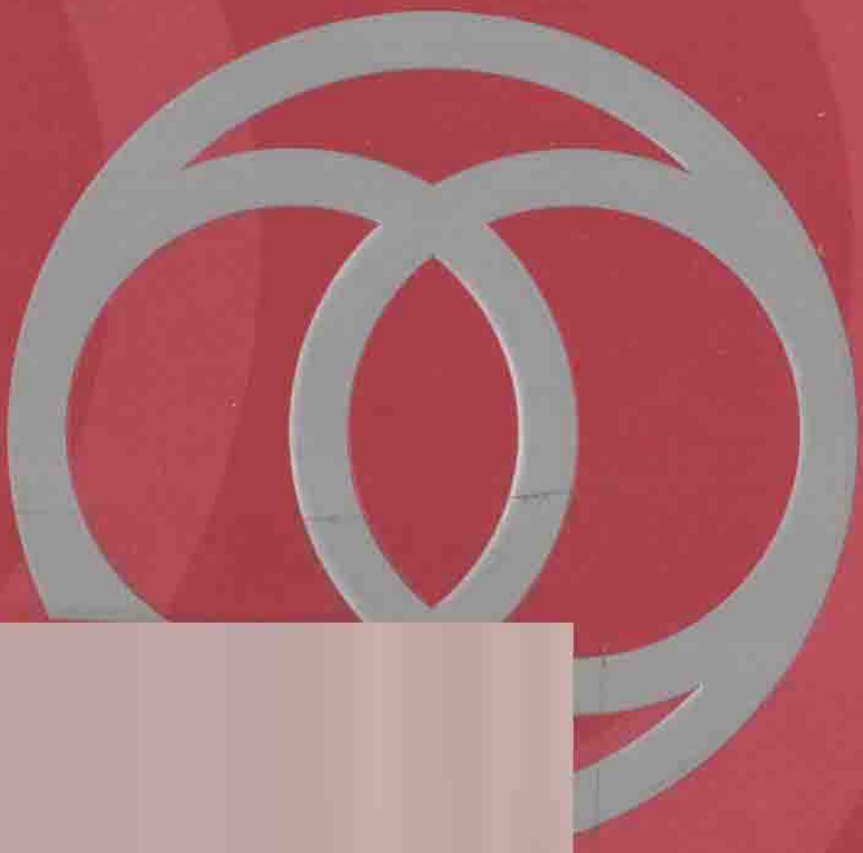
Lynda Juall Carpenito

HANDBOOK OF Nursing Diagnosis

Sixth Edition



TT COMPANY

Includes NEW 1994 Nursing Diagnoses

Handbook of Nursing Diagnosis

Sixth Edition

Lynda Juall Carpenito, R.N., M.S.N.
Nursing Consultant, Mickleton, New Jersey

J. B. Lippincott Company Philadelphia

Sponsoring Editor: Donna L. Hilton, R.N., B.S.N.
Coordinating Editorial Assistant: Susan Keneally
Project Editor: Tom Gibbons
Indexer: Ellen Murray
Design Coordinator: Kathy Kelley-Luedtke
Cover Designer: Tom Jackson
Production Manager: Helen Ewan
Production Coordinator: Kathryn Rule
Compositor: Tapsco, Incorporated
Printer/Binder: R. R. Donnelley & Sons Company/Crawfordsville
Cover Printer: Lehigh
Insert Printer: Alva Plastics

6th Edition

6 5 4 3 2

Library of Congress Cataloging in Publication Data

Carpenito, Lynda Juall.
Handbook of nursing diagnosis/Lynda Juall Carpenito.—6th ed.
p. cm.
Includes bibliographical references and index.
ISBN 0-397-55160-6 (paper)
1. Nursing diagnosis—Handbooks, manuals, etc. I. Title.
[DNLM: 1. Nursing Diagnosis—handbooks. WY 39 C294h 1995]
RT48.6.C385 1995
616.07'5—dc20
DNLM/DLC
for Library of Congress 94-41978
CIP

Handbook of Nursing Diagnosis

Sixth Edition

To Olen, my son

for your wisdom and commitment to justice
for our quiet moments and sudden hugs
for your unsolicited distractions
. . . I am grateful

for you are my daily reminder of what is
really important . . .
love, health, and human trust

Acknowledgments

I would like to thank the following people for their consultation during the development of the manual:

Rosalinda Alfaro-LeFevre, R.N., M.S.N.
President, NDNP Consultants
Malvern, Pennsylvania

Martha Cress, R.N., B.S.N.
Nursing Education and Development
Duke University Medical Center
Durham, North Carolina

Mary Sieggreen, R.N., M.S.N., C.S.
Case Manager
Surgical Product Line
Harper Hospital
Detroit, Michigan

Joan Wagger, R.N., M.S.N.
Nursing Education and Development
Duke University Medical Center
Durham, North Carolina

Anne E. Willard, R.N., M.S.N.
Associate Professor
Cumberland County College
Vineland, New Jersey

A sincere "thank you" to Lippincott's Donna Hilton, Susan Keneally, and Tom Gibbons for help in this

undertaking, and once again, to my husband, Richard, for preparing the manuscript and his support on yet another project.

Please Note: In order to reflect a society where nurses are male and female and clients are male and female, the pronouns *she, her, he, his, him,* etc., will be used interchangeably throughout this book. The intent is to retain the use of gender pronouns without stereotyping.

INTRODUCTION

Nursing Diagnoses

In 1973, the North American Nursing Diagnosis Association (NANDA; formerly, the National Group for the Classification of Nursing Diagnosis) published its first list of nursing diagnoses. Since that time, the interest in nursing diagnosis and its application in clinical settings has grown substantially. In the 1970s, the main issue in nursing centered on the value of establishing a classification system for nursing diagnoses. Now that there is general agreement about the need for a formal taxonomy, the current issue is the implementation of nursing diagnoses with varied delivery models, *e.g.*, case management, client-focused care. The challenge that nurses face today is one of identifying specific nursing diagnoses for those persons assigned to their care and of incorporating these diagnoses into a plan of care.

This handbook does not focus on teaching nurses about the concept of nursing diagnosis. For information describing the concept and specific instructions for clinical use the reader is referred to Carpenito, L.J. (1995). *Nursing diagnosis: Application to clinical practice* (6th ed.). Philadelphia: J.B. Lippincott.

This handbook is intended to supplement texts on nursing diagnosis in three ways:

- By providing a quick reference to each diagnostic label in terms of its definition, defining characteristics, or risk factor, and related factors
- By providing interventions and outcome criteria for each nursing diagnosis to serve as concise reminders of the indicated nursing care
- By identifying possible nursing diagnoses and collaborative problems that could be associated with the major medical conditions or therapies

Section I consists of 137 nursing diagnoses, including 123 approved by NANDA and 14 additional diagnoses. The following definition for a nursing diagnosis was approved at the ninth conference of NANDA:

- A nursing diagnosis is a clinical judgment about individual, family, or community responses to actual or potential health problems/life processes. Nursing diagnoses provide the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable.

In 1994, NANDA-approved diagnoses formerly designated as High Risk were labeled Risk for. This change has been incorporated into this edition.

Each nursing diagnosis is described in terms of

- Definition
- Defining characteristics or risk factors. Defining characteristics for actual nursing diagnoses are observable or reportable signs or symptoms that represent the presence of the diagnosis. Diagnoses with clinical validation studies have major signs and symptoms that are present 80% to 100% of the time and minor signs and symptoms present 50% to 79% of the time. Minor characteristics are not less serious than the major ones; they are just not present in 80% of the individuals. Risk nursing diagnoses have risk factors. Risk factors are situations or factors that increase the vulnerability of an individual, family, or community to develop a problem over others in the same situation.
- Related factors, which are examples of pathophysiological, treatment-related, situational, and maturational factors that can cause or influence the health status or contribute to the development of a problem. Related factors for risk diagnoses are risk factors.

TYPES OF NURSING DIAGNOSES

A nursing diagnosis can be actual, risk, or a wellness or syndrome type.

Actual: An actual nursing diagnosis describes a clinical judgment that the nurse has validated because of the presence of major defining characteristics.

Risk: A risk nursing diagnosis describes a clinical judgment that an individual/group is more vulnerable to develop the problem than others in the same or a similar situation.

Wellness: A wellness nursing diagnosis is a clinical judgment about an individual, family, or community in transition from a specific level of wellness to a higher level of wellness (NANDA).

Syndrome: A syndrome diagnosis comprises a cluster of actual or high risk nursing diagnoses that are predicted to present because of a certain situation or event.

Possible nursing diagnoses are not a type of diagnosis as are actual, risk, or syndrome. Possible nursing diagnoses are a diagnostician's option to indicate that some data are present to confirm a diagnosis but they are insufficient.

DIAGNOSTIC STATEMENTS

The diagnostic statement describes the health status of an individual or group and the factors that have contributed to the status.

Statement of health status		Factors that have contributed
↓		↓
Diagnostic label	Related to	Contributing/risk factors
↓	↓	↓
Fear	Related to	Unknown prognosis secondary to cancer diagnosis

One-Part Statements

Wellness nursing diagnoses will be written as one-part statements: Potential for Enhanced _____, *e.g.*, Potential for Enhanced Parenting. Related factors are not present for wellness nursing diagnoses because they would all be the same: motivated to achieve a higher level of wellness. Syndrome diagnoses, such as Rape Trauma Syndrome, have no "related to"s.

Two-Part Statements

Risk and *possible* nursing diagnoses have two parts. The validation for a risk nursing diagnosis is the presence of risk factors. The risk factors are the second part.

Risk nursing diagnosis	Related to	Risk factors

Possible nursing diagnoses are suspected because of the presence of certain factors. The nurse then either rules out or confirms the existence of an actual or a risk diagnosis.

Examples of two-part statements are

Risk for Impaired Skin Integrity related to immobility secondary to fractured hip
Possible Self-Care Deficit related to impaired ability to use left hand secondary to IV

Designating a diagnosis as possible provides the nurse with a method to communicate to other nurses that a diagnosis may be present. Additional data collection is indicated to rule out or confirm the tentative diagnosis.

Three-Part Statements

An actual nursing diagnosis consists of three parts.

Diagnostic label + contributing factors
+ signs and symptoms

The presence of major signs and symptoms (defining characteristics) validates that an actual diagnosis is present. It is not possible to have a third part for risk or possible diagnoses because signs and symptoms do not exist.

Examples of three-part statements are

Anxiety related to unpredictable nature of asthmatic episodes as evident by statements of "I'm afraid I won't be able to breathe"
Urge Incontinence related to diminished bladder capacity secondary to habitual frequent voiding evident by inability to hold off urination after desire to void and report of voiding out of habit, not need

The presence of a nursing diagnosis is determined by assessing the individual's health status and his ability to function. To guide the nurse who is gathering this information, a Screening Assessment Tool is included in the Appendix at the end of the book. This guide directs the nurse to collect data according to the individual's functional health patterns. Functional health patterns and the corresponding nursing diagnoses are listed in Table 1, at the end of this introduction. If significant data are collected in a particular functional pattern, the next step is to check the related nursing diagnosis to see if any nursing diagnoses are substantiated by the data that are collected.

DIAGNOSTIC CLUSTERS

Section II of this handbook consists of seven parts: (1) Medical Conditions, (2) Surgical Procedures, (3) Obstetrical/Gyneco-

logical Conditions, (4) Neonatal Conditions, (5) Pediatric/Adolescent Disorders, (6) Mental Health Disorders, and (7) Diagnostic and Therapeutic Procedures. Each of these subjects is represented by a series of diagnostic clusters under which groups of associated nursing diagnoses and collaborative problems are listed. A diagnostic cluster represents a set of collaborative problems and/or nursing diagnoses that are predicted to be present because of the situation. The intent of this section is to help the nurse identify possible nursing diagnoses and collaborative problems in each of these areas. Seventy (70) of the diagnostic clusters found in acute care settings have the nursing diagnoses and collaborative problems grouped according to frequency of monitoring or treatment. These data are based on the findings of a validation project at 17 clinical sites.* The groupings are frequent (75–100%), often (50–74%) and infrequent (<50%). These findings can help novice nurses and student nurses with planning initial care. It is important to note that each nursing diagnosis must be confirmed or ruled out on the basis of the data collected. The use of a nursing diagnosis without clinical validation based on defining characteristics is hazardous and unsound, and jeopardizes the effectiveness and validity of the nursing care plan. The listing of tentative nursing diagnoses under medical and surgical diagnoses was intended to facilitate the assessment, identification, and validation process, *not to replace it.*

These diagnostic clusters represent predicted nursing diagnoses and collaborative problems associated with medical and surgical problems. In addition to these predicted diagnoses, the nurse must assess for additional nursing diagnoses or collaborative problems that need nursing interventions.

THE BIFOCAL CLINICAL PRACTICE MODEL

Nurses are accountable to treat two types of clinical judgments or diagnoses—nursing diagnoses and collaborative problems.

Nursing interventions are classified as nurse-prescribed or physician-prescribed. Nurse-prescribed interventions are those that the nurse can legally order for nursing staff to implement. Nurse-prescribed interventions treat, prevent, and monitor

* A description of the study can be found in Carpenito, L. J. (1995). *Nursing care plans and documentation* (2nd ed.). Philadelphia: J.B. Lippincott.

nursing diagnoses. Nurse-prescribed interventions manage and monitor collaborative problems. Physician-prescribed interventions represent treatments for collaborative problems that the nurse initiates and manages. Display 1 represents these relationships.

Collaborative problems are certain physiological complications that nurses monitor to detect onset or changes of status. Nurses manage collaborative problems utilizing physician-prescribed and nursing-prescribed interventions to minimize the complications of the events.

The nurse makes independent decisions regarding both collaborative problems and nursing diagnoses. The decisions differ in that, for nursing diagnoses, the nurse prescribes the definitive treatment for the situation and is responsible for outcome achievement; for collaborative problems the nurse monitors the client's condition to detect onset or status of physiological complications and manages the events with nursing and physician-prescribed interventions. Collaborative problems are labeled "Potential Complications:" (specify).
Examples:

Potential Complication: Hemorrhage
Potential Complication: Renal Failure

The physiological complications that nurses monitor are usually related to disease, trauma, treatments, and diagnostic studies. The following illustrates some collaborative problems:

Situation	***Collaborative Problem***
Anticoagulant therapy	Potential Complication: Hemorrhage
Pneumonia	Potential Complication: Hypoxemia

Outcome criteria or client goals are used to measure the effectiveness of nursing care. When a client is not progressing to goal achievement or has worsened, the nurse must reevaluate the situation. Display 2 represents the questions to be considered. If none of these options is appropriate, the situation may not be a nursing diagnosis. For example:

Risk for Fluid Volume Deficit related to the effects of prolonged PTT secondary to anticoagulant therapy

Goal: The client will have hemoglobin >13

Examine the questions in Display 2; which option is appropriate? None. The nurse would initiate physician-prescribed

DISPLAY 1. RELATIONSHIP BETWEEN NURSING-PRESCRIBED INTERVENTIONS AND PHYSICIAN-PRESCRIBED INTERVENTIONS

NURSING-PRESCRIBED INTERVENTIONS	NURSING DIAGNOSES	PHYSICIAN-PRESCRIBED INTERVENTIONS
● Reposition q2h ● Lightly massage vulnerable areas ● Teach how to reduce pressure when sitting	Risk for Impaired Skin Integrity related to immobility secondary to fatigue	Usually not needed

NURSING-PRESCRIBED INTERVENTIONS	COLLABORATIVE PROBLEMS	PHYSICIAN-PRESCRIBED INTERVENTIONS
● Maintain NPO state ● Monitor: Hydration Vital signs Intake/output Specific gravity ● Monitor electrolytes ● Maintain IV at prescribed rate ● Provide/encourage mouth care	Potential Complication: Fluid and Electrolyte Imbalances	● IV (type, amount) ● Laboratory studies

DISPLAY 2. EVALUATION QUESTIONS

Is the diagnosis correct?
Has the goal been mutually set?
Is more time needed for the plan to work?
Does the goal need to be revised?
Do the interventions need to be revised?

orders if the client presented signs of bleeding. This situation is a collaborative problem, not a nursing diagnosis, *e.g.*,

Potential Complication: Bleeding with a nursing goal of:

The nurse will manage and minimize episodes of bleeding. Collaborative problems have nursing goals that represent the accountability of the nurse—to detect early and to manage. Nursing diagnoses have client goals that represent the accountability of the nurse—to achieve or maintain a favorable status after nursing care.

Table 1 includes frequently used collaborative problems.

Some physiological complications, such as pressure ulcers and infection from invasive lines, are problems that nurses can prevent. Prevention is different from detection. Nurses do not prevent paralytic ileus but, instead, detect its presence early to prevent greater severity of illness or even death. Physicians cannot treat collaborative problems without nursing knowledge, vigilance, and judgment.

Thus the type of intervention differentiates a nursing diagnosis from a collaborative problem and also differentiates an actual nursing diagnosis from a risk or possible one. Below are each type and the corresponding intervention focus:

Type	***Focus of Nursing Interventions***
Actual (is present)	To reduce, eliminate, or promote (positive) and monitor
Risk (may happen)	To prevent onset and monitor
Possible (may be present)	To rule out or confirm with additional data
Wellness	To teach higher level of wellness
Collaborative Problem	To monitor and manage changes in conditions

TABLE 1.
Conditions That Necessitate Nursing Care

NURSING DIAGNOSES*

1. **Health Perception–Health Management**
   - †Energy Field Disturbance
   - Growth and Development, Altered
   - Health Maintenance, Altered
   - Health Seeking Behaviors
   - Injury, Risk for
     - Risk for Suffocation
     - Risk for Poisoning
     - Risk for Trauma
   - †Injury, Risk for Perioperative Positioning
   - †Management of Therapeutic Regimen, Effective
   - Management of Therapeutic Regimen, Ineffective
   - †Management of Therapeutic Regimen, Ineffective: Family
   - †Management of Therapeutic Regimen, Ineffective: Community
   - Noncompliance
2. **Nutritional–Metabolic**
   - †Adaptive Capacity, Intracranial: Decreased
   - Body Temperature, High Risk for Altered
     - Hypothermia
     - Hyperthermia
     - Thermoregulation, Ineffective
   - Fluid Volume Deficit
   - Fluid Volume Excess
   - Infection, Risk for
   - ‡Infection Transmission, Risk for
   - Nutrition, Altered: Less Than Body Requirements
   - Nutrition, Altered: More Than Body Requirements
   - Nutrition, Altered: Potential for More Than Body Requirements
   - Breastfeeding, Effective
   - Breastfeeding, Ineffective
   - †Breastfeeding, Interrupted

(*Continued*)

TABLE 1. (*Continued*)

†Feeding Pattern, Ineffective Infant
Swallowing, Impaired
Protection, Altered
Tissue Integrity, Impaired
Oral Mucous Membrane, Altered
Skin Integrity, Impaired

3. Elimination

‡Bowel Elimination, Altered
Constipation
Colonic Constipation
Perceived Constipation
Diarrhea
Bowel Incontinence
Urinary Elimination, Altered Patterns of
Urinary Retention
Total Incontinence
Functional Incontinence
Reflex Incontinence
Urge Incontinence
Stress Incontinence
‡Maturational Enuresis

4. Activity–Exercise

Activity Intolerance
Cardiac Output, Decreased
Disuse Syndrome
Diversional Activity Deficit
Home Maintenance Management, Impaired
†Infant Behavior, Disorganized
†Infant Behavior, Risk for Disorganized
†Infant Behavior, Potential for Enhanced Organized
Mobility, Impaired Physical
†Peripheral Neurovascular Dysfunction, High Risk for
‡Respiratory Function, High Risk for Altered
Dysfunctional Ventilatory Weaning Response
Ineffective Airway Clearance
Ineffective Breathing Patterns
Impaired Gas Exchange
Ventilation, Inability to Sustain Spontaneous
‡Self-Care Deficit Syndrome (Specify): (Feeding, Bathing/Hygiene, Dressing/Grooming, Toileting, ‡Instrumental)

(*Continued*)