NURSING DIAGNOSIS GUIDE AND LIST: ALL YOU NEED TO KNOW TO MASTER DIAGNOSING

2023-Nursing-Diagnosis-Guide-and-Complete-List

گردآوری و تدوین: شهنازمیری سوپروایزر آموزش بیمارستان محب کوثر

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WHAT IS A NURSING DIAGNOSIS?

- A nursing diagnosis is a clinical judgment concerning a human response to health conditions/life processes, or a vulnerability to that response, by an individual, family, group, or community. A nursing diagnosis provides the basis for selecting nursing interventions to achieve outcomes for which the nurse has accountability. Nursing diagnoses are developed based on data obtained during the nursing assessment and enable the nurse to develop the care plan.

PURPOSES OF NURSING DIAGNOSIS

- Helps identify nursing priorities and helps direct nursing interventions based on identified priorities.
- Helps the formulation of expected outcomes for quality assurance requirements of third-party payers.
- Nursing diagnoses help identify how a client or group responds to actual or potential health and life processes and knowing their available resources of strengths that can be drawn upon to prevent or resolve problems.
- Provides a common language and forms a basis for communication and understanding between nursing professionals and the healthcare team.
- Provides a basis of evaluation to determine if nursing care was beneficial to the client and cost-effective.
- For nursing students, nursing diagnoses are an effective teaching tool to help sharpen their problem-solving and critical thinking skills

DIFFERENTIATING NURSING DIAGNOSES, MEDICAL DIAGNOSES, AND COLLABORATIVE PROBLEMS

- The term **nursing diagnosis** is associated with different concepts. It may refer to the distinct second step in the nursing process, **diagnosis** ("D" in "ADPIE"). Also, **nursing diagnosis** applies to the label when nurses assign meaning to collected data appropriately labeled a nursing diagnosis.

- For example, during the assessment, the nurse may recognize that the client feels anxious, fearful, and finds it difficult to sleep. Those problems are labeled with nursing diagnoses: respectively, Anxiety, Fear, and Disturbed Sleep Pattern. In this context, a nursing diagnosis is based upon the patient's response to the medical condition

- **COMPARED.** Nursing diagnoses vs medical diagnoses vs collaborative problems
- On the other hand, **a medical diagnosis** is made by the physician or advanced health care practitioner that deals more with the disease, medical condition, or pathological state only a practitioner can treat. Moreover, through experience and know-how, the specific and precise clinical entity that might be the possible cause of the illness will then be undertaken by the doctor, therefore, providing the proper medication that would cure the illness. Examples of medical diagnoses are *Diabetes Mellitus*, *Tuberculosis*, *Amputation*, *Hepatitis*, *and Chronic Kidney Disease*. The medical diagnosis normally does not change. Nurses must follow the physician's orders and carry out prescribed treatments and therapies

- **Collaborative problems** are potential problems that nurses manage using both independent and physician-prescribed interventions. These are problems or conditions that require both medical and nursing interventions, with the nursing aspect focused on monitoring the client's condition and preventing the development of the potential complication.
- As explained above, now it is easier to distinguish a nursing diagnosis from a medical diagnosis. Nursing diagnosis is directed towards the patient and his physiological and psychological response. On the other hand, a medical diagnosis is particular to the disease or medical condition. Its center is on the illness.

Nursing Diagnosis, Medical Diagnosis, and Collaborative Problems

Nursing Diagnosis	*Medical Diagnosis*	*Collaborative Problems*
Ineffective Airway Clearance	Pneumonia	Potential complication of Head Injury: increased intracranial pressure
Distrubed Body Image	Amputation	Potential complication of myocardial infarction: congestive heart failure
Risk for Unstable Blood Glucose	Type 2 Diabetes Mellitus	
Impaired Urinary Elimination	Post-op Prostatectomy	
Self-Care Deficit: Dressing	Cerebrovascular Accident	

CLASSIFICATION OF NURSING DIAGNOSES (TAXONOMY II)

- **NURSING DIAGNOSIS TAXONOMY II.** Taxonomy II for nursing diagnosis contains 13 domains and 47 classes.

NURSING DIAGNOSIS TAXONOMY II. TAXONOMY II FOR NURSING DIAGNOSIS CONTAINS 13 DOMAINS AND 47 CLASSES

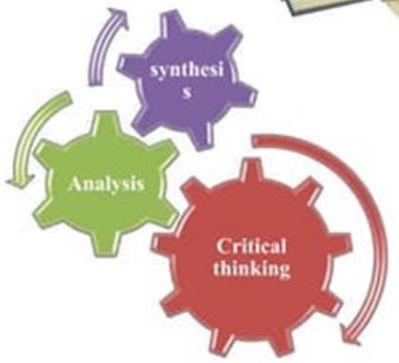
- **Domain 1. Health Promotion**
  - Class 1. Health Awareness
  - Class 2. Health Management
- **Domain 2. Nutrition**
  - Class 1. Ingestion
  - Class 2. Digestion
  - Class 3. Absorption
  - Class 4. Metabolism
  - Class 5. Hydration
- **Domain 3. Elimination and Exchange**
  - Class 1. Urinary function
  - Class 2. Gastrointestinal function
  - Class 3. Integumentary function
  - Class 4. Respiratory function
- **Domain 4. Activity/Rest**
  - Class 1. Sleep/Rest
  - Class 2. Activity/Exercise
  - Class 3. Energy balance
  - Class 4. Cardiovascular/Pulmonary responses
  - Class 5. Self-care

- **Domain 5. Perception/Cognition**
  - Class 1. Attention
  - Class 2. Orientation
  - Class 3. Sensation/Perception
  - Class 4. Cognition
  - Class 5. Communication
- **Domain 6. Self-Perception**
  - Class 1. Self-concept
  - Class 2. Self-esteem
  - Class 3. Body image
- **Domain 7. Role relationship**
  - Class 1. Caregiving roles
  - Class 2. Family relationships
  - Class 3. Role performance
- **Domain 8. Sexuality**
  - Class 1. Sexual identity
  - Class 2. Sexual function
  - Class 3. Reproduction
- **Domain 9. Coping/stress tolerance**
  - Class 1. Post-trauma responses
  - Class 2. Coping responses
  - Class 3. Neurobehavioral stress
- **Domain 10. Life principles**
  - Class 1. Values
  - Class 2. Beliefs
  - Class 3. Value/Belief/Action congruence

- **Domain 11. Safety/Protection**
  - Class 1. Infection
  - Class 2. Physical injury
  - Class 3. Violence
  - Class 4. Environmental hazards
  - Class 5. Defensive processes
  - Class 6. Thermoregulation
- **Domain 12. Comfort**
  - Class 1. Physical comfort
  - Class 2. Environmental comfort
  - Class 3. Social comfort
- **Domain 13. Growth/Development**
  - Class 1. Growth
  - Class 2. Development

Domain	Health promotion	Nutrition	Elimination/ Exchange	Activity/ Rest	Perception/ Cognition	Self-perception	Role relationship	Sexuality	Coping/Stress tolerance	Life principles	Safety/ Protection	Comfort	Growth/ Development
Class 1	Health awareness	Ingestion	Urinary function	Sleep/Rest	Attention	Self-concept	Caregiving roles	Sexual identity	Post-trauma responses	Values	Infection	Physical comfort	Growth
Class 2	Health management	Digestion	Gastrointestinal function	Activity/ Exercise	Orientation	Self-esteem	Family relationships	Sexual function	Coping responses	Beliefs	Physical injury	Environmental comfort	Development
Class 3		Absorption	Integumentary function	Energy balance	Sensation/ Perception	Body image	Role performance	Reproduction	Neuro-behavioral stress	Value/Belief/ Action congruence	Violence	Social comfort	
Class 4		Metabolism	Respiratory function	Cardio-vascular/ Pulmonary responses	Cognition						Environmental hazards		
Class 5		Hydration		Self-care	Communi-cation						Defensive processes		
Class 6											Thermo-regulation		

Diagnostic process….



Steps of diagnostic process…..

1. Analyzing data
2. Identifying health problems risks and strengths
3. Formulate diagnostic statement

Formulating diagnostic statement……

NURSING PROCESS

- The five stages of the **nursing process** are assessment, diagnosing, planning, implementation, and evaluation. All steps in the nursing process require critical thinking by the nurse. Apart from understanding nursing diagnoses and their definitions, the nurse promotes awareness of defining characteristics and behaviors of the diagnoses, related factors to the selected nursing diagnoses, and the interventions suited for treating the diagnoses.

TYPES OF NURSING DIAGNOSES

- **TYPES OF NURSING DIAGNOSES. The four types of nursing diagnosis are Actual (Problem-Focused), Risk, Health Promotion, and Syndrome.**

PROBLEM-FOCUSED NURSING DIAGNOSIS

- A **problem-focused diagnosis** (also known as **actual diagnosis**) is a client problem present at the time of the nursing assessment. These diagnoses are based on the presence of associated signs and symptoms. Actual nursing diagnosis should not be viewed as more important than risk diagnoses. There are many instances where a risk diagnosis can be the diagnosis with the highest priority for a patient.

- Examples of actual nursing diagnoses are:
- **Ineffective Breathing Pattern** related to pain as evidenced by pursed-lip breathing, reports of pain during inhalation, use of accessory muscles to breathe
- **Anxiety** related to stress as evidenced by increased tension, apprehension, and expression of concern regarding upcoming surgery
- **Acute Pain** related to decreased myocardial flow as evidenced by grimacing, expression of pain, guarding behavior.
- **Impaired Skin Integrity** related to pressure over bony prominence as evidenced by pain, bleeding, redness, wound drainage.
- **Delayed Surgical Recovery** related to increased blood glucose level and obesity as evidenced by poor wound healing, fatigue, and excessive time

RISK NURSING DIAGNOSIS

- The second type of nursing diagnosis is called **risk nursing diagnosis.** These are clinical judgments that a problem does not exist, but the presence of risk factors indicates that a problem is likely to develop unless nurses intervene. A risk diagnosis is based on the patient's current health status, past health history, and other risk factors that may increase the patient's likelihood of experiencing a health problem. These are integral part of nursing care because they help to identify potential problems early on and allows the nurse to take steps to prevent or mitigate the risk

- There are no etiological factors (related factors) for risk diagnoses. The individual (or group) is more susceptible to developing the problem than others in the same or a similar situation because of risk factors. For example, an elderly client with diabetes and vertigo who has difficulty walking refuses to ask for assistance during ambulation may be appropriately diagnosed with *Risk for Injury* or *Risk for Adult Falls*.
- Components of a risk nursing diagnosis include (1) risk diagnostic label, and (2) risk factors. Examples of risk nursing diagnosis are:
- **Risk for Falls** *as evidenced by* muscle weakness
- **Risk for Injury** *as evidenced by* altered mobility
- **Risk for Infection** *as evidenced by* immunosuppression
- Risk for Adult Falls
- Risk for Suffocation

HEALTH PROMOTION DIAGNOSIS

- **Health promotion diagnosis** (also known as **wellness diagnosis**) is a clinical judgment about motivation and desire to increase well-being. It is a statement that identifies the patient's readiness for engaging in activities that promote health and well-being. For example, if a first-time mother shows interest on how to properly breastfeed her baby, a nurse make make a health promotion diagnosis of "Readiness for Enhanced Breastfeeding." This nursing diagnosis will be then used to guide nursing interventions aimed at supporting the patient in learning about proper breastfeeding.

- Additionally, health promotion diagnosis is concerned with the individual, family, or community transition from a specific level of wellness to a higher level of wellness. Components of a health promotion diagnosis generally include only the diagnostic label or a one-part statement. Examples of health promotion diagnosis:
- Readiness for Enhanced Spiritual Well Being
- Readiness for Enhanced Family Coping
- Readiness for Enhanced Parenting
- Readiness for Enhanced Health Literacy
- Readiness for Enhanced Exercise Management

SYNDROME DIAGNOSIS

- A **syndrome diagnosis** is a clinical judgment concerning a cluster of problem or risk nursing diagnoses that are predicted to present because of a certain situation or event. They, too, are written as a one-part statement requiring only the diagnostic label. Examples of a syndrome nursing diagnosis are:
- Chronic Pain Syndrome
- Post-trauma Syndrome
- Frail Elderly Syndrome
- Relocation Stress Syndrome
- Neonatal Abstinence Syndrome

POSSIBLE NURSING DIAGNOSIS

- A possible nursing diagnosis is not a type of diagnosis as are actual, risk, health promotion, and syndrome. Possible nursing diagnoses are statements describing a suspected problem for which additional data are needed to confirm or rule out the suspected problem. It provides the nurse with the ability to communicate with other nurses that a diagnosis may be present but additional data collection is indicated to rule out or confirm the diagnosis. Examples include:

- Possible Chronic Low Self-Esteem
- Possible Social Isolation.

Types of Nursing Diagnoses

Problem-Focused

Ineffective Breathing Pattern related to decreased lung expansion as evidenced by dyspnea, coughing, difficulty of breathing

Risk

Risk for Ineffective Airway Clearance as evidenced by accumulation of secretions in lungs

Health Promotion

Readiness for Enhanced Family Coping as evidenced by verbalization of desire to information that will enhance health choices

Syndrome

Chronic Pain Syndrome

*Possible**

Possible Chronic Low Self-Esteem

**A possible nursing diagnosis is not a type of diagnosis. They are statements describing a suspected problem for which additional data are needed to confirm or rule out the suspected problem.*

COMPONENTS OF A NURSING DIAGNOSIS

A nursing diagnosis has typically three components:

(1) the problem and its definition,

(2) the etiology,

(3) the defining characteristics or risk factors (for risk diagnosis).

Components of a NANDA-I Nursing Diagnostic Statement

Example

Qualifier
Acute Pain
Focus
Diagnostic Label
related to
tissue ischemia
Etiology / Related Factor
as evidenced by
pain rating of 8/10, grimacing, guarding behavior
Defining Characteristics/ Risk Factors

PROBLEM AND DEFINITION

- The **problem statement**, or the **diagnostic label**, describes the client's health problem or response to which nursing therapy is given concisely. A diagnostic label usually has two parts: qualifier and focus of the diagnosis. **Qualifiers** (also called **modifiers**) are words that have been added to some diagnostic labels to give additional meaning, limit, or specify the diagnostic statement. Exempted in this rule are one-word nursing diagnoses (e.g., Anxiety, Constipation, Diarrhea, Nausea, etc.) where their qualifier and focus are inherent in the one term.

Qualifier	Focus of the Diagnosis
Deficient	Fluid volume
Imbalanced	Nutrition: Less Than Body Requirements
Impaired	Gas Exchange
Ineffective	Tissue Perfusion
Risk for	Injury

ETIOLOGY

- The **etiology**, or **related factors**, component of a nursing diagnosis label identifies one or more probable causes of the health problem, are the conditions involved in the development of the problem, gives direction to the required nursing therapy, and enables the nurse to individualize the client's care. Nursing interventions should be aimed at etiological factors in order to remove the underlying cause of the nursing diagnosis. Etiology is linked with the problem statement with the phrase "*related to*" such as:

- Decreased activity tolerance related to **generalized weakness**.
- Impaired physical mobility related to **imposed bed rest**.

RISK FACTORS

- Risk factors are used instead of etiological factors for risk nursing diagnosis. Risk factors are forces that put an individual (or group) at an increased vulnerability to an unhealthy condition. Risk factors are written following the phrase “as evidenced by” in the diagnostic statement.

- Risk for Falls as evidenced by old age and use of walker.
- Risk for Infection as evidenced by break in skin integrity.

DEFINING CHARACTERISTICS

- **Defining characteristics** are the clusters of signs and symptoms that indicate the presence of a particular diagnostic label. In actual nursing diagnosis, the defining characteristics are the identified signs and symptoms of the client. For risk nursing diagnosis, no signs and symptoms are present therefore the factors that cause the client to be more susceptible to the problem form the etiology of a risk nursing diagnosis. Defining characteristics are written following the phrase "as evidenced by" or "as manifested by" in the diagnostic statement.

DIAGNOSTIC PROCESS: HOW TO DIAGNOSE

There are three phases during the diagnostic process:

(1) data analysis,
(2) identification of the client's health problems, health risks, and strengths,
(3) formulation of diagnostic statements.

➢ Analyzing Data

Analysis of data involves comparing patient data against standards, clustering the cues, and identifying gaps and inconsistencies.

➢ Identifying Health Problems, Risks, and Strengths

In this decision-making step, after data analysis, the nurse and the client identify problems that support tentative actual, risk, and possible diagnoses. It involves determining whether a problem is a nursing diagnosis, medical diagnosis, or a collaborative problem. Also, at this stage, the nurse and the client identify the client's strengths, resources, and abilities to cope.

➢ Formulating Diagnostic Statements

Formulation of diagnostic statements is the last step of the diagnostic process wherein the nurse creates diagnostic statements. The process is detailed below.

HOW TO WRITE A NURSING DIAGNOSIS?

- In writing nursing diagnostic statements, describe an individual's health status and the factors that have contributed to the status. You do not need to include all types of diagnostic indicators. Writing diagnostic statements vary per type of nursing diagnosis.

PES FORMAT

- Another way of writing nursing diagnostic statements is by using the PES format, which stands for Problem (diagnostic label), Etiology (related factors), and Signs/Symptoms (defining characteristics). Diagnostic statements can be one-part, two-part, or three-part using the PES format

ONE-PART NURSING DIAGNOSIS STATEMENT

- Health promotion nursing diagnoses are usually written as one-part statements because related factors are always the same: motivated to achieve a higher level of wellness through related factors may be used to improve the chosen diagnosis. Syndrome diagnoses also have no related factors. Examples of one-part nursing diagnosis statements include:
- Readiness for Enhance Breastfeeding
- Readiness for Enhanced Coping
- Rape Trauma Syndrome

TWO-PART NURSING DIAGNOSIS STATEMENT

- Risk and possible nursing diagnoses have two-part statements: the first part is the diagnostic label and the second is the validation for a risk nursing diagnosis or the presence of risk factors. It's not possible to have a third part for risk or possible diagnoses because signs and symptoms do not exist. Examples of two-part nursing diagnosis statements include:

- Risk for Infection as evidenced by compromised host defenses
- Risk for Injury as evidenced by abnormal blood profile
- Possible Social Isolation related to unknown etiology

THREE-PART NURSING DIAGNOSIS STATEMENT

- An actual or problem-focus nursing diagnosis has three-part statements: diagnostic label, contributing factor ("related to"), and signs and symptoms ("as evidenced by" or "as manifested by"). The three-part nursing diagnosis statement is also called the PES format which includes the Problem, Etiology, and Signs and Symptoms. Examples of three-part nursing diagnosis statements include:
- Impaired Physical Mobility related to decreased muscle control as evidenced by inability to control lower extremities.
- Acute Pain related to tissue ischemia as evidenced by statement of "I feel severe pain on my chest!"

Writing Diagnostic Statements (PES Format)

Three-Part Statement

[Problem / Diagnostic Label] + "related to" (rt) [Etiology] + "as evidenced by" (a.e.b.) [Symptoms]

Examples of three-part statements

Impaired Physical Mobility related to decreased muscle control as evidenced by inability to control lower extremities

Acute Pain related to tissue ischemia as evidenced by statement of "my chest is so painful," pain scale of 8/10

Two-Part Statement

[Risk Diagnosis/ Diagnostic Label] + "as evidenced by" (AEB) [Etiology]

Examples of two-part statements

Risk for Falls as evidenced by improper use of crutches

Risk for Injury as evidenced by altered clotting factors

One-Part Statement

[Problem / Diagnostic Label]

Examples of one-part statements

Readiness for Enhanced Breastfeeding

Rape Trauma Syndrome

Readiness for Enhanced Coping

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VARIATIONS ON BASIC STATEMENT FORMATS

- Variations in writing nursing diagnosis statement formats include the following:
- Using "*secondary to*" to divide the etiology into two parts to make the diagnostic statement more descriptive and useful. Following the "secondary to" is often a pathophysiologic or disease process or a medical diagnosis.

- For example, *Risk for Decreased Cardiac Output related to reduced preload secondary to myocardial infarction.*
- Using "*complex factors*" when there are too many etiologic factors or when they are too complex to state in a brief phrase. For example, *Chronic Low Self-Esteem related to complex factors.*
- Using "*unknown etiology*" when the defining characteristics are present but the nurse does not know the cause or contributing factors.
- For example, *Ineffective Coping related to unknown etiology.*
- Specifying a second part of the general response or diagnostic label to make it more precise.
- For example, *Impaired Skin Integrity (Right Anterior Chest) related to disruption of skin surface secondary to burn injury.*

NURSING DIAGNOSIS FOR CARE PLANS

- Acute Pain
- Anxiety
- Chronic Pain
- Constipation
- Decreased Cardiac Output
- Deficient Fluid Volume
- Deficient Knowledge
- Diarrhea
- Excess Fluid Volume
- Fatigue
- Fear
- Grieving
- Hopelessness
- Hyperthermia
- Hypothermia
- Impaired Gas Exchange
- Impaired Tissue (Skin) Integrity
- Impaired Urinary Elimination
- Ineffective Airway Clearance
- Ineffective Breathing Pattern
- Ineffective Tissue Perfusion
- Risk for Falls
- Risk for Impaired Skin Integrity
- Risk for Infection
- Risk for Injury
- Risk for Unstable Blood Glucose Level

RECOMMENDED RESOURCES

- **Ackley and Ladwig's Nursing Diagnosis Handbook: An Evidence-Based Guide to Planning Care**
- **Nursing Care Plans – Nursing Diagnosis & Intervention (10th Edition)**
- **Nursing Diagnosis Manual: Planning, Individualizing, and Documenting Client Care**
- **All-in-One Nursing Care Planning Resource – E-Book: Medical-Surgical, Pediatric, Maternity, and Psychiatric-Mental Health**

REFERENCES AND SOURCES

- Berman, A., Snyder, S., & Frandsen, G. (2016). Kozier & Erb's Fundamentals of Nursing: Concepts, process and practice. Boston, MA: Pearson.
- Edel, M. (1982). The nature of nursing diagnosis. In J. Carlson, C. Craft, & A. McGuire (Eds.), Nursing diagnosis (pp. 3-17). Philadelphia: Saunders.
- Fry, V. (1953). The Creative approach to nursing. AJN, 53(3), 301-302.
- Gordon, M. (1982). Nursing diagnosis: Process and application. New York: McGraw-Hill.
- Gordon, M. (2014). Manual of nursing diagnosis. Jones & Bartlett Publishers.
- Gebbie, K., & Lavin, M. (1975.) Classification of nursing diagnoses: Proceedings of the First National Conference. St. Louis, MO: Mosby.
- McManus, R. L. (1951). Assumption of functions in nursing. In Teachers College, Columbia University, Regional planning for nurses and nursing education. New York: Columbia University Press.
- Powers, P. (2002). A discourse analysis of nursing diagnosis. Qualitative health research, 12(7), 945-965

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