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NURSING DIAGNOSIS
AN ESSENTIAL ELEMENT OF NURSING PROCESS

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INTRODUCTION

The beginning phase of the nursing process is gathering data or assessing the client standing alone these data are useless until you determine what they mean. The second phase of the nursing process in analyzing the data and identify the nursing care problem otherwise called nursing diagnosis.

DEFINITION

Nursing diagnosis is clinical judgment about it individual about it individual family or community response to actual or potential health of life process. Nursing diagnosis provides the basis for selection of nursing intervention to achieve outcomes for which the nurses accountable. (NANDA: 1990)

A nursing diagnosis is a statement about a clients actual or potential health concern that can be managed through independent nursing interventions nursing diagnosis are concise , ideas , client centered and client specific statement . (TAYLOR LILLIS PHEMORE 1987)

A nursing [process ids a statement that describe the actual or potential response to the health problem that the nurse and competent to treat. (POTTER & PERREY)

PURPOSE OF NURSING DIAGNOSIS

1. To identify nursing priorities
2. To direct nursing interventions to meet the client's high priority needs.
3. To provide a common language and from a basis for communication & understanding between professionals and health care team .
4. To formulate expected outcomes for quality assmance requirement of third party payers.
5. To provide a basis of evaluation to determine if nursing care was beneficial to the client and cost effective.
6. To assist in nursing staff assignment.

HISTORICAL DEVELOPMENT

As early as 1926 harmer suggested that nurses should include problem statement when documenting client care.

In 1947 Lesnich and Andeson argue that diagnosis was with in the scope of nursing practice.

In 1953 Fry's generally credited with the fresh use of team nursing diagnosis in the literature.

During 1960s a series of research studies focused on the nurse's ability to make clinical judgment using client cause.

These studies revealed that knowledge and interpretation varied widely and that the terms used to describe clients problem where not standardized.

- In 1972 Gordon completed her dissertation on diagnostic reasoning in nursing. The formal development of the identification and classification of nursing diagnosis with the first national conference on the classification by Gebbic and Lavin 1973.
- The formal development of the identification and classification of nursing diagnosis began with the fist national conference on the classification of nursing diagnosis convinced by Gebbic and Larin in 1973.
- The act of diagnosing was recognized by the American nurses association (ANA) in standards nursing practice (ANA 1973) and reformed by the application of revised standards in 1991(ANA 1991).
- In 1996, JCAHO, joint commission on the accreditation of health care organization mandate that each client nursing care based o identified nursing diagnosis on client care needs.
- Nurses continue to develop new nursing diagnosis refine existing diagnosis and organization in to a classification system useful to practice nurses.

NANDA has been the leader nursing diagnosis classification and has been accepted by the ANA.

TYPES OF NURSING DIAGONOSIS

1. Actual nursing diagnosis
2. Risk nursing diagnosis
3. Possible nursing diagnosis
4. Syndrome nursing diagnosis
5. Wellness nursing diagnosis

1. Actual diagnosis

Actual diagnosis is a client problem that present at the time of nursing assessment.

An actual nursing diagnosis is based on the presences of associated signs and syndromes. E.g. are ineffective breathing pattern and anxiety.

2. A Risk nursing diagnosis

It is a clinical judgment that a problem does not exist but the presence of risk factors indicates that a problem is likely to develop unless nursing intervene it.

E.g. all people admitted to hospital have some possibility of acquiring an infection how ever a client with diabetics is at higher risk than other.

3. A possible nursing diagnosis :

It is one in which evidences about a health problem is in complete or unclear. A possible diagnosis requires data either to support or to refuse it.

4. A syndrome diagnosis

It is a diagnosis that is associated with a cluster of other diagnosis.

E.g.: impaired physical nobility. Risk for altered respiratory functions, risk for activity intolerance.

5. A wellness diagnosis

A wellness diagnosis is a clinical judgment about an individual, Family or community in transition from a specific level of wellness to a higher level of wellness.

E.g. potential for enhanced nutrition

DIFFERENCE BETWEEN MEDICAL DIAGNOSIS AND NURSING DIAGNOSIS

1. A medical diagnosis of a disease condition based on a specific evaluation of physical symptoms, history, diagnostic tests and it is a treatment of a client actual or potential response to health problem that the nurse is licensed and component to treat.
2. Medical diagnosis is to identify and design a treatment plan for caring the disease or the pathological process.

   Nursing diagnosis is to identify actual and potential client response
3. Objective of nursing diagnosis is to development of a individualized plan of care, so that the client and family can adopt to change resulting from health problems.
4. Medical diagnosis is treatable by physician with in scope of medical practice. Nursing diagnosis treatable by nurses with in the scope of nursing practice.
5. Medical diagnosis is staying the same as long as the disease is present. Nursing diagnosis may change from day to day as human reaction change.
6. Medical diagnosis applies to diseased in individuals only. Nursing diagnosis may apply to alteration in individuals or groups.

GUIDELINES FOR WRITING A NURSING DIAGNOSIS

1. State in terms of a problem not a need.

   Correct statement eg. Fluid volume deficit related to fever.

   (We should not mention fluid replacement)
2. Would the statement so that is legally advisable. E.g. Impaired skin integrity related to immobility. (Legally acceptable). Not mention as improper positioning.
3. Use non judgment statements.
4. Be sure that causes and effect are correctly stated.
5. .Word the diagnosis specifically and precisecily to provide direction for planning nursing interventions.
6. Use nursing terminology rather than medical terminology.

DIAGNOSTIC PROCESS

A diagnostic process is the decision making steps the nurses uses to develop a develop a diagnostic statement.

This process includes

1. Analysis and interpretation of data
2. Identification of problem
3. Formulation of the nursing diagnoses

ANALYSIS AND INTERPRETATION DATA

The analysis includes recognizing patterns and trends company them with normal healthful standards and coming to the reasoned Conclusion about the clients responses when looking for patterns or trends then identify the problem and make a nursing diagnosis .

E.g: 1. Recognize pattern

No bowel movements for 4 days.

2. Compare with normal standards.

Soft formed stool daily

3. Make a reasoned conclusion

Bowel elimination problem

COMPONENTS OF NURSING DIAGNOSIS

1. **Diagnostic label**

   It is the name of the nursing diagnosis as lasted in the taxonomy it describes as essence of the problem using as a few words as possible.

2. **Description**

   Descriptions are words used to give additional meaning to a nursing diagnosis. They describe changes in condition state of the client.

E.g: from NANDA (2001) include.

Ability: Capacity to do or act

Balance: State of equilibrium

3. **Definition**

   Each nursing diagnosis that a NANDA approves for clinical use and testing has a definition that describes the characteristic of the human response under consideration .

E.g: the definition of the diagnostic label hypothermia is body temperature below normal range (NANDA 2001)

4. Defining characteristics

Defining characteristics are the observable client influence that cluster of manifestation of an actual or wellness using diagnosis (NANDA 2001) Each piece of the client information is considered as clinical care. A set of clinical care forms a cluster that is present if diagnosis is an accurate.

5. Risk factors

The term risk factor is used to describe clinical care in risk nursing diagnosis. They are environmental factors and physiological psychological genetic or chemical elements that increase the vulnerability of an individual family or community to an unhealthful event.

E.g: risk for difficult fluid volume extreme of are physical immobility.

6. Related factors

Related factors describes the conditions, circumstances or a etionlogies that contribute to the problem terminology's that can be used as associated with related to or contribution to.

NURSING DIAGNOSIS TAXONOMY

Profession require a sound scientific base, the nursing process is nursing scientific base. To achieve this scientific foundation nursing requires a taxonomy or a classification system can to provide a statue for nursing practice.

North American nursing diagnosis association (NANDA) developa nursing diagnosis taxonomy. At the first conference in 1973, 86 nursing diagnosis were developed alphabetically and published in 2000, 155 nursing, diagnosis has accepted for clinical use and testing.

The main two purpose of the NANDA are to develop a diagnostic classification system and to identify nursing diagnosis .

PES FORMAT TO WRITE NURSING DIAGNOSIS

A Nursing diagnosis may have 2 or 3 parts system

The two part system consist of nursing diagnosis the related statement and the defining characterizes.

The three – part diagnosis statement called as PES SYSTEM according to Gordon (1970)

PES format includes.

'P' – Problem – the diagnosis the label

'E'- etiology – related to phase or etiology related cause or contributor to the problem.

'S' – symptom – defining characteristics phase symptoms that the nurse identified in the assessment

e.g: P : Distributed sleeping pattern

E : Related to worrying too much my mother passed away recently.

S: Difficulty in falling asleep I am so tired

WRITING TWO PARTS AND THREE PARTS NURSING DIAGNOSIS

1. **Actual nursing diagnosis :** (three part statement – PES)

   e.g.: Self care deficit related to in ability to move arm as maintained by cast on both hanks and wrises.

2. **Potential nursing diagnosis** (two parts system – P + E)

   E.g: Pctential in effective airway clearance related to smoking.

PRIORITY SETTING OR NURSING DIAGNOSIS

Many methods can be used for priority setting nursing diagnosis one method for settings priority reflects the bio psycholosical approach and involves looking for the must life threatening problems following by problems that interfere with normal life functioning. Second method for setting priority is according to the client preference.

DOCUMENTATION

After analyzing assessment data the identifies clients problem sand decides how they listed on the care plan. First highest priority nursing diagnosis should listed and there after additional nursing diagnosis added to the list, each nursing diagnosis is dated at the time of entry.

LISING DIAGNOSTIC TERMINOLOGY

1. Don't state nursing diagnosis in medical terminology .
2. Don't state nursing diagnosis as nursing interventions.
3. Don't write nursing diagnosis as a problem
4. Mention nursing diagnosis specifically don't vague five.
5. Don't write nursing diagnosis which repeats the physicians order.
6. Don't state two problems at the same time E.g: pain and fear.
7. Don't write the diagnostic statement is such a way that it may be legally incriminating.
8. Don't name a medical problem as a nursing diagnosis eg:

   Alteration in homodynamic should mention hypovolumia.

ADVANTAGES OF NURSING DIAGNOSIS

Nursing diagnosis is advantageous for the health care team nurse and client.

1. Communication among nurse and other health care provider about a client level of wellness. Current needs and discharge planning is facilitated.
2. It helps the health care team to effectively coordinate the care.

3. Through the nursing diagnosis effectively in client is increased because the client problems have been identified and the nurse can begin care to solve them .
4. Well stated nursing diagnosis helps to keep the nurses from staying into the realm of medical practice.
5. Nursing diagnosis individualized do specific health care needs results in consistent care.
6. Nursing care is client centered, goal directed and coordinated.
7. Nursing diagnosis result in personalized care effective problem resolution that promotes client and family function after discharge and return to the community .

LIMITATIONS

Continuous evaluation of the term and use of nursing diagnosis, the language can occasionally be wordy and contain jargon.

SOURCES OF ERROR

A common error that nurse make is to state all of the client problem as a nursing diagnosis. Two types of error commonly made by nurses when making diagnostic statement.

1. Error of commission
2. Error of omission

An error of commission occurs when the nurse over diagnosis client or when non existent health problems are diagnosed.

An error of omission occurs when the nurse fail to identify a health care problem.

Errors usually occur as the result of incomplete date collection or in correctly interpreted date.

SUMMARY

So far we have seen about the second step of nursing process that is nursing diagnosis. Its definitions, purposes, historical.