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Nursing diagnoses in institutionalized elderly victims of violence

Diagnósticos de enfermagem em idosos institucionalizados vítimas de violência

Diagnósticos de enfermería en ancianos institucionalizados víctimas de violencia

Francielle Renata Danielli Martins Marques[1]
Dayane Akinara Toledo Ribeiro[1]
Grazieli Adrieli Rodrigues Pires[1]
Aline Balandis Costa[1]
Lígia Carreira[1]
Maria Aparecida Salci[1]

1. Universidade Estadual de Maringá. Maringá, PR. Brazil.

Abstract

Objective: to identify nursing diagnoses in institutionalized elderly victims of violence. **Method:** this was a qualitative descriptive exploratory study conducted by the basic human needs framework and developed in a long-term institution. Data collection took place from May to June 2020, and information was obtained from clinical records. Data were submitted to thematic and content analysis and directed to NANDA International Taxonomy II. All ethical aspects were respected. **Results:** 14 medical records were analyzed, and 25 nursing diagnoses were identified; of these, 12 were related to psychobiological needs, 13 were related to psychosocial needs, and one was related to a psychospiritual need. As for the diagnostic category, 20 were related to health issues, four to potential risks, and one to health promotion. **Conclusion and implications for practice:** exposure to domestic violence, the presence of chronic conditions, and institutionalization revealed diagnoses that showed weaknesses. Greater emphasis is required in interventions related to motivating the elderly who wish to achieve their well-being, directing assistance to psychobiological, psychosocial, and psychospiritual needs, with a focus on recovering the health of the elderly and their dignity. By using nursing diagnoses to construct the care process in long-stay institutions, care is expanded, enabling a differentiated look at victims of violence.

Keywords: Nursing Diagnosis; Aged; Elder Abuse; Nursing Theory; Violence.

Resumo

Objetivo: identificar os diagnósticos de enfermagem em idosos institucionalizados vítimas de violência. **Método:** estudo exploratório descritivo qualitativo, conduzido pelo referencial das Necessidades Humanas Básicas, desenvolvido em instituição de longa permanência. A coleta de dados ocorreu de maio a junho de 2020, com informações obtidas em prontuários clínicos. Os dados foram submetidos à análise temática e de conteúdo dirigida à taxonomia II da NANDA Internacional. Todos os aspectos éticos foram respeitados. **Resultados:** foram analisados 14 prontuários e identificados 25 diagnósticos de enfermagem, dos quais 12 se relacionaram às necessidades psicobiológicas, 13 às psicossociais e 1 às psicoespirituais. Quanto à categoria diagnóstica, 20 se relacionaram aos problemas de saúde, 4 aos riscos potenciais e 1 à promoção da saúde. **Conclusão e implicações para a prática:** a exposição à violência intrafamiliar, a presença de condições crônicas e a institucionalização revelaram diagnósticos que demonstraram fragilidades. Destaca-se a demanda de intervenções relacionadas à motivação dos idosos em alcançar seu bem-estar, direcionando a assistência de acordo com necessidades psicobiológicas, psicossociais e psicoespirituais, com foco na recuperação da saúde do idoso e de sua dignidade. Utilizar os diagnósticos de enfermagem para construir o processo de cuidado em idosos institucionalizados amplia a assistência e possibilita um olhar diferenciado às vítimas de violência.

Palavras-chave: Diagnóstico de Enfermagem; Idoso; Maus-Tratos ao Idoso; Teoria de Enfermagem; Violência.

Resumen

Objetivo: identificar diagnósticos de enfermería en ancianos institucionalizados, víctimas de violencia. **Método:** estudio exploratorio descriptivo cualitativo, realizado por el marco de Necesidades Humanas Básicas, desarrollado en una institución de larga estancia. La recolección de datos se realizó desde mayo hasta junio de 2020, con informaciones obtenidas de las historias clínicas. Los datos se sometieron a un Análisis Temático y de contenido dirigido a la taxonomía II de la NANDA Internacional. Se respetaron todos los aspectos éticos. **Resultados:** se analizaron 14 historias clínicas y se identificaron 25 diagnósticos de enfermería; de estos, 12 estaban relacionados con necesidades psicobiológicas; 13, con psicosociales y uno con psicoespirituales. En cuanto a la categoría de diagnóstico, 20 se relacionaron con problemas de salud, cuatro con riesgos potenciales y uno con promoción de la salud. **Conclusión e implicaciones para la práctica:** la exposición a la violencia doméstica, la presencia de afecciones crónicas y la institucionalización revelaron diagnósticos que demostraban debilidades. Es necesario hacer un mayor énfasis en las intervenciones relacionadas con la motivación de los ancianos para lograr su bienestar, dirigiendo la asistencia a las necesidades psicobiológicas, psicosociales y psicoespirituales, con un enfoque en la recuperación de la salud y la dignidad del anciano. La utilización de los diagnósticos de enfermería para construir el proceso de atención al anciano institucionalizado, amplía la asistencia y posibilita una atención diferenciada a las víctimas de violencia.

Palabras clave: Diagnóstico de Enfermería; Anciano; Maltratos al Anciano; Teoría de Enfermería; Violencia.

Corresponding author:
Francielle Renata Danielli Martins Marques.
E-mail: franrenata.martins@gmail.com

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INTRODUCTION

The number of elderly people in Brazil jumped from 14 million in 2000 to over 29 million in 2020, with Paraná State having 1,745,728 elderly people alone.[1] The aging of the Brazilian population imposes on the health system the challenge of taking care of elderly people's health and guaranteeing aging with quality and dignity. Issues related to the elderly population are prevalent among political, social, and human rights movements as the predominance of the elderly has accompanied the growth in violence perpetrated against people over 60.[2]

The physiological changes caused by aging impair the ability to perform daily and instrumental activities, making elderly individuals dependent on periodic assistance and, consequently, increasing their degree of vulnerability.[3-5] Thus, with the physiological process of aging and the need for assistance for daily activities, many elderly people become unable to live independently and start needing help, becoming more vulnerable to violence perpetrated by family members, such as children, grandchildren, or even caregivers.[4,6]

Violence against the elderly may occur through neglect and/or be psychological, financial, physical, and sexual in nature.[4,6,7] What is more, this violence has become not only a public health problem but also a social and legal matter as it threatens the dignity of the elderly since it robs them of their quality of life and limits their freedom.[4-6] Providing specific services to protect the elderly from all types of violence and ensuring dignified aging is part of the actions developed to fulfill the protection policies for elderly victims of violence.[6] Once violence is identified, the elderly are removed from their family life - as a protective measure and for their integrity - and taken into long-stay institutions for the elderly (LSIE), which are appropriate for these cases as determined by the prosecutors who defend the rights of these individuals.[2]

Nurses are indispensable in LSIE, reinforcing the need to regulate the presence of nursing professionals in these establishments. The nurse has the technical-scientific capacity to provide integral and humanized care to the elderly and understand the nuances of violence occurring in the family sphere in order to identify the problems that interfere with the quality of life of the victims and welcome them, building an atmosphere of trust and respect for their decisions.[5]

Nursing consultation aimed at basic human needs (BHN)[8] allows for establishing nursing diagnoses (ND) related to the needs of the individual, their family, and the community. This consultation is guided by theoretical models that help nurses apply a nursing process in line with the elderly victim of violence, respecting and maintaining their uniqueness, authenticity, and individuality.

The application of the NDs supported by Horta's theory empowers nurses in their care practice because they now have a comprehensive and perceptive view of the various aspects of the individual, enabling them to plan care directed at the individual's needs and evaluate the efficiency of the care provided.[8-10] It is considered of utmost importance that nurses know the public with whom they work; for this, the NDs provide care focused on individual needs based on the peculiarities of each person.[9,11]

Although research on violence is widespread in the scientific literature,[2,4-7] the theme related to the elderly is still not very expressive. Thus, we highlight the originality and relevance of this study in identifying the NDs in elderly victims of violence, encouraging the use of the nursing process in LSIEs and, in this case, the importance of NDs in implementing nurses' interventions.

Given the above, this study posed the following research question: What are the most common NDs in institutionalized elderly victims of violence? Hence, this study aimed to identify the nursing diagnoses in institutionalized elderly victims of violence.

METHOD

This is a descriptive exploratory study with a qualitative approach using Wanda Aguiar Horta's Theory of Basic Human Needs as a theoretical reference.[8,12] This study was carried out in a nursing home in a medium-sized city in southern Brazil. This is a governmental institution and acts based on the National Policy of Social Assistance (PNAS/2004) and Unified System of Social Assistance, with activities focused on sheltering elderly people over 60 years old in situations of violence, mistreatment, exploitation, neglect, homelessness and abandonment, and with weakened or broken family ties.

Data collection occurred from May to June 2020 by two researchers linked to the Graduate Program in Nursing and with experience in the techniques used; one of the researchers worked as a nurse in the LSIE in question. As a data source, the information was obtained from clinical records, which were recorded in a specific document prepared by the researchers in light of the theoretical framework, with topics related to psychobiological, psychosocial, and psychospiritual needs.[8]

In this document, the following notes were made: identification data (age and marital status), anamnesis, current health status, history of violence (type of violence suffered and place of occurrence), and data obtained by the Clinical and Functional Vulnerability Index (IVCF-20).[13] The instrument present in the clinical records allowed us to acquire information about the multidimensional aspects of aging, such as self-perception of health, functional disabilities, cognition, mood, mobility, communication, multiple comorbidities, polypathologies, polypharmacy, or hospitalization.

The IVCF-20 instrument, which was validated in 2014 and used in the norms for evaluating the elderly in Paraná State for risk stratification, allows researchers to identify clinical-functional impairments as it can synthesize the points of frailty, which allows for interdisciplinary care.[13]

The thematic analysis and directed content analysis techniques were used to organize and systematize the data.[12,14] In the pre-analysis,[12] the documents were skimmed to know the health conditions, process, or existing vulnerabilities resulting in the main parts that composed the record units. In the analysis stage,[12] these main parts were coded, producing the units of meaning, revealing the problem categories, potential risks, and state of health promotion. In the interpretation step,[12] the NDs were identified from the nurse's clinical judgment about

the health conditions, process, or vulnerability of an individual, family, group, or community.[10]

The NANDA International Taxonomy II was used to support the directed content analysis,[10,14] guiding the choices and decisions according to the phenomenon of violence suffered by the institutionalized elderly. The process of identifying the NDs was established by clinical reasoning, scientifically grounded, and with standardized language.[15]

The theoretical contribution, experiences of the researchers with the nursing process, and assistance to elderly victims of violence allowed clinical reasoning with solidity when evaluating each person.[15] The problems, potential risks, or health promotion status identified were grouped by similarity, considering the components of title, domain, and defining characteristics. The NDs were then correlated with the theoretical framework and interpreted from critical and reflective inferences.[8,12]

Finally, the accuracy of the ND found was verified. The accuracy of the ND is validated when the nurse can clearly identify the defining characteristics and link them to related factors and/or risk factors found by assessing the individual, family, group, or community.[10] Thus, the validation technique by consensus was applied to establish a unanimous opinion about the pertinence and relevance of a certain ND.[16]

For validation,[16] three experts were selected; these individuals were required to meet the following criteria: be linked to the Nursing Graduate Program, be a member of the GEPECRON research group, have experience with care work, and have experience in applying the ND and nursing classifications or taxonomies. The disagreement of one or more specialists conditioned the non-validation of the respective NDs.[16]

The pre-analysis, analysis, and interpretation were performed using the MAXQDA software (version 20.0.8, reference 230594870).[12] After validating the NDs, a tree with the self-reported health conditions, process, or vulnerability was created, which included the relations with the defining characteristics expressed by each ND. The qualification of the results was expanded using the consolidated criteria for reporting qualitative research (COREQ) protocol.

All ethical and legal precepts defined by Resolutions nos. 466/2012 and 510/2016 of the National Health Council were respected. On June 11, 2019, the study was approved by the Permanent Commission for Project Evaluation and Permanent Committee for Ethics in Research with Human Beings under Opinion no. 3.384.162, CAAE: 08167419.7.0000.0104.

RESULTS

Fourteen records of elderly patients were analyzed, eight of which were female. There was a predominance of single elderly individuals and victims of intrafamily violence, such as neglect. The elderly patients' ages ranged from 60 to 88. Only one person was independent in performing daily instrumental activities. Furthermore, we verified that 10 elderly were dependent in basic activities, 8 had some sign/symptom of cognitive disorder, 11 presented altered gait patterns, 9 had urinary incontinence, 11 used polypharmacy, 8 had more than five chronic diseases, and 11 were stratified as frail elderly.

Chronic diseases were predominant, which were present in the medical records of all the elderly patients, especially dementia. As for chronic diseases, there were 9 elderly with hypertension, 7 with mental disorders, 6 with heart disease, 5 with diabetes mellitus, and 4 with Parkinson's disease. Oncological, ophthalmological, gynecological or prostatic, autoimmune, renal, infectious, and pulmonary diseases were registered to a lesser extent.

From the recognized health conditions, process, or vulnerabilities, 25 NDs were identified, grouped, and interpreted as proposed by NANDA-I Taxonomy II and related to Horta's Theory (Chart 1).[8,10]

The ND frail elderly syndrome is considered multidimensional as its damage generates somatic effects that potentiate the onset of geriatric disabilities. The health conditions, process, or vulnerability that enabled this ND to be identified were impaired ambulation, impaired self-care for bathing, impaired self-care for dressing, activity intolerance, social isolation, and unbalanced diet. Given it is a complex ND, it is related to psychobiological and psychosocial needs and therefore present in both definitions (Chart 1).

Twelve NDs were related to psychobiological needs, 13 to psychosocial needs, and 1 to a psychospiritual need. The identified NDs were grounded on the biological, psychological, and social spheres, which can be explained by the profile of the study participants, showing that the nursing assessment is more focused on aspects involving the physical component, coping with health conditions, and the weakening of the support network of elderly victims of violence.

The domains comprising the NDs identified were activity/rest, safety/protection, coping/tolerance to stress, health promotion, roles and relationships, elimination/exchange, perception/cognition, self-perception, life principles, and comfort.

Regarding the diagnostic category, 20 NDs were related to health problems, 4 were correlated to potential risks, and 1 to health promotion. This result shows that nursing performance is basically focused on interventions related to pre-existing issues.

DISCUSSION

The NDs are the fruit of the nurse's clinical reasoning.[15] By identifying the ND, the assistance to the triad individual/family/community is outlined with elements that propose interventions in the face of the identified situations, supporting the recognition of Nursing as the science of care.[9,17] Nursing care based on the BHN theory provides institutionalized elderly victims of violence with care focused on their biological needs and on the other dimensions of care.[8]

Given the complexity of the care provided to elderly residents in homes for the elderly, nurses must guide the assistance with a holistic approach that understands the frail elderly in their fullness.[9] It is the nurse's role to develop different skills to deal with families and the elderly to help ensure their safety.[6] The choice of the BHN theory as a support for the discussions of

Chart 1. Nursing diagnoses according to NANDA-I Taxonomy II in elderly victims of violence according to the defining characteristics and based on the identified health conditions, Maringá, Paraná State, Brazil, 2021.

Psychobiological needs		
Identified health conditions, process, or vulnerability	**Domain**	**Nursing diagnoses**
Urinary incontinence; urinary urgency; multiple causes.	Disposal and exchange	Impaired urinary elimination
Neurological impairment; recent environmental change; emotional disorder.	Elimination and exchange	Risk of constipation
Impaired ability to swallow.	Safety/ protection	Risk of aspiration
Age ≥65 years; altered cognitive function; hearing impairment; neuropathy; impaired vision.	Safety/ protection	Risk of falls
Diabetes mellitus; hypertension; decreased peripheral pulses; edema.	Activity/rest	Ineffective peripheral tissue perfusion
Lack of physical conditioning; insufficient muscle strength; pain; altered cognitive function; impaired vision.	Activity/rest	Impaired wheelchair mobility
Postural instability; altered cognitive function; musculoskeletal impairment; neuromuscular impairment.	Activity/rest	Impaired physical mobility
Impaired balance; impaired vision.	Activity/rest	Impaired ambulation
Impaired balance; impaired vision; altered cognitive function.	Activity/rest	Impaired transfer ability
Altered cognitive function; musculoskeletal impairment; neuromuscular impairment.	Activity/rest	Impaired self-care for bathing
Alteration in cognitive function; musculoskeletal impairment; neuromuscular impairment.	Activity/rest	Impaired self-care for dressing
Impaired ambulation; impaired self-care for bathing; impaired self-care for dressing; activity intolerance; social isolation; unbalanced diet.	Health promotion	* Frail elderly syndrome
Psychosocial needs		
Identified health conditions, process, or vulnerability	**Domain**	**Nursing diagnoses**
Impaired decision making; altered cognitive function.	Perception/ cognition	Ineffective health maintenance
Persistent forgetfulness; mild cognitive impairment; neurological impairment.	Perception/ cognition	Impaired memory
Decreased affection; social isolation; History of abandonment.	Self-perception	Hopelessness
History of abandonment; history of abuse; history of neglect.	Self-perception	Low situational self-esteem
Sad affection; excessive self-blame; social isolation; chronic illness.	Confrontation/ stress tolerance	Impaired mood regulation
Learned response to a threat; little-known scenario.	Confrontation/ stress tolerance	Fear
Depression; disturbed family dynamics; violence in the community.	Confrontation/ stress tolerance	Impaired resilience
Abandonment; neglect of the patient's basic needs; neglect of the relationship with the family member; rejection.	Confrontation/ stress tolerance	Disabled family coping
Changes in participation and decision making; change in family conflict resolution; decreased mutual support; abandonment.	Roles and relationships	Dysfunctional family processes
Insufficient mutual support in daily activities between partners; history of intrafamily violence.	Roles and relationships	Ineffective relationship
Social isolation; affective deprivation; emotional deprivation.	Comfort	Risk of loneliness
Extremes of age; prolonged institutionalization.	Health promotion	Decreased involvement in recreational activities
Impaired ambulation; impaired self-care for bathing; impaired self-care for dressing; social isolation; unbalanced nutrition.	Health promotion	* Frail elderly syndrome
Psychospiritual needs		
Identified health conditions, process, or vulnerability	**Domain**	**Nursing diagnoses**
Expresses desire to reinforce religious customs used in the past; expresses desire to increase the use of religious material.	Principles of life	Improved willingness for religiosity

Source: Research data, 2020.

this study makes it possible to comprehensively and integrally understand the reality of this population based on their individual needs, hence proving that the NDs are applicable nursing practice.

The perpetration of violence is associated with the frailty of the elderly, who show declines in strength, endurance, and physiological function, making them more vulnerable to violence than more robust elderly individuals.[7] Violence against the elderly is associated with cognitive decline,[5] which may explain the predominance of cognitively impaired elderly in the study site. Oftentimes, the physical and mental deficits in elderly victims of maltreatment may have been aggravated or resulted from the violence they have suffered.[4]

The NDs ineffective health maintenance, impaired memory, impaired self-care for dressing, impaired transfer ability, impaired self-care for bathing, impaired physical mobility, impaired wheelchair mobility, risk of falls, risk of aspiration, risk of constipation, impaired urinary elimination, and the frail elderly syndrome were identified from the health conditions, process, or vulnerability related to cognitive changes. The high number of NDs associated with cognitive decline may be due to the predominance of elderly people with dementia diseases at the study site.

As for the primary ND found, we observed that, within the psychobiological needs, the domain with the highest representation was activity/rest. One study addressed the elderly in an LSIE in Minas Gerais State and also identified the prevalence of this domain in the NDs in its sample, indicating impaired mobility as something frequent in institutionalized elderly and contributing to their dependence to perform psychobiological BHN.[9]

The ND impaired wheelchair mobility, impaired physical mobility, impaired ambulation, impaired transfer ability, ineffective peripheral tissue perfusion, and frail elderly syndrome contemplate health conditions, process, or vulnerability related to impaired balance, altered cognitive function, musculoskeletal impairment, and neuropathic complications resulting from diabetes mellitus, aspects that contribute to another ND: the risk of falls. Falls in the elderly are related to intrinsic factors, including urinary incontinence, postural instability, and cognitive decline - and extrinsic factors - such as steps, slippery floors, and inadequate footwear.[9,13]

As a characteristic of institutionalization, the elderly are more vulnerable to cognitive decline associated with mobility limitation. This is because brain diseases produce important motor alterations that make them more fragile and have less functional capacity. For this reason, it is essential to establish, in these institutions, measures to stimulate physical mobility and activities that encourage body balance.[3,9] The organization of the work of health professionals in homes for the elderly resembles the care routine of a hospital sector, in which curative activities prevail over health promotion actions.[3] Thus, inserting stimulation programs in the context of LSIE is necessary and urgent to minimize the functional decline and achieve the integrality of care for the elderly.[3]

Regarding psychosocial needs, the NDs hopelessness, low situational self-esteem, impaired mood regulation, fear, impaired resilience, impaired family coping, dysfunctional family processes, ineffective relationships, and risk of loneliness stood out, which were identified from the health conditions, process, or vulnerability related to violence that occurred in the family context.

Intrafamily violence has particularities that deserve careful attention from health professionals. The victims are afraid to provide information, which, combined with feelings of fear, shame, helplessness, guilt, and judgment of values, collaborate for the elderly to develop a state of deep sadness and loneliness.[4] Nonetheless, despite being prevalent in institutionalized elderly people, NDs related to depressed mood are, most of the time, underdiagnosed and undertreated.[18,19]

The self-perception of health has been used as a valid indicator of the quality of life, morbidity, and decreased functionality. It analyzes multidimensional physical, cognitive, and emotional aspects, working mainly as a good predictor of mortality.[19] The negative perception of health status has an important impact on the aging process and is often associated with a more significant number of chronic diseases and functional disabilities in elderly people.[5,19]

The NDs hopelessness and low situational self-esteem are specific in revealing how violence in the family setting and institutionalization interfered with the self-perceptions of health. In this study, both hopelessness and low situational self-esteem were identified from health conditions, process, or vulnerabilities related to a history of neglect or abandonment.

The domain principles of life stood out regarding psychospiritual needs, as represented by the ND improved willingness for religiosity. The aging process can be permeated by adversities that can affect the well-being of the elderly, although this process should be mediated with different strategies, such as approaching spirituality and religiosity.

Spiritual well-being is associated with higher levels of life satisfaction in the elderly, serving as a refuge amidst the insecurities of aging and providing a sense of resilience.[18,20] Elderly people in vulnerable situations tend to become isolated and may develop depressive symptoms. In light of this, religiosity presents itself as a comforting factor for social and personal well-being.[20]

The lack of research on the benefits of care in the spiritual sphere does not allow us to dive deeper into the discussion. However, we emphasize that this dimension requires further attention from health professionals - especially nurses - because it points to the need to develop strategies to strengthen support networks that promote holistic care according to the individual needs of each person.[20]

It is understood that Horta's theory as theoretical support to systematize the assistance of nurses who work in the LSIE allows the provision of care focused on the individual needs of victims of violence.[8] Thus, identifying problems and subsequent interventions contemplate the elderly according to their needs.

The NDs identified herein focus on the biological and psychosocial spheres, which can be explained by the participants' profile and the legacy of the previous health care models, which prioritized detecting problems of biological origin. Considering the

characteristics of the biomedical model imposed in the training of nurses, a greater tendency of these professionals to identify psychobiological needs is observed.[11]

Despite the psychosocial NDs being more numerous in this study, the NDs related to the biological component had a significant representation, revealing that the culture of the investigation of health problems is still grounded on biological foundations. The fragility in the survey of health conditions, process, or vulnerability related to the psychospiritual component indicates that this aspect's nursing evaluation is incipient. Hence, it is necessary for nurses to conduct their nursing consultation by investigating aspects of the spiritual component as an integral part of the person's needs. In one study, the authors also identified the lack of attention given to the spiritual component and that most NDs were also related to psychobiological and social needs.[11]

Regarding the diagnostic categories described by NANDA-I,[10] only one nursing diagnosis belonged to health promotion. In this category, the defining characteristics include people wanting to improve their current health status or the nurse recognizing signs of motivation and willingness to achieve well-being.[10]

Some authors who addressed the construction of NDs also reported similar findings and with a greater focus on health problems.[9,17] Planning nursing care based on problem-focused NDs does not meet the integrality of care as preventive actions for risk NDs also need to be implemented in elderly care.[17]

This result may indicate weaknesses in the actions that encourage health promotion in the studied population, with support for the person to feel stimulated to practice actions that promote the improvement of their conditions. Due to institutionalization, the elderly start to present an idle routine, which is pivotal to carrying out health promotion activities with cognitive and motor stimuli; besides promoting specific benefits for these areas, such activities can improve mental health.[3]

The results of this study contribute to encouraging the nursing process - especially the NDs - in the care practices of nurses, directing care through the promotion, maintenance, and recovery of the aging person's health. As a result, it is possible to plan actions supported by scientific knowledge that are effective, safe, and focused on individual needs to provide quality of life to the elderly victim of violence.

CONCLUSION AND IMPLICATIONS FOR PRACTICE

The identification of nursing diagnosis in elderly victims of violence based on Horta's theory revealed the predominance of NDs related to the biopsychosocial component, highlighting the frailty of the elderly participants in this study. Exposure to intra-family violence, chronic conditions (mainly related to cognitive deficits), and institutionalization are aspects that can worsen the fragility of the health of this population and hinder its stabilization.

The inexpressive number of NDs related to the diagnostic category of health promotion signals the seriousness of health professionals planning their interventions to support and promote the motivation of the elderly so this population can achieve their well-being. Nurses inserted in this context must be aware of identifying health conditions, processes, or vulnerabilities that interfere with the quality of life of the elderly. Thus, this professional must establish NDs and interventions, evaluate and reevaluate their responses to current problems, and prevent complications that worsen pre-existing health issues. In addition, little attention has been given to the benefits of care in the spiritual realm, which denotes the need for further scientific study on this topic.

As a limitation of this study, we point out the small number of participants. Nonetheless, we clarify that this is the only regional reference institution to receive elderly victims of violence; therefore, its replication in other realities is highly recommended.

The contributions of this study to research, care management, and nursing care lie in the planning of systematized health actions and implementing care focused on individual needs and the strengthening of public policies for protecting the elderly, especially the regulation of nurses in homes for the elderly. It is hoped that the results can improve nursing care in homes for the elderly and trigger a novel look at victims of violence, as well as for the academic community, fostering discussions regarding the importance of NDs for the construction of the care process.

Systematized care by nurses in these institutions and knowledge of the basic health needs of elderly victims of maltreatment may break the cycle of violence and help better shelter frail elderly individuals with attention to their psychobiological, psychosocial, and psychospiritual needs.

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AUTHOR'S CONTRIBUTIONS

Study design. Francielle Renata Danielli Martins Marques. Lígia Carreira. Maria Aparecida Salci

Data Collection. Francielle Renata Danielli Martins Marques.

Data Analysis. Francielle Renata Danielli Martins Marques. Dayane Akinara Toledo Ribeiro. Grazieli Adrieli Rodrigues Pires. Aline Balandis Costa.

Interpretation of results. Francielle Renata Danielli Martins Marques. Dayane Akinara Toledo Ribeiro. Grazieli Adrieli Rodrigues Pires. Aline Balandis Costa.

Writing and critical revision of the manuscript. Francielle Renata Danielli Martins Marques. Dayane Akinara Toledo Ribeiro. Grazieli Adrieli Rodrigues Pires. Aline Balandis Costa. Lígia Carreira. Maria Aparecida Salci.

Approval of the final version of the article. Francielle Renata Danielli Martins Marques. Dayane Akinara Toledo Ribeiro. Grazieli Adrieli Rodrigues Pires. Aline Balandis Costa. Lígia Carreira. Maria Aparecida Salci.

Responsibility for all aspects of the content and integrity of the published article. Francielle Renata Danielli Martins Marques. Dayane Akinara Toledo Ribeiro. Grazieli Adrieli Rodrigues Pires. Aline Balandis Costa. Lígia Carreira. Maria Aparecida Salci.

ASSOCIATED EDITOR

Cristina Rosa Baixinho

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Marcelle Miranda da Silva

REFERENCES

1. Brasil. Ministério da Saúde. Data SUS [Internet] Brasília: MS; 2015. [citado 2020 set 02]. Disponível em: https://datasus.saude.gov.br/
2. Leindecker CR, Bennemann RM, Macuch RS. Idoso no Brasil: agressões, políticas e programas públicos-revisão de literatura. Aletheia. 2020;53(2):116-29. http://dx.doi.org/10.29327/226091.53.2-9.
3. Mariano PP, Carreira L, Lucena ACRM, Salci MA. Development of cognitive and motor stimulation activities: perspective of institutionalized elderly. Esc Anna Nery. 2020;24(3):e20190265. http://dx.doi.org/10.1590/2177-9465-ean-2019-0265.
4. Machado DR, Kimura M, Duarte YAO, Lebrão ML. Violence perpetrated against the elderly and health-related quality of life: a populational study in the city of São Paulo, Brazil. Cien Saude Colet. 2020 mar;25(3):1119-28. http://dx.doi.org/10.1590/1413-81232020253.19232018 PMid:32159679.
5. Sousa RCRD, Araújo GKND, Souto RQ, Santos RCD, Santos RDC, Almeida LR. Factors associated with the risk of violence against older adult women: a cross-sectional study. Rev Lat Am Enfermagem. 2021;29:e3394. http://dx.doi.org/10.1590/1518-8345.4039.3394 PMid:33439947.
6. Rodrigues RAP, Silva LM, Seredynskyj FL, Fhon JRS, Bolina AF, Miyamura K et al. Analysis of violence against older adults in police reports. Arch Psychiatr Nurs. 2019;33(4):407-13. http://dx.doi.org/10.1016/j.apnu.2019.05.004 PMid:31280787.
7. Andrade FMD, Ribeiro AP, Bernal RTI, Machado ÍE, Malta DC. Profile of care for violence against the elderly in urgency and emergency services: VIVA analysis Survey 2017. Rev Bras Epidemiol. 2020;23(Suppl 1):e200008. PMid:32638992.
8. Horta WA. Processo de enfermagem. Rio de Janeiro: Guanabara Koogan; 2011.
9. Santana ET, Coutinho GG, Silva DVA, Bernardes TAA, Camisasca LR, Gusmão ROM et al. Nursing diagnoses of NANDA-I taxonomy for the elderly in a long-term institution. Esc Anna Nery. 2021;25(1):e20200104. http://dx.doi.org/10.1590/2177-9465-ean-2020-0104.
10. Herdman TH, Kamitsuru S. Diagnósticos de enfermagem da NANDA International: definições e classificações 2018-2020. Porto Alegre: Art Med, 2018.
11. Jacon JC, Barbosa TP, Coneglian TV, Manzano JP, Dias GC. Identificação de diagnósticos de enfermagem em nefropatas em hemodiálise à luz da teoria das necessidades humanas básicas. Cuid Enferm [Internet]. 2020 [citedo 2021 maio 12]; 14(1):48-54. Disponível em: http://www.webfipa.net/facfipa/ner/sumarios/cuidarte/2020v1/p.48-54.pdf.
12. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 9. ed. São Paulo: Hucitec; 2006. 406 p.
13. Secretaria de Estado da Saúde do Paraná. Superintendência de Atenção à Saúde. Linha guia da saúde do idoso/SAS-SESA. Curitiba: SESA, 2018.
14. Hsieh HF, Shannon SE. Three approaches to qualitative content analysis. Qual Health Res. 2005;15(9):1277-88. http://dx.doi.org/10.1177/1049732305276687 PMid:16204405.
15. Carvalho EC, Oliveira-Kumakura ARS, Morais SCRV. Raciocínio clínico em enfermagem: estratégias de ensino e instrumentos de avaliação. Rev Bras Enferm. 2017 may-jun;70(3):662-8. http://dx.doi.org/10.1590/0034-7167-2016-0509. PMid:28562818.
16. Carlson J. Consensus validation process: a standardized research method to identify and link the relevant NANDA, NIC and NOC terms for local populations. Int J Nurs Terminol Classif. 2006;17(1):23-4.
17. Sampaio FC, Oliveira PP, Mata LRF, Moraes JT, Fonseca DF, Vieira VAS. Profile of nursing diagnoses in people with hypertension and diabetes. Invest Educ Enferm. 2017 jun;35(2):139-53. http://dx.doi.org/10.17533/udea.iee.v35n2a03. PMid:29767933.
18. Fernandes AM, Sousa C, Valentim O, Sousa L, Vinagre H, Carvalho JC. Well-being and spirituality in senior adults. Rev ROL Enferm [Internet]. 2020 [citado 2021 mar 10]; 43(1): 414-419. Disponível em: https://dspace.uevora.pt/rdpc/bitstream/10174/27439/1/IC_RESEARCH_INNOVATION_DEVELOPMENT_NURSING2019_414-19_h.pdf
19. Carneiro JA, Gomes CAD, Durães W, Jesus DR, Chaves KLL, Lima CA et al. Autopercepção negativa da saúde: prevalência e fatores associados entre idosos assistidos em centro de referência. Cien Saude Colet. 2020 mar;25(3):909-18. http://dx.doi.org/10.1590/1413-81232020253.16402018. PMid:32159661.
20. Nery BLS, Cruz KCT, Faustino AM, Santos CTB. Vulnerabilidades, depressão e religiosidade em idosos internados em uma unidade de emergência. Rev Gaúcha Enferm. 2018;39:e20170184. PMid:29995074.