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CARE FOR PEOPLE WITH CARDIOLOGICAL DISEASES

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ABSTRACT

Objective: The objective of this work is to describe the care for people with cardiological disorders. **Methodology:** This is an experience report through the application of the Systematization of Nursing Care (SAE), aimed at people with cardiological disorders in the hospital context. **Results and discussion:** Adaptation theory was applied in the six phases of Calista Roy's Theory and nursing diagnoses were prepared for the four adaptation modes: physiological, interdependence, self-concept and role function. **Final considerations:** When applying SAE to individuals with cardiological disorders, the multidisciplinary team must perform it in all its stages, and use the protocols to offer holistic and comprehensive care, aiming at health promotion, potential risk prevention and adaptation to of health needs.

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INTRODUCTION

The Systematization of Nursing Care (SAE) is a fundamental work methodology to guide the actions of nursing care to the individual in the health-disease context, aiming to bring together nursing activities so that they are not carried out in isolation and are part of a process. This is called the nursing process, and can be understood as a nursing work instrument, guided at least by a theory, being composed of ordered, dynamic, interacted and independent stages, which can occur in any scenario of direct customer care¹. The SAE favors a care practice based on scientific knowledge, contributing positively to the

patient, family, the nursing team as well as to the health service, focusing on care². For Waldow³ care is our practice and is characterized by actions and behaviors carried out with the intention of favoring, maintaining and improving the living-dying process, providing attention to people's biopsychosocial and spiritual needs. Thus, the need to apply SAE to people with a clinical and surgical approach to cardiovascular diseases is necessary due to the different cardiovascular diseases that affect the Brazilian population. Examples are: unstable angina, acute myocardial infarction, congestive heart failure, among others. The Pan American Health Organization pointed out in an analysis of the health situation in the Americas in 2021 that cardiovascular diseases continue to be the number one

cause of death⁴. It is urgent that nursing professionals are trained to provide quality, comprehensive and humanized care to people with cardiovascular diseases, as well as to improve prevention actions for the disease. Considering the constant need for change and improvement in health care, which have been influenced by the historical, political, economic, cultural and social context, the nursing process has been improved⁵. Next, the nursing process is referred to by the Nursing Council, which calls it Systematization of Nursing Assistance (SAE), considering this to be a private activity of the nurse (o), regulated by the Professional Practice Law⁶, complemented by Resolution No. 358/2009 of the Federal Nursing Council⁷. Therefore, the SAE emerges as an operational tool of the nursing process, through the organization of work, in terms of method, instruments and personnel, and must be carried out in all environments, public or private, in which nursing care occurs⁷. Consequently, the nursing process through the SAE is a method to assist the other in a more organized and systematic way based on the following steps: history; diagnosis, planning, implementation and evaluation⁷. On the other hand, nursing theory works as a structural foundation to implement the SAE, considering the importance of a conceptual framework that supports the care and organization that the service aims to achieve¹. Based on the assumptions of the theory employed, the nurse can align care and management activities, enabling the implementation of effective, efficient, patient-focused and safe care. Considering the historical trajectory, the pioneering reference is Florence Nightingale, in 1854 with the adoption of nursing practices based on scientific knowledge through techniques of cleaning and organization of the environment, important in the prevention of infections, being a landmark the environmentalist theory⁸. In 1955, Lydia Hall describes for the first time three phases to the nursing process: the historical one; the planning; and, evaluation⁹. However, the term nursing process is only defined for the first time by Ida Orlando, in 1961, to explain nursing care. Three years later, in 1964, Wanda Horta begins her studies and publications and, here in Brazil, in 1970, presents her model for the development of the nursing process, based on a humanistic and empirical approach, based on the theory of human motivation of Maslow¹⁰. His model is based on the laws of balance, adaptation and holism. According to the author, nursing must recognize the human being, who has basic human needs, which are classified as psycho-biological, psychosocial and psycho-spiritual. The objective of this work is to describe the care for people with cardiological disorders.

METHODOLOGY

It is an experience report that seeks to understand and consider the complexity of the human being, contributing to the approximation of theory and practice. This report may support the quality of care for people with cardiovascular diseases. Considering the importance of allying a nursing theory to the NP and, in our case, to the person with cardiovascular diseases, the theory of adaptation by Calista Roy¹¹, proposes that the patient is a biopsychosocial -spiritual being with interactions depending on the changes in his life and advocates four models of adaptation: physiological needs, self-concept, functional role, interdependence. The first model or physiological needs are organized into five basic needs: oxygenation; nutrition; elimination; activity and rest; protection. The second model is the self-concept mode that highlights the psychological and spiritual aspects of the human being. The third model is divided into instrumental behaviors that refer to the set of roles that the subject plays in society and expressive behaviors that are related to emotions, and feedbacks. The last model is the mode of interdependence or social mode that relates to satisfied affective needs, to give and receive affection, love, affection, affirmation¹¹. Roy proposed in his theory a nursing process composed of 6 phases.

RESULTS AND DISCUSSIONS

The collection of data or nursing history of the nursing process corresponds to the 1st and 2nd stage of MAR. It is worth mentioning that at this stage it is necessary to consider the information that

permeates the subjective, objective, historical and current dimensions of the individuals' lives. It is an important moment of contact and emergence with the beliefs and customs, habits and needs of the other. At that moment, the nurse will collect data and the main problems found are: chest pain that radiates to the arm, palpitation, shortness of breath, loss of consciousness, fainting, edema in Mmii, tachycardia, nausea, loss of appetite and gain in unjustified weight. It is necessary to be attentive to this information of a biomedical nature, among others, such as emotional state and the conditions of understanding of the individual regarding the procedure to be performed, as well as involving the family in the care process. In MAR, this stage would include the assessment of stimuli, which helps the nursing professional to identify internal or external circumstances that will act on their behaviors. At this stage, the theory states that there are three stimuli, the focal, the contextual and the residual. The first refers to the person's own condition or the context inserted or how this will impact the assumed behaviors, which were evaluated in the first phase. The contextual are those elements that directly permeate the focal, interfere in the individual's way of adaptation, such as age, sex, family, ethnicity and others. Finally, residuals are indirect stimuli, often not perceived by the person, but which also contribute to the adaptive process¹¹. Therefore, communication between professionals and individuals must take place in a dialogic and negotiated way, enabling the construction of knowledge about the health process and mutual illness¹². In this way, the nurse can take ownership of the determinants and conditions of the individuals' health and, thus, plan their actions in line with the needs, with a view to fostering autonomy and consequent improvement and maintenance of health. Data collection refers to the collection of information about health status from data collected directly or indirectly (other sources such as family, friends, medical records). At this stage, the nurse identifies evidence and makes inferences. After this step, it is important to confirm the data and subsequent grouping depending on the theory used, identifying the causal factors and communicating and recording the data in medical records to ensure continuity of care¹. It should be noted that this investigation must be guided by nursing theories, including a data collection instrument, norms, routines and protocols inherent to it. In the case of cardiovascular diseases, this data collection should be based on the four adaptation models: physiological needs, self-concept, functional role, interdependence. The physical examination follows the steps of observation, inspection, percussion and auscultation.

On physical examination, the general appearance, cognition, skin, BP, arterial pulses, pressure, venous and jugular pulses, limbs, and lungs should be noted. Signs should be checked, in addition to inspection, palpation, percussion and auscultation. Inspection checks for general appearance, jugular venous distention, chest, limbs and warm skin, normal color, capillary refill <2 sec + maximum point of impulse and not visible and without jugular distention. The most common clinical manifestations are: chest pain (checking if the pain is radiating and intermittent, persistent, if it hurts on palpation, if it worsens on exertion), dyspnea (which precipitates or relieves, if it worsens with exertion, if it is necessary to elevate the sleep, if it is paroxysmal nocturnal or orthopnea), palpitations (if any, how long it lasts, what relieves or precipitates it), weakness or fatigue (characteristic on exertion, relieved with rest, if you have lower limb weakness, if does it accompany swelling or pain?), dizziness or syncope (if the episodes are frequent, what precipitates it, how long does it last, what relieves it). It should be noted that these data, added to psychological, social and spiritual issues, will support the formulation of diagnoses, considering that nurses treat human responses to health problems and/or life processes based on clinical and reflective analysis of the information. retained. It is worth mentioning that the realization of the history precedes a script that helps and orders the nurse to collect, validate, group and record data⁹. Thus, at the end of data collection, the nurse summarizes what was said for the individual, opening space for clarification and negotiation, providing the opportunity to carry out health education from the beginning of the process¹³. The 2nd stage of the NP corresponds to the 3rd stage of the MAR or nursing diagnosis are linked to the problems encountered and the elaboration of diagnoses according to the positive or negative adaptation of the

patient, potential problems and well-being situations related to biological, psychological, social and spiritual conditions, since the focus of care is the person and not the disease. This stage culminates in decision making, that is: the responses of the person, family or human community that constitute the basis for the selection of actions or interventions with which the objective is to achieve the expected results. It should be noted that diagnoses must be presented by priority and the great difference between nurses and doctors is that they diagnose diseases and we *diagnose* human responses resulting from health problems and life processes. American Nursing diagnosis Association) and should be guided by the four adaptation models. The NANDA-I framework contains seven axes or dimensions of human response. In the current taxonomy, 244 diagnoses are organized and approved, distributed in 13 domains and 47 classes. The nursing diagnosis is made up of structural components: diagnosis title, definition, related factors, defining characteristics, associated conditions, risk factors and population at risk. These structural components will comprise 3 types of diagnoses (1- Problem-focused diagnosis- composed of title, related factor and defining characteristic, 2 - Risk diagnoses- composed of title and risk factors, and health promotion diagnoses- composed of title, related factor, and defining characteristic). The main nursing diagnoses made for the person with respiratory problems are:

Physiological Mode: Acute pain related to harmful agents evidenced by self-reported pain 7/10.

Ineffective Breathing Pattern Evidenced by: Abnormal breathing pattern.

Related to: Fatigue

Decreased cardiac output related to altered contractility, as evidenced by tachycardia, change in blood pressure, cold, clammy, clammy skin.

Risk of pressure injury evidenced by bed restraint.
Risk of falls due to old age.

Interdependence / Role Function and Self-Concept

- Willingness for improved health control related to desire to improve control of prescribed regimens
- Risk of impaired religiosity evidenced by the need to participate in religious celebrations
- Disrupted family processes related to the impairment of a family member's health status evidenced by interruption in usual social activities.

The 3rd stage of the EP corresponds to the 4th stage of the MAR or setting the goals are the expected results or the final behavior that is desired to be achieved. This phase is performed after formulating diagnoses, establishing objectives and expected results, and implementing and developing specific interventions. Nursing interventions are carried out through nursing prescriptions, based on the planning carried out². The expected result must be related to the nursing diagnosis, be patient-centered, be achievable, have a time limit, be measurable and be objective.

The recording and monitoring of expected results (ER) make it possible to obtain indicators capable of pointing out how much the nursing team contributes to meeting the needs presented by those who demand their care. In this way, nursing professionals should prevent risk diagnoses from evolving into problems, minimize or solve problems and maintain a diagnosis focused on promotion. The expected result must be based on Nursing Outcomes Classification (NOC), which is a complementary taxonomy to the NANDA-I taxonomy, divided into 7 domains (functional health, physiological health, psychosocial health, health knowledge, perceived health, family health and community health) and 32 classes, with 490 nursing outcomes¹⁴. In this way, nurses can assess their behavior, maintain or modify them in order to improve the quality of care provided by the nursing team.

Some expected results from the physiological mode diagnoses.

- Acute pain- RE- Pain control. Indicator- no pain
- Ineffective Breathing Pattern Evidenced by: Abnormal breathing pattern
- Related to: Fatigue. RE- Breathing pattern within the normal range. Breathing pattern indicator between 18 and 20 inc /min
 - Decreased cardiac output related to altered contractility by tachycardia, change in blood pressure, cold, clammy, clammy skin. RE- Cardiac output within the normal range. Indicator-FR between 80 and 100bat/min.
 - Risk of pressure injury evidenced by bed restraint. RE- uncompromised skin and mucous membranes. Indicator-uncompromised tissue integrity
 - Risk of falls due to old age. RE- Occurrences of falls: none; indicator: no fall from bed
- Some expected results of the Interdependence / Paper Function and Self-Concept mode
 - Willingness for improved health control related to a desire to improve control of prescribed regimens. RE- Improve health condition. Indicator: Improved health
- Risk of impaired religiosity evidenced by the need to participate in religious celebrations. RE- Uncompromised spiritual health. Indicator: Interaction with non-committed spiritual leaders
- Disrupted family processes related to the impairment of a family member's health status evidenced by interruption in usual social activities. RE- Uncompromised family processes. Indicator: family well-being.

The 4th stage of the NP corresponds to the 5th stage of the MAR or intervention is the nursing care itself to achieve the goals.

The care related to diagnoses are:

Acute pain - Conduct a comprehensive pain assessment, including location, characteristics, onset, duration, frequency, intensity, and precipitating factors in order to determine appropriate intervention, ensure patient pain relief with medications and relaxation techniques, music therapy, massage. Ineffective breathing pattern- Monitor SSVV; mainly RR and O2 sat, Monitor lung sounds; Position the patient to minimize respiratory effort; Initiate and maintain the use of supplemental oxygen as prescribed; Decreased cardiac output - Offer real information about diagnosis, treatment and prognosis, auscultate heart sounds, Monitor neurological status, Monitor laboratory values of electrolytes that may increase the risk of arrhythmias (potassium), Monitor rhythm, heart rate and blood pressure, Auscultate the lungs in search of crackles or other adventitious noises, Obtain ECG whenever chest pain. Risk of Pressure Injury - Apply Braden scale, change of position, use of cushions and air mattress, education and health guidelines for patients and families on injury prevention. Risk of falls- Apply fall risk scales daily, leave bars up, guide patients and family members on preventive actions to avoid falls. Willingness for improved health control - Encourage the person to improve health conditions through knowledge, refer to services that are necessary for their improvement/cure, encourage the use of prescribed and therapeutic medications.

Risk of impaired religiosity - Authorize the entry of the priest, encourage the patient to continue their prayers, ask the object family to remember their faith (third or similar). Interrupted Family Processes- Encourage the presence of family members; Optimize peaceful sleep, pain relief, emotional control; Monitor sleep pattern and number of hours slept; Provide a calm and safe environment.

The 5th stage of the EP corresponds to the 6th stage of the MAR or evaluation refers to the judgment of the effectiveness of the proposed interventions. It is noteworthy that this step is a continuous process of verifying changes in the individual's responses to determine whether the nursing actions or interventions achieved the expected result¹⁵.

After the interventions are carried out, the care offered is monitored and evaluated, verifying that each result has been achieved¹⁶. In negative cases, the nurse must reassess the expected results and work together with the health team to formulate/change actions to improve this individual's health condition, and thus carry out the planning for the individual's discharge. Hospital discharge is an important step in SAE, as it directs the plan and implementation of actions, during the period between hospital admission and discharge, with the aim of providing continuity of care to the client at home¹⁷. The nurse, by identifying the individual's needs in the collection of data during the history, develops a complete action plan to improve that person's health. Discharge planning is an agreement between the nurse, the individual and the family member developed while still in the hospital and that will be extended to the individual's home after discharge. According to the WHO, discharge planning becomes a strategy to prepare the individual and family to assume responsibility for the continuity of care. Aspects of health education are essential for the continuity of this care. During the discharge plan, the nurse can formulate a script to be delivered to the individual containing information about the procedure that was performed, the necessary care, in addition to the guidance that any changes that are identified, return to the unit. The nurse then develops her planning in order to adapt the individual by promoting measures to face the new problem.

CONCLUSION

However, despite advances in scientific and technological knowledge of nursing professionals and the development of tools that enable the improvement of their service, the actions of nurses today are almost always established in the hegemonic care model, following a technicist and interventionist logic. In this way, the SAE occurs in a fragmented way and without continuity of actions and evaluation of the expected results, observing the individual only by the displayed health problem and, working only with the physiological needs, without paying attention to the social, spiritual and emotional needs of the patients. Individuals, with emphasis on the person with digestive disorders. When applying the SAE to the individual with respiratory problems, the nurse must perform it in all its stages, and use the protocols to offer holistic and comprehensive care, aiming at health promotion, potential risk prevention and adaptation to health needs. It should be noted that the use of evidence-based practice comprises the process that integrates individual clinical competence and well-founded research results (based on 5 steps: problem definition, identification of necessary information, search for studies, evaluation of the applicability of data obtained and determination of their use for the patient).

In this way, it is urgent that nurses carry out research to extract the best levels of evidence to provide safe care to patients¹. In addition to the SAE being worked based on the theory of adaptation and focusing on evidence, it is worth emphasizing the importance of health education, which constitutes an important tool for improving care and health and life conditions. Health education developed by nurses is guaranteed by the law of professional practice in article 8, where the nurse participates in health education activities, providing a better quality of life for the individual, family and community⁶. Finally, it is worth mentioning that the entire nursing process focused on the theory of adaptation must take into account patient safety with strategies aimed at risk management that have been implemented based on hospital accreditation standards, creation of protocols, guides, manuals and bundles. All these strategies can be linked to nursing diagnoses in order to minimize complications and ensure greater safety in the care provided.

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