EXPRESSION OF NURSING RECORDS - RETROSPECTIVE STUDY

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Keywords:

Nursing records, ICNP Terminology, Nursing diagnosis, Focus, Dying process, Deceased patients

Objective:

To analyze which focus/nursing diagnosis are documented by nurses in the process of caring of patients in the dying process in Medicine, Surgery and Intensive Care hospital areas

Introduction:

The documentation of the care provided by nurses does not reflect the intentionality of their practice in the context of death and the process of dying. In addition to the predominance of focus in the field of function, the predominance of records related to the action and scarcity of records related to reason for action may have repercussions on the transition experienced by the patients and deserves reflection. Furthermore, regarding the reason for action, there are focus / nursing diagnosis that would make perfect sense and do not appear documented. Fostering qualified professional help to people during the experience of death and the dying process is extremely relevant and therefore should be visible in clinical records

Method:

A descriptive, retrospective and quantitative study, conducted in 2016, in a central university hospital in the north of Portugal. Data on documentation of focus / diagnosis identified in patients who came to die in that year were collected through two information systems: SClinico and BICU care, structured on the basis of ICNP version B2

References:

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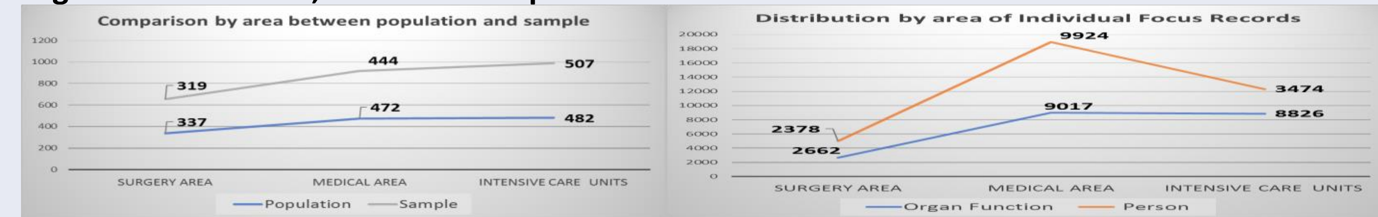
Results and Discuss:

In the study period, there were 2240 deaths, which occurred in the Medical Area (55.7%), in Intensive Care Units (28.1%) and in the Surgery area (16.2%). Associated with these deaths, a total of 36281 diagnosis/focus of nursing care were documented, using the ICNP version β2, by 1270 nurses. These 36281 records were mainly of the category of the Individual and refer to organ function in 56,5% and to the person in 43.5% of the records.



Regarding Function, the most documented diagnosis/focus were: Tegument (60.7%), Breathing (11.1%), Sensations (6.9%) and Motor Activity (6.2%). The predominance of function nursing diagnois was specially high in the Intensive Care Unit (71,8% of all nursing diagnosis). With regard to records relating to the Person, 96.3% are of the category Action (99% of these performed by the patient/selfcare) and only 3,7% of the category. Reason to Action, and this predominance is homogeneous through the different departments. Regarding Interdependent Action, with very small expression in the nursing records, the most represented areas were Social Interaction (45.2%), Interaction of roles (31.8%) and Communication (22.9%).

Conclusion:

The documentation of the care provided by nurses does not reflect the intentionality of their practice in the context of death and the process of dying. In addition to the predominance of focus in the field of function, the predominance of records related to the action and scarcity of records related to reason for action may have repercussions on the transition experienced by the patients and deserves reflection. Furthermore, regarding the reason for action, there are focus / nursing diagnosis that would make perfect sense and do not appear documented. Fostering qualified professional help to people during the experience of death and the dying process is extremely relevant and therefore should be visible in clinical records