

APPLICATION OF THE NURSING PROCESS TO AN ELDERLY HOME-BASED PATIENT IN PRIMARY HEALTH CARE: AN EXPERIENCE REPORT

APLICAÇÃO DO PROCESSO DE ENFERMAGEM À PACIENTE IDOSA DOMICILIADA NA ATENÇÃO PRIMÁRIA DE SAÚDE: RELATO DE EXPERIÊNCIA

APLICACIÓN DEL PROCESO DE ENFERMERÍA A UNA PACIENTE ADULTA MAYOR DOMICILIADA EN LA ATENCIÓN PRIMARIA DE SALUD: REPORTE DE EXPERIENCIA



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ABSTRACT

Home Care within the Brazilian Unified Health System (SUS) is a strategy that ensures comprehensive care for bedridden individuals, and the Systematization of Nursing Care (SAE) emerges as a central tool to organize and qualify care, being operationalized through the Nursing Process (NP), which enables the planning of targeted interventions; the objective

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of this study is to report the experience of nursing undergraduate students during their curricular internship in Primary Health Care regarding the application of the Nursing Process to a home-dwelling elderly patient residing in the micro-area of the Radional II Family Health Strategy in the city of Belém, Pará; this is a descriptive and qualitative study in the form of an experience report conducted in December 2025; for the organization of nursing care, the Nursing Process was applied in five stages, in accordance with COFEN Resolutions No. 358/2009 and No. 736/2024; the definition and organization of nursing diagnoses followed the NANDA International Taxonomy II, 13th edition (2024–2026); nursing interventions and outcome classifications were based on the Nursing Interventions Classification (NIC) and the Nursing Outcomes Classification (NOC), respectively; the main nursing problems identified included impaired bed mobility, pressure injury, difficulty with bowel elimination, feeding via nasogastric tube, impaired verbal communication, and risk of infection; this strategy enabled comprehensive case evaluation and the implementation of individualized care; it is concluded that the application of the Nursing Process provides several advantages, including improvement in quality of care, increased patient safety, promotion of effective communication among healthcare professionals, patients and families, optimization of time and resources, prevention of complications, and assurance of patient-centered care.

Keywords: Primary Health Care. Family Health Strategy. Home Health Care. Nursing Process. Nursing Diagnosis. Older Person.

RESUMO

A Atenção Domiciliar (AD) no SUS é uma estratégia que garante o cuidado integral às pessoas acamadas e a Sistematização da Assistência de Enfermagem (SAE) surge como ferramenta central para organizar e qualificar o cuidado, sendo operacionalizada por meio do Processo de Enfermagem (PE) que possibilita o planejamento de intervenções direcionadas. O objetivo do estudo é relatar a vivência de acadêmicos de enfermagem do estágio curricular na Atenção Primária de Saúde sobre a aplicação do Processo de Enfermagem (PE) a uma idosa domiciliada e residente na microárea da Estratégia Saúde da Família Radional II, na cidade de Belém do Pará. Trata-se de uma pesquisa descritiva e qualitativa do tipo relato de experiência, realizada em dezembro de 2025. Para a organização do cuidado de enfermagem empregou-se o PE, em 5 etapas, conforme preconiza as Portarias nº 358/2009 e 736/2024, ambas do COFEN. Para a definição e organização do diagnóstico de enfermagem utilizou-se a taxonomia II da North American Nursing Diagnosis Association - NANDA Internacional, 13ª edição (2024-2026). No que se refere às Intervenções de enfermagem e classificação dos resultados de enfermagem adotou-se a classificação Nursing Interventions Classification (NIC) e a Nursing Outcomes Classification (NOC), respectivamente. Principais problemas de enfermagem identificados foram: imobilidade no leito, lesão por pressão, dificuldade de evacuar, dieta por sonda nasogástrica, comunicação verbal prejudicada e risco de infecção. Diante dessa estratégia, foi possível avaliar o caso de modo integral e efetivar um cuidado personalizado. Concluiu-se que a aplicação do PE apresenta diversas vantagens como: Elevar a qualidade do cuidado, aumentar a segurança do paciente, promover a comunicação eficaz entre os profissionais de saúde, paciente e familiares, auxiliar na otimização do tempo e de recursos e na prevenção de complicações e garantir a oferta de um cuidado centrado no paciente.

Palavras-chave: Atenção Primária de Saúde. Estratégia Saúde da Família. Atenção Domiciliar à Saúde. Processo de Enfermagem. Diagnóstico de Enfermagem. Pessoa Idosa.

RESUMEN

La Atención Domiciliar (AD) en el Sistema Único de Salud (SUS) es una estrategia que garantiza el cuidado integral de las personas encamadas, y la Sistematización de la Atención de Enfermería (SAE) surge como una herramienta central para organizar y cualificar el

cuidado, siendo operacionalizada mediante el Proceso de Enfermería (PE), que posibilita la planificación de intervenciones dirigidas; el objetivo del estudio es relatar la experiencia de estudiantes de enfermería durante su práctica curricular en la Atención Primaria de Salud sobre la aplicación del Proceso de Enfermería a una paciente adulta mayor domiciliada y residente en la microárea de la Estrategia de Salud de la Familia Radional II, en la ciudad de Belém, Pará; se trata de un estudio descriptivo y cualitativo del tipo relato de experiencia, realizado en diciembre de 2025; para la organización del cuidado de enfermería se aplicó el Proceso de Enfermería en cinco etapas, conforme a las Resoluciones N° 358/2009 y N° 736/2024 del COFEN; la definición y organización de los diagnósticos de enfermería se realizó utilizando la Taxonomía II de NANDA Internacional, 13ª edición (2024–2026); las intervenciones y la clasificación de resultados de enfermería se fundamentaron en la Nursing Interventions Classification (NIC) y la Nursing Outcomes Classification (NOC), respectivamente; los principales problemas de enfermería identificados fueron inmovilidad en cama, lesión por presión, dificultad para evacuar, alimentación por sonda nasogástrica, comunicación verbal deteriorada y riesgo de infección; esta estrategia permitió evaluar el caso de manera integral y ejecutar un cuidado individualizado; se concluye que la aplicación del Proceso de Enfermería presenta diversas ventajas, como elevar la calidad del cuidado, aumentar la seguridad del paciente, promover la comunicación eficaz entre profesionales de salud, paciente y familiares, optimizar el tiempo y los recursos, prevenir complicaciones y garantizar un cuidado centrado en el paciente.

Palabras clave: Atención Primaria de Salud. Estrategia de Salud de la Familia. Atención Domiciliaria en Salud. Proceso de Enfermería. Diagnóstico de Enfermería. Persona Mayor.

1 INTRODUCTION

The National Primary Care Policy (PNAB) is an instrument that regulates and organizes Primary Health Care (PHC) within the scope of the Unified Health System (SUS), being responsible for establishing guidelines that guide the performance of professionals, covering actions of health promotion, prevention, protection, diagnosis, treatment, rehabilitation and maintenance of the life of the population, consolidating primary care as the preferred gateway and center of care (Brasil, 2012). In addition, its principles are based on universal access, equity and comprehensiveness of care, with the aim of minimizing the stigmatization of vulnerable groups and social inequalities that may impact the health of these individuals, especially home-based patients, who are more vulnerable and need systematic, comprehensive and longitudinal follow-up by the Primary Care team (Brasil, 2017).

In this sense, the Family Health Strategy (FHS) has become a priority model for the reorganization of PHC, as it focuses on the uniqueness and diversity of each individual, providing holistic care, in a territorialized way, which makes it possible to know the reality of each family enrolled and promote their continuous monitoring. For this purpose, the FHS is operated by a multidisciplinary team composed of a general practitioner or specialist in Family Health, a generalist nurse or specialist in Family Health, a nursing assistant or technician, and community health agents. This team aims to serve the user in its entirety, strengthening the bond with the community and carrying out actions according to the needs identified, both in community spaces and at home (Brasil, 2025).

Among the various attributions of the FHS team, home visits stand out, characterized as care aimed at the individual and his or her family (Rezende *et al.*, 2023), especially those with mobility difficulties or in a bedridden condition, who are unable to travel to the health unit to receive the necessary care. Thus, home visits enable the creation of a new space for promotion, prevention and treatment, favoring evaluation, early identification of diseases and the continuity of comprehensive care. This practice is essential for understanding the reality experienced by the user and for planning interventions compatible with their resources and limitations (Brasil, 2025).

In this context, nurses play a central role in home care, as they are responsible for the comprehensive clinical assessment of the user, the coordination of the care plan, and the systematic guidance of patients and caregivers regarding self-care practices (Lima *et al.*, 2024). Its work involves the continuous monitoring of clinical evolution, the early identification of diseases and risk factors, as well as the implementation of interventions aimed at preventing complications associated with immobility and chronic conditions. In addition, the

nurse establishes a therapeutic bond, recognizes the specific demands of the home environment, and articulates with the multiprofessional team, ensuring the continuity of care and promoting humanized, longitudinal care centered on the individual needs of the user (Rezende *et al.*, 2023).

In view of this, the nursing consultation is a fundamental instrument of care practice, as it enables the systematized collection of data, the identification of health needs and the establishment of an individualized care plan. Through this activity, the nurse performs a comprehensive assessment of the user, considering biopsychosocial, family and environmental aspects, which favors clinical decision-making, the strengthening of the professional-user bond and the promotion of autonomy in self-care. In addition, the nursing consultation contributes to the prevention of diseases, therapeutic follow-up and continuity of care, especially in the context of home care, where the professional has the opportunity to understand the reality experienced by the patient and adapt the interventions to their limitations and potentialities (Cofen, 2018).

From this perspective, the Systematization of Nursing Care (NCS) is a fundamental instrument for nurses, as it ensures safe and quality care, based on scientific evidence, the use of technical resources and a humanized approach (Cofen, 2024). The NCS enables the organization of nursing work, guides clinical reasoning and supports professional decision-making, being operationalized by the Nursing Process (NP), consisting of five stages, namely: Evaluation, Diagnosis, Planning, Implementation and Evolution, which favor the identification of the patient's needs, the planning of actions and the continuous evaluation of the care provided (Rodrigues *et al.*, 2025). Among these stages, the nursing diagnosis assumes the central role in the present study, as it directs the proposed interventions.

In addition, the use of standardized language systems, such as NANDA-I, NIC and NOC, strengthens the Nursing Process by organizing clinical reasoning, supporting the formulation of diagnoses, guiding the choice of interventions and enabling the evaluation of care results. These systems make it possible to identify human responses to health conditions, establish expected results, and select evidence-based interventions, favoring communication among professionals and the qualification of care. In addition, they contribute to the standardization of records, to the continuity of care, and to the strengthening of nursing as a science, especially in the context of home care, in which the individualization of conducts and the participation of the caregiver are fundamental to achieving better clinical outcomes (Argenta *et al.*, 2020).

Therefore, nursing diagnoses allow the recognition of human responses to health conditions and the limitations imposed by immobility, guiding the planning of interventions

aimed at preventing complications, promoting comfort and improving quality of life. This stage of the Nursing Process acquires even greater relevance in home care, since it considers the home environment, the available resources and the caregiver's participation in care, favoring individualized and continuous care (Santos *et al.*, 2025). Thus, the articulation between the NCS and the nursing diagnoses supports the professional practice of nurses and qualifies the care provided to bedridden people at home.

The objective of this chapter is to report the experience of nursing students in the curricular internship in Primary Health Care about the application of the Nursing Process (NP) to an elderly user who lives in the micro-area of the Family Health Strategy Radional II.

2 METHODOLOGY

This is a descriptive research, with a qualitative approach, of the experience report type on the application of the Nursing Process in Primary Health Care, carried out by students of the undergraduate Nursing course of the discipline Curricular Internship in Nursing I of a public university, under faculty coordination.

The target of the study was an elderly user who was domiciled, bedridden and had comorbidities, living in the micro-area covered by the Radional II Family Health Strategy, located on the outskirts of Belém do Pará and the practice setting of the aforementioned interns.

The experience took place from 12/01 to 12/18/25 and the nursing care for the elderly began through the home visit, scheduled by the community health agent, responsible for the user's micro-area, who accompanied the team at home. For the organization of nursing care for the elderly, the methodology of Systematization of Nursing Care was used, through the Nursing Process, in 5 stages, regulated by the Federal Nursing Council (COFEN), through ordinances No. 358/2009 and 736/2024, which are: 1. Nursing evaluation/Data collection (Interview, physical examination, collection of information about the patient), 2. Nursing diagnosis (Identification of health problems), 3. Planning (Definition of actions, goals and expected results for care), 4. Implementation (Execution of planned actions) and 5. Evolution/Nursing evaluation (Continuous reevaluation of the patient and the results of the actions).

For the definition and organization of the nursing diagnosis, taxonomy II of the North American Nursing Diagnosis Association - NANDA International, 13th edition (2024-2026) was used. Nursing interventions and nursing outcomes classification were used, the Nursing Interventions Classification (NIC) and the Nursing Outcomes Classification (NOC), respectively.

In accordance with Law 14.874/2024, which establishes the National System of Ethics in Research with Human Beings, this research was developed in order to ensure the anonymity and privacy of the participants, as well as the confidentiality of the information passed on during the visits, without physical or moral damage.

3 RESULT

Nurses play a fundamental role in the scenario of home visits, characterized by comprehensive care, which involves assessment, treatment, rehabilitation and prevention. It is through home visits that nurses get to know and understand the social context of individuals, enabling the identification, detection and mitigation of diseases. Thus, the approximation between nurse and patient, established through home visits, becomes essential for the effectiveness of care in Primary Care (Gomes *et al.*, 2021).

In this context, the result of the study is the Nursing Process in 5 stages, elaborated for the target user of the research, with the aim of structuring nursing care and providing qualified and responsible care.

a) Nursing assessment/Data collection (Interview, physical examination, collection of information about the patient)

In a home visit, an 87-year-old woman was observed, bedridden and bedridden, under the care of family members and daughter-in-law, with diagnoses of arterial hypertension, type 2 diabetes mellitus and Alzheimer's disease. Disoriented in time and space, serene, calm, does not verbalize or emit communication reactions and/or expressions of pain. Breathing ambient air. Altered sleep and rest, hydrated skin and good personal hygiene. Pressure injuries (PF) in the lumbar region and right calcaneus, both stage 3. The wounds were wound dressing daily by the FHS Radional II health team. Diet and fluid intake by nasogastric tube and administered four times a day and was based on soups, vegetables and meats beaten in a blender, plus food supplementation (Nutren and Glucerna), hardened bowel movements and diapers; did not occur spontaneously, requiring digital removal of fecaloma by the caregiver and diuresis by an indwelling urinary catheter, yellowish and concentrated. Delay in the vaccination schedule. The elderly woman was integrated into the Better at Home Program.

b) Nursing diagnosis, Planning, Implementation and Evolution/Evaluation of nursing.

In these stages of the NP, medical and nursing developments in the period 2010-2025 were determined, which enabled the historical analysis of the patient's previous health problems, such as hospitalizations, surgeries, chronic diseases, continuous use

medications, among others. The team performed the anamnesis based on the information provided by the caregiver, due to the aphasia presented by the elderly woman, the physical examination was objective, respecting the limitations and managing the agitation after the procedures.

Next, the students analyzed the data looking for health problems or risks, signs and symptoms, pressure ulcers, devices and biopsychosocial issues of the domiciled and the support network, to define the nursing diagnoses. The expected results were listed and based on the main complications, with independent and interdependent interventions in this case. The implementation of the care plan was performed by the trainees in collaboration with the professor of the discipline, as well as the nursing evaluation and changes in the prescriptions at each visit.

Table 1 is presented below with the main nursing problems, nursing diagnoses according to NANDA I, Interventions (NIC) and Outcomes (NOC), selected from the nursing planning.

Table 1

Nursing care plan according to NANDA-I, NIC and NOC. Belém (PA), Brazil, 2026

Nursing Problems	Diagnostics - NANDA-I	Interventions - NCI	Results - NOC
Immobility in bed	Impaired bed mobility related to prolonged immobility evidenced by difficulty in rolling over in bed.	Promotion of body mechanics; Foot care; Perineal care; Monitor and record daily evidence of complications.	State of physical comfort; The patient will not exhibit complications associated with impaired mobility in bed.
Pressure injuries in the sacral region	Pressure Injury in Adults Related to Inadequate Caregiver Knowledge of Prevention of Strategic Pressure Injuries, Excessive Moisture, Pressure on Bone Prominence, and Shear Forces Evidenced by Full-Thickness Tissue Loss with Exposed Muscle	Pressure control; Care with traction/immobilization; 2/2-hour change of decubitus; Use preventive skin care devices, such as foam mattress, pressure mattress; Implement daily skin inspection and care routine.	Wound healing: second intention; The patient's skin remains intact.
Difficulty bowel movement	Impaired bowel elimination related to impaired physical mobility evidenced by the need for manual maneuvers to facilitate evacuation.	Identify the factors (medications and diet) that may cause or contribute to constipation; Remove the fecal impaction manually.	Intestinal Elimination
NGS Diet	Risk of inadequate	Avoid feeding if there is a	Aspiration

	nutritional intake related to impaired swallowing.	large residual volume (i.e., more than 250 mL in the feeding tubes); Keep the head of the bed elevated between 30 to 45 minutes after feeding; Check the nasogastric positioning before feeding.	prevention
Impaired verbal communication	Impaired verbal communication related to central nervous system disease evidenced by aphasia	Promote interaction with the patient through short sentences and gestures; Maintain attention to other cognitive impairments.	Care bond
Risk of indwelling urinary catheter infection	Risk of infection related to difficulty in managing long-term invasive devices.	Maintain asepsis for the patient at risk; Provide appropriate skin care in edematous areas.	Risk Control
Risk of wound infection	Risk of infection related to difficulty in managing wound care.	Monitor lesion characteristics, including drainage, color, size, and odor; Clean with saline solution or non-toxic substance; Apply dressing appropriate to the type of injury; Advise family members on how to care for the injury.	Risk Control: Infectious process.

Source: Prepared by the authors (2026).

4 DISCUSSION

Following current regulations, the Nursing Process must be applied deliberately and systematically in all care scenarios (Cofen, 2024). At home, the NCS operationalizes this method by guiding the stages of data collection, diagnosis, planning, implementation, and evaluation in line with the patient's needs. Thus, the structured use of NCS, associated with the participation of the family/caregiver, leads to concrete clinical improvements, in addition to reinforcing the importance of NCS as a tool for organizing nursing work, supporting clinical reasoning and providing a basis for individualized interventions.

The immobility in bed identified in the patient is a relevant risk factor for the development of multiple complications, requiring systematized nursing interventions. This condition favors musculoskeletal changes, impaired circulation, reduced lung expansion, constipation, and increased vulnerability to the occurrence of pressure injuries, directly impacting functionality and quality of life. In this context, nursing care focuses on the implementation of measures such as frequent changes in decubitus, adequate positioning, use of support surfaces, encouragement of passive mobilization, monitoring of skin integrity

and guidance to the caregiver, actions that aim to minimize the effects of immobility, prevent injuries and promote greater comfort for the patient. The comprehensive approach also allows for early identification of signs of associated complications, strengthening the continuity of care in the home environment (Lima *et al.*, 2024).

Regarding pressure lesions (PF) in the patient's sacral region, at the first visit of the team, the lesion presented moderate exudate, without foul odor and without signs of infection, irregular, macerated and epibole borders, in addition to a tunnel in the right upper quadrant. The presence of 60% granulation tissue and 40% of sloughing was observed, with perilesional skin fragile and susceptible to friction injuries. The treatment performed in the subsequent visits consisted of cleaning with 0.9% saline solution and 2% chlorhexidine degerming, followed by the application of a silver and calcium alginate plate and barrier cream, with secondary coverage with gauze and protection with transparent film.

During the visits, a significant evolution of the wound appearance was observed, with a reduction in its diameter, tunnel closure, through the growth of granulation tissue and edges with signs of epithelialization. From this perspective, the advancement of the healing process evidenced the importance of patient-centered care, considering their individual needs.

Regarding the LP of the calcaneal region, initially, the lesion presented 90% liquefaction necrosis and 10% coagulation necrosis, with delimited and regular borders. The treatment was performed by cleaning with 0.9% saline solution and 2% chlorhexidine degerming, application of hydrogel ointment on the wound bed and barrier cream on the perilesional skin, hydrocolloid plate, followed by coverage with transparent film. Evolution of the lesion was observed, with reduction of liquefaction necrosis, total removal of coagulation necrosis and the appearance of granulation tissue.

Pressure injuries are frequent aggravations in bedridden patients and require specialized attention. The literature highlights that home nursing care, combined with caregiver health education, is fundamental in the prevention and management of these wounds. Targeted assistance to LP includes not only local treatment (advanced dressings, use of skin barriers, and proper hygiene), but also guidance on moisture management, nutrition, and coverage. The case report illustrates this principle: The combination of silver alginate dressings, hydrogels, hydrocolloids, and barrier cream, together with instructions to the caregiver, resulted in progressive healing of sacral and calcaneal ulcers, with reduced necrosis and evolution of granulation tissue. These results are in line with studies that emphasize that home nursing care for PF provides a comprehensive view of the patient, creating effective care plans and favoring recovery (Freitas; Pereira; Padilha, 2023).

In bedridden patients with Alzheimer's disease, constipation is a frequent and multifactorial aggravation, mainly associated with prolonged immobility, inadequate fluid and fiber intake, continuous use of multiple medications, and cognitive impairment, which makes it difficult to recognize and communicate the need to evacuate. Studies show that older people with dementia have a higher prevalence of constipation and a higher risk of complications, such as fecaloma and a negative impact on quality of life, requiring systematic monitoring and continuous preventive measures by the health team (Salari *et al.*, 2023). In addition, evidence points to an association between constipation and functional and cognitive worsening in patients with Alzheimer's disease, suggesting a possible influence on the course of the disease and reinforcing the importance of early and individualized interventions (Nakase *et al.*, 2022).

The use of the nasogastric tube requires strict surveillance of the position of the tube, safe administration of the diet, and prevention of bronchial aspiration, in addition to the observation of signs of food intolerance (Lima *et al.*, 2024). Integrative reviews on advanced dementia highlight that enteral nutrition is controversial in this population: most publications and guidelines do not recommend tubes in advanced Alzheimer's, favoring palliative approaches and careful feeding without a tube (Macedo; Alencastro; Wiegert, 2023). When the nasogastric tube is adopted, nursing care is crucial to prevent complications. Safe fixation of the probe (e.g., hypoallergenic tape), elevation of the headboard, washing with water before and after infusions, and frequent monitoring to avoid displacement and skin lesions are recommended (Ministry of Health, 2018). These findings reinforce the need for evidence-based nursing protocols for insertion and management of the nasogastric tube at home, in addition to constant support for the family caregiver.

Impaired verbal communication limits the expression of basic needs, making it essential to carefully observe non-verbal signals and the active participation of the caregiver in the care process (Spezzia; Baptista, 2025). In the care of patients with Alzheimer's, deteriorated verbal communication resulting from progressive cognitive decline represents a significant challenge for the nursing team. The literature shows that people with dementia often have reduced ability to express needs and understand verbal information, which requires adapted communication approaches focused on nonverbal techniques, respect for individual rhythm, and strategies that value the patient's identity to promote humanized care and reduce frustrations and resistance behaviors (Van Manen *et al.*, 2020).

In addition, the risk of infection related to the indwelling urinary catheter and wounds require aseptic care, adequate dressing changes, strict hygiene, and monitoring of phlogistic signs, aiming to prevent infectious complications (Freitas; Pereira; Padilha, 2023). Indwelling

urinary catheter permanence is strongly associated with increased risk of catheter-associated urinary tract infections (UCTI), with time of use being the main risk factor identified. Recent evidence from nursing protocols demonstrates that careful assessment of catheter need, rigorous aseptic technique during insertion, maintenance of a closed drainage system, and early removal when possible are effective strategies to reduce the incidence of UCTI, underscoring nurses' responsibility to implement evidence-based practices for patient safety (Miranda *et al.*, 2023).

In bedridden patients with Alzheimer's, prolonged immobility and cognitive impairment increase the likelihood of developing pressure sores and chronic sores, which in turn increase the risk of local and systemic infection if there is no adequate prevention and management. Recent studies on people with dementia show that adults living with dementia are at increased risk of chronic wounds due to limitations in mobility, self-care, and communication, factors that make it difficult to assess pain and early signs of infection and slow healing of injured skin (Leblanc *et al.*, 2024). In addition, systematic reviews have identified that immobility is one of the main risk factors for pressure injuries in hospitalized older adults, being associated with a higher incidence of secondary complications, including infection of the injuries when they develop (Wu *et al.*, 2025). These findings underscore that the combination of functional decline, symptom communication barriers, and care challenges in bedridden Alzheimer's people creates an environment of heightened vulnerability for wounds and their infections.

These conditions highlight the complexity of home care and highlight the importance of the systematized performance of nurses, through the NCS/NP, to plan individualized interventions, reduce risks and promote safety, comfort and quality of life for the patient.

Based on the interventions performed by the students, under the supervision of the professor, the patient showed significant improvement of the lesions, with appropriate treatment, in addition to the guidance provided to the family member/caregiver. Thus, the importance of nursing care for home-based users of high dependence is inferred, with care consisting of appropriate techniques, effective management and a humanized view.

It is recorded that the patient was integrated into the Better at Home Program because she had the appropriate profile. The integration of home care with SUS initiatives strengthens continuity of care. The Better at Home Program exemplifies this articulation, offering continuous home care to complex patients and avoiding prolonged hospitalizations (Better at Home Program, 2024). In the case studied, the patient's inclusion in the program allowed the intensive treatment to continue at home, respecting the comfort of the family environment. This reflects the objectives of the program, which values the humanization of

home care, reduction of unnecessary hospitalizations and improvement of the patient's quality of life. By moving part of the care from the hospital to the home in an organized way, the SUS expands access to an efficient service and offers continuous support to patients and families, consolidating a comprehensive and person-centered care model.

5 CONCLUSION

The clinical follow-up visits by the students during the curricular internship made it possible to experience home care and the complexity that primary health care can reach. The implementation of the NCS as an organizational and planning tool facilitated the application of the Nursing Process, which resulted in a comprehensive planning that included the main health problems faced by bedridden elderly women. The development of the stages of the NP provided the practice of clinical reasoning of the trainees and independence in the prescriptions of nursing interventions.

The care of PF is highlighted as the main activity performed by the students, given the leading role of the category in the prevention and treatment of these types of injuries. The continuous execution of the dressings promoted technical improvement and the search for knowledge to improve the procedures and adequate selection of materials for different therapeutic approaches.

Thus, the report evidenced that the contact with cases that require private functions in PHC during the undergraduate course is essential for the professional training of nurses and reinforces their autonomy beyond health education, being active in the intervention of specific care. In this sense, the use of NCS ensured the organization of the work, the team, the instruments and the evolution of the bedridden patient, as it ordered the best decision-making during the supervised visits by articulating the theoretical framework and skills.

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