CLINICAL APPLICATIONS OF NURSING DIAGNOSIS:

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

Second Edition

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Clinical Applications of Nursing Diagnosis

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To the administration, faculty, students and staff of Texas Tech University Health Sciences Center School of Nursing for support and encouragement above and beyond the usual.

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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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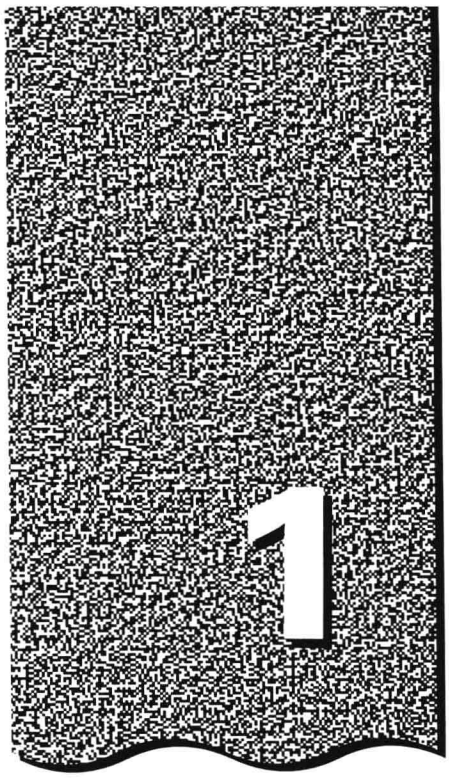

Introduction

Why This Book?

At the time the first edition of this book was written, all of the authors were faculty members at the same school of nursing. We had become frustrated with the books that were available for teaching nursing diagnosis to students, and we found that the students were expressing some of the same frustrations.

The students felt the need to bring several books to the clinical area because the books related to nursing diagnosis had limited information regarding pathophysiology, psychosocial, or developmental factors that definitely impacted individualized care planning. The students were also expressing confusion regarding the different definitions, defining characteristics, and related factors each of the authors was using. The students were having difficulty in writing individualized nursing actions for their patient because the various authors appeared to focus on specifics related to the etiology or signs and symptoms of the nursing diagnosis rather than the concept represented by the nursing diagnosis that had been emphasized to our students. We were also concerned about the number of books our students were having to buy since the majority of books relating to the use of nursing diagnosis in the clinical area focused on just one clinical area such as adult health or pediatrics but not both. Thus, as the students progressed through the school, they had to buy different books for different clinical areas even though each of the books had the common theme of the use of nursing diagnosis. Another concern we, as faculty, had was the lack of information in the various books regarding the final phase of the nursing process, evaluation. This most vital phase was briefly mentioned, but very little guidance was given in how to do this phase. For these reasons we have written this book, and for these reasons the book is particularly geared to student use. The final concern that led to the writing of the book was our desire to focus on nursing actions and nursing care, not medical care and medical diagnosis. We strongly believe in and support the vital role that nurses play in the provision of health care for our nation and so have focused, in this book, strictly on nursing. After all, statistics show that the largest number of health care providers are nurses and that the general public has a high respect for nurses. Therefore, let us work on developing our profession and its contributions.

Specifically, this book was written to assist students in learning how to apply nursing diagnosis in the clinical area. By using the framework of the nursing process and the materials generated by the North American Nursing Diagnosis Association (NANDA), we believe this book makes it easier for you, the student, to learn and use nursing diagnosis in planning care for your patients.

The Nursing Process

PURPOSE

Gordon[1] indicates that Lydia Hall was one of the first nurses to use the term "nursing process" in the early 1950s. Since that time the term "nursing process" has been used to describe the accepted method of delivering nursing care. Iyer, Taptich, and Bernocchi-Losey[2] state, "The major purpose of the nursing process is to provide a framework within which the individualized needs of the client, family, and community can be met."

It may be easier to think of a "framework" as a blueprint or an outline that

guides the planning of care for a patient.* As Doenges and Moorhouse write,[3] "The nursing process is central to nursing actions in any setting because it is an efficient method of organizing thought processes for clinical decision making and problem solving." Use of the nursing process framework is beneficial for both the patient and the nurse because it helps ensure that care is planned, individualized, and reviewed over the period of time that the nurse and patient have a professional relationship. It is important to emphasize that the nursing process requires the involvement of the patient throughout all the phases. If the patient is not involved in all phases, then the plan of care is not individualized.

DEFINITION

Alfaro[4] defines "nursing process" as "an organized, systematic method of giving individualized nursing care that focuses on identifying and treating unique responses of individuals or groups to actual or potential alterations in health." This definition fits very nicely with the American Nurses Association (ANA) Social Policy Statement[5] that states specifically that "nursing is the diagnosis and treatment of human responses to actual and potential health problems." Alfaro's definition is further supported by the ANA Standards of Clinical Nursing Practice[6] (Table 1–1), practice standards written by several boards of nursing,[7] and the definition of nursing that is written into the majority of nurse practice acts in the United States. (The Board of Nurse Examiners for the State of Texas Nursing Practice Standards are used as an example. See Table 1–2.)

Basically, the nursing process provides each nurse a framework to utilize in working with the patient. The process begins at the time the patient needs assistance with health care through the time the patient no longer needs assistance to meet health care maintenance. The nursing process represents the cognitive (thinking, reasoning), psychomotor (physical), and affective (emotion, feelings, and values) skills and abilities used by the nurse to plan care for a patient.

**Note*: Throughout this book we use the terms "patient" and "client" interchangeably. In most instances these terms refer to the individual who is receiving nursing care; however, a patient can also be a community, such as in the community–home health nursing actions, or the patient can be a family, such as in the nursing diagnosis Ineffective Family Coping: Compromised.

Table 1–1 STANDARDS OF CARE

Standard I. Assessment
The nurse collects client health data.
Standard II. Diagnosis
The nurse analyzes the assessment data in determining diagnoses.
Standard III. Outcome Identification
The nurse identifies expected outcomes individualized to the client.
Standard IV. Planning
The nurse develops a plan of care that prescribes interventions to attain expected outcomes.
Standard V. Implementation
The nurse implements the interventions identified in the plan of care.
Standard VI. Evaluation
The nurse evaluates the client's progress toward attainment of outcomes.

Source: Reprinted with permission from Standards of Clinical Nursing Practice,[6] © 1991, American Nurses Association, Kansas City, MO, p 9.