NURSING DIAGNOSES

Definitions and Classification

2018–2020

Eleventh Edition

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NANDA International, Inc.

Nursing Diagnoses

Definitions and Classification

2018–2020
Eleventh Edition

Edited by

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and
Shigemi Kamitsuru, PhD, RN, FNI

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The editors of this edition would like to
dedicate this book to the memory of our founder,

Dr. Marjory Gordon

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Risk for impaired **skin integrity**
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Risk for impaired **tissue integrity**
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Risk for **latex allergy reaction**

Concepts

Preface

In the early 1970s, nurses and educators in the United States uncovered the fact that nurses independently diagnosed and treated “something” related to patients and their families, which was different from medical diagnoses. Their great insight opened the new door to the taxonomy of nursing diagnoses, and the establishment of the professional organization that is now known as NANDA International (NANDA-I). As is usual with medical diagnoses for physicians, nurses should have “something” to document a holistic scope of practice to help students acquire our unique body of knowledge, and to enable nurses to collect and analyze data to advance the discipline of nursing. More than 40 years have passed, and the idea of “nursing diagnosis” has inspired and encouraged nurses around the world who seek independent practice based upon professional knowledge.

Initially, nurses living outside North America may have been simply the end users of the NANDA-I taxonomy. Today, development and refinement of the taxonomy is heavily based on a global effort. In fact, we received more submissions of new diagnoses and proposals for revisions from countries outside North America than within it during this publication cycle. Moreover, the organization has become truly international; members from the Americas, Europe, and Asia are actively participating on committees, leading committees as chairs, and managing the organization as directors of the Board. Who could have imagined that a non-native English speaker from a small Asian country would become the president of NANDA-I in 2016?

In this 2018–2020 version, the Eleventh Edition, the taxonomy provides 244 diagnoses, with the addition of 17 new diagnoses. Each nursing diagnosis has been the product of one or more of our many NANDA-I volunteers, and most have a defined evidence base. Each new diagnosis has been debated and refined by our Diagnosis Development Committee (DDC) members, before finally being submitted to NANDA-I members for a vote of approval. Membership approval does not mean the diagnosis is “completed” or “ready to be used” across all countries or practice areas. We all know that practice and regulation of nursing varies from country to country. It is our hope that publication of these new diagnoses will facilitate further validation studies in different parts of the world,

to achieve a higher level of evidence.

We always welcome submissions for new nursing diagnoses. At the same time, we have a serious need for revision of existing diagnoses to reflect the most recent evidence. While preparing for this edition, we took a bold step highlighting the underlying problems with many of the current diagnoses. Please note that more than 70 diagnoses have no level of evidence (LOE); that means there has been no major update on these diagnoses since at least 2002, when the LOE criteria were introduced. In addition, to treat the problems described in each nursing diagnosis effectively, related or risk factors are required. However, after sorting some of these factors into “At-Risk Populations” and “Associated Conditions” (things that are not independently treatable by nurses), there are several diagnoses that now have no related or risk factors.

NANDA-I is translated into nearly 20 distinct languages. Translating abstract English terms into other languages can often be frustrating. When I faced difficulties translating from English to Japanese, I remembered the story from the eighteenth-century about scholars who translated a Dutch anatomy textbook into Japanese without any dictionary. They say the scholars sometimes spent one month to translate just one page! Today, we have dictionaries and even automatic translation systems, but translation of diagnostic labels, definitions, and diagnostic indicators is still not an easy task. Conceptual translation, rather than word-for-word translation, requires that the translators clearly understand the intent of the concept. When the terms in English are abstract or very loosely defined, this increases the difficulty in assuring a correct translation of the concepts. Over the years, I have learned that sometimes a very minor modification of the original English term can alleviate a burden on translators. Your comments and feedback will help make our terminology, not only more translatable, but it will also increase the clarity of English expressions.

Beginning with this edition, we have three primary publishing partners. We have directly partnered with GrupoA for our Portuguese translation, and Igaku-Shoin for much of our Asian market. The remainder of the world, including the original English version, will be spearheaded by a team from Thieme Medical Publishers, Inc. We are very excited about these partnerships and the possibilities that these fine organizations bring to our association and the availability of our terminology around the globe.

I want to commend 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 want to thank our staff, led by our Chief Executive, Dr. T. Heather Herdman, for its efforts and support.

My special thanks to the members of the DDC for their outstanding and timely efforts to review and edit the terminology represented within this book, and especially for the leadership of the DDC Chair, Professor Dickon Weir-Hughes, since 2014. This remarkable committee, with representation from North and South America and Europe, is the true “powerhouse” of the NANDA-I knowledge content. I am deeply impressed and pleased by the astonishing, comprehensive work of these volunteers over the years

Shigemi Kamitsuru, PhD, RN, FNI
President, NANDA International, Inc.

Acknowledgments

It goes without saying that the dedication of several individuals to the work of NANDA International, Inc. (NANDA-I) is evident in their donation of time and work to the improvement of the NANDA-I terminology and taxonomy. Without question, this terminology reflects the dedication of individuals who research and develop or refine diagnoses, and the volunteers that make up the Diagnosis Development Committee, as well as its Chair, Prof. Dickon Weir-Hughes. This text represents the culmination of tireless volunteer work by a very dedicated, extremely talented group of individuals who have developed, revised, and studied nursing diagnoses for more than 40 years.

We would like to offer a particularly significant note of appreciation to Dr. Camila Takao Lopes of the College of Nursing of the Universidade Federal de São Paulo in Brazil, who worked to organize, update, and maintain the NANDA-I terminology database, and supported the work on standardization of the terminology.

Additionally, we would like to take the opportunity to acknowledge and personally thank Susan Gallagher-Lepak, PhD, RN, Dean of the College of Health, Education & Social Welfare, at the University of Wisconsin–Green Bay, for her contribution to this particular edition of the NANDA-I text, as the author of the revised Nursing Diagnosis Basics chapter.

Please contact us at **execdir@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.

T. Heather Herdman, PhD, RN, FNI
Shigemi Kamitsuru, PhD, RN, FNI
NANDA International, Inc.

Part 1
The NANDA International Terminology – Organization and General Information

1 Introduction

Part 1 presents introductory information on the new edition of the NANDA International Taxonomy, 2018–2020. This includes an overview of major changes to this edition: new and revised diagnoses, retired diagnoses, label changes, continued revision to standardize diagnostic indicator terms, and the introduction of *associated conditions* and *at risk populations*.

Those individuals and groups who submitted new or revised diagnoses that were approved are identified.

Readers will note that nearly every diagnosis has some changes, as we have worked to increase the standardization of the terms used within our diagnostic indicators (defining characteristics, related factors, risk factors). Further, the adoption of at-risk populations and associated conditions was a pain-staking process, led by Dr. Shigemi Kamitsuru. Each diagnosis was reviewed for related factors or risk factors that met the definitions of these terms.

2 What's New in the 2018–2020 Edition of *Diagnoses and Classification*

Changes have been made in this edition based on feedback from users, to address the needs of both students and clinicians, as well as to provide additional support to educators. New information has been added on clinical reasoning; all chapters are revised for this edition. There are corresponding internet-based presentations available for teachers and students that augment the information found within the chapters; icons appear in chapters that have these accompanying support tools.

3 Changes and Revisions

3.1 Processes and Procedures for Diagnosis Submission and Review

3.1.1 NANDA-I Diagnosis Submission: Review Process

Proposed diagnoses and revisions of diagnoses undergo a systematic review to determine consistency with the established criteria for a nursing diagnosis. All submissions are subsequently staged according to evidence supporting either the level of development or validation.

Diagnoses may be submitted at various levels of development (e.g., label and definition; label, definition, defining characteristics, or risk factors; theoretical level for development, and clinical validation; or, label, definition, defining characteristics, and related factors).

The current review process for accepting new and revised diagnoses into the terminology is under review, as the organization strives to move to a stronger, evidence-based process. As new rules are developed, these will be available on the NANDA-I website (**www.nanda.org**).

Information on the *full review process* and *expedited review process* for all new and revised diagnosis submissions will be available once the process is fully articulated and approved by the NANDA-I Board of Directors.

Information regarding the *procedure to appeal a DDC decision on diagnosis review* is also available on our website. This process explains the recourse available to a submitter if a submission is not accepted.

3.1.2 NANDA-I Diagnosis Submission: Level of Evidence (LOE) Criteria

The NANDA-I Education and Research Committee has been tasked to review and revise, as appropriate, these criteria to better reflect the state of the science related to evidence-based nursing. Individuals interested in submitting a diagnosis are advised to refer to the NANDA-I website for updates, as they

become available (www.nanda.org).

LOE 1: Received for Development (Consultation from NANDA-I)

LOE 1.1: Label Only

The label is clear, stated at a basic level, and supported by literature references, which are identified. NANDA-I will consult with the submitter and provide education related to diagnostic development through printed guidelines and workshops. At this stage, the label is categorized as "Received for Development" and identified as such on the NANDA-I website.

LOE 1.2: Label and Definition

The label is clear and stated at a basic level. The definition is consistent with the label. The label and definition are distinct from other NANDA-I diagnoses and definitions. The definition differs from the defining characteristics and label. These components are not included in the definition. At this stage, the diagnosis must be consistent with the current NANDA-I definition of nursing diagnosis (see the "Glossary of Terms"). The label and definition are supported by literature references, which are identified. At this stage, the label and its definition are categorized as "Received for Development" and identified as such on the NANDA-I website.

LOE 1.3: Theoretical Level

The definition, defining characteristics and related factors, or risk factors, are provided with theoretical references cited, if available. Expert opinion may be used to substantiate the need for a diagnosis. The intention of diagnoses received at this level is to enable discussion of the concept, testing for clinical usefulness and applicability, and to stimulate research. At this stage, the label and its component parts are categorized as "Received for Development and Clinical Validation," and identified as such on the NANDA-I website and in a separate section in this book.

LOE 2: Accepted for Publication and Inclusion in the NANDA-I Taxonomy

LOE 2.1: Label, Definition, Defining Characteristics and Related Factors, or Risk Factors, and References

References are cited for the definition, each defining characteristic, and each related factor, or risk factor. In addition, it is required that nursing outcomes and nursing interventions from a standardized nursing terminology (e.g., Nursing

Outcomes Classification [NOC], Nursing Interventions Classification [NIC]) are provided for each diagnosis.

LOE 2.2: Concept Analysis

The criteria in LOE 2.1 are met. In addition, a narrative review of relevant literature, culminating in a written concept analysis, is required to demonstrate the existence of a substantive body of knowledge underlying the diagnosis. The literature review/concept analysis supports the label and definition, and includes discussion and support of the defining characteristics and related factors (for problem-focused diagnoses), risk factors (for risk diagnoses), or defining characteristics (for health promotion diagnoses).

LOE 2.3: Consensus Studies Related to Diagnosis Using Experts

The criteria in LOE 2.1 are met. Studies include those soliciting expert opinion, Delphi, and similar studies of diagnostic components in which nurses are the subjects.

LOE 3: Clinically Supported (Validation and Testing)

LOE 3.1: Literature Synthesis

The criteria in LOE 2.2 are met. The synthesis is in the form of an integrated review of the literature. Search terms/MeSH (Medical Subject Headings) terms used in the review are provided to assist future researchers.

LOE 3.2: Clinical Studies Related to Diagnosis, but Not Generalizable to the Population

The criteria in LOE 2.2 are met. The narrative includes a description of studies related to the diagnosis, which includes defining characteristics and related factors, or risk factors. Studies may be qualitative in nature, or quantitative using nonrandom samples, in which patients are subjects.

LOE 3.3: Well-Designed Clinical Studies with Small Sample Sizes

The criteria in LOE 2.2 are met. The narrative includes a description of studies related to the diagnosis, which includes defining characteristics and related factors, or risk factors. Random sampling is used in these studies, but the sample size is limited.

LOE 3.4: Well-Designed Clinical Studies with Random Sample of Sufficient Size to Allow for Generalizability to the Overall Population

The criteria in LOE 2.2 are met. The narrative includes a description of studies related to the diagnosis, which includes defining characteristics and related factors, or risk factors. Random sampling is used in these studies, and the sample size is sufficient to allow for generalizability of results to the overall population.

3.2 Changes to Definitions of Health Promotion Diagnoses

The overall definition for a health promotion nursing diagnosis was changed during this cycle. This change reflects the recognition that there are populations for whom health may be enhanced, with the nurse acting as an agent for the patients, even if the patients impacted are unable to verbalize intent (e.g., neonatal patients, those with conditions preventing verbalization of desire, etc.). The revised definition is as follows (new wording italicized).

Health Promotion Diagnosis

A clinical judgment concerning motivation and desire to increase well-being and to actualize health potential. These responses are expressed by a readiness to enhance specific health behaviors, and can be used in any health state. *In individuals who are unable to express their own readiness to enhance health behaviors, the nurse may determine that a condition for health promotion exists and act on the client' s behalf.* Health promotion responses may exist in an individual, family, group, or community.

3.3 New Nursing Diagnoses

A significant body of work representing new and revised nursing diagnoses was submitted to the NANDA-I Diagnosis Development Committee, with a significant number of those diagnoses being presented to the NANDA-I membership for consideration during this review cycle. NANDA-I would like to take this opportunity to congratulate those submitters who successfully met the level of evidence criteria with their submissions and/or revisions. Seventeen new diagnoses were approved by the Diagnosis Development Committee, the NANDA-I Board of Directors, and the NANDA-I membership (▶ Table 3.1).

3.4 Revised Nursing Diagnoses

Seventy-two diagnoses were revised during this cycle. ▶ Table 3.2 shows those diagnoses, highlights the revisions that were made for each of them, and identifies the submitters/revisers.

3.5 Retired Nursing Diagnosis

Eight diagnoses were removed from the terminology during this edition. One diagnosis had been slotted, in the 10th edition, to be retired if it was not revised. No revision occurred, so this diagnosis was therefore removed. We encourage pediatric nurses to consider reconceptualization of this diagnosis, and to present it to NANDA-I as a new diagnosis.

Risk for disproportionate growth (00113), Domain 13, Class 1.

Seven remaining diagnoses were retired from the terminology, after review by the Diagnosis Development Committee. These diagnoses were inconsistent with the current literature, or lacked sufficient evidence to support their continuation within the terminology.

Table 3.1 New NANDA-I Nursing Diagnoses, 2018–2020

Approved diagnosis (new)	Submitter(s)
Domain 1: Health Promotion	
Readiness for enhanced health literacy Class 1: Health awareness	B. Flores, PhD, RN, WHNP-BC
Domain 2: Nutrition	
Ineffective adolescent eating dynamics Class 1: Ingestion	S. Mlynarczyk, PhD, RN; M. Dewys, PhD, RN; G. Lyte, PhD, RN
Ineffective child eating dynamics Class 1: Ingestion	S. Mlynarczyk, PhD, RN; M. Dewys, PhD, RN; G. Lyte, PhD, RN
Ineffective infant eating dynamics Class 1: Ingestion	S. Mlynarczyk, PhD, RN; M. Dewys, PhD, RN; G. Lyte, PhD, RN
Risk for metabolic imbalance syndrome Class 4: Metabolism	V.E. Fernández-Ruiz, PhM; M.M. Lopez-Santos, PhM; D. Armero-Barranco, PhD; J.M. Xandri-Graupera, PhM; J.A. Paniagua-Urban, PhM; M. Solé-Agusti, PhM; M.D. Arrillo-Izquierdo, PhM; A. Ruiz-Sanchez, PhM
Domain 4: Activity/Rest	
Imbalanced energy field	N. Frisch, PhD, RN, FAAN; H. Butcher, PhD, RN;

Class 3: Energy balance	D. Shields, PhD, RN, CCRN, AHN-BC, QTTT
Risk for unstable blood pressure Class 4: Cardiovascular/pulmonary responses	C. Amoin, DSN, MN, RN
Domain 9: Coping/stress Tolerance	
Risk for complicated immigration transition Class 1: Posttrauma responses	R. Rifa, RN, PhD
Neonatal abstinence syndrome Class 3: Neurobehavioral stress	L. M. Cleveland, PhD, RN, PNP-BC
Acute substance withdrawal syndrome Class 3: Neurobehavioral stress	L. Clapp, RN, MS, CACIII; K. Mahler, RN, BSN
Risk for acute substance withdrawal syndrome Class 3: Neurobehavioral stress	L. Clapp, RN, MS, CACIII; K. Mahler, RN, BSN
Domain 11: Safety/Protection	
Risk for surgical site infection Class 1: Infection	F. F. Ercole, PhD, RN; T.C.M. Chianca, PhD, RN; C. Campos, MSN, RN; T.G.R. Macieira, BSN, RN; L.M.C. Franco, MSN
Risk for dry mouth Class 2: Physical injury	I. Eser, PhD, RN (1); N. Duruk, PhD, RN (2)
Risk for venous thromboembolism Class 2: Physical injury	G. Meyer, PhD, RN, CNL
Risk for female genital mutilation	I.J. Ruiz, RN
Class 3: Violence	
Risk for occupational injury Class 4: Environmental hazards	F. Sanchez-Ayllon, PhD, RN
Risk for ineffective thermoregulation Class 6: Thermoregulation	Diagnosis Development Committee

Noncompliance (00079), Domain 1, Class 2. This diagnosis was quite old, with a last revision in 1998. It is no longer consistent with the majority of current research in the area, which has as its focus the concept of adherence rather than compliance.

Readiness for enhanced fluid balance (00160), Domain 2, Class 5.

Readiness for enhanced urinary elimination (00166), Domain 3, Class 1.

These diagnoses lacked sufficient evidence to support their continuation within the terminology.

Risk for impaired cardiovascular function (00239), Domain 4, Class 4. This diagnosis lacked sufficient differentiation from other cardiovascular diagnoses within the terminology.

Risk for ineffective gastrointestinal perfusion (00202), Domain 4, Class 4.

Risk for ineffective renal perfusion (00203), Domain 4, Class 4.

These diagnoses were not found to be independently modifiable by nursing practice.

Risk for imbalanced body temperature (00005), Domain 11, Class 6 – replaced by new diagnosis, *Risk for ineffective thermoregulation (00274)*. Revisions to this diagnosis led to the recognition that the concept of interest was thermoregulation, and the definition and risk factors were consistent with the current diagnosis, *ineffective thermoregulation* (00008). Therefore, the label and definition were changed, leading to the need to retire the current code and assign a new code.

3.6 Revisions to Nursing Diagnosis Labels

Changes were made to 11 nursing diagnosis labels. These changes were made to ensure that the diagnostic label was consistent with current literature, and reflected a human response. The diagnostic label changes are shown in ▶ Table 3.3.

Table 3.2 Revised NANDA-I Nursing Diagnoses, 2018–2020

Approved diagnosis (revised)	Revision						Submitter(s)
	DC removed	DC added	ReF/RiF removed	ReF/RiF added	Definition revised	Comment	
Domain 1: Health promotion							
Decreased diversional activity engagement (00097)	1	5		6	Yes	Definition was changed to make it consistent with current literature, and to reflect a human response.	S. Kamitsuru, RN, PhD, FNI
Deficient community health (00215)					Yes	The word "aggregate" was removed from the definition and defining characteristics, and was replaced with the word "groups." The word, aggregate, has a very strong, negative connotation in some languages, which is not the intent in this diagnosis.	Diagnosis Development Committee
Risk-prone health behavior (00188)			2	1	Yes	One related factors were approved for addition. The phrase "lifestyle/behaviors" was changed to "lifestyle and/or actions" and the phrase "health status" was changed to "the level of wellness."	Diagnosis Development Committee
Ineffective health maintenance (00099)					Yes	The phrase "maintain health" was changed to "maintain wellbeing."	Diagnosis Development Committee

Domain 2: Nutrition							
Insufficient breast milk production (00216)					Yes	Definition chnaged to clarify the concept. Label changed to reflect a human response.	S. Kamitsuru, RN, PhD, FNI
Ineffective infant feeding pattern (00107)					Yes	Definition changed to remove slash, "/", from the definition in the "suck/swallow" phrase and to clarify the concept.	Diagnosis Development Committee
Risk for unstable blood glucose level (00179)					Yes	Removal of the word "sugar" from definition.	Diagnosis Development Committee
Neonatal hyperbilirubinemia (00194)				1	Yes	Revised to reflect the actual change in circulating unconjugated bilirubin, with removal of the change in skin color from the diagnosis definition.	Diagnosis Development Committee
Risk for neonatal hyperbilirubinemia (00230)				1	Yes	Revised to reflect the actual change in circulating unconjugated bilirubin, with removal of the change in skin color from the diagnosis definition.	Diagnosis Development Committee
Excess fluid volume (00026)					Yes	Definition revised to clarify concept.	Diagnosis Development Committee
Domain 3: Elimination and exchange							
Urinary retention (00023)					Yes	Definition revised to clarify concept.	Diagnosis Development Committee
Dysfunctional gastrointestinal motility (00196)				5	No		Diagnosis Development Committee
Risk for dysfunctional gastrointestinal motility (00197)				1	Yes	Revised to be congruent with the problem-focused diagnosis.	Diagnosis Development Committee
Bowel incontinence (00014)	4	1			Yes	Definition revised to improve conciseness.	Diagnosis Development Committee
Domain 4: Activity / Rest							
Disturbed sleep pattern (00198)	1	1			Yes	Definition revised to remove the word sleep and clarify the concept.	Diagnosis Development Committee
Impaired physical mobility (00085)					Yes	Definition revised to remove the word "physical", which is now included in the label, *Impaired physical mobility (00085)*.	Diagnosis Development Committee
Activity intolerance (00092)			1	2	No		Diagnosis Development Committee
Risk for activity intolerance (00094)				2	No		Diagnosis Development Committee
Impaired spontaneous ventilation (00033)	1				Yes	Definition revised to clarify concept.	Diagnosis Development Committee
Ineffective peripheral tissue perfusion (00204)				2	No		Diagnosis Development Committee
Bathing self-care deficit (00108)					Yes	Definition revised to clarify concept.	Diagnosis Development Committee
Dressing self-care deficit (00109)					Yes	Definition revised to clarify concept.	Diagnosis Development Committee
Feeding self-care deficit (00102)					Yes	Definition revised to clarify concept.	Diagnosis Development Committee
Toileting self-care deficit (00110)					Yes	Definition revised to clarify concept.	Diagnosis Development Committee
Domain 5: Perception / Cognition							
Acute confusion (00128)				7	Yes	Definition was revised to be congruent with the risk diagnosis on acute confusion.	Diagnosis Development Committee
Chronic confusion (00129)	7	8			Yes	Definition was changed to make it consistent with current literature.	P. Alfradique de Souza, RN, PhD; K. Avant, RN, PhD, FAAN, FNI; A.E.

							Berndt, PhD; R. Ferreira Santana, RN, PhD; T.H. Herdman, RN, PhD, FNI
Deficient knowledge (00126)					Yes	Definition was revised to be congruent with the health promotion diagnosis health promotion.	Diagnosis Development Committee
Impaired memory	9	11			Yes	Definition was changed to make it consistent with current literature.	P. Alfradique de Souza, RN, PhD; K. Avant, RN, PhD, FAAN, FNI; A.E. Berndt, PhD; R. Ferreira Santana, RN, PhD; T.H. Herdman, RN, PhD, FNI
Domain 6: Self-perception							
Chronic low self-esteem (00119)					Yes	Definition changed to remove slash, "/", from the definition in the "self-evaluating/feelings" phrase.	Diagnosis Development Committee
Domain 7: Role relationships							
Caregiver role strain (00061)				9	Yes	Definition changed to remove slash, "/", from the definition in the "family / significant other" phrase, and to bring clarity to the concept.	Diagnosis Development Committee
Risk for caregiver role strain (00062)				32	Yes	Definition changed to remove slash, "/", from the definition in the "family / significant other" phrase, and to bring clarity to the concept.	Diagnosis Development Committee
Impaired parenting (00056)				5	Yes	Definition revised to be congruent with the health promotion and risk diagnoses on parenting.	Diagnosis Development Committee
Risk for impaired parenting (00057)				2	Yes	Definition revised to be congruent with the health promotion and problem-focused diagnoses on parenting.	Diagnosis Development Committee
Readiness for enhanced parenting (00164)					Yes	Definition revised to be congruent with the risk and problem-focused diagnoses on parenting.	Diagnosis Development Committee
Risk for impaired attachment (00058)					Yes	Definition changed to remove slash, "/", from the definition in the "parent / significant other" phrase.	Diagnosis Development Committee
Dysfunctional family processes (00063)	3				Yes	Definition changed to be congruent with the health promotion diagnosis.	Diagnosis Development Committee
Interrupted family processes (00060)					Yes	The word "excitation" was changed to "arousal" in the definition, to be consistent with the literature.	Diagnosis Development Committee
Domain 8: Sexuality							
Sexual dysfunction (00059)					Yes	Definition changed to clarify concept.	Diagnosis Development Committee
Ineffective childbearing process (00221)				1	Yes	Definition changed to clarify concept.	Diagnosis Development Committee
Risk for ineffective childbearing process (00207)				1	Yes	Definition changed to clarify concept.	Diagnosis Development Committee
Risk for maternal-fetal dyad (00209)					Yes	Definition changed to remove the term, "maternal-fetal dyad", and to clarify concept.	Diagnosis Development Committee
Domain 9: Coping / Stress tolerance							
Post-trauma syndrome (00141)				6	No		Diagnosis Development Committee
Relocation stress syndrome (00114)				1	No		Diagnosis Development Committee

Risk for relocation stress syndrome (00149)				2	No		Diagnosis Development Committee
Ineffective activity planning (00199)				1	No		Diagnosis Development Committee
Ineffective coping (00069)					Yes	Definition changed to be congruent with other coping diagnoses, and to clarify the concept.	Diagnosis Development Committee
Readiness for enhanced coping (00158)					Yes	Definition changed to be congruent with other coping diagnoses, and to clarify the concept.	Diagnosis Development Committee
Powerlessness (00125)				9	No		Diagnosis Development Committee
Risk for powerlessness (00152)				2	No		Diagnosis Development Committee
Impaired resilience (00211)		2		9	Yes	Definition changed to be congruent with other resilience diagnoses, and to clarify the concept.	S. Caldeira, RN, PhD
Risk for impaired resilience (00210)				13	Yes	Definition changed to be congruent with other coping diagnoses, and to clarify the concept.	S. Caldeira, RN, PhD
Readiness for enhanced resilience (00212)					Yes	Definition changed to be congruent with other coping diagnoses, and to clarify the concept.	S. Caldeira, RN, PhD
Autonomic dysreflexia (00009)				19	No		Diagnostic Development Committee
Risk for autonomic dysreflexia (00010)				3	No		Diagnostic Development Committee
Disorganized infant behavior (00116)					Yes	Definition changed to be congruent with other organized behavior diagnoses, and to clarify the concept.	Diagnosis Development Committee
Risk for disorganized infant behavior (00115)				9	Yes	Definition changed to be congruent with other organized behavior diagnoses, and to clarify the concept.	Diagnosis Development Committee
Readiness for enhanced organized infant behavior (00117)					Yes	Definition changed to be congruent with other organized behavior diagnoses, and to clarify the concept.	Diagnosis Development Committee
Domain 10: Life principles							
Impaired emancipated decision-making (00242)				3	No		Diagnosis Development Committee
Risk for impaired emancipated decision-making (00244)				2	No		Diagnosis Development Committee
Moral distress (00175)					Yes	Definition changed to remove slashes, "/", from the phrase, "ethical / moral decision / action".	Diagnosis Development Committee
Impaired religiosity (00169)				3	No		Diagnosis Development Committee
Risk for impaired religiosity (00170)				4	No		Diagnosis Development Committee
Spiritual distress (00066)				13	No		Diagnosis Development Committee
Domain 11: Safety / Protection							
Risk for impaired oral mucous membrane integrity (00247)				1	No		Diagnosis Development Committee
Impaired skin integrity (00046)		5		3	No		Diagnosis Development Committee
Risk for sudden infant death (00156)				2	No	Revised for consistency with new guidelines for sudden infant death.	Diagnosis Development Committee

Impaired tissue integrity (00044)		5			No		Diagnosis Development Committee
Risk for impaired physical trauma (00038)					Yes	Definition revised to remove the word, "accidental," as not all traumas are accidental in nature. Label was changed to reflect the definition, which is specific to physical trauma: *risk for physical trauma.*	Diagnosis Development Committee
Self-mutilation (00151)				1	No		Diagnosis Development Committee
Risk for self-mutilation (00139)				4	No		Diagnosis Development Committee
Ineffective thermoregulation (00008)				5	No		Diagnosis Development Committee
Domain 12: Comfort							
Acute pain (00132)					Yes	Definition revised to provide time limitation of < 3 months, for congruence with the definition of chronic pain.	Diagnosis Development Committee
Abbreviations: DC, defining characteristic; ReF, related factor; RiF, risk factor							

Table 3.3 Revisions to nursing diagnosis labels of NANDA-I nursing diagnoses, 2018–2020

Domain	Previous diagnostic label	New diagnostic label
1. Health promotion	Deficient diversional activity (00097)	Decreased diversional activity engagement
2. Nutrition	Insufficient breast milk (00216)	Insufficient breast milk production
2. Nutrition	Neonatal jaundice (00194)	Neonatal hyperbilirubinemia
2. Nutrition	Risk for neonatal jaundice (00230)	Risk for hyperbilirubinemia
11. Safety/Protection	Impaired oral mucous membrane (00045)	Impaired oral mucous membrane integrity
11. Safety/Protection	Risk for impaired oral mucous membrane (00247)	Risk for impaired oral mucous membrane integrity
11. Safety/Protection	Risk for sudden infant death syndrome (00156)	Risk for sudden infant death
11. Safety/Protection	Risk for trauma (00038)	Risk for physical trauma
11. Safety/Protection	Risk for allergy response (00217)	Risk for allergic reaction
11. Safety/Protection	Latex allergy response (00041)	Latex allergic reaction
11. Safety/Protection	Risk for latex allergy response (00042)	Risk for latex allergic reaction

3.7 Standardization of Diagnostic Indicator Terms

For the past three cycles of this book, work has been underway to decrease variation in terms used for defining characteristics, related factors, and risk factors. This work was undertaken in earnest during the previous cycle of the book (10th edition), with several months being dedicated for the review, revision, and standardization of terms being used. This involved many hours of

review, literature searches, discussion, and consultation with clinical experts in different fields.

The process used included individual review of assigned domains, followed by a second reviewer independently reviewing the current and newly recommended terms. The two reviewers then met—either in person or via webbased video conferencing—and reviewed each line a third time, together. Once consensus was reached, the third reviewer took the current and recommended terms, and independently reviewed them. Any discrepancies were discussed until consensus was reached. After the entire process was completed for every diagnosis—including new and revised diagnoses—a process of filtering for similar terms began. For example, every term with the stem "pulmo-" was searched, to ensure that consistency was maintained. Common phrases, such as verbalizes, reports, states, lack of, insufficient, inadequate, excess, etc., were also used to filter. This process continued until the team was unable to find additional terms that had not previously been reviewed.

This work continued during this 11th cycle of the taxonomy. That said, we know the work is not done, it is not perfect, and there may be disagreements with some of the changes that were made. However, we do believe these changes continue to improve the diagnostic indicators, making them more clinically useful, and providing better diagnostic support.

The benefits of this are many, but the following are perhaps the most notable:

- **Translations should be improved**. There have been multiple questions regarding previous editions that were difficult to answer. Some examples are the following:
  - When you say *lack* in English, does that mean *absence of* or *insufficient*? The answer is often, "Both!" Although the duality of this word is well accepted in English, the lack of clarity creates confusion for clinicians who are non-native English speakers, and it makes it very difficult to translate into languages in which a different word would be used depending on the intended meaning.
  - Is there a reason why some defining characteristics are noted in singular form and yet in another diagnosis, the same characteristic is noted in plural form (e.g., absence of significant other(s), absence of significant other, absence of significant others)?
  - There are many terms that are similar or that are examples of other terms used in the terminology. For example, what is the difference between *abnormal skin color (e.g., pale, dusky)*, *color changes*, *cyanosis*, *pale*, *skin color changes*, and *slight cyanosis*? Are the differences significant? Could

these terms be combined into one? Some of the translations are almost the same—for example, *abnormal skin color, color changes, skin color changes*—can we use one single term or must we translate the exact English term? It is truly important that translators "struggle" to ensure conceptual clarity when translating the terms—there is a difference between the terms "dusky skin color" and "cyanotic skin color," and this can impact one's clinical judgment.

Decreasing the variation in these terms should simplify the translation process, as one term/phrase will be used throughout the terminology for similar diagnostic indicators.

– **Clarity for clinicians should be improved**. It is confusing to students and practicing nurses alike when they see similar but slightly different terms in different diagnoses. Are they the same? Is there some subtle difference they do not understand? Why cannot NANDA-I be more clear? And what about all of those "e.g.'s" in the terminology? Are they there to teach, to clarify, to list every potential example? There seems to be a mixture of possible reasons for their appearance in the terminology.

  You will notice that many of the "e.g.'s" have been removed, unless it was felt that they were truly needed to clarify intent. "Teaching tips" that were present in some parentheses are gone, too—the terminology is not the place for these. We have also done our best to condense terms and standardize them, whenever possible.

– This work facilitates the coding **of the diagnostic indicators**, which should allow their use for populating assessment databases within electronic health records (EHR), and increase the availability of decision-support tools regarding accuracy in diagnosis and linking diagnosis to appropriate treatment plans. All terms are now coded for use in EHR systems, which is something we have been asked to do repeatedly by many organizations and vendors alike.

3.8 Introduction of At-Risk Populations and Associated Conditions

Users of this book will notice the use of the following new terms as they review the diagnostic indicators for most diagnoses: *at-risk populations* and *associated conditions*. One of the issues we have often struggled with in the terminology is a "laundry list" of related factors, many of which are not amenable to

independent nursing intervention. The issue has been that the data are helpful when diagnosing a patient, and it was decided that these data needed to be available to nurses as they considered potential nursing diagnoses. However, because we indicate that interventions should be aimed at related factors, this caused confusion among students and practicing nurses.

Therefore, we have added two new terms in this edition to clearly indicate data which are helpful when making a diagnosis, even though they are not amenable to independent nursing intervention. Users will notice that many of the former related factors or risk factors have now been recategorized into either at-risk populations or associated conditions. The phrases were moved “as is,” meaning that no new conceptual work was completed on these phrases; this work will need to be undertaken in the future.

At-risk populations are groups of people who share a characteristic that causes each member to be susceptible to a particular human response, such as demographics, health/family history, stages of growth/development, or exposure to certain events/experiences.

Associated conditions are medical diagnoses, injuries, procedures, medical devices, or pharmaceutical agents. These conditions are not independently modifiable by the professional nurse, but may support accuracy in nursing diagnosis.

4 Governance and Organization

4.1 International Considerations on the Use of the *NANDA-I Nursing Diagnoses*

T. Heather Herdman

As we noted earlier, NANDA International, Inc. initially began as a North American organization and, therefore, the earliest nursing diagnoses were primarily developed by nurses from the United States and Canada. However, over the past 20 to 30 years, there has been an increasing involvement by nurses from around the world, and membership in NANDA International, Inc. now includes nurses from nearly 40 countries, with nearly two-thirds of its members coming from countries outside North America. Work is occurring across all continents using NANDA-I nursing diagnoses in curricula, clinical practice, research, and informatics applications. Development and refinement of diagnoses is ongoing across multiple countries, and the majority of research related to the NANDA-I nursing diagnoses is occurring outside North America.

As a reflection of this increased international activity, contribution, and utilization, the North American Nursing Diagnosis Association changed its scope to an international organization in 2002, changing its name to **NANDA International, Inc.** So, please, we ask that you **do not refer to the organization as the *North American Nursing Diagnosis Association (or as the North American Nursing Diagnosis Association International)***, unless referring to something that happened prior to 2002—it simply does not reflect our international scope, and **it is not the legal name of the organization**. We retained "NANDA" within our name because of its status in the nursing profession, so think of it more as a trademark or brand name than as an acronym, since it no longer "stands for" the original name of the association.

As NANDA-I experiences increased worldwide adoption, issues related to differences in the scope of nursing practice, diversity of nurse practice models, divergent laws and regulations, nurse competency, and educational differences

must be addressed. In 2009, NANDA-I held an International Think Tank Meeting, which included 86 individuals representing 16 countries. During that meeting, significant discussions occurred as to how best to handle these and other issues. Nurses in some countries are not able to utilize nursing diagnoses of a more physiologic nature because they are in conflict with their current scope of nursing practice. Nurses in other nations are facing regulations aimed to ensure that everything done within nursing practice can be demonstrated to be evidence-based, and therefore face difficulties with some of the older nursing diagnoses and/or those linked interventions that are not supported by a strong level of research literature. Discussions were therefore held with international leaders in nursing diagnosis use and research, looking for direction that would meet the needs of the worldwide community.

These discussions resulted in a unanimous decision to maintain the taxonomy as an intact body of knowledge in all languages, in order to enable nurses around the world to view, discuss, and consider diagnostic concepts being used by nurses within and outside of their countries, and to engage in discussions, research, and debate regarding the appropriateness of all of the diagnoses. A critical statement agreed upon in that Summit is noted here prior to introducing the nursing diagnoses themselves:

> Not every nursing diagnosis within the NANDA-I taxonomy is appropriate for every nurse in practice—nor has it ever been. Some of the diagnoses are specialty-specific, and would not necessarily be used by all nurses in clinical practice …. There are diagnoses within the taxonomy that may be outside the scope or standards of nursing practice governing a particular geographic area in which a nurse practices.

Those diagnoses would, in these instances, not be appropriate for practice, and should not be used if they lie outside the scope or standards of nursing practice for a particular geographic region. However, it is appropriate for these diagnoses to remain visible in the taxonomy, because the taxonomy represents clinical judgments made by nurses *around the world*, not just those made in one region or country. Every nurse should be aware of, and work within, the standards and scope of practice and any laws or regulations within which he/she is licensed to practice. However, it is also important for all nurses to be aware of the areas of nursing practice that exist globally, as this informs discussion and may over time support the broadening of nursing practice across other countries. Conversely, these individuals may be able to provide evidence that would support the

removal of diagnoses from the current taxonomy, which, if they were not shown in their translations, would be unlikely to occur.

That said, it is important that you are not avoiding the use of a diagnosis because, in the opinion of one local expert or published textbook, it is not appropriate. I have met nurse authors who indicate that operating room nurses “cannot diagnose because they don't assess,” or that intensive care unit nurses “have to practice under strict physician protocol that doesn't include nursing diagnosis.” Neither of these statements is factual, but rather represents the personal opinions of those nurses. It is, therefore, important to truly educate oneself on regulation, law, and professional standards of practice in one's own country and area of practice, rather than relying on the word of one person, or group of people, who may be inaccurately defining or describing nursing diagnosis.

Ultimately, nurses must identify those diagnoses that are appropriate for their area of practice, that fit within their scope of practice or legal regulations, and for which they have competency. Nurse educators, clinical experts, and nurse administrators are critical to ensuring that nurses are aware of diagnoses that are truly outside the scope of nursing practice in a certain geographic region. Multiple textbooks in many languages are available that include the entire NANDA-I taxonomy, so for the NANDA-I text to remove diagnoses from country to country would no doubt lead to a great level of confusion worldwide. Publication of the taxonomy in no way requires that a nurse utilize every diagnosis within it, nor does it justify practicing outside the scope of an individual's nursing license or regulations to practice.

4.2 NANDA International Position Statements

From time to time, the NANDA International Board of Directors provides position statements as a result of requests from members or users of the NANDA-I taxonomy. Currently, there are two position statements: one addresses the use of the NANDA-I taxonomy as an assessment framework, and the other addresses the structure of the nursing diagnosis statement when included in a care plan. NANDA-I publishes these statements in an attempt to prevent others from interpreting NANDA-I's stance on important issues, and to prevent misunderstandings or misinterpretations.

4.2.1 NANDA INTERNATIONAL Position

Statement Number 1

The Use of Taxonomy II as an Assessment Framework

Nursing assessments provide the starting point for determining nursing diagnoses. It is vital that a recognized nursing assessment framework is used in practice to identify the patient's* problems, risks, and outcomes for enhancing health.

NANDA International does not endorse one single assessment method or tool. The use of an evidence-based nursing framework, such as Gordon's functional health pattern (FHP) assessment, should guide assessment that supports nurses in determination of NANDA-I nursing diagnoses.

For accurate determination of nursing diagnoses, a useful, evidence-based assessment framework is the best practice.

* NANDA International defines patient as “individual, family, group or community.”

4.2.2 NANDA INTERNATIONAL Position Statement Number 2

The Structure of the Nursing Diagnosis Statement When Included in a Care Plan

NANDA International believes that the structure of a nursing diagnosis as a statement, including the diagnosis label and the related factors as exhibited by defining characteristics, is the best clinical practice, and may be an effective teaching strategy.

The accuracy of the nursing diagnosis is validated when a nurse is able to clearly identify and link to the defining characteristics, related factors, and/or risk factors found within the patient's* assessment.

While this is recognized as best practice, it may be that some information systems do not provide this opportunity. Nurse leaders and nurse informaticists must work together to ensure that vendor solutions are available which allow the nurse to validate accurate diagnoses through clear identification of the

diagnostic statement, related and/or risk factors, and defining characteristics.

* NANDA International defines patient as “individual, family, group or community.”

4.3 An Invitation to Join NANDA International

Words are powerful. They allow us to communicate ideas and experiences to others so that they may share our understanding. Nursing diagnoses are an example of a powerful and precise terminology that highlights and renders visible the unique contribution of nursing to global health. Nursing diagnoses communicate the professional judgments that nurses make every day—to our patients, our colleagues, members of other disciplines, and the public. They are our words.

4.3.1 NANDA International: A Member-Driven Organization

Our Vision

NANDA International, Inc. (NANDA-I) will be a global force for the development and use of nursing's standardized diagnostic terminology to improve the health care of all people.

Our Mission

To facilitate the development, refinement, dissemination, and use of standardized nursing diagnostic terminology.

– We provide the world's leading evidence-based nursing diagnoses for use in practice and to determine interventions and outcomes.
– We fund research through the NANDA-I Foundation.
– We are a supportive and energetic global network of nurses who are committed to improving the quality of nursing care through evidence-based practice.

Our Purpose

Implementation of nursing diagnosis enhances every aspect of nursing practice, from garnering professional respect to assuring accurate documentation for reimbursement.

NANDA International exists to develop, refine, and promote terminology that

accurately reflects nurses' clinical judgments. This unique, evidence-based perspective includes social, psychological, and spiritual dimensions of care.

Our History

NANDA International was originally named the North American Nursing Diagnosis Association (NANDA) and was founded in 1982. The organization grew out of the National Conference Group, a task force established at the First National Conference on the Classification of Nursing Diagnoses, held in St. Louis, MO, United States, in 1973. This conference and the ensuing task force ignited interest in the concept of standardizing nursing terminology. In 2002, NANDA was relaunched as NANDA International to reflect increasing worldwide interest in the field of nursing terminology development. Although we no longer use the name "North American Nursing Diagnosis Association," and it is not appropriate to refer to the organization by this name (nor is North American Nursing Diagnosis Association, International correct to use), unless quoting it prior to 2002, we did maintain "NANDA" as a brand name or trademark within our name, because of its international recognition as the leader in nursing diagnostic terminology.

As of this edition, NANDA-I has approved 244 diagnoses for clinical use, testing, and refinement. A dynamic, international process of diagnosis review and classification approves and updates terms and definitions for identified human responses.

NANDA-I has international networks in Brazil, Colombia, Ecuador, Italy, Mexico, Nigeria–Ghana, Peru, and Portugal, as well as a German-language group; other country, specialty, and/or language groups interested in forming a NANDA-I Network should contact the CEO/Executive Director of NANDA-I at **execdir@nanda.org**. NANDA-I also has collaborative links with nursing terminology societies around the world such as the Japanese Society of Nursing Diagnosis (JSND), the Association for Common European Nursing Diagnoses, Interventions and Outcomes (ACENDIO), the Asociacíon Española de Nomenclatura, Taxonomia y Diagnóstico de Enfermeria (AENTDE), the Association Francophone Européenne des Diagnostics Interventions Résultats Infirmiers (AFEDI), the Nursing Interventions Classification (NIC), and the Nursing Outcomes Classification (NOC).

NANDA International's Commitment

NANDA-I is a member-driven, grassroots organization committed to the development of nursing diagnostic terminology. The desired outcome of the association's work is to provide nurses at all levels and in all areas of practice

with a standardized nursing terminology with which to:

– Name actual or potential human responses to health problems, and life processes.
– Develop, refine, and disseminate evidence-based terminology representing clinical judgments made by professional nurses.
– Facilitate study of the phenomena of concern to nurses for the purpose of improving patient care, patient safety, and patient outcomes for which nurses have accountability.
– Document care for reimbursement of nursing services.
– Contribute to the development of informatics and information standards, ensuring the inclusion of nursing terminology in electronic health care records.

Nursing terminology is the key to defining the future of nursing practice and ensuring the knowledge of nursing is represented in the patient record—NANDA-I is the global leader in this effort. Join us and become a part of this exciting process.

Involvement Opportunities

The participation of NANDA-I members is critical to the growth and development of nursing terminology. Many opportunities exist for participation on committees, as well as in the development, use, and refinement of diagnoses, and in research. Opportunities also exist for international liaison work and networking with nursing leaders.

4.3.2 Why Join NANDA-I?

Professional Networking

– Professional relationships are built through serving on committees, attending our various conferences, participation in the Nursing Diagnosis Discussion Forum, and reaching out through the Online Membership Directory.
– NANDA-I Membership Network Groups connect colleagues within a specific country, region, language, or nursing specialty.
– Professional contribution and achievement are recognized through our Founders, Mentors, Unique Contribution, and Editor's Awards. Research grant awards are offered through the NANDA-I Foundation.
– Fellows are identified by NANDA-I as nursing leaders with standardized nursing language expertise in the areas of education, administration, clinical practice, informatics, and research.

Resources

– Members receive a complimentary subscription to our online scientific journal, the *International Journal of Nursing Knowledge* (IJNK). IJNK communicates efforts to develop and implement standardized nursing language across the globe.
– The NANDA-I website offers resources for nursing diagnosis development, refinement, and submission, NANDA-I taxonomy updates, and an Online Membership Directory.

Member Benefits

– Members receive discounts on English-language NANDA-I taxonomy publications, including print and electronic versions of NANDA-I Nursing Diagnoses and Classification.
– We partner with organizations offering products/services of interest to the nursing community, with a price advantage for members. Member discounts apply to our biennial conference and NANDA-I products, such as our T-shirts and tote bags.
– Our Regular Membership fees are based on the World Health Organization's classification of countries. It is our hope this will enable more individuals with interest in the work of NANDA-I to participate in setting the future direction of the organization.

How to Join

Go to www.nanda.org for more information and instructions for membership registration.

4.3.3 Who Is Using the NANDA International Taxonomy?

– International Standards Organization compatible
– Health Level 7 International registered
– SNOMED-CT available
– Unified Medical Language System compatible
– American Nurses' Association recognized terminology

The NANDA-I taxonomy is currently available in Bahasa Indonesian, Basque, Chinese, Czech, Dutch, English, Estonian, French, German, Italian, Japanese, Portuguese, Spanish (European and Hispanoamerican editions), and Swedish.

For more information, and to apply for membership online, please visit:

www.nanda.org.

Part 2
The Theory Behind NANDA International Nursing Diagnoses

5 Nursing Diagnosis Basics

Susan Gallagher-Lepak

5.1 Introduction

Health care is delivered by various types of health care professionals, including nurses, physicians, and physical therapists, to name just a few. This is true in hospitals as well as other settings across the continuum of care (e.g., clinics, homecare, long-term care, churches, prisons). Each health care discipline brings its unique body of knowledge to the care of the client. In fact, a unique body of knowledge is a critical characteristic of a profession.

Collaboration, and at times overlap, occurs between professionals in providing care (▶ Fig. 5.1). For example, a physician in a hospital setting may write an order for the client to walk twice per day. Physical therapy focuses on core muscles and movements necessary for walking. Respiratory therapy may be involved if oxygen therapy is used to treat a respiratory condition. Nursing has a holistic view of the patient, including balance and muscle strength related to walking, as well as confidence and motivation. Social work may be involved with insurance coverage for necessary equipment.

Each health profession has a way to describe "**what**" the profession knows and "**how**" it acts on what it knows. This chapter is primarily focused on the "what." A profession may have a common language that is used to describe and code its knowledge. Physicians treat diseases and use the International Classification of Disease (ICD) taxonomy to represent and code the medical problems they treat. Psychologists, psychiatrists, and other mental health professionals treat mental health disorders, and use the Diagnostic and Statistical Manual of Mental Disorders (DSM). Nurses treat human responses to health problems and/or life processes and use the NANDA International, Inc. (NANDA-I) nursing diagnosis taxonomy. The nursing diagnosis taxonomy, and the process of diagnosing using this taxonomy, will be described further.

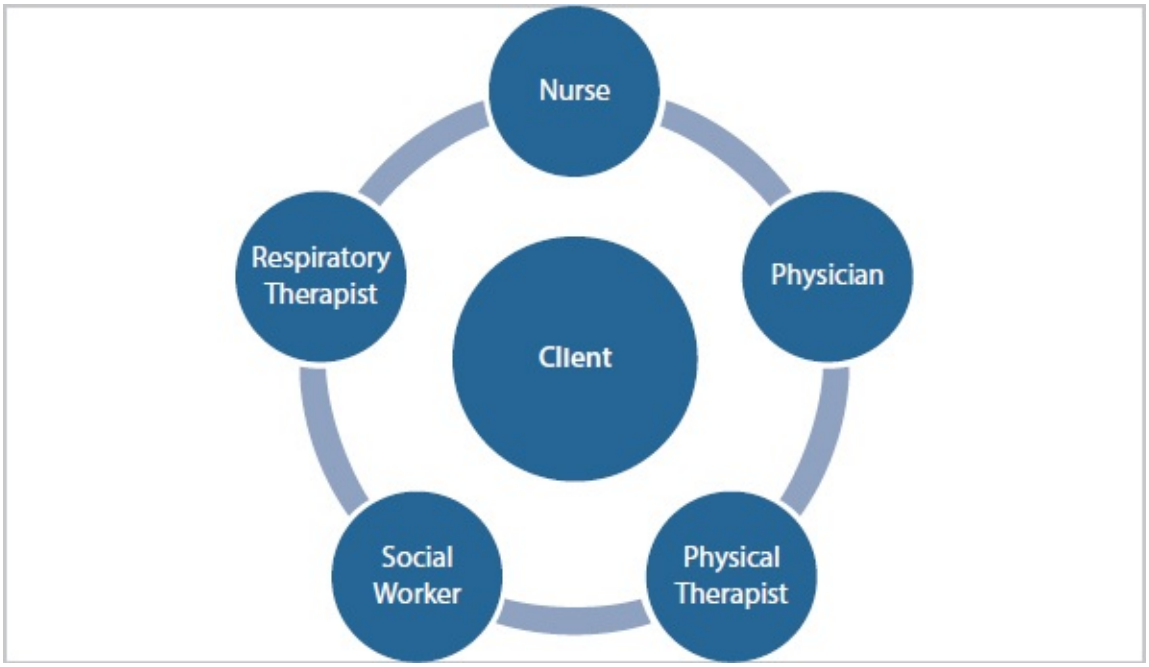

Fig. 5.1 Example of a collaborative health care team.

The NANDA-I taxonomy provides a way to classify and categorize areas of concern to the nursing professional (i.e., diagnostic foci). It contains 244 nursing diagnoses grouped into 13 domains and 47 classes. According to the Cambridge Dictionary On-Line (2017), a domain is "an area of interest;" examples of domains in the NANDA-I taxonomy include activity/rest, coping/stress tolerance, elimination/exchange, and nutrition. Domains are divided into classes, which are groupings that share common attributes.

Nurses deal with responses to health problems/life processes among individuals, families, groups, and communities. Such responses are the central concern of nursing care and fill the circle ascribed to nursing in ▶ Fig. 5.1. A nursing diagnosis can be problem-focused, a state of health promotion, or a potential risk.

- **Problem-focused diagnosis**—a clinical judgment concerning an *undesirable human response* to a health condition/life process that exists in an individual, family, group, or community
- **Risk diagnosis**—a clinical judgment concerning the *susceptibility* of an individual, family, group, or community for developing an undesirable human response to health conditions/life processes
- **Health promotion diagnosis**—a clinical judgment concerning *motivation and desire* to increase well-being and to actualize health potential. 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. Health promotion responses may exist in an individual, family, group, or community.

Although limited in number in the NANDA-I taxonomy, a **syndrome** can be present. A syndrome is a clinical judgment concerning a specific *cluster of nursing diagnoses* that occur together, and are therefore best addressed together and through similar interventions. An example of a syndrome diagnosis is *chronic pain syndrome* (00255). Chronic pain is recurrent or persistent pain that has lasted at least 3 months and that significantly affects daily functionings or well-being. Chronic pain syndrome is differentiated from chronic pain in that, in addition to the chronic pain, it has significant impact on other human responses and thus includes other diagnoses, such as *disturbed sleep pattern* (00198), *fatigue* (00093), *impaired physical mobility* (00085), or *social isolation* (00053).

5.2 How Does a Nurse (or Nursing Student) Diagnose?

The nursing process includes assessment, nursing diagnosis, planning, outcome setting, intervention, and evaluation (▶ Fig. 5.2). Nurses use assessment and clinical judgment to formulate hypotheses or explanations about presenting problems, risks, and/or health promotion opportunities. All of these steps require knowledge of underlying concepts of nursing science before patterns can be identified in clinical data or accurate diagnoses can be made.

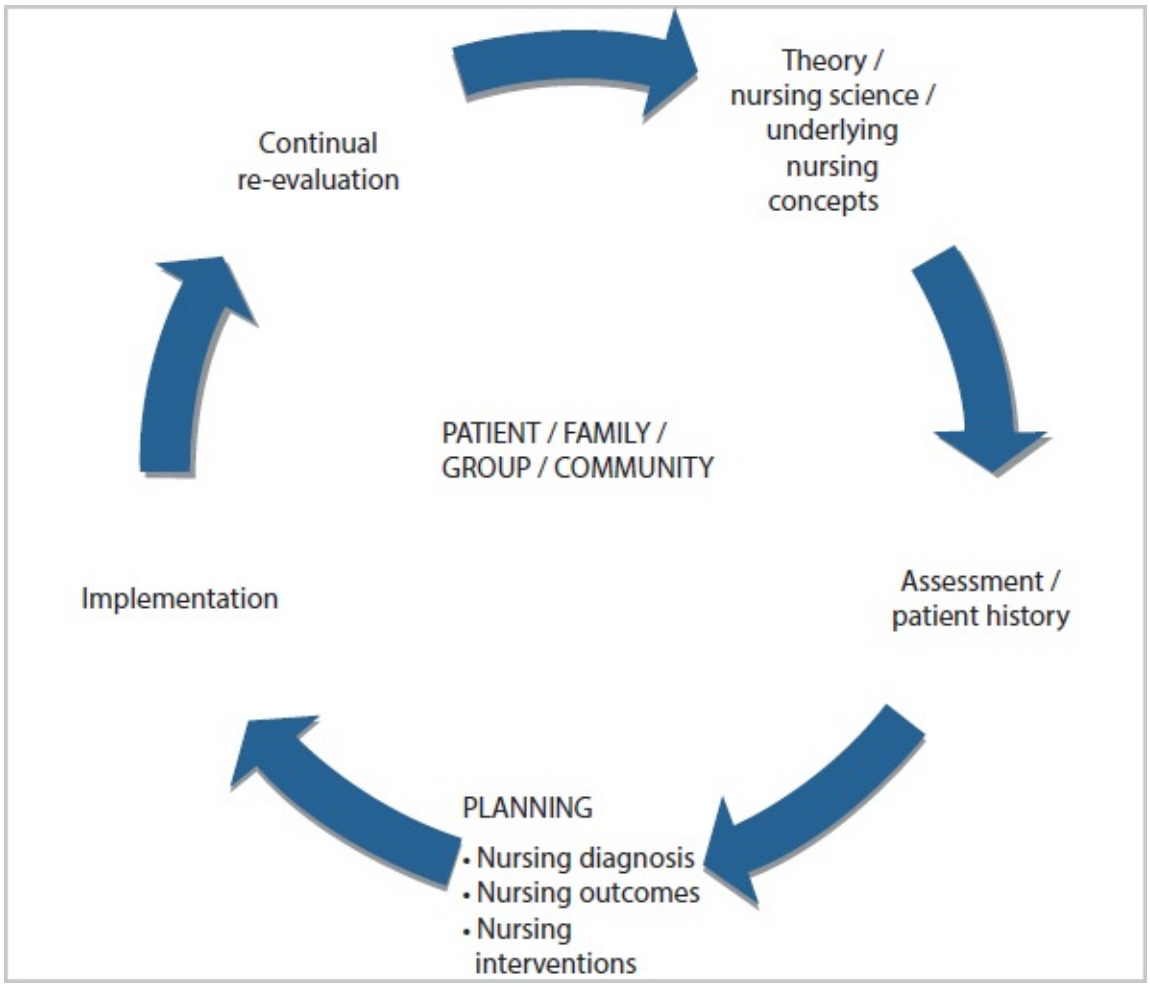

Fig. 5.2 The modified nursing process. Adapted from Herdman 2013.

5.3 Understanding Nursing Concepts

Knowledge of key concepts, or nursing diagnostic foci, is necessary before beginning an assessment. Examples of critical concepts important to nursing practice include breathing, elimination, thermoregulation, physical comfort, self-care, and skin integrity. Understanding such concepts allows the nurse to see patterns in the data and accurately diagnose. Key areas to understand within the concept of pain, for example, include manifestations of pain, theories of pain, populations at risk, related pathophysiological concepts (fatigue, depression), and management of pain. Full understanding of key concepts is needed, as well, to differentiate diagnoses. For example, to understand issues related to respiration, a nurse must first understand the core concepts of ventilation, gas exchange, and breathing pattern. In looking at problems that can occur with

regard to *ventilation*, the nurse will be faced with the diagnoses of *impaired spontaneous ventilation* (00033) and *dysfunctional ventilatory weaning response* (00034); concerns with gas exchange may lead the nurse to the diagnosis of *impaired gas exchange* (00030), while issues related to breathing pattern might lead to a diagnosis of *ineffective breathing pattern* (00032). As you can see, although each of these diagnoses is related to the respiratory system, they are not all concerned with the same core concept. Thus, the nurse may collect a significant amount of data, but without a sufficient understanding of the core concepts of ventilation, gas exchange, and breathing pattern, the data needed for accurate diagnosis may have been omitted and patterns in the assessment data go unrecognized.

5.4 Assessment

Assessment involves the collection of subjective and objective data (e.g., vital signs, patient/family interview, physical exam) and review of historical information provided by the patient/family, or found within the patient chart. Nurses also collect data on patient/family strengths (to identify health promotion opportunities) and risks (to prevent or postpone potential problems). Assessments can be based on a specific nursing theory, such as one developed by Florence Nightingale, Wanda Horta, or Sr. Callista Roy, or on a standardized assessment framework such as Marjory Gordon's Functional Health Patterns. These frameworks provide a way of categorizing large amounts of data into a manageable number of related patterns or categories of data.

The foundation of nursing diagnosis is clinical reasoning. Clinical reasoning involves the use of clinical judgment to decide what is wrong with a patient, and clinical decision-making to decide what needs to be done (Levett-Jones et al 2010). Clinical judgment is “an interpretation or conclusion about a patient's needs, concerns, or health problems, and/or the decision to take action (or not)” (Tanner 2006, p. 204). Key issues, or diagnostic foci, may be evident early in the assessment (e.g., altered skin integrity, loneliness) and allow the nurse to begin the diagnostic process. For example, a patient may report pain and/or show agitation while holding a body part. The nurse will recognize the client's discomfort based on client report and/or pain behaviors. Expert nurses can quickly identify clusters of clinical cues from assessment data and seamlessly progress to nursing diagnoses. Novice nurses take a more sequential process in determining appropriate nursing diagnoses.

Practice Reflection from a Nurse in the United States: As I went through nursing school, we created numerous care plans that were built around nursing diagnoses … On Day 1 of the clinical rotation, we reviewed our patient's chart, met with, and assessed the patient, and then developed a care plan that we would then initiate and/or continue on Day 2.

5.5 Nursing Diagnosis

A nursing diagnosis is a clinical judgment concerning a human response to health conditions/life processes, or vulnerability for that response, by an individual, family, group, or community (NANDA-I 2013). A nursing diagnosis typically contains two parts: (1) descriptor or modifier and (2) focus of the diagnosis or the key concept of the diagnosis (▶ Table 5.1). There are some exceptions in which a nursing diagnosis is only one word, such as *anxiety* (00146), *constipation* (00011), *fatigue* (00093), and *nausea* (00134). In these diagnoses, the modifier and focus are inherent in the one term.

Nurses diagnose health problems, risk states, and readiness for health promotion. Problem-focused diagnoses should not be viewed as more important than risk diagnoses. Sometimes a risk diagnosis can be the diagnosis with the highest priority for a patient. An example may be a patient who has the nursing diagnoses of *activity intolerance* (00092), *impaired memory* (00131), *readiness for enhanced health management* (00162), and *risk for falls* (00155), and has been newly admitted to a skilled nursing facility. Although *activity intolerance* and *impaired memory* are the problem-focused diagnoses, the patient's *risk for falls* may be the number one priority diagnosis, especially as the individual adjusts to a new environment. This may be especially true when related risk factors are identified in the assessment (e.g., poor vision, difficulty with gait, history of falls, anxiety with relocation).

Table 5.1 Parts of a nursing diagnosis label

Modifier	Focus of the diagnosis
Ineffective	Breathing pattern
Risk for	Constipation
Deficient	Fluid volume
Impaired	Skin integrity
Readiness for enhanced	Resilience

Each nursing diagnosis has a label and a clear definition. It is important to state that merely having a label or a list of labels is insufficient. It is critical that nurses know the definitions of the diagnoses they most commonly use. In addition, they need to know the "diagnostic indicators"—the information that is used to diagnose and differentiate one diagnosis from another. These diagnostic indicators include defining characteristics and related factors or risk factors (▶ Table 5.2). **Defining characteristics** are observable cues/inferences that cluster as manifestations of a diagnosis (e.g., signs or symptoms). An assessment that identifies the presence of a number of defining characteristics lends support to the accuracy of the nursing diagnosis. **Related factors** are an integral component of all problem-focused nursing diagnoses. Related factors are etiologies, circumstances, facts, or influences that have some type of relationship with the nursing diagnosis (e.g., cause, contributed factor). A review of client history often helps to identify related factors. Whenever possible, nursing interventions should be aimed at these etiological factors in order to remove the underlying cause of the nursing diagnosis. **Risk factors** are influences that increase the vulnerability of an individual, family, group, or community to an unhealthy event (e.g., environmental, psychological, genetic).

Table 5.2 Key terms at a glance

Term	Brief description
Nursing diagnosis	Problem, strength, or risk identified for a patient, family, group, or community
Defining characteristic	Sign or symptom (objective or subjective cues)
Related factor	Causes or contributing factors (etiological factors)
Risk factor	Determinant (increase risk)
At-risk populations	Groups of people who share a characteristic that causes 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, injury procedures, medical devices, or pharmaceutical agents. These conditions are not independently modifiable by the professional nurse.

New to this edition of the *Nursing Diagnosis: Definitions and Classifications* book are the categories of at-risk populations and associated conditions within relevant nursing diagnoses (see ▶ Table 5.2). At-risk populations are groups of individuals who share characteristics that cause each member to be susceptible to a particular human response. For example, individuals at extremes of age are

an at-risk population that share a greater susceptibility to deficient fluid volume. Associated conditions are medical diagnoses, injuries, procedures, medical devices, or pharmaceutical agents. These conditions are not independently modifiable by a professional nurse. Examples of associated conditions include a myocardial infarction, pharmaceutical agents, or surgical procedure. Data on both at-risk populations and associated conditions are important, are often collected during an assessment, and can help the nurse to consider potential diagnoses and confirm them. However, at-risk populations and associated conditions do not meet the intent of defining characteristics or related factors, because nurses cannot change or impact these categories independently. For further information on this, see the Frequently Asked Questions section (p. 109) and the information contained in the Changes and Revisions section (p. 4) of this book.

A nursing diagnosis does not need to contain all types of diagnostic indicators (i.e., defining characteristics, related factors, and/or risk factors). Problem-focused nursing diagnoses contain defining characteristics and related factors. Health promotion diagnoses generally have only defining characteristics, although related factors may be used if they might improve the understanding of the diagnosis. Only risk diagnoses have risk factors.

A common format used when learning nursing diagnosis includes _____ [nursing diagnosis] related to _____ [cause/related factors] as evidenced by _____ [symptoms/defining characteristics]. For example, *caregiver role strain* related to *around-the-clock care responsibilities, complexity of care activities,* and *unstable health condition of the care receiver* as evidenced by *difficulty performing required tasks, preoccupation with care routine, fatigue,* and *alteration in sleep pattern*. Depending on the electronic health record in a particular health care institution, the “related to” and “as evidenced by” components may not be included within the electronic system. This information, however, should be recognized in the assessment data collected and recorded in the patient chart in order to provide support for the nursing diagnosis. Without this information, it is impossible to verify diagnostic accuracy, which puts the quality of nursing care in question.

Practice Reflection from a Nurse in the United States: Nursing diagnoses are used on the acute rehabilitation floor in a hospital where I work. Computerized charting in the nursing plans of care is mandatory on every shift for every nurse. The electronic system contains 31 prepopulated nursing diagnoses available for the nurse to choose based on the patient assessment.

There are additional boxes that are blank for nurses to input other diagnoses. Examples of the prepopulated diagnoses include *risk for falls*, *risk for infection*, *excess fluid volume*, and *acute pain*. The nurse that initiates the care plan must also fill in what the problem is related to, the goal, time frame, interventions, and outcomes. Every shift the nurse responsible has the option to click on “continue plan of care,” “revise plan of care,” or “resolved.”

5.6 Planning/Intervention

Once diagnoses are identified, prioritizing of selected nursing diagnoses must occur to determine care priorities. High-priority nursing diagnoses need to be identified (i.e., urgent need, diagnoses with high level of congruence with defining characteristics, related factors, or risk factors) so that care can be directed to resolve these problems or lessen the severity or risk of occurrence (in the case of risk diagnoses).

Nursing diagnoses are used to identify intended outcomes of care and plan nursing-specific interventions sequentially. A nursing outcome refers to a measurable behavior or perception demonstrated by an individual, a family, a group, or a community that is responsive to nursing intervention (Center for Nursing Classification & Clinical Effectiveness [CNC], n.d.). The Nursing Outcome Classification (NOC) is one system that can be used to select outcome measures related to a nursing diagnosis. Nurses often, and incorrectly, move directly from nursing diagnosis to nursing intervention without consideration of desired outcomes. Instead, outcomes need to be identified before interventions are determined. The order of this process is similar to planning a road trip. Simply getting in a car and driving will get a person somewhere, but that may not be the place the person really wanted to go. It is better to first have a clear location (outcome) in mind, and then choose a route (intervention), to get to a desired location.

An intervention is defined as “any treatment, based upon clinical judgment and knowledge that a nurse performs to enhance patient/client outcomes” (CNC, n.d.). The Nursing Interventions Classification (NIC) is one taxonomy of interventions that nurses may use across various care settings. Using nursing knowledge, nurses perform both independent and interdisciplinary interventions. These interdisciplinary interventions overlap with care provided by other health care professionals (e.g., physicians, respiratory and physical therapists). For example, blood glucose management is a concept important to nurses, *risk for*

unstable blood glucose (00179) is a nursing diagnosis, and nurses implement nursing interventions to treat this condition. *Diabetes mellitus*, in comparison, is a medical diagnosis, yet nurses provide both independent and interdisciplinary interventions to clients with diabetes who have various types of problems or risk states. Refer to Kamitsuru's Tripartite Model of Nursing Practice (p.109).

Practice Reflection from a Nurse in Brazil: Nursing diagnoses are used in my clinical setting, which is an adult ICU (intensive care unit) in a secondary-level university hospital. An electronic medical record system with NANDA-NIC-NOC linkages is used to document the nursing process. The assessment starts with the input of patient data in standardized questionnaires, which generates prepopulated NANDA-I diagnostic hypotheses that will be validated or eliminated by the nurse. There are additional boxes that are blank for nurses to input other diagnoses. Some prepopulated diagnoses include *ineffective protection*; *self-care deficit: bathing*; *ineffective tissue perfusion: cardiopulmonary*; *impaired gas exchange*; *risk for unstable blood glucose level*; *decreased cardiac output*; and *risk for infection*. Next, the system generates possible NOC outcomes for each diagnosis and the nurse chooses the one that is most representative of his/her aims. Later, the system proposes NIC interventions and activities, for selection by the nurse as a care plan. Every shift the nursing diagnoses are re-evaluated as improved, worsened, unchanged, or resolved.

5.7 Evaluation

A nursing diagnosis “provides the basis for selection of nursing interventions to achieve outcomes for which nursing has accountability” (NANDA-I 2013). The nursing process is often described as a stepwise process, but in reality a nurse will go back and forth between steps in the process. Nurses will move between assessment and nursing diagnosis, for example, as additional data are collected and clustered into meaningful patterns and the accuracy of nursing diagnoses is evaluated. Similarly, the effectiveness of interventions and achievement of identified outcomes is continuously evaluated as the client status is assessed. Evaluation should ultimately occur at each step in the nursing process, as well as once the plan of care has been implemented. Several questions to consider include the following: “What data might I have missed? Am I making an inappropriate judgment? How confident am I in this diagnosis? Do I need to

consult with someone with more experience? Have I confirmed the diagnosis with the patient/family/group/community? Are the outcomes established appropriate for this client in this setting, given the reality of the patient's condition and resources available? Are the interventions based on research evidence or tradition (e.g., “what we always do”)?

5.8 Use of Nursing Diagnosis

This description of nursing diagnosis basics, although aimed primarily at nursing students and beginning nurses learning nursing diagnosis, can benefit many nurses in that it highlights critical steps in using nursing diagnosis and provides examples of areas in which inaccurate diagnosing can occur. An area that needs continued emphasis, for example, includes the process of linking knowledge of underlying nursing concepts to assessment, and ultimately nursing diagnosis. The nurse's understanding of key concepts (or diagnostic foci) directs the assessment process and interpretation of assessment data. Relatedly, nurses diagnose problems, risk states, and readiness for health promotion. Any of these types of diagnoses can be the priority diagnosis (or diagnoses), and the nurse makes this clinical judgment.

In representing knowledge of nursing science, the taxonomy provides the structure for a standardized language in which to communicate nursing diagnoses. Using the NANDA-I terminology (the diagnoses themselves), nurses can communicate with each other as well as professionals from other health care disciplines about “what” nursing is uniquely. The use of nursing diagnosis in our patient/family interactions can help them to understand the issues on which nurses will be focusing, and can engage them in their own care. The terminology provides a shared language for nurses to address health problems, risk states, and readiness for health promotion. NANDA-I's nursing diagnoses are used internationally, with translation into nearly 20 languages. In an increasingly global and electronic world, NANDA-I also allows nurses involved in scholarship to communicate about phenomena of concern to nursing in manuscripts and at conferences in a standardized way, thus advancing the science of nursing.

Nursing diagnoses are peer reviewed, and submitted for acceptance/revision to NANDA-I by practicing nurses, nurse educators, and nurse researchers around the world. Submissions of new diagnoses and/or revisions to existing diagnoses have continued to grow in number over the more than 40 years of the NANDA-I

nursing diagnosis terminology. Continued submissions (and revisions) to NANDA-I will further strengthen the scope, extent, and supporting evidence of the terminology.

5.9 Brief Chapter Summary

This chapter describes types of nursing diagnoses (i.e., problem-focused, risk, health promotion, syndrome) and steps in the nursing process. The nursing process begins with an understanding of underlying concepts of nursing science. Assessment follows and involves collection and clustering of data into meaningful patterns. Nursing diagnosis, a subsequent step in the nursing process, involves clinical judgment about a human response to a health condition or life process, or vulnerability for that response by an individual, a family, a group, or a community. The nursing diagnosis components were reviewed in this chapter, including the label, definition, and diagnostic indicators (i.e., related factors, risk factors, at risk populations, and associated conditions). Given that a patient assessment will typically generate a number of nursing diagnoses, prioritization of nursing diagnoses is needed and this will direct care delivery. Critical next steps in the nursing process include identification of nursing outcomes and nursing interventions. Evaluation occurs at each step of the nursing process and at its conclusion.

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6 Clinical Reasoning: From Assessment to Diagnosis

T. Heather Herdman

6.1 Introduction

Clinical reasoning has been defined in a variety of ways within health disciplines. Koharchik et al (2015) indicate that it requires the application of ideas and experience to arrive at a valid conclusion; in nursing, it describes the way a nurse “analyzes and understands a patient's situation and forms conclusions” (p. 58). Tanner (2006) sees it as the process by which nurses make clinical judgments by selecting from alternatives, weighing evidence, using intuition and pattern recognition. Similarly, Banning (2008) conducted a concept analysis of clinical reasoning, using 71 publications dating from 1964 to 2005. This study defined clinical reasoning as the application of knowledge and experience to a clinical situation, and identified the need for tools to measure clinical reasoning in nursing practice, so that it might be better understood.

It is important to note that considering clinical reasoning as a process does not signify that it is a step-by-step, linear process. Rather, it occurs over time, often across multiple patient/family encounters. This is especially true early in our careers, as we have yet to develop insight from enough patient situations to enable rapid pattern formation or problem identification.

What do we mean by pattern formation? We are basically talking about how our minds pull together a variety of data points to form a picture of what we are seeing. 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 like 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.

The same is true with concepts of importance in nursing. 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. If we do not understand our basic disciplinary concepts, we will struggle to identify patterns we see in our patients, families, and communities. Thus, it is critical that we learn (and teach) these concepts so that nurses can recognize normal human responses, as well as abnormal, risk, and health promotion states related to those responses. It is fair to say that applying the nursing process (assessment, diagnosis, outcome identification, intervention, and evaluation) is meaningless if we do not understand our nursing concepts (diagnoses) well enough to identify them from the patterns in the data we collect during assessment.

Without a solid grounding in the concepts of our discipline, we will not begin to generate hypotheses regarding what is happening with our patients (their human responses, or nursing diagnoses), nor will we have direction in terms of conducting a more in-depth assessment to rule out or confirm those hypotheses. Thus, although conceptual knowledge has not generally been included within the nursing process, applying that process is impossible without it.

Now, let us look at the idea of nursing concepts using a clinical scenario. Stacy is on her first clinical placement as a nursing student, working with David, a registered nurse in an independent/assisted elderly living facility. On one of her placement days, Mrs. Randall stops in to see the nurse. She is 88 years old, and has only lived in the facility for two weeks. She tells David that she is fatigued and cannot concentrate. She is very concerned that there is something wrong with her heart. David begins by taking her vital signs, but as he is doing this, he asks Mrs. Randall to tell him what has been happening in her life since she began living at the facility. She indicates that she has not had anything unusual occur that she can identify, other than the move itself. She says this was her choice because she did not feel safe in her home anymore. She denies any chest pain, heart palpitations, or shortness of breath. When David asks her why she is worried about her heart, she says, “Well, I'm old and that's what tends to go bad.”

David asks her how much exercise she has been getting, and if she has been feeling at all stressed lately. Mrs. Randall indicates that she has not been doing any exercise since she moved here because she does not like group exercise classes, and there is no exercise equipment that she can use on her own. She had previously used an exercise bike in her home at least 30 minutes per day. She notes it was hard to leave her neighborhood because she had a very good friend who lived near her and they saw each other every day. Now they only talk by phone. Although she is glad she gets to talk with her, she says that it is not the same as enjoying a cup of tea in the kitchen with her friend. David asks if her apartment is comfortable for her. She mentions it has large windows that give plenty of natural sunlight, which she likes, but notes it is quite warm; she lives on the third floor, and even when she turns the heat off, it is warmer than she likes.

David tells Mrs. Randall that her vital signs are very good, but he suggests that she may be suffering from a change in her sleep pattern, and suggests that they try a few adjustments to see if that can impact her sleep and feelings of restfulness. First, he recommends that they speak with the environmental services director to get her heat adjusted to a comfortable temperature. He also tells her that there are some exercise bikes and treadmills in the building, located on the assisted living unit, but that all residents may use them at any time. He offers to show her where these are located and to make sure she is comfortable with how to use them, for which she is grateful. Finally, he talks with her about connecting with the director of resident life to find out how she might be able to visit her friend, or have her friend come to the facility to see her new apartment.

Stacy is amazed that David almost immediately identified a potential problem with Mrs. Randall. David draws Stacy's attention to the nursing diagnosis *insomnia (00095)*, and she realizes that his assessment data are defining characteristics and related factors of this diagnosis. David talks with Stacy about the concept of sleep and the things that can impact it, such as stress (Mrs. Randall's recent move; lack of connection with her friend; being in a new apartment) and external factors (a new environment that is too warm), as well as the impact that physical exercise can have on improving sleep. He quickly considered this nursing diagnosis because he understands normal sleep patterns and could identify factors that contribute to a disturbance in a normal pattern. Further, because he understands that *insomnia* is caused by external factors, he identified probable etiological (related) factors. Stacy, as a nursing student, did not have the conceptual knowledge yet from which to draw; for her, this diagnosis did not seem obvious.

This is the reason why studying concepts underlying diagnoses is so important. We cannot diagnose problems or risk situations if we do not first understand normal patterns of human response, nor can we consider health promotion opportunities.

6.2 The Nursing Process

Assessment is perhaps the most critical step in the nursing process. If this step is not completed in a patient-centric manner, nurses will lose control over the subsequent steps of the nursing process. Without proper nursing assessment, there can be no patient-centered nursing diagnosis, and without an appropriate nursing diagnosis, there can be no evidence-based, patient-centered, independent nursing interventions. Assessment should not be performed to merely fill in the blank spaces on a form or computer screen. If this form of rote assessment rings a bell for you, it is time to take a new look at the purpose of assessment!

6.2.1 Assessment

During the assessment and diagnosis steps of the nursing process, nurses collect data from a patient (or family/group/community), process data into information, and organize that information into meaningful categories of knowledge that represent the nursing discipline, also known as nursing diagnoses. Assessment provides the best opportunity for nurses to establish an effective therapeutic relationship with the patient. In other words, assessment is

both an intellectual and an interpersonal activity.

What is the purpose of a nursing assessment?

As you can see in ▶ Fig. 6.1, assessment involves multiple steps, with the goal being to develop diagnostic hypotheses, validate/refute these hypotheses to determine diagnoses, and prioritize these diagnoses, which then become the basis for nursing treatment. This probably sounds like a long, involved process and, frankly, who has time for all of that? In the real world, however, these steps can happen in the blink of an eye, especially for expert nurses. For instance, if a nurse sees a neonate who is irritable, showing signs of respiratory distress, and is unable to maintain sucking, he/she might immediately check a temperature and, upon finding it is 36 ° C/96.8 ° F, he/she would then conclude that the neonate is experiencing *hypothermia*. Thus, the movement from data collection (observation of the neonate's behavior) to determining potential diagnoses (e.g., *hypothermia*) occurs in a matter of minutes.

However, this quickly determined diagnosis might not be the right one—or it may not be the highest priority for your patient. So, how do you accurately diagnose? Only by starting with accurate assessment—and the proper use of the data collected during that assessment—can you ensure accuracy in diagnosis. This chapter provides foundational knowledge for what to do with all the data you have collected. After all, why bother collecting them if you are not going to use them?

In the next section, we will go through each of the steps in the process that takes us from assessment to diagnosis. But first, let us spend a few minutes discussing the purpose, because assessment is not simply a task that nurses complete. We need to understand its purpose so we can understand how it applies to our professional role as nurses

6.2.2 Why Do Nurses Assess?

Nurses need to assess patients from the viewpoint of the nursing discipline to diagnose accurately and to provide effective care. What is the “nursing discipline”? Simply put, it is the body of knowledge that comprises the science of nursing. Nursing diagnoses provide standardized terms, with clear definitions and assessment criteria, that represent that knowledge—just as medical diagnoses represent the knowledge of the medical profession. Diagnosing a patient based on his/her medical diagnosis or medical information, however, is neither a recommended nor safe diagnostic process. Such an overly

simplified conclusion could lead to inappropriate interventions, prolonged length of stay, and unnecessary readmissions.

Remember that nurses diagnose a human response to health conditions/life processes, or a vulnerability for that response, and that diagnosis then provides the basis for the selection of nursing interventions to achieve outcomes *for which the nurse has accountability*—the focus here is "human response." Human beings are complicated—every human being does not respond to the same situation in the same way. Our responses are based on a lot of factors—genetics, physiology, health condition, past experiences with illness/injury. However, responses are also influenced by the patient's culture, ethnicity, religion/spiritual beliefs, gender, and family upbringing. This means that human responses are not so easily identified. If we simply assume that every patient with a medical diagnosis will respond in a certain way, we may treat conditions (and therefore use the nurse's time and other resources) that do not exist, while missing others that truly need our attention.

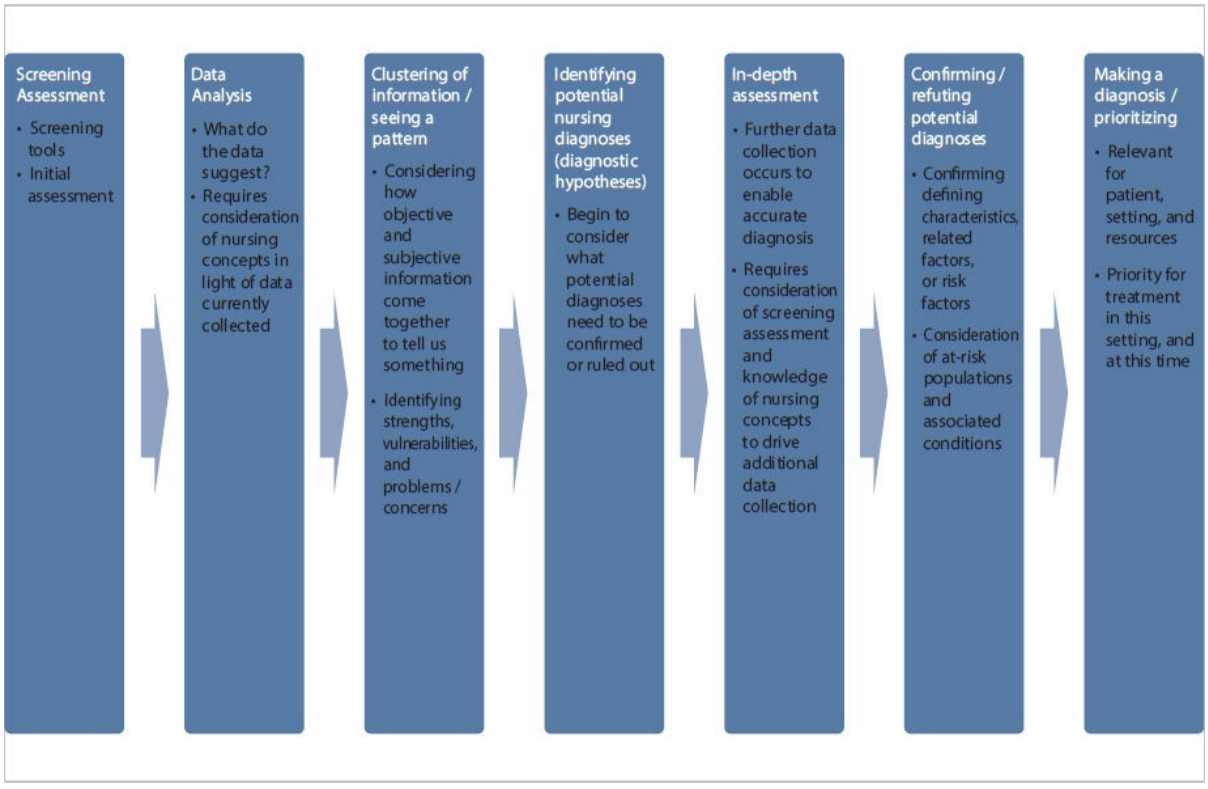

Fig. 6.1 Steps in moving from assessment to diagnosis.

It is possible that there may be close relationships between some nursing diagnoses and medical conditions; however, to date we do not have sufficient scientific evidence to definitively link all nursing diagnoses to medical

diagnoses. For instance, there is no way to know whether a patient has *deficient knowledge* (00126), based solely on a new medical diagnosis or procedure. The individual might have another family member with that same diagnosis, or who previously underwent the same procedure. One can also not assume that every patient with a medical diagnosis will respond in the same way; every patient who is undergoing a surgical procedure is not necessarily experiencing *anxiety* (00146), for example. Therefore, nursing assessment and diagnosis should be approached from the viewpoint of the nursing discipline, and should only be made when based on a patient-centric assessment.

What is wrong with this diagnostic process?

Unfortunately, in your practice, you will probably observe nurses who assign, or "pick," a diagnosis before they have assessed the patient. For example, a nurse may begin to complete a plan of care based on the nursing diagnosis of *anxiety* (00146) for a patient coming into an obstetrical unit for childbirth, before the patient has even arrived on the unit or been evaluated. Nurses working in obstetrics encounter many laboring patients, and those patients are often very anxious. Those nurses may know that labor coaching and deep breathing are effective interventions for reducing anxiety.

Therefore, assuming a relationship between labor and anxiety could be useful in practice. However, the statement "laboring patients have anxiety" may not apply to every patient (it is a hypothesis), and so it must be validated with each patient. This is especially true because anxiety is a subjective experience—although we may think the patient seems anxious, or we may expect her to be anxious, only she can tell us if she *feels* anxious. In other words, the nurse can understand how the patient feels only if the patient tells the nurse about her feelings; so, *anxiety* is a problem-focused nursing diagnosis that requires subjective data from the patient. What appears to be *anxiety* may actually be *labor pain* (00256) or *ineffective childbearing process* (00221); we simply cannot know until we assess and validate our findings. Thus, before nurses diagnose a patient, a thorough assessment is absolutely necessary. An understanding of potential, high-frequency diagnoses (those that often occur in a particular setting or with a particular patient population), however, is very helpful, as the knowledge of the diagnostic criteria related to those diagnoses can help focus the nurse's assessment as he/she tries to rule out or confirm various diagnostic hypotheses.

6.2.3 The Screening Assessment

There are two types of assessment: screening and in-depth assessment. Both require data collection; however, they serve different purposes. The screening assessment is the initial data collection step and is probably the easiest to complete.

Not Simply a Matter of Filling in the Blanks

Most schools and health care organizations provide nurses with a standardized form—on paper or in the electronic health record—that must be completed for each patient, within a specified amount of time. For example, patients who are admitted to the hospital may need to have this assessment completed within 24 hours of admission. Patients seen in an ambulatory clinic may have a required assessment prior to being seen by the primary care provider (e.g., a physician or nurse practitioner). This initial assessment may include standardized screening tools, such as the Subjective Global Assessment (SGA) and/or the Mini-Nutritional Assessment (MNA) for assessing existing malnutrition and risk for malnutrition, respectively (Young et al 2013), or the Clinically Useful Depression Outcome Scale (CUDOS) for adult depression screening (Zimmerman et al 2008). There may be open-ended screening questions, such as: “Who can you talk to if you have a difficult situation to handle?” And there will be tools that enable completion of an assessment based on a specific nursing theory or model (e.g., Gordon's functional health patterns [FHP]), body system review, or some other method of organizing the data to be collected.

The performance of a screening assessment requires specific competencies for the accurate completion of various procedures to obtain data, and it requires a high level of skill in interpersonal communication. Patients must feel safe and trust the nurse before they will feel comfortable answering personal questions or providing answers, especially if they feel their responses might not be received as culturally/spiritually “normal” or “accepted.”

We indicated that the initial screening assessment may be the easiest step because, in some ways, it is initially a process of “filling in the blanks.” The screening form might require information about the patient's vital signs, so the nurse obtains these and inputs those data into the assessment form. The form requires that information is collected about the patient's various physiologic systems, and the nurse fills in all the blank spaces on the form that deal with these systems (heart rhythm, presence of a murmur, pedal pulses, lung sounds, bowel sounds, etc.), along with basic psychosocial and spiritual data.

However, good nursing assessment requires far more than this initial

screening. Obviously, when the nurse reviews data collected during his/her assessment and starts to recognize potential diagnoses, he/she will need to collect further data that can help him/her determine if there are other human responses occurring that are of concern, that indicate risks for the patient, or that suggest health promotion opportunities. The nurse will also want to identify the etiology or precipitating factors of areas of concern. It is quite possible that these in-depth questions are not included in the organization's assessment form, because there is simply no way to include every possible question that might need to be asked for every possible human response!

Knowledge of the concepts underlying the nursing discipline should drive these more in-depth questions, based on the responses of the patient/family that were obtained during the screening assessment. For example, if a patient indicated that she was experiencing difficulty with her breathing when she walked up her steps, the nurse would rely on his knowledge of various concepts to further obtain data to confirm or refute potential diagnoses. If the nurse did not understand the concepts of *activity tolerance*, *gas exchange*, or *energy balance*, for example, he might not know what questions to ask to continue the assessment and identify an appropriate diagnosis.

6.2.4 Where Do Nurses Assess and Diagnose?

A brief point should be made about the role of professional nurses and assessment. Nurses work in a variety of settings—from primary care to hospitals, from maternity units to operating rooms. Regardless of setting or unit, professional nurses should always be assessing patients, considering diagnoses related to their needs, identifying relevant outcomes, and implementing interventions.

Nursing diagnoses are used in operating rooms, ambulatory clinics, psychiatric facilities, home health, and hospice organizations, as well as in public health, school nursing, occupational health, and, of course, in hospitals. As diverse as nursing practice is, there are core diagnoses that seem to cross them all: *acute pain* (00132), *anxiety* (00146), *deficient knowledge* (00126), *readiness for enhanced health management* (00162), for example, can probably be found anywhere a nurse might practice. For example, nurses in the operating room assess anxiety levels in patients, as well as their skin condition. As patients are being prepared for surgery, those diagnosed with *anxiety* (00146) may be gently touched, eye contact may be established, soft music might be played, questions they have can be answered, and breathing techniques can be encouraged to help them relax. As a patient's skin is being prepped for the incision, turgor, edema, pressure points, and positioning will be considered to

decrease *risk for impaired skin integrity* (00047) and *risk for perioperative positioning injury* (00087).

Sometimes nurses suggest that nursing diagnosis is irrelevant in critical care units, because much of their practice is directed at medical diagnoses. This statement basically suggests that nurses do not practice nursing in critical care—yet, we certainly know that is not the case. There is no question that critical care nurses have a strong focus on interventions related to medical conditions, and often intervene with patients using "standing protocols" (standing medical orders) that require critical thinking to correctly implement. But, let us be clear—nurses in critical care units need to practice nursing!

Patients in critical condition are at risk for many complications that can be prevented by independent, professional nursing practice: ventilator-related pneumonias (*risk for infection*, 00004), pressure ulcers (*risk for pressure ulcer*, 00249), corneal injury (*risk for corneal injury*, 00245). They are often scared (*fear*, 00148), and families are stressed, but they need to know how to care for their loved one when he/she comes home: *deficient knowledge* (00126), *stress overload* (00177), *risk for caregiver role strain* (00162). If nurses only attend to the obvious medical condition, they, as the adage says, may win the battle, but still lose the war! These patients may develop sequelae that could have been avoided, the length of stay may be prolonged, or discharge home could result in untoward events, and increased readmission rates. Do critical care nurses attend to medical conditions? Certainly! Should they also focus on the human responses? Absolutely!

6.2.5 Assessment Framework

Let us take a moment to consider the type of framework that supports a thorough nursing assessment. An evidence-based assessment framework should be used for accurate nursing diagnosis, as well as safe patient care. It should also represent the discipline of the professional using it: in this case, the assessment form should represent knowledge from the nursing discipline.

Should we use the NANDA-I taxonomy as an assessment framework?

There is sometimes confusion over the difference between the NANDA International, Inc. (NANDA-I) Taxonomy II of nursing diagnoses and the functional health pattern (FHP) assessment framework (Gordon 1994). The NANDA-I taxonomy was developed based on Gordon's work; that is why the two frameworks look similar. However, their purposes and functions are entirely

different.

The NANDA-I taxonomy serves its intended purpose of sorting/categorizing nursing diagnoses. Each domain and class is defined, so the framework helps nurses to locate a nursing diagnosis within the taxonomy. On the other hand, the FHP framework was scientifically developed to standardize the structure for nursing assessment (Gordon 1994). It guides the history-taking and physical examination by nurses, providing items to assess, and a structure for organizing assessment data. In addition, the sequence of 11 patterns provides an efficient and effective flow for the nursing assessment.

See Chapters 7 and 8 for more specific information on the NANDA-I taxonomy.

As stated in the NANDA-I Position Statement (2011), use of an evidence-based assessment framework, such as Gordon's FHP, is highly recommended for accurate nursing diagnosis and safe patient care. It is not intended that the NANDA-I taxonomy should be used as an assessment framework.

6.3 Data Analysis

The second step in the nursing process is the conversion of data to information. Its purpose is to help us to consider what the data we collected in the screening assessment might mean, or to help us identify additional data that need to be collected. The terms “information” and “data” are sometimes used interchangeably; however, the actual characteristics of data and information are quite different. In order to have a better understanding of assessment and nursing diagnosis, it is useful to take a moment to differentiate data from information.

Data are the raw facts collected by nurses through their observations, and from subjective information provided by patients/families. Nurses collect data from a patient (or family/group/community), and then, using their nursing knowledge, they transform those data into information. Information can be considered data with an assigned judgment or meaning, such as “high” or “low,” “normal” or “abnormal,” and “important” or “unimportant.” ▶ Fig. 6.2 provides an example of how objective and subjective data can be converted into information through the application of nursing knowledge in the case study of Mrs. E, a 79-year-old woman with acute abdominal pain.

We will follow her case from the initial screening assessment until we have

determined which nursing diagnoses are the most appropriate on which to base her care.

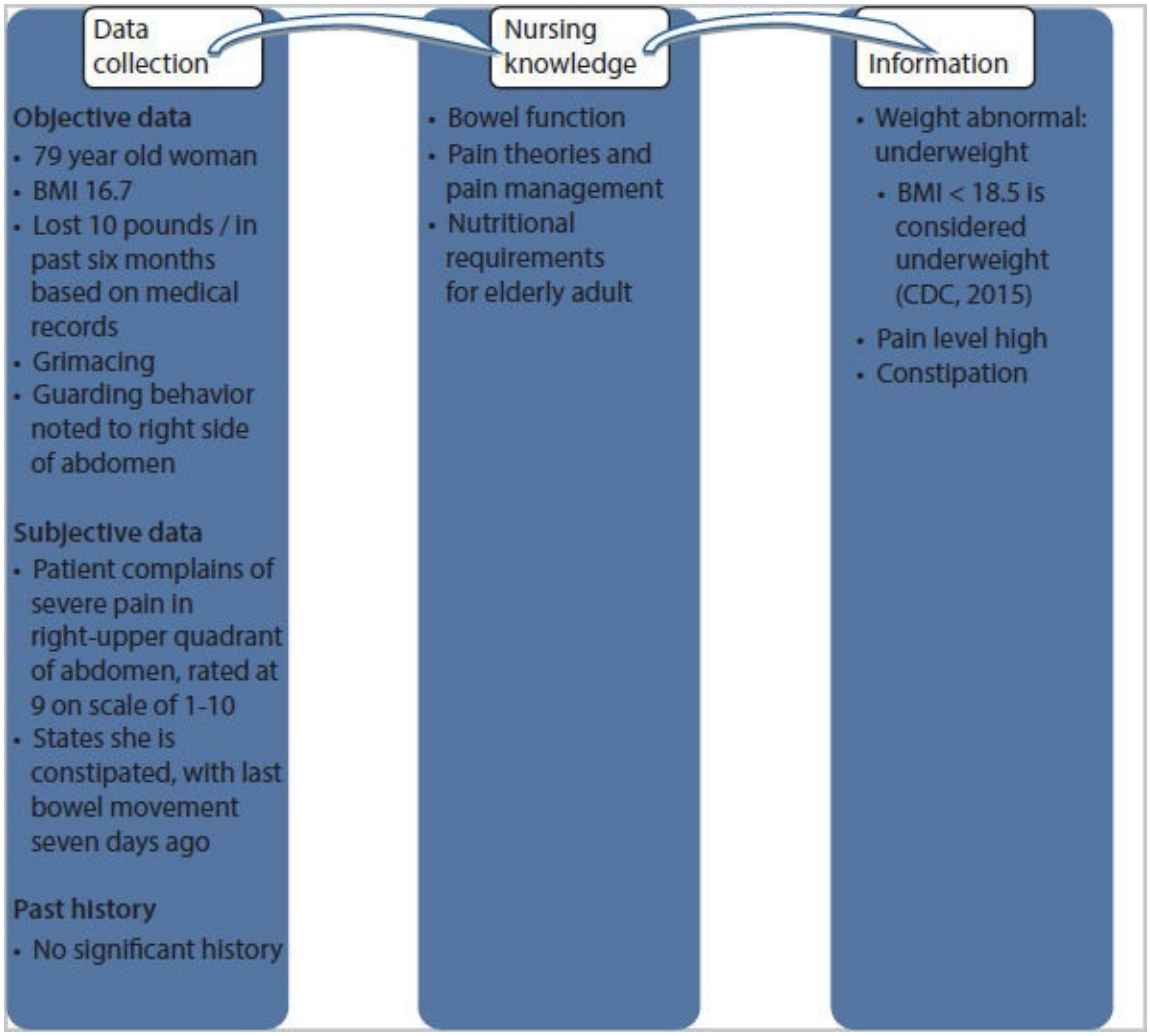

Fig. 6.2 Converting data to information: The case of Mrs. E, a 79-year-old woman with severe abdominal pain.

It is important to note that the same data can be interpreted differently depending on the context, or the gathering of new data. For example, let us suppose that a nurse in a school setting is examining Roxanne, a 9-year-old, after her fall off her bicycle on the way to school. During the exam, the nurse realizes that the scrapes and cuts suffered are superficial, and Roxanne rates her pain at a 3 on a scale of 1 to 10, with 10 being the worst pain imaginable. However, the nurse is concerned by her breathing, which is rapid (rate of 40), shallow, and punctuated with occasional audible wheezes. The nurse listens to Roxanne's lungs and notices diminished breath sounds to her right lower lobe, and crackles in her upper lobes. He/she takes Roxanne's temperature via the oral route, and

finds that it is elevated, at 37.7 ° C/99.9 ° F. These facts are given meaning by comparing them to accepted normal findings, as the nurse processes data into information. The nurse realizes that Roxanne has a slight fever, and potentially a respiratory infection. After asking Roxanne how she has been feeling, Roxanne tells the nurse that she had been away from school for three days earlier in the week with a “bad lung thing,” and was on some medication that had made her feel a lot better. With this new piece of data, the nurse may conclude that Roxanne's condition is improving, but requires surveillance over the next few days. The nurse may want to check with Roxanne's parent(s) to obtain the medical diagnosis and prescription information, so that more data are available when considering appropriate nursing diagnoses.

It is therefore important to include both data and information when documenting assessment. Information cannot be validated by others if original data are not provided. For example, simply indicating “Roxanne had a fever and respiratory wheezes” is not clinically useful. How severe was the fever? How were data gathered (oral, axillary, core temperature)? What were her lung sounds, and were they the same bilaterally? Documentation that shows that Roxanne had a fever of 37.7 °C/99.9 °F, via the oral route, with diminished breath sounds to her right lower lobe and crackles in her upper right lobe, enables another nurse to compare new data collected against the previous data, to identify if the patient is improving.

6.3.1 Subjective versus Objective Data

What is the difference between subjective and objective data?

Nurses collect and document two types of data related to a patient: subjective and objective data. While physicians value objective over subjective data for medical diagnoses, nurses value both types of data for nursing diagnoses (Gordon 2008). The Cambridge Dictionary On-Line (2017) defines *subjective* as “influenced by or based on personal beliefs or feelings, rather than based on facts”; *objective* means “not influenced by personal beliefs or feelings; fair or real.” One thing you should be careful of here is that, when these terms are used in the context of nursing assessment, they have a *slightly* different meaning from this general dictionary definition. Although the basic idea remains the same, “subjective” does not mean the *nurse*’ *s beliefs or* feelings, but that of the subject of nursing care: the patient/family/group/community. Moreover, “objective” signifies those facts observed by the nurse or other health care professionals.

In other words, the *subjective data* come from verbal reports from the patient regarding perceptions and thoughts on his/her health, daily life, comfort, relationship, and so on. For instance, a patient may report, “I need to manage my health better,” or “My partner never talks about anything important with me.” Family members/close friends can also provide this type of data, although data from the patient should be obtained whenever possible, because it is the patient's data. Sometimes, however, the patient is unable to provide subjective data, so we must rely on these other sources. For example, in a patient with significant dementia who is no longer verbal, family members may provide subjective information, based on their knowledge of the individual's behavior. An example might be an adult child of the patient telling the nurse, “She always likes to listen to soft music when she eats; it seems to calm her.”

Nurses collect these subjective data through the process of history-taking or interview. History-taking is not merely asking the patient one question after another, using a routine format. To obtain accurate data from a patient, nurses must incorporate active listening skills, and use open-ended questions as much as possible, especially as follow-up questions when potentially abnormal data are identified.

The *objective data* are those things that nurses observe about the patient. Objective data are collected through physical examinations and diagnostic test results. Here, “to observe” does not only mean the use of eyesight: it requires the use of all senses. For example, nurses look at the patient's general appearance, listen to his/her lung sounds, they may smell foul wound drainage, and feel the skin temperature using touch. Additionally, nurses use various instruments and tools to collect numerical data (e.g., body weight, blood pressure, oxygen saturation, pain level). To obtain reliable and accurate objective data, nurses must have appropriate knowledge and skills to perform physical assessment and to use standardized tools or monitoring devices.

Ask yourself… does this data signify a:

– Problem?
– Strength?
– Vulnerability?

6.3.2 Clustering of Information/Seeing a Pattern

Once the nurse has collected data and transformed it into information, the next step is to begin to answer the question: what are my patient's human

responses (nursing diagnoses)? This requires the knowledge of a variety of theories and models from nursing, as well as several related disciplines. And, as previously noted, it requires knowledge about the concepts that underlie the nursing diagnoses themselves. Do you remember the modified nursing process diagram introduced in Chapter 1 (▸ Fig. 5.2)? In this diagram, Herdman (2013) identifies the importance of theory/nursing science underlying nursing concepts. Think, too, about our discussion of the men playing Mahjong, and the difficulty in understanding that scenario unless you knew you were observing a type of game (a concept) (▸ Fig. 6.3).

In other words, assessment techniques are meaningless if we do not know how to use the data! If the nurse who assessed Mrs. E, (▸ Fig. 6.2) did not know the normal body mass index (BMI) ranges in that age group, she would not have been able to interpret that patient's weight as being underweight. If the nurse did not understand theories related to nutrition, bowel pattern, and pain, then she might not have identified other vulnerabilities or problem responses exhibited by this elderly woman.

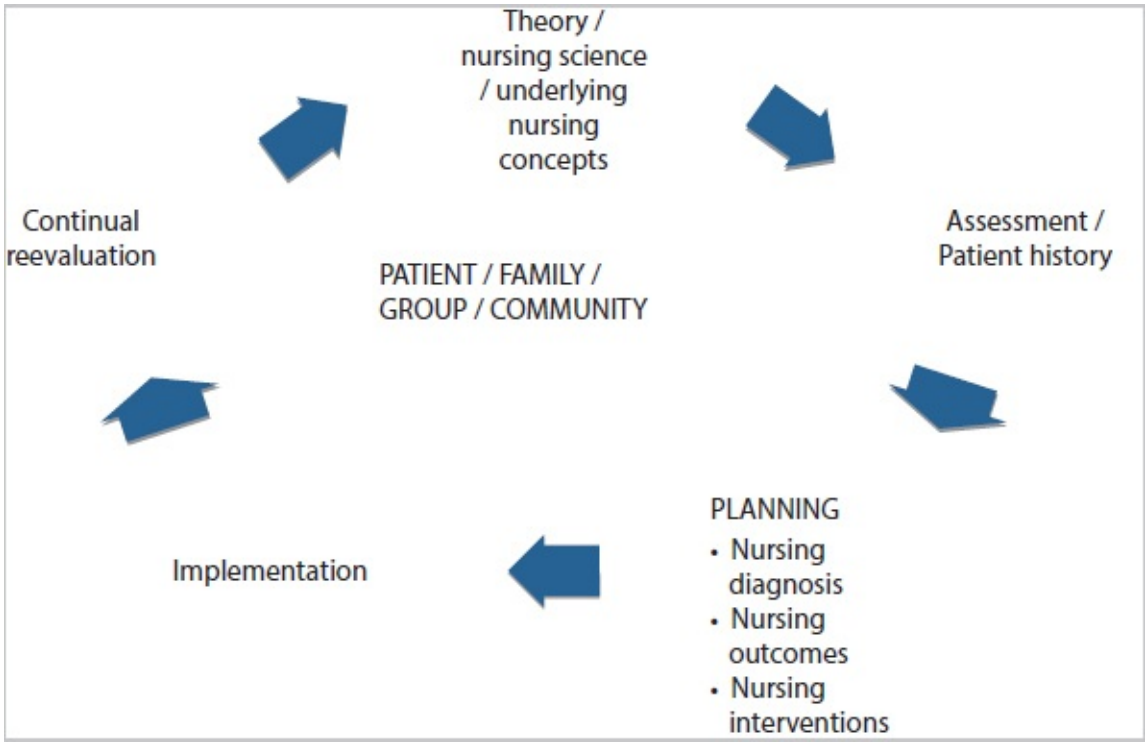

Fig. 6.3 The modified nursing process. (Adapted from Herdman 2013.)

6.4 Identifying Potential Nursing Diagnoses

(Diagnostic Hypotheses)

At this step in the process, the nurse looks at the information that is coming together to form a pattern; it provides the nurse with a way to see what human responses the patient may be experiencing. Initially, the nurse considers all potential diagnoses that may come to mind. Expert nurses can do this in seconds —novice or student nurses may ask for support from more expert nurses or faculty members to guide their thinking.

Now that I've collected my assessment data and converted it into information, how do I know what's important and what's irrelevant for this particular patient?

Seeing patterns in the data requires an understanding of the concept that supports each diagnosis. For example, you might find yourself working with a family that includes a married couple in their mid-40 s, both of whom are employed full time outside the home, who are caring for a parent (Mr. W) with dementia, as well as their own three children (ages 9, 14, and 17 years). On your visit to Mr. W, you notice an increase in his need for assistance for care since your last visit 28 days ago. His son, John, tells you that he has begun to wander, and become physically aggressive. He also needs more assistance with daily activities, such as hygiene and feeding. The family lost its daytime caregiver 20 days ago because Mr. W had become physically resistant to her care and had struck her twice. Although she realized he did not intend to cause harm, Mr. W is much stronger than the caregiver and she felt unsafe in this environment. John had to take a leave of absence from his work until a new caregiver can be found to care for him. He also tells you that he has begun to realize that Mr. W becomes highly agitated if he is left alone at all, so he finds it difficult to leave his room to do anything, and has been sleeping on a cot in his room. Previously, Mr. W had required minimal assistance with reorienting, reminding him to eat and perform hygiene tasks; he is now requiring nearly around-the-clock monitoring and care. John is clearly tired, and admits he has not been able to get much sleep because he is afraid his father will get up and hurt himself in the night.

Throughout your conversation with John, you observe that he seems frustrated and nervous, and he frequently refers to not being sure if he is doing the right thing for Mr. W. He is clearly very concerned about his father, but also mentions that he feels he has left his wife to be a "single mother" to their children, and that he has been unable to attend any of their extracurricular

activities, and even had to miss parent–teacher conferences. He notes that this has been especially hard on his youngest daughter. He also mentions that he is not sure how long he can reasonably stay away from work before it becomes an issue with his employer.

What does all of this tell you? Unless you have a good understanding of family dynamics, stress, coping, role strain, and grief theories, it may not tell you very much at all! You may know that Mr. W has increasing care needs. But would you know to also focus on the family, and look for a cause (related factors) or other data (defining characteristics) to determine an accurate diagnosis for John?

Although you might be assigned to Mr. W, if you are not attentive to what is happening in the family, are you truly attending to Mr. W's needs? Such a situation can lead to the nurse simply focusing on the patient of record, rather than considering the family and its impact on patient outcomes. Or, if you did realize the need to address what is happening with John, but did not have good baseline knowledge of the theories noted previously, you might simply "pick a diagnosis" from a list to describe his response. Conceptual knowledge of each nursing diagnosis allows the nurse to give accurate meanings to the data collected from the patient, and prepares him/her to perform the in-depth assessment.

When you have this conceptual knowledge, you will begin to look at the data you collected in a different way. You will turn that data into information, and start to observe how that information starts to group together to form patterns, or to "paint a picture" of what might be happening with your patient. Take another look at ▶ Fig. 6.2. With conceptual nursing knowledge of nutrition, pain, and bowel function, you might begin to see the information as possible nursing diagnoses, such as the following:

– Imbalanced nutrition, less than body requirements (00002)
– Constipation (00011)
– Dysfunctional gastrointestinal motility (00196)
– Acute pain (00132)

Unfortunately, this step is often where nurses stop—they develop a list of diagnoses and either launch directly into action (determining interventions) or simply "pick" one of the diagnoses that sound most appropriate, based on the diagnosis label, and then move on to selecting interventions for those diagnoses. Others may determine that they wish to obtain a certain outcome, and simply aim interventions at that outcome. The problem with this approach is that, unless we know the problem *and its cause*, the interventions selected may be

completely inappropriate for this particular patient. Quite simply, these approaches are both ineffective and inappropriate courses of action! For diagnoses to be accurate, they must be validated—and that requires additional, in-depth assessment to confirm, refute, or “rule out” a diagnosis.

By combining nursing knowledge and nursing diagnosis knowledge, the nurse can now move from identifying potential diagnoses based on the screening assessment to an in-depth assessment, and then to determining the accurate nursing diagnosis(es).

6.5 In-Depth Assessment

At this stage in your patient's assessment, you should have reviewed the information resulting from the screening assessment, to determine which items were normal, abnormal, or represented a risk (susceptibility) or a strength. Those items that were not considered normal, or were seen as a susceptibility, should have been considered in relation to a problem-focused or risk diagnosis. Areas in which the patient indicated a desire to improve something (e.g., to enhance nutrition) should be considered as a potential health promotion diagnosis.

If some data are interpreted as abnormal, further in-depth assessment is crucial to accurately diagnose the patient. However, if nurses simply collect data without paying much attention to them, critical data may be overlooked. Take another look at ▶ Fig. 6.2. The nurse could have stopped her assessment here and simply moved on to the diagnoses of *acute pain* and *constipation*—perhaps the two most “obvious” diagnoses for this patient. She could have provided education about fiber and fluid intake, as well as the importance of exercise to maintain normal bowel movements, and could have addressed the acute pain by use of heat or cold packs, for example. However, while all those things might be appropriate, she would have neglected to identify some major issues that are probably significant and that, if not addressed, will lead to continued issues with Mrs. E's status.

Mrs. E's nurse, however, understood the need for an in-depth assessment and was therefore able to identify the recent loss of her spouse, grief, and social isolation (▶ Fig. 6.4). The nurse learned that Mrs. E had vulnerabilities consistent with a stressful new living environment (recent move to the independent living facility, lack of transportation, lack of established relationships), and her fear of an acute illness and dying. However, she also identified that Mrs. E had a strength in the support she received from her church

community, and her verbalized desire to improve the way she was responding to this situation—very important things to build in to any plan of care! So, with this additional in-depth assessment, the nurse could now revise her potential diagnoses:

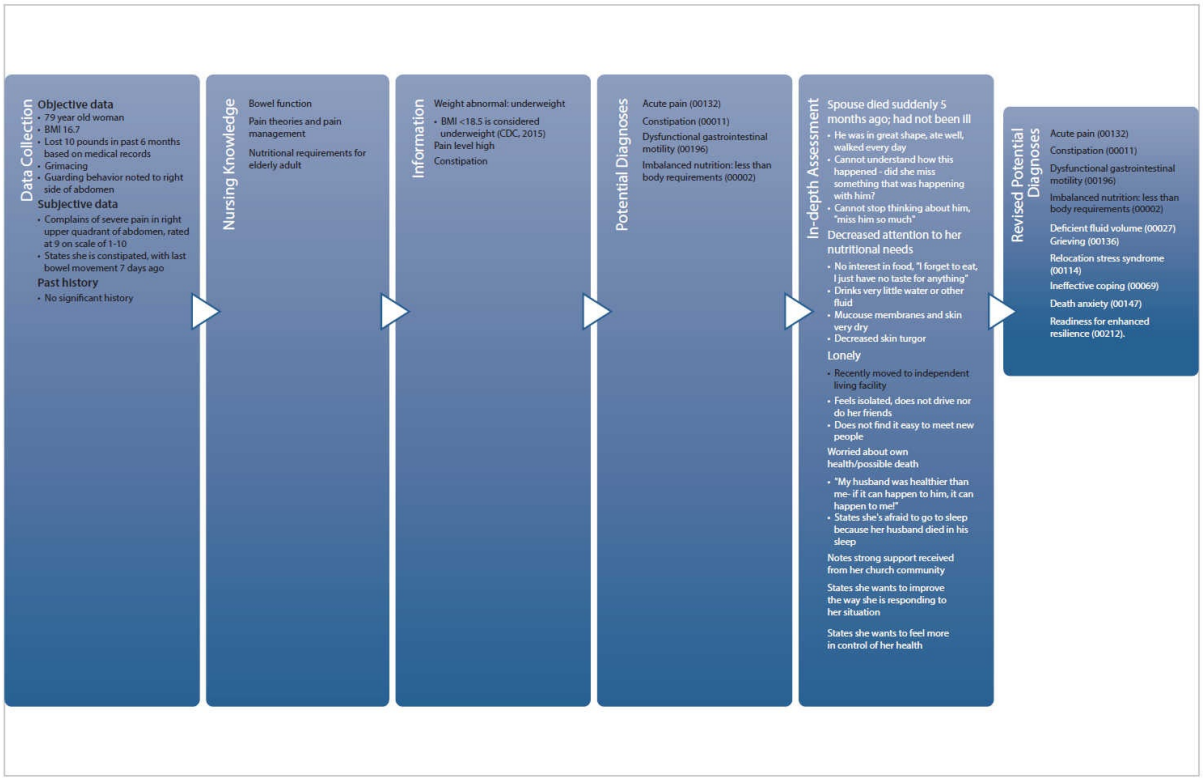

Fig. 6.4 In-depth assessment: The case of Mrs. E, a 79-year-old woman with severe abdominal pain.

– Acute pain (00132)
– Imbalanced nutrition, less than body requirements (00002)
– Deficient fluid volume (00027)
– Constipation (00011)
– Dysfunctional gastrointestinal motility (00196)
– Grieving (00136)
– Relocation stress syndrome (00114)
– Ineffective coping (00069)
– Death anxiety (00147)
– Readiness for enhanced resilience (00212)

6.5.1 Confirming/Refuting Potential Nursing Diagnoses

Whenever new data are collected and processed into information, it is time to reconsider previous potential or determined diagnoses. In this step, there are three primary things to consider:

– Did the in-depth assessment provide new data that would rule out or eliminate one or more of your potential diagnoses?
– Did the in-depth assessment point toward new diagnoses that you had not

previously considered?
– How can you differentiate between similar diagnoses?

It is also important to remember that other nurses will need to be able to continue to validate the diagnosis you make, and to understand how you arrived at your diagnosis. It is for this reason that it is important to use standardized terms, such as the NANDA-I nursing diagnoses, which provide not only a label (e.g., *readiness for enhanced resilience*), but also a definition and assessment criteria (defining characteristics and related factors, or risk factors) so that other nursing professionals can continue to validate—or perhaps refute—the diagnosis as new data become available for the patient. Terms that are simply constructed by nurses at the bedside, without these validated definitions and assessment criteria, have no consistent meaning and cannot be clinically validated or confirmed. When a NANDA-I nursing diagnosis does not exist that fits a pattern you identify in a patient, it is safer to describe the condition in detail rather than to "make up" a term that will have different meanings to different nurses. Remember that patient safety depends on good communication—so use only standardized terms that have clear definitions and assessment criteria so that they can be easily validated!

6.5.2 Eliminating Possible Diagnoses

One of the goals of in-depth assessment is to eliminate, or "rule out," one or more of the potential diagnoses you were considering. You do this by reviewing the information you've obtained and comparing it to what you know about the diagnoses. It is critical that the assessment data support the diagnosis (es).

When I look at the patient information

– Is it consistent with the definition of the potential diagnosis?
– Are the objective/subjective data identified in the patient defining characteristics of the diagnosis?
– Does it include causes (related factors) of the potential diagnosis?

Diagnoses that are not well supported through the assessment criteria provided by NANDA-I (defining characteristics, related factors, or risk factors) and/or are not supported by etiological factors (causes or contributors to the diagnoses) are not appropriate for a patient.

As we look at ▶ Fig. 6.4 and consider the potential diagnoses that Mrs. E's nurse identified, we can begin to eliminate some of these as valid diagnoses. Sometimes it is helpful to do a side-by-side comparison of the diagnoses, focusing on those defining characteristics and related factors that were identified throughout the assessment and patient history (▶ Table 6.1).

For example, after reflection, Mrs. E's nurse quickly eliminates the diagnosis, *death anxiety*, from consideration. Although Mrs. E does indicate that she is afraid that what happened to her husband might happen to her, the nurse considers that this is more related to her *grieving* than to actual dread of a real or imagined threat to her life. Further, Mrs. E does not have related factors for the diagnosis, *death anxiety*, and in fact portrays strengths that are quite contrary to it!

6.5.3 Potential New Diagnoses

It is very possible, such as in the case of Mrs. E (▶ Fig. 6.4), that new data will lead to new information, and in turn, to new diagnoses. The same questions that you used to eliminate potential diagnoses should be used as you consider these new diagnoses.

Table 6.1 The case of Mrs. E: A comparison of identified domains, classes, definitions, defining characteristics, and related factors

	Acute pain (00132)	Imbalanced nutrition, less than body requirements (00002)	Deficient fluid volume (00027)	Constipation (00011)	Dysfunctional gastrointestinal motility (00196)	Grieving (00136)	Relocation stress syndrome (00114)	Ineffective coping (00069)	Death anxiety (00147)	Readiness for enhanced resilience (00212)
Domain	**12. Comfort**	**2. Nutrition**	**2. Nutrition**	**3. Elimination and exchange**	**3. Elimination and exchange**	**9. Coping/stress**	**9. Coping/stress**	**9. Coping/stress**	**9. Coping/stress**	**9. Coping/stress**
Class	**1. Physical comfort**	**1. Ingestion**	**5. Hydration**	**2. Gastrointestinal function**	**2. Gastrointestinal function**	**2. Coping responses**	**1. Posttrauma responses**	**2. Coping responses**	**2. Coping responses**	**2. Coping responses**
Definition	Unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage (International Association for the Study of Pain); sudden or slow onset of any intensity from mild to severe with an anticipated or	Intake of nutrients insufficient to meet metabolic needs	Decreased intravascular, interstitial, and/or intracellular fluid. This refers to dehydration (water loss) alone without change in sodium	Decrease in normal frequency of defecation accompanied by difficult or incomplete passage of stool and/or passage of excessively hard, dry stool	Increased, decreased, ineffective, or lack of peristaltic activity within the gastrointestinal system	A normal complex process that includes emotional, physical, spiritual, social, and intellectual responses and behaviors by which individuals, families, and communities incorporate an actual, anticipated, or perceived loss into their daily lives.	Physiological and/or psychological disturbance following transfer from one environment to another	A pattern of invalid appraisal of stressors, with cognitive and/or behavioral efforts, that fails to manage demands related to well-being	Vague, uneasy feeling of discomfort or dread generated by perceptions of a real or imagined threat to one's existence	A pattern of ability to recover from perceived adverse or changing situations through a dynamic process of adaptation, which can be strengthened
	predictable end, and with a duration of less than 3 months									
Defining characteristics	– Guarding behavior – Appetite change – Self-report of pain characteristics using standardized pain instrument	– Body weight 20% or more below ideal weight range – Food intake less than recommended daily allowance – Misperception	– Alteration in skin turgor – Dry mucous membranes – Dry skin – Sudden weight loss	– Abdominal pain – Anorexia – Decrease in stool frequency – Fatigue – Inability to defecate	– Abdominal pain – Difficulty with defecation	– Alteration in activity level – Alteration in sleep pattern – Blaming – Finding meaning in loss – Maintaining a connection to the deceased – Psychological distress	– Aloneness – Alteration in sleep pattern – Fear – Loneliness	– Alteration in sleep pattern – Fatigue – Inability to deal with a situation – Ineffective coping strategies – Insufficient access of social support – Insufficient goal-directed behavior	– Fear of developing terminal illness – Fear of premature death – Powerlessness	– Expresses desire to enhance resilience – Expresses desire to enhance sense of control – Expresses desire to enhance use of coping skills
Related factors	– Injury agent	– Insufficient dietary intake	– Insufficient fluid intake	– Average daily physical activity is less than recommended for gender and age – Recent environmental change – Dehydration – Eating habit change	– Anxiety – Malnutrition – Sedentary lifestyle	– (None)	– Move from one environment to another – Social isolation	– Inadequate confidence in ability to deal with a situation – Insufficient sense of control – Insufficient social support	– (None)	– (None)

6.5.4 Differentiating between Similar Diagnoses

It is helpful to narrow down your potential diagnoses by considering those that are very similar, but that have a distinctive feature that makes one more relevant to the patient than the other. Let us take another look at our patient, Mrs. E. After the in-depth assessment, the nurse had ten potential

diagnoses; one diagnosis was eliminated, leaving nine potential diagnoses. One way to start the process of differentiation is to look at where the diagnoses are located within the NANDA-I taxonomy. This gives you a clue about how the diagnoses are grouped together into the broad area of nursing knowledge (domain) and the subcategories, or group of diagnoses with similar attributes (class).

After eliminating the one diagnosis for which Mrs. E had no related factors, a quick look at ▸ Table 6.1 shows her nurse is considering the following: two diagnoses in the nutrition domain (*imbalanced nutrition, less than body requirements* and *deficient fluid volume*); two in the elimination and exchange domain (*constipation* and *dysfunctional gastrointestinal motility*); four in the coping/stress domain (*grieving, relocation stress syndrome, ineffective coping* and *readiness for enhanced resilience*); and one in the comfort domain (*acute pain*).

When I look at the patient information in light of similar nursing diagnoses:

– Do the diagnoses share a similar focus, or is it different?
– If the diagnoses share a similar focus, is one more focused/specific than the other?
– Does one diagnosis potentially lead to another that I have identified? That is, could it be the causative factor of that other diagnosis?

As the nurse considers what she knows about Mrs. E, she can look at the responses identified as potential diagnoses in light of these questions. Mrs. E is clearly dehydrated; however, it appears that her decrease in nutrition (*imbalanced nutrition, less than body requirements*) and hydration (*deficient fluid volume*) and her subsequent *constipation* are actually consequences of her *grieving* and *relocation stress syndrome* responses, rather than being specific to a lack of food/fluid or a gastrointestinal motility issue (*dysfunctional gastrointestinal motility*). Therefore, although the nurse is concerned about Mrs. E's fluid and food intake, and will need to treat the symptom of constipation, she believes that these issues can be best addressed in the long term by addressing her *grieving* and *relocation stress syndrome*, which the nurse believes are the underlying causes of her current health status.

After talking with Mrs. E, the nurse also believes that using the health promotion diagnosis *readiness for enhanced resilience*, will best support her in

setting goals around her nutrition and fluid status, physical activity, and bowel elimination, while reinforcing her ability to regain control over her life and improving her resilience.

Of those diagnoses located in the coping/stress domain, all are within the same class (coping responses) except *relocation stress syndrome* (post-trauma responses). Although Mrs. E does have related factors for *ineffective coping*, the nurse recognizes that Mrs. E has verbalized a desire to improve her resilience, and feels that working with her on this issue from a health promotion perspective (*readiness for enhanced resilience*) could be more positive for her. This, coupled with the previously mentioned belief that goal setting could be used within this diagnosis to address the nutrition, fluid, and constipation issue, may make this diagnosis more appropriate for Mrs. E.

Mrs. E is clearly *grieving* the loss of her husband of nearly 60 years. While this is a normal process, the nurse is concerned that she has not been attending to her own basic needs. She feels it is imperative for Mrs. E to acknowledge her grief, and to work with her on this response. This diagnosis may be more critical because Mrs. E is also dealing with *relocation stress syndrome* after moving into an independent living facility.

Finally, it is important to manage the *acute pain* that Mrs. E is experiencing. Because one of the goals is to get her more active to support normal bowel elimination and to assist with overall well-being, it is important to increase her comfort so that her pain does not prohibit her from increasing her level of activity.

A thinking tool (▶ Fig. 6.5) used by our colleagues in medicine can be useful as a review prior to determining your final diagnosis (es): it uses the acronym, SEA TOW (Rencic 2011). This tool can easily be adapted for nursing diagnosis, too (▶ ☒).

It is always a good idea to ask a colleague, or an expert, for a *second opinion* if you are unsure of the appropriate diagnosis. Is the diagnosis you are considering the result of a "*Eureka*" moment? Did you recognize a pattern in the data from your assessment and patient interview? Did you confirm this pattern by reviewing the diagnostic indicators (defining characteristics, related factors)? Did you collect *anti-evidence*: data that seem to refute this diagnosis? Can you justify the diagnosis even with these data, or do these data suggest you need to look deeper? *Think about your thinking*—was it logical, reasoned, and built on your knowledge of nursing science and the human response that you are diagnosing? Do you need additional information about the response before you are ready to confirm it? Are you *overconfident*? This can happen when you are

accustomed to patients presenting with particular diagnoses, and so you "jump" to a diagnosis, rather than truly applying clinical reasoning skills. Finally, *what else could be missing*? Are there other data you need to collect or review in order to validate, confirm, or rule out a potential nursing diagnosis? Use of the SEA TOW acronym can help you validate your clinical reasoning process and increase the likelihood of accurate diagnosis.

Fig. 6.5 SEA TOW: A thinking tool for diagnostic decision-making. (Adapted from Rencic 2011.)

6.5.5 Making a Diagnosis/Prioritizing

The final step is to determine the diagnosis (es) that will drive nursing intervention for your patient. After reviewing everything the nurse learned about her patient, Mrs. E, the nurse may have determined four key diagnoses:

– Acute pain (00132)
– Grieving (00136)
– Relocation stress syndrome (00114)
– Readiness for enhanced resilience (00212)

Remember that the nursing process, which includes evaluation of the diagnosis, is an ongoing process and as more data become available, or as the patient's condition changes, the diagnosis (es) may also change—or the prioritization may change. Think back for a moment to the initial screening assessment the nurse performed on Mrs. E. Do you see that, without further follow-up, she would

have missed the very important diagnosis of *grieving* and *relocation stress* syndrome, along with the health promotion opportunity for Mrs. E (*readiness for enhanced resilience*), and might have designed a plan to address issues that would not have resolved her underlying issues?

Can you see why the idea of just “picking” a nursing diagnosis to go along with the medical diagnosis simply isn't the way to go? The in-depth, ongoing assessment provided so much more information about Mrs. E that can be used to determine not only the appropriate diagnoses, but also realistic outcomes and interventions that will best meet her individual needs.

6.6 Summary

Assessment plays a critical role in professional nursing and requires an understanding of nursing concepts based on which nursing diagnoses are developed. Collecting data for the sake of completing some mandatory form or computer screen is a waste of time, and it certainly does not support individualized care for our patients. Collecting data with the intent of identifying critical information, considering nursing diagnoses, and then driving in-depth assessment to validate and prioritize diagnoses: this is the hallmark of professional nursing.

So, although it might seem simple, standardizing nursing diagnoses without assessment can, and often does, lead to inaccurate diagnoses, inappropriate outcomes, and ineffective and/or unnecessary interventions for diagnoses that are not relevant to the patient, and may lead to completely missing the most important nursing diagnosis for your patient!

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7 Introduction to the NANDA International Taxonomy of Nursing Diagnoses

T. Heather Herdman

7.1 Introduction

NANDA International, Inc. provides a standardized *terminology* of nursing diagnoses, and it presents its diagnoses in a classifications scheme, more specifically a *taxonomy*. It is important to understand a little bit about a taxonomy, and how taxonomy differs from terminology. So, let us take a moment to talk about what taxonomy actually represents.

A *terminology* is a system of specialized terms, whereas *taxonomy* is the science or technique that is used to create a system by which to classify those terms.

With regard to nursing, the NANDA-I nursing diagnosis *terminology* includes the defined terms (labels) that are used to describe clinical judgments made by professional nurses: the diagnoses themselves. A definition of the NANDA-I *taxonomy* might be “a systematic ordering of phenomena/clinical judgments that define the knowledge of the nursing discipline.” More simply put, the NANDA – I taxonomy of nursing diagnoses is a classification schema to help us organize the concepts of concern (nursing judgments or nursing diagnoses) for nursing practice.

A *taxonomy* is a way of classifying or ordering things into categories; it is a hierarchical classification scheme of main groups, subgroups, and items. A *taxonomy* can be compared to a filing cabinet—in a drawer (domain) you may file all information you have related to your bills/debts. Within that drawer, you may have individual file folders (classes) for different types of bills/debt: household, automobile, health care, child care, animal care, etc. Within each file folder (class), you would then have individual bills representing each type of debt (nursing diagnoses). The current biological taxonomy originated with Carl Linnaeus in 1735. He originally identified three kingdoms (animal, plant, and mineral), which were then divided into classes, orders, families, genera, and

species (Quammen 2007). You probably learned about the revised biological taxonomy in a basic science class in your high school or university setting.

Terminology, on the other hand, is the language that is used to describe a specific thing; it is the language used in a particular discipline to describe its knowledge. Therefore, the nursing diagnoses form a discipline-specific language, so when we want to talk about the diagnoses themselves, we are talking about the *terminology* of nursing knowledge. When we want to talk about the way that we structure or categorize the NANDA-I diagnoses, then we are talking about the *taxonomy*.

Let us think about taxonomy as it relates to something we all deal with in our daily lives. When you need to buy food, you go to the grocery store. Suppose that there is a new store in your neighborhood, *Classified Groceries, Inc.*, so you decide to go there to do your shopping. When you enter the store, you notice that the layout seems very different from your regular store, but the person greeting you at the door hands you a diagram to help you learn your way around (▶ Fig. 7.1).

You can see that this store has organized the grocery items into eight main categories or grocery store aisles: proteins, grain products, vegetables, fruits, processed foods, snack foods, deli foods, and beverages. These categories/aisles could also be called “domains”—they are broad levels of classification that divide phenomena into main groups. In this case, the phenomena represent “groceries.”

You may also have noticed that the diagram does not just show the eight aisles; each aisle has a few key phrases identified that further help us to understand what types of foods would be found in each aisle. For example, in the aisle (domain) entitled “Beverages,” we see six subcategories: “Coffee,” “Tea,” “Soda,” “Water,” “Beer/hard cider,” and “Wine/sake.” Another way of saying this would be that these subcategories are “Classes” of products that are found under the “Domain” of beverages.

One of the rules people try to follow when they develop a taxonomy is that the classes should be mutually exclusive—in other words, one type of grocery product should not be found in multiple classes. This is not always possible, but this should still be the goal, because it makes it much clearer for people who want to use the structure. If you find cheddar cheese in the protein aisle, but find cheddar cheese spread in the snack foods aisle, it makes it hard for people to understand the classification system that is being used.

Looking back at our store diagram, there is additional information to be added (▶ Fig. 7.2). Each of the grocery aisles is further explained, providing a more

detailed level of information about the groceries that are found in the various aisles. As an example, ▶ Fig. 7.2 shows the detailed information provided on the "Beverages" aisle. You will note the six "classes" along with additional detail for each of those classes. These represent various types (or concepts) of beverage products, all of which share similar properties that cluster them together into one group.

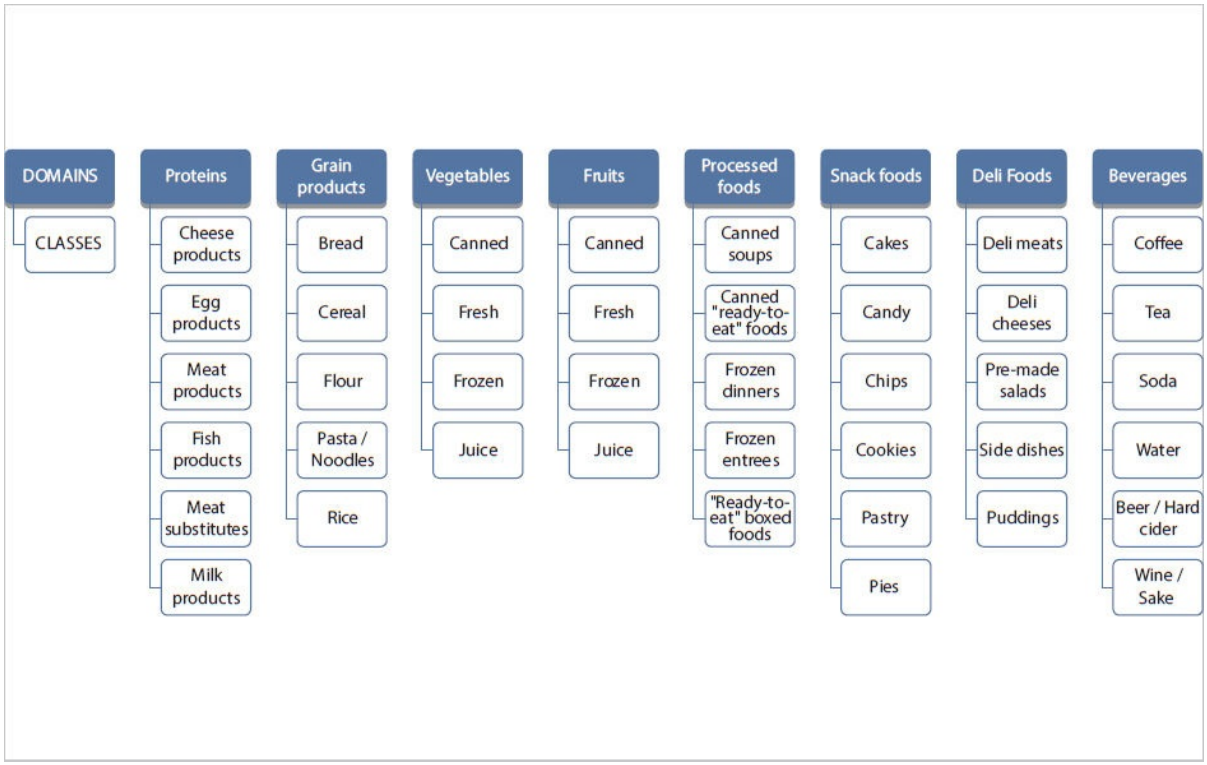

Fig. 7.1 Domains and classes of Classified Groceries, Inc.

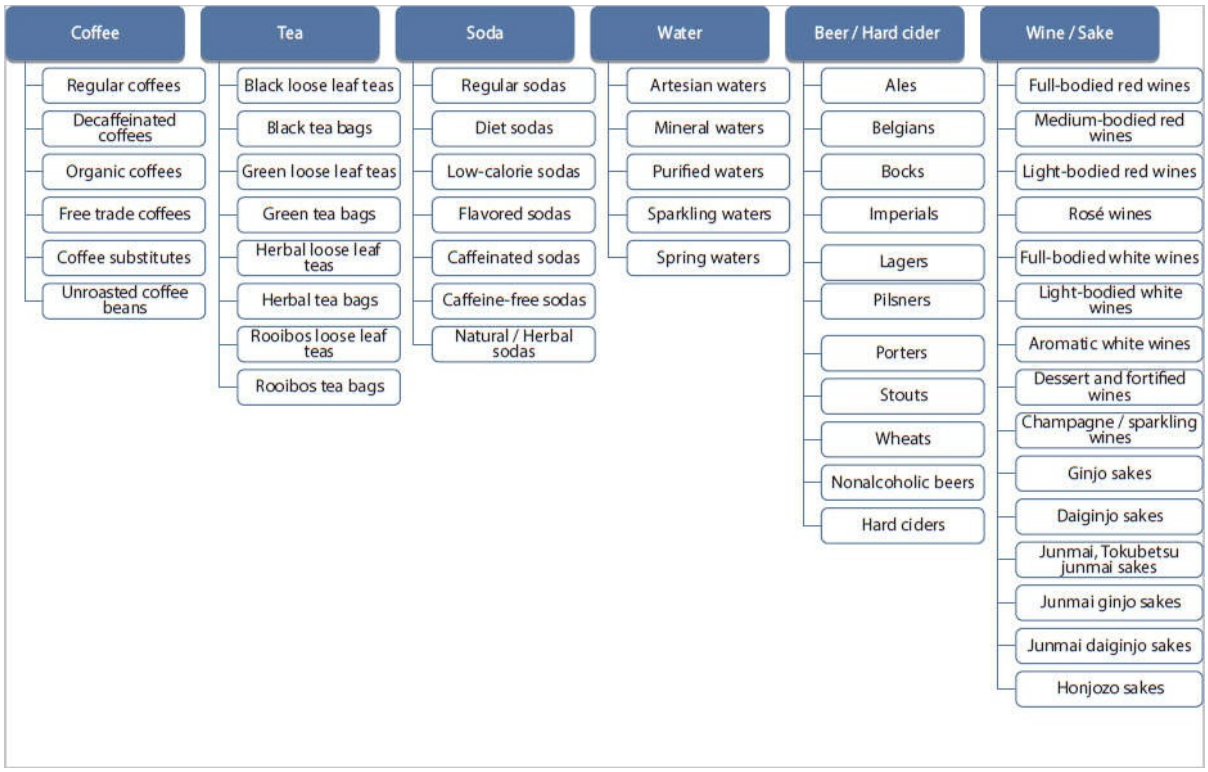

Fig. 7.2 Classes and types (concepts) of beverages at Classified Groceries, Inc.

Given the information with which we have been provided, we could easily manage our shopping list. If we wanted to find some herbal soda, we would quickly be able to find the aisle marked “Beverages,” the shelf marked “Sodas,” and we could confirm that herbal sodas would be found there. Likewise, if we wanted some loose leaf green tea, we would again look at the aisle marked “Beverages,” find the shelf marked “Tea,” and then we would find “Green loose leaf teas.”

The purpose of this grocery taxonomy is to help the shopper quickly determine what section of the store contains the grocery supplies that he/she wants to buy. Without this information, the shopper would have to walk up and down each aisle and try to make sense of what products were in which aisle; depending on the size of the store, this could be a very frustrating and confusing experience! Thus, the diagram being provided by the store personnel provides a “concept map,” or a guide for shoppers to quickly understand how the groceries have been classified into locations within the store, with the goal of improving the shopping experience.

By now, you are probably getting a good idea of the difficulty of developing a taxonomy that reflects the concepts it is trying to classify in a clear, concise, and consistent manner. Thinking about our grocery store example, can you imagine

different ways that items in the store could be grouped together?

This example of a grocery taxonomy may not meet the goal of avoiding overlap between concepts and classes in a way that is logical for all shoppers. For example, tomato juice is found in the domain *Vegetables* (vegetable juices), but *not* in the domain *Beverages*. Although one group of individuals might find this categorization logical and clear, others might suggest that all beverages should be together. What is important is that the distinction between the domains is well-defined, i.e., all vegetables and vegetable products are found within the vegetable domain, whereas the beverage domain contains beverages that are not vegetable-based. The problem with this distinction might be that we could then argue that wine and hard cider should be in the fruit aisle, and beer and sake should be in the grains aisle!

Taxonomies are works in progress—they continue to grow, evolve, and even dramatically change as more knowledge is developed about the area of study. There is often significant debate about what structure is best for categorizing phenomena of concern to different disciplines. There are many ways of categorizing things, and truly, there is no “absolutely right” way. The goal is to find a logical, consistent way to categorize similar things while avoiding overlap between the concepts and the classes. For users of taxonomies, the goal is to understand how it classifies similar concepts into its domains and classes to quickly identify specific concepts as needed.

7.2 Classification in Nursing

Professions organize their formal knowledge into consistent, logical, conceptualized dimensions so that it reflects the professional domain and makes it relevant for clinical practice. For professionals in health care, the knowledge of diagnosis is a significant part of professional knowledge and is essential for clinical practice. Knowledge of nursing diagnoses must therefore be organized in a way that legitimizes professional nursing practice and consolidates the nursing profession's jurisdiction (Abbott 1988).

Within the NANDA-I nursing diagnostic taxonomy, we use a hierarchical graphic to show our domains and classes (▶ Fig. 7.3). The diagnoses themselves are not depicted in this graphic, although they could be. The primary reason we do not include the diagnoses is that there are 244 of them, and that would make the graphic very large—and very hard to read!

Classification is a way of understanding reality by naming and ordering items,

objects, and phenomena into categories (von Krogh 2011). In health care, classification systems denote disciplinary knowledge and demonstrate how a specific group of professionals perceive what are the significant areas of knowledge of the discipline. Therefore, a classification system in health care has multiple functions, including to

– provide a view of the knowledge and practice area of a specific profession.
– organize phenomena in a way that refers to changes in health, processes, and mechanisms that are of concern to the professional.
– show the logical connection between factors that can be controlled or manipulated by professionals in the discipline (von Krogh 2011).

In nursing, it is most important that the diagnoses are classified in a way that makes sense clinically, so that when a nurse is trying to identify a diagnosis that he/she may not see very often in practice, he/she can logically use the taxonomy to find the appropriate information on possible related diagnoses. Although the NANDA-I Taxonomy II (▶ Fig. 7.3) is *not* intended to function as a nursing assessment framework, it does provide structure for classifying nursing diagnoses into domains and classes, each of which is clearly defined.

To provide an example of what it would look like if we included the nursing diagnoses in the graphic representation of the taxonomy, ▶ Fig. 7.4 shows only one domain with its classes and nursing diagnoses. As you can see, this is a lot of information to depict in graphic form.

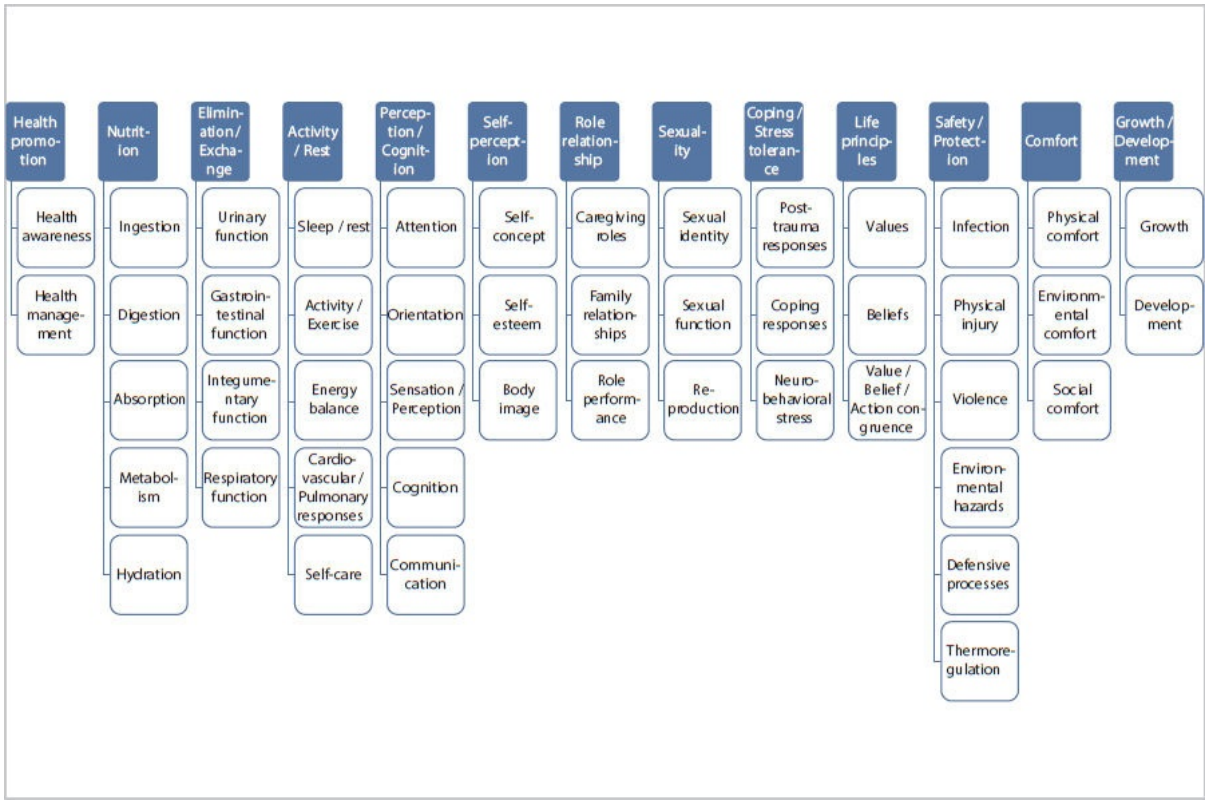

Fig. 7.3 NANDA-I Taxonomy II domains and classes.

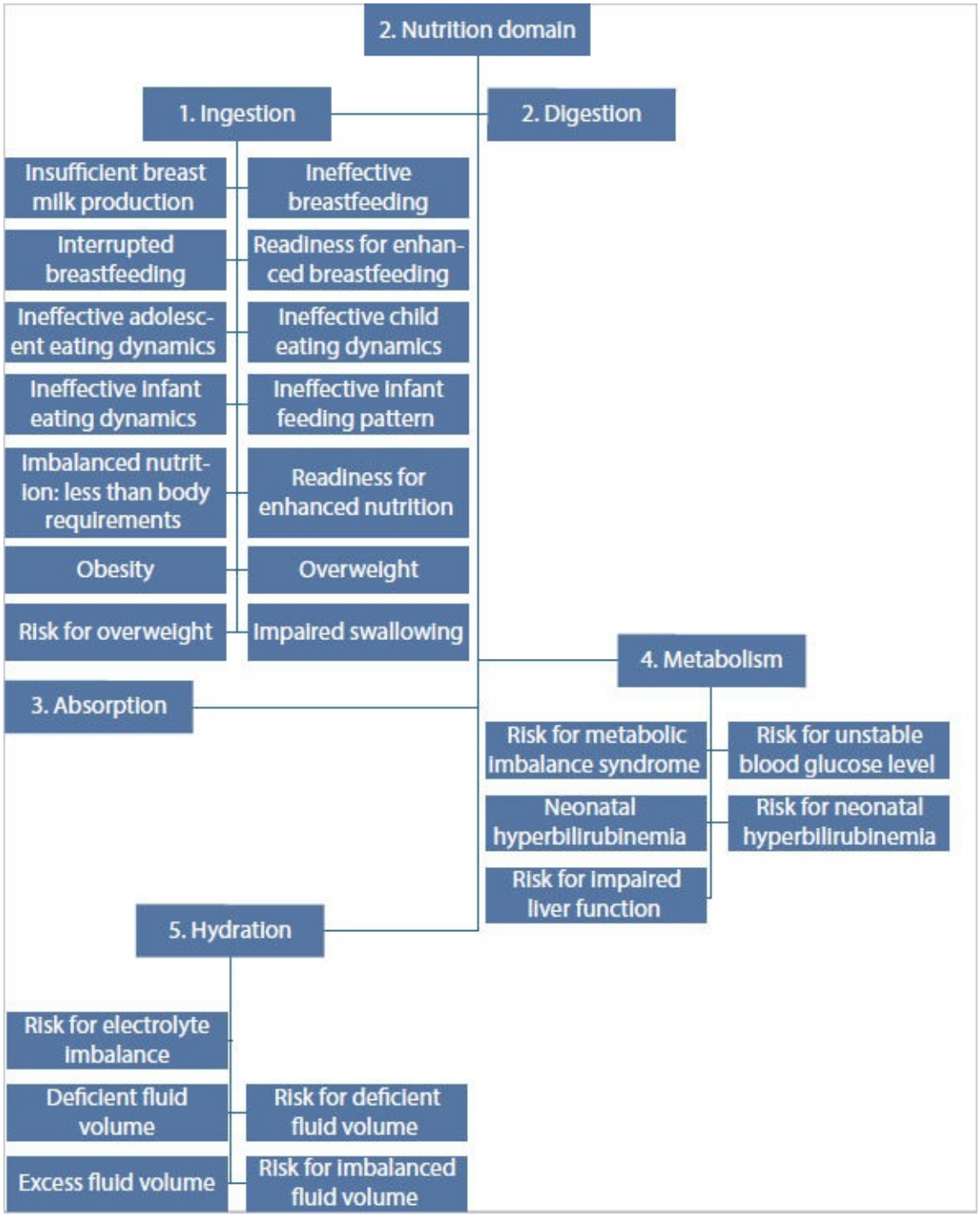

Fig. 7.4 NANDA-I Domain 2, *Nutrition*, with classes and nursing diagnoses.

Nursing knowledge includes individual, family, group, and community responses, risks, and strengths. The NANDA-I taxonomy is meant to function in the following ways; it should

– provide a model, or cognitive map, of the knowledge of the nursing discipline.
– communicate that knowledge, and those perspectives and theories.

– provide structure and order for that knowledge.
– serve as a support tool for clinical reasoning.
– provide a way to organize nursing diagnoses within an electronic health record (adapted from von Krogh 2011).

7.3 Using the NANDA-I Taxonomy

Although the taxonomy provides a way of categorizing nursing phenomena, it can also serve other functions. It can help faculty to develop a nursing curriculum, for example, and it can help a nurse identify a diagnosis, perhaps one that he/she may not use frequently, but that he/she needs for a specific patient. Let us look at both situations.

7.4 Structuring Nursing Curricula

Although the NANDA-I nursing taxonomy is not intended to be a nursing assessment framework, it can support the organization of undergraduate education. For example, curricula can be developed around the domains and classes, allowing courses to be taught that are based on the core concepts of nursing practice, and which are categorized in each of the NANDA-I domains.

A course might be built around the Nutrition domain (▶ Fig. 7.4) with units based on each of the classes. In Unit 1, the focus could be on ingestion, and the concept of balanced nutrition would be explored in depth. What is it? How does it impact individual and family health? What are some of the common nutrition-related problems that our patients encounter? In what types of patients might we be most likely to identify these conditions? What are the primary etiologies? What are the consequences if these conditions go undiagnosed and/or untreated? How can we prevent, treat, and/or improve these conditions? How can we manage the symptoms?

Building a nursing curriculum around these key concepts of nursing knowledge enables students to truly understand and build expertise in the knowledge of nursing science, while also learning about and understanding related medical diagnoses and conditions which they will encounter in everyday practice.

Designing nursing courses in this way enables students to learn a lot about the disciplinary knowledge of nursing. Eating patterns, feeding dynamics,

breastfeeding, balanced nutrition, and effective swallowing are some of the key concepts of Domain 2, Nutrition (▶ Fig. 7.4)—they are the "neutral states" that we must understand before we can identify potential or actual problems with these responses.

Understanding *balanced nutrition*, for example, as a core concept of nursing practice, requires a strong understanding of anatomy, physiology, pathophysiology (including related medical diagnoses), and responses from other domains that might coincide with problems in balanced nutrition. Once you truly understand the concept of balanced nutrition (the "normal" or neutral state), identifying the abnormal state is much easier because you know what you should be seeing if nutrition were balanced, and if you don't see those data, you start to suspect that there might be a problem (or a risk may exist for a problem to develop). So, developing nursing courses around these core concepts enables nursing faculty to focus on the knowledge of the nursing discipline and then to incorporate related medical diagnoses and/or interdisciplinary concerns in a way that allows nurses to focus first on nursing phenomena and then to bring their specific knowledge to an interdisciplinary view of the patient to improve patient care. This then moves into content on realistic patient outcomes and evidence-based interventions that nurses will utilize (dependent and independent nursing interventions) to provide the best possible care for the patient to achieve outcomes for which nurses have accountability.

7.5 Identifying a Nursing Diagnosis Outside Your Area of Expertise

Nurses gain expertise in those nursing diagnoses that they most commonly see in their clinical practice. If your area of interest is cardiovascular nursing practice, then your expertise may include such key concepts as *activity tolerance*, *breathing pattern*, and *cardiac output*, just to name a few! But you will deal with patients who, despite being primarily in your care because of a cardiac event, will also have other issues that require your attention. The NANDA-I taxonomy can help you to identify potential diagnoses for these patients and support your clinical reasoning skills by clarifying what assessment data/diagnostic indicators are necessary for quickly, but accurately, diagnosing your patients.

Perhaps, as you are admitting a 45-year old female patient for an inguinal hernia repair, you discover that she has significant rheumatoid arthritis (RA) and several cardiac risk factors. Your patient tells you her pain is normally between 5

and 6 on a 10-point scale, and she rates it at a 6 today; she has obvious rheumatoid nodules and edema in her hands and wrists. She is a current smoker, describes her physical activity level as minimal, and her BMI (body mass index) is 27.6. She has a history of hypertension and arrhythmia, although today her blood pressure seems well controlled by her antihypertensive medication, and you detect no arrhythmia.

You have not cared for many patients with RA, so you review the implications of RA on cardiovascular risk, and find that it is concerning; RA patients have higher cardiovascular morbidity and mortality than the general public. As you review the research, you realize that the inflammatory burden and antirheumatic medication–related cardiotoxicity are important contributors to cardiovascular risk. You want to reflect her risk, but you are not sure which nursing diagnosis is the most accurate for this patient in this situation. By looking at the taxonomy, you can quickly form a "cognitive map" that can help you to find more information on diagnoses of relevance to this patient (▶ Fig. 7.5).

You are concerned about a cardiovascular response, and a quick review of the taxonomy leads you to Domain 4 (activity/rest), Class 4 (cardiovascular/pulmonary responses). You then see that there are three diagnoses specifically related to cardiovascular responses, and you can review the definitions, etiologies, and diagnostic indicators to clarify the most appropriate diagnosis for this patient. Using the taxonomy in this way supports clinical reasoning and helps you to navigate a large volume of information/knowledge (244 diagnoses!) in an effective and efficient manner. A review of the risk factors or the related factors and defining characteristics of these three diagnoses can: (1) provide you with additional data that you need to obtain in order to make an informed decision and/or (2) enable you to compare your assessment with those diagnostic indicators to accurately diagnose your patient.

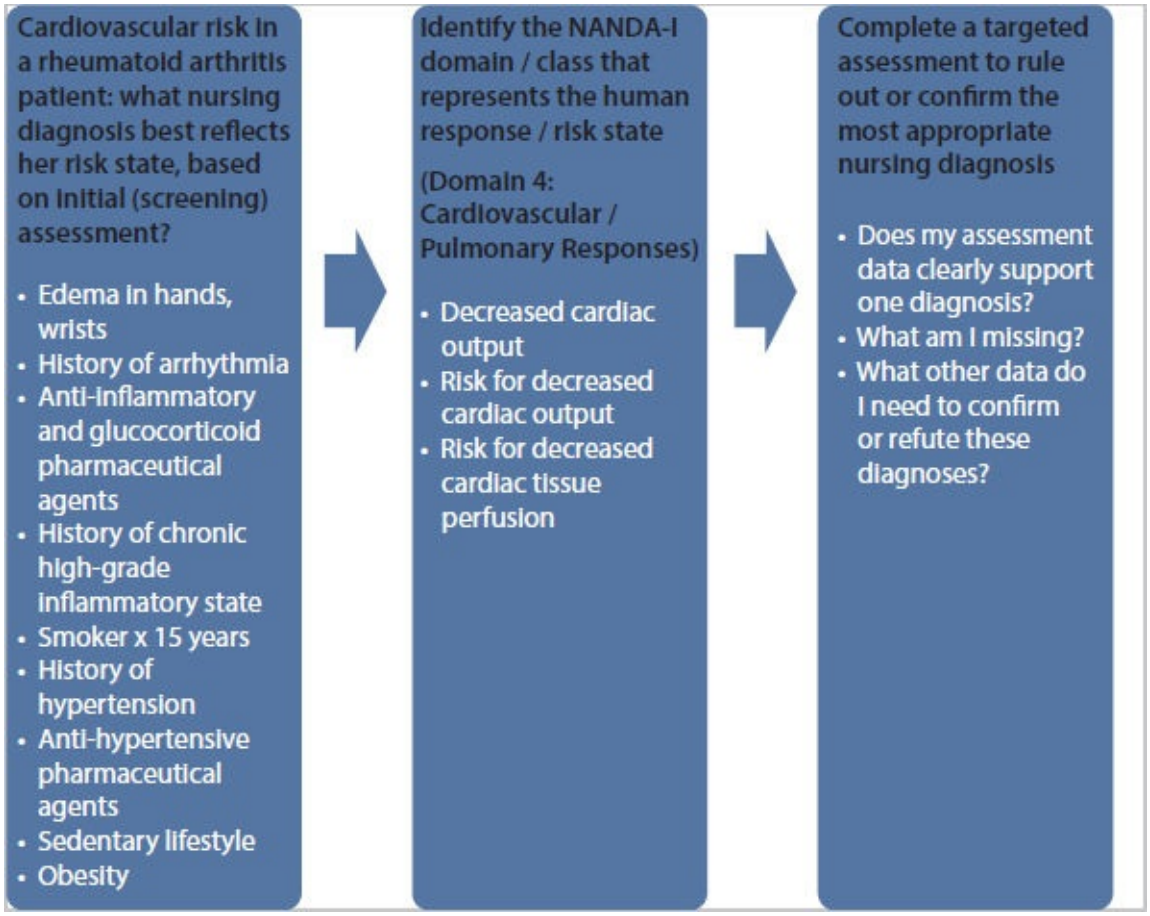

Fig. 7.5 Use of the NANDA-I Taxonomy to identify and validate a nursing diagnosis outside the nurse's area of expertise.

Think about a recent patient—did you struggle to diagnose his/her human response? Did you find it difficult to know how to identify potential diagnoses? Using the taxonomy can support you in identifying possible diagnoses because of the way the diagnoses are grouped together in classes and domains that represent specific areas of knowledge. Do not forget, however, that ***simply looking at the diagnosis label and "picking a diagnosis" is not safe care!*** You need to review the definition and diagnostic indicators (defining characteristics, related factors, or risk factors) for each of the potential diagnoses you identify, which will help you to identify what additional data you should collect or if you have enough data to accurately diagnose the patient's human response.

Let us review the case study of Mr. S to understand how you might use the taxonomy to help you to identify potential diagnoses.

Case Study: Mr. S

Let us suppose that your patient, Mr. S, an 87-year-old widower, presents with

complaints of severe, shooting pain in his right hip area. He has been living in an assisted living facility for two years, since his wife died, and the staff members there have noticed that he is very agitated and shows signs of severe pain whenever they try to help him walk. They have brought him in to rule out any possible fracture or need for a hip replacement. They note that he had his other hip replaced three years ago, due to osteoporosis. Apparently, the surgery was very successful.

Mr. S has no noticeable edema or bruising to his right hip area, but clearly complains of pain when you palpate the area. He has good lower extremity bilateral peripheral pulses and a lower extremity capillary refill time of 4 seconds. His medical history includes a cerebrovascular attack (stroke) at age 80. According to his medical records, he had initial paralysis on the right side and lost all speech function. He received alteplase IV r-tPA, a tissue plasminogen activator (TPA), and recovered full mobility and speech. He was in an inpatient rehabilitation center for 26 days, received speech, physical and occupational therapy, and cared for himself independently after he was discharged home. He has moderate coronary artery disease, but otherwise no significant medical history. According to the staff member accompanying him, Mr. S has been active until a few weeks ago when he started to complain of pain. He enjoyed ballroom dancing, exercised at the facility on a regular basis, and was frequently seen walking around the complex speaking to people, or taking walks outdoors on the grounds of the complex when the weather was nice. She also indicates he has become less social recently, and has not attended different activities that he normally enjoys. She indicates the staff members have attributed this to his level of discomfort.

What you notice most about Mr. S, however, is that he seems withdrawn, he barely speaks, and rarely makes eye contact. He struggles to answer your questions, and the staff member often jumps in to provide answers rather than allowing him to answer for himself. Although his speech does not appear to be impaired, he seems to be struggling to find answers to even basic questions, such as his age or the year that his wife died.

After completing your assessment and reviewing his history, you believe that Mr. S may be dealing with an issue related to cognition, but this is an area of nursing in which you have little experience; you need some review of potential diagnoses. Since you are considering a cognition issue, you look at the NANDA-I taxonomy to identify the logical location of these diagnoses.

You identify that Domain 5, Perception/cognition, deals with the human information processing system including attention, orientation, sensation, perception, cognition, and communication. Because you are considering issues related to cognition, you think this domain will contain diagnoses of relevance to Mr. S. You then quickly identify Class 4, Cognition. A review of this class leads to the identification of three potential diagnoses: acute confusion, chronic confusion, and impaired memory.

Questions you should ask yourself include: What other human responses should I rule out or consider? What other signs/symptoms, or etiologies, should I look for to confirm this diagnosis?

Once you review the definitions and diagnostic indicators (related factors, defining characteristics, and risk factors), you diagnose Mr. S with chronic confusion (00129).

Some final questions should include: Am I missing anything? Am I diagnosing without sufficient evidence? If you believe you are correct in your diagnosis, your questions move on to: What outcomes can I realistically expect to achieve with Mr. S? What are the evidence-based nursing interventions that I should consider? How will I evaluate whether or not they were effective?

7.6 The NANDA-I Nursing Diagnosis Taxonomy: A Short History

In 1987, NANDA-I published Taxonomy I, which was structured to reflect nursing theoretical models from North America. In 2002, Taxonomy II was adopted, which was adapted from the Functional Health Patterns assessment framework of Dr. Marjory Gordon. This assessment framework is probably the most used nursing assessment framework around the world. Over the course of the last three years, NANDA-I members and users considered whether to replace Taxonomy II with a recommendation for Taxonomy III, developed by Dr. Gunn von Krogh (discussed in detail in the 10th edition of this text). In 2016, this taxonomy was brought forward to the membership of NANDA-I to determine if the organization should maintain Taxonomy II or possibly move to this new view and adopt a Taxonomy III. After reflection, study, and discussion, the

overwhelming decision of the membership was to retain Taxonomy II. Work may continue on Taxonomy III, and it could return to the membership for reconsideration at a later date.

▶ Table 7.1 demonstrates the domains, classes, and nursing diagnoses and how they are currently located within the NANDA-I Taxonomy II.

Table 7.1 Domains, classes, and nursing diagnoses in the NANDA-I Taxonomy II

Code	Diagnosis
Domain 1. **Health promotion**	**The awareness of well-being or normality of function and the strategies used to maintain control of and enhance that well-being or normality of function**
Class 1. **Health awareness**	**Recognition of normal function and well-being**
00097	Decreased **diversional activity engagement**
00262	Readiness for enhanced **health literacy**
00168	Sedentary **lifestyle**
Class 2. **Health management**	**Identifying, controlling, performing, and integrating activities to maintain health and well-being**
00230	**Frail elderly syndrome**
00231	Risk for **frail elderly syndrome**
00215	Deficient community **health**
00188	Risk-prone **health behavior**
00099	Ineffective **health maintenance**
00078	Ineffective **health management**
00162	Readiness for enhanced **health management**
00080	Ineffective family **health management**
00043	Ineffective **protection**
Domain 2. **Nutrition**	**The activities of taking in, assimilating, and using nutrients for the purposes of tissue maintenance, tissue repair, and the production of energy**
Class 1. **Ingestion**	**Taking food or nutrients into the body**
00002	Im**balanced nutrition**: less than body requirements
00163	Readiness for enhanced **nutrition**[a]
00216	Insufficient **breast milk production**
00104	Ineffective **breastfeeding**
00105	Interrupted **breastfeeding**
00106	Readiness for enhanced **breastfeeding**
00269	Ineffective adolescent **eating dynamics**

00270	Ineffective child **eating dynamics**
00271	Ineffective infant **eating dynamics**
00107	Ineffective infant **feeding pattern**
00232	**Obesity**
00233	**Overweight**
00234	Risk for **overweight**
00103	Impaired swallowing
Class 2. Digestion	**The physical and chemical activities that convert foodstuffs into substances suitable for absorption and assimilation**
None at present time	
Class 3. Absorption	**The act of taking up nutrients through body tissues**
None at present time	
Class 4. Metabolism	**The chemical and physical processes occurring in living organisms and cells for the development and use of protoplasm, the production of waste and energy, with the release of energy for all vital processes**
00179	Risk for unstable **blood glucose level**
00194	Neonatal **hyperbilirubinemia**
00230	Risk for neonatal **hyperbilirubinemia**
00178	Risk for impaired **liver function**
00263	Risk for **metabolic imbalance syndrome**
Class 5. Hydration	**The taking in and absorption of fluids and electrolytes**
00195	Risk for **electrolyte** im**balance**
00025	Risk for im**balanced fluid volume**[b]
00027	Deficient **fluid volume**
00028	Risk for deficient **fluid volume**
00026	Excess **fluid volume**
Domain 3. Elimination and exchange	**Secretion and excretion of waste products from the body**
Class 1. Urinary function	**The process of secretion, reabsorption, and excretion of urine**
00016	Impaired urinary **elimination**
00020	Functional urinary **incontinence**
00176	Overflow urinary **incontinence**
00018	Reflex urinary **incontinence**
00017	Stress urinary **incontinence**
00019	Urge urinary **incontinence**

00022	Risk for urge urinary **incontinence**
00023	Urinary **retention**
Class 2. Gastrointestinal function	**The process of absorption and excretion of the end products of digestion**
00011	**Constipation**
00015	Risk for **constipation**
00012	Perceived **constipation**
00235	Chronic **functional constipation**
00236	Risk for chronic **functional constipation**
00013	**Diarrhea**
00196	Dysfunctional **gastrointestinal motility**
00197	Risk for dysfunctional **gastrointestinal motility**
00014	Bowel **incontinence**
Class 3. Integumentary function	**The process of secretion and excretion through the skin**
None at present time	
Class 4. Respiratory function	**The process of exchange of gases and removal of the end products of metabolism**
00030	Impaired **gas exchange**
Domain 4. Activity/rest	**The production, conservation, expenditure, or balance of energy resources**
Class 1. Sleep/rest	**Slumber, repose, ease, relaxation, or inactivity**
00095	**Insomnia**
00096	**Sleep** deprivation
00165	Readiness for enhanced **sleep**
00198	Disturbed **sleep pattern**
Class 2. Activity/exercise	**Moving parts of the body (mobility), doing work, or performing actions often (but not always) against resistance**
00040	Risk for **disuse syndrome**
00091	Impaired bed **mobility**
00085	Impaired physical **mobility**
00089	Impaired wheelchair **mobility**
00237	Impaired **sitting**
00238	Impaired **standing**
00090	Impaired **transfer ability**
00088	Impaired **walking**

Class 3. **Energy balance**	**A dynamic state of harmony between intake and expenditure of resources**
00273	Im**balanced energy field**
00093	**Fatigue**
00154	**Wandering**
Class 4. **Cardiovascular/pulmonary responses**	**Cardiopulmonary mechanisms that support activity/rest**
00092	**Activity** in**tolerance**
00094	Risk for **activity intolerance**
00032	Ineffective **breathing pattern**
00029	Decreased **cardiac output**
00240	Risk for decreased **cardiac output**
00033	Impaired **spontaneous ventilation**
00267	Risk for un**stable blood pressure**
00200	Risk for decreased cardiac **tissue perfusion**
00201	Risk for ineffective cerebral **tissue perfusion**
00204	Ineffective peripheral **tissue perfusion**
00228	Risk for ineffective peripheral **tissue perfusion**
00034	Dysfunctional **ventilatory weaning response**
Class 5. **Self-care**	**Ability to perform activities to care for one's body and bodily functions**
00098	Impaired **home maintenance**
00108	**Bathing self-care** deficit
00109	**Dressing self-care** deficit
00102	**Feeding self-care** deficit
00110	**Toileting self-care** deficit
00182	Readiness for enhanced **self-care**
00193	**Self-neglect**
Domain 5. **Perception/cognition**	**The human processing system including attention, orientation, sensation, perception, cognition, and communication**
Class 1. **Attention**	**Mental readiness to notice or observe**
00123	**Unilateral neglect**
Class 2. **Orientation**	**Awareness of time, place, and person**
None at present time	
Class 3. **Sensation/perception**	**Receiving information through the senses of touch, taste, smell, vision, hearing, and kinesthesia, and the**

	comprehension of sensory data resulting in naming, associating, and/or pattern recognition
None at present time	
Class 4. Cognition	**Use of memory, learning, thinking, problem-solving, abstraction, judgment, insight, intellectual capacity, calculation, and language**
00128	Acute **confusion**
00173	Risk for acute **confusion**
00129	Chronic **confusion**
00251	Labile **emotional control**
00222	Ineffective **impulse control**
00126	Deficient **knowledge**
00161	Readiness for enhanced **knowledge**
00131	Impaired **memory**
Class 5. Communication	**Sending and receiving verbal and nonverbal information**
00157	Readiness for enhanced **communication**
00051	Impaired **verbal communication**
Domain 6. Self-perception	**Awareness about the self**
Class 1. Self-concept	**The perception(s) about the total self**
00124	**Hope** lessness
00185	Readiness for enhanced **hope**
00174	Risk for compromised **human dignity**
00121	Disturbed **personal identity**
00225	Risk for disturbed **personal identity**
00167	Readiness for enhanced **self-concept**
Class 2. Self-esteem	**Assessment of one's own worth, capability, significance, and success**
00119	Chronic low **self-esteem**
00224	Risk for chronic low **self-esteem**
00120	Situational low **self-esteem**
00153	Risk for situational low **self-esteem**
Class 3. Body image	**A mental image of one's own body**
00118	Disturbed **body image**
Domain 7. Role relationship	**The positive and negative connections or associations between people or groups of people and the means by which those connections are demonstrated**

Class 1. **Caregiving roles**	**Socially expected behavior patterns by people providing care who are not health care professionals**
00061	Caregiver **role strain**
00062	Risk for caregiver **role strain**
00056	Impaired **parenting**
00057	Risk for impaired **parenting**
00164	Readiness for enhanced **parenting**
Class 2. **Family relationships**	**Associations of people who are biologically related or related by choice**
00058	Risk for impaired **attachment**
00063	Dysfunctional **family processes**
00060	Interrupted **family processes**
00159	Readiness for enhanced **family processes**
Class 3. **Role performance**	**Quality of functioning in socially expected behavior patterns**
00223	Ineffective **relationship**
00229	Risk for ineffective **relationship**
00207	Readiness for enhanced **relationship**
00064	Parental **role conflict**
00055	Ineffective **role performance**
00052	Impaired **social interaction**
Domain 8. **Sexuality**	**Sexual identity, sexual function, and reproduction**
Class 1. **Sexual identity**	**The state of being a specific person in regard to sexuality and/or gender**
None at present time	
Class 2. **Sexual function**	**The capacity or ability to participate in sexual activities**
00059	**Sexual** dys**function**
00065	Ineffective **sexuality pattern**
Clas 3. **Reproduction**	**Any process by which human beings are produced**
00221	Ineffective **childbearing process**
00227	Risk for ineffective **childbearing process**
00208	Readiness for enhanced **childbearing process**
00209	Risk for disturbed **maternal-fetal dyad**
Domain 9. **Coping/stress tolerance**	**Contending with life events/life processes**

Class 1. **Post-trauma responses**	**Reactions occurring after physical or psychological trauma**
00260	Risk for complicated **immigration transition**
00141	**Post-trauma syndrome**
00145	Risk for **post-trauma syndrome**
00142	**Rape-trauma syndrome**
00114	**Relocation stress syndrome**
00149	Risk for **relocation stress syndrome**
Class 2. **Coping responses**	**The process of managing environmental stress**
00199	Ineffective **activity planning**
00226	Risk for ineffective **activity planning**
00146	**Anxiety**
00071	Defensive **coping**
00069	Ineffective **coping**
00158	Readiness for enhanced **coping**
00077	Ineffective community **coping**
00076	Readiness for enhanced community **coping**
00074	Compromised family **coping**
00073	Disabled family **coping**
00075	Readiness for enhanced family **coping**
00147	**Death anxiety**
00072	Ineffective **denial**
00148	**Fear**
00136	**Grieving**
00135	Complicated **grieving**
00172	Risk for complicated **grieving**
00241	Impaired **mood regulation**
00125	**Power** lessness
00152	Risk for **power** lessness
00187	Readiness for enhanced **power**
00210	Impaired **resilience**
00211	Risk for impaired **resilience**
00212	Readiness for enhanced **resilience**
00137	Chronic **sorrow**
00177	**Stress** overload
Class 3.	**Behavioral responses reflecting nerve and brain function**

Neurobehavioral stress	
00258	**Acute substance withdrawal syndrome**
00259	Risk for **acute substance withdrawal syndrome**
00009	**Autonomic dysreflexia**
00010	Risk for **autonomic dysreflexia**
00049	Decreased **intracranial adaptive capacity**
00264	**Neonatal abstinence syndrome**
00116	Dis**organized** infant **behavior**
00115	Risk for dis**organized** infant **behavior**
00117	Readiness for enhanced **organized** infant **behavior**
Domain 10. Life principles	**Principles underlying conduct, thought, and behavior about acts, customs, or institutions viewed as being true or having intrinsic worth**
Class 1. Values	**The identification and ranking of preferred modes of conduct or end states**
None at present time	
Class 2. Beliefs	**Opinions, expectations, or judgments about acts, customs, or institutions viewed as being true or having intrinsic worth**
00068	Readiness for enhanced **spiritual well-being**
Class 3. Value/belief/action congruence	**The correspondence or balance achieved among values, beliefs, and actions**
00184	Readiness for enhanced **decision-making**
00083	**Decisional conflict**
00242	Impaired **emancipated decision-making**
00244	Risk for impaired **emancipated decision-making**
00243	Readiness for enhanced **emancipated decision-making**
00175	**Moral distress**
00169	Impaired **religiosity**
00170	Risk for impaired **religiosity**
00171	Readiness for enhanced **religiosity**
00066	**Spiritual distress**
00067	Risk for **spiritual distress**
Domain 11. Safety/protection	**Freedom from danger, physical injury, or immune system damage; preservation from loss; and protection of safety and security**
Class 1. Infection	**Host responses following pathogenic invasion**
00004	Risk for **infection**

00266	Risk for **surgical site infection**
Class 2. **Physical injury**	**Bodily harm or hurt**
00031	Ineffective **airway clearance**
00009	Risk for **aspiration**
00206	Risk for **bleeding**
00048	Impaired **dentition**
00219	Risk for **dry eye**
00261	Risk for **dry mouth**
00155	Risk for **falls**
00245	Risk for **corneal injury**[C]
00035	Risk for **injury**
00250	Risk for urinary tract **injury**
00087	Risk for **perioperative positioning injury**[C]
00220	Risk for **thermal injury**[C]
00045	Impaired oral **mucous membrane integrity**
00247	Risk for impaired oral **mucous membrane integrity**
00086	Risk for peripheral **neurovascular** dys**function**
00038	Risk for physical **trauma**
00213	Risk for vascular **trauma**
00249	Risk for **pressure ulcer**
00205	Risk for **shock**
00046	Impaired **skin integrity**
00047	Risk for impaired **skin integrity**
00156	Risk for **sudden infant death**
00036	Risk for **suffocation**
00100	Delayed **surgical recovery**
00246	Risk for delayed **surgical recovery**
00044	Impaired **tissue integrity**
00248	Risk for impaired **tissue integrity**
00268	Risk for **venous thromboembolism**
Class 3. **Violence**	**The exertion of excessive force or power to cause injury or abuse**
00272	Risk for **female genital mutilation**
00138	Risk for **other-directed violence**
00140	Risk for **self-directed violence**
00151	**Self-mutilation**

00139	Risk for **self-mutilation**
00150	Risk for **suicide**
Class 4. **Environmental hazards**	**Sources of danger in the surroundings**
00181	**Contamination**
00180	Risk for **contamination**
00265	Risk for **occupational injur**y
00037	Risk for **poisoning**
Class 5. **Defensive processes**	**The processes by which the self protects itself from the nonself**
00218	Risk for **adverse reaction to iodinated contrast media**
00217	Risk for **allergic reaction**
00041	**Latex allergic reaction**
00042	Risk for **latex allergic reaction**
Class 6. **Thermoregulation**	**The physiological process of regulating heat and energy within the body for purposes of protecting the organism**
00007	**Hyperthermia**
00006	**Hypothermia**
00253	Risk for **hypothermia**
00254	Risk for **perioperative hypothermia**
00008	Ineffective **thermoregulation**
00274	Risk for ineffective **thermoregulation**
Domain 12. **Comfort**	**Sense of mental, physical, or social well-being or ease**
Class 1. **Physical comfort**	**Sense of well-being or ease and/or freedom from pain**
00214	Impaired **comfort**
00183	Readiness for enhanced **comfort**
00134	**Nausea**
00132	Acute **pain**
00133	Chronic **pain**
00255	**Chronic pain syndrome**[d]
00256	**Labor pain**[d]
Class 2. **Environmental comfort**	**Sense of well-being or ease in/with one's environment**
00214	Impaired **comfort**
00183	Readiness for enhanced **comfort**

Class 3. **Social comfort**	**Sense of well-being or ease with one's social situation**
00214	Impaired **comfort**
00183	Readiness for enhanced **comfort**
00054	Risk for **loneliness**
00053	**Social isolation**
Domain 13. **Growth/development**	**Age-appropriate increases in physical dimensions, maturation of organ systems, and/or progression through the developmental milestones**
Class 1. **Growth**	**Increase in physical dimensions or maturity of organ systems**
None at present time	
Class 2. **Development**	**Progress or regression through a sequence of recognized milestones in life**
00112	Risk for delayed **development**

[a]The editors acknowledge this concept is not in alphabetical order; a decision was made to maintain all "nutrition" diagnoses in sequential order.

[b]The editors acknowledge this concept is not in alphabetical order; a decision was made to maintain all "fluid volume" diagnoses in sequential order.

[c]The editors acknowledge this concept is not in alphabetical order; a decision was made to maintain all "injury" diagnoses in sequential order.

[d]The editors acknowledge this concept is not in alphabetical order; a decision was made to maintain all "pain" diagnoses in sequential order.

7.7 References

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8 Specifications and Definitions Within the NANDA International Taxonomy of Nursing Diagnoses

T. Heather Herdman

8.1 Structure of Taxonomy II

Taxonomy is defined as the “system for naming and organizing things … into groups that share similar qualities” (Cambridge Dictionary On-Line, 2017). Within the taxonomy, the domains are “an area of interest or an area over which one has control”; and the classes are “a group … with similar structure” (Cambridge Dictionary On-Line, 2017).

We can adapt the definition for a nursing diagnosis taxonomy; specifically, we are concerned with the orderly classification of diagnostic foci of concern to nursing, according to their presumed natural relationships. Taxonomy II has three levels: domains, classes, and nursing diagnoses. ▶ Fig. 7.3 depicts the organization of domains and classes in Taxonomy II; ▶ Table 7.1 shows Taxonomy II with its 13 domains, 47 classes, and 244 current diagnoses.

The Taxonomy II code structure is a 32-bit integer (or if the user's database uses another notation, the code structure is a five-digit code). This structure provides for the stability, or growth and development, of the classification structure by avoiding the need to change codes when new diagnoses, refinements, and revisions are added. New codes are assigned to newly approved diagnoses.

Taxonomy II has a code structure that is compliant with recommendations from the National Library of Medicine (NLM) concerning health care terminology codes. The NLM recommends that codes do not contain information about the classified concept, as did the Taxonomy I code structure, which included information about the location and the level of the diagnosis.

The NANDA-I terminology is a recognized nursing language that meets the criteria established by the Committee for Nursing Practice Information

Infrastructure (CNPII) of the American Nurses Association (ANA) (Lundberg et al 2008). The benefit of a recognized nursing language is the indication that the classification system is accepted as supporting nursing practice by providing clinically useful terminology. The terminology is also registered with Health Level Seven International (HL7), a health care informatics standard, as a terminology to be used in identifying nursing diagnoses in electronic messages among clinical information systems (www.HL7.org).

8.2 A Multiaxial System for Constructing Diagnostic Concepts

The NANDA-I diagnoses are concepts constructed by means of a multiaxial system. An axis, for the purpose of the NANDA-I Taxonomy II, is operationally defined as a dimension of the human response that is considered in the diagnostic process. There are seven axes. The *NANDA-I Model of a Nursing Diagnosis* displays the seven axes and their relationship to each other.

– Axis 1: the focus of the diagnosis
– Axis 2: subject of the diagnosis (individual, family, group, caregiver, community, etc.)
– Axis 3: judgment (impaired, ineffective, etc.)
– Axis 4: location (oral, peripheral, cerebral, etc.)
– Axis 5: age (neonate, infant, child, adult, etc.)
– Axis 6: time (chronic, acute, intermittent)
– Axis 7: status of the diagnosis (problem-focused, risk, health promotion)

The axes are represented in the labels of the nursing diagnoses through their values. In some cases they are named explicitly, such as with the diagnoses *ineffective community coping* and *dysfunctional family processes*, in which the subject of the diagnosis is named using the two values “community” and “family” taken from Axis 2 (subject of the diagnosis). “Ineffective” and “dysfunctional” are two of the values contained in Axis 3 (judgment).

In some cases, the axis is implicit, as is the case with the diagnosis *ineffective sexuality pattern*, in which the subject of the diagnosis (Axis 2) is always the patient. In some instances, an axis may not be pertinent to a diagnosis, and therefore is not part of the nursing diagnostic label. For example, the time axis may not be relevant to every diagnosis. In the case of diagnoses without explicit identification of the subject of the diagnosis, it may be helpful to remember that

NANDA-I defines a patient as “an individual, a family, a group, or a community.”

Axis 1 (the focus of the diagnosis) and Axis 3 (judgment) are essential components of a nursing diagnosis. In some cases, however, the focus of the diagnosis contains the judgment (e.g., *fear*); in these cases, the judgment is not explicitly separated from the focus of the diagnosis in the diagnostic label. Axis 2 (subject of the diagnosis) is also essential, although, as described earlier, it may be implied and therefore not included in the label. The Diagnosis Development Committee requires these axes for submission; the other axes may be used where relevant for clarity.

8.3 Definitions of the Axes

8.3.1 Axis 1: The Focus of the Diagnosis

The focus of the diagnosis is the principal element or the fundamental and essential part, the root, of the diagnostic concept. It describes the “human response” that is the core of the diagnosis.

The focus of the diagnosis may consist of one or more nouns. When more than one noun is used (e.g., *sexual dysfunction*), each one contributes a unique meaning to the focus of the diagnosis, as if the two were a single noun; the meaning of the combined term, however, is different from when the nouns are stated separately. Frequently, a noun (*parenting*) may be used with an adjective (*impaired*) to denote the focus of the diagnosis *impaired parenting*.

In some cases, the focus of the diagnosis and the diagnostic concept are one and the same, as is seen with the diagnosis of *fear*. This occurs when the nursing diagnosis is stated at its most clinically useful level and the separation of the focus of the diagnosis adds no meaningful level of abstraction. It can be very difficult to determine exactly what should be considered the focus of the diagnosis. For example, using the diagnoses of *bowel incontinence* (00014) and *stress urinary incontinence* (00017), the question becomes: Is the focus of the diagnosis *incontinence* alone, or are there two foci—*bowel incontinence* and *urinary incontinence*? In this instance, *incontinence* is the focus and the location terms (Axis 4) of *bowel* and *urinary* provide more clarification about the focus. However, *incontinence* in and of itself is a judgment term that can stand alone, and so it becomes the focus of the diagnosis regardless of location.

In some cases, however, removing the location (Axis 4) from the diagnostic

focus would prevent it from providing meaning to nursing practice. For example, if we look at the focus of the diagnosis *risk for imbalanced body temperature*, is the focus of the diagnosis *body temperature* or simply *temperature*? Or if you look at the diagnosis *disturbed personal identity*, is the focus *identity* or *personal identity*? Decisions about what constitutes the essence of the focus of the diagnosis, then, are made on the basis of what helps to identify the nursing practice implication and whether or not the term indicates a human response. *Temperature* could mean environmental temperature, which is not a human response—so it is important to identify *body temperature* as the diagnostic concept. Similarly, *identity* can mean nothing more than one's gender, eye color, height, or age—again, these are characteristics but not human responses; *personal identity*, however, indicates one's self-perception and is a human response. In some cases, the focus may seem similar, but is in fact quite distinct: *violence* and *self-directed violence* are two different human responses, and therefore must be identified separately in terms of diagnostic foci within Taxonomy II. The diagnostic foci of the NANDA-I nursing diagnoses are shown in ▶ Table 8.1.

Table 8.1 Diagnostic foci of the NANDA-I nursing diagnoses

– Activity planning – Activity tolerance – Acute substance withdrawal syndrome – Adaptive capacity – Adverse reaction to iodinated contrast media – Airway clearance – Allergic reaction – Anxiety – Aspiration – Attachment – Autonomic dysreflexia – Balanced energy field – Balanced fluid volume – Balanced nutrition – Bathing self-care – Bleeding – Blood glucose level – Body image – Breast milk production – Breastfeeding – Breathing pattern	– Feeding self-care – Female genital mutilation – Fluid volume – Frail elderly syndrome – Funtional constipation – Gas exchange – Gastrointestinal motility – Grieving – Health behavior – Health literacy – Health maintenance – Health management – Health – Home maintenance – Hope – Human dignity – Hyperbilirubinemia – Hyperthermia – Hypothermia – Immigration transition – Impulse control – Incontinence – Infection	– Post-trauma syndrome – Power – Pressure ulcer – Protection – Rape-trauma syndrome – Relationship – Religiosity – Relocation stress syndrome – Resilience – Retention – Role conflict – Role performance – Role strain – Self-care – Self-concept – Self-directed violence – Self-esteem – Self-mutilation – Self-neglect – Sexual function – Sexuality pattern – Shock – Sitting

– Cardiac output – Childbearing process – Chronic pain syndrome – Comfort – Communication – Confusion – Constipation – Contamination – Coping – Death anxiety – Decisional conflict – Decision making – Denial – Dentition – Development – Diarrhea – Disuse syndrome – Diversional activity engagement – Dressing self-care – Dry eye – Dry mouth – Eating dynamics – Electrolyte balance – Elimination – Emancipated decision-making – Emotional control – Falls – Family processes – Fatigue – Fear – Feeding pattern	– Injury – Insomnia – Knowledge – Labor pain – Latex allergic reaction – Lifestyle – Liver function – Loneliness – Maternal–fetal dyad – Memory – Metabolic imbalance syndrome – Mobility – Mood regulation – Moral distress – Mucous membrane integrity – Nausea – Neonatal abstinence syndrome – Neurovascular function – Nutrition – Obesity – Occupational injury – Organized behavior – Other-directed violence – Overweight – Pain – Parenting – Perioperative hypothermia – Perioperative positioning injury – Personal identity – Physical trauma – Poisoning	– Skin integrity – Sleep pattern – Sleep – Social interaction – Social isolation – Sorrow – Spiritual distress – Spiritual well-being – Spontaneous ventilation – Standing – Stress – Sudden infant death – Suffocation – Suicide – Surgical recovery – Surgical site infection – Swallowing – Thermal injury – Thermoregulation – Tissue integrity – Tissue perfusion – Toileting self-care – Transfer ability – Unilateral neglect – Stable blood pressure – Venous thromboembolism – Ventilatory weaning response – Verbal communication – Walking – Wandering

8.3.2 Axis 2: Subject of the Diagnosis

The subject of the diagnosis is defined as the person(s) for whom a nursing diagnosis is determined. The values in Axis 2 are individual, caregiver, family, group, and community, representing the NANDA-I definition of "patient":

– *Individual*: A single human being distinct from others, a person.
– *Caregiver*: A family member or helper who regularly looks after a child or a sick, elderly, or disabled person.
– *Family*: Two or more people having continuous or sustained relationships,

perceiving reciprocal obligations, sensing common meaning, and sharing certain obligations toward others; related by blood and/or choice.
– *Group*: A number of people with shared characteristics.
– *Community*: A group of people living in the same locale under the same governance. Examples include neighborhoods and cities.

When the subject of the diagnosis is not explicitly stated, it becomes the individual by default. However, it is perfectly appropriate to consider such diagnoses for the other subjects of the diagnosis as well. The diagnosis *impaired comfort* (00214) could be applied to an individual who has insufficient situational control, insufficient privacy, and insufficient resources, which is evidenced by discontent with the individual's situation, an inability to relax, and alteration in the individual's sleep pattern. It could also be appropriate for a community that has experienced noxious environmental stimuli (e.g., environmental disaster), and which has insufficient control over its environment and insufficient resources to combat the problem it is facing, and whose residents are experiencing distressing symptoms, fear, anxiety, etc.

8.3.3 Axis 3: Judgment

A judgment is a descriptor or modifier that limits or specifies the meaning of the focus of the diagnosis. The focus of the diagnosis, together with the nurse's judgment about it, forms the diagnosis. All the definitions used are found in the Oxford English Living Dictionary On-Line (2017). The values in Axis 3 are found in ▶ Table 8.2.

Table 8.2 Definitions of judgment terms for Axis 3, NANDA-I Taxonomy II

Judgment	Definition
Complicated	Consisting of many interconnecting parts or elements; intricate; involving many different and confusing aspects
Compromised	Made vulnerable or to function less effectively
Decreased	Smaller or fewer in size, amount, intensity, or degree
Defensive	Used or intended to defend or protect
Deficient/deficit	Not having enough of a specified quality or ingredient; insufficient or inadequate
Delayed	Late, slow, or postponed
Deprivation	Lack or denial of something considered to be a necessity
Disabled	Limited in movements, senses, or activities

Disorganized	Not properly planned or controlled; scattered or inefficient
Disproportionate	Too large or too small in comparison with something else (norm)
Disturbed	Having had a normal pattern or function disrupted
Dysfunctional	Not operating normally or properly; unable to deal adequately with social norms
Emancipated	Free from legal, social, or political restrictions; liberated
Effective	Successful in producing a desired or intended result
Enhanced	Intensify, increase, or further improve the quality, value, or extent
Excess	An amount of something that is more than necessary, permitted, or desirable
Failure	The action or state of not functioning; lack of success
Frail	Weak and delicate; physically or mentally infirm through old age
Functional	Relating to the way in which something works or operates; of or having a specific activity, purpose, or task
Imbalanced	Lack of proportion or relation between corresponding things
Impaired	Weakened or damaged (something, especially a faculty or function)
Ineffective	Not producing any significant or desired effect
Insufficient	Not enough, inadequate; incapable, incompetent
Interrupted	A stop in continuous progress (of an activity or process); to break the continuity of something
Labile	Liable to change; easily altered; of or characterized by emotions which are easily aroused, freely expressed, and tend to alter quickly and spontaneously
Low	Below average in amount, extent, or intensity; small
Non-	Expressing negation or absence
Organized	Arranged or structured in a systematic way; efficient
Overload	Too great a burden
Perceived	Become aware or conscious (of something); come to realize or understand
Readiness for	Willingness to do something; state of being fully prepared for something
Risk for	Situation involving exposure to danger; possibility

	that something unpleasant or unwelcome will happen
Risk-prone	Likely or liable to suffer from, do, or experience something unpleasant or regrettable
Sedentary	(A way of life) characterized by much sitting and little physical exercise
Situational	Related to or dependent on a set of circumstances or state of affairs; relating to the location and surroundings of a place
Unstable	Prone to change, fail; not firmly established; likely to give way; not stable

8.3.4 Axis 4: Location

Location describes the parts/regions of the body and/or their related functions—all tissues, organs, anatomical sites, or structures. All the definitions used are found in the *Oxford English Living Dictionary On-Line* (2017). The values in Axis 4 are shown in ▶ Table 8.3.

Table 8.3 Locations and their definitions in Axis 4, NANDA-I Taxonomy II

Term	Definition
Auditory	Relating to the sense of hearing
Bladder	Muscular membranous sac in the abdomen which receives urine from the kidneys and stores it for excretion
Body	Physical structure, including the bones, flesh, and organs, of a person
Bowel	Part of the alimentary canal below the stomach; the intestine
Breast	Tissue overlying the chest (pectoral) muscles. Women's breasts are made of specialized tissue that produces milk (glandular tissue) as well as fatty tissue
Cardiac	Relating to the heart
Cardiopulmonary	Relating to the heart and lungs
Cardiovascular	Relating to the heart and blood vessels
Cerebral	Of the cerebrum of the brain
Dentition	Arrangement or condition of the teeth
Eye	One of a pair of globular organs of sight in the human head
Gastrointestinal	Relating to the stomach and the intestines
Genital	Relating to the human reproductive organs
Gustatory	Concerned with tasting or the sense of taste

Intracranial	Within the skull
Kinesthetic	Awareness of the position and movement of the parts of the body by means of sensory organs (proprioceptors) in the muscles and joints
Liver	Large lobed glandular organ in the abdomen, involved in many metabolic processes
Mouth	Opening and cavity in the lower part of the human face, surrounded by the lips, through which food is taken in and vocal sounds are emitted
Mucous membranes	Epithelial tissues which secrete mucus and line many body cavities and tubular organs including the gut and respiratory passages
Neurovascular	Containing neural and vascular structures; of or relating to the nervous and vascular systems, or their interactions
Olfactory	Relating to the sense of smell
Oral	Cavity of the mouth
Peripheral	Of or relating to the surface or outer part of a body or organ; external
Peripheral vascular	System of veins and arteries not in the chest or abdomen
Renal	Relating to the kidneys
Skin	The thin layer of tissue forming the natural outer covering of the body
Tactile	Of or connected with the sense of touch
Tissue	Any of the distinct types of material of which humans are made, consisting of specialized cells and their products
Vascular	Relating to, affecting, or consisting of a vessel or vessels, especially those which carry blood
Venous	Relating to a vein or the veins
Visual	Relating to seeing or sight
Urinary	Relating to urine
Urinary tract	Relating to or denoting the system of organs, structures, and ducts by which urine is produced and discharged, comprising the kidneys, ureters, bladder, and urethra

8.3.5 Axis 5: Age

Age refers to the age of the person who is the subject of the diagnosis (Axis 2). The values in Axis 5 are noted below, with all definitions, *except* that of older adult, being drawn from the World Health Organization (2013).

– *Fetus*: unborn human more than 8 weeks after conception, until birth

– *Neonate*: person < 28 days of age
– *Infant*: person ≥ 28 days and < 1 year of age
– *Child*: person aged 1 to 9 years, inclusive
– *Adolescent*: person aged 10 to 19 years, inclusive
– *Adult*: person older than 19 years of age unless national law defines a person as being an adult at an earlier age
– *Older adult*: person ≥ 65 years of age

8.3.6 Axis 6: Time

Time describes the duration of the focus of the diagnosis (Axis 1). The values in Axis 6 are:
– *Acute*: lasting < 3 months
– *Chronic*: lasting ≥ 3 months
– *Intermittent*: stopping or starting again at intervals, periodic, cyclic
– *Continuous*: uninterrupted, going on without stop

8.3.7 Axis 7: Status of the Diagnosis

The status of the diagnosis refers to the actuality or potentiality of the problem/health promotion opportunity/syndrome or to the categorization of the diagnosis as a health promotion diagnosis. The values in Axis 7 are:
– *Problem-focused*: undesirable human response to a health condition/life process that exists in the current moment (includes syndrome diagnoses)
– *Health promotion*: motivation and desire to increase well-being and to actualize human health potential that exists in the current moment (Pender et al 2006)
– *Risk*: susceptibility for developing, in the future, an undesirable human response to health conditions/life processes (includes syndrome diagnoses)

8.4 Developing and Submitting a Nursing Diagnosis

A nursing diagnosis is constructed by combining the values from Axis 1 (the focus of the diagnosis), Axis 2 (subject of the diagnosis), and Axis 3 (judgment), and adding values from the other axes for relevant clarity. Researchers or interested professional nurses would begin with the focus of the diagnosis (Axis 1) and add the appropriate judgment term (Axis 3). Remember that these two axes are sometimes combined into a single diagnostic concept, as can be seen with the nursing diagnosis *fear* (00148). Next, they would specify the subject of the diagnosis (Axis 2). If the subject is an “individual,” they need not make it

explicit. Finally, they can use the remaining axes, if they are appropriate, to add more detail.

NANDA-I does not support the *random construction* of diagnostic concepts that would occur by simply matching terms from one axis to another to create a diagnosis label to represent judgments based on a patient assessment. Clinical problems/areas of nursing foci that are identified and which do not have a NANDA-I label should be carefully described in documentation to ensure accuracy of other nurses'/health care professionals' interpretation of the clinical judgment.

Creating a diagnosis to be used in clinical practice and/or documentation by matching terms from different axes, without development of the definition and other component parts of a diagnosis (defining characteristics, related factors, risk factors, associated conditions, and at-risk populations, as appropriate) in an evidence-based manner, negates the purpose of a standardized language as a method to truly represent, inform, and direct clinical judgment and practice.

This is a serious concern with regard to patient safety, because the lack of the knowledge inherent within the component diagnostic parts makes it impossible to ensure diagnostic accuracy. Nursing terms arbitrarily created at the point of care could result in misinterpretation of the clinical problem/area of focus, and subsequently lead to inappropriate outcome setting and intervention choice. It also makes it impossible to accurately research incidence of nursing diagnoses or to conduct outcome or intervention studies related to diagnoses since, without clear component parts of a diagnosis (definitions, defining characteristics, related factors, or risk factors), it is impossible to know if the concept being studied truly represents the same phenomena.

Therefore, when discussing construction of diagnostic concepts in this chapter, the intent is to inform clinicians as to how diagnostic concepts are developed and to provide clarity for individuals who are developing diagnoses, for submission into the NANDA-I Taxonomy; **it *should not* be misinterpreted to suggest that NANDA-I supports the creation of diagnosis labels by clinicians at the point of patient care**.

8.5 Further Development

NANDA International will be focusing on revision of diagnoses that are currently included in the terminology, but which were "grandfathered" in after the level of evidence criteria was adopted in 2002. There are over 50 such

diagnoses, which will be removed from the terminology during the next edition should this revision not occur. Therefore, *we strongly discourage the development of new diagnoses at this time*, with the focus instead on bringing diagnoses to a minimum level of evidence of 2.1, and raising the level of evidence of other diagnoses. The other focus for the organization will be to strengthen the clinical usefulness of diagnostic indicators (defining characteristics and related factors). Our desire is to be able to identify, through clinical research and meta-analysis/meta-synthesis, those defining characteristics that are required for a diagnosis to be made ("critical defining characteristics") and to remove those that are not clinically useful. This will strengthen our ability to provide decision support for nurses at the bedside.

8.6 Recommended Reading

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9 Frequently Asked Questions

9.1 Introduction

We routinely receive questions via our website and email, and when members of the NANDA-I Board of Directors or the CEO/Executive Director travel and present at a variety of conferences. We include some of the most common questions here, along with their answers, with the hope that it will help others who may have the same questions.

9.2 When Do We Need Nursing Diagnoses?

Nurses often work with a patient who has medical problems. However, from a legal point of view, physicians are responsible for the diagnosis and treatment of these medical problems. Likewise, nurses are responsible for the diagnosis and treatment of nursing problems. The important point is that nursing problems are different from medical problems. To make this point clear, let us examine how nursing practice exists within health care, using a wider perspective based on the *Three Pillar Model of Nursing Practice* (Kamitsuru 2008). This model shows three main parts of nursing practice, which are distinct but interrelated.

In clinical practice, nurses are expected to perform many actions. First, we have practices/interventions that are driven by medical diagnoses. These nursing actions are related to medical treatments, patient surveillance and monitoring, and interdisciplinary collaboration. Nurses take these actions in response to medical diagnoses, and use medical standards of care as the basis for these nursing actions.

Second, we have practice that is driven by nursing diagnoses. These independent nursing interventions do not require physician approval or permission. These actions are based on nursing standards of care.

Finally, we have practice that is driven by organizational protocols. These can be actions related to basic care, such as changing linen, providing hygiene, and daily care. These actions are not specifically related to either medical diagnoses

or nursing diagnoses, but they are based on organizational standards of care.

All three actions combined form the practice of nursing. Each has a different knowledge base and different responsibilities. The three parts are equally important for nurses to understand, but only one of them relates to our unique disciplinary knowledge—and that is the area we know as nursing diagnosis. This model also shows why we do not need to rename medical diagnoses as nursing diagnoses. Medical diagnoses already exist in the medical domain. But, medical diagnoses do not always explain everything that nurses understand about patients, judgments we make about their human response, or interventions we implement for patients. So, we use nursing diagnoses to explain independent clinical judgments nurses make about our patients. Thus, nursing diagnoses provide the underpinning of independent nursing interventions.

9.3 Basic Questions about Standardized Nursing Languages

What is standardized nursing language?

Standardized nursing language (SNL) is a commonly understood set of terms used to describe the clinical judgments involved in assessments (nursing diagnoses), along with the interventions and outcomes related to the documentation of nursing care. Standardization requires terms, definitions, and indicators (either diagnostic or outcome indicators) to be clinically useful.

How many standardized nursing languages are there?

The American Nurses Association recognizes 12 languages for nursing. NANDA-I is the only diagnostic language that uses a peer-review system for inclusion in its taxonomy. It is also the only terminology to provide the critical diagnostic indicators (defining characteristics, related factors, risk factors, associated conditions, and at-risk populations) to support a nurse's clinical reasoning at the bedside.

What are the differences among standardized nursing languages?

Many nursing languages claim to be standardized; some are simply a list of terms, others provide definitions of those terms. NANDA-I maintains that a standardized language that represents any profession should provide, at a minimum, an evidence-based definition, list of defining characteristics (signs/symptoms), and related factors (etiologic factors), along with additional

data that support diagnosis, such as at-risk populations and associated conditions. Risk diagnoses should include an evidence-based definition and a list of risk factors, which are amenable to independent nursing intervention. Without these, anyone can define any term in his/her own way, which obviously violates the purpose of standardization. It also prohibits any electronic decision-support with linkage directly to nursing assessments.

I see people use terms, such as "select a diagnosis," "choose a diagnosis," and "pick a diagnosis"— it sounds as though there is an easy way to know what diagnosis to use. Is that correct?

When we speak about diagnosing, we really are not talking about something as simplistic as picking a term from a list or choosing something that "sounds right" for our patient. We are speaking about the diagnostic decision-making process, in which nurses diagnose. So, rather than using these simplistic terms (selecting, choosing, picking), we should really describe the process of diagnosing! Rather than saying "choose a diagnosis," we should be saying "diagnose the patient/family"; rather than saying "picking a diagnosis," we could use "ensure accuracy in your diagnosis," or again, simply "diagnose the patient/family." Words are powerful—so when we say things such as choose, pick, and select, it does sound simple, as if we need to simply read through a list of terms and pick one. Using diagnostic reasoning, however, is much more than that—and *diagnosing* is what we are doing, which goes far beyond "picking" something!

9.4 Basic Questions about NANDA-I

What is NANDA International?

Implementation of nursing diagnosis enhances every aspect of nursing practice, from garnering professional respect to assuring consistent documentation representing nurses' professional clinical judgment and accurate documentation to enable reimbursement. NANDA-I exists to develop, refine, and promote terminology that accurately reflects nurses' clinical judgments.

Why does NANDA-I charge a fee for access to its nursing diagnoses?

In any field, development and maintenance of a research-based body of work requires an investment of time and expertise, and dissemination of that work is

an additional expense. As a volunteer organization, we sponsor committee meetings for review of submitted diagnoses, to ensure they meet the level of evidence (LOE) criteria. We also provide educational courses and offerings in English, Spanish, and Portuguese due to the high demand of this content. We have committee members from all over the world, and the cost of videoconferencing and the occasional face-to-face meeting is an expense—as are our conferences and educational events. Our fees support this work on a breakeven basis, and are quite modest in comparison to fees charged for a license to many other available health care databases and electronic licenses.

If we buy a book and type the contents into software ourselves, do we still have to pay?

NANDA International, Inc. depends on the funds received from the sale of our textbooks and electronic licensing to maintain and improve the state of the science within our terminology. The NANDA-I terminology is a copyrighted terminology; therefore, **no part of the NANDA-I publication, *NANDA International Nursing Diagnoses: Definitions and Classification*, can be reproduced, stored in a retrieval system, or transmitted by any means, electronic, mechanical, photocopying, recording, or otherwise without the prior permission of the publisher. This includes publication in online blogs, websites, etc.**

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Should the structure of Taxonomy II be used as a nursing assessment framework?

The purpose of the taxonomy is to provide organization to the terms (diagnoses) within NANDA-I. It was never intended to serve as an assessment framework. Please see our Position Statement on the use of taxonomy as a nursing assessment framework (p.48).

What is PES, how was it developed, and what are its origins? Does

NANDA-I require the “PES format/scheme”?

“PES” is an acronym that stands for **p** roblem, **e** tiology (related factors), and **s** igns/symptoms (defining characteristics). The PES format was first published by Dr. Marjory Gordon, a founder and former President of NANDA-I. The component parts of NANDA-I diagnoses are now referred to as *related factors* and *defining characteristics*, and therefore the wording “PES format” is not used in current NANDA-I books. It is still used in several countries and in many publications. Formulating accurate diagnoses relies on assessing and documenting related factors and defining characteristics, and the PES format supports this, which is critical for accuracy in nursing diagnoses, a focus which NANDA-I strongly supports.

However, NANDA-I does not require the PES format, or any other format, to document nursing diagnoses. We are aware of the wide variety of electronic documentation systems in use and in development around the world, and it seems that there are as many ways of providing nursing documentation as there are systems! Many computer systems do not allow the use of the “related to…as evidenced by” model. However, it is important that nurses communicate the assessment data that support the diagnosis they make, so that others caring for the patient know why a diagnosis was selected. Please see the NANDA-I Position Statement Number 2: The Structure of the Nursing Diagnosis Statement When Included in a Care Plan (p.28).

The PES format remains a strong method for teaching clinical reasoning and supporting students and nurses as they learn the skill of diagnosis. Because patients usually have more than one related factor and/or defining characteristic, many sites replaced the wording “as manifested/as evidenced by” and “related to” with a list of the defining characteristics and related factors following the diagnostic statement. This list is based on the individual patient situation and by using standardized NANDA-I terms.

Regardless of the requirements for documentation, it is important to remember that for safe patient care in clinical areas, it is crucial to survey or assess defining characteristics (manifestations of diagnoses) and related factors (or causes) of nursing diagnoses. Choosing effective interventions is based on related factors and defining characteristics.

How do I write the diagnostic statement for risk, problem-focused, and health promotion diagnoses?

Documentation systems differ by organization, so in some cases you may write (or select from a computerized list) the diagnostic label that corresponds to the

human response you have diagnosed. Assessment data may be found in a different section (or "screen") of the computer system, and you would select your related factors and defining characteristics, or your risk factors, in that location. Examples of PES charting are shown below.

Problem-Focused Diagnosis. To use the PES format, start with the diagnosis itself, followed by the etiologic factors (related factors in a problem-focused diagnosis). Finally, you identify the major signs/symptoms (defining characteristics).

Impaired parenting related to insufficient cognitive readiness for parenting and young parental age (related factors) as evidenced by **deficient parent – child interaction, perceived role inadequacy, and inappropriate care-taking skills (defining characteristics).**

Risk Diagnosis. For risk diagnoses, there are no related factors (etiological factors), since you are identifying a *vulnerability* in a patient for a potential problem; the problem is not yet present. Different experts recommend different phrasing (some use "related to," others use "as evidenced by" for risk diagnoses). Because the term "related to" is used to suggest an etiology, in the case of a problem-focused diagnosis, and because there is only a vulnerability to a problem when a risk diagnosis is used, NANDA-I has decided to recommend the use of the phrase "as evidenced by" to refer to the evidence of risk that exists, if the PES format is used.

Risk for caregiver role strain as evidenced by *unpredictability of illness trajectory and caregiving task complexity* (risk factors).

Health Promotion Diagnosis. Because health promotion diagnoses do not require a related factor, there may be no "related to" in the writing of this diagnosis. Instead, the defining characteristic(s) is (are) provided as evidence of the desire on the part of the patient to improve his/her current health state (or the recognition by the professional nurse that an opportunity exists for health promotion, and action is taken to promote health on behalf of the patient who is unable to do so for himself/herself).

Readiness for enhanced sleep as evidenced by *expressed desire to enhance sleep*.

Does NANDA-I provide a list of its diagnoses?

There is no real use for simply providing a list of terms—doing so defeats the purpose of a standardized language. Unless the definition, defining

characteristics, and related and/or risk factors are known, the label itself is meaningless. Therefore, we do not believe it is in the interest of patient safety to produce simple lists of terms that could be misunderstood or used inappropriately in a clinical context.

It is essential to have the definition of the diagnosis and, more importantly, the diagnostic indicators (assessment data/patient history data) required to make the diagnosis—for example, the signs/symptoms that you collect through your assessment ("defining characteristics") and the cause of the diagnosis ("related factors") or those things that place a patient at significant risk for a diagnosis ("risk factors"). As you assess the patient, you will rely on both your clinical knowledge and "book knowledge" to see patterns in the data—diagnostic indicators that cluster together, which may relate to a diagnosis. Questions to ask to identify and validate the correct diagnosis include:

1. Are the majority of the defining characteristics/risk factors present in the patient?
2. Are there etiological factors ("related factors") for the diagnosis evident in your patient?
3. Have you validated the diagnosis with the patient/family or with another nurse peer (when possible)?

9.5 Basic Questions about Nursing Diagnoses

What are the types of nursing diagnoses in NANDA-I classification?

NANDA-I identifies three categories of nursing diagnosis: problem-focused, health promotion, and risk diagnoses. Within the problem-focused and risk categories, you can also find the use of syndromes. Definitions for each of these categories, and syndromes, can be found in the Glossary of Terms (p.133).

What are nursing diagnoses, and why should I use them?

A nursing diagnosis is a clinical judgment concerning a human response to health conditions/life processes, or a susceptibility for that response, by an individual, family, group, or community. It requires a nursing assessment to correctly diagnose your patient—you cannot safely standardize nursing diagnoses by using a medical diagnosis. Although it is true that there are common nursing diagnoses that frequently occur in patients with various medical diagnoses, the fact is that you will not know if the nursing diagnosis is

accurate unless you assess for defining characteristics and establish that key related factors exist.

A nursing diagnosis provides the basis for selection of nursing interventions to achieve outcomes for which the nurse has accountability. This means that nursing diagnoses are used to determine the appropriate plan of care for the patient, driving patient outcomes and interventions. You cannot standardize a nursing diagnosis; however, it is possible to standardize nursing interventions once you have selected the appropriate outcome for the nursing diagnosis, as interventions should be evidence-based whenever possible!

Nursing diagnoses also provide a standard language for use in the Electronic Health Record (EHR), enabling clear communication among care team members and the collection of data for continuous improvement in patient care. Using a diagnostic terminology that provides clinical decision support through the articulation of diagnostic indicators (signs/symptoms/etiologies) can enable linkages to nursing assessment tools, thus improving diagnostic accuracy and nurses' clinical reasoning skills.

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

A medical diagnosis deals with a disease or medical condition. A nursing diagnosis deals with actual or potential human responses to health problems and life processes. For example, a medical diagnosis of *cerebrovascular attack* (CVA or stroke) provides information about the patient's pathology. The nursing diagnoses of *impaired verbal communication*, *risk for falls*, *interrupted family processes*, *chronic pain*, and *powerlessness* provide a more holistic understanding of the impact of that stroke on this patient and his family—they also direct nursing interventions to obtain patient-specific outcomes. If nurses only focus on the stroke, they might miss the *chronic pain* the patient suffers, his sense of *powerlessness*, and even the *interrupted family processes*. These issues will impact his potential discharge home, his ability to manage his new therapeutic regimen, and his overall quality of life. It is also important to remember that, while a medical diagnosis belongs only to the patient, **nursing treats the patient *and* his family**, so diagnoses regarding the family are critical because they have the potential to impact—positively or negatively—the outcomes you are trying to achieve with the patient.

What are the component parts of a diagnosis, and what do they mean for nurses in practice?

There are several “parts” of a nursing diagnosis: the *diagnostic label*, *definition*, the assessment criteria used to diagnose, the *defining characteristics*, and *related factors* or *risk factors*. As we noted in Chapter 8, NANDA-I has strong concerns about the safety of using terms (diagnosis labels) that have no standardized meaning and no assessment criteria. Picking a diagnosis from a list, or making up a term at a patient's bedside, is a dangerous practice for a couple of very important reasons. First, communication between health care team members must be clear, concise, and consistent. If every person defines a “diagnosis” in a different way, there is no clarity. Second, how can we assess the validity of a diagnosis, or the diagnostic ability of a nurse, if we have no data to support the diagnosis?

It is also helpful to review the *at-risk populations* and *associated conditions* to consider nursing diagnoses that might be higher frequency in certain populations, for example.

Let us look at the example of Mrs. M in the case study below. This example shows the problem with “picking” a diagnosis from a list of terms, without knowledge of the definition or the assessment data needed to diagnose the response.

Case Study

Mrs. M is a 72-year-old woman admitted for a mastectomy due to invasive carcinoma. She arrived in the preoperative unit with her daughter, at 6:00am as scheduled. Her intravenous access was started by the night shift nurse, and her vitals and part of her admission assessment were completed. You notice that the nurse caring for Mrs. M previously documented three nursing diagnoses in the chart: *anxiety* (00146), *disturbed body image* (00118), and *deficient knowledge* (00126). Based on that communication, you form a picture in your mind of this patient and how you will want to approach her. The *anxiety* alerts you that you will want to be calming and reassuring in your approach, while the *disturbed body image* diagnosis speaks to her impending surgical procedure which will impact a part of the body that is associated with female sexuality. The diagnosis of *deficient knowledge* concerns you because you must be sure that she understands why she is here, the purpose of the surgery today, and potential complications prior to releasing her to the operating room.

A little while later, you complete your assessment and find that you have identified some differences compared to the previous nurse's assessment.

Although you understand why your colleague may have selected the diagnosis of *anxiety,* you know that *fear* (00148) is clearly more accurate—although Mrs. M states she is anxious, she tells you that she is concerned about the outcome of the surgery, and is worried that the surgeon might not be able to "get all of the cancer." Because *fear* is a response to a threat that is consciously recognized as a danger, but *anxiety* is related to an unknown or nonspecific threat, you make the more accurate diagnosis of *fear*.

Your assessment did not confirm any of the defining characteristics of *deficient knowledge*, nor did you identify any related factors. In fact, you learn that this is the patient's second mastectomy (her previous was five years earlier); she is well informed about her cancer type and the potential treatment options that may follow surgery, depending on the outcome of the procedure. She is easily able to identify for you the type of procedure she is going to have, the expected length of the procedure, and the most common risks and negative outcomes she could experience. She is a former college professor, and you find her highly intelligent, motivated to make good decisions, and well informed.

Finally, she shows no signs of *disturbed body image*. She chose not to have reconstructive surgery with her first mastectomy, and indicates she has made the same decision for this procedure. She is a widow, and says that she does not feel the additional risks are worth taking. She appears quite comfortable with her body image, even joking that her breast size was "small to begin with," so there is "little difference that is noticeable."

You do notice that Mrs. M seems to be exhibiting some guarding behavior when she moves, and she appears to be uncomfortable. When you inquire, you learn that she has severe spinal stenosis and usually uses a "narcotic pain patch" almost daily for pain, which she has not been able to use for the past 24 hours because of the surgery. She indicates her pain is a 6 to 7 on a scale of 1 to 10, with 10 being the most excruciating pain possible. She also notes that she has been lying on the stretcher now for almost two hours, and that she normally tries to move around during the morning to "loosen up," which she finds helps ease her pain. Although you are unable to medicate her, and she is about to go to surgery, you help her change her position and apply some heat to the area of discomfort, which she notes is something she also does to help when she is at home.

You amend the nursing record to indicate two diagnoses: *fear* and *chronic pain* (00133).

When you mention your difference in assessment to your colleague the next day, she responds, “I pick *knowledge deficit* for every patient—everyone can learn something. And she was having a mastectomy, so obviously she is going to have body image issues.”

Clearly, this is faulty thinking, and had your colleague validated the diagnoses by reviewing the definitions, defining characteristics, and related factors—and by speaking with the patient, it would have been obvious that these were not relevant nursing diagnoses.

Focusing on your colleague's “typical diagnoses” for mastectomy patients, *deficient knowledge* and *disturbed body image*, was not appropriate for Mrs. M, as she clearly understood her disease, its treatment options, and possible consequences. Further, she exhibited no concerns with body image and had made her own decision regarding reconstructive surgery. Focusing on these “standard” diagnoses, for which there was no assessment support noted, wastes the nurse's time and leads to provision of unnecessary care, while at the same time limiting time spent on care that could impact the patient's outcomes. Likewise, your colleague failed to conduct a complete assessment that would have led to the important diagnosis of *chronic pain*. This error in clinical reasoning delayed the initiation of nonpharmacological interventions that could have made her time in your unit more comfortable.

How do I write a care plan including a nursing diagnosis for patients with a specific medical condition/diagnosis, e.g., congestive heart failure or knee replacement?

Nursing diagnoses are individual (family, group, or community) responses to health problems or life processes. This means one cannot standardize nursing diagnoses based on medical diagnoses or procedures. Although many patients with congestive heart failure may exhibit nursing diagnoses such as *activity intolerance* (00092) or *decreased cardiac output* (00029), others may not have these responses or may only be at risk for them at this point in their trajectory. Patients who are about to undergo a knee replacement may suffer from *acute pain* (00132), *chronic pain* (00133), *risk for falls* (00155), and/or *impaired walking* (00088); others might respond with *anxiety* (00146) or *fatigue* (00093). Without a nursing assessment, it is simply impossible to determine the correct diagnosis, and thus doing so does not contribute to safe, quality patient care.

The care plan for each individual patient is based on assessment data. The assessment data and patient preferences guide the nurse in prioritizing nursing diagnoses and interventions—the medical diagnosis is only one piece of assessment data and therefore cannot be used as the only determining factor for selecting a nursing diagnosis. A thinking tool used by our colleagues in medicine can be useful as you determine your diagnoses: it uses the acronym SEA TOW (Rencic 2011, ▶ Fig. 6.5).

It is always a good idea to ask a colleague, or an expert, for a second opinion if you are unsure of the diagnosis. Is the diagnosis you are considering the result of a “eureka” moment? Did you recognize a pattern in the data from your assessment and patient interview? Can you confirm this pattern by reviewing the diagnostic indicators? Did you collect data that seem to oppose this diagnosis? Can you justify the diagnosis even with the data, or do the data suggest you need to look deeper? Think about your thinking—was it logical, reasoned, built on your knowledge of nursing science and the human response that you are diagnosing? Do you need additional information about the response before you are ready to confirm it? Are you overconfident? This can happen when you are accustomed to patients presenting with particular diagnoses, and so you “jump” to a diagnosis, rather than truly applying clinical reasoning skills. Finally, what other data might you need to collect or review in order to validate, confirm, or rule out a potential nursing diagnosis? Use of the SEA TOW acronym can help you validate your clinical reasoning process and increase the likelihood of accurate diagnosis.

How many diagnoses should my patient have?

Students are often encouraged to identify every diagnosis that a patient has—this is a learning method to improve clinical reasoning and mastery of nursing science. However, in practice, it is important to prioritize nursing diagnoses, as these should form the basis for nursing interventions. You should consider which diagnoses are the most critical—from the patient's perspective as well as from a nursing perspective—and the resources and time available for treatment. Other diagnoses may require referral to other health care providers or settings, e.g., home health care, a different hospital unit, skilled nursing facility, etc. In a practical sense, having one diagnosis per NANDA-I domain, or a minimum of 5 or 10 diagnoses, does not reflect reality. Although it is important to identify all diagnoses (problem-focused, risk, and health promotion), nurses must focus on high-priority, high-risk diagnoses first; other diagnoses may be added later (moved up on the priority list) to replace those that are resolved or for which interventions are clearly being effective. Also, if the patient's condition

deteriorates or additional data are identified that leads to a more urgent diagnosis, prioritization of the diagnoses must be readdressed. Planning care for patients is not a “one time thing”—as with all facets of the nursing process, it needs to be constantly reevaluated and adjusted to meet the needs of the patient and his family.

Can I change a nursing diagnosis after it has been documented in a patient record?

Absolutely! As you continue to assess your patient and collect additional data, you may find that your initial diagnosis was not the most critical—or your patient's condition may have resolved, or new data become available that refocus the priority. It is very important to continually evaluate your patient to determine if the diagnosis is still the most accurate for the patient at any particular point in time.

Can I document nursing diagnoses of family members of a patient in the patient chart?

Documentation rules vary by organization and particular state and country requirements. However, the concept of family-based care is becoming quite standard, and certainly diagnoses that impact the patient, and which can contribute to patient outcomes, should be considered by nurses. For example, if a patient is admitted for exacerbation of a chronic condition, and the nurse recognizes that the spouse is exhibiting signs/symptoms of *caregiver role strain* (00061), it is critical that she confirms or refutes this diagnosis. Taking advantage of the patient's hospitalization, the nurse can work with the spouse to mobilize resources for caregiving at home, such as to identify sources of support for stress management, respite, and financial concerns. A review of the therapeutic regimen, along with recommendations to simplify or organize care, may be very helpful. Diagnosis and treatment of the spouse's *caregiver role strain* will not only impact the caregiver, but also have significant impact on the patient's outcomes when he/she returns home.

Can all nursing diagnoses be used safely and legally in every country?

The NANDA-I classification represents international nursing practice; therefore, all diagnoses will not be appropriate for every nurse in the world. Please see *International Considerations on the Use of the NANDA-I Nursing Diagnoses* (p.25).

9.6 Questions about Defining Characteristics

What are defining characteristics?

Defining characteristics are observable cues/inferences that cluster as manifestations of a problem-focused or health-promotion diagnosis or syndrome. This implies not only things that the nurse can see, but also things that are seen, heard (e.g., the patient/family tells us), touched, or smelled.

This book is using the terms “associated conditions” and “at-risk populations” with many of the diagnoses. These are not conditions which we, as nurses, can independently impact. How can we use them in assessment?

The intent behind these new categories is to provide information to the professional nurse to support her diagnosis and also to clearly identify those assessment data that she can and cannot directly influence. By separating out these indicators, it allows the nurse to more quickly recognize related factors at which to aim her interventions, or defining characteristics which might require symptom control. These new categories of data are another way of providing decision support to nurses at the point of care.

Are the defining characteristics in the book arranged in order of importance?

No! The defining characteristics (and related/risk factors) are listed in alphabetical order, based on the original English language version. Ultimately, the goal is to identify critical defining characteristics—those that must be present for the diagnosis to be made. As that occurs, we will reorganize the diagnostic indicators into order of importance.

How many defining characteristics do I need to identify to diagnose a patient with a particular nursing diagnosis?

That is a difficult question, and it really depends on the diagnosis. For some diagnoses, one defining characteristic is all that is necessary—for example, with the health promotion diagnoses, a patient's expressed desire to enhance some facet of a human response is all that is required. Other diagnoses require a cluster of symptoms, probably three or four, to have accuracy in diagnosis. In the future, we would like to be able to limit the number of diagnostic indicators provided within NANDA-I, because long lists of signs/symptoms are not necessarily clinically useful. As more research is conducted on nursing concepts,

this work will be facilitated.

9.7 Questions about Related Factors

How many related factors do I need to identify to diagnose a patient with a particular nursing diagnosis?

As with the defining characteristics, this really depends on the diagnosis. One factor is probably not adequate, and this is especially true if you are using a medical diagnosis alone as a related factor. As we saw earlier in the case of Mrs. M, this would mean that every patient admitted for a mastectomy gets “labelled” with *disturbed body image* (00118), or every patient with a surgical procedure gets “labelled” with *acute pain* (00132). This practice is not a diagnostic practice; it truly is labelling a patient based on an assumption that one person's response will be exactly the same as another's. This is an erroneous assumption at best, and can risk misdiagnosis and lead to nurses spending time on unnecessary interventions. In the worst case scenario, it can lead to an error of omission in which a significant diagnosis goes unnoticed, and leads to significant problems with patient care and quality outcomes.

Related factors within NANDA-I diagnoses are not always factors that a nurse can eliminate or decrease. Should I include them in a diagnosis statement?

After separating out related factors from the previous edition of the terminology into the categories at-risk populations and associated conditions, there are many diagnoses with few or no related factors that are modifiable by the nurse. Therefore, during this next cycle, we will be focusing on developing more clinically useful related factors on which you could intervene and for which intervention could lead to a decrease in or cessation of the unfavorable human response you have diagnosed.

9.8 Questions about Risk Factors

How many risk factors do I need to identify to diagnose a patient with a particular risk nursing diagnosis?

As with the defining characteristics and related factors, this really depends on the diagnosis. For example, in the new diagnosis *risk for pressure ulcer*, having a

Braden Q score of ≤ 16 in a child, or a Braden scale score of ≤ 18 in an adult, or a low score on the Risk Assessment Pressure Sore (RAPS) scale might be all that is needed to diagnosis this risk. That is because these standardized tools have been clinically validated as predictors of risk for pressure ulcer. For other diagnoses that do not yet have this level of diagnostic indicator validation, a clustering of risk factors is needed, although probably no more than three or four.

Is there a relationship between related factors and risk factors, such as with diagnoses that have a problem-based and/or health promotion diagnosis, and a risk diagnosis?

Yes! You should notice strong similarities between the related factors for a problem-focused diagnosis and the risk factors of a risk diagnosis related to the same concept. Indeed, the lists of factors could be identical. The same condition that puts you at risk for an undesirable response would most often be an etiology of that response if it were to occur. For example, in the diagnosis *risk for disorganized infant behavior* (00115), environmental overstimulation is noted as a risk factor. In the problem-focused diagnosis *disorganized infant behavior* (00116), environmental sensory overstimulation is noted as a related factor. In both cases, this is something for which many nursing interventions are available which can decrease the unfavorable response or modify its risk of occurrence.

9.9 Differentiating between Similar Nursing Diagnoses

How can I decide between diagnoses that are very similar—how do I know which one is the most accurate diagnosis?

Accuracy in diagnosis is critical! Avoid reaching a conclusion too quickly, and use some easy tools to reflect on your decision-making process. SNAPPS (Rencic, 2011), a diagnostic aid that is used in medicine for differentiation between diagnoses, can be easily adapted for nursing. Using this tool, you summarize the data you collected in your interview and assessment, as well as any other relevant data from the patient record. You then seek to narrow the differential between the diagnoses—eliminate the data that fit for both diagnoses, so you are left with only data that differ. Analyze the data—is a pattern more evident now that you are looking at a narrower cluster of data? Probe a colleague, professor, or expert when you have doubts or unanswered

questions—do not ask for the answer; ask them to walk through their thinking with you to help you determine the more appropriate diagnosis. Plan a management strategy, which should include frequent reassessment, especially at the beginning of the plan, to ensure that your diagnosis truly was accurate. Finally, select case-related issues for further investigation and study. Find an article, a case study in a journal, or information from a recent text that can deepen your understanding of the human response you have just diagnosed (▸ Fig. 9.1).

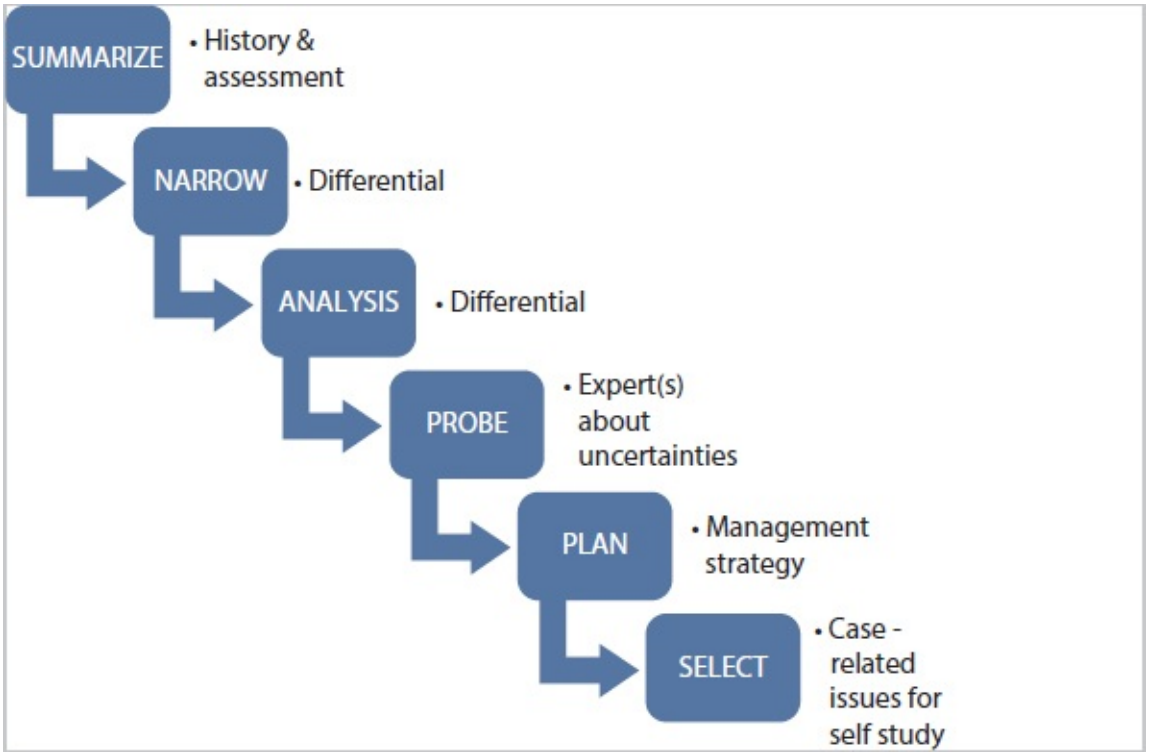

Fig. 9.1 The SNAPPS diagnostic aid (Rencic, 2011)

Can I add “risk for” to a problem-focused diagnosis to make it a risk diagnosis? Or remove “risk for” from a risk diagnosis to make it a problem-focused diagnosis?

Simply put, the answer to this question is “no.” In fact, to randomly “make up” a label is meaningless and, we believe, could be dangerous. Why? Ask yourself these questions: How is the diagnosis defined? What are the risk factors (for risk diagnoses) or the defining characteristics/related factors (for problem-focused diagnoses) that should be identified during your nursing assessment? How would other people know what you mean if the diagnosis is not clearly defined or provided in a resource format (text, computer system) to review and to enable validation of the diagnosis?

If you identify a patient who you feel might be at risk for something, for which there is not a nursing diagnosis, it is better to document very clearly what it is that you are seeing in your patient and why you feel he/she is at risk, so that others can easily follow your clinical reasoning. This is critical for patient safety.

When considering whether a risk diagnosis should be modified to create an actual diagnosis, the question should be asked: “Is this already identified as a medical diagnosis?” If so, there is no reason to rename it as a nursing diagnosis, unless there is a distinctive view that nursing would bring to that phenomena, which would be different from that of medicine. For example, “anxiety” is a nursing/medical/psychiatric diagnosis—and all disciplines may approach it differently, from their disciplinary perspectives. On the other hand, when considering a diagnosis such as “pneumonia” (infection), what viewpoint would the nurse bring that would differ from that of medicine? To date, we have not identified that there would be a difference in treatment among disciplines, so it is a medical diagnosis for which nurses utilize nursing interventions. Perfectly acceptable!

Finally, if you have identified a human response that you believe should be identified as a nursing diagnosis, check out our information on diagnosis development, review the literature, or work with experts to develop it, and submit it to NANDA-I. It is generally nurses in practice who identify diagnoses that we need, which allows the terminology to grow or to be refined and to better reflect the reality of practice.

9.10 Questions Regarding the Development of a Treatment Plan

How do I find interventions to be used with nursing diagnoses?

Interventions should be directed at the related or etiologic factors whenever possible. Sometimes, however, that is not possible and so interventions are chosen to control symptoms (defining characteristics). Take a look at two different situations using the same diagnosis:

- *Acute pain* (*related factors*: inappropriate lifting technique and body posture; *defining characteristics*: report of sharp back pain, guarding behavior, and positioning to avoid pain).
- *Acute pain* (*related factors*: surgical procedures; *defining characteristics*: verbal report of sharp incisional pain, guarding behavior, and positioning to avoid pain).

In the first example, the nurse can aim interventions at the symptoms (providing pain relief interventions) but also at the etiology (providing education on proper lifting techniques, proper body mechanics, and exercises to strengthen the core muscles and back muscles).

In the second example, the nurse cannot intervene to remove the causative factor (the surgical procedure), so her interventions are all aimed at symptom control (providing pain relief interventions).

Choosing interventions for a specific patient is also influenced by the severity and duration of the nursing diagnosis, effectiveness of interventions, patient preferences, organizational guidelines, and ability to perform the intervention (e.g., is the intervention realistic?).

When does a nursing care plan need revision?

There is not a clear-cut standard for the frequency for revision—it depends on the patient's condition, the severity and complexity of care, and organizational standards. In general, a minimum guideline would be once every 24 hours—but in intensive care environments or with complex patient conditions, it is often done one or more times per shift.

What does it mean to "revise" the care plan? This requires a reassessment of the patient's current conditions to identify current human responses that require nursing intervention—and that means reviewing those conditions that were previously identified to determine the following:

- Are they still present?
- Are they still high priority?
- Are they improving, staying the same, or worsening?
- Are the current interventions being effective?
- *And*, perhaps most importantly, did you identify the correct response to treat (did you diagnose accurately)?

These questions require ongoing reassessment of the patient. When intervention is not being successful in reaching determined patient outcomes, continuing the same intervention may not be the best policy! Is it possible that there is something else going on that was not noted previously? What other data might you need to collect to identify other issues? Is the patient in agreement with you about prioritization of care? Are there other interventions that might be more effective? All of this is involved in reviewing and revising the plan of care. Remember that the nursing care plan is a computerized (or written) representation of your clinical judgment—it is not something you "do" and then forget about; it should drive every single step you undertake in the patient's care

—every question you ask, every diagnostic test result, every piece of physical exam data add more information to consider when looking at patient responses, which means assessment and evaluation should be occurring every time you look at, talk with, or touch a patient and every time you interact with the patient's family or enter/review data in the patient's record.

Clinical reasoning, diagnosis, and appropriate treatment planning require mindful, reflective practice. It is not a task to check off so you can move on to something else—it is the key component of professional nursing practice.

9.11 Questions about Teaching/Learning Nursing Diagnoses

I never learned about nursing diagnosis while I was in school. What is the best way to study nursing diagnosis?

You are getting a good start by using this book! But first, we really recommend that you spend some time learning/reviewing the concepts that support the diagnoses. Think about how much you know about ventilation, coping, activity tolerance, mobility, feeding patterns, sleep patterns, tissue perfusion, etc. You really need to start with a solid understanding of these "neutral" phenomena; what is *normal*? What would you expect to see in a healthy patient? What physiological/psychological/sociological factors influence these normal patterns? Once you really understand the concepts, then you can move into deviations from the norm—how would you assess for these? What other areas of the person's health might be impacted if a deviation occurred? What kinds of things would put someone at risk for developing an undesired response? What are the strengths that people might draw on to improve this area of their health? What are nurses saying about these phenomena—what research is being done? Are there clinical guidelines for practice? All of these areas of knowledge will contribute to your understanding of nursing diagnosis—after all, nursing diagnoses name the knowledge of the discipline. It simply is not enough to pick up this book, or any other, and start writing down diagnoses that "sound like" they fit your patient, or that have been linked to a medical diagnosis in some standardized way. Once you truly understand the concepts, you will start to see the patterns in your assessment data that will point you to risk states, problem states, and strengths—then you can begin to sharpen your understanding of the diagnoses by reviewing the definitions and diagnostic indicators for the diagnoses that seem to represent the majority of patient responses that you see in

your practice. There are core diagnoses in every area of practice, and those are the ones that you will want to focus on so that you build expertise in them first.

Should I choose one diagnosis from each of the 13 domains and combine those diagnoses at the end of assessment?

Although we know that some professors teach this way, it is not a method that we support. Arbitrarily assigning a set number of diagnoses to consider is not practical and does not necessarily reflect the patient's reality. Also, as noted previously, the domains are not an assessment format. You should complete a nursing assessment, and as you are conducting your assessment, you may begin to hypothesize about potential diagnoses. That in turn should lead you to more focused assessment to either rule out or confirm those hypotheses. Assessment is a fluid process—one piece of data may lead you back to previously obtained data, or it may require further in-depth assessment to collect additional information. We recommend the use of an assessment based on a nursing model, such as Gordon's functional health patterns. Although the taxonomy is currently adapted from these patterns, the assessment framework provides support for nurses in conducting an interview and patient assessment, allowing (and encouraging!) fluid consideration of how data and information obtained from other patterns interact while assessment is occurring.

My professors do not allow us to use risk diagnoses, because they say we have to focus on the “real” diagnoses. Are patient risk states not “real”?

Absolutely! Risk diagnoses are often the highest priority diagnosis that a patient may have—a patient with a significant vulnerability to infection, falls, a pressure ulcer, or bleeding may have no more critical diagnosis than this risk. The prior use of the term “actual” diagnosis may have led to this confusion—some people interpreted this to mean that the actual (problem-focused) diagnosis was more “real” than the risk. Think about the young woman who has just given birth to a healthy newborn baby—but who developed disseminated intravascular coagulation during this pregnancy and has a history of postpartum hemorrhage. She most likely has no higher priority nursing diagnosis than *risk for bleeding* (00206)! She may have *acute pain* (00132) from her episiotomy, she may have *anxiety* (00146), and she may have *readiness for enhanced breastfeeding* (00106)—but any perinatal nurse will tell you that the number one focus will be the *risk for bleeding*!

Our basic nursing curriculum is already full. When and who

should teach nursing diagnoses?

Nursing, as with other disciplines, is struggling to move from a content-laden educational system to a learner-based, reasoning-focused educational process. For at least the last several decades, the pattern within nursing education has been to try to include more and more information in lectures, readings, and assignments—leading to a pattern of "memorization and regurgitation" of knowledge, often followed by forgetting most of what was "learned" shortly thereafter. It simply does not work! The speed of knowledge development has increased exponentially—we cannot continue to teach every piece of information necessary. Instead, we need to teach core concepts, teach students how to reason, how to discover knowledge and know if it is trustworthy, and to know how to apply it. We have to give them the tools that lead to lifelong learning, and clinical reasoning is probably the most critical of these tools. But critical reasoning requires a field of knowledge—nursing, in this case—and that requires mastery of our disciplinary knowledge, which is represented by nursing diagnoses.

Every nursing professor needs to teach nursing diagnoses—in every course, and as the focus of the course. By teaching the concepts, students will learn about related disciplines, their diagnoses, and standard treatments. They will learn about human responses and how they differ under a variety of situations or by age, gender, culture, etc. Restructuring curricula to truly focus on nursing may sound radical, but it is the only way to solidly provide nursing content to the nurses of our future. Teach the core diagnoses that cross all areas of practice first, then as students gain knowledge, teach the core specialty diagnoses. The remaining diagnoses—those that do not occur often or only occur in very specialized conditions—the students will learn as they practice and as they encounter patients who exhibit these responses.

9.12 Questions about Using NANDA-I in Electronic Health Records

Is there any regulatory mandate that patient problems, interventions, and outcomes included in an electronic health record should be stated using NANDA-I terminology? Why should we need to use NANDA-I nursing diagnoses with an electronic health system?

There is no regulatory mandate; however, NANDA International nursing diagnoses are strongly suggested by standards organizations for inclusion into the EHR. Several international expert papers and studies promote inclusion of the NANDA-I taxonomy into the EHR based on several reasons:

- The safety of patients requires accurate documentation of health problems (e.g., risk states, actual diagnoses, health promotion diagnoses), and NANDA-I is the single classification having a broad literature base (with many diagnoses evidence-based including LOE formats). Most importantly, NANDA-I diagnoses are comprehensive concepts including related factors and defining characteristics. This is a major difference from other nursing terminologies.
- NANDA-I, NIC, and NOC (NNN) not only are the most frequently used classifications internationally; studies have shown these to be the most evidence-based and comprehensive classifications.
- NANDA-I diagnoses are under continual refinement and development. The classification is not a single-author product—it is based on the work of professional nurses around the world, members and nonmembers of NANDA International (Anderson et al 2009; Bernhart-Just et al 2009; Keenan et al 2008; Lunney 2006; Lunney et al 2005; Müller-Staub 2007; Müller-Staub 2009; Müller-Staubet al 2007).

9.13 Questions about Diagnosis Development and Review

Who develops and revises NANDA-I diagnoses?

New and revised diagnoses are submitted to the NANDA-I Diagnosis Development Committee (DDC) by nurses from around the world. Primarily, these nurses come from the areas of practice and education, although we have researchers and theorists who occasionally submit diagnoses, too. The DDC formulates and conducts review processes of proposed diagnoses. The duties of the committee include but are not limited to: the review of newly proposed nursing diagnoses, proposed revisions, or proposed deletions of nursing diagnoses; soliciting and disseminating feedback from experts; implementing processes for review by the membership and voting by the general assembly/membership on diagnoses development matters.

Why are certain diagnoses revised?

Knowledge is constantly evolving within nursing practice, and as research clarifies and refines that knowledge, it is important that the NANDA-I terminology reflects those changes. Nurses in practice, as well as educators and researchers, submit revisions based on their own work or a review of research literature. The purpose is to refine the diagnoses, providing information that enables accuracy in diagnosis.

9.14 Questions about the NANDA-I Definitions and Classification Text

How do I know which diagnoses are new?

The new and revised diagnoses are highlighted in the section of this text entitled Changes and Revisions (p.4).

When I reviewed the informatics codes provided in the book, I noticed that there were some codes missing—does that mean that there are missing diagnoses?

No, the missing codes represent codes that were not assigned, or diagnoses that have been retired, or removed, from the taxonomy over time. Codes are not reused, but rather are retired along with the diagnosis. Likewise, unassigned codes are never assigned later, out of sequence, but simply remain permanently unassigned.

When a diagnosis is revised, how do we know what was changed? I noticed changes to some diagnoses, but they are not listed as revisions—why?

The section *Changes and Revisions* (p.4) provides detailed information on changes made in this edition. However, the best way to see each individual change is to compare the current edition with the previous one. We do not list all of the edits made as we standardized terms for the diagnostic indicators, however, nor were these changes considered as revisions. There was an emphasis during the last two cycles to continue previous work of refining and standardizing terms of the defining characteristics, related factors, and risk factors. In addition, many of the current diagnostic indicators were assigned to at-risk populations and associated conditions. This is a work in progress, and it requires slow and meticulous work to ensure that changes do not impact the intended meaning of the terms.

Why do not all of the diagnoses show a level of evidence (LOE)?

NANDA International did not begin using LOE criteria until 2002. Therefore, diagnoses that were entered into the taxonomy prior to that time do not show LOE criteria because none was identified when the diagnoses were submitted. All diagnoses that existed in the taxonomy in 2002 were "grandfathered" into the taxonomy, with those clearly not meeting criteria (e.g., no identified related factors, multiple diagnostic foci in the label, etc.) targeted for revision or removal over the next few editions. The last of these diagnoses are slotted for removal in the next edition. We strongly encourage work on the older diagnoses to bring them up to an LOE consistent with a minimum of 2.1 for maintenance in the taxonomic structure.

What happened to the references? Why does not NANDA-I print all of the references used for all of the diagnoses?

NANDA-I began publishing references by asking submitters to identify their three most important references. In the 2009–2011 edition, we began to publish the full list of references, due to the large number of requests received from individuals regarding the literature reviewed for different diagnoses. We have now heard from many individuals that they would prefer to have access to the references online, rather than in the book. There have also been concerns raised about the environmental impact of a larger book, and recommendations to publish information specific to researchers and informaticists electronically, for those who want to access this information. After discussion, we determined that this course of action would be the best one for the purposes of this text. Therefore, all references that we have for all diagnoses will be located on the companion websites for this text (**www.thieme.com/nanda-i** and **http://MediaCenter.thieme.com**) to enable ease of searching for and retrieving this information.

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10 Glossary of Terms

10.1 Nursing Diagnosis

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

10.1.1 Problem-Focused Nursing Diagnosis

A clinical judgment concerning an undesirable human response to health conditions/life processes that exists in an individual, family, group, or community.

To make a problem-focused diagnosis, the following must be present: defining characteristics (manifestations, signs, and symptoms) that cluster in patterns of related cues or inferences. Related factors (etiological factors) that are related to, contribute to, or antecedent to the diagnostic focus are also required.

10.1.2 Health Promotion Nursing Diagnosis

A clinical judgment concerning motivation and desire to increase well-being and to actualize health potential.

These responses are expressed by a readiness to enhance specific health behaviors, and can be used in any health state. In individuals who are unable to express their own readiness to enhance health behaviors, the nurse may determine a condition for health promotion exists and act on the client's behalf. Health promotion responses may exist in an individual, family, group, or community.

10.1.3 Risk Nursing Diagnosis

A clinical judgment concerning the susceptibility of an individual, family, group, or community for developing an undesirable human response to

health conditions/life processes.

To make a risk-focused diagnosis, the following must be present: supported by risk factors that contribute to increased susceptibility.

10.1.4 Syndrome

A clinical judgment concerning a specific cluster of nursing diagnoses that occur together, and are best addressed together and through similar interventions.

To use a syndrome diagnosis, the following must be present: two or more nursing diagnoses must be used as defining characteristics. Related factors may be used if they add clarity to the definition, but are not required.

10.2 Diagnostic Axes

10.2.1 Axis

An axis is operationally defined as a dimension of the human response that is considered in the diagnostic process. There are seven axes that parallel the International Standards Reference Model for a Nursing Diagnosis.

– Axis 1: the focus of the diagnosis
– Axis 2: subject of the diagnosis (individual, family, group, caregiver, community)
– Axis 3: judgment (impaired, ineffective, etc.)
– Axis 4: location (bladder, auditory, cerebral, etc.)
– Axis 5: age (neonate, infant, child, adult, etc.)
– Axis 6: time (chronic, acute, intermittent)
– Axis 7: status of the diagnosis (problem-focused, risk, health promotion)

The axes are represented in the labels of the nursing diagnoses through their values. In some cases, they are named explicitly, such as with the diagnoses *ineffective community coping* and *compromised family coping*, in which the subject of the diagnosis (in the first instance “community” and in the second instance “family”) is named using the two values “community” and “family” taken from Axis 2 (subject of the diagnosis). “Ineffective” and “compromised” are two of the values contained in Axis 3 (judgment).

In some cases, the axis is implicit, as is the case with the diagnosis *activity intolerance*, in which the subject of the diagnosis (Axis 2) is always the patient. In some instances, an axis may not be pertinent to a particular diagnosis and

therefore is not part of the nursing diagnostic label. For example, the time axis may not be relevant to every diagnosis. In the case of diagnoses without explicit identification of the subject of the diagnosis, it may be helpful to remember that NANDA-I defines patient as “an individual, family, group, or community.”

Axis 1 (the focus of the diagnosis) and Axis 3 (judgment) are essential components of a nursing diagnosis. In some cases, however, the focus of the diagnosis contains the judgment (e.g., nausea); in these cases, the judgment is not explicitly separated out in the diagnostic label. Axis 2 (subject of the diagnosis) is also essential, although, as described above, it may be implied and therefore not included in the label. The DDC requires these axes for submission; the other axes may be used where relevant for clarity.

10.2.2 Definitions of the Axes

Axis 1: The Focus of the Diagnosis

The focus of the diagnosis is the principal element or the fundamental and essential part, the root, of the diagnostic concept. It describes the “human response” that is the core of the diagnosis.

The focus of the diagnosis may consist of one or more nouns. When more than one noun is used (e.g., activity intolerance), each one contributes a unique meaning to the focus of the diagnosis, as if the two were a single noun; the meaning of the combined term, however, is different from when the nouns are stated separately. Frequently, an adjective (spiritual) may be used with a noun (distress) to denote the focus of the diagnosis *spiritual distress* (see ▸ Table 8.1).

Axis 2: Subject of the Diagnosis

The person(s) for whom a nursing diagnosis is determined. The values in Axis 2 that represent the NANDA-I definition of “patient” are the following:

– *Individual*: a single human being distinct from others, a person
– *Caregiver*: a family member or helper who regularly looks after a child or a sick, elderly, or disabled person
– *Family*: two or more people having continuous or sustained relationships, perceiving reciprocal obligations, sensing common meaning, and sharing certain obligations toward others; related by blood and/or choice
– *Group*: a number of people with shared characteristics
– *Community:* a group of people living in the same locale under the same governance; examples include neighborhoods and cities

Axis 3: Judgment

A descriptor or modifier that limits or specifies the meaning of the focus of the diagnosis. The focus of the diagnosis together with the nurse's judgment about it forms the diagnosis. The values in Axis 3 are found in ▸ Table 8.2:

Axis 4: Location

Describes the parts/regions of the body and/or their related functions—all tissues, organs, anatomical sites, or structures. For the locations in Axis 4, see ▸ Table 8.3.

Axis 5: Age

Refers to the age of the person who is the subject of the diagnosis (Axis 2). The values in Axis 5 are noted below, with all definitions except that of older adult being drawn from the World Health Organization (2013):

– *Fetus*: unborn human more than 8 weeks after conception, until birth
– *Neonate*: person < 28 days of age
– *Infant*: person > 28 days and < 1 year of age
– *Child*: person aged 1 to 9 years, inclusive
– *Adolescent*: person aged 10 to 19 years, inclusive
– *Adult*: person older than 19 years of age unless national law defines a person as being an adult at an earlier age
– *Older adult*: person > 65 years of age

Axis 6: Time

Describes the duration of the diagnostic concept (Axis 1). The values in Axis 6 are as follows:

– *Acute*: lasting < 3 months
– *Chronic*: lasting > 3 months
– *Intermittent*: stopping or starting again at intervals, periodic, cyclic
– *Continuous*: uninterrupted, going on without stop

Axis 7: Status of the Diagnosis

Refers to the actuality or potentiality of the problem/syndrome or health promotion opportunity to the categorization of the diagnosis as a health promotion diagnosis. The values in Axis 7 are problem-focused, health promotion, risk.

10.3 Components of a Nursing Diagnosis

10.3.1 Diagnosis Label

Provides a name for a diagnosis that reflects, at a minimum, the focus of the diagnosis (from Axis 1) and the nursing judgment (from Axis 3). It is a concise term or phrase that represents a pattern of related cues. It may include modifiers.

10.3.2 Definition

Provides a clear, precise description; delineates its meaning and helps differentiate it from similar diagnoses.

10.3.3 Defining Characteristics

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 seen, heard (e.g., the patient/family tells us), touched, or smelled.

10.3.4 Risk Factors

Environmental factors and physiological, psychological, genetic, or chemical elements that increase the vulnerability of an individual, family, group, or community to an unhealthy event. Only risk diagnoses have risk factors.

10.3.5 Related Factors

Factors that appear to show some type of patterned relationship with the nursing diagnosis. Such factors may be described as antecedent to, associated with, related to, contributing to, or abetting. Only problem-focused nursing diagnoses and syndromes must have related factors; health promotion diagnoses may have related factors, if they help clarify the diagnosis.

10.3.6 At-Risk Populations

Groups of people who share a characteristic that causes each member to be susceptible to a particular human response. These are characteristics that are not modifiable by the professional nurse.

10.3.7 Associated Conditions

Medical diagnoses, injury procedures, medical devices, or pharmaceutical agents; these conditions are not independently modifiable by the professional nurse.

10.4 Definitions for Classification of Nursing Diagnoses

10.4.1 Classification

The arrangement of related phenomena in taxonomic groups according to their observed similarities; a category into which something is put (English Oxford Living Dictionary On-Line 2017).

10.4.2 Level of Abstraction

Describes the concreteness/abstractness of a concept:

- Very abstract concepts are theoretical, may not be directly measurable, are defined by concrete concepts, are inclusive of concrete concepts, are disassociated from any specific instance, are independent of time and space, have more general descriptors, and may not be clinically useful for planning treatment.
- Concrete concepts are observable and measurable, limited by time and space, constitute a specific category, are more exclusive, name a real thing or class of things, are restricted by nature, and may be clinically useful for planning treatment.

10.4.3 Nomenclature

The devising or choosing of names for things, especially in a science or other discipline (English Oxford Living Dictionary On-Line 2017).

10.4.4 Taxonomy

The branch of science concerned with classification, especially of organisms; systematics (English Oxford Living Dictionary On-Line 2017).

10.5 References

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Part 3
The NANDA International Nursing Diagnoses

Domain 1.
Health promotion

Class 1.	Health awareness
Code	**Diagnosis**
00097	Decreased **diversional activity engagement**
00262	Readiness for enhanced **health literacy**
00168	Sedentary **lifestyle**

Class 2.	Health management
Code	**Diagnosis**
00257	**Frail elderly syndrome**
00231	Risk for **frail elderly syndrome**
00215	Deficient community **health**
00188	Risk-prone **health behavior**
00099	Ineffective **health maintenance**
00078	Ineffective **health management**
00162	Readiness for enhanced **health management**
00080	Ineffective family **health management**
00043	Ineffective **protection**

NANDA International, Inc. Nursing Diagnoses: Definitions and Classification 2018–2020, 11th Edition.
Edited by T. Heather Herdman and Shigemi Kamitsuru.

Companion website: **www.thieme.com/nanda-i**.

Domain 1 • Class 1 • Diagnosis Code 00097

Decreased diversional activity engagement

Approved 1980 • Revised 2017 • Level of Evidence 2.1

Definition

Reduced stimulation, interest, or participation in recreational or leisure activities.

Defining characteristics

- Alteration in mood
- Boredom
- Discontent with situation
  - Flat affect
  - Frequent naps
  - Physical deconditioning

Related factors

- Current setting does not allow engagement in activity
- Impaired mobility
- Environmental barrier
- Insufficient energy
  - Insufficient motivation
  - Physical discomfort
  - Insufficient diversional activity

At risk population

- Extremes of age
- Prolonged hospitalization
  - Prolonged institutionalization

Associated condition

- Prescribed immobility
- Psychological distress
  - Therapeutic isolation

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 1 • Class 1 • Diagnosis Code 00262

Readiness for enhanced health literacy

Approved 2016 • Level of Evidence 2.1

Definition

A pattern of using and developing a set of skills and competencies (literacy, knowledge, motivation, culture and language) to find, comprehend, evaluate and use health information and concepts to make daily health decisions to promote and maintain health, decrease health risks and improve overall quality of life, which can be strengthened.

Defining characteristics

- Expresses desire to enhance ability to read, write, speak and interpret numbers for everyday health needs
- Expresses desire to enhance awareness of civic and/or government processes that impact public health
- Expresses desire to enhance health communication with healthcare providers
- Expresses desire to enhance knowledge of current determinants of health on social and physical environments
  - Expresses desire to enhance personal healthcare decision-making
  - Expresses desire to enhance social support for health
  - Expresses desire to enhance understanding of customs and beliefs to make healthcare decisions
  - Expresses desire to enhance understanding of health information to make healthcare choices
  - Expresses desire to obtain sufficient information to navigate the healthcare system

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 1 • Class 1 • Diagnosis Code 00168

Sedentary lifestyle

Approved 2004 • Level of Evidence 2.1

Definition

A habit of life that is characterized by a low physical activity level.

Defining characteristics

- Average daily physical activity is less than recommended for gender and age
- Physical deconditioning
  - Preference for activity low in physical activity

Related factors

- Insufficient interest in physical activity
- Insufficient knowledge of health benefits associated with physical exercise
  - Insufficient motivation for physical activity
  - Insufficient resources for physical activity
  - Insufficient training for physical exercise

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 1 • Class 2 • Diagnosis Code 00257

Frail elderly syndrome

Approved 2013 • Revised 2017 • Level of Evidence 2.1

Definition

Dynamic state of unstable equilibrium that affects the older individual experiencing deterioration in one or more domain of health (physical, functional, psychological, or social) and leads to increased susceptibility to adverse health effects, in particular disability.

Defining characteristics

- Activity intolerance (00092)
- Bathing self-care deficit (00108)
- Decreased cardiac output (00029)
- Dressing self-care deficit (00109)
- Fatigue (00093)
- Feeding self-care deficit (00102)
- Hopelessness (00124)
- Imbalanced nutrition: less than body requirements (00002)
- Impaired memory (00131)
- Impaired physical mobility (00085)
- Impaired walking (00088)
- Social isolation (00053)
- Toileting self-care deficit (00110)

Related factors

- Activity intolerance
- Anxiety
- Average daily physical activity is less than recommended for gender and age
- Decrease in energy
- Decrease in muscle strength
- Depression
- Exhaustion
- Fear of falling
- Immobility
- Impaired balance
- Impaired mobility
- Insufficient social support
- Malnutrition
- Muscle weakness
- Obesity
- Sadness
- Sedentary lifestyle
- Social isolation

At risk population

- Age > 70 years
- Constricted living space
- History of falls
- Living alone

- Economically disadvantaged
- Ethnicity other than Caucasian
- Female gender
– Low educational level
– Prolonged hospitalization
– Social vulnerability

Associated condition

- Alteration in cognitive functioning
- Altered clotting process
- Anorexia
- Chronic illness
- Decrease in serum 25-hydroxyvitamin D concentration
- Endocrine regulatory dysfunction
- Psychiatric disorder
- Sarcopenia
- Sarcopenic obesity
– Sensory deficit
– Suppressed inflammatory response
– Unintentional loss of 25% of body weight over one year
– Unintentional weight loss > 10 pounds (> 4.5 kg) in one year
– Walking 15 feet requires > 6 seconds (4 meters > 5 seconds)

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 1 • Class 2 • Diagnosis Code 00231

Risk for frail elderly syndrome

Approved 2013 • Revised 2017 • Level of Evidence 2.1

Definition

Susceptible to a dynamic state of unstable equilibrium that affects the older individual experiencing deterioration in one or more domain of health (physical, functional, psychological, or social) and leads to increased susceptibility to adverse health effects, in particular disability.

Risk factors

- Activity intolerance
- Anxiety
- Average daily physical activity is less than recommended for gender and age
- Decrease in energy
- Decrease in muscle strength
- Depression
- Exhaustion
- Fear of falling
- Immobility
- Impaired balance
- Impaired mobility
- Insufficient knowledge of modifiable factors
- Insufficient social support
- Malnutrition
- Muscle weakness
- Obesity
- Sadness
- Sedentary lifestyle
- Social isolation

At risk population

- Age > 70 years
- Constricted living space
- Economically disadvantaged
- Ethnicity other than Caucasian
- Female gender
- History of falls
- Living alone
- Low educational level
- Prolonged hospitalization
- Social vulnerability

Associated condition

- Alteration in cognitive functioning
- Altered clotting process
- Anorexia
- Sarcopenic obesity
- Sensory deficit
- Suppressed inflammatory response

- Chronic illness
- Decrease in serum 25-hydroxyvitamin D concentration
- Endocrine regulatory dysfunction
- Psychiatric disorder
- Sarcopenia

– Unintentional loss of 25% of body weight over one year
– Unintentional weight loss > 10 pounds (> 4.5 kg) in one year
– Walking 15 feet requires > 6 seconds (4 meters > 5 seconds)

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 1 • Class 2 • Diagnosis Code 00215

Deficient community health

Approved 2010 • Level of Evidence 2.1

Definition

Presence of one or more health problems or factors that deter wellness or increase the risk of health problems experienced by an aggregate.

Defining characteristics

- Health problem experienced by groups or populations
- Program unavailable to eliminate health problem(s) of a group or population
- Program unavailable to enhance wellness of a group or population
- Program unavailable to prevent health problem(s) of a group or population
- Program unavailable to reduce health problem(s) of a group or population
- Risk of hospitalization experienced by groups or populations
- Risk of physiological states experienced by groups or populations
- Risk of psychological states experienced by groups or populations

Related factors

- Inadequate consumer satisfaction with program
- Inadequate program budget
- Inadequate program evaluation plan
- Inadequate program outcome data
- Inadequate social support for program
- Insufficient access to healthcare provider
- Insufficient community experts
- Insufficient resources
- Program incompletely addresses health problem

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 1 • Class 2 • Diagnosis Code 00188

Risk-prone health behavior

Approved 1986 • Revised 1998, 2006, 2008, 2017 • Level of Evidence 2.1

Definition

Impaired ability to modify lifestyle and/or actions in a manner that improves the level of wellness.

Defining characteristics

- Failure to achieve optimal sense of control
- Failure to take action that prevents health problem
- Minimizes health status change
  - Nonacceptance of health status change
  - Smoking
  - Substance misuse

Related factors

- Inadequate comprehension
- Insufficient social support
- Low self-efficacy
- Negative perception of health care provider
  - Negative perception of recommended health care strategy
  - Social anxiety
  - Stressors

At risk population

- Family history of alcoholism
  - Economically disadvantaged

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 1 • Class 2 • Diagnosis Code 00099

Ineffective health maintenance

Approved 1982 • Revised 2017

Definition

Inability to identify, manage, and/or seek out help to maintain well-being.

Defining characteristics

- Absence of adaptive behaviors to environmental changes
- Absence of interest in improving health behaviors
- Inability to take responsibility for meeting basic health practices
- Insufficient knowledge about basic health practices
- Insufficient social support
- Pattern of lack of health-seeking behavior

Related factors

- Complicated grieving
- Impaired decision-making
- Ineffective communication skills
- Ineffective coping strategies
- Insufficient resources
- Spiritual distress

At risk population

- Developmental delay

Associated condition

- Alteration in cognitive functioning
- Decrease in fine motor skills
- Decrease in gross motor skills
- Perceptual disorders

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 1 • Class 2 • Diagnosis Code 00078

Ineffective health management

Approved 1994 • Revised 2008, 2017 • Level of Evidence 2.1

Definition

Pattern of regulating and integrating into daily living a therapeutic regimen for the treatment of illness and its sequelae that is unsatisfactory for meeting specific health goals.

Defining characteristics

- Difficulty with prescribed regimen
- Failure to include treatment regimen in daily living
- Failure to take action to reduce risk factor
- Ineffective choices in daily living for meeting health goal

Related factors

- Decisional conflict
- Difficulty managing complex treatment regimen
- Difficulty navigating complex healthcare systems
- Excessive demands
- Family conflict
- Family pattern of healthcare
- Inadequate number of cues to action
- Insufficient knowledge of therapeutic regimen
- Insufficient social support
- Perceived barrier
- Perceived benefit
- Perceived seriousness of condition
- Perceived susceptibility
- Powerlessness

At risk population

- Economically disadvantaged

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 1 • Class 2 • Diagnosis Code 00162

Readiness for enhanced health management

Approved 2002 • Revised 2010, 2013 • Level of Evidence 2.1

Definition

A pattern of regulating and integrating into daily living a therapeutic regimen for the treatment of illness and its sequelae, which can be strengthened.

Defining characteristics

- Expresses desire to enhance choices of daily living for meeting goals
- Expresses desire to enhance immunization/vaccination status
- Expresses desire to enhance management of illness
– Expresses desire to enhance management of prescribed regimens
– Expresses desire to enhance management of risk factors
– Expresses desire to enhance management of symptoms

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 1 • Class 2 • Diagnosis Code 00080

Ineffective family health management

Approved 1992 • Revised 2013, 2017

Definition

A pattern of regulating and integrating into family processes a program for the treatment of illness and its sequelae that is unsatisfactory for meeting specific health goals of the family unit.

Defining characteristics

- Acceleration of illness symptoms of a family member
- Decrease in attention to illness
- Difficulty with prescribed regimen
- Failure to take action to reduce risk factor
- Inappropriate family activities for meeting health goal

Related factors

- Decisional conflict
- Difficulty managing complex treatment regimen
- Difficulty navigating complex healthcare systems
- Family conflict

At risk population

- Economically disadvantaged

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 1 • Class 2 • Diagnosis Code 00043

Ineffective protection

Approved 1990 • Revised 2017

Definition

Decrease in the ability to guard self from internal or external threats such as illness or injury.

Defining characteristics

- Alteration in clotting
- Alteration in perspiration
- Anorexia
- Chilling
- Coughing
- Deficient immunity
- Disorientation
- Dyspnea
- Fatigue
- Immobility
- Insomnia
- Itching
- Maladaptive stress response
- Neurosensory impairment
- Pressure ulcer
- Restlessness
- Weakness

Related factors

- Inadequate nutrition
- Substance misuse

At risk population

- Extremes of age

Associated condition

- Abnormal blood profile
- Cancer
- Immune disorder
- Pharmaceutical agent
- Treatment regimen

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 2.
Nutrition

Class 1.	Ingestion
Code	**Diagnosis**
00002	Im**balanced nutrition**: less than body requirements
00163	Readiness for enhanced **nutrition**
00216	Insufficient **breast milk production**
00104	Ineffective **breastfeeding**
00105	Interrupted **breastfeeding**
00106	Readiness for enhanced **breastfeeding**
00269	Ineffective adolescent **eating dynamics**
00270	Ineffective child **eating dynamics**
00271	Ineffective infant **feeding dynamics**
00107	Ineffective infant **feeding pattern**
00232	**Obesity**
00233	**Overweight**
00234	Risk for **overweight**
00103	Impaired **swallowing**

Class 2.	Digestion
Code	**Diagnosis**
	This class does not currently contain any diagnoses.

Class 3.	Absorption
Code	**Diagnosis**
	This class does not currently contain any diagnoses.

Class 4.	Metabolism
Code	**Diagnosis**
00179	Risk for unstable **blood glucose level**
00194	Neonatal **hyperbilirubinemia**
00230	Risk for neonatal **hyperbilirubinemia**
00178	Risk for impaired **liver function**
00263	Risk for **metabolic imbalance syndrome**

Class 5.	Hydration
Code	**Diagnosis**
00195	Risk for **electrolyte** im**balance**
00025	Risk for im**balanced fluid volume**
00027	Deficient **fluid volume**
00028	Risk for deficient **fluid volume**
00026	Excess **fluid volume**

NANDA International, Inc. Nursing Diagnoses: Definitions and Classification 2018–2020, 11th Edition. Edited by T. Heather Herdman and Shigemi Kamitsuru.

Domain 2 • Class 1 • Diagnosis Code 00002

Imbalanced nutrition: less than body requirements

Approved 1975 • Revised 2000, 2017

Definition

Intake of nutrients insufficient to meet metabolic needs.

Defining characteristics

- Abdominal cramping
- Abdominal pain
- Alteration in taste sensation
- Body weight 20% or more below ideal weight range
- Capillary fragility
- Diarrhea
- Excessive hair loss
- Food aversion
- Food intake less than recommended daily allowance (RDA)
- Hyperactive bowel sounds
- Insufficient information
- Insufficient interest in food
- Insufficient muscle tone
- Misinformation
- Misperception
- Pale mucous membranes
- Perceived inability to ingest food
- Satiety immediately upon ingesting food
- Sore buccal cavity
- Weakness of muscles required for mastication
- Weakness of muscles required for swallowing
- Weight loss with adequate food intake

Related factors

- Insufficient dietary intake

At risk population

- Biological factors
- Economically disadvantaged

Associated condition

- Inability to absorb nutrients
- Inability to digest food
- Inability to ingest food
- Psychological disorder

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 2 • Class 1 • Diagnosis Code 00163

Readiness for enhanced nutrition

Approved 2002 • Revised 2013 • Level of Evidence 2.1

Definition

A pattern of nutrient intake, which can be strengthened.

Defining characteristics

– Expresses desire to enhance nutrition

Domain 2 • Class 1 • Diagnosis Code 00216

Insufficient breast milk production

Approved 2010 • Revised 2017 • Level of Evidence 3.1

Definition

Inadequate supply of maternal breast milk to support nutritional state of an infant or child.

Defining characteristics

- Absence of milk production with nipple stimulation
- Breast milk expressed is less than prescribed volume for infant
- Delay in milk production
- Infant constipation
- Infant frequently crying
- Infant frequently seeks to suckle at breast
- Infant refuses to suckle at breast
- Infant voids small amounts of concentrated urine
- Infant weight gain < 500 g in a month
- Prolonged breastfeeding time
- Unsustained suckling at breast

Related factors

- Ineffective latching on to breast
- Ineffective sucking reflex
- Insufficient opportunity for suckling at the breast
- Insufficient suckling time at breast
- Maternal alcohol consumption
- Maternal insufficient fluid volume
- Maternal malnutrition
- Maternal smoking
- Maternal treatment regimen
- Rejection of breast

Associated condition

- Pregnancy

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 2 • Class 1 • Diagnosis Code 00104

Ineffective breastfeeding

Approved 1988 • Revised 2010, 2013, 2017 • Level of Evidence 3.1

Definition

Difficulty feeding milk from the breasts, which may compromise nutritional status of the infant/child.

Defining characteristics

- Inadequate infant stooling
- Infant arching at breast
- Infant crying at the breast
- Infant crying within the first hour after breastfeeding
- Infant fussing within one hour of breastfeeding
- Infant inability to latch on to maternal breast correctly
- Infant resisting latching on to breast
- Infant unresponsive to other comfort measures
- Insufficient emptying of each breast per feeding
- Insufficient infant weight gain
- Insufficient signs of oxytocin release
- Perceived inadequate milk supply
- Sore nipples persisting beyond first week
- Sustained infant weight loss
- Unsustained suckling at the breast

Related factors

- Delayed stage II lactogenesis
- Inadequate milk supply
- Insufficient family support
- Insufficient opportunity for suckling at the breast
- Insufficient parental knowledge regarding breastfeeding techniques
- Insufficient parental knowledge regarding importance of breastfeeding
- Interrupted breastfeeding
- Maternal ambivalence
- Maternal anxiety
- Maternal breast anomaly
- Maternal fatigue
- Maternal obesity
- Maternal pain
- Pacifier use
- Poor infant sucking reflex
- Supplemental feedings with artificial nipple

At risk population

- Prematurity
- Previous breast surgery
- Previous history of breastfeeding failure
- Short maternity leave

Associated condition

– Oropharyngeal defect

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 2 • Class 1 • Diagnosis Code 00105

Interrupted breastfeeding

Approved 1992 • Revised 2013, 2017 • Level of Evidence 2.2

Definition

Break in the continuity of feeding milk from the breasts, which may compromise breastfeeding success and/or nutritional status of the infant/child.

Defining characteristics

– Nonexclusive breastfeeding

Related factors

- Maternal employment
- Maternal-infant separation
– Need to abruptly wean infant

At risk population

- Hospitalization of child
– Prematurity

Associated condition

- Contraindications to breastfeeding
- Infant illness
– Maternal illness

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 2 • Class 1 • Diagnosis Code 00106

Readiness for enhanced breastfeeding

Approved 1990 • Revised 2010, 2013, 2017 • Level of Evidence 2.2

Definition

A pattern of feeding milk from the breasts to an infant or child, which may be strengthened.

Defining characteristics

- Mother expresses desire to enhance ability to exclusively breastfeed
- Mother expresses desire to enhance ability to provide breast milk for child's nutritional needs

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 2 • Class 1 • Diagnosis Code 00269

Ineffective adolescent eating dynamics

Approved 2016 • Level of Evidence 2.1

Definition

Altered eating attitudes and behaviors resulting in over or under eating patterns that compromise nutritional health

Defining characteristics

- Avoids participation in regular mealtimes
- Complains of hunger between meals
- Food refusal
- Frequent snacking
- Frequently eating from fast food restaurants
  - Frequently eating poor quality food
  - Frequently eating processed food
  - Overeating
  - Poor appetite
  - Undereating

Related factors

- Altered family dynamics
- Anxiety
- Changes to self-esteem upon entering puberty
- Depression
- Eating disorder
- Eating in isolation
- Excessive family mealtime control
- Excessive stress
- Inadequate choice of food
- Irregular mealtime
  - Media influence on eating behaviors of high caloric unhealthy foods
  - Media influence on knowledge of high caloric unhealthy foods
  - Negative parental influences on eating behaviors
  - Psychological abuse
  - Psychological neglect
  - Stressful mealtimes

Associated condition

- Physical challenge with eating
- Physical challenge with feeding
- Physical health issues of parents
  - Psychological health issues of parents

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 2 • Class 1 • Diagnosis Code 00270

Ineffective child eating dynamics

Approved 2016 • Level of Evidence 2.1

Definition

Altered attitudes, behaviors and influences on child eating patterns resulting in compromised nutritional health

Defining characteristics

- Avoids participation in regular mealtimes
- Complains of hunger between meals
- Food refusal
- Frequent snacking
- Frequently eating from fast food restaurants
– Frequently eating poor quality food
– Frequently eating processed food
– Overeating
– Poor appetite
– Undereating

Related factors

Eating Habit

- Bribing child to eat
- Consumption of large volumes of food in a short period of time
- Disordered eating habits
- Eating in isolation
- Excessive parental control over child's eating experience
- Excessive parental control over family mealtime
- Forcing child to eat
– Inadequate choice of food
– Lack of regular mealtimes
– Limiting child's eating
– Rewarding child to eat
– Stressful mealtimes
– Unpredictable eating patterns
– Unstructured eating of snacks between meals

Family Process

- Abusive relationship
- Anxious parent-child relationship
- Disengaged parenting style
- Hostile parent-child relationship
– Insecure parent-child relationship
– Over-involved parenting style
– Tense parent-child relationship
– Under-involved parenting style

Parental

- Anorexia
- Depression
- Inability to divide eating responsibility between parent and child
- Inability to divide feeding responsibility between parent and child
- Inability to support healthy eating patterns
  - Ineffective coping strategies
  - Lack of confidence in child to develop healthy eating habits
  - Lack of confidence in child to grow appropriately
  - Substance misuse

Environmental

- Media influence on eating behaviors of high caloric unhealthy foods
  - Media influence on knowledge of high caloric unhealthy foods

At risk population

- Economically disadvantaged
- Homeless
- Involvement with the foster care system
  - Life transition
  - Parental obesity

Associated condition

- Physical challenge with eating
- Physical challenge with feeding
- Physical health issues of parents
  - Psychological health issues of parents

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 2 • Class 1 • Diagnosis Code 00271

Ineffective infant feeding dynamics

Approved 2016 • Level of Evidence 2.1

Definition

Altered parental feeding behaviors resulting in over or under eating patterns

Defining characteristics

- Food refusal
- Inappropriate transition to solid foods
- Overeating
- Poor appetite
- Undereating

Related factors

- Abusive relationship
- Attachment issues
- Disengaged parenting style
- Lack of confidence in child to develop healthy eating habits
- Lack of confidence in child to grow appropriately
- Lack of knowledge of appropriate methods of feeding infant for each stage of development
- Lack of knowledge of infant's developmental stages
- Lack of knowledge of parent's responsibility in infant feeding
- Media influence on feeding infant high caloric, unhealthy foods
- Media influence on knowledge of high caloric, unhealthy foods
- Multiple caregivers
- Over-involved parenting style
- Under-involved parenting style

At risk population

- Abandonment
- Economically disadvantaged
- History of unsafe eating and feeding experiences
- Homeless
- Involvement with the foster care system
- Life transition
- Neonatal intensive care experiences
- Prematurity
- Prolonged hospitalization
- Small for gestational age

Associated condition

- Chromosomal disorders
- Physical challenge with eating

- Cleft lip
- Cleft palate
- Congenital heart disease
- Genetic disorder
- Neural tube defects

– Physical health issues of parents
– Prolonged enteral feedings
– Psychological health issues of parents
– Sensory integration problems

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 2 • Class 1 • Diagnosis Code 00107

Ineffective infant feeding pattern

Approved 1992 • Revised 2006 • Level of Evidence 2.1

Definition

Impaired ability of an infant to suck or coordinate the suck-swallow response resulting in inadequate oral nutrition for metabolic needs.

Defining characteristics

- Inability to coordinate sucking, swallowing, and breathing
- Inability to initiate an effective suck
- Inability to sustain an effective suck

Related factors

- Oral hypersensitivity
- Prolonged nil per os (NPO) status

At risk population

- Prematurity

Associated condition

- Neurological delay
- Neurological impairment
- Oral hypersensitivity

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 2 • Class 1 • Diagnosis Code 00232

Obesity

Approved 2013 • Revised 2017 • Level of Evidence 3.2

Definition

A condition in which an individual accumulates excessive fat for age and gender that exceeds overweight.

Defining characteristics

- ADULT: Body mass index (BMI) > 30 kg/m^2
- CHILD < 2 years: Term not used with children at this age
  - CHILD 2-18 years: Body mass index (BMI) > 95th percentile or 30 kg/m^2 for age and gender

Related factors

- Average daily physical activity is less than recommended for gender and age
- Consumption of sugar-sweetened beverages
- Disordered eating behaviors
- Disordered eating perceptions
- Energy expenditure below energy intake based on standard assessment
- Excessive alcohol consumption
- Fear regarding lack of food supply
- Frequent snacking
  - High frequency of restaurant or fried food
  - Low dietary calcium intake in children
  - Portion sizes larger than recommended
  - Sedentary behavior occurring for ≥ 2 hours/day
  - Shortened sleep time
  - Sleep disorder
  - Solid foods as major food source at < 5 months of age

At risk population

- Economically disadvantaged
- Formula- or mixed-fed infants
- Heritability of interrelated factors
- High disinhibition and restraint eating behavior score
- Maternal diabetes mellitus
- Maternal smoking
- Overweight in infancy
  - Parental obesity
  - Premature pubarche
  - Rapid weight gain during childhood
  - Rapid weight gain during infancy, including the first week, first 4 months, and first year

Associated condition

– Genetic disorder

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 2 • Class 1 • Diagnosis Code 00233

Overweight

Approved 2013 • Revised 2017 • Level of Evidence 3.2

Definition

A condition in which an individual accumulates excessive fat for age and gender.

Defining characteristics

- ADULT: Body mass index (BMI) > 25 kg/m^2
- CHILD < 2 years: Weight-for-length > 95th percentile
– CHILD 2-18 years: Body mass index (BMI) > 85th percentile or 25 kg/m^2 but < 95th percentile or 30 kg/m^2 for age and gender

Related factors

- Average daily physical activity is less than recommended for gender and age
- Consumption of sugar-sweetened beverages
- Disordered eating behaviors
- Disordered eating perceptions
- Energy expenditure below energy intake based on standard assessment
- Excessive alcohol consumption
- Fear regarding lack of food supply
- Frequent snacking
– High frequency of restaurant or fried food
– Insufficient knowledge of modifiable factors
– Low dietary calcium intake in children
– Portion sizes larger than recommended
– Sedentary behavior occurring for > 2 hours/day
– Shortened sleep time
– Sleep disorder
– Solid foods as major food source at < 5 months of age

At risk population

- ADULT: Body mass index (BMI) approaching 25 kg/m^2
- CHILD < 2 years: Weight-for-length approaching 95th percentile
- CHILD 2-18 years: Body mass index (BMI) approaching 85th percentile or 25 kg/m^2
- Children who are crossing body mass index (BMI) percentiles upward
– Children with high body mass index (BMI) percentiles
– Economically disadvantaged
– Formula- or mixed-fed infants
– Heritability of interrelated factors
– High disinhibition and restraint eating behavior score
– Maternal diabetes mellitus

- Premature pubarche
- Rapid weight gain during childhood

– Maternal smoking
– Obesity in childhood
– Parental obesity
– Rapid weight gain during infancy, including the first week, first 4 months, and first year

Associated condition

– Genetic disorder

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 2 • Class 1 • Diagnosis Code 00234

Risk for overweight

Approved 2013 • Revised 2017 • Level of Evidence 3.2

Definition

Susceptible to excessive fat accumulation for age and gender, which may compromise health.

Risk factors

- Average daily physical activity is less than recommended for gender and age
- Consumption of sugar-sweetened beverages
- Disordered eating behaviors
- Disordered eating perceptions
- Energy expenditure below energy intake based on standard assessment
- Excessive alcohol consumption
- Fear regarding lack of food supply
- Frequent snacking
- High frequency of restaurant or fried food
- Insufficient knowledge of modifiable factors
- Low dietary calcium intake in children
- Portion sizes larger than recommended
- Sedentary behavior occurring for > 2 hours/day
- Shortened sleep time
- Sleep disorder
- Solid foods as major food source at < 5 months of age

At risk population

- ADULT: Body mass index (BMI) approaching 25 kg/m^2
- CHILD < 2 years: Weight-for-length approaching 95th percentile
- CHILD 2-18 years: Body mass index (BMI) approaching 85th percentile or 25 kg/m^2
- Children who are crossing body mass index (BMI) percentiles upward
- Children with high body mass index (BMI) percentiles
- Economically disadvantaged
- Formula- or mixed-fed infants
- Heritability of interrelated factors
- High disinhibition and restraint eating behavior score
- Maternal diabetes mellitus
- Maternal smoking
- Obesity in childhood
- Parental obesity
- Premature pubarche
- Rapid weight gain during childhood
- Rapid weight gain during infancy, including the first week, first 4 months, and first year

Associated condition

– Genetic disorder

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 2 • Class 1 • Diagnosis Code 00103

Impaired swallowing

Approved 1986 • Revised 1998, 2017

Definition

Abnormal functioning of the swallowing mechanism associated with deficits in oral, pharyngeal, or esophageal structure or function.

Defining characteristics

First Stage: Oral

- Abnormal oral phase of swallow study
- Choking prior to swallowing
- Coughing prior to swallowing
- Drooling
- Food falls from mouth
- Food pushed out of mouth
- Gagging prior to swallowing
- Inability to clear oral cavity
- Incomplete lip closure
- Inefficient nippling
  - Inefficient suck
  - Insufficient chewing
  - Nasal reflux
  - Piecemeal deglutition
  - Pooling of bolus in lateral sulci
  - Premature entry of bolus
  - Prolonged bolus formation
  - Prolonged meal time with insufficient consumption
  - Tongue action ineffective in forming bolus

Second Stage: Pharyngeal

- Abnormal pharyngeal phase of swallow study
- Alteration in head position
- Choking
- Coughing
- Delayed swallowing
- Fevers of unknown etiology
- Food refusal
  - Gagging sensation
  - Gurgly voice quality
  - Inadequate laryngeal elevation
  - Nasal reflux
  - Recurrent pulmonary infection
  - Repetitive swallowing

Third Stage: Esophageal

- Abnormal esophageal phase of swallow study
- Acidic-smelling breath
- Bruxism
  - Heartburn
  - Hematemesis
  - Hyperextension of head

- Difficulty swallowing
- Epigastric pain
- Food refusal
- Repetitive swallowing
- Reports “something stuck”
- Unexplained irritability surrounding mealtimes
– Nighttime awakening
– Nighttime coughing
– Odynophagia
– Regurgitation
– Volume limiting
– Vomiting
– Vomitus on pillow

Related factors

- Behavioral feeding problem
– Self-injurious behavior

At risk population

- Behavioral feeding problem
- Failure to thrive
- History of enteral feeding
– Self-injurious behavior
– Developmental delay
– Prematurity

Associated condition

- Achalasia
- Acquired anatomic defects
- Brain injury
- Cerebral palsy
- Conditions with significant hypotonia
- Congenital heart disease
- Cranial nerve involvement
- Esophageal reflux disease
- Laryngeal abnormality
- Laryngeal defect
- Mechanical obstruction
– Nasal defect
– Nasopharyngeal cavity defect
– Neurological problems
– Neuromuscular impairment
– Oropharynx abnormality
– Protein-energy malnutrition
– Respiratory condition
– Tracheal defect
– Trauma
– Upper airway anomaly

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 2 • Class 2

This class does not currently contain any diagnoses.

Domain 2 • Class 3

This class does not currently contain any diagnoses.

Domain 2 • Class 4 • Diagnosis Code 00179

Risk for unstable blood glucose level

Approved 2006 • Revised 2013, 2017 • Level of Evidence 2.1

Definition

Susceptible to variation in serum levels of glucose from the normal range, which may compromise health.

Risk factors

- Average daily physical activity is less than recommended for gender and age
- Does not accept diagnosis
- Excessive stress
- Excessive weight gain
- Excessive weight loss
- Inadequate blood glucose monitoring
– Ineffective medication management
– Insufficient diabetes management
– Insufficient dietary intake
– Insufficient knowledge of disease management
– Insufficient knowledge of modifiable factors
– Nonadherence to diabetes management plan

At risk population

- Alteration in mental status
- Compromised physical health status
– Delay in cognitive development
– Rapid growth period

Associated condition

– Pregnancy

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 2 • Class 4 • Diagnosis Code 00194

Neonatal hyperbilirubinemia

Approved 2008 • Revised 2010, 2017 • Level of Evidence 2.1

Definition

The accumulation of unconjugated bilirubin in the circulation (less than 15 ml/dl) that occurs after 24 hours of life.

Defining characteristics

- Abnormal blood profile
- Bruised skin
- Yellow mucous membranes
- Yellow sclera
- Yellow-orange skin color

Related factors

- Deficient feeding pattern
- Delay in meconium passage
- Infants with inadequate nutrition

At risk population

- ABO incompatibility
- Age ≤ 7 days
- American Indian ethnicity
- Blood type incompatibility between mother and infant
- East Asian ethnicity
- Infant who is breastfed
- Infant with low birthweight
- Maternal diabetes mellitus
- Populations living at high altitudes
- Premature infant
- Previous sibling with jaundice
- Rhesus (Rh) incompatibility
- Significant bruising during birth

Associated condition

- Bacterial infection
- Infant with liver malfunction
- Infant with enzyme deficiency
- Internal bleeding
- Prenatal infection
- Sepsis
- Viral infection

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 2 • Class 4 • Diagnosis Code 00230

Risk for neonatal hyperbilirubinemia

Approved 2010 • Revised 2013, 2017 • Level of Evidence 2.1

Definition

Susceptible to the accumulation of unconjugated bilirubin in the circulation (less than 15 ml/dl) that occurs after 24 hours of life which may compromise health.

Risk factors

- Deficient feeding pattern
  - Infants with inadequate nutrition
- Delay in meconium passage

At risk population

- ABO incompatibility
- Age ≤ 7 days
- American Indian ethnicity
- Blood type incompatibility between mother and infant
- East Asian ethnicity
- Infant who is breastfed
- Infant with low birthweight
  - Maternal diabetes mellitus
  - Populations living at high altitudes
  - Premature infant
  - Previous sibling with jaundice
  - Rhesus (Rh) incompatibility
  - Significant bruising during birth

Associated condition

- Bacterial infection
  - Prenatal infection
- Infant with liver malfunction
  - Sepsis
- Infant with enzyme deficiency
  - Viral infection
- Internal bleeding

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 2 • Class 4 • Diagnosis Code 00178

Risk for impaired liver function

Approved 2006 • Revised 2008, 2013, 2017 • Level of Evidence 2.1

Definition

Susceptible to a decrease in liver function, which may compromise health.

Risk factors

– Substance misuse

Associated condition

- Human immunodeficiency virus (HIV) coinfection – Viral infection
- Pharmaceutical agent

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition if no additional risk factors are developed.

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 2 • Class 4 • Diagnosis Code 00263

Risk for metabolic imbalance syndrome

Approved 2016 • Level of Evidence 2.1

Definition

Susceptible to a toxic cluster of biochemical and physiological factors associated with the development of cardiovascular disease arising from obesity and type 2 diabetes, which may compromise health.

Risk factors

- Ineffective health maintenance (00099)
- Obesity (00232)
- Overweight (00233)
  - Risk for unstable blood glucose level (00179)
  - Risk-prone health behavior (00188)
  - Sedentary lifestyle (00168)
  - Stress overload (00177)

At risk population

- Age > 30 years
- Family history of diabetes mellitus
- Family history of dyslipidemia
  - Family history of hypertension
  - Family history of obesity

Associated condition

- Excessive endogenous or exogenous glucocorticoids > 25 g/dl
- Microalbuminuria > 30 mg/dl
- Polycystic ovary syndrome
  - Unstable blood pressure
  - Uric acid > 7 mg/dl

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 2 • Class 5 • Diagnosis Code 00195

Risk for electrolyte imbalance

Approved 2008 • Revised 2013, 2017 • Level of Evidence 2.1

Definition

Susceptible to changes in serum electrolyte levels, which may compromise health.

Risk factors

- Diarrhea
- Excessive fluid volume
- Insufficient fluid volume
– Insufficient knowledge of modifiable factors
– Vomiting

Associated condition

- Compromised regulatory mechanism
- Endocrine regulatory dysfunction
– Renal dysfunction
– Treatment regimen

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 2 • Class 5 • Diagnosis Code 00025

Risk for imbalanced fluid volume

Approved 1998 • Revised 2008, 2013, 2017 • Level of Evidence 2.1

Definition

Susceptible to a decrease, increase, or rapid shift from one to the other of intravascular, interstitial and/or intracellular fluid, which may compromise health. This refers to body fluid loss, gain, or both.

Risk factors

– To be developed

Associated condition

- Apheresis
- Ascites
- Burn injury
- Intestinal obstruction
- Pancreatitis
- Sepsis
- Trauma
- Treatment regimen

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition if no risk factors are developed.

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 2 • Class 5 • Diagnosis Code 00027

Deficient fluid volume

Approved 1978 • Revised 1996, 2017

Definition

Decreased intravascular, interstitial, and/or intracellular fluid. This refers to dehydration, water loss alone without change in sodium.

Defining characteristics

- Alteration in mental status
- Alteration in skin turgor
- Decrease in blood pressure
- Decrease in pulse pressure
- Decrease in pulse volume
- Decrease in tongue turgor
- Decrease in urine output
- Decrease in venous filling
- Dry mucous membranes
- Dry skin
- Increase in body temperature
- Increase in heart rate
- Increase in hematocrit
- Increase in urine concentration
- Sudden weight loss
- Thirst
- Weakness

Related factors

- Barrier to accessing fluid
- Insufficient fluid intake
- Insufficient knowledge about fluid needs

At risk population

- Extremes of age
- Extremes of weight
- Factors influencing fluid needs

Associated condition

- Active fluid volume loss
- Compromised regulatory mechanism
- Deviations affecting fluid absorption
- Deviations affecting fluid intake
- Excessive fluid loss through normal route
- Fluid loss through abnormal route
- Pharmaceutical agent

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 2 • Class 5 • Diagnosis Code 00028

Risk for deficient fluid volume

Approved 1978 • Revised 2010, 2013, 2017

Definition

Susceptible to experiencing decreased intravascular, interstitial, and/or intracellular fluid volumes, which may compromise health.

Risk factors

- Barrier to accessing fluid
- Insufficient fluid intake
– Insufficient knowledge about fluid needs

At risk population

- Extremes of age
- Extremes of weight
– Factors influencing fluid needs

Associated condition

- Active fluid volume loss
- Compromised regulatory mechanism
- Deviations affecting fluid absorption
- Deviations affecting fluid intake
– Excessive fluid loss through normal route
– Fluid loss through abnormal route
– Pharmaceutical agent

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 2 • Class 5 • Diagnosis Code 00026

Excess fluid volume

Approved 1982 • Revised 1996, 2013, 2017 • Level of Evidence 2.1

Definition

Surplus intake and/or retention of fluid.

Defining characteristics

- Adventitious breath sounds
- Alteration in blood pressure
- Alteration in mental status
- Alteration in pulmonary artery pressure (PAP)
- Alteration in respiratory pattern
- Alteration in urine specific gravity
- Anasarca
- Anxiety
- Azotemia
- Decrease in hematocrit
- Decrease in hemoglobin
- Dyspnea
- Edema
- Electrolyte imbalance
- Hepatomegaly
- Increase in central venous pressure (CVP)
- Intake exceeds output
- Jugular vein distension
- Oliguria
- Orthopnea
- Paroxysmal nocturnal dyspnea
- Pleural effusion
- Positive hepatojugular reflex
- Presence of S3 heart sound
- Pulmonary congestion
- Restlessness
- Weight gain over short period of time

Related factors

- Excessive fluid intake
- Excessive sodium intake

Associated condition

- Compromised regulatory mechanism

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 3.
Elimination and exchange

Class 1.	Urinary function
Code	**Diagnosis**
00016	Impaired urinary **elimination**
00020	Functional urinary **incontinence**
00176	Overflow urinary **incontinence**
00018	Reflex urinary **incontinence**
00017	Stress urinary **incontinence**
00019	Urge urinary **incontinence**
00022	Risk for urge urinary **incontinence**
00023	Urinary **retention**

Class 2.	Gastrointestinal function
Code	**Diagnosis**
00011	**Constipation**
00015	Risk for **constipation**
00012	Perceived **constipation**
00235	Chronic **functional constipation**
00236	Risk for chronic **functional constipation**
00013	**Diarrhea**
00196	Dysfunctional **gastrointestinal motility**
00197	Risk for dysfunctional **gastrointestinal motility**
00014	Bowel **incontinence**

Class 3.	Integumentary function
Code	**Diagnosis**

	This class does not currently contain any diagnoses.

Class 4.	**Respiratory function**
Code	**Diagnosis**
00030	Impaired **gas exchange**

NANDA International, Inc. Nursing Diagnoses: Definitions and Classification 2018–2020, 11th Edition. Edited by T. Heather Herdman and Shigemi Kamitsuru.

Domain 3 • Class 1 • Diagnosis Code 00016

Impaired urinary elimination

Approved 1973 • Revised 2006, 2017 • Level of Evidence 2.1

Definition

Dysfunction in urine elimination.

Defining characteristics

- Dysuria
- Frequent voiding
- Hesitancy
- Nocturia
- Urinary incontinence
- Urinary retention
- Urinary urgency

Related factors

- Multiple causality

Associated condition

- Anatomic obstruction
- Sensory motor impairment
- Urinary tract infection

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition if no specific related factors are developed.

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 3 • Class 1 • Diagnosis Code 00020

Functional urinary incontinence

Approved 1986 • Revised 1998, 2017

Definition

Inability of a usually continent person to reach the toilet in time to avoid unintentional loss of urine.

Defining characteristics

- Completely empties bladder
- Early morning urinary incontinence
- Sensation of need to void
  - Time required to reach toilet is too long after sensation of urge
  - Voiding prior to reaching toilet

Related factors

- Alteration in environmental factor
  - Weakened supporting pelvic structure

Associated condition

- Alteration in cognitive functioning
- Impaired vision
  - Neuromuscular impairment
  - Psychological disorder

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 3 • Class 1 • Diagnosis Code 00176

Overflow urinary incontinence

Approved 2006 • Revised 2017 • Level of Evidence 2.1

Definition

Involuntary loss of urine associated with overdistention of the bladder.

Defining characteristics

- Bladder distention
- High post-void residual volume
– Involuntary leakage of small volume of urine
– Nocturia

Related factors

– Fecal impaction

Associated condition

- Bladder outlet obstruction
- Detrusor external sphincter dyssynergia
- Detrusor hypocontractility
– Severe pelvic organ prolapse
– Treatment regimen
– Urethral obstruction

Additional modifiable related factors to be developed.
Original literature support available at **http://MediaCenter.thieme.com**.

Domain 3 • Class 1 • Diagnosis Code 00018

Reflex urinary incontinence

Approved 1986 • Revised 1998, 2017

Definition

Involuntary loss of urine at somewhat predictable intervals when a specific bladder volume is reached.

Defining characteristics

- Absence of voiding sensation
- Absence of urge to void
- Inability to voluntarily inhibit voiding
- Inability to voluntarily initiate voiding
- Incomplete emptying of bladder with lesion above pontine micturition center
- Predictable pattern of voiding
- Sensation of urgency to void without voluntary inhibition of bladder contraction
- Sensations associated with full bladder

Related factors

- To be developed

Associated condition

- Neurological impairment above level of pontine micturition center
- Neurological impairment above level of sacral micturition center
- Tissue damage

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 3 • Class 1 • Diagnosis Code 00017

Stress urinary incontinence

Approved 1986 • Revised 2006, 2017 • Level of Evidence 2.1

Definition

Sudden leakage of urine with activities that increase intra-abdominal pressure.

Defining characteristics

- Involuntary leakage of small volume of urine
- Involuntary leakage of small volume of urine in the absence of detrusor contraction
- Involuntary leakage of small volume of urine in the absence of overdistended bladder

Related factors

- Weak pelvic floor muscles

Associated condition

- Degenerative changes in pelvic floor muscles
- Increase in intra-abdominal pressure
- Intrinsic urethral sphincter deficiency

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 3 • Class 1 • Diagnosis Code 00019

Urge urinary incontinence

Approved 1986 • Revised 2006, 2017 • Level of Evidence 2.1

Definition

Involuntary passage of urine occurring soon after a strong sensation or urgency to void.

Defining characteristics

- Inability to reach toilet in time to avoid urine loss
- Involuntary loss of urine with bladder contractions
– Involuntary loss of urine with bladder spasms
– Urinary urgency

Related factors

- Alcohol consumption
- Caffeine intake
- Fecal impaction
– Ineffective toileting habits
– Involuntary sphincter relaxation

Associated condition

- Atrophic urethritis
- Atrophic vaginitis
- Bladder infection
- Decrease in bladder capacity
– Detrusor hyperactivity with impaired bladder contractility
– Impaired bladder contractility
– Treatment regimen

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 3 • Class 1 • Diagnosis Code 00022

Risk for urge urinary incontinence

Approved 1998 • Revised 2008, 2013, 2017 • Level of Evidence 2.1

Definition

Susceptible to involuntary passage of urine occurring soon after a strong sensation or urgency to void, which may compromise health.

Risk factors

- Alcohol consumption
- Caffeine intake
- Fecal impaction
– Ineffective toileting habits
– Involuntary sphincter relaxation

Associated condition

- Atrophic urethritis
- Atrophic vaginitis
- Bladder infection
- Decrease in bladder capacity
– Detrusor hyperactivity with impaired bladder contractility
– Impaired bladder contractility
– Treatment regimen

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 3 • Class 1 • Diagnosis Code 00023

Urinary retention

Approved 1986 • Revised 2017

Definition

Inability to empty bladder completely.

Defining characteristics

- Absence of urinary output
- Bladder distention
- Dribbling of urine
- Dysuria
- Frequent voiding
- Overflow incontinence
- Residual urine
- Sensation of bladder fullness
- Small voiding

Related factors

- To be developed

Associated condition

- Blockage in urinary tract
- High urethral pressure
- Reflex arc inhibition
- Strong sphincter

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 3 • Class 2 • Diagnosis Code 00011

Constipation

Approved 1975 • Revised 1998, 2017

Definition

Decrease in normal frequency of defecation accompanied by difficult or incomplete passage of stool and/or passage of excessively hard, dry stool.

Defining characteristics

- Abdominal pain
- Abdominal tenderness with palpable muscle resistance
- Abdominal tenderness without palpable muscle resistance
- Anorexia
- Atypical presentations in older adults
- Borborygmi
- Bright red blood with stool
- Change in bowel pattern
- Decrease in stool frequency
- Decrease in stool volume
- Distended abdomen
- Fatigue
- Hard, formed stool
- Headache
- Hyperactive bowel sounds
- Hypoactive bowel sounds
- Inability to defecate
- Increase in intra-abdominal pressure
- Indigestion
- Liquid stool
- Pain with defecation
- Palpable abdominal mass
- Palpable rectal mass
- Percussed abdominal dullness
- Rectal fullness
- Rectal pressure
- Severe flatus
- Soft, paste-like stool in rectum
- Straining with defecation
- Vomiting

Related factors

- Abdominal muscle weakness
- Average daily physical activity is less than recommended for gender and age
- Confusion
- Decrease in gastrointestinal motility
- Dehydration
- Depression
- Eating habit change
- Habitually suppresses urge to defecate
- Inadequate dietary habits
- Inadequate oral hygiene
- Inadequate toileting habits
- Insufficient fiber intake
- Insufficient fluid intake
- Irregular defecation habits
- Laxative abuse

- Emotional disturbance
– Obesity
– Recent environmental change

Associated condition

- Electrolyte imbalance
- Hemorrhoids
- Hirschprung's disease
- Inadequate dentition
- Iron salts
- Neurological impairment
- Postsurgical bowel obstruction
- Pregnancy
– Prostate enlargement
– Rectal abscess
– Rectal anal fissure
– Rectal anal stricture
– Rectal prolapse
– Rectal ulcer
– Rectocele
– Tumor

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 3 • Class 2 • Diagnosis Code 00015

Risk for constipation

Approved 1998 • Revised 2013, 2017

Definition

Susceptible to a decrease in normal frequency of defecation accompanied by difficult or incomplete passage of stool, which may compromise health.

Risk factors

- Abdominal muscle weakness
- Average daily physical activity is less than recommended for gender and age
- Confusion
- Decrease in gastrointestinal motility
- Dehydration
- Depression
- Eating habit change
- Emotional disturbance
- Habitually suppresses urge to defecate
- Inadequate dietary habits
- Inadequate oral hygiene
- Inadequate toileting habits
- Insufficient fiber intake
- Insufficient fluid intake
- Irregular defecation habits
- Laxative abuse
- Obesity
- Recent environmental change

Associated condition

- Electrolyte imbalance
- Hemorrhoids
- Hirschprung's disease
- Inadequate dentition
- Iron salts
- Neurological impairment
- Postsurgical bowel obstruction
- Pregnancy
- Prostate enlargement
- Rectal abscess
- Rectal anal fissure
- Rectal anal stricture
- Rectal prolapse
- Rectal ulcer
- Rectocele
- Tumor

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 3 • Class 2 • Diagnosis Code 00012

Perceived constipation

Approved 1988

Definition

Self-diagnosis of constipation combined with abuse of laxatives, enemas, and/or suppositories to ensure a daily bowel movement.

Defining characteristics

- Enema abuse
- Expects daily bowel movement
- Expects daily bowel movement at same time every day
- Laxative abuse
- Suppository abuse

Related factors

- Cultural health beliefs
- Family health beliefs
- Impaired thought process

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 3 • Class 2 • Diagnosis Code 00235

Chronic functional constipation

Approved 2013 • Revised 2017 • Level of Evidence 2.2

Definition

Infrequent or difficult evacuation of feces, which has been present for at least 3 of the prior 12 months.

Defining characteristics

Adult: Presence of ≥ 2 of the following symptoms on Rome III classification system:

- Lumpy or hard stools in ≥ 25% defecations
- Straining during ≥ 25% of defecations
- Sensation of incomplete evacuation for ≥ 25% of defecations
  - Sensation of anorectal obstruction/blockage for ≥ 25% of defecations
  - Manual maneuvers to facilitate ≥ 25% of defecations (digital manipulation, pelvic floor support)
  - ≤ 3 evacuations per week

Child > 4 years: Presence of ≥ 2 criteria on Rome III Pediatric classification system for ≥ 2 months:

- ≤ 2 defecations per week
- ≥ 1 episode of fecal incontinence per week
- Stool retentive posturing
- Painful or hard bowel movements
  - Presence of large fecal mass in the rectum
  - Large diameter stools that may obstruct the toilet

Child ≤ 4 years: Presence of ≥ 2 criteria on Rome III Pediatric classification system for ≥ 1 month:

- ≤ 2 defecations per week
- ≥ 1 episode of fecal incontinence per week
- Stool retentive posturing
- Painful or hard bowel movements
  - Presence of large fecal mass in the rectum
  - Large diameter stools that may obstruct the toilet

General

- Distended abdomen
- Fecal impaction
- Leakage of stool with digital stimulation
- Pain with defecation
– Palpable abdominal mass
– Positive fecal occult blood test
– Prolonged straining
– Type 1 or 2 on Bristol Stool Chart

Related factors

- Decrease in food intake
- Dehydration
- Depression
- Diet disproportionally high in fat
- Diet disproportionally high in protein
- Frail elderly syndrome
- Habitually suppresses urge to defecate
– Impaired mobility
– Insufficient dietary intake
– Insufficient fluid intake
– Insufficient knowledge of modifiable factors
– Low caloric intake
– Low-fiber diet
– Sedentary lifestyle

Associated condition

- Amyloidosis
- Anal fissure
- Anal stricture
- Autonomic neuropathy
- Cerebral vascular accident
- Chronic intestinal pseudoobstruction
- Chronic renal insufficiency
- Colorectal cancer
- Dementia
- Dermatomyositis
- Diabetes mellitus
- Extra intestinal mass
- Hemorrhoids
- Hirschprung's disease
- Hypercalcemia
- Hypothyroidism
- Inflammatory bowel disease
- Ischemic stenosis
– Multiple sclerosis
– Myotonic dystrophy
– Panhypopituitarism
– Paraplegia
– Parkinson's disease
– Pelvic floor dysfunction
– Perineal damage
– Pharmaceutical agent
– Polypharmacy
– Porphyria
– Postinflammatory stenosis
– Pregnancy
– Proctitis
– Scleroderma
– Slow colon transit time
– Spinal cord injury
– Surgical stenosis

Domain 3 • Class 2 • Diagnosis Code 00236

Risk for chronic functional constipation

Approved 2013 • Revised 2017 • Level of Evidence 2.2

Definition

Susceptible to infrequent or difficult evacuation of feces, which has been present nearly 3 of the prior 12 months, which may compromise health.

Risk factors

- Decrease in food intake
- Dehydration
- Depression
- Diet disproportionally high in fat
- Diet disproportionally high in protein
- Frail elderly syndrome
- Habitually suppresses urge to defecate
– Impaired mobility
– Insufficient dietary intake
– Insufficient fluid intake
– Insufficient knowledge of modifiable factors
– Low caloric intake
– Low-fiber diet
– Sedentary lifestyle

Associated condition

- Amyloidosis
- Anal fissure
- Anal stricture
- Autonomic neuropathy
- Cerebral vascular accident
- Chronic intestinal pseudoobstruction
- Chronic renal insufficiency
- Colorectal cancer
- Dementia
- Dermatomyositis
- Diabetes mellitus
- Extra intestinal mass
- Hemorrhoids
- Hirschprung's disease
- Hypercalcemia
- Hypothyroidism
- Inflammatory bowel disease
- Ischemic stenosis
– Multiple sclerosis
– Myotonic dystrophy
– Panhypopituitarism
– Paraplegia
– Parkinson's disease
– Pelvic floor dysfunction
– Perineal damage
– Pharmaceutical agent
– Polypharmacy
– Porphyria
– Postinflammatory stenosis
– Pregnancy
– Proctitis
– Scleroderma
– Slow colon transit time
– Spinal cord injury
– Surgical stenosis

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 3 • Class 2 • Diagnosis Code 00013

Diarrhea

Approved 1975 • Revised 1998, 2017

Definition

Passage of loose, unformed stools.

Defining characteristics

- Abdominal pain
- Bowel urgency
- Cramping
- Hyperactive bowel sounds
- Loose liquid stools, > 3 in 24 hours

Related factors

- Anxiety
- Increase in stress level
- Laxative abuse
- Substance misuse

At risk population

- Exposure to contaminant
- Exposure to toxin
- Exposure to unsanitary food preparation

Associated condition

- Enteral feedings
- Gastrointestinal inflammation
- Gastrointestinal irritation
- Infection
- Malabsorption
- Parasite
- Treatment regimen

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 3 • Class 2 • Diagnosis Code 00196

Dysfunctional gastrointestinal motility

Approved 2008 • Revised 2017 • Level of Evidence 2.1

Definition

Increased, decreased, ineffective, or lack of peristaltic activity within the gastrointestinal system.

Defining characteristics

- Abdominal cramping
- Abdominal pain
- Absence of flatus
- Acceleration of gastric emptying
- Bile-colored gastric residual
- Change in bowel sounds
- Diarrhea
- Difficulty with defecation
- Distended abdomen
- Hard, formed stool
- Increase in gastric residual
- Nausea
- Regurgitation
- Vomiting

Related factors

- Anxiety
- Change in water source
- Eating habit change
- Immobility
- Malnutrition
- Sedentary lifestyle
- Stressors
- Unsanitary food preparation

At risk population

- Aging
- Ingestion of contaminated material
- Prematurity

Associated condition

- Decrease in gastrointestinal circulation
- Diabetes mellitus
- Enteral feedings
- Food intolerance
- Gastroesophageal reflux disease
- Infection
- Pharmaceutical agent
- Treatment regimen

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 3 • Class 2 • Diagnosis Code 00197

Risk for dysfunctional gastrointestinal motility

Approved 2008 • Revised 2013, 2017 • Level of Evidence 2.1

Definition

Susceptible to increased, decreased, ineffective, or lack of peristaltic activity within the gastrointestinal system, which may compromise health.

Risk factors

- Anxiety
- Change in water source
- Eating habit change
- Immobility
- Malnutrition
- Sedentary lifestyle
- Stressors
- Unsanitary food preparation

At risk population

- Aging
- Ingestion of contaminated material
- Prematurity

Associated condition

- Decrease in gastrointestinal circulation
- Diabetes mellitus
- Enteral feedings
- Food intolerance
- Gastroesophageal reflux disease
- Infection
- Pharmaceutical agent
- Treatment regimen

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 3 • Class 2 • Diagnosis Code 00014

Bowel incontinence

Approved 1975 • Revised 1998, 2017

Definition

Involuntary passage of stool.

Defining characteristics

- Bowel urgency
- Constant passage of soft stool
- Does not recognize urge to defecate
- Fecal staining
- Inability to delay defecation
- Inability to expel formed stool despite recognition of rectal fullness
- Inability to recognize rectal fullness
- Inattentive to urge to defecate

Related factors

- Difficulty with toileting self-care
- Environmental factor
- Generalized decline in muscle tone
- Immobility
- Inadequate dietary habits
- Incomplete emptying of bowel
- Laxative abuse
- Stressors

Associated condition

- Abnormal increase in abdominal pressure
- Abnormal increase in intestinal pressure
- Alteration in cognitive functioning
- Chronic diarrhea
- Colorectal lesion
- Dysfunctional rectal sphincter
- Impaction
- Impaired reservoir capacity
- Lower motor nerve damage
- Pharmaceutical agent
- Rectal sphincter abnormality
- Upper motor nerve damage

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 3 • Class 3

This class does not currently contain any diagnoses.

Domain 3 • Class 4 • Diagnosis Code 00030

Impaired gas exchange

Approved 1980 • Revised 1996, 1998, 2017

Definition

Excess or deficit in oxygenation and/or carbon dioxide elimination at the alveolar-capillary membrane.

Defining characteristics

- Abnormal arterial blood gases
- Abnormal arterial pH
- Abnormal breathing pattern
- Abnormal skin color
- Confusion
- Decrease in carbon dioxide (CO_2) level
- Diaphoresis
- Dyspnea
- Headache upon awakening
- Hypercapnia
- Hypoxemia
- Hypoxia
- Irritability
- Nasal flaring
- Restlessness
- Somnolence
- Tachycardia
- Visual disturbance

Related factors

- To be developed

Associated condition

- Alveolar-capillary membrane changes
- Ventilation-perfusion imbalance

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 4.
Activity/rest

Class 1.	Sleep/rest
Code	**Diagnosis**
00095	**Insomnia**
00096	**Sleep** deprivation
00165	Readiness for enhanced **sleep**
00198	Disturbed **sleep pattern**

Class 2.	Activity/exercise
Code	**Diagnosis**
00040	Risk for **disuse syndrome**
00091	Impaired bed **mobility**
00085	Impaired physical **mobility**
00089	Impaired wheelchair **mobility**
00237	Impaired **sitting**
00238	Impaired **standing**
00090	Impaired **transfer ability**
00088	Impaired **walking**

Class 3.	Energy balance
Code	**Diagnosis**
00273	Im**balanced energy field**
00093	**Fatigue**
00154	**Wandering**

Class 4.	Cardiovascular/pulmonary responses

Code	Diagnosis
00092	**Activity** in**tolerance**
00094	Risk for **activity** in**tolerance**
00032	Ineffective **breathing pattern**
00029	Decreased **cardiac output**
00240	Risk for decreased **cardiac output**
00033	Impaired **spontaneous ventilation**
00267	Risk for un**stable blood pressure**
00200	Risk for decreased cardiac **tissue perfusion**
00201	Risk for ineffective cerebral **tissue perfusion**
00204	Ineffective peripheral **tissue perfusion**
00228	Risk for ineffective peripheral **tissue perfusion**
00034	Dysfunctional **ventilatory weaning response**

Class 5.	**Self-care**
Code	**Diagnosis**
00098	Impaired **home maintenance**
00108	**Bathing self-care** deficit
00109	**Dressing self-care** deficit
00102	**Feeding self-care** deficit
00110	**Toileting self-care** deficit
00182	Readiness for enhanced **self-care**
00193	**Self-neglect**

NANDA International, Inc. Nursing Diagnoses: Definitions and Classification 2018–2020, 11th Edition. Edited by T. Heather Herdman and Shigemi Kamitsuru.

Domain 4 • Class 1 • Diagnosis Code 00095

Insomnia

Approved 2006 • Revised 2017 • Level of Evidence 2.1

Definition

A disruption in amount and quality of sleep that impairs functioning.

Defining characteristics

- Alteration in affect
- Alteration in concentration
- Alteration in mood
- Alteration in sleep pattern
- Compromised health status
- Decrease in quality of life
- Difficulty initiating sleep
- Difficulty maintaining sleep state
- Dissatisfaction with sleep
- Early awakening
- Increase in absenteeism
- Increase in accidents
- Insufficient energy
- Nonrestorative sleep pattern
- Sleep disturbance producing nextday consequences

Related factors

- Alcohol consumption
- Anxiety
- Average daily physical activity is less than recommended for gender and age
- Depression
- Environmental barrier
- Fear
- Frequent naps
- Grieving
- Inadequate sleep hygiene
- Physical discomfort
- Stressors

Associated condition

- Hormonal change
- Pharmaceutical agent

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 4 • Class 1 • Diagnosis Code 00096

Sleep deprivation

Approved 1998 • Revised 2017

Definition

Prolonged periods of time without sustained natural, periodic suspension of relative consciousness that provides rest.

Defining characteristics

- Agitation
- Alteration in concentration
- Anxiety
- Apathy
- Combativeness
- Confusion
- Decrease in functional ability
- Decrease in reaction time
- Drowsiness
- Fatigue
- Fleeting nystagmus
- Hallucinations
- Hand tremors
- Heightened sensitivity to pain
- Irritability
- Lethargy
- Malaise
- Perceptual disorders
- Restlessness
- Transient paranoia

Related factors

- Age-related sleep stage shifts
- Average daily physical activity is less than recommended for gender and age
- Environmental barrier
- Late day confusion
- Nonrestorative sleep pattern
- Overstimulating environment
- Prolonged discomfort
- Sleep terror
- Sleep walking
- Sustained circadian asynchrony
- Sustained inadequate sleep hygiene

At risk population

- Familial sleep paralysis

Associated condition

- Conditions with periodic limb movement
- Dementia
- Idiopathic central nervous system hypersomnolence
- Narcolepsy

– Nightmares
– Sleep apnea
– Sleep-related enuresis
– Sleep-related painful erections
– Treatment regimen

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 4 • Class 1 • Diagnosis Code 00165

Readiness for enhanced sleep

Approved 2002 • Revised 2013 • Level of Evidence 2.1

Definition

A pattern of natural, periodic suspension of relative consciousness to provide rest and sustain a desired lifestyle, which can be strengthened.

Defining characteristics

– Expresses desire to enhance sleep

Domain 4 • Class 1 • Diagnosis Code 00198

Disturbed sleep pattern

Approved 1980 • Revised 1998, 2006 • Level of Evidence 2.1

Definition

Time-limited awakenings due to external factors.

Defining characteristics

- Difficulty in daily functioning
- Difficulty initiating sleep
- Difficulty maintaining sleep state
– Dissatisfaction with sleep
– Feeling unrested
– Unintentional awakening

Related factors

- Disruption caused by sleep partner
- Environmental barrier
- Immobilization
– Insufficient privacy
– Nonrestorative sleep pattern

Domain 4 • Class 2 • Diagnosis Code 00040

Risk for disuse syndrome

Approved 1988 • Revised 2013, 2017

Definition

Susceptible to deterioration of body systems as the result of prescribed or unavoidable musculoskeletal inactivity, which may compromise health.

Risk factors

– Pain

Associated condition

- Alteration in level of consciousness
- Mechanical immobility
– Paralysis
– Prescribed immobility

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 4 • Class 2 • Diagnosis Code 00091

Impaired bed mobility

Approved 1998 • Revised 2006, 2017 • Level of Evidence 2.1

Definition

Limitation of independent movement from one bed position to another.

Defining characteristics

- Impaired ability to move between long sitting and supine positions
- Impaired ability to move between prone and supine positions
- Impaired ability to move between sitting and supine positions
- Impaired ability to reposition self in bed
- Impaired ability to turn from side to side

Related factors

- Environmental barrier
- Insufficient knowledge of mobility strategies
- Insufficient muscle strength
- Obesity
- Pain
- Physical deconditioning

Associated condition

- Alteration in cognitive functioning
- Musculoskeletal impairment
- Neuromuscular impairment
- Pharmaceutical agent

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless strongly differentiated from Impaired physical mobility (00085).

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 4 • Class 2 • Diagnosis Code 00085

Impaired physical mobility

Approved 1973 • Revised 1998, 2013, 2017 • Level of Evidence 2.1

Definition

Limitation in independent, purposeful movement of the body or of one or more extremities.

Defining characteristics

- Alteration in gait
- Decrease in fine motor skills
- Decrease in gross motor skills
- Decrease in range of motion
- Decrease in reaction time
- Difficulty turning
- Discomfort
- Engages in substitutions for movement
- Exertional dyspnea
- Movement-induced tremor
- Postural instability
- Slowed movement
- Spastic movement
- Uncoordinated movement

Related factors

- Activity intolerance
- Anxiety
- Body mass index (BMI) > 75th percentile appropriate for age and gender
- Cultural belief regarding acceptable activity
- Decrease in endurance
- Decrease in muscle control
- Decrease in muscle mass
- Decrease in muscle strength
- Depression
- Disuse
- Insufficient environmental support
- Insufficient knowledge of value of physical activity
- Joint stiffness
- Malnutrition
- Pain
- Physical deconditioning
- Reluctance to initiate movement
- Sedentary lifestyle

Associated condition

- Alteration in bone structure integrity
- Alteration in cognitive functioning
- Alteration in metabolism
- Contractures
- Musculoskeletal impairment
- Neuromuscular impairment
- Pharmaceutical agent
- Prescribed movement restrictions

- Developmental delay

– Sensory-perceptual impairment

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 4 • Class 2 • Diagnosis Code 00089

Impaired wheelchair mobility

Approved 1998 • Revised 2006, 2017 • Level of Evidence 2.1

Definition

Limitation of independent operation of wheelchair within environment.

Defining characteristics

- Impaired ability to operate power wheelchair on a decline
- Impaired ability to operate power wheelchair on an incline
- Impaired ability to operate power wheelchair on curbs
- Impaired ability to operate power wheelchair on even surface
- Impaired ability to operate power wheelchair on uneven surface
- Impaired ability to operate wheelchair on a decline
- Impaired ability to operate wheelchair on an incline
- Impaired ability to operate wheelchair on curbs
- Impaired ability to operate wheelchair on even surface
- Impaired ability to operate wheelchair on uneven surface

Related factors

- Alteration in mood
- Decrease in endurance
- Environmental barrier
- Insufficient knowledge of wheelchair use
- Insufficient muscle strength
- Obesity
- Pain
- Physical deconditioning

Associated condition

- Alteration in cognitive functioning
- Impaired vision
- Musculoskeletal impairment
- Neuromuscular impairment

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless strongly differentiated from Impaired physical mobility (00085).

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 4 • Class 2 • Diagnosis Code 00237

Impaired sitting

Approved 2013 • Revised 2017 • Level of Evidence 2.1

Definition

Limitation of ability to independently and purposefully attain and/or maintain a rest position that is supported by the buttocks and thighs, in which the torso is upright.

Defining characteristics

- Impaired ability to adjust position of one or both lower limbs on uneven surface
- Impaired ability to attain a balanced position of the torso
- Impaired ability to flex or move both hips
- Impaired ability to flex or move both knees
- Impaired ability to maintain the torso in balanced position
- Impaired ability to stress torso with body weight

Related factors

- Insufficient endurance
- Insufficient energy
- Insufficient muscle strength
- Malnutrition
- Pain
- Self-imposed relief posture

Associated condition

- Alteration in cognitive functioning
- Impaired metabolic functioning
- Neurological disorder
- Orthopedic surgery
- Prescribed posture
- Psychological disorder
- Sarcopenia

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 4 • Class 2 • Diagnosis Code 00238

Impaired standing

Approved 2013 • Revised 2017 • Level of Evidence 2.1

Definition

Limitation of ability to independently and purposefully attain and/or maintain the body in an upright position from feet to head.

Defining characteristics

- Impaired ability to adjust position of one or both lower limbs on uneven surface
- Impaired ability to attain a balanced position of the torso
- Impaired ability to extend one or both hips
- Impaired ability to extend one or both knees
- Impaired ability to flex one or both hips
- Impaired ability to flex one or both knees
- Impaired ability to maintain the torso in balanced position
- Impaired ability to stress torso with body weight

Related factors

- Emotional disturbance
- Insufficient endurance
- Insufficient energy
- Insufficient muscle strength
- Malnutrition
- Obesity
- Pain
- Self-imposed relief posture

Associated condition

- Circulatory perfusion disorder
- Impaired metabolic functioning
- Injury to lower extremity
- Neurological disorder
- Prescribed posture
- Sarcopenia
- Surgical procedure

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 4 • Class 2 • Diagnosis Code 00090

Impaired transfer ability

Approved 1998 • Revised 2006, 2017 • Level of Evidence 2.1

Definition

Limitation of independent movement between two nearby surfaces.

Defining characteristics

- Impaired ability to transfer between bed and chair
- Impaired ability to transfer between bed and standing position
- Impaired ability to transfer between car and chair
- Impaired ability to transfer between chair and floor
- Impaired ability to transfer between chair and standing position
- Impaired ability to transfer between floor and standing position
- Impaired ability to transfer between uneven levels
- Impaired ability to transfer in or out of bath tub
- Impaired ability to transfer in or out of shower
- Impaired ability to transfer on or off a commode
- Impaired ability to transfer on or off a toilet

Related factors

- Environmental barrier
- Impaired balance
- Insufficient knowledge of transfer techniques
- Insufficient muscle strength
- Obesity
- Physical deconditioning
- Pain

Associated condition

- Alteration in cognitive functioning
- Impaired vision
- Musculoskeletal impairment
- Neuromuscular impairment

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 4 • Class 2 • Diagnosis Code 00088

Impaired walking

Approved 1998 • Revised 2006, 2017 • Level of Evidence 2.1

Definition

Limitation of independent movement within the environment on foot.

Defining characteristics

- Impaired ability to climb stairs
- Impaired ability to navigate curbs
- Impaired ability to walk on decline
- Impaired ability to walk on incline
- Impaired ability to walk on uneven surface
- Impaired ability to walk required distance

Related factors

- Alteration in mood
- Decrease in endurance
- Environmental barrier
- Fear of falling
- Insufficient knowledge of mobility strategies
- Physical deconditioning
- Insufficient muscle strength
- Obesity
- Pain

Associated condition

- Alteration in cognitive functioning
- Impaired balance
- Impaired vision
- Musculoskeletal impairment
- Neuromuscular impairment

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 4 • Class 3 • Diagnosis Code 00273

Imbalanced energy field

Approved 2016 • Level of Evidence 2.1

Definition

A disruption in the vital flow of human energy that is normally a continuous whole and is unique, dynamic, creative and nonlinear.

Defining characteristics

- Arrhythmic energy field patterns
- Blockage of the energy flow
- Congested energy field patterns
- Congestion of the energy flow
- Dissonant rhythms of the energy field patterns
- Energy deficit of the energy flow
- Expression of the need to regain the experience of the whole
- Hyperactivity of the energy flow
- Irregular energy field patterns
- Magnetic pull to an area of the energy field
- Pulsating to pounding frequency of the energy field patterns
- Pulsations sensed in the energy flow
- Random energy field patterns
- Rapid energy field patterns
- Slow energy field patterns
- Strong energy field patterns
- Temperature differentials of cold in the energy flow
- Temperature differentials of heat in the energy flow
- Tingling sensed in the energy flow
- Tumultuous energy field patterns
- Unsynchronized rhythms sensed in the energy flow
- Weak energy field patterns

Related factors

- Anxiety
- Discomfort
- Excessive stress
- Interventions that disrupt the energetic pattern or flow
- Pain

At risk population

- Crisis states
- Life transition

Associated condition

- Illness – Injury

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 4 • Class 3 • Diagnosis Code 00093

Fatigue

Approved 1988 • Revised 1998, 2017

Definition

An overwhelming sustained sense of exhaustion and decreased capacity for physical and mental work at the usual level.

Defining characteristics

- Alteration in concentration
- Alteration in libido
- Apathy
- Disinterest in surroundings
- Drowsiness
- Guilt about difficulty maintaining responsibilities
- Impaired ability to maintain usual physical activity
- Impaired ability to maintain usual routines
- Increase in physical symptoms
- Increase in rest requirement
- Ineffective role performance
- Insufficient energy
- Introspection
- Lethargy
- Nonrestorative sleep pattern
- Tiredness

Related factors

- Anxiety
- Depression
- Environmental barrier
- Increase in physical exertion
- Malnutrition
- Nonstimulating lifestyle
- Demanding occupation
- Physical deconditioning
- Sleep deprivation
- Stressors

At risk population

- Demanding occupation
- Exposure to negative life event

Associated condition

- Anemia
- Pregnancy
- Illness

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 4 • Class 3 • Diagnosis Code 00154

Wandering

Approved 2000 • Revised 2017

Definition

Meandering, aimless, or repetitive locomotion that exposes the individual to harm; frequently incongruent with boundaries, limits, or obstacles.

Defining characteristics

- Continuous movement from place to place
- Eloping behavior
- Frequent movement from place to place
- Fretful locomotion
- Haphazard locomotion
- Hyperactivity
- Impaired ability to locate landmarks in a familiar setting
- Locomotion into unauthorized spaces
- Locomotion resulting in getting lost

– Locomotion that cannot be easily dissuaded
– Long periods of locomotion without an apparent destination
– Pacing
– Periods of locomotion interspersed with periods of nonlocomotion
– Persistent locomotion in search of something
– Scanning behavior
– Searching behavior
– Shadowing a caregiver's locomotion
– Trespassing

Related factors

- Alteration in sleep-wake cycle
- Desire to go home
- Overstimulating environment

– Physiological state
– Separation from familiar environment

At risk population

– Premorbid behavior

Associated condition

- Alteration in cognitive functioning
- Cortical atrophy

– Psychological disorder
– Sedation

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 4 • Class 4 • Diagnosis Code 00092

Activity intolerance

Approved 1982 • Revised 2017

Definition

Insufficient physiological or psychological energy to endure or complete required or desired daily activities.

Defining characteristics

- Abnormal blood pressure response to activity
- Abnormal heart rate response to activity
- Electrocardiogram (ECG) change
– Exertional discomfort
– Exertional dyspnea
– Fatigue
– Generalized weakness

Related factors

- Imbalance between oxygen supply/demand
- Immobility
- Inexperience with an activity
– Physical deconditioning
– Sedentary lifestyle

At risk population

– History of previous activity intolerance

Associated condition

- Circulatory problem
– Respiratory condition

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 4 • Class 4 • Diagnosis Code 00094

Risk for activity intolerance

Approved 1982 • Revised 2013, 2017

Definition

Susceptible to experiencing insufficient physiological or psychological energy to endure or complete required or desired daily activities, which may compromise health.

Risk factors

- Imbalance between oxygen supply/demand
- Immobility
- Inexperience with an activity
– Physical deconditioning
– Sedentary lifestyle

At risk population

– History of previous activity intolerance

Associated condition

- Circulatory problem
– Respiratory condition

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 4 • Class 4 • Diagnosis Code 00032

Ineffective breathing pattern

Approved 1980 • Revised 1996, 1998, 2010, 2017 • Level of Evidence 2.1

Definition

Inspiration and/or expiration that does not provide adequate ventilation.

Defining characteristics

- Abnormal breathing pattern
- Altered chest excursion
- Bradypnea
- Decrease in expiratory pressure
- Decrease in inspiratory pressure
- Decrease in minute ventilation
- Decrease in vital capacity
- Dyspnea
- Increase in anterior-posterior chest diameter
- Nasal flaring
- Orthopnea
- Prolonged expiration phase
- Pursed-lip breathing
- Tachypnea
- Use of accessory muscles to breathe
- Use of three-point position

Related factors

- Anxiety
- Body position that inhibits lung expansion
- Fatigue
- Hyperventilation
- Obesity
- Pain
- Respiratory muscle fatigue

Associated condition

- Bony deformity
- Chest wall deformity
- Hypoventilation syndrome
- Musculoskeletal impairment
- Neurological immaturity
- Neurological impairment
- Neuromuscular impairment
- Spinal cord injury

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 4 • Class 4 • Diagnosis Code 00029

Decreased cardiac output

Approved 1975 • Revised 1996, 2000, 2017

Definition

Inadequate blood pumped by the heart to meet the metabolic demands of the body.

Defining characteristics

Altered Heart Rate/Rhythm

- Bradycardia
- Electrocardiogram (ECG) change
– Heart palpitations
– Tachycardia

Altered Preload

- Decrease in central venous pressure (CVP)
- Decrease in pulmonary artery wedge pressure (PAWP)
- Edema
- Fatigue
- Heart murmur
– Increase in central venous pressure (CVP)
– Increase in pulmonary artery wedge pressure (PAWP)
– Jugular vein distension
– Weight gain

Altered Afterload

- Abnormal skin color
- Alteration in blood pressure
- Clammy skin
- Decrease in peripheral pulses
- Decrease in pulmonary vascular resistance (PVR)
- Decrease in systemic vascular resistance (SVR)
– Dyspnea
– Increase in pulmonary vascular resistance (PVR)
– Increase in systemic vascular resistance (SVR)
– Oliguria
– Prolonged capillary refill

Altered Contractility

- Adventitious breath sounds
- Coughing
– Decrease in stroke volume index (SVI)
– Orthopnea

- Decrease in cardiac index
- Decrease in ejection fraction
- Decrease in left ventricular stroke work index (LVSWI)
– Paroxysmal nocturnal dyspnea
– Presence of S3 heart sound
– Presence of S4 heart sound

Behavioral/Emotional

- Anxiety
– Restlessness

Related factors

– To be developed

Associated condition

- Alteration in afterload
- Alteration in contractility
- Alteration in heart rate
– Alteration in heart rhythm
– Alteration in preload
– Alteration in stroke volume

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 4 • Class 4 • Diagnosis Code 00240

Risk for decreased cardiac output

Approved 2013 • Revised 2017 • Level of Evidence 2.1

Definition

Susceptible to inadequate blood pumped by the heart to meet metabolic demands of the body, which may compromise health.

Risk factors

– To be developed

Associated condition

- Alteration in afterload
- Alteration in contractility
- Alteration in heart rate
– Alteration in heart rhythm
– Alteration in preload
– Alteration in stroke volume

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition if no modifiable risk factors are developed.

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 4 • Class 4 • Diagnosis Code 00033

Impaired spontaneous ventilation

Approved 1992 • Revised 2017

Definition

Inability to initiate and/or maintain independent breathing that is adequate to support life.

Defining characteristics

- Apprehensiveness
- Decrease in arterial oxygen saturation (SaO_2)
- Decrease in cooperation
- Decrease in partial pressure of oxygen (PO_2)
- Decrease in tidal volume
- Dyspnea
- Increase in accessory muscle use
- Increase in heart rate
- Increase in metabolic rate
- Increase in partial pressure of carbon dioxide (PCO_2)
- Restlessness

Related factors

- Respiratory muscle fatigue

Associated condition

- Alteration in metabolism

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 4 • Class 4 • Diagnosis Code 00267

Risk for unstable blood pressure

Approved 2016 • Level of Evidence 2.1

Definition

Susceptible to fluctuating forces of blood flowing through arterial vessels, which may compromise health.

Risk factors

- Inconsistency with medication regimen
  - Orthostasis

Associated condition

- Adverse effects of cocaine
- Adverse effects of nonsteroidal anti-inflammatory drugs (NSAIDS)
- Adverse effects of steroids
- Cardiac dysrhythmia
- Cushing Syndrome
- Electrolyte imbalance
- Fluid retention
- Fluid shifts
- Hormonal change
- Hyperosmolar solutions
- Hyperparathyroidism
  - Hyperthyroidism
  - Hypothyroidism
  - Increased intracranial pressure
  - Rapid absorption and distribution of anti-arrhythmia agent
  - Rapid absorption and distribution of diuretic agent
  - Rapid absorption and distribution of vasodilator agents
  - Sympathetic responses
  - Use of antidepressant agents

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 4 • Class 4 • Diagnosis Code 00200

Risk for decreased cardiac tissue perfusion

Approved 2008 • Revised 2013, 2017 • Level of Evidence 2.1

Definition

Susceptible to a decrease in cardiac (coronary) circulation, which may compromise health.

Risk factors

- Insufficient knowledge of modifiable factors
– Substance misuse

At risk population

– Family history of cardiovascular disease

Associated condition

- Cardiac tamponade
- Cardiovascular surgery
- Coronary artery spasm
- Diabetes mellitus
- Hyperlipidemia
- Hypertension
– Hypovolemia
– Hypoxemia
– Hypoxia
– Increase in C-reactive protein
– Pharmaceutical agent

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 4 • Class 4 • Diagnosis Code 00201

Risk for ineffective cerebral tissue perfusion

Approved 2008 • Revised 2013, 2017 • Level of Evidence 2.1

Definition

Susceptible to a decrease in cerebral tissue circulation, which may compromise health.

Risk factors

– Substance misuse

At risk population

– Recent myocardial infarction

Associated condition

- Abnormal partial thromboplastin time (PTT)
- Abnormal prothrombin time (PT)
- Akinetic left ventricular wall segment
- Aortic atherosclerosis
- Arterial dissection
- Atrial fibrillation
- Atrial myxoma
- Brain injury
- Brain neoplasm
- Carotid stenosis
- Cerebral aneurysm
- Coagulopathy
- Dilated cardiomyopathy
- Disseminated intravascular coagulopathy
- Embolism
- Hypercholesterolemia
- Hypertension
- Infective endocarditis
- Mechanical prosthetic valve
- Mitral stenosis
- Pharmaceutical agent
- Sick sinus syndrome
- Treatment regimen

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition if no additional risk factors are developed.

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 4 • Class 4 • Diagnosis Code 00204

Ineffective peripheral tissue perfusion

Approved 2008 • Revised 2010, 2017 • Level of Evidence 2.1

Definition

Decrease in blood circulation to the periphery, which may compromise health.

Defining characteristics

- Absence of peripheral pulses
- Alteration in motor function
- Alteration in skin characteristic
- Ankle-brachial index < 0.90
- Capillary refill time > 3 seconds
- Color does not return to lowered limb after 1 minute leg elevation
- Decrease in blood pressure in extremities
- Decrease in pain-free distances during a 6-minute walk test
- Decrease in peripheral pulses
- Delay in peripheral wound healing
- Distance in the 6-minute walk test below normal range
- Edema
- Extremity pain
- Femoral bruit
- Intermittent claudication
- Paresthesia
- Skin color pales with limb elevation

Related factors

- Excessive sodium intake
- Insufficient knowledge of disease process
- Insufficient knowledge of modifiable factors
- Sedentary lifestyle
- Smoking

Associated condition

- Diabetes mellitus
- Endovascular procedure
- Hypertension
- Trauma

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 4 • Class 4 • Diagnosis Code 00228

Risk for ineffective peripheral tissue perfusion

Approved 2010 • Revised 2013, 2017 • Level of Evidence 2.1

Definition

Susceptible to a decrease in blood circulation to the periphery, which may compromise health.

Risk factors

- Excessive sodium intake
- Insufficient knowledge of disease process
  - Insufficient knowledge of modifiable factors
  - Sedentary lifestyle
  - Smoking

Associated condition

- Diabetes mellitus
- Endovascular procedure
  - Hypertension
  - Trauma

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 4 • Class 4 • Diagnosis Code 00034

Dysfunctional ventilatory weaning response

Approved 1992 • Revised 2017

Definition

Inability to adjust to lowered levels of mechanical ventilator support that interrupts and prolongs the weaning process.

Defining characteristics

Mild

- Breathing discomfort
- Fatigue
- Fear of machine malfunction
- Feeling warm
- Increase in focus on breathing
- Mild increase in respiratory rate over baseline
- Perceived need for increase in oxygen
- Restlessness

Moderate

- Abnormal skin color
- Apprehensiveness
- Decrease in air entry on auscultation
- Diaphoresis
- Facial expression of fear
- Hyperfocused on activities
- Impaired ability to cooperate
- Impaired ability to respond to coaching
- Increase in blood pressure from baseline (< 20 mmHg)
- Increase in heart rate from baseline (< 20 beats/min)
- Minimal use of respiratory accessory muscles
- Moderate increase in respiratory rate over baseline

Severe

- Abnormal skin color
- Adventitious breath sounds
- Agitation
- Asynchronized breathing with the ventilator
- Decrease in level of consciousness
- Deterioration in arterial blood gases from baseline
- Increase in heart rate from baseline (≥ 20 beats/min)
- Paradoxical abdominal breathing
- Profuse diaphoresis
- Shallow breathing
- Significant increase in respiratory rate above baseline

- Gasping breaths
- Increase in blood pressure from baseline (≥ to 20 mmHg)
– Use of significant respiratory accessory muscles

Related factors

Physiological

- Alteration in sleep pattern
- Inadequate nutrition
– Ineffective airway clearance
– Pain

Psychological

- Anxiety
- Decrease in motivation
- Fear
- Hopelessness
- Insufficient knowledge of weaning process
– Insufficient trust in healthcare professional
– Low self-esteem
– Powerlessness
– Uncertainty about ability to wean

Situational

- Environmental barrier
- Inappropriate pace of weaning process
– Insufficient social support
– Uncontrolled episodic energy demands

Associated condition

- History of unsuccessful weaning attempt
– History of ventilator dependence > 4 days

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 4 • Class 5 • Diagnosis Code 00098

Impaired home maintenance

Approved 1980 • Revised 2017

Definition

Inability to independently maintain a safe growth-promoting immediate environment.

Defining characteristics

- Difficulty maintaining a comfortable environment
- Excessive family responsibilities
- Impaired ability to maintain home
- Insufficient clothing
- Insufficient cooking equipment
- Insufficient equipment for maintaining home
- Insufficient linen
- Pattern of disease caused by unhygienic conditions
- Pattern of infection caused by unhygienic conditions
- Request for assistance with home maintenance
- Unsanitary environment

Related factors

- Inadequate role model
- Insufficient family organization
- Insufficient family planning
- Insufficient knowledge of home maintenance
- Insufficient knowledge of neighborhood resources
- Insufficient support system

At risk population

- Financial crisis

Associated condition

- Alteration in cognitive functioning

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 4 • Class 5 • Diagnosis Code 00108

Bathing self-care deficit

Approved 1980 • Revised 1998, 2008, 2017 • Level of Evidence 2.1

Definition

Inability to independently complete cleansing activities.

Defining characteristics

- Impaired ability to access bathroom
- Impaired ability to access water
- Impaired ability to dry body
- Impaired ability to gather bathing supplies
- Impaired ability to regulate bath water
- Impaired ability to wash body

Related factors

- Anxiety
- Decrease in motivation
- Environmental barrier
- Pain
- Weakness

Associated condition

- Alteration in cognitive functioning
- Impaired ability to perceive body part
- Impaired ability to perceive spatial relationships
- Musculoskeletal impairment
- Neuromuscular impairment
- Perceptual disorders

Domain 4 • Class 5 • Diagnosis Code 00109

Dressing self-care deficit

Approved 1980 • Revised 1998, 2008, 2017 • Level of Evidence 2.1

Definition

Inability to independently put on or remove clothing.

Defining characteristics

- Impaired ability to choose clothing
- Impaired ability to fasten clothing
- Impaired ability to gather clothing
- Impaired ability to maintain appearance
- Impaired ability to pick up clothing
- Impaired ability to put clothing on lower body
- Impaired ability to put clothing on upper body
- Impaired ability to put on various items of clothing
- Impaired ability to remove clothing item
- Impaired ability to use assistive device
- Impaired ability to use zipper

Related factors

- Anxiety
- Decrease in motivation
- Discomfort
- Environmental barrier
- Fatigue
- Pain
- Weakness

Associated condition

- Alteration in cognitive functioning
- Musculoskeletal impairment
- Neuromuscular impairment
- Perceptual disorders

Domain 4 • Class 5 • Diagnosis Code 00102

Feeding self-care deficit

Approved 1980 • Revised 1998, 2008, 2017 • Level of Evidence 2.1

Definition

Inability to eat independently.

Defining characteristics

- Impaired ability to bring food to mouth
- Impaired ability to chew food
- Impaired ability to get food onto utensil
- Impaired ability to handle utensils
- Impaired ability to manipulate food in mouth
- Impaired ability to open containers
- Impaired ability to pick up cup
- Impaired ability to prepare food
- Impaired ability to self-feed a complete meal
- Impaired ability to self-feed in an acceptable manner
- Impaired ability to swallow food
- Impaired ability to swallow sufficient amount of food
- Impaired ability to use assistive device

Related factors

- Anxiety
- Decrease in motivation
- Discomfort
- Environmental barrier
- Fatigue
- Pain
- Weakness

Associated condition

- Alteration in cognitive functioning
- Musculoskeletal impairment
- Neuromuscular impairment
- Perceptual disorders

Domain 4 • Class 5 • Diagnosis Code 00110

Toileting self-care deficit

Approved 1980 • Revised 1998, 2008, 2017 • Level of Evidence 2.1

Definition

Inability to independently perform tasks associated with bowel and bladder elimination.

Defining characteristics

- Impaired ability to complete toilet hygiene
- Impaired ability to flush toilet
- Impaired ability to manipulate clothing for toileting
- Impaired ability to reach toilet
- Impaired ability to rise from toilet
- Impaired ability to sit on toilet

Related factors

- Anxiety
- Decrease in motivation
- Environmental barrier
- Fatigue
- Impaired ability to transfer
- Impaired mobility
- Pain
- Weakness

Associated condition

- Alteration in cognitive functioning
- Musculoskeletal impairment
- Neuromuscular impairment
- Perceptual disorders

Domain 4 • Class 5 • Diagnosis Code 00182

Readiness for enhanced self-care

Approved 2006 • Revised 2013 • Level of Evidence 2.1

Definition

A pattern of performing activities for oneself to meet health-related goals, which can be strengthened.

Defining characteristics

- Expresses desire to enhance independence with health
- Expresses desire to enhance independence with life
- Expresses desire to enhance independence with personal development
- Expresses desire to enhance independence with well-being
- Expresses desire to enhance knowledge of self-care strategies
- Expresses desire to enhance self-care

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 4 • Class 5 • Diagnosis Code 00193

Self-neglect

Approved 2008 • Revised 2017 • Level of Evidence 2.1

Definition

A constellation of culturally framed behaviors involving one or more self-care activities in which there is a failure to maintain a socially accepted standard of health and well-being (Gibbons, Lauder & Ludwick, 2006).

Defining characteristics

- Insufficient environmental hygiene
- Insufficient personal hygiene
– Nonadherence to health activity

Related factors

- Deficient executive function
- Fear of institutionalization
- Inability to maintain control
– Lifestyle choice
– Stressors
– Substance misuse

Associated condition

- Alteration in cognitive functioning
- Capgras syndrome
- Frontal lobe dysfunction
- Functional impairment
– Learning disability
– Malingering
– Psychiatric disorder
– Psychotic disorder

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 5.
Perception/cognition

Class 1.	Attention
Code	**Diagnosis**
00123	**Unilateral neglect**

Class 2.	Orientation
Code	**Diagnosis**
	This class does not currently contain any diagnoses.

Class 3.	Sensation/perception
Code	**Diagnosis**
	This class does not currently contain any diagnoses.

Class 4.	Cognition
Code	**Diagnosis**
00128	Acute **confusion**
00173	Risk for acute **confusion**
00129	Chronic **confusion**
00251	Labile **emotional control**
00222	Ineffective **impulse control**
00126	Deficient **knowledge**
00161	Readiness for enhanced **knowledge**
00131	Impaired **memory**

Class 5.	Communication

Code	Diagnosis
00157	Readiness for enhanced **communication**
00051	Impaired **verbal communication**

NANDA International, Inc. Nursing Diagnoses: Definitions and Classification 2018–2020, 11th Edition. Edited by T. Heather Herdman and Shigemi Kamitsuru.

Domain 5 • Class 1 • Diagnosis Code 00123

Unilateral neglect

Approved 1986 • Revised 2006, 2017 • Level of Evidence 2.1

Definition

Impairment in sensory and motor response, mental representation, and spatial attention of the body, and the corresponding environment, characterized by inattention to one side and overattention to the opposite side. Left-side neglect is more severe and persistent than right-side neglect.

Defining characteristics

- Alteration in safety behavior on neglected side
- Disturbance of sound lateralization
- Failure to dress neglected side
- Failure to eat food from portion of plate on neglected side
- Failure to groom neglected side
- Failure to move eyes in the neglected hemisphere
- Failure to move head in the neglected hemisphere
- Failure to move limbs in the neglected hemisphere
- Failure to move trunk in the neglected hemisphere
- Failure to notice people approaching from the neglected side
- Hemianopsia
- Impaired performance on line cancellation, line bisection, and target cancellation tests
- Left hemiplegia from cerebrovascular accident
- Marked deviation of the eyes to stimuli on the non-neglected side
- Marked deviation of the trunk to stimuli on the non-neglected side
- Omission of drawing on the neglected side
- Perseveration
- Representational neglect
- Substitution of letters to form alternative words when reading
- Transfer of pain sensation to the non-neglected side
- Unaware of positioning of neglected limb
- Unilateral visuospatial neglect
- Use of vertical half of page only when writing

Related factors

- To be developed

Associated condition

- Brain injury

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition if no related factors are developed.

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 5 • Class 2

This class does not currently contain any diagnoses.

Domain 5 • Class 3

This class does not currently contain any diagnoses.

Domain 5 • Class 4 • Diagnosis Code 00128

Acute confusion

Approved 1994 • Revised 2006, 2017 • Level of Evidence 2.1

Definition

Reversible disturbances of consciousness, attention, cognition and perception that develop over a short period of time, and which last less than 3 months.

Defining characteristics

- Agitation
- Alteration in cognitive functioning
- Alteration in level of consciousness
- Alteration in psychomotor functioning
- Hallucinations
- Inability to initiate goal-directed behavior
  - Inability to initiate purposeful behavior
  - Insufficient follow-through with goal-directed behavior
  - Insufficient follow-through with purposeful behavior
  - Misperception
  - Restlessness

Related factors

- Alteration in sleep-wake cycle
- Dehydration
- Impaired mobility
- Inappropriate use of restraints
- Malnutrition
  - Pain
  - Sensory deprivation
  - Substance misuse
  - Urinary retention

At risk population

- Age ≥ 60 years
- History of cerebral vascular accident
  - Male gender

Associated condition

- Alteration in cognitive functioning
- Delirium
- Dementia
  - Impaired metabolic functioning
  - Infection
  - Pharmaceutical agent

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 5 • Class 4 • Diagnosis Code 00173

Risk for acute confusion

Approved 2006 • Revised 2013, 2017 • Level of Evidence 2.2

Definition

Susceptible to reversible disturbances of consciousness, attention, cognition and perception that develop over a short period of time, which may compromise health.

Risk factors

- Alteration in sleep-wake cycle
- Dehydration
- Impaired mobility
- Inappropriate use of restraints
- Malnutrition
- Pain
- Sensory deprivation
- Substance misuse
- Urinary retention

At risk population

- Age ≥ 60 years
- History of cerebral vascular accident
- Male gender

Associated condition

- Alteration in cognitive functioning
- Delirium
- Dementia
- Impaired metabolic functioning
- Infection
- Pharmaceutical agent

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 5 • Class 4 • Diagnosis Code 00129

Chronic confusion

Approved 1994 • Revised 2017 • Level of Evidence 3.1

Definition

Irreversible, progressive, insidious, and long-term alteration of intellect, behavior and personality, manifested by impairment in cognitive functions (memory, speech, language, decision making, and executive function), and dependency in execution of daily activities

Defining characteristics

- Adequate alertness to surroundings
- Alteration in at least one cognitive function other than memory
- Alteration in behavior
- Alteration in long-term memory
- Alteration in personality
- Alteration in short-term memory
- Alteration in social functioning
- Inability to perform at least one daily activity
- Insidious and irreversible onset in cognitive impairment
- Long-term cognitive impairment
- Progressive impairment in cognitive functioning

Associated condition

- Cerebral vascular accident
- Dementia

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 5 • Class 4 • Diagnosis Code 00251

Labile emotional control

Approved 2013 • Revised 2017 • Level of Evidence 2.1

Definition

Uncontrollable outbursts of exaggerated and involuntary emotional expression.

Defining characteristics

- Absence of eye contact
- Crying
- Difficulty in use of facial expressions
- Embarrassment regarding emotional expression
- Excessive crying without feeling sadness
- Excessive laughing without feeling happiness
- Expression of emotion incongruent with triggering factor
- Involuntary crying
- Involuntary laughing
- Uncontrollable crying
- Uncontrollable laughing
- Withdrawal from occupational situation
- Withdrawal from social situation

Related factors

- Alteration in self-esteem
- Emotional disturbance
- Fatigue
- Insufficient knowledge about symptom control
- Insufficient knowledge of disease
- Insufficient muscle strength
- Social distress
- Stressors
- Substance misuse

Associated condition

- Brain injury
- Functional impairment
- Mood disorder
- Musculoskeletal impairment
- Pharmaceutical agent
- Physical disability
- Psychiatric disorder

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 5 • Class 4 • Diagnosis Code 00222

Ineffective impulse control

Approved 2010 • Revised 2017 • Level of Evidence 2.1

Definition

A pattern of performing rapid, unplanned reactions to internal or external stimuli without regard for the negative consequences of these reactions to the impulsive individual or to others.

Defining characteristics

- Acting without thinking
- Asking personal questions despite discomfort of others
- Gambling addiction
- Inability to save money or regulate finances
- Inappropriate sharing of personal details
- Irritability
- Overly familiar with strangers
- Sensation seeking
- Sexual promiscuity
- Temper outbursts
- Violent behavior

Related factors

- Hopelessness
- Mood disorder
- Smoking
- Substance misuse

Associated condition

- Alteration in cognitive functioning
- Alteration in development
- Organic brain disorder
- Personality disorder

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 5 • Class 4 • Diagnosis Code 00126

Deficient knowledge

Approved 1980 • Revised 2017

Definition

Absence of cognitive information related to a specific topic, or its acquisition.

Defining characteristics

- Inaccurate follow-through of instruction
- Inaccurate performance on a test
– Inappropriate behavior
– Insufficient knowledge

Related factors

- Insufficient information
- Insufficient interest in learning
- Insufficient knowledge of resources
– Misinformation presented by others

Associated condition

- Alteration in cognitive functioning
– Alteration in memory

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 5 • Class 4 • Diagnosis Code 00161

Readiness for enhanced knowledge

Approved 2002 • Revised 2013 • Level of Evidence 2.1

Definition

A pattern of cognitive information related to a specific topic, or its acquisition, which can be strengthened.

Defining characteristics

– Expresses desire to enhance learning

Domain 5 • Class 4 • Diagnosis Code 00131

Impaired memory

Approved 1994 • Revised 2017 • Level of Evidence 3.1

Definition

Persistent inability to remember or recall bits of information or skills

Defining characteristics

- Consistently forgets to perform a behavior at the scheduled time
- Persistent forgetfulness
- Persistent inability to learn a new skill
- Persistent inability to learn new information
- Persistent inability to perform a previously learned skill
- Persistent inability to recall factual information or events
- Persistent inability to recall familiar names, words, or objects
- Persistent inability to recall if a behavior was performed
- Persistent inability to retain a new skill
- Persistent inability to retain new information
- Preserved capacity to perform daily activities independently

Related factors

- Alteration in fluid volume

Associated condition

- Anemia
- Brain injury
- Decrease in cardiac output
- Electrolyte imbalance
- Hypoxia
- Mild cognitive impairment
- Neurological impairment
- Parkinson's Disease

Additional modifiable related factors to be developed.

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 5 • Class 5 • Diagnosis Code 00157

Readiness for enhanced communication

Approved 2002 • Revised 2013 • Level of Evidence 2.1

Definition

A pattern of exchanging information and ideas with others, which can be strengthened.

Defining characteristics

– Expresses desire to enhance communication

Domain 5 • Class 5 • Diagnosis Code 00051

Impaired verbal communication

Approved 1983 • Revised 1996, 1998, 2017

Definition

Decreased, delayed, or absent ability to receive, process, transmit, and/or use a system of symbols.

Defining characteristics

- Absence of eye contact
- Difficulty comprehending communication
- Difficulty expressing thoughts verbally
- Difficulty forming sentences
- Difficulty forming words
- Difficulty in selective attending
- Difficulty in use of body expressions
- Difficulty in use of facial expressions
- Difficulty maintaining communication
- Difficulty speaking
- Difficulty verbalizing

– Disoriented to person
– Disoriented to place
– Disoriented to time
– Dyspnea
– Inability to speak
– Inability to speak language of caregiver
– Inability to use body expressions
– Inability to use facial expressions
– Inappropriate verbalization
– Partial visual deficit
– Slurred speech
– Stuttering
– Total visual deficit

Related factors

- Alteration in self-concept
- Cultural incongruence
- Emotional disturbance
- Environmental barrier

– Insufficient information
– Insufficient stimuli
– Low self-esteem
– Vulnerability

At risk population

– Absence of significant other

Associated condition

- Alteration in development
- Alteration in perception
- Central nervous system impairment
- Oropharyngeal defect
– Physical barrier
– Physiological condition
– Psychotic disorder
– Treatment regimen

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 6.
Self-perception

Class 1.	Self-concept
Code	**Diagnosis**
00124	**Hope**lessness
00185	Readiness for enhanced **hope**
00174	Risk for compromised **human dignity**
00121	Disturbed **personal identity**
00225	Risk for disturbed **personal identity**
00167	Readiness for enhanced **self-concept**

Class 2.	Self-esteem
Code	**Diagnosis**
00119	Chronic low **self-esteem**
00224	Risk for chronic low **self-esteem**
00120	Situational low **self-esteem**
00153	Risk for situational low **self-esteem**

Class 3.	Body image
Code	**Diagnosis**
00118	Disturbed **body image**

NANDA International, Inc. Nursing Diagnoses: Definitions and Classification 2018–2020, 11th Edition. Edited by T. Heather Herdman and Shigemi Kamitsuru.

Companion website: **www.thieme.com/nanda-i**.

Domain 6 • Class 1 • Diagnosis Code 00124

Hopelessness

Approved 1986 • Revised 2017

Definition

Subjective state in which an individual sees limited or no alternatives or personal choices available and is unable to mobilize energy on own behalf.

Defining characteristics

- Alteration in sleep pattern
- Decrease in affect
- Decrease in appetite
- Decrease in initiative
- Decrease in response to stimuli
- Decrease in verbalization
- Despondent verbal cues
- Inadequate involvement in care
- Passivity
- Poor eye contact
- Shrugging in response to speaker
- Turning away from speaker

Related factors

- Chronic stress
- Loss of belief in spiritual power
- Loss of belief in transcendent values
- Prolonged activity restriction
- Social isolation

At risk population

- History of abandonment

Associated condition

- Deterioration in physiological condition

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 6 • Class 1 • Diagnosis Code 00185

Readiness for enhanced hope

Approved 2006 • Revised 2013 • Level of Evidence 2.1

Definition

A pattern of expectations and desires for mobilizing energy on one's own behalf, which can be strengthened.

Defining characteristics

- Expresses desire to enhance ability to set achievable goals
- Expresses desire to enhance belief in possibilities
- Expresses desire to enhance congruency of expectation with goal
- Expresses desire to enhance connectedness with others
- Expresses desire to enhance hope
- Expresses desire to enhance problem-solving to meet goal
- Expresses desire to enhance sense of meaning in life
- Expresses desire to enhance spirituality

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 6 • Class 1 • Diagnosis Code 00174

Risk for compromised human dignity

Approved 2006 • Revised 2013 • Level of Evidence 2.1

Definition

Susceptible for perceived loss of respect and honor, which may compromise health.

Risk factors

- Cultural incongruence
- Dehumanizing treatment
- Disclosure of confidential information
- Exposure of the body
- Humiliation
- Insufficient comprehension of health information
– Intrusion by clinician
– Invasion of privacy
– Limited decision-making experience
– Loss of control over body function
– Stigmatization

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 6 • Class 1 • Diagnosis Code 00121

Disturbed personal identity

Approved 1978 • Revised 2008, 2017 • Level of Evidence 2.1

Definition

Inability to maintain an integrated and complete perception of self.

Defining characteristics

- Alteration in body image
- Confusion about cultural values
- Confusion about goals
- Confusion about ideological values
- Delusional description of self
- Feeling of emptiness
- Feeling of strangeness
- Fluctuating feelings about self
  - Gender confusion
  - Inability to distinguish between internal and external stimuli
  - Inconsistent behavior
  - Ineffective coping strategies
  - Ineffective relationships
  - Ineffective role performance

Related factors

- Alteration in social role
- Cult indoctrination
- Cultural incongruence
- Discrimination
- Dysfunctional family processes
  - Low self-esteem
  - Manic states
  - Perceived prejudice
  - Stages of growth

At risk population

- Developmental transition
- Situational crisis
  - Exposure to toxic chemical

Associated condition

- Dissociative identity disorder
- Organic brain disorder
  - Pharmaceutical agent
  - Psychiatric disorder

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 6 • Class 1 • Diagnosis Code 00225

Risk for disturbed personal identity

Approved 2010 • Revised 2013, 2017 • Level of Evidence 2.1

Definition

Susceptible to the inability to maintain an integrated and complete perception of self, which may compromise health.

Risk factors

- Alteration in social role
- Cult indoctrination
- Cultural incongruence
- Discrimination
- Dysfunctional family processes
  - Low self-esteem
  - Manic states
  - Perceived prejudice
  - Stages of growth

At risk population

- Developmental transition
- Exposure to toxic chemical
  - Situational crisis

Associated condition

- Dissociative identity disorder
- Organic brain disorder
  - Pharmaceutical agent
  - Psychiatric disorder

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 6 • Class 1 • Diagnosis Code 00167

Readiness for enhanced self-concept

Approved 2002 • Revised 2013 • Level of Evidence 2.1

Definition

A pattern of perceptions or ideas about the self, which can be strengthened.

Defining characteristics

- Acceptance of limitations
- Acceptance of strengths
- Actions congruent with verbal expressions
- Expresses confidence in abilities
- Expresses desire to enhance role performance
- Expresses desire to enhance self-concept
– Expresses satisfaction with body image
– Expresses satisfaction with personal identity
– Expresses satisfaction with sense of worth
– Expresses satisfaction with thoughts about self

Domain 6 • Class 2 • Diagnosis Code 00119

Chronic low self-esteem

Approved 1988 • Revised 1996, 2008, 2017 • Level of Evidence 2.1

Definition

Negative evaluation and/or feelings about one's own capabilities, lasting at least three months.

Defining characteristics

- Dependent on others' opinions
- Exaggerates negative feedback about self
- Excessive seeking of reassurance
- Guilt
- Hesitant to try new experiences
- Indecisive behavior
- Nonassertive behavior
- Overly conforming
- Passivity
- Poor eye contact
- Rejection of positive feedback
- Repeatedly unsuccessful in life events
- Shame
- Underestimates ability to deal with situation

Related factors

- Cultural incongruence
- Inadequate affection received
- Inadequate belonging
- Inadequate group membership
- Inadequate respect from others
- Ineffective coping with loss
- Receiving insufficient approval from others
- Spiritual incongruence

At risk population

- Exposure to traumatic situation
- Pattern of failure
- Repeated negative reinforcement

Associated condition

- Psychiatric disorder

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 6 • Class 2 • Diagnosis Code 00224

Risk for chronic low self-esteem

Approved 2010 • Revised 2013, 2017 • Level of Evidence 2.1

Definition

Susceptible to longstanding negative self-evaluating/feelings about self or self-capabilities, which may compromise health.

Risk factors

- Cultural incongruence
- Inadequate affection received
- Inadequate belonging
- Inadequate group membership
- Inadequate respect from others
- Ineffective coping with loss
- Receiving insufficient approval from others
- Spiritual incongruence

At risk population

- Exposure to traumatic situation
- Pattern of failure
- Repeated negative reinforcement

Associated condition

- Psychiatric disorder

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 6 • Class 2 • Diagnosis Code 00120

Situational low self-esteem

Approved 1988 • Revised 1996, 2000, 2017

Definition

Development of a negative perception of self-worth in response to a current situation.

Defining characteristics

- Helplessness
- Indecisive behavior
- Nonassertive behavior
- Purposelessness
  - Self-negating verbalizations
  - Situational challenge to self-worth
  - Underestimates ability to deal with situation

Related factors

- Alteration in body image
- Alteration in social role
- Behavior inconsistent with values
- Decrease in control over environment
  - Inadequate recognition
  - Pattern of helplessness
  - Unrealistic self-expectations

At risk population

- Developmental transition
- History of abandonment
- History of abuse
- History of loss
  - History of neglect
  - History of rejection
  - Pattern of failure

Associated condition

- Functional impairment
  - Physical illness

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is

completed to bring it up to a level of evidence 2.1 or higher.

Domain 6 • Class 2 • Diagnosis Code 00153

Risk for situational low self-esteem

Approved 2000 • Revised 2013, 2017

Definition

Susceptible to developing a negative perception of self-worth in response to a current situation, which may compromise health.

Risk factors

- Alteration in body image
- Alteration in social role
- Behavior inconsistent with values
- Decrease in control over environment
– Inadequate recognition
– Pattern of helplessness
– Unrealistic self-expectations

At risk population

- Developmental transition
- History of abandonment
- History of abuse
- History of loss
– History of neglect
– History of rejection
– Pattern of failure

Associated condition

- Functional impairment
– Physical illness

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 6 • Class 3 • Diagnosis Code 00118

Disturbed body image

Approved 1973 • Revised 1998, 2017

Definition

Confusion in mental picture of one's physical self.

Defining characteristics

- Absence of body part
- Alteration in body function
- Alteration in body structure
- Alteration in view of one's body
- Avoids looking at one's body
- Avoids touching one's body
- Behavior of acknowledging one's body
- Behavior of monitoring one's body
- Change in ability to estimate spatial relationship of body to environment
- Change in lifestyle
- Change in social involvement
- Depersonalization of body part by use of impersonal pronouns
- Depersonalization of loss by use of impersonal pronouns
- Emphasis on remaining strengths
- Extension of body boundary
- Fear of reaction by others
- Focus on past appearance
- Focus on past function
- Focus on previous strength
- Heightened achievement
- Hiding of body part
- Negative feeling about body
- Nonverbal response to change in body
- Nonverbal response to perceived change in body
- Overexposure of body part
- Perceptions that reflect an altered view of one's body appearance
- Personalization of body part by name
- Personalization of loss by name
- Preoccupation with change
- Preoccupation with loss
- Refusal to acknowledge change
- Trauma to nonfunctioning body part

Related factors

- Alteration in self-perception
- Cultural incongruence
- Spiritual incongruence

At risk population

- Developmental transition

Associated condition

- Alteration in body function
- Alteration in cognitive functioning
- Illness
- Impaired psychosocial functioning
– Injury
– Surgical procedure
– Trauma
– Treatment regimen

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 7.
Role relationship

Class 1.	Caregiving roles
Code	**Diagnosis**
00061	Caregiver **role strain**
00062	Risk for caregiver **role strain**
00056	Impaired **parenting**
00057	Risk for impaired **parenting**
00164	Readiness for enhanced **parenting**

Class 2.	Family relationships
Code	**Diagnosis**
00058	Risk for impaired **attachment**
00063	Dysfunctional **family processes**
00060	Interrupted **family processes**
00159	Readiness for enhanced **family processes**

Class 3.	Role performance
Code	**Diagnosis**
00223	Ineffective **relationship**
00229	Risk for ineffective **relationship**
00207	Readiness for enhanced **relationship**
00064	Parental **role conflict**
00055	Ineffective **role performance**
00052	Impaired **social interaction**

NANDA International, Inc. Nursing Diagnoses: Definitions and Classification 2018–2020, 11th Edition. Edited by T. Heather Herdman and Shigemi Kamitsuru.

 Published 2017 by Thieme Medical Publishers, Inc., New York. Companion website: **www.thieme.com/nanda-i**.

Domain 7 • Class 1 • Diagnosis Code 00061

Caregiver role strain

Approved 1992 • Revised 1998, 2000, 2017 • Level of Evidence 2.1

Definition

Difficulty in fulfilling care responsibilities, expectations and/or behaviors for family or significant others.

Defining characteristics

Caregiving Activities

- Apprehensiveness about future ability to provide care
- Apprehensiveness about future health of care receiver
- Apprehensiveness about potential institutionalization of care receiver
- Apprehensiveness about well-being of care receiver if unable to provide care
- Difficulty completing required tasks
- Difficulty performing required tasks
- Dysfunctional change in caregiving activities
- Preoccupation with care routine

Caregiver Health Status: Physiological

- Fatigue
- Gastrointestinal distress
- Headache
- Hypertension
- Rash
- Weight change

Caregiver Health Status: Emotional

- Alteration in sleep pattern
- Anger
- Depression
- Emotional vacillation
- Frustration
- Impatience
- Ineffective coping strategies
- Insufficient time to meet personal needs
- Nervousness
- Somatization
- Stressors

Caregiver Health Status: Socioeconomic

- Change in leisure activities
- Low work productivity
– Refusal of career advancement
– Social isolation

Caregiver-Care Receiver Relationship

- Difficulty watching care receiver with illness
- Grieving of changes in relationship with care receiver
– Uncertainty about changes in relationship with care receiver

Family Processes

- Concern about family member(s)
– Family conflict

Related factors

Care Receiver

- Condition inhibits conversation
- Dependency
- Discharged home with significant needs
- Increase in care needs
– Problematic behavior
– Substance misuse
– Unpredictability of illness trajectory
– Unstable health condition

Caregiver

- Physical conditions
- Substance misuse
- Unrealistic self-expectations
- Competing role commitments
- Ineffective coping strategies
- Inexperience with caregiving
- Insufficient emotional resilience
- Insufficient energy
- Insufficient fulfillment of others' expectations
– Insufficient fulfillment of self-expectations
– Insufficient knowledge about community resources
– Insufficient privacy
– Insufficient recreation
– Isolation
– Not developmentally ready for caregiver role
– Stressors

Caregiver-Care Receiver Relationship

- Abusive relationship
- Codependency
- Pattern of ineffective relationships
- Presence of abuse
– Unrealistic care receiver expectations
– Violent relationship

Caregiving Activities

- Around-the-clock care responsibilities
- Change in nature of care activities
- Complexity of care activities
- Excessive caregiving activities
- Extended duration of caregiving required
– Inadequate physical environment for providing care
– Insufficient assistance
– Insufficient equipment for providing care
– Insufficient respite for caregiver
– Insufficient time
– Unpredictability of care situation

Family Processes

- Family isolation
- Ineffective family adaptation
- Pattern of family dysfunction
– Pattern of family dysfunction prior to the caregiving situation
– Pattern of ineffective family coping

Socioeconomic

- Alienation
- Difficulty accessing assistance
- Difficulty accessing community resources
- Difficulty accessing support
– Insufficient community resources
– Insufficient social support
– Insufficient transportation
– Social isolation

At risk population

- Care receiver's condition inhibits conversation
- Developmental delay of care receiver
- Developmental delay of caregiver
- Exposure to violence
– Female caregiver
– Financial crisis
– Partner as caregiver
– Prematurity

Associated condition

Care Receiver

- Alteration in cognitive functioning
- Chronic illness
- Congenital disorder
– Illness severity
– Psychiatric disorder
– Psychological disorder

Caregiver

- Alteration in cognitive functioning
- Health impairment
– Psychological disorder

Domain 7 • Class 1 • Diagnosis Code 00062

Risk for caregiver role strain

Approved 1992 • Revised 2010, 2013, 2017 • Level of Evidence 2.1

Definition

Susceptible to difficulty in fulfilling care responsibilities, expectations and/or behaviors for family or significant others, which may compromise health.

Risk factors

Care Receiver

- Dependency
- Discharged home with significant needs
- Increase in care needs
- Problematic behavior
- Substance misuse
- Unpredictability of illness trajectory
- Unstable health condition
- Unstable health condition

Caregiver

- Substance misuse
- Unrealistic self-expectations
- Competing role commitments
- Ineffective coping strategies
- Inexperience with caregiving
- Insufficient emotional resilience
- Insufficient energy
- Insufficient fulfillment of others' expectations
- Insufficient fulfillment of self-expectations
- Insufficient knowledge about community resources
- Insufficient privacy
- Insufficient recreation
- Isolation
- Not developmentally ready for caregiver role
- Physical conditions
- Stressors

Caregiver-Care Receiver Relationship

- Abusive relationship
- Codependency
- Pattern of ineffective relationships
- Presence of abuse
- Unrealistic care receiver expectations
- Violent relationship

Caregiving Activities

- Around-the-clock care responsibilities
- Change in nature of care activities
- Complexity of care activities
- Inadequate physical environment for providing care
- Insufficient assistance
- Insufficient equipment for providing care
– Excessive caregiving activities
– Extended duration of caregiving required
– Insufficient respite for caregiver
– Insufficient time
– Unpredictability of care situation

Family Processes

- Family isolation
- Ineffective family adaptation
- Pattern of family dysfunction
– Pattern of family dysfunction prior to the caregiving situation
– Pattern of ineffective family coping

Socioeconomic

- Alienation
- Difficulty accessing assistance
- Difficulty accessing community resources
- Difficulty accessing support
– Insufficient community resources
– Insufficient social support
– Insufficient transportation
– Social isolation

At risk population

- Care receiver's condition inhibits conversation
- Developmental delay of care receiver
- Developmental delay of caregiver
- Exposure to violence
– Female caregiver
– Financial crisis
– Partner as caregiver
– Prematurity

Associated condition

Care Receiver

- Alteration in cognitive functioning
- Chronic illness
- Congenital disorder
– Illness severity
– Psychological disorder
– Psychiatric disorder

Caregiver

- Alteration in cognitive functioning
- Health impairment
– Psychological disorder

Domain 7 • Class 1 • Diagnosis Code 00056

Impaired parenting

Approved 1978 • Revised 1998, 2017

Definition

Inability of primary caregiver to create, maintain or regain an environment that promotes the optimum growth and development of the child.

Defining characteristics

Infant or Child

- Behavioral disorder
- Delay in cognitive development
- Diminished separation anxiety
- Failure to thrive
- Frequent accidents
- Frequent illness
– History of abuse
– History of trauma
– Impaired social functioning
– Insufficient attachment behavior
– Low academic performance
– Run away from home

Parental

- Abandonment of child
- Failure to provide safe home environment
- Decrease in ability to manage child
- Decrease in cuddling
- Deficient parent-child interaction
- Frustration with child
- Hostility
- Inadequate child health maintenance
- Inappropriate care-taking skills
- Inappropriate child-care arrangements
– Inappropriate stimulation
– Inconsistent behavior management
– Inconsistent care
– Inflexibility in meeting needs of child
– Neglects needs of child
– Perceived inability to meet child's needs
– Perceived role inadequacy
– Punitive
– Rejection of child
– Speaks negatively about child

Related factors

Infant or Child

- Prolonged separation from parent
– Temperament conflicts with parental expectations

Parental

- Alteration in sleep pattern
- Conflict between partners
- Depression
- Failure to provide safe home environment
- Father of child uninvolved
- Inability to put child's needs before own
- Inadequate child-care arrangements
- Ineffective communication skills
- Ineffective coping strategies
- Insufficient access to resources
- Insufficient family cohesiveness
- Insufficient knowledge about child development
- Insufficient knowledge about child health maintenance
- Insufficient knowledge about parenting skills
- Insufficient parental role model
- Insufficient prenatal care
- Insufficient problem-solving skills
- Insufficient resources
- Insufficient response to infant cues
- Insufficient social support
- Insufficient transportation
- Insufficient valuing of parenthood
- Late-term prenatal care
- Low self-esteem
- Mother of child uninvolved
- Nonrestorative sleep pattern
- Preference for physical punishment
- Role strain
- Sleep deprivation
- Social isolation
- Stressors
- Unrealistic expectations

At risk population

Infant or Child

- Developmental delay
- Difficult temperament
- Gender other than desired
- Prematurity

Parental

- Change in family unit
- Closely spaced pregnancies
- Difficult birthing process
- Economically disadvantaged
- High number of pregnancies
- History of abuse
- History of being abusive
- History of mental illness
- History of substance misuse
- Insufficient cognitive readiness for parenting
- Legal difficulty
- Low educational level
- Multiple births
- Relocation
- Single parent
- Unemployment
- Unplanned pregnancy
- Unwanted pregnancy
- Work difficulty
- Young parental age

Associated condition

Infant or Child

- Alteration in perceptual abilities
- Behavioral disorder
– Chronic illness
– Disabling condition

Parental

- Alteration in cognitive functioning
- Disabling condition
– Physical illness

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 7 • Class 1 • Diagnosis Code 00057

Risk for impaired parenting

Approved 1978 • Revised 1998, 2013, 2017

Definition

Susceptible to primary caregiver difficulty in creating, maintaining or regaining an environment that promotes the optimum growth and development of the child, which may compromise the well-being of the child.

Risk factors

Infant or Child

- Prolonged separation from parent
– Temperament conflicts with parental expectations

Parental

- Alteration in sleep pattern
- Conflict between partners
- Depression
- Failure to provide safe home environment
- Father of child uninvolved
- Inability to put child's needs before own
- Inadequate child-care arrangements
- Ineffective communication skills
- Ineffective coping strategies
- Insufficient access to resources
- Insufficient family cohesiveness
- Insufficient knowledge about child development
- Insufficient knowledge about child health maintenance
- Insufficient knowledge about parenting skills
– Insufficient parental role model
– Insufficient prenatal care
– Insufficient problem-solving skills
– Insufficient resources
– Insufficient response to infant cues
– Insufficient social support
– Insufficient transportation
– Insufficient valuing of parenthood
– Late-term prenatal care
– Low self-esteem
– Mother of child uninvolved
– Nonrestorative sleep pattern
– Preference for physical punishment
– Role strain
– Sleep deprivation
– Social isolation
– Stressors
– Unrealistic expectations

At risk population

Infant or Child

- Developmental delay
- Difficult temperament
– Gender other than desired
– Prematurity

Parental

- Change in family unit
- Closely spaced pregnancies
- Difficult birthing process
- Economically disadvantaged
- High number of pregnancies
- History of abuse
- History of being abusive
- History of mental illness
- History of substance misuse
- Insufficient cognitive readiness for parenting
– Legal difficulty
– Low educational level
– Multiple births
– Relocation
– Single parent
– Unemployment
– Unplanned pregnancy
– Unwanted pregnancy
– Work difficulty
– Young parental age

Associated condition

Infant or Child

- Alteration in perceptual abilities
- Behavioral disorder
– Chronic illness
– Disabling condition

Parental

- Alteration in cognitive functioning
- Disabling condition
– Physical illness

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 7 • Class 1 • Diagnosis Code 00164

Readiness for enhanced parenting

Approved 2002 • Revised 2013 • Level of Evidence 2.1

Definition

A pattern of providing an environment for children to nurture growth and development, which can be strengthened.

Defining characteristics

- Children express desire to enhance home environment
- Parent expresses desire to enhance parenting
  - Parent expresses desire to enhance emotional support of children
  - Parent expresses desire to enhance emotional support of other dependent person

Domain 7 • Class 2 • Diagnosis Code 00058

Risk for impaired attachment

Approved 1994 • Revised 2008, 2013, 2017 • Level of Evidence 2.1

Definition

Susceptible to disruption of the interactive process between parent or significant other and child that fosters the development of a protective and nurturing reciprocal relationship.

Risk factors

- Anxiety
- Child's illness prevents effective initiation of parental contact
- Disorganized infant behavior
- Inability of parent to meet personal needs
- Insufficient privacy
- Parental conflict resulting from disorganized infant behavior
- Parent-child separation
- Physical barrier
- Substance misuse

At risk population

- Premature infant

Domain 7 • Class 2 • Diagnosis Code 00063

Dysfunctional family processes

Approved 1994 • Revised 2008, 2017 • Level of Evidence 2.1

Definition

Family functioning which fails to support the well-being of its members.

Defining characteristics

Behavioral

- Agitation
- Alteration in concentration
- Blaming
- Broken promises
- Chaos
- Complicated grieving
- Conflict avoidance
- Contradictory communication pattern
- Controlling communication pattern
- Criticizing
- Decrease in physical contact
- Denial of problems
- Dependency
- Difficulty having fun
- Difficulty with intimate relationship
- Difficulty with life-cycle transition
- Disturbance in academic performance in children
- Enabling substance use pattern
- Escalating conflict
- Failure to accomplish developmental tasks
- Harsh self-judgment
- Immaturity
- Inability to accept a wide range of feelings
- Inability to accept help
- Inability to adapt to change
- Inability to deal constructively with traumatic experiences
- Unreliable behavior
– Inability to express a wide range of feelings
– Inability to meet the emotional needs of its members
– Inability to meet the security needs of its members
– Inability to meet the spiritual needs of its members
– Inability to receive help appropriately
– Inappropriate anger expression
– Ineffective communication skills
– Insufficient knowledge about substance misuse
– Insufficient problem-solving skills
– Lying
– Manipulation
– Nicotine addiction
– Orientation favors tension relief rather than goal attainment
– Paradoxical communication pattern
– Power struggles
– Rationalization
– Refusal to get help
– Seeking of affirmation
– Seeking of approval
– Self-blame
– Social isolation
– Special occasions centered on substance use
– Stress-related physical illness
– Substance misuse

- Verbal abuse of children
  - Verbal abuse of parent
  - Verbal abuse of partner

Feelings

- Abandonment
- Anger
- Anxiety
- Confuses love and pity
- Confusion
- Depression
- Dissatisfaction
- Distress
- Embarrassment
- Emotional isolation
- Emotionally controlled by others
- Failure
- Fear
- Feeling different from others
- Feeling misunderstood
- Feeling unloved
- Frustration
- Guilt
- Hopelessness
- Hostility
  - Hurt
  - Insecurity
  - Lingering resentment
  - Loneliness
  - Loss
  - Loss of identity
  - Low self-esteem
  - Mistrust
  - Moodiness
  - Powerlessness
  - Rejection
  - Repressed emotions
  - Shame
  - Taking responsibility for substance misuser's behavior
  - Tension
  - Unhappiness
  - Vulnerability
  - Worthlessness

Roles and Relationships

- Change in role function
- Chronic family problems
- Closed communication system
- Conflict between partners
- Deterioration in family relationships
- Diminished ability of family members to relate to each other for mutual growth and maturation
- Disruption in family rituals
- Disruption in family roles
- Disturbance in family dynamics
- Family denial
- Inconsistent parenting
  - Ineffective communication with partner
  - Insufficient cohesiveness
  - Insufficient family respect for autonomy of its members
  - Insufficient family respect for individuality of its members
  - Insufficient relationship skills
  - Neglect of obligation to family member
  - Pattern of rejection
  - Perceived insufficient parental support
  - Triangulating family relationships

Related factors

- Addictive personality
  - Insufficient problem-solving skills

- Ineffective coping strategies
– Substance misuse

At risk population

- Economically disadvantaged
- Family history of resistance to treatment
– Family history of substance misuse
– Genetic predisposition to substance misuse

Associated condition

- Biological factors
- Intimacy dysfunction
– Surgical procedure

Domain 7 • Class 2 • Diagnosis Code 00060

Interrupted family processes

Approved 1982 • Revised 1998, 2017

Definition

Break in the continuity of family functioning which fails to support the well-being of its members.

Defining characteristics

- Change in availability for affective responsiveness
- Change in family conflict resolution
- Change in family satisfaction
- Change in intimacy
- Change in participation for problem-solving
- Assigned tasks change
- Change in communication pattern
- Change in somatization
- Change in stress-reduction behavior
- Changes in expressions of conflict with community resources
- Changes in expressions of isolation from community resources
- Changes in participation for decision-making
- Changes in relationship pattern
- Decrease in available emotional support
- Decrease in mutual support
- Ineffective task completion
- Power alliance change
- Ritual change

Related factors

- Changes in interaction with community
- Power shift among family members
- Shift in family roles

At risk population

- Change in family finances
- Change in family social status
- Developmental crisis
- Developmental transition
- Situational crisis
- Situational transition

Associated condition

- Shift in health status of a family member

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 7 • Class 2 • Diagnosis Code 00159

Readiness for enhanced family processes

Approved 2002 • Revised 2013 • Level of Evidence 2.1

Definition

A pattern of family functioning to support the well-being of its members, which can be strengthened.

Defining characteristics

- Expresses desire to enhance balance between autonomy and cohesiveness
- Expresses desire to enhance communication pattern
- Expresses desire to enhance energy level of family to support activities of daily living
- Expresses desire to enhance family adaptation to change
- Expresses desire to enhance family dynamics
- Expresses desire to enhance family resilience
- Expresses desire to enhance growth of family members
- Expresses desire to enhance interdependence with community
- Expresses desire to enhance maintenance of boundaries between family members
- Expresses desire to enhance respect for family members
- Expresses desire to enhance safety of family members

Domain 7 • Class 3 • Diagnosis Code 00223

Ineffective relationship

Approved 2010 • Revised 2017 • Level of Evidence 2.1

Definition

A pattern of mutual partnership that is insufficient to provide for each other's needs.

Defining characteristics

- Delay in meeting of developmental goals appropriate for family life-cycle stage
- Dissatisfaction with complementary relationship between partners
- Dissatisfaction with emotional need fulfillment between partners
- Dissatisfaction with idea sharing between partners
- Dissatisfaction with information sharing between partners
- Dissatisfaction with physical need fulfillment between partners
- Inadequate understanding of partner's compromised functioning
- Insufficient balance in autonomy between partners
- Insufficient balance in collaboration between partners
- Insufficient mutual respect between partners
- Insufficient mutual support in daily activities between partners
- Partner not identified as support person
- Unsatisfying communication with partner

Related factors

- Ineffective communication skills
- Stressors
- Substance misuse
- Unrealistic expectations

At risk population

- Developmental crisis
- History of domestic violence
- Incarceration of one partner

Associated condition

- Alteration in cognitive functioning in one partner

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 7 • Class 3 • Diagnosis Code 00229

Risk for ineffective relationship

Approved 2010 • Revised 2013, 2017 • Level of Evidence 2.1

Definition

Susceptible to developing a pattern that is insufficient for providing a mutual partnership to provide for each other's needs.

Risk factors

- Ineffective communication skills
- Stressors
– Substance misuse
– Unrealistic expectations

At risk population

- Developmental crisis
- History of domestic violence
– Incarceration of one partner

Associated condition

– Alteration in cognitive functioning in one partner

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 7 • Class 3 • Diagnosis Code 00207

Readiness for enhanced relationship

Approved 2006 • Revised 2013 • Level of Evidence 2.1

Definition

A pattern of mutual partnership to provide for each other's needs, which can be strengthened.

Defining characteristics

- Expresses desire to enhance autonomy between partners
- Expresses desire to enhance collaboration between partners
- Expresses desire to enhance communication between partners
- Expresses desire to enhance emotional need fulfillment for each partner
- Expresses desire to enhance mutual respect between partners
- Expresses desire to enhance satisfaction with complementary relationship between partners
- Expresses desire to enhance satisfaction with emotional need fulfillment for each partner
- Expresses desire to enhance satisfaction with idea sharing between partners
- Expresses desire to enhance satisfaction with information sharing between partners
- Expresses desire to enhance satisfaction with physical need fulfillment for each partner
- Expresses desire to enhance understanding of partner's functional deficit

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 7 • Class 3 • Diagnosis Code 00064

Parental role conflict

Approved 1988 • Revised 2017

Definition

Parental experience of role confusion and conflict in response to crisis.

Defining characteristics

- Anxiety
- Concern about change in parental role
- Concern about family
- Disruption in caregiver routines
- Fear
- Frustration
- Guilt
- Perceived inadequacy to provide for child's needs
- Perceived loss of control over decisions relating to child
- Reluctance to participate in usual caregiver activities

Related factors

- Interruptions in family life due to home care regimen
- Intimidated by invasive modalities
- Intimidated by restrictive modalities
- Parent-child separation

At risk population

- Change in marital status
- Home care of a child with special needs
- Living in nontraditional setting

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 7 • Class 3 • Diagnosis Code 00055

Ineffective role performance

Approved 1978 • Revised 1996, 1998, 2017

Definition

A pattern of behavior and self-expression that does not match the environmental context, norms, and expectations.

Defining characteristics

- Alteration in role perception
- Anxiety
- Change in capacity to resume role
- Change in others' perception of role
- Change in self-perception of role
- Change in usual pattern of responsibility
- Depression
- Discrimination
- Domestic violence
- Harassment
- Inappropriate developmental expectations
- Ineffective adaptation to change
- Ineffective coping strategies
- Ineffective role performance
- Insufficient confidence
  - Insufficient external support for role enactment
  - Insufficient knowledge of role requirements
  - Insufficient motivation
  - Insufficient opportunity for role enactment
  - Insufficient self-management
  - Insufficient skills
  - Pessimism
  - Powerlessness
  - Role ambivalence
  - Role conflict
  - Role confusion
  - Role denial
  - Role dissatisfaction
  - Role strain
  - System conflict
  - Uncertainty

Related factors

- Alteration in body image
- Conflict
- Depression
- Domestic violence
- Fatigue
- Inadequate role model
- Inappropriate linkage with the healthcare system
- Insufficient resources
- Insufficient rewards
  - Insufficient role preparation
  - Insufficient role socialization
  - Insufficient support system
  - Low self-esteem
  - Pain
  - Stressors
  - Substance misuse
  - Unrealistic role expectations

At risk population

- Developmental level inappropriate for role expectation
- Economically disadvantaged
- High demands of job schedule
– Low educational level
– Young age

Associated condition

- Neurological defect
- Personality disorder
– Physical illness
– Psychosis

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 7 • Class 3 • Diagnosis Code 00052

Impaired social interaction

Approved 1986 • Revised 2017

Definition

Insufficient or excessive quantity or ineffective quality of social exchange.

Defining characteristics

- Discomfort in social situations
- Dissatisfaction with social engagement
- Dysfunctional interaction with others
- Family reports change in interaction
- Impaired social functioning

Related factors

- Communication barrier
- Disturbance in self-concept
- Disturbance in thought processes
- Environmental barrier
- Impaired mobility
- Insufficient knowledge about how to enhance mutuality
- Insufficient skills to enhance mutuality
- Sociocultural dissonance

At risk population

- Absence of significant other

Associated condition

- Therapeutic isolation

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 8.
Sexuality

Class 1.	Sexual identity
Code	**Diagnosis**
	This class does not currently contain any diagnoses.

Class 2.	Sexual function
Code	**Diagnosis**
00059	**Sexual** dys**function**
00065	Ineffective **sexuality pattern**

Class 3.	Reproduction
Code	**Diagnosis**
00221	Ineffective **childbearing process**
00227	Risk for ineffective **childbearing process**
00208	Readiness for enhanced **childbearing process**
00209	Risk for disturbed **maternal-fetal dyad**

NANDA International, Inc. Nursing Diagnoses: Definitions and Classification 2018–2020, 11th Edition. Edited by T. Heather Herdman and Shigemi Kamitsuru.

Companion website: **www.thieme.com/nanda-i**.

Domain 8 • Class 1

This class does not currently contain any diagnoses.

Domain 8 • Class 2 • Diagnosis Code 00059

Sexual dysfunction

Approved 1980 • Revised 2006, 2017 • Level of Evidence 2.1

Definition

A state in which an individual experiences a change in sexual function during the sexual response phases of desire, arousal, and/or orgasm, which is viewed as unsatisfying, unrewarding, or inadequate.

Defining characteristics

- Alteration in sexual activity
- Alteration in sexual excitation
- Alteration in sexual satisfaction
- Change in interest toward others
- Change in self-interest
- Change in sexual role
– Decrease in sexual desire
– Perceived sexual limitation
– Seeking confirmation of desirability
– Undesired change in sexual function

Related factors

- Absence of privacy
- Inadequate role model
- Insufficient knowledge about sexual function
- Misinformation about sexual function
– Presence of abuse
– Psychosocial abuse
– Value conflict
– Vulnerability

At risk population

– Absence of significant other

Associated condition

- Alteration in body function
– Alteration in body structure

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 8 • Class 2 • Diagnosis Code 00065

Ineffective sexuality pattern

Approved 1986 • Revised 2006, 2017 • Level of Evidence 2.1

Definition

Expressions of concern regarding own sexuality.

Defining characteristics

- Alteration in relationship with significant other
- Alteration in sexual activity
- Alteration in sexual behavior
- Change in sexual role
– Difficulty with sexual activity
– Difficulty with sexual behavior
– Value conflict

Related factors

- Conflict about sexual orientation
- Conflict about variant preference
- Fear of pregnancy
- Fear of sexually transmitted infection
- Impaired relationship with a significant other
– Inadequate role model
– Insufficient knowledge about alternatives related to sexuality
– Skill deficit about alternatives related to sexuality
– Absence of privacy

At risk population

– Absence of significant other

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 8 • Class 3 • Diagnosis Code 00221

Ineffective childbearing process

Approved 2010 • Revised 2017 • Level of Evidence 2.1

Definition

Inability to prepare for and/or maintain a healthy pregnancy, childbirth process and care of the newborn for ensuring well-being.

Defining characteristics

During Pregnancy

- Inadequate prenatal care
- Inadequate prenatal lifestyle
- Inadequate preparation of newborn care items
- Inadequate preparation of the home environment
- Ineffective management of unpleasant symptoms in pregnancy
- Insufficient access of support system
- Insufficient respect for unborn baby
- Unrealistic birth plan

During Labor and Delivery

- Decrease in proactivity during labor and delivery
- Inadequate lifestyle for stage of labor
- Inappropriate response to onset of labor
- Insufficient access of support system
- Insufficient attachment behavior

After Birth

- Inadequate baby care techniques
- Inadequate postpartum lifestyle
- Inappropriate baby feeding techniques
- Inappropriate breast care
- Insufficient access of support system
- Insufficient attachment behavior
- Unsafe environment for an infant

Related factors

- Domestic violence
- Inadequate maternal nutrition
- Inconsistent prenatal health visits
- Insufficient cognitive readiness for parenting
- Insufficient knowledge of childbearing process
- Insufficient parental role model
- Insufficient prenatal care
- Insufficient support system

- Low maternal confidence
- Maternal powerlessness
- Maternal psychological distress
– Substance misuse
– Unrealistic birth plan
– Unsafe environment

At risk population

– Unplanned pregnancy
– Unwanted pregnancy

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 8 • Class 3 • Diagnosis Code 00227

Risk for ineffective childbearing process

Approved 2010 • Revised 2013, 2017 • Level of Evidence 2.1

Definition

Susceptible to an inability to prepare for and/or maintain a healthy pregnancy, childbirth process and care of the newborn for ensuring well-being.

Risk factors

- Domestic violence
- Inadequate maternal nutrition
- Inconsistent prenatal health visits
- Insufficient cognitive readiness for parenting
- Insufficient knowledge of childbearing process
- Insufficient parental role model
- Insufficient prenatal care
- Insufficient support system
- Low maternal confidence
- Maternal powerlessness
- Maternal psychological distress
- Substance misuse
- Unrealistic birth plan
- Unsafe environment

At risk population

- Unplanned pregnancy
- Unwanted pregnancy

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 8 • Class 3 • Diagnosis Code 00208

Readiness for enhanced childbearing process

Approved 2008 • Revised 2013 • Level of Evidence 2.1

Definition

A pattern of preparing for and maintaining a healthy pregnancy, childbirth process and care of the newborn for ensuring well-being which can be strengthened.

Defining characteristics

During Pregnancy

- Expresses desire to enhance knowledge of childbearing process
- Expresses desire to enhance management of unpleasant pregnancy symptoms
- Expresses desire to enhance prenatal lifestyle
- Expresses desire to enhance preparation for newborn

During Labor and Delivery

- Expresses desire to enhance lifestyle appropriate for stage of labor
- Expresses desire to enhance proactivity during labor and delivery

After Birth

- Expresses desire to enhance attachment behavior
- Expresses desire to enhance baby care techniques
- Expresses desire to enhance baby feeding techniques
- Expresses desire to enhance breast care
- Expresses desire to enhance environmental safety for the baby
- Expresses desire to enhance postpartum lifestyle
- Expresses desire to enhance use of support system

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 8 • Class 3 • Diagnosis Code 00209

Risk for disturbed maternal-fetal dyad

Approved 2008 • Revised 2013, 2017 • Level of Evidence 2.1

Definition

Susceptible to a disruption of the symbiotic mother-fetal relationship as a result of comorbid or pregnancy-related conditions, which may compromise health.

Risk factors

- Inadequate prenatal care
- Presence of abuse
- Substance misuse

Associated condition

- Alteration in glucose metabolism
- Compromised fetal oxygen transport
- Pregnancy complication
- Treatment regimen

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 9.
Coping/stress tolerance

Class 1.	Post-trauma responses
Code	**Diagnosis**
00260	Risk for complicated **immigration transition**
00141	**Post-trauma syndrome**
00145	Risk for **post-trauma syndrome**
00142	**Rape-trauma syndrome**
00114	**Relocation stress syndrome**
00149	Risk for **relocation stress syndrome**

Class 2.	Coping responses
Code	**Diagnosis**
00199	Ineffective **activity planning**
00226	Risk for ineffective **activity planning**
00146	**Anxiety**
00071	Defensive **coping**
00069	Ineffective **coping**
00158	Readiness for enhanced **coping**
00077	Ineffective community **coping**
00076	Readiness for enhanced community **coping**
00074	Compromised family **coping**
00073	Disabled family **coping**
00075	Readiness for enhanced family **coping**
00147	**Death anxiety**
00072	Ineffective **denial**
00148	**Fear**

00136	**Grieving**
00135	Complicated **grieving**
00172	Risk for complicated **grieving**
00241	Impaired **mood regulation**
00125	**Power** lessness
00152	Risk for **power** lessness
00187	Readiness for enhanced **power**
00210	Impaired **resilience**
00211	Risk for impaired **resilience**
00212	Readiness for enhanced **resilience**
00137	Chronic **sorrow**
00177	**Stress** overload

Class 3.	**Neurobehavioral stress**
Code	**Diagnosis**
00258	**Acute substance withdrawal syndrome**
00259	Risk for **acute substance withdrawal syndrome**
00009	**Autonomic dysreflexia**
00010	Risk for **autonomic dysreflexia**
00049	Decreased intracranial **adaptive capacity**
00264	**Neonatal abstinence syndrome**
00116	Dis**organized** infant **behavior**
00115	Risk for dis**organized** infant **behavior**
00117	Readiness for enhanced **organized** infant **behavior**

NANDA International, Inc. Nursing Diagnoses: Definitions and Classification 2018–2020, 11th Edition. Edited by T. Heather Herdman and Shigemi Kamitsuru.

Domain 9 • Class 1 • Diagnosis Code 00260

Risk for complicated immigration transition

Approved 2016 • Level of Evidence 2.1

Definition

Susceptible to experiencing negative feelings (loneliness, fear, anxiety) in response to unsatisfactory consequences and cultural barriers to one's immigration transition, which may compromise health.

Risk factors

- Available work below educational preparation
- Cultural barriers in host country
- Unsanitary housing
- Insufficient knowledge about the process to access resources in the host country
- Insufficient social support in host country
  - Language barriers in host country
  - Multiple non-related persons within household
  - Overcrowded housing
  - Overt discrimination
  - Parent-child conflicts related to enculturation in the host country
  - Abusive landlord

At risk population

- Forced migration
- Hazardous work conditions with inadequate training
- Illegal status in host country
- Labor exploitation
- Precarious economic situation
  - Separation from family in home country
  - Separation from friends in home country
  - Unfulfilled expectations of immigration

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 9 • Class 1 • Diagnosis Code 00141

Post-trauma syndrome

Approved 1986 • Revised 1998, 2010, 2017 • Level of Evidence 2.1

Definition

Sustained maladaptive response to a traumatic, overwhelming event.

Defining characteristics

- Aggression
- Alienation
- Alteration in concentration
- Alteration in mood
- Anger
- Anxiety (00146)
- Avoidance behaviors
- Compulsive behavior
- Denial
- Depression
- Dissociative amnesia
- Enuresis
- Exaggerated startle response
- Fear (00148)
- Flashbacks
- Gastrointestinal irritation
- Grieving (00136)
- Guilt
- Headache
- Heart palpitations
- History of detachment
- Hopelessness (00124)
- Horror
- Hypervigilance
- Intrusive dreams
- Intrusive thoughts
- Irritability
- Neurosensory irritability
- Nightmares
- Panic attacks
- Rage
- Reports feeling numb
- Repression
- Shame
- Substance misuse

Related factors

- Diminished ego strength
- Environment not conducive to needs
- Exaggerated sense of responsibility
- Insufficient social support
- Perceives event as traumatic
- Self-injurious behavior
- Survivor role

At risk population

- Destruction of one's home
- Displacement from home
- Duration of traumatic event
- Event outside the range of usual human experience
- Exposure to disaster
- History of criminal victimization
- History of torture
- Human service occupations
- Serious accident
- Serious injury to loved one
– Exposure to epidemic
– Exposure to event involving multiple deaths
– Exposure to war
– History of abuse
– History of being a prisoner of war
– Serious threat to loved one
– Serious threat to self
– Witnessing mutilation
– Witnessing violent death

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to meet definition of a syndrome.

Domain 9 • Class 1 • Diagnosis Code 00145

Risk for post-trauma syndrome

Approved 1998 • Revised 2013, 2017 • Level of Evidence 2.1

Definition

Susceptible to sustained maladaptive response to a traumatic, overwhelming event, which may compromise health.

Risk factors

- Diminished ego strength
- Environment not conducive to needs
- Exaggerated sense of responsibility
- Insufficient social support
- Perceives event as traumatic
- Self-injurious behavior
- Survivor role

At risk population

- Destruction of one's home
- Displacement from home
- Duration of traumatic event
- Event outside the range of usual human experience
- Exposure to disaster
- Exposure to epidemic
- Exposure to event involving multiple deaths
- Exposure to war
- History of abuse
- History of being a prisoner of war
- History of criminal victimization
- History of torture
- Human service occupations
- Serious accident
- Serious injury to loved one
- Serious threat to loved one
- Serious threat to self
- Witnessing mutilation
- Witnessing violent death

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work along with Post-trauma syndrome (00141) is completed.

Domain 9 • Class 1 • Diagnosis Code 00142

Rape-trauma syndrome

Approved 1980 • Revised 1998, 2017

Definition

Sustained maladaptive response to a forced, violent, sexual penetration against the victim's will and consent.

Defining characteristics

- Aggression
- Agitation
- Alteration in sleep pattern
- Anger
- Anxiety (00146)
- Change in relationship(s)
- Confusion
- Denial
- Dependency
- Depression
- Disorganization
- Dissociative identity disorder
- Embarrassment
- Fear (00148)
- Guilt
- Helplessness
- History of suicide attempt
- Humiliation
- Hyperalertness
- Impaired decision-making
- Low self-esteem
- Mood swings
- Muscle spasm
- Muscle tension
- Nightmares
- Paranoia
- Perceived vulnerability
- Phobias
- Physical trauma
- Powerlessness (00125)
- Self-blame
- Sexual dysfunction (00059)
- Shame
- Shock
- Substance misuse
- Thoughts of revenge

Related factors

– To be developed

At risk population

– Rape

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 9 • Class 1 • Diagnosis Code 00114

Relocation stress syndrome

Approved 1992 • Revised 2000, 2017

Definition

Physiological and/or psychosocial disturbance following transfer from one environment to another.

Defining characteristics

- Alienation
- Aloneness
- Alteration in sleep pattern
- Anger
- Anxiety (00146)
- Concern about relocation
- Dependency
- Depression
- Fear (00148)
- Frustration
- Increase in illness
- Increase in physical symptoms
- Increase in verbalization of needs
- Insecurity
- Loneliness
- Loss of identity
- Loss of self-worth
- Low self-esteem
- Pessimism
- Preoccupation
- Unwillingness to move
- Withdrawal

Related factors

- Ineffective coping strategies
- Insufficient predeparture counseling
- Insufficient support system
- Language barrier
- Move from one environment to another
- Powerlessness
- Significant environmental change
- Social isolation
- Unpredictability of experience

At risk population

- History of loss

Associated condition

- Compromised health status
- Deficient mental competence

– Impaired psychosocial functioning

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 9 • Class 1 • Diagnosis Code 00149

Risk for relocation stress syndrome

Approved 2000 • Revised 2013, 2017

Definition

Susceptible to physiological and/or psychosocial disturbance following transfer from one environment to another, which may compromise health.

Risk factors

- Ineffective coping strategies
- Insufficient predeparture counseling
- Insufficient support system
- Language barrier

– Move from one environment to another
– Powerlessness
– Significant environmental change
– Social isolation
– Unpredictability of experience

At risk population

– History of loss

Associated condition

- Compromised health status
- Deficient mental competence

– Impaired psychosocial functioning

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 9 • Class 2 • Diagnosis Code 00199

Ineffective activity planning

Approved 2008 • Revised 2017 • Level of Evidence 2.1

Definition

Inability to prepare for a set of actions fixed in time and under certain conditions.

Defining characteristics

- Absence of plan
- Excessive anxiety about a task to be undertaken
- Fear about a task to be undertaken
- Insufficient organizational skills
- Insufficient resources
- Pattern of failure
- Pattern of procrastination
- Unmet goals for chosen activity
- Worried about a task to be undertaken

Related factors

- Flight behavior when faced with proposed solution
- Hedonism
- Insufficient information processing ability
- Insufficient social support
- Pattern of procrastination
- Unrealistic perception of event
- Unrealistic perception of personal abilities

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 9 • Class 2 • Diagnosis Code 00226

Risk for ineffective activity planning

Approved 2010 • Revised 2013 • Level of Evidence 2.1

Definition

Susceptible to an inability to prepare for a set of actions fixed in time and under certain conditions, which may compromise health.

Risk factors

- Flight behavior when faced with proposed solution
- Hedonism
- Insufficient information processing ability
- Insufficient social support
  - Pattern of procrastination
  - Unrealistic perception of event
  - Unrealistic perception of personal abilities

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 9 • Class 2 • Diagnosis Code 00146

Anxiety

Approved 1973 • Revised 1982, 1998, 2017

Definition

Vague, uneasy feeling of discomfort or dread accompanied by an autonomic response (the source is often nonspecific or unknown to the individual); a feeling of apprehension caused by anticipation of danger. It is an alerting sign that warns of impending danger and enables the individual to take measures to deal with that threat.

Defining characteristics

Behavioral

- Decrease in productivity
- Extraneous movement
- Fidgeting
- Glancing about
- Hypervigilance
- Insomnia
- Poor eye contact
- Restlessness
- Scanning behavior
- Worried about change in life event

Affective

- Anguish
- Apprehensiveness
- Distress
- Fear
- Feeling of inadequacy
- Helplessness
- Increase in wariness
- Irritability
- Nervousness
- Overexcitement
- Rattled
- Regretful
- Self-focused
- Uncertainty

Physiological

- Facial tension
- Hand tremors
- Increase in perspiration
- Increase in tension
- Trembling
- Tremor
- Voice quivering

Sympathetic

- Alteration in respiratory pattern
- Anorexia
- Brisk reflexes
- Cardiovascular excitation
- Increase in blood pressure
- Increase in heart rate
- Increase in respiratory rate
- Pupil dilation
– Diarrhea
– Dry mouth
– Facial flushing
– Heart palpitations
– Superficial vasoconstriction
– Twitching
– Weakness

Parasympathetic

- Abdominal pain
- Alteration in sleep pattern
- Decrease in blood pressure
- Decrease in heart rate
- Diarrhea
- Faintness
– Fatigue
– Nausea
– Tingling in extremities
– Urinary frequency
– Urinary hesitancy
– Urinary urgency

Cognitive

- Alteration in attention
- Alteration in concentration
- Awareness of physiological symptoms
- Blocking of thoughts
- Confusion
- Decrease in perceptual field
– Diminished ability to learn
– Diminished ability to problemsolve
– Forgetfulness
– Preoccupation
– Rumination
– Tendency to blame others

Related factors

- Conflict about life goals
- Interpersonal contagion
- Interpersonal transmission
- Stressors
- Substance misuse
– Threat of death
– Threat to current status
– Unmet needs
– Value conflict

At risk population

- Exposure to toxin
- Family history of anxiety
- Heredity
– Major change
– Maturational crisis
– Situational crisis

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 9 • Class 2 • Diagnosis Code 00071

Defensive coping

Approved 1988 • Revised 2008 • Level of Evidence 2.1

Definition

Repeated projection of falsely positive self-evaluation based on a self-protective pattern that defends against underlying perceived threats to positive selfregard.

Defining characteristics

- Alteration in reality testing
- Denial of problems
- Denial of weaknesses
- Difficulty establishing relationships
- Difficulty maintaining relationships
- Grandiosity
- Hostile laughter
- Hypersensitivity to a discourtesy
- Hypersensitivity to criticism
- Insufficient follow through with treatment
- Insufficient participation in treatment
- Projection of blame
- Projection of responsibility
- Rationalization of failures
- Reality distortion
- Ridicule of others
- Superior attitude toward others

Related factors

- Conflict between self-perception and value system
- Fear of failure
- Fear of humiliation
- Fear of repercussions
- Insufficient confidence in others
- Insufficient resilience
- Insufficient self-confidence
- Insufficient support system
- Uncertainty
- Unrealistic self-expectations

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 9 • Class 2 • Diagnosis Code 00069

Ineffective coping

Approved 1978 • Revised 1998

Definition

A pattern of invalid appraisal of stressors, with cognitive and/or behavioral efforts, that fails to manage demands related to well-being.

Defining characteristics

- Alteration in concentration
- Alteration in sleep pattern
- Change in communication pattern
- Destructive behavior toward others
- Destructive behavior toward self
- Difficulty organizing information
- Fatigue
- Frequent illness
- Inability to ask for help
- Inability to attend to information
- Inability to deal with a situation
- Inability to meet basic needs
- Inability to meet role expectation
- Ineffective coping strategies
- Insufficient access of social support
- Insufficient goal-directed behavior
- Insufficient problem resolution
- Insufficient problem-solving skills
- Risk-taking behavior
- Substance misuse

Related factors

- High degree of threat
- Inability to conserve adaptive energies
- Inaccurate threat appraisal
- Inadequate confidence in ability to deal with a situation
- Inadequate opportunity to prepare for stressor
- Inadequate resources
- Ineffective tension release strategies
- Insufficient sense of control
- Insufficient social support

At risk population

- Maturational crisis
- Situational crisis

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 9 • Class 2 • Diagnosis Code 00158

Readiness for enhanced coping

Approved 2002 • Revised 2013 • Level of Evidence 2.1

Definition

A pattern of valid appraisal of stressors with cognitive and/or behavioral efforts to manage demands related to well-being, which can be strengthened.

Defining characteristics

- Awareness of possible environmental change
- Expresses desire to enhance knowledge of stress management strategies
- Expresses desire to enhance management of stressors
  - Expresses desire to enhance social support
  - Expresses desire to enhance use of emotion-oriented strategies
  - Expresses desire to enhance use of problem-oriented strategies
  - Expresses desire to enhance use of spiritual resource

Domain 9 • Class 2 • Diagnosis Code 00077

Ineffective community coping

Approved 1994 • Revised 1998, 2017

Definition

A pattern of community activities for adaptation and problem-solving that is unsatisfactory for meeting the demands or needs of the community.

Defining characteristics

- Community does not meet expectations of its members
- Deficient community participation
- Elevated community illness rate
- Excessive community conflict
- Excessive stress
  - High incidence of community problems
  - Perceived community powerlessness
  - Perceived community vulnerability

Related factors

- Inadequate resources for problem-solving
- Insufficient community resources
  - Nonexistent community systems

At risk population

- Exposure to disaster
  - History of disaster

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 9 • Class 2 • Diagnosis Code 00076

Readiness for enhanced community coping

Approved 1994 • Revised 2013

Definition

A pattern of community activities for adaptation and problem-solving for meeting the demands or needs of the community, which can be strengthened.

Defining characteristics

- Expresses desire to enhance availability of community recreation programs
- Expresses desire to enhance availability of community relaxation programs
- Expresses desire to enhance communication among community members
- Expresses desire to enhance communication between groups and larger community
- Expresses desire to enhance community planning for predictable stressors
- Expresses desire to enhance community resources for managing stressors
- Expresses desire to enhance community responsibility for stress management
- Expresses desire to enhance problem-solving for identified issue

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 9 • Class 2 • Diagnosis Code 00074

Compromised family coping

Approved 1980 • Revised 1996, 2017

Definition

An usually supportive primary person (family member, significant other, or close friend) provides insufficient, ineffective, or compromised support, comfort, assistance, or encouragement that may be needed by the client to manage or master adaptive tasks related to his or her health challenge.

Defining characteristics

- Assistive behaviors by support person produce unsatisfactory results
- Client complaint about support person's response to health problem
- Client concern about support person's response to health problem
- Limitation in communication between support person and client
- Protective behavior by support person incongruent with client's abilities
- Protective behavior by support person incongruent with client's need for autonomy
- Support person reports inadequate understanding that interferes with effective behaviors
- Support person reports insufficient knowledge that interferes with effective behaviors
- Support person reports preoccupation with own reaction to client's need
- Support person withdraws from client

Related factors

- Coexisting situations affecting the support person
- Exhaustion of support person's capacity
- Family disorganization
- Insufficient information available to support person
- Insufficient reciprocal support
- Insufficient support given by client to support person
- Insufficient understanding of information by support person
- Misinformation obtained by support person
- Misunderstanding of information by support person
- Preoccupation by support person with concern outside of family

At risk population

- Developmental crisis experienced by support person
- Prolonged disease that exhausts capacity of support person

- Family role change – Situational crisis faced by support person

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 9 • Class 2 • Diagnosis Code 00073

Disabled family coping

Approved 1980 • Revised 1996, 2008 • Level of Evidence 2.1

Definition

Behavior of primary person (family member, significant other, or close friend) that disables his or her capacities and the client's capacities to effectively address tasks essential to either person's adaptation to the health challenge.

Defining characteristics

- Abandonment
- Adopts illness symptoms of client
- Aggression
- Agitation
- Client dependence
- Depression
- Desertion
- Disregard for client's needs
- Distortion of reality about client's health problem
- Family behaviors detrimental to well-being
- Hostility
- Impaired ability to structure a meaningful life
- Impaired individualism
- Intolerance
- Neglect of basic needs of client
- Neglect of relationship with family member
- Neglect of treatment regimen
- Performing routines without regard for client's needs
- Prolonged hyperfocus on client
- Psychosomatic symptoms
- Rejection

Related factors

- Ambivalent family relationships
- Chronically unexpressed feelings by support person
- Differing coping styles between support person and client
- Differing coping styles between support persons
- Inconsistent management of family's resistance to treatment

Domain 9 • Class 2 • Diagnosis Code 00075

Readiness for enhanced family coping

Approved 1980 • Revised 2013

Definition

A pattern of management of adaptive tasks by primary person (family member, significant other, or close friend) involved with the client's health challenge, which can be strengthened.

Defining characteristics

- Expresses desire to acknowledge growth impact of crisis
- Expresses desire to choose experiences that optimize wellness
- Expresses desire to enhance connection with others who have experienced a similar situation
– Expresses desire to enhance enrichment of lifestyle
– Expresses desire to enhance health promotion

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 9 • Class 2 • Diagnosis Code 00147

Death anxiety

Approved 1998 • Revised 2006, 2017 • Level of Evidence 2.1

Definition

Vague, uneasy feeling of discomfort or dread generated by perceptions of a real or imagined threat to one's existence.

Defining characteristics

- Concern about strain on the caregiver
- Deep sadness
- Fear of developing terminal illness
- Fear of loss of mental abilities when dying
- Fear of pain related to dying
- Fear of premature death
- Fear of prolonged dying process
- Fear of suffering related to dying
- Fear of the dying process
- Negative thoughts related to death and dying
- Powerlessness
- Worried about the impact of one's death on significant other

Related factors

- Anticipation of adverse consequences of anesthesia
- Anticipation of impact of death on others
- Anticipation of pain
- Anticipation of suffering
- Discussions on the topic of death
- Nonacceptance of own mortality
- Observations related to death
- Perceived imminence of death
- Uncertainty about encountering a higher power
- Uncertainty about life after death
- Uncertainty about the existence of a higher power
- Uncertainty of prognosis

At risk population

- Discussions on the topic of death
- Experiencing dying process
- Near-death experience
- Observations related to dying process

Associated condition

– Terminal illness

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 9 • Class 2 • Diagnosis Code 00072

Ineffective denial

Approved 1988 • Revised 2006 • Level of Evidence 2.1

Definition

Conscious or unconscious attempt to disavow the knowledge or meaning of an event to reduce anxiety and/or fear, leading to the detriment of health.

Defining characteristics

- Delay in seeking healthcare
- Denies fear of death
- Denies fear of invalidism
- Displaces fear of impact of the condition
- Displaces source of symptoms
- Does not admit impact of disease on life
- Does not perceive relevance of danger
  - Does not perceive relevance of symptoms
  - Inappropriate affect
  - Minimizes symptoms
  - Refusal of healthcare
  - Use of dismissive comments when speaking of distressing event
  - Use of dismissive gestures when speaking of distressing event
  - Use of treatment not advised by healthcare professional

Related factors

- Anxiety
- Excessive stress
- Fear of death
- Fear of losing autonomy
- Fear of separation
- Ineffective coping strategies
  - Insufficient emotional support
  - Insufficient sense of control
  - Perceived inadequacy in dealing with strong emotions
  - Threat of unpleasant reality

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 9 • Class 2 • Diagnosis Code 00148

Fear

Approved 1980 • Revised 1996, 2000, 2017

Definition

Response to perceived threat that is consciously recognized as a danger.

Defining characteristics

- Apprehensiveness
- Decrease in self-assurance
- Excitedness
- Feeling of alarm
- Feeling of dread
- Feeling of fear
- Feeling of panic
- Feeling of terror
- Fidgeting
- Increase in blood pressure
- Increase in tension
- Muscle tension
- Nausea
- Pallor
- Pupil dilation
- Vomiting

Cognitive

- Decrease in learning ability
- Decrease in problem-solving ability
- Decrease in productivity
- Identifies object of fear
- Stimulus believed to be a threat

Behaviors

- Attack behaviors
- Avoidance behaviors
- Focus narrowed to the source of fear
- Impulsiveness
- Increase in alertness

Physiological

- Anorexia
- Change in physiological response
- Diarrhea
- Dry mouth
- Dyspnea
- Fatigue
- Increase in perspiration

Related factors

- Language barrier
- Learned response to threat
- Response to phobic stimulus
– Separation from support system
– Unfamiliar setting

Associated condition

– Sensory deficit

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 9 • Class 2 • Diagnosis Code 00136

Grieving

Approved 1980 • Revised 1996, 2006, 2017 • Level of Evidence 2.1

Definition

A normal, complex process that includes emotional, physical, spiritual, social, and intellectual responses and behaviors by which individuals, families, and communities incorporate an actual, anticipated, or perceived loss into their daily lives.

Defining characteristics

- Alteration in activity level
- Alteration in dream pattern
- Alteration in immune functioning
- Alteration in neuroendocrine functioning
- Alteration in sleep pattern
- Anger
- Blaming
- Despair
- Detachment
- Disorganization
- Distress
- Finding meaning in a loss
- Guilt about feeling relieved
- Maintaining a connection to the deceased
- Pain
- Panic behavior
- Personal growth
- Psychological distress

Related factors

- To be developed

At risk population

- Anticipatory loss of significant object
- Anticipatory loss of significant other
- Death of significant other
- Loss of significant object

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition if no related factors are developed.

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 9 • Class 2 • Diagnosis Code 00135

Complicated grieving

Approved 1980 • Revised 1986, 2004, 2006, 2017 • Level of Evidence 2.1

Definition

A disorder that occurs after the death of a significant other, in which the experience of distress accompanying bereavement fails to follow normative expectations and manifests in functional impairment.

Defining characteristics

- Anger
- Anxiety
- Avoidance of grieving
- Decrease in functioning in life roles
- Depression
- Disbelief
- Distress about the deceased person
- Excessive stress
- Experiencing symptoms the deceased experienced
- Fatigue
- Feeling dazed
- Feeling of detachment from others
- Feeling of emptiness
- Feeling of shock
- Feeling stunned
- Insufficient sense of well-being
- Longing for the deceased person
- Low levels of intimacy
- Mistrust
- Nonacceptance of a death
- Persistent painful memories
- Preoccupation with thoughts about a deceased person
- Rumination
- Searching for a deceased person
- Self-blame
- Separation distress
- Traumatic distress

Related factors

- Emotional disturbance
- Insufficient social support

At risk population

- Death of significant other

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 9 • Class 2 • Diagnosis Code 00172

Risk for complicated grieving

Approved 2004 • Revised 2006, 2013, 2017 • Level of Evidence 2.1

Definition

Susceptible to a disorder that occurs after death of a significant other in which the experience of distress accompanying bereavement fails to follow normative expectations and manifests in functional impairment, which may compromise health.

Risk factors

- Emotional disturbance
– Insufficient social support

At risk population

– Death of significant other

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 9 • Class 2 • Diagnosis Code 00241

Impaired mood regulation

Approved 2013 • Revised 2017 • Level of Evidence 2.1

Definition

A mental state characterized by shifts in mood or affect and which is comprised of a constellation of affective, cognitive, somatic, and/or physiologic manifestations varying from mild to severe.

Defining characteristics

- Change in verbal behavior
- Disinhibition
- Dysphoria
- Excessive guilt
- Excessive self-awareness
- Excessive self-blame
- Flight of thoughts
- Hopelessness
- Impaired concentration
- Influenced self-esteem
- Irritability
- Psychomotor agitation
- Psychomotor retardation
- Sad affect
- Withdrawal

Related factors

- Alteration in sleep pattern
- Anxiety
- Appetite change
- Hypervigilance
- Impaired social functioning
- Loneliness
- Pain
- Recurrent thoughts of death
- Recurrent thoughts of suicide
- Social isolation
- Substance misuse
- Weight change

Associated condition

- Chronic illness
- Functional impairment
- Psychosis

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 9 • Class 2 • Diagnosis Code 00125

Power lessness

Approved 1982 • Revised 2010, 2017 • Level of Evidence 2.1

Definition

The lived experience of lack of control over a situation, including a perception that one's actions do not significantly affect an outcome.

Defining characteristics

- Alienation
- Dependency
- Depression
- Doubt about role performance
- Frustration about inability to perform previous activities
- Inadequate participation in care
- Insufficient sense of control
- Shame

Related factors

- Dysfunctional institutional environment
- Insufficient interpersonal interactions
- Anxiety
- Caregiver role
- Ineffective coping strategies
- Insufficient knowledge to manage a situation
- Insufficient social support
- Low self-esteem
- Pain
- Social marginalization
- Stigmatization

At risk population

- Economically disadvantaged

Associated condition

- Complex treatment regimen
- Illness
- Progressive illness
- Unpredictability of illness trajectory

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 9 • Class 2 • Diagnosis Code 00152

Risk for power lessness

Approved 2000 • Revised 2010, 2013, 2017 • Level of Evidence 2.1

Definition

Susceptible to the lived experience of lack of control over a situation, including apperception that one's actions do not significantly affect the outcome, which may compromise health.

Risk factors

- Dysfunctional institutional environment
- Insufficient interpersonal interactions
- Anxiety
- Caregiver role
- Ineffective coping strategies
- Insufficient knowledge to manage a situation
- Insufficient social support
- Low self-esteem
- Pain
- Social marginalization
- Stigmatization

At risk population

- Economically disadvantaged

Associated condition

- Complex treatment regimen
- Illness
- Progressive illness
- Unpredictability of illness trajectory

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 9 • Class 2 • Diagnosis Code 00187

Readiness for enhanced power

Approved 2006 • Revised 2013 • Level of Evidence 2.1

Definition

A pattern of participating knowingly in change for well-being, which can be strengthened.

Defining characteristics

- Expresses desire to enhance awareness of possible changes
- Expresses desire to enhance identification of choices that can be made for change
- Expresses desire to enhance independence with actions for change
- Expresses desire to enhance involvement in change
  - Expresses desire to enhance knowledge for participation in change
  - Expresses desire to enhance participation in choices for daily living
  - Expresses desire to enhance participation in choices for health
  - Expresses desire to enhance power

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 9 • Class 2 • Diagnosis Code 00210

Impaired resilience

Approved 2008 • Revised 2017 • Level of Evidence 2.1

Definition

Decreased ability to recover from perceived adverse or changing situations, through a dynamic process of adaptation.

Defining characteristics

- Decreased interest in academic activities
- Decreased interest in vocational activities
- Depression
- Guilt
- Impaired health status
- Ineffective coping strategies
  - Ineffective integration
  - Ineffective sense of control
  - Low self-esteem
  - Renewed elevation of distress
  - Shame
  - Social isolation

Related factors

- Community violence
- Disruption in family rituals
- Disruption in family roles
- Disturbance in family dynamics
- Dysfunctional family processes
- Inadequate resources
- Inconsistent parenting
- Ineffective family adaptation
  - Insufficient impulse control
  - Insufficient resources
  - Insufficient social support
  - Multiple coexisting adverse situations
  - Perceived vulnerability
  - Substance misuse

At risk population

- Chronicity of existing crisis
- Demographics that increase chance of maladjustment
- Economically disadvantaged
- Ethnic minority status
- Exposure to violence
- Female gender
  - Large family size
  - Low intellectual ability
  - Low maternal educational level
  - New crisis
  - Parental mental illness

Associated condition

– Psychological disorder

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 9 • Class 2 • Diagnosis Code 00211

Risk for impaired resilience

Approved 2008 • Revised 2013, 2017 • Level of Evidence 2.1

Definition

Susceptible to decreased ability to recover from perceived adverse or changing situations, through a dynamic process of adaptation, which may compromise health.

Risk factors

- Community violence
- Disruption in family rituals
- Disruption in family roles
- Disturbance in family dynamics
- Dysfunctional family processes
- Inadequate resources
- Inconsistent parenting
- Ineffective family adaptation
- Insufficient impulse control
- Insufficient resources
- Insufficient social support
- Multiple coexisting adverse situations
- Perceived vulnerability
- Substance misuse

At risk population

- Chronicity of existing crisis
- Demographics that increase chance of maladjustment
- Economically disadvantaged
- Ethnic minority status
- Exposure to violence
- Female gender
- Large family size
- Low intellectual ability
- Low maternal educational level
- New crisis
- Parental mental illness

Associated condition

- Psychological disorder

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 9 • Class 2 • Diagnosis Code 00212

Readiness for enhanced resilience

Approved 2008 • Revised 2013 • Level of Evidence 2.1

Definition

A pattern of ability to recover from perceived adverse or changing situations, through a dynamic process of adaptation, which can be strengthened.

Defining characteristics

- Expresses desire to enhance available resources
- Expresses desire to enhance communication skills
- Expresses desire to enhance environmental safety
- Expresses desire to enhance goalsetting
- Expresses desire to enhance involvement in activities
- Expresses desire to enhance own responsibility for action
- Expresses desire to enhance positive outlook
- Expresses desire to enhance progress toward goal
- Expresses desire to enhance relationships with others
- Expresses desire to enhance resilience
- Expresses desire to enhance self-esteem
- Expresses desire to enhance sense of control
- Expresses desire to enhance support system
- Expresses desire to enhance use of conflict management strategies
- Expresses desire to enhance use of coping skills
- Expresses desire to enhance use of resource

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 9 • Class 2 • Diagnosis Code 00137

Chronic sorrow

Approved 1998 • Revised 2017

Definition

Cyclical, recurring, and potentially progressive pattern of pervasive sadness experienced (by a parent, caregiver, individual with chronic illness or disability) in response to continual loss, throughout the trajectory of an illness or disability.

Defining characteristics

- Feeling that interferes with well-being
- Overwhelming negative feelings
– Sadness

Related factors

- Crisis in disability management
- Crisis in illness management
– Missed milestones
– Missed opportunities

At risk population

- Death of significant other
- Developmental crisis
– Length of time as a caregiver

Associated condition

- Chronic disability
– Chronic illness

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 9 • Class 2 • Diagnosis Code 00177

Stress overload

Approved 2006 • Level of Evidence 3.2

Definition

Excessive amounts and types of demands that require action.

Defining characteristics

- Excessive stress
- Feeling of pressure
- Impaired decision-making
- Impaired functioning
- Increase in anger
  - Increase in anger behavior
  - Increase in impatience
  - Negative impact from stress
  - Tension

Related factors

- Insufficient resources
- Repeated stressors
  - Stressors

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 9 • Class 3 • Diagnosis Code 00258

Acute substance withdrawal syndrome

Approved 2016 • Level of Evidence 2.1

Definition

Serious, multifactorial sequelae following abrupt cessation of an addictive compound.

Defining characteristics

- Acute confusion (00128)
- Anxiety (00146)
- Disturbed sleep pattern (00198)
- Nausea (00134)
- Risk for electrolyte imbalance (00195)
- Risk for injury (00035)

Risk factors

- Developed dependence to alcohol or other addictive substance
- Heavy use of an addictive substance over time
- Malnutrition
- Sudden cessation of an addictive substance

At risk population

- History of previous withdrawal symptoms
- Older adults

Associated condition

- Comorbid mental disorder
- Comorbid serious physical illness

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 9 • Class 3 • Diagnosis Code 00259

Risk for acute substance withdrawal syndrome

Approved 2016 • Level of Evidence 2.1

Definition

Susceptible to serious, multifactorial sequelae following abrupt cessation of an addictive compound, which may compromise health.

Risk factors

- Developed dependence to alcohol or other addictive substance
- Heavy use of an addictive substance over time
- Malnutrition
- Sudden cessation of an addictive substance

At risk population

- History of previous withdrawal symptoms
- Older adults

Associated condition

- Comorbid mental disorder
- Comorbid serious physical illness

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 9 • Class 3 • Diagnosis Code 00009

Autonomic dysreflexia

Approved 1988 • Revised 2017

Definition

Life-threatening, uninhibited sympathetic response of the nervous system to a noxious stimulus after a spinal cord injury at the 7th thoracic vertebra (T7) or above.

Defining characteristics

- Blurred vision
- Bradycardia
- Chest pain
- Chilling
- Conjunctival congestion
- Diaphoresis above the injury
- Diffuse pain in different areas of the head
- Horner's syndrome
- Metallic taste in mouth
- Nasal congestion
- Pallor below injury
- Paresthesia
- Paroxysmal hypertension
- Pilomotor reflex
- Red blotches on skin above the injury
- Tachycardia

Related factors

Gastrointestinal Stimuli

- Constipation
- Difficult passage of feces
- Digital stimulation
- Enemas
- Fecal impaction
- Suppositories

Integumentary Stimuli

- Cutaneous stimulation
- Skin irritation

Musculoskeletal-Neurological Stimuli

- Irritating stimuli below level of injury
- Painful stimuli below level of injury
- Pressure over bony prominence
- Pressure over genitalia
- Range of motion exercises
- Spasm

Regulatory -Situational Stimuli

- Constrictive clothing
- Environmental temperature fluctuations
– Positioning

Reproductive-Urological Stimuli

- Bladder distention
- Bladder spasm
– Instrumentation
– Sexual intercourse

Other

- Insufficient caregiver knowledge of disease process
– Insufficient knowledge of disease process

At risk population

- Ejaculation
- Extremes of environmental temperature
– Menstruation

Associated condition

- Bowel distention
- Cystitis
- Deep vein thrombosis
- Detrusor sphincter dyssynergia
- Epididymitis
- Esophageal reflux disease
- Fracture
- Gallstones
- Gastric ulcer
- Gastrointestinal system pathology
- Hemorrhoids
- Heterotopic bone
- Labor and delivery period
– Ovarian cyst
– Pharmaceutical agent
– Pregnancy
– Pulmonary emboli
– Renal calculi
– Substance withdrawal
– Sunburn
– Surgical procedure
– Urethritis
– Urinary catheterization
– Urinary tract infection
– Wound

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 9 • Class 3 • Diagnosis Code 00010

Risk for autonomic dysreflexia

Approved 1998 • Revised 2000, 2013, 2017

Definition

Susceptible to life-threatening, uninhibited response of the sympathetic nervous system post-spinal shock, in an individual with spinal cord injury or lesion at the 6th thoracic vertebra (T6) or above (has been demonstrated in patients with injuries at the 7th thoracic vertebra [T7] and the 8th thoracic vertebra [T8]), which may compromise health.

Risk factors

Gastrointestinal Stimuli

- Bowel distention
- Constipation
- Difficult passage of feces
- Digital stimulation
  - Enemas
  - Fecal impaction
  - Suppositories

Integumentary Stimuli

- Cutaneous stimulation
- Skin irritation
  - Sunburn
  - Wound

Musculoskeletal-Neurological Stimuli

- Irritating stimuli below level of injury
- Painful stimuli below level of injury
- Pressure over bony prominence
  - Pressure over genitalia
  - Range of motion exercises
  - Spasm

Regulatory-Situational Stimuli

- Constrictive clothing
- Environmental temperature fluctuations
  - Positioning

Reproductive-Urological Stimuli

- Bladder distention
- Bladder spasm
– Instrumentation
– Sexual intercourse

Other

- Insufficient caregiver knowledge of disease process
– Insufficient knowledge of disease process

At risk population

- Ejaculation
- Extremes of environmental temperature
– Menstruation

Associated condition

- Bowel distention
- Cystitis
- Deep vein thrombosis
- Detrusor sphincter dyssynergia
- Epididymitis
- Esophageal reflux disease
- Fracture
- Gallstones
- Gastric ulcer
- Gastrointestinal system pathology
- Hemorrhoids
- Heterotopic bone
- Labor and delivery period
– Ovarian cyst
– Pharmaceutical agent
– Pregnancy
– Pulmonary emboli
– Renal calculi
– Substance withdrawal
– Sunburn
– Surgical procedure
– Urethritis
– Urinary catheterization
– Urinary tract infection
– Wound

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 9 • Class 3 • Diagnosis Code 00049

Decreased intracranial adaptive capacity

Approved 1994

Definition

Compromise in intracranial fluid dynamic mechanisms that normally compensate for increases in intracranial volumes, resulting in repeated disproportionate increases in intracranial pressure (ICP) in response to a variety of noxious and non-noxious stimuli.

Defining characteristics

– Baseline intracranial pressure (ICP) ≥ 10 mmHg
– Disproportionate increase in intracranial pressure (ICP) following stimuli
– Elevated tidal wave intracranial pressure (P2 ICP) waveform
– Repeated increase in intracranial pressure (ICP) ≥ 10 mmHg for ≥ 5 minutes following external stimuli
– Volume-pressure response test variation (volume: pressure ratio 2, pressure-volume index < 10)
– Wide-amplitude intracranial pressure (ICP) waveform

Related factors

– To be developed

Associated condition

- Brain injury
- Decrease in cerebral perfusion ≤ 50-60 mmHg
– Sustained increase in intracranial pressure (ICP) of 10-15 mmHg
– Systemic hypotension with intracranial hypertension

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 9 • Class 3 • Diagnosis Code 00264

Neonatal abstinence syndrome

Approved 2016 • Level of Evidence 2.1

Definition

A constellation of withdrawal symptoms observed in newborns as a result of in-utero exposure to addicting substances, or as a consequence of postnatal pharmacological pain management.

Defining characteristics

- Diarrhea (00013)
- Disorganized infant behavior (00116)
- Disturbed sleep pattern (00198)
- Impaired comfort (00214)
- Ineffective infant feeding pattern (00107)
- Neurobehavioral stress

Related factors

– To be developed

At risk population

- Iatrogenic substance exposure for pain control following a critical illness or surgery
- In-utero substance exposure secondary to maternal substance use
- Risk for aspiration (00039)
- Risk for imbalanced body temperature (00005)
- Risk for impaired attachment (00058)
- Risk for impaired skin integrity (00047)
- Risk for injury (00035)

The Finnegan Neonatal Abstinence Scoring Tool (FNAST) is recommended for assessment of withdrawal symptoms and for making decisions related to the plan of care. An FNAST score of 8 or greater, in combination with a history of in-utero substance exposure, is often used to make the diagnosis of Neonatal Abstinence Syndrome. This instrument was developed and is used predominantly in the U.S. and other western countries, so it may not be appropriate to recommend for the international community. Modifiable related factors to be developed.

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 9 • Class 3 • Diagnosis Code 00116

Disorganized infant behavior

Approved 1994 • Revised 1998, 2017

Definition

Disintegration of the physiological and neurobehavioral systems of functioning.

Defining characteristics

Attention-Interaction System

– Impaired response to sensory stimuli

Motor System

- Alteration in primitive reflexes
- Exaggerated startle response
- Fidgeting
- Finger splaying
- Fisting
- Hands to face
– Hyperextension of extremities
– Impaired motor tone
– Tremor
– Twitching
– Uncoordinated movement

Physiological

- Abnormal skin color
- Arrhythmia
- Bradycardia
- Feeding intolerance
– Oxygen desaturation
– Tachycardia
– Time-out signals

Regulatory Problems

- Inability to inhibit startle reflex
– Irritability

State-Organization System

- Active-awake
– Irritable crying

- Diffuse alpha electroencephalogram (EEG) activity with eyes closed
  – Quiet-awake
  – State oscillation

Related factors

- Caregiver cue misreading
- Environmental overstimulation
- Infant malnutrition
- Insufficient caregiver knowledge of behavioral cues
- Insufficient containment within environment
  – Feeding intolerance
  – Inadequate physical environment
  – Insufficient environmental sensory stimulation
  – Pain
  – Sensory deprivation
  – Sensory overstimulation

At risk population

- Low postconceptual age
- Prematurity
  – Prenatal exposure to teratogen

Associated condition

- Congenital disorder
- Genetic disorder
- Infant illness
- Immature neurological functioning
  – Impaired infant motor functioning
  – Invasive procedure
  – Infant oral impairment

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 9 • Class 3 • Diagnosis Code 00115

Risk for disorganized infant behavior

Approved 1994 • Revised 2013, 2017

Definition

Susceptible to disintegration in the pattern of modulation of the physiological and neurobehavioral systems of functioning, which may compromise health.

Risk factors

- Caregiver cue misreading
- Environmental overstimulation
- Feeding intolerance
- Inadequate physical environment
- Infant malnutrition
- Insufficient caregiver knowledge of behavioral cues
- Insufficient containment within environment
- Insufficient environmental sensory stimulation
- Pain
- Sensory deprivation
- Sensory overstimulation

At risk population

- Low postconceptual age
- Prematurity
- Prenatal exposure to teratogen

Associated condition

- Congenital disorder
- Genetic disorder
- Infant illness
- Immature neurological functioning
- Impaired infant motor functioning
- Invasive procedure
- Infant oral impairment

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 9 • Class 3 • Diagnosis Code 00117

Readiness for enhanced organized infant behavior

Approved 1994 • Revised 2013

Definition

An integrated pattern of modulation of the physiological and neurobehavioral systems of functioning, which can be strengthened.

Defining characteristics

- Parent expresses desire to enhance cue recognition
- Parent expresses desire to enhance environmental conditions
– Parent expresses desire to enhance recognition of infant's self-regulatory behaviors

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 10.
Life principles

Class 1.	Values
Code	**Diagnosis**
	This class does not currently contain any diagnoses.

Class 2.	Beliefs
Code	**Diagnosis**
00068	Readiness for enhanced **spiritual well-being**

Class 3.	Value/belief/action congruence
Code	**Diagnosis**
00184	Readiness for enhanced **decision-making**
00083	**Decisional conflict**
00242	Impaired **emancipated decision-making**
00244	Risk for impaired **emancipated decision-making**
00243	Readiness for enhanced **emancipated decision-making**
00175	**Moral distress**
00169	Impaired **religiosity**
00170	Risk for impaired **religiosity**
00171	Readiness for enhanced **religiosity**
00066	**Spiritual distress**
00067	Risk for **spiritual distress**

NANDA International, Inc. Nursing Diagnoses: Definitions and Classification 2018–2020, 11th Edition. Edited by T. Heather Herdman and Shigemi Kamitsuru.
 Published 2017 by Thieme Medical Publishers, Inc., New York. Companion website: **www.thieme.com/nanda-i**.

Domain 10 • Class 1

This class does not currently contain any diagnoses.

Domain 10 • Class 2 • Diagnosis Code 00068

Readiness for enhanced spiritual well-being

Approved 1994 • Revised 2002, 2013 • Level of Evidence 2.1

Definition

A pattern of experiencing and integrating meaning and purpose in life through connectedness with self, others, art, music, literature, nature, and/or a power greater than oneself, which can be strengthened.

Defining characteristics

Connections to Self

- Expresses desire to enhance acceptance
- Expresses desire to enhance coping
- Expresses desire to enhance courage
- Expresses desire to enhance hope
- Expresses desire to enhance joy
- Expresses desire to enhance love
- Expresses desire to enhance meaning in life
- Expresses desire to enhance meditative practice
- Expresses desire to enhance purpose in life
- Expresses desire to enhance satisfaction with philosophy of life
- Expresses desire to enhance selfforgiveness
- Expresses desire to enhance serenity
- Expresses desire to enhance surrender

Connections with Others

- Expresses desire to enhance forgiveness from others
- Expresses desire to enhance interaction with significant other
- Expresses desire to enhance interaction with spiritual leaders
- Expresses desire to enhance service to others

Connections with Art, Music, Literature, and Nature

- Expresses desire to enhance creative energy
- Expresses desire to enhance spiritual reading
- Expresses desire to enhance time outdoors

Connections with Power Greater than Self

- Expresses desire to enhance mystical experiences
- Expresses desire to enhance participation in religious activity
- Expresses desire to enhance prayerfulness
- Expresses desire to enhance reverence

Domain 10 • Class 3 • Diagnosis Code 00184

Readiness for enhanced decision-making

Approved 2006 • Revised 2013 • Level of Evidence 2.1

Definition

A pattern of choosing a course of action for meeting short- and long-term health-related goals, which can be strengthened.

Defining characteristics

- Expresses desire to enhance congruency of decision with sociocultural goal
- Expresses desire to enhance congruency of decision with sociocultural values
- Expresses desire to enhance congruency of decisions with goal
- Expresses desire to enhance congruency of decisions with values
- Expresses desire to enhance decision-making
- Expresses desire to enhance riskbenefit analysis of decisions
- Expresses desire to enhance understanding of choices for decision-making
- Expresses desire to enhance understanding of meaning of choices
- Expresses desire to enhance use of reliable evidence for decisions

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 10 • Class 3 • Diagnosis Code 00083

Decisional conflict

Approved 1988 • Revised 2006 • Level of Evidence 2.1

Definition

Uncertainty about course of action to be taken when choice among competing actions involves risk, loss, or challenge to values and beliefs.

Defining characteristics

- Delay in decision-making
- Distress while attempting a decision
- Physical sign of distress
- Physical sign of tension
- Questioning of moral principle while attempting a decision
- Questioning of moral rule while attempting a decision
- Questioning of moral values while attempting a decision
- Questioning of personal beliefs while attempting a decision
- Questioning of personal values while attempting a decision
- Recognizes undesired consequences of actions being considered
- Self-focused
- Uncertainty about choices
- Vacillating among choices

Related factors

- Conflict with moral obligation
- Conflicting information sources
- Inexperience with decision-making
- Insufficient information
- Insufficient support system
- Interference in decision-making
- Moral principle supports mutually inconsistent actions
- Moral rule supports mutually inconsistent actions
- Moral value supports mutually inconsistent actions
- Perceived threat to value system
- Unclear personal beliefs
- Unclear personal values

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 10 • Class 3 • Diagnosis Code 00242

Impaired emancipated decision-making

Approved 2013 • Revised 2017 • Level of Evidence 2.1

Definition

A process of choosing a healthcare decision that does not include personal knowledge and/or consideration of social norms, or does not occur in a flexible environment, resulting in decisional dissatisfaction.

Defining characteristics

- Delay in enacting chosen healthcare option
- Distress when listening to other's opinion
- Excessive concern about what others think is the best decision
- Excessive fear of what others think about a decision
- Feeling constrained in describing own opinion
- Inability to choose a healthcare option that best fits current lifestyle
- Inability to describe how option will fit into current lifestyle
- Limited verbalization about healthcare option in other's presence

Related factors

- Decrease in understanding of all available healthcare options
- Inability to adequately verbalize perceptions about healthcare options
- Inadequate time to discuss healthcare options
- Insufficient confidence to openly discuss healthcare options
- Insufficient information regarding healthcare options
- Insufficient privacy to openly discuss healthcare options
- Insufficient self-confidence in decision-making

At risk population

- Limited decision-making experience
- Traditional hierarchical family
- Traditional hierarchical healthcare systems

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 10 • Class 3 • Diagnosis Code 00244

Risk for impaired emancipated decision-making

Approved 2013 • Revised 2017 • Level of Evidence 2.1

Definition

Susceptible to a process of choosing a healthcare decision that does not include personal knowledge and/or consideration of social norms, or does not occur in a flexible environment, resulting in decisional dissatisfaction.

Risk factors

- Decrease in understanding of all available healthcare options
- Inability to adequately verbalize perceptions about healthcare options
- Inadequate time to discuss healthcare options
  - Insufficient confidence to openly discuss healthcare options
  - Insufficient information regarding healthcare options
  - Insufficient privacy to openly discuss healthcare options
  - Insufficient self-confidence in decision-making

At risk population

- Limited decision-making experience
- Traditional hierarchical family
  - Traditional hierarchical healthcare systems

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 10 • Class 3 • Diagnosis Code 00243

Readiness for enhanced emancipated decision-making

Approved 2013 • Level of Evidence 2.1

Definition

A process of choosing a healthcare decision that includes personal knowledge and/or consideration of social norms, which can be strengthened.

Defining characteristics

- Expresses desire to enhance ability to choose healthcare options that best fit current lifestyle
- Expresses desire to enhance ability to enact chosen healthcare option
- Expresses desire to enhance ability to understand all available healthcare options
- Expresses desire to enhance ability to verbalize own opinion without constraint
- Expresses desire to enhance comfort to verbalize healthcare options in the presence of others
- Expresses desire to enhance confidence in decision-making
- Expresses desire to enhance confidence to discuss healthcare options openly
- Expresses desire to enhance decision-making
- Expresses desire to enhance privacy to discuss healthcare options

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 10 • Class 3 • Diagnosis Code 00175

Moral distress

Approved 2006 • Level of Evidence 2.1

Definition

Response to the inability to carry out one's chosen ethical or moral decision and/or action.

Defining characteristics

– Anguish about acting on one's moral choice

Related factors

- Conflict among decision-makers
- Conflicting information available for ethical decision-making
- Conflicting information available for moral decision-making
- Cultural incongruence
– Difficulty reaching end-of-life decisions
– Difficulty reaching treatment decision
– Time constraint for decision-making

At risk population

- Loss of autonomy
– Physical distance of decision-maker

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 10 • Class 3 • Diagnosis Code 00169

Impaired religiosity

Approved 2004 • Revised 2017 • Level of Evidence 2.1

Definition

Impaired ability to exercise reliance on beliefs and/or participate in rituals of a particular faith tradition.

Defining characteristics

- Desire to reconnect with previous belief pattern
- Desire to reconnect with previous customs
- Difficulty adhering to prescribed religious beliefs
– Difficulty adhering to prescribed religious rituals
– Distress about separation from faith community
– Questioning of religious belief patterns
– Questioning of religious customs

Related factors

- Anxiety
- Cultural barrier to practicing religion
- Depression
- Environmental barrier to practicing religion
- Fear of death
- Ineffective caregiving
- Ineffective coping strategies
– Insecurity
– Insufficient social support
– Insufficient sociocultural interaction
– Insufficient transportation
– Pain
– Spiritual distress

At risk population

- Aging
- End-stage life crisis
- History of religious manipulation
- Hospitalization
– Life transition
– Personal crisis
– Spiritual crisis

Associated condition

– Illness

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 10 • Class 3 • Diagnosis Code 00170

Risk for impaired religiosity

Approved 2004 • Revised 2013, 2017 • Level of Evidence 2.1

Definition

Susceptible to an impaired ability to exercise reliance on religious beliefs and/or participate in rituals of a particular faith tradition, which may compromise health.

Risk factors

- Insufficient transportation
- Pain
- Anxiety
- Depression
- Fear of death
- Ineffective caregiving
- Ineffective coping strategies
- Insecurity
- Insufficient social support
- Cultural barrier to practicing religion
- Environmental barrier to practicing religion
- Insufficient sociocultural interaction
- Spiritual distress

At risk population

- Aging
- End-stage life crisis
- Life transition
- History of religious manipulation
- Hospitalization
- Personal crisis
- Spiritual crisis

Associated condition

- Illness

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 10 • Class 3 • Diagnosis Code 00171

Readiness for enhanced religiosity

Approved 2004 • Revised 2013 • Level of Evidence 2.1

Definition

A pattern of reliance on religious beliefs and/or participation in rituals of a particular faith tradition, which can be strengthened.

Defining characteristics

- Expresses desire to enhance belief patterns used in the past
- Expresses desire to enhance connection with a religious leader
- Expresses desire to enhance forgiveness
- Expresses desire to enhance participation in religious experiences
- Expresses desire to enhance participation in religious practices
- Expresses desire to enhance religious customs used in the past
- Expresses desire to enhance religious options
- Expresses desire to enhance use of religious material

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 10 • Class 3 • Diagnosis Code 00066

Spiritual distress

Approved 1978 • Revised 2002, 2013, 2017 • Level of Evidence 2.1

Definition

A state of suffering related to the impaired ability to experience meaning in life through connections with self, others, the world, or a superior being.

Defining characteristics

- Anxiety
- Crying
- Fatigue
- Fear
– Insomnia
– Questioning identity
– Questioning meaning of life
– Questioning meaning of suffering

Connections to Self

- Anger
- Decrease in serenity
- Feeling unloved
- Guilt
- Inadequate acceptance
– Ineffective coping strategies
– Insufficient courage
– Perceived insufficient meaning in life

Connections with Others

- Alienation
- Refuses to interact with spiritual leader
– Refuses to interact with significant other
– Separation from support system

Connections with Art, Music, Literature, and Nature

- Decrease in expression of previous pattern of creativity
- Disinterest in nature
– Disinterest in reading spiritual literature

Connections with Power Greater than Self

- Anger toward power greater than self
– Inability to pray

- Feeling abandoned
- Hopelessness
- Inability for introspection
- Inability to experience the transcendent
- Inability to participate in religious activities
– Perceived suffering
– Request for a spiritual leader
– Sudden change in spiritual practice

Related factors

- Anxiety
- Barrier to experiencing love
- Change in religious ritual
- Change in spiritual practice
- Cultural conflict
- Depression
- Environmental change
- Inability to forgive
- Increasing dependence on another
- Ineffective relationships
- Loneliness
– Low self-esteem
– Pain
– Perception of having unfinished business
– Self-alienation
– Separation from support system
– Social alienation
– Sociocultural deprivation
– Stressors
– Substance misuse

At risk population

- Aging
- Birth of a child
- Death of significant other
- Exposure to death
- Life transition
– Loss
– Exposure to natural disaster
– Racial conflict
– Receiving bad news
– Unexpected life event

Associated condition

- Actively dying
- Chronic illness
- Illness
- Imminent death
– Loss of a body part
– Loss of function of a body part
– Physical illness
– Treatment regimen

Domain 10 • Class 3 • Diagnosis Code 00067

Risk for spiritual distress

Approved 1998 • Revised 2004, 2013, 2017 • Level of Evidence 2.1

Definition

Susceptible to an impaired ability to experience and integrate meaning and purpose in life through connectedness within self, literature, nature, and/or a power greater than oneself, which may compromise health.

Risk factors

- Anxiety
- Barrier to experiencing love
- Change in religious ritual
- Change in spiritual practice
- Cultural conflict
- Depression
- Environmental change
- Inability to forgive
- Increasing dependence on another
- Ineffective relationships
- Loneliness
- Low self-esteem
- Pain
- Perception of having unfinished business
- Self-alienation
- Separation from support system
- Social alienation
- Sociocultural deprivation
- Stressors
- Substance misuse

At risk population

- Aging
- Birth of a child
- Death of significant other
- Exposure to death
- Life transition
- Loss
- Exposure to natural disaster
- Racial conflict
- Receiving bad news
- Unexpected life event

Associated condition

- Actively dying
- Chronic illness
- Illness
- Imminent death
- Loss of a body part
- Loss of function of a body part
- Physical illness
- Treatment regimen

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 11.
Safety/protection

Class 1.	Infection
Code	**Diagnosis**
00004	Risk for **infection**
00266	Risk for **surgical site infection**

Class 2.	Physical injury
Code	**Diagnosis**
00031	Ineffective **airway clearance**
00039	Risk for **aspiration**
00206	Risk for **bleeding**
00048	Impaired **dentition**
00219	Risk for **dry eye**
00261	Risk for **dry mouth**
00155	Risk for **falls**
00245	Risk for corneal **injury**
00035	Risk for **injury**
00250	Risk for urinary tract **injury**
00087	Risk for **perioperative positioning injury**
00220	Risk for **thermal injury**
00045	Impaired oral **mucous membrane integrity**
00247	Risk for impaired oral **mucous membrane integrity**
00086	Risk for peripheral **neurovascular** dys**function**
00038	Risk for **physical trauma**
00213	Risk for vascular **trauma**

00249	Risk for **pressure ulcer**
00205	Risk for **shock**
00046	Impaired **skin integrity**
00047	Risk for impaired **skin integrity**
00156	Risk for **sudden** infant **death**
00036	Risk for **suffocation**
00100	Delayed **surgical recovery**
00246	Risk for delayed **surgical recovery**
00044	Impaired **tissue integrity**
00248	Risk for impaired **tissue integrity**
00268	Risk for **venous thromboembolism**

Class 3.	**Violence**
Code	**Diagnosis**
00272	Risk for **female genital mutilation**
00138	Risk for **other-directed violence**
00140	Risk for **self-directed violence**
00151	**Self-mutilation**
00139	Risk for **self-mutilation**
00150	Risk for **suicide**

Class 4.	**Environmental hazards**
Code	**Diagnosis**
00181	**Contamination**
00180	Risk for **contamination**
00265	Risk for **occupational injury**
00037	Risk for **poisoning**

Class 5.	**Defensive processes**
Code	**Diagnosis**
00218	Risk for **adverse reaction to iodinated contrast media**
00217	Risk for **allergy reaction**
00041	**Latex allergy reaction**
00042	Risk for **latex allergy reaction**

Class 6.	**Thermoregulation**

Code	Diagnosis
00007	**Hyperthermia**
00006	**Hypothermia**
00253	Risk for **hypothermia**
00254	Risk for **perioperative hypothermia**
00008	Ineffective **thermoregulation**
00274	Risk for ineffective **thermoregulation**

NANDA International, Inc. Nursing Diagnoses: Definitions and Classification 2018–2020, 11th Edition. Edited by T. Heather Herdman and Shigemi Kamitsuru.

Domain 11 • Class 1 • Diagnosis Code 00004

Risk for infection

Approved 1986 • Revised 2010, 2013, 2017 • Level of Evidence 2.1

Definition

Susceptible to invasion and multiplication of pathogenic organisms, which may compromise health.

Risk factors

- Alteration in peristalsis
- Alteration in skin integrity
- Inadequate vaccination
- Insufficient knowledge to avoid exposure to pathogens
– Malnutrition
– Obesity
– Smoking
– Stasis of body fluid

At risk population

– Exposure to disease outbreak

Associated condition

- Alteration in pH of secretion
- Chronic illness
- Decrease in ciliary action
- Decrease in hemoglobin
- Immunosuppression
- Invasive procedure
- Leukopenia
– Premature rupture of amniotic membrane
– Prolonged rupture of amniotic membrane
– Suppressed inflammatory response

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 11 • Class 1 • Diagnosis Code 00266

Risk for surgical site infection

Approved 2016 • Level of Evidence 2.1

Definition

Susceptible to invasion of pathogenic organisms at surgical site, which may compromise health.

Risk factors

- Alcoholism
- Obesity
- Smoking

At risk population

- Cold temperature of operating room
- Excessive number of personnel present during the surgical procedure
- Increased environmental exposure to pathogens
- Sub-optimal American Society of Anaesthesiologists (ASA) physical health status score
- Surgical wound contamination

Associated condition

- Comorbidity
- Diabetes mellitus
- Duration of surgery
- Hypertension
- Immunosuppression
- Inadequate antibiotic prophylaxis
- Ineffective antibiotic prophylaxis
- Infections at other surgical sites
- Invasive procedure
- Post-traumatic osteoarthritis
- Rheumatoid arthritis
- Type of anesthesia
- Type of surgical procedure
- Use of implants and/or prostheses

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 11 • Class 2 • Diagnosis Code 00031

Ineffective airway clearance

Approved 1980 • Revised 1996, 1998, 2017

Definition

Inability to clear secretions or obstructions from the respiratory tract to maintain a clear airway.

Defining characteristics

- Absence of cough
- Adventitious breath sounds
- Alteration in respiratory pattern
- Alteration in respiratory rate
- Cyanosis
- Difficulty verbalizing
- Diminished breath sounds
- Dyspnea
- Excessive sputum
- Ineffective cough
- Orthopnea
- Restlessness
- Wide-eyed look

Related factors

- Excessive mucus
- Exposure to smoke
- Foreign body in airway
- Retained secretions
- Second-hand smoke
- Smoking

Associated condition

- Airway spasm
- Allergic airway
- Asthma
- Chronic obstructive pulmonary disease
- Exudate in the alveoli
- Hyperplasia of the bronchial walls
- Infection
- Neuromuscular impairment
- Presence of artificial airway

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 11 • Class 2 • Diagnosis Code 00039

Risk for aspiration

Approved 1988 • Revised 2013, 2017

Definition

Susceptible to entry of gastrointestinal secretions, oropharyngeal secretions, solids, or fluids to the tracheobronchial passages, which may compromise health.

Risk factors

- Barrier to elevating upper body
- Decrease in gastrointestinal motility
– Ineffective cough
– Insufficient knowledge of modifiable factors

Associated condition

- Decrease in level of consciousness
- Delayed gastric emptying
- Depressed gag reflex
- Enteral feedings
- Facial surgery
- Facial trauma
- Impaired ability to swallow
- Incompetent lower esophageal sphincter
- Increase in gastric residual
– Increase in intragastric pressure
– Neck surgery
– Neck trauma
– Oral surgery
– Oral trauma
– Presence of oral/nasal tube
– Treatment regimen
– Wired jaw

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 11 • Class 2 • Diagnosis Code 00206

Risk for bleeding

Approved 2008 • Revised 2013, 2017 • Level of Evidence 2.1

Definition

Susceptible to a decrease in blood volume, which may compromise health.

Risk factors

– Insufficient knowledge of bleeding precautions

At risk population

– History of falls

Associated condition

- Aneurysm
- Circumcision
- Disseminated intravascular coagulopathy
- Gastrointestinal condition
- Impaired liver function
– Inherent coagulopathy
– Postpartum complication
– Pregnancy complication
– Trauma
– Treatment regimen

Additional risk factors to be developed.

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 11 • Class 2 • Diagnosis Code 00048

Impaired dentition

Approved 1998 • Revised 2017

Definition

Disruption in tooth development/eruption pattern or structural integrity of individual teeth.

Defining characteristics

- Absence of teeth
- Abraded teeth
- Dental caries
- Enamel discoloration
- Erosion of enamel
- Excessive oral calculus
- Excessive oral plaque
- Facial asymmetry
- Halitosis
- Incomplete tooth eruption for age
- Loose tooth
- Malocclusion
- Premature loss of primary teeth
- Root caries
- Tooth fracture
- Tooth misalignment
- Toothache

Related factors

- Barrier to self-care
- Difficulty accessing dental care
- Excessive intake of fluoride
- Excessive use of abrasive oral cleaning agents
- Habitual use of staining substance
- Inadequate dietary habits
- Inadequate oral hygiene
- Insufficient knowledge of dental health
- Malnutrition

At risk population

- Economically disadvantaged
- Genetic predisposition

Associated condition

- Bruxism
- Chronic vomiting
- Oral temperature sensitivity
- Pharmaceutical agent

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 11 • Class 2 • Diagnosis Code 00219

Risk for dry eye

Approved 2010 • Revised 2013, 2017 • Level of Evidence 2.1

Definition

Susceptible to eye discomfort or damage to the cornea and conjunctiva due to reduced quantity or quality of tears to moisten the eye, which may compromise health.

Risk factors

- Air conditioning
- Air pollution
- Caffeine intake
- Excessive wind
- Insufficient knowledge of modifiable factors
- Low humidity
- Prolonged reading
- Smoking
- Sunlight exposure
- Vitamin A deficiency

At risk population

- Aging
- Contact lens wearer
- Female gender
- History of allergy

Associated condition

- Autoimmune disease
- Hormonal change
- Mechanical ventilation
- Neurological lesion with sensory or motor reflex loss
- Ocular surface damage
- Treatment regimen

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 11 • Class 2 • Diagnosis Code 00261

Risk for dry mouth

Approved 2016 • Level of Evidence 2.1

Definition

Susceptible to discomfort or damage to the oral mucosa due to reduced quantity or quality of saliva to moisten the mucosa, which may compromise health.

Risk factors

- Dehydration
- Depression
- Excessive stress
– Excitement
– Smoking

Associated condition

- Chemotherapy
- Fluid restriction
- Inability to feed orally
- Oxygen therapy
- Pharmaceutical agent
– Pregnancy
– Radiation therapy to the head and neck
– Systemic diseases

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 11 • Class 2 • Diagnosis Code 00155

Risk for falls

Approved 2000 • Revised 2013, 2017

Definition

Susceptible to increased susceptibility to falling, which may cause physical harm and compromise health.

Risk factors

Children

- Absence of stairway gate
- Absence of window guard
– Inadequate supervision
– Insufficient automobile restraints

Environment

- Cluttered environment
- Exposure to unsafe weatherrelated condition
- Insufficient anti-slip material in bathroom
– Insufficient lighting
– Unfamiliar setting
– Use of restraints
– Use of throw rugs

Physiological

- Alteration in blood glucose level
- Decrease in lower extremity strength
- Diarrhea
- Difficulty with gait
- Faintness when extending neck
– Faintness when turning neck
– Impaired mobility
– Incontinence
– Sleeplessness
– Urinary urgency

Other

- Alcohol consumption
– Insufficient knowledge of modifiable factors

At risk population

- Age ≥ 65 years
– Living alone

- Age ≤ 2 years
- History of falls
– Male gender when < 1 year of age

Associated condition

- Acute illness
- Alteration in cognitive functioning
- Anemia
- Arthritis
- Condition affecting the foot
- Hearing impairment
- Impaired balance
- Impaired vision
- Lower limb prosthesis
– Neoplasm
– Neuropathy
– Orthostatic hypotension
– Pharmaceutical agent
– Postoperative recovery period
– Proprioceptive deficit
– Use of assistive device
– Vascular disease

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 11 • Class 2 • Diagnosis Code 00245

Risk for corneal injury

Approved 2013 • Revised 2017 • Level of Evidence 2.1

Definition

Susceptible to infection or inflammatory lesion in the corneal tissue that can affect superficial or deep layers, which may compromise health.

Risk factors

- Exposure of the eyeball
– Insufficient knowledge of modifiable factors

At risk population

– Prolonged hospitalization

Associated condition

- Blinking < 5 times per minute
- Glasgow Coma Scale score < 6
- Intubation
- Mechanical ventilation
– Oxygen therapy
– Periorbital edema
– Pharmaceutical agent
– Tracheostomy

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 11 • Class 2 • Diagnosis Code 00035

Risk for injury

Approved 1978 • Revised 2013, 2017

Definition

Susceptible to physical damage due to environmental conditions interacting with the individual's adaptive and defensive resources, which may compromise health.

Risk factors

- Compromised nutritional source
- Exposure to pathogen
- Exposure to toxic chemical
- Immunization level within community
  - Insufficient knowledge of modifiable factors
  - Malnutrition
  - Nosocomial agent
  - Physical barrier
  - Unsafe mode of transport

At risk population

- Extremes of age
  - Impaired primary defense mechanisms

Associated condition

- Abnormal blood profile
- Alteration in cognitive functioning
- Alteration in psychomotor functioning
- Alteration in sensation
- Autoimmune dysfunction
  - Biochemical dysfunction
  - Effector dysfunction
  - Immune dysfunction
  - Sensory integration dysfunction
  - Tissue hypoxia

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 11 • Class 2 • Diagnosis Code 00250

Risk for urinary tract injury

Approved 2013 • Revised 2017 • Level of Evidence 2.1

Definition

Susceptible to damage of the urinary tract structures from use of catheters, which may compromise health.

Risk factors

- Confusion
- Deficient patient or caregiver knowledge regarding care of urinary catheter

– Obesity

At risk population

– Extremes of age

Associated condition

- Anatomical variation in the pelvic organs
- Condition preventing ability to secure catheter
- Detrusor sphincter dyssynergia
- Impaired cognition
- Latex allergy

– Long term use of urinary catheter
– Medullary injury
– Multiple catheterizations
– Retention balloon inflated to ≥ 30 ml
– Use of large caliber urinary catheter

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 11 • Class 2 • Diagnosis Code 00087

Risk for perioperative positioning injury

Approved 1994 • Revised 2006, 2013, 2017 • Level of Evidence 2.1

Definition

Susceptible to inadvertent anatomical and physical changes as a result of posture or positioning equipment used during an invasive/surgical procedure, which may compromise health.

Risk factors

– Immobilization

Associated condition

- Disorientation
- Edema
- Emaciation
- Muscle weakness
– Obesity
– Sensoriperceptual disturbance from anesthesia

Due to limited amount of the patient contact preoperatively, nurses may not be able to intervene on many of these associated conditions.

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 11 • Class 2 • Diagnosis Code 00220

Risk for thermal injury

Approved 2010 • Revised 2013, 2017 • Level of Evidence 2.1

Definition

Susceptible to extreme temperature damage to skin and mucous membranes, which may compromise health.

Risk factors

- Fatigue
- Inadequate protective clothing
- Inadequate supervision
- Inattentiveness
- Insufficient caregiver knowledge of safety precautions
- Insufficient knowledge of safety precautions
- Smoking
- Unsafe environment

At risk population

- Extremes of age
- Extremes of environmental temperature

Associated condition

- Alcohol intoxication
- Drug intoxication
- Alteration in cognitive functioning
- Neuromuscular impairment
- Neuropathy
- Treatment regimen

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 11 • Class 2 • Diagnosis Code 00045

Impaired oral mucous membrane integrity

Approved 1982 • Revised 1998, 2013, 2017 • Level of Evidence 2.1

Definition

Injury to the lips, soft tissue, buccal cavity, and/or oropharynx.

Defining characteristics

- Bad taste in mouth
- Bleeding
- Cheilitis
- Coated tongue
- Decrease in taste sensation
- Desquamation
- Difficulty eating
- Difficulty speaking
- Enlarged tonsils
- Exposure to pathogen
- Geographic tongue
- Gingival hyperplasia
- Gingival pallor
- Gingival pocketing deeper than 4 mm
- Gingival recession
- Halitosis
- Hyperemia
- Impaired ability to swallow
- Macroplasia
- Mucosal denudation
- Oral discomfort
- Oral edema
- Oral fissure
- Oral lesion
- Oral mucosal pallor
- Oral nodule
- Oral pain
- Oral papule
- Oral ulcer
- Oral vesicles
- Presence of mass
- Purulent oral-nasal drainage
- Purulent oral-nasal exudates
- Smooth atrophic tongue
- Spongy patches in mouth
- Stomatitis
- White patches in mouth
- White plaque in mouth
- White, curd-like oral exudate
- Xerostomia

Related factors

- Alcohol consumption
- Barrier to dental care
- Barrier to oral self-care
- Chemical injury agent
- Decrease in salivation
- Dehydration
- Inadequate oral hygiene
- Insufficient knowledge of oral hygiene
- Malnutrition
- Mouth breathing
- Smoking
- Stressors

- Depression
- Inadequate nutrition

At risk population

– Economically disadvantaged

Associated condition

- Allergy
- Alteration in cognitive functioning
- Autoimmune disease
- Autosomal disorder
- Behavioral disorder
- Chemotherapy
- Cleft lip
- Cleft palate
- Decrease in hormone level in women
- Decrease in platelets
- Immunodeficiency
– Immunosuppression
– Infection
– Loss of oral support structure
– Mechanical factor
– Nil per os (NPO) > 24 hours
– Oral trauma
– Radiation therapy
– Sjögren's Syndrome
– Surgical procedure
– Trauma
– Treatment regimen

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 11 • Class 2 • Diagnosis Code 00247

Risk for impaired oral mucous membrane integrity

Approved 2013 • Revised 2017 • Level of Evidence 2.1

Definition

Susceptible to injury to the lips, soft tissues, buccal cavity, and/or oropharynx, which may compromise health.

Risk factors

- Alcohol consumption
- Barrier to dental care
- Barrier to oral self-care
- Chemical injury agent
- Decrease in salivation
- Dehydration
- Depression
- Inadequate nutrition
– Inadequate oral hygiene
– Insufficient knowledge of oral hygiene
– Malnutrition
– Mouth breathing
– Smoking
– Stressors

At risk population

– Economically disadvantaged

Associated condition

- Allergy
- Alteration in cognitive functioning
- Autoimmune disease
- Autosomal disorder
- Behavioral disorder
- Chemotherapy
- Cleft lip
- Cleft palate
- Decrease in hormone level in women
- Decrease in platelets
- Immunodeficiency
– Immunosuppression
– Infection
– Loss of oral support structure
– Mechanical factor
– Nil per os (NPO) > 24 hours
– Oral trauma
– Radiation therapy
– Surgical procedure
– Sjögren's Syndrome
– Trauma
– Treatment regimen

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 11 • Class 2 • Diagnosis Code 00086

Risk for peripheral neurovascular dysfunction

Approved 1992 • Revised 2013, 2017

Definition

Susceptible to disruption in the circulation, sensation, and motion of an extremity, which may compromise health.

Risk factors

– To be developed

Associated condition

- Burn injury
- Fracture
- Immobilization
- Mechanical compression
– Orthopedic surgery
– Trauma
– Vascular obstruction

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 11 • Class 2 • Diagnosis Code 00038

Risk for physical trauma

Approved 1980 • Revised 2013, 2017

Definition

Susceptible to physical injury of sudden onset and severity which require immediate attention.

Risk factors

External

- Absence of call-for-aid device
- Absence of stairway gate
- Absence of window guard
- Access to weapon
- Bathing in very hot water
- Bed in high position
- Children riding in front seat of car
- Defective appliance
- Delay in ignition of gas appliance
- Dysfunctional call-for-aid device
- Electrical hazard
- Exposure to corrosive product
- Exposure to dangerous machinery
- Exposure to radiation
- Exposure to toxic chemical
- Flammable object
- Grease on stove
- Icicles hanging from roof
- Inadequate stair rails
- Inadequately stored combustible
- Inadequately stored corrosive
- Insufficient anti-slip material in bathroom
- Insufficient lighting
– Insufficient protection from heat source
– Misuse of headgear
– Misuse of seat restraint
– Nonuse of seat restraints
– Obstructed passageway
– Playing with dangerous object
– Playing with explosive
– Pot handle facing front of stove
– Proximity to vehicle pathway
– Slippery floor
– Smoking in bed
– Smoking near oxygen
– Struggling with restraints
– Unanchored electric wires
– Unsafe operation of heavy equipment
– Unsafe road
– Unsafe walkway
– Use of cracked dishware
– Use of throw rugs
– Use of unstable chair
– Use of unstable ladder
– Wearing loose clothing around open flame

Internal

- Emotional disturbance
- Impaired balance
- Insufficient knowledge of safety precautions
– Insufficient vision
– Weakness

At risk population

- Economically disadvantaged
- Extremes of environmental temperature
- Gas leak
– High crime neighborhood
– History of trauma

Associated condition

- Alteration in cognitive functioning
- Alteration in sensation
– Decrease in eye-hand coordination
– Decrease in muscle coordination

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 11 • Class 2 • Diagnosis Code 00213

Risk for vascular trauma

Approved 2008 • Revised 2013, 2017 • Level of Evidence 2.1

Definition

Susceptible to damage to vein and its surrounding tissues related to the presence of a catheter and/or infused solutions, which may compromise health.

Risk factors

- Inadequate available insertion site
– Prolonged period of time catheter is in place

Associated condition

- Irritating solution
– Rapid infusion rate

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 11 • Class 2 • Diagnosis Code 00249

Risk for pressure ulcer

Approved 2013 • Revised 2017 • Level of Evidence 2.2

Definition

Susceptible to localized injury to the skin and/or underlying tissue usually over a bony prominence as a result of pressure, or pressure in combination with shear (NPUAP, 2007).

Risk factors

- Decrease in mobility
- Dehydration
- Dry skin
- Extended period of immobility on hard surface
- Hyperthermia
- Inadequate nutrition
- Incontinence
- Insufficient caregiver knowledge of pressure ulcer prevention
- Insufficient knowledge of modifiable factors
- Pressure over bony prominence
- Scaly skin
- Self-care deficit
- Shearing forces
- Skin moisture
- Smoking
- Surface friction
- Use of linen with insufficient moisture wicking property

At risk population

- ADULT: Braden Scale score of < 17
- American Society of Anesthesiologists (ASA) Physical Status classification score ≥ 1
- CHILD: Braden Q Scale of ≤ 15
- Extremes of age
- Extremes of weight
- Female gender
- History of cerebral vascular accident
- History of pressure ulcer
- History of trauma
- Low score on Risk Assessment Pressure Sore (RAPS) scale
- New York Heart Association (NYHA) Functional Classification ≥ 1

Associated condition

- Alteration in cognitive functioning
- Alteration in sensation
- Anemia
- Elevated skin temperature by 1-2 ° C
- Hip fracture
- Impaired circulation

- Cardiovascular disease
- Decrease in serum albumin level
- Decrease in tissue oxygenation
- Decrease in tissue perfusion
- Edema
- Lymphopenia
- Pharmaceutical agent
- Physical immobilization
- Reduced triceps skin fold thickness

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 11 • Class 2 • Diagnosis Code 00205

Risk for shock

Approved 2008 • Revised 2013, 2017 • Level of Evidence 2.1

Definition

Susceptible to an inadequate blood flow to the body's tissues that may lead to life-threatening cellular dysfunction, which may compromise health.

Risk factors

– To be developed

Associated condition

- Hypotension
- Hypovolemia
- Hypoxemia
- Hypoxia

– Infection
– Sepsis
– Systemic inflammatory response syndrome (SIRS)

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition if no risk factors are developed.

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 11 • Class 2 • Diagnosis Code 00046

Impaired skin integrity

Approved 1975 • Revised 1998. 2017 • Level of Evidence 2.1

Definition

Altered epidermis and/or dermis.

Defining characteristics

- Acute pain
- Alteration in skin integrity
- Bleeding
- Foreign matter piercing skin
– Hematoma
– Localized area hot to touch
– Redness

Related factors

External

- Chemical injury agent
- Excretions
- Humidity
- Hyperthermia
– Hypothermia
– Moisture
– Pressure over bony prominence
– Secretions

Internal

- Alteration in fluid volume
- Inadequate nutrition
– Psychogenic factor

At risk population

– Extremes of age

Associated condition

- Alteration in metabolism
- Alteration in pigmentation
– Immunodeficiency
– Impaired circulation

- Alteration in sensation
- Alteration in skin turgor
- Arterial puncture
- Hormonal change

– Pharmaceutical agent
– Radiation therapy
– Vascular trauma

Domain 11 • Class 2 • Diagnosis Code 00047

Risk for impaired skin integrity

Approved 1975 • Revised 1998, 2010, 2013, 2017 • Level of Evidence 2.1

Definition

Susceptible to alteration in epidermis and/or dermis, which may compromise health.

Risk factors

External

- Chemical injury agent
- Excretions
- Humidity
- Hyperthermia
– Hypothermia
– Moisture
– Secretions

Internal

- Alteration in fluid volume
- Inadequate nutrition
– Pressure over bony prominence
– Psychogenic factor

At risk population

– Extremes of age

Associated condition

- Alteration in metabolism
- Alteration in pigmentation
- Alteration in sensation
- Alteration in skin turgor
- Arterial puncture
- Hormonal change
– Immunodeficiency
– Impaired circulation
– Pharmaceutical agent
– Radiation therapy
– Vascular trauma

Domain 11 • Class 2 • Diagnosis Code 00156

Risk for sudden infant death

Approved 2002 • Revised 2013, 2017 • Level of Evidence 3.2

Definition

Susceptible to unpredicted death of an infant.

Risk factors

- Delay in prenatal care
- Exposure to second hand smoke
- Infant overheating
- Infant overwrapping
- Infant placed in prone position to sleep
- Infant placed in side-lying position to sleep
- Insufficient prenatal care
- Soft sleep surface
- Soft, loose objects placed near infant
- Infant less than 4 months, placed in sitting devices for routine sleep

At risk population

- African American Ethnicity
- Age 2-4 months
- Infant not breastfed exclusively or fed with expressed breast milk
- Low birth weight
- Male gender
- Maternal smoking during pregnancy
- Native American Ethnicity
- Postnatal exposure to alcohol
- Postnatal exposure to elicit drug
- Prematurity
- Prenatal exposure to alcohol
- Prenatal exposure to elicit drug
- Young parental age

Associated condition

- Cold weather

Domain 11 • Class 2 • Diagnosis Code 00036

Risk for suffocation

Approved 1980 • Revised 2013, 2017

Definition

Susceptible to inadequate air availability for inhalation, which may compromise health.

Risk factors

- Access to empty refrigerator/freezer
- Eating large mouthfuls of food
- Emotional disturbance
- Gas leak
- Insufficient knowledge of safety precautions
- Low-strung clothesline
- Pacifier around infant's neck
– Playing with plastic bag
– Propped bottle in infant's crib
– Small object in airway
– Smoking in bed
– Soft underlayment
– Unattended in water
– Unvented fuel-burning heater
– Vehicle running in closed garage

Associated condition

- Alteration in cognitive functioning
- Alteration in olfactory function
- Face/neck disease
– Face/neck injury
– Impaired motor functioning

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 11 • Class 2 • Diagnosis Code 00100

Delayed surgical recovery

Approved 1998 • Revised 2006, 2013, 2017 • Level of Evidence 2.1

Definition

Extension of the number of postoperative days required to initiate and perform activities that maintain life, health, and well-being.

Defining characteristics

- Discomfort
- Evidence of interrupted healing of surgical area
- Excessive time required for recuperation
- Impaired mobility
  - Inability to resume employment
  - Loss of appetite
  - Postpones resumption of work
  - Requires assistance for self-care

Related factors

- Malnutrition
- Obesity
  - Pain
  - Postoperative emotional response

At risk population

- Extremes of age
- History of delayed wound healing

Associated condition

- American Society of Anesthesiologists (ASA) Physical Status classification score ≥ 2
- Diabetes mellitus
- Edema at surgical site
- Extensive surgical procedure
- Impaired mobility
- Perioperative surgical site infection
- Persistent nausea
  - Persistent vomiting
  - Pharmaceutical agent
  - Prolonged surgical procedure
  - Psychological disorder in postoperative period
  - Surgical site contamination
  - Trauma at surgical site

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 11 • Class 2 • Diagnosis Code 00246

Risk for delayed surgical recovery

Approved 2013 • Revised 2017 • Level of Evidence 2.1

Definition

Susceptible to an extension of the number of postoperative days required to initiate and perform activities that maintain life, health, and well-being, which may compromise health.

Risk factors

- Malnutrition
- Obesity
  - Pain
  - Postoperative emotional response

At risk population

- Extremes of age
  - History of delayed wound healing

Associated condition

- American Society of Anesthesiologists (ASA) Physical Status classification score ≥ 2
- Diabetes mellitus
- Edema at surgical site
- Extensive surgical procedure
- Impaired mobility
- Perioperative surgical site infection
- Persistent nausea
  - Persistent vomiting
  - Pharmaceutical agent
  - Prolonged surgical procedure
  - Psychological disorder in postoperative period
  - Surgical site contamination
  - Trauma at surgical site

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 11 • Class 2 • Diagnosis Code 00044

Impaired tissue integrity

Approved 1986 • Revised 1998, 2013, 2017 • Level of Evidence 2.1

Definition

Damage to the mucous membrane, cornea, integumentary system, muscular fascia, muscle, tendon, bone, cartilage, joint capsule, and/or ligament.

Defining characteristics

- Acute pain
- Bleeding
- Destroyed tissue
- Hematoma
– Localized area hot to touch
– Redness
– Tissue damage

Related factors

- Chemical injury agent
- Excessive fluid volume
- Humidity
- Imbalanced nutritional state
- Insufficient fluid volume
– Insufficient knowledge about maintaining tissue integrity
– Insufficient knowledge about protecting tissue integrity

At risk population

- Extremes of age
- Extremes of environmental temperature
– Exposure to high-voltage power supply

Associated condition

- Alteration in metabolism
- Alteration in sensation
- Arterial puncture
- Impaired circulation
- Impaired mobility
– Peripheral neuropathy
– Pharmaceutical agent
– Radiation therapy
– Surgical procedure
– Vascular trauma

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 11 • Class 2 • Diagnosis Code 00248

Risk for impaired tissue integrity

Approved 2013 • Revised 2017 • Level of Evidence 2.1

Definition

Susceptible to damage to the mucous membrane, cornea, integumentary system, muscular fascia, muscle, tendon, bone, cartilage, joint capsule, and/or ligament, which may compromise health.

Risk factors

- Chemical injury agent
- Excessive fluid volume
- Humidity
- Imbalanced nutritional state
- Insufficient fluid volume
  - Insufficient knowledge about maintaining tissue integrity
  - Insufficient knowledge about protecting tissue integrity

At risk population

- Extremes of age
- Extremes of environmental temperature
  - Exposure to high-voltage power supply

Associated condition

- Alteration in metabolism
- Alteration in sensation
- Arterial puncture
- Impaired circulation
- Impaired mobility
  - Peripheral neuropathy
  - Pharmaceutical agent
  - Radiation therapy
  - Surgical procedure
  - Vascular trauma

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 11 • Class 2 • Diagnosis Code 00268

Risk for venous thromboembolism

Approved 2016 • Level of Evidence 2.1

Definition

Susceptible to the development of a blood clot in a deep vein, commonly in the thigh, calf or upper extremity, which can break off and lodge in another vessel, which may compromise health.

Risk factors

- Dehydration
- Impaired mobility
  - Obesity

At risk population

- Age > 60 years
- Critical care admission
- Current smoker
- First degree relative with history of venous thromboembolism
  - History of cerebral vascular accident (CVA)
  - History of previous venous thromboembolism
  - Less than 6 weeks postpartum

Associated condition

- Cerebral vascular accident (CVA)
- Current cancer diagnosis
- Trauma below the waist
- Significant medical comorbidity
- Postoperative for major surgery
- Postoperative for orthopedic surgery
- Surgery and total anesthesia time > 90 minutes
  - Thrombophilia
  - Trauma of upper extremity
  - Use of estrogen-containing contraceptives
  - Use of hormone replacement therapy
  - Varicose veins

Domain 11 • Class 3 • Diagnosis Code 00272

Risk for female genital mutilation

Approved 2016 • Level of Evidence 2.1

Definition

Susceptible to full or partial ablation of the female external genitalia and other lesions of the genitalia, whether for cultural, religious or any other non-therapeutic reasons, which may compromise health.

Risk factors

- Lack of family knowledge about impact of practice on physical health
- Lack of family knowledge about impact of practice on reproductive health
- Lack of family knowledge about impact of practice on psychosocial health

At risk population

- Residing in country where practice is accepted
- Family leaders belong to ethnic group in which practice is accepted
- Belonging to family in which any female member has been subjected to practice
- Favorable attitude of family towards practice
- Female gender
- Belonging to ethnic group in which practice is accepted
- Planning to visit family's country of origin

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 11 • Class 3 • Diagnosis Code 00138

Risk for other-directed violence

Approved 1980 • Revised 1996, 2013, 2017

Definition

Susceptible to behaviors in which an individual demonstrates that he or she can be physically, emotionally, and/or sexually harmful to others.

Risk factors

- Access to weapon
- Impulsiveness
- Negative body language
- Pattern of indirect violence
- Pattern of other-directed violence
  - Pattern of threatening violence
  - Pattern of violent anti-social behavior
  - Suicidal behavior

At risk population

- History of childhood abuse
- History of cruelty to animals
- History of fire-setting
- History of motor vehicle offense
  - History of substance misuse
  - History of witnessing family violence

Associated condition

- Alteration in cognitive functioning
- Neurological impairment
- Pathological intoxication
  - Perinatal complications
  - Prenatal complications
  - Psychotic disorder

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 11 • Class 3 • Diagnosis Code 00140

Risk for self-directed violence

Approved 1994 • Revised 2013, 2017

Definition

Susceptible to behaviors in which an individual demonstrates that he or she can be physically, emotionally, and/or sexually harmful to self.

Risk factors

- Behavioral cues of suicidal intent
- Conflict about sexual orientation
- Conflict in interpersonal relationship(s)
- Employment concern
- Engagement in autoerotic sexual acts
- Insufficient personal resources
- Social isolation
- Suicidal ideation
- Suicidal plan
- Verbal cues of suicidal intent

At risk population

- Age ≥ 45 years
- Age 15-19 years
- History of multiple suicide attempts
- Marital status
- Occupation
- Pattern of difficulties in family background

Associated condition

- Mental health issue
- Physical health issue
- Psychological disorder

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 11 • Class 3 • Diagnosis Code 00151

Self-mutilation

Approved 2000 • Revised 2017

Definition

Deliberate self-injurious behavior causing tissue damage with the intent of causing nonfatal injury to attain relief of tension.

Defining characteristics

- Abrading
- Biting
- Constricting a body part
- Cuts on body
- Hitting
- Ingestion of harmful substance
- Inhalation of harmful substance
- Insertion of object into body orifice
- Picking at wound
- Scratches on body
- Self-inflicted burn
- Severing of a body part

Related factors

- Absence of family confidant
- Alteration in body image
- Dissociation
- Disturbance in interpersonal relationships
- Eating disorder
- Emotional disturbance
- Feeling threatened with loss of significant relationship
- Impaired self-esteem
- Impulsiveness
- Inability to express tension verbally
- Ineffective communication between parent and adolescent
- Ineffective coping strategies
- Irresistible urge for self-directed violence
- Irresistible urge to cut self
- Isolation from peers
- Labile behavior
- Loss of control over problem-solving situation
- Low self-esteem
- Mounting tension that is intolerable
- Negative feeling
- Pattern of inability to plan solutions
- Pattern of inability to see long-term consequences
- Perfectionism
- Requires rapid stress reduction
- Substance misuse
- Use of manipulation to obtain nurturing relationship with others

At risk population

- Adolescence
- Childhood surgery

- Battered child
- Childhood illness
- Family history of self-destructive behavior
- Family substance misuse
- History of childhood abuse
- History of self-directed violence
- Incarceration
– Developmental delay
– Family divorce
– Living in nontraditional setting
– Peers who self-mutilate
– Sexual identity crisis
– Violence between parental figures

Associated condition

- Autism
- Borderline personality disorder
- Character disorder
– Depersonalization
– Psychotic disorder

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 11 • Class 3 • Diagnosis Code 00139

Risk for self-mutilation

Approved 1992 • Revised 2000, 2013, 2017

Definition

Susceptible to deliberate self-injurious behavior causing tissue damage with the intent of causing nonfatal injury to attain relief of tension.

Risk factors

- Absence of family confidant
- Alteration in body image
- Dissociation
- Disturbance in interpersonal relationships
- Eating disorder
- Emotional disturbance
- Feeling threatened with loss of significant relationship
- Impaired self-esteem
- Impulsiveness
- Inability to express tension verbally
- Ineffective communication between parent and adolescent
- Ineffective coping strategies
- Irresistible urge for self-directed violence
  - Irresistible urge to cut self
  - Isolation from peers
  - Labile behavior
  - Loss of control over problem-solving situation
  - Low self-esteem
  - Mounting tension that is intolerable
  - Negative feeling
  - Pattern of inability to plan solutions
  - Pattern of inability to see long-term consequences
  - Perfectionism
  - Requires rapid stress reduction
  - Substance misuse
  - Use of manipulation to obtain nurturing relationship with others

At risk population

- Adolescence
- Battered child
- Childhood illness
- Childhood surgery
- Developmental delay
- Family divorce
- Family history of self-destructive behavior
- Family substance misuse
  - History of childhood abuse
  - History of self-directed violence
  - Incarceration
  - Living in nontraditional setting
  - Loss of significant relationship
  - Peers who self-mutilate
  - Sexual identity crisis
  - Violence between parental figures

Associated condition

- Autism
- Borderline personality disorder
- Character disorder
– Depersonalization
– Psychotic disorder

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 11 • Class 3 • Diagnosis Code 00150

Risk for suicide

Approved 2000 • Revised 2013, 2017

Definition

Susceptible to self-inflicted, life-threatening injury.

Risk factors

Behavioral

- Changing a will
- Giving away possessions
- Impulsiveness
- Making a will
- Marked change in attitude
- Marked change in behavior
- Marked change in school performance
- Purchase of a gun
- Stockpiling medication
- Sudden euphoric recovery from major depression

Psychological

- Guilt
- Substance misuse

Situational

- Access to weapon
- Loss of autonomy
- Loss of independence

Social

- Cluster suicides
- Disciplinary problems
- Disruptive family life
- Grieving
- Helplessness
- Hopelessness
- Insufficient social support
- Legal difficulty
- Loneliness
- Loss of significant relationship
- Social isolation

Verbal

- Reports desire to die
– Threat of killing self

Other

– Chronic pain

At risk population

- Adolescence
- Adolescents living in nontraditional settings
- Caucasian ethnicity
- Divorced status
- Economically disadvantaged
- Older adults
- Family history of suicide
- History of childhood abuse
- History of suicide attempt
– Homosexual youth
– Institutionalization
– Living alone
– Male gender
– Native American ethnicity
– Relocation
– Retired
– Widowed
– Young adult males

Associated condition

- Physical illness
- Psychiatric disorder
– Terminal illness

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 11 • Class 4 • Diagnosis Code 00181

Contamination

Approved 2006 • Revised 2017 • Level of Evidence 2.1

Definition

Exposure to environmental contaminants in doses sufficient to cause adverse health effects.

Defining characteristics

Pesticides

- Dermatological effects of pesticide exposure
- Gastrointestinal effects of pesticide exposure
– Neurological effects of pesticide exposure
– Pulmonary effects of pesticide exposure
– Renal effects of pesticide exposure

Chemicals

- Dermatological effects of chemical exposure
- Gastrointestinal effects of chemical exposure
- Immunological effects of chemical exposure
– Neurological effects of chemical exposure
– Pulmonary effects of chemical exposure
– Renal effects of chemical exposure

Biologics

- Dermatological effects of biologic exposure
- Gastrointestinal effects of biologic exposure
– Neurological effects of biologic exposure
– Pulmonary effects of biologic exposure
– Renal effects of biologic exposure

Pollution

- Neurological effects of pollution exposure
– Pulmonary effects of pollution exposure

Waste

- Dermatological effects of waste exposure
- Gastrointestinal effects of waste exposure
– Hepatic effects of waste exposure
– Pulmonary effects of waste exposure

Radiation

- Genetic effects of radiation exposure
- Immunological effects of radiation exposure
- Neurological effects of radiation exposure
- Oncological effects of radiation exposure

Related factors

External

- Carpeted flooring
- Chemical contamination of food
- Chemical contamination of water
- Flaking, peeling surface in presence of young children
- Inadequate breakdown of contaminant
- Inadequate household hygiene practices
- Inadequate municipal services
- Inadequate personal hygiene practices
- Inadequate protective clothing
- Inappropriate use of protective clothing
- Ingestion of contaminated material
- Playing where environmental contaminants are used
- Unprotected exposure to chemical
- Unprotected exposure to heavy metal
- Unprotected exposure to radioactive material
- Use of environmental contaminant in the home
- Use of noxious material in insufficiently ventilated area
- Use of noxious material without effective protection

Internal

- Concomitant exposure
- Inadequate nutrition
- Smoking

At risk population

- Children < 5 years
- Economically disadvantaged
- Exposure to areas with high contaminant level
- Exposure to atmospheric pollutants
- Exposure to bioterrorism
- Exposure to disaster
- Exposure to radiation
- Female gender
- Gestational age during exposure
- Older adults
- Previous exposure to contaminant

Associated condition

- Pre-existing disease
- Pregnancy

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 11 • Class 4 • Diagnosis Code 00180

Risk for contamination

Approved 2006 • Revised 2013, 2017 • Level of Evidence 2.1

Definition

Susceptible to exposure to environmental contaminants, which may compromise health.

Risk factors

External

- Carpeted flooring
- Chemical contamination of food
- Chemical contamination of water
- Flaking, peeling surface in presence of young children
- Inadequate breakdown of contaminant
- Inadequate household hygiene practices
- Inadequate municipal services
- Inadequate personal hygiene practices
- Inadequate protective clothing
- Inappropriate use of protective clothing
- Ingestion of contaminated material
- Playing where environmental contaminants are used
- Unprotected exposure to chemical
- Unprotected exposure to heavy metal
- Unprotected exposure to radioactive material
- Use of environmental contaminant in the home
- Use of noxious material in insufficiently ventilated area
- Use of noxious material without effective protection

Internal

- Concomitant exposure
- Inadequate nutrition
- Smoking

At risk population

- Children < 5 years
- Economically disadvantaged
- Exposure to areas with high contaminant level
- Exposure to atmospheric pollutants
- Exposure to bioterrorism
- Exposure to disaster
- Exposure to radiation
- Female gender
- Gestational age during exposure
- Older adults
- Previous exposure to contaminant

Associated condition

- Pre-existing disease – Pregnancy

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 11 • Class 4 • Diagnosis Code 00265

Risk for occupational injury

Approved 2016 • Level of Evidence 2.1

Definition

Susceptible to sustain a work-related accident or illness, which may compromise health.

Risk factors

Individual

- Excessive stress
- Improper use of personal protective equipment
- Inadequate role performance
- Inadequate time management
- Ineffective coping strategies
- Insufficient knowledge
- Misinterpretation of information
- Psychological distress
- Unsafe acts of overconfidence
- Unsafe acts of unhealthy negative habits

Environmental

- Distraction from social relationships
- Exposure to biological agents
- Exposure to chemical agents
- Exposure to extremes of temperature
- Exposure to noise
- Exposure to radiation
- Exposure to teratogenic agents
- Exposure to vibration
- Inadequate physical environment
- Labor relationships
- Lack of personal protective equipment
- Night shift work rotating to day shift work
- Occupational burnout
- Physical workload
- Shift work

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 11 • Class 4 • Diagnosis Code 00037

Risk for poisoning

Approved 1980 • Revised 2006, 2013, 2017 • Level of Evidence 2.1

Definition

Susceptible to accidental exposure to, or ingestion of, drugs or dangerous products in sufficient doses, which may compromise health.

Risk factors

External

- Access to dangerous product
- Access to illicit drugs potentially contaminated by poisonous additives
– Access to pharmaceutical agent
– Occupational setting without adequate safeguards

Internal

- Emotional disturbance
- Inadequate precautions against poisoning
- Insufficient knowledge of pharmacological agents
– Insufficient knowledge of poisoning prevention
– Insufficient vision

Associated condition

– Alteration in cognitive functioning

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 11 • Class 5 • Diagnosis Code 00218

Risk for adverse reaction to iodinated contrast media

Approved 2010 • Revised 2013, 2017 • Level of Evidence 2.1

Definition

Susceptible to noxious or unintended reaction associated with the use of iodinated contrast media that can occur within seven days after contrast agent injection, which may compromise health.

Risk factors

- Dehydration
  - Generalized weakness

At risk population

- Extremes of age
- History of allergy
  - History of previous adverse effect from iodinated contrast media

Associated condition

- Chronic illness
- Concurrent use of pharmaceutical agents
  - Contrast media precipitates adverse event
  - Fragile vein
  - Unconsciousness

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 11 • Class 5 • Diagnosis Code 00217

Risk for allergy reaction

Approved 2010 • Revised 2013, 2017 • Level of Evidence 2.1

Definition

Susceptible to an exaggerated immune response or reaction to substances, which may compromise health.

Risk factors

- Exposure to allergen
- Exposure to environmental allergen
– Exposure to toxic chemical

At risk population

- History of food allergy
- History of insect sting allergy
– Repeated exposure to allergenproducing environmental substance

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 11 • Class 5 • Diagnosis Code 00041

Latex allergy reaction

Approved 1998 • Revised 2006, 2017 • Level of Evidence 2.1

Definition

A hypersensitive reaction to natural latex rubber products.

Defining characteristics

Life-Threatening Reactions within 1 Hour of Exposure

- Bronchospasm
- Chest tightness
- Contact urticaria progressing to generalized symptoms
- Dyspnea
- Edema
- Hypotension
- Myocardial infarction
- Respiratory arrest
- Syncope
- Wheezing

Type IV Reactions Occurring ≥ 1 Hour after Exposure

- Discomfort reaction to additives
- Eczema
- Skin irritation
- Skin redness

Generalized Characteristics

- Generalized discomfort
- Generalized edema
- Reports total body warmth
- Restlessness
- Skin flushing

Gastrointestinal Characteristics

- Abdominal pain
- Nausea

Orofacial Characteristics

- Erythema
- Itching
- Periorbital edema
- Rhinorrhea

- Nasal congestion
– Tearing of the eyes

Related factors

– To be developed

At risk population

- Frequent exposure to latex product
- History of allergy
- History of asthma
- History of food allergy
– History of latex reaction
– History of poinsettia plant allergy
– History of surgery during infancy

Associated condition

- Hypersensitivity to natural latex rubber protein
– Multiple surgical procedures

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition if no related factors are developed.

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 11 • Class 5 • Diagnosis Code 00042

Risk for latex allergy reaction

Approved 1998 • Revised 2006, 2013, 2017 • Level of Evidence 2.1

Definition

Susceptible to a hypersensitive reaction to natural latex rubber products, which may compromise health.

Risk factors

– To be developed

At risk population

- Frequent exposure to latex product
- History of allergy
- History of asthma
- History of food allergy
– History of latex reaction
– History of poinsettia plant allergy
– History of surgery during infancy

Associated condition

- Hypersensitivity to natural latex rubber protein
– Multiple surgical procedures

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition if no risk factors are developed.

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 11 • Class 6 • Diagnosis Code 00007

Hyperthermia

Approved 1986 • Revised 2013, 2017 • Level of Evidence 2.2

Definition

Core body temperature above the normal diurnal range due to failure of thermoregulation.

Defining characteristics

- Abnormal posturing
- Apnea
- Coma
- Flushed skin
- Hypotension
- Infant does not maintain suck
- Irritability
- Lethargy
- Seizure
- Skin warm to touch
- Stupor
- Tachycardia
- Tachypnea
- Vasodilation

Related factors

- Dehydration
- Inappropriate clothing
- Increase in metabolic rate
- Vigorous activity

At risk population

- Exposure to high environmental temperature

Associated condition

- Decrease in sweat response
- Illness
- Ischemia
- Pharmaceutical agent
- Sepsis
- Trauma

Refer to staging criteria.

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 11 • Class 6 • Diagnosis Code 00006

Hypothermia

Approved 1986 • Revised 1988, 2013, 2017 • Level of Evidence 2.2

Definition

Core body temperature below the normal diurnal range due to failure of thermoregulation.

Defining characteristics

- Acrocyanosis
- Bradycardia
- Cyanotic nail beds
- Decrease in blood glucose level
- Decrease in ventilation
- Hypertension
- Hypoglycemia
- Hypoxia
  - Increase in metabolic rate
  - Increase in oxygen consumption
  - Peripheral vasoconstriction
  - Piloerection
  - Shivering
  - Skin cool to touch
  - Slow capillary refill
  - Tachycardia

Neonates

- Infant with insufficient energy to maintain sucking
- Infant with insufficient weight gain (< 30 g/day)
- Irritability
  - Jaundice
  - Metabolic acidosis
  - Pallor
  - Respiratory distress

Related factors

- Alcohol consumption
- Decrease in metabolic rate
- Excessive conductive heat transfer
- Excessive convective heat transfer
- Excessive evaporative heat transfer
- Excessive radiative heat transfer
  - Inactivity
  - Insufficient caregiver knowledge of hypothermia prevention
  - Insufficient clothing
  - Low environmental temperature
  - Malnutrition

Neonates

- Delay in breastfeeding
- Early bathing of newborn
– Increase in oxygen demand

At risk population

- Economically disadvantaged
- Extremes of age
- Extremes of weight
- High-risk out-of-hospital birth
– Increased body surface area to weight ratio
– Insufficient supply of subcutaneous fat
– Unplanned out-of-hospital birth

Associated condition

- Damage to hypothalamus
- Immature stratum corneum
- Increase in pulmonary vascular resistance (PVR)
- Ineffective vascular control
– Inefficient nonshivering thermogenesis
– Pharmaceutical agent
– Radiation therapy
– Trauma

Refer to appropriate and validated staging criteria.

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 11 • Class 6 • Diagnosis Code 00253

Risk for hypothermia

Approved 2013 • Revised 2017 • Level of Evidence 2.2

Definition

Susceptible to a failure of thermoregulation that may result in a core body temperature below the normal diurnal range, which may compromise health.

Risk factors

- Alcohol consumption
- Excessive conductive heat transfer
- Excessive convective heat transfer
- Excessive evaporative heat transfer
- Excessive radiative heat transfer
- Inactivity
– Insufficient caregiver knowledge of hypothermia prevention
– Insufficient clothing
– Low environmental temperature
– Malnutrition

Neonates

- Decrease in metabolic rate
- Delay in breastfeeding
– Early bathing of newborn
– Increase in oxygen demand

At risk population

- Economically disadvantaged
- Extremes of age
- Extremes of weight
- High-risk out-of-hospital birth
– Increased body surface area to weight ratio
– Insufficient supply of subcutaneous fat
– Unplanned out-of-hospital birth

Associated condition

- Damage to hypothalamus
- Immature stratum corneum
- Increase in pulmonary vascular resistance (PVR)
- Ineffective vascular control
– Inefficient nonshivering thermogenesis
– Pharmaceutical agent
– Radiation therapy
– Trauma

Refer to appropriate and validated staging criteria.
Original literature support available at **http://MediaCenter.thieme.com**.

Domain 11 • Class 6 • Diagnosis Code 00254

Risk for perioperative hypothermia

Approved 2013 • Revised 2017 • Level of Evidence 2.1

Definition

Susceptible to an inadvertent drop in core body temperature below 36 ° C/96.8 ° F occurring one hour before to 24 hours after surgery, which may compromise health.

Risk factors

- Excessive conductive heat transfer
- Excessive convective heat transfer
– Excessive radiative heat transfer
– Low environmental temperature

At risk population

- American Society of Anesthesiologists (ASA) Physical Status classification score > 1
- Low body weight
– Low preoperative temperature (< 36 ° C/96.8 ° F)

Associated condition

- Cardiovascular complications
- Combined regional and general anesthesia
– Diabetic neuropathy
– Surgical procedure

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 11 • Class 6 • Diagnosis Code 00008

Ineffective thermoregulation

Approved 1986 • Revised 2017 • Level of Evidence 2.1

Definition

Temperature fluctuation between hypothermia and hyperthermia.

Defining characteristics

- Cyanotic nail beds
- Flushed skin
- Hypertension
- Increase in body temperature above normal range
- Increase in respiratory rate
- Mild shivering
- Moderate pallor
- Piloerection
- Reduction in body temperature below normal range
- Seizure
- Skin cool to touch
- Skin warm to touch
- Slow capillary refill
- Tachycardia

Related factors

- Dehydration
- Fluctuating environmental temperature
- Inactivity
- Inappropriate clothing for environmental temperature
- Increase in oxygen demand
- Vigorous activity

At risk population

- Extremes of age
- Extremes of weight
- Extremes of environmental temperature
- Increased body surface area to weight ratio
- Insufficient supply of subcutaneous fat

Associated condition

- Alteration in metabolic rate
- Brain injury
- Condition affecting temperature regulation
- Decrease in sweat response
- Inefficient nonshivering thermogenesis
- Pharmaceutical agent
- Sedation
- Sepsis

- Illness

– Trauma

Domain 11 • Class 6 • Diagnosis Code 00274

Risk for ineffective thermoregulation

Approved 2016 • Level of Evidence 2.1

Definition

Susceptible to temperature fluctuation between hypothermia and hyperthermia, which may compromise health.

Risk factors

- Dehydration
- Fluctuating environmental temperature
- Inactivity
  - Inappropriate clothing for environmental temperature
  - Increase in oxygen demand
  - Vigorous activity

At risk population

- Extremes of age
- Extremes of weight
- Extremes of environmental temperature
  - Increased body surface area to weight ratio
  - Insufficient supply of subcutaneous fat

Associated condition

- Alteration in metabolic rate
- Brain injury
- Condition affecting temperature regulation
- Decrease in sweat response
- Illness
  - Inefficient nonshivering thermogenesis
  - Pharmaceutical agent
  - Sedation
  - Sepsis
  - Trauma

Domain 12.
Comfort

Class 1.	Physical comfort
Code	**Diagnosis**
00214	Impaired **comfort**
00183	Readiness for enhanced **comfort**
00134	**Nausea**
00132	Acute **pain**
00133	Chronic **pain**
00255	**Chronic pain syndrome**
00256	**Labor pain**

Class 2.	Environmental comfort
Code	**Diagnosis**
00214	Impaired **comfort**
00183	Readiness for enhanced **comfort**

Class 3.	Social comfort
Code	**Diagnosis**
00214	Impaired **comfort**
00183	Readiness for enhanced **comfort**
00054	Risk for **loneliness**
00053	**Social isolation**

Edited by T. Heather Herdman and Shigemi Kamitsuru.
 Published 2017 by Thieme Medical Publishers, Inc., New York.
Companion website: **www.thieme.com/nanda-i**.

Domain 12 • Class 1 • Diagnosis Code 00214

Impaired comfort

Approved 2008 • Revised 2010, 2017 • Level of Evidence 2.1

Definition

Perceived lack of ease, relief, and transcendence in physical, psychospiritual, environmental, cultural, and/or social dimensions.

Defining characteristics

- Alteration in sleep pattern
- Anxiety
- Crying
- Discontent with situation
- Distressing symptoms
- Fear
- Feeling cold
- Feeling of discomfort
- Feeling of hunger
- Feeling warm
- Inability to relax
- Irritability
- Itching
- Moaning
- Restlessness
- Sighing
- Uneasy in situation

Related factors

- Insufficient environmental control
- Insufficient privacy
- Insufficient resources
- Insufficient situational control
- Noxious environmental stimuli

Associated condition

- Illness-related symptoms
- Treatment regimen

This diagnosis is classified under Class 1 (Physical comfort), Class 2 (Environmental comfort), and Class 3 (Social comfort).

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 12 • Class 1 • Diagnosis Code 00183

Readiness for enhanced comfort

Approved 2006 • Revised 2013 • Level of Evidence 2.1

Definition

A pattern of ease, relief, and transcendence in physical, psychospiritual, environmental, and/or social dimensions, which can be strengthened.

Defining characteristics

- Expresses desire to enhance comfort
- Expresses desire to enhance feeling of contentment
– Expresses desire to enhance relaxation
– Expresses desire to enhance resolution of complaints

This diagnosis is classified under Class 1 (Physical comfort), Class 2 (Environmental comfort), and Class 3 (Social comfort).

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 12 • Class 1 • Diagnosis Code 00134

Nausea

Approved 1998 • Revised 2002, 2010, 2017 • Level of Evidence 2.1

Definition

A subjective phenomenon of an unpleasant feeling in the back of the throat and stomach, which may or may not result in vomiting.

Defining characteristics

- Aversion toward food
- Gagging sensation
- Increase in salivation
- Increase in swallowing
- Sour taste

Related factors

- Anxiety
- Exposure to toxin
- Fear
- Noxious environmental stimuli
- Noxious taste
- Unpleasant visual stimuli

Associated condition

- Biochemical dysfunction
- Esophageal disease
- Gastric distention
- Gastrointestinal irritation
- Increase in intracranial pressure (ICP)
- Intra-abdominal tumors
- Labyrinthitis
- Liver capsule stretch
- Localized tumor
- Meniere's disease
- Meningitis
- Motion sickness
- Pancreatic disease
- Pregnancy
- Psychological disorder
- Splenic capsule stretch
- Treatment regimen

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 12 • Class 1 • Diagnosis Code 00132

Acute pain

Approved 1996 • Revised 2013 • Level of Evidence 2.1

Definition

Unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage (International Association for the Study of Pain); sudden or slow onset of any intensity from mild to severe with an anticipated or predictable end, and with a duration of less than 3 months.

Defining characteristics

- Appetite change
- Change in physiological parameter
- Diaphoresis
- Distraction behavior
- Evidence of pain using standardized pain behavior checklist for those unable to communicate verbally
- Expressive behavior
- Facial expression of pain
- Guarding behavior
- Hopelessness
- Narrowed focus
- Positioning to ease pain
- Protective behavior
- Proxy report of pain behavior/activity changes
- Pupil dilation
- Self-focused
- Self-report of intensity using standardized pain scale
- Self-report of pain characteristics using standardized pain instrument

Related factors

- Biological injury agent
- Chemical injury agent
- Physical injury agent

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 12 • Class 1 • Diagnosis Code 00133

Chronic pain

Approved 1986 • Revised 1996, 2013, 2017 • Level of Evidence 2.1

Definition

Unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage (International Association for the Study of Pain); sudden or slow onset of any intensity from mild to severe, constant or recurring without an anticipated or predictable end, and with a duration of greater than 3 months.

Defining characteristics

- Alteration in ability to continue previous activities
- Alteration in sleep pattern
- Anorexia
- Evidence of pain using standardized pain behavior checklist for those unable to communicate verbally
- Facial expression of pain
- Proxy report of pain behavior/activity changes
- Self-focused
- Self-report of intensity using standardized pain scale
- Self-report of pain characteristics using standardized pain instrument

Related factors

- Alteration in sleep pattern
- Emotional distress
- Fatigue
- Increase in body mass index
- Ineffective sexuality pattern
- Injury agent
- Malnutrition
- Nerve compression
- Prolonged computer use
- Repeated handling of heavy loads
- Social isolation
- Whole-body vibration

At risk population

- Age > 50 years
- Female gender
- History of abuse
- History of genital mutilation
- History of over indebtedness
- History of static work postures
- History of substance misuse
- History of vigorous exercise

Associated condition

- Chronic musculoskeletal condition
- Contusion
- Crush injury
- Damage to the nervous system
- Fracture
- Genetic disorder
- Imbalance of neurotransmitters, neuromodulators and receptors
- Immune disorder
- Impaired metabolic functioning
- Ischemic condition
- Muscle injury
- Post-trauma related condition
- Prolonged increase in cortisol level
- Spinal cord injury
- Tumor infiltration

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 12 • Class 1 • Diagnosis Code 00255

Chronic pain syndrome

Approved 2013 • Level of Evidence 2.2

Definition

Recurrent or persistent pain that has lasted at least 3 months, and that significantly affects daily functioning or well-being.

Defining characteristics

- Anxiety (00146)
- Constipation (00011)
- Deficient knowledge (00126)
- Disturbed sleep pattern (00198)
- Fatigue (00093)
- Fear (00148)
- Impaired mood regulation (00241)
- Impaired physical mobility (00085)
- Insomnia (00095)
- Obesity (00232)
- Social isolation (00053)
- Stress overload (00177)

Related factors

– To be developed

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition if no related factors are developed.

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 12 • Class 1 • Diagnosis Code 00256

Labor pain

Approved 2013 • Revised 2017 • Level of Evidence 2.2

Definition

Sensory and emotional experience that varies from pleasant to unpleasant, associated with labor and childbirth.

Defining characteristics

- Alteration in blood pressure
- Alteration in heart rate
- Alteration in muscle tension
- Alteration in neuroendocrine functioning
- Alteration in respiratory rate
- Alteration in sleep pattern
- Alteration in urinary functioning
- Decrease in appetite
- Diaphoresis
- Distraction behavior
- Expressive behavior
- Facial expression of pain
- Increase in appetite
- Narrowed focus
- Nausea
- Pain
- Perineal pressure
- Positioning to ease pain
- Protective behavior
- Pupil dilation
- Self-focused
- Uterine contraction
- Vomiting

Related factors

- To be developed

Associated condition

- Cervical dilation
- Fetal expulsion

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition if no related factors are developed.

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 12 • Class 2 • Diagnosis Code 00214

Impaired comfort

Approved 2008 • Revised 2010, 2017 • Level of Evidence 2.1

Definition

Perceived lack of ease, relief, and transcendence in physical, psychospiritual, environmental, cultural, and/or social dimensions.

Defining characteristics

- Alteration in sleep pattern
- Anxiety
- Crying
- Discontent with situation
- Distressing symptoms
- Fear
- Feeling cold
- Feeling of discomfort
- Feeling of hunger
- Feeling warm
- Inability to relax
- Irritability
- Itching
- Moaning
- Restlessness
- Sighing
- Uneasy in situation

Related factors

- Insufficient environmental control
- Insufficient privacy
- Insufficient resources
- Insufficient situational control
- Noxious environmental stimuli

Associated condition

- Illness-related symptoms
- Treatment regimen

This diagnosis is classified under Class 1 (Physical comfort), Class 2 (Environmental comfort), and Class 3 (Social comfort).

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 12 • Class 2 • Diagnosis Code 00183

Readiness for enhanced comfort

Approved 2006 • Revised 2013 • Level of Evidence 2.1

Definition

A pattern of ease, relief, and transcendence in physical, psychospiritual, environmental, and/or social dimensions, which can be strengthened.

Defining characteristics

- Expresses desire to enhance comfort
- Expresses desire to enhance feeling of contentment
– Expresses desire to enhance relaxation
– Expresses desire to enhance resolution of complaints

This diagnosis is classified under Class 1 (Physical comfort), Class 2 (Environmental comfort), and Class 3 (Social comfort).

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 12 • Class 3 • Diagnosis Code 00214

Impaired comfort

Approved 2008 • Revised 2010, 2017 • Level of Evidence 2.1

Definition

Perceived lack of ease, relief, and transcendence in physical, psychospiritual, environmental, cultural, and/or social dimensions.

Defining characteristics

- Alteration in sleep pattern
- Anxiety
- Crying
- Discontent with situation
- Distressing symptoms
- Fear
- Feeling cold
- Feeling of discomfort
- Feeling of hunger
- Feeling warm
- Inability to relax
- Irritability
- Itching
- Moaning
- Restlessness
- Sighing
- Uneasy in situation

Related factors

- Insufficient environmental control
- Insufficient privacy
- Insufficient resources
- Insufficient situational control
- Noxious environmental stimuli

Associated condition

- Illness-related symptoms
- Treatment regimen

This diagnosis is classified under Class 1 (Physical comfort), Class 2 (Environmental comfort), and Class 3 (Social comfort).

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 12 • Class 3 • Diagnosis Code 00183

Readiness for enhanced comfort

Approved 2006 • Revised 2013 • Level of Evidence 2.1

Definition

A pattern of ease, relief, and transcendence in physical, psychospiritual, environmental, and/or social dimensions, which can be strengthened.

Defining characteristics

- Expresses desire to enhance comfort
- Expresses desire to enhance feeling of contentment
– Expresses desire to enhance relaxation
– Expresses desire to enhance resolution of complaints

This diagnosis is classified under Class 1 (Physical comfort), Class 2 (Environmental comfort), and Class 3 (Social comfort).

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 12 • Class 3 • Diagnosis Code 00054

Risk for loneliness

Approved 1994 • Revised 2006, 2013 • Level of Evidence 2.1

Definition

Susceptible to experiencing discomfort associated with a desire or need for more contact with others, which may compromise health.

Risk factors

- Affectional deprivation
- Emotional deprivation
– Physical isolation
– Social isolation

Original literature support available at **http://MediaCenter.thieme.com**.

Domain 12 • Class 3 • Diagnosis Code 00053

Social isolation

Approved 1982 • Revised 2017

Definition

Aloneness experienced by the individual and perceived as imposed by others and as a negative or threatening state.

Defining characteristics

- Absence of support system
- Aloneness imposed by others
- Cultural incongruence
- Desire to be alone
- Developmental delay
- Disabling condition
- Feeling different from others
- Flat affect
- History of rejection
- Hostility
- Illness
- Inability to meet expectations of others
- Insecurity in public
- Meaningless actions
- Member of a subculture
- Poor eye contact
- Preoccupation with own thoughts
- Purposelessness
- Repetitive actions
- Sad affect
- Values incongruent with cultural norms
- Withdrawn

Related factors

- Developmentally inappropriate interests
- Difficulty establishing relationships
- Inability to engage in satisfying personal relationships
- Insufficient personal resources
- Social behavior incongruent with norms
- Values incongruent with cultural norms

Associated condition

- Alteration in mental status
- Alteration in physical appearance
- Alteration in wellness

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

Domain 13.
Growth/development

Class 1.	Growth
Code	**Diagnosis**
	This class does not currently contain any diagnoses.

Class 2.	Development
Code	**Diagnosis**
00112	Risk for delayed **development**

NANDA International, Inc. Nursing Diagnoses: Definitions and Classification 2018–2020, 11th Edition. Edited by T. Heather Herdman and Shigemi Kamitsuru.

Domain 13 • Class 1

This class does not currently contain any diagnoses.

Domain 13 • Class 2 • Diagnosis Code 00112

Risk for delayed development

Approved 1998 • Revised 2013, 2017

Definition

Susceptible to delay of 25% or more in one or more of the areas of social or self-regulatory behavior, or in cognitive, language, gross, or fine motor skills, which may compromise health.

Risk factors

- Inadequate nutrition
- Presence of abuse
  - Substance misuse
  - Technology dependence

At risk population

- Behavioral disorder
- Economically disadvantaged
- Exposure to natural disaster
- Exposure to violence
- History of adoption
- Inadequate maternal nutrition
- Insufficient prenatal care
- Involvement with the foster care system
- Late-term prenatal care
  - Maternal age ≤ 15 years
  - Maternal age ≥ 35 years
  - Maternal functional illiteracy
  - Maternal substance misuse
  - Positive drug screen
  - Prematurity
  - Unplanned pregnancy
  - Unwanted pregnancy

Associated condition

- Brain injury
- Caregiver learning disability
- Caregiver mental health issue
- Chronic illness
- Congenital disorder
- Endocrine disorder
- Failure to thrive
- Genetic disorder
  - Hearing impairment
  - Impaired vision
  - Lead poisoning
  - Prenatal infection
  - Recurrent otitis media
  - Seizure disorder
  - Treatment regimen

This diagnosis will retire from the NANDA-I Taxonomy in the 2021-2023 edition unless additional work is completed to bring it up to a level of evidence 2.1 or higher.

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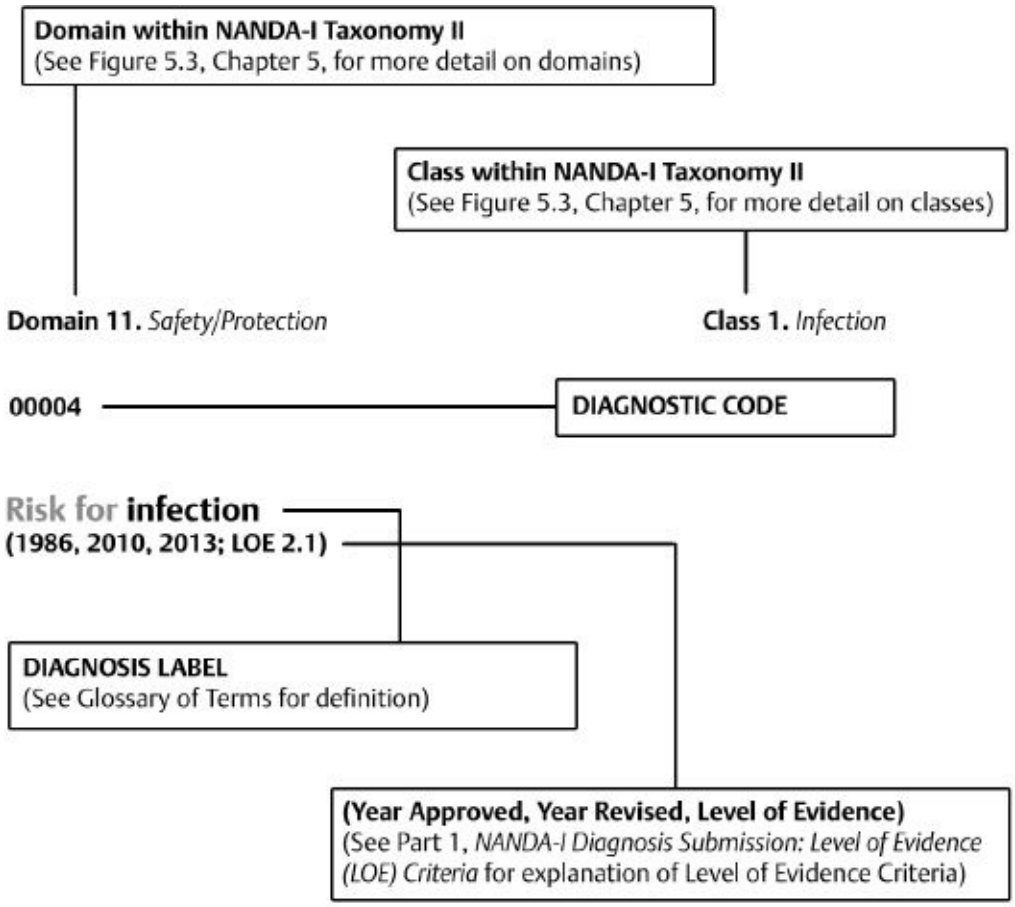

Domain	"an area of interest" (Cambridge Dictionary Online, 2017)
Class	"a group . . . with a similar structure" (Cambridge Dictionary Online, 2017)
Diagnosis Label	A term that is used to represent the diagnostic concept. It is a concise term or phrase that represents a pattern of related cues. It may include modifiers.
Diagnostic Code	32-bit integer or 5-digit code that is assigned to a nursing compliant with the National Library of Medicine (NLM) recommendations concerning healthcare terminology codes.

Reference

Cambridge University Press. Cambridge Dictionary Online. Cambridge, UK: Cambridge University Press, 2017. Available at: http://dictionary.cambridge.org/