REVISTA DA ESCOLA DE ENFERMAGEM DA USP
JOURNAL OF SCHOOL OF NURSING · UNIVERSITY OF SÃO PAULO

ORIGINAL ARTICLE

DOI: https://doi.org/10.1590/1980-220X-REEUSP-2020-0549

Nursing diagnosis in older adults at risk for pressure injury*

Diagnóstico de enfermagem em pessoa idosa com risco para lesão por pressão

Diagnóstico de enfermería en personas mayores con riesgo de lesión por presión

How to cite this article:
Garcia EQM, Silva BT, Abreu DPG, Roque TS, Sousa, JIS, Ilha S. Nursing diagnosis in older adults at risk for pressure injury. Rev Esc Enferm USP. 2021;55:e20200549. doi: https://doi.org/10.1590/1980-220X-REEUSP-2020-0549

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* Extracted from the dissertation "Perfil de pessoas idosas hospitalizadas: fatores de risco, prevalência e intervenções para prevenção de lesões por pressão", Programa de Pós-Graduação em Enfermagem, Universidade Federal do Rio Grande, 2020.

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ABSTRACT

Objective: To develop nursing diagnoses and care plans for older adults with pressure injuries based on risk factors, aiming at preventing their occurrence in hospitalized older adults. **Method:** Exploratory, descriptive, cross-sectional, quantitative study conducted with 87 medical records at the Medical Clinic Unit of a University Hospital. **Results:** Among older adults at some risk for the development of pressure injury, there was a prevalence of the female sex, age over 80 years and moderate risk classification on the Braden Scale. Nursing interventions that encourage patient mobility, pressure control, skin supervision, nutrition, incontinence and hygiene stood out. **Conclusion:** Nursing has an important role in maintaining the integrity of patients' skin. It is worth highlighting the use of injury predictive scales as a complement to clinical practice in order to assist in the nursing diagnosis with a view to interventions aimed at risk factors.

DESCRIPTORS

Aged; Hospitalization; Pressure Ulcer; Nursing Diagnosis; Nursing Care.

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Received: 12/05/2020
Approved: 03/23/2021

INTRODUCTION

Pressure injuries (PI) are chronic wounds that occur due to compression of the skin with a surface for a prolonged time, leading to cell death. This usually occurs in an area of bone prominence and may be related to the use of medical devices. They can be classified in stages from 1 to 4, which represent the extent of skin damage in ascending order. Such damage is determined by the intensity and duration of the pressure and is influenced by intrinsic and extrinsic factors. Intrinsic factors are related to the organism itself, such as reduction and/or loss of sensation, muscle strength and immobility. Extrinsic factors refer to influences of the external environment, such as friction, shear and humidity[1].

By taking into account the intrinsic and extrinsic factors influencing PI, the population of older adults is at significant risk for its development. In addition to physiological aging, called senescence, that may be linked to the decline in homeostatic reserves and the response to aggression; there is senility, a term related to diseases and external causes that subsequently result in multiple comorbidities and represent the main cause of disabilities in older adults. Both senility and senescence can trigger functional dependence, which further affects homeostatic reserves and generates a vicious cycle associated with the progression of disabilities, hospitalization and death[2].

With regard to hospitalized older adults, a study conducted in Portugal sought to estimate the effect of PI on the increase in length of hospital stay and the gains in health acquired from nurses' preventive interventions. Data were collected for nine consecutive months and there were 8274 hospitalizations of people aged 65 and over, with an average hospital stay of 9–11 days. Therefore, it was possible to identify the length of hospital stay according to the staging of a PI: a patient who develops PI stage 1 remains hospitalized for an extra 9.07% of time, stage 2 for a further 13.61%, stage 3 for a further 22.28% and stage 4 for an extra 55.99%. The author states that investigating is a fundamental act to justify prevention, aiming at sustainability and better care[3].

This topic is relevant to clinical practice, especially with regard to nursing care, since the incidence of PI, "in addition to being related to the clinical condition of older adults, directly reflects the quality of care provided by health care professionals, as its prevention is easy to perform and low cost"[4].

In the context of prevention, nursing care for older adults at risk of developing PI is essential and should be focused on the search for information through a complete anamnesis and detailed physical examination, identifying the risk factors for PI and the specific nursing diagnoses, developing a care plan, implementing interventions and evaluating the outcome[5]. Therefore, the aim of this study was to develop nursing diagnoses and care plans for older adults with pressure injuries based on risk factors, with a view to prevent their occurrence in hospitalized older adults.

METHOD

Type of Study

This is an exploratory, descriptive, cross-sectional, quantitative study.

Scenario

It was conducted at a university hospital located in a municipality in the state of Rio Grande do Sul. This hospital is linked to a Federal Higher Education Institution (HEI).

Population

The inclusion criterion comprised all medical records of patients aged 60 years or older admitted to the mentioned unit during the data collection period. The exclusion criteria were selected according to the objectives of the article; medical records with incomplete information, patients who already had an installed PI and patients who did not have a Braden scale (BS) score were excluded. A total of 101 medical records were included in the study. The following were excluded: one with incomplete information; 11 from patients who already had PI; and two who did not have BS. Eighty-seven participants remained.

Data Collection

Data collection was performed on medical records of older adults admitted to the Medical Clinic Unit of the University Hospital. The initial collection was performed between February 7 and May 31, 2019. From April of the same year, data were extracted for the development of this article.

An instrument containing sociodemographic issues, clinical history, reason for hospitalization and medications administered was used to assist in the collection and registration of data. The following questions were selected to answer the objectives of this article: sex; age; marital status; monthly income; chronic diseases; lifestyle habits (smoking and drinking); weight and height (BMI); laboratory tests (hematocrit, hemoglobin, blood glucose and leukocytes); restriction to the hospital diet; control of eliminations (urinary and intestinal); restricted positioning; need for mobility assistance; presence of PI; and finally, the BS score.

For variables related to laboratory tests, the following normal values were used: hematocrit of 45% to 52% for men and 37% to 48% for women; hemoglobin from 13.8 g/dl to 17.2 g/dl for men and from 12.1 g/dl to 15.1 g/dl for women; leukocytes from 4,300 to 10,800 cells per cubic millimeter[6]; and blood glucose from 60 mg/dl to 100 mg/dl[7]. The BMI reference values were used according to the Geriatrics and Gerontology Treaty[8], as follows: underweight, less than or equal to 22; appropriate, greater than 22 and less than 27; and overweight, greater than or equal to 27.

Data Analysis and Treatment

For the organization of data, a Microsoft® Excel 2016 spreadsheet containing a dictionary (codebook) was created.

The Statistical Package for the Social Sciences® (SPSS), version 20.0 was used for fata analysis. A descriptive statistical analysis was performed with description of the absolute and relative frequency of the variables. An inferential analysis was also performed, in which the chi-square test was used to assess the association between the dependent categorical variable (risk of injury) and other variables. For inferential analyzes, the significance level of $p < 0.05$ was considered.

Based on the risk factors, a care plan with nursing interventions was proposed according to the taxonomy of the Nursing Interventions Classification (NIC)[9]. To this end, nursing diagnoses were assigned, considering their defining characteristics and related/risk factors from the North American Nursing Diagnosis Association International (NANDA-I). The nursing diagnoses are performed by the nurse after anamnesis and complete physical examination of the patient, which was not done in this study. Thus, the possible nursing diagnoses of patients in the sample were listed according to the (associated) risk factors for the development of PI[10].

The Nursing Outcomes Classification (NOC) taxonomy was also used to assign the expected outcomes for each nursing diagnosis[11].

Ethical Aspects

This study is part of a macro project approved by the Research Ethics Committee under Opinion number 166/2018 with consent granted by the Teaching and Research Management of the hospital where it was developed. It complied with Resolution 466/2012 of the National Health Council, which concerns research with human beings.

RESULTS

Of the 87 elderly, 24 (27.6%) were at risk for PI according to the BS. Of these, five (20.8%) were at mild risk, 16 (66.7%) at moderate risk, and three (12.5%) at severe risk. Most of both hospitalized older adults at risk and those without risk had a partner and an income between two and three minimum wages. Hospitalized older adults at risk for injury differed in relation to sex and age group; most were female (54.2%) and aged 80 years or over (37.5%). No sociodemographic variable showed a statistically significant association ($p < 0.05$) with the risk for PI. These data are shown in Table 1.

Most hospitalized older adults with or without risk for PI had chronic diseases, were smokers, were not alcoholics, had no urinary control, had no bowel control, had a normal diet, did not have restricted positioning, did not need mobility assistance and had adequate BMI. The profile of older adults at risk for injury was similar, with only a slightly higher percentage of people with restricted positioning and who needed mobility assistance, compared to those without risk. The only variable that differed completely was being bedridden, as those at risk were mostly bedridden and those without risk were not. In this sense, there was a significant statistical association between the variables being bedridden, restricted positioning and needing mobility assistance and the presence of risk with a value of $p < 0.001$, $p = 0.019$ and $p = 0.002$ respectively, as shown in Table 2.

Table 1 – Frequency distribution of sociodemographic variables of hospitalized older adults according to the presence of risk for pressure injury – Rio Grande, RS, Brazil, 2019.

Variable	No risk (n%)	At risk (n%)	p-value
Sex			0.497
Female	29 (46)	13 (54.2)	
Male	34 (54)	11 (45.8)	
Total	63 (100)	24 (100)	
Age group (years)			0.225
60–69	30 (47.6)	7 (29.2)	
70–79	19 (30.2)	8 (33.3)	
80 or older	14 (22.2)	9 (37.5)	
Total	63 (100)	24 (100)	
Marital status			0.631
With partner	39 (63.9)	14 (58.3)	
No partner	22 (26.1)	10 (41.7)	
Total	61 (100)	24 (100)	
Income*			0.193
Up to 1.5	13 (23.2)	8 (34.8)	
2 to 3	37 (66.1)	15 (65.2)	
More than 3	6 (10.7)	0 (0.0)	
Total	56 (100)	23 (100)	

* minimum wage at the time of data collection = R$ 998.00.

Most hospitalized older adults, both at risk and without risk, had a hematocrit with a reference value below normal, hemoglobin below normal, normal blood glucose, normal leukocytes. The profile of older adults at risk for injury was similar, with only a higher percentage of people with hemogram and hemoglobin values below normal and with leukocytes above normal. However, there was no statistically significant association between variables related to laboratory tests and the presence of PI.

From these results, few variables showed a statistical relationship with the risk for developing PI, namely: being bedridden, restricted positioning in bed and the need for mobility assistance. Even so, as prevention occurs based on the knowledge and intervention in all factors contributing to the onset of injuries, all risk factors found in the medical records were considered for the development of the ND and the care plan, according to Chart 1.

Based on the overview of NANDA – NIC – NOC connections for each pertinent nursing diagnosis, the care plan for patients at risk for developing PI was developed, according to the main nursing interventions of the NIC. Interventions related to patient mobility predominated (observed in all proposed nursing diagnoses), followed

Table 2 – Frequency distribution of variables related to the health of hospitalized older adults according to the presence of risk for pressure injury – Rio Grande, RS, Brazil, 2019.

Variable	No risk (n%)	At risk (n%)	p-value
Presence of chronic disease			0.866
Yes	38 (60.3)	14 (58.3)	
No	25 (39.7)	10 (41.7)	
Total	63 (100)	24 (100)	
Smoking			0.534
Yes	35 (55.6)	13 (54.2)	
No	21 (33.3)	10 (41.7)	
Ex-smoker	7 (11.1)	1 (4.1)	
Total	63 (100)	24 (100)	
Alcoholic			0.599
Yes	8 (12.7)	3 (12.6)	
No	48 (76.2)	20 (83.3)	
Ex-alcoholic	7 (11.1)	1 (4.1)	
Total	63 (100)	24 (100)	
Diet			0.864
Normal	57 (90.5)	22 (91.7)	
Changed	6 (9.5)	2 (8.3)	
Total	63 (100)	24 (100)	
Urinary control			0.287
Yes	14 (22.2)	8 (33.3)	
No	49 (87.8)	16 (66.7)	
Total	63 (100)	24 (100)	
Bowel control			0.217
Yes	15 (24.2)	9 (37.5)	
No	47 (75.8)	15 (62.5)	
Total	62 (100)	24 (100)	
Bedridden			< 0.001
Yes	0	17	
No	62	6	
Total	62 (100)	23(100)	
Restricted positioning			0.019
Yes	3 (4.9)	5 (21.7)	
No	58 (95.1)	18 (78.3)	
Total	61 (100)	23 (100)	
Need for mobility assistance			0.002
Yes	8 (12.9)	8 (47.5)	
No	54 (87.1)	9 (52.5)	
Total	62 (100)	17 (100)	
BMI			0.771
Low weight	12 (19.4)	6 (25.0)	
Appropriate	31 (49.2)	10 (41.7)	
Overweight	20 (31.4)	8 (33.3)	
Total	63 (100)	24 (100)	

by interventions related to pressure control, supervision and nutrition control/monitoring. Last but not least, were interventions related to urinary/bowel incontinence and hygiene.

DISCUSSION

The BS is used as a health indicator in the context of patient safety because of its preventive nature and provision of support for an overall assessment of the risk for the development of PI[12]. In this sense, the BS was chosen as a tool to measure the risk of PI, as its use is predominant, compared to other predictive scales of PI[13–14].

The total sample of the study, a literature review that aimed to identify predisposing factors for the onset of PI in older adults, corroborates the findings, since most articles analyzed in the review related the female sex to the risk for PI and in nine out of the 21 articles, the extreme age was indicated as a predisposing factor[4]. Likewise, in a study that aimed to assess the occurrence and risk factors for the development of PI in patients admitted to three units of a hospital in Minas Gerais, most participants who developed PI were older adults aged between 60 and 96 years, women and white[15].

Among the variables manifested in patients at risk for developing PI, those related to mobility, such as being bedridden, having restricted positioning and needing mobility assistance stood out. Restricted positioning was considered when the patient has some type of limitation restricting his/her positioning in bed, such as, for example, fractures or surgical procedures. In addition, the need for mobility assistance is understood as the patient's need or not for an assistance device or help from family members/caregivers when walking or moving outside the bed.

It is the nurse's responsibility to guide the rest of the team and family members/patients in an educational and informative way, regarding the care of changing decubitus, skin hydration, use of pneumatic mattresses, use of support cushions and pillows to protect vulnerable areas and use of equipment that assist in movement and positioning[14]. These precautions are aimed at preventing PI, especially in older adults with risk factors related to mobility, identified in the present study. These are some examples of easy-to-use and low-cost interventions for the institution, which, if not performed, can trigger skin involvement.

In the present study, laboratory tests did not show a statistically significant association with the risk of developing PI, although most patients at risk had hemogram and hemoglobin values below normal and leukocytes above normal. In a study conducted in the state of Paraná, the risk for PI showed a statistical association only with low levels of albumin[16].

We highlight the importance of the nurse's knowledge about all biochemical parameters, which contributes to evidence-based practice in the prevention of PI, since by having mastered the biochemical indicators, the professional can develop a more assertive care plan. In this sense, the treatment and prevention of injuries are aspects that enhance the nurse's autonomy[16].

Chart 1 – Nursing diagnoses, related factors, expected nursing outcomes and interventions – Rio Grande, RS, Brazil, 2020.

DOMAIN 4 – ACTIVITY/REST (Class 2 – activity/exercise) IMPAIRED PHYSICAL MOBILITY	
Related factors: decrease in muscle control; malnutrition; disuse; pain; sedentary lifestyle; physical deconditioning; decrease in muscle strength; activity intolerance; decrease in muscle mass; body mass index (BMI) percentile> 75 age and sex appropriate; reluctance to initiate movement; decrease in endurance; joint stiffness.	
Expected outcomes	**Nursing interventions**
Gait Balance Body mechanics performance Client satisfaction: functional assistance Mobility Transfer performance	Exercise therapy: ambulation Exercise promotion: strength training Exercise therapy: balance Body mechanics promotion Exercise therapy: joint mobility Exercise therapy: muscle control
DOMAIN 4 – ACTIVITY/REST (Class 2 – activity/exercise) IMPAIRED BED MOBILITY	
Related factors: environmental barrier; insufficient knowledge of mobility strategies; pain; physical deconditioning; insufficient muscle strength; obesity.	
Expected outcomes	**Nursing interventions**
Body positioning: self-initiated Coordinated movement Mobility	Exercise promotion: strength training Exercise therapy: muscle control
DOMAIN 4 – ACTIVITY/REST (Class 2 – activity/exercise) IMPAIRED WALKING	
Related factors: insufficient knowledge of mobility strategies; pain; physical deconditioning; insufficient muscle strength; decrease in endurance.	
Expected outcomes	**Nursing interventions**
Locomotion: walking Balance	Exercise therapy: ambulation Exercise therapy: balance
DOMAIN 4 – ACTIVITY/REST (Class 4 – Cardiovascular/pulmonary responses) INEFFECTIVE PERIPHERAL TISSUE PERFUSION	
Related factors: insufficient knowledge of disease process; insufficient knowledge of aggravating factors; smoking.	
Expected outcomes	**Nursing interventions**
Tissue integrity: skin and mucous membranes Tissue perfusion: peripheral Cutaneous sensory function Circulation status	Pressure injury prevention Positioning Skin surveillance Temperature regulation Blood pressure control Lower extremity monitoring Fluid monitoring Hydroelectrolytic management
DOMAIN 4 – ACTIVITY/REST (Class 5 – self-care) TOILETING SELF-CARE DEFICIT	
Related factors: anxiety; environmental barrier; impaired ability to transfer; pain; fatigue; weakness; impaired mobility; decrease in motivation.	
Expected outcomes	**Nursing interventions**
Self-care: toileting	Urinary/bowel incontinence care Exercise promotion Perineal care Skin surveillance
DOMAIN 9 – STRESS COPING/TOLERANCE ANXIETY (Class 2 – coping responses)	
Related factors: threat to current status; threat of death; stressors; unmet needs.	
Expected outcomes	**Nursing interventions**
Anxiety self-control Anxiety level	Active listening Decision-making support Crisis intervention Dementia management Vital signs monitoring Medication administration Anxiety reduction Environmental management

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DOMAIN 11 – SAFETY AND PROTECTION (Class 2 – physical injury) RISK FOR IMPAIRED SKIN NTEGRITY	
Related factors: excretions; hydration; pressure over bony prominence; secretions; moisture.	
Expected outcomes	**Nursing interventions**
Tissue integrity: skin and mucous membranes Body positioning: self-initiated Hydration Immobility consequences: physiological Immune status Nutritional status Nutritional status: food and fluid intake Urinary continence Weight: body mass	Bath Bed rest care Bowel incontinence care Urinary incontinence care Lower extremity monitoring Nutrition management Positioning Blood pressure control Skin surveillance Pressure injury prevention
DOMAIN 11 – SAFETY AND PROTECTION (Class 2 – physical injury) RISK FOR PRESSURE INJURY	
Related factors: surface friction; insufficient caregiver knowledge of pressure injury prevention; insufficient knowledge of aggravating factors; self-care deficit; shearing forces; incontinence; inadequate nutrition; extended period of immobility on hard surface; pressure over bony prominence; decrease in mobility; smoking.	
Expected outcomes	**Nursing interventions**
Mobility Nutritional status: food and fluid intake Risk control Risk detection Self-care status Sensory function Tissue integrity: skin and mucous membranes Transfer performance	Energy management Exercise promotion Exercise therapy: ambulation Nutritional management Pressure control Surveillance
DOMAIN 11 – SAFETY AND PROTECTION (Class 5 – defensive processes) RISK FOR ALLERGY RESPONSE	
Related factors: exposure to allergen (moisture by body fluids)	
Expected outcomes	**Nursing interventions**
Allergic response: localized	Allergy management

In this context, a study with the objective of "establishing relationships between nursing interventions and outcomes for the diagnosis of risk for pressure injury in critically ill patients", established outcomes and interventions for each factor/domain present in the BS: 100% of patients were bedridden, 60.3% had a higher chance of friction/shear and 52.4% had impaired nutrition[17]. The relationship with the current study stands out, in which interventions on mobility predominated. We emphasize the importance of each domain of the BS as a risk factor for the development of the care plan, as well as the need for its presence in patients' medical records.

In addition to the risk factors already discussed, regarding mobility, pressure control and skin supervision, the nutritional aspect stands out, where nurses must act actively, since they have daily contact with the patient and observe factors such as swallowing and acceptance of the offered diet. A recent study highlighted the early performance of nutritional assessment, which is a fundamental tool in the recognition of malnourished or nutritionally at-risk older adults. The nutritional status of patients should be assessed in such a way that the supply of energy and protein is guaranteed as recommended by the guidelines[18].

Last but not least, interventions related to urinary/bowel incontinence and hygiene appeared. Incontinence has physiological and psychological consequences, since patients often do not accept to use geriatric diapers. When their use is necessary, it can contribute to skin moisture and predispose to the occurrence of PI. In a current study, when analyzing the use of diapers in adult and older adult patients, the authors emphasized this is a non-standard practice, in which cognition, mobility and incontinence criteria are not screened[19].

In this sense, a study developed with the objective of analyzing the sociodemographic and clinical profile associated with skin care and wounds in hospitalized older adults identified a high number of nursing interventions associated with skin care[19]. The need for nursing interventions proved to be relevant both in the association between prolonged hospitalization, chronic diseases and aging, which demonstrated a strong relationship with PI, and in the association between extremes of age and skin aging[20].

In the present study, possible interventions with older adults that can be implemented within the hospital environment were considered, since a hospitalization period requires the participation of a multidisciplinary team. Each

nursing intervention considers several activities that can be developed by nurses, and according to the NIC, many interventions require specialized nurse training, whereas others describe practices that can be developed by technicians, although they must always be planned and evaluated by nurses[9].

New research on nursing interventions capable of acting in the prevention of PI is encouraged, especially in older adult patients, as this is a vulnerable population to diseases, and if hospital stay is necessary, it should be quick and resolving, because events like PIs can be fatal in these clients.

Pressure injuries represent a problem that affects patients, the health system and the work team, especially nursing professionals. In this sense, this study contributes to the health area when thinking about the various consequences of the lack of PI prevention, especially in the hospital environment and with older adult patients, where this disease can lead to death.

The limitations of this study regard the information contained in the medical records, since the BS could not be analyzed considering its domains but only the final score.

CONCLUSION

The nursing outcomes and interventions were proposed in view of the possible diagnoses for these patients, highlighting interventions that encourage patient mobility, pressure control, skin supervision, nutrition, incontinence and hygiene.

By developing nursing diagnoses and interventions, it is possible to systematize the care provided by nurses and stimulate clinical reasoning in order to provide qualified and individualized care for the individual needs of older adults with skin injuries from the identification of risk factors to the assessment of expected outcomes. Aiming at preventing pressure injuries, the present study contributes to the dissemination of a care plan designed specifically for hospitalized older adults, highlighting the importance of the nurse's mastery of the scientific tools involved in the profession.

RESUMO

Objetivo: Elaborar diagnósticos de enfermagem e plano de cuidados para indivíduos idosos com lesão por pressão com base nos fatores de risco, visando a prevenção de sua ocorrência nas pessoas idosas hospitalizadas. **Método:** Estudo exploratório, descritivo, transversal com abordagem quantitativa, realizado na Unidade de Clínica Médica de um Hospital Universitário, com 87 prontuários. **Resultados:** Entre as pessoas idosas que apresentaram algum risco para o desenvolvimento de lesão por pressão, verificou-se uma prevalência do sexo feminino, com mais de 80 anos de idade e classificados em risco moderado na Escala de Braden. Destacaram-se as intervenções de enfermagem que estimulam a mobilidade do paciente, controle da pressão, supervisão da pele, nutrição, incontinência e higiene. **Conclusão:** A enfermagem tem papel importante na manutenção da integridade da pele dos pacientes. Cabe salientar a utilização das escalas preditivas de lesão como dispositivo complementar à clínica, para auxiliar no diagnóstico de enfermagem com vistas às intervenções direcionadas aos fatores de risco.

DESCRITORES

Idoso; Hospitalização; Lesão por Pressão; Diagnóstico de Enfermagem; Cuidados de Enfermagem.

RESUMEN

Objetivo: Desarrollar diagnósticos y planes de atención de enfermería para adultos mayores con lesiones por presión basados en factores de riesgo, con el objetivo de prevenir su ocurrencia en adultos mayores hospitalizados. **Método:** Estudio exploratorio, descriptivo, transversal y cuantitativo realizado en la Unidad de Clínica Médica de un Hospital Universitario con 87 historias clínicas. **Resultados:** Entre los adultos mayores con algún riesgo de desarrollar una lesión por presión, hubo una prevalencia del sexo femenino, mayor de 80 años y clasificado en riesgo moderado en la Escala de Braden. Destacaron las intervenciones de enfermería que favorecen la movilidad del paciente, el control de la presión, la supervisión cutánea, la nutrición, la incontinencia y la higiene. **Conclusión:** La enfermería tiene un papel importante en el mantenimiento de la integridad de la piel de los pacientes. Cabe destacar el uso de escalas predictivas de lesiones como complemento a la práctica clínica para ayudar en el diagnóstico de enfermería con miras a intervenciones dirigidas a factores de riesgo.

DESCRIPTORES

Anciano; Hospitalización; Úlcera por Presión; Diagnóstico de Enfermería; Atención de Enfermería.

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