THIRD EDITION

Nursing Diagnosis Handbook

A Guide to Planning Care

ACKLEY LADWIG

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BETTY J. ACKLEY, MSN, EdS, RN

GAIL B. LADWIG, MSN, RN

with 4 Consultants and 38 Contributors

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To

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Preface

Nursing Diagnosis Handbook: A Guide to Planning Care is a convenient reference to help the practicing nurse or nursing student make a nursing diagnosis and write a care plan with ease and confidence. This handbook helps nurses correlate nursing diagnoses with known information about clients on the basis of assessment findings, established medical or psychiatric diagnoses, and the current treatment plan.

Making a nursing diagnosis and planning care are complex processes that involve diagnostic reasoning and critical thinking skills. Nursing students and practicing nurses cannot possibly memorize the more than 1000 defining characteristics, related factors, and risk factors for the 129 diagnoses approved by the North American Nursing Diagnosis Association (NANDA). This book correlates suggested nursing diagnoses with what nurses know about clients and offers a care plan for each nursing diagnosis.

Section I, Nursing Diagnosis and the Nursing Process, explains how the nurse formulates a nursing diagnosis statement using assessment findings and other data. In Section II, Guide to Nursing Diagnoses, the nurse can look up symptoms and problems and their suggested nursing diagnoses for more than 1000 client symptoms, medical and psychiatric diagnoses, diagnostic procedures, surgical interventions, and clinical states. In Section III, Guide to Planning Care, the nurse can find care plans for all nursing diagnoses suggested in Section II. In this edition, we have included the suggested nursing interventions from the Nursing Interventions Classification (NIC) by the Iowa Intervention Project as well as a listing of all NIC interventions in Appendix E. We are excited about this work and believe it is a significant addition to the nursing process to further define nursing practice.

Nursing Diagnosis Handbook: A Guide to Planning Care includes medical diagnoses because nurses find them useful in suggesting appropriate nursing diagnoses. For example, under the medical diagnosis of **AIDS,** the nurse will find the nursing diagnosis **Body image disturbance** related to (r/t) chronic contagious illness, cachexia. The nurse needs to determine whether this suggested nursing diagnosis relates to the client.

New special features of the third edition of *Nursing Diagnosis Handbook: A Guide to Planning Care* include the following:

- Addition of Home Care Interventions written by Elizabeth L. Foster, a specialist in home care
- Inclusion of suggested NIC interventions for each nursing diagnosis
- Inclusion of a complete list of NIC Interventions in Appendix E
- Increased depth of the nursing research base utilizing three consultants in nursing research: Ann F. Jacobson, PhD, RN; Brenda J. Wagner, PhD, RN; and Elizabeth H. Winslow, PhD, RN
- Addition of two contributors who are nationally known specialists in their fields: Dr.

Mikel Gray, writing on problems with urology, and Dr. Pamela H. Mitchell, writing on intracranial pressure

The following features of *Nursing Diagnosis Handbook: A Guide to Planning Care* are included from the second edition:

- Suggested nursing diagnoses for more than 1000 clinical entities including 300 signs and symptoms, 300 medical diagnoses, 120 surgeries, 200 maternal-child disorders, 100 mental health disorders, and 50 geriatric disorders
- Rationales for nursing interventions that are based on nursing research and literature
- Nursing references identified for each care plan
- Major clinical practice guidelines of the Agency for Health Care Policy and Research (AHCPR) used in appropriate care plans
- Nursing care plans that contain many holistic interventions
- Care plans for **Pain** written by national experts on pain, Margo McCaffery and Christine L. Pasero
- Care plans for **Skin integrity** written by national expert Diane Krasner who has lectured and written extensively on the topic
- Care plans for **Community** written by national expert Dr. Margaret Lunney
- A format that facilitates analyzing signs and symptoms by the process already known by nurses, which is using defining characteristics of nursing diagnoses to make a diagnosis
- Use of NANDA terminology and approved diagnoses
- Inclusion of two additional nursing diagnoses, **Grieving** and **Altered comfort**
- An alphabetical format for Section II, Guide to Nursing Diagnoses, and Section III, Guide to Planning Care, which allows rapid access to information
- Nursing care plans for all nursing diagnoses listed in Section II
- Specific geriatric interventions in appropriate plans of care
- Specific client/family teaching interventions in each plan of care
- Inclusion of commonly used abbreviations (e.g., AIDS, MI, CHF) and cross-references to the complete term in Section II
- Contributions by 44 nurse experts from throughout the United States who together represent all of the major nursing specialties and have extensive experience with nursing diagnoses and the nursing process

We acknowledge the work of NANDA, which is used extensively throughout this text. In some cases the authors and contributors have modified the NANDA work to increase ease of use. The original NANDA work can be found in *NANDA Nursing Diagnoses: Definitions and Classification 1997-1998.*

Several contributors are the original authors of the nursing diagnoses established by NANDA. These contributors include the following:

Mary A. Fuerst-DeWys
Disorganized infant behavior
Potential for enhanced organized infant behavior
Risk for disorganized behavior

Dr. Nancy English
Impaired environmental interpretation syndrome

Dr. Margaret Lunney
Effective management of therapeutic regimen
Ineffective community coping
Ineffective management of therapeutic regimen
Ineffective management of therapeutic regimen: community
Ineffective management of therapeutic regimen: families
Potential for enhanced community coping

Vicki E. McClurg, Mary Henrikson, and Virginia R. Wall
Effective breast-feeding
Ineffective breast-feeding
Interrupted breast-feeding

Dr. Pamela H. Mitchell
Decreased adaptive capacity: intracranial

Kathy Wyngarden
Risk for altered parent/infant/child attachment

We and the consultants and contributors trust that nurses will find this third edition of *Nursing Diagnosis Handbook: A Guide to Planning Care* to be a valuable tool that simplifies the process of diagnosing clients and planning for their care and thus allows nurses more time to provide care that speeds each client's recovery.

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Betty J. Ackley
Gail B. Ladwig

Contents

Section I

Nursing Diagnosis and the Nursing Process

The nursing process is an organizing framework for professional nursing practice. Components of the process include performing a nursing assessment; making nursing diagnoses; planning: writing outcome/goal statements, determining appropriate nursing interventions; implementing care; and evaluating the nursing care that has been given. An essential part of this process is the nursing diagnosis:

> A nursing diagnosis is a clinical judgment about individual, family, or community responses to actual or potential health problems or life processes. Nursing diagnoses provide the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable (NANDA, 1990).

ASSESSMENT

Before determining appropriate nursing diagnoses, the nurse must perform a thorough holistic nursing assessment of the client. The nurse may use the assessment format adopted by the facility in which the practice is situated. Several organizational approaches to assessment are available, including Gordon's Functional Health Patterns and head-to-toe and body systems approaches. Regardless of the approach used, the nurse assesses for client symptoms to help formulate a nursing diagnosis.

To elicit as many symptoms as possible, the nurse uses open-ended rather than yes/no questions during the assessment. The nurse also obtains information via physical assessment and diagnostic test results. If the client is critically ill or unable to respond verbally, the nurse obtains most of the data from physical assessment and diagnostic test results and possibly from the client's significant others. The nurse can use data from each of these sources to formulate a nursing diagnosis.

NURSING DIAGNOSTIC STATEMENT

A working nursing diagnostic statement has three parts:

1. The nursing diagnosis
2. "Related to" phrase or etiology
3. Defining characteristics phrase

Nursing Diagnosis

The nurse makes a nursing diagnosis by categorizing symptoms as common patterns of response to actual or potential health problems. After completing the assessment, the nurse lists all identified symptoms and clusters similar symptoms together. For example, the following symptoms may be identified in the assessment of a client with an admitting medical diagnosis of asthma: dyspnea, anxiety, hypertension, respiratory rate of 28, temperature of 99° F. Of these signs and symptoms, dyspnea and respiratory rate of 28 (tachypnea) would be clustered because they are related. Using Section II: Guide to Nursing Diagnoses, the nurse can then look up dyspnea or tachypnea and find the nursing diagnosis **Ineffective breathing pattern** suggested for each symptom.

To validate that the diagnosis **Ineffective breathing pattern** is appropriate for the client, the nurse then turns to Section III: Guide to Planning Care and reads through its definition and its list of defining characteristics. The definition should describe the condition that the nurse is observing in the client. Many of the nursing diagnoses in Section III differentiate between major and minor defining characteristics or specify critical defining characteristics. For a diagnosis to be accurate, NANDA suggests that the client should have most of the major or critical defining characteristics.

To help verify the diagnoses made on the basis of client signs and symptoms, the nurse may look up the client's medical diagnoses in Section II: Guide to Nursing Diagnoses. For example, one of the nursing diagnoses listed under the medical diagnosis asthma is **Ineffective breathing pattern.**

The process of identifying significant symptoms, clustering them into logical patterns, and then choosing an appropriate nursing diagnosis involves diagnostic reasoning skills (critical thinking) that must be learned in the process of becoming a nurse. Our text serves as a tool to help the nurse in this process.

"Related to" Phrase or Etiology

The second part of the nursing diagnosis statement is the "related to" (r/t) phrase. This phrase states what may be causing or contributing to the nursing diagnosis, or the etiology. Pathophysiological and psychosocial changes, such as developmental age and cultural and environmental situations, may be causative factors.

Ideally, the etiology, or cause, of the nursing diagnosis is something the nurse can treat. A carefully written, individualized r/t statement enables the nurse to plan nursing interventions that will assist the client in accomplishing goals and returning to a state of optimum health.

For each suggested nursing diagnosis, the nurse should refer to the statements listed under the heading "Related Factors (r/t)" in Section III. These r/t factors may or may not be appropriate for the individual client. If they are not appropriate, the nurse should write an appropriate r/t statement.

Defining Characteristics Phrase

The third part of the nursing diagnostic statement consists of defining characteristics (signs and symptoms) that the nurse has gathered during the assessment phase. The phrase "as evidenced by" (aeb) may be used to connect the etiology (r/t) and defining characteristics. The use of defining characteristics is similar to the process the physician uses when making a medical diagnosis. For example, for the medical diagnosis of asthma the physician may observe the following signs and symptoms: wheezing, chest retractions, and pulmonary function testing abnormalities. The nurse uses the same process.

Examples of Writing a Nursing Diagnostic Statement

To write a nursing diagnostic statement for a client with the symptom of alopecia, the nurse should use Section II. Listed under the heading **Alopecia** is the following information:

> **Alopecia**
> **Body image disturbance** (nursing diagnosis) r/t loss of hair, change in appearance (etiology)

To the information found in Section II, the defining characteristics phrase is added: aeb verbalization of fear of rejection by others because of hair loss.

With the preceding information, the nurse is able to make the following nursing diagnosis statement:

> **Body image disturbance** r/t loss of hair, change in appearance aeb verbalization of fear of rejection by others because of hair loss.

To use Section II to write a nursing diagnostic statement for a client who has peritonitis, the nurse should look up the diagnosis **Peritonitis.** Listed under this medical diagnosis is the following information:

Peritonitis
Fluid volume deficit (nursing diagnosis) r/t retention of fluid in the bowel with loss of circulating blood volume (etiology).

To the information in Section II, the defining characteristics phrase is added: aeb dry mucous membranes, poor skin turgor.

With the preceding information, the nurse is able to make the following nursing diagnostic statement:

Fluid volume deficit r/t retention of fluid in the bowel with loss of circulating blood volume aeb dry mucous membranes, poor skin turgor.

PLANNING

For most clients the nurse will make more than one nursing diagnosis. Therefore the next step in the nursing process is to determine the priority for care from the list of nursing diagnoses. The nurse can determine the highest priority nursing diagnoses by using Maslow's Hierarchy of Needs. In this hierarchy, highest priority is generally given to immediate problems that may be life threatening. For example, **Ineffective airway clearance** would have a higher priority than **Ineffective individual coping.** Refer to Appendix A, "Nursing Diagnoses Arranged by Maslow's Hierarchy of Needs" for assistance in prioritizing nursing diagnoses.

Outcomes/Goals

After determining the appropriate priority of the nursing diagnoses, the nurse writes client outcome/goal statements. Section III lists suggested choices of outcomes/goals for each nursing diagnosis. If at all possible, the nurse involves the client in determining appropriate outcomes/goals. After a discussion with the client, the nurse plans nursing care that will assist the client in accomplishing the outcome/goal.

After the client's outcomes/goals are selected, the nurse establishes a means to accomplish the outcomes/goals. The usual means are by nursing interventions.

INTERVENTIONS

Interventions are like road maps directing the best ways to provide nursing care. The more clearly a nurse writes an intervention, the easier it will be to complete the journey and arrive at the destination of successful client outcomes/goals.

This text includes suggested Nursing Interventions Classification (NIC) interventions for each nursing diagnosis. The NIC interventions are a comprehensive, standardized classification of treatments that nurses perform. The classification includes both physiological and psychosocial interventions and covers all nursing specialities. See Appendix E for a listing of the NIC interventions. For further information on NIC, see McCloskey JC, Bulechek GM: *Nursing interventions classification (NIC),* ed 2, St Louis, 1996, Mosby.

Section III supplies choices of interventions for each nursing diagnosis. The nurse may choose the ones appropriate for the client and individualize them accordingly or determine additional interventions.

Putting It All Together—Writing the Care Plan

The final planning phase is writing the actual care plan, including prioritized nursing diagnostic statements, outcomes/goals, and interventions. The care plan must be written and shared with all health care personnel caring for the client to ensure continuity of care.

IMPLEMENTATION

The implementation phase of the nursing process is the actual initiation of the nursing care plan. Client outcomes/goals are achieved by the performance of the nursing interventions. During this phase the nurse continues to assess the client to determine whether the interventions are effective. An important part of this phase is documentation. The nurse should use the facility's tool for documentation and record the results of implementing nursing interventions. Documentation is also necessary for legal reasons because in a legal dispute, "If it wasn't charted, it wasn't done."

EVALUATION

Although the evaluation is listed as the last phase of the nursing process, it is actually an integral part of each phase that the nurse does continuously. When the evaluation is performed as the last phase, the nurse refers to the client's outcomes/goals and determines whether they were met. If the outcomes/goals were not met, the nurse begins again with assessment and determines why they were not met. Were the goals attainable? Was the wrong nursing diagnosis made? Should the interventions be changed? At this point the nurse can look up any new symptoms or conditions that have been identified in the client and then adjust the care plan as needed.

Many health care providers are using critical pathways to plan nursing care. The use of nursing diagnoses should be an integral part of any critical pathway to ensure that nursing care needs are being assessed and appropriate nursing interventions are planned and implemented.

The use of nursing diagnoses ensures that nurses are speaking a common language when taking care of client problems. This system is also easily computerized for easier documentation and analysis of patterns of care. Nursing diagnosis is the essence of nursing to ensure that clients receive excellent, holistic nursing care.