








ORIGINAL ARTICLE

## Nursing diagnoses in families of hospitalized adults: application of the Calgary Model

### HIGHLIGHTS

1. The most prevalent diagnoses were Anxiety and Caregiver role Tension.
2. The Coping/stress tolerance was the most frequent domain.
3. Risk diagnoses revealed family vulnerability and burden.
4. Health promotion diagnoses highlighted the potential for family adaptation.

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### ABSTRACT

**Objective:** To identify the most frequent nursing diagnoses in families of hospitalized adult patients, in light of the Calgary Family Assessment and Intervention Model and the NANDA-I taxonomy. **Method:** A descriptive, quantitative study conducted in a university hospital in southern Brazil between July 2023 and June 2024 with 35 family members. Data were obtained through nursing consultations structured according to the Calgary Model, including the construction of a genogram, ecomap, and the recording of family needs. Nursing diagnoses were defined according to NANDA-I. **Results:** A total of 284 diagnostic occurrences were identified, corresponding to 63 nursing diagnosis titles: 39 problem-focused diagnoses, 14 risk diagnoses, eight health promotion diagnoses, and two syndrome diagnoses. Anxiety and Caregiver Role Strain were the most prevalent. Risk diagnoses revealed vulnerability and burden among families, whereas health promotion diagnoses indicated potential for family adaptation. **Conclusion:** The diagnoses demonstrated that hospitalization impacts family dynamics, highlighting the need for interventions that strengthen and support families.

**DESCRIPTORS:** Models, Nursing; Nursing Process; Nursing Diagnosis; Hospitalization; Family.

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## INTRODUCTION

The family is configured as a fundamental unit of care, composed of interdependent subsystems that, when articulated together, form a larger system with its own dynamics<sup>1</sup>. The relationships of circularity and reciprocity established among its members shape patterns of interaction and bonding, which are constantly influenced by cultural, social, and contextual aspects<sup>2-3</sup>. During hospitalization, the family's role in preserving well-being and supporting the patient becomes even more evident as vulnerability intensifies. However, especially in the hospitalization of adult patients, this role often remains undervalued and little recognized by health teams<sup>4-5</sup>.

Overcoming this gap implies adopting strategies that promote the effective integration of the family into care, recognizing their particularities, needs, and potential contributions. Moreover, families should be understood as an extension of the patient, holding their own demands that also need to be considered by health professionals. In this sense, given the social and scientific relevance of bringing nursing care closer to the reality of families in the hospital context, this study articulated the Calgary Model of Family Assessment and Intervention (CMFAI)<sup>1</sup> with the Nursing Process (NP), specifically to the assessment stage, through data collection and identification of Nursing Diagnoses.

The CMFAI consists of two interdependent stages: assessment and intervention. The assessment phase encompasses structural, developmental, and functional dimensions, allowing the nurse to understand aspects such as family composition, bonds, communication, beliefs, and internal organization. The intervention stage seeks to promote, enhance, or sustain the family's effective functioning in the cognitive, affective, and behavioral domains<sup>1</sup>. Thus, the CMFAI presents stages that align with the phases of the NP, where assessment corresponds to the stages of data collection and diagnosis identification, while intervention relates to the phases of care planning, implementation, and evaluation<sup>6</sup>.

To support the development of the distinct stages of the NP, it is important for the nurse to use Standardized Language Systems such as the NANDA-I taxonomy<sup>6</sup>. This taxonomy recommends developing family diagnoses whenever they have a direct impact on patient care, which aligns with the CMFAI's proposal. However, there is a certain scarcity of investigations addressing nursing diagnoses in families experiencing illness, especially among those undergoing the hospitalization of one of their members<sup>7-9</sup>.

Studies conducted nearly two decades ago using the NANDA 2001-2002 and NANDA 2005-2006 versions showed that the main family diagnoses in the context of hospitalization included: Tension due to the caregiver role; Impaired verbal communication of the family; Impaired home maintenance; Interrupted family processes; Impaired social interaction; Deficient knowledge; and Anxiety<sup>7-9</sup>. Updating this knowledge is essential to inform care plans aligned with families' real needs, enhancing nursing assistance and positively impacting care in the hospital setting.

It is also worth noting that the contemporary scenario, marked by an aging population, an increase in prolonged hospitalizations, and the post-pandemic repercussions, has intensified the needs of families in the hospital environment, requiring professionals to be prepared to welcome and intervene under these demands<sup>3</sup>. Updating the nursing diagnoses applicable to hospitalized families becomes essential not only to expand scientific knowledge on the subject but also to support care protocols and guide educational strategies with nursing teams. This will enable nurses to develop care plans that address the real needs of families experiencing the hospitalization of a loved one.

Furthermore, considering that care should not be limited to the disease and the individual, but should encompass and involve families, the nurse must utilize their competencies and skills to identify the main diagnoses related to the family, understanding its dynamics, resources, vulnerabilities, and strengths<sup>1,7</sup>. From then on, it is possible to develop interventions that enhance emotional support, promote adherence to treatment, and facilitate the transition of care from hospital to home, thereby promoting collaborative and safe care<sup>1</sup>.

In light of the above, the objective of this study was to identify the most frequent nursing diagnoses in families of hospitalized adult patients, in light of the CMFAI and the NANDA-I taxonomy<sup>6</sup>.

## METHOD

Descriptive research with a quantitative approach was conducted in the medical-surgical clinic sector of a public university hospital in the southern region of Brazil. The sector consists of 75 nursing beds, divided into 25 rooms and three nursing stations. It has a profile of adult/elderly patients with exacerbated chronic conditions and patients in pre- or post-operative stages. Regarding families, the institutional policy guarantees the presence of a companion for those over 60 years old, under 18 years old, women, or people with care dependencies.

Participants met the following inclusion criteria: being over 18 years old, able to read and write, a relative of a hospitalized adult patient, and the patient's companion. Conversely, those who were in visiting hours and/or had communication difficulties, such as deaf-muteness, lack of proficiency in the Portuguese language, and/or dyslalia, were not included. There were no exclusions under such criteria.

Data collection was conducted through nursing consultations with families during hospitalization, held in a reserved room within the sector, and lasting an average of 1.5 hours. Undergraduate and graduate students, as well as professors from the nursing course at the Universidade Estadual de Maringá, conducted the consultations, having been previously prepared and trained for the instrument's standardization and having immersed themselves in the theme of family nursing. Families were located through an extension project, the Calgary Model of assessment and intervention with families during hospitalization, which aims to evaluate and intervene with families of patients through the CMFAI.

The selection of potential participants was based on assessments of nurses in the sector, who identified patients with high dependency care needs (using the Fuglin Scale, which is routine for the service) and who were accompanied by relatives capable of communicating with the research team. Once patients were identified, students analyzed the data from their medical records to offer possible clarifications about the clinical picture to the relative during the consultation.

The approach with family members took place at the bedside and began with the presentation of the study and its objectives, followed by an invitation to participate in the nursing consultation to collect data. After the approach, three caregivers refused to leave their loved ones without family supervision. Once participation was accepted, the consultation began with a detailed explanation of the research's nature and purpose. Next, the Informed Consent Form was provided, requesting careful reading and signing to ensure the participant's formal and voluntary agreement.

Data collection took place between July 2023 and June 2024, involving a non-probabilistic sample of 35 family members, a number limited by the researchers' availability, who conducted project activities once a week. Considering that there were, on average, 40 school weeks and that there were sometimes research group meetings for training and alignment of nursing consultations, the number of families reached was 35 over the course of a year.

The consultations were guided by a semi-structured instrument adapted from the original model provided by CMFA11, which aimed to understand the family's structure, stage of development, and functionality. The instrument also included specific fields to identify the challenges and/or concerns presented by the family, as well as the "family history, family strengths, and family suffering hypotheses." In addition, there was space to report the interventions carried out during the consultation and to record the genogram and ecomap (developed in graphic design applications), which were offered to families at the end of the consultation. Such tools facilitated the understanding of each family case.

After collection, the data were entered into a virtual form identical to the physical instrument to be analyzed later for the identification of nursing diagnoses. To this end, a structured diagnostic process was used, which included data categorization, detection of gaps and inconsistencies, pattern grouping, comparison with references, diagnostic inference, and determination of relationships between findings. The final labeling of the diagnoses was based on the NANDA-I Taxonomy 2021-2023<sup>6</sup> and was carried out by two researchers simultaneously, analyzing discrepancies until consensus was reached. Subsequently, the identified diagnoses were analyzed using descriptive statistics and presented in tables of absolute and relative frequency.

All ethical principles set out in resolutions 466/2012 and 510/2016 of the National Health Council were followed. The project was previously approved by the Permanent Committee of Ethics in Research with Human Beings of the Universidade Estadual de Maringá (UEM) - Opinion: 6117092.

## RESULTS

Thirty-five families of hospitalized adult patients were interviewed. Regarding the family members, 14% were men and 86% were women. Among the male participants, the family ties to the patient were: husband, father, brother, son, and cousin. Among the female family members, the distribution of ties to the patients was as follows: 11 daughters, nine wives, four sisters, two nieces, one aunt, one mother, one granddaughter, and one daughter-in-law.

Among the patients, a higher proportion of men was observed (60%). The patients had various clinical diagnoses, mainly ranging from polytrauma due to falls and traffic accidents; traumatic amputations or due to infected wounds; burns; cardiovascular insufficiencies; nephrological issues such as ureterolithiasis and nephrolithiasis; neurological problems like stroke and epilepsy; neoplasms; exogenous intoxication/suicidal attempts; and also cases of rare diseases like Duchenne Syndrome and Fahr Syndrome.

After the analyses, 284 diagnostic occurrences were identified, based on 63 distinct nursing diagnoses (39 focused on the problem, 14 on risk, eight on health promotion,

and two on syndrome). Per family, there was a range of 2 to 21 diagnoses (an average of 8). Table 01 presents the list of actual diagnoses.

**Table 1.** Distribution of the actual nursing diagnoses identified in the families under study. Maringá, PR, Brazil, 2024

Domain	Diagnosis (code)	n	%
7	Stress in the caregiver role (00061)	22	7.8
9	Anxiety (00146)	22	7.8
7	Dysfunctional family processes (00063)	13	4.6
7	Interrupted family processes (00060)	12	4.2
9	Stress overload (00177)	11	3.9
7	Conflict in the parent role (00064)	10	3.6
7	Ineffective role performance (00055)	07	2.4
7	Ineffective relationship (00223)	06	2.1
9	Ineffective activity planning (00199)	06	2.1
9	Compromised family coping (00073)	06	2.1
9	Fear (00148)	06	2.1
4	Disturbance in sleep pattern (00198)	05	1.7
9	Grief (00136)	05	1.7
9	Feeling of helplessness (00125)	05	1.7
9	Death-related anxiety (00147)	05	1.7
9	Ineffective coping (00069)	05	1.7
9	Disabled family coping (00074)	05	1.7
1	Decreased involvement in recreational activities (00097)	04	1.4
4	Fadiga (00093)	04	1.4
4	Impaired home maintenance (00098)	04	1.4
5	Labile emotional control (00251)	04	1.4
7	Impaired social interaction (00052)	04	1.4
12	Impaired comfort (00214)	04	1.4
1	Ineffective family health control (00078)	03	1.0
9	Chronic sadness (00137)	03	1.0
9	Defensive coping (00071)	03	1.0
10	Impaired religiosity (00169)	03	1.0
6	Situational low self-esteem (00120)	03	1.0
1	Health behavior subject to risk (00188)	02	<1
9	Ineffective denial (00072)	02	<1
9	Ineffective community coping (00077)	02	<1
9	Impaired resilience (00210)	02	<1
-	Others*	07	2.4

Legend: n= 205; \*frequency of a diagnostic occurrence.

Source: The authors (2024).

Of the actual diagnoses identified, Anxiety (00146) and Caregiver role strain (00061) were the most frequent, with 22 occurrences each. It was found that 62.8% of families experienced these two diagnoses. Following that, the most frequent diagnoses were Dysfunctional family processes (00063) and Interrupted family processes (00060), observed in 13 and 12 families, respectively. Stress overload (00177) was identified 11 times.

The second type of diagnosis most identified was risk diagnoses, as represented in Table 2. Regarding risk diagnoses, there were 11 occurrences of the diagnosis Caregiver role strain risk (00062) and 10 occurrences of the diagnosis Feelings of helplessness risk (00152).

**Table 2.** Distribution of identified nursing risk diagnoses in the families under study. Maringá, PR, Brazil, 2024

Domain	Diagnosis (code)	n	%
7	Caregiver role strain risk (00062)	11	3.9%
9	Feelings of helplessness risk (00152)	10	3.5%
9	Impaired resilience risk (00211)	06	2.1%
9	Risk of stress syndrome due to change (00149)	06	2.1%
9	Risk of ineffective activity planning (00226)	05	1.7%
6	Risk of situational low self-esteem (00153)	03	1%
9	Risk of complicated grief (00172)	03	1%
6	Risk of chronic low self-esteem (00224)	02	<1%
12	Risk of loneliness (00054)	02	<1%
6	Risk of compromised human dignity (00174)	01	<1%
7	Risk of ineffective relationships (00229)	01	<1%
7	Risk of impaired parenthood (00057)	01	<1%
8	Risk of ineffective perinatal process (00227)	01	<1%
10	Risk of impaired religiosity (00170)	01	<1%

Legend: n= 53

Source: The authors (2024).

Health promotion diagnoses were also identified (Table 3). The most frequent were: Willingness for improved self-concept (00167) and willingness for improved coping (00158), both with three occurrences each.

**Table 3.** Distribution of identified health promotion nursing diagnoses in families. Maringá, PR, Brazil, 2024

Domain	Diagnosis (code)	n	%
6	Willingness for improved self-concept (00167)	03	1%
9	Willingness for improved coping (00158)	03	1%
7	Willingness for improved relationships (00207)	02	<1%
7	Willingness for improved family processes (00159)	02	<1%
4	Willingness for improved sleep (00165)	01	<1%
5	Willingness for improved communication (00157)	01	<1%
6	Willingness for increased hope (00185)	01	<1%
9	Willingness for improved family coping (00075)	01	<1%
12	Willingness for improved comfort (00183)	01	<1%

Legend: n= 15

Source: The authors (2024).

Among the syndrome diagnoses, the following were identified: Change stress syndrome (00114) with seven occurrences and disturbed family identity syndrome (00283) with two occurrences (data not presented in table).

The diagnoses found represented nine of the 13 domains present in the NANDA-I taxonomy<sup>6</sup>. The domains with the most diagnoses were: Domain 9: Coping/stress tolerance, recording 23 diagnoses, responsible for 131 occurrences, and Domain 7: Roles and relationships, with 13 diagnoses and 94 occurrences (Table 4).

**Table 4.** Absolute and relative frequency of NANDA-I domains. Maringá, PR, Brazil, 2024

NANDA-I Domain	Diagnoses represented	n	%
Domain 9: Coping/stress tolerance	23	131	46.1
Domain 7: Roles and relationships	13	94	33.0
Domain 6: Self-perception	08	15	5.3
Domain 4: Activity/rest	05	15	5.3
Domain 1: Health Promotion	03	09	3.1
Domain 12: Comfort	04	08	2.8
Domain 5: Perception/Cognition	03	06	2.1
Domain 10: Principles of life	03	05	1.7
Domain 8: Sexuality	01	01	<1%

Legend: n= 284

Source: The authors (2024).

## DISCUSSION

Studies conducted nearly two decades ago showed that the main nursing diagnoses of NANDA-I in families experiencing the hospitalization process were: Caregiver role strain; Impaired verbal communication of the family; Impaired home maintenance; Interrupted family processes; Impaired social interaction; Deficient knowledge; and Anxiety<sup>7-9</sup>. The findings of the present research demonstrate continuity, while also providing an update to these results.

It is observed that diagnoses such as Caregiver role strain, Interrupted family processes, and Anxiety remain relevant in the contemporary context, while others, such as Impaired home maintenance, Impaired social interaction, and Deficient knowledge, give way to emerging diagnoses, such as Risk of caregiver role strain, Dysfunctional family processes, and Stress overload. It is also noteworthy that the family's Impaired verbal communication diagnosis was not identified in this analysis, possibly because new digital communication tools currently available to families facilitate interaction among their members.

The hospitalization process directly impacts family dynamics, requiring one of the members to assume the caregiver role, both in cases of acute conditions and in the decompensation of chronic diseases<sup>10-11</sup>. This role, in general, falls on a single person, historically associated with women<sup>12</sup>. Overload, sudden or progressive, can generate physical, emotional, and spiritual suffering, manifesting as nervousness, frustration, changes in leisure activities, family conflicts, constant worries, and fatigue<sup>3</sup>. Moreover, the illness of a loved one tends to intensify existing relational fragilities<sup>11</sup>.

In this context, the diagnoses of Caregiver Role Strain and Risk of Caregiver Role Strain – which, combined, were present in 94.2% of participating families – are particularly representative, as they synthesize the multiple physical, emotional, social, and economic impacts of caregiving<sup>10,13-14</sup>. The defining characteristics of this diagnosis encompass aspects related to caregiving activities, the caregiver's health status (physiological,

emotional, and socioeconomic), the caregiver–care recipient relationship, and family processes. Related factors include variables linked to the patient, the caregiver, their interactions, the socioeconomic context, and family dynamics<sup>6</sup>. This breadth justifies the relevance and frequency of these diagnoses in the analyzed cases.

Hospitalization, in itself, is a source of anxiety, insecurity, and fear for family members<sup>11</sup>. The diagnosis of Anxiety, defined by NANDA-I<sup>6</sup> as a feeling of discomfort or fear in anticipation of danger, proved to be recurrent. Its defining characteristics encompass cognitive, physiological, and behavioral manifestations, associated with factors such as threats to the integrity of the family member, multiple stressors, unmet needs, and uncertainties about the prognosis<sup>6</sup>. Thus, the diagnosis of Anxiety and its analogs, such as Death-related Anxiety and Fear, are relevant to families experiencing hospitalization<sup>7-9</sup>. The literature shows that effective support from professionals, family members, friends, or spiritual networks acts as a protective factor, reducing the intensity of these symptoms and strengthening coping strategies<sup>10,15-16</sup>. Thus, it is noted that the inclusion of the family as the focus of care should be reinforced within the hospital environment.

Family conflict emerged as a central element, associated with lack of support, dependency, and scarcity of financial resources, conditions that favor diagnoses such as "Impaired Family Coping, Compromised Family Coping, Interrupted Family Processes, and Dysfunctional Family Processes"<sup>17-18</sup>. These diagnoses encompass situations of reduced mutual and emotional support, communication failures, difficulties in decision-making, inability to express feelings, denial, and chronic conflicts, as well as feelings of helplessness and stress overload<sup>6</sup>.

On the other hand, health promotion diagnoses were observed, such as Willingness for improved communication, Willingness for increased hope, Willingness for improved relationships, and Willingness for improved family processes, among others. These diagnoses reflected both situations of conflict, in which the desire for overcoming emerged, and the perception of hospitalization as an opportunity for reconciliation and redefinition of family relationships. In this context, it is up to the nurse to support and create conditions that favor such health promotion processes.

In summary, the findings of this study confirm the persistence of classic diagnoses in the context of family hospitalization, while also highlighting the emergence of new diagnoses that reflect social transformations and greater complexity of caregiving demands. The coexistence of diagnoses related to overload, anxiety, and interrupted family processes, along with health promotion diagnoses, reveals not only vulnerability but also resilience and the ability of families to adapt in the face of a loved one's illness. These results reinforce the need for family-centered nursing practices that recognize both risk factors and coping mechanisms, to support more comprehensive, personalized interventions aimed at promoting health and quality of life.

Among the limitations of this study, it is noteworthy that the sample was non-probabilistic and comprised 35 families from a single university hospital, which limits the generalizability of the findings. Furthermore, women predominated among family participants (86%), which may limit understanding of the male experience in the caregiver role. Another relevant aspect concerns the selection criteria for participants, which were based on the nurses' departmental recommendations and may have introduced selection bias, as families considered more accessible or with greater communicative availability may have been prioritized. However, the findings are relevant for advancing the understanding of the main family needs affected by the hospitalization process.

Moreover, the findings expand understanding of family care as a unit of care; the diagnoses support actions that promote comprehensive care and a culture of safety and quality in individual assistance. Possible interventions can be proposed based on the listed diagnoses, such as therapeutic communication, strengthening bonds, active family participation in decision-making, as well as the development of educational strategies for disease management, emotional support, and reorganization of roles in the face of illness, in addition to actions that can empower the family so that both the patient and their family are protagonists in the care process<sup>1</sup>.

The contribution of this study to the science of nursing lies in expanding knowledge about family care in hospital settings and the possibility of reviewing, updating, or validating existing diagnoses, ensuring greater applicability to contemporary realities. In addition, there is a need to develop studies on concept analysis and clinical validation across different populations to improve diagnostic accuracy, strengthen clinical reasoning, and enhance nursing care practice.

## CONCLUSION

The findings of this study showed that the main nursing diagnoses identified in the participating families were Caregiver role strain, Anxiety, Risk of caregiver role strain, Dysfunctional family processes, Interrupted family processes, Stress overload, and Risk of feelings of helplessness.

The high frequency of diagnoses in each family points to their vulnerability in the hospital context, often receiving little assistance from health professionals. In light of this, it is essential for the nurse to act to facilitate early detection of diagnoses, develop coping strategies, and strengthen support networks for the primary caregiver, in order to minimize risks, reduce overload, and promote greater family quality of life.

It is recommended that new investigations explore effective interventions for managing nursing diagnoses across different institutional and sociocultural contexts, as well as focus on the experiences of male family caregivers, and expand to multicenter studies with probabilistic sampling to validate the findings.

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**Conflicts of interest:**

The authors have no conflicts of interest to declare.

**Data availability:**

The authors declare that the data can be made available upon request to the corresponding author.

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