EDITION 10

Nurse's Pocket Guide

Diagnoses, Prioritized Interventions, and Rationales

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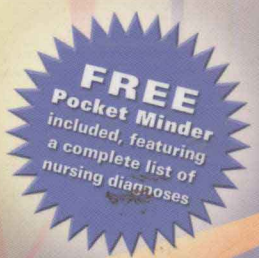

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Dedication

This book is dedicated to:

Our families, who helped with the mundane activities of daily living that allowed us to write this book and who provide us with love and encouragement in all our endeavors.

Our friends, who support us in our writing, put up with our memory lapses, and love us still.

Bob Martone, Publisher, Nursing, who asks questions that stimulate thought and discussion, and who maintains good humor throughout.

The F.A. Davis production staff and Alan Sorkowitz, who coordinated and expedited the project through the editing and printing processes, meeting unreal deadlines, and sending pages to us with bated breath.

Robert H. Craven, Jr., and the F.A. Davis family.

And last and most important:

The nurses we are writing for, to those who have found the previous editions of the Pocket Guide helpful, and to other nurses who are looking for help to provide quality nursing care in a period of transition and change, we say, "Nursing Diagnosis is the way."

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To our colleagues in NANDA who continue to formulate and refine nursing diagnoses to provide nursing with the tools to enhance and promote the growth of the profession.

Marilynn E. Doenges
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How to Use the Nurse's Pocket Guide

The American Nurses Association (ANA) Social Policy Statement of 1980 was the first to define nursing as the diagnosis and treatment of human responses to actual and potential health problems. This definition, when combined with the ANA Standards of Practice, has provided impetus and support for the use of nursing diagnosis. Defining nursing and its effect on client care supports the growing awareness that nursing care is a key factor in client survival and in the maintenance, rehabilitative, and preventive aspects of healthcare. Changes and new developments in healthcare delivery in the last decade have given rise to the need for a common framework of communication to ensure continuity of care for the client moving between multiple healthcare settings and providers. Evaluation and documentation of care are important parts of this process.

This book is designed to aid the practitioner and student nurse in identifying interventions commonly associated with specific nursing diagnoses as proposed by NANDA International (formerly the North American Nursing Diagnosis Association). These interventions are the activities needed to implement and document care provided to the individual client and can be used in varied settings from acute to community/home care.

Chapters 1 and 2 present brief discussions of the nursing process, data collection, and care plan construction. Chapter 3 contains the Diagnostic Divisions, Assessment Tool, a sample plan of care, mind map, and corresponding documentation/charting examples. For more in-depth information and inclusive plans of care related to specific medical/psychiatric conditions (with rationale and the application of the diagnoses), the nurse is referred to the larger works, all published by the F.A. Davis Company: *Nursing Care Plans Across the Life Span*, ed. 7 (Doenges, Moorhouse, Geissler-Murr, 2006); *Psychiatric Care Plans: Guidelines for Individualizing Care*, ed. 3 (Doenges, Townsend, Moorhouse, 1998); and *Maternal/Newborn Plans of Care: Guidelines for Individualizing Care*, ed. 3 (Doenges, Moorhouse, 1999) with updated versions included on the CD-ROM provided with *Nursing Care Plans.*

Nursing diagnoses are listed alphabetically in Chapter 4 for ease of reference and include the diagnoses accepted for use by NANDA through 2005–2006. Each diagnosis approved for testing includes its definition and information divided into the NANDA categories of Related or Risk Factors and Defining Characteristics. Related/Risk Factors information reflects causative or contributing factors that can be useful for determining whether the diagnosis is applicable to a particular client. Defining Characteristics (signs and symptoms or cues) are listed as subjective and/or objective and are used to confirm actual diagnoses, aid in formulating outcomes, and provide additional data for choosing appropriate interventions. The authors have not deleted or altered NANDA's listings; however, on occasion, they have added to their definitions and suggested additional criteria to provide clarification and direction. These additions are denoted with brackets [ ].

With the development and acceptance of Taxonomy II following the biennial conference in 2000, significant changes were made to better reflect the content of the diagnoses within the taxonomy. Taxonomy II was designed to reduce miscalculations, errors, and redundancies. The framework has been changed from the Human Response Patterns and is organized in Domains and Classes, with 13 domains, 47 classes, and 172 diagnoses. Although clinicians will use the actual diagnoses, understanding the taxonomic structure will help the nurse to find the desired information quickly. Taxonomy II is designed to be multiaxial with 7 axes (see Appendix 2). An axis is defined as a dimension of the human response that is considered in the diagnostic process. Sometimes an axis may be included in the diagnostic concept, such as ineffective community Coping, in which the unit of care (e.g., community) is named. Some are implicit, such as Activity Intolerance, in which the individual is the unit of care. Sometimes an axis may not be pertinent to a particular diagnosis and will not be a part of the nursing diagnosis label or code. For example, the time axis may not be relevant to each diagnostic situation. The Taxonomic Domain and Class are noted under each nursing diagnosis heading. An Axis 6 descriptor is included in each nursing diagnosis label.

The ANA, in conjunction with NANDA, proposed that specific nursing diagnoses currently approved and structured according to Taxonomy I Revised be included in the International Classification of Diseases (ICD) within the section "Family of Health-Related Classifications." While the World Health Organization did not accept this initial proposal because of lack of documentation of the usefulness of nursing diagnoses at the international level, the NANDA list

has been accepted by SNOMED (Systemized Nomenclature of Medicine) for inclusion in its international coding system and is included in the Unified Medical Language System of the National Library of Medicine. Today, researchers from around the world are validating nursing diagnoses in support for resubmission and acceptance in future editions of ICD.

The authors have chosen to categorize the list of nursing diagnoses approved for clinical use and testing into Diagnostic Divisions, which is the framework for an assessment tool (Chapter 3) designed to assist the nurse to readily identify an appropriate nursing diagnosis from data collected during the assessment process. The Diagnostic Division label follows the Taxonomic label under each nursing diagnosis heading.

Desired Outcomes/Evaluation Criteria are identified to assist the nurse in formulating individual client outcomes and to support the evaluation process.

Interventions in this pocket guide are primarily directed to adult care settings (although general age span considerations are included) and are listed according to nursing priorities. Some interventions require collaborative or interdependent orders (e.g., medical, psychiatric), and the nurse will need to determine when this is necessary and take the appropriate action. Although all defining characteristics are listed, interventions that address specialty areas outside the scope of this book are not routinely presented (e.g., obstetrics/gynecology/pediatrics) except for diagnoses that are infancy-oriented, such as ineffective Breastfeeding, disorganized infant Behavior, and risk for impaired parent/infant/child Attachment. For example, when addressing deficient [isotonic] Fluid Volume, (hemorrhage), the nurse is directed to stop blood loss; however, specific direction to perform fundal massage is not listed.

The inclusion of Documentation Focus suggestions is to remind the nurse of the importance and necessity of recording the steps of the nursing process.

Finally, in recognition of the ongoing work of numerous researchers over the past 15 years, the authors have referenced the Nursing Interventions and Outcomes labels developed by the Iowa Intervention Projects (Bulechek & McCloskey; Johnson, Mass & Moorhead). These groups have been classifying nursing interventions and outcomes to predict resource requirements and measure outcomes, thereby meeting the needs of a standardized language that can be coded for computer and reimbursement purposes. As an introduction to this work in progress, sample NIC and NOC labels have been included under the heading Sample Nursing Interventions & Outcomes Classifications at the conclusion of each nursing diagnosis section. The reader is referred to the various publica-

tions by Joanne C. McCloskey and Marion Johnson for more in-depth information.

Chapter 5 presents over 400 disorders/health conditions reflecting all specialty areas, with associated nursing diagnoses written as client diagnostic statements that include the "related to" and "evidenced by" components. This section will facilitate and help validate the assessment and problem/need identification steps of the nursing process.

As noted, with few exceptions, we have presented NANDA's recommendations as formulated. We support the belief that practicing nurses and researchers need to study, use, and evaluate the diagnoses as presented. Nurses can be creative as they use the standardized language, redefining and sharing information as the diagnoses are used with individual clients. As new nursing diagnoses are developed, it is important that the data they encompass are added to the current database. As part of the process by clinicians, educators, and researchers across practice specialties and academic settings to define, test, and refine nursing diagnosis, nurses are encouraged to share insights and ideas with NANDA at the following address: NANDA International, 100 N. 20th Street, 4th Floor, Philadelphia, PA 19103, USA; e-mail: info@nanda.org

Contents

CHAPTER 1

The Nursing Process

Nursing is both a science and an art concerned with the physical, psychological, sociological, cultural, and spiritual concerns of the individual. The science of nursing is based on a broad theoretical framework; its art depends on the caring skills and abilities of the individual nurse. In its early developmental years, nursing did not seek or have the means to control its own practice. In more recent times, the nursing profession has struggled to define what makes nursing unique and has identified a body of professional knowledge unique to nursing practice. In 1980, the American Nurses Association (ANA) developed the first *Social Policy Statement* defining nursing as "the diagnosis and treatment of human responses to actual or potential health problems." Along with the definition of nursing came the need to explain the method used to provide nursing care.

Thus, years ago, nursing leaders developed a problem-solving process consisting of three steps—assessment, planning, and evaluation—patterned after the scientific method of observing, measuring, gathering data, and analyzing findings. This method, introduced in the 1950s, was called *nursing process.* Shore (1988) described the nursing process as "combining the most desirable elements of the art of nursing with the most relevant elements of systems theory, using the scientific method." This process incorporates an interactive/interpersonal approach with a problem-solving and decision-making process (Peplau, 1952; King, 1971; Yura & Walsh, 1988).

Over time, the nursing process expanded to five steps and has gained widespread acceptance as the basis for providing effective nursing care. Nursing process is now included in the conceptual framework of all nursing curricula, is accepted in the legal definition of nursing in the *Nurse Practice Acts* of most states, and is included in the ANA *Standards of Clinical Nursing Practice.*

The five steps of the nursing process consist of the following:

1. ***Assessment*** is an organized dynamic process involving three basic activities: a) systematically gathering data, b) sorting and organizing the collected data, and c) documenting the data in a retrievable fashion. Subjective and objective data are collected from various sources, such as the client

interview and physical assessment. Subjective data are what the client or significant others report, believe, or feel, and objective data are what can be observed or obtained from other sources, such as laboratory and diagnostic studies, old medical records, or other healthcare providers. Using a number of techniques, the nurse focuses on eliciting a profile of the client that supplies a sense of the client's overall health status, providing a picture of the client's physical, psychological, sociocultural, spiritual, cognitive, and developmental levels; economic status; functional abilities; and lifestyle. The profile is known as the *client database.*

2. ***Diagnosis/need identification*** involves the analysis of collected data to identify the client's needs or problems, also known as the nursing diagnosis. The purpose of this step is to draw conclusions regarding the client's specific needs or human responses of concern so that effective care can be planned and delivered. This process of data analysis uses diagnostic reasoning (a form of clinical judgment) in which conclusions are reached about the meaning of the collected data to determine whether or not nursing intervention is indicated. The end product is the *client diagnostic statement* that combines the specific client need with the related factors or risk factors (etiology), and defining characteristics (or cues) as appropriate. The status of the client's needs are categorized as *actual* or currently existing diagnoses and potential or *risk* diagnoses that could develop due to specific vulnerabilities of the client. Ongoing changes in healthcare delivery and computerization of the client record require a commonality of communication to ensure continuity of care for the client moving from one setting/level of healthcare to another. The use of standardized terminology or NANDA International nursing diagnosis labels provides nurses with a common language for identifying client needs. Furthermore, the use of standardized nursing diagnosis labels also promotes identification of appropriate goals, provides acuity information, is useful in creating standards for nursing practice, provides a base for quality improvement, and facilitates research supporting evidence-based nursing practices.

3. ***Planning*** includes setting priorities, establishing goals, identifying desired client outcomes, and determining specific nursing interventions. These actions are documented as the *plan of care.* This process requires input from the client/significant others to reach agreement regarding the plan to facilitate the client taking responsibility for his or her own care and the achievement of the desired outcomes and goals.

Setting priorities for client care is a complex and dynamic challenge that helps ensure that the nurse's attention and subsequent actions are properly focused. What is perceived today to be the number one client care need or appropriate nursing intervention could change tomorrow, or, for that matter, within minutes, based on changes in the client's condition or situation. Once client needs are prioritized, goals for treatment and discharge are established that indicate the general direction in which the client is expected to progress in response to treatment. The goals may be short-term—those that usually must be met before the client is discharged or moved to a lesser level of care—and/or long-term, which may continue even after discharge. From these goals, desired outcomes are determined to measure the client's progress toward achieving the goals of treatment or the discharge criteria. To be more specific, outcomes are client responses that are achievable and desired by the client that can be attained within a defined period, given the situation and resources. Next, nursing interventions are chosen that are based on the client's nursing diagnosis, the established goals and desired outcomes, the ability of the nurse to successfully implement the intervention, and the ability and the willingness of the client to undergo or participate in the intervention, and they reflect the client's age/situation and individual strengths, when possible. Nursing interventions are direct-care activities or prescriptions for behaviors, treatments, activities, or actions that assist the client in achieving the measurable outcomes. Nursing interventions, like nursing diagnoses, are key elements of the knowledge of nursing and continue to grow as research supports the connection between actions and outcomes (McCloskey & Bulechek, 2000). Recording the planning step in a written or computerized plan of care provides for continuity of care, enhances communication, assists with determining agency or unit staffing needs, documents the nursing process, serves as a teaching tool, and coordinates provision of care among disciplines. A valid plan of care demonstrates individualized client care by reflecting the concerns of the client and significant others, as well as the client's physical, psychosocial, and cultural needs and capabilities.

4. ***Implementation*** occurs when the plan of care is put into action, and the nurse performs the planned interventions. Regardless of how well a plan of care has been constructed, it cannot predict everything that will occur with a particular client on a daily basis. Individual knowledge and expertise and agency routines allow the flexibility that is necessary to

adapt to the changing needs of the client. Legal and ethical concerns related to interventions also must be considered. For example, the wishes of the client and family/significant others regarding interventions and treatments must be discussed and respected. Before implementing the interventions in the plan of care, the nurse needs to understand the reason for doing each intervention, its expected effect, and any potential hazards that can occur. The nurse must also be sure that the interventions are a) consistent with the established plan of care, b) implemented in a safe and appropriate manner, c) evaluated for effectiveness, and d) documented in a timely manner.

5. ***Evaluation*** is accomplished by determining the client's progress toward attaining the identified outcomes and by monitoring the client's response to/effectiveness of the selected nursing interventions for the purpose of altering the plan as indicated. This is done by direct observation of the client, interviewing the client/significant other, and/or reviewing the client's healthcare record. Although the process of evaluation seems similar to the activity of assessment, there are important differences. Evaluation is an ongoing process, a constant measuring and monitoring of the client status to determine: a) appropriateness of nursing actions, b) the need to revise interventions, c) development of new client needs, d) the need for referral to other resources, and e) the need to rearrange priorities to meet changing demands of care. Comparing overall outcomes and noting the effectiveness of specific interventions are the clinical components of evaluation that can become the basis for research for validating the nursing process and supporting evidenced-based practice. The external evaluation process is the key for refining standards of care and determining the protocols, policies, and procedures necessary for the provision of quality nursing care for a specific situation or setting.

When a client enters the healthcare system, whether as an acute care, clinic, or homecare client, the steps of the process noted above are set in motion. Although these steps are presented as separate or individual activities, the nursing process is an interactive method of practicing nursing, with the components fitting together in a continuous cycle of thought and action.

To effectively use the nursing process, the nurse must possess, and be able to apply, certain skills. Particularly important is a thorough knowledge of science and theory, as applied not only in nursing but also in other related disciplines, such as medicine

and psychology. A sense of caring, intelligence, and competent technical skills are also essential. Creativity is needed in the application of nursing knowledge as well as adaptability for handling constant change in healthcare delivery and the many unexpected happenings that occur in the everyday practice of nursing.

Because decision making is crucial to each step of the process, the following assumptions are important for the nurse to consider:

- The client is a human being who has worth and dignity. This entitles the client to participate in his/her own healthcare decisions and delivery. It requires a sense of the personal in each individual and the delivery of competent healthcare.
- There are basic human needs that must be met, and when they are not, problems arise that may require interventions by others until and if the individual can resume responsibility for self. This requires healthcare providers to anticipate and initiate actions necessary to save another's life or to secure the client's return to health and independence.
- The client has the right to quality health and nursing care delivered with interest, compassion, competence, and a focus on wellness and prevention of illness. The philosophy of caring encompasses all of these qualities.
- The therapeutic nurse-client relationship is important in this process, providing a milieu in which the client can feel safe to disclose and talk about his/her deepest concerns.

The revised *Nursing's Social Policy Statement* (ANA, 1995) acknowledges that since the release of the original statement, nursing has been influenced by many social and professional changes as well as by the science of caring. Nursing has integrated these changes with the 1980 definition to include treatment of human responses to health and illness. The new statement provides four essential features of today's contemporary nursing practice:

- Attention to the full range of human experiences and responses to health and illness without restriction to a problem-focused orientation (in short, clients may have needs for wellness or personal growth that are not "problems" to be corrected)
- Integration of objective data with knowledge gained from an understanding of the client's or group's subjective experience
- Application of scientific knowledge to the process of diagnosis and treatment
- Provision of a caring relationship that facilitates health and healing