Nursing diagnoses

Nursing diagnosis is part of the nursing process . We must find the real and expected needs and problems of the patient. Discuss them with the patient if possible and work out the order of their urgency. Based on this, we will make a nursing plan.

Classification of nursing diagnoses

The North American Association for Nursing Diagnosis International (North American Association for Nursing Diagnosis International) created the NANDA domain diagnostic system. This system contains the names of nursing diagnoses. These are combined in the international classification of nursing diagnoses NANDA - International. These nursing diagnoses are divided into so-called diagnostic domains - circuits/areas and further into so-called classes..

Establishing a nursing diagnosis must be based on the anamnesis. The concept of the **NANDA domain system** is holistic and follows the individual in all areas of personality and life. The diagnostic domains follow Gordon's functional and dysfunctional patterns of health (valid since 2000). Domains declare the inclusion of client problems in 13 unmistakable areas. The domains offer nursing diagnoses (problems) that could appear in the client when their needs are not being met. Domains are divided into **classes** and each class defines the client's problems or nursing diagnoses that could occur in one of his human needs. If any of the client's human needs are not within the norm corresponding to age, development and culture, we speak of a nursing problem or a nursing diagnosis. Each nursing diagnosis is determined by so-called diagnostic elements: **numerical code** , **definition** , defining features, related or risk factors.[1]

We divide diagnoses into three basic groups:

- **current** – when the dysfunction of a need is determined, e.g. acute pain, functional urinary incontinence, etc.,
- **potencial** – the client is at risk of a possible nursing problem, e.g. risk of constipation, risk of infection,
- **educational** – to support health, when no dysfunctions are proven, but with education and support we can improve the condition, the client behaves appropriately, but improvement can be achieved, e.g. willingness to improve the treatment regimen, willingness to improve nutrition. When creating nursing diagnoses, we always proceed according to the given scheme, which differs for each group. [2]

Diagnostic domains

According to the NANDA system, we distinguish the following '*13 diagnostic domains:*

1. *Health support* (**class:** health management)
2. *Nutrition* (**class:** food intake, hydration)
3. *Excretion and exchange* (**class:** urinary excretion, gastrointestinal function, respiratory function)
4. *Activity, rest* (**class:** sleep - rest, activity - movement, energy balance, cardiopulmonary response, self-care)
5. *Perception/cognition* (**class:** attention, orientation, hearing - perception, cognition, communication)
6. *Self-perception* (**class:** self-concept, self-esteem, body image)
7. *Relationships* (**class:** caregiver roles, family relationships, role performance)
8. *Sexuality* (**class:** sexual function)
9. *Coping, stress resistance* (**class:** post-traumatic response, coping response, neurobehavioral stress)
10. *Life principle* (**class:** beliefs, alignment of values/beliefs and actions)
11. *Safety/Protection* (**class:** infection, bodily harm, violence, environmental hazards, defense processes, thermoregulation)
12. *Comfort* (**class:** physical comfort, social comfort)
13. *Growth, development* (**class:** growth, development)

Standardized names of nursing diagnoses according to NANDA

Numerical codes and names.

1. Health promotion

00078 Ineffective treatment regimen
00099 Inefficient health support
00080 Ineffective family treatment regimen
00081 Ineffective community healing mode
00082 Effective treatment regimen
00162 Willingness to improve treatment regimen
00084 Seeking for a healthy lifestyle
00163 Willingness to improve nutrition<br

2. Nutrition

00107 Inefficient infant feeding
00103 Impaired swallowing
00002 Undernutrition
00001 Overnutrition
00003 Risk of overnutrition
00027 Deficiency of body fluids
00026 Increased volume of body fluids
00028 Risk of body fluid deficit
00025 Risk of imbalanced body fluid volume
00160 Willingness to improve fluid balance

3. Exclusion and Exchange

00016 Impaired voiding of urine
00021 Complete urinary incontinence
00023 Urinary retention
00020 Functional urinary incontinence
00017 Stress Urinary Incontinence
00018 Reflex urinary incontinence
00019 Urgent urinary incontinence
00022 Risk of Urinary Urinary Incontinence
00166 Willingness to improve urination

00014 Faecal incontinence
00013 Diarrhea
00011 Constipation
00012 Habitual constipation
00015 Risk of constipation

00030 Violated gas exchange

4. Activity, rest

00095 Disturbed sleep
00096 Sleep deprivation
00165 Willingness to improve sleep

00085 Impaired mobility
00091 Impaired mobility in bed
00089 Impaired control of the mobile cart
00090 Impaired ability to move
00088 Broken walk
00097 Lack of interest activities
00100 Delayed postoperative recovery
00168 Sedentary lifestyle
00040 Risk of immobilization syndrome

00050 Violated internal energy
00093 Fatigue

00029 Decreased cardiac output
00033 Weakened breathing
00032 Inefficient breathing
00092 Activity intolerance
00034 Dysfunctional ventilatory disconnection
00024 Inefficient tissue perfusion
00094 Risk of activity intolerance

00109 Self-care deficit in dressing and grooming
00108 Self-care deficit in bathing and hygiene
00102 Self-care deficit while eating
00110 Deficit in self-care when defecating

5. Perception / Cognition

00123 Neglecting one side of the body

00127 Corrupted interpretation of surroundings
00154 Wandering

00122 Disorder of sensory perception

00126 Deficit knowledge
00128 Acute confusion
00129 Chronic confusion
00131 Damaged memory
00130 Impaired thinking
00161 Willingness to supplement deficient knowledge

00051 Impaired verbal communication
00157 Willingness to improve communication

6. Perception of self

00121 Disrupted personal identity
00125 Helplessness
00124 Hopelessness
00152 Risk of helplessness
00054 Risk of loneliness
00167 Willingness to improve self-concept

00119 Chronically low self-esteem
00120 Situationally low self-esteem
00153 Risk of situationally reduced self-esteem

00118 Distorted body image

7. Relationships

00061 Caregiver overload
00056 Impaired parental role
00062 Risk of caregiver overload
00057 Risk of deteriorating parental role
00164 Willingness to improve the parental role

00060 Disrupted family life
00063 Dysfunctional family life with alcoholism
00058 Risk of weakening the parent-child bond
00159 Willingness to improve family function
00104 Ineffective breastfeeding
00105 Interrupted breastfeeding
00055 Inefficient role performance
00064 Parent role conflict
00052 Impaired social interaction
00106 Effective breastfeeding

8. Sexuality

00059 Sexual Dysfunction
00065 Ineffective sex life

9. Stress management, resistance to stress

00114 Post-Relocation Stress Syndrome
00142 Post-Rape Trauma Syndrome
00144 Silent Post-Rape Trauma Syndrome
00143 Mixed Rape Trauma Syndrome
00141 Post-Traumatic Syndrome
00149 Risk of Post-Relocation Stress Syndrome
00145 Risk of Post-Traumat Syndrome

00148 Fear
00146 Anxiety
00147 Death Anxiety
00137 Chronic Grief
00072 Inefficient denial
00070 Weakened customization
00069 Inefficient load handling
00071 Defensive load handling
00136 Anticipatory Grief
00135 Dysfunctional grief
00073 Family Inability to Cope
00074 Threatening coping with family
00077 Ineffective coping with the situation in the community
00172 Risk of dysfunctional sadness

00158 Willingness to improve workload management
00075 Willingness of a close person to handle the load better
00076 Community willingness to improve burden management

00009 Autonomic dysreflexia
00116 Disturbed child behavior
00049 Reduced intracranial adaptive capacity
00010 Risk of autonomic dysreflexia
00115 Risk of disturbed child behavior
00117 Possible improvement in child behavior

10. Life Principle

00068 Willingness to improve spiritual well-being

00066 Spiritual Distress
00083 Conflict in decision making
00079 Non-compliance
00169 Violated religiosity
00067 Risk of spiritual distress
00170 Risk of violation of religiosity
00171 Willingness to improve religiosity

11. Safety/Security

00004 Risk of infection

00045 Damaged oral mucosa
00046 Damaged skin integrity
00044 Damaged tissue integrity
00048 Damaged dentition
00031 Ineffective airway patency
00043 Ineffective resistance
00035 Risk of damage
00087 Risk of perioperative damage
00155 Risk of falls
00047 Risk of violation of skin integrity
00039 Risk of aspiration
00156 Risk of sudden infant death syndrome
00038 Risk of trauma
00036 Risk of suffocation
00086 Risk of peripheral neurovascular dysfunction

00151 Self-harm
00139 Risk of self harm
00138 Risk of violence towards others
00140 Risk of violence towards self
00150 Risk of suicide

00037 Risk of intoxication

00041 Allergic reaction to latex
00042 Risk of allergic reaction to latex

00008 Inefficient thermoregulation
00006 Hypothermia
00007 Hyperthermia
00005 Risk of body temperature imbalance

12. Comfort

00132 Acute pain
00133 Chronic Pain
00134 Nausea

00053 Social Isolation

13. Growth, development

00101 Failure to thrive in an adult
00113 Risk of uneven growth

00111 Delayed growth and development
00112 Risk of delayed development

Example of nursing diagnosis according to NANDA in practice

Number Code and Name of Nursing Diagnosis:
00136 Mourning
Definition:
A normal, complex process that includes emotional, physical, spiritual, social, and intellectual responses and behaviors by which individuals, families, and communities integrate actual, anticipated, and/or perceived loss into their daily lives.
Determining characters:
altered activity, changes in sleep, impaired immunity, anger, blame, despair, distance, finding meaning in loss, guilt arising from a sense of relief, maintaining contact with the deceased, pain, panicked behavior, personal growth
Reason and Manifestation:
Mourning due to the loss of a loved one, manifested by self-blame and tearfulness.
Goal:
- support the grieving process
- educate about the grieving process
Priority:
- medium
Outcome Criteria:
- the patient is not afraid to turn to us for psychological support
- the patient goes through the grieving process
Intervention:
- empathically approach the grieving person
- find out the cause of mourning
- educate the patient about the grieving process
- support the grieving process
- monitor possible pathologies in the grieving process
- report pathological grief to doctors

Links

Related Articles

- Nursing Process

Recommended reading

Examples of other nursing diagnoses according to NANDA can be found here:

- MAREČKOVÁ, John. *Nursing diagnoses in NANDA domains.* First edition. Grada, 2006. 264 pp. ISBN 80-247-1399-3.
- INTERNATIONAL, NANDA. *Nursing diagnoses : Definition and classification 2015-2017.* First edition. Grada, 2016. 464 pp. ISBN 9788024754123.

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Reference

1. HIGHER VOCATIONAL MEDICAL SCHOOL AND SECONDARY MEDICAL SCHOOL,. *Nursing care planning multimedia trainer: Characteristics of the nursing process* [online]. Hradec Králové, ©2008. [cit. 2019-03-10]. <https://ose.zshk.cz/projekt/o-projektu.aspx>.
2. HEALTHCARE AND MEDICINE,. *NANDA taxonomie II* [online]. [cit. 2019-03-10]. <https://zdravi.euro.cz/clanek/sestra/nanda-taxonomie-ii-448158>.