Original Article

Nursing Diagnoses of the Patients Who Have Been Treated in Acute Psychiatry Clinics in the Recent Year

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Abstract

Background: Nursing process is a planned process based on problem solving approach in defining and solving patient problems.
Aim: This study was conducted to evaluate the nursing diagnoses of patients who have been treated in acute psychiatric clinics in the recent year.
Method: Socio-demographic and clinical data of 16.073 in-patients who have been treated in acute psychiatric clinics of a public hospital between November 2016 and November 2017 were analyzed descriptively and retrospectively by using the hospital information management system. The data of the research was collected between 1 and 31 December 2017. Care plans that were made by the nurses were reviewed by the researchers taking into account the functional health models (FHM) and the diagnostic system of North American Nursing Diagnosis Association (NANDA) and recorded in the data collection form. The data were calculated in percentage by using SPSS (Version 21.0) program.
Results: Nurses collected the highest percentage data about health perception and management (80.9%), role and relationship function (41.6%), coping/stress tolerance (28.2%) among the patients who were evaluated in accordance with FHM in the research. It was determined that nurses recorded 41 NANDA nursing diagnoses data belonging to total of 16.073 patients by entering them 1.330.976 times hospital information management systems. It was determined that the nursing diagnoses which were mostly recorded by nurses were the risk of falling (73%), deterioration in social interaction (41.32%), risk of violence against others (16.50%), anxiety (13.06%), risk of transmission of infection (11%), lack of selfcare (5.24%), ineffective individual coping (7.41%) and deterioration in thought processes (6.55%). When nursing diagnoses were examined in terms of standard terminology, it was determined that 41 of the diagnoses did not comply with the standard terminology and were expressed and recorded in different forms.
Conclusion: It was observed that the diagnoses identified by nurses according to the FHM were about the psychosocial field which is more easily detectable in relation to the psychiatric field, and that they were not analyzed in the way that provide holistic nursing care by excluding the data regarding the sexuality-reproduction and the values and beliefs.

Key words: NANDA diagnosis; nursing records; psychiatric patient.

Introduction

The aim of nursing care is to support and maintain the health of the individual and raise his/her health level. On the basis of this aim, improving the sense of self of the individual, helping him/her to deal with stress, to helping him/her to organize his/her relationships positively, and ensuring him/her to reach a conclusion with these experiences by reducing the sickness and suffering, are the basic care approaches of the psychiatric nursing. The tools that enable these basic aims and approaches to be achieved with a scientific approach in nursing care, are nursing models and nursing process (Sabanciogullari et al., 2011).

The nursing process has been used for the planning, evaluation and recording of nursing care for the last thirty-forty years, (Korhan et al., 2015). Nursing process is a planned process based on problem solving approach in defining and solving patient problems (Avsar et al., 2014). According to the World Health Organization (WHO), scientific problem solving method is used in the nursing process (Aidin, 2013).

For this purpose, NANDA-I (North American Nursing Diagnosis Association-International) is used as a guide to make accurate nursing diagnosis nowadays (Uysal et al., 2016). It is stated in the literature that using an international nursing diagnosis system such as NANDA will improve the quality of nursing care, enable comparison between the local, regional, national and international level, increase communication between nurses and other health professionals and enable to use the computerized forms (Sabanciogullari et al., 2011; Sendir & Buyukyilmaz, 2012). Making accurate nursing diagnoses help patients get nursing care of good quality, and in doing so, to be achieved the desired results. At the same time, well-planned nursing care is very important in increasing the life span of the individual (Korhan et al., 2015; Uysal et al., 2016).

At clinics, nurses establish a nursing care plan specific to each patient in order to record their interventions and procedures (Karadakovan, 2004). In this context, the nursing process enables to provide solutions and determine the needs by considering the individuality in many patients who have the same medical problems and develop the confidence between caregiver and patient (Avsar et al., 2014).

Therefore, the use of nursing process and nursing care plan in practice and education is of great importance. However, it was determined in a small number of studies that nurses do not systematically apply the nursing process steps and are not at the desired level to determine nursing diagnoses correctly (Uysal et al., 2016; Muller Staub et al., 2007; Karadakovan, 2004; Aidin, 2013; Avsar et al., 2014). In addition, the studies in which the care plans of the student nurses for the patients for whom they care and the care plans of the nurses who work in the clinics are examined, are limited (Uysal et al., 2016). In the light of these informations, the aim of the study is to analyze the nursing diagnoses of patients who have been treated in the acute psychiatric service of a public hospital in the recent year.

Methodology

This retrospective and descriptive study was conducted between November 2016 and November 2017 by reviewing the records of in-patients who were treated in acute psychiatric clinics of a public hospital. The care plan records of 16.073 patients who were hospitalized to acute psychiatric services in accordance with ICD-10 (International Classification of Diseases and Related Health Problems Version) at the specified date range, and which were created by nurses working in these services in the direction of the NANDA diagnosis system, were examined.

The data of the research were collected by using the hospital information management system between the dates of 1 and 31 December 2017. Care plans made by nurses were reviewed retrospectively by researchers, taking into account the NANDA diagnostic system. The information in the care plans of patients were recorded in the data collection form. The data collection form consists of questions about the patient's personal information, his/her medical diagnoses and nursing diagnoses. The data were calculated in percentage by using SPSS (Version 21.0) program. In order to be able to conduct the research, the written and verbal permission was gotten from the hospital where the research was conducted. This study is in line with the Helsinki Declaration Manifesto, which was developed as ethical principles for

medical research.

Results

According to the clinical information in the files of the patients which were obtained from the hospital information management system; 34.18% of the patients were male and the majority (80%) were resident in Istanbul Province. When the information of patients was examined, it was determined that ICD-10 diagnostic criteria were used as a base. According to this, when the medical diagnoses of in-patients in clinics are sorted descending, it is seen that 27.34% of them have schizophrenia, 25.6% of them have mind-behavior disorder and addiction to opioid, drug, alcohol, hallucinogen use, 23% of them have bipolar affective disorder, 23% of them have depression and 1.06% of them have adjustment disorder. Sociodemographic data of the examined patients such as age, education level, occupation, study and economic situation could not be obtained from the hospital information management system.

When the findings regarding the nursing diagnoses of the patients (16.073) in the study were examined, it was determined that 41 nursing diagnoses were recorded by nurses in the hospital information management system by using NANDA nursing diagnoses which were grouped in accordance with functional health models. It was determined that three diagnoses of them were identified for collaborative problems. It was determined that these collaborative diagnoses which are known as nursing diagnoses are diagnosis of hypertension (3%), epileptic seizure (1%) and diabetic ketoacidosis (0.07%) even though they are not nursing diagnoses. These are diagnoses that require the nurse to cooperate with physicians and therefore are accepted as a medical diagnosis. It was found that nurses determined NANDA diagnosis in 1.330.976 times totally in this study. The nursing diagnoses which were most frequently recorded by nurses were the risk of falling (73%), deterioration in social interaction (41.32%), risk of violence against others (16.50%), anxiety (13.06%), risk of transmission of infection (11%), lack of selfcare (5.24%), ineffective individual coping (7.41%) and deterioration in thought process (6.55%).

When the nursing diagnoses recorded through the hospital information management system were analyzed according to Gordon's Functional Health models; It was found that nurses determined 11 nursing diagnoses regarding "Nutrition-Metabolic" pattern, five nursing diagnoses regarding the "Activity-Exercise" and "Cognitive-Perceptual" pattern, four nursing diagnoses regarding the "Elimination" pattern, three nursing diagnoses regarding the patterns of "Self-Perception", "Role-Relationship", "Health Perception and Management Function" and "Coping-Stress Tolerance" and one nursing diagnoses regarding "Sleep-Rest" pattern (Table-1). It was observed in this study that the nurses working in psychiatry clinics did not determine the nursing diagnosis regarding "Sexuality-Reproduction" and "Values and Beliefs" patterns.

When nursing diagnoses were examined in terms of standard terminology, it was determined that most of the 41 diagnoses did not conform to the standard terminology and were expressed and recorded in different forms. For example; it was determined that nurses used the following expressions: They used the expression of "discharge training", instead of "lack of information", the "inadequacy in individual care / ineffective care pattern" instead of "lack of self-care", the "ineffectiveness in participating in individual and group activities" instead of "deterioration in social interaction", the "deterioration in communication" instead of "deterioration in verbal communication", the "risk of unauthorized leaving from clinic and the non-compliance with treatment and requests" instead of "difficulty in compliance with defined regime", the "showing of manipulative behavior" instead of "ineffectiveness in management of self-health", the "feelings of mental distress and feeling of distress due to alcohol / substance abstinence" instead of "anxiety", the "suisid risk" instead of "suicide risk", the "delirium-hallucination-delusion-visual and auditory hallucination instead of "change in the process of thinking", the "risk of acute confusion due to ECT therapy" instead of "confusion" and the "physical restraint-aggression" instead of "risk of violence against others".

Table.1: Distribution of NANDA nursing diagnoses according to FSO model

FSO model data collection areas	NANDA diagnoses	Percent (%)
Health detection and management function	Risk for Falling	73
	Difficulty / Incompatibility in The Defined Regime Compliance	3.299
	Ineffectiveness to Manage Your Health	4.662
Nutritional-Metabolic	Risk for Infection	2
	Risk for Infection Transmission	11
	Deterioration in Oral Mucous Membranes	0.017
	Distortion in Skin Integrity	0.240
	Hyperthermia	0.241
	Hypothermia	0.002
	Liquid Volume Incomplete	0.026
	Liquid Volume Peak	0.013
	Imbalance in Feeding: Less than Needed	0.165
	Imbalance in Feeding: More than Needed	2
	Risk for Electrolyte Imbalance	0.078
Elimination	Constipation	0.254
	Diarrhea	0.069
	Impaired Urinary Elimination	0.007
	Intestinal Urinary Incontinence	0.004
Activity-Exercise	Lack of Self Care	5.24
	Risk for Bleeding	1.045
	Activity Intolerance	0.0001
	Ineffective Tissue Perfusion	0.007
	Risk for Disturbance in Respiratory Function	0.680
Sleep-Rest	Sleep Pattern Discomfort	1.298
Cognitive-Recognition	Information Lack	3.165
	Ache	3
	Nausea	0.221
	Distortion in Thought Processes	6.553
	Confusion	2.633
Self-Perception	Anxiety	13.06
	Decrease in Self-Esteem	0.13
	Discomfort in Self Concept	2.13
Role-Relationship	Deterioration in Verbal Communication	0.336
	Distortion in Role Performance	0.005
	Deterioration in Social Interaction	41.325
Head-to-Stress Tolerance	Ineffective Individual Head	7.41
	Risk for Suicide	4.36
	Risk for Violence Against Others	16.501
Collobrative Problems	Hypertension	3
	Acidosis	0,007
	Seizures	1

Discussion

In order that nurses are able to approach psychiatric patients holistically and provide quality care, primarily, it is necessary to identify the problems of the patients and take initiatives for these problems (Terzi & Kaya, 2011). Trusted interventions can only be achieved by establishing the right nursing diagnosis. Nevertheless, in studies conducted on patients with acute psychiatric clinics, there are some deficiencies in the nursing diagnosis regarding the problems that may arise in nursing care, the risky situations that may be encountered and the treatment and care needs that they need as a result of these situations (Sabanciogullari et al., 2011).

It was determined in this study that the nurses identified the medical diagnoses as nursing diagnosis and recorded them. It was found that these diagnoses were hypertension, diabetic ketoacidosis and epileptic seizures. In the study in which they done with patients having heart failure in coronary intensive care unit; Turen et al (2017) determined that seven different diagnoses (hyperglycemia, hypoglycemia, hypertension, dysrhythmia, cardiac tamponade, embolism and digoxin intoxication) were recorded as nursing diagnoses, even though they are the medical diagnoses (Turen et al., 2017). Korhan et al. (2015) found in the study that medical diagnoses of hypertension and hypotension were recorded as nursing diagnosis (Korhan et al., 2015). Similar to the results of other studies, it was observed that there were deficiencies in the knowledge level of nurses about nursing diagnoses in this study. Since the fact that nursing diagnoses are not correctly diagnosed will cause care requirements to be incomplete or not met at all, it is vital for patients.

On the other hand, it was determined that most of the nursing diagnoses recorded in this study were the current diagnoses and that the risk diagnoses were used rarely. Risks used are the risk of falling, risk of infection, risk of transmission of infection, risk of electrolyte imbalance, risk of bleeding, risk of suicide, impairment risk of respiratory function and risk of violence towards others. However, the patients in psychiatric clinics are faced with many risks threatening health (such as aspiration risk, injury risk) (Donmez & Yilmaz, 2011). Planning of appropriate nursing interventions by assessing possible risks is among the responsibilities of psychiatric nurses.

When the nursing diagnoses recorded by nurses in this research in which nursing diagnoses of the most patients were examined according to NANDA depending on Gordon's Functional Health Patterns, were examined; It was determined that nurses working in psychiatric clinics used nursing diagnoses belonging to the nine patterns. It was observed that the nurses did not determine the nursing diagnosis regarding "Values and Beliefs" and "Sexuality-Reproduction". In the study of Sabanciogullari et al., it was found that the nurses working in the psychiatry clinic evaluated the fields of the sexuality pattern and values and beliefs in the care plans of patients less frequently (Sabanciogullari et al., 2011). Additionally, Korhan et al. (2015) found in their study done in intensive care unit that nurses did not evaluate the fields such as sexuality pattern, values, and beliefs in care plans, and did not determine any nursing diagnosis related to these fields (Korhan et al., 2015). Serbest et al. found that nursing diagnoses related to the sexuality-reproduction form and beliefs and values did not take place in the care plans of patients on which they studied (Serbest et al., 2013). In the study done on patients with spinal cord injuries, Babadag et al. (2004) emphasized that while they knew that the individual should evaluate holistically the student nurses did not give place to the nursing diagnoses related to sexual dysfunction. While the results of the study is consistent with the results of other studies in this field, it is thought that nurses did not make evaluations about fields of the sexual and reproductive and values and beliefs of the patients which are included in the subjects regarding the abstract concepts and patient confidentiality.

It is emphasized in the literature that if it is approached to the patient with a holistic viewpoint, the physiological and psychosocial problems of the patient should be considered together (Korhan et al., 2015). In the study of Cam et al in which nursing process reports of student nurses in psychiatric nursing clinical practices were evaluated, it was determined that NANDA nursing diagnoses used by students most frequently in the psychiatric clinic were sleep disorder, social isolation, inadequacy of individual coping, decrease in self-esteem, and change in thought

process (Cam et al., 2004). Furthermore, it is seen that nursing diagnoses are different in studies conducted with in-patients in clinics except psychiatry. Korhan et al., found in their study that almost all of the nursing diagnoses recorded in the study included problems related to the patient's physical health condition (Korhan et al., 2015). In another study in which the care needs of patients having brain tumors were determined, the first five nurses diagnoses that were determined were sorted as constipation, nausea, insufficient fluid volume, acute pain, and hyperthermia (Ilce et al., 2010). It was determined in this study that nurses working in psychiatric clinics emphasize the psychosocial problems of the patients in keeping with the findings of Sabanciogullari et al. (Sabanciogullari et al., 2011). It was found in the study that the fields diagnosed mostly were the risk of falling in the physical area and the social interaction in the spiritual area. Based on these findings, it can be said that physical health problems are primarily diagnosed in general clinics, whereas psychosocial problems are emphasized in psychiatric clinics. This is because; it is thought that psychiatric diseases may be related to being influenced of feelings, thoughts and behaviors primarily.

It was stated in the literature that nursing diagnoses have many beneficial such as the providing communication between nurses and patients, and between nurses and other members of the health professionals, degrading misunderstood to the lowest level, providing the being recorded of nursing practices clearly, supporting the continuity of care, providing documentation of care and outcomes, enhancing the knowledge of the profession, and perhaps the most important, providing the use of standard language among nurses (Erdemir & Karaca, 2016; Lunney, 2016; Mitchell et al., 2009). It was determined that the standard terminology was not used in the records related to the nursing process in the study conducted by Ayral et al in the physical therapy and rehabilitation center of a hospital (Ayral et al., 2003). It was also found in the study of Korhan et al that seven nursing diagnoses did not meet the standard terminology (Korhan et al., 2015). While nursing diagnoses are recorded in a similar way with the results of this study, it was determined that there was deficiency in use of standard terminology and many of the 41 diagnoses were not in accordance with standard terminology and recorded in different forms.

Conclusion

In this study in which a large number of patient files were examined, it was determined that the diagnoses identified by the nurses according to the FHM model are focused on the psychosocial field that can be detected more easily in relation to the psychiatric field, and that they leave the data regarding fields of sexuality-reproduction and values and beliefs outside of the diagnosis and did not diagnose in accordance with the terminology. When considering the treatment and care needs of patients who are treated in acute psychiatric clinics, it can be said that there are deficiencies in the defined nursing diagnoses. In order that nurses are able to evaluate the individual with a holistic view, it is necessary to raise their awareness regarding the fields of privacy and abstract concept. In this respect, it is suggested that the ability of nurses to make diagnosis should be improved, and the training programs on correct use of nursing diagnoses and on the importance of nursing records to ensure the visibility of the nursing profession.

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