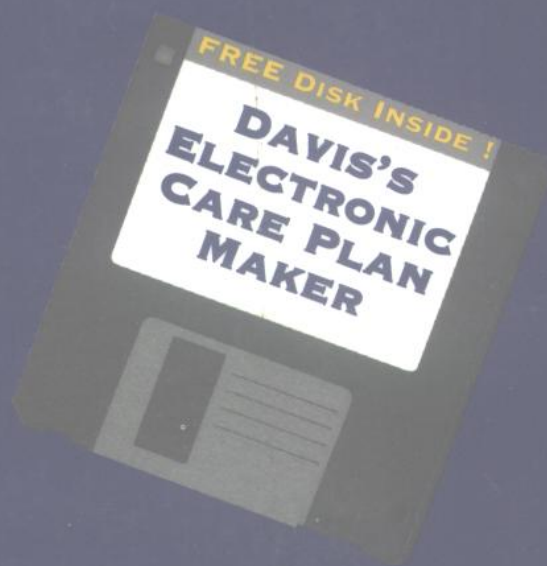




NURSING CARE PLANS

**GUIDELINES FOR
INDIVIDUALIZING
PATIENT CARE**



EDITION 4

**MARILYNN E. DOENGES
MARY FRANCES MOORHOUSE
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CLASSIFICATION OF NANDA NURSING DIAGNOSES BY GORDON'S FUNCTIONAL HEALTH PATTERNS*

HEALTH PERCEPTION—HEALTH MANAGEMENT PATTERN

Altered health maintenance
Effective management of individual therapeutic regimen
Ineffective management of individual therapeutic regimen
Ineffective management of therapeutic regimen: community
Ineffective management of family therapeutic regimen
Total health management deficit
Health management deficit (specify)
Noncompliance (specify)
High risk for noncompliance (specify)
Health-seeking behaviors (specify)
Risk for infection
Risk for injury (trauma)
Risk for poisoning
Risk for suffocation
Altered protection

NUTRITIONAL-METABOLIC PATTERN

Adaptive capacity, intracranial: decreased
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
Risk for aspiration
Impaired swallowing or uncompensated swallowing impairment
Altered oral mucous membrane
Risk for fluid volume deficit
Fluid volume deficit
Fluid volume excess
Risk for impaired skin integrity or high risk for skin breakdown
Impaired skin integrity
Pressure ulcer (specify stage)
Impaired tissue integrity
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

Risk for activity intolerance
Activity intolerance (specify level)
Fatigue
Impaired physical mobility (specify level)
Risk for disuse syndrome
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)
Self-toileting deficit (specify level)
Altered growth and development: self-care skills (specify)
Diversional activity deficit
Impaired home maintenance management (mild, moderate, severe, potential, chronic)
Infant behavior, disorganized
Risk for disorganized infant behavior
Potential for enhanced organized infant behavior
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
Risk for peripheral neurovascular dysfunction
Altered growth and development

SLEEP-REST PATTERN

Sleep-pattern disturbance

COGNITIVE-PERCEPTUAL PATTERN

Pain
Chronic pain
Acute confusion
Chronic confusion
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
Impaired environmental interpretation syndrome
Impaired thought processes
Knowledge deficit (specify)
Uncompensated short-term memory deficit
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)
Fatigue
Reactive depression (situational)
Hopelessness
Powerlessness (severe, low, moderate)
Self-esteem disturbance
Chronic low self-esteem
Situational low self-esteem
Body image disturbance
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
Altered family process: alcoholism
Altered parenting
Risk for altered parent-infant-child attachment
Risk for altered parenting
Parental role conflict
Parent-infant separation
Weak mother-infant or parent-infant attachment
Caregiver role strain
Risk for caregiver role strain
Impaired verbal communication
Altered growth and development: communication skills (specify)
Risk for loneliness
High risk 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
Ineffective community coping
Potential for enhanced community coping
Risk for self-harm
Risk for self-abuse
Risk for self-mutilation
Risk for suicide
Risk for violence

VALUE-BELIEF PATTERN

Spiritual distress (distress of the human spirit)
Potential for enhanced spiritual well-being

* Based on Gordon, M: Nursing Diagnosis: Process and Applications. McGraw Hill, New York, 1996, with permission.

KEY TO ESSENTIAL TERMINOLOGY

PATIENT ASSESSMENT DATA BASE

Provides an overview of the more commonly occurring etiology and coexisting factors associated with a specific medical/surgical diagnosis as well as the signs/symptoms and corresponding diagnostic findings.

NURSING PRIORITIES

Establishes a general ranking of needs/concerns on which the Nursing Diagnoses are ordered in constructing the plan of care. This ranking would be altered according to the individual patient situation.

DISCHARGE GOALS

Identifies generalized statements that could be developed into short-term and intermediate goals to be achieved by the patient before being “discharged” from nursing care. They may also provide guidance for creating long-term goals for the patient to work on after discharge.

NURSING DIAGNOSES

The general problem/concern (diagnosis) is stated without the distinct cause and signs/symptoms, which would be added to create a patient diagnostic statement when specific patient information is available. For example, when a patient displays increased tension, apprehension, quivering voice, and focus on self, the nursing diagnosis of Anxiety could be stated: Anxiety, severe, related to unconscious conflict, threat to self-concept as evidenced by statements of increased tension, apprehension; observations of quivering voice, focus on self.

In addition, diagnoses identified within these guides for planning care as actual or risk can be changed or deleted and new diagnoses added, depending entirely on the specific patient information.

MAY BE RELATED TO/POSSIBLY EVIDENCED BY

These lists provide the usual/common reasons (etiology) why a particular problem may occur with probable signs/symptoms, which would be used to create the “related to” and “evidenced by” portions of the *patient diagnostic statement* when the specific patient situation is known.

When a risk diagnosis has been identified, signs/symptoms have not yet developed and therefore are not included in the nursing diagnosis statement. However, interventions are provided to prevent progression to an *actual* problem. The exception to this occurs in the nursing diagnosis *Violence, risk for*, which has possible indicators that reflect the patient’s risk status.

DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL

These give direction to patient care as they identify what the patient or nurse hopes to achieve. They are stated in general terms to permit the practitioner to modify/individualize them by adding time lines and individual patient criteria so they become “measurable.” For example, “Patient will appear relaxed and report anxiety is reduced to a manageable level within 24 hours.”

ACTIONS/INTERVENTIONS

Activities are divided into independent and collaborative and are ranked in this book from most to least common. When creating the individual plan of care, interventions would normally be ranked to reflect the patient’s specific needs/situation. In addition, the division of independent/collaborative is arbitrary and is actually dependent on the individual nurse’s capabilities and hospital/community standards.

RATIONALE

Although not commonly appearing in patient plans of care, rationale has been included here to provide a pathophysiologic basis to assist the nurse in deciding about the relevance of a specific intervention for an individual patient situation.

CLINICAL PATHWAY

This abbreviated plan of care or care map is event- (task-)oriented and provides outcome-based guidelines for goal achievement within a designated length of stay. Several samples have been included to demonstrate alternative planning formats.

NURSING DIAGNOSES (THROUGH 12TH NANDA CONFERENCE)*

Activity Intolerance
 Activity Intolerance, risk for
 Adaptive Capacity: Intracranial, decreased
 Adjustment, impaired
 Airway Clearance, ineffective
 Anxiety [specify level]*
 Aspiration, risk for
 Body Image disturbance
 Body Temperature, altered, risk for
 Bowel Incontinence
 Breastfeeding, effective
 Breastfeeding, ineffective
 Breastfeeding, interrupted
 Breathing Pattern, ineffective
 Cardiac Output, decreased
 Caregiver Role Strain
 Caregiver Role Strain, risk for
 Communication, impaired verbal
 Community Coping, potential for enhanced
 Community Coping, ineffective
 Confusion, acute
 Confusion, chronic
 Constipation
 Constipation, colonic
 Constipation, perceived
 Coping, defensive
 Coping, Individual, ineffective
 Decisional Conflict (specify)
 Denial, ineffective
 Diarrhea
 Disuse Syndrome, risk for
 Diversional Activity deficit
 Dysreflexia
 Energy Field disturbance
 Environmental Interpretation Syndrome, impaired
 Family Coping: ineffective, compromised
 Family Coping: ineffective, disabling
 Family Coping: potential for growth
 Family Process, altered: alcoholism
 Family Processes, altered
 Fatigue
 Fear
 Fluid Volume deficit [active loss]*
 Fluid Volume deficit [regulatory failure]*
 Fluid Volume deficit, risk for
 Fluid Volume excess
 Gas Exchange, impaired
 Grieving, anticipatory
 Grieving, dysfunctional
 Growth and Development, altered
 Health Maintenance, altered
 Health-Seeking Behaviors (specify)
 Home Maintenance Management, impaired
 Hopelessness
 Hyperthermia
 Hypothermia
 Incontinence, functional
 Incontinence, reflex
 Incontinence, stress
 Incontinence, total
 Incontinence, urge
 Infant Behavior, disorganized
 Infant Behavior, disorganized, risk for
 Infant Behavior, organized, potential for enhanced
 Infant Feeding Pattern, ineffective
 Infection, risk for

Injury, risk for
 Knowledge deficit [learning need]* (specify)
 Loneliness, risk for
 Memory, impaired
 Noncompliance [Compliance, altered]* (specify)
 Nutrition: altered, less than body requirements
 Nutrition: altered, more than body requirements
 Nutrition: altered, risk for more than body requirements
 Oral Mucous Membrane, altered
 Pain [acute]
 Pain, chronic
 Parental Role Conflict
 Parent/Infant/Child Attachment, altered, risk for
 Parenting, altered
 Parenting, altered, risk for
 Perioperative Positioning Injury, risk for
 Peripheral Neurovascular dysfunction, risk for
 Personal Identity disturbance
 Physical Mobility, impaired
 Poisoning, risk for
 Post-Trauma Response
 Powerlessness
 Protection, altered
 Rape-Trauma Syndrome
 Rape-Trauma Syndrome: compound reaction
 Rape-Trauma Syndrome: silent reaction
 Relocation Stress Syndrome
 Role Performance, altered
 Self Care Deficit, feeding, bathing/hygiene, dressing/
 grooming, toileting
 Self Esteem, chronic low
 Self Esteem disturbance
 Self Esteem, situational low
 Self-Mutilation, risk for
 Sensory/Perceptual alterations (specify): visual, auditory,
 kinesthetic, gustatory, tactile, olfactory
 Sexual dysfunction
 Sexuality Patterns, altered
 Skin Integrity, impaired
 Skin Integrity, impaired: risk for
 Sleep Pattern disturbance
 Social Interaction, impaired
 Social Isolation
 Spiritual Distress (distress of the human spirit)
 Spiritual Well-Being, potential for enhanced
 Spontaneous Ventilation, inability to sustain
 Suffocation, risk for
 Swallowing, impaired
 Therapeutic Regimen: Community, ineffective management
 Therapeutic Regimen: Families, ineffective management
 Therapeutic Regimen: Individuals, effective management
 Therapeutic Regimen (Individuals), ineffective
 management
 Thermoregulation, ineffective
 Thought Processes, altered
 Tissue Integrity, impaired
 Tissue Perfusion, altered (specify): cerebral,
 cardiopulmonary, renal, gastrointestinal, peripheral
 Trauma, risk for
 Unilateral Neglect
 Urinary Elimination, altered
 Urinary Retention [acute/chronic]*
 Ventilatory Weaning Response, dysfunctional (DVWR)
 Violence, risk for, directed at self/others

3-P42/07

* [Author recommendations]

*Permission from North American Nursing Diagnosis Association (1994). NANDA Nursing Diagnoses: Definitions and Classifications 1995-1996. Philadelphia: NANDA. Copyright 1994 by the North American Nursing Diagnosis Association.

To our spouses, children, parents, and friends, who much of the time have had to manage without us while we work as well as cope with our struggles and frustrations.

The Doenges families: Dean, Jim, Barbara, and Bob Lanza; David, Monita, Matthew, and Tyler; John, Holly, Nicole, and Kelsey; and the Daigle family, Nancy, Jim, Jennifer, and Jonathan.

The Moorhouse family: Jan, Paul, Jason, Ellaina, and Alexa.

To Mary and Marilyn, couldn't have done it without you—Alice.

In loving memory of my mother, Norma Loughmiller, who was my biggest promoter in my early days of writing.

To our FAD family, especially Bob Martone, Ruth De George, Herb Powell, and Bob Butler, whose support is so vital to the completion of a project of this magnitude.

To the nurses we are writing for, who daily face the challenge of caring for the acutely ill patient and are looking for a practical way to organize and document this care. We believe that nursing diagnosis and these guides will help.

To NANDA and to the International nurses who are developing and using nursing diagnoses—here we come!

Finally, to the late Mary Lisk Jeffries, who initiated the original project. The memory of our early friendship and struggles remains with us. We miss her and wish she were here to see the growth of the profession and how nursing diagnosis has contributed to the process.

PREFACE

One of the most significant achievements in the healthcare field during the past 20 years has been the emergence of the professional nurse as an active coordinator and initiator of patient care. While the transition from helpmate to healthcare professional has been painfully slow and is not yet complete, the importance of the nurse within the system can no longer be denied or ignored. Today's nurse designs nursing care interventions that will move the total patient toward the goal of improved health.

The current state of the theory of Nursing Process, Diagnosis, and Intervention has been brought to the clinical setting to be implemented by the nurse. This book gives definition and direction to the development and use of individualized nursing care. The book is therefore not an end in itself but a beginning for the future growth and development of the profession.

Professional care standards, other healthcare professionals, and patients will continue to increase expectations for nurses' performance as each day brings advances in the struggle to understand the mysteries of normal body function and human response to actual and potential health problems. With this increased knowledge comes greater responsibility for the nurse. To meet these challenges competently, the nurse must have up-to-date physical assessment skills and a working knowledge of pathophysiologic concepts concerning the more common diseases/conditions encountered in general healthcare. This book is a tool, a means of attaining that competency.

In the past, plans of care were viewed principally as learning tools for students and seemed to have little relevance after graduation. However, the need for a written format to communicate and document individualized patient care has been recognized in all care settings. In addition, governmental regulations and third-party payor requirements have created the need to validate the appropriateness of the care provided, as well as the need to justify patient care charges and staffing patterns. Thus, although the student's "case studies" were too cumbersome to be practical in the clinical setting, the patient plan of care meets the aforementioned identified needs. The practicing nurse, as well as the nursing student, will welcome this text as a ready reference in clinical practice. The book is designed for use in the acute medical/surgical setting, as well as the community setting, and is organized by systems for easy reference. Rationales (which state not only why an intervention is important but also provide a brief related pathophysiology, when applicable) enhance the reader's understanding of the intervention. This information also serves as a catalyst for thought in planning and evaluating the care being rendered.

Chapter 1 discusses some current issues and trends affecting the nursing profession. An overview of cultural, community, sociologic, and ethical concepts affecting the nurse is included. The important concept of cooperation and coordination with other healthcare professionals is integrated throughout the plans of care.

Chapter 2 reviews the historic use of the nursing process in formulating plans of

care and the nurse's role in the delivery of that care. Nursing diagnosis is discussed to assist the nurse in understanding its role in the nursing process.

Chapter 3 demonstrates construction of the plan of care and the use and adaptation of the guides for care planning presented in this book. A nursing-based assessment tool is presented with a sample patient situation, data base, and corresponding plan of care to aid the nurse to make the transition from theory to practice. Additionally, a clinical pathway reflecting the sample situation is included to demonstrate another method of evaluating and documenting the patient's response to care.

Chapters 4 through 15 present guides for planning care that include information from multiple disciplines to help the nurse provide holistic care. Each plan of care is developed by identifying nursing diagnoses with "related to" and "evidenced by" factors that provide an explanation of patient problems/needs. Each plan includes a patient assessment data base (presented in a nursing format) and associated diagnostic studies. After the data base is collected, nursing priorities are sifted from the information to help focus and structure the patient care provided. Discharge goals are also listed to identify the general goals that should be accomplished by the time of discharge from care. In addition, mean length of stay has been identified to provide a general idea of time constraints for achieving discharge goals in the inpatient setting. Desired patient outcomes are stated in behavioral terms that can be measured to evaluate the patient's progress and the effectiveness of care provided. (Time lines have been omitted here because they are individually determined by specific patient data.) The interventions are designed to assist with problem resolution. Rationales for these actions are provided to enable the nurse to decide whether the intervention applies to a particular patient situation. Additional information is provided to assist the nurse in identifying and planning for rehabilitation/care in the community setting as the patient progresses toward discharge. As in Chapter 3, samples of clinical pathways have been included to demonstrate alternative plan-of-care formats and enhance the learning experience.

As a final note, this book is not intended to be a procedure manual, and efforts have been made to avoid detailed descriptions of techniques/protocols that might be viewed as individual/regional in nature. Instead, the reader is referred to procedure manual/standards of care resources for in-depth direction for these concerns.

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