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PROFILE OF NURSING DIAGNOSES OF PATIENTS HOSPITALIZED AT A MEDICAL CLINIC UNIT

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ABSTRACT
This research aimed to identify the frequency of main nursing diagnoses (ND) among patients hospitalized at a medical unit. This was a quantitative research of descriptive-exploratory typewith a sample of 25 participants. Of the 13 fields described by NANDA II, all were represented by at least one diagnosis. A total of 530 diagnoses were surveyed, with an average of 21.2 per patient. Predominant diagnoses were: Risk of infection (100%), Impaired skin integrity (88%), Ineffective health maintenance (76%), Impaired walking (76%), Impaired comfort (76%), Ineffective sexuality patterns(72%), Impaired physical mobility (68%), Impaired tissue integrity (68%), Deficient self-care for showering (64%), for personal hygiene (64%), for dressing (64%), and Impaired mobility in bed (60%). These results contributed to the identification of the most affected needs of the hospitalized patients, facilitating the development of more efficient nursing care plans.

Keywords: Nursing diagnosis. Nursing Assessment. Clinical Nursing Research.

INTRODUCTION

Deemed very important in nursing processes, the second stage is where data collected during the investigation will be analyzed and interpreted, generating accurate and individual diagnoses. At this phase, there is need for a complex intellectual process, cognitive skills, experience and scientific knowledge through which nurses elaborate judgments and interpretations about objective and subjective data on patients[1].

Nursing diagnoses (ND) categorization systems are important to all levels of nursing practice, facilitating communication and providing a standardized language, promoting information exchange within the nursing team and contributing to ongoing assistance[2]. Diagnoses should be identified and listed by priority order, based on the degree of threat to the client's wellbeing, thus favoring a central focus for subsequent stages[3].

Every day more healthcare institutions are adopting ND in their working processes. But to do that, nurses need to comprehend the language used, in order to favor understanding about phenomena occurred with the clients we take care of, to assist in the proposition of nursing interventions and assessment of obtained results[4-6].

The North America Nursing Diagnosis Association (NANDA) contributes significantly to the development and refinement of nursing diagnoses, developing a conceptual system to categorize diagnoses into a taxonomy, standardizing the language used by nurses[7].

Nursing development over the years has shown that patients' answers to health problems can be easily confounded or misinterpreted[8]. A ND is taken as accurate when it represents the patient's real state[9]. The accuracy of a nursing diagnosis was defined as the "*the judgment of an assessor as to the degree of relevance, specificity and consistency of existing clues for the diagnosis*"[9].

Studies about ND prevalence in specific populations such as, for instance, patients admitted to medical-surgical units[3,10], medical clinics[5,11], intensive care units[6], communicable disease hospitalization units[12], patients subjected to heart surgery[13], hospitalized elderly people[14,15], patients subjected to hemodialysis[16] and patients at risk of developing pressure ulcer[17] show the relevance in observing clinical manifestations in groups of patients with common characteristics. This clinical mapping allows the surveying of more significant problems, generating greater probability of correct findings and diagnostic

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accuracy. As a consequence, it triggers specific and personalized nursing interventions, resulting in the implementation of efficient actions towards the resolution of the problems surveyed.

We consider that ND characterizations in specific populations become more relevant as results are assessed. For this reason, this study aimed to identify the frequency of nursing diagnoses among clients hospitalized at a medical clinic unit.

METHODOLOGY

This is a quantitative research of descriptive-exploratory type conducted at the medical clinic unit of Maringá's Regional University Hospital [*Hospital Universitário Regional de Maringá*] (HUM), from October to November 2013. The unit counts with 15 beds for the hospitalization of men and women with several clinical specialties, aged over 14 years old, and with an average occupation rate of 8 to 12 patients per day.

The sample was composed of 25 patients randomly chosen, aged over 18 years old, admitted from July to October 2013, and who accepted to participate in the study by means of the signing of an informed consent form. All of them were subjected to an interview, non-invasive clinical assessment and medical records analysis.

Data were collected through the application of an instrument prepared by the researchers, based on the Functional Health Patterns (FHP) proposed by Gordon and present in NANDA taxonomy II (2012-2014)[7]. Nursing diagnoses were surveyed and interpreted from defining characteristics and related factors, and then analyzed in absolute and relative frequencies.

The research was conducted in compliance with all required ethical standards after favorable legal opinion from the institution and the standing ethics committee on research involving humans, according to CAAE16315913.4.0000.0104 and approval legal opinion No 409.125.

RESULTS AND DISCUSSION

The research counted with 25 participants aged between 18 and 79 years old. The greatest prevalence was found for those aged 50 years old or over (60%). As for sex, 13 were men (52%) and 12 women (48%). None of the participants had higher education and most of them had not completed elementary school (68%).

A total of 25 medical diagnoses were found among the participants at the moment of assessment. Among them the most prevalent one, according to CID-10[18], was Systemic Arterial Hypertension (SAH) (32%), followed by Hemorrhagic Cerebrovascular Accident (CVA) and pneumonia (20%). In some cases, one patient had more than one medical diagnosis. Other medical diagnoses are displayed in Table 1.

The research participants were randomly chosen, without taking into consideration the treatment stage at which they were. The patients' hospitalization time varied between 1 and 24 days, with 8.5 days on average. Table 2 shows the hospitalization time of the patients at the moment they were subjected to the assessment.

Table 3 shows the distribution of nursing diagnosis categories identified among the patients hospitalized at the medical clinic who participated in the research. Among the 216 diagnostic titles currently described by NANDA[7], 71 were identified in this research, accounting for 32.9% of that total. For the 25 patients, 529 ND(s) were surveyed, with an average of 21.2 per patient, varying from six to forty-two.

It can be observed that among the 13 domains described by NANDA II[7], all were represented by at least one diagnosis. The Activity/Rest, Security/Protection and Nutrition domains were those which presented a larger number of diagnostic categories, with 15, 12 and 8 diagnostic categories, respectively. These three domains were those which most frequently appeared in results of other three studies whose populations were patients admitted to medical-surgical clinics, medical clinics, and elderly people[3,11,14]. However, if we consider only the first two most frequent domains, we will find more studies with similar results[5,6,15].

These similarities corroborate the greater frequency of patients aged over 50 years old and the complexity of this study sample. We can also infer that these characteristics are common in the studied sector type, in agreement with two studies conducted at similar units[3,5]. Such characteristics require nurses to work at similar units and have broad knowledge in order to plan an assistance that is adequate to the needs of these patients[3].

Table 1. Medical diagnoses of adults hospitalized at the medical clinic of Maringá's Regional University Hospital. Maringá, 2013.

Medical diagnoses	n(%)
Cardiovascular Diseases	15
Systemic Arterial Hypertension	8 (32)
Acute Heart Attack	3(12)
Dilated cardiomyopathy	3(12)
Congestive heart failure	1(4)
Respiratory Diseases	10
Pneumonia	5(20)
Bronchopneumonia	2(8)
Bronchiolitis	1(4)
Chronic obstructive pulmonary disease	1(4)
Bronchospasm	1(4)
Urinary Diseases	3
Chronic Renal Failure	2(8)
Urinary tract infection	1(4)
Neurologic diseases	10
Hemorrhagic CVA	5(20)
Ischemic CVA	3(12)
Parkinson	1(4)
Alzheimer	1(4)
Infectious Diseases	8
Sepsis	3(12)
Erysipelas	2(8)
Salmonellosis	1(4)
Pancreatitis	1(4)
Bacterial Meningitis	1(4)
Other	9
Diabetes Mellitus	4(16)
Alcoholic Cirrhosis	2(8)
Arthritis	1(4)
Psoriasis	1(4)
Achalasia	1(4)

Table 2. Hospitalization time (in days) of patients admitted to the medical clinic of Maringá's Regional University Hospital. Maringá, 2013.

Hospitalization time (in days)	n(%)
1-3	9(36)
4-6	5(20)
7-9	3(12)
10-12	1(4)
13-15	1(4)
16-18	1(4)
19-21	4(16)
22-24	1(4)
Total	25(100)

In this study, the number of nursing diagnoses presented per patient varied from 6 to 42, with an average of 21.2 per patient.

Two studies conducted with similar populations presented opposite averages concerning ND in relation to our results. One of them was conducted at the medical clinic unit of the University of São Paulo University Hospital[5] and identified, among 30 patients, 144 nursing diagnoses with 31 different diagnostic categories, with the average being 4.8(± 4.0) diagnoses, varying from 1 to 10 diagnoses per patient. Another study conducted at a medical clinic unit of a university hospital as well[11] identified in 93 medical records an incidence of 671 nursing diagnoses, with 106 diagnostic categories. However, it did not report the average number of diagnoses per patient. From these results, we can initially reflect on the diversity of the diagnostic reasoning elaborated by the professional for him/her to infer diagnoses, including the amount of available data so that a certain diagnosis is surveyed. Another aspect that is worth attention is the fact that in one of the studies[11] data was obtained from medical records, without approach to the ill person in order to obtain more elements in case of doubts.

In the present study, predominant nursing diagnoses were (Table 4): Risk of infection (100%), Impaired skin integrity (88%), Inefficient health maintenance (76%), Impaired walking (76%), Impaired comfort (76%), Inefficient sexuality patterns (72%), Impaired physical mobility (68%), Impaired tissue integrity (68%), Deficient self-care for showering (64%), for personal hygiene (64%), for dressing (64%) and Impaired mobility in bed (60%), Willingness to improve spiritual wellbeing (52%), Deficient self-care for eating (52%), Anxiety (48%), Risk of aspiration (48%), Impaired teething (44%), Constipation (44%), Feeling of powerlessness (44%), Impaired social interaction, Risk of loneliness (40%), Impaired verbal communication (40%) and Impaired sleeping pattern (40%).

The Risk of infection diagnosis was present in most researches[3,6,10-13,15-17], regardless of population, and always with higher frequencies among the diagnoses found, being evidenced by the high number of invasive procedures deriving from hospitalization, due to the high prevalence of chronic diseases and increased environmental exposure to pathogens.

Table 3. Distribution and frequency of nursing diagnoses, according to the domains of NANDA taxonomy II (2012-2014), of patients admitted to the medical clinic of Maringá's Regional University Hospital (n=25). Maringá, 2013.

Domain	Diagnostic Categories		n (%)
Health Promotion	**Inefficient Health Maintenance***		**19 (76)**
	Inefficient Health Self-Control		4 (16)
		subtotal	23
Nutrition	Risk of unbalanced liquid volume		8 (32)
	Unbalanced nutrition: less than body needs		8 (32)
	Excessive liquid volume		5 (20)
	Risk of impaired hepatic function		2 (8)
	Risk of electrolytic unbalance		2 (8)
	Risk of deficient liquid volume		2 (8)
	Deficient liquid volume		1 (4)
	Unbalanced nutrition: more than body needs		1 (4)
		subtotal	29
Release and Exchange	**Constipation***		**11 (44)**
	Impaired urinary release		7 (28)
	Diarrhea		4 (16)
		subtotal	22
Activity/Rest	**Impaired walking ***		**19 (76)**
	Impaired physical mobility*		**17 (68)**
	Deficient self-care for showering*		**16 (64)**
	Deficient self-care for personal hygiene*		**16 (64)**
	Deficient self-care for dressing *		**16 (64)**
	Impaired mobility in bed *		**15 (60)**
	Activity intolerance*		**14 (56)**
	Deficient self-care for eating*		**13 (52)**
	Impaired sleeping pattern*		**10 (40)**
	Risk of activity intolerance		7 (28)
	Inefficient respiratory pattern		5 (20)
	Impaired spontaneous ventilation		4 (16)
	Decreased cardiac output		3 (12)
	Inefficient peripheral tissue perfusion		3 (12)
	Impaired mobility on a wheelchair		1 (4)
		subtotal	159
Perception/ Cognition	**Impaired verbal communication ***		**10 (40)**
	Acute confusion		3 (12)
	Impaired memory		3 (12)
	Chronic confusion		2 (8)
	Impaired environmental interpretation syndrome		2 (8)
		subtotal	20
Self-perception	**Risk of loneliness ***		**10 (40)**
	Hopelessness		6 (24)
	Low situational self-esteem		5 (20)
	Low chronic self-esteem		4 (16)
	Body image disorder		4 (16)
		subtotal	29
Roles and relationships	**Impaired social interaction***		**10 (40)**
	Inefficient role play		8 (32)
	Interrupted family processes		7 (28)
	Risk of impaired bonds		2 (8)
	Impaired fatherhood or motherhood		2 (8)
		subtotal	29
Sexuality	**Inefficient sexuality pattern***		**18 (72)**
	Sexual dysfunction		2 (8)
		subtotal	20
Stress coping/tolerance	**Anxiety***		**12 (48)**
	Feeling of powerlessness*		**11 (44)**
	Fear		3 (12)
	Autonomic dysreflexia		2 (8)
	Death-related anxiety		2 (8)
	Change-related stress syndrome		2 (8)
		subtotal	32
Life principles	**Willingness to improve spiritual wellbeing***		**13 (52)**
	Risk of impaired religiosity		9 (36)
	Spiritual suffering		3 (12)
		subtotal	25
Security/ Protection	**Risk of infection***		**25 (100)**
	Impaired skin integrity*		**22 (88)**
	Impaired tissue integrity*		**17 (68)**
	Risk of aspiration*		**12 (48)**
	Impaired teething*		**11 (44)**
	Risk of impaired skin integrity		8 (32)
	Inefficient clearance of air passages		7 (28)
	Risk of falls		5 (20)
	Risk of violence towards others		3 (12)
	Delayed surgical recovery		2 (8)
	Risk of unbalanced body temperature		1 (4)
	Risk of bleeding		1 (4)
		subtotal	114
Comfort	**Impaired comfort***		**19 (76)**
	Acute pain		3 (12)
	Chronic pain		2 (8)
	Nausea		2 (8)
		subtotal	26
Growth/ Development	Delayed growth and development		1 (4)
		subtotal	1

*Most prevalent diagnoses

The Impaired skin integrity ND was present in six researches[3,5,10,11,13,15]; however, the study which showed greater proximity in terms of percentage was also conducted at a school hospital in the city of Londrina, at the men's medical-surgical admission unit. The similarity between these units is characterized by invasive procedures and bedridden patients, whose factors result from the destruction of skin layers by peripheral or central venous puncture, chest tube, tracheostomy or gastrostomy and the patient's difficulty of mobility, favoring the formation of pressure ulcers.

The Inefficient health maintenance diagnosis is defined as "*Inability to identify, control and/or seek help to maintain health*"[7], and was represented in this study by the following defining characteristics: expressed lack of interest in improving healthcare behaviors; shown lack of knowledge about basic healthcare practices, and history of absence of behaviors towards seeking help. Related factors that might be contributing to these responses are: poor financial resources, inability to elaborate proper judgments, and poor communication skills, since most of the studied population is elderly (60%) and has incomplete elementary school (68%).

The Impaired walking diagnosis present in 19 patients (76%) also appears abundantly in other studies[14,11] whose populations were elderly people and patients admitted to a medical clinic unit, respectively. This diagnosis is defined as "*Limited independent walking, on foot, around the environment*"[7], and can be justified by the high number of patients who are bedridden or recovering, participating in the research.

Impaired comfort, Inefficient sexuality patterns, Willingness to improve spiritual wellbeing and Risk of aspiration are ND that did not appear in other studies. Inserted into the Comfort domain, the most present diagnosis of this category was Impaired Comfort, which appeared in 19 patients (76%), contradicting other similar studies[3,5,6,14,15], in which it is not mentioned. Defined as "*Lack of perceived sensation of comfort, relief and transcendence on physical, psycho-spiritual, environmental and social dimensions*"[7], this diagnosis can be characterized by several factors such as anxiety, crying, lack of privacy, irritability, fear, disturbed sleeping pattern, symptoms related to the disease, among others. It can also be observed that such factors are related to hospitalization and eventual emotional repercussions for the patient. Some authors refer to the lack of qualification of professionals for them to provide assistance to the patient's emotional problems, evidencing the need to strengthen the nurse-patient bond[11].

The Inefficient sexuality patterns diagnosis, present in 18 patients (72%) and in only one study[11], brings as defining characteristics: changes in the perception of sexual roles, reported difficulties and limitations concerning sexual activities, and report of changes in sexual behaviors. What justified the formulation of this diagnosis was: physical and psychological limitations acquired with the disease and/or with the treatment, and also the impairment of a relationship with a significant person.

The Impaired physical mobility and Impaired mobility in bed diagnoses are mentioned in several studies[3,6,10,11,13-15,17] and can be justified, as well as the Impaired walking diagnosis, by the high number of serious, sedated and bedridden patients of the sample of the present study and of the studies mentioned. It should be taken into consideration that these two diagnosis are the main factors that contribute to the development of other nursing diagnoses, such as Impaired skin/tissue integrity, deficient self-care for showering, hygiene and dressing.

About the Impaired tissue integrity diagnosis, two studies presented frequencies very similar to that of the present research, 68%, 63.3%[5] and 76.6%[10]. Such results corroborate the relevance of this type of study to confirm the profile of nursing diagnoses and draws nurses' attention to this response from the patient.

Deficient self-care for showering and for personal hygiene were reported in five studies[6,10,11,14,17], in three studies[10,11,14] for dressing, and deficient self-care for eating was reported in only one study[12]. The high frequency of the first two diagnoses confirms that this type of diagnosis is more frequent among patients at different hospital sectors.

Eight diagnoses were presented by approximately 47% to 48% of the patients, and the most frequent one was anxiety (48%); other

diagnoses were identified in a small number of patients. Feeling of powerlessness, Impaired social interaction and Risk of Loneliness are diagnoses that characterize emotional aspects of patients. They appear in few studies[11,14], but the latter are more recent researches, showing an increasing concern regarding detection and intervention when it comes to biological and psychosocial aspects of hospitalized individuals.

In a study conducted with similar population[5], the most frequent diagnoses were: acute pain (66.7%), impaired tissue integrity (63.3%), inefficient clearance of air passages (43.3%). It is worth highlighting the fact that risk of infection and impaired tissue integrity (risk or real) are not identified among the most frequent categories, which could be expected for the profile of patients hospitalized at a medical clinic.

In the present study the Acute pain diagnosis showed a 12% frequency (Table 3), much lower than that of the mentioned study[5]. From this result we can perhaps infer that there was improvement in the nursing assistance to this response from the patient. The nursing focus, related to the assessment and relief of pain, may have been incremented over the years, as suggested in the very study mentioned[5].

As for Inefficient clearance of air passages, the present study showed a frequency much lower than that of the mentioned studied, 43.3% against 28%. These results are justified by the most frequent pathologies in the studies: respiratory diseases with 30%, in the mentioned study, and cardiovascular diseases with 41.8%, in the present research.

"Willingness to improve spiritual wellbeing", that is, "Pattern concerning experimenting and attributing meaning and objectives to life through a connection with oneself, with others [...] and/or with a superior being, which is enough for wellbeing can be strengthened"[7], was found in 52% of the sample. Most of the clients showed devotion to a superior being, verbalized faith, hope, joy and courage as a response to spiritual belief. Patients with this diagnosis have potential resources of support when facing a disease or threat to their wellbeing. If the patient does not know how to use resources to face health problems, the nurse should provide support to explore the several options[19].

This diagnosis was not reported in other studies. Authors argue that difficulty to find changes in patterns of belief, values and religious convictions comes from the short time of interaction with patients, since defining characteristics of these diagnoses are expressed in the ties of the therapeutic relationship[19,20].

With the surveying of nursing diagnoses it is possible to observe that many have the same defining characteristics and similar risk factors, that is, many diagnoses are interconnected, which suggests that nursing interventions should be interconnected as well[13]. This can serve as a guideline to help nursing professionals adjust diagnoses to clinical practice. It is worth reminding that such connections do not substitute daily assessment and a nurse's clinical judgment[13].

FINAL CONSIDERATIONS

The results showed that people hospitalized at the medical clinic unit were mostly serious patients with complex pathologies and who demanded a high level of nursing-specific knowledge. This client profile increases the importance of not only clinical practice but also nursing research and teaching, since it sediments clinical reasoning and provides a broad view of care organization and planning, considering all aspects of human beings, qualifying them to act in several specific areas.

By learning the most frequent diagnoses within a certain population it is possible to organize the basis of nursing knowledge, plan specific actions and direct them to the most affected needs. A larger number of studies about nursing diagnoses conducted with specific clients can favor the identification of priority care focuses, thus contributing to the development of critical reasoning skills and to increased diagnostic accuracy.

As for limitations, we can highlight the low patient turnover in the sector where the surveying was conducted, generating a relatively reduced number of participants. In addition, the fact that the clinical severity of the studied population results in biases in the clinical assessment leads one to consider the diagnostic survey a subjective process in itself.

PERFIL DOS DIAGNÓSTICOS DE ENFERMAGEM DE PACIENTES INTERNADOS EM UNIDADE DE CLÍNICA MÉDICA

RESUMO

O objetivo foi identificar a frequência dos diagnósticos de enfermagem em clientes hospitalizados em unidade de clínica médica. Tratou-se de um estudo quantitativo do tipo descritivo-exploratório realizado na unidade de clínica médica do Hospital Universitário Regional de Maringá (HURM) com amostra de 25 participantes. Dos 13 domínios descritos pela NANDA-I, todos foram representados por pelo menos um diagnóstico. Foram levantados 530 diagnósticos, com uma média de 21,2 por paciente. Os diagnósticos predominantes foramrisco de infecção (100%), integridade da pele prejudicada (88%), manutenção ineficaz da saúde (76%), deambulação prejudicada (76%), conforto prejudicado (76%), padrões de sexualidade ineficazes (72%), mobilidade física prejudicada (68%), integridade tissular prejudicada (68%), déficit no autocuidado para banho (64%), para higiene íntima (64%), para vestir-se (64%) e mobilidade prejudicadano leito (60%). Esses resultados contribuíram para a identificação das necessidades mais afetadas dos pacientes internados facilitando a elaboração de planos de cuidados de enfermagem mais eficazes.

Palavras-chave: Diagnóstico de enfermagem. Avaliação em enfermagem. Pesquisa em enfermagem clínica.

PERFIL DE LOS DIAGNÓSTICOS DE ENFERMERÍA DE PACIENTES INTERNADOS EN UNIDAD DE CLÍNICA MÉDICA

RESUMEN

El objetivo del estudio fue identificar la frecuencia de los diagnósticos de enfermería en clientes hospitalizados en unidad de clínica médica. Se trató de un estudio cuantitativo del tipo descriptivo-exploratorio realizado en la unidad de clínica médica del Hospital Universitario Regional de Maringá con muestra de 25 participantes. De los 13 dominios descriptos por la NANDA II, todos fueron representados por al menos un diagnóstico. Fueron recopilados 530 diagnósticos, con un promedio de 21,2 por paciente. Los diagnósticos predominantes fueron: Riesgo de infección (100%), Integridad de la piel perjudicada (88%), Mantenimiento inefectivo de la salud (76%), Deambulación perjudicada (76%), Confort perjudicado (76%), Patrones de sexualidad inefectivos (72%), Movilidad física perjudicada (68%), Integridad de la tisular perjudicada (68%), Déficit de autocuidado para baño (64%), para higiene íntima (64%), para vestirse (64%) y Movilidad en la cama perjudicada (60%). Estos resultados contribuyeron para la identificación de las necesidades más afectadas de los pacientes internados, facilitando la elaboración de planificaciones de cuidados de enfermería más eficaces.

Palabras clave: Diagnóstico de enfermería. Evaluación en enfermería. Investigación en enfermería clínica.

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