

GORDON'S FUNCTIONAL HEALTH PATTERNS*

HEALTH PERCEPTION-HEALTH MANAGEMENT PATTERN

- Health-seeking behaviors (specify) 291–293
- Ineffective health maintenance 287–291
- Ineffective therapeutic regimen management 550–553
- Effective therapeutic regimen management 543–545
- Ineffective family therapeutic regimen management 547–550
- Ineffective community therapeutic regimen management 545–547
- Readiness for enhanced therapeutic regimen management 553–555
- Noncompliance (specify) 365–369
- Risk for infection 322–325
- Risk for injury (trauma) 325–328 [this refers to 2 NDs]
- Risk for falls 226–230
- Risk for perioperative positioning injury 328–331
- Risk for poisoning 410–413
- Risk for suffocation 528–531
- Ineffective protection 428–429
- Disturbed energy field 217–220
- Sudden infant death syndrome 194–198

NUTRITIONAL-METABOLIC PATTERN

- Imbalanced nutrition: more than body requirements 374–378
- Risk for imbalanced nutrition: more than body requirements 378–381
- Imbalanced nutrition: less than body requirements 369–374
- Readiness for enhanced nutrition 381–384
- Adult failure to thrive 223–226
- Ineffective breastfeeding 123–126
- Interrupted breastfeeding 120–123
- Effective breastfeeding 113–115
- Ineffective infant feeding pattern 319–322
- Impaired swallowing 538–542
- Nausea 358–362
- Risk for aspiration 91–94
- Impaired oral mucous membrane 384–388
- Impaired dentition 200–203
- Deficient fluid volume 252–258
- Risk for deficient fluid volume 261–263
- Excess fluid volume, 258–261
- Risk for imbalanced fluid volume 263–266
- Readiness for enhanced fluid balance 248–251
- Impaired skin integrity 487–492

- Risk for impaired skin integrity 492–495
- Impaired tissue integrity (specify type) 561–565
- Latex allergy response 77–80
- Risk for latex allergy response 80–82
- Ineffective thermoregulation 555–557
- Hyperthermia 299–303
- Hypothermia 303–307
- Risk for imbalanced body temperature 108–109

ELIMINATION PATTERN

- Constipation 162–167
- Risk for constipation 167–170
- Diarrhea 206–210
- Bowel incontinence 110–113
- Impaired urinary elimination 579–583
- Readiness for enhanced urinary elimination, 583–585
- Functional urinary incontinence 586–588
- Reflex urinary incontinence 589–591
- Stress urinary incontinence 594–596
- Urge urinary incontinence 599–602
- Risk for urge urinary incontinence 591–593
- Total urinary incontinence 597–599
- Urinary retention 603–606

ACTIVITY-EXERCISE PATTERN

- Activity intolerance 65–68
- Risk for activity intolerance 68–70
- Fatigue 241–245
- Deficient diversional activity 214–217
- Impaired physical mobility 352–356
- Impaired bed mobility 350–352
- Impaired transfer ability 572–574
- Impaired wheelchair mobility 356–358
- Impaired walking 622–623
- Wandering 624–627
- Risk for disuse syndrome 210–214
- Self-care deficit (specify: bathing/hygiene, dressing/grooming, feeding, toileting) 451–456
- Delayed surgical recovery 535–538
- Delayed growth and development 283–287
- Risk for delayed development 203–206
- Risk for disproportionate growth, 279–282
- Impaired home maintenance 293–296
- Dysfunctional ventilatory weaning response 611–615
- Impaired spontaneous ventilation 606–611
- Ineffective airway clearance 74–77
- Impaired gas exchange 266–270
- Decreased cardiac output 126–131

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Ineffective tissue perfusion (specify) 565–572
Autonomic dysreflexia 97–100
Risk for autonomic dysreflexia 100–103
Disorganized infant behavior 310–316
Risk for disorganized infant behavior 318–319
Readiness for enhanced organized infant behavior 316–318
Risk for peripheral neurovascular dysfunction 407–410
Decreased intracranial adaptive capacity 331–334
Sedentary lifestyle 342–346

SLEEP-REST PATTERN

Disturbed sleep pattern 502–507
Sleep deprivation 498–502
Readiness for enhanced sleep 495–497

COGNITIVE-PERCEPTUAL PATTERN

Acute pain 388–392
Chronic pain 392–396
Disturbed sensory perception (specify) 475–480
Unilateral neglect 362–365
Deficient knowledge (specify) 334–338
Readiness for enhanced knowledge (specify) 338–340
Disturbed thought processes 557–561
Acute confusion 156–159
Chronic confusion 159–161
Impaired environmental interpretation syndrome 220–223
Impaired memory 347–349
Decisional conflict (specify) 149–152

SELF-PERCEPTION-SELF-CONCEPT PATTERN

Fear 245–248
Anxiety 82–88
Death anxiety 88–91
Risk for loneliness 344–347
Hopelessness 296–299
Powerlessness 421–425
Risk for powerlessness 425–428
Readiness for enhanced self-concept 456–459
Situational low self-esteem 463–466
Risk for situational low self-esteem 466–468
Chronic low self-esteem 459–463
Body image disturbed 103–107
Disturbed personal identity 307–310
Risk for violence, self-directed 616–621

ROLE-RELATIONSHIP PATTERN

Anticipatory grieving 270–273
Dysfunctional grieving 273–276
Risk for dysfunctional grieving 276–279

Chronic sorrow 514–516
Ineffective role performance 448–451
Social isolation 511–514
Impaired social interaction 507–511
Relocation stress syndrome 443–446
Risk for relocation stress syndrome 446–447
Interrupted family processes 234–237
Dysfunctional family processes: alcoholism 230–234
Readiness for enhanced family processes 237–241
Impaired parenting 396–401
Risk for impaired parenting 405–406
Readiness for enhanced parenting 401–404
Parental role conflict 153–155
Risk for impaired parent/infant/child attachment 94–97
Caregiver role strain 132–137
Risk for caregiver role strain 137–140
Impaired verbal communication 141–145
Readiness for enhanced communication 145–149
Risk for other-directed violence 615–616

SEXUALITY-REPRODUCTIVE

Ineffective sexuality pattern 484–487
Sexual dysfunction 480–484
Rape-trauma syndrome 429–435

COPING-STRESS TOLERANCE PATTERN

Ineffective coping 180–184
Readiness for enhanced coping 186–189
Defensive coping 173–176
Compromised family coping 170–173
Disabled family coping 176–179
Readiness for enhanced family coping 192–194
Ineffective community coping 184–186
Readiness for enhanced community coping 189–192
Ineffective denial 198–200
Impaired adjustment 70–74
Post-trauma syndrome 413–418
Risk for post-trauma syndrome 419–421
Risk for suicide 531–535
Self-mutilation 468–472
Risk for self-mutilation 472–475

VALUE-BELIEF PATTERN

Impaired religiosity 435–438
Risk for impaired religiosity 440–443
Readiness for enhanced religiosity 438–440
Spiritual distress 517–521
Risk for spiritual distress 521–524
Readiness for enhanced spiritual well-being, 524–528

Nurse's Pocket Guide

Diagnoses, Prioritized
Interventions, and Rationales

Nurse's Pocket Guide

Diagnoses, Prioritized Interventions, and Rationales

EDITION 10

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Marilynn E. Doenges
Mary Frances Moorhouse
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Contents

Health Conditions and Client Concerns with Associated Nursing Diagnoses appear on pages 628-754.

How to Use the Nurse's Pocket Guidevii

CHAPTER 1

The Nursing Process1

CHAPTER 2

Application of the Nursing Process7

CHAPTER 3

Putting Theory into Practice: Sample Assessment Tools, Plan of Care, Mind Mapping, and Documentation16

SECTION 1

Assessment Tools for Choosing Nursing Diagnoses19

Adult Medical/Surgical Assessment Tool20

Excerpt from Psychiatric Assessment Tool30

Excerpt from Prenatal Assessment Tool33

Excerpt from Intrapartal Assessment Tool35

SECTION 2

Diagnostic Divisions: Nursing Diagnoses Organized According to a Nursing Focus.....37

SECTION 3

Client Situation and Prototype Plan of Care43

Another Approach to Planning Client

Care—Mind Mapping58

SECTION 4

Documentation Techniques: SOAP and Focus Charting®60

CHAPTER 4

Nursing Diagnoses in Alphabetical Order65

For each nursing diagnosis, the following information is provided:

Taxonomy II, Domain, Class, Code, Year Submitted

Diagnostic Division
Definition
Related/Risk Factors, Defining Characteristics:
Subjective/Objective
Desired Outcomes/Evaluation Criteria
Actions/Interventions
Nursing Priorities
Documentation Focus
Sample Nursing Outcomes & Interventions Classifications
(NOC/NIC)

CHAPTER 5

**Health Conditions and Client Concerns with Associated
Nursing Diagnoses628**

APPENDIX 1

NANDA's Taxonomy II755

APPENDIX 2

Definitions of Taxonomy II Axes759

BIBLIOGRAPHY **762**

INDEX **773**

How to Use the Nurse's Pocket Guide

The American Nurses Association (ANA) Social Policy Statement of 1980 was the first to define nursing as the diagnosis and treatment of human responses to actual and potential health problems. This definition, when combined with the ANA Standards of Practice, has provided impetus and support for the use of nursing diagnosis. Defining nursing and its effect on client care supports the growing awareness that nursing care is a key factor in client survival and in the maintenance, rehabilitative, and preventive aspects of healthcare. Changes and new developments in healthcare delivery in the last decade have given rise to the need for a common framework of communication to ensure continuity of care for the client moving between multiple healthcare settings and providers. Evaluation and documentation of care are important parts of this process.

This book is designed to aid the practitioner and student nurse in identifying interventions commonly associated with specific nursing diagnoses as proposed by NANDA International (formerly the North American Nursing Diagnosis Association). These interventions are the activities needed to implement and document care provided to the individual client and can be used in varied settings from acute to community/home care.

Chapters 1 and 2 present brief discussions of the nursing process, data collection, and care plan construction. Chapter 3 contains the Diagnostic Divisions, Assessment Tool, a sample plan of care, mind map, and corresponding documentation/charting examples. For more in-depth information and inclusive plans of care related to specific medical/psychiatric conditions (with rationale and the application of the diagnoses), the nurse is referred to the larger works, all published by the F.A. Davis Company: *Nursing Care Plans Across the Life Span*, ed. 7 (Doenges, Moorhouse, Geissler-Murr, 2006); *Psychiatric Care Plans: Guidelines for Individualizing Care*, ed. 3 (Doenges, Townsend, Moorhouse, 1998); and *Maternal/Newborn Plans of Care: Guidelines for Individualizing Care*, ed. 3 (Doenges, Moorhouse, 1999) with updated versions included on the CD-ROM provided with *Nursing Care Plans*.

Nursing diagnoses are listed alphabetically in Chapter 4 for ease of reference and include the diagnoses accepted for use by NANDA through 2005–2006. Each diagnosis approved for testing includes its definition and information divided into the NANDA categories of Related or Risk Factors and Defining Characteristics. Related/Risk Factors information reflects causative or contributing factors that can be useful for determining whether the diagnosis is applicable to a particular client. Defining Characteristics (signs and symptoms or cues) are listed as subjective and/or objective and are used to confirm actual diagnoses, aid in formulating outcomes, and provide additional data for choosing appropriate interventions. The authors have not deleted or altered NANDA's listings; however, on occasion, they have added to their definitions and suggested additional criteria to provide clarification and direction. These additions are denoted with brackets [].

With the development and acceptance of Taxonomy II following the biennial conference in 2000, significant changes were made to better reflect the content of the diagnoses within the taxonomy. Taxonomy II was designed to reduce miscalculations, errors, and redundancies. The framework has been changed from the Human Response Patterns and is organized in Domains and Classes, with 13 domains, 47 classes, and 172 diagnoses. Although clinicians will use the actual diagnoses, understanding the taxonomic structure will help the nurse to find the desired information quickly. Taxonomy II is designed to be multiaxial with 7 axes (see Appendix 2). An axis is defined as a dimension of the human response that is considered in the diagnostic process. Sometimes an axis may be included in the diagnostic concept, such as ineffective community Coping, in which the unit of care (e.g., community) is named. Some are implicit, such as Activity Intolerance, in which the individual is the unit of care. Sometimes an axis may not be pertinent to a particular diagnosis and will not be a part of the nursing diagnosis label or code. For example, the time axis may not be relevant to each diagnostic situation. The Taxonomic Domain and Class are noted under each nursing diagnosis heading. An Axis 6 descriptor is included in each nursing diagnosis label.

The ANA, in conjunction with NANDA, proposed that specific nursing diagnoses currently approved and structured according to Taxonomy I Revised be included in the International Classification of Diseases (ICD) within the section "Family of Health-Related Classifications." While the World Health Organization did not accept this initial proposal because of lack of documentation of the usefulness of nursing diagnoses at the international level, the NANDA list

has been accepted by SNOMED (Systemized Nomenclature of Medicine) for inclusion in its international coding system and is included in the Unified Medical Language System of the National Library of Medicine. Today, researchers from around the world are validating nursing diagnoses in support for resubmission and acceptance in future editions of ICD.

The authors have chosen to categorize the list of nursing diagnoses approved for clinical use and testing into Diagnostic Divisions, which is the framework for an assessment tool (Chapter 3) designed to assist the nurse to readily identify an appropriate nursing diagnosis from data collected during the assessment process. The Diagnostic Division label follows the Taxonomic label under each nursing diagnosis heading.

Desired Outcomes/Evaluation Criteria are identified to assist the nurse in formulating individual client outcomes and to support the evaluation process.

Interventions in this pocket guide are primarily directed to adult care settings (although general age span considerations are included) and are listed according to nursing priorities. Some interventions require collaborative or interdependent orders (e.g., medical, psychiatric), and the nurse will need to determine when this is necessary and take the appropriate action. Although all defining characteristics are listed, interventions that address specialty areas outside the scope of this book are not routinely presented (e.g., obstetrics/gynecology/pediatrics) except for diagnoses that are infancy-oriented, such as ineffective Breastfeeding, disorganized infant Behavior, and risk for impaired parent/infant/child Attachment. For example, when addressing deficient [isotonic] Fluid Volume, (hemorrhage), the nurse is directed to stop blood loss; however, specific direction to perform fundal massage is not listed.

The inclusion of Documentation Focus suggestions is to remind the nurse of the importance and necessity of recording the steps of the nursing process.

Finally, in recognition of the ongoing work of numerous researchers over the past 15 years, the authors have referenced the Nursing Interventions and Outcomes labels developed by the Iowa Intervention Projects (Bulechek & McCloskey; Johnson, Mass & Moorhead). These groups have been classifying nursing interventions and outcomes to predict resource requirements and measure outcomes, thereby meeting the needs of a standardized language that can be coded for computer and reimbursement purposes. As an introduction to this work in progress, sample NIC and NOC labels have been included under the heading Sample Nursing Interventions & Outcomes Classifications at the conclusion of each nursing diagnosis section. The reader is referred to the various publica-

tions by Joanne C. McCloskey and Marion Johnson for more in-depth information.

Chapter 5 presents over 400 disorders/health conditions reflecting all specialty areas, with associated nursing diagnoses written as client diagnostic statements that include the “related to” and “evidenced by” components. This section will facilitate and help validate the assessment and problem/need identification steps of the nursing process.

As noted, with few exceptions, we have presented NANDA’s recommendations as formulated. We support the belief that practicing nurses and researchers need to study, use, and evaluate the diagnoses as presented. Nurses can be creative as they use the standardized language, redefining and sharing information as the diagnoses are used with individual clients. As new nursing diagnoses are developed, it is important that the data they encompass are added to the current database. As part of the process by clinicians, educators, and researchers across practice specialties and academic settings to define, test, and refine nursing diagnosis, nurses are encouraged to share insights and ideas with NANDA at the following address: NANDA International, 100 N. 20th Street, 4th Floor, Philadelphia, PA 19103, USA; e-mail: info@nanda.org

The Nursing Process

Nursing is both a science and an art concerned with the physical, psychological, sociological, cultural, and spiritual concerns of the individual. The science of nursing is based on a broad theoretical framework; its art depends on the caring skills and abilities of the individual nurse. In its early developmental years, nursing did not seek or have the means to control its own practice. In more recent times, the nursing profession has struggled to define what makes nursing unique and has identified a body of professional knowledge unique to nursing practice. In 1980, the American Nurses Association (ANA) developed the first *Social Policy Statement* defining nursing as “the diagnosis and treatment of human responses to actual or potential health problems.” Along with the definition of nursing came the need to explain the method used to provide nursing care.

Thus, years ago, nursing leaders developed a problem-solving process consisting of three steps—assessment, planning, and evaluation—patterned after the scientific method of observing, measuring, gathering data, and analyzing findings. This method, introduced in the 1950s, was called *nursing process*. Shore (1988) described the nursing process as “combining the most desirable elements of the art of nursing with the most relevant elements of systems theory, using the scientific method.” This process incorporates an interactive/interpersonal approach with a problem-solving and decision-making process (Peplau, 1952; King, 1971; Yura & Walsh, 1988).

Over time, the nursing process expanded to five steps and has gained widespread acceptance as the basis for providing effective nursing care. Nursing process is now included in the conceptual framework of all nursing curricula, is accepted in the legal definition of nursing in the *Nurse Practice Acts* of most states, and is included in the ANA *Standards of Clinical Nursing Practice*.

The five steps of the nursing process consist of the following:

1. **Assessment** is an organized dynamic process involving three basic activities: a) systematically gathering data, b) sorting and organizing the collected data, and c) documenting the data in a retrievable fashion. Subjective and objective data are collected from various sources, such as the client

interview and physical assessment. Subjective data are what the client or significant others report, believe, or feel, and objective data are what can be observed or obtained from other sources, such as laboratory and diagnostic studies, old medical records, or other healthcare providers. Using a number of techniques, the nurse focuses on eliciting a profile of the client that supplies a sense of the client's overall health status, providing a picture of the client's physical, psychological, sociocultural, spiritual, cognitive, and developmental levels; economic status; functional abilities; and lifestyle. The profile is known as the *client database*.

- 2. *Diagnosis/need identification*** involves the analysis of collected data to identify the client's needs or problems, also known as the nursing diagnosis. The purpose of this step is to draw conclusions regarding the client's specific needs or human responses of concern so that effective care can be planned and delivered. This process of data analysis uses diagnostic reasoning (a form of clinical judgment) in which conclusions are reached about the meaning of the collected data to determine whether or not nursing intervention is indicated. The end product is the *client diagnostic statement* that combines the specific client need with the related factors or risk factors (etiology), and defining characteristics (or cues) as appropriate. The status of the client's needs are categorized as *actual* or currently existing diagnoses and potential or *risk* diagnoses that could develop due to specific vulnerabilities of the client. Ongoing changes in healthcare delivery and computerization of the client record require a commonality of communication to ensure continuity of care for the client moving from one setting/level of healthcare to another. The use of standardized terminology or NANDA International nursing diagnosis labels provides nurses with a common language for identifying client needs. Furthermore, the use of standardized nursing diagnosis labels also promotes identification of appropriate goals, provides acuity information, is useful in creating standards for nursing practice, provides a base for quality improvement, and facilitates research supporting evidence-based nursing practices.
- 3. *Planning*** includes setting priorities, establishing goals, identifying desired client outcomes, and determining specific nursing interventions. These actions are documented as the *plan of care*. This process requires input from the client/significant others to reach agreement regarding the plan to facilitate the client taking responsibility for his or her own care and the achievement of the desired outcomes and goals.

Setting priorities for client care is a complex and dynamic challenge that helps ensure that the nurse's attention and subsequent actions are properly focused. What is perceived today to be the number one client care need or appropriate nursing intervention could change tomorrow, or, for that matter, within minutes, based on changes in the client's condition or situation. Once client needs are prioritized, goals for treatment and discharge are established that indicate the general direction in which the client is expected to progress in response to treatment. The goals may be short-term—those that usually must be met before the client is discharged or moved to a lesser level of care—and/or long-term, which may continue even after discharge. From these goals, desired outcomes are determined to measure the client's progress toward achieving the goals of treatment or the discharge criteria. To be more specific, outcomes are client responses that are achievable and desired by the client that can be attained within a defined period, given the situation and resources. Next, nursing interventions are chosen that are based on the client's nursing diagnosis, the established goals and desired outcomes, the ability of the nurse to successfully implement the intervention, and the ability and the willingness of the client to undergo or participate in the intervention, and they reflect the client's age/situation and individual strengths, when possible. Nursing interventions are direct-care activities or prescriptions for behaviors, treatments, activities, or actions that assist the client in achieving the measurable outcomes. Nursing interventions, like nursing diagnoses, are key elements of the knowledge of nursing and continue to grow as research supports the connection between actions and outcomes (McCloskey & Bulechek, 2000). Recording the planning step in a written or computerized plan of care provides for continuity of care, enhances communication, assists with determining agency or unit staffing needs, documents the nursing process, serves as a teaching tool, and coordinates provision of care among disciplines. A valid plan of care demonstrates individualized client care by reflecting the concerns of the client and significant others, as well as the client's physical, psychosocial, and cultural needs and capabilities.

4. **Implementation** occurs when the plan of care is put into action, and the nurse performs the planned interventions. Regardless of how well a plan of care has been constructed, it cannot predict everything that will occur with a particular client on a daily basis. Individual knowledge and expertise and agency routines allow the flexibility that is necessary to

adapt to the changing needs of the client. Legal and ethical concerns related to interventions also must be considered. For example, the wishes of the client and family/significant others regarding interventions and treatments must be discussed and respected. Before implementing the interventions in the plan of care, the nurse needs to understand the reason for doing each intervention, its expected effect, and any potential hazards that can occur. The nurse must also be sure that the interventions are a) consistent with the established plan of care, b) implemented in a safe and appropriate manner, c) evaluated for effectiveness, and d) documented in a timely manner.

5. **Evaluation** is accomplished by determining the client's progress toward attaining the identified outcomes and by monitoring the client's response to/effectiveness of the selected nursing interventions for the purpose of altering the plan as indicated. This is done by direct observation of the client, interviewing the client/significant other, and/or reviewing the client's healthcare record. Although the process of evaluation seems similar to the activity of assessment, there are important differences. Evaluation is an ongoing process, a constant measuring and monitoring of the client status to determine: a) appropriateness of nursing actions, b) the need to revise interventions, c) development of new client needs, d) the need for referral to other resources, and e) the need to rearrange priorities to meet changing demands of care. Comparing overall outcomes and noting the effectiveness of specific interventions are the clinical components of evaluation that can become the basis for research for validating the nursing process and supporting evidenced-based practice. The external evaluation process is the key for refining standards of care and determining the protocols, policies, and procedures necessary for the provision of quality nursing care for a specific situation or setting.

When a client enters the healthcare system, whether as an acute care, clinic, or homecare client, the steps of the process noted above are set in motion. Although these steps are presented as separate or individual activities, the nursing process is an interactive method of practicing nursing, with the components fitting together in a continuous cycle of thought and action.

To effectively use the nursing process, the nurse must possess, and be able to apply, certain skills. Particularly important is a thorough knowledge of science and theory, as applied not only in nursing but also in other related disciplines, such as medicine

and psychology. A sense of caring, intelligence, and competent technical skills are also essential. Creativity is needed in the application of nursing knowledge as well as adaptability for handling constant change in healthcare delivery and the many unexpected happenings that occur in the everyday practice of nursing.

Because decision making is crucial to each step of the process, the following assumptions are important for the nurse to consider:

- The client is a human being who has worth and dignity. This entitles the client to participate in his/her own healthcare decisions and delivery. It requires a sense of the personal in each individual and the delivery of competent healthcare.
- There are basic human needs that must be met, and when they are not, problems arise that may require interventions by others until and if the individual can resume responsibility for self. This requires healthcare providers to anticipate and initiate actions necessary to save another's life or to secure the client's return to health and independence.
- The client has the right to quality health and nursing care delivered with interest, compassion, competence, and a focus on wellness and prevention of illness. The philosophy of caring encompasses all of these qualities.
- The therapeutic nurse-client relationship is important in this process, providing a milieu in which the client can feel safe to disclose and talk about his/her deepest concerns.

The revised *Nursing's Social Policy Statement* (ANA, 1995) acknowledges that since the release of the original statement, nursing has been influenced by many social and professional changes as well as by the science of caring. Nursing has integrated these changes with the 1980 definition to include treatment of human responses to health and illness. The new statement provides four essential features of today's contemporary nursing practice:

- Attention to the full range of human experiences and responses to health and illness without restriction to a problem-focused orientation (in short, clients may have needs for wellness or personal growth that are not "problems" to be corrected)
- Integration of objective data with knowledge gained from an understanding of the client's or group's subjective experience
- Application of scientific knowledge to the process of diagnosis and treatment
- Provision of a caring relationship that facilitates health and healing

Whereas nursing actions were once based on variables such as diagnostic tests and medical diagnoses, use of the nursing process and nursing diagnoses provides a uniform method of identifying and dealing with specific client needs/responses in which the nurse can intervene. The nursing diagnosis is thus helping to set standards for nursing practice and should lead to improved care delivery.

Nursing and medicine are interrelated and have implications for each other. This interrelationship includes the exchange of data, the sharing of ideas/thinking, and the development of plans of care that include all data pertinent to the individual client as well as the family/significant others. Although nurses work within medical and psychosocial domains, nursing's phenomena of concern are the patterns of human response, not disease processes. Thus, the written plan of care should contain more than just nursing actions in response to medical orders and may reflect plans of care encompassing all involved disciplines to provide holistic care for the individual/family.

Summary

Because the nursing process is the basis of all nursing actions, it is the essence of nursing. It can be applied in any healthcare or educational setting, in any theoretical or conceptual framework, and within the context of any nursing philosophy. In using nursing diagnosis labels as an integral part of the nursing process, the nursing profession has identified a body of knowledge that contributes to the prevention of illness as well as to the maintenance/restoration of health (or relief of pain and discomfort when a return to health is not possible).

Subsequent chapters help the nurse applying the nursing processes to review the current NANDA list of nursing diagnoses, their definitions, related/risk factors (etiology), and defining characteristics. Aware of desired outcomes and the most commonly used interventions, the nurse can write, implement, and document an individualized plan of care.

Nursing Diagnoses in Alphabetical Order

Activity Intolerance [specify level]

Taxonomy II: Activity/Rest—Class 4 Cardiovascular/
Pulmonary Responses (00092)
[Diagnostic Division: Activity/Rest]
Submitted 1982

Definition: Insufficient physiological or psychological energy to endure or complete required or desired daily activities

Related Factors

Generalized weakness
Sedentary lifestyle
Bedrest or immobility
Imbalance between oxygen supply and demand
[Cognitive deficits/emotional status; secondary to underlying disease process/depression]
[Pain, vertigo, extreme stress]

Defining Characteristics

SUBJECTIVE

Report of fatigue or weakness
Exertional discomfort or dyspnea
[Verbalizes no desire and/or lack of interest in activity]

OBJECTIVE

Abnormal heart rate or blood pressure response to activity
Electrocardiographic changes reflecting dysrhythmias or ischemia [pallor, cyanosis]

Functional Level Classification (Gordon, 1987):

Level I: Walk, regular pace, on level indefinitely; one flight or more but more short of breath than normally

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



Level II: Walk one city block [or] 500 ft on level; climb one flight slowly without stopping

Level III: Walk no more than 50 ft on level without stopping; unable to climb one flight of stairs without stopping

Level IV: Dyspnea and fatigue at rest

Desired Outcomes/Evaluation Criteria—Client Will:

- Identify negative factors affecting activity tolerance and eliminate or reduce their effects when possible.
- Use identified techniques to enhance activity tolerance.
- Participate willingly in necessary/desired activities.
- Report measurable increase in activity tolerance.
- Demonstrate a decrease in physiological signs of intolerance (e.g., pulse, respirations, and blood pressure remain within client's normal range).

Actions/Interventions

NURSING PRIORITY NO. 1. To identify causative/precipitating factors:



- Note presence of factors contributing to fatigue (e.g., acute or chronic illness, heart failure, hypothyroidism, cancer, and cancer therapies).
- Evaluate current limitations/degree of deficit in light of usual status. (**Provides comparative baseline.**)
- Note client reports of weakness, fatigue, pain, difficulty accomplishing tasks, and/or insomnia.
- Assess cardiopulmonary response to physical activity, including vital signs before, during, and after activity. Note progression/accelerating degree of fatigue.
- Ascertain ability to stand and move about and degree of assistance necessary/use of equipment.
- Identify activity needs versus desires (e.g., is barely able to walk upstairs but would like to play racquetball).
- Assess emotional/psychological factors affecting the current situation (e.g., **stress and/or depression may be increasing the effects of an illness, or depression might be the result of being forced into inactivity**).
- Note treatment-related factors, such as side effects/interactions of medications.

NURSING PRIORITY NO. 2. To assist client to deal with contributing factors and manage activities within individual limits:






- Monitor vital/cognitive signs, watching for changes in blood pressure, heart and respiratory rate; note skin pallor and/or cyanosis, and presence of confusion.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.





- Adjust activities to **prevent overexertion**. Reduce intensity level or discontinue activities that cause undesired physiological changes.
-  • Provide/monitor response to supplemental oxygen and medications and changes in treatment regimen.
- Increase exercise/activity levels gradually; teach methods to **conserve energy**, such as stopping to rest for 3 minutes during a 10-minute walk, sitting down instead of standing to brush hair.
- Plan care with rest periods between activities to **reduce fatigue**.
- Provide positive atmosphere, while acknowledging difficulty of the situation for the client. (Helps to minimize frustration, rechannel energy.)
- Encourage expression of feelings contributing to/resulting from condition.
- Involve client/SO(s) in planning of activities as much as possible.
- Assist with activities and provide/monitor client's use of assistive devices (crutches, walker, wheelchair, oxygen tank, etc.) to **protect client from injury**.
- Promote comfort measures and provide for relief of pain to **enhance ability to participate in activities**. (Refer to NDs acute or chronic Pain.)
-  • Provide referral to other disciplines as indicated (e.g., exercise physiologist, psychological counseling/therapy, occupational/physical therapists, and recreation/leisure specialists) to **develop individually appropriate therapeutic regimens**.

NURSING PRIORITY NO. 3. To promote wellness (Teaching/Discharge Considerations):

- Plan for maximal activity within the client's ability.
- Review expectations of client/SO(s)/providers to **establish individual goals**. Explore conflicts/differences to **reach agreement for the most effective plan**.
-  • Instruct client/SO(s) in monitoring response to activity and in recognizing signs/symptoms that **indicate need to alter activity level**.
-  • Plan for progressive increase of activity level as client tolerates.
-  • Give client information that provides evidence of daily/weekly progress to **sustain motivation**.
-  • Assist client in learning and demonstrating appropriate safety measures to **prevent injuries**.
-  • Provide information about the effect of lifestyle and overall health factors on activity tolerance (e.g., nutrition, adequate fluid intake, mental health status).

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



-  • Encourage client to maintain positive attitude; suggest use of relaxation techniques, such as visualization/guided imagery as appropriate, **to enhance sense of well-being.**
-  • Encourage participation in recreation/social activities and hobbies appropriate for situation. (Refer to ND deficient Diversional Activity.)

Documentation Focus

ASSESSMENT/REASSESSMENT

- Level of activity as noted in Functional Level Classification.
- Causative/precipitating factors.
- Client reports of difficulty/change.

PLANNING

- Plan of care and who is involved in planning.

IMPLEMENTATION/EVALUATION

- Response to interventions/teaching and actions performed.
- Implemented changes to plan of care based on assessment/reassessment findings.
- Teaching plan and response/understanding of teaching plan.
- Attainment/progress toward desired outcome(s).

DISCHARGE PLANNING

- Referrals to other resources.
- Long-term needs and who is responsible for actions.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Activity Tolerance

NIC—Energy Management

risk for Activity Intolerance

Taxonomy II: Activity/Rest—Class 4 Cardiovascular/
Pulmonary Response (00094)
[Diagnostic Division: Activity/Rest]
Submitted 1982

Definition: At risk of experiencing insufficient physiological or psychological energy to endure or complete required or desired daily activities

Risk Factors

History of previous intolerance

Presence of circulatory/respiratory problems

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



Deconditioned status

Inexperience with the activity

[Diagnosis of progressive disease state/debilitating condition, such as cancer, multiple sclerosis—MS, extensive surgical procedures]

[Verbalized reluctance/inability to perform expected activity]

NOTE: A risk diagnosis is not evidenced by signs and symptoms, as the problem has not occurred and nursing interventions are directed at prevention.

Desired Outcomes/Evaluation

Criteria—Client Will:



- Verbalize understanding of potential loss of ability in relation to existing condition.
- Participate in conditioning/rehabilitation program to enhance ability to perform.
- Identify alternative ways to maintain desired activity level (e.g., if weather is bad, walking in a shopping mall could be an option).
- Identify conditions/symptoms that require medical reevaluation.

Actions/Interventions

NURSING PRIORITY NO. 1. To assess factors affecting current situation:

- Identify factors that could block/affect desired level of activity (e.g., age, arthritis, climate, or weather).
- Note presence of medical diagnosis and/or therapeutic regimen that has potential for interfering with client's ability to perform at a desired level of activity.
- Determine baseline activity level and physical condition. (Provides opportunity to track changes.)




NURSING PRIORITY NO. 2. To develop/investigate alternative ways to remain active within the limits of the disabling condition/situation:

-  • Implement physical therapy/exercise program in conjunction with the client and other team members (e.g., physical and/or occupational therapist, exercise/rehabilitation physiologist). **Coordination of program enhances likelihood of success.**
-  • Promote/implement conditioning program and support inclusion in exercise/activity groups to **prevent/limit deterioration.**
- Instruct client in unfamiliar activities and in alternate ways of doing familiar activities to **conserve energy and promote safety.**

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



NURSING PRIORITY NO. 3. To promote wellness (Teaching/Discharge Considerations):

- Discuss relationship of illness/debilitating condition to inability to perform desired activity(ies).
- Provide information regarding potential interferences to activity.
-  • Assist client/SO(s) with planning for changes that may become necessary.
-  • Identify and discuss symptoms for which client needs to seek medical assistance/evaluation **providing for timely intervention.**
-  • Refer to appropriate sources for assistance and/or equipment as needed **to sustain activity level.**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Identified/potential risk factors for individual.
- Current level of activity tolerance and blocks to activity.

PLANNING

- Treatment options, including physical therapy/exercise program, other assistive therapies, and devices.
- Lifestyle changes that are planned, who is to be responsible for each action, and monitoring methods.

IMPLEMENTATION/EVALUATION

- Responses to interventions/teaching and actions performed.
- Attainment/progress toward desired outcome(s).
- Modification of plan of care.

DISCHARGE PLANNING

- Referrals for medical assistance/evaluation.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Endurance

NIC—Energy Management

impaired Adjustment

Taxonomy II: Coping/Stress Tolerance—Class 2 Coping Responses (00070)

[Diagnostic Division: Ego Integrity]

Submitted 1986; Nursing Diagnosis Extension and Classification (NDEC) Revision 1998

Definition: Inability to modify lifestyle/behavior in a manner consistent with a change in health status

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



Related Factors

Disability or health status requiring change in lifestyle
 Multiple stressors; intense emotional state
 Low state of optimism; negative attitudes toward health behavior; lack of motivation to change behaviors
 Failure to intend to change behavior
 Absence of social support for changed beliefs and practices
 [Physical and/or learning disability]

Defining Characteristics

SUBJECTIVE

Denial of health status change
 Failure to achieve optimal sense of control

OBJECTIVE



Failure to take actions that would prevent further health problems
 Demonstration of nonacceptance of health status change

Desired Outcomes/Evaluation Criteria—Client Will:

- Demonstrate increasing interest/participation in self-care.
- Develop ability to assume responsibility for personal needs when possible.
- Identify stress situations leading to impaired adjustment and specific actions for dealing with them.
- Initiate lifestyle changes that will permit adaptation to current life situations.
- Identify and use appropriate support systems.

Actions/Interventions

NURSING PRIORITY NO. 1. To assess degree of impaired function:

- Perform a physical and/or psychosocial assessment to determine the extent of the limitation(s) of the current condition.
- Listen to the client's perception of inability/reluctance to adapt to situations that are occurring currently.
-  • Survey (with the client) past and present significant support systems (e.g., family, church, groups, and organizations) to identify helpful resources.
- Explore the expressions of emotions signifying impaired adjustment by client/SO(s) (e.g., overwhelming anxiety, fear, anger, worry, passive and/or active denial).
-  • Note child's interaction with parent/care provider (development of coping behaviors is limited at this age, and primary

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.





care providers provide support for the child and serve as role models).

- ∞ Determine whether child displays problems with school performance, withdraws from family/peers, or demonstrates aggressive behavior toward others/self.



NURSING PRIORITY NO. 2. To identify the causative/contributing factors relating to the impaired adjustment:

- Listen to client's perception of the factors leading to the present impairment, noting onset, duration, presence/absence of physical complaints, social withdrawal.
- Review previous life situations and role changes with client to **determine coping skills used.**
- Determine lack of/inability to use available resources.
- Review available documentation and resources to determine actual life experiences (e.g., medical records, statements by SO[s], consultants' notes). **In situations of great stress, physical and/or emotional, the client may not accurately assess occurrences leading to the present situation.**



NURSING PRIORITY NO. 3. To assist client in coping/dealing with impairment:

-  • Organize a team conference (including client and ancillary services) **to focus on contributing factors of impaired adjustment and plan for management of the situation.**
- Acknowledge client's efforts to adjust: "Have done your best." **Lessens feelings of blame/guilt and defensive response.** Share information with adolescent's peers when illness/injury affects body image (**peers are primary support for this age group**).
- Explain disease process/causative factors and prognosis as appropriate and promote questioning **to enhance understanding.**
- Provide an open environment encouraging communication so that **expression of feelings concerning impaired function can be dealt with realistically.**
- Use therapeutic communication skills (Active-listening, acknowledgment, silence, I-statements).
-  • Discuss/evaluate resources that have been useful to the client in adapting to changes in other life situations (e.g., vocational rehabilitation, employment experiences, psychosocial support services).
- Develop a plan of action with client **to meet immediate needs** (e.g., physical safety and hygiene, emotional support of professionals and SO[s]) and assist in implementation of the plan. **Provides a starting point to deal with current situation for moving ahead with plan and for evaluation of progress.**

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.

- Explore previously used coping skills and application to current situation. Refine/develop new strategies as appropriate.
-  • Identify and problem-solve with the client frustration in daily care. (Focusing on the smaller factors of concern gives the individual the ability to perceive the impaired function from a less-threatening perspective, one-step-at-a-time concept.)
-  • Involve SO(s) in long-range planning for emotional, psychological, physical, and social needs.

NURSING PRIORITY NO. 4. To promote wellness (Teaching/Discharge Considerations):

- Identify strengths the client perceives in current life situation. Keep focus on the present, as **unknowns of the future may be too overwhelming.**
-  • Refer to other resources in the long-range plan of care (e.g., occupational therapy, vocational rehabilitation) as indicated.
- Assist client/SO(s) to see appropriate alternatives and potential changes in locus of control.
- Assist SO(s) to learn methods for managing present needs. (Refer to NDs specific to client's deficits.)
-  • Pace and time learning sessions **to meet client's needs.** Provide feedback during and after learning experiences (e.g., self-catheterization, range-of-motion exercises, wound care, therapeutic communication) **to enhance retention, skill, and confidence.**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Reasons for/degree of impairment.
- Client's/SO's perception of the situation.
- Effect of behavior on health status/condition.

PLANNING

- Plan for adjustments and interventions for achieving the plan and who is involved.
- Teaching plan.

IMPLEMENTATION/EVALUATION

- Client responses to the interventions/teaching and actions performed.
- Attainment/progress toward desired outcome(s).
- Modifications to plan of care.

DISCHARGE PLANNING

- Resources that are available for the client and SO(s) and referrals that are made.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Acceptance: Health Status

NIC—Coping Enhancement

ineffective Airway Clearance

Taxonomy II: Safety/Protection—Class 2 Physical Injury (00031)

[Diagnostic Division: Respiration]

Submitted 1980; Revised 1996, and Nursing Diagnosis Extension and Classification (NDEC) 1998

Definition: Inability to clear secretions or obstructions from the respiratory tract to maintain a clear airway

Related Factors

ENVIRONMENTAL

Smoking; second-hand smoke; smoke inhalation

OBSTRUCTED AIRWAY

Retained secretions; secretions in the bronchi; exudate in the alveoli; excessive mucus; airway spasm; foreign body in airway; presence of artificial airway

PHYSIOLOGICAL

Chronic obstructive pulmonary disease (COPD); asthma; allergic airways; hyperplasia of the bronchial walls; neuromuscular dysfunction; infection

Defining Characteristics

SUBJECTIVE

Dyspnea

OBJECTIVE

Diminished or adventitious breath sounds (rales, crackles, rhonchi, wheezes)

Cough, ineffective or absent; sputum

Changes in respiratory rate and rhythm

Difficulty vocalizing

Wide-eyed; restlessness

Orthopnea

Cyanosis

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.






Desired Outcomes/Evaluation Criteria—Client Will:



- Maintain airway patency.
- Expectorate/clear secretions readily.
- Demonstrate absence/reduction of congestion with breath sounds clear, respirations noiseless, improved oxygen exchange (e.g., absence of cyanosis, ABG results within client norms).
- Verbalize understanding of cause(s) and therapeutic management regimen.
- Demonstrate behaviors to improve or maintain clear airway.
- Identify potential complications and how to initiate appropriate preventive or corrective actions.

Actions/Interventions

NURSING PRIORITY NO. 1. To maintain adequate, patent airway:

- Position head midline with flexion appropriate for age/condition to open or maintain open airway in at-rest or compromised individual.
-  • Assist with appropriate testing (e.g., pulmonary function/sleep studies) to identify causative/precipitating factors.
- Suction naso/tracheal/oral prn to clear airway when secretions are blocking airway.
- Elevate head of the bed/change position every 2 hours and prn to take advantage of gravity decreasing pressure on the diaphragm and enhancing drainage of/ventilation to different lung segments (pulmonary toilet).
-  • Monitor infant/child for feeding intolerance, abdominal distention, and emotional stressors that may compromise airway.
- Insert oral airway as appropriate to maintain anatomic position of tongue and natural airway.
-  • Assist with procedures (e.g., bronchoscopy, tracheostomy) to clear/maintain open airway.
- Keep environment allergen free (e.g., dust, feather pillows, smoke) according to individual situation.

NURSING PRIORITY NO. 2. To mobilize secretions:

- Encourage deep-breathing and coughing exercises; splint chest/incision to maximize effort.
-  • Administer analgesics to improve cough when pain is inhibiting effort. (Caution: Overmedication can depress respirations and cough effort.)
-  • Give expectorants/bronchodilators as ordered.
- Increase fluid intake to at least 2000 mL/day within level of cardiac tolerance (may require IV) to help liquefy secretions.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



Monitor for signs/symptoms of congestive heart failure (crackles, edema, weight gain).

- Encourage/provide warm versus cold liquids as appropriate.
- Provide supplemental humidification, if needed (ultrasonic nebulizer, room humidifier).
- Perform/assist client with postural drainage and percussion as indicated if not contraindicated by condition, such as asthma.
- Assist with respiratory treatments (intermittent positive-pressure breathing—IPPB, incentive spirometer).
- Support reduction/cessation of smoking to **improve lung function**.
- Discourage use of oil-based products around nose to **prevent aspiration into lungs**.

NURSING PRIORITY NO. 3. To assess changes, note complications:

- Auscultate breath sounds and assess air movement to **ascertain status and note progress**.
- Monitor vital signs, noting blood pressure/pulse changes.
- Observe for signs of respiratory distress (increased rate, restlessness/anxiety, use of accessory muscles for breathing).
- Evaluate changes in sleep pattern, noting insomnia or daytime somnolence.



- Document response to drug therapy and/or development of adverse side effects or interactions with antimicrobials, steroids, expectorants, bronchodilators.
- Observe for signs/symptoms of infection (e.g., increased dyspnea with onset of fever, change in sputum color, amount, or character) to **identify infectious process/promote timely intervention**.



- Obtain sputum specimen, preferably before antimicrobial therapy is initiated, to **verify appropriateness of therapy**.



- Monitor/document serial chest x-rays/ABGs/pulse oximetry readings.
- Observe for improvement in symptoms.

NURSING PRIORITY NO. 4. To promote wellness (Teaching/Discharge Considerations):

- Assess client's knowledge of contributing causes, treatment plan, specific medications, and therapeutic procedures.



- Provide information about the necessity of raising and expectorating secretions versus swallowing them, to **examine and report changes in color and amount**.



- Demonstrate pursed-lip or diaphragmatic breathing techniques, if indicated.



- Review breathing exercises, effective cough, use of adjunct devices (e.g., IPPB or incentive spirometer) in preoperative teaching.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



- Encourage/provide opportunities for rest; limit activities to level of respiratory tolerance. (Prevents/lessens fatigue.)
- Refer to appropriate support groups (e.g., stop-smoking clinic, COPD exercise group, weight reduction).
- Instruct in use of nocturnal positive pressure air flow for **treatment of sleep apnea**. (Refer to NDs disturbed Sleep Pattern; Sleep Deprivation.)

Documentation Focus

ASSESSMENT/REASSESSMENT

- Related Factors for individual client.
- Breath sounds, presence/character of secretions, use of accessory muscles for breathing.
- Character of cough/sputum.

PLANNING

- Plan of care and who is involved in planning.
- Teaching plan.

IMPLEMENTATION/EVALUATION

- Client's response to interventions/teaching and actions performed.
- Attainment/progress toward desired outcome(s).
- Modifications to plan of care.

DISCHARGE PLANNING

- Long-term needs and who is responsible for actions to be taken.
- Specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Respiratory Status: Airway Patency

NIC—Airway Management

Latex Allergy Response

Taxonomy II: Safety/Protection—Class 5 Defensive Processes (00041)

[Diagnostic Division: Safety]

Submitted 1998

Definition: An allergic response to natural latex rubber products

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



Related Factors

No immune mechanism response [although this is true of irritant and allergic contact dermatitis, type I/immediate reaction is a true allergic response]

Defining Characteristics

Type I reactions [hypersensitivity; IgE-mediated reaction]: immediate reaction (<1 hour) to latex proteins (can be life-threatening); contact urticaria progressing to generalized symptoms; edema of the lips, tongue, uvula, and/or throat; shortness of breath, tightness in chest, wheezing, bronchospasm leading to respiratory arrest; hypotension, syncope, cardiac arrest. May also include: Orofacial characteristics—edema of sclera or eyelids; erythema and/or itching of the eyes; tearing of the eyes; nasal congestion, itching, and/or erythema; rhinorrhea; facial erythema; facial itching; oral itching; Gastrointestinal characteristics—abdominal pain; nausea; Generalized characteristics—flushing; general discomfort; generalized edema; increasing complaint of total body warmth; restlessness

Type IV reactions [chemical and delayed-type hypersensitivity]: delayed onset (hours); eczema; irritation; reaction to additives (e.g., thiurams, carbamates) causes discomfort; redness

Irritant [contact dermatitis] reactions: erythema; [dry, crusty, hard bumps] chapped or cracked skin; blisters

Desired Outcomes/Evaluation

Criteria—Client Will:

- Be free of signs of hypersensitive response.
- Verbalize understanding of individual risks/responsibilities in avoiding exposure.
- Identify signs/symptoms requiring prompt intervention.



Actions/Interventions

NURSING PRIORITY NO. 1. To assess contributing factors:




- Identify persons in high-risk categories (e.g., those with history of allergies, eczema, and other dermatitis); those routinely exposed to latex products: healthcare workers, police/firefighters, emergency medical technicians (EMTs), food handlers (restaurant, grocery stores, cafeterias), hairdressers, cleaning staff, factory workers in plants that manufacture latex-containing products; those with neural tube defects (e.g., spina bifida) or congenital urological conditions requiring frequent surgeries and/or catheterizations (e.g., extrophy of the bladder).

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.





- Discuss history of recent exposure, for example, blowing up balloons (this might be an acute reaction to the powder); use of condoms (may affect either partner).
-  • Note presence of positive skin-prick test (SPT). (Sensitive indicator of IgE sensitivity reflecting immune system activation/type I reaction.)
-  • Perform challenge/patch test, if appropriate, placing gloves to skin for 15 minutes (appearance of hives, itching, reddened areas indicates sensitivity) or assist with/note response to radioallergosorbent test (RAST). This is the only safe test for the client with a history of type I reaction.

NURSING PRIORITY NO. 2. To take measures to reduce/limit allergic response/avoid exposure to allergens:

- Ascertain client's current symptoms, noting reports of rash, hives, itching, eye symptoms, edema, diarrhea, nausea, feeling of faintness.
- Assess skin (usually hands but may be anywhere) for dry, crusty, hard bumps, horizontal cracks caused by irritation from chemicals used in/on the latex item (e.g., powder in gloves, condoms, etc.).
-  • Assist with treatment of contact dermatitis/type IV reaction (most common response) (e.g., wash affected skin with mild soap and water, possible application of topical steroid ointment, avoidance of latex). Inform client that the most common cause is latex gloves, but that many other products contain latex and could aggravate condition.
- Monitor closely for signs of systemic reactions because type IV response can lead to/progress to type I anaphylaxis. Be watchful for onset of difficulty breathing, wheezing, hypotension, tachycardia, dysrhythmias (indicative of anaphylactic reaction and can lead to cardiac arrest).
-  • Administer treatment as appropriate if type I reaction occurs, including antihistamines, epinephrine, IV fluids, corticosteroids, and oxygen mechanical ventilation, if indicated.
-  • Post latex precaution signs, and document allergy to latex in client's file. Encourage client to wear medical ID bracelet and to inform care providers.
- Survey and routinely monitor client's environment for latex-containing products, and remove.

NURSING PRIORITY NO. 3. To promote wellness (Teaching/Learning):

-  • Emphasize the critical importance of taking immediate action for type I reaction.
-  • Instruct client/family/SO about signs of reaction and emergency treatment. Promotes awareness of problem and facilitates timely intervention.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



- Provide work-site review/recommendations to prevent exposure.
- Ascertain that latex-safe products are available, including equipment supplies, such as rubber gloves, PCV IV tubing, latex-free tape, thermometers, electrodes, oxygen cannulas, even pencil erasers and rubber bands as appropriate.
- Refer to resources (e.g., *Latex Allergy News*, National Institute for Occupational Safety and Health—NIOSH) for further information and assistance.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings/pertinent history of contact with latex products/frequency of exposure.
- Type/extent of symptomatology.

PLANNING

- Plan of care and interventions and who is involved in planning.
- Teaching plan.

IMPLEMENTATION/EVALUATION

- Response to interventions/teaching and actions performed.
- Attainment/progress toward desired outcome(s).
- Modifications to plan of care.

DISCHARGE PLANNING

- Discharge needs/referrals made, additional resources available.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Immune Hypersensitivity Control

NIC—Latex Precautions

risk for latex Allergy Response

Taxonomy II: Safety/Protection—Class 5 Defensive Processes (00042)

[Diagnostic Division: Safety]

Submitted 1998

Definition: At risk for allergic response to natural latex rubber products

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



Risk Factors

- History of reactions to latex (e.g., balloons, condoms, gloves); allergies to bananas, avocados, tropical fruits, kiwi, chestnuts, poinsettia plants
- History of allergies and asthma
- Professions with daily exposure to latex (e.g., medicine, nursing, dentistry)
- Conditions associated with continuous or intermittent catheterization
- Multiple surgical procedures, especially from infancy (e.g., spina bifida)

NOTE: A risk diagnosis is not evidenced by signs and symptoms, as the problem has not occurred and nursing interventions are directed at prevention.

Desired Outcomes/Evaluation

Criteria—Client Will:

- Identify and correct potential risk factors in the environment.
- Demonstrate appropriate lifestyle changes to reduce risk of exposure.
- Identify resources to assist in promoting a safe environment.
- Recognize need for/seek assistance to limit response/complications.

Actions/Interventions

NURSING PRIORITY NO. 1. To assess causative/contributing factors:

- Identify persons in high-risk categories (e.g., those with positive history of allergies, eczema, and other dermatitis); those routinely exposed to latex products: healthcare workers, police/firefighters, EMTs, food handlers, hairdressers, cleaning staff, factory workers in plants that manufacture latex-containing products; those with neural tube defects (e.g., spina bifida) or congenital urological conditions requiring frequent surgeries and/or catheterizations.
- Ascertain if client could be exposed through catheters, IV tubing, dental/other procedures in healthcare setting. **Recent information indicates that latex is found in thousands of medical supplies.**

NURSING PRIORITY NO. 2. To assist in correcting factors that could lead to latex allergy:

- Discuss necessity of avoiding latex exposure. Recommend/assist client/family to survey environment, and remove any medical or household products containing latex.
- Substitute nonlatex products, such as natural rubber gloves,




Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



PCV IV tubing, latex-free tape, thermometers, electrodes, oxygen cannulas, and so forth.

- Obtain lists of latex-free products and supplies for client/care provider.
- Ascertain that facilities have established policies and procedures to address safety and reduce risk to workers and clients.
- Promote good skin care, for example, handwashing immediately after glove removal (reduces effects of latex in powder in gloves).

NURSING PRIORITY NO. 3. To promote wellness (Teaching/Discharge Considerations):

-  Instruct client/care providers about potential for and possible progression of reaction.
-  Identify measures to take if reactions occur and ways to avoid exposure to latex products.
-  Refer to allergist for testing as appropriate. Perform challenge/patch test with gloves to skin (hives, itching, and reddened areas indicate sensitivity).

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings/pertinent history of contact with latex products/frequency of exposure.

PLANNING

- Plan of care, interventions, and who is involved in planning.
- Teaching plan.

IMPLEMENTATION/EVALUATION

- Response to interventions/teaching and actions performed.

DISCHARGE PLANNING

- Discharge needs/referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Immune Hypersensitivity Control

NIC—Latex Precautions

Anxiety [specify level: mild, moderate, severe, panic]

Taxonomy II: Coping/Stress Tolerance—Class 2 Coping Responses (00146)
[Diagnostic Division: Ego Integrity]

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



Submitted 1973; Revised 1982, and 1998 (by small group work 1996)

Definition: Vague uneasy feeling of discomfort or dread accompanied by an autonomic response (the source often nonspecific or unknown to the individual); a feeling of apprehension caused by anticipation of danger. It is an altering signal that warns of impending danger and enables the individual to take measures to deal with threat.

Related Factors

Unconscious conflict about essential [beliefs]/goals and values of life

Situational/maturational crises

Stress

Familial association/heredity

Interpersonal transmission/contagion

Threat to self-concept [perceived or actual]; [unconscious conflict]

Threat of death [perceived or actual]

Threat to or change in health status [progressive/debilitating disease, terminal illness], interaction patterns, role function/status, environment [safety], economic status

Unmet needs

Exposure to toxins

Substance abuse

[Positive or negative self-talk]

[Physiological factors, such as hyperthyroidism, pheochromocytoma, drug therapy, including steroids]

Defining Characteristics

SUBJECTIVE

Behavioral

Expressed concerns due to change in life events

Affective

Regretful; scared; rattled; distressed; apprehension; uncertainty; fearful; feeling inadequate; anxious; jittery; [sense of impending doom]; [hopelessness]

Cognitive

Fear of unspecified consequences; awareness of physiological symptoms

Physiological

Shakiness; worried; regretful; dry mouth (s); tingling in extremities (p); heart pounding (s); nausea (p); abdominal pain

p = parasympathetic nervous system; s = sympathetic nervous system



(p); diarrhea (p); urinary hesitancy (p); urinary frequency (p); faintness (p); weakness (s); decreased pulse (p); respiratory difficulties (s); fatigue (p); sleep disturbance (p); [chest, back, neck pain]

OBJECTIVE

Behavioral

Poor eye contact; glancing about; scanning and vigilance; extraneous movement (e.g., foot shuffling, hand/arm movements); fidgeting; restlessness; diminished productivity; [crying/tearfulness]; [pacing/purposeless activity]; [immobility]

Affective

Increased wariness; focus on self; irritability; overexcited; anguish; painful and persistent increased helplessness

Physiological

Voice quivering; trembling/hand tremors; increased tension; facial tension; increased pulse; increased perspiration; cardiovascular excitation (s); facial flushing (s); superficial vasoconstriction (s); increased blood pressure (s); twitching (s); increased reflexes (s); urinary urgency (p); decreased blood pressure (p); insomnia; anorexia (s); increased respiration (s)

Cognitive

Preoccupation; impaired attention; difficulty concentrating; forgetfulness; diminished ability to problem-solve; diminished learning ability; rumination; tendency to blame others; blocking of thought; confusion; decreased perceptual field

Desired Outcomes/Evaluation

Criteria—Client Will:

- Appear relaxed and report anxiety is reduced to a manageable level.
- Verbalize awareness of feelings of anxiety.
- Identify healthy ways to deal with and express anxiety.
- Demonstrate problem-solving skills.
- Use resources/support systems effectively.

Actions/Interventions

NURSING PRIORITY NO. 1. To assess level of anxiety:

- Review familial/physiological factors, current prescribed medications, and recent drug history (e.g., genetic depressive factors, history of thyroid problems, metabolic imbalances, pulmonary disease, anemia, dysrhythmias; use of steroids, thyroid, appetite control medications; and substance abuse).
- Identify client's perception of the threat represented by the situation.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



- Monitor physical responses; for example, palpitations/rapid pulse, repetitive movements, pacing.
- Observe behavior indicative of level of anxiety (the nurse needs to be aware of own feelings of anxiety or uneasiness, **which can be a clue to the client's level of anxiety**):

Mild

Alert, more aware of environment, attention focused on environment and immediate events.

Restless, irritable, wakeful, reports of insomnia.

Motivated to deal with existing problems in this state.

Moderate

Perception narrower, concentration increased and able to ignore distractions in dealing with problem(s).

Voice quivers or changes pitch.

Trembling, increased pulse/respirations.

Severe

Range of perception is reduced; anxiety interferes with effective functioning.

Preoccupied with feelings of discomfort/sense of impending doom.

Increased pulse/respirations with reports of dizziness, tingling sensations, headache, and so on.

Panic

Ability to concentrate is disrupted; behavior is disintegrated; the client distorts the situation and does not have realistic perceptions of what is happening. The individual may be experiencing terror or confusion or be unable to speak or move (paralyzed with fear).



- Note use of drugs (including alcohol), insomnia or excessive sleeping, limited/avoidance of interactions with others, **which may be behavioral indicators of use of withdrawal to deal with problems.**
- Be aware of defense mechanisms being used (client may be in denial, regression, and so forth) **that interfere with ability to deal with problem.**
- Identify coping skills the individual is using currently, such as anger, daydreaming, forgetfulness, eating, smoking, lack of problem-solving.
- Review coping skills used in past **to determine those that might be helpful in current circumstances.**

NURSING PRIORITY NO. 2. To assist client to identify feelings and begin to deal with problems:

- Establish a therapeutic relationship, conveying empathy and unconditional positive regard.
- Be available to client for listening and talking.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



- Encourage client to acknowledge and to express feelings, for example, crying (sadness), laughing (fear, denial), swearing (fear, anger).
- Assist client to develop self-awareness of verbal and nonverbal behaviors.
- Clarify meaning of feelings/actions by providing feedback and checking meaning with the client.
- Acknowledge anxiety/fear. Do not deny or reassure client that everything will be all right.
- Provide accurate information about the situation. **Helps client to identify what is reality based.**
- ∞ Be truthful with child, avoid bribing, and provide physical contact (e.g., hugging, rocking) **to soothe fears and provide assurance.**
- Provide comfort measures (e.g., calm/quiet environment, soft music, warm bath, back rub).
- ∞ Modify procedures as possible (e.g., substitute oral for intramuscular medications, combine blood draws/use fingerstick method) **to limit degree of stress, avoid overwhelming child or anxious adult.**
- ∞ Manage environmental factors, such as harsh lighting and high traffic flow, which may be confusing/stressful to older individuals.
- Accept client as is. **(The client may need to be where he or she is at this point in time, such as in denial after receiving the diagnosis of a terminal illness.)**
- Allow the behavior to belong to the client; do not respond personally **because this may escalate the situation.**
- Assist client to use anxiety for coping with the situation, if helpful. **(Moderate anxiety heightens awareness and permits the client to focus on dealing with problems.)**

Panic State

- Stay with client, maintaining a calm, confident manner.
- Speak in brief statements using simple words.
- Provide for nonthreatening, consistent environment/atmosphere. Minimize stimuli. Monitor visitors and interactions **to lessen effect of transmission of feelings.**
- Set limits on inappropriate behavior and help client to develop acceptable ways of dealing with anxiety.

NOTE: Staff may need to provide safe controls/environment until client regains control.

- Gradually increase activities/involvement with others as anxiety is decreased.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



- Use cognitive therapy to focus on/correct faulty catastrophic interpretations of physical symptoms.
- Administer antianxiety medications (antianxiety agents/sedatives) as ordered.

NURSING PRIORITY NO. 3. To promote wellness (Teaching/Discharge Considerations):

- Assist client to learn precipitating factors and new methods of coping with disabling anxiety.
- Review happenings, thoughts, and feelings preceding the anxiety attack.
- Identify things the client has done previously to cope successfully when feeling nervous/anxious.
- List helpful resources/people, including available “hotline” or crisis managers to provide ongoing/timely support.
- Encourage client to develop an exercise/activity program; may be helpful in reducing level of anxiety by relieving tension.
- Assist in developing skills (e.g., awareness of negative thoughts, saying “Stop,” and substituting a positive thought) to eliminate negative self-talk. Mild phobias seem to respond better to behavioral therapy.
- Review strategies, such as role playing, use of visualizations to practice anticipated events, prayer/meditation; useful for dealing with anxiety-provoking situations.
- Review medication regimen and possible interactions, especially with over-the-counter drugs/alcohol and so forth. Discuss appropriate drug substitutions, changes in dosage or time of dose to lessen side effects.
- Refer to physician for drug management program/alteration of prescription regimen. (Drugs often causing symptoms of anxiety include aminophylline/theophylline, anticholinergics, dopamine, levodopa, salicylates, steroids.)
- Refer to individual and/or group therapy as appropriate to deal with chronic anxiety states.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Level of anxiety and precipitating/aggravating factors.
- Description of feelings (expressed and displayed).
- Awareness/ability to recognize and express feelings.
- Related substance use, if present.

PLANNING

- Treatment plan and individual responsibility for specific activities.
- Teaching plan.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



IMPLEMENTATION/EVALUATION

- Client involvement and response to interventions/teaching and actions performed.
- Attainment/progress toward desired outcome(s).
- Modifications to plan of care.

DISCHARGE PLANNING

- Referrals and follow-up plan.
- Specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Anxiety Control

NIC—Anxiety Reduction

death Anxiety

Taxonomy II: Coping/Stress Tolerance—Class 2 Coping Response (00147)

[Diagnostic Division: Ego Integrity]

Submitted 1998

Definition: Apprehension, worry, or fear related to death or dying

Related Factors

To be developed

Defining Characteristics**SUBJECTIVE**

Fear of: developing a terminal illness; the process of dying; loss of physical and/or mental abilities when dying; premature death because it prevents the accomplishment of important life goals; leaving family alone after death; delayed demise

Negative death images or unpleasant thoughts about any event related to death or dying; anticipated pain related to dying

Powerlessness over issues related to dying; total loss of control over any aspect of one's own death

Worrying about: the impact of one's own death on SOs; being the cause of other's grief and suffering

Concerns of overworking the caregiver as terminal illness incapacitates self; about meeting one's creator or feeling doubtful about the existence of God or higher being

Denial of one's own mortality or impending death

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



OBJECTIVE




Deep sadness
(Refer to ND anticipatory Grieving.)

**Desired Outcomes/Evaluation
Criteria—Client Will:**

- Identify and express feelings (e.g., sadness, guilt, fear) freely/effectively.
- Look toward/plan for the future one day at a time.
- Formulate a plan dealing with individual concerns and eventualities of dying.

Actions/Interventions

NURSING PRIORITY NO. 1. To assess causative/contributing factors:

- Determine how client sees self in usual lifestyle role functioning and perception and meaning of anticipated loss to him or her and SO(s).
- Ascertain current knowledge of situation to **identify misconceptions, lack of information, other pertinent issues.**
- Determine client's role in family constellation. Observe patterns of communication in family and response of family/SO to client's situation and concerns. **In addition to identifying areas of need/concern, also reveals strengths useful in addressing the concerns.**
- Assess impact of client reports of subjective experiences and past experience with death (or exposure to death); for example, witnessed violent death or as a child viewed body in casket, and so on.
-  • Identify cultural factors/expectations and impact on current situation/feelings.
- Note physical/mental condition, complexity of therapeutic regimen.
- Determine ability to manage own self-care, end-of-life and other affairs, awareness/use of available resources.
- Observe behavior indicative of the level of anxiety present (mild to panic) as it affects client's/SO's ability to process information/participate in activities.
- Identify coping skills currently used and how effective they are. Be aware of defense mechanisms being used by the client.
-  • Note use of drugs (including alcohol), presence of insomnia, excessive sleeping, avoidance of interactions with others.
-  • Note client's religious/spiritual orientation, involvement in religious/church activities, presence of conflicts regarding spiritual beliefs.
- Listen to client/SO reports/expressions of anger/concern,

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



alienation from God, belief that impending death is a punishment for wrongdoing, and so on.

- Determine sense of futility, feelings of hopelessness, helplessness, lack of motivation to help self. **May indicate presence of depression and need for intervention.**
- Active-listen comments regarding sense of isolation.
- Listen for expressions of inability to find meaning in life or suicidal ideation.

NURSING PRIORITY NO. 2. To assist client to deal with situation:

- Provide open and trusting relationship.
- Use therapeutic communication skills of Active-listening, silence, acknowledgment. Respect client desire/request not to talk. Provide hope within parameters of the individual situation.
- Encourage expressions of feelings (anger, fear, sadness, etc.). Acknowledge anxiety/fear. Do not deny or reassure client that everything will be all right. Be honest when answering questions/providing information. **Enhances trust and therapeutic relationship.**
- Provide information about normalcy of feelings and individual grief reaction.
- Make time for nonjudgmental discussion of philosophic issues/questions about spiritual impact of illness/situation.
- Review life experiences of loss and use of coping skills, noting client strengths and successes.
- Provide calm, peaceful setting and privacy as appropriate. **Promotes relaxation and ability to deal with situation.**



- Assist client to engage in spiritual growth activities, experience prayer/meditation and forgiveness to heal past hurts. Provide information that anger with God is a normal part of the grieving process. **Reduces feelings of guilt/conflict, allowing client to move forward toward resolution.**



- Refer to therapists, spiritual advisors, counselors to facilitate grief work.



- Refer to community agencies/resources to assist client/SO for planning for eventualities (legal issues, funeral plans, etc.).

NURSING PRIORITY NO. 3. To promote independence:



- Support client's efforts to develop realistic steps to put plans into action.



- Direct client's thoughts beyond present state to enjoyment of each day and the future when appropriate.



- Provide opportunities for client to make simple decisions. **Enhances sense of control.**



- Develop individual plan using client's locus of control to assist client/family through the process.



- Treat expressed decisions and desires with respect and convey to others as appropriate.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



- Assist with completion of Advance Directives and cardiopulmonary resuscitation (CPR) instructions.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings, including client's fears and signs/symptoms being exhibited.
- Responses/actions of family/SO(s).
- Availability/use of resources.

PLANNING

- Plan of care and who is involved in planning.

IMPLEMENTATION/EVALUATION

- Client's response to interventions/teaching and actions performed.
- Attainment/progress toward desired outcome(s).
- Modifications to plan of care.

DISCHARGE PLANNING

- Identified needs and who is responsible for actions to be taken.
- Specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Dignified Dying

NIC—Dying Care

risk for Aspiration

Taxonomy II: Safety/Protection—Class 2 Physical Injury (00039)

[Diagnostic Division: Respiration]

Submitted 1988

Definition: At risk for entry of gastrointestinal secretions, oropharyngeal secretions, or [exogenous food] solids or fluids into tracheobronchial passages [due to dysfunction or absence of normal protective mechanisms]

Risk Factors

Reduced level of consciousness

Depressed cough and gag reflexes

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



Impaired swallowing [owing to inability of the epiglottis and true vocal cords to move to close off trachea]

Facial/oral/neck surgery or trauma; wired jaws

Situation hindering elevation of upper body [weakness, paralysis]

Incomplete lower esophageal sphincter [hiatal hernia or other esophageal disease affecting stomach valve function], delayed gastric emptying, decreased gastrointestinal motility, increased intragastric pressure, increased gastric residual

Presence of tracheostomy or endotracheal (ET) tube; [inadequate or overinflation of tracheostomy/ET tube cuff]

[Presence of] gastrointestinal tubes; tube feedings/medication administration

NOTE: A risk diagnosis is not evidenced by signs and symptoms, as the problem has not occurred and nursing interventions are directed at prevention.

Desired Outcomes/Evaluation

Criteria—Client Will:

- Experience no aspiration as evidenced by noiseless respirations, clear breath sounds; clear, odorless secretions.
- Identify causative/risk factors.
- Demonstrate techniques to prevent and/or correct aspiration.

Actions/Interventions










NURSING PRIORITY NO. 1. To assess causative/contributing factors:

- Note level of consciousness/awareness of surroundings, cognitive impairment.
- Evaluate presence of neuromuscular weakness, noting muscle groups involved, degree of impairment, and whether they are of an acute or progressive nature (e.g., Guillain-Barré, amyotrophic lateral sclerosis—ALS).
- Assess amount and consistency of respiratory secretions and strength of gag/cough reflex.
- Observe for neck and facial edema, for example, client with head/neck surgery, tracheal/bronchial injury (upper torso burns, inhalation/chemical injury).
- Note administration of enteral feedings, being aware of potential for regurgitation and/or misplacement of tube.
- Ascertain lifestyle habits, for instance, use of alcohol, tobacco, and other CNS-suppressant drugs; **can affect awareness and muscles of gag/swallow.**



NURSING PRIORITY NO. 2. To assist in correcting factors that can lead to aspiration:

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



- Monitor use of oxygen masks in clients at risk for vomiting. Refrain from using oxygen masks for comatose individuals.
-  • Keep wire cutters/scissors with client at all times when jaws are wired/banded to facilitate clearing airway in emergency situations.
- Maintain operational suction equipment at bedside/chairside.
- Suction (oral cavity, nose, and ET/tracheostomy tube) as needed to clear secretions. Avoid triggering gag mechanism when performing suction or mouth care.
- Assist with postural drainage to mobilize thickened secretions that may interfere with swallowing.
- Auscultate lung sounds frequently (especially in client who is coughing frequently or not coughing at all; ventilator client being tube-fed) to determine presence of secretions/silent aspiration.
-  • Elevate client to highest or best possible position for eating and drinking and during tube feedings.
-  • Feed slowly, instruct client to chew slowly and thoroughly.
-  • Give semisolid foods; avoid pureed foods (increased risk of aspiration) and mucus-producing foods (milk). Use soft foods that stick together/form a bolus (e.g., casseroles, puddings, stews) to aid swallowing effort.
-  • Provide very warm or very cold liquids (activates temperature receptors in the mouth that help to stimulate swallowing). Add thickening agent to liquids as appropriate.
-  • Avoid washing solids down with liquids.
- Ascertain that feeding tube is in correct position. Measure residuals when appropriate to prevent overfeeding. Add food coloring to feeding to identify regurgitation.
-  • Determine best position for infant/child (e.g., with the head of bed elevated 30 degrees and infant propped on right side after feeding because upper airway patency is facilitated by upright position and turning to right side decreases likelihood of drainage into trachea).
-  • Provide oral medications in elixir form or crush, if appropriate.
-  • Refer to speech therapist for exercises to strengthen muscles and techniques to enhance swallowing.

NURSING PRIORITY NO. 3. To promote wellness (Teaching/Discharge Considerations):

- Review individual risk/potentiating factors.
- Provide information about the effects of aspiration on the lungs.
-  • Instruct in safety concerns when feeding oral or tube feeding. Refer to ND impaired Swallowing.
-  • Train client to suction self or train family members in suction

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.





techniques (especially if client has constant or copious oral secretions) to enhance safety/self-sufficiency.

- Instruct individual/family member to avoid/limit activities that increase intra-abdominal pressure (straining, strenuous exercise, tight/constrictive clothing), which may slow digestion/increase risk of regurgitation.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings/conditions that could lead to problems of aspiration.
- Verification of tube placement, observations of physical findings.

PLANNING

- Interventions to prevent aspiration or reduce risk factors and who is involved in the planning.
- Teaching plan.

IMPLEMENTATION/EVALUATION

- Client's responses to interventions/teaching and actions performed.
- Foods/fluids client handles with ease/difficulty.
- Amount/frequency of intake.
- Attainment/progress toward desired outcome(s).
- Modifications to plan of care.

DISCHARGE PLANNING

- Long-term needs and who is responsible for actions to be taken.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Risk Control

NIC—Aspiration Precautions

risk for impaired parent/infant/child Attachment

Taxonomy II: Role Relationships—Class 2 Family Relationships (00058)
[Diagnostic Division: Social Interaction]
Submitted 1994

Definition: Disruption of the interactive process between parent/SO and infant that fosters the development of a protective and nurturing reciprocal relationship

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



Risk Factors

- Inability of parents to meet personal needs
- Anxiety associated with the parent role
- Substance abuse
- Premature infant; ill infant/child who is unable to effectively initiate parental contact due to altered behavioral organization
- Separation; physical barriers
- Lack of privacy
- [Parents who themselves experienced altered attachment]
- [Uncertainty of paternity; conception as a result of rape/sexual abuse]
- [Difficult pregnancy and/or birth (actual or perceived)]




NOTE: A risk diagnosis is not evidenced by signs and symptoms, as the problem has not occurred and nursing interventions are directed at prevention.

Desired Outcomes/Evaluation Criteria—Parent Will:



- Identify and prioritize family strengths and needs.
- Exhibit nurturant and protective behaviors toward child.
- Identify and use resources to meet needs of family members.
- Demonstrate techniques to enhance behavioral organization of the infant/child.
- Engage in mutually satisfying interactions with child.

Actions/Interventions

NURSING PRIORITY NO. 1. To identify causative/contributing factors:

- Interview parents, noting their perception of situation, individual concerns.
-  • Assess parent/child interactions.
-  • Ascertain availability/use of resources to include extended family, support groups, and financial.
-  • Evaluate parents' ability to provide protective environment, participate in reciprocal relationship.

NURSING PRIORITY NO. 2. To enhance behavioral organization of infant/child:

-  • Identify infant's strengths and vulnerabilities. **Each child is born with his or her own temperament that affects interactions with caregivers.**
-  • Educate parents regarding child growth and development, addressing parental perceptions. **Helps clarify realistic expectations.**

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



- ∞ Assist parents in modifying the environment to provide appropriate stimulation.
 - Model caregiving techniques that best support behavioral organization.
- ∞ Respond consistently with nurturance to infant/child.

NURSING PRIORITY NO. 3. To enhance best functioning of parents:

- Develop therapeutic nurse-client relationship. Provide a consistently warm, nurturant, and nonjudgmental environment.
- 🏠 Assist parents in identifying and prioritizing family strengths and needs. Promotes positive attitude by looking at what they already do well and using those skills to address needs.
- 🏠 Support and guide parents in process of assessing resources.
- ∞ Involve parents in activities with the infant/child that they can accomplish successfully. Enhances self-concept.
- 🏠 Recognize and provide positive feedback for nurturant and protective parenting behaviors. Reinforces continuation of desired behaviors.
- 👥 Minimize number of professionals on team with whom parents must have contact to foster trust in relationships.

NURSING PRIORITY NO. 4. To support parent/child attachment during separation:

- 🏠 Provide parents with telephone contact as appropriate.
 - Establish a routine time for daily phone calls/initiate calls as indicated. Provides sense of consistency and control; allows for planning of other activities.
 - Invite parents to use Ronald McDonald House or provide them with a listing of a variety of local accommodations, restaurants when child is hospitalized out of town.
 - Arrange for parents to receive photos, progress reports from the child.
 - Suggest parents provide a photo and/or audiotape of themselves for the child.
- 🏠 Consider use of contract with parents to clearly communicate expectations of both family and staff.
 - Suggest parents keep a journal of infant/child progress.
 - Provide “homelike” environment for situations requiring supervision of visits.

NURSING PRIORITY NO. 5. To promote wellness (Teaching/Discharge Considerations):

- 👥 Refer to addiction counseling/treatment, individual counseling, or family therapies as indicated.
- 🏠 Identify services for transportation, financial resources, housing, and so forth.
- 🏠 Develop support systems appropriate to situation (e.g., extended family, friends, social worker).

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.

- Explore community resources (e.g., church affiliations, volunteer groups, day/respite care).

Documentation Focus

ASSESSMENT/REASSESSMENT

- Identified behaviors of both parents and child.
- Specific risk factors, individual perceptions/concerns.
- Interactions between parent and child.

PLANNING

- Plan of care and who is involved in planning.
- Teaching plan.

IMPLEMENTATION/EVALUATION

- Parents'/child's responses to interventions/teaching and actions performed.
- Attainment/progress toward desired outcomes.
- Modifications to plan of care.

DISCHARGE PLANNING

- Long-term needs and who is responsible.
- Plan for home visits to support parents and to ensure infant/child safety and well-being.
- Specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Parent-Infant Attachment

NIC—Attachment Promotion

Autonomic Dysreflexia

Taxonomy II: Coping/Stress Tolerance—Class 3
Neurobehavioral Stress (00009)
[Diagnostic Division: Circulation]
Submitted 1988

Definition: Life-threatening, uninhibited sympathetic response of the nervous system to a noxious stimulus after a spinal cord injury [SCI] at T7 or above

Related Factors

Bladder or bowel distention; [catheter insertion, obstruction, irrigation]
Skin irritation

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



Lack of client and caregiver knowledge

[Sexual excitation]

[Environmental temperature extremes]

Defining Characteristics

SUBJECTIVE

Headache (a diffuse pain in different portions of the head and not confined to any nerve distribution area)

Paresthesia, chilling, blurred vision, chest pain, metallic taste in mouth, nasal congestion

OBJECTIVE

Paroxysmal hypertension (sudden periodic elevated blood pressure in which systolic pressure >140 mm Hg and diastolic >90 mm Hg)

Bradycardia or tachycardia (heart rate <60 or >100 beats per minute, respectively)

Diaphoresis (above the injury), red splotches on skin (above the injury), pallor (below the injury)

Horner's syndrome (contraction of the pupil, partial ptosis of the eyelid, enophthalmos and sometimes loss of sweating over the affected side of the face); conjunctival congestion

Pilomotor reflex (gooseflesh formation when skin is cooled)

Desired Outcomes/Evaluation Criteria—Client/Caregiver Will:

- Identify risk factors.
- Recognize signs/symptoms of syndrome.
- Demonstrate corrective techniques.
- Experience no episodes of dysreflexia or will seek medical intervention in a timely manner.

Actions/Interventions

NURSING PRIORITY NO. 1. To assess precipitating risk factors:

- Monitor for bladder distention, presence of bladder spasms/stones or infection.
- Assess for bowel distention, fecal impaction, problems with bowel management program.
- Observe skin/tissue pressure areas, especially following prolonged sitting.
- Remove client from and/or instruct to avoid environmental temperature extremes/drafts.
- Monitor closely during procedures/diagnostics that manipulate bladder or bowel.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



NURSING PRIORITY NO. 2. To provide for early detection and immediate intervention:

- Investigate associated complaints/symptoms (e.g., severe headache, chest pains, blurred vision, facial flushing, nausea, metallic taste, Horner's syndrome).
- Correct/eliminate causative stimulus (e.g., distended bladder/bowel, skin pressure/irritation, temperature extremes).
- Elevate head of bed to 45-degree angle or place in sitting position to lower blood pressure.
- Monitor vital signs frequently during acute episode. Continue to monitor blood pressure at intervals after symptoms subside to evaluate effectiveness of interventions.
- Administer medications as required to block excessive autonomic nerve transmission, normalize heart rate, and reduce hypertension.
- Carefully adjust dosage of antihypertensive medications for children, the elderly, or pregnant women. (Assists in preventing seizures and maintaining blood pressure within desired range.)
- Apply local anesthetic ointment to rectum; remove impaction after symptoms subside to remove causative problem without causing additional symptoms.

NURSING PRIORITY NO. 3. To promote wellness (Teaching/Discharge Considerations):

- Discuss warning signs and how to avoid onset of syndrome with client/SO(s).
- Instruct client/caregivers in bowel and bladder care, prevention of skin breakdown, care of existing skin breaks, prevention of infection.
- Instruct family member/healthcare provider in blood pressure monitoring during acute episodes.
- Review proper use/administration of medication if indicated.
- Assist client/family in identifying emergency referrals (e.g., physician, rehabilitation nurse/home care supervisor). Place phone number(s) in prominent place.
- Refer to ND risk for Autonomic Dysreflexia.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, noting previous episodes, precipitating factors, and individual signs/symptoms.

PLANNING

- Plan of care and who is involved in planning.
- Teaching plan.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



IMPLEMENTATION/EVALUATION

- Client's responses to interventions and actions performed, understanding of teaching.
- Attainment/progress toward desired outcome(s).
- Modifications to plan of care.

DISCHARGE PLANNING

- Long-term needs and who is responsible for actions to be taken.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Neurological Status: Autonomic

NIC—Dysreflexia Management

risk for Autonomic Dysreflexia

Taxonomy II: Coping/Stress Tolerance—Class 3

Neurobehavioral Stress (00010)

[Diagnostic Division: Circulation]

Nursing Diagnosis Extension and Classification (NDEC)

Submission 1998/Revised 2000

Definition: At risk for life-threatening, uninhibited response of the sympathetic nervous system post spinal shock, in an individual with a spinal cord injury [SCI] or lesion at T6 or above (has been demonstrated in clients with injuries at T7 and T8)

Risk Factors

MUSCULOSKELETAL—INTEGUMENTARY STIMULI

Cutaneous stimulations (e.g., pressure ulcer, ingrown toenail, dressing, burns, rash); sunburns; wounds

Pressure over bony prominences or genitalia; range-of-motion exercises; spasms

Fractures; heterotrophic bone

GASTROINTESTINAL STIMULI

Constipation; difficult passage of feces; fecal impaction; bowel distention; hemorrhoids

Digital stimulation; suppositories; enemas

Gastrointestinal system pathology; esophageal reflux; gastric ulcers; gallstones

UROLOGICAL STIMULI

Bladder distention/spasm

Detrusor sphincter dyssynergia

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



Instrumentation or surgery; calculi
 Urinary tract infection; cystitis; urethritis; epididymitis

REGULATORY STIMULI

Temperature fluctuations; extreme environmental temperatures

SITUATIONAL STIMULI

Positioning; surgical procedure
 Constrictive clothing (e.g., straps, stockings, shoes)
 Drug reactions (e.g., decongestants, sympathomimetics, vasoconstrictors, narcotic withdrawal)

NEUROLOGICAL STIMULI

Painful or irritating stimuli below the level of injury

CARDIAC/PULMONARY STIMULI

Pulmonary emboli; deep vein thrombosis

REPRODUCTIVE [AND SEXUALITY] STIMULI

Sexual intercourse; ejaculation
 Menstruation; pregnancy; labor and delivery; ovarian cyst

NOTE: A risk diagnosis is not evidenced by signs and symptoms, as the problem has not occurred and nursing interventions are directed at prevention.

Desired Outcomes/Evaluation Criteria—Client Will:

- Identify risk factors present.
- Demonstrate preventive/corrective techniques.
- Be free of episodes of dysreflexia.

Actions/Interventions

NURSING PRIORITY NO. 1. To assess risk factors present:




- Monitor for potential precipitating factors, including urological (e.g., bladder distention, urinary tract infections, kidney stones); gastrointestinal (bowel overdistention, hemorrhoids, digital stimulation); cutaneous (e.g., pressure ulcers, extreme external temperatures, dressing changes); reproductive (e.g., sexual activity, menstruation, pregnancy/delivery); and miscellaneous (e.g., pulmonary emboli, drug reaction, deep vein thrombosis).

NURSING PRIORITY NO. 2. To prevent occurrence:




- Monitor vital signs, noting changes in blood pressure, heart rate, and temperature, especially during times of physical stress **to identify trends and intervene in a timely manner.**

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



-  • Instruct in preventive interventions (e.g., routine bowel care, appropriate padding for skin and tissue care, proper positioning, temperature control).
-  • Instruct all care providers in safe and necessary bowel and bladder care, and immediate and long-term care for the prevention of skin stress/breakdown. **These problems are associated most frequently with dysreflexia.**
-  • Administer antihypertensive medications when at-risk client is placed on routine “maintenance dose,” as **might occur when noxious stimuli cannot be removed (presence of chronic sacral pressure sore, fracture, or acute postoperative pain).**
 - Refer to ND Autonomic Dysreflexia.

NURSING PRIORITY NO. 3. To promote wellness (Teaching/Discharge Considerations):

-  • Discuss warning signs of autonomic dysreflexia with client/caregiver (i.e., congestion, anxiety, visual changes, metallic taste in mouth, increased blood pressure/acute hypertension, severe pounding headache, diaphoresis and flushing above the level of SCI, bradycardia, cardiac irregularities). **Early signs can develop rapidly (in minutes), requiring quick intervention.**
-  • Review proper use/administration of medication if preventive medications are anticipated.
-  • Assist client/family in identifying emergency referrals (e.g., healthcare provider number in prominent place).

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, noting previous episodes, precipitating factors, and individual signs/symptoms.

PLANNING

- Plan of care and who is involved in planning.
- Teaching plan.

IMPLEMENTATION/EVALUATION

- Client’s responses to interventions and actions performed, understanding of teaching.
- Attainment/progress toward desired outcome(s).
- Modifications to plan of care.

DISCHARGE PLANNING

- Long-term needs and who is responsible for actions to be taken.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Risk Control

NIC—Dysreflexia Management

disturbed Body Image

Taxonomy II: Self-Perception—Class 3 Body Image (00118)

[Diagnostic Division: Ego Integrity]

Submitted 1973; Revised 1998 (by small group work 1996)

Definition: Confusion [and/or dissatisfaction] in mental picture of one's physical self

Related Factors

Biophysical illness; trauma or injury; surgery; [mutilation, pregnancy]; illness treatment [change caused by biochemical agents (drugs), dependence on machine]

Psychosocial

Cultural or spiritual

Cognitive/perceptual; developmental changes

[Significance of body part or functioning with regard to age, sex, developmental level, or basic human needs]

[Maturational changes]

Defining Characteristics

SUBJECTIVE

Verbalization of feelings/perceptions that reflect an altered view of one's body in appearance, structure, or function; change in life style

Fear of rejection or of reaction by others

Focus on past strength, function, or appearance

Negative feelings about body (e.g., feelings of helplessness, hopelessness, or powerlessness); [depersonalization/grandiosity]

Preoccupation with change or loss

Refusal to verify actual change

Emphasis on remaining strengths, heightened achievement

Personalization of part or loss by name

Depersonalization of part or loss by impersonal pronouns

OBJECTIVE

Missing body part

Actual change in structure and/or function

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



- Nonverbal response to actual or perceived change in structure and/or function; behaviors of avoidance, monitoring, or acknowledgment of one's body
- Not looking at/not touching body part
- Trauma to nonfunctioning part
- Change in ability to estimate spatial relationship of body to environment
- Extension of body boundary to incorporate environmental objects
- Hiding or overexposing body part (intentional or unintentional)
- Change in social involvement
[Aggression; low frustration tolerance level]

Desired Outcomes/Evaluation Criteria—Client Will:

- Verbalize acceptance of self in situation (e.g., chronic progressive disease, amputee, decreased independence, weight as is, effects of therapeutic regimen).
- Verbalize relief of anxiety and adaptation to actual/altered body image.
- Verbalize understanding of body changes.
- Recognize and incorporate body image change into self-concept in accurate manner without negating self-esteem.
- Seek information and actively pursue growth.
- Acknowledge self as an individual who has responsibility for self.
- Use adaptive devices/prosthesis appropriately.





Actions/Interventions

NURSING PRIORITY NO. 1. To assess causative/contributing factors:



- Discuss pathophysiology present and/or situation affecting the individual and refer to additional NDs as appropriate. For example, when alteration in body image is related to neurological deficit (e.g., cerebrovascular accident—CVA), refer to ND unilateral Neglect; in the presence of severe, ongoing pain, refer to chronic Pain; or in loss of sexual desire/ability, refer to Sexual Dysfunction.
- Determine whether condition is permanent/no hope for resolution. (May be associated with other NDs, such as Self-Esteem [specify] or risk for impaired parent/infant/child Attachment, when child is affected.)
- Assess mental/physical influence of illness/condition on the client's emotional state (e.g., diseases of the endocrine system, use of steroid therapy, and so on).

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



- Evaluate level of client's knowledge of and anxiety related to situation. Observe emotional changes.
- Recognize behavior indicative of overconcern with body and its processes.
- Have client describe self, noting what is positive and what is negative. Be aware of how client believes others see self.
-  • Discuss meaning of loss/change to client. A small (seemingly trivial) loss may have a big impact (such as the use of a urinary catheter or enema for continence). A change in function (such as immobility) may be more difficult for some to deal with than a change in appearance. Permanent facial scarring of child may be difficult for parents to accept.
-  • Use developmentally appropriate communication techniques for determining exact expression of body image in child (e.g., puppet play or constructive dialogue for toddler). Developmental capacity must guide interaction to gain accurate information.
-  • Note signs of grieving/indicators of severe or prolonged depression to evaluate need for counseling and/or medications.
-  • Determine ethnic background and cultural/religious perceptions and considerations.
- Identify social aspects of illness/disease (e.g., sexually transmitted diseases, sterility, chronic conditions).
- Observe interaction of client with SO(s). Distortions in body image may be unconsciously reinforced by family members, and/or secondary gain issues may interfere with progress.

NURSING PRIORITY NO. 2. To determine coping abilities and skills:

- Assess client's current level of adaptation and progress.
- Listen to client's comments and responses to the situation. Different situations are upsetting to different people, depending on individual coping skills and past experiences.
- Note withdrawn behavior and the use of denial. May be normal response to situation or may be indicative of mental illness (e.g., schizophrenia). (Refer to ND ineffective Denial.)
-  • Note use of addictive substances/alcohol; may reflect dysfunctional coping.
- Identify previously used coping strategies and effectiveness.
-  • Determine individual/family/community resources.

NURSING PRIORITY NO. 3. To assist client and SO(s) to deal with/accept issues of self-concept related to body image:

- Establish therapeutic nurse-client relationship conveying an attitude of caring and developing a sense of trust.
- Visit client frequently and acknowledge the individual as someone who is worthwhile. Provides opportunities for listening to concerns and questions.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.






- Assist in correcting underlying problems to promote optimal healing/adaptation.
- Provide assistance with self-care needs/measures as necessary while promoting individual abilities/independence.
- Work with client's self-concept without moral judgments regarding client's efforts or progress (e.g., "You should be progressing faster; you're weak/lazy/not trying hard enough").
- Discuss concerns about fear of mutilation, prognosis, rejection when client facing surgery or potentially poor outcome of procedure/illness, to address realities and provide emotional support.
- Acknowledge and accept feelings of dependency, grief, and hostility.
- Encourage verbalization of and role-play anticipated conflicts to enhance handling of potential situations.
- Encourage client and SO(s) to communicate feelings to each other.
- Assume all individuals are sensitive to changes in appearance but avoid stereotyping.
- Alert staff to monitor own facial expressions and other nonverbal behaviors because they need to convey acceptance and not revulsion when the client's appearance is affected.
- Encourage family members to treat client normally and not as an invalid.
- Encourage client to look at/touch affected body part to begin to incorporate changes into body image.
- Allow client to use denial without participating (e.g., client may at first refuse to look at a colostomy; the nurse says "I am going to change your colostomy now" and proceeds with the task). Provides individual time to adapt to situation.
- Set limits on maladaptive behavior, and assist client to identify positive behaviors to aid in recovery.
- Provide accurate information as desired/requested. Reinforce previously given information.
- Discuss the availability of prosthetics, reconstructive surgery, and physical/occupational therapy or other referrals as dictated by individual situation.
- Help client to select and use clothing/makeup to minimize body changes and enhance appearance.
- Discuss reasons for infectious isolation and procedures when used and make time to sit down and talk/listen to client while in the room to decrease sense of isolation/loneliness.

NURSING PRIORITY NO. 4. To promote wellness (Teaching/Discharge Considerations):

- Begin counseling/other therapies (e.g., biofeedback/relaxation) as soon as possible to provide early/ongoing sources of support.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



- Provide information at client's level of acceptance and in small pieces **to allow easier assimilation**. Clarify misconceptions. Reinforce explanations given by other health team members.
- Include client in decision-making process and problem-solving activities.
-  • Assist client to incorporate therapeutic regimen into activities of daily living (ADLs) (e.g., including specific exercises, housework activities). **Promotes continuation of program.**
-  • Identify/plan for alterations to home and work environment/activities **to accommodate individual needs and support independence.**
 - Assist client in learning strategies for dealing with feelings/venting emotions.
 - Offer positive reinforcement for efforts made (e.g., wearing makeup, using prosthetic device).
-  • Refer to appropriate support groups.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Observations, presence of maladaptive behaviors, emotional changes, stage of grieving, level of independence.
- Physical wounds, dressings; use of life-support–type machine (e.g., ventilator, dialysis machine).
- Meaning of loss/change to client.
- Support systems available (e.g., SOs, friends, groups).

PLANNING

- Plan of care and who is involved in planning.
- Teaching plan.

IMPLEMENTATION/EVALUATION

- Client's response to interventions/teaching and actions performed.
- Attainment/progress toward desired outcome(s).
- Modifications of plan of care.

DISCHARGE PLANNING

- Long-term needs and who is responsible for actions.
- Specific referrals made (e.g., rehabilitation center, community resources).

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Body Image

NIC—Body Image Enhancement

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



risk for imbalanced Body Temperature

Taxonomy II: Safety/Protection—Class 6
 Thermoregulation (00005)
 [Diagnostic division: Safety]
 Submitted 1986; Revised 2000

Definition: At risk for failure to maintain body temperature within normal range

Risk Factors

Extremes of age, weight
 Exposure to cold/cool or warm/hot environments
 Dehydration
 Inactivity or vigorous activity
 Medications causing vasoconstriction/vasodilation, altered metabolic rate, sedation, [use or overdose of certain drugs or exposure to anesthesia]
 Inappropriate clothing for environmental temperature
 Illness or trauma affecting temperature regulation [e.g., infections, systemic or localized; neoplasms, tumors; collagen/vascular disease]




NOTE: A risk diagnosis is not evidenced by signs and symptoms, as the problem has not occurred and nursing interventions are directed at prevention.

Desired Outcomes/Evaluation Criteria—Client Will:

- Maintain body temperature within normal range.
- Verbalize understanding of individual risk factors and appropriate interventions.
- Demonstrate behaviors for monitoring and maintaining appropriate body temperature.





Actions/Interventions

NURSING PRIORITY NO. 1. To identify causative/risk factors present:




-  Determine if present illness/condition results from exposure to environmental factors, surgery, infection, trauma.
-  Monitor laboratory values (e.g., tests indicative of infection, drug screens).
-  Note client's age (e.g., premature neonate, young child, or aging individual), as it can directly impact ability to maintain/regulate body temperature and respond to changes in environment.
- Assess nutritional status.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.

NURSING PRIORITY NO. 2. To prevent occurrence of temperature alteration:

- Monitor/maintain comfortable ambient environment. Provide heating/cooling measures as indicated.
-  • Cover head with knit cap, place infant under radiant warmer or adequate blankets. **Heat loss in newborn/infants is greatest through head and by evaporation and convection.**
- Monitor core body temperature. (Tympanic temperature may be preferred, as it is the most accurate noninvasive method.)
-  • Restore/maintain core temperature within client's normal range. (Refer to NDs Hypothermia and Hyperthermia.)
-   • Refer at-risk persons to appropriate community resources (e.g., home care/social services, Foster Adult Care, housing agencies) to provide assistance to meet individual needs.

NURSING PRIORITY NO. 3. To promote wellness (Teaching/Discharge Considerations):

-  • Review potential problem/individual risk factors with client/SO(s).
-  • Instruct in measures to protect from identified risk factors (e.g., too warm, too cold environment; improper medication regimen; drug overdose; inappropriate clothing/shelter; poor nutritional status).
-  • Review ways to prevent accidental alterations, such as induced hypothermia as a result of overzealous cooling to reduce fever or maintaining too warm an environment for client who has lost the ability to perspire.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Identified individual causative/risk factors.
- Record of core temperature, initially and prn.
- Results of diagnostic studies/laboratory tests.

PLANNING

- Plan of care and who is involved in planning.
- Teaching plan, including best ambient temperature, and ways to prevent hypothermia or hyperthermia.

IMPLEMENTATION/EVALUATION

- Response to interventions/teaching and actions performed.
- Attainment/progress toward desired outcome(s).
- Modifications to plan of care.

DISCHARGE PLANNING

- Long-term needs and who is responsible for actions.
- Specific referrals made.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Risk Control

NIC—Temperature Regulation

Bowel Incontinence

Taxonomy II: Elimination—Class 2 Gastrointestinal System (00014)

[Diagnostic Division: Elimination]

Submitted 1975; Nursing Diagnosis Extension and Classification (NDEC) Revision 1998

Definition: Change in normal bowel habits characterized by involuntary passage of stool

Related Factors

Self-care deficit—inefficient toileting; impaired cognition; immobility; environmental factors (e.g., inaccessible bathroom)

Dietary habits; medications; laxative abuse

Stress

Colorectal lesions

Incomplete emptying of bowel; impaction; chronic diarrhea

General decline in muscle tone; abnormally high abdominal or intestinal pressure

Impaired reservoir capacity

Rectal sphincter abnormality; loss of rectal sphincter control; lower/upper motor nerve damage

Defining Characteristics

SUBJECTIVE

Recognizes rectal fullness but reports inability to expel formed stool

Urgency

Inability to delay defecation

Self-report of inability to feel rectal fullness

OBJECTIVE

Constant dribbling of soft stool

Fecal staining of clothing and/or bedding

Fecal odor

Red perianal skin

Inability to recognize/inattention to urge to defecate

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



Desired Outcomes/Evaluation Criteria—Client Will:

- Verbalize understanding of causative/controlling factors.
- Identify individually appropriate interventions.
- Participate in therapeutic regimen to control incontinence.
- Establish/maintain as regular a pattern of bowel functioning as possible.

Actions/Interventions

NURSING PRIORITY NO. 1. To assess causative/contributing factors:

- Identify pathophysiological factors present (e.g., multiple sclerosis, acute/chronic cognitive impairment, spinal cord injury, stroke, ileus, ulcerative colitis).
- Note times/aspects of incontinent occurrence, preceding/precipitating events.
- Check for presence/absence of anal sphincter reflex or impaction, which may be contributing factors.
- Review medication regimen for side effects/interactions.
- Test stool for blood (guaiac) as appropriate.
- Palpate abdomen for distention, masses, tenderness.



NURSING PRIORITY NO. 2. To determine current pattern of elimination:

- Note stool characteristics (color, odor, consistency, amount, shape, and frequency). Provides comparative baseline.
- Encourage client or SO to record times at which incontinence occurs, to note relationship to meals, activity, client's behavior.
- Auscultate abdomen for presence, location, and characteristics of bowel sounds.

NURSING PRIORITY NO. 3. To promote control/management of incontinence:

- Assist in treatment of causative/contributing factors (e.g., as listed in the Related Factors and Defining Characteristics).
- Establish bowel program with regular time for defecation; use suppositories and/or digital stimulation when indicated. Maintain daily program initially. Progress to alternate days dependent on usual pattern/amount of stool.
- Take client to the bathroom/place on commode or bedpan at specified intervals, taking into consideration individual needs and incontinence patterns to maximize success of program.
- Encourage and instruct client/caregiver in providing diet high in bulk/fiber and adequate fluids (minimum of 2000 to

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



2400 mL/day). Encourage warm fluids after meals. Identify/eliminate problem foods to avoid diarrhea/constipation, gas formation.



- Give stool softeners/bulk formers as indicated/needed.
- Provide pericare to avoid excoriation of the area.
- Promote exercise program, as individually able, to increase muscle tone/strength, including perineal muscles.
- Provide incontinence aids/pads until control is obtained.
- Demonstrate techniques (e.g., contracting abdominal muscles, leaning forward on commode, manual compression) to increase intra-abdominal pressure during defecation, and left to right abdominal massage to stimulate peristalsis.
- Refer to ND Diarrhea if incontinence is due to uncontrolled diarrhea; ND Constipation if diarrhea is due to impaction.

NURSING PRIORITY NO. 4. To promote wellness (Teaching/Discharge Considerations):



- Review and encourage continuation of successful interventions as individually identified.
- Instruct in use of laxatives or stool softeners, if indicated, to stimulate timed defecation.
- Identify foods that promote bowel regularity.
- Provide emotional support to client and SO(s), especially when condition is long-term or chronic.
- Encourage scheduling of social activities within time frame of bowel program as indicated (e.g., avoid a 4-hour excursion if bowel program requires toileting every 3 hours and facilities will not be available) to maximize social functioning and success of bowel program.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Current and previous pattern of elimination/physical findings, character of stool, actions tried.

PLANNING

- Plan of care and who is involved in planning.
- Teaching plan.

IMPLEMENTATION/EVALUATION

- Client's/caregiver's responses to interventions/teaching and actions performed.
- Changes in pattern of elimination, characteristics of stool.
- Attainment/progress toward desired outcome(s).
- Modifications to plan of care.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



DISCHARGE PLANNING

- Identified long-term needs, noting who is responsible for each action.
- Specific bowel program at time of discharge.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Bowel Continence

NIC—Bowel Incontinence Care

effective Breastfeeding [Learning Need]*

Taxonomy II: Role Relationships—Class 3 Role
Performance (00106)
[Diagnostic Division: Food/Fluid]
Submitted 1990

Definition: Mother-infant dyad/family exhibits adequate proficiency and satisfaction with breastfeeding process

Related Factors

Basic breastfeeding knowledge
Normal breast structure
Normal infant oral structure
Infant gestational age greater than 34 weeks
Support sources [available]
Maternal confidence

Defining Characteristics**SUBJECTIVE**

Maternal verbalization of satisfaction with the breastfeeding process

OBJECTIVE

Mother able to position infant at breast to promote a successful latch-on response
Infant is content after feedings

*This nursing diagnosis is difficult to address, as the Related Factors and Defining Characteristics are in fact the outcome/evaluation criteria that would be desired. We believe that normal breastfeeding behaviors need to be learned and supported, with interventions directed at learning activities for enhancement.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



Regular and sustained suckling/swallowing at the breast [e.g., 8 to 10 times/24 h]

Appropriate infant weight patterns for age

Effective mother/infant communication pattern (infant cues, maternal interpretation and response)

Signs and/or symptoms of oxytocin release (let-down or milk ejection reflex)

Adequate infant elimination patterns for age; [stools soft; more than 6 wet diapers/day of unconcentrated urine]



Eagerness of infant to nurse

Desired Outcomes/Evaluation Criteria – Client Will:

- Verbalize understanding of breastfeeding techniques.
- Demonstrate effective techniques for breastfeeding.
- Demonstrate family involvement and support.
- Attend classes/read appropriate materials as necessary.

Actions/Interventions



NURSING PRIORITY NO. 1. To assess individual learning needs:

- Assess mother's knowledge and previous experience with breastfeeding.
-  • Monitor effectiveness of current breastfeeding efforts.
-  • Determine support systems available to mother/family.





NURSING PRIORITY NO. 2. To promote effective breastfeeding behaviors:

- Initiate breastfeeding within first hour after birth.
- Demonstrate how to support and position infant.
- Observe mother's return demonstration.
- Keep infant with mother for **unrestricted breastfeeding duration and frequency.**
- Encourage mother to drink at least 2000 mL of fluid per day or 8 oz every hour.
- Provide information as needed.

NURSING PRIORITY NO. 3. To promote wellness (Teaching/Discharge Considerations):

-  • Provide for follow-up contact/home visit 48 hours after discharge; repeat visit as necessary to **provide support and assist with problem-solving, if needed.**
-  • Recommend monitoring number of infant's wet diapers (at least 6 wet diapers in 24 hours suggests adequate hydration).
- Encourage mother/other family members to express feelings/concerns, and **Active-listen to determine nature of concerns.**

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.

-  • Review techniques for expression and storage of breast milk to help sustain breastfeeding activity.
-  • Problem-solve return-to-work issues or periodic infant care requiring bottle feeding.
-   • Refer to support groups, such as La Leche League, as indicated.
- Refer to ND Breastfeeding, ineffective for more specific information as appropriate.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Identified assessment factors (maternal and infant).
- Number of daily wet diapers and periodic weight.

PLANNING

- Plan of care/interventions and who is involved in the planning.
- Teaching plan.

IMPLEMENTATION/EVALUATION

- Mother's response to actions/teaching plan and actions performed.
- Effectiveness of infant's efforts to feed.
- Attainment/progress toward desired outcome(s).
- Modifications to plan of care.

DISCHARGE PLANNING

- Long-term needs/referrals and who is responsible for follow-up actions.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Breastfeeding Maintenance

NIC—Lactation Counseling

ineffective Breastfeeding

Taxonomy II: Role Relationships—Class 3 Role

Performance (00104)

[Diagnostic Division: Food/Fluid]

Submitted 1988

Definition: Dissatisfaction or difficulty that a mother, infant, or child experiences with the breastfeeding process

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



Related Factors

Prematurity; infant anomaly; poor infant sucking reflex
 Infant receiving [numerous or repeated] supplemental feedings with artificial nipple
 Maternal anxiety or ambivalence
 Knowledge deficit
 Previous history of breastfeeding failure
 Interruption in breastfeeding
 Nonsupportive partner/family
 Maternal breast anomaly; previous breast surgery; [painful nipples/breast engorgement]

Defining Characteristics

SUBJECTIVE

Unsatisfactory breastfeeding process
 Persistence of sore nipples beyond the first week of breastfeeding
 Insufficient emptying of each breast per feeding
 Actual or perceived inadequate milk supply

OBJECTIVE

Observable signs of inadequate infant intake [decrease in number of wet diapers, inappropriate weight loss/or inadequate gain]
 Nonsustained or insufficient opportunity for suckling at the breast; infant inability [failure] to attach onto maternal breast correctly
 Infant arching and crying at the breast; resistant latching on
 Infant exhibiting fussiness and crying within the first hour after breastfeeding; unresponsive to other comfort measures
 No observable signs of oxytocin release

Desired Outcomes/Evaluation Criteria—Client Will:

- Verbalize understanding of causative/contributing factors.
- Demonstrate techniques to improve/enhance breastfeeding.
- Assume responsibility for effective breastfeeding.
- Achieve mutually satisfactory breastfeeding regimen with infant content after feedings and gaining weight appropriately.





Actions/Interventions

NURSING PRIORITY NO. 1. To identify maternal causative/contributing factors:






- Assess client knowledge about breastfeeding and extent of instruction that has been given.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



- Encourage discussion of current/previous breastfeeding experience(s).
- Note previous unsatisfactory experience (including self or others) **because it may be affecting current situation.**
- Do physical assessment, noting appearance of breasts/nipples, marked asymmetry of breasts, obvious inverted or flat nipples, minimal or no breast enlargement during pregnancy.
- Determine whether lactation failure is primary (i.e., maternal prolactin deficiency/serum prolactin levels, inadequate mammary gland tissue, breast surgery that has damaged the nipple, areola enervation-irremediable) or secondary (i.e., sore nipples, severe engorgement, plugged milk ducts, mastitis, inhibition of let-down reflex, maternal/infant separation with disruption of feedings-treatable).
- Note history of pregnancy, labor and delivery (vaginal or cesarean section), other recent or current surgery; preexisting medical problems (e.g., diabetes, epilepsy, cardiac diseases, or presence of disabilities).
-  • Identify maternal support systems; presence and response of SO(s), extended family, friends.
-  • Ascertain mother's age, number of children at home, and need to return to work.
-  • Determine maternal feelings (e.g., fear/anxiety, ambivalence, depression).
-  • Ascertain cultural expectations/conflicts.






NURSING PRIORITY NO. 2. To assess infant causative/contributing factors:

-  • Determine suckling problems, as noted in Related Factors/Defining Characteristics.
- Note prematurity and/or infant anomaly (e.g., cleft palate).
-  • Review feeding schedule, **to note increased demand for feeding (at least 8 times/day, taking both breasts at each feeding for more than 15 minutes on each side) or use of supplements with artificial nipple.**
-  • Evaluate observable signs of inadequate infant intake (e.g., baby latches onto mother's nipples with sustained suckling but minimal audible swallowing/gulping noted, infant arching and crying at the breasts with resistance to latching on, decreased urinary output/frequency of stools, inadequate weight gain).
-  • Determine whether baby is content after feeding, or exhibits fussiness and crying within the first hour after breastfeeding, **suggesting unsatisfactory breastfeeding process.**
-  • Note any correlation between maternal ingestion of certain foods and "colicky" response of infant.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



NURSING PRIORITY NO. 3. To assist mother to develop skills of adequate breastfeeding:

-  • Give emotional support to mother. Use 1:1 instruction with each feeding during hospital stay/clinic/home visit.
- Inform mother that some babies do not cry when they are hungry; instead some make “rooting” motions and suck their fingers.
- Recommend avoidance or overuse of supplemental feedings and pacifiers (unless specifically indicated) **that can lessen infant’s desire to breastfeed.**
- Restrict use of breast shields (i.e., only temporarily to help draw the nipple out), then place baby directly on nipple.
-  • Demonstrate use of electric piston-type breast pump with bilateral collection chamber when necessary **to maintain or increase milk supply.**
-  • Encourage frequent rest periods, sharing household/child-care duties **to limit fatigue and facilitate relaxation at feeding times.**
-  • Suggest abstinence/restriction of tobacco, caffeine, alcohol, drugs, excess sugar **because they may affect milk production/let-down reflex or be passed on to the infant.**
-  • Promote early management of breastfeeding problems. For example:



Engorgement: Heat and/or cool applications to the breasts, massage from chest wall down to nipple; use synthetic oxytocin nasal spray **to enhance let-down reflex**; soothe “fussy baby” before latching on the breast, properly position baby on breast/nipple, alternate the side baby starts nursing on, nurse round-the-clock and/or pump with piston-type electric breast pump with bilateral collection chambers at least 8 to 12 times/day.



Sore nipples: Wear 100% cotton fabrics, do not use soap/alcohol/drying agents on nipples, avoid use of nipple shields or nursing pads that contain plastic; cleanse and then air dry, use thin layers of lanolin (if mother/baby not sensitive to wool); provide exposure to sunlight/sunlamps with extreme caution; administer mild pain reliever as appropriate, apply ice before nursing; soak with warm water before attaching infant **to soften nipple and remove dried milk**, begin with least sore side or begin with hand expression **to establish let-down reflex**, properly position infant on breast/nipple, and use a variety of nursing positions.

Clogged ducts: Use larger bra or extender to avoid pressure on site; use moist or dry heat, gently massage from above plug down to nipple; nurse infant, hand express, or pump after massage; nurse more often on affected side.

Inhibited let-down: Use relaxation techniques before nursing

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.






(e.g., maintain quiet atmosphere, assume position of comfort, massage, apply heat to breasts, have beverage available); develop a routine for nursing, concentrate on infant; administer synthetic oxytocin nasal spray as appropriate.












Mastitis: Promote bedrest (with infant) for several days; administer antibiotics; provide warm, moist heat before and during nursing; empty breasts completely, continuing to nurse baby at least 8 to 12 times/day, or pumping breasts for 24 hours; then resuming breastfeeding as appropriate.

NURSING PRIORITY NO. 4. To condition infant to breastfeed:

- Scent breast pad with breast milk and leave in bed with infant along with mother's photograph when separated from mother for medical purposes (e.g., prematurity).
- Increase skin-to-skin contact.
- Provide practice times at breast.
- Express small amounts of milk into baby's mouth.
- Have mother pump breast after feeding to enhance milk production.
- Use supplemental nutrition system cautiously when necessary.
-  • Identify special interventions for feeding in presence of cleft lip/palate.

NURSING PRIORITY NO. 5. To promote wellness (Teaching/Discharge Considerations):

-  • Schedule follow-up visit with healthcare provider 48 hours after hospital discharge and 2 weeks after birth for evaluation of milk intake/breastfeeding process.
-  • Recommend monitoring number of infant's wet diapers (at least 6 wet diapers in 24 hours suggests adequate hydration).
-  • Weigh infant at least every third day as indicated and record (to verify adequacy of nutritional intake).
-  • Encourage spouse education and support when appropriate. Review mother's need for rest, relaxation, and time with other children as appropriate.
-  • Discuss importance of adequate nutrition/fluid intake, prenatal vitamins, or other vitamin/mineral supplements, such as vitamin C, as indicated.
-  • Address specific problems (e.g., suckling problems, prematurity/anomalies).
-  • Inform mother that return of menses within first 3 months after infant's birth may indicate inadequate prolactin levels.
-  • Refer to support groups (e.g., La Leche League, parenting support groups, stress reduction, or other community resources as indicated).
-  • Provide bibliotherapy for further information.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



Documentation Focus

ASSESSMENT/REASSESSMENT

- Identified assessment factors, both maternal and infant (e.g., is engorgement present, is infant demonstrating adequate weight gain without supplementation).

PLANNING

- Plan of care/interventions and who is involved in planning.
- Teaching plan.

IMPLEMENTATION/EVALUATION

- Mother's/infant's responses to interventions/teaching and actions performed.
- Attainment/progress toward desired outcome(s).
- Modifications to plan of care.

DISCHARGE PLANNING

- Referrals that have been made and mother's choice of participation.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Breastfeeding Establishment: Maternal or Infant

NIC—Breastfeeding Assistance

interrupted Breastfeeding

Taxonomy II: Role Relationships—Class 3 Role
Performance (00105)
[Diagnostic Division: Food/Fluid]
Submitted 1992

Definition: Break in the continuity of the breastfeeding process as a result of inability or inadvisability to put baby to breast for feeding

Related Factors

Maternal or infant illness

Prematurity

Maternal employment

Contraindications to breastfeeding (e.g., drugs, true breast milk jaundice)

Need to abruptly wean infant

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



Defining Characteristics

SUBJECTIVE

Infant does not receive nourishment at the breast for some or all of feedings

Maternal desire to maintain lactation and provide (or eventually provide) her breast milk for her infant's nutritional needs

Lack of knowledge regarding expression and storage of breast milk

OBJECTIVE

Separation of mother and infant




Desired Outcomes/Evaluation

Criteria—Client Will:




- Identify and demonstrate techniques to sustain lactation until breastfeeding is reinitiated.
- Achieve mutually satisfactory feeding regimen with infant content after feedings and gaining weight appropriately.
- Achieve weaning and cessation of lactation if desired or necessary.

Actions/Interventions

NURSING PRIORITY NO. 1. To identify causative/contributing factors:

- Assess client knowledge and perceptions about breastfeeding and extent of instruction that has been given.
- Encourage discussion of current/previous breastfeeding experience(s).
-  • Determine maternal responsibilities, routines, and scheduled activities (e.g., caretaking of siblings, employment in/out of home, work/school schedules of family members, ability to visit hospitalized infant).
-  • Note contraindications to breastfeeding (e.g., maternal illness, drug use); desire/need to wean infant.
-  • Ascertain cultural expectations/conflicts.

NURSING PRIORITY NO. 2. To assist mother to maintain or conclude breastfeeding as desired/required:

-  • Give emotional support to mother and accept decision regarding cessation/continuation of breastfeeding.
-  • Demonstrate use of manual and/or electric piston-type breast pump.
-  • Suggest abstinence/restriction of tobacco, caffeine, alcohol, drugs, excess sugar as appropriate when breastfeeding is reinitiated.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



tiated because they may affect milk production/let-down reflex or be passed on to the infant.

- Provide information (e.g., wearing a snug, well-fitting brassiere, avoiding stimulation, and using medication for discomfort to support weaning process).

NURSING PRIORITY NO. 3. To promote successful infant feeding:

- Review techniques for storage/use of expressed breast milk to provide optimal nutrition and promote continuation of breastfeeding process.
- Discuss proper use and choice of supplemental nutrition and alternate feeding method (e.g., bottle/syringe).
- Review safety precautions (e.g., proper flow of formula from nipple, frequency of burping, holding bottle instead of propping, formula preparation, and sterilization techniques).
- Determine if a routine visiting schedule or advance warning can be provided so that infant will be hungry/ready to feed.
- Provide privacy, calm surroundings when mother breastfeeds in hospital setting.
- Recommend/provide for infant sucking on a regular basis, especially if gavage feedings are part of the therapeutic regimen. Reinforces that feeding time is pleasurable and enhances digestion.

NURSING PRIORITY NO. 4. To promote wellness (Teaching/Discharge Considerations):

- Encourage mother to obtain adequate rest, maintain fluid and nutritional intake, and schedule breast pumping every 3 hours while awake as indicated to sustain adequate milk production and breastfeeding process.
- Identify other means of nurturing/strengthening infant attachment (e.g., comforting, consoling, play activities).
- Refer to support groups (e.g., La Leche League, Lact-Aid), community resources (e.g., public health nurse, lactation specialist).
- Promote use of bibliotherapy for further information.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Baseline findings maternal/infant factors.
- Number of wet diapers daily/periodic weight.

PLANNING

- Plan of care and who is involved in planning.
- Teaching plan.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.

IMPLEMENTATION/EVALUATION

- Maternal response to interventions/teaching and actions performed.
- Infant's response to feeding and method.
- Whether infant appears satisfied or still seems to be hungry.
- Attainment/progress toward desired outcome(s).
- Modifications to plan of care.

DISCHARGE PLANNING

- Plan for follow-up and who is responsible.
- Specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Breastfeeding Maintenance

NIC—Lactation Counseling

ineffective Breathing Pattern

Taxonomy II: Activity/Rest—Class 4

Cardiovascular/Pulmonary Responses (00032)

[Diagnostic Division: Respiration]

Submitted 1980; Revised 1996, and Nursing Diagnosis Extension and Classification (NDEC) 1998

Definition: Inspiration and/or expiration that does not provide adequate ventilation

Related Factors

Neuromuscular dysfunction; SCI; neurological immaturity

Musculoskeletal impairment; bony/chest wall deformity

Anxiety

Pain

Perception/cognitive impairment

Decreased energy/fatigue; respiratory muscle fatigue

Body position; obesity

Hyperventilation; hypoventilation syndrome; [alteration of client's normal O₂:CO₂ ratio (e.g., O₂ therapy in COPD)]

Defining Characteristics**SUBJECTIVE**

Shortness of breath

OBJECTIVE

Dyspnea; orthopnea

Respiratory rate:

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



Adults >14 yr: ≤ 11 or $[>]24$
 Children 1 to 4 yr, <20 or >30
 5 to 14 yr, <14 or >25
 Infants [0 to 12 mo], <25 or >60

Depth of breathing:

Adult tidal volume: 500 mL at rest

Infant tidal volume: 6 to 8 mL/kg

Timing ratio; prolonged expiration phases; pursed-lip breathing

Decreased minute ventilation; vital capacity

Decreased inspiratory/expiratory pressure

Use of accessory muscles to breathe; assumption of three-point position

Altered chest excursion; [paradoxical breathing patterns]

Nasal flaring; [grunting]

Increased anterior-posterior diameter

Desired Outcomes/Evaluation

Criteria—Client Will:

- Establish a normal/effective respiratory pattern.
- Be free of cyanosis and other signs/symptoms of hypoxia with ABGs within client's normal/acceptable range.
- Verbalize awareness of causative factors and initiate needed lifestyle changes.
- Demonstrate appropriate coping behaviors.

Actions/Interventions





NURSING PRIORITY NO. 1. To identify etiology/precipitating factors:

- Auscultate chest, noting presence/character of breath sounds, presence of secretions.
- Note rate and depth of respirations, type of breathing pattern: tachypnea, Cheyne-Stokes, other irregular patterns.
- Assist with necessary testing (e.g., lung volumes/flow studies, pulmonary function/sleep studies) to diagnose presence/severity of lung diseases.
- Review chest x-rays as indicated for severity of acute/chronic conditions.
- Review laboratory data, for example, ABGs (**determine degree of oxygenation, CO₂ retention**); drug screens; and pulmonary function studies (**determine vital capacity/tidal volume**).
- Note emotional responses, for example, gasping, crying, tingling fingers. (**Hyperventilation may be a factor.**)
- Assess for concomitant pain/discomfort that may restrict/limit respiratory effort.





NURSING PRIORITY NO. 2. To provide for relief of causative factors:

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



- Administer oxygen at lowest concentration indicated for underlying pulmonary condition, respiratory distress, or cyanosis.
- Suction airway as needed to clear secretions.
-  • Assist with bronchoscopy or chest tube insertion as indicated.
- Elevate HOB as appropriate to promote physiological/psychological ease of maximal inspiration.
- Encourage slower/deeper respirations, use of pursed-lip technique, and so on to assist client in “taking control” of the situation.
- Have client breathe into a paper bag to correct hyperventilation.
- Maintain calm attitude while dealing with client and SO(s) to limit level of anxiety.
- Assist client in the use of relaxation techniques.
- Deal with fear/anxiety that may be present. (Refer to NDs Fear and/or Anxiety.)
- Encourage position of comfort. Reposition client frequently if immobility is a factor.
- Splint rib cage during deep-breathing exercises/cough if indicated.
-  • Medicate with analgesics as appropriate to promote deeper respiration and cough. (Refer to NDs acute Pain, or chronic Pain.)
- Encourage ambulation as individually indicated.
- Avoid overeating/gas-forming foods; may cause abdominal distention.
-  • Provide use of adjuncts, such as incentive spirometer, to facilitate deeper respiratory effort.
- Supervise use of respirator/diaphragmatic stimulator, rocking bed, apnea monitor, and so forth when neuromuscular impairment is present.
-  • Maintain emergency equipment in readily accessible location and include age/size appropriate ET/trach tubes (e.g., infant, child, adolescent, or adult).

NURSING PRIORITY NO. 3. To promote wellness (Teaching/Discharge Considerations):

-  • Review etiology and possible coping behaviors.
-  • Teach conscious control of respiratory rate as appropriate.
-  • Maximize respiratory effort with good posture and effective use of accessory muscles.
- Assist client to learn breathing exercises: diaphragmatic, abdominal breathing, inspiratory resistive, and pursed-lip as indicated.
-  • Recommend energy conservation techniques and pacing of activities.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



- Encourage adequate rest periods between activities to limit fatigue.
- Discuss relationship of smoking to respiratory function.
- Encourage client/SO(s) to develop a plan for smoking cessation. Provide appropriate referrals.
- Instruct in proper use and safety concerns for home oxygen therapy as indicated.
- Make referral to support groups/contact with individuals who have encountered similar problems.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Relevant history of problem.
- Respiratory pattern, breath sounds, use of accessory muscles.
- Laboratory values.
- Use of respiratory supports, ventilator settings, and so forth.

PLANNING

- Plan of care/interventions and who is involved in the planning.
- Teaching plan.

IMPLEMENTATION/EVALUATION

- Response to interventions/teaching, actions performed, and treatment regimen.
- Mastery of skills, level of independence.
- Attainment/progress toward desired outcome(s).
- Modifications to plan of care.

DISCHARGE PLANNING

- Long-term needs, including appropriate referrals and action taken, available resources.
- Specific referrals provided.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Respiratory Status: Ventilation

NIC—Ventilation Assistancess

decreased Cardiac Output

Taxonomy II: Activity/Rest—Class 4
 Cardiovascular/Pulmonary Responses (00029)
 [Diagnostic Division: Circulation]
 Submitted 1975; Revised 1996, 2000

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



Definition: Inadequate blood pumped by the heart to meet the metabolic demands of the body. [Note: In a hypermetabolic state, although cardiac output may be within normal range, it may still be inadequate to meet the needs of the body's tissues. Cardiac output and tissue perfusion are interrelated, although there are differences. When cardiac output is decreased, tissue perfusion problems will develop; however, tissue perfusion problems can exist without decreased cardiac output.]

Related Factors

Altered heart rate/rhythm, [conduction]
 Altered stroke volume: altered preload [e.g., decreased venous return]; altered afterload [e.g., systemic vascular resistance]; altered contractility [e.g., ventricular-septal rupture, ventricular aneurysm, papillary muscle rupture, valvular disease]

Defining Characteristics

SUBJECTIVE

Altered Heart Rate/Rhythm: Palpitations
 Altered Preload: Fatigue
 Altered Afterload: Shortness of breath/dyspnea
 Altered Contractility: Orthopnea/paroxysmal nocturnal dyspnea [PND]
 Behavioral/Emotional: Anxiety

OBJECTIVE

Altered Heart Rate/Rhythm: [Dys]arrhythmias (tachycardia, bradycardia); EKG [ECG] changes
 Altered Preload: Jugular vein distention (JVD); edema; weight gain; increased/decreased central venous pressure (CVP); increased/decreased pulmonary artery wedge pressure (PAWP); murmurs
 Altered Afterload: Cold, clammy skin; skin [and mucous membrane] color changes [cyanosis, pallor]; prolonged capillary refill; decreased peripheral pulses; variations in blood pressure readings; increased/decreased systemic vascular resistance (SVR)/pulmonary vascular resistance (PVR); oliguria; [anuria]
 Altered Contractility: Crackles; cough; cardiac output, 4 L/min; cardiac index, 2.5 L/min; decreased ejection fraction, stroke volume index (SVI), left ventricular stroke work index (LVSWI); S3 or S4 sounds [gallop rhythm]
 Behavioral/Emotional: Restlessness

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



Desired Outcomes/Evaluation Criteria—Client Will:

- Display hemodynamic stability (e.g., blood pressure, cardiac output, renal perfusion/urinary output, peripheral pulses).
- Report/demonstrate decreased episodes of dyspnea, angina, and dysrhythmias.
- Demonstrate an increase in activity tolerance.
- Verbalize knowledge of the disease process, individual risk factors, and treatment plan.
- Participate in activities that reduce the workload of the heart (e.g., stress management or therapeutic medication regimen program, weight reduction, balanced activity/rest plan, proper use of supplemental oxygen, cessation of smoking).
- Identify signs of cardiac decompensation, alter activities, and seek help appropriately.

Actions/Interventions

NURSING PRIORITY NO. 1. To identify causative/contributing factors:

- Review clients at risk as noted in Related Factors. Note: Individuals with brainstem trauma, spinal cord injuries at T7 or above, may be at risk for altered cardiac output due to an uninhibited sympathetic response. (Refer to ND risk for Autonomic Dysreflexia.)



- Evaluate medication regimen; note drug use/abuse.
- Assess potential for/type of developing shock states: hematogenic, bacteremic, cardiogenic, vasogenic, and psychogenic.



- Review laboratory data (e.g., complete blood cell—CBC—count, electrolytes, ABGs, blood urea nitrogen/creatinine—BUN/Cr—cardiac enzymes, and cultures, such as blood/wound/secretions).

NURSING PRIORITY NO. 2. To assess degree of debilitation:

- Determine baseline vital signs/hemodynamic parameters including peripheral pulses. (Provides opportunities to track changes.)
- Review signs of impending failure/shock, noting vital signs, invasive hemodynamic parameters, breath sounds, heart tones, and urinary output. Note presence of pulsus paradoxus, reflecting cardiac tamponade.









- Review diagnostic studies (e.g., pharmacological stress testing, ECG, scans, echocardiogram, heart catheterization).
- Note response to activity/procedures and time required to return to baseline vital signs.

NURSING PRIORITY NO. 3. To minimize/correct causative factors, maximize cardiac output:

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



ACUTE PHASE

- Position with HOB flat or keep trunk horizontal while raising legs 20 to 30 degrees in shock situation (contraindicated in congestive state, in which semi-Fowler's position is preferred).
- Monitor vital signs frequently **to note response to activities.**
-  • Perform periodic hemodynamic measurements as indicated (e.g., arterial, CVP, pulmonary, and left atrial pressures; cardiac output).
- Monitor cardiac rhythm continuously **to note effectiveness of medications and/or devices (e.g., implanted pacemaker/defibrillator).**
-  • Administer blood/fluid replacement, antibiotics, diuretics, inotropic drugs, antidysrhythmics, steroids, vasopressors, and/or dilators as indicated. Evaluate response **to determine therapeutic, adverse, or toxic effects of therapy.**
- Restrict or administer fluids (IV/PO) as indicated. Provide adequate fluid/free water, depending on client needs. Assess hourly or periodic urinary output, noting total fluid balance **to allow for timely alterations in therapeutic regimen.**
-  • Monitor rate of IV drugs closely, using infusion pumps as appropriate **to prevent bolus/overdose.**
-  • Administer supplemental oxygen as indicated **to increase oxygen available to tissues.**
- Promote adequate rest by decreasing stimuli, providing quiet environment. Schedule activities and assessments **to maximize sleep periods.**
- Assist with or perform self-care activities for client.
- Avoid the use of restraints whenever possible if client is confused. (May increase agitation and increase the cardiac workload.)
-  • Use sedation and analgesics as indicated with caution **to achieve desired effect without compromising hemodynamic readings.**
- Maintain patency of invasive intravascular monitoring and infusion lines. Tape connections **to prevent air embolus and/or exsanguination.**
- Maintain aseptic technique during invasive procedures. Provide site care as indicated.
-  • Provide antipyretics/fever control actions as indicated.
- Weigh daily.
- Avoid activities, such as isometric exercises, rectal stimulation, vomiting, spasmodic coughing, **which may stimulate a Valsalva response.** Administer stool softener as indicated.
- Encourage client to breathe deeply in/out during activities that increase risk for Valsalva effect.
- Alter environment/bed linens **to maintain body temperature in near-normal range.**

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



- Provide psychological support. Maintain calm attitude but admit concerns if questioned by the client. **Honesty can be reassuring when so much activity and “worry” are apparent to the client.**
- Provide information about testing procedures and client participation.
- Assist with special procedures as indicated (e.g., invasive line placement, intra-aortic—IA—balloon insertion, pericardiocentesis, cardioversion, pacemaker insertion).
- Explain dietary/fluid restrictions.
- Refer to ND ineffective Tissue Perfusion.

NURSING PRIORITY NO. 4. To promote venous return:

POSTACUTE/CHRONIC PHASE

- Provide for adequate rest, positioning client for maximum comfort. Administer analgesics as appropriate.
- Encourage relaxation techniques to **reduce anxiety.**
- Elevate legs when in sitting position; apply abdominal binder if indicated; use tilt table as needed to **prevent orthostatic hypotension.**
- Give skin care, provide sheepskin or air/water/gel/foam mattress, and assist with frequent position changes to **avoid the development of pressure sores.**
- Elevate edematous extremities and avoid restrictive clothing. When support hose are used, be sure they are individually fitted and appropriately applied.
- Increase activity levels as permitted by individual condition.

NURSING PRIORITY NO. 5. To maintain adequate nutrition and fluid balance:

- Provide for diet restrictions (e.g., low-sodium, bland, soft, low-calorie/residue/fat diet, with frequent small feedings as indicated).
- Note reports of anorexia/nausea and withhold oral intake as indicated.
- Provide fluids as indicated (may have some restrictions; may need to consider electrolyte replacement/supplementation to **minimize dysrhythmias.**)
- Monitor intake/output and calculate 24-hour fluid balance.






NURSING PRIORITY NO. 6. To promote wellness (Teaching/Discharge Considerations):

- Note individual risk factors present (e.g., smoking, stress, obesity) and specify interventions for reduction of identified factors.
- Review specifics of drug regimen, diet, exercise/activity plan.
- Discuss significant signs/symptoms that need to be reported to healthcare provider (e.g., muscle cramps, headaches, dizzi-

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



ness, skin rashes) that may be signs of drug toxicity and/or mineral loss, especially potassium.

-  Review “danger” signs requiring immediate physician notification (e.g., unrelieved or increased chest pain, dyspnea, edema).
- Encourage changing positions slowly, dangling legs before standing to **reduce risk for orthostatic hypotension**.
- Give information about positive signs of improvement, such as decreased edema, improved vital signs/circulation to **provide encouragement**.
-  • Teach home monitoring of weight, pulse, and/or blood pressure as appropriate to **detect change and allow for timely intervention**.
- Promote visits from family/SO(s) who provide positive input.
-  • Encourage relaxing environment, using relaxation techniques, massage therapy, soothing music, quiet activities.
-  • Instruct in stress management techniques as indicated, including appropriate exercise program.
-  • Identify resources for weight reduction, cessation of smoking, and so forth to **provide support for change**.
- Refer to NDs Activity Intolerance; deficient Diversional Activity; ineffective Coping, compromised family Coping; Sexual Dysfunction; acute or chronic Pain; imbalanced Nutrition; deficient or excess Fluid Volume, as indicated.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Baseline and subsequent findings and individual hemodynamic parameters, heart and breath sounds, ECG pattern, presence/strength of peripheral pulses, skin/tissue status, renal output, and mentation.

PLANNING

- Plan of care and who is involved in planning.
- Teaching plan.

IMPLEMENTATION/EVALUATION

- Client’s responses to interventions/teaching and actions performed.
- Status and disposition at discharge.
- Attainment/progress toward desired outcome(s).
- Modifications to plan of care.

DISCHARGE PLANNING

- Discharge considerations and who will be responsible for carrying out individual actions.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



- Long-term needs.
- Specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Cardiac Pump Effectiveness

NIC—Hemodynamic Regulations

Caregiver Role Strain

Taxonomy II: Role Relationships—Class 1 Caregiving Roles (00061)

[Diagnostic Division: Social Interaction]

Submitted 1992; Nursing Diagnosis Extension and Classification (NDEC) Revision 1998; 2000

Definition: Difficulty in performing caregiver role

Related Factors

CARE RECEIVER HEALTH STATUS

Illness severity/chronicity

Unpredictability of illness course; instability of care receiver's health

Increasing care needs and dependency

Problem behaviors; psychological or cognitive problems

Addiction or co-dependency of care receiver

CAREGIVING ACTIVITIES

Discharge of family member to home with significant care needs [e.g., premature birth/congenital defect]

Unpredictability of care situation; 24-hour care responsibility; amount/complexity of activities

Ongoing changes in activities; years of caregiving

CAREGIVER HEALTH STATUS

Physical problems; psychological or cognitive problems

Inability to fulfill one's own or others' expectations; unrealistic expectations of self

Marginal coping patterns

Addiction or co-dependency

SOCIOECONOMIC

Competing role commitments

Alienation from family, friends, and coworkers; isolation from others

Insufficient recreation

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



CAREGIVER-CARE RECEIVER RELATIONSHIP

Unrealistic expectations of caregiver by care receiver
 History of poor relationship
 Mental status of elder inhibits conversation
 Presence of abuse or violence

FAMILY PROCESSES

History of marginal family coping/dysfunction

RESOURCES

Inadequate physical environment for providing care (e.g., housing, temperature, safety)
 Inadequate equipment for providing care; inadequate transportation
 Insufficient finances
 Inexperience with caregiving; insufficient time; physical energy; emotional strength; lack of support
 Lack of caregiver privacy
 Lack of knowledge about or difficulty accessing community resources; inadequate community services (e.g., respite care, recreational resources); assistance and support (formal and informal)
 Caregiver is not developmentally ready for caregiver role

[Author's note: The presence of this problem may encompass other numerous problems/high-risk concerns, such as deficient Diversional Activity, disturbed Sleep Pattern, Fatigue, Anxiety, ineffective Coping, compromised family Coping, and disabled family Coping, decisional Conflict, ineffective Denial, anticipatory Grieving, Hopelessness, Powerlessness, Spiritual Distress, ineffective Health Maintenance, impaired Home Maintenance, ineffective sexuality Pattern, readiness for enhanced family Coping, interrupted Family Processes, Social Isolation. Careful attention to data gathering will identify and clarify the client's specific needs, which can then be coordinated under this single diagnostic label.]

Defining Characteristics**SUBJECTIVE****CAREGIVING ACTIVITIES**

Apprehension about possible institutionalization of care receiver, the future regarding care receiver's health and caregiver's ability to provide care, care receiver's care if caregiver becomes ill or dies

CAREGIVER HEALTH STATUS—PHYSICAL

Gastrointestinal (GI) upset (e.g., mild stomach cramps, vomiting, diarrhea, recurrent gastric ulcer episodes)

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



Weight change, rash, headaches, hypertension, cardiovascular disease, diabetes, fatigue

CAREGIVER HEALTH STATUS—EMOTIONAL

Feeling depressed; anger; stress; frustration; increased nervousness

Disturbed sleep

Lack of time to meet personal needs

CAREGIVER HEALTH STATUS—SOCIOECONOMIC

Changes in leisure activities; refuses career advancement

CAREGIVER-CARE RECEIVER RELATIONSHIP

Difficulty watching care receiver go through the illness

Grief/uncertainty regarding changed relationship with care receiver

FAMILY PROCESSES—CAREGIVING ACTIVITIES

Concern about family members

OBJECTIVE**CAREGIVING ACTIVITIES**

Difficulty performing/completing required tasks

Preoccupation with care routine

Dysfunctional change in caregiving activities

CAREGIVER HEALTH STATUS—EMOTIONAL

Impatience; increased emotional lability; somatization

Impaired individual coping

CAREGIVER HEALTH STATUS—SOCIOECONOMIC

Low work productivity; withdraws from social life

FAMILY PROCESSES

Family conflict

**Desired Outcomes/Evaluation
Criteria—Client Will:**








- Identify resources within self to deal with situation.
- Provide opportunity for care receiver to deal with situation in own way.
- Express more realistic understanding and expectations of the care receiver.
- Demonstrate behavior/lifestyle changes to cope with and/or resolve problematic factors.
- Report improved general well-being, ability to deal with situation.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.









Actions/Interventions

NURSING PRIORITY NO. 1. To assess degree of impaired function:

-  • Inquire about/observe physical condition of care receiver and surroundings as appropriate.
-  • Assess caregiver's current state of functioning (e.g., hours of sleep, nutritional intake, personal appearance, demeanor).
-  • Determine use of prescription/over-the-counter (OTC) drugs, alcohol to deal with situation.
-  • Identify safety issues concerning caregiver and receiver.
-  • Assess current actions of caregiver and how they are received by care receiver (e.g., caregiver may be trying to be helpful but is not perceived as helpful; may be too protective or may have unrealistic expectations of care receiver). **May lead to misunderstanding and conflict.**
-  • Note choice/frequency of social involvement and recreational activities.
-  • Determine use/effectiveness of resources and support systems.

NURSING PRIORITY NO. 2. To identify the causative/contributing factors relating to the impairment:

-  • Note presence of high-risk situations (e.g., elderly client with total self-care dependence, or family with several small children with one child requiring extensive assistance due to physical condition/developmental delays). **May necessitate role reversal resulting in added stress or place excessive demands on parenting skills.**
 - Determine current knowledge of the situation, noting misconceptions, lack of information. **May interfere with caregiver/care receiver response to illness/condition.**
 - Identify relationship of caregiver to care receiver (e.g., spouse/lover, parent/child, sibling, friend).
 - Ascertain proximity of caregiver to care receiver.
-  • Note physical/mental condition, complexity of therapeutic regimen of care receiver.
-  • Determine caregiver's level of responsibility, involvement in and anticipated length of care.
 - Ascertain developmental level/abilities and additional responsibilities of caregiver.
 - Use assessment tool, such as Burden Interview, when appropriate, **to further determine caregiver's abilities.**
-  • Identify individual cultural factors and impact on caregiver. **Helps clarify expectations of caregiver/receiver, family, and community.**
 - Note co-dependency needs/enabling behaviors of caregiver.
-  • Determine availability/use of support systems and resources.
-  • Identify presence/degree of conflict between caregiver/care receiver/family.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



- Determine preillness/current behaviors that may be interfering with the care/recovery of the care receiver.

NURSING PRIORITY NO. 3. To assist caregiver in identifying feelings and in beginning to deal with problems:

- Establish a therapeutic relationship, conveying empathy and unconditional positive regard.
- Acknowledge difficulty of the situation for the caregiver/family.
- Discuss caregiver's view of and concerns about situation.
- Encourage caregiver to acknowledge and express feelings. Discuss normalcy of the reactions without using false reassurance.
- Discuss caregiver's/family members' life goals, perceptions and expectations of self to **clarify unrealistic thinking and identify potential areas of flexibility or compromise.**
- Discuss impact of and ability to handle role changes necessitated by situation.

NURSING PRIORITY NO. 4. To enhance caregiver's ability to deal with current situation:




- Identify strengths of caregiver and care receiver.
- Discuss strategies to coordinate caregiving tasks and other responsibilities (e.g., employment, care of children/dependents, housekeeping activities).
- Facilitate family conference to **share information and develop plan for involvement in care activities as appropriate.**
- Identify classes and/or needed specialists (e.g., first aid/CPR classes, enterostomal/physical therapist).
- Determine need for/sources of additional resources (e.g., financial, legal, respite care).
- Provide information and/or demonstrate techniques for dealing with acting out/violent or disoriented behavior. **Enhances safety of caregiver and receiver.**
- Identify equipment needs/resources, adaptive aids to **enhance the independence and safety of the care receiver.**
- Provide contact person/case manager to **coordinate care, provide support, assist with problem-solving.**

NURSING PRIORITY NO. 5. To promote wellness (Teaching/Discharge Considerations):

- Assist caregiver to plan for changes that may be necessary (e.g., home care providers, eventual placement in long-term care facility).
- Discuss/demonstrate stress management techniques and importance of self-nurturing (e.g., pursuing self-development interests, personal needs, hobbies, and social activities).
- Encourage involvement in support group.
- Refer to classes/other therapies as indicated.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



-  Identify available 12-step program when indicated to provide tools to deal with enabling/co-dependent behaviors that impair level of function.
-  Refer to counseling or psychotherapy as needed.
-  Provide bibliotherapy of appropriate references for self-paced learning and encourage discussion of information.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings, functional level/degree of impairment, caregiver's understanding/perception of situation.
- Identified risk factors.

PLANNING

- Plan of care and individual responsibility for specific activities.
- Needed resources, including type and source of assistive devices/durable equipment.
- Teaching plan.

IMPLEMENTATION/EVALUATION

- Caregiver/receiver response to interventions/teaching and actions performed.
- Identification of inner resources, behavior/lifestyle changes to be made.
- Attainment/progress toward desired outcome(s).
- Modifications to plan of care.

DISCHARGE PLANNING

- Plan for continuation/follow-through of needed changes.
- Referrals for assistance/evaluation.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Caregiver Lifestyle Disruption

NIC—Caregiver Support

risk for Caregiver Role Strain

Taxonomy II: Role Relationships—Class 1 Caregiving Roles (00062)

[Diagnostic Division: Social Interaction]

Submitted 1992

Definition: Caregiver is vulnerable for experiencing difficulty in performing the family caregiver role

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



Risk Factors

- Illness severity of the care receiver; psychological or cognitive problems in care receiver; addiction or co-dependency
- Discharge of family member with significant home-care needs; premature birth/congenital defect
- Unpredictable illness course or instability in the care receiver's health
- Duration of caregiving required; inexperience with caregiving; complexity/amount of caregiving tasks; caregiver's competing role commitments
- Caregiver health impairment
- Caregiver is female/spouse
- Caregiver not developmentally ready for caregiver role (e.g., a young adult needing to provide care for middle-aged parent); developmental delay or retardation of the care receiver or caregiver
- Presence of situational stressors that normally affect families (e.g., significant loss, disaster or crisis, economic vulnerability, major life events [such as birth, hospitalization, leaving home, returning home, marriage, divorce, change in employment, retirement, death])
- Inadequate physical environment for providing care (e.g., housing, transportation, community services, equipment)
- Family/caregiver isolation
- Lack of respite and recreation for caregiver
- Marginal family adaptation or dysfunction prior to the caregiving situation
- Marginal caregiver's coping patterns
- History of poor relationship between caregiver and care receiver
- Care receiver exhibits deviant, bizarre behavior
- Presence of abuse or violence

NOTE: A risk diagnosis is not evidenced by signs and symptoms, as the problem has not occurred and nursing interventions are directed at prevention.

Desired Outcomes/Evaluation

Criteria—Client Will:








- Identify individual risk factors and appropriate interventions.
- Demonstrate/initiate behaviors or lifestyle changes to prevent development of impaired function.
- Use available resources appropriately.
- Report satisfaction with current situation.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.











Actions/Interventions

NURSING PRIORITY NO. 1. To assess factors affecting current situation:

-  Note presence of high-risk situations (e.g., elderly client with total self-care dependence or several small children with one child requiring extensive assistance due to physical condition/developmental delays). May necessitate role reversal resulting in added stress or place excessive demands on parenting skills.
-  Identify relationship and proximity of caregiver to care receiver (e.g., spouse/lover, parent/child, friend).
-  Note therapeutic regimen and physical/mental condition of care receiver.
-  Determine caregiver's level of responsibility, involvement in and anticipated length of care.
-  Ascertain developmental level/abilities and additional responsibilities of caregiver.
 - Use assessment tool, such as Burden Interview, when appropriate, **to further determine caregiver's abilities.**
 - Identify strengths/weaknesses of caregiver and care receiver.
-  Verify safety of caregiver/receiver.
 - Discuss caregiver's and care receiver's view of and concerns about situation.
-  Determine available supports and resources currently used.
 - Note any co-dependency needs of caregiver.









NURSING PRIORITY NO. 2. To enhance caregiver's ability to deal with current situation:

-  Discuss strategies to coordinate care and other responsibilities (e.g., employment, care of children/dependents, housekeeping activities).
-  Facilitate family conference as appropriate **to share information and develop plan for involvement in care activities.**
-  Refer to classes and/or specialists (e.g., first aid/CPR classes, enterostomal/physical therapist) **for special training as indicated.**
-  Identify additional resources to include financial, legal, respite care.
-  Identify equipment needs/resources, adaptive aids **to enhance the independence and safety of the care receiver.**
-  Identify contact person/case manager as needed **to coordinate care, provide support, and assist with problem-solving.**
-  Provide information and/or demonstrate techniques for dealing with acting out/violent or disoriented behavior.
-  Assist caregiver to recognize co-dependent behaviors (i.e., doing things for others that others are able to do for themselves) and how these behaviors affect the situation.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



NURSING PRIORITY NO. 3. To promote wellness (Teaching/Discharge Considerations):

-  • Stress importance of self-nurturing (e.g., pursuing self-development interests, personal needs, hobbies, and social activities) **to improve/maintain quality of life for caregiver.**
-  • Discuss/demonstrate stress-management techniques.
-  • Encourage involvement in specific support group(s).
-  • Provide bibliotherapy of appropriate references and encourage discussion of information.
-  • Assist caregiver to plan for changes that may become necessary for the care receiver (e.g., home care providers, eventual placement in long-term care facility).
-  • Refer to classes/therapists as indicated.
-  • Identify available 12-step program when indicated **to provide tools to deal with codependent behaviors that impair level of function.**
-  • Refer to counseling or psychotherapy as needed.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Identified risk factors and caregiver perceptions of situation.
- Reactions of care receiver/family.

PLANNING

- Treatment plan and individual responsibility for specific activities.
- Teaching plan.

IMPLEMENTATION/EVALUATION

- Caregiver/receiver response to interventions/teaching and actions performed.
- Attainment/progress toward desired outcome(s).
- Modifications to plan of care.

DISCHARGE PLANNING

- Long-term needs and who is responsible for actions to be taken.
- Specific referrals provided for assistance/evaluation.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Caregiving Endurance Potential

NIC—Caregiver Support

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.

impaired verbal Communication

Taxonomy II: Perception/Cognition—Class 5
Communication (00051)

[Diagnostic Division: Social Interaction]

Submitted 1983; Revised 1998 (by small group work
1996)

Definition: Decreased, delayed, or absent ability to receive, process, transmit, and use a system of symbols

Related Factors

Decrease in circulation to brain, brain tumor

Anatomic deficit (e.g., cleft palate, alteration of the neurovascular visual system, auditory system, or phonatory apparatus)

Difference related to developmental age

Physical barrier (tracheostomy, intubation)

Physiological conditions [e.g., dyspnea]; alteration of central nervous system (CNS); weakening of the musculoskeletal system

Psychological barriers (e.g., psychosis, lack of stimuli); emotional conditions [depression, panic, anger]; stress

Environmental barriers

Cultural difference

Lack of information

Side effects of medication

Alteration of self-esteem or self-concept

Altered perceptions

Absence of SO(s)

Defining Characteristics

SUBJECTIVE

[Reports of difficulty expressing self]

OBJECTIVE

Unable to speak dominant language

Speaks or verbalizes with difficulty

Does not or cannot speak

Disorientation in the three spheres of time, space, person

Stuttering; slurring

Dyspnea

Difficulty forming words or sentences (e.g., aphonia, dyslalia, dysarthria)

Difficulty expressing thoughts verbally (e.g., aphasia, dysphasia, apraxia, dyslexia)

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



Inappropriate verbalization, [incessant, loose association of ideas; flight of ideas]

Difficulty in comprehending and maintaining the usual communicating pattern

Absence of eye contact or difficulty in selective attending; partial or total visual deficit

Inability or difficulty in use of facial or body expressions

Willful refusal to speak

[Inability to modulate speech]

[Message inappropriate to content]

[Use of nonverbal cues (e.g., pleading eyes, gestures, turning away)]

[Frustration, anger, hostility]

Desired Outcomes/Evaluation

Criteria—Client Will:

- Verbalize or indicate an understanding of the communication difficulty and plans for ways of handling.
- Establish method of communication in which needs can be expressed.
- Participate in therapeutic communication (e.g., using silence, acceptance, restating reflecting, Active-listening, and I-messages).
- Demonstrate congruent verbal and nonverbal communication.
- Use resources appropriately.

Actions/Interventions

NURSING PRIORITY NO. 1. To assess causative/contributing factors:



- Review history for neurological conditions that could affect speech, such as CVA, tumor, multiple sclerosis, hearing loss, and so forth.






- Note results of neurological testing such as electroencephalogram (EEG), computed tomography (CT) scan.
- Note whether aphasia is motor (expressive: loss of images for articulated speech), sensory (receptive: unable to understand words and does not recognize the defect), conduction (slow comprehension, uses words inappropriately but knows the error), and/or global (total loss of ability to comprehend and speak). Evaluate the degree of impairment.
- Evaluate mental status, note presence of psychotic conditions (e.g., manic-depressive, schizoid/affective behavior). Assess psychological response to communication impairment, willingness to find alternate means of communication.
- Note presence of ET tube/tracheostomy or other physical blocks to speech (e.g., cleft palate, jaws wired).

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



- Assess environmental factors that may affect ability to communicate (e.g., room noise level).
-  • Determine primary language spoken and cultural factors.
- Assess style of speech (as outlined in Defining Characteristics).
- Note level of anxiety present; presence of angry, hostile behavior; frustration.
-  • Interview parent to determine child's developmental level of speech and language comprehension.
- Note parent's speech patterns and manner of communicating with child, including gestures.

NURSING PRIORITY NO. 2. To assist client to establish a means of communication to express needs, wants, ideas, and questions:







- Determine ability to read/write. Evaluate musculoskeletal status, including manual dexterity (e.g., ability to hold a pen and write).
- Obtain a translator/written translation or picture chart **when writing is not possible.**
-  • Facilitate hearing and vision examinations/obtaining necessary aids **when needed/desired for improving communication.** Assist client to learn to use and adjust to aids.
-  • Establish relationship with the client, listening carefully and attending to client's verbal/nonverbal expressions.
-  • Maintain eye contact, preferably at client's level. Be aware of cultural factors that may preclude eye contact (e.g., some American Indians).
- Keep communication simple, using all modes for accessing information: visual, auditory, and kinesthetic.
- Maintain a calm, unhurried manner. Provide sufficient time for client to respond. **Individuals with expressive aphasia may talk more easily when they are rested and relaxed and when they are talking to one person at a time.**
- Determine meaning of words used by the client and congruency of communication and nonverbal messages.
- Validate meaning of nonverbal communication; do not make assumptions, **because they may be wrong.** Be honest; if you do not understand, seek assistance from others.
- Individualize techniques using breathing for relaxation of the vocal cords, rote tasks (such as counting), and singing or melodic intonation to assist aphasic clients in relearning speech.
- Anticipate needs until effective communication is reestablished.
- Plan for alternative methods of communication (e.g., slate board, letter/picture board, hand/eye signals, typewriter/computer) incorporating information about type of disability present.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



- Identify previous solutions tried/used if situation is chronic or recurrent.
- Provide reality orientation by responding with simple, straightforward, honest statements.
- Provide environmental stimuli as needed to **maintain contact with reality**; or reduce stimuli to **lessen anxiety that may worsen problem**.
- Use confrontation skills, when appropriate, within an established nurse-client relationship to **clarify discrepancies between verbal and nonverbal cues**.

NURSING PRIORITY NO. 3. To promote wellness (Teaching/Discharge Considerations):

-  Review information about condition, prognosis, and treatment with client/SO(s). Reinforce that loss of speech does not imply loss of intelligence.
-  Discuss individual methods of dealing with impairment.
-  Recommend placing a tape recorder with a prerecorded emergency message near the telephone. Information to include: client's name, address, telephone number, type of airway, and a request for immediate emergency assistance.
-  Use and assist client/SO(s) to learn therapeutic communication skills of acknowledgment, Active-listening, and I-messages. **Improves general communication skills.**
-  Involve family/SO(s) in plan of care as much as possible. **Enhances participation and commitment to plan.**
-  Refer to appropriate resources (e.g., speech therapist, group therapy, individual/family and/or psychiatric counseling).
- Refer to NDs ineffective Coping; disabled family Coping (as indicated); Anxiety; Fear.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings/pertinent history information (i.e., physical/psychological/cultural concerns).
- Meaning of nonverbal cues, level of anxiety client exhibits.

PLANNING

- Plan of care and interventions (e.g., type of alternative communication/translator).
- Teaching plan.

IMPLEMENTATION/EVALUATION

- Response to interventions/teaching and actions performed.
- Attainment/progress toward desired outcome(s).
- Modifications to plan of care.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.

DISCHARGE PLANNING

- Discharge needs/referrals made, additional resources available.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Communication Ability

NIC—Communication Enhancement: Speech Deficit

readiness for enhanced Communication

Taxonomy II: Perception/Cognition—Class 4 Cognition (00161)

[Diagnostic Division: Teaching/Learning]

Submitted 2002

Definition: A pattern of exchanging information and ideas with others that is sufficient for meeting one's needs and life goals and can be strengthened

Related Factors

To be developed

Defining Characteristics**SUBJECTIVE**

Expresses willingness to enhance communication

Expresses thoughts and feelings

Expresses satisfaction with ability to share information and ideas with others

OBJECTIVE

Able to speak or write a language

Forms words, phrases, and language

Uses and interprets nonverbal cues appropriately

Desired Outcomes/Evaluation Criteria—Client/SO/Caregiver Will:

- Verbalize or indicate an understanding of the communication difficulty and ways of handling.
- Be able to express information, thoughts, and feelings in a satisfactory manner.

Actions/Interventions

NURSING PRIORITY NO 1. To assess how client is managing communication and potential difficulties:

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.





- Ascertain circumstances that result in client's desire to improve communication. Many factors are involved in communication, and identifying specific needs/expectations helps in developing realistic goals and determining likelihood of success.
- Evaluate mental status. Disorientation and psychotic conditions may be affecting speech and the communication of thoughts, needs, and desires.
- Determine client's developmental level of speech and language comprehension. Provides baseline information for developing plan for improvement.
- Determine ability to read/write. Evaluating grasp of language as well as musculoskeletal states, including manual dexterity (e.g., ability to hold a pen and write), provides information about nature of client's situation. Educational plan can address language skills. Neuromuscular deficits will require individual program to correct.
- Determine country of origin, dominant language, whether client is recent immigrant and what cultural, ethnic group client identifies as own. Recent immigrant may identify with home country, and its people, language, beliefs, and health-care practices affecting desire to learn language and improve ability to interact in new country.
- Ascertain if interpreter is needed/desired. Law mandates that interpretation services be made available. Trained, professional interpreter who translates precisely and possesses a basic understanding of medical terminology and healthcare ethics is preferred to enhance client and provider satisfaction.
- Determine comfort level in expression of feelings and concepts in nonproficient language. Anxiety about language difficulty can interfere with ability to communicate effectively.
- Note any physical barriers to effective communication (e.g., talking tracheostomy, wired jaws) or physiological/neurological conditions (e.g., severe shortness of breath, neuromuscular weakness, stroke, brain trauma, hearing impairment, cleft palate, facial trauma). Client may be dealing with speech/language comprehension or have voice production problems (pitch, loudness, or quality) that call attention to voice rather than what speaker is saying. These barriers will need to be addressed to enable client to improve communication skills.
- Clarify meaning of words used by the client to describe important aspects of life and health/well-being (e.g., pain, sorrow, anxiety). Words can easily be misinterpreted when sender and receiver have different ideas about their mean-

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.





ings. This can affect the way both client and caregiver communicate important concepts. Restating what one has heard can clarify whether an expressed statement has been understood or misinterpreted.

- Evaluate level of anxiety, frustration, or fear; presence of angry, hostile behavior. Emotional/psychiatric issues can affect communication and interfere with understanding.
- Evaluate congruency of verbal and nonverbal messages. It is estimated that 65% to 95% of communication is nonverbal, and communication is enhanced when verbal and nonverbal messages are congruent.
- Determine lack of knowledge or misunderstanding of terms related to client's specific situation. Indicators of need for additional information, clarification to help client improve ability to communicate.
- Evaluate need/desire for pictures or written communications and instructions as part of treatment plan. Alternative methods of communication can help client feel understood and promote feelings of satisfaction with interaction.

NURSING PRIORITY NO. 2. To improve client's ability to communicate thoughts, needs, and ideas:








- Maintain a calm, unhurried manner. Provide sufficient time for client to respond. An atmosphere in which client is free to speak without fear of criticism provides the opportunity to explore all the issues involved in making decisions to improve communication skills.
- Pay attention to speaker. Be an active listener. The use of Active-listening communicates acceptance and respect for the client, establishing trust and promoting openness and honest expression. It communicates a belief that the client is a capable and competent person.
- Sit down, maintain eye contact, preferably at client's level, and spend time with the client. Conveys message that the nurse has time and interest in communicating.
- Observe body language, eye movements, and behavioral clues. May reveal unspoken concerns, for example, when pain is present, client may react with tears, grimacing, stiff posture, turning away, and angry outbursts.

 • Help client identify and learn to avoid use of nontherapeutic communication. These barriers are recognized as detriments to open communication, and learning to avoid them maximizes the effectiveness of communication between client and others.



 • Establish hand/eye signals if indicated. Neurological impairments may allow client to understand language but not be able to speak and/or may have a physical barrier to writing.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.





- Obtain interpreter with language or signing abilities as needed. May be needed to enhance understanding of words, language concepts, or needs to promote accurate interpretation of communication.
-  • Suggest use of pad and pencil, slate board, letter/picture board, if indicated. When client has physical impairments that interfere with spoken communication, alternate means can provide concepts that are understandable to both parties.
-  • Obtain/provide access to typewriter/computer. Use of these devices may be more helpful when impairment is long-standing or when client is used to using them.
-  • Respect client's cultural communication needs. Different cultures can dictate beliefs of what is normal or abnormal (i.e., in some cultures, eye-to-eye contact is considered disrespectful, impolite, or an invasion of privacy; silence and tone of voice have various meanings, and slang words can cause confusion).
-  • Provide glasses, hearing aids, dentures, electronic speech devices as needed. These devices maximize sensory perception and can improve understanding and enhance speech patterns.
-  • Reduce distractions and background noises (e.g., close the door, turn down the radio/TV). A distracting environment can interfere with communication, limiting attention to tasks and making speech and communication more difficult. Reducing noise can help both parties hear clearly, improving understanding.
-  • Associate words with objects using repetition and redundancy, point to objects, or demonstrate desired actions. Speaker's own body language can be used to enhance client's understanding when neurological conditions result in difficulty understanding language.
-  • Use confrontation skills carefully when appropriate, within an established nurse-client relationship. Can be used to clarify discrepancies between verbal and nonverbal cues, enabling client to look at areas that may require change.

NURSING PRIORITY NO. 3. To promote optimum communication:

-  • Discuss with family/SO and other caregivers effective ways in which the client communicates. Identifying positive aspects of current communication skills enables family members to learn and move forward in desire to enhance ways of interacting.
-  • Encourage client and family use of successful techniques for communication, whether it is speech/language techniques or alternate modes of communicating. Enhances family relationships and promotes self-esteem for all members as they

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.

are able to communicate clearly regardless of the problems that have interfered with ability to interact.

-  Reinforce client/SO(s) learning and use of therapeutic communication skills of acknowledgment, Active-listening, and I-messages. Improves general communication skills, emphasizes acceptance, and conveys respect, enabling family relationships to improve.
-  Refer to appropriate resources (e.g., speech therapist, language classes, individual/family and/or psychiatric counseling). May need further assistance to overcome problems that are preventing family from reaching desired goal of enhanced communication.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings/pertinent history information (i.e., physical/psychological/cultural concerns).
- Meaning of nonverbal cues, level of anxiety client exhibits.

PLANNING

- Plan of care and interventions (e.g., type of alternative communication/translator).
- Teaching plan.

IMPLEMENTATION/EVALUATION

- Progress toward desired outcome(s).
- Modifications to plan of care.

DISCHARGE PLANNING

- Discharge needs/referrals made, additional resources available.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Communication Ability

NIC—Communication Enhancement [specify]

decisional Conflict (specify)

Taxonomy II: Life Principles—Class 3 Value/Belief/Action Congruence (00083)

[Diagnostic Division: Ego Integrity]

Submitted 1988

Definition: Uncertainty about course of action to be taken when choice among competing actions involves risk, loss, or challenge to personal life values

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



Related Factors

- Unclear personal values/beliefs; perceived threat to value system
- Lack of experience or interference with decision making
- Lack of relevant information, multiple or divergent sources of information
- Support system deficit
 - [Age, developmental state]
 - [Family system, sociocultural factors]
 - [Cognitive, emotional, behavioral level of functioning]

Defining Characteristics

SUBJECTIVE

- Verbalized uncertainty about choices or of undesired consequences of alternative actions being considered
- Verbalized feeling of distress or questioning personal values and beliefs while attempting a decision

OBJECTIVE

- Vacillation between alternative choices; delayed decision making
- Self-focusing
- Physical signs of distress or tension (increased heart rate; increased muscle tension; restlessness; etc.)



Desired Outcomes/Evaluation

Criteria—Client Will:

- Verbalize awareness of positive and negative aspects of choices/alternative actions.
- Acknowledge/ventilate feelings of anxiety and distress associated with choice/related to making difficult decision.
- Identify personal values and beliefs concerning issues.
- Make decision(s) and express satisfaction with choices.
- Meet psychological needs as evidenced by appropriate expression of feelings, identification of options, and use of resources.
- Display relaxed manner/calm demeanor, free of physical signs of distress.

Actions/Interventions

NURSING PRIORITY NO. 1. To assess causative/contributing factors:

-  Determine usual ability to manage own affairs. Clarify who has legal right to intervene on behalf of child (e.g., parent, other relative, or court appointed guardian/advocate). **(Family disruption/conflicts can complicate decision process.)**
-  Note expressions of indecision, dependence on others, avail-

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.

ability/involvement of support persons (e.g., lack of/conflicting advice). Ascertain dependency of other(s) on client and/or issues of codependency.

- Active-listen/identify reason for indecisiveness to help client clarify problem.
- Determine effectiveness of current problem-solving techniques.
- Note presence/intensity of physical signs of anxiety (e.g., increased heart rate, muscle tension).
- Listen for expressions of inability to find meaning in life/reason for living, feelings of futility, or alienation from God and others around them. (Refer to ND Spiritual Distress as indicated.)

NURSING PRIORITY NO. 2. To assist client to develop/effectively use problem-solving skills:

- Promote safe and hopeful environment, as needed, while client regains inner control.
- Encourage verbalization of conflicts/concerns.
- Accept verbal expressions of anger/guilt, setting limits on maladaptive behavior to promote client safety.
- Clarify and prioritize individual goals, noting where the subject of the “conflict” falls on this scale.
- Identify strengths and presence of positive coping skills (e.g., use of relaxation technique, willingness to express feelings).
- Identify positive aspects of this experience and assist client to view it as a learning opportunity to develop new and creative solutions.
- Correct misperceptions client may have and provide factual information. Provides for better decision making.
- Provide opportunities for client to make simple decisions regarding self-care and other daily activities. Accept choice not to do so. Advance complexity of choices as tolerated.
- Encourage child to make developmentally appropriate decisions concerning own care. Fosters child’s sense of self-worth, enhances ability to learn/exercise coping skills.
- Discuss time considerations, setting time line for small steps and considering consequences related to not making/postponing specific decisions to facilitate resolution of conflict.
- Have client list some alternatives to present situation or decisions, using a brainstorming process. Include family in this activity as indicated (e.g., placement of parent in long-term care facility, use of intervention process with addicted member). Refer to NDs interrupted Family Processes; dysfunctional Family Processes: alcoholism; compromised family Coping.
- Practice use of problem-solving process with current situation/decision.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



- Discuss/clarify spiritual concerns, accepting client's values in a nonjudgmental manner.

NURSING PRIORITY NO. 3. To promote wellness (Teaching/Discharge Considerations):

- Promote opportunities for using conflict-resolution skills, identifying steps as client does each one.
- Provide positive feedback for efforts and progress noted. **Promotes continuation of efforts.**
- Encourage involvement of family/SO(s) as desired/available to provide support for the client.
- Support client for decisions made, especially if consequences are unexpected, difficult to cope with.
- Encourage attendance at stress reduction, assertiveness classes.
- Refer to other resources as necessary (e.g., clergy, psychiatric clinical nurse specialist/psychiatrist, family/marital therapist, addiction support groups).

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings/behavioral responses, degree of impairment in lifestyle functioning.
- Individuals involved in the conflict.
- Personal values/beliefs.

PLANNING

- Plan of care/interventions and who is involved in the planning process.
- Teaching plan.

IMPLEMENTATION/EVALUATION

- Client's and involved individual's responses to interventions/teaching and actions performed.
- Ability to express feelings, identify options; use of resources.
- Attainment/progress toward desired outcome(s).
- Modifications to plan of care.

DISCHARGE PLANNING

- Long-term needs/referrals, actions to be taken, and who is responsible for doing.
- Specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Decision Making

NIC—Decision-Making Support

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.

parental role Conflict

Taxonomy II: Role Relationships—Class 1 Role
Performance (00064)
[Diagnostic Division: Social Interaction]
Submitted 1988

Definition: Parent experience of role confusion and conflict in response to crisis

Related Factors

Separation from child because of chronic illness [/disability]
Intimidation with invasive or restrictive modalities (e.g., isolation, intubation); specialized care centers, policies
Home care of a child with special needs (e.g., apnea monitoring, postural drainage, hyperalimentation)
Change in marital status
Interruptions of family life because of home-care regimen (treatments, caregivers, lack of respite)

Defining Characteristics

SUBJECTIVE

Parent(s) express(es) concerns/feeling of inadequacy to provide for child's physical and emotional needs during hospitalization or in the home
Parent(s) express(es) concerns about changes in parental role, family functioning, family communication, family health
Express(es) concern about perceived loss of control over decisions relating to child
Verbaliz(es) feelings of guilt, anger, fear, anxiety and/or frustrations about effect of child's illness on family process

OBJECTIVE

Demonstrates disruption in caretaking routines
Reluctant to participate in usual caretaking activities even with encouragement and support
Demonstrates feelings of guilt, anger, fear, anxiety, and/or frustrations about the effect of child's illness on family process

Desired Outcomes/Evaluation

Criteria—Parent(s) Will:

- Verbalize understanding of situation and expected parent's/child's role.
- Express feelings about child's illness/situation and effect on family life.








Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.







- Demonstrate appropriate behaviors in regard to parenting role.
- Assume caretaking activities as appropriate.
- Handle family disruptions effectively.

Actions/Interventions

NURSING PRIORITY NO. 1. To assess causative/contributory factors:





-  • Assess individual situation and parent's perception of concern about what is happening and expectations of self as caregiver.
-  • Note parental status including age and maturity, stability of relationship, other responsibilities. (Increasing numbers of elderly individuals are providing full-time care for young grandchildren whose parents are unavailable or unable to provide care.)
-  • Ascertain parent's understanding of child's developmental stage and expectations for the future **to identify misconceptions/strengths.**
-  • Note coping skills currently being used by each individual as well as how problems have been dealt with in the past. **Provides basis for comparison and reference for client's coping abilities.**
-  • Determine use of substances (e.g., alcohol, other drugs, including prescription medications). **May interfere with individual's ability to cope/problem-solve.**
-  • Assess availability/use of resources, including extended family, support groups, and financial.
-  • Perform testing such as Parent-Child Relationship Inventory (PCRI) for further evaluation as indicated.

NURSING PRIORITY NO. 2. To assist parents to deal with current crisis:





-  • Encourage free verbal expression of feelings (including negative feelings of anger and hostility), setting limits on inappropriate behavior.
-  • Acknowledge difficulty of situation and normalcy of feeling overwhelmed and helpless. Encourage contact with parents who experienced similar situation with child and had positive outcome.
-  • Provide information, including technical information when appropriate, **to meet individual needs/correct misconceptions.**
-  • Promote parental involvement in decision making and care as much as possible/desired. **Enhances sense of control.**

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



-  • Encourage interaction/facilitate communication between parent(s) and children.
-  • Promote use of assertiveness, relaxation skills to help individuals to deal with situation/crisis.
-  • Assist parent to learn proper administration of medications/treatments as indicated.
-  • Provide for/encourage use of respite care, parent time off to enhance emotional well-being.

NURSING PRIORITY NO. 3. To promote wellness (Teaching/Discharge Considerations):

-  • Provide anticipatory guidance to encourage making plans for future needs.
-  • Encourage setting realistic and mutually agreed-on goals.
-  • Provide/identify learning opportunities specific to needs (e.g., parenting classes, equipment use/troubleshooting).
-  • Refer to community resources as appropriate (e.g., visiting nurse, respite care, social services, psychiatric care/family therapy, well-baby clinics, special needs support services).
- Refer to ND impaired Parenting, for additional interventions.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Findings, including specifics of individual situation/parental concerns, perceptions, expectations.

PLANNING

- Plan of care and who is involved in the planning.
- Teaching plan.

IMPLEMENTATION/EVALUATION

- Parent's responses to interventions/teaching and actions performed.
- Attainment/progress toward desired outcome(s).
- Modifications to plan of care.

DISCHARGE PLANNING

- Long-term needs and who is responsible for each action to be taken.
- Specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Parenting

NIC—Parenting Promotion

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



acute Confusion

Taxonomy II: Perception/Cognition—Class 4 Cognition
(00128)

[Diagnostic Division: Neurosensory]

Submitted 1994

Definition: Abrupt onset of a cluster of global, transient changes and disturbances in attention, cognition, psychomotor activity, level of consciousness, and/or sleep/wake cycle

Related Factors

Over 60 years of age

Dementia

Alcohol abuse, drug abuse

Delirium [including febrile epilepticum (following or instead of an epileptic attack), toxic and traumatic]

[Medication reaction/interaction; anesthesia/surgery; metabolic imbalances]

[Exacerbation of a chronic illness, hypoxemia]

[Severe pain]

[Sleep deprivation]

Defining Characteristics

SUBJECTIVE

Hallucinations [visual/auditory]

[Exaggerated emotional responses]

OBJECTIVE

Fluctuation in cognition

Fluctuation in sleep/wake cycle

Fluctuation in level of consciousness

Fluctuation in psychomotor activity [tremors, body movement]

Increased agitation or restlessness

Misperceptions, [inappropriate responses]

Lack of motivation to initiate and/or follow through with goal-directed or purposeful behavior

Desired Outcomes/Evaluation

Criteria—Client Will:

- Regain/maintain usual reality orientation and level of consciousness.
- Verbalize understanding of causative factors when known.
- Initiate lifestyle/behavior changes to prevent or minimize recurrence of problem.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



Actions/Interventions

NURSING PRIORITY NO. 1. To assess causative/contributing factors:

- Identify factors present, including substance abuse, seizure history, recent ECT therapy, episodes of fever/pain, presence of acute infection (especially urinary tract infection in elderly client), exposure to toxic substances, traumatic events; change in environment, including unfamiliar noises, excessive visitors.
- Investigate possibility of drug withdrawal, exacerbation of psychiatric conditions (e.g., mood disorder, dissociative disorders, dementia).
- Evaluate vital signs for indicators of poor tissue perfusion (i.e., hypotension, tachycardia, tachypnea).
- Determine current medications/drug use—especially anti-anxiety agents, barbiturates, lithium, methyl dopa, disulfiram, cocaine, alcohol, amphetamines, hallucinogens, opiates (associated with high risk of confusion)—and schedule of use as combinations increase risk of adverse reactions/interactions (e.g., cimetidine + antacid, digoxin + diuretics, antacid + propranolol).
- Assess diet/nutritional status.
- Note presence of anxiety, fear, other physiological reactions.
- Monitor laboratory values, noting hypoxemia, electrolyte imbalances, BUN/Cr, ammonia levels, serum glucose, signs of infection, and drug levels (including peak/trough as appropriate).
- Evaluate sleep/rest status, noting deprivation/oversleeping. Refer to ND disturbed Sleep Pattern, as appropriate.

NURSING PRIORITY NO. 2. To determine degree of impairment:

- Talk with SO(s) to determine historic baseline, observed changes, and onset/recurrence of changes to understand and clarify current situation.
- Evaluate extent of impairment in orientation, attention span, ability to follow directions, send/receive communication, appropriateness of response.
- Note occurrence/timing of agitation, hallucinations, violent behaviors. (“Sundown syndrome” may occur, with client oriented during daylight hours but confused during night.)
- Determine threat to safety of client/others.

NURSING PRIORITY NO. 3. To maximize level of function, prevent further deterioration:

- Assist with treatment of underlying problem (e.g., drug intoxication/substance abuse, infectious process, hypoxemia, biochemical imbalances, nutritional deficits, pain management).

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.





- Monitor/adjust medication regimen and note response. Eliminate nonessential drugs as appropriate.
- Orient client to surroundings, staff, necessary activities as needed. Present reality concisely and briefly. Avoid challenging illogical thinking—**defensive reactions may result.**
- Encourage family/SO(s) to participate in reorientation as well as providing ongoing input (e.g., current news and family happenings).
- Maintain calm environment and eliminate extraneous **noise/stimuli to prevent overstimulation.** Provide normal levels of essential sensory/tactile stimulation—include personal items/pictures, and so on.
- Encourage client to use vision/hearing aids when needed.
- Give simple directions. Allow sufficient time for client to respond, to communicate, to make decisions.
- Provide for safety needs (e.g., supervision, siderails, seizure precautions, placing call bell within reach, positioning needed items within reach/clearing traffic paths, ambulating with devices).
- Note behavior that may be indicative of potential for violence and take appropriate actions.



- Administer psychotropics cautiously to **control restlessness, agitation, hallucinations.**
- Avoid/limit use of restraints—**may worsen situation, increase likelihood of untoward complications.**



- Provide undisturbed rest periods. Administer short-acting, nonbenzodiazepine sleeping medication (e.g., Benadryl) at bedtime.



NURSING PRIORITY NO. 4. To promote wellness (Teaching/Discharge Considerations):



- Explain reason for confusion, if known.
- Review drug regimen.



- Assist in identifying ongoing treatment needs.



- Stress importance of keeping vision/hearing aids in good repair and necessity of periodic evaluation to **identify changing client needs.**



- Discuss situation with family and involve in planning to **meet identified needs.**



- Provide appropriate referrals (e.g., cognitive retraining, substance abuse support groups, medication monitoring program, Meals on Wheels, home health, and adult day care).

Documentation Focus

ASSESSMENT/REASSESSMENT

- Nature, duration, frequency of problem.
- Current and previous level of function, effect on independence/lifestyle (including safety concerns).

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



PLANNING

- Plan of care and who is involved in planning.
- Teaching plan.

IMPLEMENTATION/EVALUATION

- Response to interventions and actions performed.
- Attainment/progress toward desired outcomes.
- Modifications to plan of care.

DISCHARGE PLANNING

- Long-term needs and who is responsible for actions to be taken.
- Available resources and specific referrals.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Cognitive Ability

NIC—Delirium Management

chronic Confusion

Taxonomy II: Perception/Cognition—Class 4 Cognition (00129)

[Diagnostic Division: Neurosensory]

Submitted 1994

Definition: Irreversible, long-standing, and/or progressive deterioration of intellect and personality characterized by decreased ability to interpret environmental stimuli; decreased capacity for intellectual thought processes; and manifested by disturbances of memory, orientation, and behavior

Related Factors

Alzheimer's disease [dementia of the Alzheimer's type]

Korsakoff's psychosis

Multi-infarct dementia

Cerebrovascular accident

Head injury

Defining Characteristics**OBJECTIVE**

Clinical evidence of organic impairment

Altered interpretation/response to stimuli

Progressive/long-standing cognitive impairment

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



No change in level of consciousness
 Impaired socialization
 Impaired memory (short-term, long-term)
 Altered personality

Desired Outcome/Evaluation Criteria—Client Will:

- Remain safe and free from harm.

Family/SO Will:

- Verbalize understanding of disease process/prognosis and client's needs.
- Identify/participate in interventions to deal effectively with situation.
- Provide for maximal independence while meeting safety needs of client.

Actions/Interventions

NURSING PRIORITY NO. 1. To assess degree of impairment:



- Evaluate responses on diagnostic examinations (e.g., memory impairments, reality orientation, attention span, calculations).
- Test ability to receive and send effective communication.
- Note deterioration/changes in personal hygiene or behavior.



- Talk with SO(s) regarding baseline behaviors, length of time since onset/progression of problem, their perception of prognosis, and other pertinent information and concerns for client.
- Evaluate response to care providers/receptiveness to interventions.
- Determine anxiety level in relation to situation. Note behavior that may be indicative of potential for violence.

NURSING PRIORITY NO. 2. To prevent further deterioration/ maximize level of function:



- Provide calm environment, eliminate extraneous noise/stimuli.



- Ascertain interventions previously used/tried and evaluate effectiveness.



- Avoid challenging illogical thinking because defensive reactions may result.





- Encourage family/SO(s) to provide ongoing orientation/ input to include current news and family happenings.






- Maintain reality-oriented relationship/environment (e.g., clocks, calendars, personal items, seasonal decorations). Encourage participation in resocialization groups.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.






-  • Allow client to reminisce, exist in own reality if not detrimental to well-being.
-  • Provide safety measures (e.g., close supervision, identification bracelet, medication lockup, lower temperature on hot water tank).

NURSING PRIORITY NO. 3. To assist SO(s) to develop coping strategies:

-  • Determine family resources, availability and willingness to participate in meeting client's needs.
-  • Identify appropriate community resources (e.g., Alzheimer's or brain injury support group, respite care) **to provide support and assist with problem-solving.**
-  • Evaluate attention to own needs, including grieving process.
- Refer to ND risk for Caregiver Role Strain.

NURSING PRIORITY NO. 4. To promote wellness (Teaching/Discharge Considerations):

-  • Determine ongoing treatment needs and appropriate resources.
-  • Develop plan of care with family **to meet client's and SO's individual needs.**
-  • Provide appropriate referrals (e.g., Meals on Wheels, adult day care, home care agency, respite care).



Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including current level of function and rate of anticipated changes.

PLANNING

- Plan of care and who is involved in planning.

IMPLEMENTATION/EVALUATION

- Response to interventions and actions performed.
- Attainment/progress toward desired outcomes.
- Modifications to plan of care.

DISCHARGE PLANNING

- Long-term needs/referrals and who is responsible for actions to be taken.
- Available resources, specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Cognitive Ability

NIC—Dementia Management

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



Constipation

Taxonomy II: Elimination—Class 2 Gastrointestinal System (00011)

[Diagnostic Division: Elimination]

Submitted 1975; Nursing Diagnosis Extension and Classification (NDEC) Revision 1998

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

Related Factors

FUNCTIONAL

Irregular defecation habits; inadequate toileting (e.g., timeliness, positioning for defecation, privacy)

Insufficient physical activity; abdominal muscle weakness

Recent environmental changes

Habitual denial/ignoring of urge to defecate

PSYCHOLOGICAL

Emotional stress; depression; mental confusion

PHARMACOLOGICAL

Antilipemic agents; laxative overdose; calcium carbonate; aluminum-containing antacids; nonsteroidal anti-inflammatory agents; opiates; anticholinergics; diuretics; iron salts; phenothiazides; sedatives; sympathomimetics; bismuth salts; antidepressants; calcium channel blockers

MECHANICAL

Hemorrhoids; pregnancy; obesity

Rectal abscess or ulcer, anal fissures, prolapse; anal strictures; rectocele

Prostate enlargement; postsurgical obstruction

Neurological impairment; megacolon (Hirschsprung's disease); tumors

Electrolyte imbalance

PHYSIOLOGICAL

Poor eating habits; change in usual foods and eating patterns; insufficient fiber intake; insufficient fluid intake, dehydration

Inadequate dentition or oral hygiene

Decreased motility of gastrointestinal tract

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



Defining Characteristics

SUBJECTIVE

Change in bowel pattern; unable to pass stool; decreased frequency; decreased volume of stool

Change in usual foods and eating patterns; increased abdominal pressure; feeling of rectal fullness or pressure

Abdominal pain; pain with defecation; nausea and/or vomiting; headache; indigestion; generalized fatigue

OBJECTIVE

Dry, hard, formed stool

Straining with defecation

Hypoactive or hyperactive bowel sounds; change in abdominal growling (borborygmi)

Distended abdomen; abdominal tenderness with or without palpable muscle resistance

Percussed abdominal dullness

Presence of soft pastelike stool in rectum; oozing liquid stool; bright red blood with stool; dark or black or tarry stool

Severe flatus; anorexia

Atypical presentations in older adults (e.g., change in mental status, urinary incontinence, unexplained falls, elevated body temperature)

Desired Outcomes/Evaluation

Criteria—Client Will:

- Establish/regain normal pattern of bowel functioning.
- Verbalize understanding of etiology and appropriate interventions/solutions for individual situation.
- Demonstrate behaviors or lifestyle changes to prevent recurrence of problem.
- Participate in bowel program as indicated.



Actions/Interventions

NURSING PRIORITY NO. 1. To identify causative/contributing factors:

- Review daily dietary regimen. Note oral/dental health that can impact intake.
- Determine fluid intake, to note deficits.
- Evaluate medication/drug usage and note interactions or side effects (e.g., narcotics, antacids, chemotherapy, iron, contrast media such as barium, steroids).
- Note energy/activity level and exercise pattern.
- Identify areas of stress (e.g., personal relationships, occupational factors, financial problems).

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



-  Determine access to bathroom, privacy, and ability to perform self-care activities.
- Investigate reports of pain with defecation. Inspect perianal area for hemorrhoids, fissures, skin breakdown, or other abnormal findings.
- Discuss laxative/enema use. Note signs/reports of laxative abuse.
- Review medical/surgical history (e.g., metabolic or endocrine disorders, pregnancy, prior surgery, megacolon).
- Palpate abdomen for presence of distention, masses.
- Check for presence of fecal impaction as indicated.
-  Assist with medical workup for identification of other possible causative factors.

NURSING PRIORITY NO. 2. To determine usual pattern of elimination:

- Discuss usual elimination pattern and problem.
- Note factors that usually stimulate bowel activity and any interferences present.






NURSING PRIORITY NO. 3. To assess current pattern of elimination:

- Note color, odor, consistency, amount, and frequency of stool. Provides a baseline for comparison, promotes recognition of changes.
- Ascertain duration of current problem and degree of concern (e.g., long-standing condition that client has “lived with” or a postsurgical event that causes great distress) as client’s response may be inappropriate in relation to severity of condition.
- Auscultate abdomen for presence, location, and characteristics of bowel sounds reflecting bowel activity.



- Note laxative/enema use.
- Review current fluid/dietary intake.

NURSING PRIORITY NO. 4. To facilitate return to usual/acceptable pattern of elimination:

-  Instruct in/encourage balanced fiber and bulk in diet to improve consistency of stool and facilitate passage through colon.
-  Promote adequate fluid intake, including high-fiber fruit juices; suggest drinking warm, stimulating fluids (e.g., decaffeinated coffee, hot water, tea) to promote moist/soft stool.
-  Encourage activity/exercise within limits of individual ability to stimulate contractions of the intestines.
-  Provide privacy and routinely scheduled time for defecation (bathroom or commode preferable to bedpan).
-  Encourage/support treatment of underlying medical cause

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



where appropriate (e.g., thyroid treatment) to improve body function, including the bowel.



- Administer stool softeners, mild stimulants, or bulk-forming agents as ordered, and/or routinely when appropriate (e.g., client receiving opiates, decreased level of activity/immobility).



- Apply lubricant/anesthetic ointment to anus if needed.



- Administer enemas; digitally remove impacted stool.



- Provide sitz bath after stools for soothing effect to rectal area.



- Establish bowel program to include glycerin suppositories and digital stimulation as appropriate when long-term or permanent bowel dysfunction is present.

NURSING PRIORITY NO. 5. To promote wellness (Teaching/Discharge Considerations):

- Discuss physiology and acceptable variations in elimination.
- Provide information about relationship of diet, exercise, fluid, and appropriate use of laxatives as indicated.
- Discuss rationale for and encourage continuation of successful interventions.



- Encourage client to maintain elimination diary if appropriate to facilitate monitoring of long-term problem.



- Identify specific actions to be taken if problem recurs to promote timely intervention, enhancing client's independence.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Usual and current bowel pattern, duration of the problem, and individual contributing factors.
- Characteristics of stool.
- Underlying dynamics.

PLANNING

- Plan of care/interventions and changes in lifestyle that are necessary to correct individual situation, and who is involved in planning.
- Teaching plan.

IMPLEMENTATION/EVALUATION

- Responses to interventions/teaching and actions performed.
- Change in bowel pattern, character of stool.
- Attainment/progress toward desired outcomes.
- Modifications to plan of care.

DISCHARGE PLANNING

- Individual long-term needs, noting who is responsible for actions to be taken.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



- Recommendations for follow-up care.
- Specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Bowel Elimination

NIC—Constipation/Impaction Management

perceived Constipation

Taxonomy II: Elimination—Class 2 Gastrointestinal System (00012)

[Diagnostic Division: Elimination]

Submitted 1988

Definition: Self-diagnosis of constipation and abuse of laxatives, enemas, and suppositories to ensure a daily bowel movement

Related Factors

Cultural/family health beliefs

Faulty appraisal, [long-term expectations/habits]

Impaired thought processes

Defining Characteristics

SUBJECTIVE

Expectation of a daily bowel movement with the resulting over-use of laxatives, enemas, and suppositories

Expected passage of stool at same time every day


Desired Outcomes/Evaluation

Criteria—Client Will:

- Verbalize understanding of physiology of bowel function.
- Identify acceptable interventions to promote adequate bowel function.
- Decrease reliance on laxatives/enemas.
- Establish individually appropriate pattern of elimination.

Actions/Interventions

NURSING PRIORITY NO. 1. To identify factors affecting individual beliefs:





-  • Determine client's understanding of a "normal" bowel pattern and cultural expectations.
- Compare with client's current bowel functioning.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



- Identify interventions used by client to correct perceived problem.

NURSING PRIORITY NO. 2. To promote wellness (Teaching/Discharge Considerations):

-   • Discuss physiology and acceptable variations in elimination.
- Identify detrimental effects of drug/enema use.
-  • Review relationship of diet/exercise to bowel elimination.
- Provide support by Active-listening and discussing client's concerns/fears.
-  • Encourage use of stress-reduction activities/refocusing of attention while client works to establish individually appropriate pattern.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings/client's perceptions of the problem.
- Current bowel pattern, stool characteristics.

PLANNING

- Plan of care/interventions and who is involved in the planning.
- Teaching plan.

IMPLEMENTATION/EVALUATION

- Client's responses to interventions/teaching and actions performed.
- Changes in bowel pattern, character of stool.
- Attainment/progress toward desired outcome(s).
- Modifications to plan of care.

DISCHARGE PLANNING

- Referral for follow-up care.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Health Beliefs

NIC—Bowel Management

risk for Constipation

Taxonomy II: Elimination—Class 2 Gastrointestinal System (00015)

[Diagnostic Division: Elimination]

Nursing Diagnosis Extension and Classification (NDEC) Submission 1998

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



Definition: At risk for a decrease in normal frequency of defecation accompanied by difficult or incomplete passage of stool and/or passage of excessively hard, dry stool

Risk Factors

FUNCTIONAL

Irregular defecation habits; inadequate toileting (e.g., timeliness, positioning for defecation, privacy)
 Insufficient physical activity; abdominal muscle weakness
 Recent environmental changes
 Habitual denial/ignoring of urge to defecate

PSYCHOLOGICAL

Emotional stress; depression; mental confusion

PHYSIOLOGICAL

Change in usual foods and eating patterns; insufficient fiber/fluid intake, dehydration; poor eating habits
 Inadequate dentition or oral hygiene
 Decreased motility of gastrointestinal tract

PHARMACOLOGICAL

Phenothiazides; nonsteroidal anti-inflammatory agents; sedatives; aluminum-containing antacids; laxative overuse; iron salts; anticholinergics; antidepressants; anticonvulsants; antilipemic agents; calcium channel blockers; calcium carbonate; diuretics; sympathomimetics; opiates; bismuth salts

MECHANICAL

Hemorrhoids; pregnancy; obesity
 Rectal abscess or ulcer; anal stricture; anal fissures; prolapse; rectocele
 Prostate enlargement; postsurgical obstruction
 Neurological impairment; megacolon (Hirschsprung's disease); tumors
 Electrolyte imbalance

NOTE: A risk diagnosis is not evidenced by signs and symptoms, as the problem has not occurred and nursing interventions are directed at prevention.

Desired Outcomes/Evaluation

Criteria—Client Will:

- Maintain usual pattern of bowel functioning.
- Verbalize understanding of risk factors and appropriate interventions/solutions related to individual situation.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



- Demonstrate behaviors or lifestyle changes to prevent developing problem.

Actions/Interventions

NURSING PRIORITY NO. 1. To identify individual risk factors/needs:

- Auscultate abdomen for presence, location, and characteristics of bowel sounds **reflecting bowel activity.**
- Discuss usual elimination pattern and use of laxatives.
- Ascertain client's beliefs and practices about bowel elimination, such as "must have a bowel movement every day or I need an enema."
- Determine current situation and possible impact on bowel function (e.g., surgery, use of medications affecting intestinal function, advanced age, weakness, depression, and other risk factors as listed previously).
- Evaluate current dietary and fluid intake and implications for effect on bowel function.



- Review medications (new and chronic use) **for impact on effects of changes in bowel function.**

NURSING PRIORITY NO. 2. To facilitate normal bowel function:



- Instruct in/encourage balanced fiber and bulk in diet **to improve consistency of stool and facilitate passage through the colon.**



- Promote adequate fluid intake, including water and high-fiber fruit juices; suggest drinking warm, stimulating fluids (e.g., decaffeinated coffee, hot water, tea) **to promote moist/soft stool.**



- Encourage activity/exercise within limits of individual ability **to stimulate contractions of the intestines.**

- Provide privacy and routinely scheduled time for defecation (bathroom or commode preferable to bedpan).



- Administer routine stool softeners, mild stimulants, or bulk-forming agents prn and/or routinely when appropriate (e.g., client taking pain medications, especially opiates, or who is inactive, immobile, or unconscious).

- Ascertain frequency, color, consistency, amount of stools. **Provides a baseline for comparison, promotes recognition of changes.**

NURSING PRIORITY NO. 3. To promote wellness (Teaching/Discharge Considerations):

- Discuss physiology and acceptable variations in elimination. **May help reduce concerns/anxiety about situation.**



- Review individual risk factors/potential problems and specific interventions.

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.





- Review appropriate use of medications.
- Encourage client to maintain elimination diary if appropriate to help monitor bowel pattern.
- Refer to NDs Constipation; perceived Constipation.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Current bowel pattern, characteristics of stool, medications.

PLANNING

- Plan of care and who is involved in planning.
- Teaching plan.

IMPLEMENTATION/EVALUATION

- Responses to interventions/teaching and actions performed.
- Attainment/progress toward desired outcomes.
- Modifications to plan of care.

DISCHARGE PLANNING

- Individual long-term needs, noting who is responsible for actions to be taken.
- Specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Bowel Elimination

NIC—Constipation/Impaction Management

compromised family Coping

Taxonomy II: Coping/Stress Tolerance—Class 2 Coping Responses (00074)

[Diagnostic Division: Social Interaction]

Submitted 1980; Revised 1996

Definition: Usually supportive primary person (family member or close friend [SO]) provides insufficient, ineffective, or compromised support, comfort, assistance, or encouragement that may be needed by the client to manage or master adaptive tasks related to his/her health challenge

Related Factors

Inadequate or incorrect information or understanding by a primary person

Information in brackets added by authors to clarify and enhance the use of nursing diagnoses.



CHAPTER 5

Health Conditions and Client Concerns with Associated Nursing Diagnoses

This chapter presents over 400 disorders/health conditions reflecting all specialty areas, with associated nursing diagnoses written as client problem/need statements that include “related to” and “evidenced by” statements.

This section will facilitate and help validate the assessment and diagnosis steps of the nursing process. Because the nursing process is perpetual and ongoing, other nursing diagnoses may be appropriate based on changing individual situations. Therefore, the nurse must continually assess, identify, and validate new client needs and evaluate subsequent care. Once the appropriate nursing diagnoses have been selected from this chapter, the reader may refer to Chapter 4, which lists the 172 NANDA diagnoses, and review the diagnostic definition, defining characteristics, and related or risk factors for further validation. This step is necessary to determine if the nursing diagnosis statement is an accurate match, if more data are required, or if another diagnosis needs to be investigated.

To facilitate access to the health conditions/concerns and nursing diagnoses, the client needs have been listed alphabetically and coded to identify nursing specialty areas.

MS: Medical-Surgical

PED: Pediatric

OB: Obstetric

CH: Community/Home

PSY: Psychiatric/Behavioral

GYN: Gynecological

A separate category for geriatric has not been made because geriatric concerns/conditions actually are subsumed under the other specialty areas, because elderly persons are susceptible to the majority of these problems.

Abdominal hysterectomy

(Refer to Hysterectomy)

MS

Alkalosis, respiratory**MS**

(Also refer to underlying cause/condition)

impaired Gas Exchange may be related to ventilation perfusion imbalance (decreased oxygen-carrying capacity of blood, altered oxygen-supply, alveolar-capillary membrane changes) possibly evidenced by dyspnea, tachypnea, changes in mentation, tachycardia, hypoxia, hypocapnia.

Allergies, seasonal**CH**

(Refer to Hay fever)

Alopecia**CH**

disturbed Body Image may be related to effects of illness/therapy or aging process, change in appearance possibly evidenced by verbalization of feelings/concerns, fear of rejection/reaction of others, focus on past appearance, preoccupation with change, feelings of helplessness.

ALS**CH**

(Refer to Amyotrophic lateral sclerosis)

Alzheimer's disease**CH**

(Also refer to Dementia, presenile/senile)

risk for Injury/Trauma: risk factors may include inability to recognize/identify danger in environment, disorientation, confusion, impaired judgment, weakness, muscular incoordination, balancing difficulties, and altered perception.*

chronic Confusion related to physiological changes (neuronal degeneration); possibly evidenced by inaccurate interpretation of/response to stimuli, progressive/long-standing cognitive impairment, short-term memory deficit, impaired socialization, altered personality, and clinical evidence of organic impairment.

disturbed Sensory Perception (specify) may be related to altered sensory reception, transmission, and/or integration (neurological disease/deficit), socially restricted environment (homebound/institutionalized), sleep deprivation possibly evidenced by changes in usual response to stimuli, change in problem-solving abilities, exaggerated emotional responses (anxiety, paranoia, hallucinations), inability to tell position of body parts, diminished/altered sense of taste.

disturbed Sleep Pattern may be related to sensory impairment, changes in activity patterns, psychological stress (neurological impairment), possibly evidenced by wakefulness, disorientation (day/night reversal); increased aimless wandering, inability to identify need/time for sleeping, changes in behavior/performance, lethargy; dark circles under eyes, and frequent yawning.

ineffective Health Maintenance may be related to deterioration affecting ability in all areas, including coordination/communication, cognitive impairment; ineffective individual/family coping, possibly evidenced by reported or observed inability to take responsibility for meeting basic health practices, lack of equipment/financial or other resources, and impairment of personal support system.

*A risk diagnosis is not evidenced by signs and symptoms, as the problem has not occurred and nursing interventions are directed at prevention.

compromised family Coping/Caregiver Role Strain may be related to family disorganization, role changes, family/caregiver isolation, long-term illness/complexity and amount of homecare needs exhausting supportive/financial capabilities of family member(s), lack of respite; possibly evidenced by verbalizations of frustrations in dealing with day-to-day care, reports of conflict, feelings of depression, expressed anger/guilt directed toward client, and withdrawal from interaction with client/social contacts.

risk for Relocation Stress Syndrome: risk factors may include little or no preparation for transfer to a new setting, changes in daily routine, sensory impairment, physical deterioration, separation from support systems.*

Amphetamine abuse

PSY

(Refer to Stimulant abuse)

Amputation

MS

risk for ineffective peripheral Tissue Perfusion: risk factors may include reduced arterial/venous blood flow; tissue edema, hematoma formation; hypovolemia.*

acute Pain may be related to tissue and nerve trauma, psychological impact of loss of body part, possibly evidenced by reports of incisional/phantom pain, guarding/protective behavior, narrowed/self-focus, and autonomic responses.

impaired physical Mobility may be related to loss of limb (primarily lower extremity), altered sense of balance, pain/discomfort, possibly evidenced by reluctance to attempt movement, impaired coordination; decreased muscle strength, control, and mass.

disturbed Body Image may be related to loss of a body part, possibly evidenced by verbalization of feelings of powerlessness, grief, preoccupation with loss, and unwillingness to look at/touch stump.

Amiotrophic lateral sclerosis (ALS)

MS

impaired physical Mobility may be related to muscle wasting/weakness, possibly evidenced by impaired coordination, limited range of motion, and impaired purposeful movement.

ineffective Breathing Pattern/impaired spontaneous Ventilation may be related to neuromuscular impairment, decreased energy, fatigue, tracheobronchial obstruction, possibly evidenced by shortness of breath, fremitus, respiratory depth changes, and reduced vital capacity.

impaired Swallowing may be related to muscle wasting and fatigue, possibly evidenced by recurrent coughing/choking and signs of aspiration.

PSY

Powerlessness [specify level] may be related to chronic/debilitating nature of illness, lack of control over outcome, possibly evidenced by expressions of frustration about inability to care for self and depression over physical deterioration.

*A risk diagnosis is not evidenced by signs and symptoms, as the problem has not occurred and nursing interventions are directed at prevention.

bly evidenced by verbal or coded report, protective behavior, autonomic responses.

risk for Trauma: risk factors may include increased bone fragility, general weakness, balancing difficulties.*

Borderline personality disorder

PSY

risk for self/other-directed Violence/Self-Mutilation: risk factors may include use of projection as a major defense mechanism, pervasive problems with negative transference, feelings of guilt/need to “punish” self, distorted sense of self, inability to cope with increased psychological/physiological tension in a healthy manner.*

Anxiety [severe to panic] may be related to unconscious conflicts (experience of extreme stress), perceived threat to self-concept, unmet needs, possibly evidenced by easy frustration and feelings of hurt, abuse of alcohol/other drugs, transient psychotic symptoms and performance of self-mutilating acts.

chronic low Self-Esteem/disturbed Personal Identity may be related to lack of positive feedback, unmet dependency needs, retarded ego development/fixation at an earlier level of development, possibly evidenced by difficulty identifying self or defining self-boundaries, feelings of depersonalization, extreme mood changes, lack of tolerance of rejection or of being alone, unhappiness with self, striking out at others, performance of ritualistic self-damaging acts, and belief that punishing self is necessary.

Social Isolation may be related to immature interests, unaccepted social behavior, inadequate personal resources, and inability to engage in satisfying personal relationships, possibly evidenced by alternating clinging and distancing behaviors, difficulty meeting expectations of others, experiencing feelings of difference from others, expressing interests inappropriate to developmental age, and exhibiting behavior unaccepted by dominant cultural group.

Botulism (food-borne)

MS

deficient Fluid Volume [isotonic] may be related to active losses—vomiting, diarrhea; decreased intake—nausea, dysphagia, possibly evidenced by reports of thirst; dry skin/mucous membranes, decreased BP and urine output, change in mental state, increased hematocrit (Hct).

impaired physical Mobility may be related to neuromuscular impairment possibly evidenced by limited ability to perform gross/fine motor skills.

Anxiety [specify level]/Fear may be related to threat of death, interpersonal transmission possibly evidenced by expressed concerns, apprehension, awareness of physiological symptoms, focus on self.

risk for impaired spontaneous Ventilation: risk factors may include neuromuscular impairment, presence of infectious process.*

CH

risk for Poisoning: risk factors may include lack of proper precautions in food storage/preparation.*

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Brain tumor**MS**

acute Pain may be related to pressure on brain tissues, possibly evidenced by reports of headache, facial mask of pain, narrowed focus, and autonomic responses (changes in vital signs).

disturbed Thought Processes may be related to altered circulation to and/or destruction of brain tissue, possibly evidenced by memory loss, personality changes, impaired ability to make decisions/conceptualize, and inaccurate interpretation of environment.

disturbed Sensory Perception (specify) may be related to compression/displacement of brain tissue, disruption of neuronal conduction, possibly evidenced by changes in visual acuity, alterations in sense of balance/gait disturbance, and paresthesia.

risk for deficient Fluid Volume: risk factors may include recurrent vomiting from irritation of vagal center in medulla and decreased intake.*

Self-Care Deficit [specify] may be related to sensory/neuromuscular impairment interfering with ability to perform tasks, possibly evidenced by unkempt/disheveled appearance, body odor, and verbalization/observation of inability to perform activities of daily living.

Breast cancer**MS/CH**

(Also refer to Cancer)

Anxiety [specify level] may be related to change in health status, threat of death, stress, interpersonal transmission possibly evidenced by expressed concerns, apprehension, uncertainty, focus on self, diminished productivity.

deficient Knowledge regarding diagnosis, prognosis, and treatment options may be related to lack of exposure/unfamiliarity with information resources, information misinterpretation, cognitive limitation/anxiety possibly evidenced by verbalizations, statements of misconceptions, inappropriate behaviors.

risk for disturbed Body Image: risk factors may include significance of body part with regard to sexual perceptions.*

risk for ineffective Sexual Pattern: risk factors may include health-related changes, medical treatments, concern about relationship with SO.*

Bronchitis**CH**

ineffective Airway Clearance may be related to excessive, thickened mucus secretions, possibly evidenced by presence of rhonchi, tachypnea, and ineffective cough.

Activity Intolerance [specify level] may be related to imbalance between O₂ supply and demand, possibly evidenced by reports of fatigue, dyspnea, and abnormal vital sign response to activity.

acute Pain may be related to localized inflammation, persistent cough, aching associated with fever, possibly evidenced by reports of discomfort, distraction behavior, and facial mask of pain.

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mucous membranes, decreased skin turgor, change in mental state, elevated Hct.

impaired Tissue Integrity may be related to immunological deficit possibly evidenced by disruption of skin surface, cornea, mucous membranes.

Anxiety [specify level]/Fear may be related to threat of death, interpersonal transmission/contagion, separation from support system possibly evidenced by expressed concerns, apprehension, restlessness, focus on self.

CH

interrupted Family Processes may be related to temporary family disorganization, situational crisis, change in health status of family member possibly evidenced by changes in satisfaction with family, stress-reduction behaviors, mutual support; expression of isolation from community resources.

ineffective community Coping may be related to human-made disaster (bioterrorism), inadequate resources for problem-solving possibly evidenced by deficits of community participation, high illness rate, excessive community conflicts, expressed vulnerability/powerlessness.

Snow blindness

CH

disturbed visual Sensory Perception may be related to altered status of sense organ (irritation of the conjunctiva, hyperemia), possibly evidenced by intolerance to light (photophobia) and decreased/loss of visual acuity.

acute Pain may be related to irritation/vascular congestion of the conjunctiva, possibly evidenced by verbal reports, guarding/distraction behaviors, and self-focus.

Anxiety [specify level] may be related to situational crisis and threat to/change in health status, possibly evidenced by increased tension, apprehension, uncertainty, worry, restlessness, and focus on self.

Somatoform disorders

PSY

ineffective Coping may be related to severe level of anxiety that is repressed, personal vulnerability, unmet dependency needs, fixation in earlier level of development, retarded ego development, and inadequate coping skills, possibly evidenced by verbalized inability to cope/problem-solve, high illness rate, multiple somatic complaints of several years' duration, decreased functioning in social/occupational settings, narcissistic tendencies with total focus on self/physical symptoms, demanding behaviors, history of "doctor shopping," and refusal to attend therapeutic activities.

chronic Pain may be related to severe level of repressed anxiety, low self-concept, unmet dependency needs, history of self or loved one having experienced a serious illness, possibly evidenced by verbal reports of severe/prolonged pain, guarded movement/protective behaviors, facial mask of pain, fear of reinjury, altered ability to continue previous activities, social withdrawal, demands for therapy/medication.

disturbed Sensory Perception (specify) may be related to psychological

stress (narrowed perceptual fields, expression of stress as physical problems/deficits), poor quality of sleep, presence of chronic pain, possibly evidenced by reported change in voluntary motor or sensory function (paralysis, anosmia, aphonia, deafness, blindness, loss of touch or pain sensation), *la belle indifférence* (lack of concern over functional loss).

impaired Social Interaction may be related to inability to engage in satisfying personal relationships, preoccupation with self and physical symptoms, altered state of wellness, chronic pain, and rejection by others, possibly evidenced by preoccupation with own thoughts, sad/dull affect, absence of supportive SO(s), uncommunicative/withdrawn behavior, lack of eye contact, and seeking to be alone.

Spinal cord injury (SCI)

MS/CH

(Refer to Paraplegia; Quadriplegia)

Sprain of ankle or foot

CH

acute Pain may be related to trauma to/swelling in joint, possibly evidenced by verbal reports, guarding/distraction behaviors, self-focusing, and autonomic responses (changes in vital signs).

impaired Walking may be related to musculoskeletal injury, pain, and therapeutic restrictions, possibly evidenced by reluctance to attempt movement, inability to move about environment easily.

Stapedectomy

MS

risk for Trauma: risk factors may include increased middle-ear pressure with displacement of prosthesis and balancing difficulties/dizziness.*

risk for Infection: risk factors may include surgically traumatized tissue, invasive procedures, and environmental exposure to upper respiratory infections.*

acute Pain may be related to surgical trauma, edema formation, and presence of packing, possibly evidenced by verbal reports, guarding/distraction behaviors, and self-focus.

STD

CH

(refer to Sexually transmitted disease)

Substance dependence/abuse rehabilitation

PSY/CH

(following acute detoxification)

ineffective Denial/Coping may be related to personal vulnerability, difficulty handling new situations, learned response patterns, cultural factors, personal/family value systems, possibly evidenced by lack of acceptance that drug use is causing the present situation, use of manipulation to avoid responsibility for self, altered social patterns/participation, impaired adaptive behavior and problem-solving skills, employment difficulties, financial affairs in disarray, and decreased ability to handle stress of recent events.

Powerlessness may be related to substance addiction with/without periods of abstinence, episodic compulsive indulgence, attempts at recov-

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ery, and lifestyle of helplessness, possibly evidenced by ineffective recovery attempts, statements of inability to stop behavior/requests for help, continuous/constant thinking about drug and/or obtaining drug, alteration in personal/occupational and social life.

imbalanced Nutrition: less than body requirements may be related to insufficient dietary intake to meet metabolic needs for psychological/physiological/economic reasons, possibly evidenced by weight less than normal for height/body build, decreased subcutaneous fat/muscle mass, reported altered taste sensation, lack of interest in food, poor muscle tone, sore/inflamed buccal cavity, laboratory evidence of protein/vitamin deficiencies.

Sexual Dysfunction may be related to altered body function (neurological damage and debilitating effects of drug use), changes in appearance, possibly evidenced by progressive interference with sexual functioning, a significant degree of testicular atrophy, gynecomastia, impotence/decreased sperm counts in men; and loss of body hair, thin/soft skin, spider angiomas, and amenorrhea/increase in miscarriages in women.

dysfunctional Family Processes: alcoholism [substance abuse] may be related to abuse/history of alcoholism/drug use, inadequate coping skills/lack of problem-solving skills, genetic predisposition/biochemical influences, possibly evidenced by feelings of anger/frustration/responsibility for alcoholic's behavior, suppressed rage, shame/embarrassment, repressed emotions, guilt, vulnerability; disturbed family dynamics/deterioration in family relationships, family denial/rationalization, closed communication systems, triangulating family relationships, manipulation, blaming, enabling to maintain substance use, inability to accept/receive help.

OB

risk for fetal Injury: risk factors may include drug/alcohol use, exposure to teratogens.*

deficient Knowledge [Learning Need] regarding condition/pregnancy, prognosis, treatment needs may be related to lack/misinterpretation of information, lack of recall, cognitive limitations/interference with learning possibly evidenced by statements of concern, questions/misconceptions, inaccurate follow-through of instructions, development of preventable complications, continued use in spite of complications.

S

Surgery, general

MS

(Also refer to Postoperative recovery period)

deficient Knowledge [Learning Need] regarding surgical procedure/expectation, postoperative routines/therapy, and self-care needs may be related to lack of information/misinterpretation, possibly evidenced by statements of concern, questions, and misconceptions.

Anxiety [specify level]/Fear may be related to situational crisis, unfamiliarity with environment, change in health status/threat of death and separation from usual support systems, possibly evidenced by

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increased tension, apprehension, decreased self-assurance, fear of unspecified consequences, focus on self, sympathetic stimulation, and restlessness.

risk for perioperative-positioning Injury: risk factors may include disorientation, immobilization, muscle weakness, obesity/edema.*

risk for ineffective Breathing Pattern: risk factors may include chemically induced muscular relaxation, perception/cognitive impairment, decreased energy.*

risk for deficient Fluid Volume: risk factors may include preoperative fluid deprivation, blood loss, and excessive GI losses (vomiting/gastric suction).*

Synovitis (knee)

CH

acute Pain may be related to inflammation of synovial membrane of the joint with effusion, possibly evidenced by verbal reports, guarding/distraction behaviors, self-focus, and autonomic responses (changes in vital signs).

impaired Walking may be related to pain and decreased strength of joint, possibly evidenced by reluctance to attempt movement, inability to move about environment as desired.

Syphilis, congenital

PED

(Also refer to Sexually transmitted disease—STD)

acute Pain may be related to inflammatory process, edema formation, and development of skin lesions, possibly evidenced by irritability/crying that may be increased with movement of extremities and autonomic responses (changes in vital signs).

impaired Skin/Tissue Integrity may be related to exposure to pathogens during vaginal delivery, possibly evidenced by disruption of skin surfaces and rhinitis.

delayed Growth and Development may be related to effect of infectious process, possibly evidenced by altered physical growth and delay or difficulty performing skills typical of age group.

deficient Knowledge [Learning Need] regarding pathophysiology of condition, transmissibility, therapy needs, expected outcomes, and potential complications may be related to caretaker/parental lack of information, misinterpretation, possibly evidenced by statements of concern, questions, and misconceptions.

Syringomyelia

MS

disturbed Sensory Perception (specify) may be related to altered sensory perception (neurological lesion), possibly evidenced by change in usual response to stimuli and motor incoordination.

Anxiety [specify level]/Fear may be related to change in health status, threat of change in role functioning and socioeconomic status, and threat to self-concept, possibly evidenced by increased tension, apprehension, uncertainty, focus on self, and expressed concerns.

impaired physical Mobility may be related to neuromuscular and

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