Enfermería Intensiva 34 (2023) 109–111

Enfermería *Intensiva*

www.elsevier.es/ei

LETTER TO THE EDITOR

Nursing methodology applied to a patient through structural intervention in cardiology

Metodología enfermera aplicada a una paciente mediante intervencionismo estructural en cardiología

Dear Editor,

Parellada-Vendrell et al.[1] recently published a clinical case in the journal *ENFERMERÍA INTENSIVA* about treatment in the field of structural interventional cardiology. We congratulate the authors on the optimisation of the patient's care and their outcome. However, there are some comments related to the methodology used in this study which, if not clarified, could lead to errors in clinical practice and the taking on of functions not appropriate to our profession.[2]

Firstly, we perceive some confusion in the discussion section with the context of the case, as the authors mention certain nursing interventions that would be key to the patient arriving in the best possible clinical conditions for mitral valve implantation. The case description explains that the patient was admitted to the acute cardiac care unit after implantation and after referral from the outpatient clinic due to their symptoms. In fact, the assessment and the corresponding care plan were made post-intervention, as they cover the complications that developed after implantation; this is confusing for the reader.

Secondly, a care plan is created that does not correspond at all to the competencies acquired in our day-to-day work, and does not provide a solution to the problems detected.[2] The nursing diagnoses (ND) identified by the authors[1] are erroneous, because we cannot manage them autonomously; a medical prescription is needed for a series of measures to be adopted and which the nurse is obliged to carry out. An ''Ineffective breathing pattern'' (00032) in which oxygen and certain drugs will be needed or the ''Decreased activity tolerance'' (00298) caused by the condition for which the patient was admitted are not autonomous interventions. Incidentally, the ''Intolerance'' (00092) that the authors mention in the case was changed to ND (00298). Furthermore, risk diagnoses cannot be related to medical problems or treatments, since, if we do not eliminate the source of risk, the problem will continue to exist, and again it is the doctor who has the autonomy to do so. Specifically, the ''Risk of deterioration of skin integrity'' (00047) would be well formulated if it were not related to physical immobility; remember, the patient was on complete bedrest as ordered by the doctor and unable to undertake any activity due to their incapacitating condition.

Thirdly, ''Disturbed sleep pattern'' (00198) cannot be considered an ND when pharmacological support is needed to treat it, since nurses do not prescribe this type of treatment. We would be taking on roles, therefore, that are not appropriate to our field of activity. All the clinical nursing judgements identified by the authors[1] are problems of collaboration.

Finally, we believe it appropriate to consider hypothyroidism and hypertension collaborative problems, diseases that the patient suffered prior to this acute condition, and which are completely ignored in this care plan, although they are very relevant for a good outcome.

To conclude, according to NANDA I,[3] an ND involves making a clinical judgement about a human response (there is certainly no assessment of the patient's state of mind in the acute process) and confirms that nurses in practice cannot use all the available NDs if they are outside the standards or competencies of the country in which they exercise their profession.

It does little to help us advance in the development of models, theoretical frameworks, and methodology if we do not assimilate the basics, and intrude into the roles of other professions.

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DOI of original article: https://doi.org/10.1016/j.enfi.2022.03.004

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https://doi.org/10.1016/j.enfie.2022.03.003

In response to ''Nursing methodology applied to a patient through structural intervention in cardiology''

En respuesta a «Metodología enfermera aplicada a una paciente mediante intervencionismo estructural en cardiología»

Dear Editor,

We would like to thank Alconero-Camarero et al.[1] for the interest shown, as well as the observations and comments in relation to the article recently published in ENFERMERÍA INTENSIVA ''Valve in valve mitral: about a case report.'' We would like to respond to the questions raised, as we consider that the case has been read or contextualised in a preconceived and erroneous way. Their letter to the editor gives us the opportunity to clarify any aspect or doubt.

Firstly, as described in the article,[2] the patient was admitted to the Acute Cardiac Care Unit from outpatient cardiology consultations, as she presented symptoms compatible with severe mitral regurgitation due to dysfunction of the mitral bioprosthesis implanted in 2016 by cardiac surgery. It was during her stay in this unit that the management and care for clinical stabilisation before the percutaneous valve in valve mitral implant was optimised in order to arrive at the procedure in optimal conditions.

It was during admission to the unit that this therapeutic option was proposed to the patient, as she is not a candidate for a new valve replacement due to the high surgical risk, and where she returned after the structural procedure, for close monitoring and control of possible alterations and complications.

This is reflected in the article, specifically in the summary, introduction and description of the case: ''The clinical case describes the admission of a patient to the acute cardiac care unit, where, once clinically stabilised and treatment optimised, percutaneous mitral valve implantation is performed as a therapeutic alternative due to severe symptomatic mitral bioprosthetic mitral regurgitation and high surgical risk''.[2]

DOI of refers to article: https://doi.org/10.1016/j.enfi.2022.05.002

Secondly, the nursing assessment and the corresponding individualised care plan was carried out on admission to the Acute Cardiac Care Unit, and given that it is a dynamic process and in no way static, it was updated and modified according to the alterations resolved and the problems that arose during their stay in the Acute Cardiac Care Unit.

Thirdly, Alconero-Camarero et al. state that: ''*All* clinical nursing judgments identified by the authors are collaborative problems'', and ''The nursing diagnoses (DXE) identified by the authors are *erroneous* because we cannot solve them autonomously''[1] (italics added). NANDA Internacional[3] defines DXEs as ''clinical judgements about the reactions of the individual, family or community to actual or potential health problems/life processes''. Following this criterion, *all t*he DXE proposed (both actual and risk) are included in the NANDA Internacional[3] and follow a nursing methodology, where care of the cardiovascular critically ill patient is approached from an autonomous perspective without any intrusion of labour or competencies, with objectives and activities specific to our role, which are described in the care plan of the article[2] and included in the classification of outcomes (NOC)[4] and nursing interventions (NIC)[5] with the aim of resolving the problem detected or minimising its impact on the patient.

The article[2] is based on the international nomenclature, where we do not find an activity that is not reflected in this nomenclature, and we firmly believe that it is the total competence of the nurse. Even so, discussion and divergence of opinions are positive aspects, as they encourage reflection and enrich the profession.

Another aspect they comment on: ''the disturbed sleep pattern (00198) cannot be considered a DXE at the moment when pharmacological support is needed to treat it, as the nurse does not prescribe such treatments'' makes us doubt the critical reading of the article made, where you can see that the nursing intervention is NIC 2304 Administration of oral medication, where, of course, the nurse is in charge of preparing, informing the patient, administering, observing the response and recording its effects.

Thus, we consider that these are indeed competencies of our profession and clinical nursing judgements in the face of the diagnoses identified: monitoring haemodynamic status, assessing the respiratory pattern and lung sounds, providing comfort measures to relieve tachypnoea and dyspnoea, administering prescribed pharmacological treatment and assessing its effectiveness, assessing skin integrity and implementing preventive measures, monitoring the presence of oedema and water balance, provide help and