Assessing nursing diagnoses and interventions in labour and high-risk pregnancies

Avaliando diagnósticos e intervenções de enfermagem no trabalho de parto e na gestação de risco

Evaluar diagnóstico y la intervención de enfermería en trabajo y riesgo durante el embarazo

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ABSTRACT
Objective: To evaluate the use of nursing diagnoses and interventions proposed for women in labour and high-risk pregnancies.
Method: This is a descriptive, retrospective study with documentary analysis of 1000 medical records and a checklist conducted from July to September 2014, at a maternity hospital in Paraiba, Brazil. It consisted of analysing descriptive measures and comparing the relationship between nursing diagnoses and interventions using NANDA – International and the Nursing Interventions Classification.
Results: The most common diagnoses in labour were acute pain (62%), fatigue (24.7%), and anxiety (22%). For high-risk pregnant women they were impaired sleep and rest (100%), risk of infection (81.8%), and anxiety (77.2%). The interventions were hand washing (80.8%) and identify and accommodate patient in the bed (78%).
Conclusion: The diagnoses express needs during parturition and the psychobiological changes in high-risk pregnancy. The interventions are disconnected from the diagnoses and should therefore be reviewed and altered.
Keywords: Nursing diagnosis. Nursing care. Obstetrics.

RESUMO
Objetivo: Avaliar o uso de diagnósticos e intervenções de enfermagem propostos para mulheres em trabalho de parto e gestantes de alto risco.
Método: Estudo descritivo, documental e retrospectivo realizado com 1000 prontuários, através de *checklist*, durante julho a setembro de 2014, em uma maternidade da Paraíba. Analisaram-se as medidas descritivas e a relação comparativa entre os diagnósticos e as intervenções de enfermagem utilizadas no serviço por meio da NANDA-Internacional e da Classificação das Intervenções de Enfermagem.
Resultados: Os diagnósticos mais evidenciados no trabalho de parto: dor aguda (62%), fadiga (24,7%) e ansiedade (22%). Para as gestantes de alto risco: sono e repouso prejudicados (100%), risco de infecção (81,8) e ansiedade (77,2%). As intervenções foram: lavar as mãos (80,8%), identificar e acomodar no leito (78%).
Conclusão: Os diagnósticos expressam as necessidades na parturição e nas alterações psicobiológicas na gestação de risco. As intervenções estão desarticuladas dos diagnósticos, necessitando de revisões e mudanças.
Palavras-chave: Diagnóstico de enfermagem. Cuidados de enfermagem. Obstetrícia.

RESUMEN
Objetivo: Evaluar el uso de intervenciones de enfermería de diagnóstico y propuestas para mujeres en trabajo de parto y embarazadas de alto riesgo.
Método: Estudio descriptivo, documental y retrospectivo con 1.000 registros a través de lista de verificación durante julio a septiembre de 2014, en una maternidad de Paraíba. Se analizaron las medidas descriptivas y la relación comparativa entre los diagnósticos y las intervenciones de enfermería utilizados en el servicio con la NANDA-Internacional y la Clasificación de Intervenciones de enfermería.
Resultados: Los diagnósticos más evidentes en el trabajo de parto: el dolor agudo (62%), fatiga (24,7%) y ansiedad (22%). Para las mujeres embarazadas de alto riesgo: sueño y reposo perjudicados (100%), riesgo de infección (81,8) y ansiedad (77,2%). Las intervenciones fueron: lavarse las manos (80,8%), identificar y acomodarse en la cama (78%).
Conclusión: Las necesidades expresas de diagnóstico durante el parto y los cambios psicobiológicos en el embarazo de riesgo. Las intervenciones son diagnósticos inconexos que requieren revisiones y cambios.
Palabras claves: Diagnóstico de enfermería. Atención de enfermería. Obstetricia.

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■ INTRODUCTION

Pregnancy is a physiological phenomenon characterised by changes and biological and psychosocial adaptation that generally evolve in a healthy manner. However, due to specific characteristics or factors, some pregnant women have complications and/or problems that classifies their condition as a high-risk pregnancy and possibly lead to a negative mother/child evolution[1]. When this risk is detected, the nurses and healthcare team must provide appropriate and quality care.

In the gravid-puerperal period, multidisciplinary care is important since most of these women require minimal interventions. In some situations, life-threatening complications or emergencies can occur and must be identified efficiently. All the persons involved, from the health professionals to the local administrators, must perform effective actions to ensure risk-free, quality mother and child assistance[2]. Nurses have direct participation during this period and, in light of maternal and neonatal morbidity and mortality data, have sought to improve their technical and scientific knowledge and create quality care strategies. The role of nurses in obstetrics includes monitoring pregnant women in prenatal care, in labour, during delivery, and in the postpartum, and assisting high-risk pregnant women in the maternal ICU. Therefore, nurses require clinical preparation to identify real and potential problems, correctly manage diagnoses and the different practice situations, and plan and implement care.

The modalities of the nursing practice include the systematisation of nursing care ("SAE") that is developed through the nursing process to improve the quality of care by allowing nurses to systematise interventions in a clear, organised and patient-centered way[3]. Thus, this process is the technological tool that supports the intellectual activity of nurses and provides the guidelines they need to adopt a given clinical and therapeutic judgement style. This instrument is the essence of today's nursing practice[4].

With the use of this methodology, some nursing classification systems have been developed to standardise the language between nurses and the nursing staff. There is the language proposed by the former North American Nursing Diagnosis Association, currently known as NANDA-I, the Nursing Interventions Classification (NIC), the Nursing Outcomes Classification (NOC), the International Classification for Nursing Practice (ICNP), and the International Nursing Practice Classification in Collective Health (CIPESC)[5].

The world's most recognised and widespread taxonomy of nursing diagnoses is the taxonomy of North American Nursing Diagnosis Association (NANDA), which uses the reasoning and clinical judgment of nurses to diagnose the human responses to health problems and real or potential life processes and thus enable the use of standardised language to better communicate the phenomena of interest in the nursing practice and document and assess care[1, 6].

Today, the implementation of SAE has become an ethical issue rather than an option to organise nursing work. Resolution COFEN No. 358/2009 emphasises the need to apply the SAE in the different nursing work scenarios and that nurses – as part of their work activities – should be responsible for implementing, planning, organising and assessing the whole process[4].

However, a study conducted in obstetrics services in the state of Paraíba showed that some of the factors that hamper this operationalisation singled out by the nurses were lack of a theoretical foundation regarding the nursing process that leads to deficiencies in the design of data collection instruments, in the establishment of incorrect or incomplete diagnoses for specific sectors, and in the construction of nursing interventions that are different to the needs of parturition and clinical problems in high-risk pregnancies; the lack of credibility of nursing technicians regarding the SAE; the workload of nurses; and the lack of interest of managers to implement SAE[7].

With regard to the gravid and puerperal cycle in Brazilian maternity wards, regardless of the development of an SAE, the instruments used to collect data and identify the nursing diagnoses and interventions must be designed to meet the needs that arise during this period, support personalised and holistic assistance, and help nurses provide adequate and quality care.

Consequently the question this work sought to answer was what are the nursing diagnoses and interventions in parturient women and high-risk pregnant women at the benchmark state public maternity hospital?

The aim of this paper was to assess the use of nursing diagnoses and interventions proposed for women in labour and high-risk pregnant women at a maternity hospital in Paraíba, Brazil

■ METHODOLOGY

This is a descriptive study based on retrospective and documentary analysis and a quantitative approach that could support the systematic search of records and information of past events in official documents to obtain reliable data. This study is also based on the initial part of the thesis titled, *Uso da Tecnologia da Informação Móvel e Sem Fio para a Sistematização da Assistência de Enfermagem na Obstetrícia*, of the graduate specialisation programme of the Universidade Federal da Paraíba – UFPB.

This investigation was conducted at the maternity hospital of the Complexo Hospitalar de Cruz das Armas, a benchmark public state institution, called Hospital Amigo da Criança, located in the city of João Pessoa, PB, Brazil, that provides obstetric care for women and low and high-risk pregnancies.

The hospital attends around 40 patients per day at the studied sectors, or an average of 1200 users per month, resulting in around 500 hospital admissions per month. The study sample was 1000 records that complied with the inclusion criteria. These criteria were records of nursing diagnoses and interventions and records of women assisted during the prepartum stage and woman admitted to the maternal ICU from January to April 2014. The criteria for exclusion were records that contained torn forms or forms that did not have data of nursing diagnoses or nursing interventions, and records of other maternity sectors.

The records were selected with the help of two structured checklists created by the author using NANDA-I. One of the checklists was a specific instrument to collect data from the parturient women containing 36 items, of which 16 were nursing diagnoses and 20 were nursing interventions. The other was a specific instrument to collect data from the high-risk pregnant women of the ICU containing 29 items, of which 13 were nursing diagnoses and 16 were nursing interventions. The nursing diagnoses and interventions, which were the same diagnoses and interventions that were used at the maternity hospital, were confirmed and improved according to literature. Data were collected by four authors and researchers – two obstetrics specialists and two SAE specialists – between July and September 2014.

The data were compiled according to descriptive statistics with a sample calculation of 50% of 2000 consultations during the four investigated months and arranged in Microsoft Office Excel spreadsheets to present the results. The results were analysed using descriptive measures according to the parameters and the comparative relationship between the nursing diagnoses and interventions at the service and literature based on the basic human needs of Horta and with the aid of the nursing diagnoses classification according to the domains and classes of Taxonomy II of NANDA International to additionally analyse relevant aspects of SAE application and the practice of nurses in the area of obstetrics.

Research observed the ethical guidelines of Resolution No. 466/12. This study was approved by the research ethics committee of the Hospital Universitário Lauro Wanderley of the Universidade Federal da Paraíba, filed under opinion No. 555.524 and CAAE No. 20523814.5.0000.5183 .

■ RESULTS

The results show that the nursing history is included in all the patient records of the institution. Of the 1000 investigated records, 890 were of the prepartum sector and the delivery room and 110 were of the high-risk pregnancy and maternal ICU sector.

The maternity records contained 16 nursing diagnoses that were specifically related to labour and childbirth. In all, there was a frequency of 1,276 records distributed among the 16 diagnoses of the checklists, as shown in Table 1.

To better represent the results, the diagnoses were divided into seven domains according to Taxonomy II of NANDA – I. The most prominent nursing diagnoses in the prepartum and delivery room were related to the domains comfort, activity/rest, coping/stress tolerance, nutrition, and safety/protection.

With respect to the number of records, for the domain comfort, "acute pain related to uterine contractions" was found in 552 (62%) records; for the domain activity/home, "fatigue related to labour" was found in 220 (24.7%) records; for the domain coping/tolerance, "anxiety related to labour" was found in 195 (22%) records; for the domain nutrition, "imbalanced nutrition: less than body requirements related to lack of appetite and pain" was found in 82 (9.2%) records; and for the domain safety/protection, "risk for infection related to invasive procedures" was found in 64 (7.2%) records.

The nursing process comprises complementary, interdependent and continuous steps. Therefore, after establishing the nursing diagnoses, some nursing interventions were also identified and presented in Table 2.

For the care provided by the nursing staff, a frequency of 5,822 interventions/activities was recorded and distributed in the 20 interventions in the nursing process checklist for the prepartum and delivery room sectors of the hospital. Of these interventions, the most frequent were "hand washing before and after contact with the patient" found in 720 (80.8%) records; "identify the bed/box" in 695 (78.0%) records; "accommodate pregnant women in bed/box and offer appropriate clothing" in 686 (75.0%) records; "rapid HIV test after counselling" in 522 (58.6%) records; and "report abnormal findings to the nurse" in 520 (58.4%) records.

Given the characteristics of obstetric urgencies and emergencies and the complications of the labour and puerperal period, the maternal ICU sector also had other diagnoses, which are listed in Table 3. The most prevalent of these diagnoses were related to the domains activity/rest, coping/stress tolerance, and safety/protection.

Table 1 – Nursing diagnoses in the prepartum and delivery room for the domains according to the medical records of parturient women at the maternity hospital of the Complexo Hospitalar de Cruz das Armas. João Pessoa, Paraíba, Brazil, July – September 2014

Nursing diagnoses	N°	%
DOMAIN – Comfort		
Acute pain related to uterine contractions	552	62.0
Nausea related to labour	20	2.2
DOMAIN – Activity and Rest		
Fatigue related to labour	220	24.7
Impaired physical mobility related to discomfort and pain	34	3.8
Disturbed sleep pattern related to physical and emotional alterations	20	2.2
Bathing/Toileting self-care deficit related to pain	08	0.9
DOMAIN – Coping and Stress Tolerance		
Anxiety related to labour	195	22.0
Risk of altered parent-child connectedness due to ignorance of the maternity/paternity	06	0.7
DOMAIN – Nutrition		
Imbalanced nutrition: less than body requirements related to lack of appetite and pain	82	9.2
DOMAIN – Safety and Protection		
Risk for infection related to invasive procedures	64	7.2
Impaired skin integrity related to oedema	12	1.3
DOMAIN – Elimination and Exchange		
Impaired urinary elimination related to urinary infection	18	2.0
Constipation related to pregnancy	17	1.9
Risk for constipation related to haemorrhoids	10	1.1
Risk for altered breathing pattern related to anxiety	06	0.7
DOMAIN – Perception and Cognition		
Impaired verbal communication related to labour pain	12	1.2

Source: Research data, 2014.

For the domain activity/rest, the most prominent diagnoses was "impaired sleep and rest related to change of environment" found in 110 (100%) records; for the domain coping/stress tolerance, the most prominent diagnosis was "anxiety related to the uncertainty of the evolution" found in 85 (77.2%) records and "fear related to hospitalisation" found in 70 (63.6%) records; and for the domain safety/protection the most frequent diagnosis was" risk for infection related to invasive procedures" found in 90 (82%) records.

Several interventions were also identified for the surveyed diagnoses of the high-risk pregnant women in the maternal ICU. However, all the interventions prescribed in the care plan of this sector were recorded to be performed in routine care and they were consequently checked, as shown in Chart 1.

According to Chart 1, these interventions are similar to the general conduct of the nursing routines rather than directly elaborated or prescribed interventions for the nursing diagnoses or interventions that accord with scientific literature. It is important to highlight that the interventions found in the medical records of the pregnant women admitted to the ICU were established by the maternity nurses and the nursing coordinators of the institution.

■ DISCUSSION

Although pregnancy is considered a biologically physiological moment in women's lives, some factors can trigger complications that affect the health of mother and child and make this unique moment into a period of tension, fear and uncertainties. These issues require nurses to remain alert so they may detect and identify any potential problems in the early stages, and consequently implement care that is grounded on knowledge and clinical reasoning[8].

With regard to the parturient women, the results show that the nursing diagnoses express the phenomena that

Table 2 – Nursing interventions of the prepartum and delivery rooms for the domains according to the medical records of parturient women at the maternity hospital of the Complexo Hospitalar de Cruz das Armas. João Pessoa, Paraíba, Brazil, July – September 2014

Nursing interventions	N°	%
Hand washing before and after contact with the patient	720	80.8
Identify the bed/box	695	78.0
Accommodate pregnant women in bed/box and offer appropriate clothing	686	77.0
Rapid HIV testing after counselling	522	58.6
Report abnormal findings to the nurse	520	58.4
Measure and record vital signs	515	57.8
Perform venous access with Jelco	345	38.7
Observe uterine contractions	345	38.7
Observe and record vaginal discharge	338	37.9
Send patient to delivery room	300	33.7
Administer medication, spm	210	23.5
Offer oral liquid	186	21.2
Accompany patient to the restroom	180	20.2
Offering hot baths to patient	170	19.1
Observe and record vesicle eliminations	160	17.9
Observe location of venipuncture	155	17.4
Offer stool to patient in labour	140	15.7
Send patient to operating room	135	15.1
Observe and record vesicle eliminations	125	14.0
Offer sweets (molasses) to patient	95	10.6

Source: Research data, 2014.

are intrinsic to the needs of women in labour and represent elements that should be the focus of nurses during labour and delivery. These phenomena are presented as real and high risk and they are related to functional, emotional and environmental aspects according to basic human needs, as proposed in the care model of Horta. The use of NANDA – I as a classification system therefore allowed the standardisation of professional language to determine the concepts identified in the care practice[9].

It should be noted that when analysing the situation in which the women were admitted, the diagnoses in the charts are not marked for needs and/or problems during labour since labour usually features a very low number of diagnoses. If the records had been more efficient and true to the real situation, they would probably have registered that in practice most parturient women in labour experience some intensity of "pain" due to effective, rhythmic contractions of moderate intensity and plastic changes of the cervix. Evidently, these clinical features can be per-

ceived in the form of pain. Therefore, this diagnosis should be included in most of the records.

The defining characteristics of the nursing diagnoses "acute pain" are changes in blood pressure, observed evidence of pain measured in the uterine dynamics, changes in heart rate, and verbal reports of pain. Parturition is considered a subjective, multidimensional, and physiological response to sensorial stimuli and is related to physical and environmental aspects. In fact, it triggers concerns and fear that affect the behaviour of parturient women, especially if they do not feel assisted and allowed to be the protagonists of labour[10].

Other diagnoses like "anxiety" also occurred, albeit to a lesser extent. Regardless of how well accompanied the parturient women feel in prenatal care, the level of information they have of this process, and the quality of the team, parturition and childbirth are phenomena that can lead to complications and cause fear and insecurity. Records of anxiety were therefore expected, but only found in 195 of the files.

Table 3 – Nursing diagnoses in the maternal ICU for the domains according to the medical records of parturient women at the maternity hospital of the Complexo Hospitalar de Cruz das Armas. João Pessoa, Paraíba, Brazil, July – September 2014

Nursing diagnoses	N°	%
DOMAIN – Activity and Rest:		
Impaired sleep and rest related to change of environment	110	100
Impaired physical mobility related to the hospital admission process	70	63.6
Bathing/Toileting self-care and feeding deficit related to immediate postpartum discomfort	40	36.3
DOMAIN – Coping and Stress Tolerance		
Anxiety related to uncertainty of evolution of the period	85	77.2
Anxiety related to the threat of death	30	27.2
Fear related to hospitalisation	70	63.6
Impaired adaptation related to multiple stressors	40	36.3
Risk for stress related to change in behaviour	35	31.8
DOMAIN – Self-Perception		
Low self-esteem related to disturbed body image	25	22.7
DOMAIN – Role Relationships		
Altered parenting related to unmet expectations of the capabilities of the newborn	15	13.6
DOMAIN – Safety and Protection		
Risk for infection related to invasive procedures	90	81.8
Risk for puerperal infection related to changes in body temperature	05	4.5
Hypothermia related to blood loss	05	4.5
Impaired skin integrity related to oedema	46	42
DOMAIN – Comfort		
Pain related to uterine contractions	10	9.0

Source: Research data, 2014.

Further analysis of the diagnoses revealed that "fatigue" can be caused by discomfort due to inappropriate positioning of the parturient women when they are experiencing the pain of labour, ineffective breathing, impaired sleep and rest, and anxiety. Parturient women must be able to adapt in a dim, noise-free environment to improve their sleep and rest patterns, which is not available or possible in most maternity wards[11].

The diagnoses "altered nutrition", which is the result of nutritional intake under the recommended body requirement, is related to lack of appetite and pain. However, the urge to eat is a metabolic process of the body to obtain nutrients, control digestion, and store nutrients to maintain the body's strength and vitality. The increased energy expenditure of parturient women during the prepartum and labour can increase their appetite.

"Risk of infection" is related to invasive procedures that primarily involve premature rupture of the amniotic membranes and a high number of digital vaginal examinations. Other defining characteristics of this diagnosis include vulvovaginitis and urinary tract infection.

Once the nursing diagnoses were identified, they were related to the nursing interventions and counted to determine their frequency in the records. When they were analysed individually and specifically, however, it was found that the identified interventions were directly related to labour care and labour and therefore considered part of the practice routine of the nursing assistants and technicians.

A nursing intervention is regarded as "any treatment based on clinical judgement and reasoning performed by a nurse to improve patient/user results"[12]. Thus, the NIC, which is the nursing interventions classification proposed to nurses, was not used to establish the interventions described in the analysed records.

For nursing diagnoses like "acute pain", "fatigue", and "impaired comfort" identified in the records, the nurses should record specific interventions such as alternative pain relief like massages with oils on shoulders and sacral region, walking, pelvic exercises, warm bath or shower, and respiratory techniques.

In obstetric nursing, care technologies involve the techniques, procedures and knowledge used by nurses during

Accommodate patient in bed/box and offer appropriate clothing
Measure and record vital signs every 2 hours
Support patients regarding their needs
Notify nurse of alterations in saturation, heart rate and blood pressure
Wash hands before and after contact with the patient
Keep bed clean and organised
Continuous cardiac monitoring and pulse oximetry
Observe and record breastfeeding
Observe location of venipuncture
Observe level of consciousness
Promote change of decubitus every 2 hours
Perform venous access s/n
Perform daily oral and body hygiene
Change peripheral venous access every 72 hours
Change medication gear

Chart 1 – Nursing Interventions prescribed in the maternal ICU of the maternity hospital of the Complexo Hospitalar de Cruz das Armas. João Pessoa, Paraíba, Brazil, July – September 2014

Source: Research data, 2014.

the process of care in the various stages of labour and childbirth. These care technologies are based on the idea that pregnancy, labour and childbirth are natural events of life and should therefore be applied without interrupting this physiological process. Consequently, when these technologies are applied in this scenario, they promote comfort and relaxation, reduce risks, and ensure effective and beneficial care that meets the needs of women[13].

Contrarily, the care needs of pregnant women or parturient women in a maternal ICU can be related to several socioeconomic and biological factors, from difficulty to access the basic and reference health systems and quality of the institutions to the team's inability to manage serious situations at the early stages. The impact of complications in the perinatal period can mark women for life, unless the obstetrics professionals perform appropriately and the institution provides a good intensive care structure[14].

The recorded nursing diagnoses are related to maladaptation that requires the nurses' intervention so these women can better adapt to the hospital environment.

The admission of women with obstetrical complications to the ICU is a challenge for all intensive care teams. Pregnancy differentiates patients in relation to other intensive care situations due to the aggravated clinical condition, and it can affect the interpretation of diagnostic and laboratory tests. It is therefore imperative that IC professionals have solid experience in obstetrical and intensive care matters to assist these patients. Moreover, studies show that adequate intensive treatment for unstable obstetric causes has significantly reduced maternal mortality in the past decade[15].

However, the nursing interventions recorded by the nurses in the ICU were noticeably disconnected considering that they are routine practices and were consequently checked by the professionals. This finding reveals the need to reflect on and adapt these practices to ensure that nursing interventions are based on the validated and identified diagnoses since they determine the care that the patients must receive according to the established diagnoses.

Nursing care is a specific professional work with interrelated dynamics that requires a specific manner of doing that is based on the nursing process. Standardising the language of nursing problems and treatment helps clarify and notify some essential rules in the implementation of care. Despite these efforts, there are still many non-standardised nursing problems and treatments[12, 16].

The planning of nursing care consists of determining nursing actions by means of a method of work to meet the needs of users coherently and responsibly. Nurses should no longer be the mere executors of a task or standards dictated by other professionals; they should assume the self-determination of their functions and adjust administrative principles and clinical measures to solve specific problems in their field of work[12, 17].

For this reason, the quality of care provided to these women is directly related to the competence, commitment, and responsibility of health professionals, especially

nurses. This can be expressed in the form of qualified care achieved by implementing the SAE in women's care[18].

Withal, the nursing process is considered the most solid conceptual and practical structure for the provision of nursing care because it ensures the continuity and integration of the entire team. It has been presented as an instrument of great utility that facilitates nursing practice performance and documenting[11, 17].

■ FINAL CONSIDERATIONS

The findings of this study show that a large number of nursing diagnoses were not identified in the records of the parturient women, but that those that were identified express the phenomena inherent in the needs of women who experience parturition, and that the NANDA – I serves as a tool to denominate these phenomena by providing a standardised professional language.

Most of the nursing diagnoses recorded for women with high-risk pregnancies targeted the category of physical and biological needs, such as impaired sleep and rest, anxiety, and fear. These diagnoses were more frequent among this population because the pregnancy and puerperal cycle causes physiological and/or pathological changes that may require more complex intensive care and assistance. It is important to remember that any emotional, social or spiritual changes should be treated, valued, and never overlooked when providing nursing care to these women.

The study also shows that the recorded nursing interventions were disconnected from the diagnoses of the parturient women and the high-risk pregnant women, which stresses the importance of reviewing and possibly changing the manner in which interventions are recorded in the nursing process of the studied maternity hospital. Suggestions include the use of a conceptual structure, such as the NIC, that offers a theoretical nursing care framework to replace the systematic and logical organisation of the hospital environment and solve the identified problems.

The limitation of the study lies in the need to validate the content of these diagnoses and the interventions for each diagnosis by a group of experts with experience in use of the NANDA – I, and the clinical validation of the proposed clientele. This study will hopefully encourage new projections for further investigations that help improve the documenting of professional practices and the visibility of nurses in the obstetric care scenario based on tests and use of the NANDA – I as a tool for determining, specifying and describing phenomena inherent in the practice of obstetric nurses.

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