State, Brazil, and lives with a female caregiver.

Family History:

She belongs to a family composed of 5 persons (father, mother, brother and a twin sister), all deceased.

Personal History:

Bearer of Systemic Lupus Erythematosus, she was diagnosed with cancer in the endometrium in 2010. She underwent total hysterectomy and treatment with radiotherapy and brachytherapy (laser). In 2012, the disease evolved to colon cancer and ileostomy was required; an enterocutaneous fistula developed in the umbilical region, with slight drains averaging 20 mL 24 hours^{-1}. RPP is currently undergoing chemotherapy for 6 sessions using taxol 300 mg and evocarb 4250 mg.

Physical Examination:

RPP has a general regular healthy state; she is conscious, well-oriented and concerned on treatment and recovery; she goes around with a walking aid (due to pain in the bones); she is completely bald (due to chemotherapy) and has impaired eyesight. Her mouth and nasal mucus are healthy, albeit with dry skin, diminished skin turgor and elasticity. Edema in MMII. Sleep and rest are compromised due to her emotional state. Dyspnea occurred while chest examination was being conducted without oxygen therapy, although adventitious noises were audible. She had regular heart rate, palpable peripheral pulses, with normal heart beat and normophonetics in 2 T. Flat abdomen, audible RHA in all quadrants, with anorexia and nausea, were detected. Bladder release was spontaneous, with intestinal defecation through intestinal stoma (ileostomy).

Stoma Evaluation:

Permanent ileostomy was reported in the lower right quadrant, measuring 25 mm in a fully retracted circular shape. Dried peristomal skin hernia with adhesion of waste, macerated at the proximal margin, and a round and flaccid abdomen was also reported.

Vital Signs:

T: 36.6 c; P: 89 bpm; FC: 91 bpm; PA: 110 60 mmHg^{-1}; R: 21 irpm.

Complaints:

She complains of not feeling well, nausea and vomiting after chemotherapy. She is angry with her doctor because she feels ileostomy could have been avoided. Sometimes she feels sad, but does not consider herself an unhappy person. She enjoys sightseeing and driving, but feels very lonely.

Nursing Care Planning

After researching the patient's history, other steps within the nursing process followed. The need for care planning is proportional to the number of the patient's needs and the systematization of activities is aimed at the organization, quality and validity of the care provided (PRIMO et al., 2010). Table 1 shows eleven nursing diagnosis/results and their respective interventions outlined according to the terms in ICNP®.

Diagnosis / results statements were prepared by norms for the construction of diagnosis established by ICNP® which resulted in the construction of the eleven statements explained below.

The diagnoses of 'compromised immune system' and 'liquid retention' are related to the pathology of Systemic Lupus Erythematosus (SLE), a chronic and inflammatory sickness of the connective tissue, caused by multi-factorial etiology, affecting several organs and systems, and presenting important immunological disorders (FREIRE et al., 2011).

The diagnosis 'Compromised skin integrity' is characterized by the stoma and the enterocutaneous fistula, as well as by skin fragility that appears in skin peristomal hernias. It also develops the nursing diagnosis 'risk of infection' that qualifies a situation in which an individual has an increased risk of being invaded by pathogenic organisms. The above is easily identified in current patient's case study, due to the recurrence of exposed wounds

Regarding to the diagnosis of 'moderate pain', there is an association with the inflammatory process characteristic of SLE and, mainly, definitive stoma.

Table 1. Nursing diagnoses/results and interventions following terms in ICNP®. João Pessoa, Paraíba State, Brazil, 2014.

Diagnosis	Expected Results	Interventions
Impaired nutritional intake	Improved nutritional status and balanced nutrition	Identify problems related to nutrition; Provide guidance on the importance of diet on health recovery; Frequent small meals are provided.
Impaired skin integrity	Preserved skin and mucous membranes	Explain care with regard to stomas, skin and surrounding areas; Carry out exchange of apparatus when necessary and percutaneous protectors; Provide guidance on peristomal skin care; Keep skin clean and dry; Provide guidance on body and mouth hygiene; Prevent skin injuries; Protect the skin against infections; Supervise skin care; Educate in preventive skin care; Control ingestion and excretion – water balance; Encourage hydration (steroids cause dry skin); Provide guidance on the use of sunscreens when exposed to sunlight (due to LUPUS);
Fluids retention	Reduced retention of fluids	Monitor edema in the lower members and on the face; Check vital signs three times a day; Control liquid intake; Explain the side effects of corticosteroid therapy;
Anxiety	Reduced anxiety	Encourage the patient to listen to music, engage in conversations, report an event or tell a story; Encourage expressing oneself on feelings, perceptions and fears; Listen carefully to the patient; Support decision-making process; Provide guidance for psychological help for evaluation;
Moderate pain	Control of pain	Evaluate pain with regard to site, frequency and duration; Apply numeric pain scale or other relevant range; Evaluate the effectiveness of measures for pain control; Encourage rest and adequate sleep for pain relief; Teach non-pharmacological techniques (relaxation, image oriented, music therapy, fun, application of cold and hot compresses, massage) before, after and if possible, during pain;
Infection risk	Prevent systemic infection	Monitor signs and symptoms of infection; Be aware of allergic processes; Monitor white blood cells count; Provide guidance on body and mouth hygiene; Prevent skin injuries; Protect the skin against infection; Supervise skin care;
Impaired walking	Improve physical capacity	Evaluate patient's progress in walking; Encourage independent walking, within safe limits; Plan activities within tolerance level; Instruct the patient to walk with a walking aid to avoid falling risks;
Nausea	Nausea control	Explain the cause and duration of nausea, if known (chemotherapy drugs may be mentioned); Limit liquid intake during meals; Provide small ice cubes; Take deep breaths when feeling nausea; Avoid lying down immediately after meals; Watch factors that contribute towards the onset of nausea; Register factors that contribute to the onset of nausea;
Degraded sleep pattern	Provide adequate sleep and rest	Help in stressful situations before bedtime; Assist the patient in controlling daytime sleep; Discuss with patient comfort measures, monitoring sleeping techniques, and changes in lifestyle; Teach the patient relaxation techniques; Encourage a night routine by facilitating the transition from the alert to the sleep state; Observe the physical circumstances – sleep apnea, obstructed airways, pain/discomfort; Monitor the sleep pattern and number of hours slept overnight; Register sleep pattern and number of hours slept overnight; Provide a calm and safe environment.
Compromised immune system	Prevent infection	Monitor site, systemic signs and symptoms of infection; Monitor white blood cells count; Advise as to the need for adequate protein intake with less salt, lipids and carbohydrates; Teach methods to prevent infection: good body hygiene, hand washing when using the toilet and before meals, keeping nails clean and trimmed; cleaning of ostomy whenever necessary, with change of collecting bag;
Decreased vision	Adapting to new visual conditions	Evaluate visual acuity, asking the patient to read texts; Assist the patient in establishing goals to learn how to "see" with her other senses; Assist the patient with regard to her knowledge of the environment; Evaluate the size of the pupils and their response to light; Assess visual fields and perception of depth; Demonstrate willingness to listen; Provide guidance towards the real when the patient is confused or disoriented.
Risk of falls	Absence of fall	Orient patient and caregiver on risk of falls; Guide on a safe environment; Inform patient on the use of handrails in the bathroom and toilet; report on the use of safe shoes; Avoid carpets and wet floors; Identify the patient's physical deficits that may increase the risk of falls in a given environment; Identify characteristics of the surroundings which increasing potential falls; Guide the patient with regard to walking aids (cane, walkers, etc.); Encourage walking with caution.

Source: Direct research.

The above strongly influences the 'anxiety' status characterized by fear of the unknown and even by concern on her physical integrity, as a result of this pathological process (ORIA et al., 2004). The same process also enhances the diagnosis of 'Degraded sleep pattern'.

The nursing diagnosis of 'Impaired nutritional intake' and 'Nausea' is associated to the therapeutic process used in the fight against cancerous cells (chemotherapy). Chemotherapy is a drug treatment to destroy the diseased cells forming a tumor. Inside the human body, each drug acts in a different way, causing several side effects, among which nausea, vomiting and loss of appetite may be mentioned (INCA, 2013).

In the case of an individual with multiple pathological factors, systematized assistance aims beyond a humanized and individualized service; it rather focuses on specific actions to achieve the expected results.

Nursing aiming at the maintenance or recovery of a person's health (client, family or community) must include all possibilities of caring-with-the-client, in other words, it must be dialogical. The nursing profession will thus achieve autonomy and professional recognition (SIMÕES, 2007).

Although there are difficulties in implementing the systematization of nursing as an instrument for the work process, it is believed that the professional practice of nurses in care activities and coordination with the managerial activities, will be better characterized without the division between taking care and managing care (TORRES et al., 2011).

Impaired mobility is associated with the worsening of the Lupus process which, among other structures, affects the motor system with asymmetric and migratory trends, jeopardizing fingers, wrists, knees and, less frequently, elbows, shoulders, hips and ankles. In general, morning stiffness is similar to that of rheumatoid arthritis (RA). Rheumatic diseases cause various disabilities, such as joint and neurological functional deficits, which require actions that enhance the individual's quality of life (LAZARO et al., 2015).

Mobility associated with a diagnosis of vision deficit corroborates the statement Risk of Falling since difficulty in getting around and in seeing are a predisposition to falls. Study developed in Cuiaba MT Brazil, assessing the patient's life quality with SLE, showed that the most affected aspects are related to physical and emotional limitations. In the case of the situation discussed in current paper, it may be assumed that decrease in visual acuity enhances mobility restriction in the patient´s conditions which may lead towards a worsening of her emotional state due to falls (SALICIO et al., 2013).

In this context, the authors know the relevance of the application of a theory that materializes the nursing practice and makes possible the systematization of assistance so as to meet the needs of patients according to their complexity (ALBUQUERQUE et al., 2008).

Due to the complexity of its pathologies, the proposed case study could not be followed up to the end nor all implementations be performed. The patient was transferred to another place. She became extremely moody, alternating between depression and denial of her condition and, consequently, impairing the process of cooperation and realization of care, which are the study´s limiting factors.

Conclusion

The results of current study are relevant since the planned diagnosis assistance enhances the communication process among nursing professionals. The systematization of nursing was built on the clinical real state, enabling assistance based on methodological principles, better scientific visualization of the professional and assistance with higher resolutions for the client.

One of the major challenges in this study has been working with the construction of diagnosis on clinical aspects of different pathologies, coping with problems likely to be treated by nurses, by such strategies as clinical reasoning and technical-scientific knowledge and, from then on, grouping signs and symptoms, to establish diagnoses / results and nursing interventions.

Finally, the authors would like to highlight the role of the nurse in this context. A practice grounded on systematization enables the early identification of problems, the prevention of the deterioration of patients´ health, ensuring better care quality during the nursing consultations. Studies at this level direct nursing professionals towards the need of planning and executing their theoretically informed activities consolidating nursing as a science and promoting effective care for the patient.

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