The Why and How of Nursing Diagnosis

The classification activities of NANDA-I, known as the North American Nursing Diagnosis Association International prior to 2002, have been instrumental in defining nursing's unique body of knowledge through the identification of nursing diagnoses. Prior to nursing diagnoses, nurses were defined by what they did, not by what they know. Nurses were seen as assistants to physicians, not professionals. Nursing interventions focused on the medical diagnosis or the surgical procedure, NOT the individual experiencing the medical condition or surgery.

This classification system of terminology defines the accountability of nursing and differentiates this profession from other healthcare professions with consistent language for oral, written, and electronic communication.

Clarification of the NANDA-I classification structure for professional nurses:

- Stimulates nurses to examine new knowledge
- Establishes a system for automation and reimbursement
- Provides an educational framework
- Allows efficient information retrieval for research and quality assurance
- Provides a consistent structure for literature presentation of nursing knowledge
- Clarifies nursing as an art and a science for its members and society
- Establishes standards to which nurses are held accountable

Appendix A provides a list of nursing diagnoses grouped under Functional Health Patterns.

Clearly, nursing diagnosis has influenced the nursing profession positively; however, integration of nursing diagnosis into nursing practice has proved problematic. Myths of nursing diagnoses serve to increase its rejection first by students and thus practicing nurses.

Myth: Student nurses and practicing nurses should learn all the nursing diagnoses.
Fact: As one reviews the list, does one think "I do not know what that diagnosis means, or I would never use that diagnosis!" The list of nursing diagnoses represents a variety of responses, some appropriate for a beginning student to recognize and confirm and many for only specialty or experienced nurses.

Myth: Nursing diagnoses must be in care plans to be utilized.

Fact: Care plans exist to direct the next nurse to provide the care determined to be appropriate for an individual. In hospitals, nursing care can be predicted from the admitting medical diagnoses or the surgical procedure planned. This care can be on standardized care plans, which can be preprinted or in the computer for the nurse to review if needed. These plans represent the standard of care expected to be needed for this clinical situation. Most often, experienced nurses know the standard without referring to it.

Standardized care plans:

- Represent a quality of care that is scientific and indicated for the primary medical diagnosis or surgical procedure.
- Eliminate the need for nurses to create this standard over and over for each assigned individual.
- Should allow additions, which are derived from interactions with the individual or family.
- Should allow additions of comorbidities, when relevant to the care. For example, an individual scheduled for total hip replacement, who also has diabetes mellitus type 2.

For nurses encountering an individual and responding to that individual based on the assessment, addition assessment data may be important to add to the standardized care plan. For example, while a nurse is preparing a woman for surgery, she reveals her son died in an accident 1 year from this day. The nurse's response would include acknowledgement of the loss as "I cannot imagine your grief; I am so sorry! What has helped you through this last year?" The nursing diagnosis is Grieving. Grieving individuals want recognition of their grief. They often want to share their grief. They do not want any reference that their sorrow will diminish. A simple "I am sorry for your loss. I cannot imagine how you feel."

This new edition of *Handbook of Nursing Diagnosis* has been organized with interventions that are timely and realistic, even if the time the nurse has is limited. In addition, interventions are differentiated into three levels of expertise and experience of the student or nurse. Some nursing diagnoses are advanced and require an experienced nurse specialist. For example, interventions for Risk for Other-Directed Violence have interventions that can be initiated by an inexperienced nurse and other interventions for specialty nurses. The majority of nursing diagnoses have at least one intervention for a beginning student.

Barriers to Using Nursing Diagnoses

Although references to nursing diagnosis in the literature have increased exponentially since the first meeting in 1973 of the National Group for the Classification of Nursing Diagnoses (which later became NANDA-I), nurses have not seen applications that allow efficient use.

The average nurse equated nursing diagnosis with care plans and endless typing or writing. This new edition of *Handbook of Nursing Diagnosis* has been organized with interventions that are powerful even if the time the nurse has to spend with an individual is limited.

Nevertheless, nurses who strongly support nursing diagnoses often become frustrated when they try to attach a nursing diagnosis label to every facet of nursing practice. Even today, some nurses and students are directed to use nursing diagnoses exclusively to describe their clinical focus. Some of the rejection of the use of nursing diagnoses results from the attempt to label as nursing diagnoses all situations in which nurses intervene.

Renaming medical diagnoses. Clinical nurses know that an important component of their practice is monitoring for the onset and status of physiologic complications of medical diagnoses, surgery, or other treatments and initiating both nurse-prescribed and physician-prescribed interventions. Morbidity and mortality are reduced and prevented because of nursing's expert monitoring and management.

Table 1-1 represents examples of the misuse of nursing diagnoses and the renaming of medical diagnoses. The examination of the substitution of nursing diagnosis terminology for medical diagnoses or pathophysiology in Table 1-1 gives rise to several questions:

- Should nursing diagnoses describe all situations in which nurses intervene?
- If a situation is not called a nursing diagnosis, is it then less important or scientific?
- How will it serve the profession to rename medical diagnoses as nursing diagnoses?
- Will using the examples in Table 1-1 improve communication and clarify nursing?

Table 1-1 **Diagnostic Errors: Renaming Medical Diagnoses with Nursing Diagnosis Terminology**

Medical Diagnosis	Nursing Diagnosis
Acute coronary syndrome	Decreased cardiac output
Shock	Decreased cardiac output
Adult respiratory distress	Impaired gas exchange
Chronic obstructive lung disease	Impaired gas exchange
Asthma	Impaired gas exchange
Alzheimer's disease	Impaired cerebral tissue perfusion
Increased intracranial pressure	Impaired cerebral tissue perfusion
Retinal detachment	Disturbed sensory perception: visual
Thermal burns	Impaired tissue integrity
Incisions, lacerations	Impaired skin integrity
Hemorrhage	Deficient fluid volume
Heart failure	Excess fluid volume
Paralytic ileus	Gastrointestinal dysfunction

Bifocal Clinical Practice Model

Nursing's theoretical knowledge derives from the natural, physical, and behavioral sciences, as well as the humanities and nursing research. Nurses can use various theories in practice, including family systems, loss, growth and development, crisis intervention, and general systems theories.

The difference between nursing and the other healthcare disciplines is the depth and breadth of the focus of nursing. Certainly, the nutritionist has more expertise in the field of nutrition and the pharmacist in the field of therapeutic pharmacology than any nurse. Every nurse, however, brings a knowledge of nutrition and pharmacology to interactions. The depth of this knowledge is sufficient for many clinical situations; when it is insufficient, consultation is required. No other discipline has this varied knowledge, which explains why attempts to substitute other disciplines for nursing have proved costly and ultimately unsuccessful.

Figure 1-1 illustrates this varied expertise.

The Bifocal Clinical Practice Model (Carpenito-Moyet, 2014) represents situations that influence the well-being of individual group and communities as well as the classification of these responses from a nursing perspective. The situations are organized into 5 broad categories: pathophysiologic, treatment related, personal, environmental, and maturational (**Figure 1-2**). Without an understanding of such situations, the nurse will be unable to diagnose responses and intervene appropriately.
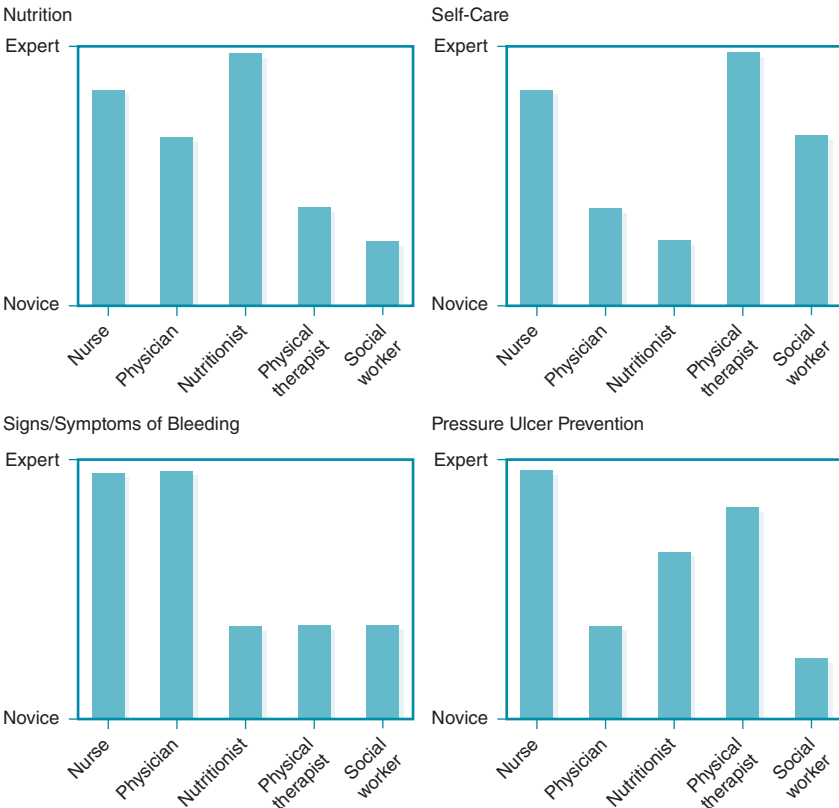

Figure 1-1 Knowledge of multidiscipline of selected topics

Pathophysiologic
Myocardial infarction
Borderline personality disorder
Burns

Treatment-related
Anticoagulants
Dialysis
Arteriogram

Personal
Dying
Divorce
Relocation

Environmental
Overcrowded school
No handrails on stairs
Rodents

Maturational
Peer pressure
Parenthood
Aging

Figure 1-2 Examples of pathophysiologic, treatment-related, personal, environmental, and maturational situations

Clinically, these situations are important to nurses. Thus, as nursing diagnoses evolved, nurses sought to substitute nursing terminology for these situations; for example, Impaired Tissue Integrity for burns and High Risk for Injury for dialysis. Nurses do not prescribe for and treat these situations (e.g., burns and dialysis); rather, they prescribe for and treat the *responses* to these situations in individuals as pain and/or fatigue.

The practice focus for clinical nursing is at the response level, not at the situation level. For example, an individual who has sustained burns may exhibit a wide variety of responses to the burns and the treatments. Some responses may be predicted, such as High Risk for Infection; others, such as fear of losing a job, may not be predictable. In the past, nurses focused on the nursing interventions associated with the treatment of burns rather than on those associated with the individual's responses. *This resulted in nurses being described as "doers" rather than "knowers"; as technicians rather than scientists.*

Nursing Diagnoses and Collaborative Problems

The Bifocal Clinical Practice Model describes the 2 focal points of clinical nursing: nursing diagnoses and collaborative problems (**Figure 1-3**).

A nursing diagnosis is a clinical judgment concerning a human response to health conditions/life processes or a vulnerability for that response by an individual, family, group, or community. A nursing diagnosis provides the basis for selection of nursing interventions to achieve outcomes for which the nurse has accountability (NANDA, 2014).

Collaborative problems are certain physiologic complications that nurses monitor to detect onset or changes of status. Nurses manage collaborative problems using physician-prescribed and nursing-prescribed interventions to minimize the complications of the events (Carpenito, 1999).

The nurse makes independent decisions for both collaborative problems and nursing diagnoses. The difference is that, in nursing diagnoses, nursing prescribes the definitive treatment to achieve the desired outcome, while in collaborative
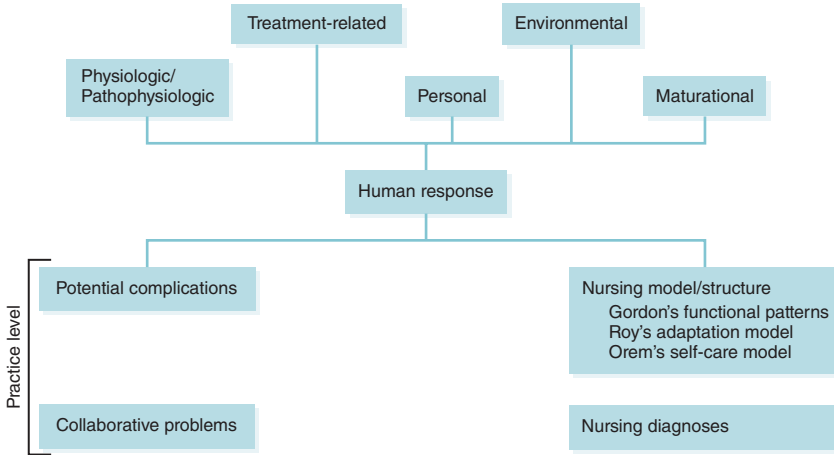
Figure 1-3 Bifocal Clinical Practice Model

problems, prescription for definitive treatment comes from both nursing and physicians/nurse practitioners (NPs)/physician assistants (PAs). Some physiologic complications (such as Risk for Infection and Risk for Pressure Ulcers) are nursing diagnoses because nurses can order the definitive treatment. In a collaborative problem, the nurse uses surveillance to monitor for the onset and change in status of physiologic complications and manages these changes to prevent morbidity and mortality. These physiologic complications are usually related to disease, trauma, treatments, medications, or diagnostic studies. Thus, collaborative problems can be labeled Risk for Complications (RC) of (specify);[1] for example, Risk for Complications of Hemorrhage or Risk for Complications of Renal Failure.

Monitoring, however, is not the sole nursing responsibility for collaborative problems. For example, in addition to monitoring an individual with increased intracranial pressure, the nurse also restricts certain activities, maintains head elevation, implements the medical regimen, and continually addresses the individual's psychosocial and educational needs.

The following are some collaborative problems that commonly apply to certain situations:

Situation	Collaborative Problem
Myocardial infarction	RC of Arrhythmias
Craniotomy	RC of Increased Intracranial Pressure
Hemodialysis	RC of Fluid/Electrolyte Imbalance
Surgery	RC of Hemorrhage
Cardiac catheterization	RC of Arrhythmias, RC of Allergic Reaction to Dye

[1]Previously labeled Potential Complications: (specify).

If the situation calls for the nurse to monitor for a cluster or group of physiologic complications, the collaborative problems may be documented as

RC of Cardiac Dysfunction

or

RC of Postsurgical Procedure   RC of Thrombophlebitis
    RC of Urinary Retention   RC of Renal Insufficiency
    RC of Hemorrhage   RC of Paralytic Ileus
    RC of Hypovolemia   RC of Evisceration
    RC of Hypoxia

A list of common collaborative problems grouped under conditions that necessitate nursing care appears in Section 3. **Not all physiologic complications, however, are collaborative problems**. Nurses themselves can prevent some physiologic complications, such as infections from external sources (e.g., wounds and catheters), contractures, complications of immobility, stress incontinence, and pressure injuries. Thus, such complications fall under the category of nursing diagnosis.

Nursing Interventions

Nursing interventions are treatments or actions that can reduce or eliminate a problem or promote a healthier adaptation. Nursing interventions can be classified as either of 2 types: nurse prescribed or physician/physician assistant/nurse practitioner[2] prescribed. Independent interventions are nurse prescribed; delegated interventions are physician/NP/PA prescribed. Both types of interventions, however, require independent nursing judgment. By law, the nurse must determine if it is appropriate to initiate an intervention regardless of whether it is independent or delegated (Carpenito, 1999).

Carpenito-Moyet (2014) stated that the relationship of diagnosis to interventions is a critical element in defining nursing diagnoses. This type of intervention distinguishes a nursing diagnosis from a collaborative problem and also differentiates between problem risk/high risk and possible nursing diagnoses. **Table 1-2** outlines definitions of each type and the corresponding intervention focus. For example, for a nursing diagnosis of Pressure Injury related to immobility as manifested by a 2-cm epidermal lesion on the left heel, the nurse would order interventions to monitor the lesion and to heal it. In another with a surgical wound, the nurse would focus on the prevention of infection and promotion of healing. Risk for Infection would better describe the situation than Impaired Tissue Integrity.

Nursing diagnoses are not more important than collaborative problems, and collaborative problems are not more important than nursing diagnoses.

Priorities are determined by the situation, not by whether it is a nursing diagnosis or a collaborative problem.

A diagnostic cluster represents those nursing diagnoses and collaborative problems that have a high likelihood of occurring in a population. The nurse

---

[2]In the US, nurse practitioners/physician assistants have the legal authority to prescribe medical interventions, such as diagnostic tests, medications, treatments; thus, they can diagnose and treat collaborative problems.

Table 1-2 **Differentiation among Types of Diagnoses**

Diagnostic Statement	Corresponding Individual Outcomes or Nursing Goals	Focus of Intervention
Problem Nursing Diagnosis		
Three-part statement, including nursing diagnostic label, etiology, and signs/symptoms	Change in behavior moving toward resolution of the diagnosis or improved status	Reduce or eliminate problem
Risk/High-Risk Nursing Diagnosis		
Two-part statement, including nursing diagnostic label and risk factors	Maintenance of present conditions	Reduce risk factors to prevent an actual problem
Possible Nursing Diagnosis		
Two-part statement, including nursing diagnostic label and unconfirmed etiology or unconfirmed defining characteristics	Undetermined until problem is validated	Collect additional data to confirm or rule out signs/symptoms or risk factors
Collaborative Problems		
Potential or actual physiologic complication	Collaborative goals	Determine onset or status of the problem; manage change in status with physician, nurse practitioner, or physician assistant

validates their presence in the individual. **Figure 1-4** represents the diagnostic cluster for an individual after abdominal surgery.

Goals/Outcome Criteria

In a nursing care plan, goals (outcome criteria) are "statements describing a measurable behavior of family that denote a favorable status (changed or maintained) after nursing care has been delivered" (*Alfaro, 2014). Outcome criteria help to determine the success or appropriateness of the nursing care plan. If the nursing care plan does not achieve a favorable status even though the diagnosis is correct, the nurse must change the goal or change the plan. If neither option is indicated, the nurse confers with the physician/NA/PA for delegated orders. Nursing diagnoses should *not* represent situations that require physician/NP orders for treatment; otherwise, how can nurses assume accountability for diagnosis and treatment? For example, consider an individual with a nursing diagnosis:
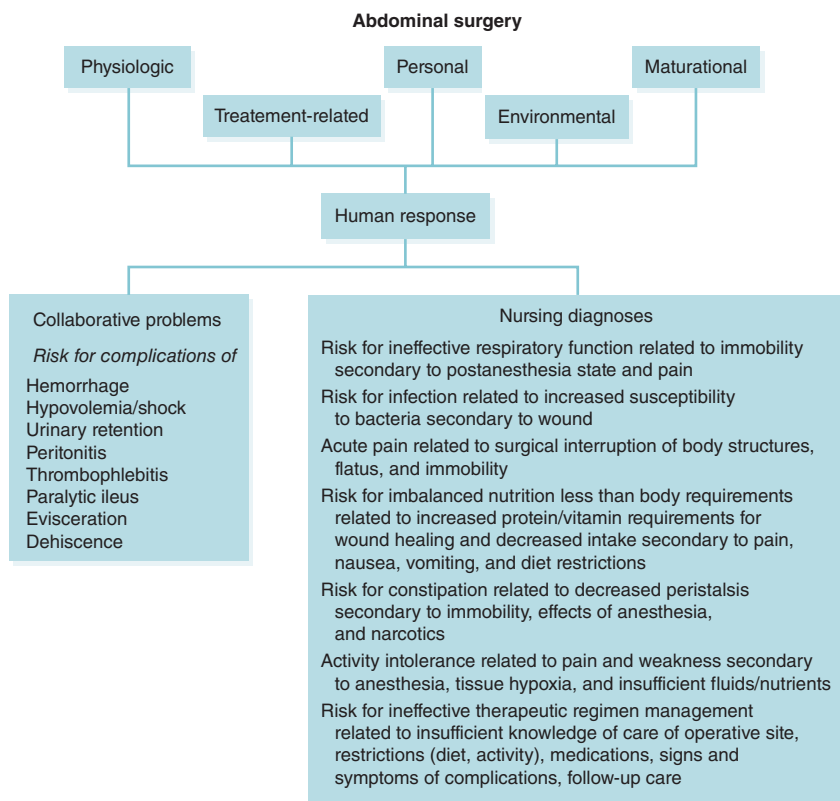
Abdominal surgery

Physiologic

Treatement-related

Personal

Environmental

Maturational

Human response

Collaborative problems

Risk for complications of

Hemorrhage
Hypovolemia/shock
Urinary retention
Peritonitis
Thrombophlebitis
Paralytic ileus
Evisceration
Dehiscence

Nursing diagnoses

Risk for ineffective respiratory function related to immobility
secondary to postanesthesia state and pain

Risk for infection related to increased susceptibility
to bacteria secondary to wound

Acute pain related to surgical interruption of body structures,
flatus, and immobility

Risk for imbalanced nutrition less than body requirements
related to increased protein/vitamin requirements for
wound healing and decreased intake secondary to pain,
nausea, vomiting, and diet restrictions

Risk for constipation related to decreased peristalsis
secondary to immobility, effects of anesthesia,
and narcotics

Activity intolerance related to pain and weakness secondary
to anesthesia, tissue hypoxia, and insufficient fluids/nutrients

Risk for ineffective therapeutic regimen management
related to insufficient knowledge of care of operative site,
restrictions (diet, activity), medications, signs and
symptoms of complications, follow-up care

Figure 1-4 Diagnostic cluster for an individual recovering from abdominal surgery

*Risk for Impaired Cerebral Tissue Perfusion related to effects of recent head injury and
these goals*

They will demonstrate continued optimal cerebral pressure as evidenced by

- Pupils equally reactive to light and accommodation
- No change in orientation or consciousness

If this were to exhibit evidence of increased intracranial pressure, would it be
appropriate for the nurse to change the goals? What changes in the nursing care plan
would the nurse make to stop the cranial pressure from increasing? Actually, neither
action is warranted. Rather, the nurse should confer with the physician/NP/PA for
delegated orders to treat increased intracranial pressure. When the nurse formulates
goals or outcomes that require delegated medical orders for goal achievement, the
situation is not a nursing diagnosis but a collaborative problem. In this case, the
problem would be described better as a collaborative problem:

Risk for Complications of Increased Intracranial Pressure

Collaborative Outcomes

The individual will be monitored for early signs and symptoms of increased intra-
cranial pressure and will receive interventions to achieve physiologic stability.

Indicators of physiologic stability:

- Alert, oriented, calm
- Pupils, equal, reactive to light and accommodation
- Pulse 60–100 beats per minute
- Respirations 16–20 breaths per minute
- Blood pressure (BP) >90/60, <140/90 mm Hg
- No nausea/vomiting
- Mild to no headache

These collaborative goals represent the nursing accountability for monitoring for physiologic instability and providing interventions (nursing and medical) to maintain or restore stability.

Summary

The Bifocal Clinical Practice Model provides nurses with a framework to diagnose the unique responses of individuals and significant others to various situations. Clear definition of the 2 dimensions of nursing enhances the use and minimizes the misuse of nursing diagnoses. The Bifocal Clinical Practice Model describes the unique knowledge and focus of professional nursing.