CLINICAL APPLICATIONS OF NURSING DIAGNOSIS:

Adult, Child, Women's, Mental Health, Gerontic and Home Health Considerations

Second Edition

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CLASSIFICATION OF NANDA NURSING DIAGNOSES BY GORDON'S FUNCTIONAL HEALTH PATTERNS*

HEALTH PERCEPTION—HEALTH MANAGEMENT PATTERN
- Altered health maintenance
- Ineffective management of therapeutic regimen
- Total health management deficit
- Health management deficit (specify)
- Noncompliance (specify)
- High risk for noncompliance (specify)
- Health-seeking behaviors (specify)
- High risk for infection
- High risk for injury (trauma)
- High risk for poisoning
- High risk for suffocation
- Altered protection

NUTRITIONAL-METABOLIC PATTERN
- Altered nutrition: potential for more than body requirements or high risk for obesity
- Altered nutrition: more than body requirements or exogenous obesity
- Altered nutrition: less than body requirements or nutritional deficit (specify)
- Ineffective breastfeeding
- Effective breastfeeding
- Interrupted breastfeeding
- Ineffective infant feeding pattern
- High risk for aspiration
- Impaired swallowing or uncompensated swallowing impairment
- Altered oral mucous membrane
- High risk for fluid volume deficit
- Fluid volume deficit (1)
- Fluid volume deficit (2)
- Fluid volume excess
- High risk for impaired skin integrity or high risk for skin breakdown
- Impaired skin integrity
- Pressure ulcer (specify stage)
- Impaired tissue integrity
- High risk for altered body temperature
- Ineffective thermoregulation
- Hyperthermia
- Hypothermia

ELIMINATION PATTERN
- Constipation or intermittent constipation pattern
- Colonic constipation
- Perceived constipation
- Diarrhea
- Bowel incontinence
- Altered urinary elimination pattern
- Functional incontinence
- Reflex incontinence
- Stress incontinence
- Urge incontinence
- Total incontinence
- Urinary retention

ACTIVITY-EXERCISE PATTERN
- High risk for activity intolerance
- Activity intolerance (specify level)
- Fatigue
- Impaired physical mobility (specify level)
- High risk for disuse syndrome
- High risk for joint contractures
- Total self-care deficit (specify level)
- Self-bathing-hygiene deficit (specify level)
- Self-dressing-grooming deficit (specify level)
- Self-feeding deficit (specify level)
- Selt-toileting deficit (specify level)
- Altered growth and development: self-care skills (specify)
- Diversional activity deficit
- Impaired home maintenance management (mild, moderate, severe, potential, chronic)
- Dysfunctional ventilatory weaning response (DVWR)
- Inability to sustain spontaneous ventilation
- Ineffective airway clearance
- Ineffective breathing pattern
- Impaired gas exchange
- Decreased cardiac output
- Altered tissue perfusion (specify)
- Dysreflexia
- High risk for peripheral neurovascular dysfunction
- Altered growth and development

SLEEP-REST PATTERN
- Sleep-pattern disturbance

COGNITIVE-PERCEPTUAL PATTERN
- Pain
- Chronic pain
- Pain self-management deficit (acute, chronic)
- Uncompensated sensory deficit (specify)
- Sensory-perceptual alterations: input deficit or sensory deprivation
- Sensory-perceptual alterations: input excess or sensory overload
- Unilateral neglect
- Knowledge deficit (specify)
- Impaired thought processes
- Uncompensated short-term memory deficit
- High risk for cognitive impairment
- Decisional conflict (specify)

SELF-PERCEPTION–SELF-CONCEPT PATTERN
- Fear (specify focus)
- Anxiety
- Mild anxiety
- Moderate anxiety
- Severe anxiety (panic)
- Anticipatory anxiety (mild, moderate, severe)
- Reactive depression (situational)
- Hopelessness
- Powerlessness (severe, low, moderate)
- Self-esteem disturbance
- Chronic low self-esteem
- Situational low self-esteem
- Body image disturbance
- High risk for self-mutilation
- Personal identity confusion

ROLE-RELATIONSHIP PATTERN
- Anticipatory grieving
- Dysfunctional grieving
- Disturbance in role performance
- Unresolved independence-dependence conflict
- Social isolation or social rejection
- Social isolation
- Impaired social interaction
- Altered growth and development: social skills (specify)
- Relocation stress syndrome
- Altered family processes
- High risk for altered parenting
- Altered parenting
- Parental role conflict
- Parent-infant separation
- Weak mother-infant or parent-infant attachment
- Caregiver role strain
- High risk for caregiver role strain
- Impaired verbal communication
- Altered growth and development: communication skills (specify)
- Potential for violence

SEXUALITY-REPRODUCTIVE PATTERN
- Sexual dysfunction (specify type)
- Altered sexuality patterns
- Rape trauma syndrome
- Rape trauma syndrome: compound reaction
- Rape trauma syndrome: silent reaction

COPING-STRESS TOLERANCE PATTERN
- Coping, ineffective (individual)
- Avoidance coping
- Defensive coping
- Ineffective denial or denial
- Impaired adjustment
- Post-trauma response
- Family coping: potential for growth
- Ineffective family coping: compromised
- Ineffective family coping: disabling

VALUE-BELIEF PATTERN
- Spiritual distress (distress of the human spirit)

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Preface

The North American Nursing Diagnosis Association (NANDA) has been identifying, classifying, and testing diagnostic nomenclature since the early '70s. In our opinion, use of nursing diagnosis helps to define the essence of nursing and to give direction to care that is uniquely nursing care.

In this second edition we have made numerous changes to stay abreast of changes in national standards and criteria. In doing so we have moved from talking about specific care plan forms to talking about the process of planning care. This allows the reader to adapt information in this book to a variety of care documentation formats and to focus on the full process of planning care to meet the individual needs of the patient.

If nurses (in all instances we are referring to registered nurses) enter the medical diagnosis of acute appendicitis as the patient's problem, they have met defeat before a start can be made. A nurse cannot intervene for this medical diagnosis; intervention requires a medical practitioner who can perform an appendectomy. However, if the nurse enters the nursing diagnosis "Pain", then a number of nursing interventions come to mind.

Several books use nursing diagnosis to contribute to planning care. However, these books generally focus outcome and nursing interventions on the related factors; that is, nursing interventions deal with resolving, to the extent possible, the causative and contributing factors that result in the nursing diagnosis. We have chosen to focus nursing intervention on the nursing diagnosis. To focus on the nursing diagnosis promotes the use of concepts in nursing rather than worrying about a multitude of specifics; for example, there are common nursing measures that can be used to relieve pain regardless of the etiologic pain factor involved. Likewise, the outcomes focus on the nursing diagnosis. The main outcome nurses want to achieve when working with the nursing diagnosis, "Pain," is control of the patient's response to pain to the extent possible. Again, the outcome allows the use of a conceptual approach rather than a multitude-of-specifics approach. To clarify further, we ask you to look again at the medical diagnosis of appendicitis. The physician's first concern is not related to whether the appendicitis is caused by a fecalith, intestinal helminths, or *Escherichia coli* run amok. The physician focuses first on intervening for the appendicitis, which usually results in an appendectomy. The physician will deal with etiologic factors following the appendectomy, but the appendectomy is the first level of intervention. Likewise, the nurse can deal with the related factors through nursing actions, but the first level of intervention is directed to resolving the patient's problem that is reflected by the nursing diagnosis. With the decreasing length of stay for the majority of patients entering a hospital, we may indeed do well to complete the first level of nursing actions.

Additionally, there is continuing debate among NANDA members as to whether the current list of diagnoses that are accepted for testing are nursing diagnoses or a list of diagnostic categories or concepts. We therefore have chosen to focus on concepts. Using a conceptual approach allows focus on independent nursing functions and helps avoid focusing on medical intervention. This book has been designed to serve as a guide to using NANDA accepted nursing diagnoses as the primary base for the planning of care. The expected outcomes, target dates, nursing actions, and evaluation algorithms (flowcharts) are not meant to serve as standardized plans of care but rather as guides and references in promoting the visibility of nursing's contribution to health care.

Marjory Gordon's "Functional Health Patterns" are used as an organizing framework for the book. The functional health patterns allow grouping of the nursing diagnoses into specific groups, which in our opinion, promotes a conceptual approach to assessment and formulation of a nursing diagnosis.

Chapter 1 serves as the overview-introductory chapter and gives basic content related to the process of planning care and information regarding the relationship between nursing process and nursing models (theories). Titles for Chapters 2 through 12 are taken from the functional patterns. Included in each of these chapters is a pattern description, pattern assessment, a list of diagnoses within the pattern, conceptual information, and developmental information related to the pattern.

The pattern description gives a succinct summary of the pattern's content and assists in explaining how the diagnoses within the pattern are related. The pattern assessment serves to pinpoint information from the initial assessment base and was specifically written to direct the reader to the most likely diagnosis within the pattern. Each assessment factor is designed to allow an answer of "Yes" or "No". If the patient's answer or signs are indicative of a diagnosis within the pattern, the reader is directed to the most likely diagnosis or diagnoses. The list of diagnoses within the pattern is given to simplify location of the diagnoses. The conceptual and developmental information is included to provide a quick, ready reference to the physiological, psychological, sociological and age related factors that could cause modification of the nursing actions in order to make them more specific for your patient. The conceptual and developmental information can be used to determine the rationale for each nursing action.

Each nursing diagnosis within the pattern is then introduced with accompanying information of definition, defining characteristics, and related factors. We have added a section titled Related Clinical Concerns. This section serves to highlight the most common medical diagnoses or cluster of diagnoses that could involve the individual nursing diagnosis. Immediately after the related clinical concerns section is a section titled "Have you selected the correct diagnosis?"

The "Have you selected the correct diagnosis?" section was included as a validation check because we realize that several of the diagnoses appear very closely related and that it can be difficult to distinguish between these diagnoses. A part of this problem is related to the fact that the diagnoses have been accepted for testing, not as statements of absolute, discrete diagnoses. Thus, having this section assists the reader in learning how to pinpoint the differences between diagnoses and in feeling more comfortable in selecting a diagnosis that most clearly reflects a patient's problem area that can be helped by nursing actions.

After the diagnosis validation section are Expected Outcomes. Expected Outcomes serve as the end point against which progress can be measured. Also called objectives, patient goals, and outcome standards, the expected outcomes are con-

nected by the words "and/or," signifying that the reader may choose to use only one of the outcomes or to use both of the outcomes. Readers might also choose to design their own patient-specific expected outcomes using the given expected outcomes as guidelines.

Target dates are suggested following the expected outcomes. The target dates DO NOT indicate the time or day the outcome must be fully achieved; instead, the target date signifies the time or day when evaluation should be completed in order to measure the patient's progress TOWARD achievement of the expected outcome. Target dates are given in reference to short-term care. For home health, particularly, the target date would be in terms of weeks and months rather than days.

Nursing actions/interventions and rationales are the next information given. In each instance the adult health nursing actions serve as the generic nursing actions. Subsequent sets of nursing actions (child health, women's health, mental health, gerontic health, and home health) show only the nursing actions that are different from the generic nursing actions. The different nursing actions make each set specific for the target population, but MUST BE used in conjunction with the adult health nursing actions to be complete. Gerontic health nursing actions are new to the second edition in recognition of our aging population. Gerontology will be a major practice arena for nurses in the very near future. Rationales have been included to assist the student in learning the reason for particular nursing actions. While some of the rationales are scientific in nature, that is, supported by documented research, others could be more appropriately termed common sense or usual practice rationales. These rationales are reasons nurses have cited for particular nursing actions and result from nursing experience BUT, research has not been conducted to document these rationales. After the home health actions, evaluation algorithms are shown that help judge the patient's progress toward achieving the expected outcome.

Evaluation of the patient's care is based on the degree of progress the patient has made toward achieving the expected outcome. For each stated outcome, there is an evaluation flowchart (algorithm). The flowcharts provide minimum information, but demonstrate the decision-making process that must be used.

In all instances, the authors have used the definitions, major and minor defining characteristics, and related factors that have been accepted by NANDA for testing. A grant was provided to NANDA by F.A. Davis for the use of these materials. All of these materials may be ordered from NANDA (1211 Locust Street, Philadelphia, PA 19107).

In some instances, additional information is included following a set of nursing actions. The additional information includes material that either needs to be highlighted or does not logically fall within the defined outline areas.

Throughout the nursing actions we have used "patient" and "client" interchangeably. The terms refer to the system of care and include the individual as well as the family and other social support systems. The nursing actions are written very specifically. This specificity aids in communication between and among nurses and promotes consistency of care for the patient.

We have written this book for any nurse or nursing student who is beginning to work with nursing diagnosis. We hope to promote the use of nursing diagnosis to the end that nursing itself is advanced. If you, our readers, begin to feel more comfortable with using nursing diagnosis nomenclature and begin to use nursing diagnosis more in your practice, then our hope will have become reality.

Helen Cox, RNC, EdD, FAAN

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