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Rebecca Nissanka (Jadhav)



2nd Edition

Comprehensive Textbook on Foundation of NURSING-II

As per the Revised Syllabus for BSc Nursing

Foreword
Rupa Ashok Verma

JAYPEE

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2

CHAPTER

The Nursing Process

INTRODUCTION

- In every clinical situation, it is important for a nurse to think critically and make sound judgment so that client ultimately receives the very best nursing care.
- Critical thinking is a process acquired only through hard work, commitment and an active curiosity towards learning.
- *"Ideally, critical thinking becomes a habit of mind, a part of each nurse's character".* **—Facione and Facione (1996).**

DEFINITION AND MEANING OF CRITICAL THINKING

"Critical thinking is the active, organized, cognitive process used to carefully examine one's thinking and the thinking of others."

—Chaffee 1994

"Critical thinking involves use of the mind informing, conclusions, making decisions, drawing inferences and reflecting. It means taking nothing for granted."

—Gordon 1995

Meaning

- A critical thinker identifies and challenges, assumptions, considers what is important in a situation, imagines and explores alternatives, applies reason and logic, and thus makes informed decisions, for a new student nurse, critical thinking begins when the student seriously questions, and in a continuing way tries to answer again and again.
- Critical thinking presupposes a certain basic level of intellectual humility, (e.g., acknowledging one's own ignorance) and a commitment to think clearly, precisely and accurately and to act on the basis of genuine knowledge.
- When the nurse directs critical thinking towards understanding and assisting clients in finding solutions, to their health problems, the process becomes purposeful and goal oriented.
- Every clinical experience becomes a lesson that informs the nurse about the next practice experience.
- No nursing action or interaction with a client is trivial or ordinary. Although the responsibility of making clinical decisions may seem frightening to a new student it is what makes nursing rewarding and challenging profession

CRITICAL THINKING: THINKING AND LEARNING

Critical Thinking Model

- Models help to explain concepts. Because critical thinking in nursing is complex, a model can help to explain all of the factors involved in making decisions and judgments about clients.
- Kataoka-Yahiro and Saylor (1994) have developed a model of critical thinking for nursing judgement based in part on previous work by Paul (1993), Glaser (1941), Perry (1979) and Miller and Malcolm (1990).
- **The model defines the outcome of critical thinking:** Nursing judgment that is relevant to nursing problems in a variety of settings.
- According to this model, there are five components of critical thinking—knowledge base, experience, competence, attitudes, standards and the critical thinking competency of the nursing process.
- The elements of the model combine to explain how nurses make clinical judgment that is necessary for safe, effective, nursing care.

Components of Critical Thinking in Nursing

- Specific knowledge base in nursing
- Experience in nursing
- **Critical thinking competencies:**
  - General critical thinking competencies
  - Specific critical thinking competencies in clinical situation
  - Specific critical thinking competency in nursing.
- **Attitudes for critical thinking:**
  - Confidence
  - Independence
  - Fairness
  - Responsibility
  - Risk taking
  - Discipline
  - Perseverance
  - Creativity
  - Curiosity
  - Integrity
  - Humility

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❖ **Standards for critical thinking:**
- *Intellectual standards*
  - Clear
  - Logical
  - Precise
  - Deep
  - Specific
  - Broad
  - Accurate
  - Complete
  - Relevant
  - Significant
  - Plausible
  - Adequate (for purpose)
  - Consistent
  - Fair
- *Professional standards:*
  - Ethical criteria for nursing judgement
  - Criteria for evaluation
  - Professional responsibility

Critical Thinking Attitudes and Applications in Nursing Practice

Confidence

Learn how to introduce yourself to a client. Speak with conviction when you begin a treatment or procedure. Do not lead a client to think that you are uncertain of being able to perform care safely, especially when there are different views on the same subject.

Thinking independently

Read the nursing literature, especially where there are deferent views on the same subject. Talk with colleagues and share ideas about nursing interventions.

Fairness

Listen to both sides in any discussion. If client or family members complain about a colleague, listen to the story and then speak with the colleague as well.

Responsibility and authority

Ask for help if you are uncertain about an aspect of client care. Report any problems immediately. Follows standards of practice in your care.

Risk taking

If your knowledge causes you to question a physician's order, do so. Be willing to recommend alternative approach to nursing care when colleagues are having little success with client.

Discipline

Be thorough in whatever you do.

Use Known Scientific and Practice-based Criteria

for activities, such as assessment and evolution. Take time to be thorough, and manage your time effectively.

Perseverance

Beware of an easy answer. If colleagues give you information about a client, and some fact seems to be missing, go clarify information or talk to the client directly. If problem of the same type continues to occur on a nursing division, bring colleagues together, look for a pattern, and find a solution.

Creativity

Look for different approaches if interventions are not working. A client we need a different positioning technique or a different instructional approach that will suit his or her unique needs.

Curiosity

Always ask why. A clinic sign or symptoms can indicate a variety of problems. Explore and learn more about the client so as to make appropriate clinical judgment.

Integrity

Recognized when your opinion may conflict with those of a client, review your position, and decide how best to proceed to reach usually beneficial outcome. Do not compromise nursing standard or honesty in delivering nursing care.

Humility

Recognized when you need more information to make a decision when you are newly assigned to clinical division and you are unfamiliar with the client, ask to be oriented to the area. Ask RNs regularly assigned to the area for assistance. Read the professional generals regularly to keep updated on new approaches to care.

Levels of Critical Tinking in Nursing

The ability to think critically expands as a nurse gains new knowledge and experience and matures into a competent professional.

Critical Thinking in Nursing

By Kataoka Yahiro and Baylor (1994)

According to this model there are three levels of critical thinking in nursing:
1. Basic
2. Complex
3. Commitment.

Basic Critical Thinking

- ❖ At the basic level of critical thinking, a learner trusts that experts have the right answers for every problem.
- ❖ Thinking is concrete and based on a set of rules or principles.
- ❖ For basic critical thinkers, answers to complex problems are either right or wrong and one right answer usually exists for each problem.
- ❖ This is an early step in the development of reasoning ability, revealing that the individual has had limited critical thinking experience.
- ❖ Despite the tendency to be governed by others, a person learns to accept the diverse opinions one values of experts.

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- However, in experience, weak competencies, and inflexible attitudes can restrict a person's ability to move to the next level of critical thinking.

Complex Critical Thinking

- A person begins to detach from authorities and analyze and examine alternatives more independently at the complex level of critical thinking.
- The nurse's best answer to a problem at this level is "It depends".
- The person's thinking ability and initiative to look beyond expert opinion begin to change.
- A nurse realizes that alternative and perhaps conflicting, solutions do exist.
- In complex critical thinking each solution has benefits and risks that the nurse weighs before making a final decision.
- There are options.
- Thinking can become more creative and innovative.
- There is a willingness to consider deviations from standard protocols or policies when complex situations develop.
- Nurses learn a variety of different approaches for the same therapy.

Commitment

- The third level of critical thinking is commitment.
- The individual anticipates the need to make choices without assistance from others and then assumes accountability to them.
- At this level the nurse does more than first counter the complex alternatives a problem poses.
- At the commitment level the nurse chooses an action or belief based on the alternative available and stands by it.
- Sometimes an action may be no action, or the nurse may choose to delay an action until a later time, but does it as a result of experience and knowledge, because the nurse assumes accountability for the decision, alternation, is given to the results of the decision and a determination of whether it was appropriate.

NURSING PROCESS

The nursing process has been accepted as the essence of nursing.

Definition

"Nursing process is a deliberate, problem-identification, and problem-solving approach to meeting the health care and nursing needs of patient." **—Brunner and Suddarth**

"Process as a whole is cyclic different steps is involved interdependent, interrelated, and recurrent till the patient is satisfied." **—Brunner and Suddarth**

"Nursing process is a data–collecting, decision–making process that incorporates evaluation and subsequent modification as feedback mechanisms that promote the ultimate resolution of the patient's nursing diagnoses."

ASSESSMENT

"Assessment involves the systematic collection of data about the patient's health status, analysis of the data to determine his actual and potential health needs, and use of the data to formulate nursing diagnosis." **—Brunner and Suddarth**

"Nursing process is a system of inter-related and interdependent problem-solving steps directed at meeting the needs of people." **—Luckman and Sorenson**

"Nursing assessment is a systematic collection and ordering of information to identify unmet human needs and a person's responses to actual and potential health problems. It involves data gathering, problem reinter relation and establishing a nursing diagnosis."

Steps

- Conduct the health history.
- Perform the health assessment.
- Interview the patient's family or significant others.
- Study the health record. Organize, analyze, synthesize and summarize the collected data which help to formulate the nursing diagnosis.

Health History

The health history is carried out for the purpose of determining the patient's state of wellness or illness and is best accomplished as part of a planned interview. Interview requires wisdom, judgment, tact and experience.

Skills for Interviewing Includes

- Listening and questioning
- Observing and interpreting
- Synthesizing
- Incorporating what is learned into a plan of care.

Suggestions for Interviewing the Patient

- At the beginning of the interview, focus on what is most troublesome to the patient.
- Learn about the patient's background and experience in order to determine his needs.
- As certain what can be done to support the patient and help him to make the best use of his resources.

Health Assessment (Physical Examination)

The health assessment of the patient may be carried out prior to, during or following the health history, depending on the patient's physical and emotional state, his response to his illness and hospitalization, and the immediate priorities of his illness situation.

Purposes

- Identify those parameters of physical, psychological, and emotional functioning that indicates that a nursing need exists.
- It requires the use of the senses of sight, hearing, touch, and smell as well as the appropriate interview skills and techniques.

Other Components of the Data Base

Following the health history and the health assessment, the nurse seeks additional relevant, information from the patient's family or significant others, from other members of the health team, and from the patient's health record or chart.

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Recording of the Data Base

After completion of the health history and health assessment the information obtained must be recorded in the patient's permanent record.

Function of Record

- Provides a means of communication between the members of the health care team and facilitates coordinated planning and continuity of care.
- It serves as the legal record for the hospital and for the professional staff responsible for the patient's care.
- It serves as a basis for evaluating the quality and appropriateness of care as well as for renewing the effective use of patient care health practices.

Therapeutic Communication Techniques

- Listening
- Silence
- Establishing guidelines
- Open ended comments
- Reducing distance
- Acknowledgement
- Restating
- Reflecting
- Seeking unification
- Sorting consensual validation
- Focusing
- Summarizing
- Planning

NURSING DIAGNOSIS

"Those actual or potential health problems that are amenable to resolution by nursing actions are identified as nursing diagnosis."

"A nursing diagnosis is a diagnoses judgment about, individual, family, or community response to actual or potential health problems/life processes. Nursing diagnosis produces the basis for selection of nursing interventions to achieve out comes for which the nurse is accountable."

A well-worded nursing diagnosis has 2 parts:
1. Problem
2. Etiology of the problem.

Recording the Nursing Diagnosis

- The patient's nursing diagnoses are recorded on the nursing care plans well as in the patient problem list.
- "A problem is defined as anything that concerns the patient, endangers his health, requires management and concerns any member of the health care team."
- The problems are used by all concerned members for writing the progress notes.

Steps

- Identify the patient's nursing problem.
- Identify the defining characteristic of the nursing problems.
- Identify the etiology of the nursing problem.
- State nursing diagnosis concisely and precisely.

Brunner and Suddarth 1970s

Brought a surge of professional activity aimed at making nursing diagnosis a function for which the nurse is held legally responsible and accountable.

"A large number of nurse practice acts were revised to include nursing diagnosis as a nursing function."

1973

Nursing diagnosis was included in the American Nurses Association (ANA) standards of nursing practice and in the standards developed by many nursing specialty organizations. The National Conferences on the classification of nursing diagnosis held regularly since 1973 have proved an impetus for the identification and classification of nursing diagnoses according to symptomatology.

1982

At the fifth conference, held in 1982, a major step was taken toward coordinating the work of developing nursing diagnoses.

"A new organization, the North American Nursing Diagnosis Association (NANDA) was formulated.

1986

NANDA approved its first taxonomy for classification of nursing diagnosis, this taxonomy sometimes to be further developed.

1990

At the NANDA Biennial Conference, the association officially adopted a definition for nursing diagnosis.

Objectives of Care and Goals that Reflect Outcome (May be Short-term or Long-term Goals)

- **Short-term goals:** Used for actual problem.
- Intermediate goals.
- **Long-term goals:** Used for potential problem.

PLANNING

- "Development of goal and a plan of care designed to assist the patient in resolving the nursing diagnosis."
- Once the nursing diagnosis is identified the planning component of the nursing process is developed.
- In this phase, it is the responsibility of the nurse to communicate to appropriate persons any assessment data indicative of health needs that can be best met by other members of the health care team.

Definition

"During planning phase, of nursing process, the nurse establishes priorities of care, writes desired patient's outcome (goals), selects and converts nursing interventions into nursing orders, and communicates the plan of care."

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Steps of Planning

- Assign priority to the nursing diagnosis.
- **Specify the goals:**
  - Develop immediate; intermediate and long-term goals.
  - State the goals in realistic and measurable terms.
- Identify nursing interventions appropriate for goal achievement
- Establish expected outcome:
  - Make sure that the outcomes are realistic and measurable.
  - Identify critical times for attainment of outcomes.
- **Develop the written nursing care plan:**
  - Include nursing diagnosis, goals, nursing interventions, expected outcomes at critical times.
  - Write all entries precisely, concisely and systematically.
  - Keep the plan current and flexible to meet the patient's changing problems and needs.
  - Involve the patient, his family or significant others, nursing team members and other health team members in all aspects of planning.

IMPLEMENTATIONS

- "Implementations is actualization of the plan of care through nursing interventions or supervision of others to do the same."
- "Nursing interventions are those actions that should promote the achievement of the desired patient's outcome."

They are classified into 2 types:

1. **Independent interventions:** These are those that nurse can perform without direction from others.
2. **Dependent interventions:** These are prescribed by the physician and carried out by the nurse. They are aimed at reducing or eliminating the causative factors affecting health. The nurse uses judgment and decision-making talks in relation of appropriate interventions that are based on physiologic principles. All nursing interventions are patient focused and goal-directed. They are based on scientific principles and implemented with compassion, confidence and a willingness to accept and understand the patient's response.

Steps

- Put the nursing care plan into action.
- Coordinate the activities of the patient his family or significant others, nursing team members and other health team members.
- Record the patient's responses to the nursing actions.

Patient's Progress Notes

Are written in a narrative form using the acronym **SOAPIE**:
S—Subjective Data
O—Objective Data
A—Assessment
P—Plan
I—Interventions
E—Evaluations

RATIONALE

Are the scientific principles and have a physical or pathophysiological basis.

- Implementation phase of the nursing process follows the formulation of the nursing care plan.
- The nurse assumes responsibility for the implementation, but includes the patient and his family and other members of the nursing team and the health care team as appropriate in implementation, and coordinated by the nurse.
- The nursing care plan serves as the basis for un-implementation.
- The immediate, intermediate and long-term goals are used as a focus for the implementing of the designed nursing interventions.
- While implementing nursing care, the nurse continually assesses the patient and his response to the nursing care.
- Alternations are made in the care plan as the Patient's condition, problems, and responses change and as reassignment of priorities are required.
- Implementation includes all the nursing interventions that are directed toward resolution of the patient's nursing diagnosis and meeting his health needs.

FORMULATING THE NURSING CARE PLAN

The entire planning phase of the nursing process culminates in the formulation, of the patient's nursing care plan by the professional nurse.

The nursing care plan serves to communicate the following information to all members of the nursing team:

- The nursing diagnosis and their priorities.
- The goals of the nursing interventions.
- The nursing interventions which are expressed in the form of nursing orders.
- The expected outcomes, which identify the expected behavioral responses for the patient.
- The critical time period within which each outcome must be met.

EVALUATION

"It is the determination of the patient's responses to the nursing interventions and the extent to which the goals have been achieved." **—Brunner and Suddarth**

- The nurse receives the patient-centered goals or desired patient outcome.
- The nurse reassesses the patient to gather data including the patient's actual response to the nursing interventions.
- The nurse compares the actual outcome with the desired outcome and makes critical judgment about whether the patient-centered goal or desired patient outcome was achieved. (Outcome criteria).

Steps

- Collect objective data.
- Compare the patient's behavioral outcomes with the expected outcomes.

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- Determine the extent to which the goals were achieved.
- Include the patient his family and significant others, nursing team members, and other health care team members in evaluation.
- Identify alterations that are to be made in the nursing diagnosis, goals, and nursing interventions and expected outcomes.
- Continue all steps of nursing process assessment, nursing diagnosis, planning, implementation and evaluation.
- Evaluation is the final component of the nursing process and is directed toward determining the patient's response to the nursing interventions and the extent to which the goals have been achieved.
- The nursing care plan provides the basis for evaluation.
- The nursing diagnoses, goals, nursing interventions, and expected outcomes provide the specific guidelines that dictate the focus of the evaluation.

Evaluation will answer the following question:

- Were the nursing diagnoses accurate?
- Did the patient reach the expected outcome?
- Did the patient attain the expected outcomes within the critical time periods?
- Has the patient's nursing diagnosis been resolved?
- Have the patient's nursing needs been met?
- Should the nursing interventions be retained, alerted or discontinued?
- Have new problems evolved for which nursing interventions have not been planned or implemented?
- What factors influenced the achievement or lack of achievement of the goals?
- Do priorities need to be reassigned?
- Should changes be made in the goals and expected outcomes?
- Objective data that answer their questions must be collected from all available sources.
- This data should be available in the patient's record and should be substantiated by direct observation of the patient.

NANDA NURSING DIAGNOSIS (TABLE 1.1)

1. Health Promotion

Class 1. Health Awareness

- Decreased diversional activity engagement (Nursing care plan)
- Readiness for enhanced health literacy sedentary lifestyle (Nursing care plan)

Class 2. Health Management

- Frail elderly syndrome (Nursing care plan)
- Risk for frail elderly syndrome
- Deficient community health
- Risk-prone health behavior
- Ineffective health maintenance (Nursing care plan)
- Ineffective health management
- Readiness for enhanced health management
- Ineffective family health management
- Ineffective protection

TABLE 1.1: NANDA classification.

Domain	*Health promotion*	*Nutrition*	*Elimination/ exchange*	*Activity*	*Perception/ cognition*	*Self-perception*	*Role relationship*	*Sexuality*	*Coping/ stress tolerance*	*Life principles*	*Safety/ protection*	*Comfort*	*Growth/ development*
Class 1	Health awareness	Ingestion	Urinary function	Sleep/ rest	Attention	Self-concept	Caregiving roles	Sexual identity	Post trauma responses	Values	Infection	Physical comfort	Growth
Class 2	Health Management	Digestion	Gastro-intestinal function	Activity/exercise	Orientation	Self esteem	Family relationships	Sexual function	Coping responses	Beliefs	Physical injury	Environmental comfort	Development
Class 3		Absorption	Integumentary function	Energy balance	Sensation/ perception	Body image	Role performance	Reproduction	Neuro behavioural stress	Value/ belief/action congruence	Violence	Social comfort	
Class 4		Metabolism	Respiratory function	Cardiovascular/ pulmonary responses	perception						Environmental hazards		
Class 5		Hydration		Self-care	Cognition						Defensive processes		
Class 6					Communication						Thermo-regulation		

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2. Nutrition

Class 1. Ingestion

Imbalanced nutrition:
- Less than body requirements (Nursing care plan)
- Readiness for enhanced nutrition
- Insufficient breast milk production
- Ineffective breastfeeding (Nursing care plan)
- Interrupted breastfeeding (Nursing care plan)
- Readiness for enhanced breastfeeding
- Ineffective adolescent eating dynamics
- Ineffective child eating dynamics
- Ineffective infant feeding dynamics
- Ineffective infant feeding pattern (Nursing care plan)
- Obesity
- Overweight
- Risk for overweight
- Impaired swallowing (Nursing care plan)

Class 2. Digestion

This class does not currently contain any diagnoses

Class 3. Absorption

This class does not currently contain any diagnoses

Class 4. Metabolism

- Risk for unstable blood glucose level (Nursing care plan)
- Neonatal hyperbilirubinemia
- Risk for neonatal hyperbilirubinemia
- Risk for impaired liver function
- Risk for metabolic imbalance syndrome

Class 5. Hydration

- Risk for electrolyte imbalance
- Risk for imbalanced fluid volume
- Deficient fluid volume (Nursing care plan)
- Risk for deficient fluid volume
- Excess fluid volume (Nursing care plan)

3. Elimination and Exchange

Class 1. Urinary Function

- Impaired urinary elimination
- Functional urinary incontinence
- Overflow urinary incontinence
- Reflex urinary incontinence
- Stress urinary incontinence
- Urge urinary incontinence
- Risk for urge urinary incontinence
- Urinary retention

Class 2. Gastrointestinal Function

- Constipation (Nursing care plan)
- Risk for constipation
- Perceived constipation
- Chronic functional constipation
- Risk for chronic functional constipation
- Diarrhea
- Dysfunctional gastrointestinal motility
- Risk for dysfunctional gastrointestinal motility
- Bowel incontinence

Class 3. Integumentary Function

This class does not currently contain any diagnoses.

Class 4. Respiratory Function

Impaired gas exchange

4. Activity/rest

Class 1. Sleep/Rest

- Insomnia Sleep deprivation
- Readiness for enhanced sleep
- Disturbed sleep pattern

Class 2. Activity/Exercise

- Risk for disuse syndrome
- Impaired bed mobility
- Impaired physical mobility
- Impaired wheelchair mobility
- Impaired sitting
- Impaired standing
- Impaired transfer ability
- Impaired walking

Class 3. Energy Balance

Imbalanced energy field fatigue wandering

Class 4. Cardiovascular/Pulmonary Responses

- Activity intolerance
- Risk for activity intolerance
- Ineffective breathing pattern
- Decreased cardiac output
- Risk for decreased cardiac output
- Impaired spontaneous ventilation
- Risk for unstable blood pressure
- Risk for decreased cardiac tissue perfusion
- Risk for ineffective cerebral tissue perfusion
- Ineffective peripheral tissue perfusion
- Risk for ineffective peripheral tissue perfusion
- Dysfunctional ventilatory weaning response

Class 5. Self-care

- Impaired home maintenance
- Bathing self-care deficit
- Dressing self-care deficit
- Feeding self-care deficit
- Toileting self-care deficit
- Readiness for enhanced self-care
- Self-neglect

5. Perception/cognition

Class 1. Attention

Unilateral neglect

Class 2. Orientation

This class does not currently contain any diagnoses.

Class 3. Sensation/Perception

This class does not currently contain any diagnoses.

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Class 4. Cognition

- Acute confusion
- Risk for acute confusion
- Chronic confusion
- Labile emotional control
- Ineffective impulse control
- Deficient knowledge
- Readiness for enhanced knowledge
- Impaired memory

Class 5. Communication

- Readiness for enhanced communication
- Impaired verbal communication

6. Self-perception

Class 1. Self-concept

- Hopelessness
- Readiness for enhanced hope
- Risk for compromised human dignity
- Disturbed personal identity
- Risk for disturbed personal identity
- Readiness for enhanced self-concept

Class 2. Self-esteem

- Chronic low self-esteem
- Risk for chronic low self-esteem
- Situational low self-esteem
- Risk for situational low self-esteem

Class 3. Body Image

Disturbed body image

7. Role Relationship

Class 1. Caregiving Roles

- Caregiver role strain
- Risk for caregiver role strain
- Impaired parenting
- Risk for impaired parenting
- Readiness for enhanced parenting

Class 2. Family Relationships

- Risk for impaired attachment
- Dysfunctional family processes
- Interrupted family processes
- Readiness for enhanced family processes

Class 3. Role Performance

- Ineffective relationship
- Risk for ineffective relationship
- Readiness for enhanced relationship
- Parental role conflict
- Ineffective role performance Impaired social interaction

8. Sexuality

Class 1. Sexual Identity

This class does not currently contain any diagnoses.

Class 2. Sexual Function

Sexual dysfunction: Ineffective sexuality pattern

Class 3. Reproduction

- Ineffective childbearing process
- Risk for ineffective childbearing process
- Readiness for enhanced childbearing process
- Risk for disturbed maternal-fetal dyad

9. Coping/Stress Tolerance

Class 1. Post-trauma Responses

- Risk for complicated immigration transition
- Post-trauma syndrome
- Risk for post-trauma syndrome
- Rape-trauma syndrome
- Relocation stress syndrome
- Risk for relocation stress syndrome

Class 2. Coping Responses

- Ineffective activity planning
- **Risk for ineffective activity planning:** Anxiety (Nursing care plan)
- **Defensive coping:** Ineffective coping
- **Readiness for enhanced coping:** Ineffective community coping
- Readiness for enhanced community coping
- Compromised family coping
- Disabled family coping
- Readiness for enhanced family coping
- Death anxiety
- **Ineffective denial:** Fear
- Grieving complicated grieving
- Risk for complicated grieving
- Impaired mood regulation
- Powerlessness
- Risk for powerlessness
- Readiness for enhanced power
- Impaired resilience
- Risk for impaired resilience
- Readiness for enhanced resilience
- Chronic sorrow
- Stress overload

Class 3. Neurobehavioral Stress

- Acute substance withdrawal syndrome
- Risk for acute substance withdrawal syndrome
- Autonomic dysreflexia
- Risk for autonomic dysreflexia
- Decreased intracranial adaptive capacity
- Neonatal abstinence syndrome
- Disorganized infant behavior
- Risk for disorganized infant behavior
- Readiness for enhanced organized infant behavior

10. Life Principles

Class 1. Values

This class does not currently contain any diagnoses.

Class 2. Beliefs

Readiness for enhanced spiritual well-being

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Class 3. Value/Belief/Action Congruence

- Readiness for enhanced decision-making
- Decisional conflict
- Impaired emancipated decision-making
- Risk for impaired emancipated decision-making
- Readiness for enhanced emancipated decision-making
- **Moral distress:** Impaired religiosity
- Risk for impaired religiosity
- Readiness for enhanced religiosity
- Spiritual distress
- Risk for spiritual distress

11. Safety/protection

Class 1. Infection

Risk for infection: Risk for surgical site infection

Class 2. Physical Injury

- Ineffective airway clearance
- Risk for aspiration
- Risk for bleeding (Nursing care plan)
- Impaired dentition
- Risk for dry eye
- Risk for dry mouth
- Risk for falls
- Risk for corneal injury
- Risk for injury
- Risk for urinary tract injury
- Risk for perioperative positioning injury
- Risk for thermal injury
- Impaired oral mucous membrane integrity
- Risk for impaired oral mucous membrane integrity
- Risk for peripheral neurovascular dysfunction
- Risk for physical trauma
- Risk for vascular trauma
- Risk for pressure ulcer
- Risk for shock
- Impaired skin integrity (Nursing care plan)
- Risk for impaired skin integrity
- Risk for sudden infant death
- Risk for suffocation
- Delayed surgical recovery
- Risk for delayed surgical recovery
- Impaired tissue integrity
- Risk for impaired tissue integrity
- Risk for venous thromboembolism

Class 3. Violence

- Risk for female genital mutilation
- Risk for other-directed violence
- Risk for self-directed violence
- Self-mutilation
- Risk for self-mutilation
- Risk for suicide

Class 4. Environmental Hazards

- Contamination
- Risk for contamination
- Risk for occupational injury
- Risk for poisoning

Class 5. Defensive Processes

- Risk for adverse reaction to iodinated contrast media
- Risk for allergy reaction
- Latex allergy reaction
- Risk for latex allergy reaction

Class 6. Thermoregulation

- Hyperthermia
- Hypothermia
- Risk for hypothermia
- Risk for perioperative hypothermia
- Ineffective thermoregulation
- Risk for ineffective thermoregulation

12. Comfort

Class 1. Physical Comfort

- Impaired comfort
- Readiness for enhanced comfort
- Nausea
- Acute pain
- Chronic pain
- Chronic pain syndrome
- Labor pain

Class 2. Environmental Comfort

- Impaired comfort
- Readiness for enhanced comfort

Class 3. Social Comfort

- Impaired comfort
- Readiness for enhanced comfort
- Risk for loneliness
- Social isolation

13. Growth/development

Class 1. Growth

This class does not currently contain any diagnoses

Class 2. Development

Risk for delayed development

Comparison Between Nursing and Medical Diagnosis

See **Table 2.2**.

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TABLE 2.2: Shows the comparison between the nursing diagnosis and medical diagnosis.

Parameters of comparison	*Nursing diagnosis*	*Medical diagnosis*
Focus	This type of diagnosis focuses more on care for a patient	This type of diagnosis focuses more on the etiologic of a patient
Meaning	There is a process of identification in this type of diagnosis of all the possibilities of risks and problems in a patient	There is a process of identification in this type of diagnosis of a clear medical entity that caused the illness to a patient
Identification	This identifies the signs and symptoms of an illness of a patient	This identifies the pathology that caused the illness to a patient
Main feature	This helps to focus on the reactions in physical and psychological reactions of a patient	This helps to focus on the actual illness of a patient
Example	Diagnosis of heartbeats	Diagnosis of infarction

Nursing Process

Patient Name: **Date:** / / **Ward**

Date	*Assessment*	*Nursing diagnosis*	*Objective*	*Plan of care*	*Implementation*	*Rationale*	*Evaluation*

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