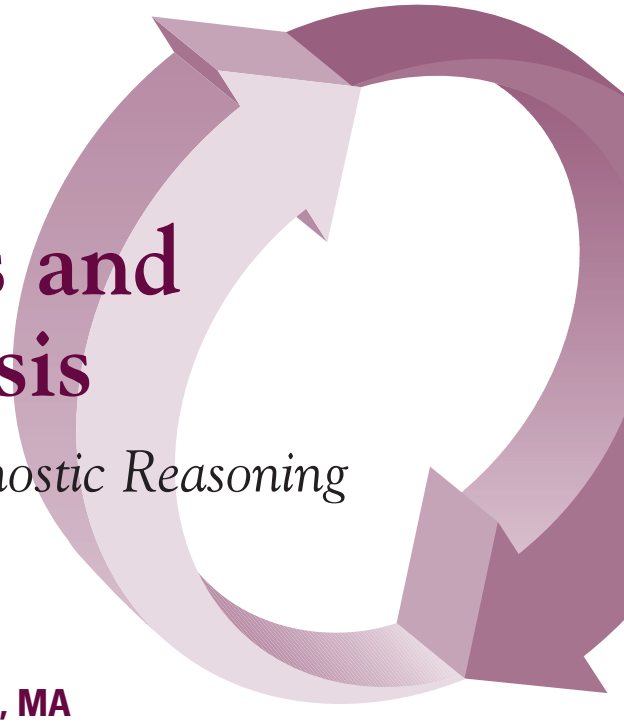
Application of Nursing Process and Nursing Diagnosis

An Interactive Text for Diagnostic Reasoning

FOURTH EDITION



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F. A. DAVIS COMPANY • Philadelphia

F. A. Davis Company
1915 Arch Street
Philadelphia, PA 19103

Printed in the United States of America

Last digit indicates print number: 10 9 8 7 6 5 4 3 2 1

Publisher: Robert Martone
Cover Designer: Louis J. Forgione

ISBN 0-8036-1066-1

To our families, who support us in all we do and who continue to support our dreams, fantasies, and obsessions.

With special thanks to:

The Doenges family: the late Dean, whose support and encouragement are sorely missed; Jim; Barbara and Bob Lanza; David, Monita, Matthew, and Tyler; John, Holly, Nicole, and Kelsey; and the Daigle family: Nancy, Jim, Jennifer, and Brandon Smith-Daigle, and Jonathan and Kim.

The Moorhouse family: Jan, Paul; Jason, Alexa, and Mary Isabella.

Alice Geissler-Murr, for being available when we need help.

The staff at Memorial Hospital library, for cheerfully filling in all the blanks and by helping us find those elusive references.

To the students of Beth-El College of Nursing and the nursing students of the Pikes Peak Community College, who continue to challenge us to make the nursing process and nursing diagnosis understandable.

To our colleagues, who continue to provide a sounding board and feedback for our professional beliefs and expectations. We hope this interactive text will help you and your students at all stages to clarify and apply these concepts.

To our F. A. Davis family, especially our publisher and friend, Robert (Bob) Martone;

Bob Butler, Jessica Howie Martin, and all who facilitated the revision process to get this project completed in a timely fashion.

To NANDA and the international nurses who are developing and using nursing diagnoses. And to the nurses who have patiently awaited this revision, we hope it will help in applying theory to practice and will enhance the delivery and effectiveness of your care.

Notes to the Educator

The nursing process has been used for over 25 years as a systematic approach to nursing practice. The process is an efficient and effective method for organizing nursing knowledge and clinical decision making in providing planned client care. Although it has been undergoing constant re-evaluation and revision, the concepts within the process still remain central to nursing practice.

Healthcare accrediting agencies and nursing organizations have developed standards of nursing practice that focus on the tenets of the nursing process, that is, assessing, diagnosing, planning, implementing, evaluating, and documenting client care. Although the formats used to document the plan of care may change with the interpretation and evaluation of standards, the nursing responsibilities and interventions required for planned client care still need to be learned, shared, performed, evaluated, and documented.

The nursing process is by its nature an interactive method of practicing nursing. This text mirrors that interactive focus by presenting a step-by-step problem-solving design to help students develop an understanding of the meaning and language of nursing. We have included definitions and professional standards that will serve as a solid foundation for your students to understand and apply the nursing process. The vignettes, practice activities, work pages, and case studies provide an opportunity to examine and scrutinize client situations and dilemmas in practice, consider alternatives, and evaluate outcomes. The worksheets serve as graphic summaries that provide students with criteria to evaluate their decisions and demonstrate their understanding of the concepts and integration of the material presented. Tear-out pages for independent learning provide an opportunity for practical application and beginning mastery of the nursing process. These pages can be taken to the clinical area to reinforce selected aspects of the nursing process. Finally, review of client situations and the Code for Nurses can serve as a catalyst for philosophical and ethical discussions. All these activities encourage the student to actively seek solutions rather than passively assimilate knowledge, thus stimulating the student's critical thinking ability.

Chapter 1, The Nursing Process: Delivering Quality Care

This introductory chapter presents an overview of the nursing process. Students are introduced to the definitions of nursing and nursing diagnosis and the American Nurses Association's Standards of Clinical Nursing Practice.

Chapter 2, The Assessment Step: Developing the Client Database

This chapter introduces students to the first step of the nursing process. Organizational formats for constructing nursing assessment tools are discussed, and both the physical and psychosocial aspects of assessment are blended into the interview process. Examples of client data assist students to identify categories of nursing diagnostic labels.

Chapter 3, The Diagnosis or Need Identification Step: Analyzing the Data

The definition and concepts of nursing diagnosis are presented in this chapter. We use the term *Client Diagnostic Statement* to describe the combination of the NANDA-approved label, the client's related factors (etiology), and associated defining characteristics (signs/symptoms). A six-step diagnostic reasoning process is presented to assist students in their beginning efforts to accurately analyze the client's assessment data. The remainder of this chapter focuses on ruling out, synthesizing, evaluating, and constructing the client diagnostic statement.

Chapter 4, The Planning Step: Creating the Plan of Care

Information on developing the individualized outcomes for the client is provided in this chapter. A focus on correctly writing measurable outcomes is initially presented. In addition, examples from the standardized nursing language for outcomes, Nursing Outcomes Classification (NOC), are also presented. Nursing interventions are defined and acknowledgment of the work by the Iowa Intervention Project's Nursing Interventions Classification (NIC) is included. The topics, priorities of interventions, discharge planning, and selecting appropriate nursing interventions are discussed along with examples of a fourth standardized language, the Omaha System. A practice activity for recording the steps of the nursing process learned thus far is included to provide the student with a realistic application. An interactive plan of care worksheet is used to present examples and guidelines for developing the client's outcome statement, selecting nursing interventions, and providing rationales for nursing interventions. Finally, information about the use of mind mapping to stimulate right brain activity to facilitate the planning process is presented along with a sample plan of care.

Chapter 5, The Implementation Step: Putting the Plan of Care into Action

Information is presented about the validation and implementation of the plan of care. Concerns regarding the day-to-day organization of the nurse's work is creatively used in a practice activity in which students use time management to plan the day's client care interventions. Change-of-shift reporting principles are also discussed and practiced.

Chapter 6, The Evaluation Step: Determining Whether Desired Outcomes Have Been Met

The crucial step of evaluation and its accompanying reassessment and revision processes are presented in this chapter on the last step of the nursing process. A practice activity is provided to help students evaluate the plan of care partially constructed in Chapter 4. Revisions to the plan of care are necessary, and the activity provides a realistic exercise for this final step. The interactive plan of care worksheet is designed to ask your students questions about their client's progress and the effectiveness of their implemented nursing interventions.

Chapter 7, Documenting the Nursing Process

This chapter introduces students to ways of successfully documenting their use of the nursing process. Communication, legal responsibilities, and reimbursement are a few of the topics introduced in this chapter. The documentation systems of SOAP and FOCUS CHARTING™ are presented to depict two possible methods of documenting the nursing process. The last section of the interactive worksheet focuses the students' attention on three important aspects of documentation: the reassessment data, interventions implemented, and the client's response.

Chapter 8, Interactive Care Planning: from Assessment to Client Response

This final chapter provides an evaluation checklist that can be used to evaluate your students' progress in all aspects of the nursing process. The checklist is designed to include the criteria listed on the Interactive Care Plan Worksheets, ANA Standards of Clinical Nursing Practice, and the JCAHO nursing standards. The chapter ends with a case study that gives your students an opportunity to apply all the steps of the nursing process. The evaluation checklist along with the TIME OUTS included in the plan of care worksheets provide the students with the required guidance when constructing their first complete plan of care.

Appendices

A listing of the NANDA (formerly the North American Nursing Diagnosis Association) nursing diagnoses are included in Appendix A. Each nursing diagnosis' definition, related/risk factors, and defining characteristics are provided to assist the student in accurately selecting the appropriate nursing diagnosis.

Appendix B defines the seven axes of the new NANDA Taxonomy II.

Appendix C provides an adult medical-surgical nursing assessment tool as referenced in Chapter 2, along with excerpts from assessment tools developed for the psychiatric and obstetric settings. The tools are helpful to students in their assessment of the client's response to health problems as well as the gathering of physical assessment data.

Appendix D organizes the NANDA diagnostic labels within Maslow's hierarchy of needs to aid in visualizing and determining priorities for providing client care.

Appendix E, ANA's Code of Ethics for Nurses, was included for your use both in the classroom and during clinical rounds to share with your students the values that guide nursing practice today. A reference to the Code and the introduction of a discussion of beliefs that affect nursing practice are contained in Chapter 1, and an ethical activity is presented in Chapter 5.

Appendices F and G provide tools for the student to measure the accuracy of their choice of nursing diagnosis labels. The Ordinal Scale of Accuracy of a Nursing Diagnosis assigns a point value to a diagnosis that is consistent with the number of cues and disconfirming cues identified. This tool aids students in validating their analysis of the collected data and choice of nursing diagnosis. The Integrated Model for Self-Monitoring of the Diagnostic Process provides direct feedback to students but can also be shared with you to demonstrate the students' progress in data analysis and diagnosis.

Appendix H is a sample of a Clinical (Critical) Pathway, providing you with the opportunity to address alternate forms for planning and evaluating care.

Appendix I presents some commonly accepted charting abbreviations, which may be useful in your discussion of the documentation process.

Appendix J provides a glossary of common terms.

Appendix K outlines the 17 Likert scales used to measure the variability in the client's state, behavior, or perception as depicted in NOC outcomes.

Finally, Appendices K and L are the Keys to the Learning Activities provided in the text.

The National League for Nursing emphasizes the need for graduates of nursing programs to think critically, make decisions, and formulate independent judgments. To achieve this outcome, you as an instructor are encouraged to use teaching strategies that will "stimulate higher-order critical thinking in both theory and practice situations" (Klaassens, 1988). These strategies include: questioning, analysis, synthesis, application, writing, problem-solving games, and philosophical discussions.

It is our hope that the interactive features of this text will provide the strategies to assist you in successfully sharing with your students the meaning and language of the nursing process and in making a smooth and effective transition from the classroom to any clinical setting.

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Notes to the Student

The nursing process will be described by your instructors as a systematic approach to the practice of nursing. Shortly, you will find that this process is an efficient and effective method for organizing both nursing knowledge and practice. The process will also assist you in accurately performing clinical decision-making activities in planning your client's care. The process has been continually refined since its inception in the 1960s. However, to date, the concepts within the process still remain central to nursing practice. Through the use of this text, your instructors will share the meaning of the concepts and this evolving nursing practice language with you.

The nursing process is an interactive method of practicing nursing, with the components fitting together in a continuous cycle of thought and action. This interactive focus was used in developing and writing this text for you. The text focuses on the steps of the nursing process and provides information and exercises to aid your understanding and application of the process. Included are practice activities, ongoing reference to simulated clinical experiences through the use of vignettes, and end-of-chapter work pages to promote your understanding. Definitions of both nursing and the nursing process, along with the American Nurses Association's (ANA) Standards of Clinical Nursing Practice, are presented to provide a solid foundation for you to build an understanding of the language and knowledge of nursing and application of the nursing process.

In addition, a six-step diagnostic reasoning/critical thinking process is presented for accurately analyzing the client's assessment data. It will assist you in ruling out, synthesizing, evaluating, and constructing the client diagnostic statement, which is pivotal for developing individualized plans of care for your clients. A practice activity for writing a nursing plan of care was developed to provide a realistic application of your newly learned knowledge. An example of a typical day's work requirements is used in a practice activity in which you are given the opportunity to use time management principles and skills to plan your client's care within an 8-hour shift. A third practice activity is provided to give you a chance to choose client information you would include in a change-of-shift report to communicate the outcomes of your use of the nursing process.

Next, you are given an opportunity to test your beginning skills in developing a complete plan of care. A set of step-by-step forms is provided for you to document your clinical judgment by selecting client diagnostic statements, developing the goals/outcomes, and identifying the nursing interventions. Finally, an evaluation checklist is provided to serve as a valuable self-assessment of the appropriateness and accuracy of your comprehension of the planning exercise and future plans of care that you will design for your clients.

At the end of the chapters, a bibliography and list of suggested readings are included to guide you in further and future reading and understanding of both nursing knowledge and nursing process. In Chapter 1, a suggested reading list provides a listing of publications from a historical perspective. The listing should be helpful to you in searching out the meaning of nursing and the nursing process. The list may also prove valuable in writing varied required papers on similar topics. Use and enjoy. The second section gives you the most current listing of publications at the time of the printing of this edition. Once again, the selected publications are provided to assist you in this learning process.

The perforated tear-out pages for the end-of-chapter work pages, interactive care plan worksheets, and the evaluation checklist were especially designed for your independent learning. These tear-out pages can be taken to the clinical area to reinforce selected aspects of the nursing process. It is our hope that the interactive features of this text will assist you in making the successful and effective transition from the classroom to your assigned clinical setting. We wish you well in this beginning phase of your new profession.

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Acknowledgments

To Joe Burley, RN, MNED
College of Nursing
University of Florida
Gainesville, Florida

To Jean Jenny, MS, MEd, BScNEd, RN
Former Professor
Faculty of Health Sciences
University of Ottawa
School of Nursing
Ottawa, Ontario
Canada

To Alice C. Geissler-Murr, RN, BSN
Triage Nurse
Legal Nurse Consultant
Colorado Springs, Colorado

To Paladin Productions,
whose computer talents clarified
our ideas and made them visible

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Practice Activities and Work Pages

Chapter 3

The Diagnosis or Need Identification Step: Analyzing the Data

■ **ANA STANDARD 2:** Diagnosis: The nurse analyzes the assessment data in determining diagnoses.

The second step of the nursing process is often referred to as **ANALYSIS**, as well as **NEED (OR PROBLEM) IDENTIFICATION** or **NURSING DIAGNOSIS**. Although all these terms may be used interchangeably, the purpose of this step of the nursing process is to draw conclusions regarding a client's specific needs or human responses of concern so that effective care can be planned and delivered. We have chosen to label this step of the nursing process **DIAGNOSIS** or **NEED IDENTIFICATION**. To be more specific, this is a process of data analysis using diagnostic reasoning (a form of clinical judgment) in which judgments, decisions, and conclusions are made about the meaning of the data collected to determine whether or not nursing intervention is indicated.

ANALYSIS: the process of examining and categorizing information to reach a conclusion about a client's needs.

NEED IDENTIFICATION: the second step of the nursing process, in which the data collected are analyzed and, through the process of diagnostic reasoning, specific client diagnostic statements are created.

DIAGNOSIS: Forming a clinical judgment identifying a disease/condition or human response through scientific evaluation of signs/symptoms, history, and diagnostic studies.

NURSING DIAGNOSES:
Noun: a label approved by NANDA identifying specific client needs. The means of describing health problems amenable to treatment by nurses; may be physical, sociological, or psychological.
Verb: the process of identifying specific client needs; used by some as the title of the second step of the nursing process.

The **DIAGNOSIS** of client needs has been determined by nurses on an informal basis since the beginning of the profession. The term came into formal use in the nursing literature during the 1950s (Fry, 1953), although its meaning continued to be seen in the context of medical diagnosis. A group of interested nursing leaders met and held a national conference in 1973 (Gebbie & Lavin, 1975). Their purpose was to identify the client needs that fall within the scope of nursing, label them, and develop a classification system that could be used by nurses throughout the world. This group called these labels **NURSING DIAGNOSES.** Regional, national, and international workshops and conferences continue to be held since the first conference. NANDA International Inc. (formerly North American Nursing Diagnosis Association) meets every 2 years to review its work on the development and classification of nursing diagnoses, as well as the work of other nursing groups worldwide, representing various clinical specialties and healthcare settings.

American Nurses' Association (ANA) standards of practice were first developed in 1973, and with the acceptance of the ANA Social Policy Statement in 1980, which defined nursing as the "diagnosis and treatment of human responses to actual or potential health problems," and the 1995 update description as the "diagnosis and treatment of human responses to health and illness" (ANA, 1995), the movement for broad use of a common language was enhanced. The system developed by NANDA provides a standard terminology that is accepted by ANA and various specialty groups and is being used across the United States and in many countries around the world. NANDA has established a liaison with the International Council of Nursing to support and contribute to the global effort to standardize the language of health care with the goal that NANDA labels will be included in the International Classification of Diseases (ICD-11). In the meantime, NANDA nursing diagnoses are included in the United States version of International Classification of Diseases–Clinical Modifications (ICD-10CM) and the NANDA, Nursing Interventions Classification (NIC), and Nursing Outcomes Classification (NOC) classifications have been coded into Systematized Nomenclature of Medicine (SNOMED). (Inclusion in an international coded terminology is essential if nursing's contribution to health care is to be recognized. Indexing of the entire medical record supports disease management activities, research, and analysis of outcomes for quality improvement for all healthcare disciplines. Coding also supports telehealth, the use of telecommunications technology to provide medical information and healthcare services over distance, and facilitates access to healthcare data across care settings and different computer systems.)

Today, the use of the nursing process and nursing diagnoses is rapidly becoming an integral part of an effective system of nursing practice. It is a system that can be used within existing conceptual frameworks, because it is a generic approach adaptable to all academic and clinical settings. In addition, as mentioned in the first chapter, organizing schemata of nursing problems other than NANDA are used within the profession. Additional schemata, such as the Omaha System, the Patient Care Data Set, the Home Health Care Classification, and the Perioperative Nursing Data Set (see individual bibliographies for each of these four additional schema), have been approved for use. In this edition, we introduce you to the Omaha System by presenting associated Omaha System problems with the NANDA diagnoses in the case studies.

Defining Nursing Diagnosis

The term *nursing diagnosis* has been used as both a verb and a noun. This may result in confusion. Nursing diagnosis is used as a noun in reference to the work of NANDA. For the purposes of this text, *nursing diagnosis* refers to the NANDA list of nursing diagnosis labels (Table 3–1) that form the stem of the **CLIENT DIAGNOSTIC STATEMENT**.

Although nurses work within the nursing, medical, and psychosocial domains, nursing's phenomena of concern are patterns of human response, not disease processes. Therefore, nursing diagnoses do not parallel medical/psychiatric diagnoses but do involve independent nursing activities, as well as collaborative roles and actions.

The nursing diagnosis is a conclusion drawn from the data collected about a client that serves as a means of describing a health need amenable to treatment by nurses. A uniform or standardized way of identifying, focusing on, and labeling specific phenomena allows the nurse to deal effectively with individual client responses.

Although there are different definitions of the term *nursing diagnosis*, NANDA has accepted the following:

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

The nursing diagnosis is as correct as the current data allow because it is supported by these data. It says what the client's situation is at the present time and reflects changes in the client's condition as they occur. Each decision the nurse makes is time dependent and, with additional information gathered later, decisions may change. Unlike medical diagnoses, nursing diagnoses change as the client progresses through various stages of illness/maladaptation, to resolution of the need for nursing intervention or to the conclusion of the condition. For example, for a client undergoing cardiac surgery, initial needs may be acute Pain; decreased Cardiac Output; ineffective Airway Clearance; and risk for Infection. As the client progresses, needs may shift to risk for Activity Intolerance; deficient Knowledge (Learning Need) (specify); and ineffective Role Performance.

CLIENT DIAGNOSTIC STATEMENT: the outcome of the diagnostic reasoning process; a three-part statement identifying the client's need, the cause of the need (or human response of concern), and the associated signs/symptoms. Distinguishing between Medical and Nursing Diagnoses….

- **Medical Diagnoses** are illnesses/conditions, such as diabetes, heart failure, hepatitis, cancer, and pneumonia, that reflect alteration of the structure or function of organs/systems and are verified by medical diagnostic studies. The medical diagnosis usually does not change
- **Nursing Diagnoses** address human responses to actual and potential health problems/life processes, such as Activity Intolerance (specify level); Health Maintenance, ineffective; Airway Clearance, ineffective; Self Care deficit (specify). The nursing diagnoses change as the client's situation or perspective changes/resolves.

The Use of Nursing Diagnoses

Although not yet comprehensive, the current NANDA list of diagnostic labels defines/refines professional nursing activity. The list of labels is now at a point where nurses need to use the proposed diagnoses on a daily basis, becoming familiar with the parameters of each individual diagnosis and identifying its strengths and weaknesses, thus promoting research and further development.

A frequently asked question is "Why should we use a nursing diagnosis … what is its value to the nursing profession?" The use of a nursing diagnosis can provide many benefits. The accurate choice of a nursing diagnosis to label a client need:

- **Gives Nurses a Common Language:** Promotes improved communication among nurses, other healthcare providers, and alternate care settings.

  FOR EXAMPLE: Using the nursing diagnosis "ineffective Airway Clearance"

TABLE 3–1. **Nursing Diagnoses (accepted for use and research [2001])**

Activity Intolerance [specify level]
Activity Intolerance, risk for
Adjustment, impaired
Airway Clearance, ineffective
Allergy, latex
Allergy, latex, risk for
Anxiety [specify level]
Anxiety, death
Aspiration, risk for
Attachment, risk for impaired parent/infant/child
Autonomic Dysreflexia
Autonomic Dysreflexia, risk for

Body Image, disturbed
Body Temperature, risk for imbalanced
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
Conflict, decisional (specify)
Confusion, acute
Confusion, chronic
Constipation
Constipation, perceived
Constipation, risk for
Coping, community, ineffective
Coping, community, readiness for enhanced
Coping, defensive
Coping, ineffective
Coping, family: compromised
Coping, family: disabling
Coping, family: readiness for enhanced

Denial, ineffective
Dentition, impaired
Development, risk for delayed
Diarrhea
Disuse Syndrome, risk for
Diversional Activity, deficient

Energy Field, disturbed
Environmental Interpretation Syndrome, impaired

Failure to Thrive, adult
Falls, risk for
Family Processes, dysfunctional: alcoholism
Family Processes, interrupted
Fatigue
Fear
[Fluid Volume, deficient (hyper/hypotonic)]
Fluid Volume, deficient [isotonic]
Fluid Volume, excess
Fluid Volume, risk for deficient
Fluid Volume, risk for imbalanced

Gas Exchange, impaired
Grieving, anticipatory
Grieving, dysfunctional
Growth, risk for disproportionate
Growth & Development, delayed

Health Maintenance, ineffective
Health-Seeking Behaviors [specify]
Home Maintenance, impaired
Hopelessness
Hyperthermia
Hypothermia

Infant Behavior, disorganized
Infant Behavior, readiness for enhanced, organized
Infant Behavior, risk for disorganized
Infant Feeding Pattern, ineffective
Infection, risk for
Injury, risk for
Injury, risk for perioperative positioning
Intracranial Adaptive Capacity, decreased

Knowledge, deficient [Learning Need] [specify]

TABLE 3–1. **Nursing Diagnoses (accepted for use and research [2001])** (Continued)

Loneliness, risk for

Memory, impaired
Mobility, impaired bed
Mobility, impaired physical
Mobility, impaired wheelchair
Nausea
Noncompliance [Adherence, ineffective] [specify]
Nutrition: imbalanced, less than body requirements
Nutrition: imbalanced, more than body requirements
Nutrition: imbalanced, risk for more than body requirements

Oral Mucous Membrane, impaired

Pain, acute
Pain, chronic
Parental Role Conflict
Parenting, impaired
Parenting, risk for impaired
Peripheral Neurovascular Dysfunction, risk for
Personal Identity, disturbed
Poisoning, risk for
Post-Trauma Syndrome
Post-Trauma Syndrome, risk for
Powerlessness
Powerlessness, risk for
Protection, ineffective

Rape-Trauma Syndrome
Rape-Trauma Syndrome: compound reaction
Rape-Trauma Syndrome: silent reaction
Relocation Stress Syndrome
Role Performance, ineffective

Self Care Deficit, bathing/hygiene
Self Care Deficit, dressing/grooming
Self Care Deficit, feeding
Self Care Deficit, toileting
Self Esteem, chronic low
Self Esteem, risk for situational low
Self Esteem, situational low
Self Mutilation
Self Mutilation, risk for
Sensory Perception, disturbed (specify: visual, auditory, kinesthetic, gustatory, tactile, olfactory)
Sexual Dysfunction
Sexuality Patterns, ineffective
Skin Integrity, impaired
Skin Integrity, risk for impaired
Sleep Deprivation
Sleep Pattern, disturbed
Social Interaction, impaired
Social Isolation
Sorrow, chronic
Spiritual Distress
Spiritual Distress, risk for
Spiritual Well-being, readiness for enhanced
Suffocation, risk for
Suicide, risk for
Surgical Recovery, delayed
Swallowing, impaired

Therapeutic Regimen: community, ineffective management
Therapeutic Regimen: family, ineffective management
Therapeutic Regimen, effective management
Therapeutic Regimen, ineffective management
Thermoregulation, ineffective
Thought Processes, impaired
Tissue Integrity, impaired
Tissue Perfusion, ineffective (specify type: cerebral, cardiopulmonary, renal, gastrointestinal, peripheral)
Transfer Ability, impaired
Trauma, risk for

Unilateral Neglect
Urinary Elimination, impaired

(*Continued*)

TABLE 3–1. **Nursing Diagnoses (accepted for use and research [2001])** (Continued)

Urinary Incontinence, functional	Ventilation, impaired spontaneous
Urinary Incontinence, reflex	Ventilatory Weaning Response, dysfunctional
Urinary Incontinence, stress	Violence, [actual/]risk for, directed at others
Urinary Incontinence, total	Violence, [actual/]risk for, self-directed
Urinary Incontinence, risk for urge	
Urinary Incontinence, urge	Walking, impaired
Urinary Retention [acute/chronic]	Wandering [specify sporadic or continual]

Information that appears in brackets has been added by the authors to clarify and facilitate the use of nursing diagnoses.

SIGN: objective or observable evidence or manifestation of a health need.

SYMPTOM: subjectively perceptible change in the body or its functions that indicates disease or the kind or phases of disease.

REMEMBER …nursing diagnoses may represent a physical, sociological, or psychological finding. **Physical Nursing Diagnoses** include those that pertain to circulation (e.g., ineffective peripheral Tissue Perfusion), ventilation (e.g., ineffective Airway Clearance), elimination (e.g., Constipation), and so on.

instead of saying "difficulty breathing" conveys a distinct image. When the former is heard, a clear picture begins to develop in your mind, as your thoughts focus on the musculature of the upper airway, mucus production, and cough effort. With the second label, you do not have a clear idea as to what is happening with this client, and you question whether the client is experiencing an airway maintenance problem, movement of the chest, or perfusion to the lungs.

This improved communication may result in improved quality and continuity of the care provided to the client.

- **Promotes Identification of Appropriate Goals:** Aids in the choice of correct nursing interventions to alleviate the identified need and provides guidance for evaluation. Whereas nursing actions were once based on variables such as SIGNS and SYMPTOMS, test results, or a medical diagnosis, nursing diagnosis is a uniform way of identifying, focusing on, and dealing with specific client responses to health and illness (i.e., the phenomena of concern for nurses).

  FOR EXAMPLE: "Risk for Infection" compared with "presence of urinary catheter." The risk or potential threat of an infection brings to mind specific goals/outcomes and interventions to protect the client, but what is your concern, if any, with the urinary catheter?

- **Provides Acuity Information:** Ranks the amount of work that involves nursing care and can serve as a basis for client classification systems. This method of ranking can be used to determine individual staffing needs. It can also serve as documentation to provide justification for third-party reimbursement.

  FOR EXAMPLE: Nursing diagnoses can be given different, weighted values according to the degree of nursing involvement required; that is, "impaired Gas Exchange" may require a considerable amount of skilled nursing time to promote adequate ventilation, to provide oxygen and respiratory treatments, and to monitor laboratory studies. "Acute Urinary Retention" may require a much shorter period to insert a catheter into the bladder and periodically measure the urine output.

In addition, some third-party payors (such as Medicare and other insurance companies) include nursing diagnoses when considering extended length of stay or delayed discharge.

- **Can Create a Standard for Nursing Practice:** Provides a foundation for quality assurance programs, a means of evaluating nursing practice, and a mechanism of costing-out delivery of nursing care.

  FOR EXAMPLE: Did the nursing interventions address and resolve the need? Did the client experience the desired result (e.g., alleviation of pain)? Were the goals met, or is there documentation of the reasons why they were not met? Were the expected outcomes changed to meet changing client needs?

- **Provides a Quality Improvement Base:** Clinicians, administrators, educators, and researchers can document, validate, or alter the process of care delivery, which then improves the profession.

  FOR EXAMPLE: The use of universally understood labels enhances retrieval of specific data for review to determine accuracy, to validate and/or change nursing actions related to specific nursing diagnoses, and to evaluate an individual nurse's performance.

Psychosocial Nursing Diagnoses include those that pertain to the mind (e.g., disturbed Thought Processes), emotion (e.g., Anxiety [specify level]), or lifestyle/relationships (e.g., ineffective Sexuality Patterns, or Social Isolation).

Identifying Client Needs

During the **ASSESSMENT** step, the collection, clustering, and validation of client data flow directly into the **DIAGNOSIS** or **NEED IDENTIFICATION** step of the nursing process, where you sense needs or problems and choose nursing diagnoses.

DIAGNOSTIC REASONING: ANALYZING THE CLIENT DATABASE

Identifying client needs and then selecting a nursing diagnosis label involves the use of experience, expertise, and intuition on your part. There are six steps involved in need identification that constitute the activities of diagnostic reasoning. The result is the creation of a client diagnostic statement that identifies the client need, suggests its potential cause or etiology, and notes its signs and symptoms. This is known as the **PES** format, reflecting **P**roblem, **E**tiology, and **S**igns/symptoms (Gordon, 1976).

PES: format for combining a nursing diagnosis label, client-specific cause, and signs/symptoms to create an individualized diagnostic statement.
CUE: a signal that indicates a possible need/direction for care.

Step 1: Problem-Sensing

Data are reviewed and analyzed to identify **CUES** (signs and symptoms) suggesting client needs that can be described by nursing diagnosis labels. If the data have been recorded in a nursing format (e.g., Diagnostic Divisions or Functional Health Patterns), the nurse is automatically guided to specific groups of nursing diagnoses when certain cues from the data are identified (Box 3–1). This helps to focus attention on appropriate diagnoses. Reviewing the NANDA definitions of specific diagnoses (see Appendix A) can be of further assistance in deciding between two or more similar diagnostic labels; for instance, there are five different diagnoses for urinary incontinence (see step 4).

FOR EXAMPLE: When the Diagnostic Divisions format is used, body temperature is recorded in the Safety section. When the client's temperature rises, the nurse reviews the diagnostic labels under Safety to find a possible fit, such as Hyperthermia or risk for Infection. At the same time, cues are noted in other

BOX 3–1

Nursing Diagnoses Organized According to Diagnostic Divisions

After data have been collected and areas of concern/need identified, consult the Diagnostic Divisions framework to review the list of nursing diagnoses that fall within the individual categories. This will assist with the choice of specific diagnostic labels to accurately describe data from the client database. Then, with the addition of etiology (when known) and signs and symptoms, the client diagnostic statement emerges.

Diagnostic Division: Activity/Rest

Ability to engage in necessary/desired activities of life (work and leisure) and to obtain adequate sleep/rest

Diagnoses

Activity Intolerance [specify level]
Activity Intolerance, risk for
Disuse Syndrome, risk for
Diversional Activity, deficient
Fatigue
Mobility, impaired bed
Mobility, impaired wheelchair
Sleep Deprivation
Sleep Pattern, disturbed
Transfer Ability, impaired
Walking, impaired

Diagnostic Division: Circulation

Ability to transport oxygen and nutrients necessary to meet cellular needs

Diagnoses

Autonomic Dysreflexia
Autonomic Dysreflexia, risk for
Cardiac Output, decreased
Intracranial Adaptive Capacity, decreased
Tissue Perfusion, ineffective (specify type: cerebral, cardiopulmonary, renal, gastrointestinal, peripheral)

Diagnostic Division: Ego Integrity

Ability to develop and use skills and behaviors to integrate and manage life experiences

Nursing Diagnoses Organized According to Diagnostic Divisions

Diagnoses

Adjustment, impaired
Anxiety [specify level]
Anxiety, death
Body Image, disturbed
Conflict, decisional (specify)
Coping, defensive
Coping, ineffective
Denial, ineffective
Energy Field, disturbed
Fear
Grieving, anticipatory
Grieving, dysfunctional
Hopelessness
Personal Identity, disturbed
Post-Trauma Syndrome
Post-Trauma Syndrome, risk for
Powerlessness
Powerlessness, risk for
Rape-Trauma Syndrome
Rape-Trauma Syndrome: compound reaction
Rape-Trauma Syndrome: silent reaction
Relocation Stress Syndrome
Relocation Stress Syndrome, risk for
Self-Esteem, chronic low
Self-Esteem, risk for situational low
Self-Esteem, situational low
Sorrow, chronic
Spiritual Distress
Spiritual Distress, risk for
Spiritual Well-being, readiness for enhanced

Diagnostic Division: Elimination

Ability to excrete waste products

(Continued)

Nursing Diagnoses Organized According to Diagnostic Divisions (Continued)

Diagnoses

Bowel Incontinence
Constipation
Constipation, perceived
Constipation, risk for
Diarrhea
Urinary Elimination, impaired
Urinary Incontinence, functional
Urinary Incontinence, reflex
Urinary Incontinence, risk for urge
Urinary Incontinence, stress
Urinary Incontinence, total
Urinary Incontinence, urge
Urinary Retention [acute/chronic]

Diagnostic Division: Food/Fluid

Ability to maintain intake of and use nutrients and liquids to meet physiological needs

Diagnoses

Breastfeeding, effective
Breastfeeding, ineffective
Breastfeeding, interrupted
Dentition, impaired
Failure to Thrive, adult
Fluid Volume, deficient [hyper/hypotonic]
Fluid Volume, deficient [isotonic]
Fluid Volume, excess
Fluid Volume, risk for deficient
Fluid Volume, risk for imbalanced
Infant Feeding Pattern, ineffective
Nausea
Nutrition: imbalanced, less than body requirements
Nutrition: imbalanced, more than body requirements
Nutrition: imbalanced, risk for more than body requirements
Oral Mucous Membrane, impaired
Swallowing, impaired

Diagnostic Division: Hygiene

Ability to perform basic activities of daily living

Nursing Diagnoses Organized According to Diagnostic Divisions

Diagnoses

Self-Care Deficit, bathing/hygiene
Self-Care Deficit, dressing/grooming
Self-Care Deficit, feeding
Self-Care Deficit, toileting

Diagnostic Division: Neurosensory

Ability to perceive, integrate, and respond to internal and external cues

Diagnoses

Confusion, acute
Confusion, chronic
Infant Behavior, disorganized
Infant Behavior, readiness for enhanced, organized
Infant Behavior, risk for disorganized
Memory, impaired
Peripheral Neurovascular Dysfunction, risk for
Sensory Perception, disturbed (specify: visual, auditory, kinesthetic, gustatory, tactile, olfactory)
Thought Processes, disturbed
Unilateral Neglect

Diagnostic Division: Pain/Discomfort

Ability to control internal/external environment to maintain comfort

Diagnoses

Pain, acute
Pain, chronic

Diagnostic Division: Respiration

Ability to provide and use oxygen to meet physiological needs

Diagnoses

Airway Clearance, ineffective
Aspiration, risk for
Breathing Pattern, ineffective
Gas Exchange, impaired
Ventilation, impaired spontaneous
Ventilatory Weaning Response, dysfunctional

(Continued)

Nursing Diagnoses Organized According to Diagnostic Divisions (Continued)

Diagnostic Division: Safety

Ability to provide safe, growth-promoting environment

Diagnoses

Allergy Response, latex
Allergy Response, risk for latex
Body Temperature, risk for imbalanced
Environmental Interpretation Syndrome, impaired
Falls, risk for
Home Maintenance, impaired
Health Maintenance, ineffective
Hyperthermia
Hypothermia
Infection, risk for
Injury, risk for
Injury, risk for perioperative positioning
Mobility, impaired physical
Poisoning, risk for
Protection, ineffective
Self-Mutilation
Self-Mutilation, risk for
Skin Integrity, impaired
Skin Integrity, risk for impaired
Suffocation, risk for
Surgical Recovery, delayed
Thermoregulation, ineffective
Tissue Integrity, impaired
Trauma, risk for
Violence, [actual/]risk for, directed at others
Violence, [actual/]risk for, self-directed
Wandering [specify sporadic or continual]

Diagnostic Division: Sexuality

(Component of Ego Integrity and Social Interaction) Ability to meet requirements/characteristics of male/female role

Diagnoses

Sexual Dysfunction
Sexuality Patterns, ineffective

Nursing Diagnoses Organized According to Diagnostic Divisions

Diagnostic Division: Social Interaction

Ability to establish and maintain relationships

Diagnoses

Attachment, risk for impaired parent/infant/child
Caregiver Role Strain
Caregiver Role Strain, risk for
Communication, impaired verbal
Coping, community, ineffective
Coping, community, readiness for enhanced
Coping, family: compromised
Coping, family: disabling
Coping, readiness for enhanced
Family Processes, dysfunctional: alcoholism
Family Processes, interrupted
Loneliness, risk for
Parental Role Conflict
Parenting, impaired
Parenting, risk for impaired
Role Performance, ineffective
Social Interaction, impaired
Social Isolation

Diagnostic Division: Teaching/Learning

Ability to incorporate and use information to achieve healthy lifestyle/optimal wellness

Diagnoses

Development, risk for delayed
Growth, risk for disporportionate
Growth and Development, delayed
Health-Seeking Behaviors [specify]
Knowledge, deficient [Learning Need] [specify]
Noncompliance [Adherence, ineffective] [specify]
Therapeutic Regimen: community, ineffective management
Therapeutic Regimen: family, ineffective management
Therapeutic Regimen, effective management
Therapeutic Regimen, ineffective management

sections of the database that may be combined with fever or may be totally unrelated. In fact, cues may have relevance in more than one section, as you can see in Box 3–2.

BOX 3–2

Walking Through the Use of Diagnostic Divisions

During the Assessment phase, the following data were obtained from Robert:

Activity/Rest

Reports (Subjective)

Occupation: Retired truck driver
Usual Activities/Hobbies: Used to like to hunt and fish
Leisure Time Activities: Mostly watches baseball on TV, takes short walks—one to two blocks
Feelings of Boredom/Dissatisfaction: "Wish I could do more; just getting too old"
Limitations Imposed by Condition: "I get short of breath; stay at home mostly"
Sleep: Hours: 5 **Naps:** After lunch **Aids:** None
Insomnia: Only if short of breath (1 or 2 ×/wk) or needs to void (1 ×/night)
Rested on Awakening: Not always; "feel weak most of the time"
Other: "Sometimes, it feels like there isn't enough air"

Exhibits (Objective)

Observed Response to Activity: Cardiovascular: BP 178/102, P 100 after walking half-length of corridor from floor scale
Respiratory: 32, rapid, leaning forward ("to catch breath")
Mental Status (i.e., withdrawn/lethargic): Alert, responding to all questions
Neuromuscular Assessment: Muscle mass/tone: Decreased/bilaterally equal/diminished Posture: Leans forward to breathe
Tremors: No **ROM:** Movement in all extremities **Strength:** Moderate
Deformity: No

Having previously noted respiratory cues of dyspnea with activity when you reviewed the respiratory data in Box 2–3, you return to the Activity/Rest section of the Diagnostic Divisions, where the effects/limitations of this condition on both activity and sleep would also be considered. You are referred to the following nursing diagnoses: Activity Intolerance [specify level]; Activity Intolerance, risk for; Mobility, impaired bed; Disuse Syndrome, risk for; Diversional Activity, deficient; Fatigue; Sleep Deprivation; Sleep Pattern, disturbed; Walking, impaired; Mobility, impaired wheelchair; and Transfer Ability, impaired, as possible choices to describe or label Robert's needs.

Step 2: Rule-Out Process

Alternative explanations are considered for the identified cues to determine which nursing diagnosis label may be the most appropriate. This step is crucial in establishing an adequate list of diagnostic statements. As you compare and contrast the relationships among and between data, etiologic factors are identified within or between categories based on an understanding of the biologic, physical, and behavioral sciences.

FOR EXAMPLE: Although Hyperthermia or risk for Infection was suggested during the first step of diagnostic reasoning, another consideration might be deficient Fluid Volume. In another example, cues of increased tension, restlessness, elevated pulse rate, and reported apprehension may initially be thought to indicate Anxiety (specify level). However, a similar diagnosis of Fear should be considered, as well as the possibility that these cues may be physiologically based, requiring medical treatment and nursing interventions related to education and monitoring.

If you encounter difficulty in choosing a nursing diagnosis label, asking yourself the following questions may provide additional guidance:

1. What are my concerns about this client?
2. Can I/am I doing something about it?
3. Can the overall risk be reduced by nursing intervention?

For example, in the teen client with bulimia, electrolyte imbalance may occur. Questions to ask might be:

- What is a major concern about electrolyte imbalance?

The client may develop a cardiac dysrhythmia or even arrest.

- Can I do something about it?

Monitor signs of imbalance, encourage foods/fluids rich in necessary electrolytes, administer supplements, and educate client regarding nutritional needs.

- Can the overall risk be reduced by nursing interventions?

Yes, the risk of cardiac dysrhythmias can be reduced if electrolyte balance is maintained/restored.

Conclusion: The Nursing Diagnosis would be risk for decreased Cardiac Output; and the client diagnostic statement would be risk for decreased Cardiac Output, risk factor of decreased potassium intake/excessive loss.

Step 3: Synthesizing the Data

A view of the data as a whole (including information collected by other members of the healthcare team) can provide a comprehensive picture of the client in relation to past, present, and future health status. This is called **SYNTHESIZING** the data. The suggested nursing diagnosis label is combined with the identified related factor(s) and cues to create a hypothesis.

SYNTHESIZING: reviewing all data as a whole to obtain a comprehensive picture of the client.

FOR EXAMPLE: Sally had a period of bleeding during delivery of the placenta following the unexpected delivery of twins. Blood loss was estimated to be approximately 600 ml. In addition, she experienced several episodes of vomiting

before delivery and reduced oral intake because of nausea. The nursing diagnosis label: deficient Fluid Volume (isotonic); related factors of hemorrhage, vomiting, poor oral intake; cues of dark urine, dry mouth/lips, low blood pressure.

Step 4: Evaluating or Confirming the Hypothesis

ETIOLOGY: identified causes and/or contributing factors responsible for the presence of a specific client need.

RELATED FACTOR: the conditions/circumstances that contribute to the development/maintenance of a nursing diagnosis; forms the "related to" component of the client diagnostic statement.

RISK FACTOR: environmental factors and physiological, psychological, genetic, or chemical elements that increase the vulnerability of an individual, family, or community to an unhealthy event.

Test the hypothesis for appropriate fit; that is, review the NANDA nursing diagnosis and definition. Then, compare the assessed possible **ETIOLOGY** with NANDA's **RELATED FACTORS** or **RISK FACTORS.** Next, compare the assessed client cues with NANDA's Defining Characteristics, which are used to support and provide an increased level of confidence in your selected nursing diagnosis. Appendix A provides a complete listing of NANDA nursing diagnostic labels, definitions, defining characteristics, and related factors. This listing will be helpful as you work through the Practice Activities and Work Pages contained in each chapter. Take a moment to review Box 3–3. The information contained within the box provides a beginning effort in assessing the appropriateness of a specific nursing diagnosis label.

Lunney (1989, 1990) addressed the self-monitoring task of accuracy determination, defining the characteristics of accuracy and providing an ordinal scale for measurement. The scale ranges from a high assigned accuracy point value describing a diagnosis that is consistent with all the cues, to the lowest point value, which describes a diagnosis indicated by more than one cue but recommended for rejection based on the presence of at least two disconfirming cues (see Appendix F).

BOX 3–3

Elements of NANDA Nursing Diagnostic Labels

Appendix A supplies a complete listing of NANDA nursing diagnosis labels, which will be helpful to you as you work through the exercises in this chapter and throughout the book. It is important to become familiar with this list, so that you can find information quickly in the clinical setting. Take a moment to identify the key elements of the diagnostic label, "Deficient Fluid Volume" as excerpted below.

Deficient Fluid Volume [isotonic]

Definition: Decreased intravascular, interstitial, and/or intracellular fluid. This refers to dehydration—water loss alone without change in sodium.
Related Factors: Active fluid volume loss, failure of regulatory mechanisms.
Defining Characteristics: Decreased urine output; increased urine concentration; weakness; sudden weight loss (except in third-spacing); decreased venous filling; increased body temperature; change in mental state; elevated hematocrit; decreased skin/tongue turgor; dry skin/mucous membranes; thirst; increased pulse rate; decreased blood pressure; decreased pulse volume/pressure.

Additionally, Appendix G, Lunney's Integrated Model for Self-Monitoring of Accuracy of the Diagnostic Process, is an excellent self-evaluation of your progress in diagnostic efforts. (Also, a separate section in the Suggested Readings is dedicated to the topic of accuracy of nursing diagnoses.) The completed evaluation provides feedback regarding your diagnostic abilities. Reflection and self-monitoring are tools to assist you in developing your critical thinking skills. The attention you give to measuring the accuracy of your suggested nursing diagnosis is time well spent. Comparing the subjective and objective data gathered from the client with the defining characteristics of the possible nursing diagnoses that are listed not only helps ensure the accuracy of your statement, but also stresses the importance of objectivity in this diagnostic process.

Now return to Box 3–2. In reviewing Robert's database, you sense that he may have a problem with activity. After reviewing the NANDA nursing diagnosis labels and definitions relevant to the Activity/Rest Diagnostic Division, you choose risk for Activity Intolerance. Next, to confirm your hypothesis, compare the cues from the database with the related factors and defining characteristics noted in Appendix A. Practice Activity 3–1 presents an Interactive Care Plan Worksheet for the client problem of Activity Intolerance, on which you can document the identified cues.

Step 5: List the Client's Needs

Based on the data obtained from steps 3 and 4, the accurate nursing diagnosis label is combined with the assessed etiology and signs/symptoms, if present, to finalize the client diagnostic statement.

FOR EXAMPLE, Sally is diagnosed with deficient Fluid Volume (isotonic) related to hemorrhage, vomiting, reduced intake as evidenced by dark urine, dry mucous membranes, hypotension, and hemoconcentration. This individualized diagnosis reflects the PES format for a three-part diagnostic statement, as described in Box 3–4. A diagnostic statement is needed for each need or problem you identify. Take a moment here to complete Practice Activity 3–2.

Step 6: Re-evaluate the Problem List

Be sure all areas of concern are noted. Once all nursing diagnoses are identified, list them according to priority and classify them according to status: an actual need; a risk need; or a resolved need.

- **Actual Diagnoses:** describe human responses to health conditions/life processes that currently exist in an individual, family, or community. They are supported by defining characteristics (manifestations/signs and symptoms) that cluster in patterns of related cues or inferences (NANDA, 2001). They are expressed by the use of a three-part PES statement.

  FOR EXAMPLE: A client is admitted for a medical workup because of difficulties with bladder function related to her diagnosis of multiple sclerosis. An actual diagnosis might be Urinary Retention.

PRACTICE ACTIVITY 3–1

Record the cues from Box 3–2 that are relevant to the problem of Activity Intolerance, identified for Robert, in the appropriate spaces on this worksheet.

INTERACTIVE CARE PLAN WORKSHEET **Student Name:**

ACTIVITY INTOLERANCE		Client's Medical Diagnosis:
DEFINITION:		Insufficient physiological or psychological energy to endure or complete required or desired daily activities.
DEFINING CHARACTERISTICS:		Verbal report of fatigue or weakness; abnormal heart rate or blood pressure response to activity; exertional discomfort or dyspnea; ECG changes reflecting dysrhythmias or ischemia.
RELATED FACTORS:		Bedrest and/or immobility; generalized weakness; sedentary lifestyle; imbalance between oxygen supply and/or demand.
STUDENT INSTRUCTIONS:		In the space below, enter the subjective and objective data gathered during your client assessment.
ASSESSMENT	**Subjective Data Entry**	**Objective Data Entry**
	TIME OUT!	**Student Instructions:** To be sure your client diagnostic statement written below is accurate, you need to review the defining characteristics and related factors associated with the nursing diagnosis and see how your client data match. Do you have an accurate match or are additional data required, or does another nursing diagnosis need to be investigated?
DIAGNOSIS	**CLIENT DIAGNOSTIC STATEMENT:**	**Activity Intolerance (specify)** _____ _____ **Related to** _____ _____ _____

BOX 3–4

Components of the Client Diagnostic Statement: Problem (Need), Etiology, and Signs and Symptoms (PES)

P = Problem (Need) is the name or diagnostic label identified from the NANDA list. The key to accurate nursing diagnosis is need identification that focuses attention on a current risk or potential physical or behavioral response to health or illness that may interfere with the client's quality of life. It deals with concerns of the client/significant other(s) and the nurse that require nursing intervention and management.

E = Etiology is the suspected cause or reason for the response that has been identified from the assessment (client database). The nurse makes inferences based on knowledge and expertise, such as understanding of pathophysiology, and situational or developmental factors. The etiology is stated as "related to." *Note:* One problem or need may have several suspected causes, such as Self Esteem, chronic low, related to lack of positive feedback and dysfunctional family system.

S = Signs and Symptoms are the manifestations (or cues) identified in the assessment that substantiate the nursing diagnosis. They are stated as "evidenced by," followed by a list of subjective and objective data. It is important to note that risk diagnoses are not accompanied by signs and symptoms because the need has not yet actually occurred. In this instance, the "S" component of the diagnostic statement is omitted, and the "E" component would be replaced by an itemization of the identified risk factors that suggest that the diagnosis could occur (e.g., risk for Infection, risk factors of Malnutrition and Invasive Procedures).

- **Wellness Diagnoses:** provide another form of an actual diagnosis that has a wellness focus that is more of an opportunity than a need. In such cases, clients (i.e., individuals, family, or community) have an assessed opportunity to improve an aspect of their health or well-being. (**Note:** See section on Wellness and Health Promotion in Suggested Readings.) The diagnostic statement would be written as readiness for enhanced ….

  FOR EXAMPLE: A client's need to improve his or her sense of harmony with others (i.e., family members) could be labeled readiness for enhanced Spiritual Well-being. Or, the family of a client with multiple sclerosis (MS) has been very supportive during periods of exacerbated symptoms; however, they want to learn to optimize the client's health status and enrich their lifestyle. A wellness diagnosis of readiness for enhanced Family Coping is appropriate.

- **Risk Diagnoses:** refer to human responses to health conditions/life processes that may develop in a vulnerable individual, family, or community. They are supported by risk factors that contribute to increased vulnerability (NANDA,

PRACTICE ACTIVITY 3–2
Identifying the PES Components of the Client Diagnostic Statement

Instructions (questions 1–5): Identify the "PES" components of each of these diagnostic statements:

1. Severe Anxiety, related to changes in health status of fetus/self and threat of death as evidenced by restlessness, tremors, focus on self/fetus.

   P = _____ E = _____ S = _____

2. Disturbed Thought Processes, related to pharmacological stimulation of the nervous system as evidenced by altered attention span, disorientation, and hallucinations.

   P = _____ E = _____ S = _____

3. Ineffective Coping, related to maturational crisis as evidenced by inability to meet role expectations and alcohol abuse.

   P = _____ E = _____ S = _____

4. Hyperthermia, related to increased metabolic rate and dehydration as evidenced by elevated temperature, flushed skin, tachycardia, and tachypnea.

   P = _____ E = _____ S = _____

5. Acute Pain, related to tissue distention and edema as evidenced by verbal reports, guarding behavior, and changes in vital signs.

   P = _____ E = _____ S = _____

6. Explain the difference between actual and risk diagnoses: _____

   _____

7. Give an example of an actual and a risk need for a client with second-degree burns of the hand.

   _____

2001). They represent a need that you believe could develop, but because it has not yet occurred, there are no signs or symptoms—only "risk factors"—so it would be written as a two-part statement.

FOR EXAMPLE: The client's MS has been in remission; however, she has had difficulty in the past with physical mobility. This past problem must be considered when planning this client's care to minimize the possibility of recurrence. A potential problem would then be identified as risk for impaired Physical Mobility.

- **Resolved Diagnoses:** are those that no longer require intervention. Because the need no longer exists, no diagnostic statement is needed.

BOX 3–5

Potential Errors in Choosing a Nursing Diagnosis

- **Overlooking Cues** resulting in a missed diagnosis can lead to worsening of the problem.

  FOR EXAMPLE: A client reports discomfort at the insertion site of an intravenous (IV) catheter. You notice that the area is slightly reddened but fail to consider the risk for infection. As a result, the client develops sepsis or a blood infection, requiring emergency intervention and longer hospital stay.

- **Making a Diagnosis with an Insufficient Database** can lead in the wrong direction, wasting valuable time and resources.

  FOR EXAMPLE: The client displays signs of anxiety. Without additional assessment, you administer a tranquilizer on the belief that the signs and symptoms are psychologically based. Later, when checking the client, you find signs of cyanosis, suggesting inadequate oxygenation. Thus, the anxiety probably was at least in part physiologically based and needed other nursing interventions.

- **Stereotyping** leads to treatment of all clients in the same way and negates individualization.

  FOR EXAMPLE: In a medical-surgical setting, the assumption is often made that a client with a psychiatric diagnosis is apt to become violent.

FOR EXAMPLE: Your client once suffered a decubitus ulcer (impaired Skin Integrity); however, she has learned techniques to prevent recurrence of this problem, and her skin is in good condition. Therefore, as long as she is able to participate in or direct her own care, this is of no significant concern to you at this time.

Finally, validate the diagnostic conclusions/impressions with the client and/or a colleague. This helps reduce the possibility of **DIAGNOSTIC ERRORS** and/or omissions as discussed in Box 3–5. Inclusion of the client/significant others promotes understanding and participation in the planning of individualized care.

DIAGNOSTIC ERROR: a mistaken assumption leading to a wrong conclusion.

As you can see, the process of need identification is more complex than simply attaching a label to your client. In reviewing the definition of nursing, it can be seen that "the human responses to health and illness" are complex, and the process of accurately diagnosing these human responses attests to the complexity of nursing.

OTHER CONSIDERATIONS FOR NEED IDENTIFICATION

The medical/psychiatric diagnosis can provide a starting point for identifying associated client needs (problem-sensing). Review Box 3–6 for several medical/psychiatric diagnoses with examples of associated nursing diagnoses. Although the presence of a

BOX 3–6

Applicable Nursing Diagnoses Associated with Selected Medical/Psychiatric Disorders

Certain nursing diagnoses may be linked to specific health problems (e.g., medical disorders). This linkage is often presented as choices in a diagnostic database, in various types of clinical pocket manuals, or on preprinted or computerized care planning forms. The purposes are to assist the clinician in rapidly identifying other applicable nursing diagnoses, based on the changing needs of the client, and to develop a decisive plan of care.

Because the nursing process is cyclical and ongoing, other nursing diagnoses may become appropriate as the individual client situation changes. Therefore, you must continually assess, identify, and validate new needs and evaluate the effectiveness of subsequent care. Keep in mind that the client may have needs unrelated to the medical diagnosis.

AIDS (Acquired Immunodeficiency Syndrome)

Risk for Infection, progression to sepsis/opportunistic overgrowth: risk factors may include depressed immune system, inadequate primary defenses, use of antimicrobial agents, broken skin, malnutrition, and chronic disease processes.
Risk for Deficient Fluid Volume: risk factors may include excessive losses (copious diarrhea, profuse sweating, vomiting, hypermetabolic state, and fever) and impaired intake (nausea, anorexia, lethargy).
Fatigue, may be related to disease state, malnutrition, anemia, negative life events, stress/anxiety possibly evidenced by inability to maintain usual routines, decreased performance, lethargy/listlessness, and disinterest in surroundings.

Labor Stage I (Active Phase)

Acute Pain/[Discomfort], may be related to contraction-related hypoxia, dilation of tissues, and pressure on adjacent structures combined with stimulation of both parasympathetic and sympathetic nerve endings, possibly evidenced by verbal reports, guarding/distraction behaviors (restlessness), muscle tension, and narrowed focus.
Impaired Urinary Elimination, may be related to retention of fluid in the prenatal period, increased glomerular filtration rate, decreased adrenal stimulation, dehydration, pressure of the presenting part, and regional anesthesia, possibly evidenced by increased/decreased output, decreased circulating blood volume, spasms of glomeruli and albuminuria, and reduced sensation.
Risk for Ineffective Coping [Individual/Couple]: risk factors may include stressors accompanying labor, personal vulnerability, use of ineffective coping mechanisms, inadequate support systems, and pain.

Applicable Nursing Diagnoses Associated with Selected Medical/Psychiatric Disorders

Fractures

Acute Pain, may be related to movement of bone fragments, muscle spasms, tissue trauma/edema, traction/immobility device, stress, and anxiety, possibly evidenced by verbal reports, distraction behaviors, self-focusing/narrowed focus, facial mask of pain, guarding/protective behavior, alteration in muscle tone, and autonomic responses (changes in vital signs).
Deficient Knowledge [Learning Need] regarding healing process, therapy requirements, potential complications, and self-care needs, may be related to lack of information, possibly evidenced by statements of concern, questions, and misconceptions.
Impaired Physical Mobility, may be related to neuromuscular/skeletal impairment, pain/discomfort, restrictive therapies (bedrest, extremity immobilization), and psychological immobility, possibly evidenced by inability to purposefully move within the physical environment, imposed restrictions, reluctance to attempt movement, limited range of motion, and decreased muscle strength/control.

Depressive Disorders (Mood Disorders)

Major Depression/Dysthymia

Risk for Violence, directed at self/others: risk factors may include depressed mood and feelings of worthlessness and hopelessness.
Anxiety [moderate to severe]/Disturbed Thought Processes, may be related to psychological conflicts, unconscious conflict about essential values/goals of life, unmet needs, threat to self-concept, sleep deprivation, interpersonal transmission/contagion, possibly evidenced by reports of nervousness or fearfulness, feelings of inadequacy, agitation, angry/tearful outbursts, rambling/discoordinated speech, restlessness, hand rubbing or wringing, tremulousness, poor memory/concentration, decreased ability to grasp ideas, inability to follow/impaired ability to make decisions, numerous/repetitious physical complaints without organic cause, ideas of reference, hallucinations/delusions.
Disturbed Sleep Pattern, may be related to biochemical alterations (decreased serotonin levels), unresolved fears and anxieties, and inactivity, possibly evidenced by difficulty in falling/remaining asleep, early morning awakening/awakening later than desired (hypersomnia), reports of not feeling well rested, and physical signs (e.g., dark circles under eyes, excessive yawning).

* A risk diagnosis is not evidenced by signs and symptoms because the problem has not occurred, and nursing interventions are directed at prevention.

Extracted from Doenges, M. E., Moorhouse, M. F., & Geissler-Murr, A. C. (2002). *Nurse's Pocket Guide, Nursing Diagnoses with Interventions*, ed 8 . Philadelphia: F. A. Davis.

medical/psychiatric diagnosis can suggest several nursing diagnoses, these nursing diagnoses must be supported by cues in the client database.

FOR EXAMPLE: In the experience of a myocardial infarction, the client often suffers pain, anxiety, and activity intolerance and requires teaching activities. In addition, the client may be at risk for decreased Cardiac Output, ineffective Tissue Perfusion, and excess Fluid Volume. These needs do not necessarily occur in each client with this condition. One client may actually be pain-free, whereas another could demonstrate a sleep disturbance or report spiritual distress. Therefore, a medical diagnosis can provide an initial point for problem-sensing, but the validity of a nursing diagnosis depends on the presence of individually appropriate supporting data.

The client's or family member's understanding of normal body function, individual expectations (including cultural), or mistaken perceptions may result in the belief that a need exists, even in the absence of diagnostically appropriate supporting data. Even though the need seems to exist only in the mind of the client/significant other, it needs to be addressed and resolved in order to promote optimal wellness and allow the client to focus on the supported needs.

FOR EXAMPLE:

1. The parent of a child with cancer may believe that the child is incapable of self-care activities even though the child's level of function and development would indicate otherwise. This then is not a client problem with self-care but rather the parent's problem—possibly, compromised Family Coping.
2. A female client may believe that sexual desire normally disappears after menopause/hysterectomy, and the fact that it does not indicates to her that something is wrong. Although sexual dysfunction may have occurred, the assessment reveals inadequate information and misconceptions. Therefore, the nursing diagnosis is deficient Knowledge of normal sexual functioning.
3. An elderly, confused client with a diagnosis of Alzheimer's disease is found wandering in the day room. She has soiled herself and is smearing feces on the walls and couch. The problem would not be one of bowel elimination but of disturbed Thought Processes. Interventions would be addressed to behavioral management, rather than only to a bowel control program.

As noted in the previous examples, it is important to "reduce" the need to its basic component in order to focus interventions on the "roots" of the human response. It is also important to take the related factors and the defining characteristics to the lowest "denominator" possible so the client and nurse are better able to formulate individually specific goals/outcomes and can identify more clearly the appropriate interventions/actions to be taken to correct or alleviate the need.

FOR EXAMPLE: Impaired Social Interaction related to neurological impairment and the resulting sequelae (i.e., cognitive, behavioral, and emotional changes) is better stated, "related to skill deficit about ways to enhance mutuality, commu-

nication barriers, limited physical mobility as evidenced by family report of change in pattern of interacting, dysfunctional interactions with peers and family, observed discomfort in social situations." This simplifies care and increases the likelihood of a timely and satisfactory resolution.

Neurological impairment is a broad umbrella that reflects general pathophysiology and lacks the specificity that is necessary to guide nursing actions/interventions. By identifying specific responses, you focus attention directly on issues that can be corrected or altered by nursing interventions.

For beginners, it is advisable to use the NANDA list in Appendix A when choosing a diagnostic label. Because the list is still evolving, "holes" may exist. With practice and experience, you may very well identify a need that is treatable with nursing interventions but for which there is no appropriate NANDA label. In this situation, the diagnosis should be stated clearly using the PES format and then reviewed with other nursing colleagues to verify that the meaning and intent are accurately communicated. Finally, the work should be documented and submitted to NANDA for consideration.

Nursing knowledge is both objective and subjective, and it is the combination of intuition and analysis that guides nursing's methodology. Experienced nurses may use **INTUITION** to arrive at a conclusion as an integral part of critical thinking. This skill is difficult to teach, and it may not develop in all nurses; however, it needs to be respected, valued, and encouraged. Intuition is grounded in both knowledge and experience and is involved in nursing judgments.

INTUITION: a sense of something that is not clearly evidenced by known facts.

Paying attention to the feelings or sense of something for which there are no visible data can add an important dimension to the diagnostic reasoning process. Intuition, responsibly applied by checking, rechecking, and validating these impressions (to avoid errors in judgment), can lead to insights not available in any other way.

Finally, identification of a client's needs may be assisted by entering the client database into a computer. On-line diagnostic software programs are available that contain lists of frequently used nursing diagnoses correlated to specific medical diagnoses. Other programs may suggest possible nursing diagnoses based on cues that the program identifies in the client database. Such programs are support tools and do not eliminate your need to use the diagnostic reasoning process to identify and formulate appropriate client diagnostic statements *independently* of computer recommendations.

Writing a Client Diagnostic Statement: Using PES Format

As NANDA's list of nursing diagnosis labels has increased, issues of **WELLNESS** are being addressed. The focus of a nursing diagnosis is no longer limited solely to "problems" but may also include the client's needs and strength areas for potential enhancement. For this reason, although we use the PES format, we have chosen to identify the outcome of the diagnostic reasoning process as the *Client Diagnostic Statement* instead of the commonly used term *Client Problem*.

WELLNESS: a state of optimal health, physical and psychosocial.

According to the PES format as previously outlined, the problem (need), etiology, and signs and symptoms (or risk factors) are combined into a "neutral" statement that avoids value-laden or judgmental language. The use of ambiguous or judgmental terms such as "too often," "uncooperative," or "manipulative" can lead to misunderstanding on the part of the reader. Clients may become defensive, or readers may be influenced to make an inaccurate or biased decision, resulting in a negative treatment outcome.

The *need* and *etiology* sections of the diagnostic statement are joined by the phrase "related to." Phrases such as "due to" or "caused by" indicate a specific/limited causal link that should therefore be avoided. "Related to" suggests a connection between the nursing diagnosis and the identified factors, leaving open the possibility that there may be other contributing factors not yet recognized.

When writing a diagnostic statement, remember to include qualifiers or quantifiers as appropriate. NANDA has provided for some flexibility of the nursing language by creating a multi-axial taxonomy. An *axis* is defined as a dimension of the human response that is considered in the diagnostic process. The first axis is the diagnostic concept. The other six axes (time, unit of care, age, health status, descriptor, and topology) can be used to modify the diagnostic concept (see Appendix B). Some modifiers are already included in the label.

> **FOR EXAMPLE:** *Ineffective family Coping.* Coping (diagnostic concept) is the principal element or human response of concern. It has been modified by a descriptor (ineffective) and a unit of care (family). Or, in *adult Failure to Thrive*, "adult" reflects an age modifier.

If the term "specify" is noted with a diagnostic label, it is important that the correct information for the individual client be provided to make the communication clear.

> **FOR EXAMPLE:** In *ineffective Tissue Perfusion (specify)*, the modifier to be specified is from the topology axis (e.g., cerebral, renal). However, in the diagnostic label *deficient Knowledge (specify)*, the modifier is actually the area or topic for which the client has deficient knowledge, such as *regarding care of the newborn*. In the case of *Decisional Conflict (specify)*, the modifier is the subject of the conflict or life crisis. The client diagnostic statement might read "Decisional Conflict regarding divorce related to perceived threat to value system as evidenced by vacillation between alternative choices, increased muscle tension, and reports of distress."

PROTOCOL: written guidelines of steps to be taken for providing client care in a particular situation/condition.

COLLABORATIVE PROBLEM: a need identified by another discipline that contains a nursing component requiring nursing intervention and/or monitoring and therefore is an element of the interdisciplinary plan of care.

By definition, nursing diagnoses identify client needs that can be positively affected, or possibly prevented, by nursing actions. Some diagnoses permit greater independent function, whereas others are more collaborative. This may be visualized as a continuum without a fixed midpoint differentiating independent from dependent actions (Fig. 3–1). Furthermore, the extent of independent function is influenced by the individual nurse's experience, level of expertise, and work setting and the presence of established **PROTOCOLS**, or standards of care. For this reason, the authors recommend that nurses identify the nursing component and appropriate interventions for any client need, instead of labeling independent versus **COLLABORATIVE PROBLEMS** or potential complications.

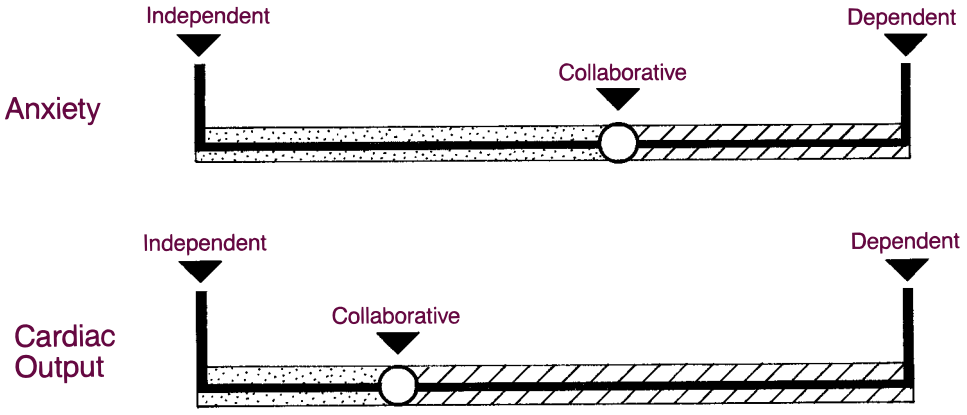

FIGURE 3–1. Representative comparison of the degree of independent nursing function in two nursing diagnoses. Nursing diagnoses have a varying degree of independent function, and nursing actions can be identified for any client situation. As shown in this diagram, the nursing diagnosis Anxiety has a high degree of independent nursing action, whereas Cardiac Output has a lower degree.

FOR EXAMPLE:

- During and following Sally's bleeding episode, the nursing component would be deficient Fluid Volume [isotonic] and the nurse not only would monitor the problem, but would take action to control/prevent further blood loss (e.g., fundal massage), increase fluid intake (oral, IV, or both), and provide assurance to the client.
- A low serum potassium level may result in dysrhythmias that can be addressed in risk for decreased Cardiac Output requiring electrocardiographic (ECG) interpretation, possible limiting of activities, provision of potassium-containing foods/fluids as appropriate, and possibly other interventions based on protocols.
- Michelle has a subclavian intravenous catheter. You might be concerned with risk for Infection with implications for sterile dressing changes, observation of the site, and monitoring of vital signs.

Debate concerning the amount of independent function associated with nursing diagnoses and the interpretation of the definition of nursing diagnoses has been ongoing. These debates attest to the perceived and actual importance that nursing diagnoses have had and continue to have in the structuring of both the education and the practice of nursing. A bifocal model of nursing diagnosis and collaborative problems has existed for many years (Carpenito, 2002; Wallace et al., 1989). Also, a trifocal model of nursing diagnosis (Kelly et al., 1995) that reinforces the wellness diagnoses has been proposed (Fig. 3–2).

In creating a diagnostic statement, it is important to be aware of common errors that can result in an incorrect nursing diagnosis. An incorrect nursing diagnosis or misstatement of needs can lead to incorrect goals/outcomes and inappropriate nursing interventions. This can result in inappropriate/inadequate treatment of the client

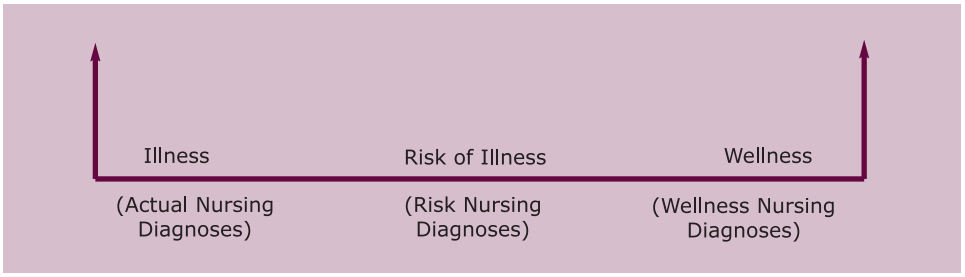

FIGURE 3–2. Trifocal model for client assessment. Adapted from Kelly, Frisch, & Avant, 1995.

that may not resolve the need and that may occasionally place the nurse at risk for legal liability.

- **Using the Medical Diagnosis:** Self Care deficit related to stroke.
  Correct: Self Care deficit related to neuromuscular impairment.
- **Relating the Problem to an Unchangeable Situation:** Risk for Injury related to blindness.
  Correct: Risk for Injury, risk factors of unfamiliarity with surroundings.
- **Confusing the Etiology or Signs/Symptoms for the Need:** Postoperative lung congestion related to bedrest.
  Correct: Ineffective Airway Clearance related to general weakness and immobility.
- **Use of a Procedure Instead of the "Human Response":** Catheterization related to urinary retention.
  Correct: Urinary Retention related to perineal swelling.
- **Lack of Specificity:** Constipation related to nutritional intake.
  Correct: Constipation related to inadequate dietary bulk and fluid intake.
- **Combining Two Nursing Diagnoses:** Anxiety and Fear related to separation from parents.
  Correct: Fear related to separation from parents, or Moderate Anxiety related to change in environment and unmet needs.
- **Relating One Nursing Diagnosis to Another:** Ineffective Coping related to anxiety.
  Correct: Severe Anxiety related to change in role functioning and socioeconomic status.
- **Use of Judgmental/Value-Laden Language:** Chronic Pain related to secondary/monetary gain.
  Correct: Chronic Pain related to recurrent muscle spasms and psychosocial disability.
  Note: The patient's report is valid, but the issue of secondary gain may require additional assessment to reveal other appropriate nursing diagnoses and interventions.
- **Making Assumptions:** Risk for impaired Parenting, risk factors of inexperience (new mother).

Correct: Deficient Knowledge regarding child care issues related to lack of previous experience, unfamiliarity with resources.
Note: The label "Deficient Knowledge" can have negative connotations for the client and may result in defensive responses. The authors support the use of a substitute label "Learning Need."

- **Writing a Legally Inadvisable Statement:** Impaired Skin Integrity related to not being turned every 2 hours.
  Correct: Impaired Skin Integrity related to prolonged pressure and altered circulation.
  Note: If a client complication occurs as a result of poor care/failure to meet standards of care, an incident report would be completed to document what happened.

With this in mind, review In a Nutshell before proceeding to Practice Activity 3–3.

In a Nutshell …

How to Write a Client Diagnostic Statement

1. Using physical assessment and history-taking interview techniques, collect both subjective and objective data from the client, significant other, family members, other healthcare professionals, and/or client records as appropriate. A nursing framework is recommended, such as Diagnostic Divisions (Doenges and Moorhouse) or Functional Health Patterns (Gordon).
2. Organize the collected data using a nursing framework (see item 1, above), a body systems approach (cardiovascular, gastrointestinal, and so on), a head-to-toe review (head, neck, thorax, and so on), or a combination of these. Your institution may use its own clustering model. If you have used a nursing framework, however, you will discover that information in the client database is already conveniently structured for ease in identifying applicable nursing diagnoses.
3. Using diagnostic reasoning skills, review and analyze the database to identify cues (signs and symptoms) suggesting needs that can be described by nursing diagnostic labels. Check the NANDA definitions of specific diagnoses for further assistance in distinguishing between two or more potentially applicable labels (see Appendix A).
4. Consider alternative rationales for the identified cues by comparing and contrasting the relationships among and between data, and isolating etiologic factors. This will allow you to determine which nursing diagnostic labels may be most appropriate, while ruling out those that are not.
5. Test your selection of nursing diagnostic label(s) and associated etiology(ies) for appropriate "fit" by:
   - Confirming the NANDA nursing diagnosis and definition for your choice of diagnostic label [P]
   - Comparing your proposed etiology with the NANDA "Related Factors" or "Risk Factors" associated with that particular diagnosis [E]

(*Continued*)

In a Nutshell … *(Continued)*

- Comparing your identified signs and symptoms (cues) with the NANDA "Defining Characteristics" for the selected diagnosis [S]

6. Re-evaluate your list of selected diagnoses to be sure that all client needs are accounted for. Then, order your list according to a needs priority model (the Maslow or Kalish model is usually used) with validation from the client, and classify each diagnosis as actual (signs and symptoms supporting it are already present), risk for (risk factors are present, but the problem has not yet occurred), potential for enhanced (there is a desire to move to a higher state), or resolved (need no longer requires nursing action).
7. Write the client diagnostic statement for each diagnosis on your list. A three-part statement using the PES format is indicated for actual or wellness diagnoses, and an adaptation of the PES format is used to create the two-part statement for risk diagnoses. Resolved diagnoses do not require diagnostic statements.

Three-Part Client Diagnostic Statement

To write the client diagnostic statement for actual/wellness diagnoses, combine (1) the confirmed nursing diagnosis label [P], (2) related factors [E], and (3) defining characteristics [S]. These elements are linked together by the phrases "related to" and "as evidenced by":

NEED (PROBLEM): [nursing diagnostic label]
ETIOLOGY: Related to [etiologic factors]
SIGNS AND SYMPTOMS: As evidenced by [defining characteristics]

Two-Part Client Diagnostic Statement

To write the diagnostic statement for risk diagnoses, combine (1) the confirmed risk nursing diagnosis label [P] and (2) the associated risk factors [E]. These elements are linked together by the phrase "risk factors of."

NEED (PROBLEM): [risk nursing diagnosis label]
ETIOLOGY: Risk factors of [associated risk factors]

Finally, although the PES format is a commonly recognized way of structuring the client diagnostic statement, other formats may be appropriate when a different standardized language is used. For example, the Omaha System identifies four levels of a diagnostic statement: Level 1—Domain, Level 2—Problem Classification, Level 3—Modifier, and Level 4—Signs/Symptoms (Box 3–7).

Summary

Although identification of an accurate nursing diagnosis requires time to analyze the gathered data and to validate the diagnosis, this process is critical and essential because it is the pivotal part of the nursing process. The time you take to formulate an accurate client diagnostic statement and to plan the required care results in increased nursing efficiency, better use of time for all nursing staff, and the delivery of appropriate client care, with the end result of better client outcomes.

PRACTICE ACTIVITY 3–3
Identifying Correct and Incorrect Client Diagnostic Statements

Label each client diagnostic statement as correct or incorrect. Identify why a statement is incorrect

____ **1.** Ineffective Airway Clearance, related to increased pulmonary secretions and bronchospasm, evidenced by wheezing, tachypnea, and ineffective cough. _____

_____

____ **2.** Impaired Thought Processes, related to delusional thinking or reality base, evidenced by persecutory thoughts of "I am victim," and interference with ability to think clearly and logically. _____

_____

____ **3.** Impaired Gas Exchange, related to bronchitis, evidenced by rhonchi, dyspnea, and cyanosis. _____

_____

____ **4.** Deficient Knowledge regarding diabetic care, related to inaccurate follow-through of instructions, evidenced by information misinterpretation and lack of recall. _____

_____

____ **5.** Acute Pain, related to tissue distention and edema, evidenced by reports of severe colicky pain in right flank, elevated pulse and respirations, and restlessness. _____

_____

Some nurses still organize care directly around medical diagnoses, spending most of their time following medical orders. Medical diagnoses have a narrower focus than nursing diagnoses because they are based on pathology. A nursing diagnosis takes into account the psychological, social, spiritual, and physiological responses of the client and family. NANDA diagnostic labels listed in Appendix A are used in formulating diagnostic statements that are structured in a three-part Problem (Need), Etiology, and Signs/Symptoms (PES) format. Two-part statements may be used for risk diagnoses.

At times, something that appears easy to do in theory may seem difficult to achieve in practice. Nurses often have visionary ideas for the delivery of quality care to all clients. All too frequently, turning those ideas into actions can seem to be an exercise in futility. However, as you work with and become more familiar with nursing diagnoses, the client goals, related outcomes, and nursing interventions for attaining these goals and outcomes become more readily apparent. As you can see, an accurate and complete nursing diagnosis serves as the basis for the activities of the Planning step of the nursing process, discussed in Chapter 4.

Before continuing, let us return to the second ANA Standard of Clinical Nursing Practice and review the measurement criteria necessary to achieve and ensure compliance with the standard as discussed in this chapter (Box 3–8).

BOX 3–7

Omaha System Example

In Box 3–2, Robert is assessed using the Activity/Rest Diagnostic Division, revealing a range of possible NANDA nursing diagnosis labels:

Activity Intolerance
Disuse Syndrome, risk for
Diversional Activity, deficient
Fatigue
Mobility, impaired bed
Sleep Deprivation
Sleep Pattern, disturbed
Walking, impaired

These lead to a client diagnostic statement of: Activity Intolerance related to imbalance between oxygen supply/demand as evidenced by dyspnea and tachycardia with exertion, weakness, and limitation of desired activities. If we apply the Omaha System to the assessment data for Robert's level of physical activity, his problem would be documented as:

Level 1—Domain IV, Health-Related Behaviors
Level 2—Problem Classification, No. 37. Physical Activity
Level 3—Modifier, Individual Impairment
Level 4—Signs/Symptoms, No. 3. Inappropriate Type/Physical Condition

You are encouraged to read the articles and texts included in the Omaha System section of the Suggested Readings at the end of this chapter.

BOX 3–8

Measurement Criteria for ANA Standard II

ANA Standard II: Diagnosis: The nurse analyzes the assessment data in determining diagnoses.

1. Diagnoses are derived from the assessment data.
2. Diagnoses are validated with the client, family, and healthcare providers, when possible and appropriate.
3. Diagnoses are documented in a manner that facilitates the determination of expected outcomes and plan of care.

WORK PAGE: CHAPTER 3

1. What is the definition of Need Identification? _____

_____

2. What two factors influenced the development and acceptance of *nursing diagnosis* as the language of nursing? _____

_____

3. List three reasons for using nursing diagnosis.

   a. _____

   b. _____

   c. _____

4. List the six steps of diagnostic reasoning.

   a. _____

   b. _____

   c. _____

   d. _____

   e. _____

   f. _____

5. Name the components of the Client Diagnostic Statement.

   a. _____

   b. _____

   c. _____

6. If a risk diagnosis is identified, how is the Client Diagnostic Statement altered?

_____

_____

7. What is the difference between a medical and a nursing diagnosis?

_____

_____

8. Which of these client diagnostic statements are stated correctly? Indicate by placing a C before correct or an *I* before incorrect statements. Then, differentiate actual *(A)* from risk *(R)* needs by placing an *A* or *R* by each statement.

   _____ a. Deficient Knowledge regarding drug therapy, related to misinterpretation and unfamiliarity with resources as evidenced by request for information and statement of misconception.

_____ b. Risk for Infection, risk factors of altered lung expansion, decreased ciliary action, decreased hemoglobin, and invasive procedures.

_____ c. Impaired Urinary Elimination, related to indwelling catheter evidenced by inability to void.

_____ d. Anxiety (moderate), related to change in health status, role functioning, and socioeconomic status evidenced by apprehension, insomnia, and feelings of inadequacy.

9. Underline the cues in the following client database that indicate that a need may exist, and write a Client Diagnostic Statement based on your findings.

VIGNETTE: Sally is 2 days post delivery. She reports that her bowels have not moved but says she has been drinking plenty of fluids, including fruit juices, and has been eating a balanced diet.

ELIMINATION (EXCERPT FROM THE CLIENT DATABASE)

Subjective

Usual bowel patterns: every morning
Laxative use: rare/MOM PM
Character of stool: brown, formed
Last BM: 4 days ago
History of bleeding: No
Hemorrhoids: last 5 weeks
Constipation: currently
Diarrhea: No
Usual voiding pattern: 3–4 ×/day
Character of urine: Yellow
Incontinence: No
Urgency: No
Pain/burning/difficulty voiding: No
History of kidney/bladder disease: several bladder infections, last one 6 years ago
Associated concerns: pain with stool, nausea, "I just can't go no matter what I do."

Objective

Abdomen tender: Yes
Soft/firm: somewhat firm
Palpable mass: No
Size/girth: enlarged/postpartal
Bowel sounds: present all four quadrants, hypoactive every 1 to 2 minutes
Hemorrhoids: Visual examination not done

Now, write the Client Diagnostic Statement. Refer to the listing of Nursing Diagnoses in Appendix A to compare diagnostic labels addressing bowel elimination.

_____

_____

_____

_____

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