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Why do we call them nursing diagnoses when they are problems of collaboration?*



¿Por qué los llamamos diagnósticos de enfermería cuando son problemas de colaboración?

Dear Editor:

We congratulate the authors,¹ for the publication in the *Enfermería Intensiva* journal of their clinical case report, corresponding treatment with a left ventricular assist device, for stimulating a constructive debate that is always positive for our professional development. Nevertheless, certain methodological inaccuracies were found, unless these are clarified they may lead to errors in clinical practice, our profession accepting assignments which do, not correspond to it.

Although the authors describe a clinical case using NANDA I taxonomy, the nursing diagnoses (ND) mentioned in the text are problems with co-working rather than ND. According to the NANDA I-accepted definition:² “a ND is a clinical judgement on the response of an individual, family or community to vital processes/real or potential health problems which supply the basis for the therapy to achieve the aims for which the nurse is responsible”. The patient is under sedation and analgesia with orotracheal intubation, so that the ND which appear in the manuscript have no basis within the

situation that is described, as no supporting verbal communication takes place. None of the clinical judgements in question are such, firstly because we cannot resolve a fall in cardiac output or a deterioration in spontaneous ventilation if the doctor does not provide guidelines for a series of measures to be adopted, which the nurse has to implement, given that we are not independent in this respect. On the other hand, risk diagnoses cannot be associated with medical problems or treatments, as if we do not eliminate the source of the risk the problem will continue to exist, and once again it is the doctor who has the independence to be able to do so.³ Although in this situation the “*risk of cutaneous integrity deterioration*”² would be valid, this would be so in connection with the humidity, pressure or shear forces that the patient may suffer in their disease process. Nevertheless, nor would it be methodologically correct if the appropriate tasks for the relevant independence problems were implemented.

We are also surprised by the lack of family data, in the search for ND given the severity of the case.

Lastly, we find it striking that the evaluation is based on needs and practically omits certain relevant systems for this pathology (the neurological system and haemodynamics) and that the sole potential complication is constipation, more so in a situation where the first 48–72 hours are crucial. We cannot place this consideration before other more important ones, such as the arrhythmias, hypovolemia, lack of right ventricle or complications deriving from the poor working of the device, such as the pump ceasing to work.⁴

Skin care to prevent the appearance of pressure ulcers should be given the emphasis it deserves, as the authors mention this almost anecdotally. Although the appearance of club foot is mentioned, at no time do the authors refer to alternating pressures in the relevant zones. They use a diaper as a precaution, although this would not be indicated given that an excess of humidity arises in the perineal and sacral areas, and although it is more than evident that a patient with an open thorax cannot be placed on one side,

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it is possible to relieve pressures while washing, as these critical patients are washed on a tray, which is a suitable moment to examine and evaluate the area.

To conclude, we cannot benefit from using a model or specific theoretical framework if we have not clearly delimited our field of action and our responsibilities. Terms should be clarified and working criteria and guidelines should be unified to achieve the proposed objectives, so that we all work in the same direction to prevent duplicating tasks and conceding responsibilities that are not our own.

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