Mary Beth Flynn Makic
Marina Reyna Martinez-Kratz

Ackley and Ladwig's

NURSING DIAGNOSIS HANDBOOK

An Evidence-Based Guide to Planning Care

THIRTEENTH EDITION

Interventions and rationales for
Adult, Geriatric, Mental Health,
Pediatric, Maternal/Child Health,
Multicultural, Home Care, Client/Family
Teaching, and Discharge Planning

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NANDA-I Diagnoses

Decreased **activity** tolerance, 126
Risk for decreased **activity** tolerance, 131
Ineffective **activity** planning, 131
Risk for ineffective **activity** planning, 134
Ineffective **airway** clearance, 135
Risk for **allergy** reaction, 140
Anxiety, 144
Death **anxiety**, 147
Risk for **aspiration**, 151
Risk for impaired **attachment**, 157
Autonomic dysreflexia, 162
Risk for **autonomic dysreflexia**, 166
Risk for **bleeding**, 167
Risk for unstable **blood pressure**, 171
Disturbed **body image**, 175
Insufficient **breast milk** production, 178
Ineffective **breastfeeding**, 181
Interrupted **breastfeeding**, 184
Readiness for enhanced **breastfeeding**, 187
Ineffective **breathing** pattern, 189
Decreased **cardiac** output, 194
Risk for decreased **cardiac** output, 202
Risk for decreased **cardiac** tissue perfusion, 203
Risk for impaired **cardiovascular** function, 208
Caregiver role strain, 209
Risk for **caregiver role strain**, 214
Risk for ineffective **cerebral** tissue perfusion, 215
Ineffective **childbearing** process, 218
Readiness for enhanced **childbearing** process, 222
Risk for ineffective **childbearing** process, 226
Impaired **comfort**, 226
Readiness for enhanced **comfort**, 230
Readiness for enhanced **communication**, 234
Impaired verbal **communication**, 237
Acute **confusion**, 242
Chronic **confusion**, 248
Risk for acute **confusion**, 253
Constipation, 254
Risk for **constipation**, 260
Perceived **constipation**, 261
Chronic functional **constipation**, 264
Risk for chronic functional **constipation**, 269
Contamination, 270
Risk for **contamination**, 274
Impaired bowel **continence**, 275
Risk for adverse reaction to iodinated **contrast media**, 281
Readiness for enhanced community **coping**, 284
Defensive **coping**, 287
Ineffective **coping**, 290
Readiness for enhanced **coping**, 296
Ineffective community **coping**, 300
Compromised family **coping**, 303
Disabled family **coping**, 309
Readiness for enhanced family **coping**, 312
Readiness for enhanced **decision-making**, 314
Decisional conflict, 317
Risk for **elopement** attempt, 320
Impaired emancipated **decision-making**, 323
Readiness for enhanced emancipated **decision-making**, 327
Risk for impaired emancipated **decision-making**, 330
Readiness for enhanced **exercise** engagement, 333
Ineffective **denial**, 337
Impaired **dentition**, 341
Delayed child **development**, 349
Risk for delayed child **development**, 352
Delayed infant motor **development**, 353
Risk for delayed infant motor **development**, 356
Diarrhea, 357
Risk for **disuse** syndrome, 363
Decreased **diversional activity** engagement, 368
Ineffective adolescent **eating** dynamics, 372
Ineffective child **eating** dynamics, 375
Risk for **electrolyte** imbalance, 378
Labile **emotional control**, 381
Imbalanced **energy field**, 385
Ineffective dry **eye** self-management, 387
Risk for dry **eye**, 390
Risk for adult **falls**, 391
Risk for child **falls**, 398
Dysfunctional **family** processes, 401
Interrupted **family** processes, 405
Readiness for enhanced **family** processes, 408
Fatigue, 411
Fear, 417
Ineffective infant **feeding** dynamics, 421
Risk for **female genital mutilation**, 424
Risk for imbalanced **fluid** volume, 427
Deficient **fluid** volume, 431
Excess **fluid** volume, 437
Risk for deficient **fluid** volume, 442
Frail elderly syndrome, 442
Risk for **frail elderly** syndrome, 445
Impaired **gas** exchange, 446
Risk for dysfunctional **gastrointestinal** motility, 451
Dysfunctional **gastrointestinal** motility, 451
Risk for unstable blood **glucose** level, 456
Maladaptive **grieving**, 462
Risk for maladaptive **grieving**, 466
Readiness for enhanced **grieving**, 467
Deficient community **health**, 473
Risk-prone **health** behavior, 475
Ineffective **health** self-management, 480
Readiness for enhanced **health** self-management, 484
Ineffective family **health** self-management, 488
Ineffective **health** maintenance behaviors, 491
Ineffective **home** maintenance behaviors, 495
Readiness for enhanced **home** maintenance behaviors, 499
Risk for ineffective **home** maintenance behaviors, 501
Readiness for enhanced **hope**, 502
Hopelessness, 504
Risk for compromised **human dignity**, 508
Neonatal **hyperbilirubinemia**, 511
Risk for neonatal **hyperbilirubinemia**, 515
Hyperthermia, 517

Hypothermia, 523
Risk for **hypothermia**, 530
Neonatal **hypothermia**, 530
Risk for neonatal **hypothermia**, 532
Risk for **perioperative hypothermia**, 533
Disturbed family **identity** syndrome, 538
Risk for disturbed family **identity** syndrome, 541
Disturbed personal **identity**, 542
Risk for disturbed personal **identity**, 549
Risk for complicated **immigration transition**, 549
Ineffective **impulse** control, 552
Disability-associated urinary **incontinence**, 555
Mixed urinary **incontinence**, 559
Stress urinary **incontinence**, 563
Urge urinary **incontinence**, 567
Risk for urge urinary **incontinence**, 572
Disorganized **infant** behavior, 573
Readiness for enhanced organized **infant** behavior, 578
Risk for disorganized **infant** behavior, 578
Risk for **infection**, 579
Risk for surgical site **infection**, 585
Risk for **injury**, 592
Risk for corneal **injury**, 596
Risk for occupational **injury**, 599
Nipple-areolar complex **injury**, 604
Risk for nipple-areolar complex **injury**, 606
Risk for urinary tract **injury**, 607
Insomnia, 610
Deficient **knowledge**, 614
Readiness for enhanced **knowledge**, 618
Risk for **latex allergy** reaction, 620
Readiness for enhanced health **literacy**, 623
Risk for impaired **liver** function, 626
Risk for **loneliness**, 630
Ineffective **lymphedema** self-management, 633
Risk for ineffective **lymphedema** self-management, 638
Risk for disturbed **maternal–fetal** dyad, 639
Impaired **memory**, 642
Risk for **metabolic** syndrome, 646
Impaired bed **mobility**, 650
Impaired physical **mobility**, 655
Impaired wheelchair **mobility**, 659
Impaired **mood** regulation, 663
Moral distress, 665
Risk for dry **mouth**, 668
Nausea, 674
Neonatal abstinence syndrome, 680
Readiness for enhanced **nutrition**, 683
Imbalanced **nutrition:** less than body requirements, 686
Impaired **oral mucous membrane** integrity, 692
Risk for impaired **oral mucous membrane** integrity, 698
Obesity, 698
Overweight, 703
Risk for **overweight**, 707
Acute **pain**, 712
Chronic **pain**, 719
Chronic **pain** syndrome, 728
Labor **pain**, 728
Impaired **parenting**, 732
Readiness for enhanced **parenting**, 736
Risk for impaired **parenting**, 739
Risk for **perioperative positioning** injury, 739
Risk for **peripheral neurovascular** dysfunction, 745
Risk for **poisoning**, 747
Post-trauma syndrome, 752
Risk for **post-trauma** syndrome, 756
Readiness for enhanced **power**, 759
Powerlessness, 761
Risk for **powerlessness**, 765
Adult **pressure injury**, 765
Risk for adult **pressure injury**, 770
Child **pressure injury**, 771
Risk for child **pressure injury**, 776
Neonatal **pressure injury**, 777
Risk for neonatal **pressure injury**, 780
Ineffective **protection**, 781
Rape-trauma syndrome, 787
Ineffective **relationship**, 791
Readiness for enhanced **relationship**, 794
Risk for ineffective **relationship**, 797
Impaired **religiosity**, 798
Readiness for enhanced **religiosity**, 801
Risk for impaired **religiosity**, 805
Relocation stress syndrome, 805
Risk for **relocation** stress syndrome, 811
Impaired **resilience**, 811
Readiness for enhanced **resilience**, 814
Risk for impaired **resilience**, 816
Parental **role** conflict, 819
Ineffective **role** performance, 822
Sedentary lifestyle, 825
Readiness for enhanced **self-care**, 830
Bathing **self-care** deficit, 836
Dressing **self-care** deficit, 840
Feeding **self-care** deficit, 843
Toileting **self-care** deficit, 847
Readiness for enhanced **self-concept**, 851
Chronic low **self-esteem**, 854
Situational low **self-esteem**, 858
Risk for chronic low **self-esteem**, 861
Risk for situational low **self-esteem**, 861
Risk for **self-mutilation**, 864
Self-mutilation, 864
Self-neglect, 868
Sexual dysfunction, 871
Ineffective **sexuality** pattern, 877
Risk for **shock**, 882
Impaired **sitting**, 887
Impaired **skin** integrity, 890
Risk for impaired **skin** integrity, 895
Sleep deprivation, 898
Readiness for enhanced **sleep**, 902
Disturbed **sleep** pattern, 906
Impaired **social** interaction, 910
Social isolation, 913
Chronic **sorrow**, 916

Spiritual distress, 920
Risk for **spiritual** distress, 924
Readiness for enhanced **spiritual** well-being, 924
Impaired **standing**, 929
Stress overload, 931
Acute **substance withdrawal** syndrome, 935
Risk for acute **substance withdrawal** syndrome, 940
Ineffective infant **suck-swallow response**, 945
Risk for **sudden infant death**, 949
Risk for **suffocation**, 951
Risk for **suicidal behavior**, 955
Delayed **surgical** recovery, 962
Risk for delayed **surgical** recovery, 966
Impaired **swallowing**, 967
Risk for **thermal** injury, 972
Ineffective **thermoregulation**, 974
Risk for ineffective **thermoregulation**, 979
Risk for **thrombosis**, 979
Disturbed **thought process**, 983
Impaired **tissue** integrity, 986
Risk for impaired **tissue** integrity, 991
Ineffective peripheral **tissue perfusion**, 992
Risk for ineffective peripheral **tissue perfusion**, 997
Impaired **transfer** ability, 997
Risk for physical **trauma**, 1002
Unilateral neglect, 1008
Impaired **urinary** elimination, 1010
Urinary retention, 1015
Risk for **urinary retention**, 1020
Risk for **vascular trauma**, 1020
Impaired spontaneous **ventilation**, 1024
Dysfunctional adult **ventilatory** weaning response, 1030
Dysfunctional **ventilatory** weaning response, 1036
Risk for other-directed **violence**, 1037
Risk for self-directed **violence**, 1042
Impaired **walking**, 1045
Wandering, 1048

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To nursing colleagues throughout the world who continue to demonstrate unwavering commitment to providing exceptional care, physical, emotional, and spiritual care. Special thanks to my family. To my husband and children, whose unconditional love and support are ever present in my life. To my parents and sisters for always encouraging me to follow my passion. Finally, to Betty Ackley and Gail Ladwig for their steadfast commitment to the profession of nursing as expert teachers and prolific authors. Your leadership and spirit continue to inform nursing practice excellence.
Mary Beth Flynn Makic

To all the nurses who are working on the front lines. To my best friend and the love of my life, Kent Martinez-Kratz. To my children, Maxwell, Jesse, and Sierra, whose love, inspiration, and wit make my life complete. To my first fans, my parents Angel and Eva, and siblings, Debra and Jason. To Gail Ladwig for being the absolute best nursing professor, mentor, colleague, and comadre. And finally, to Betty Ackley's memory, for inspiring excellence in nursing education and practice.
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Preface

Ackley and Ladwig's Nursing Diagnosis Handbook: An Evidence-Based Guide to Planning Care is a convenient reference to help the practicing nurse or nursing student make a nursing diagnosis and write a care plan with ease and confidence. This handbook helps nurses correlate nursing diagnoses with known information about clients on the basis of assessment findings; established medical, surgical, or psychiatric diagnoses; and the current treatment plan.

Making a nursing diagnosis and planning care are complex processes that involve diagnostic reasoning and critical thinking skills. Nursing students and practicing nurses cannot possibly memorize the extensive list of defining characteristics, related factors, and risk factors for the 267 diagnoses approved by NANDA-International (NANDA-I). There are also two additional diagnoses that the authors think are significant: Hearing Loss and Vision Loss. These diagnoses are contained in Appendix E (on the Evolve website). This book correlates suggested nursing diagnoses with what nurses know about clients and offers a care plan for each nursing diagnosis.

Section I, Nursing Process, Clinical Reasoning, Nursing Diagnosis, and Evidence-Based Nursing, is divided into two parts. Part A includes an overview of the nursing process. This section provides information on how to make a nursing diagnosis and directions on how to plan nursing care. It also includes information on using clinical reasoning and judgment skills, eliciting the "client's story," recognizing patterns in client responses, and synthesizing information to form decisions that will guide care based on analyzing and understanding the client's concerns. Part B includes advanced nursing concepts: concept mapping, QSEN (Quality and Safety Education for Nurses), evidence-based nursing care, quality nursing care, person-centered care, safety, informatics in nursing, and team/collaborative work with a multiprofessional team.

In **Section II, Guide to Nursing Diagnosis,** the nurse can look up symptoms and problems and their suggested nursing diagnoses for more than 1450 client symptoms; medical, surgical, and psychiatric diagnoses; diagnostic procedures; surgical interventions; and clinical states.

In **Section III, Guide to Planning Care,** the nurse can find care plans for all nursing diagnoses suggested in Section II. We have included the suggested nursing outcomes from the Nursing Outcomes Classification (NOC) and interventions from the Nursing Interventions Classification (NIC) by the Iowa Intervention Project. We believe this work is a significant addition to the nursing process to further define nursing practice with standardized language.

Scientific rationales based on research are included for most of the interventions. This is done to make the evidence basis for the specific nursing practice apparent to the nursing student and practicing nurse.

Special features of the 13th edition of *Ackley and Ladwig's Nursing Diagnosis Handbook: An Evidence-Based Guide to Planning Care* include the following:

- Labeling of classic older research studies that are still relevant as Classic Evidence-Based (CEB)
- Sixty-seven revised nursing diagnoses approved by NANDA-I
- Use of the terms *At-Risk Populations* and *Associated Conditions* with the diagnostic indicators as approved by NANDA-I.
- Twenty-nine new nursing diagnoses recently approved by NANDA-I, along with the retirement of four nursing diagnoses: Reflex Urinary Incontinence, Grieving, Decreased Intracranial Adaptive Capacity, and Latex Allergy Reaction.
- Seventeen revisions of nursing diagnoses made by NANDA-I in existing nursing diagnoses:
  - **Old diagnosis:** Ineffective Health Maintenance
    Revised diagnosis: Ineffective Health Maintenance Behaviors
  - **Old diagnosis:** Ineffective Health Management
    Revised diagnosis: Ineffective Health Self-Management
  - **Old diagnosis:** Readiness for Enhanced Health Management
    Revised diagnosis: Readiness for Enhanced Health Self-Management
  - **Old diagnosis:** Ineffective Family Health Management
    Revised diagnosis: Ineffective Family Health Self-Management
  - **Old diagnosis:** Impaired Home Maintenance
    Revised diagnosis: Ineffective Home Maintenance Behaviors
    - **Old domain:** 4 Activity/Rest
    - **New domain:** 1 Health Promotion
  - **Old diagnosis:** Ineffective Infant Feeding Pattern
    Revised diagnosis: Ineffective Infant Suck-Swallow Response
  - **Old diagnosis:** Risk for Metabolic Imbalance Syndrome
    Revised diagnosis: Risk for Metabolic Syndrome
  - **Old diagnosis:** Functional Urinary Incontinence
    Revised diagnosis: Disability-Associated Urinary Incontinence
  - **Old diagnosis:** Bowel Incontinence
    Revised diagnosis: Impaired Bowel Continence

- **Old diagnosis:** Activity Intolerance
  Revised diagnosis: Decreased Activity Tolerance
- **Old diagnosis:** Risk for Activity Intolerance
  Revised diagnosis: Risk for Decreased Activity Tolerance
- **Old diagnosis:** Complicated Grieving
  Revised diagnosis: Maladaptive Grieving
- **Old diagnosis:** Risk for Complicated Grieving
  Revised diagnosis: Risk for Maladaptive Grieving
- **Old diagnosis:** Risk for Falls
  Revised diagnosis: Risk for Adult Falls
- **Old diagnosis:** Risk for Pressure Ulcer
  Revised diagnosis: Risk for Adult Pressure Injury
- **Old diagnosis:** Risk for Suicide
  Revised diagnosis: Risk for Suicidal Behavior
- **Old diagnosis:** Risk for Delayed Development
  Revised diagnosis: Risk for Delayed Child Development

- Further addition of pediatric and critical care interventions to appropriate care plans
- An associated Evolve Online Course Management System that includes a Care Plan Template, critical thinking case studies, NIC and NOC labels, PowerPoint slides, review questions for the NCLEX-RN® exam, and appendixes for Nursing Diagnoses Arranged by Maslow's Hierarchy of Needs, Nursing Diagnoses Arranged by Gordon's Functional Health Patterns, Motivational Interviewing for Nurses, Wellness-Oriented Diagnostic Categories, and Nursing Care Plans for Hearing Loss and Vision Loss

The following features of *Ackley and Ladwig's Nursing Diagnosis Handbook: A Guide to Planning Care* are also available:

- Suggested nursing diagnoses for more than 1450 clinical entities, including signs and symptoms, medical diagnoses, surgeries, maternal-child disorders, mental health disorders, and geriatric disorders
- Labeling of nursing research as EBN (Evidence-Based Nursing) and clinical research as EB (Evidence-Based) to identify the source of evidence-based rationales
- An Evolve Online Courseware System with a Care Plan Template that helps the student or nurse write a nursing care plan
- Rationales for nursing interventions that are based on nursing research and best practices
- Nursing references identified for each care plan
- A complete list of NOC Outcomes on the Evolve website
- A complete list of NIC Interventions on the Evolve website
- Nursing care plans that contain many holistic interventions
- Care plans written by leading national nursing experts from throughout the United States, along with international contributors, who together represent all of the major nursing specialties and have extensive experience with nursing diagnoses, the nursing process, and evidence-based practice. Several contributors are the original submitters/authors of the nursing diagnoses established by NANDA-I
- A format that facilitates analyzing signs and symptoms by the process already known by nurses, which involves using defining characteristics of nursing diagnoses to make a diagnosis
- Use of NANDA-I terminology and approved diagnoses
- An alphabetical format for Sections II and III, which allows rapid access to information
- Nursing care plans also listed by domains and class, consistent with NANDA-I
- Nursing care plans for all nursing diagnoses listed in Section II
- Specific geriatric interventions in appropriate plans of care
- Specific client/family teaching interventions in each plan of care
- Information on culturally competent nursing care included where appropriate
- Inclusion of commonly used abbreviations (e.g., AIDS, MI, HF) and cross-references to complete terms in Section II

We acknowledge the work of NANDA-I, which is used extensively throughout this text. The original NANDA-I work can be found in *NANDA-I Nursing Diagnoses: Definitions & Classification 2021–2023*, 12th edition.

We and the consultants and contributors trust that nurses will find this 13th edition of *Ackley and Ladwig's Nursing Diagnosis Handbook: An Evidence-Based Guide to Planning Care* a valuable tool that simplifies the process of identifying appropriate nursing diagnoses for clients and planning for their care, thus allowing nurses more time to provide evidence-based care that promote each client's recovery.

Mary Beth Flynn Makic
Marina Reyna Martinez-Kratz

Acknowledgments

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With gratitude, we acknowledge nurses and student nurses, who are always an inspiration for us to provide fresh and accurate material. We are honored that they continue to value this text and to use it in their studies and practice.

We would like to thank all of the dedicated contributors who are experts in their fields of nursing. We appreciate all of their hard work.

Care has been taken to confirm the accuracy of the information presented in this book. However, the authors, editors, and publisher cannot accept any responsibility for consequences resulting from errors or omissions of the information in this book and make no warranty, expressed or implied, with respect to its contents. The reader should use practices suggested in this book in accordance with agency policies and professional standards. Every effort has been made to ensure the accuracy of the information presented in this text.

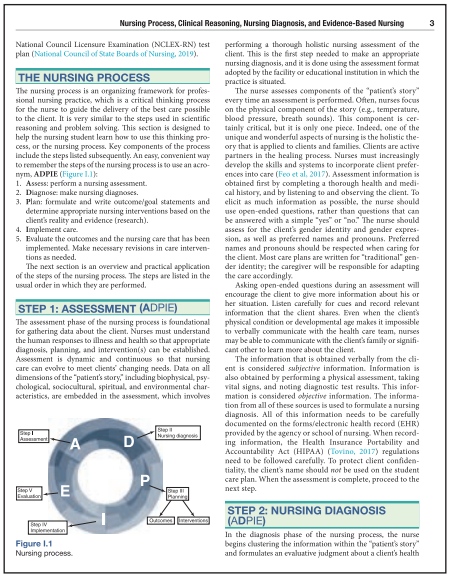
We hope you find this text a useful resource for your nursing practice.

Mary Beth Flynn Makic
Marina Reyna Martinez-Kratz

How to Use *Nursing Diagnosis Handbook: An Evidence-Based Guide to Planning Care*

STEP 1: ASSESS

Following the guidelines in Section I (Nursing Process, Clinical Reasoning, Nursing Diagnosis, and Evidence-Based Nursing), begin to formulate your nursing diagnosis by gathering and documenting the objective and subjective information about the client.



Nursing Process, Clinical Reasoning, Nursing Diagnosis, and Evidence-Based Nursing 3

National Council Licensure Examination (NCLEX-RN) test plan (National Council of State Boards of Nursing, 2019).

THE NURSING PROCESS

The nursing process is an organizing framework for professional nursing practice, which is a critical thinking process for the nurse to guide the delivery of the best care possible to the client. It is very similar to the steps used in scientific reasoning and problem solving. This section is designed to help the nursing student learn how to use this thinking process, or the nursing process. Key components of the process include the steps listed subsequently. An easy, convenient way to remember the steps of the nursing process is to use an acronym, **ADPIE** (Figure I.1):

1. Assess: perform a nursing assessment.
2. Diagnose: make nursing diagnoses.
3. Plan: formulate and write outcome/goal statements and determine appropriate nursing interventions based on the client's reality and evidence (research).
4. Implement care.
5. Evaluate the outcomes and the nursing care that has been implemented. Make necessary revisions in care interventions as needed.

The next section is an overview and practical application of the steps of the nursing process. The steps are listed in the usual order in which they are performed.

STEP 1: ASSESSMENT (ADPIE)

The assessment phase of the nursing process is foundational for gathering data about the client. Nurses must understand the human responses to illness and health so that appropriate diagnosis, planning, and intervention(s) can be established. Assessment is dynamic and continuous so that nursing care can evolve to meet clients' changing needs. Data on all dimensions of the "patient's story," including biophysical, psychological, sociocultural, spiritual, and environmental characteristics, are embedded in the assessment, which involves performing a thorough holistic nursing assessment of the client. This is the first step needed to make an appropriate nursing diagnosis, and it is done using the assessment format adopted by the facility or educational institution in which the practice is situated.

The nurse assesses components of the "patient's story" every time an assessment is performed. Often, nurses focus on the physical component of the story (e.g., temperature, blood pressure, breath sounds). This component is certainly critical, but it is only one piece. Indeed, one of the unique and wonderful aspects of nursing is the holistic theory that is applied to clients and families. Clients are active partners in the healing process. Nurses must increasingly develop the skills and systems to incorporate client preferences into care (Feo et al, 2017). Assessment information is obtained first by completing a thorough health and medical history, and by listening to and observing the client. To elicit as much information as possible, the nurse should use open-ended questions, rather than questions that can be answered with a simple "yes" or "no." The nurse should assess for the client's gender identity and gender expression, as well as preferred names and pronouns. Preferred names and pronouns should be respected when caring for the client. Most care plans are written for "traditional" gender identity; the caregiver will be responsible for adapting the care accordingly.

Asking open-ended questions during an assessment will encourage the client to give more information about his or her situation. Listen carefully for cues and record relevant information that the client shares. Even when the client's physical condition or developmental age makes it impossible to verbally communicate with the health care team, nurses may be able to communicate with the client's family or significant other to learn more about the client.

The information that is obtained verbally from the client is considered *subjective* information. Information is also obtained by performing a physical assessment, taking vital signs, and noting diagnostic test results. This information is considered *objective* information. The information from all of these sources is used to formulate a nursing diagnosis. All of this information needs to be carefully documented on the forms/electronic health record (EHR) provided by the agency or school of nursing. When recording information, the Health Insurance Portability and Accountability Act (HIPAA) (Tovino, 2017) regulations need to be followed carefully. To protect client confidentiality, the client's name should *not* be used on the student care plan. When the assessment is complete, proceed to the next step.

Figure I.1
Nursing process.

STEP 2: NURSING DIAGNOSIS (ADPIE)

In the diagnosis phase of the nursing process, the nurse begins clustering the information within the "patient's story" and formulates an evaluative judgment about a client's health

STEP 2: DIAGNOSE

Turn to Section II, Guide to Nursing Diagnosis, and locate the client's symptoms, clinical state, medical or psychiatric diagnoses, and anticipated or prescribed diagnostic studies or surgical interventions (listed in alphabetical order). Note suggestions for appropriate nursing diagnoses.

Then use Section III, Guide to Planning Care, to evaluate each suggested nursing diagnosis and "related to" (r/t) etiology statement. Section III is a listing of care plans according to NANDA-I, arranged alphabetically by diagnostic concept, for each nursing diagnosis referred to in Section II. Determine the appropriateness of each nursing diagnosis by comparing the Defining Characteristics and/or Risk Factors to the client data collected.

40 Chronic Obstructive Pulmonary Disease (COPD)

C

Chronic Obstructive Pulmonary Disease (COPD)
See COPD (Chronic Obstructive Pulmonary Disease)

Chronic Pain
See Pain Management, Chronic

Chronic Renal Failure (Chronic Renal Disease)
See Renal Failure

Chvostek's Sign
See Hypocalcemia

Circumcision
Acute Pain r/t surgical intervention
Risk for Bleeding: Risk factor: surgical trauma
Risk for Infection: Risk factor: surgical wound
Readiness for Enhanced Knowledge: Parent: expresses an interest in learning

Cirrhosis
Chronic Confusion r/t chronic organic disorder with increased ammonia levels, substance abuse
Defensive Coping r/t inability to accept responsibility to stop substance abuse
Fatigue r/t malnutrition
Ineffective Health Maintenance Behaviors r/t deficient knowledge regarding correlation between lifestyle habits and disease process
Nausea r/t irritation to gastrointestinal system
Imbalanced Nutrition: Less than Body Requirements r/t loss of appetite, nausea, vomiting
Chronic Pain r/t liver enlargement
Chronic Low Self-Esteem r/t chronic illness
Chronic Sorrow r/t presence of chronic illness
Risk for Bleeding: Risk factors: impaired blood coagulation, bleeding from portal hypertension
Risk for Injury: Risk factors: substance intoxication, potential delirium tremens
Risk for Impaired Oral Mucous Membrane Integrity: Risk factors: altered nutrition, inadequate oral care
Risk for Impaired Skin Integrity: Risk factors: altered nutritional state, altered metabolic state

Cleft Lip/Cleft Palate
Ineffective Airway Clearance r/t common feeding and breathing passage, postoperative laryngeal, incisional edema
Ineffective Breastfeeding r/t infant anomaly
Impaired Verbal Communication r/t inadequate palate function, possible hearing loss from infected eustachian tubes
Fear: Parental r/t special care needs, surgery
Maladaptive Grieving r/t loss of perfect child
Ineffective Infant Feeding Dynamics r/t fear resulting in inadequate feeding
Ineffective Infant Suck-Swallow Response r/t cleft lip, cleft palate
Impaired Physical Mobility r/t imposed restricted activity, use of elbow restraints
Impaired Oral Mucous Membrane Integrity r/t surgical correction
Acute Pain r/t surgical correction, elbow restraints
Impaired Skin Integrity r/t incomplete joining of lip, palate ridges
Chronic Sorrow r/t birth of child with congenital defect
Risk for Aspiration: Risk factor: common feeding and breathing passage
Risk for Disturbed Body Image: Risk factors: disfigurement, speech impediment
Risk for deficient Fluid Volume: Risk factor: inability to take liquids in usual manner
Risk for Infection: Risk factors: invasive procedure, disruption of eustachian tube development, aspiration
Readiness for Enhanced Knowledge: Parent: expresses an interest in learning

Clotting Disorder
Fear r/t threat to well being
Risk for Bleeding: Risk factor: impaired clotting
Readiness for Enhanced Knowledge: expresses an interest in learning
See Anticoagulant Therapy; DIC (Disseminated Intravascular Coagulation); Hemophilia

Cocaine Baby
See Neonatal Abstinence Syndrome

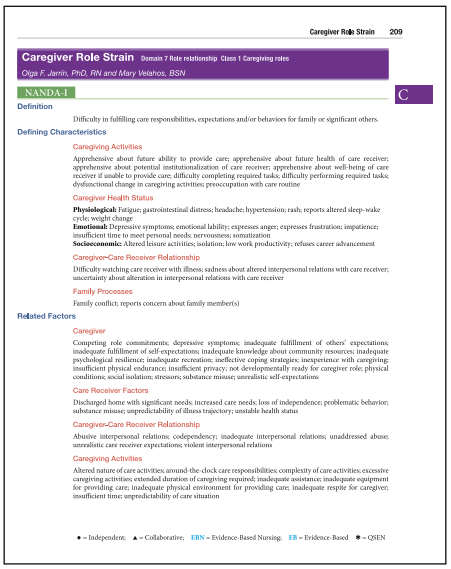
Codependency
Caregiver Role Strain r/t codependency
Impaired Verbal Communication r/t psychological barriers
Ineffective Coping r/t inadequate support systems
Decisional Conflict r/t support system deficit
Ineffective Denial r/t unmet self-needs
Powerlessness r/t lifestyle of helplessness

Cold, Viral
See Infectious Processes

Colectomy
Constipation r/t decreased activity, decreased fluid intake
Imbalanced Nutrition: Less than Body Requirements r/t high metabolic needs, decreased ability to ingest or digest food
Acute Pain r/t recent surgery
Risk for Surgical Site Infection: Risk factor: invasive procedure
Readiness for Enhanced Knowledge: expresses an interest in learning
See Abdominal Surgery

STEP 3: DETERMINE OUTCOMES

Use Section III, Guide to Planning Care, to find appropriate outcomes for the client. Use either the NOC Outcomes with the associated rating scales or Client Outcomes as desired.



Caregiver Role Strain 209

Caregiver Role Strain Domain 7 Role relationship Class 1 Caregiving roles
Olga F. Jarrín, PhD, RN and Mary Velahos, BSN

NANDA-I C

Definition
Difficulty in fulfilling care responsibilities, expectations and/or behaviors for family or significant others.

Defining Characteristics

Caregiving Activities
Apprehensive about future ability to provide care; apprehensive about future health of care receiver; apprehensive about potential institutionalization of care receiver; apprehensive 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; reports altered sleep-wake cycle; weight change
Emotional: Depressive symptoms; emotional lability; expresses anger; expresses frustration; impatience; insufficient time to meet personal needs; nervousness; somatization
Socioeconomic: Altered leisure activities; isolation; low work productivity; refuses career advancement

Caregiver–Care Receiver Relationship
Difficulty watching care receiver with illness; sadness about altered interpersonal relations with care receiver; uncertainty about alteration in interpersonal relations with care receiver

Family Processes
Family conflict; reports concern about family member(s)

Related Factors

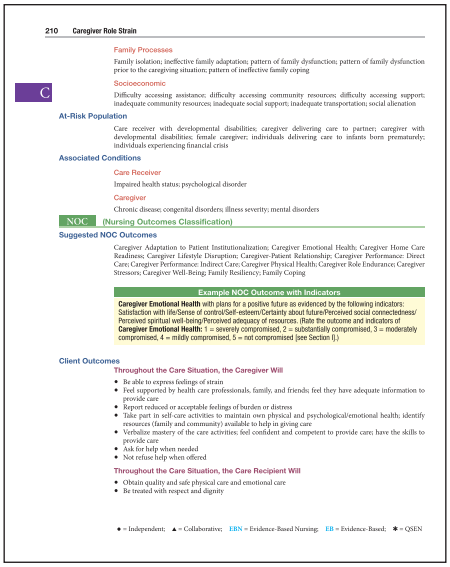
Caregiver
Competing role commitments; depressive symptoms; inadequate fulfillment of others' expectations; inadequate fulfillment of self-expectations; inadequate knowledge about community resources; inadequate psychological resilience; inadequate recreation; ineffective coping strategies; inexperience with caregiving; insufficient physical endurance; insufficient privacy; not developmentally ready for caregiver role; physical conditions; social isolation; stressors; substance misuse; unrealistic self-expectations

Care Receiver Factors
Discharged home with significant needs; increased care needs; loss of independence; problematic behavior; substance misuse; unpredictability of illness trajectory; unstable health status

Caregiver–Care Receiver Relationship
Abusive interpersonal relations; codependency; inadequate interpersonal relations; unaddressed abuse; unrealistic care receiver expectations; violent interpersonal relations

Caregiving Activities
Altered nature of care activities; around-the-clock care responsibilities; complexity of care activities; excessive caregiving activities; extended duration of caregiving required; inadequate assistance; inadequate equipment for providing care; inadequate physical environment for providing care; inadequate respite for caregiver; insufficient time; unpredictability of care situation

● = Independent; ▲ = Collaborative; EBN = Evidence-Based Nursing. EB = Evidence-Based ★ = QSEN



210 Caregiver Role Strain

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

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Socioeconomic

Difficulty accessing assistance; difficulty accessing community resources; difficulty accessing support; inadequate community resources; inadequate social support; inadequate transportation; social alienation

At-Risk Population

Care receiver with developmental disabilities; caregiver delivering care to partner; caregiver with developmental disabilities; female caregiver; individuals delivering care to infants born prematurely; individuals experiencing financial crisis

Associated Conditions

Care Receiver

Impaired health status; psychological disorder

Caregiver

Chronic disease; congenital disorders; illness severity; mental disorders

NOC (Nursing Outcomes Classification)

Suggested NOC Outcomes

Caregiver Adaptation to Patient Institutionalization; Caregiver Emotional Health; Caregiver Home Care Readiness; Caregiver Lifestyle Disruption; Caregiver-Patient Relationship; Caregiver Performance: Direct Care; Caregiver Performance: Indirect Care; Caregiver Physical Health; Caregiver Role Endurance; Caregiver Stressors; Caregiver Well-Being; Family Resiliency; Family Coping

Example NOC Outcome with Indicators

Caregiver Emotional Health with plans for a positive future as evidenced by the following indicators: Satisfaction with life/Sense of control/Self-esteem/Certainty about future/Perceived social connectedness/Perceived spiritual well-being/Perceived adequacy of resources. (Rate the outcome and indicators of **Caregiver Emotional Health:** 1 = severely compromised, 2 = substantially compromised, 3 = moderately compromised, 4 = mildly compromised, 5 = not compromised [see Section I].)

Client Outcomes

Throughout the Care Situation, the Caregiver Will

- Be able to express feelings of strain
- Feel supported by health care professionals, family, and friends; feel they have adequate information to provide care
- Report reduced or acceptable feelings of burden or distress
- Take part in self-care activities to maintain own physical and psychological/emotional health; identify resources (family and community) available to help in giving care
- Verbalize mastery of the care activities; feel confident and competent to provide care; have the skills to provide care
- Ask for help when needed
- Not refuse help when offered

Throughout the Care Situation, the Care Recipient Will

- Obtain quality and safe physical care and emotional care
- Be treated with respect and dignity

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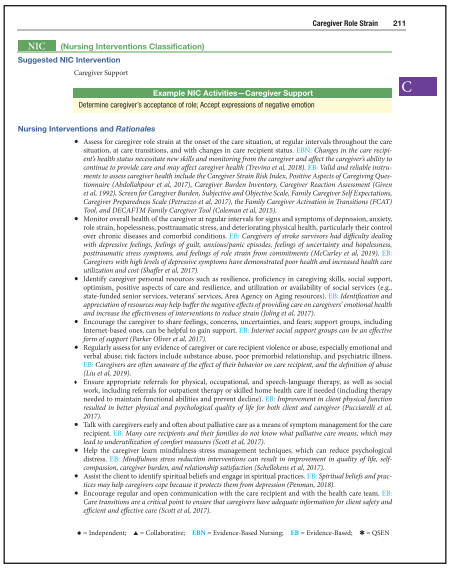

Caregiver Role Strain 211

NIC (Nursing Interventions Classification)

Suggested NIC Intervention

Caregiver Support

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Example NIC Activities—Caregiver Support

Determine caregiver's acceptance of role; Accept expressions of negative emotion

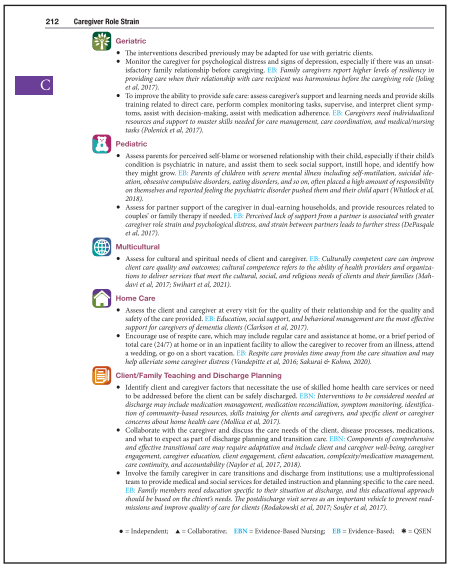
Nursing Interventions and *Rationales*

- Assess for caregiver role strain at the onset of the care situation, at regular intervals throughout the care situation, at care transitions, and with changes in care recipient status. EBN: *Changes in the care recipient's health status necessitate new skills and monitoring from the caregiver and affect the caregiver's ability to continue to provide care and may affect caregiver health (Trevino et al, 2018).* EB: *Valid and reliable instruments to assess caregiver health include the Caregiver Strain Risk Index, Positive Aspects of Caregiving Questionnaire (Abdollahpour et al, 2017), Caregiver Burden Inventory, Caregiver Reaction Assessment (Given et al, 1992), Screen for Caregiver Burden, Subjective and Objective Scale, Family Caregiver Self Expectations, Caregiver Preparedness Scale (Potrazca et al, 2017), the Family Caregiver Activation in Transitions (FCAT) Tool, and DECAFTM Family Caregiver Tool (Coleman et al, 2015).*
- Monitor overall health of the caregiver at regular intervals for signs and symptoms of depression, anxiety, role strain, hopelessness, posttraumatic stress, and deteriorating physical health, particularly their control over chronic diseases and comorbid conditions. EB: *Caregivers of stroke survivors had difficulty dealing with depressive feelings, feelings of guilt, anxious/panic episodes, feelings of uncertainty and hopelessness, posttraumatic stress symptoms, and feelings of role strain from commitments (McCurley et al, 2019).* EB: *Caregivers with high levels of depressive symptoms have demonstrated poor health and increased health care utilization and cost (Shaffer et al, 2017).*
- Identify caregiver personal resources such as resilience, proficiency in caregiving skills, social support, optimism, positive aspects of care and resilience, and utilization or availability of social services (e.g., state-funded senior services, veterans' services, Area Agency on Aging resources). EB: *Identification and appreciation of resources may help buffer the negative effects of providing care on caregivers' emotional health and increase the effectiveness of interventions to reduce strain (Isling et al, 2017).*
- Encourage the caregiver to share feelings, concerns, uncertainties, and fears; support groups, including Internet-based ones, can be helpful to gain support. EB: *Internet social support groups can be an effective form of support (Parker Oliver et al, 2017).*
- Regularly assess for any evidence of caregiver or care recipient violence or abuse, especially emotional and verbal abuse; risk factors include substance abuse, poor premorbid relationship, and psychiatric illness. EB: *Caregivers are often unaware of the effect of their behavior on care recipient, and the definition of abuse (Liu et al, 2019).*
- Ensure appropriate referrals for physical, occupational, and speech-language therapy, as well as social work, including referrals for outpatient therapy or skilled home health care if needed (including therapy needed to maintain functional abilities and prevent decline). EB: *Improvement in client physical function resulted in better physical and psychological quality of life for both client and caregiver (Pucciarelli et al, 2017).*
- Talk with caregivers early and often about palliative care as a means of symptom management for the care recipient. EB: *Many care recipients and their families do not know what palliative care means, which may lead to underutilization of comfort measures (Scott et al, 2017).*
- Help the caregiver learn mindfulness stress management techniques, which can reduce psychological distress. EB: *Mindfulness stress reduction interventions can result in improvement in quality of life, self-compassion, caregiver burden, and relationship satisfaction (Schellekens et al, 2017).*
- Assist the client to identify spiritual beliefs and engage in spiritual practices. EB: *Spiritual beliefs and practice may help caregivers cope because it protects them from depression (Penman, 2018).*
- Encourage regular and open communication with the care recipient and with the health care team. EB: *Care transitions are a critical point to ensure that caregivers have adequate information for client safety and efficient and effective care (Scott et al, 2017).*

● = Independent; ▲ = Collaborative; EBN = Evidence-Based Nursing; EB = Evidence-Based; ★ = QSEN

PLAN INTERVENTIONS

Use Section III, Guide to Planning Care, to find appropriate interventions for the client. Use the Nursing Interventions as found in that section.



212 Caregiver Role Strain

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Geriatric

- The interventions described previously may be adapted for use with geriatric clients.
- Monitor the caregiver for psychological distress and signs of depression, especially if there was an unsatisfactory family relationship before caregiving. EB: *Family caregivers report higher levels of resiliency in providing care when their relationship with care recipient was harmonious before the caregiving role (Isling et al, 2017).*
- To improve the ability to provide safe care: assess caregiver's support and learning needs and provide skills training related to direct care, perform complex monitoring tasks, supervise, and interpret client symptoms, assist with decision-making, assist with medication adherence. EB: *Caregivers need individualized resources and support to master skills needed for care management, care coordination, and medical/nursing tasks (Polenick et al, 2017).*

Pediatric

- Assess parents for perceived self-blame or worsened relationship with their child, especially if their child's condition is psychiatric in nature, and assist them to seek social support, instill hope, and identify how they might grow. EB: *Parents of children with severe mental illness including self-mutilation, suicidal ideation, obsessive compulsive disorders, eating disorders, and so on, often placed a high amount of responsibility on themselves and reported feeling the psychiatric disorder pushed them and their child apart (Whitlock et al, 2018).*
- Assess for partner support of the caregiver in dual-earning households, and provide resources related to couples' or family therapy if needed. EB: *Perceived lack of support from a partner is associated with greater caregiver role strain and psychological distress, and strain between partners leads to further stress (DePasquale et al, 2017).*

Multicultural

- Assess for cultural and spiritual needs of client and caregiver. EB: *Culturally competent care can improve client care quality and outcomes; cultural competence refers to the ability of health providers and organizations to deliver services that meet the cultural, social, and religious needs of clients and their families (Mahdavi et al, 2017; Swihart et al, 2021).*

Home Care

- Assess the client and caregiver at every visit for the quality of their relationship and for the quality and safety of the care provided. EB: *Education, social support, and behavioral management are the most effective support for caregivers of dementia clients (Clarkson et al, 2017).*
- Encourage use of respite care, which may include regular care and assistance at home, or a brief period of total care (24/7) at home or in an inpatient facility to allow the caregiver to recover from an illness, attend a wedding, or go on a short vacation. EB: *Respite care provides time away from the care situation and may help alleviate some caregiver distress (Vandepitte et al, 2016; Sakurai & Kohno, 2020).*

Client/Family Teaching and Discharge Planning

- Identify client and caregiver factors that necessitate the use of skilled home health care services or need to be addressed before the client can be safely discharged. EBN: *Interventions to be considered needed at discharge may include medication management, medication reconciliation, symptom monitoring, identification of community-based resources, skills training for clients and caregivers, and specific client or caregiver concerns about home health care (Mollica et al, 2017).*
- Collaborate with the caregiver and discuss the care needs of the client, disease processes, medications, and what to expect as part of discharge planning and transition care. EBN: *Components of comprehensive and effective transitional care may require adaptation and include client and caregiver well-being, caregiver engagement, caregiver education, client engagement, client education, complexity/medication management, care continuity, and accountability (Naylor et al, 2017, 2018).*
- Involve the family caregiver in care transitions and discharge from institutions; use a multiprofessional team to provide medical and social services for detailed instruction and planning specific to the care need. EB: *Family members need education specific to their situation at discharge, and this educational approach should be based on the client's needs. The postdischarge visit serves as an important vehicle to present readmissions and improve quality of care for clients (Rodakowski et al, 2017; Snyder et al, 2017).*

● = Independent; ▲ = Collaborative; EBN = Evidence-Based Nursing; EB = Evidence-Based; ★ = QSEN

GIVE NURSING CARE

Administer nursing care following the plan of care based on the interventions.

EVALUATE NURSING CARE

Evaluate nursing care administered using either the NOC Outcomes or Client Outcomes. If the outcomes were not met and the nursing interventions were not effective, reassess the client and determine if the appropriate nursing diagnoses were made.

DOCUMENT

Document all of the previous steps using the format provided in the clinical setting. A Care Plan Template is available in the Evolve online resources to assist with documentation.

Contents

SECTION I **Nursing Process, Clinical Reasoning, Nursing Diagnosis, and Evidence-Based Nursing, 1**

An explanation of how to make a nursing diagnosis using diagnostic reasoning, which is critical thinking, followed by information on how to plan care using the nursing process, standardized nursing language, and evidence-based nursing.

SECTION II **Guide to Nursing Diagnosis, 17**

An alphabetized list of medical, surgical, and psychiatric diagnoses, diagnostic procedures, clinical states, symptoms, and problems, with suggested nursing diagnoses. This section enables the nursing student as well as the practicing nurse to make a nursing diagnosis quickly to save time.

SECTION III **Guide to Planning Care, 125**

Section III contains the actual nursing diagnosis care plans for each accepted nursing diagnosis of the North American Nursing Diagnosis Association—International (NANDA-I): the definition, defining characteristics, risk factors, related factors, suggested NOC outcomes, client outcomes, suggested NIC interventions, interventions with rationales, geriatric interventions, pediatric interventions, critical care interventions (when appropriate), home care interventions, culturally competent nursing interventions (when appropriate), and client/family teaching and discharge planning for each alphabetized nursing diagnosis.

Index, 1052

SECTION

I Nursing Process, Clinical Reasoning, Nursing Diagnosis, and Evidence-Based Nursing

Mary Beth Flynn Makic, PhD, RN, CCNS, CCRN-K, FAAN, FNAP, FCNS, and Marina Martinez-Kratz, MS, RN, CNE

Section I is divided into two parts. Part A includes an overview of the nursing process. This section provides information on how to make a nursing diagnosis and directions on how to plan nursing care. It also includes information on using clinical reasoning skills and eliciting the "patient's story." Part B includes advanced nursing concepts.

Part A: The Nursing Process: Using Clinical Reasoning Skills to Determine Nursing Diagnoses and Plan Care

1. **A**ssessing: performing a nursing assessment by gathering subjective and objective data.
2. **D**iagnosing: identifying and making nursing diagnoses.
3. **P**lanning: formulating and writing outcome statements and determining appropriate nursing interventions based on appropriate best evidence (e.g., research, practice guidelines, practice standards).
4. **I**mplementing: applying nursing care interventions to achieve client outcomes.
5. **E**valuating: appraising the outcomes and the nursing care that has been implemented. Make necessary revisions in care interventions as needed to achieve client-centered goals.

Part B: Advanced Nursing Process Concepts

- Concept mapping
- Evidence-based nursing care
- Person-centered care
- Quality and Safety Education for Nurses (QSEN)

PART A The Nursing Process: Using Clinical Reasoning Skills to Determine Nursing Diagnoses and Plan Care

The primary goals of nursing care are to (1) determine client/family responses to human problems, level of wellness, and need for assistance; (2) provide physical care, emotional care, teaching, guidance, and counseling; and (3) implement interventions aimed at prevention and assisting the client in meeting his or her own needs and health-related goals. The nurse must always focus on assisting clients and families to their highest level of functioning and self-care. The nursing care that is provided should be structured in a way that allows clients the ability to influence their health care and accomplish their self-efficacy goals.

The nursing process, which is a problem-solving approach to the identification and treatment of client problems, provides a framework for assisting clients and families to their optimal level of functioning. The nursing process involves five dynamic and fluid phases: **assessment, diagnosis, planning, implementation,** and **evaluation.** Clinical reasoning is inherent within the nursing process and is an iterative process by which the nurse makes clinical judgments to analyze and understand clients' concerns and form decisions to guide care (Tanner, 2006; Koharchik et al, 2015). It is a process by which the nurse gathers data, recognizes patterns in client responses, and synthesizes information to guide nursing care decisions. Although clinical reasoning skills evolve with experience, it is a logical process by which nurses gather cues (assessment and outcome data), process the information to understand the client's needs and goals (diagnosis), initiate a plan of care (planning and implementation), observe and evaluate outcomes (evaluation), and finally reflect on what was learned from this client–nurse interaction (Levett-Jones et al, 2010; Cappelletti et al, 2014). Clinical judgment is the prioritization of decisions based on the assessment data to guide nursing care (Thompson et al, 2013; Cappelletti et al, 2014). The nurse employs complex cognitive processes that require gathering and analyzing client data and understanding the significance of the information to determine interventions, weigh alternative actions, and adjust the plan of care as deemed necessary based on the nurse's clinical judgment (Cappelletti et al, 2014; Wright & Scardaville, 2021). Identifying priority nursing diagnoses can facilitate clinical judgment based on the understanding of client priorities for care and desired health outcomes.

Within each phase of the nursing process, the client and family story is embedded and is used as a foundation for knowledge, judgment, and actions brought to the client care experience. A description of the "patient's story" and each aspect of the nursing process follows.

THE "PATIENT'S STORY"

The "patient's story" is a term used to describe objective and subjective information about the client that describes who the client is as a person in addition to their medical history. Specific aspects of the story include physiological, psychological, family, and social characteristics; available resources; environmental context; knowledge; and motivation. Care is influenced, and often driven, by what the client states—verbally, nonverbally, and through their physiological state. The "patient's story" is fluid and must be explored and understood throughout the client's health care experience.

There are multiple sources for obtaining the "patient's story." The primary source for eliciting this story is through communicating directly with the client and the client's family. It is important to understand how the illness (or wellness) state has affected the client physiologically, psychologically, and spiritually. The client's perception of his or her health state is important to understand and may have an impact on subsequent interventions and the established goals for care. At times, clients will be unable to tell their story verbally, but there is still much they can communicate through their physical state. The client's family (as the client defines them) is a valuable source of information and can provide a rich perspective on the client. Other valuable sources of the "patient's story" include the client's health record. Every time a piece of information is added to the health record, it becomes a part of the "patient's story."

Understanding the "patient's story" is critically important, in that psychological, socioeconomic, and spiritual characteristics play a significant role in the client's ability and desire to access health care. Also, knowing and understanding the "patient's story" is an integral first step in giving person-centered care. In today's health care world, the focus is on the client, which leads to increased satisfaction with care. Improving the client's health care experience is tied to reimbursement through value-based purchasing of care to reward providers for the quality of care they provide (Centers for Medicare and Medicaid Services, 2019).

All nursing care is driven by the client's story. The nurse must have a clear understanding of the story to effectively complete the nursing process. Understanding the full story also provides an avenue for identifying mutual goals with the client and family aimed at improving client outcomes and goals. The "patient's story" is terminology that is used to describe a holistic assessment of information about the client, including the client's and the family's input as much as possible. In this text, we use the term "patient's story" in quotes whenever we refer to the specific process. In all other places, we use the term *client* in place of the word *patient*. The term *patient* aligns with the understanding of an individual awaiting medical care (Merriam-Webster, 2021). Use of the word *client,* on the other hand, represents engagement in service, which we believe is more respectful and empowering for the person. *Client* is also the term that is used in the National

Council Licensure Examination (NCLEX-RN) test plan (National Council of State Boards of Nursing, 2019).

THE NURSING PROCESS

The nursing process is an organizing framework for professional nursing practice, which is a critical thinking process for the nurse to guide the delivery of the best care possible to the client. It is very similar to the steps used in scientific reasoning and problem solving. This section is designed to help the nursing student learn how to use this thinking process, or the nursing process. Key components of the process include the steps listed subsequently. An easy, convenient way to remember the steps of the nursing process is to use an acronym, **ADPIE** (Figure I.1):

1. **A**ssess: perform a nursing assessment.
2. **D**iagnose: make nursing diagnoses.
3. **P**lan: formulate and write outcome/goal statements and determine appropriate nursing interventions based on the client's reality and evidence (research).
4. **I**mplement care.
5. **E**valuate the outcomes and the nursing care that has been implemented. Make necessary revisions in care interventions as needed.

The next section is an overview and practical application of the steps of the nursing process. The steps are listed in the usual order in which they are performed.

STEP 1: ASSESSMENT (ADPIE)

The assessment phase of the nursing process is foundational for gathering data about the client. Nurses must understand the human responses to illness and health so that appropriate diagnosis, planning, and intervention(s) can be established. Assessment is dynamic and continuous so that nursing care can evolve to meet clients' changing needs. Data on all dimensions of the "patient's story," including biophysical, psychological, sociocultural, spiritual, and environmental characteristics, are embedded in the assessment, which involves performing a thorough holistic nursing assessment of the client. This is the first step needed to make an appropriate nursing diagnosis, and it is done using the assessment format adopted by the facility or educational institution in which the practice is situated.

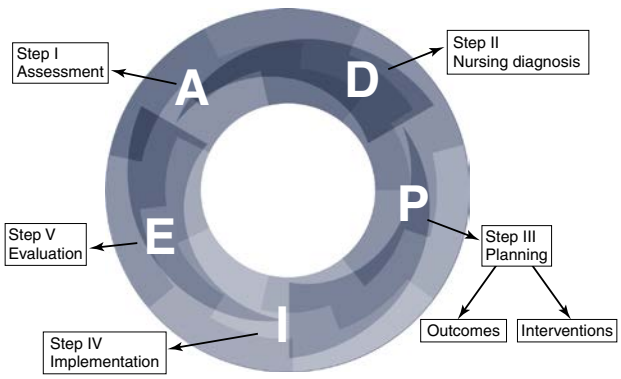

Figure I.1
Nursing process.

The nurse assesses components of the "patient's story" every time an assessment is performed. Often, nurses focus on the physical component of the story (e.g., temperature, blood pressure, breath sounds). This component is certainly critical, but it is only one piece. Indeed, one of the unique and wonderful aspects of nursing is the holistic theory that is applied to clients and families. Clients are active partners in the healing process. Nurses must increasingly develop the skills and systems to incorporate client preferences into care (Feo et al, 2017). Assessment information is obtained first by completing a thorough health and medical history and by listening to and observing the client. To elicit as much information as possible, the nurse should use open-ended questions rather than questions that can be answered with a simple "yes" or "no." The nurse should assess for the client's gender identity and gender expression, as well as preferred names and pronouns. Preferred names and pronouns should be respected when caring for the client. Most care plans are written for "traditional" gender identity; the caregiver will be responsible for adapting the care accordingly.

Asking open-ended questions during an assessment will encourage the client to give more information about his or her situation. Listen carefully for cues and record relevant information that the client shares. Even when the client's physical condition or developmental age makes it impossible to verbally communicate with the health care team, nurses may be able to communicate with the client's family or significant other to learn more about the client.

The information that is obtained verbally from the client is considered *subjective* information. Information is also obtained by performing a physical assessment, taking vital signs, and noting diagnostic test results. This information is considered *objective* information. The information from all of these sources is used to formulate a nursing diagnosis. All of this information needs to be carefully documented on the forms/electronic health record (EHR) provided by the agency or school of nursing. When recording information, Health Insurance Portability and Accountability Act (HIPAA) (Tovino, 2017) regulations need to be followed carefully. To protect client confidentiality, the client's name should *not* be used on the student care plan. When the assessment is complete, proceed to the next step.

STEP 2: NURSING DIAGNOSIS (ADPIE)

In the diagnosis phase of the nursing process, the nurse begins clustering the information within the "patient's story" and formulates an evaluative judgment about a client's health

status. Only after a thorough analysis—which includes recognizing cues, sorting through and organizing or clustering the information, and determining client strengths and unmet needs—can an appropriate diagnosis be made. This process of thinking is called *clinical reasoning*. Clinical reasoning is a cognitive process that uses formal and informal thinking strategies to gather and analyze client information, evaluate the significance of this information, and determine the value of alternative actions (Benner, 2010). Benner (2010) described this cognitive process as "thinking like a nurse." Watson and Rebair (2014) referred to "noticing" as a precursor to clinical reasoning. By noticing, the nurse can preempt possible risks or support subtle changes toward recovery. Noticing can be the activity that stimulates nursing action before words are exchanged, preempting need. The nurse synthesizes the evidence while also knowing the client as part of clinical reasoning that informs client-specific diagnoses (Cappelletti et al, 2014; Koharchik et al, 2015).

The nursing diagnoses that are used throughout this book are taken from NANDA International, Inc. (NANDA-I) (Herdman et al, 2020). The complete nursing diagnosis list is on the inside front cover of this text, and it can also be found on the Evolve website that accompanies this text. The diagnoses used throughout this text are listed in alphabetical order by the **diagnostic concept.** For example, *impaired wheelchair mobility* is found under *mobility,* not under *wheelchair* or *impaired* (Herdman et al, 2020). There are 13 domains for nursing diagnosis and these are listed below the nursing diagnosis along with the class.

The holistic assessment of the client helps determine the type of diagnosis that should be used to guide nursing interventions. For example, if during the assessment a client is noted to have unsteady gait and balance disturbance and states, "I'm concerned I will fall while walking down my stairs," but has not fallen previously, the client would be identified as having a "risk" nursing diagnosis. However, if a client states, "I am having increasing problems with leaking urine when I sneeze or cough," this is an actual problem for the client.

Once the diagnosis is determined, the next step is to determine defining characteristics and related factors. A client may have many nursing and medical diagnoses, and determining the priority with which each should be addressed requires clinical reasoning and application of knowledge.

Formulating a Nursing Diagnosis With Defining Characteristics and Related Factors

A working nursing diagnosis may have two or three parts. The two-part system consists of the nursing diagnosis and the "related to" (r/t) statement: "Related factors are etiologies, circumstances, facts, or influences that have some type of relationship with the nursing diagnosis (e.g., cause, contributed factor)" (Herdman et al, 2020). The two-part system is often used when the defining characteristics, or signs and symptoms identified in the assessment, may be obvious to those caring for the client.

The three-part system consists of the nursing diagnosis, the r/t statement, and the defining characteristics, which are "observable cues/inferences that cluster as manifestations of an actual or wellness nursing diagnosis" (Herdman et al, 2020).

Some nurses refer to the three-part diagnostic statement as the **PES system:**

P (problem)—The nursing diagnosis label: a concise term or phrase that represents a pattern of related cues. The nursing diagnosis is taken from the official NANDA-I list.
E (etiology)—"Related to" (r/t) phrase or etiology: related cause or contributor to the problem.
S (symptoms)—Defining characteristics phrase: symptoms that the nurse identified in the assessment.

Here we use the example of a beginning nursing student who is attempting to understand the nursing process and how to make a nursing diagnosis:

Problem: Use the nursing diagnosis label deficient **Knowledge** from the NANDA-I list. Remember to check the definition: "Absence or deficiency of cognitive information related to a specific topic" (Herdman et al, 2020).
Etiology: r/t unfamiliarity with information about the nursing process and nursing diagnosis. At this point, the beginning nurse would not be familiar with available resources regarding the nursing process.
Symptoms: Defining characteristics, as evidenced by (aeb) verbalization of lack of understanding: "I don't understand this, and I really don't know how to make a nursing diagnosis."

When using the **PES** system, look at the **S** first and then formulate the three-part statement. (You would have gotten the **S,** symptoms, which are defining characteristics, from your assessment.)

Therefore, the three-part nursing diagnosis is: Deficient **Knowledge** r/t unfamiliarity with information about the nursing process and nursing diagnosis aeb verbalization of lack of understanding.

Types of Nursing Diagnoses

There are three different types of nursing diagnoses.

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" (Herdman et al, 2020, p 98). Defining characteristics are observable cues/inferences that cluster as manifestations of a diagnosis (e.g., signs or symptoms) (Herdman et al, 2020, p 103). "Related factors are an integral component of all problem-focused diagnoses. Related factors, also called etiological factors are antecedent factors shown to have a patterned relationship with the human response (e.g., cause, contributing factor)" (Herdman et al, 2020, p 103).

Example of a Problem-Focused Nursing Diagnosis. **Overweight** related to excessive intake in relation to metabolic

needs, concentrating food intake at the end of the day aeb weight 25% over ideal for height and frame. Note: This is a three-part nursing diagnosis.

Risk Diagnosis. Risk nursing diagnosis is a "clinical judgment concerning the susceptibility of an individual, caregiver, family, group, or community for developing an undesirable human response to health conditions/life processes" (Herdman et al, 2020, p 98). "Risk factors are antecedent factors that increase the susceptibility of an individual, caregiver, family, group, or community to an undesirable human response (e.g. environmental, psychological)" (Herdman et al, 2020, p 103).

Example of a Risk Nursing Diagnosis. Risk for **Overweight:** Risk factor: abnormal eating behavior pattern, concentrating food at the end of the day. Note: This is a two-part nursing diagnosis.

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. Health promotion responses may exist in an individual, caregiver, family, group, or community (Herdman et al, 2020). Health promotion is different from prevention in that health promotion focuses on being as healthy as possible, as opposed to preventing a disease or problem. The difference between health promotion and disease prevention is that the reason for the health behavior should always be a positive one. *With a health promotion diagnosis, the outcomes and interventions should be focused on enhancing health.*

Example of a Health Promotion Nursing Diagnosis. Readiness for Enhanced **Nutrition** aeb willingness to change eating pattern and eat healthier foods. Note: This is a two-part nursing diagnosis.

Application and Examples of Making a Nursing Diagnosis

When the assessment is complete, identify common patterns/symptoms of response *to actual or potential health problems from the assessment* and select an appropriate nursing diagnosis label using clinical reasoning skills. Use the steps with Case Study 1. (The same steps can be followed using an actual client assessment in the clinical setting or in a student assessment.)

A. Highlight or underline the relevant symptoms (defining characteristics). As you review your assessment information, ask the following questions: Is this normal? Is this an ideal situation? Is this a problem for the client? You may go back and validate information with the client.
B. Make a list of the symptoms (underlined or highlighted information).
C. Cluster similar symptoms.
D. Analyze/interpret the symptoms. (What do these symptoms mean or represent when they are together?)
E. Select a nursing diagnosis label from the NANDA-I list that fits the appropriate defining characteristics and nursing diagnosis definition.

Case Study 1—Older Client with Breathing Problems

A. Underline the Symptoms (Defining Characteristics)

A 73-year-old man has been admitted to the unit with a diagnosis of chronic obstructive pulmonary disease (COPD). He states that he has "difficulty breathing when walking short distances." He also states that his "heart feels like it is racing" (heart rate is 110 beats per minute) at the same time. He states that he is "tired all the time," and while talking to you about his story, he is continually wringing his hands and looking out the window.

B. List the Symptoms (Subjective and Objective)

"Difficulty breathing when walking short distances"; "heart feels like it is racing"; heart rate is 110 beats per minute; "tired all the time"; continually wringing his hands and looking out the window.

C. Cluster Similar Symptoms

"Difficulty breathing when walking short distances"
"Heart feels like it is racing"; heart rate = 110 beats per minute
"Tired all the time"
Continually wringing his hands
Looking out the window

D. Analyze

Interpret the Subjective Symptoms (What the Client Has Stated)

"Difficulty breathing when walking short distances" = exertional discomfort: a defining characteristic of Decreased **Activity** Tolerance
"Heart feels like it is racing" = abnormal heart rate response to activity: a defining characteristic of Decreased **Activity** Tolerance
"Tired all the time" = verbal report of weakness: a defining characteristic of Decreased **Activity** Tolerance

Interpret the Objective Symptoms (Observable Information)

Continually wringing his hands = extraneous movement, hand/arm movements: a defining characteristic of **Anxiety**
Looking out the window = poor eye contact, glancing about: a defining characteristic of **Anxiety**
Heart rate = 110 beats per minute

E. Select the Nursing Diagnosis Label

In Section II look up *dyspnea (difficulty breathing)* or *dysrhythmia (abnormal heart rate or rhythm),* which are chosen because they are high priority, and you will find the nursing diagnosis Decreased **Activity** Tolerance listed with these symptoms. Is this diagnosis appropriate for this client?

To validate that the diagnosis Decreased **Activity** Tolerance is appropriate for the client, turn to Section III and read the NANDA-I definition of the nursing diagnosis Decreased **Activity** Tolerance: "Insufficient endurance to complete

required or desired daily activities" (Herdman et al, 2020, p 307). When reading the definition, ask, "Does this definition describe the symptoms demonstrated by the client?" "Is any more assessment information needed?" "Should I take his blood pressure or take an apical pulse rate?" If the appropriate nursing diagnosis has been selected, the definition should describe the condition that has been observed.

The client may also have defining characteristics for this particular diagnosis. Are the client's symptoms that you identified in the list of defining characteristics (e.g., verbal report of fatigue, abnormal heart rate response to activity, exertional dyspnea)?

Another way to use this text and to help validate the diagnosis is to look up the client's medical diagnosis in Section II. This client has a medical diagnosis of COPD. Is Decreased **Activity** Tolerance listed with this medical diagnosis? Consider whether the nursing diagnosis makes sense given the client's medical diagnosis (in this case, COPD). There may be times when a nursing diagnosis is not directly linked to a medical diagnosis (e.g., Ineffective **Coping**) but is nevertheless appropriate given nursing's holistic approach to the client/family.

The process of identifying significant symptoms, clustering or grouping them into logical patterns, and then choosing an appropriate nursing diagnosis involves diagnostic reasoning (critical thinking) skills that must be learned in the process of becoming a nurse. This text serves as a tool to help the learner in this process.

"Related to" Phrase or Etiology

The second part of the nursing diagnosis is the "related to" (r/t) phrase. Related factors (etiological factors) are those that appear to show some type of patterned relationship with the human response that supports the nursing diagnosis. Such factors may be described as antecedent to, associated with, related to, contributing to, or abetting. Pathophysiological and psychosocial changes, such as developmental age and cultural and environmental situations, may be causative or contributing factors.

Often, a nursing diagnosis is complementary to a medical diagnosis and vice versa. Ideally, the etiology (r/t statement), or cause, of the nursing diagnosis is something that can be treated independently by a nurse. When this is the case, the diagnosis is identified as an independent nursing diagnosis.

If medical intervention is also necessary, it might be identified as a collaborative nursing diagnosis. A carefully written, individualized r/t statement enables the nurse to plan nursing interventions and refer for diagnostic procedures, medical treatments, pharmaceutical interventions, and other interventions that will assist the client/family in accomplishing goals and return to a state of optimum health. Diagnoses and treatments provided by the multiprofessional team all contribute to the client/family outcome. The coordinated effort of the team can only improve outcomes for the client/family and decrease duplication of effort and frustration among the health care team and the client/family.

The etiology is *not* the medical diagnosis. It may be the underlying issue contributing to the nursing diagnosis, but a medical diagnosis is *not* something the nurse can treat independently, without provider orders. In the case of the client with COPD, think about what happens when someone has COPD. How does this condition affect the client? What is happening to him because of this diagnosis?

For each suggested nursing diagnosis, the nurse should refer to the statements listed under the heading Related Factors (r/t) in Section III. These r/t factors may or may not be appropriate for the individual client. If they are not appropriate, the nurse should develop and write an r/t statement that is appropriate for the client. For the client from Case Study 1, a two-part statement could be made here:

Problem = Decreased **Activity** Tolerance
Etiology = r/t imbalance between oxygen supply and demand

It was already determined that the client had Decreased **Activity** Tolerance. With the respiratory symptoms identified from the assessment, the imbalance between oxygen supply and demand is appropriate.

Defining Characteristics Phrase

The defining characteristics phrase is the third part of the three-part diagnostic system, and it consists of the signs and symptoms that have been gathered during the assessment phase. The phrase "as evidenced by" (aeb) may be used to connect the etiology (r/t) with the defining characteristics. The use of identifying defining characteristics is similar to the process that the health care provider uses when making a medical diagnosis. For example, the health care provider who observes the following signs and symptoms—diminished inspiratory and expiratory capacity of the lungs, complaints of dyspnea on exertion, difficulty in inhaling and exhaling deeply, and sometimes chronic cough—may make the medical diagnosis of COPD. This same process is used to identify the nursing diagnosis of Decreased **Activity** Tolerance.

Put It All Together: Writing the Three-Part Nursing Diagnosis Statement

Problem—Choose the label (nursing diagnosis) using the guidelines explained previously. A list of nursing diagnosis labels can be found in Section II.

Etiology—Write an r/t phrase (etiology). These can be found in Section II.

Symptoms—Write the defining characteristics (signs and symptoms) or the "as evidenced by" (aeb) list. A list of the signs and symptoms associated with each nursing diagnosis can be found in Section III.

Case Study 1—73-Year-Old Male Client With Chronic Obstructive Pulmonary Disease (Continued)

Using the information from the earlier case study/example, the nursing diagnostic statement would be as follows:

Problem—Decreased **Activity** Tolerance.
Etiology—r/t imbalance between oxygen supply and demand.

Symptoms—Verbal reports of fatigue, exertional dyspnea ("difficulty breathing when walking"), and abnormal heart rate response to activity ("racing heart"); heart rate 110 beats per minute.

Therefore, the nursing diagnostic statement for the client with COPD is Decreased **Activity** Tolerance r/t imbalance between oxygen supply and demand aeb verbal reports of fatigue, exertional dyspnea, and abnormal heart rate in response to activity.

Consider a second case study:

Case Study 2—Woman with Insomnia

As before, the nurse always begins with an assessment. To make the nursing diagnosis, the nurse follows the steps below.

A. Underline the Symptoms

A 45-year-old woman comes to the clinic and asks for medication to help her sleep. She states that she is worrying too much and adds, "It takes me about an hour to get to sleep, and it is very hard to fall asleep. I feel like I can't do anything because I am so tired. My job has become very stressful because of a new boss and too much work."

B. List the Symptoms (Subjective and Objective)

Asks for medication to help her sleep; states she is worrying about too much; "It takes me about an hour to get to sleep"; "it is very hard to fall asleep"; "I feel like I can't do anything because I am so tired"; "My job has become very stressful because of a new boss and too much work."

C. Cluster Similar Symptoms

Asks for medication to help her sleep.
"It takes me about an hour to get to sleep."
"It is very hard to fall asleep."
"I feel like I can't do anything because I am so tired."
"I am worrying too much."
"My job is stressful."
"Too much work."

D. Analyze/Interpret the Symptoms

Subjective Symptoms

Asks for medication to help her sleep; "It takes me about an hour to get to sleep"; "it is very hard to fall asleep"; "I feel like I can't do anything because I am so tired." (All defining characteristics = verbal complaints of difficulty with sleeping.)
States she is worrying too much (anxiety): "My job is stressful."

Objective Symptoms

None

E. Select a Nursing Diagnosis with Related Factors and Defining Characteristics

Look up "sleep" in Section II. Listed under the heading "Disturbed **Sleep** Pattern" in Section II is the following information:

Insomnia (nursing diagnosis) r/t anxiety and stressors

This client states she is worrying too much, which may indicate anxiety; she also recently has increased job stress.

Look up **Insomnia** in Section III. Check the definition: "Inability to initiate or maintain sleep, which impairs functioning" (Herdman et al, 2020, p 301). Does this describe the client in the case study? What are the related factors? What are the symptoms? Write the diagnostic statement:

Problem—**Insomnia**
Etiology—r/t anxiety, stressors
Symptoms—Difficulty falling asleep; "I am so tired, I can't do anything."

The nursing diagnostic statement is written in this format: **Insomnia** r/t anxiety and stressors aeb difficulty falling asleep.

Note: There are additional case studies available for both student and faculty use on the Evolve website that accompanies this text.

After the diagnostic statement is written, proceed to the next step: planning.

STEP 3: PLANNING (ADPIE)

The planning phase of the nursing process includes the identification of priorities and the determination of appropriate client-specific outcomes and interventions. The nurse, in collaboration with the client and family (as applicable) and the rest of the health care team, must determine the urgency of the identified problems and prioritize client needs. *Mutual goal setting,* along with *symptom pattern recognition* and *triggers,* helps prioritize interventions and determine which interventions are going to provide the greatest impact. *Symptom pattern recognition* and/or *triggers* is a process of identifying symptoms that clients have related to their illness, understanding which symptom patterns require intervention, and identifying the associated time frame to intervene effectively. For example, a client with heart failure is noted to gain 5 pounds overnight. Coupling this symptom with other symptoms of edema and shortness of breath while walking can be referred to as "symptom pattern recognition"; in this case, that the client is retaining fluid. The nurse, and often the client/family, recognize these symptoms as an immediate *cause* and that more action/intervention is needed to avoid a potential adverse outcome.

Nursing diagnoses should be prioritized based on urgent needs, diagnoses with a high level of congruence with defining characteristics, related factors, or risk factors (Herdman et al, 2020, p 105). The use of ABC (airway, breathing, and circulation) and safety is a method to rank threats to the client's immediate survival or safety. The highest priority can also be determined by using Maslow's hierarchy of needs. In this hierarchy, priority is given to immediate problems that may be life-threatening (thus ABC). For example, Ineffective **Airway** Clearance, aeb the symptoms of increased secretions and increased use of inhaler related to asthma, creates an immediate cause compared with the nursing diagnosis of **Anxiety,** a love and belonging or security need, which makes

it a lesser priority than Ineffective **Airway** Clearance. Refer to Appendix A on Evolve for assistance in prioritizing nursing diagnoses.

The planning phase should be done, whenever possible, with the client/family and the multidisciplinary team to maximize efforts and understanding and increase compliance with the proposed plan and outcomes. For a successful plan of care, measurable goals and outcomes, including nursing interventions, must be identified.

SMART Outcomes

When writing outcome statements, it can be helpful to use the acronym SMART, which means the outcome must be:

Specific
Measurable
Attainable
Realistic
Timed

The SMART acronym is used in business, education, and health care settings. This method assists the nurse in identifying client outcomes more effectively.

Once priorities are established, outcomes for the client can be easily identified. Client-specific outcomes are determined based on the mutually set goals. Outcomes refer to the measurable degree of the client's response. The client's response/outcome may be intentional and favorable, such as leaving the hospital 2 days after surgery without any complications. The client's outcome can be negative and unintentional, such as demonstrating a surgical site infection. Generally, outcomes are described in relation to the client's response to interventions; for example, the client's cough becomes more productive after the client begins using the controlled coughing technique.

Based on the "patient's story"; the nursing assessment; the mutual goals and outcomes identified by the caregiving team and the client, caregiver, and family; and the clinical reasoning that the nurse uses to prioritize his or her work, the nurse then decides what interventions to use. Based on the nurse's clinical judgment and knowledge, nursing interventions are defined as *all treatments that a nurse performs to enhance client outcomes*.

The selection of appropriate, effective interventions can be individualized to meet the mutual goals established by the client/family. It is then the nurses' education, experiences, and skills that allow them to select and carry out interventions to meet that mutual goal.

Outcomes

After the appropriate priority setting of the nursing diagnoses and interventions are determined, outcomes are developed and decided on. This text includes standardized Nursing Outcomes Classification (NOC) measurement of health outcomes written by a large team of University of Iowa College of Nursing faculty and students in conjunction with clinicians from a variety of settings (Moorhead et al, 2018). NOC was developed to be used with nursing diagnosis and provides a standard language by which nurse-sensitive outcomes can be measured along a continuum in response to a nursing intervention or interventions. The outcomes are stated as concepts that reflect a client, caregiver, family, or community state, as a perception of behavior rather than as expected goals (Moorhead et al, 2018).

It is very important for the nurse to *involve* the client and/or family in determining appropriate outcomes. The use of outcomes information creates a continuous feedback loop that is essential to improve nursing quality, ensure client safety, and secure the best possible client outcomes (Sim et al, 2018). The minimum requirements for rating an outcome are when the outcome is selected (i.e., the baseline measure) and when care is completed (i.e., the discharge summary). Depending on how rapidly the client's condition is expected to change, some settings (e.g., acute care hospitals, rehabilitation centers, community care settings) may evaluate once a week, once a day, or once a shift. A five-point Likert-type scale is used with all outcomes and indications used to evaluate progress toward achieving the outcome; however, because measurement times are not standardized, they can be individualized for the client and the setting (Moorhead et al, 2018).

Development of appropriate outcomes can be completed one of two ways: using the NOC list or developing an appropriate outcome statement, both of which are included in Section III with each nursing diagnosis. The suggested outcome statements for each nursing diagnosis in this text can be used as written or modified as necessary to meet the needs of the client. The Evolve website includes a list of additional NOC outcomes. For more information about NOC, refer to the NOC text (Moorhead et al, 2018).

Because the NOC outcomes are specific, they enhance nursing professional practice by helping the nurse measure and record the nurse sensitive outcomes before and after interventions have been performed. The nurse can also choose to have clients rate their own progress using the Likert-type rating scale. This involvement can help increase client motivation to progress *toward* outcomes.

After client outcomes are selected or written and *discussed* with a client, the nurse plans nursing care with the client and establishes a means that will help the client achieve the selected outcomes. The usual means are through nursing interventions.

Interventions

Interventions are like road maps directing the best ways to provide nursing care. The more clearly a nurse writes an intervention, the easier it will be to complete the journey and arrive at the destination of desired client outcomes. Nursing interventions are treatments based on clinical judgment and knowledge, supported by evidence, that a nurse performs to enhance client outcomes (Butcher et al, 2018). Section

III includes suggested interventions and rationales for each nursing diagnosis. The interventions are identified as independent (autonomous actions that are initiated by the nurse in response to a nursing diagnosis) or collaborative (actions that the nurse performs in collaboration with other health care professionals and that may require a health care provider's order and may be in response to both medical and nursing diagnoses). The nurse may choose the interventions appropriate for the client and individualize them accordingly or determine additional interventions.

This text also contains several suggested interventions from the Nursing Interventions Classification (NIC), which is a comprehensive standardized classification of interventions that nurses perform (Butcher et al, 2018). NIC is used along with NOC and nursing diagnoses as client-specific care plans are developed. NIC includes both physiological and psychosocial interventions and covers all nursing specialties. A list of NIC interventions is included on the Evolve website. For more information about NIC interventions, refer to the NIC text (Butcher et al, 2018).

Putting It All Together—Recording the Care Plan

The nurse must document the actual care plan, including prioritized nursing diagnostic statements, outcomes, and interventions. This may be done electronically or in writing. To ensure continuity of care, the plan must be documented and shared with all health care personnel caring for the client. This text provides rationales, most of which are research based, to validate that the interventions are appropriate and workable.

The Evolve website includes an electronic care plan constructor that can be easily accessed, updated, and individualized. Many agencies are using electronic records, and this is an ideal resource. See the inside front cover of this text for information regarding access to the Evolve website, or go to http://evolve.elsevier.com/Ackley/NDH.

STEP 4: IMPLEMENTATION (ADPIE)

The implementation phase includes the "carrying out" of the specific, individualized, jointly agreed-on interventions in the plan of care. Often, the interventions implemented are focused on *symptom management,* which is alleviating symptoms. Typically, nursing care does not involve "curing" the medical condition causing the symptom; rather, nursing care focuses on caring for the client, caregiver, and family so that they can function at their highest level.

The implementation phase of the nursing process is the point at which you actually give nursing care. You perform the interventions that have been individualized to the client. All the hard work you put into the previous steps (ADP) can now be actualized to assist the client. As the interventions are performed, make sure that they are appropriate for the client. Consider that the client who was having difficulty breathing was also older. He may need extra time to carry out any activity. Check the rationale and research that are provided to determine why the intervention is being used. The evidence should support the individualized actions that you are implementing.

Client outcomes are achieved by the performance of the nursing interventions in collaboration with other disciplines and the client, caregiver, or family. During this phase, the nurse continues to assess the client to determine whether the interventions are effective and the desired outcomes are met.

STEP 5: EVALUATION (ADPIE)

The final phase of the nursing process is evaluation. This step occurs not only at the end of the nursing process but also throughout the process. Evaluation of an intervention is, in essence, another nursing assessment; hence, the dynamic feature of the nursing process. The nurse reassesses the client, taking into consideration where the client was before the intervention (i.e., baseline) and where the client is after the intervention. Nurses are also in a great place (at the bedside) to evaluate how clients respond to other, multiprofessional interventions, and their assessment of the client's response is valuable to determine whether the client's plan of care needs to be altered or not. For example, the client may receive 2 mg of morphine intravenously for pain (a pharmaceutical intervention to treat pain), and the nurse is the member of the health care team who can best assess how the client responded to that medication. Did the client receive relief from pain? Did the client develop any side effects? The nurse's documented evaluation of the client's response will be very helpful to the entire health care team.

The client/family can often tell the nurse how the intervention helped or did not help. This reassessment requires the nurse to revisit the mutual outcomes and goals set earlier and ask, "Are we moving toward that goal, or does the goal seem unreachable after the intervention?" If the outcomes were not met, the nurse begins again with assessment and determines the reason they were not met. Consider the SMART acronym and Case Study 1. Were the outcomes **S**pecific? Were the outcomes **M**easurable? Did the client's heart rate decrease? Did the client indicate that it was easier to breathe when walking from his bed to the bathroom? Were the outcomes **A**ttainable and **R**ealistic? Did he still report "being tired"? Did you allow adequate **T**ime for a positive outcome? Also ask yourself whether you identified the correct nursing diagnosis. Should the interventions be changed? At this point, the nurse can look up any new symptoms or conditions that have been identified and adjust the care plan as needed. Decisions about implementing additional interventions may be necessary; if so, they should be made in collaboration with the client, caregiver, and family, if possible. In some instances, the client/caregiver-family/nurse triad will establish new, achievable goals and continue to cycle through the nursing process until the mutual goals are achieved.

Another important part of the evaluation phase is documentation. The nurse should use the facility's tool for

documentation and record the nursing activity that was performed, as well as the results of the nursing interventions. Many facilities use problem-oriented charting, in which the nurse evaluates the care and client outcomes as part of charting. Documentation is also necessary for legal reasons, because in a legal dispute, *if it wasn't charted or recorded, it wasn't done*.

Many health care providers use critical pathways or care maps to plan nursing care. The use of nursing diagnoses should be an integral part of any critical pathway/care map to ensure that nursing care needs are being assessed and appropriate nursing interventions are planned and implemented.

PART B Advanced Nursing Process Concepts

Conceptual Mapping and the Nursing Process

Conceptual mapping is an active learning strategy that promotes critical thinking and clinical judgment by providing a schematic representation of concepts and meaning within a framework that helps increase clinical understanding and competency (George et al, 2014; Daley et al, 2016; Kaddoura et al, 2016). Nurses identify complex client problems that require critical thinking to identify priority interventions based on current best evidence to affect client outcomes (Kaddoura et al, 2016). Concept mapping facilitates critical thinking and encourages a deeper understanding of the complexity of concepts that influence nursing practice interventions (George et al, 2014; Daley et al, 2016). The process involves developing a diagram or pictorial representation of newly generated ideas. A concept map begins with a central theme or concept, and then related information is diagrammed radiating from the central theme. A concept map can be used to diagram the critical thinking strategy involved in applying the nursing process in practice.

Start with a blank sheet of paper; the client should be at the center of the paper. The next step involves linking to the person, via lines, the symptoms (defining characteristics, related factors, and risk factors) from the assessment to help determine the appropriate nursing diagnosis.

Figure I.2 is an example of how a concept map can be used to begin the nursing diagnostic process.

After the symptoms are visualized, similar ones can be put together to formulate a nursing diagnosis using another concept map (Figure I.3).

The central theme in this concept map is the nursing diagnosis: Decreased **Activity** Tolerance, with the defining characteristics/client symptoms as concepts that lead to and support the nursing diagnosis. The conceptual map can then be used as a method for determining outcomes and interventions as desired. The nursing process is a thinking process. Using conceptual mapping is a method to help the nurse or nursing student think more effectively about the client.

Quality and Safety Education for Nurses

The Quality and Safety Education for Nurses (QSEN; https://qsen.org/) project represents the nursing profession's response to the five health care competencies articulated by the Institute of Medicine (now called the National Academy of Medicine) (Institute of Medicine, 2003). These competencies were adopted by nursing leaders to guide nursing education to better meet the evolving needs of clients and the health care system (Cronenwett et al, 2007). The QSEN project defined the six competencies for nursing: person-centered care, teamwork and collaboration, evidence-based practice (EBP), quality improvement, safety, and informatics (Cronenwett et al, 2007). The objective of the QSEN project is to provide nurses with the knowledge, skills, and attitudes critical for improving the quality and safety of health care systems. Initially, QSEN was developed to enhance nursing education, but it has since been incorporated into practice settings (Lyle-Edrosolo & Waxman, 2016). Additionally, the core elements of the QSEN map to key practice initiatives identified by The Joint Commission (TJC) and the American Nurses Credentialing Center Magnet (Magnet) recognition program (The Joint Commission, 2021). A crosswalk of the similarities of the QSEN competencies to TJC and Magnet demonstrates the alignment of the QSEN competencies to guide nursing practice excellence to improve the quality and safety of health care (Lyle-Edrosolo & Waxman, 2016; QSEN, 2020). The following are the competencies that were identified.

Person-Centered Care

Person-centered care is the ability to "recognize the patient or designee as the source of control and full partner in providing compassionate and coordinated care based on respect

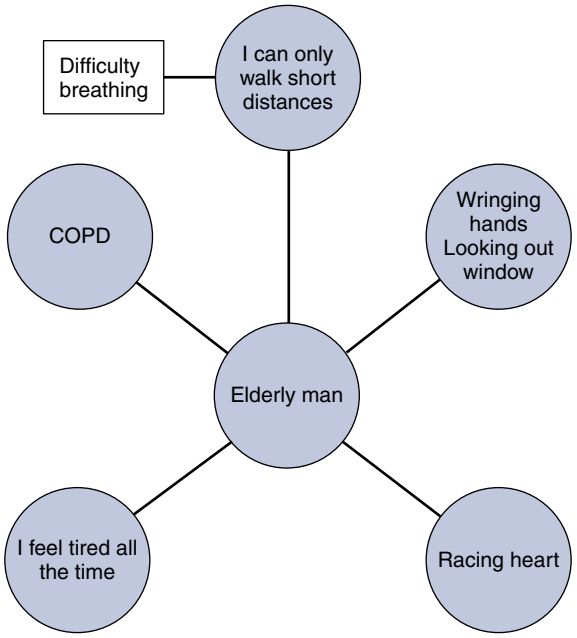

Figure I.2
Example of a concept map.

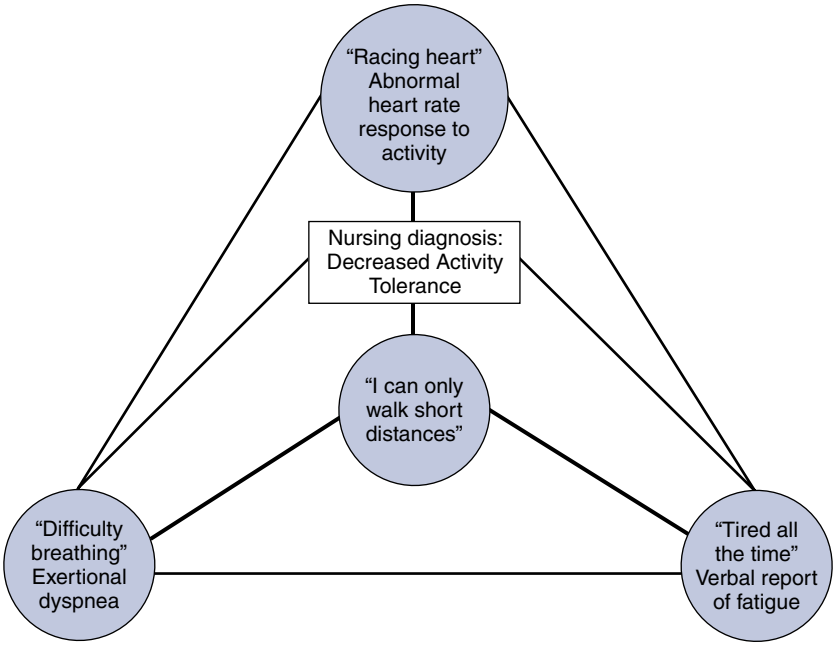

Figure I.3
Formulating a nursing diagnosis using a concept map.

for patient's preferences, values, and needs" (QSEN, 2020). Person-centered care begins with the nurse learning as much as possible about the client, including their "patient's story," as explained in Part A of this text. The nursing process, using nursing diagnosis, is intrinsically all about person-centered care when the nurse engages the client/family as a full partner in the entire process: assessment, nursing diagnosis selection, outcomes, interventions, and evaluation. This competency is about providing care in partnership with the client and family. The client, family, nurse, health care provider, and other health care workers form a team to collaborate with the client and family in every way possible to achieve health.

Client education needs to be centered on the needs of the client, addressing behavior-changing techniques to accomplish the defined goals. At present, too often new health information is given to clients in the form of a lecture, handout, admonishment, or direction where the client is powerless. Conversations need to occur between the client and nurse to understand behavioral changes that can be implemented to achieve goals. Motivational interviewing is a technique based on reinforcement of the client's present thoughts and motivations on behavior change and based on respect for the client as an individual (Moradi et al, 2016). This technique has been used for almost 30 years and has an extensive research base showing effectiveness by engaging in conversations to empower clients to identify strategies and tools to achieve health care goals. To learn more about motivational interviewing, refer to Appendix C on Evolve.

Addressing the unique cultural needs of clients is another example of person-centered care. Culturally competent care planning is based on cultural awareness and assessments, which enables integration of client values, beliefs, and preferences linked to culture(s). Cultural awareness encompasses the nurse's assessment of personal knowledge, sensitivity, humility, and organizational support to deliver culturally focused care (Sharifi et al, 2019). This text provides the addition of multicultural interventions that reflect the client's cultural preferences, values, and needs.

Person-centered care can help nurses change attitudes toward clients, especially when caring for older clients (Flagg, 2015). Caring for the retired school teacher who raised four children can be different from just caring for the client woman in Room 234 who has her call light on frequently and is incontinent of urine at too-frequent intervals. Including the client and family in the bedside report and care decisions is key to client satisfaction and enhances the overall quality of care (Flagg, 2015).

Teamwork and Collaboration

Teamwork and collaboration are defined as the ability to "function effectively within nursing and interprofessional teams, fostering open communication, mutual respect, and shared decision-making to achieve quality client care" (QSEN, 2020). Multiprofessional collaboration and practice has the ability to embrace care interventions that improve quality and safety initiatives across clients' lifespans and all health care settings (Stalter et al, 2017). The need for collaboration by health care professionals is a reality of contemporary health care practice and is identified within each nursing diagnosis in this text. Many nursing interventions are referrals to other health care

personnel to best meet the client's needs; thus collaborative interventions are designated with a triangular symbol ▲.

Evidence-Based Practice

QSEN defines evidence-based practice (EBP) as the integration of best current evidence with clinical expertise and client, caregiver, and family preferences and values for delivery of optimal health care (QSEN, 2020). It is well established that EBP results in higher quality care for clients than care that is based on traditional nursing knowledge (Buccheri & Sharifi, 2017; Makic & Granger, 2019). It is imperative that each nurse and nursing student develop clinical inquiry skills, which means the nurse continually questions whether care is being given in the best way possible based on a review of the quality and strength of the evidence (Buccheri & Sharifi, 2017). Basing nursing practice on evidence, inclusive of research and other forms of evidence, is a concept that is incorporated throughout this text. EBP is a systematic process that uses current evidence in making decisions about the care of clients, including evaluation of quality and applicability of existing research, client preferences, clinical expertise, and available health care resources (Melnyk & Fineout-Overholt, 2019). To determine the best way of giving care, the use of EBP is needed. To make this happen, nurses need to access the evidence, critically appraise the evidence, and then apply the evidence in practice (Makic & Granger, 2019).

This text includes evidence-based rationales whenever possible. An effort is made to provide research-based rationales. The evidence ranges along a continuum from a case study about a single client to a systematic review performed by experts to quality improvement reports that provide information to guide nursing care. Every attempt has been made to supply the most current evidence for the nursing interventions. In Section III, the abbreviation **EBN** is used when interventions have a scientific rationale supported by nursing research. The abbreviation **EB** is used when interventions have a scientific rationale supported by research that has been obtained from disciplines other than nursing. **CEB** is used as a heading for classic research that has not been replicated or is older. It may be either nursing research or research from other disciplines. Many times the **CEB**-labeled research will be the seminal studies that were conducted addressing client concern or nursing care intervention.

When using **EBP,** it is vitally important that the client's concerns and individual situations be taken into consideration. The nurse must always use critical thinking when applying evidence-based guidelines to any particular nursing situation. Each client is unique in his or her needs and capabilities. To improve outcomes, clinicians and clients should collaborate to formulate a treatment plan that incorporates both evidence-based data and client preferences within the context of each client's specific clinical situation (Mackey & Bassendowski, 2017). This text integrates current best evidence and the nursing process, and it assists the nurse in increasing the use of evidence-based interventions in the clinical setting.

Quality Improvement

Quality improvement has been used for many years, with processes in place to ensure that the client receives appropriate care. The QSEN quality improvement competency is defined as the ability of the nurse to use data to monitor the outcomes of care processes and use improvement methods to design and test changes to continuously improve the quality and safety of health care systems (QSEN, 2020). QSEN resources supporting quality improvement initiatives are available at the QSEN website (http://qsen.org/competencies/quality-improvement-resources-2/). As with EBP, quality improvement initiatives need to critically examine research and other forms of strong evidence in supporting process changes. Research is the basis on which best practices should be supported (Makic, 2020). Research and other forms of evidence, such as quality improvement studies, provide a growing body of evidence to guide practice.

It is essential for nurses to participate in the work of quality and performance improvement to attain and sustain excellence in nursing care. As nurses are educated about performance and quality measures, they are more likely to value these activities and make quality improvement part of their nursing practice (Trent et al, 2017). Although there is a potential overlap of work in quality departments and EBP/research departments, the hope is that quality departments collaborate closely with EBP/research departments to improve the practice of nursing. Best evidence should be used to guide nursing practice interventions, and quality improvement critically evaluates and enhances the process of care to ensure effective delivery of high-quality, evidence-based care to clients.

Safety

Safety is defined as minimizing risk of harm to clients and providers through both system effectiveness and individual performance (QSEN, 2020). Client safety is a priority when health care is delivered. Nurses are required to adhere to established standards of care as a guideline for providing safe client care. Internal organizational policies and procedures established by health care institutions should be based on the most relevant and current evidence to guide safe practice standards. External standards of care are established by regulatory agencies (e.g., TJC), professional organizations (e.g., the American Nurses Association), and health care organizations. QSEN competencies align well with external agencies guiding safe practice expectations (Lyle-Edrosolo & Waxman, 2016).

Client safety was identified as a priority of care by TJC through the launch of the National Patient Safety Goals in 2002. TJC continually reviews and establishes standards for improving client safety that include the need for increased handwashing, better client identification before receiving medications or treatments, and protection of suicidal clients from self-harm. Many of the safety standards have been incorporated into the care plans in this text.

Informatics

QSEN defines informatics as the nurse's ability to use information and technology to communicate, manage knowledge,

mitigate error, and support decision-making (QSEN, 2020). The use of information technology is a critical part of the nurse's professional role, and every nurse must be computer literate (Technology Informatics Guiding Education Reform [TIGER], 2018). Key technology and computer proficiencies for nursing practice should include basic computer system and desktop skills; the ability to search for client information; communication using email; ability to search electronic health care databases; and use of technology for client education, client documentation, and client monitoring (Hubner et al, 2017; TIGER, 2018).

In addition to computer literacy, nurses must also acquire informatic knowledge that addresses client privacy and the security of health care information as it applies to the use of technology (Hubner et al, 2017; TIGER, 2018). Because nurses document on the EHR and use smartphones for access to information on medications, diagnoses, and treatments, there are constant threats to client confidentiality, which needs to be maintained through secure-access systems. Nurses also use clinical decision support systems in many facilities that contain order sets tailored for conditions or types of clients. These systems include information vital to nurses and also may provide alerts about potentially dangerous situations when giving client care.

Nurses need access to technology to effectively bring evidence to the client's bedside because evidence is constantly evolving. The use of informatics is integral in the use of EBP. As evidence changes, practice should also change. Moving best evidence consistently into practice requires behavior changes by the clinician and system to effectively implement best evidence into practice. Similarly, habits in practice that result in unnecessary care need to be deimplemented (van Bodegrom-Vos et al, 2017). The Choosing Wisely campaign primarily focused on deimplementing unnecessary medical tests or treatments that were found to not provide benefit to clients (Levinson et al, 2015). Similarly, there are interventions that nurses should question because these interventions may not be beneficial for clients. The American Academy of Nursing maintains a list of nursing interventions that should be questioned as to client benefit. Continually reviewing the evidence to implement best practices while deimplementing interventions that are no longer supported by evidence or may no longer be truly necessary requires the nurses to remain actively engaged in EBP as a practice norm (Makic & Granger, 2019; American Academy of Nursing, 2021).

EBP, safety initiatives, informatics, person-centered care, teamwork, and quality work together in a synergistic manner, leading to excellence in nursing care. Quality care needs to be more than safe; the care should result in the best outcome possible for the client. For this to happen, the client should receive care that is based on evidence of the effectiveness of the nursing care interventions.

The nursing process is continually evolving. This text is all about *thinking* for the nurse to help the client in any way possible. Our goal is to present state-of-the-art information to help the nurse and nursing student provide the best care possible.

REFERENCES

American Academy of Nursing. (2021). *Choosing wisely: Twenty-five things nurses and patients should question.* Retrieved from https://www.aannet.org/initiatives/choosing-wisely. (Accessed 11 January 2021).

Benner, P. (2010). *Educating nurses: A call for radical transformation*. San Francisco: Jossey-Bass.

Buccheri, R. K., & Sharifi, C. (2017). Critical appraisal of tools and reporting guidelines for evidence-based practice. *World Views on Evidence-Based Nursing*, *14*(6), 463–472.

Butcher, H., Bulechek, G., et al. (2018). *Nursing interventions classification (NIC) e-book* (7th ed.). St Louis: Mosby/Elsevier.

Cappelletti, A., Engel, J. E., & Prentice, D. (2014). Systematic review of clinical judgment and reasoning in nursing. *The Journal of Nursing Education*, *53*(8), 453–458.

Centers for Medicare and Medicaid Services. (2019). *Hospital value-based purchasing*. Retrieved from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Hospital-Value-Based-Purchasing-.html. (Accessed 10 January 2021).

Cronenwett, L., Sherwood, G., Barnsteiner, J., et al. (2007). Quality and safety education for nurses. *Nursing Outlook*, *55*, 121–131.

Daley, B. J., Morgan, S., & Black, S. B. (2016). Concept maps in nursing education: A historical literature review and research directions. *The Journal of Nursing Education*, *55*(11), 631–639. https://doi.org/10.3928/01484834-20161011-05.

Feo, R., et al. (2017). Using holistic interpretive synthesis to create practice-relevant guidance for person-centred fundamental care delivered by nurses. *Nursing Inquiry*, *24*(2), 1–11. https://doi.org/10.1111/nin.12152.

Flagg, A. J. (2015). The role of patient centered care in nursing. *The Nursing Clinics of North America*, *50*(1), 75–86.

George, A., Geethakrishnan, R., & D'Souza, P. (2014). Concept mapping. *Holistic Nursing Practice*, *28*(1), 43–47.

Herdman, T. H., Kamitsuru, S., & Lopes, C. T. (Eds.). (2020). *NANDA International, Inc. Nursing diagnoses. Definitions and classification. 2021-2023*. New York: Thieme Medical Publishers, Inc.

Hubner, U., Shaw, T., Thye, J., et al. (2017). *Towards an international framework for recommendations of core competencies in nursing and interprofessional informatics: The TIGER competency synthesis project.* Retrieved from http://www.himss.org/library/towards-international-framework-recommendations-core-competencies-nursing-and-interprofessional. (Accessed 1 January 2021).

Institute of Medicine (IOM). (2003). *Health professions education: a bridge to quality.* Washington, DC: National Academies Press. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK221528/pdf/Bookshelf_NBK221528.pdf. (Accessed 11 January 2021).

Levett-Jones, T., Hoffman, K., Dempsey, J., Jeong, S. Y., Noble, D., Norton, C. A., et al. (2010). The "five rights" of clinical reasoning: An educational model to enhance nursing students' ability to identify and manage clinically "at risk" patients. *Nurse Education Today*, *30*(6), 515–520. https://doi.org/10.1016/j.nedt.2009.10.020.

The Joint Commission. (2021). *2018 National patient safety goals.* Retrieved from https://www.jointcommission.org/standards_information/npsgs.aspx. (Accessed 11 January 2021).

Kaddoura, M., Van-Dyke, O., & Yang, Q. (2016). Impact of a concept map teaching approach on nursing students' critical thinking skills. *Nursing and Health Sciences*, *18*(3), 350–354.

Koharchik, L., Caputi, L., Robb, M., & Culleiton, A. L. (2015). Fostering clinical reasoning in nursing students. *The American Journal of Nursing*, *115*(1), 58–61. https://doi.org/10.1097/01.NAJ.0000459638.68657.9b.

Levinson, W., Kallewaard, M., Bhatia, S. R., et al. (2015). Choosing wisely: A growing international campaign. *BMJ Quality and Safety*, *24*(12), 167–174.

Lyle-Edrosolo, G., & Waxman, K. T. (2016). Aligning healthcare safety and quality competencies: Quality and safety education for nurses, the Joint Commissions, and American Nurses Credentialing Center, Magnet Standards Crosswalk. *Nurse Leader*, *7*(2), 70–75.

Mackey, A., & Bassendowski, S. (2017). The history of evidence-based practice in nursing education and practice. *Journal of Professional Nursing*, *33*(1), 51–55.

Makic, M., & Granger, B. B. (2019). Deimplementation in clinical practice: What are we waiting for? *AACN Advanced Critical Care*, *30*(3), 282–286. https://doi.org/10.4037/aacnacc2019607.

Makic, M. (2020). Providing evidence-based practice during the COVID-19 Pandemic. *Critical Care Nurse*, *40*(5), 72–74. https://doi.org/10.4037/ccn2020908.

Melnyk, B., & Fineout-Overholt, E. (2019). *Evidence-based practice in nursing & healthcare: A guide to best practice* (4th ed.). Philadelphia: Wolters Kluwer Health.

Merriam-Webster Dictionary. (2021). https://www.merriam-webster.com/dictionary/patient?utm_campaign=sd&utm_medium=serp&utm_source=jsonld (Accessed 10 January 2021)

Moorhead, S., Johnson, M., Maas, M. L., et al. (Eds.). (2018). *Nursing outcomes classification (NOC): Measurement of health outcomes* (6th ed.) St Louis: Elsevier.

Moradi, K., Najarkolai, A. R., & Keshmiri, F. (2016). Interprofessional Teamwork Education: Moving toward the patient-centered approach. *Journal of Continuing Education in Nursing*, *47*(10), 449–460. https://doi.org/10.3928/00220124-20160920-06.

National Council of State Boards of Nursing. (2019). *NCLEX-RN examination, detailed test plan*. Retrieved from https://www.ncsbn.org/2019_RN_TestPlan-English.pdf. (Accessed 11 January 2021).

Quality and Safety Education for Nurses (QSEN). (2020). Retrieved from http://qsen.org/competencies/pre-licensure-ksas/. (Accessed 11 January 2021).

Sharifi, N., Adib-Hajbaghery, M., & Najafi, M. (2019). Cultural competence in nursing: A concept analysis. *International Journal of Nursing Studies*, *99*, 103386. https://doi.org/10.1016/j.ijnurstu.2019.103386.

Sim, J., et al. (2018). Measuring the outcomes of nursing practice: A Delphi study. *Journal of Clinical Nursing*, *27*(1–2), e368–e378. https://doi.org/10.1111/jocn.13971.

Stalter, A. M., Phillips, J. M., Ruggiero, J. S., Scardaville, D. L., Merriam, D., Dolansky, M. A., et al. (2017). A concept analysis of systems thinking. *Nursing Forum*, *52*(4), 323–330. https://doi.org/10.1111/nuf.12196.

Tanner, C. A. (2006). Thinking like a nurse: a research-based model of clinical judgment in nursing. *The Journal of Nursing Education*, *45*(6), 204–211. https://doi.org/10.3928/01484834-20060601-04.

Technology Informatics Guiding Education Reform (TIGER). (2018). *The TIGER initiative: Informatics competencies for every practicing nurse: Recommendations from the TIGER Collaborative*. Retrieved from http://www.himss.org/professionaldevelopment/tiger-initiative. (Accessed 1 January 2021).

Thompson, C., Aiken, L., Doran, D., et al. (2013). An agenda for clinical decision making and judgement in nursing research and education. *International Journal of Nursing Studies*, *50*, 1720–1726.

Tovino, S. A. (2017). Teaching the HIPAA privacy rule. *Saint Louis University Law Journal*, *61*(3), 469–494.

Trent, P., Dolansky, M. A., DeBrew, J. K., & Petty, G. M. (2017). RN-to-BSN Students' quality improvement knowledge, skills, confidence, and systems thinking. *The Journal of Nursing Education*, *56*(12), 737–740. https://doi.org/10.3928/01484834-20171120-06.

van Bodegrom-Vos, L., Davidoff, F., & Marang-van de Mheen, P. (2017). Implementation and de-implementation: Two sides of the same coin? *BMJ Quality & Safety*, *26*(8), 495–501.

Watson, F., & Rebair, A. (2014). The art of noticing: Essential to nursing practice. *The British Journal of Nursing*, *23*(10), 514–517.

Wright, J., & Scardaville, D. (2021). A nursing residency program: A window into clinical judgement and clinical decision making. *Nurse Education in Practice*, *50*, 102931. https://doi.org/10.1016/j.nepr.2020.102931.

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SECTION

II

Guide to Nursing Diagnosis

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Section II is an alphabetical listing of client symptoms, client problems, medical diagnoses, psychosocial diagnoses, and clinical states. Each of these will have a list of possible nursing diagnoses. You may use this section to find suggestions for nursing diagnoses for your client.

- Assess the client using the format provided by the clinical setting.
- Locate the client's symptoms, problems, clinical state, diagnoses, surgeries, and diagnostic testing in the alphabetical listing contained in this section.
- Note suggestions given for appropriate nursing diagnoses.
- Evaluate the suggested nursing diagnoses to determine whether they are appropriate for the client and are supported by the information that was found in the assessment.
- Use Section III (which contains an alphabetized list of all NANDA-I approved nursing diagnoses) to validate this information and check the definition, defining characteristics (if appropriate), risk factors, related factors, at-risk populations, and associated conditions. Determine whether the nursing diagnosis you have selected is appropriate for the client.

A

Abdominal Distention

Chronic Functional Constipation r/t habitually suppresses urge to defecate, impaired physical mobility, inadequate dietary intake, insufficient fiber intake, insufficient fluid intake

Constipation r/t decreased activity, decreased fluid intake, decreased fiber intake, pathological process

Dysfunctional Gastrointestinal Motility r/t decreased perfusion of intestines, medication effect

Nausea r/t irritation of gastrointestinal tract

Imbalanced Nutrition: Less Than Body Requirements r/t nausea, vomiting

Acute Pain r/t retention of air, gastrointestinal secretions

Delayed Surgical Recovery r/t retention of gas, secretions

Abdominal Hysterectomy

See Hysterectomy

Abdominal Pain

Dysfunctional Gastrointestinal Motility r/t decreased perfusion, medication effect

Acute Pain r/t injury, pathological process

Abdominal Surgery

Constipation r/t decreased activity, decreased fluid intake, anesthesia, opioids

Dysfunctional Gastrointestinal Motility r/t medication or anesthesia effect, trauma from surgery

Imbalanced Nutrition: Less Than Body Requirements r/t high metabolic needs, decreased ability to ingest or digest food

Acute Pain r/t surgical procedure

Ineffective Peripheral Tissue Perfusion r/t immobility, abdominal surgery

Risk for Delayed Surgical Recovery: Risk factor: extensive surgical procedure

Risk for Surgical Site Infection: Risk factor: invasive procedure

Risk for Thrombosis: Risk factor: impaired physical mobility, smoking

Readiness for Enhanced Knowledge: expresses an interest in learning

See Surgery, Perioperative Care; Surgery, Postoperative Care; Surgery, Preoperative Care

Abdominal Trauma

Disturbed Body Image r/t scarring, change in body function, need for temporary colostomy

Ineffective Breathing Pattern r/t abdominal distention, pain

Deficient Fluid Volume r/t hemorrhage, active fluid volume loss

Dysfunctional Gastrointestinal Motility r/t decreased perfusion

Acute Pain r/t abdominal trauma

Risk for Bleeding: Risk factor: trauma and possible contusion/rupture of abdominal organs

Risk for Infection: Risk factor: possible perforation of abdominal structures

Ablation, Radiofrequency Catheter

Fear r/t invasive procedure

Risk for Decreased Cardiac Tissue Perfusion: Risk factor: catheterization of heart

Abortion, Induced

Compromised Family Coping r/t unresolved feelings about decision

Acute Pain r/t surgical intervention

Chronic Low Self-Esteem r/t feelings of guilt

Chronic Sorrow r/t loss of potential child

Risk for Bleeding: Risk factor: trauma from abortion

Risk for Infection: Risk factors: open uterine blood vessels, dilated cervix

Risk for Post-Trauma Syndrome: Risk factor: psychological trauma of abortion

Risk for Spiritual Distress: Risk factor: perceived moral implications of decision

Readiness for Enhanced Health Literacy: expresses desire to enhance personal health care decisions

Readiness for Enhanced Knowledge: expresses an interest in learning

Abortion, Spontaneous

Disturbed Body Image r/t perceived inability to carry pregnancy, produce child

Disabled Family Coping r/t unresolved feelings about loss

Ineffective Coping r/t personal vulnerability

Interrupted Family Processes r/t unmet expectations for pregnancy and childbirth

Fear r/t implications for future pregnancies

Risk for Maladaptive Grieving r/t loss of fetus

Acute Pain r/t uterine contractions, surgical intervention

Situational Low Self-Esteem r/t feelings about loss of fetus

Chronic Sorrow r/t loss of potential child

Risk for Bleeding: Risk factor: trauma from abortion

Risk for Infection: Risk factors: septic or incomplete abortion of products of conception, open uterine blood vessels, dilated cervix

Risk for Post-Trauma Syndrome: Risk factor: psychological trauma of abortion

Risk for Spiritual Distress: Risk factor: loss of fetus

Readiness for Enhanced Knowledge: expresses an interest in learning

Abruptio Placentae <36 Weeks

Anxiety r/t unknown outcome, change in birth plans

Death Anxiety r/t unknown outcome, hemorrhage, or pain

Interrupted Family Processes r/t unmet expectations for pregnancy and childbirth

Fear r/t threat to well-being of self and fetus

Impaired Gas Exchange: Placental r/t decreased uteroplacental area

Acute Pain r/t irritable uterus, hypertonic uterus

Impaired Tissue Integrity: Maternal r/t possible uterine rupture

Risk for Bleeding: Risk factor: separation of placenta from uterus causing bleeding

Risk for Infection: Risk factor: partial separation of placenta

Risk for Disturbed Maternal–Fetal Dyad: Risk factors: trauma of process, lack of energy of mother

Risk for Shock: Risk factor: separation of placenta from uterus

Readiness for Enhanced Knowledge: expresses an interest in learning

Abscess Formation

Acute Pain r/t inflammation

Ineffective Protection r/t inadequate nutrition, abnormal blood profile, drug therapy, depressed immune function

Impaired Tissue Integrity r/t altered circulation, nutritional deficit or excess

Readiness for Enhanced Knowledge: expresses an interest in learning

Abuse, Child

See Child Abuse

Abuse, Spouse, Parent, or Significant Other

Anxiety r/t threat to self-concept, situational crisis of abuse

Caregiver Role Strain r/t chronic illness, self-care deficits, lack of respite care, extent of caregiving required

Impaired Verbal Communication r/t psychological barriers of fear

Compromised Family Coping r/t abusive patterns

Defensive Coping r/t low self-esteem

Disturbed Family Identity Syndrome r/t unaddressed domestic violence

Dysfunctional Family Processes r/t inadequate coping skills

Insomnia r/t psychological stress

Post-Trauma Syndrome r/t history of abuse

Powerlessness r/t lifestyle of helplessness

Chronic Low Self-Esteem r/t negative family interactions

Risk for Impaired Emancipated Decision-Making: Risk factor: inability to verbalize needs and wants

Risk for Female Genital Mutilation: Risk factor: lack of family knowledge about impact of practice on physical health

Risk for Self-Directed Violence: Risk factor: history of abuse

Accessory Muscle Use (to Breathe)

Ineffective Breathing Pattern (See **Breathing Pattern, Ineffective,** Section III)

See Asthma; Bronchitis; COPD (Chronic Obstructive Pulmonary Disease); Respiratory Infections, Acute Childhood (Croup, Epiglottis, Pertussis, Pneumonia, Respiratory Syncytial Virus)

Accident Prone

Frail Elderly Syndrome r/t history of falls

Acute Confusion r/t altered level of consciousness

Ineffective Coping r/t personal vulnerability, situational crises

Ineffective Impulse Control (See **Impulse Control, Ineffective,** Section III)

Risk for Injury: Risk factor: history of accidents

Wandering r/t overstimulating environment

Achalasia

Ineffective Coping r/t chronic disease

Acute Pain r/t stasis of food in esophagus

Impaired Swallowing r/t neuromuscular impairment

Risk for Aspiration: Risk factor: nocturnal regurgitation

Acid-Base Imbalances

Risk for Electrolyte Imbalance: Risk factors: renal dysfunction, diarrhea, treatment-related side effects (e.g., medications, drains)

Acidosis, Metabolic

Acute Confusion r/t acid-base imbalance, associated electrolyte imbalance

Impaired Memory r/t effect of metabolic acidosis on brain function

Imbalanced Nutrition: Less Than Body Requirements r/t inability to ingest, absorb nutrients

Risk for Electrolyte Imbalance: Risk factor: effect of metabolic acidosis on renal function

Risk for Injury: Risk factors: disorientation, weakness, stupor

Risk for Decreased Cardiac Tissue Perfusion: Risk factor: dysrhythmias from hyperkalemia

Risk for Shock: Risk factors: abnormal metabolic state, presence of acid state impairing function, decreased tissue perfusion

Acidosis, Respiratory

Decreased Activity Tolerance r/t imbalance between oxygen supply and demand

Impaired Gas Exchange r/t ventilation-perfusion imbalance

Impaired Memory r/t hypoxia

Risk for Decreased Cardiac Tissue Perfusion: Risk factor: dysrhythmias associated with respiratory acidosis

Acne

Disturbed Body Image r/t biophysical changes associated with skin disorder

Ineffective Health Self-Management r/t insufficient knowledge of therapeutic regimen

Impaired Skin Integrity r/t hormonal changes (adolescence, menstrual cycle)

Acromegaly

Decreased Activity Tolerance

Ineffective Airway Clearance r/t airway obstruction by enlarged tongue

Disturbed Body Image r/t changes in body function and appearance

A

Impaired Physical Mobility r/t joint pain

Risk for Decreased Cardiac Tissue Perfusion: Risk factor: increased atherosclerosis from abnormal health status

Risk for Unstable Blood Glucose Level: Risk factor: abnormal physical health status

Sexual Dysfunction r/t changes in hormonal secretions

Risk for Overweight: Risk factor: energy expenditure less than energy intake

Activity Intolerance, Potential to Develop

Decreased Activity Tolerance r/t sedentary behavior, deconditioning

Acute Abdominal Pain

Deficient Fluid Volume r/t air and fluids trapped in bowel, inability to drink

Acute Pain r/t pathological process

Risk for Dysfunctional Gastrointestinal Motility: Risk factor: ineffective gastrointestinal tissue perfusion

See Abdominal Pain

Acute Alcohol Intoxication

Ineffective Breathing Pattern r/t depression of the respiratory center from excessive alcohol intake

Acute Confusion r/t central nervous system depression

Dysfunctional Family Processes r/t abuse of alcohol

Risk for Aspiration: Risk factor: depressed reflexes with acute vomiting

Risk for Infection: Risk factor: impaired immune system from malnutrition associated with chronic excessive alcohol intake

Risk for Injury: Risk factor: chemical (alcohol)

Acute Back Pain

Anxiety r/t situational crisis, back injury

Constipation r/t decreased activity, effect of pain medication

Ineffective Coping r/t situational crisis, back injury

Impaired Physical Mobility r/t pain

Acute Pain r/t back injury

Readiness for Enhanced Knowledge: expresses an interest in learning

Acute Confusion

See Confusion, Acute

Acute Coronary Syndrome

Decreased Cardiac Output r/t cardiac disorder

Risk for Decreased Cardiac Tissue Perfusion (See **Cardiac Tissue Perfusion, Risk for Decreased,** Section III)

See Angina; Myocardial Infarction (MI)

Acute Lymphocytic Leukemia (ALL)

See Cancer; Chemotherapy; Child with Chronic Condition; Leukemia

Acute Renal Failure

See Renal Failure

Acute Respiratory Distress Syndrome

See ARDS (Acute Respiratory Distress Syndrome)

Acute Substance Withdrawal

Acute Substance Withdrawal Syndrome: Risk factor: developed dependence to alcohol or other addictive substances

Anxiety r/t unknown outcome of withdrawal sequence, physiological effects

Imbalanced Energy Field r/t hyperactivity of energy flow

Impaired Comfort r/t restlessness and agitation

Acute Confusion r/t effects of substance withdrawal

Ineffective Coping r/t situational crisis, withdrawal

Labile Emotional Control r/t lack of control over the progression of withdrawal process

Fear r/t threat to well-being of self

Insomnia r/t physical and psychological effects of substance withdrawal

Imbalanced Nutrition: Less than Body Requirements r/t nausea, anxiety

Powerlessness r/t loss of ability to control withdrawal process

Risk for Acute Confusion: Risk factor: possible alteration in level of consciousness

Risk for Injury: Risk factor: alteration in sensory perceptual functioning

Risk for Suicidal Behavior: Risk factor: psychic pain

Risk for Other-Directed Violence: Risk factors: poor impulse control, hallucinations

Risk for Self-Directed Violence: Risk factors: poor impulse control, hallucinations

Adams–Stokes Syndrome

See Dysrhythmia

Addiction

See Alcoholism; Substance Abuse

Addison's Disease

Decreased Activity Tolerance r/t weakness, fatigue

Disturbed Body Image r/t increased skin pigmentation

Deficient Fluid Volume r/t failure of regulatory mechanisms

Imbalanced Nutrition: Less than Body Requirements r/t chronic illness

Risk for Injury: Risk factor: weakness

Readiness for Enhanced Knowledge: expresses an interest in learning

Adenoidectomy

Acute Pain r/t surgical incision

Ineffective Airway Clearance r/t hesitation or reluctance to cough as a result of pain, fear

Nausea r/t anesthesia effects, drainage from surgery

Risk for Aspiration: Risk factors: postoperative drainage, impaired swallowing

Risk for Bleeding: Risk factor: surgical incision

Risk for Deficient Fluid Volume: Risk factors: decreased intake as a result of painful swallowing, effects of anesthesia

Risk for Dry Mouth: Risk factor: mouth breathing due to nasal congestion

Risk for Imbalanced Nutrition: Less than Body Requirements: Risk factor: reluctance to swallow

Readiness for Enhanced Knowledge: expresses an interest in learning

Adhesions, Lysis of

See Abdominal Surgery

Adjustment Disorder

Anxiety r/t inability to cope with psychosocial stressor

Ineffective Coping r/t stressors

Impaired Mood Regulation r/t emotional instability

Labile Emotional Control r/t emotional disturbance

Risk-Prone Health Behavior r/t assault to self-esteem

Disturbed Personal Identity r/t psychosocial stressor (specific to individual)

Situational Low Self-Esteem r/t change in role function

Impaired Social Interaction r/t absence of significant others or peers

Adjustment Impairment

Risk-Prone Health Behavior (See **Health Behavior, Risk-Prone,** Section III)

Adolescent, Pregnant

Anxiety r/t situational and maturational crisis, pregnancy

Disturbed Body Image r/t pregnancy superimposed on developing body

Decisional Conflict: Keeping Child Versus Giving up Child Versus Abortion r/t lack of experience with decision-making, interference with decision-making, multiple or divergent sources of information, lack of support system

Disabled Family Coping r/t highly ambivalent family relationships, chronically unresolved feelings of guilt, anger, despair

Ineffective Coping r/t situational and maturational crisis, personal vulnerability

Ineffective Denial r/t fear of consequences of pregnancy becoming known

Ineffective Adolescent Eating Dynamics r/t lack of knowledge of nutritional needs during pregnancy

Interrupted Family Processes r/t unmet expectations for adolescent, situational crisis

Fear r/t labor and delivery

Deficient Knowledge r/t pregnancy, infant growth and development, parenting

Imbalanced Nutrition: Less than Body Requirements r/t lack of knowledge of nutritional needs during pregnancy and as growing adolescent

Ineffective Role Performance r/t pregnancy

Situational Low Self-Esteem r/t feelings of shame and guilt about becoming or being pregnant

Impaired Social Interaction r/t self-concept disturbance

Social Isolation r/t absence of supportive significant others

Risk for Impaired Attachment: Risk factor: anxiety associated with the parent role

Risk for Disturbed Family Identity Syndrome: Risk Factor: excessive stress

Risk for Urge Urinary Incontinence: Risk factor: pressure on bladder by growing uterus

Risk for Disturbed Maternal–Fetal Dyad: Risk factors: immaturity, substance use

Risk for Impaired Parenting: Risk factors: adolescent parent, unplanned or unwanted pregnancy, single parent

Readiness for Enhanced Childbearing Process: reports appropriate prenatal lifestyle

Readiness for Enhanced Health Literacy: expresses desire to enhance social support for health

Readiness for Enhanced Knowledge: expresses an interest in learning

Adoption, Giving Child up for

Decisional Conflict r/t unclear personal values or beliefs, perceived threat to value system, support system deficit

Ineffective Coping r/t stress of loss of child

Interrupted Family Processes r/t conflict within family regarding relinquishment of child

Maladaptive Grieving r/t loss of child, loss of role of parent

Insomnia r/t depression or trauma of relinquishment of child

Social Isolation r/t making choice that goes against values of significant others

Chronic Sorrow r/t loss of relationship with child

Risk for Spiritual Distress: Risk factor: perceived moral implications of decision

Readiness for Enhanced Spiritual Well-Being: harmony with self-regarding final decision

Adrenocortical Insufficiency

Deficient Fluid Volume r/t insufficient ability to reabsorb water

Ineffective Protection r/t inability to tolerate stress

Delayed Surgical Recovery r/t inability to respond to stress

Risk for Shock: Risk factors: deficient fluid volume, decreased cortisol to initiate stress response to insult to body

See Addison's Disease; Shock, Hypovolemic

Advance Directives

Death Anxiety r/t planning for end-of-life health decisions

Decisional Conflict r/t unclear personal values or beliefs, perceived threat to value system, support system deficit

Maladaptive Grieving r/t possible loss of self, significant other

Readiness for Enhanced Spiritual Well-Being: harmonious interconnectedness with self, others, higher power, God

Affective Disorders

See Depression (Major Depressive Disorder); Dysthymic Disorder; Manic Disorder, Bipolar I; SAD (Seasonal Affective Disorder)

A

Age-Related Macular Degeneration

See Macular Degeneration

Aggressive Behavior

Fear r/t real or imagined threat to own well-being

Risk for Other-Directed Violence (See **Violence, Other-Directed, Risk for,** Section III)

Aging

Death Anxiety r/t fear of unknown, loss of self, impact on significant others

Impaired Dentition r/t ineffective oral hygiene

Risk for Frail Elderly Syndrome: Risk factors: >70 years, activity intolerance, impaired vision

Maladaptive Grieving r/t multiple losses, impending death

Ineffective Health Maintenance Behaviors r/t powerlessness

Hearing Loss r/t exposure to loud noises, aging

Impaired Urinary Elimination r/t impaired vision, impaired cognition, neuromuscular limitations, altered environmental factors

Impaired Resilience r/t aging, multiple losses

Sleep Deprivation r/t aging-related sleep-stage shifts

Risk for Caregiver Role Strain: Risk factor: inability to handle increasing needs of significant other

Risk for Impaired Emancipated Decision-Making: Risk factor: inability to process information regarding health care decisions

Risk for Injury: Risk factors: vision loss, hearing loss, decreased balance, decreased sensation in feet

Risk for Loneliness: Risk factors: inadequate support system, role transition, health alterations, depression, fatigue

Risk for Ineffective Thermoregulation: Risk factor: aging

Readiness for Enhanced Community Coping: providing social support and other resources identified as needed for elderly client

Readiness for Enhanced Family Coping: ability to gratify needs, address adaptive tasks

Readiness for Enhanced Health Self-Management: knowledge about medication, nutrition, exercise, coping strategies

Readiness for Enhanced Knowledge: specify need to improve health

Readiness for Enhanced Nutrition: need to improve health

Readiness for Enhanced Relationship: demonstrates understanding of partner's insufficient function

Readiness for Enhanced Sleep: need to improve sleep

Readiness for Enhanced Spiritual Well-Being: one's experience of life's meaning, harmony with self, others, higher power, God, environment

Agitation

Acute Confusion r/t side effects of medication, hypoxia, decreased cerebral perfusion, alcohol abuse or withdrawal, substance abuse or withdrawal, sensory deprivation or overload

Sleep Deprivation r/t sustained inadequate sleep hygiene, sundown syndrome

Agoraphobia

Anxiety r/t real or perceived threat to physical integrity

Ineffective Coping r/t inadequate support systems

Fear r/t leaving home, going out in public places

Impaired Social Interaction r/t disturbance in self-concept

Social Isolation r/t altered thought process

Agranulocytosis

Delayed Surgical Recovery r/t abnormal blood profile

Risk for Infection: Risk factor: abnormal blood profile

Readiness for Enhanced Knowledge: expresses an interest in learning

AIDS (Acquired Immunodeficiency Syndrome)

Death Anxiety r/t fear of premature death

Disturbed Body Image r/t chronic contagious illness, cachexia

Caregiver Role Strain r/t unpredictable illness course, presence of situation stressors

Diarrhea r/t inflammatory bowel changes

Interrupted Family Processes r/t distress about diagnosis of human immunodeficiency virus (HIV) infection

Fatigue r/t disease process, stress, decreased nutritional intake

Fear r/t powerlessness, threat to well-being

Maladaptive Grieving: Family/Parental r/t potential or impending death of loved one

Maladaptive Grieving: Individual r/t loss of physical and psychosocial well-being

Hopelessness r/t deteriorating physical condition

Imbalanced Nutrition: Less than Body Requirements r/t decreased ability to eat and absorb nutrients as a result of anorexia, nausea, diarrhea; oral candidiasis

Chronic Pain r/t tissue inflammation and destruction

Impaired Resilience r/t chronic illness

Situational Low Self-Esteem r/t crisis of chronic contagious illness

Ineffective Sexuality Pattern r/t possible transmission of disease

Social Isolation r/t self-concept disturbance, therapeutic isolation

Chronic Sorrow r/t chronic illness

Spiritual Distress r/t challenged beliefs or moral system

Risk for Deficient Fluid Volume: Risk factors: diarrhea, vomiting, fever, bleeding

Risk for Infection: Risk factor: inadequate immune system

Risk for Loneliness: Risk factor: social isolation

Risk for Impaired Oral Mucous Membrane Integrity: Risk factor: immunological deficit

Risk for Impaired Skin Integrity: Risk factors: immunological deficit, diarrhea

Risk for Spiritual Distress: Risk factor: physical illness

Readiness for Enhanced Health Literacy: expresses desire to enhance understanding of health information to make health care choices

Readiness for Enhanced Knowledge: expresses an interest in learning

See AIDS, Child; Cancer; Pneumonia

AIDS, Child

Impaired Parenting r/t congenital acquisition of infection secondary to intravenous (IV) drug use, multiple sexual partners, history of contaminated blood transfusion

Risk for Disturbed Family Identity Syndrome: Risk factor: excessive stress

See AIDS (Acquired Immunodeficiency Syndrome); Child with Chronic Condition; Hospitalized Child; Terminally Ill Child, Adolescent; Terminally Ill Child, Infant/Toddler; Terminally Ill Child, Preschool Child; Terminally Ill Child, School-Age Child/Preadolescent; Terminally Ill Child/Death of Child, Parent

AIDS Dementia

Chronic Confusion r/t viral invasion of nervous system

See Dementia

Airway Obstruction/Secretions

Ineffective Airway Clearance (See **Airway Clearance, Ineffective,** Section III)

Alcohol Withdrawal

Anxiety r/t situational crisis, withdrawal

Acute Confusion r/t effects of alcohol withdrawal

Ineffective Coping r/t personal vulnerability

Dysfunctional Family Processes r/t abuse of alcohol

Insomnia r/t effect of alcohol withdrawal, anxiety

Imbalanced Nutrition: Less than Body Requirements r/t poor dietary habits

Chronic Low Self-Esteem r/t repeated unmet expectations

Acute Substance Withdrawal Syndrome: Risk factor: developed dependence to alcohol

Risk for Deficient Fluid Volume: Risk factors: excessive diaphoresis, agitation, decreased fluid intake

Risk for Other-Directed Violence: Risk factor: substance withdrawal

Risk for Self-Directed Violence: Risk factor: substance withdrawal

Readiness for Enhanced Knowledge: expresses an interest in learning

Alcoholism

Anxiety r/t loss of control

Risk-Prone Health Behavior r/t lack of motivation to change behaviors, addiction

Acute Confusion r/t alcohol abuse

Chronic Confusion r/t neurological effects of chronic alcohol intake

Defensive Coping r/t denial of reality of addiction

Disabled Family Coping r/t codependency issues due to alcoholism

Ineffective Coping r/t use of alcohol to cope with life events

Labile Emotional Control r/t substance abuse

Ineffective Denial r/t refusal to acknowledge addiction

Dysfunctional Family Processes r/t alcohol abuse

Ineffective Home Maintenance Behaviors r/t memory deficits, fatigue

Insomnia r/t irritability, nightmares, tremors

Impaired Memory r/t alcohol abuse

Self-Neglect r/t effects of alcohol abuse

Imbalanced Nutrition: Less than Body Requirements r/t anorexia, inappropriate diet with increased carbohydrates

Powerlessness r/t alcohol addiction

Ineffective Protection r/t malnutrition, sleep deprivation

Chronic Low Self-Esteem r/t failure at life events

Social Isolation r/t unacceptable social behavior, values

Acute Substance Withdrawal Syndrome: Risk factor: developed dependence to alcohol

Risk for Injury: Risk factor: alteration in sensory or perceptual function

Risk for Loneliness: Risk factor: unacceptable social behavior

Risk for Acute Substance Withdrawal Syndrome: Risk factor: developed dependence to alcohol

Risk for Other-Directed Violence: Risk factors: reactions to substances used, impulsive behavior, disorientation, impaired judgment

Risk for Self-Directed Violence: Risk factors: reactions to substances used, impulsive behavior, disorientation, impaired judgment

Alcoholism, Dysfunctional Family Processes

Dysfunctional Family Processes (See **Family Processes, Dysfunctional,** Section III)

Disturbed Family Identity Syndrome: Risk factor: excessive stress

Alkalosis

See Metabolic Alkalosis

ALL (Acute Lymphocytic Leukemia)

See Cancer; Chemotherapy; Child with Chronic Condition; Leukemia

Allergies

Risk for Allergy Reaction: Risk factors: chemical factors, dander, environmental substances, foods, insect stings, medications

Risk for Latex Allergic Reaction: Risk factor: repeated exposure to products containing latex

Readiness for Enhanced Knowledge: expresses an interest in learning

Alopecia

Disturbed Body Image r/t loss of hair, change in appearance

A

Readiness for Enhanced Knowledge: expresses an interest in learning

ALS (Amyotrophic Lateral Sclerosis)

See Amyotrophic Lateral Sclerosis (ALS)

Altered Mental Status

See Confusion, Acute; Confusion, Chronic; Memory Deficit

Alzheimer's Disease

Caregiver Role Strain r/t duration and extent of caregiving required

Chronic Confusion r/t loss of cognitive function

Compromised Family Coping r/t interrupted family processes

Frail Elderly Syndrome r/t alteration in cognitive functioning

Ineffective Home Maintenance Behaviors r/t impaired cognitive function, inadequate support systems

Hopelessness r/t deteriorating condition

Insomnia r/t neurological impairment, daytime naps

Impaired Memory r/t neurological disturbance

Impaired Physical Mobility r/t severe neurological dysfunction

Self-Neglect r/t loss of cognitive function

Powerlessness r/t deteriorating condition

Self-Care Deficit: Specify r/t loss of cognitive function, psychological impairment

Social Isolation r/t fear of disclosure of memory loss

Wandering r/t cognitive impairment, frustration, physiological state

Risk for Chronic Functional Constipation: Risk factor: impaired cognitive functioning

Risk for Injury: Risk factor: confusion

Risk for Loneliness: Risk factor: potential social isolation

Risk for Relocation Stress Syndrome: Risk factors: impaired psychosocial health, decreased health status

Risk for Other-Directed Violence: Risk factors: frustration, fear, anger, loss of cognitive function

Readiness for Enhanced Knowledge: Caregiver: expresses an interest in learning

See Dementia

AMD (Age-Related Macular Degeneration)

See Macular Degeneration

Amenorrhea

Imbalanced Nutrition: Less than Body Requirements r/t inadequate food intake

See Sexuality, Adolescent

AMI (Acute Myocardial Infarction)

See MI (Myocardial Infarction)

Amnesia

Acute Confusion r/t alcohol abuse, delirium, dementia, drug abuse

Dysfunctional Family Processes r/t alcohol abuse, inadequate coping skills

Impaired Memory r/t excessive environmental disturbance, neurological disturbance

Post-Trauma Syndrome r/t history of abuse, catastrophic illness, disaster, accident

Amniocentesis

Anxiety r/t threat to self and fetus, unknown future

Decisional Conflict r/t choice of treatment pending results of test

Risk for Infection: Risk factor: invasive procedure

Amnionitis

See Chorioamnionitis

Amniotic Membrane Rupture

See Premature Rupture of Membranes

Amputation

Disturbed Body Image r/t negative effects of amputation, response from others

Maladaptive Grieving r/t loss of body part, future lifestyle changes

Impaired Physical Mobility r/t musculoskeletal impairment, limited movement

Acute Pain r/t surgery, phantom limb sensation

Chronic Pain r/t surgery, phantom limb sensation

Ineffective Peripheral Tissue Perfusion r/t impaired arterial circulation

Impaired Skin Integrity r/t poor healing, prosthesis rubbing

Risk for Bleeding: Risk factor: vulnerable surgical site

Risk for Impaired Tissue Integrity: Risk factor: mechanical factors impacting site

Readiness for Enhanced Knowledge: expresses an interest in learning

Amyotrophic Lateral Sclerosis (ALS)

Death Anxiety r/t impending progressive loss of function leading to death

Ineffective Breathing Pattern r/t compromised muscles of respiration

Impaired Verbal Communication r/t weakness of muscles of speech, deficient knowledge of ways to compensate and alternative communication devices

Decisional Conflict: Ventilator Therapy r/t unclear personal values or beliefs, lack of relevant information

Impaired Resilience r/t perceived vulnerability

Chronic Sorrow r/t chronic illness

Impaired Swallowing r/t weakness of muscles involved in swallowing

Impaired Spontaneous Ventilation r/t weakness of muscles of respiration

Risk for Aspiration: Risk factor: impaired swallowing

Risk for Spiritual Distress: Risk factor: chronic debilitating condition

See Neurological Disorders

Anal Fistula

See Hemorrhoidectomy

Anaphylactic Shock

Deficient Fluid Volume r/t compromised regulatory mechanism

Ineffective Airway Clearance r/t laryngeal edema, bronchospasm

Risk for Latex Allergic Reaction r/t abnormal immune mechanism response

Impaired Spontaneous Ventilation r/t acute airway obstruction from anaphylaxis process

Anaphylaxis Prevention

Risk for Allergy Reaction (See **Allergy Reaction, Risk for,** Section III)

Anasarca

Excess Fluid Volume r/t excessive fluid intake, cardiac/renal dysfunction, loss of plasma proteins

Risk for Decreased Cardiac Output: Risk factor: imbalanced fluid volume

Risk for Impaired Skin Integrity: Risk factor: impaired circulation to skin from edema

Anemia

Anxiety r/t cause of disease

Impaired Comfort r/t feelings of always being cold from decreased hemoglobin and decreased metabolism

Fatigue r/t decreased oxygen supply to the body, increased cardiac workload

Impaired Memory r/t change in cognition from decreased oxygen supply to the body

Delayed Surgical Recovery r/t decreased oxygen supply to body, increased cardiac workload

Risk for Bleeding (See **Bleeding, Risk for,** Section III)

Risk for Injury: Risk factor: alteration in peripheral sensory perception

Readiness for Enhanced Knowledge: expresses an interest in learning

Anemia, in Pregnancy

Anxiety r/t concerns about health of self and fetus

Fatigue r/t decreased oxygen supply to the body, increased cardiac workload

Risk for Infection: Risk factor: reduction in oxygen-carrying capacity of blood

Risk for Disturbed Maternal–Fetal Dyad: Risk factor: compromised oxygen transport

Readiness for Enhanced Knowledge: expresses an interest in learning

Anemia, Sickle Cell

See Anemia; Sickle Cell Anemia/Crisis

Anencephaly

See Neural Tube Defects (Meningocele, Myelomeningocele, Spina Bifida, Anencephaly)

Aneurysm, Abdominal Aortic Repair Surgery

Risk for Deficient Fluid Volume: Risk factor: hemorrhage r/t potential abnormal blood loss

Risk for Surgical Site Infection: Risk factor: invasive procedure

See Abdominal Surgery

Aneurysm, Cerebral

See Craniectomy/Craniotomy; Subarachnoid Hemorrhage

Anger

Anxiety r/t situational crisis

Defensive Coping r/t inability to acknowledge responsibility for actions and results of actions

Labile Emotional Control r/t stressors

Fear r/t environmental stressor, hospitalization

Maladaptive Grieving r/t significant loss

Risk-Prone Health Behavior r/t assault to self-esteem, disability requiring change in lifestyle, inadequate support system

Powerlessness r/t health care environment

Risk for Compromised Human Dignity: Risk factors: inadequate participation in decision-making, perceived dehumanizing treatment, perceived humiliation, exposure of the body, cultural incongruity

Risk for Post-Trauma Syndrome: Risk factor: inadequate social support

Risk for Other-Directed Violence: Risk factors: history of violence, rage reaction

Risk for Self-Directed Violence: Risk factors: history of violence, history of abuse, rage reaction

Angina

Decreased Activity Tolerance r/t acute pain, dysrhythmias

Anxiety r/t situational crisis

Decreased Cardiac Output r/t myocardial ischemia, medication effect, dysrhythmia

Ineffective Coping r/t personal vulnerability to situational crisis of new diagnosis, deteriorating health

Ineffective Denial r/t deficient knowledge of need to seek help with symptoms

Maladaptive Grieving r/t pain, loss of health

Acute Pain r/t myocardial ischemia

Ineffective Sexuality Pattern r/t disease process, medications, loss of libido

Readiness for Enhanced Knowledge: expresses an interest in learning

See MI (Myocardial Infarction)

Angiocardiography (Cardiac Catheterization)

See Cardiac Catheterization

Angioplasty, Coronary

Fear r/t possible outcome of interventional procedure

Ineffective Peripheral Tissue Perfusion r/t vasospasm, hematoma formation

A

Risk for Bleeding: Risk factors: possible damage to coronary artery, hematoma formation

Risk for Decreased Cardiac Tissue Perfusion: Risk factors: ventricular ischemia, dysrhythmias

Readiness for Enhanced Knowledge: expresses an interest in learning

Anomaly, Fetal/Newborn (Parent Dealing with)

Anxiety r/t threat to role functioning, situational crisis

Decisional Conflict: Interventions for Fetus or Newborn r/t lack of relevant information, spiritual distress, threat to value system

Disabled Family Coping r/t chronically unresolved feelings about loss of perfect baby

Ineffective Coping r/t personal vulnerability in situational crisis

Interrupted Family Processes r/t unmet expectations for perfect baby, lack of adequate support systems

Fear r/t real or imagined threat to baby, implications for future pregnancies, powerlessness

Maladaptive Grieving r/t loss of ideal child

Hopelessness r/t long-term stress, deteriorating physical condition of child, lost spiritual belief

Deficient Knowledge r/t limited exposure to situation

Impaired Parenting r/t interruption of bonding process

Powerlessness r/t complication threatening fetus or newborn

Parental Role Conflict r/t separation from newborn, intimidation with invasive or restrictive modalities, specialized care center policies

Situational Low Self-Esteem r/t perceived inability to produce a perfect child

Social Isolation r/t alterations in child's physical appearance, altered state of wellness

Chronic Sorrow r/t loss of ideal child, inadequate bereavement support

Spiritual Distress r/t test of spiritual beliefs

Risk for Impaired Attachment: Risk factor: ill infant unable to effectively initiate parental contact as result of altered behavioral organization

Risk for Disorganized Infant Behavior: Risk factor: congenital disorder

Risk for Impaired Parenting: Risk factors: interruption of bonding process; unrealistic expectations for self, infant, or partner; perceived threat to own emotional survival; severe stress; lack of knowledge

Risk for Spiritual Distress: Risk factor: lack of normal child to raise and carry on family name

Anorectal Abscess

Disturbed Body Image r/t odor and drainage from rectal area

Acute Pain r/t inflammation of perirectal area

Risk for Constipation: Risk factor: fear of painful elimination

Readiness for Enhanced Knowledge: expresses an interest in learning

Anorexia

Deficient Fluid Volume r/t inability to drink

Imbalanced Nutrition: Less than Body Requirements r/t loss of appetite, nausea, vomiting, laxative abuse

Delayed Surgical Recovery r/t inadequate nutritional intake

Risk for Delayed Surgical Recovery: Risk factor: inadequate nutritional intake

Anorexia Nervosa

Decreased Activity Tolerance r/t fatigue, weakness

Disturbed Body Image r/t misconception of actual body appearance

Constipation r/t lack of adequate food, fiber, and fluid intake

Defensive Coping r/t psychological impairment, eating disorder

Disabled Family Coping r/t highly ambivalent family relationships

Ineffective Denial r/t fear of consequences of therapy, possible weight gain

Diarrhea r/t laxative abuse

Interrupted Family Processes r/t situational crisis

Ineffective Adolescent Eating Dynamics r/t food refusal

Ineffective Family Health Self-Management r/t family conflict, excessive demands on family associated with complexity of condition and treatment

Imbalanced Nutrition: Less than Body Requirements r/t inadequate food intake, excessive exercise

Chronic Low Self-Esteem r/t repeated unmet expectations

Ineffective Sexuality Pattern r/t loss of libido from malnutrition

Risk for Infection: Risk factor: malnutrition resulting in depressed immune system

Risk for Spiritual Distress: Risk factor: low self-esteem

See Maturational Issues, Adolescent

Anosmia (Smell, Loss of Ability to)

Imbalanced Nutrition: Less than Body Requirements r/t loss of appetite associated with loss of smell

Antepartum Period

See Pregnancy, Normal; Prenatal Care, Normal

Anterior Repair, Anterior Colporrhaphy

Urinary Retention r/t edema of urinary structures

Risk for Urge Urinary Incontinence: Risk factor: trauma to bladder

Readiness for Enhanced Knowledge: expresses an interest in learning

See Vaginal Hysterectomy

Anticoagulant Therapy

Risk for Bleeding: Risk factor: altered clotting function from anticoagulant

Risk for Deficient Fluid Volume: Hemorrhage: Risk factor: altered clotting mechanism

Readiness for Enhanced Knowledge: expresses an interest in learning

Antisocial Personality Disorder

Defensive Coping r/t excessive use of projection

Ineffective Coping r/t frequently violating the norms and rules of society

Labile Emotional Control r/t psychiatric disorder

Hopelessness r/t abandonment

Impaired Social Interaction r/t sociocultural conflict, chemical dependence, inability to form relationships

Spiritual Distress r/t separation from religious or cultural ties

Ineffective Health Self-Management r/t excessive demands on family

Risk for Loneliness: Risk factor: inability to interact appropriately with others

Risk for Impaired Parenting: Risk factors: inability to function as parent or guardian, emotional instability

Risk for Self-Mutilation: Risk factors: self-hatred, depersonalization

Risk for Other-Directed Violence: Risk factor: history of violence, altered thought patterns

Anuria

See Renal Failure

Anxiety

See **Anxiety,** Section III

Anxiety Disorder

Ineffective Activity Planning r/t unrealistic perception of events

Anxiety r/t unmet security and safety needs

Death Anxiety r/t fears of unknown, powerlessness

Decisional Conflict r/t low self-esteem, fear of making a mistake

Defensive Coping r/t overwhelming feelings of dread

Disabled Family Coping r/t ritualistic behavior, actions

Imbalanced Energy Field r/t feelings of restlessness and apprehension

Impaired Mood Regulation r/t functional impairment, impaired social functioning, alteration in sleep pattern

Ineffective Coping r/t inability to express feelings appropriately

Ineffective Denial r/t overwhelming feelings of hopelessness, fear, threat to self

Insomnia r/t psychological impairment, emotional instability

Labile Emotional Control r/t emotional instability

Powerlessness r/t lifestyle of helplessness

Self-Care Deficit r/t ritualistic behavior, activities

Sleep Deprivation r/t prolonged psychological discomfort

Risk for Spiritual Distress: Risk factor: psychological distress

Readiness for Enhanced Knowledge: expresses an interest in learning

Aortic Valvular Stenosis

See Congenital Heart Disease/Cardiac Anomalies

Aphasia

Anxiety r/t situational crisis of aphasia

Impaired Verbal Communication r/t decrease in circulation to brain

Ineffective Coping r/t loss of speech

Ineffective Health Maintenance Behaviors r/t deficient knowledge regarding information on aphasia and alternative communication techniques

Aplastic Anemia

Decreased Activity Tolerance r/t imbalance between oxygen supply and demand

Fear r/t ability to live with serious disease

Risk for Bleeding: Risk factor: inadequate clotting factors

Risk for Infection: Risk factor: inadequate immune function

Readiness for Enhanced Knowledge: expresses an interest in learning

Apnea in Infancy

See Premature Infant (Child); Premature Infant (Parent); SIDS (Sudden Infant Death Syndrome)

Apneustic Respirations

Ineffective Breathing Pattern r/t perception or cognitive impairment, neurological impairment

Appendectomy

Deficient Fluid Volume r/t fluid restriction, hypermetabolic state, nausea, vomiting

Acute Pain r/t surgical incision

Delayed Surgical Recovery r/t rupture of appendix

Risk for Infection: Risk factors: perforation or rupture of appendix, peritonitis

Risk for Surgical Site Infection: Risk factor: surgical incision

Readiness for Enhanced Knowledge: expresses an interest in learning

See Hospitalized Child; Surgery, Postoperative Care

Appendicitis

Deficient Fluid Volume r/t anorexia, nausea, vomiting

Acute Pain r/t inflammation

Risk for Infection: Risk factor: possible perforation of appendix

Readiness for Enhanced Knowledge: expresses an interest in learning

Apprehension

Anxiety r/t threat to self-concept, threat to health status, situational crisis

Death Anxiety r/t apprehension over loss of self, consequences to significant others

A

ARDS (Acute Respiratory Distress Syndrome)

Ineffective Airway Clearance r/t excessive tracheobronchial secretions

Death Anxiety r/t seriousness of physical disease

Impaired Gas Exchange r/t damage to alveolar-capillary membrane, change in lung compliance

Impaired Spontaneous Ventilation r/t damage to alveolar-capillary membrane

See Ventilated Client, Mechanically

Arrhythmia

See Dysrhythmia

Arterial Insufficiency

Ineffective Peripheral Tissue Perfusion r/t interruption of arterial flow

Delayed Surgical Recovery r/t ineffective tissue perfusion

Arthritis

Decreased Activity Tolerance r/t chronic pain, fatigue, weakness

Disturbed Body Image r/t ineffective coping with joint abnormalities

Impaired Physical Mobility r/t joint impairment

Chronic Pain r/t progression of joint deterioration

Self-Care Deficit: Specify r/t pain with movement, damage to joints

Readiness for Enhanced Knowledge: expresses an interest in learning

See JRA (Juvenile Rheumatoid Arthritis)

Arthrocentesis

Acute Pain r/t invasive procedure

Arthroplasty (Total Hip Replacement)

See Total Joint Replacement (Total Hip/Total Knee/Shoulder); Surgery, Perioperative Care; Surgery, Postoperative Care; Surgery, Preoperative Care

Arthroscopy

Impaired Physical Mobility r/t surgical trauma of knee

Readiness for Enhanced Knowledge: expresses an interest in learning

Ascites

Ineffective Breathing Pattern r/t increased abdominal girth

Imbalanced Nutrition: Less than Body Requirements r/t loss of appetite

Chronic Pain r/t altered body function

Readiness for Enhanced Knowledge: expresses an interest in learning

See Ascites; Cancer; Cirrhosis

Asperger's Syndrome

Ineffective Relationship r/t poor communication skills, lack of empathy

See Autism

Asphyxia, Birth

Ineffective Breathing Pattern r/t depression of breathing reflex secondary to anoxia

Ineffective Coping r/t uncertainty of child outcome

Fear (Parental) r/t concern over safety of infant

Impaired Gas Exchange r/t poor placental perfusion, lack of initiation of breathing by newborn

Maladaptive Grieving r/t loss of perfect child, concern of loss of future abilities

Impaired Spontaneous Ventilation r/t brain injury

Risk for Impaired Attachment: Risk factors: ill infant who is unable to initiate parental contact, hospitalization in critical care environment

Risk for Delayed Child Development: Risk factors: lack of oxygen to brain

Risk for Disorganized Infant Behavior: Risk factor: lack of oxygen to brain

Risk for Injury: Risk factor: lack of oxygen to brain

Risk for Ineffective Cerebral Tissue Perfusion: Risk factor: poor placental perfusion or cord compression resulting in lack of oxygen to brain

Aspiration, Danger of

Risk for Aspiration (See **Aspiration, Risk for,** Section III)

Assault Victim

Post-Trauma Syndrome r/t assault

Rape-Trauma Syndrome r/t rape

Impaired Resilience r/t frightening experience, post-trauma stress response

Risk for Post-Trauma Syndrome: Risk factors: perception of event, inadequate social support, unsupportive environment, diminished ego strength, duration of event

Risk for Spiritual Distress: Risk factors: physical, psychological stress

Assaultive Client

Risk for Injury: Risk factors: confused thought process, impaired judgment

Risk for Other-Directed Violence: Risk factors: paranoid ideation, anger

Asthma

Decreased Activity Tolerance r/t fatigue, energy shift to meet muscle needs for breathing to overcome airway obstruction

Ineffective Airway Clearance r/t tracheobronchial narrowing, excessive secretions

Anxiety r/t inability to breathe effectively, fear of suffocation

Disturbed Body Image r/t decreased participation in physical activities

Ineffective Breathing Pattern r/t anxiety

Ineffective Coping r/t personal vulnerability to situational crisis

Ineffective Health Self-Management (See **Health Management, Ineffective,** Section III)

Ineffective Home Maintenance Behaviors r/t deficient knowledge regarding control of environmental triggers

Sleep Deprivation r/t ineffective breathing pattern, cough

Readiness for Enhanced Health Self-Management (See **Health Self-Management, Readiness for Enhanced,** Section III)

Readiness for Enhanced Knowledge: expresses an interest in learning

See Child with Chronic Condition; Hospitalized Child

Ataxia

Anxiety r/t change in health status

Disturbed Body Image r/t staggering gait

Impaired Physical Mobility r/t neuromuscular impairment

Risk for Falls: Risk factors: gait alteration, instability

Atelectasis

Ineffective Breathing Pattern r/t loss of functional lung tissue, depression of respiratory function or hypoventilation because of pain

Impaired Gas Exchange r/t decreased alveolar-capillary surface

Anxiety r/t alteration in respiratory pattern

See Atelectasis

Atherosclerosis

See MI (Myocardial Infarction); CVA (Cerebrovascular Accident); Peripheral Vascular Disease (PVD)

Athlete's Foot

Impaired Skin Integrity r/t effects of fungal agent

Readiness for Enhanced Knowledge: expresses an interest in learning

See Pruritus

ATN (Acute Tubular Necrosis)

See Renal Failure

Atrial Fibrillation

See Dysrhythmia

Atrial Septal Defect

See Congenital Heart Disease/Cardiac Anomalies

Attention Deficit Disorder

Risk-Prone Health Behavior r/t intense emotional state

Disabled Family Coping r/t significant person with chronically unexpressed feelings of guilt, anxiety, hostility, and despair

Ineffective Impulse Control (See **Impulse Control, Ineffective,** Section III)

Chronic Low Self-Esteem r/t difficulty in participating in expected activities, poor school performance

Social Isolation r/t unacceptable social behavior

Risk for Delayed Child Development: Risk factor: behavior disorders

Risk for Falls: Risk factor: rapid non-thinking behavior

Risk for Loneliness: Risk factor: social isolation

Risk for Impaired Parenting: Risk factor: lack of knowledge of factors contributing to child's behavior

Risk for Spiritual Distress: Risk factor: poor relationships

Autism

Impaired Verbal Communication r/t speech and language delays

Compromised Family Coping r/t parental guilt over etiology of disease, inability to accept or adapt to child's condition, inability to help child and other family members seek treatment

Disturbed Personal Identity r/t inability to distinguish between self and environment, inability to identify own body as separate from those of other people, inability to integrate concept of self

Self-Neglect r/t impaired socialization

Impaired Social Interaction r/t communication barriers, inability to relate to others, failure to develop peer relationships

Risk for Delayed Child Development: Risk factor: autism

Risk for Disturbed Family Identity Syndrome: Risk factor: excessive stress

Risk for Loneliness: Risk factor: difficulty developing relationships with other people

Risk for Self-Mutilation: Risk factor: autistic state

Risk for Other-Directed Violence: Risk factors: frequent destructive rages toward others secondary to extreme response to changes in routine, fear of harmless things

Risk for Self-Directed Violence: Risk factors: frequent destructive rages toward self, secondary to extreme response to changes in routine, fear of harmless things

See Child with Chronic Condition

Autonomic Dysreflexia

Autonomic Dysreflexia r/t bladder distention, bowel distention, noxious stimuli

Risk for Autonomic Dysreflexia: Risk factors: bladder distention, bowel distention, noxious stimuli

Autonomic Hyperreflexia

See Autonomic Dysreflexia

B

Baby Care

Readiness for Enhanced Childbearing Process: demonstrates appropriate feeding and baby care techniques, along with attachment to infant and providing a safe environment

Anxiety r/t situational crisis, back injury

Ineffective Coping r/t situational crisis, back injury

Impaired Physical Mobility r/t pain

Acute Pain r/t back injury

Chronic Pain r/t back injury

Risk for Constipation: Risk factors: decreased activity, side effect of pain medication

Risk for Disuse Syndrome: Risk factor: severe pain

Readiness for Enhanced Knowledge: expresses an interest in learning

Bacteremia

Risk for Infection: Risk factor: compromised immune system

Risk for Shock: Risk factor: development of systemic inflammatory response from presence of bacteria in bloodstream