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Experience Report

ELABORAÇÃO DE UM INSTRUMENTO DE SISTEMATIZAÇÃO DA ASSISTÊNCIA DE ENFERMAGEM: RELATO DE EXPERIÊNCIA

ELABORATION OF A NURSING ASSISTANCE SYSTEMATIZATION INSTRUMENT: EXPERIENCE REPORT

ELABORACIÓN DE UN INSTRUMENTO DE SISTEMATIZACIÓN DE LA ASISTENCIA DE ENFERMERÍA: RELATO DE EXPERIENCIA

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RESUMO
Objetivo: descrever a experiência do enfermeiro residente de enfermagem cirúrgica na elaboração de um instrumento de sistematização da assistência de enfermagem baseado na teoria das necessidades humanas básicas de Wanda Aguiar Horta. **Métodos:** trata-se de uma pesquisa descritiva, exploratória com abordagem qualitativa, do tipo relato de experiência realizada em hospital púbico. **Resultados:** criação de um instrumento que contempla todas as fases do processo de enfermagem baseado na teoria das necessidades humanas básicas, onde a assistência de enfermagem seria sistematizada e documentada e, assim, arquivada no prontuário do paciente. **Conclusão:** o instrumento elaborado é uma importante estratégia para a organização das ações e operacionalização do processo de enfermagem.
Descritores: Assistência ao paciente; Teoria de enfermagem; Processo de enfermagem.

ABSTRACT
Objective: to describe resident nurse experience of surgical nursing in the elaboration of a nursing assistance systematization instrument based on Wanda Aguiar Horta's basic human needs theory. **Methodology:** This is a descriptive, exploratory research with a qualitative approach, of the type of experience report performed in a public hospital. **Results:** creation of an instrument that contemplates all phases of the nursing process based on basic human needs the theory, where nursing care would be systematized and documented and thus, stored in the patient's chart. **Conclusion**: the instrument developed is an important strategy for the actions organization and the nursing process operationalization.
Descriptors: Patient care; Nursing theory; Nursing process.

RESUMEN
Objetivo: describir la experiencia del enfermero residente de enfermería quirúrgica en la elaboración de un instrumento de sistematización de la asistencia de enfermería basado en la teoría de las necesidades humanas básicas de Wanda Aguiar Horta. **Metodología:** Se trata de una investigación descriptiva exploratoria con enfoque cualitativo, del tipo de informe de experiencia realizado en un hospital público. **Resultados**: creación de un instrumento que contemple todas las fases del proceso de enfermería basado en la teoría de las necesidades humanas básicas, donde la atención de enfermería sería sistematizada y documentada y, por lo tanto, almacenada en el cuadro del paciente. **Conclusión:** el instrumento desarrollado es una estrategia importante para la organización de acciones y operacionalización del proceso de enfermería.
Descriptores: Atención al paciente; Teoría de enfermería; Proceso de enfermería.

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INTRODUCTION

The Systematization of Nursing Care (SNC) is the scientific method of work that provides significant improvement of the quality of care provided to the client through the individualized planning of the actions developed by the nursing professional. The SNC is the Nursing Process (NP) that is developed with the elaboration of five stages: Customer history, nursing diagnoses, action planning, implementation of the proposed care plan and evaluation. With this, SNC is strengthened by the theoretical knowledge of the nurse who will carry out these steps and their commitment to the care to be provided, in order to obtain a comprehensive, continuous and documented vision that enables improvements in the quality of nursing care[1-3].

Resolution 358/2009[4] of the Federal Nursing Council (FNC) provides for the Systematization of Care and the implementation of the Nursing Process in public or private environments, where Nursing professional care takes place and offers other measures. In its article 4, it prescribes the function of the nurse whose leadership, in the execution and evaluation of the Nursing Process, follows the principle of the function.

The whole constitution of the SNC is exclusive to the nurse. The nursing diagnosis can be considered the guiding axis of systematization. It responds by identifying the state of health / illness with a clinical judgment about potential responses of the person, family or community, to health problems, providing a foundation to elaborate the nursing interventions in order to achieve results for which the nurse is responsible[5], which facilitates nursing care.

To better implement, to the SNC the use of a nursing theory is oriented, whose purpose is to describe, explain, diagnose and/or prescribe nursing care, sustaining the quality of care. In this way, the nursing theory points out versions of a reality and offers elements for solutions to problems related to professional doing.

However, nurses have faced difficulties in implementing SNC as a scientific work tool. According to the literature, these difficulties are directly related to precarious working conditions, the insufficient number of employees and the academic training of nurses that does not encourage the valorization of the SNC applicability[6-7].

Thus, this article had the objective of describing the experience of resident nurse of surgical nursing in the elaboration of an instrument of systematization of nursing care (SNC) based on the Basic Human Needs Theory (BHN) of Wanda Aguiar Horta, which was chosen by understanding the relationship between BHNs in which nurses can assess the hierarchy of needs that influence human behavior[8], planning and intervening with actions that can improve and/or re-establish the affected BHN.

METHODS

This is a descriptive research with a qualitative approach, of the related experience type, carried out at a Public Hospital in the city of Macapá-AP, in January 2017. The report was based on the experience of the resident nurse during the Module of Systematization of Nursing Care offered at the Nursing Home, in which the resident developed an instrument for the application of the SNC in the area of the Surgical Clinic of said hospital, from the search for instruments already used in other hospitals.

The surgical clinic was defined as a sector for the elaboration of the study because it is one of the fields of rounds during the residency in surgical nursing. From this point on, there was already previous knowledge of the instrument used in this sector and it was observed, during the SNC discipline, the need to adapt the instrument they used.

The work was divided into four stages. In the first stage, the theory that best suited the proposed work was defined. In the second stage, the medical records were analyzed in order to list the main problems in the nursing prescriptions based on the material already existing in the hospital's surgical clinic, and what would need to be adequate for the elaboration of the instrument was selected. In the third stage, the instrument to be used for the implementation of SNC associated to the main problems previously identified in the prescriptions was elaborated.

In the fourth stage, the instrument was presented to the resident nurses during the above mentioned module, using as a base, instruments used in reference hospitals and adapted to the theory and reality in the place, highlighting the importance of SNC and the proposal to introduce into the routine of the referred clinic to the use of the form.

RESULTS AND DISCUSSION

The elaboration of the instrument for the application of the SNC in the hospital in question

contemplated all phases of the nursing process based on Wanda de Aguiar Horta's Theory of Basic Human Needs, where nursing care would be systematized, documented and thus filed in the patient's medical records.

Resolution FNC 358/2009[4] rules that the SNC must occur in every public and private health institution, being formally registered in the patient/client/user medical record.

Thus, an instrument was constituted of three parts: the first contemplates the Nursing Records and Physical Exam; the second the Nursing Diagnostics; and the third contemplates the Nursing Prescription and Evolution in order to assist the nurse of the surgical clinic in the systematization of their patient care.

The first part of the instrument is the Nursing Records and Physical Examination that consists of: identification, interview, physical examination and important laboratory tests, as shown in Figure 1.

Figure 1 - Nursing Records and Physical Examination.

NURSING RECORDS
I – IDENTIFICATION Name:_____Age: _____ Sex: _____Marital status:_____ Religion: _____ Profession: _____ Place of birth: _____ Origin: _____ Hospitalization date: _____ Register: _____ Sector of origin: _____ Bed: _____ Diagnostic: _____
II – CLINICAL RECORDS Previous hospitalizations: _____ Priors: ( ) SAH ( ) DM ( )Smoking ( ) Alcoholism ( ) Cancer Others: _____ Previous surgeries: ( )No ( ) Yes. Which? _____. Blood transfusion: ( ) Yes ( ) No Pain ( ) Yes ( ) No Location:_____ Intensity: ( ) Light ( ) Moderate ( ) Intense Medication:_____
III – PHYSICAL EXAM
Psychobiological Needs
1.1 Neurological Regulation Conscience: ( )Conscious ( )Oriented ( ) Disoriented ( )Sedated ( )Drowsy Pupils: ( ) Isocoric ( ) Anisocortical ( ) Myoso ( ) Mydriasis Physical mobility: UL ( ) Preserved ( ) Paresis ( )Fold ( ) Paresthesia LL( ) Preserved ( ) Paresis ( )Fold ( ) Paresthesia ( ) Slow movements ( ) Involuntary movements ( ) Convulsive crisis: Speech and language: ( ) Aphonia ( ) Dyslalia ( ) Dysarthria ( ) Dysphasia ( ) Aphasia
Oxygenation Breathing: ( )Spontaneous ( )Catheter ( )Mask ( ) Tracheostomy ( )O_2: _____liters/min FR:_____mpm ( ) Dyspnea ( ) Tachipnea ( ) Bradipnea Pulmonary auscultation: Present MV () Bilaterally () Decreased: Adventitious noises: ( ) Snoring ( ) Wheezes ( ) Estertors Presence of cough: ( ) Unproductive ( ) Productive ( ) Expectoration - Coloring:_____ Thoracic Drainage ( ) Yes ( ) No Time and Characteristics:_____Volume:_____mL
1.3 Cardiovascular Regulation FC: _____ bpm PA: _____mmHg Pulse ( ) Regular ( ) Irregular ( ) Unpalatable ( ) Filiform ( ) Palpable () Full Skin Color: ( ) Flushed ( ) Hypocorated ( ) Cyanosis Presence of edema: ( ) UL ( ) LL ( ) Myxoedema ( ) Anasarca Locker Sign:___
1.4 Thermal Regulation Temperature:_____ ºC ( ) Normothermia ( ) Hypothermia ( ) Hyperthermia
1.5 Perception of Sense Organs Vision: ( )Normal ( )Altered Hearing: ( )Normal ( )Altered Touch: ( ) Normal ( ) Altered Taste: ( ) Normal ( ) Altered Smell: ( ) Normal ( ) Altered
1.6 Hormonal and Electrolytic Regulation Glycemia:_____ Na:_____ K:_____ Ca:_____
1.7 Hydration and Vesical Elimination Skin Turgidity: ( ) Preserved ( ) Decreased Urinary Elimination: Volume: _____ ml / h ( ) Spontaneous ( ) Retention ( ) Incontinence ()VC Characteristics: ( ) Dysuria ( ) Oliguria ( ) Anuria ( ) Polyuria ( ) Hematuria ( ) Other _____
1.8 Food and Intestinal Elimination Weight_____ Kg IMC: _____kg/m^2 ( )Low weight ( ) Normal ( ) Overweight ( ) Obese Appetite ( )Normal ( )Increased ( )Reduced

Route of administration ( ) Oral ( ) SNG / SNE ( ) Parenteral Presence of ( ) Nausea ( ) Vomiting (quantity and characteristic):_____ Abdomen ( ) Flat () Globose ( ) Distended ( ) Painful to palpation ( ) Other RHA ( ) Present ( ) Absent ( ) Decreased ( ) Increased Intestinal elimination ( ) Normal ( ) Constipation ( ) Diarrhea ( ) Incontinence ( ) Others:_____
1.9 Cutaneous-mucous integrity Skin ( ) Normal ( ) Cyanosis ( ) Jaundice ( ) Paleness ( ) Pruritus ( ) Petechiae ( ) Echidia ( ) Bruising Eyes: ( ) Jaundice ( ) Edema of conjunctiva ( ) Others:_____
1.10 Therapy Venous network Catheter: ( ) Peripheral puncture ( ) Jugular ( ) Subclavian ( ) Double lumen ( ) Other:_____ Lenght of stay:_____ Location characteristics:_____ Drain ( )Yes ( )No Location:_____Characteristics:_____
1.11 Physical Security Need for containment in bed ( ) Yes ( ) No Isolation ( ) Yes ( ) No
PSYCHOSOCIAL NEEDS **2.1 Gregarious and Emotional Security** Need for a companion ( ) Yes ( ) No ( ) Anxiety ( ) Fear ( ) Applicant ( ) Others:_____
PSYCHOSPIRITUAL NEEDS ( ) Practitioner ( ) Non-practitioner ( ) Need for spiritual help
RELEVANT LABORATORY EXAMS _____

The physical examination of the instrument is subsidized in the BHNs that the Wanda Aguiar Horta's Theory shows, whose objective is to identify the possible BHN affected in the patient.

Nursing records, also known as data collection and investigation, are a systematized data collection route in which it is possible to identify possible problems, that is, it is the investigation of the patient's conditions, with the purpose of knowing the individual and biopsychosocial habits, in order to identify real and/or potential problems[9].

Accurate and reliable data collection is essential for the identification of the patient's actual or potential problems, through which inferences can be made for subsidies, identification of nursing diagnoses, and the direction of the other stages of the nursing process[10].

The nursing diagnosis is considered the most complex stage of the nursing process, being an important challenge for nurses because it requires critical thinking and technical-scientific knowledge to interpret the data obtained in the physical examination and the information collected during the anamnesis[11].

Thus, the second part of the instrument is the Nursing Diagnoses that were elaborated according to the BHN Theory, according to Figure 2.

Figure 2 - Nursing diagnosis, according to BHN Theory.

NURSING DIAGNOSIS
Name:_____ Clinic:_____ Bed:_____
1 PSYCHOBIOLOGICAL NEEDS
1.1 - NEUROLOGICAL REGULATION 1 - Change in Thought Process ( ) 2 - Memory impaired ( ) 3 - Acute confusion ( ) 4 - Unilateral negligence ( )
1.2 - PERCEPTION OF THE SENSE ORGANS 1 - Sensory perceptual alterations: visual, auditory, kinesthetic, olfactory, gustatory, tactile ( ) 2 - Pain ( )
1.3 - OXYGENATION 1 - Ineffective respiratory pattern ( ) 2 - Impaired gas exchange ( ) 3 - Inability to maintain spontaneous breathing ( )
1.4 - VASCULAR REGULATION 1 - Cardiac output decreased ( ) or Risk for ( ) 2 - Alteration in tissue perfusion ( )

3 - Risk for peripheral neurovascular dysfunction ( )
1.5 - THERMAL REGULATION 1 - Risk for change in body temperature ( ) 2 - Hypothermia ( ) 3 - Hyperthermia ( )
1.6 - HYDRATION 1 - Excess volume of liquids ( ) 2 - Deficit in volume of liquids ( ) or Risk for ( ) 3 - Risk for imbalance of body fluids ( )
1.7 - FEEDING 1 - Impaired swallowing ( ) 2 - Change in nutrition: _____ of what the body needs ( ) 3 - Nausea ( )
1.8 - ELIMINATION 1 - Constipation ( ) 2 - Intestinal incontinence ( ) 3 - Diarrhea ( )
1.9 - PHYSICAL INTEGRITY 1 - Impaired skin integrity ( ) 2 - Or Risk for Pressure Injury ( ) 3 - Impaired tissue integrity ( ) 4 - Alteration in oral mucosa ( )
1.10 - SLEEP AND REST 1 - Sleep pattern disorder ( ) 2 - Deprivation of sleep ( ) 3 - Fatigue ( )
1.11 - PHYSICAL ACTIVITY 1 - Impaired physical mobility ( ) 2 - Intolerance to activity ( ) 3 - Impaired walking ( ) 4 - Impaired mobility in bed ( ) 5 - Delayed surgical recovery ( )
1.12 - BODY CARE 1 - Deficit in self-care ( )
1.13 - PHYSICAL / ENVIRONMENTAL SAFETY 1 - Changed protection ( ) 2 - Risk for infection ( ) 3 - Risk for injury ( ) 4 - Risk for trauma ( ) 5 - Stress syndrome due to change ( ) 6 - Ineffective control of the therapeutic regimen ( )
2 PSYCHOSOCIAL NEEDS 2.1 - COMMUNICATION 1 – Impaired communication ( )
2.2 GREGARIOUS 1 - Impaired social interaction ( ) 2 - Social isolation ( ) 3 - Risk for solitude ( )
3.2 - EMOTIONAL SAFETY 1 - Anxiety ( ) 2 - Fear ( ) 3 - Impotence ( ) 4 - Ineffective denial ( ) 5 - Post-traumatic syndrome ( )
3.3 - LOVE, ACCEPTANCE 1 - Altered family processes ( ) 2 - Feeling of regret ( )
3.4 - SELF-ESTEEM, SELF-CONFIDENCE, SELF-RESPECT 1 - Self-esteem Disorder ( ) 2 - Body Image Disorder ( )
3.5 - FREEDOM AND PARTICIPATION 1 - Conflict of Decision ( ) 2 - Ineffective confrontation ( ) 3 - Defensive confrontation ( )

3.6 EDUCATION FOR HEALTH / LEARNING 1 - Impaired Adjustment () 2 - Lack of knowledge ()
3.7 - SELF REALIZATION 1 - Change in role performance ()
4 - PSYCHOSPIRITAL NEEDS 3.1 – SPIRITUALITY 1 - Spiritual suffering () 2 - Risk for Spiritual Suffering

Nursing diagnoses include BHNs according to their division into: Psychobiological Needs, Psychosocial Needs and Psychospiritual Needs, being that psychobiological needs add oxygenation, hydration, elimination, sleep and rest, nutrition, physical activities, motility, sexuality, body care, skin and mucosal integrity and physical, thermal regulation, neurological, hydroelectrolytic, vascular, perception of sense organs, environment, therapeutics and locomotion.

Psychosocial needs encompass security, love and acceptance, freedom and participation, communication, health education, gregariousness, self-esteem, self-image and emotional security. Psycho-spiritual needs include religious, ethical, and life philosophy[11-12]. Thus, the instrument encompasses practically all the BHN that can be affected, providing subsidies for the professional nurse to draw the plan of care for the patient[3].

The instrument was designed in this way to facilitate the identification of nursing diagnoses according to the affected BHN that the patient can present, since the theory works as a structural foundation for the implantation of SNC, which requires a methodology to be implemented[12]. And, it should be emphasized that the nursing problems found in the BHN theory are related to the defining characteristics and related NANDA factors (*North American Nursing Diagnosis Association*)[11].

Thus, the nurse, based on the data collected in the nursing history and physical examination, should identify the affected nursing and BHN problems and make a clinical judgment about the responses of the individual, family and community to the current or potential life problems/processes[9].

Based on the problems and nursing diagnoses, the nurse must elaborate the prescription of care that is implemented by the nursing team, offering the assistance that the patient needs[11].

In this way, the third part of the instrument contemplates Nursing Prescription and nursing evolution, according to Figure 3.

Figure 3 - Nursing prescription and nursing evolution.

NURSING PRESCRIPTION		
Name:_____ Clinic:_____ Bed:_____		
PRESCRIPTION	REQUIREMENTS	RESPONSIBLE

NURSING EVOLUTION	
DATE/TIME	

The nursing prescriptions are measures for the solution of the identified nursing diagnoses, registered previously by the nurse from the analysis of the nursing history and physical examination. They should be constantly evaluated in order to know if they are being

positive to respond to the nursing diagnoses and the recovery and maintenance or not of the affected BHNs. If not, it is the responsibility of the nurse to reassess their conduct, to make a new prescription, since the nursing prescriptions are deliberate measures by this professional, who directs and coordinates the nursing care to the patient in an individualized and continuous way, aiming towards prevention, promotion, protection, recovery and maintenance of health[9-12].

The nursing evolution allows the nurse to evaluate the results of subsidized care in nursing prescription, including, excluding or modifying the interventions, according to the patient's responses to the care provided. Every 24 hours, the evolution should be updated, assessing whether the problems were resolved or not, if new problems appeared or were modified with nursing care[10-11].

Summarizing, the instrument developed for the SNC is composed of three sequenced parts, in which the second and third parts make up a daily chart, and every 24 hours an evolution must be performed in order to analyze if the nursing problems were or were not healed. It should be emphasized that the implementation of this instrument in the nursing routine of the surgical clinic is a great challenge because there are some limitations that, however, can be overcome with the labor and administrative organization.

After the elaboration and discussion of the instrument in question, it is important to emphasize the importance of this instrument for the practice of nurses during their assistance to the patient, since the hospital for which this instrument was elaborated does not rely on SNC in its daily care. In this sense, the instrument will make it possible to implement the systematization of nursing care in the hospital's surgical clinic, promoting a new routine regarding the use of the form, offering subsidies on the quality of nursing care, and strengthening and valuing the nursing team's behaviors and evaluation and evolution of the patient by the nurse.

Thus, this instrument seeks to improve the Systematization of Nursing Care in the referred hospital, since it contemplates all phases of systematization, facilitating its implementation in the clinic because it is a self-explanatory instrument of SNC. In this way, elaborating and discussing the instrument during the module, as an evaluation method, was of great relevance for the professional improvement, since the opportunity to present an instrument already used in other hospitals and to adapt it to the local reality was rewarding and could subsidize the nursing team, allowing the evaluation and daily evolution of the patient.

CONCLUSION

The instrument developed is an important strategy for the organization of actions and operationalization of the nursing process, as they standardize the records and legally support the nursing actions, in addition to allowing the continuity of care planning.

For the hospital, this instrument, if implanted, will bring a huge gain to nursing, because the SNC is not yet routinely used by the team. Thus, the instrument will help in the organization of work and provide a systematic care to the patient, promoting the autonomy of the nurse and unifying the language with the team.

Thus, the contribution of this related experience was to elaborate the instrument as it appears in the work in order to collaborate significantly with the nursing team in its systematization of patient care, emphasizing the need to continuously expand and deepen the specific knowledge of its area of action, without forgetting the interdisciplinary approach and patient care.

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