Nursing Diagnosis

INTRODUCTION

Nursing has attempted to define itself professionally and functionally since the writings of Nightingale, who stated that the purpose of Nursing care was to “PUT THE PATIENT IN BEST CONDITION FOR NATURE TO ACT UPON HIM”. Initially Nursing curriculum was organized around disease. In mid 1950s and 1960s, Nursing leaders started to revise curriculum around client centered problem.

1. 1950–First Nursing Diagnosis was found in literature
2. 1953-Fry stated that Nursing could be more creative by using Nursing Diagnosis
3. 1955-Model Nurse Practice Act
4. 1973-First National Conference for Classification of Nursing Diagnosis was held.
5. 1982-North American Nursing Diagnosis Association was established. Purpose was to “develop, refine and promote taxonomy of Nursing Diagnostic terminology of general use for Professional Nurses.” It is the common language for Nurses.

From Assessment to Diagnosis, A Pivotal Point:
Diagnosis is considered a pivotal for two reasons:
1. The problems you identify during this phase are the basis for the plan of care
2. The strengths you identify are invaluable when determining effective Nursing interventions.

Laws and standards continue to change to reflect how Nursing practice is growing. Some APNs are now qualified to diagnose and treat specific medical problems. As a beginning Nurse responsible for:
- Recognizing health problems
- Anticipating complications
- Initiating actions to ensure appropriate and timely treatment

The five major factors in health care today that impact on your diagnostic role are:
1. A shift in thinking about how to approach diagnosis and treatment. Health care delivery has moved from a model of Diagnose and treat to a model of predict, prevent, and manage.
2. The development and refinement of critical pathways.
4. More emphasis on the importance of collaborative practice.
5. Greater awareness that nursing’s scope of practice has a flexible boundary that responds to the changing needs of society and its expanding knowledge.

**Diagnose and Treat Versus Predict, Prevent and manage (DT,PPT)**

Diagnose and Treat implies that we wait for evidence of problems before beginning treatment. For example, in the past, if people were exposed to HIV, we monitored them until evidence of the virus appeared in their blood before beginning treatment. Today, using PPM model, when we know someone has had a significant risk for exposure to HIV, we begin treatment immediately, in hope of eliminating the virus before it even appears in the blood.

DT has a narrow approach that is strong on treating problems, but weak on predicting the likely course of problems and preventing and managing potential complications. On the other hand, PPM focuses on early intervention to minimize the problems and prevent or manage their potential complications. Using a PPM approach requires you to do two things:

1. In the presence of known problems, you predict the most likely and most dangerous complications, and take immediate action, to prevent them and to manage them in case they can’t be prevented.
2. Whether problems are present or not, you look for evidence of risk factors.

**Critical pathways (Clinical pathways, Care maps)**

Critical pathways are standard plans that predict the day by day care required to achieve outcomes for specific health problems within a certain time frame. But when using Critical pathways, keep an open mind and think independently. Always determine patients specific needs rather than assume he or she fits for the typical critical path.

**Computer Assisted Diagnosis**

It can also help or hinder the diagnostic process. It helps to identify the problems, enter and organize the data and suggests diagnoses to consider based on the data. Limitations are:

- Assume data that are entered are true, simply shuffling the information around.
- May not be up to date with minute-to-minute changes in patient status.
- Don’t replace humans. Computers have no common sense.
- Don’t relieve you of the responsibility of learning principles and rules of diagnostic reasoning.

**Multidisciplinary Practice**
Increased awareness of the importance of multidisciplinary approaches also impacts our role as a diagnostician. Nurses do not work in isolation. People are sent home quicker and sicker. Nursing knowledge base continues to expand to meet the changing needs of society.

Nurses knowledge base continues to expand to facilitate nurses abilities to take on greater diagnostic responsibilities. Research groups are studying what Nurses do by examining the diagnoses, outcomes, and interventions like Nursing Diagnosis Extension Classification (NDEC), Nursing intervention classification (NIC) and Nursing –Sensitive outcomes classification (NOC).

**Fundamental principles and rules of diagnostic reasoning**

- Recognizing diagnoses requires you to be familiar with the diagnoses themselves.
- Keep an open mind
- When you make a diagnosis, back it up with evidence
- Although intuition is a valuable tool for problem identification, never make diagnosis on intuition alone- look for evidence to verify your intuition.
- If you miss a problem, mislabel a problem, or identify a problem that isn’t their you have made a diagnostic error
- Just because other nurses have more experience, it doesn’t mean they’re always right.
- Know your qualifications and limitations.

**Ten steps for diagnosing health problems**

1. Start by asking the person to identify major problems or concerns.
2. Be sure you’ve completed the assessment phase.
3. Determine normal, altered, at risk, or possible altered functioning and create a list of suspected actual and potential problems.
4. Consider each suspected problem and look for other signs and symptoms associated with the problem
5. Rule in or rule out problems to looking for flaws in your thinking
6. Name the problem by using the most closely match assessment cues.
7. Determine the causes of the problem
8. If you identify risk factors but have no evidence, list it as a risk problem.
9. Share your diagnoses with the person requiring care
10. Ask the person if there’s anything else that should be listed as a problem.

Three steps for diagnosing strengths

- Ask the client to express his problems
- Cluster together data that indicate normal or positive functioning.
- List the strengths that will assist you in preventing, resolving, or controlling the identified problems.

Definitions and Key Terms Related to Diagnosis

Competency- Having the knowledge and skill to perform an action safely and efficiently.
Qualified. Having the competency and authority to perform an action.
Nursing Domain.- Activities and actions a nurse is legally qualified to perform.
Medical Domain- Activities and actions a physician is legally qualified to perform.
Accountable- Being responsible and answerable for something.
Definitive Interventions.- The most specific treatment required to prevent, resolve, or control a health problem.
Physician- Prescribed (or Delegated) Intervention. An action ordered by a physician for a nurse or another health care professional to perform (Carpenito, 1997b).
Nurse-Prescribed Intervention- An action a nurse may legally order or initiate independently (Carpenito, 1997b).
Outcome- The result of prescribed interventions. Usually refers to the desired result of interventions (ie. That the problem is prevented, resolved, or controlled) and includes a specific time frame for when the outcome is expected to be achieved.
Judgment- An opinion that’s made after analyzing and synthesizing (putting together) information.
Diagnose- To make a judgment and identify a problem or strength based on evidence from an assessment.
Diagnosis- In addition, referring to the second step of the nursing process, diagnosis can mean two things:
1. The process of analyzing data and putting related cues together to make judgments about health status.

2. The judgment that’s made after the diagnostic process is completed.

Definitive Diagnosis- The most specific, most correct diagnosis.

- Nursing diagnosis - is an action: the process of analyzing assessment data to arrive at a conclusion.
- Nursing diagnosis - is a label that describes the patient’s response to an actual or potential health problem

- Subjective & objective “cues” are organized into groups that seem to fit together & indicate actual or potential client problems.
- RN makes an educated hunch about which nursing diagnoses might fit the cue cluster
- Review the selected nursing diagnoses to decide which is most accurate

The use of Nursing Diagnoses

- Gives Nurses a common language
- Promotes identification of appropriate goals
- Promotes acuity information
- Can create a standard for Nursing Practice
- Provides a quality improvement base

Identifying Patient problems/ needs

During the assessment step, the collection, clustering, and validation of patient data flow directly into the problems/ needs identification step.

A) Diagnostic reasoning: Analyzing the patient database

Step 1: Problem-Sensing

Data are reviewed and analyzed to identify cues [signs and symptoms] suggesting patient problems or needs that can be described by nursing diagnosis labels.

Step 2: Rule-out process

Alternative explanations are considered for the identified cues to determine which Nursing Diagnosis label is suitable. 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.

Step 3: Synthesizing the data
Viewing all data as a whole to provide a comprehensive picture of the patient. When the Nursing Diagnosis label is unclear, you can ask yourself these questions:

1. What are my concerns about this patient?
2. Can I do something about it?
3. Can overall risk be reduced by nursing intervention?

Step 4: Evaluating or confirming the Hypothesis
Test the hypothesis for appropriate fit; that is, review the NANDA Nursing Diagnoses and definition.

North American Nursing Diagnosis Association (NANDA):
Official organization responsible for developing system of Naming and classifying nursing diagnoses
• Diagnostic label is often called a “NANDA”
• Each NANDA describes the essence of the problem in as few words as possible.

Then compare the assessed possible ETIOLOGY with NANDAs RELATED FACTORS or RISK FACTORS. Next compare the assessed patient cues with NANDAs Defining characteristics, which are used to support them and provide an increased level of confidence.

Example:

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NANDA Definitions
• Each NANDA-approved nursing diagnosis is accompanied by a definition that describes its characteristics:
  – NANDA: Impaired Physical Mobility
  – NANDA Definition: state in which a person experiences or is at risk of experiencing limitation of physical movement but is not immobile

Parts of a Nursing Diagnosis:
  Defining Characteristics:
  These are the signs & symptoms that validate that an actual nursing diagnosis is present.
  – Major: at least one must be present to use the nursing diagnosis
  – Minor: may not be present, but if it is, helps to validate selecting the nursing diagnosis
• Defining characteristics are not present in ‘Risk’ diagnosis because signs & symptoms don’t exist if the problem hasn’t happened

Related Factors or Risk Factors:
• Related Factors: factors that contributed to the development of patient’s problem (nursing dx)
• Risk Factors: factors that increase the possibility of the patient developing a problem
• Is a relationship rather than direct cause & effect (is ‘related to’ rather than ‘caused by’)
• Only one of these factors (risk or related) needs to be present to justify use of the nursing diagnosis.

Step 5: List the Patients problems / needs

Step 6: Reevaluate the Problem list

Status classification of patient problems / needs

Actual- Describes human responses to health condition/life processes that exist in and individual, family, or community. Its is supported by defining characteristics (manifestations, signs, and symptoms) that cluster in patterns of related cues or inferences.

Risk- Describes human responses to health conditions/ life processes that may develop in a vulnerable individual, family, or community. It is supported by risk factors that contribute to increased vulnerability. Wellness- describes human responses to levels of wellness in an individual, family, or community that have a potential for enhancement to a higher state.

Writing Diagnostic Statements for Nursing Diagnoses

Because it’s important to be clear and specific, there are accepted ways to write diagnostic statements. Follow the rules below.

Rules for Writing Diagnostic Statements

1. Actual Diagnoses (three-part statement).

   Use PES (problem +Etiology+ Signs and Symptoms) or PRS (Problem+ Related (Risk) Factors+ Signs and Symptoms) format.

   Use “related to” link the problem and the etiology or related factors. Add “as evidenced by” to state the evidence that supports that diagnosis is present.
Example:- Impaired Communication related to language barrier as evidenced by inability to speak or understand English.

2. Risk Nursing Diagnoses (two –party statement).

   Use PE (Problem+ Etiology) or PR (Problem+ Related (Risk) Factors) format.

   Use “related to” to link the potential problem with the related (risk) factors present.

   Example:- Risk for impaired skin integrity related to obesity, excessive diaphoresis, and confinement to bed.

3. Possible Diagnoses (one-part statement). Simply name the possible problem.

   Example:- Possible Altered Sexuality patterns.

4. For Wellness Diagnoses (one –part statement). Use “Potential for Enhanced” before the words that describe the area that is to be improved.

   Example:- Potential for enhanced parenting.

5. Syndrome Diagnoses (one-part statement). Simply name the syndrome.

   Example:- Rape Trauma Syndrome.

Making Sure Diagnostic Statements Direct Interventions.

   When ever possible, write nursing diagnoses in such a way that they direct nursing interventions. When someone studies your diagnostic statement, it should answer the question, “What can nurses do about this problem?” For example, consider the boldface portions of each of the statements below, and note how the first statement directs independent interventions.

   Right: Risk for Ineffective Airway Clearance related to copious thick secretions and difficulty positioning for coughing.

   Wrong: Risk for Ineffective Airway Clearance related to pneumonia.

QUALIFIERS FOR DIAGNOSTIC LABELS
(Suggested / not limited to the following)

Acute- Severe but of short duration.

Altered- A change from baseline.

Chronic- Lasting a long time, recurring, habitual, constant.

Decreased- Lessened: lesser in size, amount, or degree.

Deficient- Inadequate in amount, quality, or degree; defective; not sufficient; incomplete.
Depleted- Emptied wholly or in part; exhausted of
Disturbed- Agitated, interrupted, interfered with.
Dysfunctional- Abnormal, incomplete functioning.
Excessive- Characterized by an amount or quantity that is greater than necessary, desirable, or useful,
Increased- Greater in size, amount, or degree.
Impaired- Made worse, weakened, damaged, reduced, deteriorated.
Ineffective- Not producing the desired effect.
Intermittent- Stopping and starting again at intervals, periodic, cyclic.
Potential for Enhanced(for use with wellness diagnoses)- Made greater, to increased in quality or more desire.

Types of Diagnostic Concepts
Actual- Describes human responses to health condition/life processes that exist in an individual, family, or community. It is supported by defining characteristics (manifestations, signs, and symptoms) that cluster in patterns of related cues or inferences.
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Potential errors in choosing a Nursing Diagnoses
Diagnostic error is a mistaken assumption leading to a wrong conclusion. The common errors are
- Overlooking cues resulting in a missed diagnosis can lead to worsening of the problem.
- Making a diagnosis with an insufficient database can lead in the wrong direction, wasting valuable time and resources.
- Stereotyping leads to treating all patients in the same way and neglects individualization. Certain Nursing Diagnoses may be linked to specific health problems.
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