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RESEARCH ARTICLE (ORIGINAL)

Conceptualization of nursing care to the person with post-stroke dysphagia

Conceptualização dos cuidados de enfermagem à pessoa com deglutição comprometida após o acidente vascular cerebral

Conceptualización de los cuidados de enfermería a la persona con problemas de deglución después del accidente cerebrovascular

Isabel de Jesus Oliveira [1, 2]
https://orcid.org/0000-0001-6627-3907

Susana Isabel Faria de Almeida [3]
https://orcid.org/0000-0002-4631-5222

Liliana Andreia Neves da Mota [1, 4]
https://orcid.org/0000-0003-3357-7984

Germano Rodrigues Couto [5, 4]
https://orcid.org/0000-0002-5423-7375

[1] Portuguese Red Cross Northern Health School, Oliveira de Azeméis, Portugal

[2] Centre for Health Studies and Research of the University of Coimbra, Coimbra, Portugal

[3] Central Region Rehabilitation Medicine Center - Rovisco Pais, Tocha, Portugal

[4] Center for Health Technology and Services Research, Porto, Portugal

[5] University Fernando Pessoa, Porto, Portugal

Corresponding author
Isabel de Jesus Oliveira
E-mail: ijoliveira12@gmail.com

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Abstract
Background: Dysphagia is a clinical condition that affects a significant number of stroke patients. Its complications are among the main causes of death after a stroke, although dysphagia is not considered a cause of death.
Objective: To understand how nurses conceptualize nursing care to the person with post-stroke dysphagia.
Methodology: An exploratory descriptive study was conducted in an inpatient unit of a rehabilitation center, using the focus group and participant observation techniques, between April and July 2019.
Results: Several factors influence the decision-making process in nursing, resulting in practices based on interdependent intervention. Constraints were identified in the documentation of nursing therapeutic approaches. The focus on the person and family and their involvement in the care process is highlighted.
Conclusion: There are organizational aspects that negatively influence the conceptualization of care. The need to improve the documentation of nursing therapeutic approaches is reinforced.

Keywords: stroke; deglutition; nursing care

Resumo
Enquadramento: O compromisso na deglutição é uma condição clínica que afeta um número significativo de pessoas com acidente vascular cerebral (AVC). As suas complicações estão entre as principais causas de morte após o AVC, apesar de não ser considerada como causa de mortalidade.
Objetivo: Compreender como os enfermeiros conceptualizam os cuidados de enfermagem à pessoa com deglutição comprometida após o AVC.
Metodologia: Estudo exploratório e descritivo, realizado num serviço de internamento de um centro de reabilitação, usando a técnica de *focus group* e observação participante, durante o período de abril a julho de 2019.
Resultados: Vários fatores influenciam o processo de tomada de decisão em enfermagem, resultando em práticas assentes na lógica da intervenção interdependente. Nas terapêuticas de enfermagem identificam-se constrangimentos na documentação das práticas. Salienta-se o foco na pessoa e família e o seu envolvimento no processo de cuidados.
Conclusão: Existem aspetos organizacionais que influenciam negativamente a conceção dos cuidados. Reforça-se a necessidade de melhorar a documentação das terapêuticas de enfermagem.

Palavras-chave: acidente vascular cerebral; deglutição; cuidados de enfermagem

Resumen
Marco contextual: El deterioro de la deglución es un cuadro clínico que afecta a un número significativo de personas que han sufrido un accidente cerebrovascular (ACV). Sus complicaciones se encuentran entre las principales causas de muerte después del ACV, aunque no se la considera una causa de mortalidad.
Objetivo: Comprender cómo los enfermeros conciben el cuidado de la persona con problemas de deglución después de un ACV.
Metodología: Estudio exploratorio y descriptivo realizado en un servicio de internamiento de un centro de rehabilitación, para lo cual se utilizó la técnica de grupos focales y la técnica de observación participante durante el período de abril a julio de 2019.
Resultados: Varios factores influyen en el proceso de toma de decisiones en enfermería, lo que da lugar a prácticas basadas en la lógica de la intervención interdependiente. En las terapias de enfermería, las limitaciones se identifican en la documentación de las prácticas. Se destaca el enfoque centrado en la persona y la familia, y su participación en el proceso de atención.
Conclusión: Hay aspectos organizativos que influyen negativamente en la conceptualización de la atención. Se refuerza la necesidad de mejorar la documentación de las terapias de enfermería.

Palabras clave: accidente cerebrovascular; deglución; atención de enfermería

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Introduction

Stroke is a leading cause of mortality and morbidity and the second cause of disability-adjusted life years (GBD 2016 Stroke Collaborators, 2019). Dysphagia is one of the most common post-stroke complications, and it is associated with increased risk of pneumonia, dehydration, and malnutrition, resulting in poor functional outcomes and reduced quality of life (Cohen et al., 2016). The existence of formal guidelines that systematize nursing therapeutic approaches to the person with dysphagia has a significant impact on dysphagia-related complications, particularly in pneumonia and death, improving health outcomes (Hines, Kynoch, & Munday, 2016). Thus, it is important to implement continuous quality improvement systems, within the scope of the Quality Standards for Nursing Care, which encourage the application in clinical practice of the existing clinical guidelines for this focus of attention. Previous studies focused on the analysis of the documentation of nursing therapeutic approaches revealed the existence of limitations, highlighting the need to clarify whether the documentation found in nursing records corresponds to the actual delivery of nursing care (Abreu, Barroso, Segadães, & Teixeira, 2015; Oliveira, Couto, & Mota, 2019). In this sense, this study aimed to understand how nurses conceptualize nursing care to the person with post-stroke dysphagia. These results will be essential as a starting point for the implementation of a project for the continuous improvement of the quality of nursing care with a view to systemizing nursing therapeutics to the person with dysphagia.

Background

Nursing promotes the health and well-being of individuals, with the nurse-patient relationship being placed at the center of clinical practice (Standing, 2014). Nursing practice is the expression of the nursing process and the clinical judgment underlying the decision-making process. To understand how care is conceptualized, it is important to know the nature of the clinical reasoning that guides the decision-making process regarding the nursing process: assessment, diagnosis, outcomes, planning, and intervention (Kuiper, O'Donnell, Pesut, & Turrise, 2017). Each of these steps triggers different types of thinking related to the individual and his/her medical history, the need for care, and the response to health issues, which influences how nurses select, contextualize, and prioritize the existing data, knowledge, and evidence in the decision-making process (Kuiper et al., 2017). Clinical judgment is an informed opinion that relates the observation and assessment of individuals in identifying and evaluating nursing therapeutic options (Standing, 2014). Among the factors that influence the nurse's decision-making process are the organization culture, education, situation awareness, autonomy, the available scientific knowledge and evidence, and, above all, their nursing experience (Nibbelink & Brewer, 2018; Standing, 2014). Experience is strongly associated with the development of nursing skills, assuming that the highest level of proficiency (expert) is acquired through a dynamic process that is enhanced and deepened by experience (Benner, 2001). This is one of the requirements for evidence-based practice (EBP) in nursing, which integrates the professional's experience and expertise, the resources, the clinical state and setting, the circumstances, and patient preferences (Chinn & Kramer, 2015). In decision-making, this process ensures the delivery of high-quality nursing care. Despite the recognized advantages of EBP, many barriers persist regarding its implementation, namely the lack of EBP knowledge and skills among nurses, the lack of an environment and culture that support EBP, and the lack of resources and instruments for its implementation (Melnyk, Gallagher-Ford, & Fineout-Overholt, 2017). It is therefore urgent to promote EBP to reduce the gap between the production of evidence and its integration into clinical practice (Melnyk et al., 2017).

Hence, knowing that post-stroke dysphagia exposes the patient to a higher risk of pneumonia, disability, and death (Cohen et al., 2016), an early systematized nurse-initiated intervention for the identification and management of dysphagia has a significant impact on health outcomes, namely greater efficacy in the prevention of aspiration pneumonia, reduced death rates at discharge, and shorter length of hospital stay (Hines et al., 2016). On the other hand, based on documentation analysis, there is evidence that the systematization of nurses' practices in this context is limited (Oliveira et al., 2019). These results were also found in studies developed in other contexts and with other foci of attention (Abreu et al., 2015). Thus, it is important to clarify whether this phenomenon is not valued, for which reason it is not reflected in the documentation, or if there are constraints to its documentation. The analysis of the conceptualization and implementation of care will clarify the intention for action and the elements used by nurses, thus allowing to understand how nurses conceptualize nursing care to the person with post-stroke dysphagia.

Research question

How do nurses conceptualize nursing care to the person with post-stroke dysphagia?

Methodology

This is an exploratory and descriptive study, guided by the method proposed by Charmaz (2006) to build a grounded theory. It was conducted in an inpatient unit of a rehabilitation center in Portugal, using two data collection techniques: focus group and participant observation, complemented with field notes. Twenty nurses participated in this study, corresponding to all nurses working at the unit. Most participants were women (n = 15), corresponding to 75% of the professionals. The mean age was 36.7 ± 6.2 years (minimum of 28 and maximum of 52), the average length of service of 12.9 ± 6.5 years (minimum

of 5 and maximum of 29), and the mean length of time working in that unit was 6.9 ± 5.0 years (minimum of 1 and maximum of 18). Of this team, 45% were specialist nurses (n = 9), of whom two were specialized in medical-surgical nursing, and seven in rehabilitation nursing. The focus group was conducted with a group of nurses from the unit, who were identified as key informants. The focus group was designed to promote reflection on the practices targeting the person with post-stroke dysphagia. Focus group participants were selected using a theoretical sampling technique. The following were selected: specialist nurses in rehabilitation nursing, working as specialists and nurses with more professional experience in the context, that is, nurses who had been working in the unit for a longer period. These professionals were considered as the most relevant ones to meet the study objective. The focus group was composed of five nurses: two men and three women, with a mean age of 36.6 ± 8.7 years (minimum of 31 and maximum of 52), a mean length of service of 13.8 ± 8.5 years (minimum of 9 and maximum of 29), and a mean length of time working in that unit of 10 ± 4.4 years (minimum of 5 and maximum of 17 years). Of these, three were specialist nurses in rehabilitation nursing, working as specialist nurses. The principal investigator carried out three focus groups at the unit, from May to July 2019, with an approximate duration of one hour each. All focus groups were recorded and transcribed in full. Another data collection technique was the participant observation of the nurses' practices inherent to the therapeutic intervention to the person with post-stroke dysphagia, from admission to discharge. A participant observation grid was used with information about 1) the environment – where the activity occurs and relevant aspects of the environment; 2) the participants – who is present, their roles, and those with access; 3) the activities developed - what is being done, how communication was established, and how often; 4) frequency and duration of the activity - when the activity begins and ends, and how often it reoccurs; 5) the process – how the activity is organized; and 6) outcomes – why the activity is taking place in that way and what are the outcomes. These grids were organized based on key moments/activities of care delivery: initial admission/assessment, feeding, oral hygiene, assessment to readjust care planning, and preparation for discharge, followed by an area for field notes. One of the researchers involved in the study carried out the participant observation. This researcher was a professional of the context being studied and, therefore, an integral part of the dynamics of care delivery. The participant observation aimed to look for aspects that might have not been explicit in the data obtained from the focus groups. It took place from April to June 2019, when it ended due to data saturation. Twelve nurses were observed, in a total of 65 observations. Meanwhile, relevant field notes were made, complementing the data collected through both the focus groups and the participant observation. Data were analyzed and processed using the QDA Miner 4 Lite software, which began with an initial coding that generated a list of codes, moving on to focused coding and respective categorization. A content analysis was carried out to reduce the qualitative data, and two independent researchers coded and categorized data. Quantitative data, namely the participants' sociodemographic data, were analyzed using IBM SPSS Statistics software, version 25.0. All participants agreed to participate in this study and consented to the audio recording of the focus group. The institution's Board of Directors authorized the study, which also received a favorable opinion from the Ethics Committee.

Results

Three categories emerged from the analysis with different subcategories (Table 1): Conceptualization of nursing care, Implementation of nursing therapeutics, and Care environment.

Conceptualization of nursing care

This category emerged from the participants' reflection on the clinical reasoning involved in the process of assessment, nursing diagnosis, and care planning. Of the subcategories included in this category, the most frequent one was the *documentation of practices*, to which the participants gave particular relevance: "we don't all register in the same way. The records are the most difficult part" (nurse [N]5, May 2019), "I'd already said that, even though *SClínico* includes a part to assess swallowing, we can't do it. We can't fill in the table (N12, May 2019), "no one knows what to do with the scale in *SClínico*. . . and it's complicated to make those records" (N2, May 2019), "we don't know how to do them . . . we put them into general information" (N5, June 2019). For participants, documentation is important, "the way we register is also important" (N12, May 2019), and relevant to "enter the data on assessment, diagnosis, and interventions in the records so that we can extract the outcomes and the information" (N2, May 2019). The following observations were also recorded:

> The patient's diet, food consistency, and food restrictions are recorded in a hospital procurement and pharmacy management software, and no records are made in the patient's file. All relevant information is passed on orally between the professionals, such as the need for adaptive strategies or technical aids. (field note [FN]7, May 2019).

In addition, data concerning the patient's progress are, as mentioned above, monitored by speech therapists and "passed on orally to the other professionals" (FN18, June 2019).

In the subcategory *knowledge/training*, the participants expressed difficulties in the conceptualization of nursing care to the person with dysphagia because this topic had not been addressed during their undergraduate training, "I didn't receive any training at all on dysphagia in my basic training" (N5, May 2019). They added that: "I feel that I need training on how to care for patients with dysphagia, which interventions should be implemented to standardize care" (N2, May 2019), "we need to improve our knowledge about pathophysiology and how to assess" (N13, May 2019). This fact has an impact on the

conceptualization and planning of care, which is expressed in the subcategory of *patient assessment*, "I have some difficulty in assessing [the person]" (N12, May 2019), "and assessing is important" (N13, June 2019), and "I don't know what or how to assess in the initial process" (N5, June 2019).

The observation also showed that "observation data don't identify the instruments/strategies for assessing the interventions and restructuring the care plan" (FN2, April 2019). Within the multidisciplinary team, the *nurses' skills* are not taken into account in the assessment process, "all interventions regarding the assessment of the swallowing process are established by the physician who always refers the patient to speech therapy, not valuing the outcome of the nurses' observations" (FN5, April 2019). "We sometimes think that they can already drink without thickeners, but even if we do that, it is not up to us to make this change and say - look, from now on you can drink" (N12, May 2019), "most of the time, they come with an indication or not and the physicians end up asking for an assessment from the therapists" (N12, May 2019), "afterward, we help with the feeding and collaborate with them, but the assessment, even regarding the use of thickeners, is up to them" (N13, May 2019). "The monitoring of the progress of the patient with dysphagia is performed exclusively by the speech therapists" (FN18, June 2019).

In this context, the participants identified difficulties in the *systematization of practices*, "all interventions in the unit should be standardized, so that we all do things the same way, that would be the most important" (N13, June 2019), "and we should all use the same language" (N2, May 2019). These factors were perceived by the professionals as barriers to the conceptualization of care.

Moreover, the analysis of the textual corpus showed that the *preparation for discharge* was a focus of attention for nurses, "when families come here in the afternoon or on weekends, we observe their difficulties and identify them immediately, we see the problem and schedule" (N1, June 2019), "We'll prepare the family for when the patient is discharged" (N5, June 2019). For participants, the patient and the family are the targets of care, "we have meetings with the family every 15 days, we have a consultation with the family to establish the post-discharge objectives and destination" (N5, May 2019), "we observed several activities being carried out, particularly in the afternoon and weekend shifts, to promote the family's involvement in the care process" (FN18, June 2019), with "moments of interaction between the nurses and the patients and their families to train self-care and the use of adaptive strategies and technical aids for self-care, to prepare them for discharge" (FN18, June 2019).

Implementation of nursing therapeutics

This category emerged from the analysis of the participants' answers about how they deliver care, and it was subdivided into two subcategories. The first subcategory is associated with *care delivery*. Participants reported that "nurses know what to do with this patient and that patient" (N5, May 2019), "I think we all know what to do with a patient with dysphagia" (N2, May 2019), but "we know how to do it, but we don't all do it the same way" (N12, May 2019), which reflected a perception of appropriate practices.

> Meals are mostly made in the lunchroom, except for patients in isolation or whose clinical condition does not allow them to go to the lunchroom. Depending on the degree of dependency, nurses, operational assistants, and speech therapists (the former only during lunchtime on weekdays) assist or supervise patients during feeding. They use postural adjustments, food consistency changes, and technical aids as compensatory measures, for about 20 to 30 minutes. (FN2, April 2019)

Regarding oral health self-care, "nurses supervise, assist, or replace all patients, once a day, using a fluoridated toothpaste and benzydamine mouthwash, for about 3/4 minutes" (FN13, May 2019).

The second subcategory is the *delegation of tasks*. In the delivery of care to the post-stroke patient with dysphagia, the task of feeding the patient is delegated to the operational assistant "not at an early stage, but when the patient is stable" (N5, May 2019), "we assess the safety conditions and check if they [operational assistants] can feed the patient" (N13, May 2019), "we are always nearby and supervise" (N12, May 2019).

Care environment

The third category reflects the relevant aspects of *The organization of nursing care,* of the *Quality Standards of Nursing Care* (Ordem dos Enfermeiros, 2012). In the subcategory *work methodology*, the one with greater expression within this category, the participants reported that "the problem is the poor workflow here" (N13, May 2019), "when they [patients] are admitted, we don't do the initial assessment, it's done in the outpatient consultation, and we don't immediately meet the patients and their families" (N2, June 2019), "the patient's admission and initial assessment is done in another unit by the members of the nursing team of that unit and only then the patient and the family member (accompanying person) are sent to the inpatient unit" (FN5, April 2019).

The second most important subcategory was *material resources*, "we don't have chlorhexidine for the oral hygiene of patients with dysphagia" (N5, July 2019), "we only got the cups [cut-out for the nose] recently" (N1, July 2019), "these materials are important for patient safety" (N2, July 2019). In this subcategory, participants also reported that "we don't have pumps [for enteral feeding]" (N1, July 2019), which they identified as useful because "it is complicated when we have 4 or 5 tubes in the afternoon" (N12, July 2019), "I can't stay that long . . . half an hour for each is more than an hour" (N5, July 2019), "this would solve the problem [enteral feeding pump] . . . at the time, we asked the hospital to purchase them, we did" (N2, July 2019). Another subcategory, *staffing*, is characterized by the participants as a constraint to care delivery, "... we can't feed all the patients" (N13, May 2019), "we should always feed the patients with dysphagia" (N12, June 2019), "we needed more time to feed the patients . . . and perform their oral

hygiene" (N5, June 2019), "we don't do the oral hygiene as often as we should, we can't, it depends on how the unit is" (N2, June 2019). The other subcategories identified were *motivation*, "people [nurses] are not motivated" (N13, June 2019) and "motivation is important" (N12, June 2019), and *organizational culture/corporatism*, "the interdisciplinary part can be more difficult because we live in a very specific context in that regard" (N13, May 2019), "if we have some direct intervention there, the therapists will take it as an affront and it is more difficult then because our work should be complementary" (N5, May 2019).

Table 1
Frequency of coding of the recording units for each subcategory

Category	Subcategory	Frequency	%
Conceptualization of nursing care	documentation of practices	98	25.00%
	preparation for discharge	51	13.01%
	nurses' skills	44	11.22%
	patient assessment	35	8.93%
	systematization of practices	16	4.08%
	knowledge/ training	28	7.14%
Implementation of nursing therapeutics	care delivery	47	11.99%
	task delegation	7	1.79%
Care environment	work methodology	22	5.61%
	material resources	21	5.36%
	staffing	10	2.55%
	organizational culture/corporatism	8	2.04%
	motivation	5	1.28%
	Total	392	100.00%

Discussion

The first step of the nursing process is assessment, which implies the collection of relevant data and information regarding the person/family or community. This information is essential for identifying nursing diagnoses (Kuiper et al., 2017). In this area, the participants highlighted the influence of several factors in the decision-making process. Training is one of the factors that is positively associated with decision-making (Nibbelink & Brewer, 2018). Participants recognize the importance of continuous professional development as a strategy for promoting professional development and the quality of nursing care (Ordem dos Enfermeiros, 2012). According to the participants, assessment is critical in the conceptualization of care as the first stage of the nursing process (Kuiper et al., 2017), which contradicts studies that found a low awareness of the importance of the assessment of swallowing among nurses (Abu-Snieneh & Saleh, 2018). Moreover, the focus on the person and family during the preparation for discharge is identified as positive, with participants reporting that they are the target of care. This reinforces the importance given by nurses to the collaborative decision-making process, which places the person at the center of care (Standing, 2014). However, in terms of the conceptualization of care, the documentation of practices, and the devaluing of nurses' skills were the two factors that most negatively influenced the decision-making process. The results demonstrate the importance given by the participants to the documentation of practices as essential for assessing progress towards the achievement of health outcomes. The limitations expressed by the participants are consistent with a study that analyzed nurses' documentation of patients who were diagnosed with dysphagia in the initial assessment, but whose assessment was not recorded in the nursing diagnoses and interventions (Oliveira et al., 2019). The participants' accounts clarify that this focus of attention is valued in clinical practice, but that there are constraints in how documentation is operationalized. It is important to understand whether these limitations are associated with the information system or the professionals, considering that, at this moment, there is growing evidence of the need to improve the documentation of practices (Abreu et al., 2015; Oliveira et al., 2019). Only then will it be possible to measure nursing-sensitive patient outcomes, clarifying the contribution of nursing, within a multidisciplinary team, to the achievement of health outcomes. This is the social mandate of the profession and the existence of a nursing records system "that systematically incorporates, among other data, the patient's nursing care needs" contributes to the maximum effectiveness in nursing care organization (Ordem dos Enfermeiros, 2012, p. 18).

Another factor that strongly influences the decision-making process is the devaluing of nurses' skills. These results highlight the current logic of hierarchization where the dominant work principle is the opposition between command and execution and the relationship between nurses and speech therapists is developed based on domination/subordination rather than cooperation (Carapinheiro,

1998). This logic is enhanced by the work methodologies implemented and factors identified in the care environment, such as the organizational culture. These constraints cause the nurses' loss of autonomy, with the nurses playing an executive role in a logic of interdependent intervention (Decreto-Lei n.º 161/96, de 4 de Setembro), distancing themselves from the use of the scientific methodology that characterizes the nursing care process (Kuiper et al., 2017). Even professionals with several years of professional experience in this context, which would imply a higher level of proficiency, do not assume themselves as experts in this area, negatively influencing the decision-making process. Other subcategories identified in the care environment contribute negatively to the decision-making process: staffing and professional motivation. Staffing has an impact on the quality and safety of care and, even though it is difficult to define safe nurse staffing (Freitas & Parreira, 2013), the evidence shows that lowering the patient-to-nurse ratios improves patient outcomes (Aiken, et al., 2011), which, in turn, has an impact on motivation. The effect of the care environment, including staffing, on professional motivation, has been identified (Freitas & Parreira, 2013). Regarding care delivery, in the category *Implementation of nursing therapeutics*, participants are aware of the appropriate practices, translated in the implementation of compensatory strategies. This set of measures seems to be the most effective strategy for ensuring airway safety of patients with post-stroke dysphagia (Bath, Sean, & Everton, 2018). Participants also valued oral self-care in patients with dysphagia. Indeed, the implementation of intensified oral hygiene protocols using chlorhexidine reduces the incidence of aspiration pneumonia (Sørensen, et al., 2013).

When nurses incorporate the principles of EBP in their clinical practice, they are promoting the quality of care and patient satisfaction, improving the health of the populations, reducing health costs, and increasing professional satisfaction (Melnyk et al., 2017).

The main limitations of this study were associated with its development in a specific clinical setting and that it was focused on swallowing. There are constraints associated with this specific context, as well as others such as those associated with the information systems and the documentation of practices, which will need to be validated in other clinical settings through the replication of similar studies.

Conclusion

The *corpus* of analysis in this study consisted of the full content of the focus groups, the participant observation, and the field notes, excluding ancillary aspects. This study found that the participants' reports and their practices are consistent. In response to the research question, there are several factors that negatively influence the decision-making process in nursing for the conceptualization of care to the patient with post-stroke dysphagia. These factors are associated with, on the one hand, the participants' perception of the lack of skills and, on the other hand, the organizational barriers, which causes them to develop their practices based on the logic of interdependent intervention. Regarding the nursing therapeutics for patients with post-stroke dysphagia, with particular focus on feeding and oral self-care, participants use compensatory measures that promote airway safety. However, they recognize that there is room to improve their practices and the need for continuous training. The focus on the person and family and their involvement in the care process is emphasized, which is in line with the exercise of excellence recommended by the social mandate of the profession. From the perspective of care organization, these results show once again the importance of improving the documentation of practices because what is performed does not correspond to what is documented, as well as the existence of organizational aspects with an impact on the conceptualization of nursing care.

The implications for nursing practice include the fact that the practices based on a logic of interdependent intervention hinder the decision-making process, causing the risk of loss of autonomy of the profession. Also, there is a potential difficulty of measuring positive outcomes sensitive to nursing care due to constraints in the documentation, which represent a barrier to the production of evidence resulting from the nurse's autonomous intervention.

Author contributions

Conceptualization: Oliveira, I. J.
Methodology: Oliveira, I. J., Mota, L. N., Couto, G. R.
Data curation: Oliveira, I. J., Almeida, S. F., Couto, G. R.
Writing – original draft: Oliveira, I. J., Almeida, S. F.
Writing – review & editing: Oliveira, I. J., Almeida, S. F., Mota, L. N., Couto, G. R.

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