SYSTEMATIZATION OF NURSING ASSISTANCE IN DIABETIC FOOT WOUND TREATMENT: CASE REPORT

Introduction: Diabetes mellitus is considered a metabolic syndrome of multifactorial origin characterized by hyperglycemia and disorders in the metabolism of carbohydrates, proteins and fats that occurs when there is no insulin or when insulin does not perform its function properly. Diabetic foot injury is one of the most frequent implications of diabetes mellitus. It is associated with many factors, such as peripheral vascular disease and peripheral neuropathy, which in many cases may compromise the entire limb. In this context, the systematization of nursing care starts as a systematic method that makes it possible to identify and understand the needs of the patient. The application of the Systematization of Nursing Assistance brings benefits to the client, the institution, professionals and to nursing as a whole. Objectives: To verify the inference of the nursing diagnosis “Impaired skin integrity” and the use of the other steps of Nursing Care Systematization in the treatment of diabetic foot wound. Methods: This is an exploratory clinical study of the case-study type, carried out during the period of clinical nursing internship in a public hospital in the city of Recife-PE, from September 17 to October 11, 2018. Results: A 77-year-old male patient with diabetes mellitus, with MIE lesion and hallux amputation, fourth and fifth finger. During the aforementioned period, the data was collected through anamnesis, physical examination, records in the medical record and analysis of laboratory tests. In this way, it was possible to plan the Nursing Care Systematization and to apply the interventions for the diagnosis “Impaired skin integrity”, being: daily skin examination with image records and monitoring of wound healing, daily dressing with use of serum saline at 0.9%, Essential Fatty Acids (AGE) and Hydrogel in the necessary places, orientation on how to change the decubitus periodically and use of cushions in the regions, aiming to decrease the pressure. During the 14 days of activities implemented in the patient, the clinical progress of the patient was observed, with evolution of the wound, being observed the decrease of exudate, modification of necrotic tissue by shedding and increase of granulation tissue. Conclusion: In view of the above, it was possible to obtain satisfactory results, which emphasizes the importance of the implementation of the Nursing Assistance Systematization and nurses’ work in the treatment of wounds, requiring greater investments in this scope, regarding training, acquisition of coverages, standardization in the accomplishment, daily evaluation and respect the aseptic techniques.