

Lynda Juaal Carpenito

# HANDBOOK OF Nursing Diagnosis



EDITION

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N I N T H   E D I T I O N

*Handbook of*

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# Nursing Diagnosis

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## HOW TO USE THIS HANDBOOK



1. Collect data, both subjective and objective, from client, family, other health care professionals, and records.
2. Identify a possible pattern or problem.
3. Refer to the medical diagnostic category in Section II, and review the possible associated nursing diagnoses and collaborative problems. Select the possibilities.
4. After you have selected what physiological complications or collaborative problems are indicated to be monitored for onset or status changes, label them Potential Complications: (specify).
5. After you have determined which functional patterns are altered or at risk of altered functioning, review the list of nursing diagnoses under that pattern and select the appropriate diagnosis (refer to Table I-1).
6. If you select an actual diagnosis:
  - a. Do you have signs and symptoms to support its presence? (Refer to Section I, Nursing Diagnoses, under the selected diagnosis.)
  - b. Write the actual diagnosis in three parts: Label related to contributing factors as evident by signs and symptoms
7. If you select a risk diagnosis:
  - a. Are risk factors present? Is this person or group more vulnerable than others in the same or a similar situation?
  - b. Write the risk diagnosis in two parts: Label related to risk factors
8. If you suspect a problem but have insufficient data, gather the additional data to confirm or rule out the diagnosis. If this additional data collection must be done later or by other nurses, label the diagnosis *possible* on the care plan or problem list.\*

\*Specific focus assessment criteria questions, outcome criteria, and interventions for each nursing diagnosis category can be found in Carpenito, L. J. (2002). *Nursing diagnosis: Application to clinical practice* (9th ed.). Philadelphia: Lippincott Williams & Wilkins.



## TO OLEN, MY SON

for your wisdom and commitment to justice

for our quiet moments and embraces

for your presence in my life

... I am grateful

for you are my daily reminder of what is

really important . . .

love, health, and human trust



### **How to Make an Accurate Nursing Diagnosis**

In order to make an accurate nursing diagnosis the nurse must be able to do the following:

1. Collect data that are valid and pertinent
2. Analyze the data into clusters
3. Differentiate nursing diagnoses from collaborative problems
4. Formulate nursing diagnoses correctly
5. Select priority diagnoses

### **Collect Data That Are Valid and Pertinent**

#### **Key Concepts**

Nursing focused assessment

Screening versus focus

Significance of data

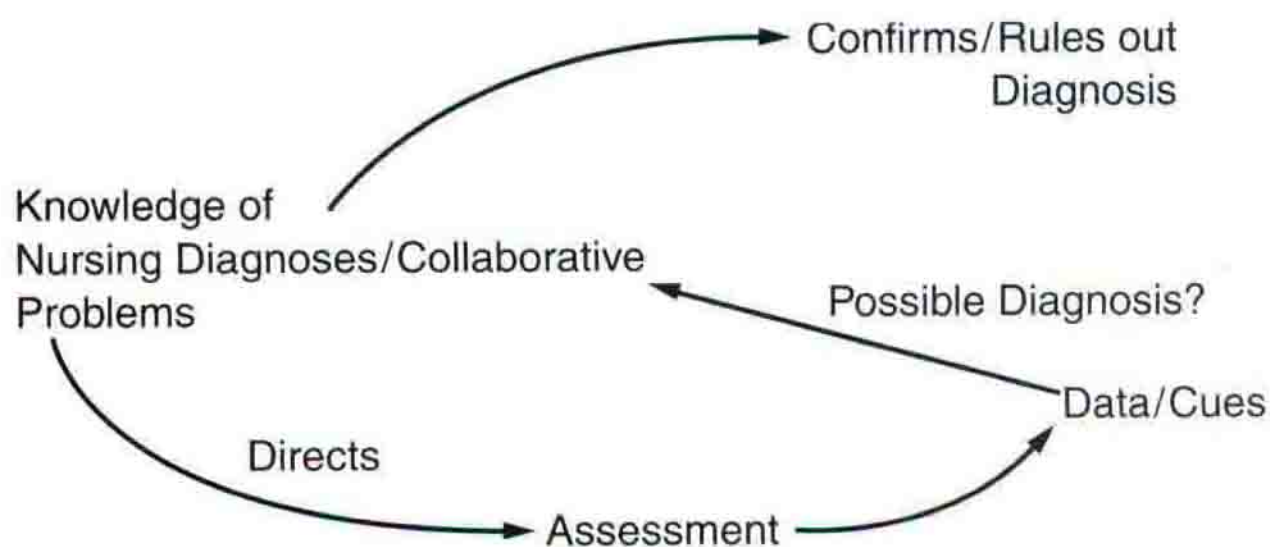
Evaluation of data

### **Nursing Focused Assessment**

Nursing is defined as the diagnosis and treatment of human responses to actual or potential health problems and life situations (*Nursing: A Social Policy Statement*, 1985. NANDA, 1990). The assessment format the nurse utilizes must be able to direct data collection on human responses ranging from skin condition and urinary function to spiritual health and self-care abilities.

In other words, the nurses' knowledge of signs and symptoms for actual diagnoses, risk factors for risk diagnoses or possible physiological complications directs the data collection. This knowledge is also used to validate the accuracy of the diagnosis.





## Screening Versus Focus

There are two types of assessments:

1. Screening: collection of predetermined data usually during initial contact
2. Focus: Collection of specific data as determined by the client, family, or situation

Frequently during first encounters with the individual, the nurse will focus on broad screening assessment questions to determine how the person is functioning in various areas. Such questions might include the following:

- Do you have a problem sleeping?
- Do you have a problem with eating?
- How often do you have a bowel movement?
- Is there a situation in your life that has been difficult for you to cope with?

If the person is complaining of a certain problem or has a specific concern, the nurse would limit the assessment. A limited assessment focus might include the following questions:

- Now tell me about your pain (Onset? Location? Severity? Duration? What helps? What aggravates?)
- What other symptoms do you have?
- How is this pain affecting sleep, eating, work, leisure?

In another situation, the nurse might be caring for a woman who has just had surgery, and complete a focus assessment of vital signs, wound appearance, intake, output, comfort level.

In many situations, the nurse would not be assessing for problem nursing diagnoses, but instead would be assessing wellness and healthy lifestyles. For example, a healthy 42-year-old woman may be assessed for fiber content in diet.

## Significance of Data

Beginning students will need to learn to determine if data are significant or not in basic functional patterns or needs such as nutrition, safety, elimination, mobility, self-care. In order to recognize significant data, the nurse must first know what is expected or normal. For example, in order to determine if a person has a nutritional problem, the nurse must first understand the food pyramid of five food groups, normal weight for height, and food preparation. In addition, the nurse needs to know that certain factors, such as nausea, poor dentures, sore mouth, or insufficient money, can interfere with food procurement, food preparation, eating, and metabolism.

Very simply, in order for assessment to be purposeful the nurse has to know the following:

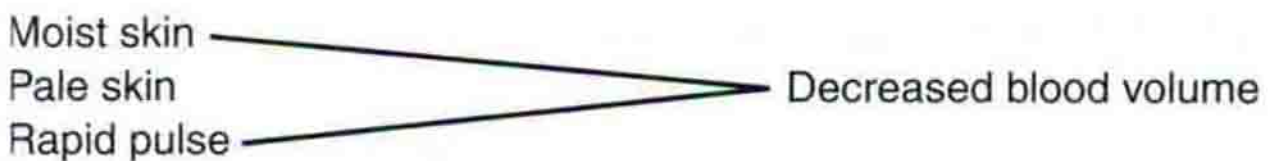
- What is the range of normal?
- What is the range of abnormal?
- What are the risk factors?

## Evaluation of Data

The evaluation of data involves:

- Differentiating cues from inferences
- Assuring validity
- Determining how much data is needed

Cues are facts that the nurse collects through interviewing, observing, examining, and reviewing the client record (eg, vital signs, feelings, laboratory results). Inferences are judgments that the nurse makes about cues, such as the following:



Validity is the extent to which data can be believed to be factual and true (Alfaro-Lefevre, 1999). Some data, such as decreasing blood pressure, are certain because there are



agreed-upon standards. For situations where there are not clear-cut criteria, such as psychosocial responses, the nurse can increase the validity of the data or diagnosis by adding more evidence to support the inference.

The judgments nurses make are only as valid as the data used. The validity or accuracy of the data can be increased if the nurse verifies information.

Alfaro-Lefevre (1999) recommends several procedures to validate data:

- Recheck your own data
- Ask someone to check
- Compare subjective and objective data
- Ask the client to verify

## Analyze the Data Into Clusters

### Key Concepts

Knowledge of diagnostic categories

Sufficient number of cues

Differentiating one diagnosis from another

Tentative diagnosis (hypothesis)

### Knowledge of Diagnostic Categories

Analysis of data is not possible unless you know which cues cluster or group to describe a diagnosis. In other words, you need to know which cues describe powerlessness before you can recognize the cluster. Some diagnoses are very easy to confirm, such as Constipation or Impaired Skin Integrity. Often a single cue, such as “I have leg pain,” can confirm a diagnosis of pain.

Other diagnoses, especially more complex psychosocial diagnoses such as Body Image Disturbance, may necessitate several nurse–client interactions before the diagnosis can be confirmed or not. Table 1, at the end of this introduction, lists nursing diagnoses under Functional Health Patterns.

### Sufficient Number of Cues

One of the most difficult aspects of making accurate diagnoses is determining if a sufficient number of cues are present to confirm an actual nursing diagnosis. The nurse should consult the list of defining characteristics for the diagnosis suspected. How many major characteristics are present? How many minor characteristics are present? Does the client



confirm your suspected diagnosis? If you are still not confident, label the diagnosis Possible and collect more data.

## **Differentiating One Diagnosis From Another**

Some diagnoses share some of the same defining characteristics as Activity Intolerance, Fatigue, and Disturbed Sleep Pattern. Review the definitions and the author's notes for help. Determine what the focus of the interventions would be for the problem, for example, energy conservation techniques (Fatigue), promotion of sleep (Disturbed Sleep Pattern) or increasing endurance (Activity Intolerance). Sometimes this technique helps to clarify the diagnosis.

## **Tentative Diagnosis (Hypothesis)**

The last cognitive activity in data analysis is the proposal of one or more likely diagnostic explanations for the clustered data. Sometimes only one diagnosis is proposed because the clustered data clearly support its presence. When more than one diagnosis is likely, the nurse should review the defining characteristics (for actual) or risk factors (for risk) for the tentative diagnosis. Systematically, the nurse should compare these signs, symptoms, or risk factors to the data assessed. If more data collection is needed, the nurse can proceed to this focused assessment. Another option is for the nurse to label the tentative diagnosis Possible if additional data collection is not realistic or feasible at this time. For example, some of the coping diagnoses require repetitive interactions for confirmation of the diagnosis.

## **Differentiate Nursing Diagnoses From Collaborative Problems**

### **Key Concepts**

Nursing diagnoses versus collaborative problems  
Selection of collaborative problems

## **Nursing Diagnoses Versus Collaborative Problems**

In 1983, Carpenito published the Bifocal Clinical Practice Model. In this model, nurses are accountable to treat two types of clinical judgments or diagnoses: nursing diagnoses and collaborative problems.



Nursing diagnoses are clinical judgments 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 (NANDA, 1990).

Collaborative problems are certain physiological complications that nurses monitor to detect onset or changes in status. Nurses manage collaborative problems using physician-prescribed and nursing-prescribed interventions to minimize the complications of the events (Carpenito, 1989).

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

The following illustrates the types of interventions associated with the collaborative problem potential complications: Hypoxemia:

- |       |  |
|-------|--|
| NP    | 1. Monitor for signs of acid–base imbalance.           |
| PP    | 2. Administer low flow oxygen as needed.               |
| NP    | 3. Ensure adequate hydration.                          |
| NP    | 4. Evaluate the effects of positioning on oxygenation. |
| NP/PP | 5. Administer medications as needed.                   |

(NP: Nurse-prescribed PP: Physician-prescribed)

## Selection of Collaborative Problems

As mentioned earlier, collaborative problems are different from nursing diagnoses.

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 examples illustrate some collaborative problems:

<i>Situation</i>	<i>Collaborative Problem</i>
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? The answer is none. The nurse would initiate physician-prescribed orders if the client presented signs of bleeding. This situation is a collaborative problem, not a nursing diagnosis. For example:

Potential Complication: Bleeding

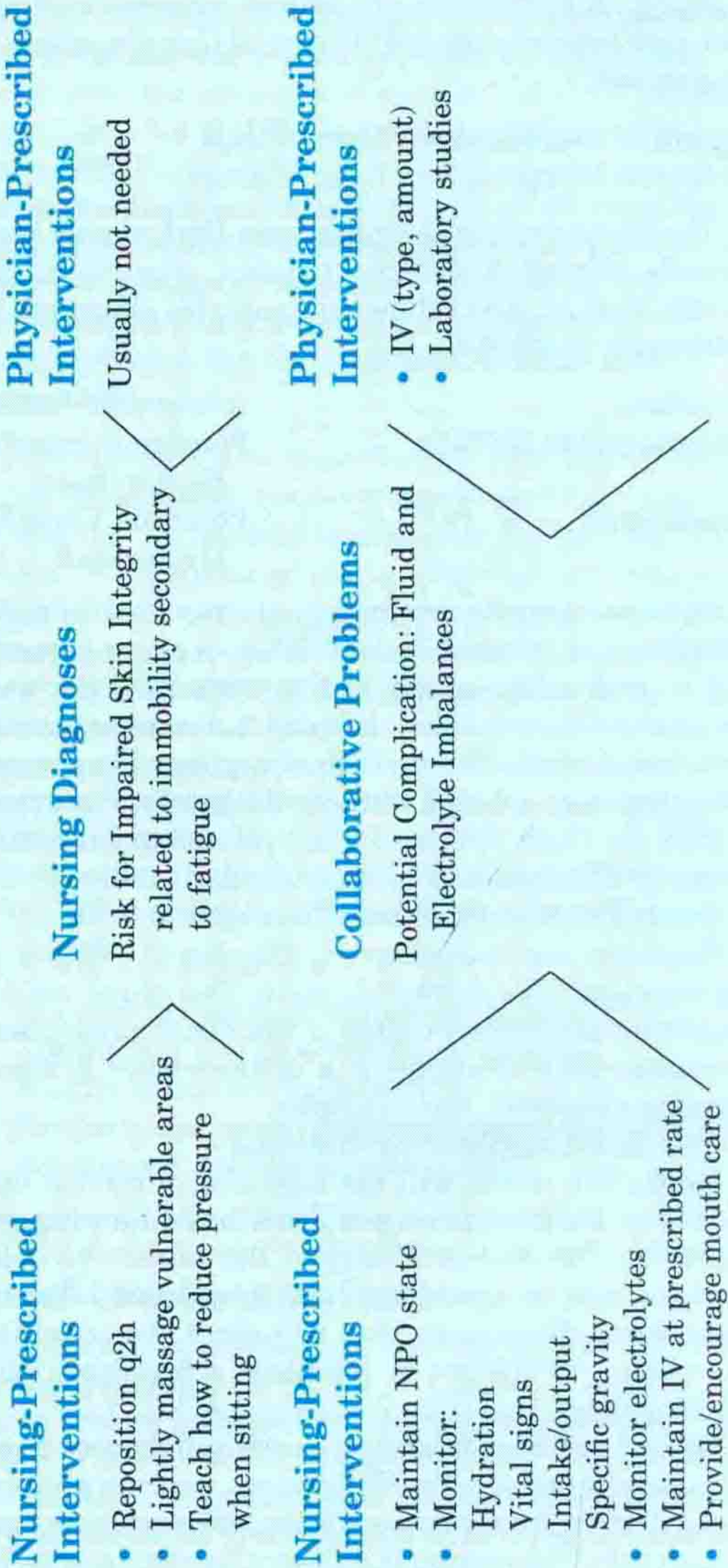
**Goal:** The nurse will manage and minimize episodes of bleeding. Collaborative problems have nursing goals that represent the accountability of the nurse—to detect early changes and to manage with physicians. Nursing diagnoses have client goals that represent the accountability of the nurse—to achieve 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 pre-vent paralytic ileus but, instead, detect its presence



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



## ⊗ **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?

early to prevent greater severity of illness or even death. Physicians cannot treat collaborative problems without nursing knowledge, vigilance, and judgment.

## **Formulate Nursing Diagnoses Correctly**

### **Key Concepts**

Types of nursing diagnoses

Diagnostic statements

Client validation

Clinical example

### **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).

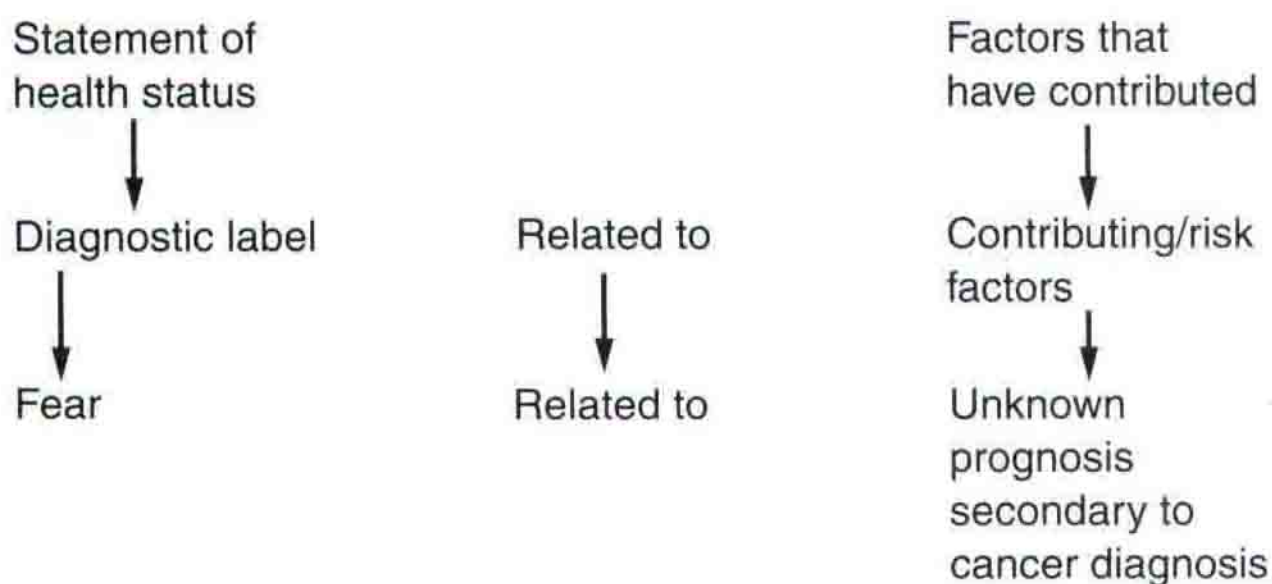
**Syndrome:** A syndrome diagnosis comprises a cluster of actual or risk nursing diagnoses that are predicted to present because of a certain situation or event.



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

## Diagnostic Statements

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



## One-Part Statements

Wellness nursing diagnoses will be written as one-part statements: Potential for Enhanced \_\_\_\_\_, eg, 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” designations.

## 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, as in:

### 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.

## **The Following Are Examples of Two-Part Statements:**

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.

## **The Following Are Examples of Three-Part Statements:**

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 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. If significant data are collected in a particular functional pattern, the next step is to check the related nursing diagnoses to see if any of them are substantiated by the data that are collected.



## Client Validation

The process of validating a nursing diagnosis should not be done in isolation from the client or family. Individuals are the experts on themselves. During assessments and interactions, nurses are provided a small glimpse of their clients. Diagnostic hunches or inferences about data should be discussed with clients for their input. Clients are given opportunities to select what they want assistance with, which problems are important to them, and which ones are not.

## Clinical Example

After the screening assessment has been completed, the nurse applies each of these questions to each functional or need area:

- Is there a possible problem in a specific area?
- Is the person at risk (or high risk) for a problem?
- Does the person desire to improve his/her health?

