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Definitions and Classification

2024–2026

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NANDA International, Inc. Nursing Diagnoses

Definitions and Classification 2024–2026 Thirteenth edition

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Dedication

The editors would like to dedicate this text to Drs. Mary Ann Lavin and Kristine Gebbie, the founders of NANDA International. These visionaries considered a world in which nurses would be valued for their judgments, and would be able to share nursing data across sites to make nursing visible, improve patient care, and advance nursing research that builds nursing knowledge. Fifty years later, we have an international classification that is used worldwide, translated into more than 20 languages, and included in electronic health records. Our work will never be done, but their first step made all that has come since possible. We offer our everlasting gratitude to Mary Ann and Kristine!

Preface

Over the last several years we have seen many changes impacting nursing practice across the globe. The availability of health care professionals and the cost of care remain major concerns as well the increasing demands for care that persist following the COVID-19 pandemic. Increasing technology and specialization have contributed to the complexity of patient care that cannot be completely explained by disease conditions. Now we are seeing a surge in activity related to artificial intelligence as electronic health records become more widely available. These shifts are prompting nurses more than ever to consider developing and using standardized language in clinical care, education and research. Indeed, we are compelled to critically examine how well nursing assessments, interventions and care outcomes can be linked and documented to improve the quality and safety of nursing care. We must also examine how these large data sets can be used to clarify nursing's unique role and impact in health care. Standardizing language will increase nursing's visibility and improve communication within the health care team.

In this 2024–2026 version, the Thirteenth Edition, the classification provides 277 diagnoses, with the addition of 56 new diagnoses. Each nursing diagnosis has been the product of one or more of our many NANDA International (NANDA-I) volunteers and has a defined level of evidence base. Each new diagnosis has been reviewed by our Diagnosis Development Committee (DDC) members assigned as primary reviewers, and by blinded content experts, and refined based on those reviews – with the acceptance of the original submitter(s) – prior to publication. Additionally, the NANDA-I axes and axial terms have been revised. It is our hope that publication of these diagnoses will facilitate further validation studies in different parts of the world, to achieve a higher level of evidence. I want to strongly encourage all students and researchers to submit their nursing diagnosis-related research results to NANDA-I, to improve the evidence base of the classification.

The NANDA-I classification is currently translated into more than 20 languages. During this cycle, we continued to incorporate standardized terms from the United States National Library of Medicine, the Medical Subject Headings (MeSH), to facilitate translation and to provide standardized definitions for our diagnostic indicators. This mapping supports consistent understanding of those diagnostic indicators while also supporting translators in their work.

We continue to encourage the ongoing revision and refinement of existing diagnoses to reflect the most recent evidence and observations from practice. Literature support for all diagnoses is provided through our online companion site, to maintain a smaller book size: www.thieme.com/nanda-i. We also always welcome submissions for new nursing diagnoses. Please visit our website at https://nanda.org/connect-engage/committees-task-forces/diagnosis-development for guidance in submitting your proposals and commentary. We also encourage you to share your ongoing and completed research on nursing knowledge and nursing diagnosis development through our online research registry, available at https://nanda.org/research-registry. This also provides a forum for those who are interested in collaborative efforts related to their area of interest.

Our organization now marks the sixth year in our strategic partnership with our academic partner, Boston College (BC) and the Connell School of Nursing. Under the direction of Dr. Dorothy Jones, the *Marjory Gordon Program for Knowledge Development and Clinical Reasoning* has welcomed scholars from Brazil, Italy, Nigeria and Spain. These scholars have enhanced our global collaboration in creating an evidence base to support the use of standardized language in all countries. Our last conference at BC in 2023 marked our 50th Anniversary as an Association. We look forward to additional conferences, educational opportunities, postdoctoral scholarships, and future opportunities that this partnership with BC will bring. I wish to extend my sincere gratitude to Dr. Jones, Dean Katherine Gregory, and Associate Dean Christopher Grillo for their collaboration, collegiality, and dedication to making this partnership a reality.

I want to acknowledge the work of all NANDA-I volunteers, committee members, chairpersons, and members of the Board of Directors for their time, commitment, devotion, and ongoing support. I would also like to thank the various content experts who, although not members of NANDA International, contributed countless hours to reviewing and revising diagnoses in their area of expertise. The NANDA-I staff, led by our Chief Executive Officer, Dr. T. Heather Herdman, is to be commended for its efforts and support.

My special thanks to the members of the DDC and the Expert Clinical Advisory Panel for their outstanding and timely efforts to review and edit the terminology represented within this book, and especially for the leadership of our DDC Chair, Dr. Camila Takáo Lopes. Representatives from Asia, Europe, Latin America and North America, serve on this important/remarkable committee and provide the essential fuel for NANDA-I's primary mission. The group offers a wealth of expertise and opportunities to engage in knowledge

development. I am deeply impressed and pleased by the astonishing, comprehensive work of these volunteers during this cycle, and I am confident that you will be, as well.

It is my honor and privilege to serve as President of this dedicated association of international nurses, and I look forward to where the future will continue to take our work.

Laura Rossi, PhD, RN, FNI
President, NANDA International, Inc.

Acknowledgments

During this edition, every diagnosis within the NANDA-I classification was revised in some manner. For some diagnoses, these changes were editorial in nature – meaning that phrases were changed to improve consistency throughout the classification. However, others received substantial changes including label changes, definition changes, and/or changes to diagnostic indicators to reflect recent evidence. This work would not be possible without a significant amount of voluntary time and effort donated by many nurses around the world. We would especially like to show appreciation to the following:

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The editors would like to extend a special acknowledgement to Mary Kalinosky, Senior Technical Developer, from Thieme Publishers. Her work to create and adapt the NANDA-I terminology database has significantly improved our ability to evaluate and revise the terms within the classification, and to improve the capabilities we can provide to our users. We are in her debt for her dedication to this enormous project, which seems to grow each cycle. In the current edition she has integrated all of our Axis values, prepared for our current and new level of evidence levels, and improved functionality within the database for us as we work to maintain, revise, and update our content. This database then provides us with the ability to offer electronic health record vendors, and individual health organizations, an electronic format that can be integrated into their varying formats. We could not do this without her, and we are grateful.

In addition, our heartfelt thanks to our entire Thieme Publishing team – Heike Schwabenthan, Marica Maric, Barbara Elias, Laura Diemand, and Michael Wachinger – who are truly part of our NANDA-I work. We especially wish to thank Michael Wachinger for his commitment to the Axis Project, improving our database, and for not only being our publishing lead, but being an integral team member. We were quite happy to present Michael with the NANDA-I *Unique Contribution Award* at our recent 50th Anniversary Conference – a testament to his commitment to moving the Association forward into the digital arena. We are in good hands with Thieme as our primary publishing partner.

We are also grateful to our partners who publish our work in multiple languages, to electronic health record vendors who recognize the importance of incorporating evidence-based nursing terminologies into the patient record, and to all of the translators and nurse reviewers who work to ensure that each language´s translation is as true to the original as possible.

Finally, we are grateful to our users who continue to revise and develop diagnoses, conduct research to improve their validity and, ultimately, improve the quality of patient care and communication about that care.

Please contact us at admin@nanda.org if you have questions on any of the content or if you find errors, so that these may be corrected for future publication and translation.

Sincerely,

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Shigemi Kamitsuru, PhD, RN, FNI
Camila Takáo Lopes, PhD, RN, FNI
NANDA International, Inc.

Contents

Part 1
The NANDA International Classification: Assessment and Diagnosis

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1 Nursing Diagnosis Basics

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1.1 A Brief Introduction to Diagnosing

We begin this discussion by exploring the concept of *diagnosing*, which encompasses the process of determining a patient's diagnosis. It's crucial for nurses to comprehend the skill of not merely assessing and documenting findings, but also engaging in a coherent process of assessment leading to an accurate diagnosis. It is insufficient to complete an assessment and swiftly transition to an electronic health record screen or paper record to haphazardly "select" a diagnosis, devoid of any logical connection to the completed assessment.

This chapter will offer a brief exploration of the nursing discipline and the nursing process before delving into the subject of nursing diagnosis. It will emphasize the significance of distinguishing between the act of *diagnosing* and the subsequent act of *documenting*, highlighting the need for a logical linkage between assessment and diagnosis in nursing practice.

Diagnosis, a fundamental responsibility of professional nurses, unfolds during the nurse's interactions with the patient and their family. This process encompasses an in-depth assessment, extensively detailed in a separate chapter, where nurses conduct physical examinations and conduct a health history to uncover potential health concerns. They gather comprehensive data encompassing the patient's medical and family history, along with current signs and symptoms.

Data collection involves scrutinizing patient records, including laboratory and diagnostic test results, medications, and progress notes from various disciplines. Additionally, crucial data is gleaned through dialogue with the patient, family, or significant others. By meticulously analyzing data acquired through these multifaceted methods, nurses bergin recognizing patterns, identifying anomalies, and ideally uncovering the patient's strengths relevant to their healthcare journey.

Leveraging disciplinary expertise, the nurses employ critical thinking to transform raw data into informed inferences. They embark on formulating hypotheses about potential nursing diagnoses possibly present in the patient, demonstrating a strategic and analytical approach to clinical decision-making.

What is meant by an *inference*? An inference refers to a conclusion or deduction drawn from evidence and logical reasoning, extending beyond explicit or directly presented data or statements. Essentially, it represents a

reasoned interpretation or explanation that goes beyond the surface of the provided raw data. Inferences are crafted by combining existing data – consisting of facts and observations – with prior knowledge derived from nursing theory and disciplinary expertise, along with clinical experience.

This process allows for the formulation of a fresh understanding or interpretation that surpasses the initial data set. Inferences often entail making well-informed conjectures or predictions based on available evidence. The ability to derive accurate inferences stands as a pivotal facet of critical thinking, problem-solving, and the diagnostic process in nursing practice.

Drawing upon the analysis of inferences, nurses proceed to diagnose the patient responses inferred from the data. They may engage in collaboration with patients, families, colleagues, and professionals from other disciplines to validate their inferences. This collaborative process aims to confirm or challenge their diagnostic hypotheses, facilitating a comprehensive understanding of the human responses evident in the patient.

However, without a grasp of the underlying concepts and theories within the nursing discipline, accurately deriving inferences from raw data becomes a challenging task. Understanding these foundational principles and theories is crucial for nurses to make accurate inferences and derive meaningful insights from the data obtained during patient assessments.

For example, James, a new nurse in the neonatal intensive care unit (NICU), gathers the following data from the patient record and during care and feeding of Baby Samuel:

> Samuel is a 27-week old neonate born 11 days ago. He has moderate respiratory distress syndrome, and is on 2 L of oxygen via nasal cannula. Today, he exhibits yawning, finger splaying and hiccoughs throughout his morning feed by orogastric feeding tube, and has 3 episodes in which his oxygen saturation level drops below 85%. His weight has been increasing between 5–10 g/day, and he is in the 28th percentile for weight.

As a novice nurse in the NICU, James might not immediately identify signs such as yawning, finger splaying, hiccoughing, and desaturation as stress responses in neonates. Recognizing these requires a deep understanding of neurodevelopmental organization in this patient population. He may perceive weight gain as positive without realizing that it falls below norms for this age group, indicating that Baby Samuel expends more calories than he consumes.

However, equipped with knowledge about neonatal growth and neurodevelopment, James would discern these stress responses and growth concerns.

These indicators suggest that the infant struggles to tolerate feeding and lacks adequate calorie intake for normal growth. Accurate inferences arising from this insight might prompt James to consider diagnoses related to neurodevelopmental behavior, stress response, and nutrition, among others, prompting further data collection.

Arriving at a diagnosis in this context necessitates holistic data collection, informed interpretation (inferences), application of clinical expertise, and comprehensive disciplinary knowledge, underscoring the complexity of neonatal care in the NICU environment.

The process of *diagnosing* stands distinct from the act of *documenting* the diagnosis. Diagnosing involves a cognitive process, while documenting serves as a mechanism for nurses to convey clinical reasoning and judgment (diagnosis) in a standardized manner, facilitating seamless communication across the interdisciplinary healthcare team.

Standardized terms play a pivotal role in ensuring that all members of the care team comprehensively understand the nursing concerns for each patient, along with the treatment plan, which can be uniformly documented. Utilizing standardized and coded terms also bolsters research endeavors by enabling the study of patient responses that possess identical definitions and diagnostic indicators across various sites, care settings, and even countries.

The adoption of standardized terminology to delineate clinical judgments and interventions maintains consistency across multiple healthcare disciplines, including nursing, medicine, physical therapy, psychology, and others. This unified approach ensures effective communication and fosters a common understanding of patient care across diverse healthcare settings.

1.2 Nursing as a Discipline

Nursing practice revolves around evaluating, diagnosing, and addressing actual or potential individual, family, or community responses to health issues or life processes. These clinical judgments, known as nursing diagnoses, form the foundation for selecting nursing interventions aimed at achieving outcomes for which nurses have accountability. While most people are familiar with medical diagnoses – the identification of diseases, illnesses, or injuries explaining an individual's signs and symptoms (Hansbauer, 2021)– many are unaware that nurses also establish diagnoses. Interestingly, in contemporary practice, some nurses may assert their disuse of nursing diagnoses, opting instead to strictly adhere to physician directives or follow established protocols, perceiving this as a form of professional autonomy. However, this trend

might stem from misconceptions surrounding the teaching of the nursing process and nursing diagnosis over time, as well as the lack of standardized systems within healthcare organizations to support the implementation of nursing diagnosis.

Despite this, many countries mandate that nurses utilize the nursing process, which encompasses the identification of nursing diagnoses as a fundamental framework for delivering nursing care. Research demonstrates that nursing diagnoses, when appropriately employed, possess greater predictability than medical diagnoses alone in critical aspects such as length of stay and hospital readmissions (Zeffiro et al., 2020; D'Agostino et al., 2019; Sanson et al., 2019; D'Agostino et al., 2017; Sanson et al., 2017).

Emphasizing that patients are the focal point of nursing practice extends beyond addressing their diseases or injuries. It encapsulates nurses' attention on how individuals, families, and communities respond to life processes or health issues and their proactive efforts to enhance their health and prevent such problems. Nurses play a pivotal role in patient safety, offering education, imparting skills to improve health, and lending an empathetic ear to understand patients' unique experiences. They stand at the forefront of advocating for patient well-being and fostering holistic care.

1.3 The Nursing Process

The nursing process serves as a foundational topic in nearly every nursing program, often introduced as one of the initial courses in the curriculum. This structured approach hinges upon clinical reasoning, which, in turn, draws heavily upon understanding crucial concepts within the nursing discipline. However, when embarking on your nursing education, you might lack familiarity with these concepts crucial for your future practice. It's challenging to effectively employ clinical reasoning in practical scenarios without first hand exposure to real patient situations and a solid grasp of core content fundamental to nursing practice. Developing proficiency in this skill requires time, consistent practice, and hands-on experience gained over time in clinical settings. It is through this iterative process that aspiring nurses evolve and refine their clinical reasoning abilities, gradually gaining competence in applying nursing concepts to real-world patient care situations.

The nursing process offers a comprehensive framework for organizing the multifaceted elements of the cognitive process nurses engage in while assessing and determining appropriate patient care. It's important to note that this process isn't strictly linear; rather, it involves a dynamic interplay, with

continuous reevaluation as new information surfaces, prompting a reassessment of potential patterns exhibited by the patient, family, or community.

Integral to the nursing process is the application of nursing knowledge, encompassing nursing theory, nursing science, and underlying nursing concepts (Herdman, 2013). This structured approach involves a series of interconnected steps: assessment, diagnosis, planning desired outcomes and interventions, implementation, and evaluation. These steps aren't confined to a linear progression but instead require flexibility, iterative thinking, and adaptability to evolving patient data and responses, ensuring a patient-centered and comprehensive approach to care. This foundational understanding serves as a lens through which nurses discern intricate connections within patient data, enabling them to recognize meaningful patterns and determine accurate clinical diagnoses. It is this application and integration of theoretical knowledge and practical application that allows nurses to form sound clinical judgments and deliver comprehensive care tailored to each patient's unique needs.

The various components of the nursing process unfold in a somewhat simultaneous manner within the nurse's cognitive framework. Notably, the rectangles in the nursing process diagram (▶ Fig. 1.1) illustrate a closer

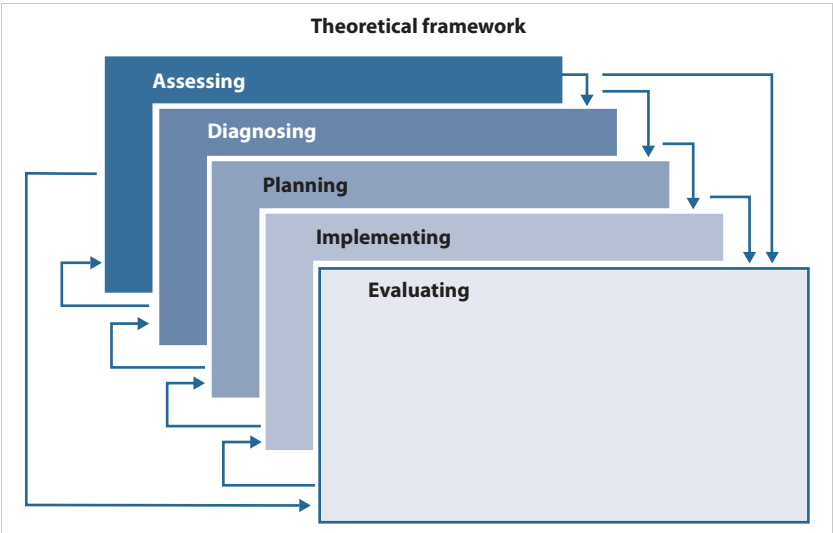

Fig. 1.1 The nursing process. (Source: From Bachion, M.M. (2009). Instrumentos básicos do cuidar: observação, interação e mensuração. [Basic instruments for delivering care: observation, interaction and measurement]. I Simpósio Brasiliense de Sistematização da Assistência de Enfermagem, 2009. Brasília, Brazil. (Portuguese). Reproduced with the author's permission.)

starting point on the left and a further endpoint on the right. This visual asymmetry signifies the time period following the commencement of data collection, where the nurse engages in reasoning and clinical judgment to initiate the identification of diagnoses, establish patient-specific outcomes, and determine appropriate interventions.

During this phase, as the nurse navigates through these cognitive operations, there is a parallel initiation of implementing the chosen interventions and concurrently assessing and evaluating their outcomes (Bachion, 2009). This dynamic and interconnected approach underscores the multifaceted nature of the nursing process, where several facets interplay concurrently, reflecting the intricate decision-making process inherent in nursing practice.

1.4 Principles of Nursing Diagnosis: Introduction

Each healthcare profession possesses its distinct approach to defining its knowledge base and applying that knowledge in practice. Many professions utilize a standardized language to articulate their expertise and encode it into electronic systems for documentation and communication. Physicians, for instance, focus on treating diseases and injuries, and employ the International Classification of Diseases (ICD) taxonomy (World Health Organization, 2019) to represent and encode the medical conditions they address.

Professionals in mental health fields such as psychologists, psychiatrists, and psychiatric-mental health advanced registered nurses concentrate on treating mental health disorders. They rely on the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) (American Psychiatric Association, 2022) to categorize and encode these conditions.

It is crucial to note that while nurses acquire knowledge about diagnoses contained within both the ICD and the DSM-5-TR, their role differs. Nurses do not diagnose using these classifications; instead, they independently diagnose and manage human responses to health problems and life processes. Nurses employ the NANDA International, Inc. (NANDA-I) nursing diagnosis classification system to diagnose and document their clinical judgments, emphasizing a holistic perspective that focuses on the patient's responses to health conditions and life processes, or a susceptibility to those responses.

1.4.1 Nursing diagnosis: what it is and what it is not

A nursing diagnosis encapsulates a clinical judgment derived from comprehensive assessment findings, informed by an understanding of crucial concepts within the nursing discipline. These concepts encompass both theoretical and practical knowledge, reflecting discernible patterns or phenomena that hold

significance in the realm of nursing care. The formal definition of nursing diagnosis for NANDA-I is:

"…a clinical judgment concerning a human response to health conditions / life processes, or a susceptibility to that response, that is recognized in an individual, family, or community. A nursing diagnosis provides the basis for selection of nursing interventions to achieve outcomes for which the nurse has accountability" (approved at the Ninth NANDA Conference; amended in 2009, 2013, 2019, 2023).

It is crucial to discern that a diagnosis is distinct from a mere observation or symptom, such as "agitation" or "peripheral edema." A diagnosis encapsulates the culmination of nursing disciplinary knowledge and clinical reasoning meticulously applied to assessment data. Conversely, observations made by nurses pertain to noting specific signs, symptoms, or patient behaviors without the interpretive framework or comprehensive analysis that defines a diagnosis.

This area often causes confusion among nurses when they encounter observations such as cardiac arrhythmia and mistakenly consider it a diagnosis. Cardiac arrhythmia is a MeSH® term (National Library of Medicine, 2023) defined as, "Any disturbances of the normal rhythmic beating of the heart or myocardial contraction." It characterizes an anomaly in heart rhythm, and is categorized as a symptom (National Institute of Health, National Heart, Lung, and Blood Institute, 2023) not a judgment term reflecting a human response. As a symptom, arrhythmia serves as a diagnostic indicator for various nursing diagnoses, including but not limited to:

- Risk for ineffective cerebral tissue perfusion (00201)
- Risk for decreased cardiac output (00240)
- Decreased body temperature (00472)
- Ineffective infant suck-swallow response (00295)
- Impaired adult ventilatory weaning response (00430).

These nursing diagnoses leverage arrhythmia as a diagnostic cue or contributing factor, highlighting its role in assessing the patient's condition rather than being a standalone diagnosis representing a specific human response.

Distinguishing between a symptom and a diagnosis involves considering whether there are autonomous nursing interventions that can prevent or ameliorate the condition. While a nurse cannot independently reverse a cardiac arrhythmia, interventions can target addressing *the risk for decreased cardiac output* (00240) by addressing factors such as inadequate self-management of arrhythmia treatment, tobacco use, and insufficient daily physical activity for age and gender.

For instance, the nurse might devise a plan with the patient at *risk for decreased cardiac output* (00240), aiming to ensure comprehension and consistent adherence to prescribed arrhythmia medication. Simultaneously, efforts may focus on gradually reducing daily smoking habits and enhancing daily physical activity levels. As these interventions unfold, the nurse monitors changes, such as a potential decrease in arrhythmia frequency or severity, a noticeable reduction in its impact on the patient, a decline in daily cigarette consumption, and an increase in physical activity. These changes serve as potential treatment outcomes.

However, effectively addressing *risk for decreased cardiac output* (00240) demands a holistic approach beyond solely managing arrhythmia. While arrhythmia is an essential aspect, the nurse's interventions and assessments span a broader spectrum to comprehensively address the patient's health status and progress throughout the treatment trajectory.

Observations encompass raw data obtained about the patient's physical, psychosocial, spiritual, and emotional condition. During patient encounters, nurses continuously gather various observations to track changes in health status, pinpoint signs, symptoms, strengths, and abnormalities that might indicate a health response. These observations, being raw data, are not diagnoses in themselves as they lack interpretation and contextualization.

Observations serve as the foundational data for diagnosis, initiating the data collection process. For instance, vital signs, skin color, consciousness level, gait patterns, family size, or an individual's underestimation of their coping abilities are examples of observations. Within NANDA-I, nurses can find these observations outlined as diagnostic indicators, including defining characteristics, related factors, risk factors, and associated conditions or populations at risk.

However, merely having observations isn't sufficient for a diagnosis. It requires nursing knowledge, explanatory theories, and the ability to interpret these observations. This transformation of raw data into meaningful information, along with organizing and identifying patterns among these observations, is essential for formulating a diagnosis. Without this interpretative step, the data remains disconnected, preventing the synthesis necessary for diagnosing patients effectively.

The NANDA-I classification encapsulates nursing diagnoses, which are clinical judgments refined into standardized, pre-coordinated terms. The term "pre-coordinated" implies that these nursing diagnosis labels are meticulously formulated as complete, defined, and evidence-based terms, ensuring their practical application in clinical settings.

It is important to note that NANDA-I nursing diagnoses are not constructed ad hoc at the bedside by combining multiple terms in real-time. This practice is not endorsed by NANDA-I as it hinders the creation of precisely defined labels backed by research evidence. Creating diagnoses in this manner does not establish a structured link between assessment data and diagnosis, impeding the validation and consistent application of the terminology in clinical practice.

Our pre-combined diagnostic labels are designed to follow a multi-axial system. NANDA-I still retains some diagnosis labels that are constructed using only one term from Axis 1, which are often regarded as symptoms, such as *contamination* (00181) or *hyperthermia* (00007). Additionally, some diagnoses, such as *labor pain* (00256), combine two nouns into a compound noun phrase, represented by the Axis 1 focus term, comfort. A few others are constructed with terms from both Axis 1 (focus) and Axis 6 (clinical course); they can also present as symptoms, such as *acute confusion* (00128), and *acute pain* (00132). According to the ISO model, these are considered clinical findings (International Standards Organization, 2023). However, it is important to note that these findings, similar to observations, do not meet our definition of nursing diagnoses, even though they are represented as such in the ISO model (2023).

Efforts are underway to eliminate these terms from the classification. In fact, in this latest cycle, we successfully removed 26 such terms, and we aim to complete this refinement with the upcoming edition. None of these diagnosis labels explicitly incorporate terms from Axis 3 (judgment). Nurses assess a wide array of aspects related to these symptoms, such as their severity, impact on the patient's self-management, their physiological or psychological manifestations, their implications on the patient's overall health condition, among other factors. Their judgment about these symptoms involves evaluating various facets, including their nature, impact, potential causes, and the appropriate interventions or responses required to address them effectively.

Nurses address various responses exhibited by individuals, families, and communities concerning health conditions and life processes, central to the realm of nursing care as depicted in the circle attributed to ▸ Fig. 1.1. Within the NANDA International classification, nursing diagnoses encompass problem-focused diagnoses and diagnoses of potential. These diagnoses can be delineated as follows:

– **Problem-focused diagnosis** – a clinical judgment concerning an *undesirable human response* to a health condition / life process that exists in an individual, family, or community

- **Potential diagnosis** – NANDA-I has to use the axes terms: *potential to improve* to represent health promotion diagnoses, and *potential to deteriorate* to represent risk diagnoses. These two potential forms of diagnostic statements within NANDA-I are entitled:
  - **Risk diagnosis** – a clinical judgment concerning the *susceptibility* of an individual, family, or community for developing an undesirable human response to health conditions/life processes (representing a *potential to deteriorate*)[1]
  - **Health promotion diagnosis** – a clinical judgment concerning *motivation and desire* to increase well-being and to actualize health potential (representing a *potential to improve*). These responses are expressed by a readiness to enhance specific health behaviors, and can be used in any health state. In cases where individuals are unable to express their own readiness to enhance health behaviors, the nurse may determine that a condition for health promotion exists and then act on the client's behalf.

While relatively scarce within the NANDA-I classification, nurses are empowered to diagnose a syndrome. A syndrome constitutes a clinical judgment encompassing a specific cluster of problem-focused nursing diagnoses co-occurring together and requiring similar interventions. For instance, *elder frailty syndrome* (00353) represents such a diagnosis, characterized as a "dynamic state of disequilibrium that includes deterioration in functions and reserves across physiologic systems". This syndrome comprises various nursing diagnoses including: *decreased activity tolerance* (00298), *excessive fatigue burden* (00477), *impaired physical mobility* (00085), *inadequate protein-energy nutritional intake* (00359), among others. Etiologic factors contributing to this syndrome include: decreased energy, anorexia of aging, fear of falling, malnutrition, muscle weakness, and sedentary behaviors. Moreover, a patient can also receive a diagnosis of being at risk for a syndrome, as exemplified by the diagnosis of *risk for elder frailty syndrome* (00357).

Certainly, in instances where the nurse observes etiological factors associated with multiple diagnoses, employing similar interventions that can positively affect each diagnosis may be plausible. Employing a syndrome diagnosis in such scenarios enables the nurse to encapsulate a comprehensive view of

1 It should be noted that in this edition, the phrase that was previously used in risk diagnoses at the end of each definition, "*which may compromise health*", has been removed. It was determined that this phrase was unnecessary, as the "*Susceptible to*" phrase makes it clear that there is a potential for this diagnosis to deteriorate into a problem-focused diagnosis, which by its own definition is an *undesirable human response*, and therefore may compromise health. However, it should be noted that a risk diagnosis is not something that is intended to be used for any patient, but for those who are at a higher risk than the average population.

the observed pattern in the patient, merging these interrelated human responses into a single overarching concept. By doing so, rather than pinpointing several individual nursing diagnoses that might essentially share identical interventions, the nurse can recognize the syndrome diagnosis that comprehensively encapsulates the interconnected response of the patient, family, or community. Subsequently, the focus can be directed towards interventions aimed at enhancing nutrient intake, addressing muscle weakness, mitigating fatigue, and alleviating fear, thereby influencing the individual diagnoses integrated within the broader context of the syndrome, while also addressing the syndrome itself.

A nursing diagnosis encompasses more than just a label; it constitutes a standardized, well-defined phrase reflecting the nurse's judgment resulting from comprehensive assessment, nursing knowledge, and clinical judgment. For instance, take the nursing diagnosis of *excessive caregiving burden* (00366) with its specific definition: "overwhelming multidimensional strain when caring for a significant other." To make this diagnosis, the nurse identifies various diagnostic indicators during assessment, serving as diagnostic indicators that corroborate this specific diagnosis. These indicators may include difficulty enjoying leisure activities, difficulty meeting personal healthcare needs, headache, gastrointestinal discomfort, weight change, an overwhelming sense of responsibility, and anxiety.

Furthermore, the assessment may reveal underlying factors contributing to the diagnosis, providing opportunities for the nurse to intervene and potentially mitigate or alleviate the severity of the diagnosis. These etiological factors might encompass difficulty navigating complex health care systems, difficulty accessing support, inadequate knowledge about community resources, or impaired resilience.

In summary, a nursing diagnosis is not simply a descriptive label or an arbitrary assortment of words; it is a meticulously constructed, standardized phrase that signifies the nurse's considered judgment. It symbolizes the observed pattern or "picture" of how the patient, family, or community is responding to a health condition or life process, synthesized through nursing knowledge and clinical judgment.

1.5 Kamitsuru's Tripartite Model of Nursing Practice

One model for considering the types of interventions nurses perform, and the basis of knowledge that underlies those interventions, is Kamitsuru's Tripartite Model of Nursing Practice (Kamitsuru, 2022; 2008).

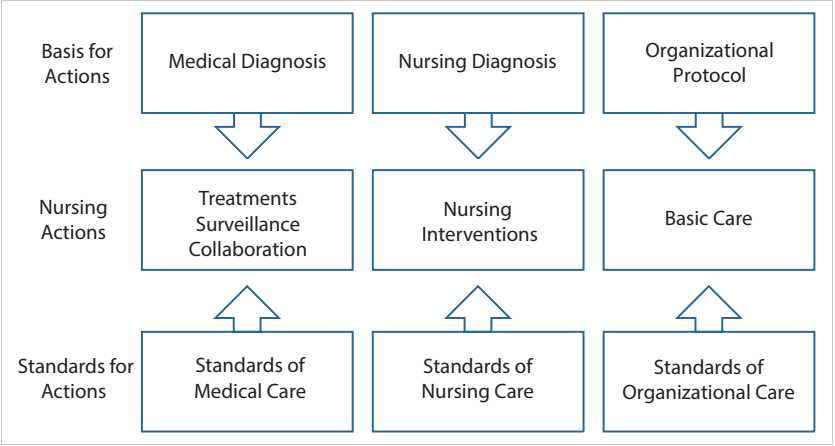

Fig. 1.2 Kamitsuru's Tripartite Model of Nursing Practice. (Source: Used with permission of Igaku-Shoin Ltd., Tokyo, Japan.)

Nurses typically collaborate closely with patients confronting various medical issues. Despite this, it is crucial to recognize the legal distinctions in roles between nurses and physicians. Physicians bear the responsibility for diagnosing and treating medical problems, while nurses assume a legal obligation for diagnosing and treating human responses within the realm of the nursing discipline. It is imperative to grasp the differentiation between issues grounded in nursing knowledge and those stemming from medical diagnoses. Consequently, nursing diagnoses are not crafted by renaming medical terms, and not every nursing intervention necessitates a corresponding nursing diagnosis.

To elucidate these concepts, let's delve into the broader context of nursing practice within healthcare, employing the Tripartite (Three Pillar) Model of Nursing Practice (▶ Fig. 1.2) as a framework (Kamitsuru, 2022; 2008). This model delineates three pivotal components, or pillars, of nursing practice, each distinct yet intricately interconnected. In the realm of clinical practice, nurses are tasked with a spectrum of actions grounded in diverse standards.

The initial pillar involves practices and interventions directly influenced by medical diagnoses. Nursing actions within this realm encompass activities tied to medical treatments, patient surveillance, monitoring, and collaborative efforts across disciplines. To illustrate, consider the following scenario:

> Mr. T is a 79-year-old, bed bound, unconscious male patient previously diagnosed with dementia, living at home with his spouse. He arrives in the hospital unit from the emergency room, after having been diagnosed with a stroke.

The physician orders intravenous (IV) medications, neurovascular checks, and places him in a "nothing by mouth" (NPO) status. The nurse implements the IV order as directed and carefully monitors the patient's response to the medications. The nurse also schedules and implements the neurovascular checks and ensures that he is NPO in the computer system, and that appropriate NPO signage is placed in his room.

Nurses implement these actions in response to medical diagnoses and medical treatment orders, and use medical standards of care as the basis for these nursing actions.

Secondly, practice may be guided by organizational protocols, encompassing activities tied to fundamental care, such as changing linens and providing hygiene and daily care. Additionally, these protocols may extend to interventions mandated by organizations for all patients or specific patient groups. For instance, a hospital may stipulate that every patient aged 60 or older undergoes screening using a standardized, validated instrument to assess the risk of falls. This screening, which is aimed at fall prevention, does not necessarily lead to a nursing diagnosis such as *risk for adult falls* (00303), as the majority of these patients may not be identified as being at risk; rather, they belong to an at risk population. These actions are not directly correlated with either medical or nursing diagnoses but are grounded in organizational standards of care.

Finally – and of critical importance to us as nursing professionals – practice may be driven by nursing diagnoses. Autonomous nursing interventions do not require physician approval or permission. Let's take another look at the case of Mr. T who was diagnosed with a stroke.

Mr. T is comprehensively assessed by the nurse, who diagnoses several human responses. Thus, the nurse will position him to address the nursing diagnosis, risk for aspiration (00039), and begin a turning schedule because of his determined diagnosis, risk for adult pressure injury (00304). Based on the fall scale results and further assessment, Mr. T is diagnosed with risk for adult falls (00303). Supportive care may also be provided to his spouse, who is also taking care of him at home, and is now anxious about this new event and how this will affect their lives together. The nurse may assess her for excessive caregiving burden (00366) to determine if this is present, or if she has risk for excessive caregiving burden (00401).

Nurses take these actions based on nursing diagnoses, and use nursing standards of care as the basis for their nursing interventions. When, after the screening required by the hospital and subsequent assessment, the nurse identified

risk for adult falls (00303) was an appropriate diagnosis, a treatment plan was initiated to address this concern, which was identified as a nursing diagnosis.

The integration of all three pillars constitutes the essence of nursing practice, each possessing a distinct knowledge base and corresponding responsibilities. While it is crucial for nurses to comprehend all three pillars, only one is directly linked to the unique disciplinary knowledge of nursing – this is the realm where nursing diagnoses come into play. This model underscores the rationale behind not rebranding medical diagnoses as nursing diagnoses, as medical diagnoses are firmly established within the medical domain. However, it is essential to recognize that medical diagnoses fall short of encapsulating the entirety of nurses' understanding about patients, the judgments they form regarding human responses, and the interventions implemented.

Nursing diagnoses, in contrast, serve the purpose of elucidating the independent clinical judgments made by nurses about their patients. Consequently, nursing diagnoses serve as the foundation for autonomous nursing interventions, providing a framework for the distinctive contributions of nursing to patient care.

1.6 Principles of Nursing Diagnosis: Knowledge of Nursing Concepts

Prior to commencing an assessment, a foundational grasp of key concepts, or nursing diagnostic foci, is imperative. Critical concepts integral to nursing practice encompass behavior, gastrointestinal function, nourishment, thermoregulation, self-care, identity, cognitive function, and relationships, to name just a few. Proficiency in these concepts empowers the nurse to discern patterns within gathered data, enabling accurate diagnoses.

Many authors focus on the nursing process, without taking the time to ensure that we understand the concepts of nursing science; yet, the nursing process begins with – and requires – an understanding of these underlying concepts of nursing and the human experience. If we do not understand our disciplinary concepts (or ideas defined by our knowledge), we will struggle to identify how pattern formation of the whole is experienced by our patients, families and communities.

A concept is an image or abstract idea. Central concepts of the discipline of nursing include environment, health, person, and nursing (Walker & Avant, 2019). Other concepts emerge as we describe phenomena of concern to nursing, such as well-being, stress, or activity. It is critical that we know (and teach) these concepts so that nurses can recognize normal human

responses and patterns inconsistent with usual responses, identify risks or threats to health, and promote health and wellness. Engaging in the nursing process is meaningless if we do not understand these underlying nursing concepts and if we cannot identify them from the individual patterns manifested within the data we collect during assessment.

Without a solid grounding in concepts, the knowledge or phenomena of concern to nursing, it is difficult to articulate hypotheses or statements of probability about patients and their experiences. Without this knowledge, we lack the ability to engage in a more in-depth assessment and obtain new data that will confirm or eliminate a tentative problem or diagnosis. Although conceptual knowledge has not generally been included within the nursing process, knowing this information enhances our ability to understand the human experience to its fullest extent.

1.6.1 Linking Concepts to Data

What do we mean by pattern formation or data synthesis? We are talking about how our minds pull together information from a variety of data points to form a picture of what we are seeing, and then recognize a name. Let us first look at a nonclinical scenario.

Assume you are out for a walk, and you go past a group of men seated at a picnic bench at a park. You notice that they are doing something with little rectangular objects, and they are speaking in very loud voices – some are even shouting – as they slam these objects on the table between them. The men seem very intense, and it appears they are arguing about these objects, but you cannot understand what these objects are or what exactly the men are doing with them. As you slow down to watch them, you notice a small crowd has gathered. Some of these individuals occasionally nod their heads or comment in what seems to be an encouraging manner, some seem concerned, and others appear to be as confused by what they are watching as you are.

What is happening here? What is it that you are observing? It may be hard for you to articulate what you are seeing if it is something with which you have no experience. When we do not understand a concept, it is hard to move forward with our thinking process. Suppose that we told you that what you were observing was men playing Mahjong, a type of tile-based board game. The tiles are used in a manner similar to cards, only they are small, rectangular objects traditionally made of bone or bamboo. Although you may not know anything about Mahjong, you can understand the concept, “game”. With this understanding, you might begin to look at the scene unfolding before you in a different way. You might begin to see the four men as

competitors, each hoping to win the game, which might explain their intensity. You might begin to consider their raised voices as a form of good-natured taunting of one another, rather than angry shouting. Once you understand the concept of "game", you can begin to paint a picture in your mind as to what is happening in this scene, and you can begin to interpret the data you are collecting (cues) in a way that makes sense within the context of a game. Without the "game" concept, though, you might continue the struggle to make sense of your observations.

Now let us look at the idea of nursing concepts (knowledge) using a clinical scenario. Lisa is on her first clinical placement as a nursing student, under the supervision of Prof. Leonard, a faculty member in an elderly independent/assisted living facility. On one of her placement days, Lisa is assessing Mr. Smith, while assisted by her professor.

Mr. Smith is a 75 year old cisgender man who has lived in the facility for two months. He tells Lisa that he lacks energy all the time which is new for him, and he finds he cannot concentrate, and many evenings he realizes he never even brushed his teeth. He is very concerned that there is something wrong with his heart. Lisa begins by taking his vital signs, but as she is doing this, she asks Mr. Smith to tell her what has been happening in his life since he began living at the facility. He indicates that he had to move in after his wife died from a heart attack, because he really didn't want to deal with all of the house chores and running errands all by himself, and his only daughter lived abroad with her husband and 4 children. He denies any chest pain, heart palpitations, or shortness of breath. When Prof. Leonard asks him why he's worried about his heart, he says "well, this thought keeps repeating in my mind every day, that my wife wouldn't have died if I had insisted that she went to see a cardiologist earlier".

Lisa tells Mr. Smith that his vital signs are very good. Lisa asks him how often his daughter gets to visit him. Mr. Smith indicates that she had to leave immediately after his wife's funeral, because she and her husband had a lot of work activities, and they had not been able to visit him since then, but they usually spoke on the phone once a week. He notes that he doesn't really have an interest in the living facility activities, and the residents don't share many interests with him. He is a retired professor, is very interested in history and cultural offerings such as theater and music, but most of the residents don't have this background and are really more interested in sports and local gossip.

He says it was very hard to leave his neighborhood because there was a couple who lived across the street and they were very good friends. They met at least three times a week for dinner, or they watched TV or played board games, and they even traveled together a couple of times. Now they only talk by phone.

Although he is glad he gets to talk with them, he says it isn't the same as enjoying dinner with his wife and them. Unfortunately, none of them drive so they aren't able to get together easily. He also indicates that his wife was the strong link to the relationship with the neighbors, because she was always proposing and planning different activities. He misses the camaraderie with the neighbors, and going to plays and music events with them and his wife.

The technician arrives to perform an ECG, so Lisa and her professor step outside of the room.

Prof. Leonard asks Lisa what her preliminary hypotheses are regarding what she now knows about Mr. Smith. She indicates that she is worried about his heart and needs more data about his cardiovascular condition, and that she is worried about him being lonely, because he does not have anyone that he can really talk with. Prof. Leonard agrees that they need further data to determine if there is, indeed, a cardiac issue. He also agrees that the lack of social support for Mr. Smith is a concern.

Prof. Leonard goes on to suggest to Lisa that Mr. Smith may be experiencing stress related to his change in living environment, which could be influencing his emotional and physical status. He also suggests that there could be a concern with regard to resilience and / or coping, and he is also concerned about Mr. Smith's social connections or networks. He notes that it is possible that some of the symptoms Mr. Smith is experiencing could be related to his grief over losing his wife to unaddressed cardiac conditions.

He recommends collecting additional information regarding Mr. Smith's coping mechanisms, resilience and his grieving process while they await results of the cardiac tests that are being performed. Prof. Leonard draws Lisa's attention to the nursing diagnoses, *maladaptive coping (00405), impaired resilience* (00210), and *inadequate social support network* (00358), and she realizes that his assessment data are defining characteristics and related factors of this diagnosis. Lisa's professor talks with her about the grieving process, and the things that can impact it, such as inadequate social support (Mr. Smith's recent move; lack of connection with his daughter and friends). He quickly considered these nursing diagnoses because he understood the normal grieving process, the importance of social connectedness, and resilience.

He explains to Lisa that, once they have more information and have confirmed a diagnosis, they could speak with Mr. Smith, and then with the facility director, to get him enrolled in a bereavement support group and / or begin counseling with mental health staff at the nursing home, so that he can express his grieving process, if this is the determined focus. He also suggests

they could speak with Mr. Smith about reconnecting with his neighborhood friends, in person, and to the director of resident life to find out how he might be able to visit his friends, or have them come to the facility to see his new apartment to slowly get Mr. Smith involved in his new community. They could also help him to explore options available through his facility that could link him to social networks he might better enjoy. These could be interventions to support the lack of social support network and to bolster his resilience, if these are determined to be priority diagnoses.

Lisa, as a nursing student, did not yet have the conceptual knowledge from which to draw; for her, these diagnoses did not seem obvious. This is the reason why studying concepts underlying diagnoses is so important. We cannot understand an individual's usual human response patterns without drawing on conceptual knowledge throughout the nursing process.

1.7 Assessing

The assessment process entails the systematic gathering of both subjective and objective data, drawing from diverse sources such as vital signs, patient and family interviews, physical examinations, and laboratory results. Historical information from the patient or family, as well as details within the patient chart, adds crucial context to this comprehensive evaluation. In addition to identifying existing health issues, nurses proactively collect data on patient and family strengths to pinpoint opportunities for health promotion, as well as potential risks to prevent or mitigate potential problems.

These assessments are grounded in theoretical frameworks, incorporating nursing theories such as Careful Nursing (Meehan et al., 2018), Culture Care Theory (Leininger, 2002), and the Theory of Transpersonal Caring (Watson, 2005). Operationalizing elements from these theoretical frameworks is facilitated by assessment tools, with Marjory Gordon's Functional Health Patterns (FHPs, 1994), which is strongly endorsed by NANDA-I, serving as an exemplary model. This model will be further developed in Chapter 2.7.

Nursing-centric frameworks offer a structured means of organizing extensive data, distilling it into manageable patterns or categories. It is essential to note the diversity of assessment approaches, ranging from broad to narrow in focus. These encompass risk assessment tools, patient-reported assessment tools, and in-depth nursing assessment tools, among others, each tailored to provide a nuanced understanding of the patient's health status.

At the core of nursing diagnosis lies clinical reasoning – an intricate process that involves employing clinical judgment to discern the patient's

condition and making informed decisions on the necessary course of action (Levett-Jones et al., 2010). Clinical judgment, as defined by Tanner (2006, p. 204), is "an interpretation or conclusion about a patient's needs, concerns, or health problems, and/or the decision to take action (or not)."

Key issues, often referred to as diagnostic foci, may surface early in the assessment, such as concerns related to physical integrity, energy levels, nourishment, and stress response, providing a starting point for the diagnostic process. For instance, a patient expressing symptoms such as insomnia, heart palpitations, intense dread, and demonstrating observable behaviors such as scanning, facial flushing, psychomotor agitation, and increased sweating, may lead an experienced nurse to identify *excessive anxiety* (00400) based on the client's report and observable signs, drawing on their expert knowledge of stress responses.

Expert nurses possess the ability to swiftly discern patterns in clinical cues from assessment data, seamlessly transitioning to nursing diagnoses. In contrast, novice nurses may follow a more sequential process in evaluating potential nursing diagnoses. This dynamic interplay of clinical reasoning underscores the complexity and nuance inherent in the diagnostic process.

Several potential diagnoses may be considered in this next example.

During an initial assessment of a cancer patient between chemotherapy appointments, she is noted to be experiencing severe breathing difficulties with the minimal activity of walking from the reception area to the treatment room. The nurse may begin to hypothesize that there could be issues related to breathing pattern, activity tolerance, and/or sedentary behaviors. The nurse might use valid and reliable instruments that measure actual responses, to further assess for potential diagnoses, and confirm or refute their diagnostic hypothesis. Some examples might include use of the Edmonton Dyspnea Inventory (Kalluri et al., 2023), the International Sedentary Assessment Tool (Prince et al., 2019), the Sedentary Behaviour Questionnaire (Rosenberg et al., 2010), or the Total Dyspnea Scale for Cancer Patients (Hashimoto et al., 2019). Other scales might help differentiate between a respiratory cause for the breathing difficulty and that of fatigue or energy imbalance, such as the Fatigue Severity Scale (Lerdal, 2021). Use of standardized instruments can support diagnosis, as the nurse considers human responses that are characterized by breathing difficulty with activity, including: *impaired gas exchange* (00030), *ineffective breathing pattern* (00032), *excessive fluid volume* (00026), *excessive fatigue burden* (00477), *impaired physical mobility* (00085), and *decreased activity tolerance* (00298).

As another example, if upon initial assessment, a potential diagnosis related to managing chronic pain is identified, nurses might work with patients to use valid and reliable instruments that measure risk or signs/symptoms of an actual response, to further assess this possibility and confirm or refute their diagnostic hypothesis. Some examples might include use of the Grade Chronic Pain Scale – Revised (Von Korff et al., 2020), Dallas Pain Questionnaire (Andersen et al., 2006), Oswestry Disability Scale (Roland et al., 2000), or the Mankowski Pain Scale (Douglas et al., 2014). These instruments can support nursing clinical judgment as the nurse considers *chronic pain* (00133), *chronic pain syndrome* (00255), *impaired physical comfort* (00380), and *ineffective pain self-management* (00418). These assessment instruments can provide valuable data to support diagnosis.

1.8 Diagnosing

A nursing diagnosis represents the culmination of diagnostic reasoning (Gordon, 1994). It is crucial to recognize that problem-focused diagnoses should not be inherently deemed more critical than risk diagnoses. In certain scenarios, a risk diagnosis may take precedence as the highest priority for a patient.

Consider a patient newly admitted to a skilled nursing facility with nursing diagnoses encompassing *impaired oral mucous membrane integrity* (00045), *impaired memory* (00131), *readiness for enhanced health self-management* (00293), and *risk for adult pressure injury* (00304). While *impaired oral mucous membrane integrity* (00045) and *impaired memory* (00131) are problem-focused diagnoses, the patient's *risk for adult pressure injury* (00304) may emerge as the top-priority diagnosis. This holds especially true when the assessment reveals related risk factors such as decreased physical activity, protein-energy malnutrition, inadequate fluid volume, and inadequate caregiver knowledge of pressure injury prevention strategies. Additionally, if a standardized, validated pressure injury screening tool indicates a high risk, particularly in individuals belonging to an at risk population (e.g., elderly, individuals in aged care and rehabilitation settings, individuals with physical disability), the risk diagnosis gains paramount importance in guiding patient care priorities.

Every NANDA-I nursing diagnosis is characterized by a distinct label accompanied by a precise definition. It is paramount for nurses to possess a comprehensive understanding of the definitions associated with the diagnoses they frequently employ. Equally crucial is the familiarity with "diagnostic

indicators," encompassing the information instrumental in diagnosing and distinguishing one diagnosis from another.

These diagnostic indicators consist of defining characteristics and related factors, or risk factors, systematically outlined in ▶ Table 1.1. A nuanced grasp of these indicators empowers nurses to make accurate and differentiating diagnoses, facilitating targeted and effective interventions tailored to the unique needs of each patient.

A nursing diagnosis does not necessarily require the inclusion of all types of diagnostic indicators. In problem-focused nursing diagnoses, a minimum set is comprised of defining characteristics and related factors. For risk diagnoses, the focus is on delineating risk factors. In both risk and problem-focused diagnoses, additional elements such as associated conditions and

Table 1.1 Key terms at a glance

Term	Brief description
Nursing diagnosis	A clinical judgment concerning a human response to health conditions / life processes, or a susceptibility to that response, by an individual, family, or community. A nursing diagnosis provides the basis for selection of nursing interventions to achieve outcomes for which the nurse has accountability
Defining characteristic	Observable cues / inferences that cluster as manifestations of a problem-focused, health promotion diagnosis or syndrome. This implies not only those things that the nurse can see, but also things that are touched, smelled, or heard (e. g., the patient / family tells us; listening to heart sounds with a stethoscope).
Related factor	Antecedent factor that appears to show some type of patterned relationship with the human response (etiological factors). These factors must be modifiable by autonomous nursing interventions, and whenever possible, interventions should be aimed at these etiological factors.
Risk factor	Antecedent factor that increases the susceptibility of an individual, family, or community to an undesirable human response. These factors must be modifiable by autonomous nursing interventions, and whenever possible, interventions should be aimed at these factors.
At risk populations	Groups of people who share sociodemographic characteristics, health / family history, stages of growth / development, exposure to certain events / experiences that cause each member to be susceptible to a particular human response. These are characteristics that are not modifiable by the professional nurse.
Associated conditions	Medical diagnoses, diagnostic / surgical procedures, medical / surgical devices, or pharmaceutical preparations. These conditions are not independently modifiable by the professional nurse.

at-risk populations may also be considered. On the other hand, health promotion diagnoses generally rely on defining characteristics, with the potential inclusion of related factors if they enhance the precision of the diagnosis.

It is also important to note that a nursing plan of care does not mandate the inclusion of every type of nursing diagnosis. The ensuing scenario serves as an illustration of how problem and risk diagnoses are employed, highlighting the dynamic nature of the process involved in determining nursing diagnoses.

The nurse has seen James, a 37-year-old cisgender man, at the ambulatory clinic for a follow-up after his hospital discharge. He was admitted for congestive heart failure that resulted from a parasitic infection he most likely experienced in his adolescence, as he has been mildly symptomatic on and off for the last two decades. During the COVID-19 pandemic, his disease was reactivated and his symptoms have increased dramatically. His heart is now significantly enlarged, he experiences frequent cardiac arrhythmias, and has been diagnosed with Chagas heart failure, and is on several medications. Additionally, he experiences gastrointestinal complications, including megacolon, which affects his fecal elimination. The nurse assesses James and identifies the following potential nursing diagnoses.

James appears overwhelmed by his condition, how it will affect his work (he is a construction worker), his family (his salary provides for his family of five), and his long-term outcomes. He notes he had significant exacerbation of disease signs and symptoms which led to his hospitalization, often fails to take his medication ("they make me so tired"), and finds the dietary and fluid recommendations difficult to follow. The nurse considers the diagnosis, *ineffective health self-management (00276)*.

He is very anxious about his work's required level of physical activity, and says he has to stop frequently for rest breaks, his stamina is decreasing, and he does nothing but work and sleep. He doesn't have the energy to attend his children's sporting or school activities, or to go on social outings with his family. His wife notes he walks much slower than he did before his COVID-19 infection, seems tired all the time, and is even lethargic most mornings. He sleeps poorly, has difficulty falling asleep and awakens multiple times each night, often because of his breathing. Then he lies awake worrying about how he will support the family. The nurse considers the diagnosis, *excessive fatigue burden (00477)*.

James also indicates he has frequent bouts of severe constipation, his abdomen is often bloated with pain and tenderness. He occasionally is so nauseous that he vomits. These episodes lead to dizziness and he notes his heart feels as if it is beating very fast at those times. He was diagnosed with megacolon, and he is to integrate dietary and life changes to address this condition, along with

pharmaceuticals. He is to be instructed to increase fiber intake using a laxative fiber drink, and has begun physical therapy twice per week that emphasizes the use of abdominal massage. The nurse considers the diagnosis *impaired intestinal elimination (00344).*

His wife indicates that she is very stressed. Their extended families live far away, and she has no support. She is worried about James' care if he gets worse, how she will manage the children without his income, and how to get their needs met as well. She indicates she doesn't understand James' condition well, and doesn't know how to access understandable information or resources to help her with providing his care. "They just sent him home and I have to figure it out." She is a full time caregiver for their 3 children (ages 3, 5, 9) and now also cares for James, while taking on additional responsibilities to earn an income. She cares for an elderly man in her apartment building, cooking and cleaning, and checks on him to give medicine, if needed, twice each night. The nurse considers the diagnosis, *risk for excessive caregiving burden (00401).*

This scenario demonstrates some of the complexity of caring for a patient and family, and identifying problem-focused and risk nursing diagnoses.

1.9 Documenting

As we have discussed, the diagnostic process is a cognitively demanding task (Ko et al., 2016), requiring nuanced clinical judgment to discern the human responses of patients. Yet, beyond its clinical implications, the diagnostic label, the actual name of the diagnosis, holds paramount importance for documentation purposes. Typically, a nursing diagnosis is articulated in two integral parts: (1) the descriptor or modifier, also referred to as a judgment term, and (2) the focus of the diagnosis or its key concept. For instance, consider the diagnosis, *excessive sedentary behaviors* (00355).

In cases where additional axis terms are incorporated into the diagnostic label, these are also meticulously documented. An illustrative example is, *maladaptive community coping* (00456), in which the subject of the information (community) becomes an integral part of the diagnostic label. Similarly, *ineffective adolescent eating dynamics* (00269) introduces an age category, specified in the definition as individuals aged 11–19 years. This dual-part structure ensures clarity and precision in conveying the nature and scope of each nursing diagnosis.

Following the assessment, the nurse is tasked with documenting the judgments made, employing various methods. While many organizations opt for the straightforward use of the nursing diagnosis label, others may adopt a

three-part format. It is a consistent position of NANDA-I that the diagnostic label alone suffices as the essential information for patient documentation. This stands true, particularly when the diagnostic indicators – comprising related / risk factors and defining characteristics – are comprehensively captured elsewhere in the patient documentation. This approach streamlines the documentation process, ensuring clarity and adherence to standards while allowing flexibility in the chosen format.

The three-part format is commonly used by students when learning to diagnose problem-focused and syndrome diagnoses, and includes: _____ [nursing diagnosis] related to _____ [etiology / related factors] as evidenced by _____ [cues / defining characteristics]. For example, from one of the examples above, a nurse might document, using the three-part format:

Excessive fatigue burden related to *excessive stress, altered sleep-wake cycle, excessive anxiety, physical deconditioning* as evidenced by *decreased aerobic capacity, decreased gait velocity, difficulty maintaining usual physical activity, increased rest requirement, inadequate physical endurance, lethargy, tiredness*.

A risk diagnosis might be documented as: risk for _____ (diagnosis) related to _____ (risk factors). For example, in the previous example about James, the nurse identified the diagnosis, *risk for excessive caregiving burden* (00401) for his wife. This could be documented as:

Risk for excessive caregiving burden related to *inadequate knowledge about community resources, difficulty prioritizing competing role commitments*, and *impaired family process*.

A health promotion diagnosis might be documented as: readiness for_____ [nursing diagnosis] as evidenced by _____ [cues / defining characteristics]. For example:

Readiness for enhanced healthy aging (0034) as evidenced by *desire to enhance functional capacity, desire to enhance healthy lifestyle,* and *desire to enhance social engagement*.

Many nurse educators endorse this approach as an effective method for fostering critical thinking skills among students, simultaneously offering faculty members a means to assess their clinical reasoning. Some scholars advocate for the comprehensive adoption of the three-part format, contending that all nursing diagnoses should be documented in patient charts using this structure. While NANDA-I aligns with the three-part format during nursing education, emphasizing its support for clinical reasoning, the Association maintains that in actual clinical practice, documenting only the label is appropriate. This is contingent upon the assurance that the related / risk factors and defining

characteristics are discernible in the assessment data, nursing notes, evaluation, or plan of care sections within the patient record, thereby providing substantiation for the nursing diagnosis. Consequently, a nurse might succinctly document, for instance, *excessive fatigue burden*.

Considering the prevalent use of electronic health records (EHRs), it's noteworthy that most systems currently in operation do not include the "related to" and "as evidenced by" components. Therefore, it becomes imperative that the nursing assessment tool integrated into the EHR system encompasses the necessary diagnostic indicators within the assessment data. This facilitates the documentation of the nursing diagnosis label only within the patient problem list. It is crucial to recognize that merely documenting a diagnosis does not inherently validate its accuracy. Analogous to our counterparts in medicine, the presence of diagnostic indicators within the patient record is imperative to substantiate our diagnoses. Without this information, the ability to verify diagnostic accuracy is compromised, raising questions about the quality of nursing care provided.

1.10 Planning / Implementing

After the nurse validates the nursing diagnoses, the next crucial step involves prioritizing them to establish care priorities. Determining which nursing diagnosis takes precedence over others is a critical decision-making process. The most apparent criterion for priority is physiological instability, particularly those deemed urgent or emergent, which always commands precedence. For instance, if an individual was diagnosed yesterday with *impaired resilience* (00210) and *excessive fatigue burden* (00477), but today develops *impaired spontaneous ventilation* (00033), the high-priority diagnosis becomes *impaired spontaneous ventilation* due to its life-threatening nature. Consequently, this diagnosis takes precedence until the patient stabilizes, allowing nurses to refocus on the other responses.

In the absence of immediate life-threatening responses, prioritization can benefit from considering diagnoses with a high congruence with defining characteristics, related/risk factors in the specific context of care. This strategic approach facilitates directing care toward resolving these issues or mitigating their severity or risk of occurrence, especially for risk diagnoses. Additionally, diagnoses predictive of complications if left untreated and those contributing to other human responses may be prioritized, ensuring a comprehensive and nuanced approach to patient care.

Let's consider another case that requires prioritization.

S.T., a 35-year-old cisgender woman, was admitted to the hospital for bariatric surgery. She has a body mass index of 43 kg/m^2, frequent musculoskeletal pain, difficulty walking and maintaining her balance. She also struggles to wash her lower body and skin folds. When the nurse talks to the patient, S.T. states "I've been on quite a journey. Setting goals has always been a struggle for me. It's like I want to make significant changes overnight. But then there are times when I find myself eating without really thinking about it, almost like it's a coping mechanism. When it comes to weight management programs, I've had my fair share of challenges there too. It's not that I don't want to participate; it's just that sometimes it feels like the programs aren't designed with someone of my size in mind. I've had instances where I felt like I couldn't fully engage or that the strategies didn't align with my needs."

The nurse identified *ineffective overweight self-management* (00398), *decreased bathing abilities* (00326), and *risk for adult falls* (00303). Even though S.T. has many defining characteristics of *ineffective overweight self-management*, the priority diagnoses that might lead to complications in the context of care are d*ecreased bathing abilities* and *risk for adult falls*. Therefore, those should be prioritized.

Coordinating prioritization with the patient represents a critical aspect of effective healthcare. Understanding the patient's primary concerns or treatment goals is paramount. There may be instances where the patient's priority differs from the nurse's, emphasizing the pivotal role patients play as decision-makers in their health and well-being. For example, if the nurse identifies *excessive fatigue burden* (00477) as a priority, but the patient emphasizes *readiness for enhanced resilience* (00212), acknowledging and respecting the patient's perspective is crucial. Failure to address the patient's primary concerns diminishes the likelihood of their engagement in addressing what the nurse perceives as the priority. Therefore, negotiating priorities, whenever feasible, fosters patient-centered care, ensuring that the healthcare plan aligns with the patient's goals and enhances collaboration in the pursuit of optimal health outcomes.

Nursing diagnoses serve as a compass for identifying the intended outcomes of care and devising a sequential plan for nursing-specific interventions. A critical aspect of this process involves developing nursing outcomes that are both specific and measurable, signifying progress in response to treatments aimed at mitigating or resolving the underlying causes of the diagnosis. In situations where improvement might not be feasible, such as in chronic conditions lacking potential for enhancement, the outcomes may pivot towards effective symptom control.

An important cautionary note is that nurses should refrain from prematurely moving from nursing diagnosis directly to nursing intervention without careful consideration of desired outcomes. This procedural sequence mirrors the thoughtful planning of a road trip. Simply getting into a car and driving will undoubtedly lead someone somewhere, but it may not align with the destination they truly desired. It is more prudent to first establish a clear destination (outcome) and subsequently chart a route (intervention) that leads to the desired location. This deliberate and strategic approach ensures that nursing interventions are purposeful, directed towards specific outcomes, and aligned with the patient's overarching goals for health and well-being.

As highlighted in the examination of Kamitsuru's Tripartite Model (2022; 2008), the foundation of nursing intervention rests on three pillars. Autonomous nursing actions or interventions constitute treatments rooted in standards of nursing knowledge, determined by the nurse to be apt for addressing the etiological factors of a nursing diagnosis or managing symptoms. Additionally, nurses bear the responsibility of executing interdisciplinary interventions within their scope of practice, founded on standards from medical or other disciplinary domains. Furthermore, adherence to organizational standards or protocols is imperative, involving tasks such as routine patient hygiene interventions or the administration of instruments to assess risk factors such as domestic violence, pressure injuries, or fall risks, particularly in populations identified as high risk by the employing institution.

In all types of interventions, nurses must apply their disciplinary knowledge judiciously. It is incumbent upon them to discern what constitutes appropriate care for their patients and delineate the boundaries of their scope of practice. This multifaceted approach ensures that nursing interventions align with the highest standards of care, encompassing autonomous actions, interdisciplinary collaboration, and organizational protocols.

It is crucial to distinguish between nursing diagnoses and medical diagnoses, highlighting the distinctive role of nurses in providing comprehensive care. Hypertension, for instance, is a medical diagnosis; however, nurses actively engage in both independent and interdisciplinary interventions for clients with diverse medical issues or risk states. Nurses often initiate standing protocols to manage medical diagnoses, sometimes perceiving these actions as independent nursing interventions because they do not necessitate a direct order for each step within the protocol. Nevertheless, these standing protocols are, in reality, dependent medical orders executed and overseen by nurses, falling outside the realm of independent nursing interventions.

True autonomous nursing interventions come to the forefront when addressing clients diagnosed with nursing phenomena, such as *risk for imbalanced blood pressure* (00362). This nursing diagnosis, defined as "susceptible to recurrent elevation or decrease in the force exerted by blood flow on the arterial wall, above or below desired individual levels," is a common occurrence in many healthcare settings. When evaluating the risk factors associated with this diagnosis, nurses take a proactive role in determining suitable outcomes for the patient. Subsequently, they strategize nursing interventions aimed at achieving these outcomes, specifically targeting the risk factors identified in the diagnosis. This meticulous approach exemplifies the distinctive and autonomous role of nurses in delivering patient-centered care.

1.11 Evaluating

The ongoing evaluation of interventions and the attainment of identified outcomes is integral to the nursing process, a practice that should be pervasive at each stage and especially after the implementation of the plan of care. Several critical questions should guide this evaluative process: "What data might I have overlooked? Am I making sound judgments, or is there potential for error? How confident am I in the accuracy of this diagnosis? Should I seek consultation from someone with greater experience? Have I corroborated the diagnosis with the patient, their family, or the community involved? Are the anticipated outcomes aligned with the unique needs of this client in this specific setting, taking into account the regulatory frameworks governing nursing practice in the region, the nuanced reality of the patient's condition, their values and beliefs, my professional expertise, and the available resources? Furthermore, are the interventions chosen grounded in research evidence or are they based on tradition, meaning 'what we've always done'?" These reflective inquiries ensure a comprehensive and nuanced assessment of the nursing process, promoting continual improvement in the delivery of patient-centered care.

1.12 Principles of Nursing Diagnosis: Clinical Application

This overview of nursing diagnosis fundamentals, initially tailored for novices, holds relevance for all nurses by illuminating essential considerations in the application of nursing diagnosis and offering examples of potential pitfalls. A crucial aspect that warrants ongoing emphasis is the seamless integration of underlying nursing concepts with the assessment process, culminating in the formulation of nursing diagnoses. The nurse's grasp of key concepts, often

referred to as diagnostic foci, not only guides the assessment process but also shapes the interpretation of gathered data. In this interconnected framework, nurses diagnose a spectrum of responses, encompassing problem-focused, risk, and health promotion diagnoses. Determining the priority diagnosis, or diagnoses, among these categories constitutes a nuanced clinical judgment on the part of the nurse, reflecting expertise and commitment to patient-centered care.

The comprehension of a patient's human response, rooted in the core concepts and phenomena relevant to our discipline, is facilitated through nursing science knowledge embedded in the NANDA-I classification. This classification serves as a structured language, offering a standardized means for nurses to communicate nursing diagnoses. Utilizing the NANDA-I classification, specifically the diagnoses labels, nurses can seamlessly exchange information not only amongst themselves but also with professionals from various health care disciplines, articulating the distinctive aspects of what nurses uniquely comprehend.

In the realm of patient interactions, employing nursing diagnoses becomes a powerful tool. It aids in elucidating the specific areas of focus for nursing care, fostering a mutual understanding between nurses and patients or their family members. This shared language enables patients to actively engage in their own care, promoting a collaborative approach. The NANDA-I classification, by providing a common language, serves as a unifying framework for nurses to address health problems, navigate risk states, and capitalize on health promotion opportunities. This standardized approach enhances communication and coordination within the healthcare team, ultimately contributing to more effective and patient-centric care delivery.

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2 From Assessment to Diagnosis

Shigemi Kamitsuru, T. Heather Herdman

2.1 Introduction to Assessment

Assessment is the initial and most pivotal phase of the nursing process. The absence of a comprehensive nursing assessment poses a potential threat to the seamless progression of the subsequent nursing process. In the absence of thorough assessment, the accurate determination of nursing diagnoses becomes unattainable. This, in turn, hinders the identification of intended nursing outcomes and the planning of autonomous nursing interventions. It is imperative to recognize that assessment extends beyond mere completion of forms, whether on paper or computer screens; such procedural compliance does not automatically or accurately yield a nursing diagnosis.

Nursing, often described as both a science and an art, exemplifies this duality throughout the journey from assessment to nursing diagnosis. Successful execution of assessment and diagnosis in the nursing process requires nurses to leverage their comprehensive understanding of nursing concepts, adept communication skills, proficiency in physical examination, a sincere and caring attitude toward patients (family / community), and the application of critical thinking. It is important to note that, hereafter in this chapter, the term "patient" encompasses groups as well as individuals, and may therefore refer to individual, family or community.

This chapter meticulously details the journey of moving from assessment to nursing diagnosis, offering detailed guidance on both what to do and how to do it.

2.2 Why do Nurses Assess?

During the assessment phase of the nursing process, nurses systematically gather data from the patient and subsequently transform this raw data into meaningful information. Nurses organize this information into purposeful, meaningful knowledge categories which encapsulate the core concepts of knowledge for the nursing discipline: the outcomes of clinical reasoning, commonly referred to as nursing diagnoses. Beyond its analytical dimension, assessment serves as the optimal opportunity for nurses to establish a robust therapeutic relationship with the patient. In essence, assessment embodies both intellectual and interpersonal facets. The meticulous execution of this step is crucial, as any unfavorable impression of the nurse by the patient could

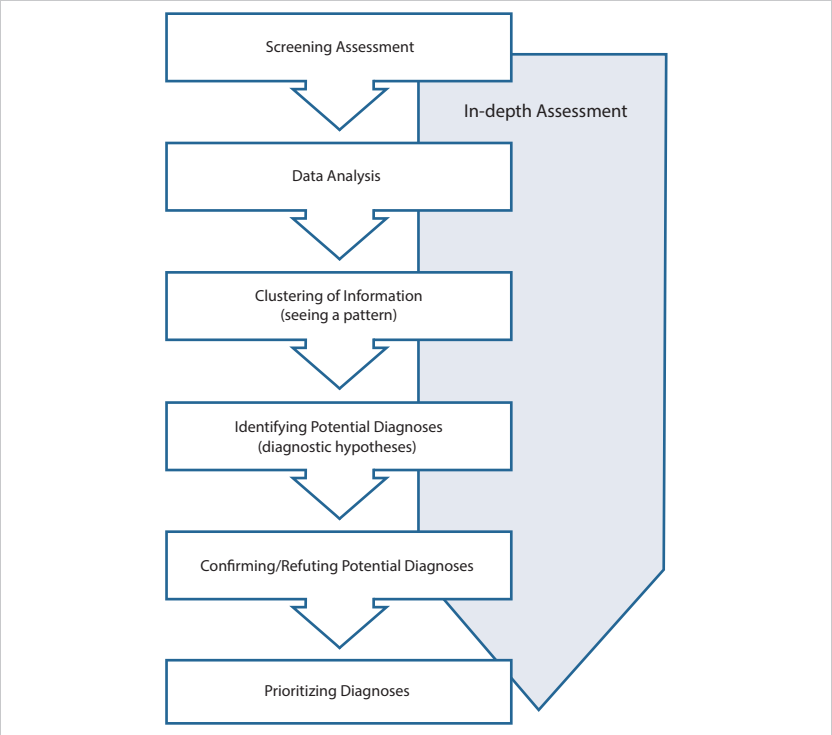

Fig. 2.1 Comprehensive Assessment-to-Diagnosis Framework.

significantly impact the ensuing therapeutic relationship. Therefore, conducting the assessment with attentiveness is paramount.

As illustrated in ▶ Fig. 2.1, the journey from assessment to nursing diagnosis unfolds through a series of dynamic, nonlinear steps, designed to diagnose and to establish prioritization of those nursing diagnoses. These identified diagnoses then serve as the foundation for discerning desired nursing outcomes and identifying appropriate interventions. Although this process may appear complex, certain steps can unfold swiftly, particularly for experienced nurses. Consider a scenario during late-night rounds: an expert nurse observes a patient awake, sighing, and restlessly shifting on their third night in the hospital. The nurse might promptly infer the presence of a concern regarding sleeping. The transition from data collection (such as observing the patient's behavior) to the identification of potential diagnoses (e.g., *ineffective sleep pattern* (00337)) can happen within a moment. However, it is critical to recognize that a hastily identified diagnosis may not always be accurate, or the highest priority for the patient. Hence, the accuracy of the diagnosis hinges on a thorough assessment, followed by meticulous analysis of the collected data.

In the following section, we will thoroughly explore each step of the process that guides us from assessment to diagnosis. Before delving into these details, let's take a moment to discuss the purpose of assessment, because it transcends being a mere task for nurses to complete; comprehending its purpose is paramount for effectively integrating it into our professional roles.

The significance lies in nurses approaching patient assessment from the vantage point of the nursing discipline, a perspective essential for accurate diagnosis and the delivery of effective care. But what exactly is the "nursing discipline"? Put simply, it constitutes the body of knowledge encompassing the science of nursing. Similar to the way in which medical diagnoses encapsulate the knowledge of the medical profession, nursing diagnoses offer standardized terms with clear definitions and diagnostic indicators (defining characteristics, risk factors, and related factors), representing nursing knowledge.

However, it is crucial to emphasize that determining nursing diagnoses solely based on a patient's medical diagnoses or medical information is neither recommended nor safe as a diagnostic process. Such an overly simplistic approach can lead to inappropriate nursing interventions and / or missed necessary care, resulting in prolonged hospital stays, and unnecessary readmissions. It can also result in the use of scarce nursing resources to perform interventions that have no merit for a particular patient. This underscores the necessity for a comprehensive understanding of the patient within the context of nursing science to ensure accurate nursing diagnoses that serve as the basis for nursing intervention.

Bear in mind that nurses diagnose the nuanced human responses to health conditions or life processes, including susceptibility to such responses. This diagnosis forms the foundation for selecting nursing interventions geared towards achieving outcomes for which the nurse bears accountability. In this context, the emphasis lies on understanding the intricate concept of "human response." The intricacy of human nature comes to the forefront, as individuals, being inherently complex, do not uniformly react to the same situations. Numerous factors, spanning genetics, physiology, health status, and past encounters with illness or injury, exert influence on these human responses. Furthermore, responses are intricately woven into the fabric of a patient's cultural background, ethnicity, religious or spiritual beliefs, gender, and family upbringing. It is also important to note that availability of healthcare resources and the healthcare systems themselves can influence diagnosis prioritization or when to identify the diagnosis across the continuum of care. This intricate interplay means that the identification of human responses is a challenging endeavor.

Assuming that every patient with a specific medical diagnosis will exhibit identical responses can lead to the inadvertent treatment of non-existent conditions. This not only squanders the nurse's time and resources but may also result in overlooking genuine concerns that demand attention. Hence, the question, "What is the nursing diagnosis for patients with this medical diagnosis?" is frequently posed, but it is inherently unanswerable due to the diverse and individualized nature of human responses in the face of any particular health condition.

While it is conceivable that certain nursing diagnoses may exhibit close associations with medical conditions / diagnoses, it is crucial to acknowledge that, as of now, we lack adequate scientific evidence to unequivocally establish links between nursing diagnoses and medical diagnoses. For instance, pinpointing the nursing diagnosis of *inadequate health knowledge* (00435) solely based on a new medical diagnosis or procedure is an illogical assumption. The patient's context might involve another family member with the same medical diagnosis or a history of the same surgical procedure. Furthermore, the assumption that every patient with a specific medical diagnosis will uniformly respond is unfounded; not all patients undergoing a surgical procedure, for instance, necessarily experience *excessive anxiety* (00400).

Given this complexity, nursing assessment must be approached from the distinctive viewpoint of the nursing discipline. The determination of nursing diagnoses should exclusively arise from a patient-centric assessment, acknowledging the unique interplay of individual factors and contexts.

Regrettably, in your professional practice, you will likely encounter instances where nurses prematurely assign or "select" a diagnosis without conducting a comprehensive patient assessment. Even more troublesome, some nurses may totally ignore the diagnostic process altogether, jumping from assessment to intervention, without identifying the response on which they seek to intervene. What undermines the comprehensive diagnostic process? Consider a scenario where a nurse initiates a plan of care based on the nursing diagnosis of *excessive anxiety* (00400) for a patient scheduled for surgery, before the patient reaches the surgical unit or has undergone a nursing assessment. In surgical units, it is common for nurses to address anxiety in preoperative patients, understanding that preoperative teaching is an effective intervention for anxiety reduction. While assuming a connection between surgery and *excessive anxiety* might seem practical, declaring "preoperative patients have *excessive anxiety*" is only a hypothesis, and every hypothesis demands validation with each patient.

This is particularly pertinent because anxiety is an inherently subjective experience. Despite our perceptions or expectations, only the patient can

articulate feelings of anxiety. In essence, *excessive anxiety* (00400), as a problem-focused nursing diagnosis, necessitates subjective data from the patient. What appears to be *excessive anxiety* may indeed represent *impaired physical comfort* (00380) or *maladaptive coping* (00405). The reality – and these differences – can only be clarified through careful assessment and validation of our findings. Therefore, a thorough assessment is an absolute prerequisite before diagnosis can occur.

Having an understanding and awareness of potential, high-frequency diagnoses – those often encountered in specific settings or patient populations – is beneficial. Knowledge of the diagnostic indicators related to these nursing diagnoses can guide nurses in focusing their assessments. This knowledge aids in systematically ruling out or confirming various diagnostic hypotheses during the assessment process. However, assigning high-frequency diagnoses without assessing their presence in a patient negates the process of diagnosis, ignores patient centered care, and potentially places the patient at risk for ineffective intervention and missed episodes of necessary care.

2.3 Screening assessment

Now, let's meticulously explore each facet of the process guiding us from assessment to nursing diagnosis, beginning with the first step – screening assessment. Various types of assessments are performed by nurses, ranging from emergency and problem-focused to brief and comprehensive assessments, among others. As illustrated in ▶ Fig. 2.1, nurses employ two distinct types of assessment in the progression from assessment to diagnosis: screening and in-depth assessment. Both require data collection; however, they serve distinct purposes.

The screening assessment stands as the initial phase of data collection. It typically involves a minimal set of evaluation items and is pivotal for distinguishing between individuals necessitating further evaluation or intervention and those who do not. It is imperative to recognize that this is slightly different from the "screening assessment" referred to in this section, as it encompasses multiple assessment items and is more comprehensive in nature.

Most healthcare organizations equip nurses with a standardized form, available in either paper or electronic health record format, grounded in a specific nursing theory or model (e.g., the Roy Adaptation Model), a body system review, or another systematic approach for organizing collected data. The initial screening assessment has a mandate for completion within a specified timeframe for each patient. For instance, patients admitted to a hospital may

require a completed nursing assessment within 24 hours of admission. In contrast, patients attending an ambulatory clinic might be required to complete a self-assessment form before their encounter with the primary care provider, whether it be a physician or nurse practitioner, for example. Nurses may subsequently review the form with the patient during the actual visit, or before the patient sees the primary care provider, ensuring a comprehensive understanding of the individual's health status and needs.

Conducting a screening assessment demands not only adept interpersonal communication skills but also specific proficiency in executing various data-gathering procedures. Establishing a sense of safety and trust is paramount; patients must feel assured in order to comfortably respond to personal questions, particularly when there may be a concern that their answers might not align with perceived social, cultural, or spiritual norms.

Although the process typically takes around 30 minutes, the initial screening assessment, in some respects, can be considered relatively straightforward. It is, in essence, a process of systematically "filling in the blanks." These assessment forms frequently include spaces for vital signs, prompting the nurse to obtain and input these data into the designated sections. Additionally, the screening assessment form may solicit information about various physiological systems (such as heart rhythm, presence of a murmur, pedal pulses, lung sounds, bowel sounds, etc.), alongside fundamental psychosocial and spiritual data.

Nevertheless, nursing assessments designed to result in nursing diagnoses extend beyond the initial screening. As the nurse analyzes the data gathered during the screening assessment and begins to discern potential diagnoses, there arises a need for additional data to either substantiate or challenge these hypotheses. This involves an exploration of other potential human responses that may be of concern, identifying risks for the patient, or uncovering opportunities for health promotion. The nurse must also delve into the etiology or precipitating factors of potential diagnoses. It is quite possible that these in-depth assessment items are not included in the organization's standardized form due to the impracticality of covering every conceivable question for every potential human response.

Guided by a profound understanding of the nursing discipline's foundational concepts, a more comprehensive, in-depth assessment emerges based on the patient's responses obtained during the screening assessment. For instance, if an elderly patient expresses a loss of confidence in living independently after experiencing a fall at home which resulted in a fractured hip, the nurse leverages her knowledge of various concepts to collect additional data to

either validate or refute potential diagnoses. Without a grasp of concepts such as self-esteem, body image, resilience, and physical mobility, the nurse may grapple with determining the right questions to ask, impeding the assessment and identification of an appropriate diagnosis.

It is essential to recognize that in-depth assessment is not a singular, uncomplicated step but rather a continual process interwoven into each phase of the process from assessment to nursing diagnosis. Assessment is positioned beneath all six steps, as indicated in ▶ Fig. 2.1, emphasizing its indispensable role throughout the comprehensive nursing diagnostic process.

Nurses collect data pertaining to a patient in two distinct categories: subjective and objective. Unlike physicians, who prioritize objective data for medical diagnoses, nurses place equal importance on both types of data for nursing diagnoses (Gordon, 2008). While the online Cambridge Dictionary (2023) defines subjective as "influenced by or based on personal beliefs or feelings, rather than on facts," and objective as "based on real facts and not influenced by personal beliefs or feelings," it is crucial to recognize the nuanced meanings these terms assume in the realm of nursing assessment.

2.4 Obtaining Subjective Data

In the nursing context, "subjective" does not pertain to the nurse's beliefs or feelings but rather to those of the subject of nursing care – the patient, family, or community. Conversely, "objective" denotes facts observed by the nurse or other healthcare professionals. These distinctions emphasize the crucial role both types of data play in developing comprehensive nursing diagnoses.

Subjective data originates from verbal reports by the patient, encompassing their perceptions and thoughts on various aspects of health, daily life, comfort, relationships, and more. For instance, a patient might articulate sentiments such as, "My mother is the most supportive person in the family", or "I feel I have no control in my life." While family members or close friends can also offer this type of data, obtaining it directly from patients is preferable whenever possible, as it accurately reflects their personal perceptions and thoughts. In situations where the patient is unable to provide subjective data, reliance on alternative sources becomes necessary. For example, in the case of an unconscious patient, family members may furnish surrogate subjective data based on their knowledge of the individual's daily life.

Nurses collect subjective data through the process of history taking or interviews, which transcends mere inquiry with standardized questions. To ensure the accuracy of this data, nurses must integrate active listening skills.

Additionally, the use of open-ended questions, which encourage more elaborate responses, aids nurses in avoiding unfounded assumptions and fosters a more comprehensive understanding of the patient's perspective.

2.5 Obtaining Objective Data

Objective data encompass the observations made by nurses regarding the patient, collected through physical examinations and diagnostic test results. In this context, "observation" extends beyond mere visual inspection to include the utilization of all senses. For instance, nurses assess the patient's general appearance, listen to lung sounds, detect odors such as foul wound drainage, and employ the sense of touch to ascertain skin temperature. Various instruments and tools are also employed to gather numerical data, such as body weight, blood pressure, oxygen saturation, and pain level.

To ensure the reliability and accuracy of objective data, nurses must possess the requisite knowledge and skills to conduct a physical assessment. Additionally, proficiency in using standardized tools or monitoring devices is essential, underlining the importance of competence in both the practical and technological aspects of data collection.

2.6 Assessment Frameworks

The framework guiding nursing practice should maintain a certain level of abstraction, considering that nurses deliver care across various settings and to diverse patient populations. Concurrently, a specific framework supporting nurses' screening assessment is crucial, as it delineates what data need to be collected, the sequence of collection, and the extent of the information required. According to the NANDA-I Position Statement (2010), the adoption of an evidence-based assessment framework, such as Gordon's Functional Health Pattern (FHP; Gordon, 1994), is strongly recommended for ensuring accurate nursing diagnoses and promoting safe patient care. It's noteworthy that the NANDA-I Taxonomy should not be utilized as an assessment framework.

Regrettably, there continues to be confusion surrounding the distinction between the NANDA-I Taxonomy II, consisting of 13 domains, and the Functional Health Pattern (FHP) assessment framework, encompassing 11 patterns. If one were to utilize the NANDA-I Taxonomy II as an assessment framework, you might encounter a format that merely checks for the presence of nursing diagnoses within each domain. However, it is crucial to recognize that this format does not accurately represent the journey from assessment to

nursing diagnosis. Although the NANDA-I Taxonomy II was developed based on Gordon's work, resulting in strikingly similar terminology in the two frameworks, their purposes and functions are fundamentally distinct.

The primary aim of the NANDA-I Taxonomy II is to categorize nursing diagnoses into domains and their subcategories or classes. Given that each domain and class is precisely defined, this framework assists nurses in identifying appropriate nursing diagnoses among conceptually related diagnoses within the taxonomy. In contrast, the FHP framework was scientifically developed by Gordon, in 1974, to standardize the structure for nursing assessment (Gordon, 1982), emphasizing a comprehensive approach to understanding patients' health responses.

2.7 Functional Health Pattern Assessment Framework

The FHP assessment framework epitomizes a holistic model of person-environment interaction and seamlessly integrates with numerous nursing theories. Its versatile application spans various nursing specialties, levels of care, age groups, and settings around the world. This framework guides nurses through history taking (collecting subjective data) and physical examination (gathering objective data), furnishing essential elements and a structured approach to systematically organize assessment data.

According to Gordon (1994), a "pattern" is defined as "a configuration of behaviors that occur sequentially across time" (p.70). In simpler terms, a pattern is not derived from a solitary observation but rather from the organized sequence of behaviors, activities, or functions related to a specific aspect of an individual's health. As the process of data collection and analysis unfolds, nurses progressively gain a holistic, comprehensive understanding of the patient, and a discernable "pattern" gradually emerges. The sequence of the 11 patterns within the FHP framework offers a streamlined and effective flow for nursing assessments, with each pattern contributing uniquely to the comprehension of the patient's health and human responses. A detailed presentation of definitions and the sequential arrangement of each pattern is outlined in ▶ Table 2.1.

The first pattern, "health awareness-health management," provides a comprehensive overview of the patient, whereas the subsequent 10 patterns focus on specific facets of health management. Beginning with the "nutritional-metabolic pattern" and extending to the "sleep-rest pattern," obtaining data is relatively straightforward, given that aspects such as physical size are often readily apparent, and patients typically encounter no difficulty responding to

Table 2.1 Functional Health Patterns: Pattern Definitions and Sequence*

Functional Health Pattern	Pattern Definition
Health perception-health management pattern	Describes the client's perceived pattern of health and well-being and how health is managed
Nutritional-metabolic pattern	Describes the client's pattern of food and fluid consumption relative to metabolic need and pattern indicators of local nutrient supply
Elimination pattern	Describes patterns of excretory function (bowel, bladder, and skin)
Activity-exercise pattern	Describes patterns of exercise, activity, leisure, and recreation
Sleep-rest pattern	Describes patterns of sleep, rest, and relaxation
Cognitive-perceptual pattern	Describes sensory-perceptual and cognitive patterns
Self-perception—self-concept pattern	Describes the client's self-concept pattern and perception of self (e.g., self-conception / worth, body image, feeling state)
Role-relationship pattern	Describes the client's pattern of role engagements and relationships
Sexuality-reproductive pattern	Describes the client's patterns of satisfaction or dissatisfaction with sexuality pattern; describes reproductive pattern
Coping-stress tolerance pattern	Describes the client's general coping pattern and effectiveness of the pattern in terms of stress tolerance
Value-belief pattern	Describes pattern of values, beliefs (including spiritual), and goals that guide the client's choices or decisions

* From Gordon, M. Nursing diagnosis: Process and application, 3rd ed. St. Louis, MO: Mosby, 1994, p.70.

most inquiries. However, as the assessment progresses from the "cognitive-perceptual pattern," it delves into more personal realms. At this juncture, the nurse may observe indicators of issues such as hearing or memory problems during communication, prompting a more focused assessment.

Advancing from the "self-perception—self-concept pattern" to the final "value-belief pattern," the assessment introduces items that patients may prefer to keep private. Hence, fostering a trusting relationship with the patient becomes paramount for obtaining accurate data. Consequently, these patterns are strategically conducted in the latter part of the assessment. While the original sequence proves generally useful in most clinical settings, Gordon (2008) recommends a modified sequence in the realm of psychiatric-mental health.

Here, the assessment begins with the "health awareness-health management pattern," followed by the "self-perception—self-concept pattern", and then the subsequent four patterns. This adjustment is particularly beneficial given the close relationship of these patterns to patients in the psychiatric-mental health domain.

Gordon (2008) developed distinct assessment items tailored for individuals, families, and communities. However, this chapter exclusively delves into individual assessment. In order to obtain a complete understanding of FHP individual, family and community assessment items, we recommend you consult Gordon's original literature. In her publication she specifies multiple potential assessment questions for each pattern. ▶ Table 2.2 presents only a few sample questions by pattern for history taking with an individual patient (Jones et al., 2021). While the number of areas and items for assessment may seem extensive, it is crucial to recognize that not all items are applicable to

Table 2.2 Functional Health Patterns (FHP) and sample questions

Pattern	Sample Questions
Health perception / health management pattern	In general how would you rate your health and why? What is the meaning of health to your life? Are you satisfied with your current health? What do you do regularly to maintain your health?
Nutritional-metabolic pattern	Describe your usual eating pattern and food and fluid intake daily? Do you eat 3 meals each day? Do you have access to adequate food? Do you snack during the day? Do you eat when you are under stress? Discuss.
Elimination pattern	How often do you urinate during a 24-hour period? Do you usually wake up during the night to urinate? Describe your normal (usual) bowel pattern. Do you take laxatives regularly?
Activity-exercise pattern	Describe your usual daily activities. Do you exercise regularly each week? Describe. How do you feel after exercising? What is it like for you to climb a flight of stairs?
Sleep-rest pattern	How many hours of sleep do you get each night? Do you feel rested when you wake up? Have you ever dozed off for a moment while driving? Do you have enough energy to carry out your daily activities? Do you take a nap? Describe.
Cognitive-perceptual pattern	How do you learn best? Do you experience pain regularly? How do you manage your pain?

Table 2.2 *continued*

Pattern	Sample Questions
Self-perception – self-concept pattern	What makes you feel good about yourself? Are you pleased with what you have accomplished? Are there things you would like to do in the future? What would you describe as your strengths? Are there things you would like to change about yourself?
Role-relationship pattern	Who is your greatest support? Are you satisfied with your current relationships? Describe current roles and responsibilities within your family? Extended family? Are you satisfied with your current work?
Sexuality – reproductive pattern	Are you comfortable with your sexuality? Discuss. Are you sexually active? Are you involved in a relationship? Do you have children?
Coping / stress tolerance pattern	How would you describe your current level of stress? Are there things in your life you would describe as stressful? Discuss. How do you manage stressful situations? Does stress interfere with your relationships / work?
Value-belief pattern	What do you value most in life? What gives your life meaning? Is health a life value? What do you do to keep yourself healthy? What do you hope to achieve in your life?

every patient. Additionally, certain items may necessitate adjustments based on country or cultural considerations.

For instance, during the history taking process for the "sleep-rest pattern," if driving is not the patient's primary mode of transportation, it may be more fitting to rephrase a question to inquire, "Have you ever dozed off for a short while while traveling by bus or train?"

While conducting a screening assessment with the FHP framework may initially be time-consuming for beginners, it is a natural progression that everyone experiences. The utilization of the FHP assessment framework across diverse patient populations and clinical settings aids in discerning which patterns warrant in-depth assessment and which patterns can be effectively screened. It is crucial to bear in mind that a thorough assessment is indispensable. Without it, potential health problems, risk states, or opportunities for health promotion may go unnoticed in your patients.

Screening assessment of Mr. Tanaka. Let's proceed with a screening assessment using a case study of Mr. Tanaka.

Mr. Tanaka, a 76-year-old cisgender male, underwent chemoradiotherapy for stage IV esophageal cancer a year ago. Today, he visited the outpatient clinic for follow-up and was subsequently admitted to the hospital due to suspected cancer metastasis.

The comprehensive information derived from the screening assessment, data analysis, and in-depth assessment for Mr. Tanaka is presented in ▶ Table 2.3. It serves as a detailed representation of the assessment process leading to nursing diagnoses. However, it is important to note that in actual clinical settings, nurses do not document data in this specific format. The table is designed solely to explain the process of moving from assessment to nursing diagnoses as clearly as possible.

Table 2.3 Screening assessment, in-depth assessment, and data analysis of Mr. Tanaka

Health perception-health management pattern	
Screening Assessment Mr. Tanaka had been doing well after the chemoradiotherapy. Now, he is experiencing fatigue and severe pain in the lower back and hips. He takes medication for hypertension daily after breakfast and uses a pillbox to ensure adherence. In the past month, Mr. Tanaka received vaccinations against the coronavirus and influenza, as he could become seriously ill if infected. He does not smoke and consumes alcohol infrequently. He adheres to safety practices such as using seat belts when driving. He has no history of falls. Mr. Tanaka demonstrates adherence to suggestions from both doctors and nurses.	**Data Analysis** – Problematic symptoms: fatigue and severe pain in lower back and hips – Need more data about his feelings regarding cancer metastasis – Chronic condition: Hypertension for over 20 years – Adheres to medication and recommendations of health care professionals – Preferred behaviors for health maintenance and disease prevention.
In-depth Assessment – His fatigue and pain began two weeks ago. – He is concerned about cancer metastasis. – He was diagnosed with hypertension 20 years ago and remains on medication, well controlled.	
Nutritional-metabolic pattern	
Screening Assessment Mr. Tanaka takes meals twice a day: breakfast and supper. He does not take any supplements or vitamins. He avoids snacks. Over the past year, he has lost 5 kg. He has no appetite, but tries to eat as much as possible. No issues with chewing, swallowing, or reflux. Adheres to a low-sodium diet. Consumes 1.5 liters of fluid per day, mostly green or herbal tea. Developed dermatitis during radiation therapy one year ago, but has since healed. Oral mucous	**Data Analysis** – Nutritional concern: meals twice a day, avoids snacks, no appetite, 5 kg weight loss – Anemia: pale mucous membranes and gums, abnormal CBC