Nursing diagnoses identified in records of hospitalized elderly

Diego Dias de Araújo[1]
Rafael Lima Rodrigues de Carvalho[2]
Tânia Couto Machado Chianca[3]

1 RN, Master's student. Universidade Federal de Minas Gerais –UFMG-, Belo Horizonte/MG, Brazil.
email: diego.dias1508 @ gmail.com
2 RN, Master's student. UFMG, Belo Horizonte/MG, Brazil.
email: rafaelsjdr@hotmail.com
3 RN, Ph.D. Professor, UFMG-, Belo Horizonte/MG, Brazil.
email: taniachianca@gmail.com

Nursing diagnoses identified in records of hospitalized elderly

Objective. To identify nursing diagnoses (ND) formulated for elderly patients in a quaternary healthcare institution. **Methodology**. This was a descriptive cross-sectional study, conducted based on information contained in the records of 112 elderly patients, admitted from January to July 2011, in a public teaching hospital of Belo Horizonte, Minas Gerais (Brazil). **Results**. 53% of patients were female and were 70 years or older. The most common diseases that led to hospitalization were cardiac (31%), neoplasms (22%), lung (10%) and vascular diseases (10%). Only 44% of the patients had a ND identified. After exclusion of repetitions, 36 different diagnosis labels were identified. The primary ND were: risk for infection (78%), impaired physical mobility (69%), risk for impaired skin integrity (59%), risk for falls (57%), imbalanced nutrition: less than body requirements (57%), risk for unstable blood glucose (51%) and self-care deficit (51%). **Conclusion**. In this study, the ND were linked to human responses related to the causes of hospitalization. These diagnoses are the basis for planning nursing interventions and provide improved quality of life, independence and preservation of functionality for these people.

Key words: nursing diagnoses; geriatric nursing; aged; hospitalization.

Diagnósticos de enfermería identificados en las historias clínicas de los ancianos hospitalizados

Objetivo. Identificar los Diagnósticos de Enfermería (DE) en las historias clínicas de los ancianos internados en una institución de salud de cuarto grado de complejidad. **Metodología.** Estudio descriptivo de tipo transversal realizado a partir de la información consignada en las historias clínicas de 112 pacientes ancianos internados en un hospital universitario de carácter público de Belo Horizonte, Minas Gerais (Brasil), en el período de enero a julio de 2011. **Resultados.** El 53% de los pacientes pertenecía al sexo femenino, 53% tenía 70 años o más; las enfermedades más frecuentes que motivaron la hospitalización fueron: cardíacas

Diego Dias de Araújo • Rafael Lima Rodrigues de Carvalho • Tânia Couto Machado Chianca

(31%), neoplasias (22%), pulmonares (10%) y vasculares (10%). Tan solo en el 44% de los pacientes de la muestra se hizo DE. Después de excluir las repeticiones, se identificaron 36 diferentes títulos diagnósticos, siendo los principales: riesgo de infección (78%), deterioro de la movilidad física (69%), riesgo de deterioro de la integridad de la piel (59%), riesgo de caídas (57%), desequilibrio nutricional: ingesta menor a las necesidades (57%), riesgo de glicemia inestable (51%) y déficit de autocuidado (51%). **Conclusión**. Los DE encontrados en este estudio están de acuerdo con las enfermedades que motivaron la hospitalización de los pacientes participantes en la investigación. Estos diagnósticos son la base para la planeación de las intervenciones de enfermería que conducen al mejoramiento de la calidad de vida, la independencia y la preservación de la funcionalidad de estas personas.

Palabras clave: diagnóstico de enfermería; enfermería geriátrica; anciano; hospitalización.

Diagnósticos de enfermagem identificados nas histórias clínicas dos anciãos hospitalizados

Objetivo. Identificar os Diagnósticos de Enfermagem (DE) formulados aos anciãos internados numa instituição de saúde de quarto grau de complexidade. **Metodologia**. Estudo descritivo de tipo transversal realizado a partir da informação consignada nas histórias clínicas de 112 pacientes anciãos internados no período de janeiro a julho de 2011 num hospital universitário de caráter público de Belo Horizonte, Minas Gerais (Brasil). **Resultados**. 53% dos pacientes foram de sexo feminino, 53% tinha 70 e mais anos e as doenças mais frequentes que motivaram a hospitalização foram: cardíacas (31%), neoplasias (22%), pulmonares (10%) e vasculares (10%). Tão só em 44% dos pacientes da mostra se fizeram DE. Depois de excluir as repetições se identificaram 36 diferentes títulos diagnósticos, sendo os principais: risco de infecção (78%), deterioração da mobilidade física (69%), risco de deterioração da integridade da pele (59%), risco de quedas (57%), desequilíbrio nutricional: ingesta menor às necessidades (57%), risco de glicemia instável (51%) e déficit de autocuidado (51%). **Conclusão**. Os DE encontrados neste estudo estão de acordo com as doenças que motivaram a hospitalização dos pacientes da investigação. Estes diagnósticos são a base para o planejamento das intervenções de enfermagem que conduzem ao melhoramento da qualidade de vida, a independência e a preservação da funcionalidade destas pessoas.

Palavras chave: diagnóstico de enfermagem; enfermagem geriátrica; idoso; hospitalização.

Introduction

The cycle of life is a continuous and permanent process of aging, in which old age is the last part of the natural evolution of life and is characterized by a number of changes and biological, economic, political and social parameters that compose the everyday life of people living this phase.[1] In 1985, the United Nations (UN) established the age of $\geq$65 years of age to define the elderly in developed countries. However, for developing countries where life expectancy is lower, the age of $\geq$60 years was defined, as is the case of Brazil.[2]

The population dynamics in recent decades brings into evidence the changes with regard to the aging process through which the population has passed. This process has occurred gradually, however, in each analysis an increasing participation of the elderly population contingent involved can be noted, which becomes an issue of concern, as the country has not experienced social, economic, and political reforms in health to meet these new demands.[3] One of the results of this dynamic is the greater demand for health services by the elderly. Hospitalizations are more frequent and the length of hospital stay is higher when compared to people in other age groups. Thus, population aging may be accompanied by a greater disease burden in the population, more disability and increased use of health services.[4]

Nursing stands as a profession committed to the care of the human being in the whole process of living and dying, including old age. With the increased demand for care in this phase, nursing has a fundamental role. One of the ways to provide quality and organized care to the hospitalized elderly is to use systematized nursing care.[5] Systematized care requires the use of a scientific method and has being increasingly implemented in healthcare practice. It can collaborate in providing greater safety to patients, improve the quality of care and provide greater autonomy to the nurses.[6] In Brazil, the Federal Council of Nursing has regulated, through Resolution No.358/2009, the Systematization of Nursing Care (SNC) that requires the use of nursing process. This must be implemented in all public and private health institutions within Brazil. It consists of the following steps: data collection, nursing diagnosis (ND), planning, implementation and nursing evaluation.[7] In the development of these steps, the nursing classifications can be used, both to designate diagnoses as well as to propose nursing interventions and outcomes.

NANDA International (NANDA-I) is now a language known worldwide and has been consolidated as a reference for the classification of ND. Nursing diagnoses are clinical judgments derived from interpretations of data collected during the nursing consultation. They constitute the synthesis of clinical reasoning and are essential in guiding nursing planning, implementation of interventions, and evaluation of the care provided.[8]

The formulation of ND provides several benefits for patient care: better planning and greater consistency in care, enhanced communication among nurses and professionals of the healthcare team, and between nurses and patients, as well as a greater recognition of the phenomena that nurses consider essential in care. From the point of view of the organization, the ND may collaborate in a greater clinical and risk control, showing a relationship between theory, education and clinical practice implemented by the nurse - in other words, it collaborates with evidence-based nursing.[8] This study aimed to identify the

ND identified for elderly patients hospitalized in a public teaching hospital of Belo Horizonte, Minas Gerais, in the period of January-July of 2011, in order to know the outcome of the clinical judgment that nurses established when confronted with the problems that the elderly, attended to by them, presented. The proposed study was justified because the adherence and implementation of SNC in the institution is currently a legally established and important method. Moreover, when the ND are identified, quality care for the elderly clients can be planned and it can be encouraged that data concerning the implementation of steps of the nursing process by nurses of that institution are obtained.

Methodology

This was a descriptive, cross-sectional study, conducted through research within the medical records of patients admitted from January to July of 2011, in the functional unit of a public teaching hospital of Belo Horizonte, Minas Gerais. The hospital in question had 501 beds, and was classified as general and large scale. Activities of teaching, research and care were performed there, and it was a municipal and state reference of health for care of patients with diseases of medium and high complexity. The hospital was integrated into the *Sistema Único de Saúde* (Unified Health System - SUS) and serves a universal customer, where 100% of the patients are from SUS, and approximately 40% of the total come from the interior of the state.

In this hospital, since February of 2008, a model of nursing care has been implemented called System of Nursing Care (SNC). In the sector where this research was conducted, the SNC was implemented beginning in June of 2009.

The inclusion criteria for the study of the records included: $\geq$60 years of age, hospitalized in the study sector in the period from January to July of 2011; availability of the records for data collection from May to June of 2012; and having a register

of NDs made by nurses in the medical record. The number of elderly patients hospitalized in the unit during the period of January-July of 2011 was 153 patients. However, among these only 112 records were available for consultation during the period of data collection. Thus, 41 records were not involved in the study because they did not meet the inclusion criteria established for the study. Despite the implementation of the steps of the nursing process in the institution, only 49 of the 112 records contained the nursing diagnoses identified by nurses. These were selected for analysis in the study.

The search for the data in the medical records was performed by one of the investigators. An instrument was used that was specifically designed for documentation of information about: sex, age, marital status, skin color, location of origin, comorbidities, medical diagnosis, and nursing diagnoses labels using the NANDA-I taxonomy,[8] identified on patient admission to the unit. Thereafter, data were inputted into an electronic spreadsheet using Microsoft Excel 2007 and exported into the Statistical Package for Social Science (SPSS), version 20.0. Descriptive analysis (simple frequencies and percentages) was conducted to obtain the frequency of the nursing diagnoses in order to obtain a nursing diagnosis profile (ND labels identified for more than 50% of the patients) among elderly inpatients on that unit. The ND labels were presented according to the NANDA-I domains,[8] to favor the identification of areas of care for the elderly.

The study conformed to Resolution No. 196/96 which provides for research with human subjects. The project was submitted to the Comitê de Ética e Pesquisa (Committee on Ethics in Research - COEP) of the Universidade Federal de Minas Gerais and obtained a favorable opinion, with the CAAE protocol number - 0550.0.203.000-11.

Results

Of the 49 medical records of elderly patients studied, 53.1% were of individuals who were female and 46.9% were male. The age ranged between 60 and 99 years, with a mean of 72.26 years and a standard deviation of 9.51. The majority were married (51%), had white (49%) or brown (36.7%) skin, and were from Belo Horizonte (59.2%). The comorbidities with higher prevalence among patients were: cardiac disease, in 83.7%; metabolic disease, in 44.9%; and pulmonary disease, with 18.4%. The primary medical diagnoses identified in individuals on admission to the unit were categorized into cardiac disease (28.6%), cancer (22.4%), and pulmonary disease (16.3%) (Table 1).

NANDA-I (2010) presents 216 ND distributed in 13 domains of human responses. For the 49 records analyzed, nurses established 470 ND. After exclusion of repetitions identified, 36 different diagnoses labels were identified. It is observed that fourteen diagnosis labels (38.9%) referred to risk ND, and 22 (61.1%) to actual ND. The most frequent ND (present in over of 50% of the patients) were: risk for infection (77.6%), impaired physical mobility (69.4%), risk of impaired skin integrity (59.2%), risk for falls (57.1%), imbalanced nutrition: less than body requirements (57.1%), risk for unstable blood glucose level (51.0%), and self-care deficit (51.0%) (Table 2).

Discussion

The data revealed that there was a greater distribution of female patients (53.1%) compared to males (46.9%). The Demographic Census of 2010[9] showed, for the total population in the country, a ratio of 96 men for every 100 women. Thus, it was found that the historical trend of female predominance in the sex composition of the population of Brazil has been accentuated, as in 2000 this indicator was 96.9 males for every 100 women.[9] Moreover, female life expectancy is higher than that for males (77 years and 69 years, respectively), which makes women more vulnerable to the onset of noncommunicable chronic diseases, among others, with a consequent increase in hospitalizations.[10]

Table 1. Profile of the 49 elderly patients ($\geq$60 years of age) admitted to the unit in a public teaching hospital of Belo Horizonte - MG, January to July of 2011

Characteristics	n	%
Sex		
Male	23	46.9
Female	26	53.1
Age range (years)		
60–69	23	46.9
70–79	13	26.5
80–89	12	24.5
90– 99	1	2.0
Marital status		
Single	5	10.2
Married	25	51.0
Widowed	21	28.6
Legally separated	5	10.2
Skin color		
White	24	49.0
Mixed race	18	36.7
Black	7	14.3
Hometown		
Belo Horizonte	29	59.2
Other localities	20	40.8
Comorbities		
Cardiac disease	41	83.7
Metabolic disease	22	44.9
Pulmonary disease	9	18.4
Neurologic disease	7	14.3
Renal disease	3	6.1
Others	20	17.9
Medical diagnosis identified on admission to the unit		
Heart disease	14	28.6
Neoplasia	11	22.4
Pulmonary disease	8	16.3
Vascular disease	4	8.2
Pneumonia	3	6.1
Infectious disease	2	4.1
Others	7	14.3

Table 2. Distribution of nursing diagnosis, identified for 49 elderly patients, hospitalized in a unit of a public teaching hospital of Belo Horizonte - MG, January to July of 2011

Nursing diagnosis labels	n	%
Domain 1 Health promotion		
Ineffective family therapeutic regimen management	11	22.4
Domain 2 Nutrition		
Imbalanced nutrition: less than body requirements	28	57.1
Risk for unstable blood glucose level	25	51
Risk for electrolyte imbalance	15	30.6
Risk for imbalanced fluid volume	12	24.5
Risk for impaired liver function	5	10.2
Domain 3 – Elimination and Exchange		
Urinary retention	7	14.3
Risk for constipation	6	12.2
Impaired gas exchange	4	8.2
Domain 4 – Activity/rest		
Impaired physical mobility	34	69.4
Self-care deficit	25	51.0
Ineffective peripheral tissue perfusion	18	36.7
Risk for bleeding	17	34.7
Decreased cardiac output	13	26.5
Insomnia	13	26.5
Ineffective peripheral tissue perfusion	7	14.3
Risk for ineffective renal perfusion	6	12.2
Disturbed sleep pattern	6	12.2
Impaired spontaneous ventilation	4	8.2
Ineffective brathing pattern	4	8.2
Domain 5 – Perception / cognition		
Acute confusion	11	22.4
Deficient knowledge	10	20.4
Domain 9 – Coping/ stress tolerance		
Anxiety	15	30.6
Domain 11 – Safety / protection		
Risk for infection	38	77.6
Risk for impaired skin integrity	29	59.2
Risk for falls	28	57.1
Impaired skin integrity	11	22.4
Impaired tissue integrity	11	22.4
Risk for aspiration	11	22.4
Risk for vascular trauma	8	16.3
Impaired oral mucous membrane	8	16.3
Risk for imbalanced body temperature	3	6.1
Ineffective airway clearance	2	4.1
Hyperthermia	1	2.0
Domain 12 – Comfort		
Acute pain	16	32.7

Consequent alterations to the physiological process are inevitable in the elderly. It can be said that aging without chronic disease is an exception. As people get older, the chances of developing chronic disease are greater. And these have become a public health problem worldwide. Among the major chronic diseases, cardiovascular, metabolic and respiratory are emphasized.[10]

The SNC is an assistance model that aims to organize the nursing care based on the adoption of a systematic method, provided to the nurse to directly assist the patient, family and community and to obtain health indicators from the records performed.[6] With the SNC it is assumed that the nursing process is implemented and this provides the basis of care that prioritizes individualized care. However, professionals face difficulties in its implementation.[11,12] Among the 112 medical records analyzed, the nurses identified ND for only 43.8% of the patients. Some reasons for not applying the steps of the nursing process in some institutions have been described by scholars and include: lack of time, theoretical knowledge, practical exercise, resources, limitation of the patient to provide information, few employees in the unit, and the lack of organization of spaces for discussion of the theme after graduation.[11,12]

Regarding the profile of the identified nursing diagnoses, it was observed that 38.9% were diagnoses of risk and 61.1% were of actual ND. This diagnostic profile is relevant, as in planning nursing care should the initial care to actual diagnoses must be prioritized, which are the human responses to health conditions demonstrated by the person. Risks must be identified and interventions implemented. In this perspective, the planning of nursing care must be done in order to control the risk, with the purpose of preserving safety.[13-16] The nurses identified the ND for patients regarding the majority of the NANDA-I domains. However no ND were identified by any nurse for patients in the following domains of human responses: Domain 6 - Self-perception, Domain 7 - Role Relationships, Domain 8 – Sexuality, and Domain 10 – Life Principles.

Similar to other studies,[15,16] the safety/protection domain was highlighted by the high frequency of ND presented by the studied population. The safety/protection domain refers to the individual being free from danger, injury, or damage to the immune system; conservation and protection against loss; security and free of danger.[8] This domain has peculiar expressions in the elderly population, since the elderly are more vulnerable to damage and/or physical and immunological injury due to the physiological process of aging itself. These may be aggravated and anticipated in the presence of multiple chronic degenerative diseases.[17] The safety and protection of these patients should be guaranteed and monitored by the nursing staff in order to confer quality in the care that is provided.

The ND identified in more than 50% of the patients were those that normally resulted from common physiological changes of the aging process, such as changes in the immune system, integumentary system, metabolic, body composition and musculoskeletal weakness. They were: risk for infection (77.6%), impaired physical mobility (69.4%), risk for impaired skin integrity (59.2%), risk for falls (57.1%), imbalanced nutrition: less than body requirements (57.1%) risk for unstable blood glucose (51%) and self-care deficit (51%). The ND encountered in this study are corroborated by other studies,[13-16] but the distribution of their frequencies is not the same in comparative terms. The *risk for infection* diagnosis is defined as the individual being at risk for being invaded by pathogenic organisms.[8] This diagnosis is also identified in patients in other studies.[13,14,16,17] Of the physiologic alterations of aging, immunosenescence is the designation for alterations from aging that occur in the immune system. It can be derived from immunoglobulin production, T lymphocytes, CD4+ cells, reduction in bactericidal neutrophils due to decrease of macro and micronutrient availability, as for example, copper, proteins, zinc, selenium, and vitamins A and D, predisposing the elderly to disease.[18] Hospitalization itself predisposes the individual to cross infections and exposes the elderly to invasive procedures such as catheterization,

venous puncture, diagnostic examinations such as endoscopy and colonoscopy. In these situations, the risk of acquiring infection is increased.[13]

Of the 49 patients, 34 (69,4%) had the diagnosis of *impaired physical mobility*, defined as limitation in independent, purposeful physical movement of the body or of one or more extremities.[8] In relation to encountered studies,[13-15] the diagnosis of *impaired physical mobility* was also identified in the evaluated patients. Among the possible causes for the problem of the loss of muscle mass, decreased strength, maximum heart rate, exercise tolerance and aerobic capacity, as well as increased body fat, pain and changes in neuromuscular functions stood out.[19] This inability may vary between individuals in similar conditions, and in the same individual at different times. The physical limitation may be a contributing factor to a series of health problems.[20]

In a considerable number of patients (59.2%) the diagnosis of *risk for impaired skin integrity* was identified, defined as at risk for alteration in epidermis and/or dermis.[8] Supported by a study[15] conducted in 196 elderly patients, the diagnosis of *risk for impaired skin integrity* was the one most identified. The skin of the elderly tends to become dry due to: the decrease in the number of sebaceous and sudoriparous glands; changes in elastic fibers, of the conjunctive collagen; wrinkling and decreased turgor and tone increase the risk of laceration due to the lowered ability of the skin to act as a barrier against external factors. Vascular irrigation decreases as capillary fragility increases. The dermic mass and subcutaneous interface became flattened and the skin is thinner, exposing the elderly to a greater risk for injuries and skin diseases.[18] In addition to the physiological changes resulting from the process of aging, external factors related to hospitalization may contribute to the increased frequency of this diagnosis, such as mechanical factors, physical restraint, humidity, unbalanced nutritional status, medications and boney prominences.[8]

The diagnosis, *risk for falls*, is defined as an individual being at risk for increased susceptibility to falling that may cause physical harm.[8] In other studies[15,16] this diagnosis was also identified in the studied patients. The occurrence of falls is one of the major health problems faced by the elderly population; the physiological changes associated with advanced age may cause functional limitations, making the elderly more prone to falls.[20] Among these changes have been cited: walking slowly and with short steps, postural instability and low physical fitness, cognitive changes, elderly over 80 years of age, and the presence of disease (neurological and musculoskeletal diseases). Thus, it can be stated that several factors are involved in this event,[18,21-23] and that they deserve identification, intervention and monitoring. Therefore, this constitutes a major challenge for the health care team.

Nutrition is essential for the promotion, maintenance and/or restoration of health. With aging, people may lose interest in ingesting meals. Meanwhile, physiological changes can affect various organs and systems with consequent damage to their functions. The reduction of gastric secretions resulting from sensory changes promotes hypochlorhydria; reduction of exogenous and/or endocrine pancreatic secretion that interferes with food absorption. A consequent decrease in intestinal motility also occurs with lower water intake, reduction of muscle tone and elasticity, and lower calorie and fiber intake in the diet.[18] *Imbalanced nutrition: less that body requirements* is defined by NANDA-I as the intake of nutrients insufficient to meet metabolic needs.[8] This diagnosis was also identified for the elderly in other studies.[13-14] The identification of a nutritional pattern that is inadequate for the needs of patients during hospitalization is an aspect that should be assessed by the nursing staff so that early monitoring strategies and monitoring of the food intake are initiated for these most vulnerable patients.[14]

The diagnosis, *risk of unstable blood glucose*, is defined as at risks for variation of blood glucose/sugar levels from the normal range that may compromise health.[8] Diabetes mellitus is a common disease with increased incidence

with advancing age.[22] This disease has a high morbidity and mortality, with a significant loss in quality of life. It is a major cause of mortality, renal failure, lower limb amputation, blindness and cardiovascular disease.[22] In a study[14] conducted with hospitalized elderly, although 18.9% of the researched patients presented diabetes mellitus as one of the major comorbidities, the ND *risk of unstable blood glucose* did not appear as one of the most common in that population. The fact was also confirmed in other studies,[13,15-16] which corroborated the results found here. Probably it is a reflection of the peculiarity of the high prevalence of metabolic diseases (31.3%) in the population studied here, in that diabetes mellitus is a clinical problem presented by most patients (80%). The risk factors related to the risk of unstable blood glucose were: lack of / deficient control of the diabetes, lack of adherence to diabetes management plan, physical and mental health status, medication management, physical activity level, dietary intake, and inadequate blood glucose monitoring.[8]

Self-care deficits are defined as impaired ability to perform or complete feeding, bathing, toileting, or dressing activities for oneself.[8] It is noteworthy that the diagnosis of self-care deficit was incompletely identified in this study. Like some studies,[14-16] it should have been mentioned by the nurses to which deficit they referred (if related to feeding, dressing, bathing and/or toileting hygiene), because it assumes that appropriate and differentiated interventions would have been planned. Some risk factors that contributed to functional decline in hospitalized elderly with consequent dependence for the performance of activities of daily living (ADLs) (eating, bathing/hygiene, toileting, and/or dressing) are: advanced age, multiple comorbidities, severity of clinical condition, nutritional status, depression, delirium, cognitive and physical impairment (falls, reduction in mobility), environmental factors (lack of adaptations), previous functional and iatrogenic disability.[24] The biggest challenge in the care of the elderly person is to contribute to a greater autonomy and independence during the aging process.[22,25]

This study made it possible to identify the most frequent diagnoses labels in hospitalized elderly patients in a functional unit of a public teaching hospital, where a system of nursing care was operationalized with the nursing process. It was observed that all of the patients hospitalized in the study period did not have, in their records, the recorded steps of the nursing process, especially data collection, nursing diagnoses and the nursing prescription.

Conclusion

Despite the implementation of the steps of the nursing process in the institution, which were initiated in the unit where this study was conducted, less than half of the records analyzed contained the nursing diagnoses identified by nurses. This finding indicates the necessity for further research to seek the causes of non-identification of the ND for all hospitalized patients assisted by nurses, an activity legally established by professional bodies and instituted in the hospital studied since 2008. The realization of the nursing process helps nurses in the effectiveness of planning care, with improvement in care practice, obtaining greater professional autonomy. The ND is the basis for the planning of nursing actions. These actions should be appropriate to help individuals to achieve maximum quality of life, independence and preservation of functionality, which can contribute to nursing care of the highest quality to elderly clients.

It was considered that the objective for this study was achieved. It was observed that not every elderly patient cared for by nursing, in the study institution, had his health data and NDs documented. It can be inferred that the adherence of nurses to the nursing care model adopted is still not satisfactory. It is suggested that the managers of the institution must work on the factors that hinder the process, in order to better promote and consolidate the SNC at the hospital in question. It is suggested that studies must be conducted aiming toward clinical validation of ND and nursing interventions in this patient population.

References

1. Silva CSO, Pereira MI, Yoshitome AY, Neto JFR, Barbosa DA. Avaliação do uso de medicamentos pela população idosa em Montes Claros, Minas Gerais, Brasil. Esc Anna Nery. 2010; 14(4):811–18.

2. Ministério da Saúde (BR). Lei n° 10.741: dispõe sobre o Estatuto do Idoso e dá outras providências. (Oct 1st 2003).

3. Araújo DD, Azevedo RS, Chianca TCM. Perfil demográfico da população idosa de Montes Claros, Minas Gerais e Brasil. R Enferm Cent O Min. 2011; 1(4):462-69.

4. Veras R. Envelhecimento populacional contemporâneo: demandas, desafios e inovações. Rev Saúde Pública. 2009; 43(3):548-54.

5. Lopes FL, Tier CG, Lunardi-Filho W, Santos SSC. Diagnósticos de enfermagem de idosos residentes em uma instituição de longa permanência (ILP). Cienc Cuid Saude. 2007; 6(1):59-67.

6. Tannure MCH, Pinheiro AM. SAE. Sistematização da Assistência de Enfermagem: Guia Prático. 2nd ed. Rio de Janeiro: Guanabara Koogan; 2010.

7. Conselho Federal de Enfermagem. Resolução 358: dispõe sobre a Sistematização da Assistência de Enfermagem e a implementação do Processo de Enfermagem em ambientes, públicos ou privados, em que ocorre o cuidado profissional de Enfermagem, e dá outras providências. (Oct 15th 2009).

8. NANDA Internacional. Diagnósticos de enfermagem da NANDA: definições e classificação, 2012-2014. Porto Alegre (RS): Artmed; 2013.

9. Instituto Brasileiro de Geografia e Estatística (BR). Sinopse do censo demográfico 2010. Rio de Janeiro (RJ): Estudos & Pesquisas; 2011.

10. Instituto Brasileiro de Geografia e Estatística (BR). Síntese de indicadores Sociais: uma análise das condições de vida da população brasileira 2010. Rio de Janeiro (RJ): Estudos & Pesquisas; 2010.

11. Remizoski J, Rocha MM, Vall J. Dificuldades na implantação da sistematização da assistência de enfermagem – SAE: Uma revisão teórica. Cad Esc Saúde. 2010; 3(3):1-14.

12. Luiz FF, Padoin SMM, Neves ET, Ribeiro AC, Tronco CS. A sistematização da assistência de enfermagem na perspectiva da equipe de um hospital de ensino. Rev Eletr Enf. 2010; 12(4):655-59.

13. Sakano LM, Yoshitome AY. Diagnosis and nursing interventions on elderly inpatients. Acta Paul Enferm. 2007; 20(4):495-98.

14. Almeida MA, Aliti GB, Franzen E, Thomé EGR, Unicovsky MR, Rabelo ER, Ludwig MLM, Moraes MA. Prevalent nursing diagnoses and interventions in the hospitalized elder care. Rev Latino Am Enfermagem. 2008; 16(4): 707-11.

15. Santos ASR, Souza PA, Valle AMD, Cavalcanti ACD, Sá SPC, Santana RF. Caracterização dos diagnósticos de enfermagem identificados em prontuários de idosos: um estudo retrospectivo. Texto contexto – enferm. 2008; 17(1):141-49.

16. Guedes HM, Santos WL, Nakatani AYK, Chianca TCM. Diagnósticos de enfermagem na admissão e alta hospitalar de idosos. Rev Enferm UERJ. 2011; 19(4):564-70.

17. Guedes HM, Nakatani AYK, Santana RF, Bachion MM. Identificação de diagnósticos de enfermagem do domínio segurança/proteção em idosos admitidos no sistema hospitalar. Rev Eletr Enf. 2009; 11(2):249-56.

18. Freitas EV, Py L. Tratado de geriatria e gerontologia. 3rd ed. Rio de Janeiro (RJ): Guanabara Koogan; 2011.

19. Bachion MM, Araújo LAO, Almeida AAMC, Santana RF. Estudo preliminar de validação clínica do diagnóstico de enfermagem "mobilidade física prejudicada" em idosos institucionalizados. Rev Eletr Enf [Internet]. 2001 [cited October 19, 2005]; 3(2). Available from: http://www.revistas.ufg.br/index.php/fen/article/view/722/782

20. Costa AGS, Oliveira ARS, Alves FEC, Chaves DBR, Moreira RP, Araújo THL. Diagnóstico de enfermagem: mobilidade física prejudicada em pacientes acometidos por acidente vascular encefálico. Rev Esc Enferm USP. 2010; 44(3):753-58.

21. Costa AGS, Oliveira ARS, Moreira RP, Cavalcante TF, Araújo THL. Identificação do risco de quedas em idosos após acidente vascular encefálico. Esc Anna Nery. 2010; 14(4):684-89.

22. Ministério da Saúde (BR), Secretaria de Atenção à Saúde. Caderno de Atenção Básica: Envelhecimento e saúde da pessoa idosa. Brasília (DF): MS; 2006.

23. Morais HCC, Holanda GF, Oliveira ARS, Costa AGS, Ximenes CMB, Araujo TL. Identificação do

diagnóstico de enfermagem "risco de quedas em idosos com acidente vascular cerebral". Rev Gaúcha Enferm. 2012; 33(2):117-24.

24. Cunha FCM, Cintra MTG, Cunha LCM, Giacomin KC; Couto ÉAB. Fatores que predispõem ao declí-

nio funcional em idosos hospitalizados. Rev Bras Geriatr Gerontol. 2009; 12(3):40-8

25. Fabrício SCC, Rodrigues RAP. Revisão da literatura sobre fragilidade e sua relação com envelhecimento. Rev RENE. 2008; 9(2):113-19.