Marilynn E. Doenges
Mary Frances Moorhouse
Alice C. Geissler-Murr

Nurse's Pocket Guide

Diagnoses, Interventions, and Rationales

Eighth Edition

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ACTIVITY-EXERCISE PATTERN
Activity intolerance, risk for
Activity intolerance (specify level)
Aspiration, risk for
Adaptive capacity, decreased, intracranial
Infant behavior, disorganized
Infant behavior, risk for disorganized
Infant behavior, readiness for enhanced organized
Fatigue
Physical mobility, impaired
Bed mobility, impaired
Walking, impaired
Wheelchair mobility, impaired
Wheelchair transfer ability, impaired
Development, risk for delayed
Dysreflexia
Autonomic dysreflexia, risk for
Disuse syndrome, risk for
Self-care deficit (specify: bathing/hygiene, dressing/grooming, feeding, toileting)
Diversional activity deficient
Home maintenance, impaired
Dysfunctional Ventilatory Weaning Response
Ventilation, impaired spontaneous
Airway clearance, ineffective
Breathing pattern, ineffective
Gas exchange, impaired
Cardiac output, decreased
Tissue perfusion, alteration (specify)
Peripheral neurovascular dysfunction, risk for
Perioperative positioning injury, risk for
Growth and development, delayed
Growth, risk for disproportionate
Wandering

SLEEP-REST PATTERN
Sleep-pattern disturbance
Sleep deprivation

COGNITIVE-PERCEPTUAL PATTERN
Pain, acute
Chronic pain
Sensory perception, disturbed (specify)
Unilateral neglect
Knowledge deficit (specify)
Unilateral neglect
Knowledge deficit (specify)
Memory, impaired
Thought processes, disturbed
Acute confusion
Chronic confusion
Decisional conflict (specify)

SELF-PERCEPTION–SELF-CONCEPT PATTERN
Fear
Anxiety
Anxiety , death
Hopelessness
Powerlessness
Powerlessness, risk for
Loneliness, risk for
Self-esteem disturbed
Chronic low self-esteem
Situational low self-esteem
Risk for self-esteem situational low
Body image disturbance
Personal identity disturbance

ROLE-RELATIONSHIP PATTERN
Anticipatory grieving
Dysfunctional grieving
Chronic sorrow
Role performance, ineffective
Social isolation
Impaired social interaction
Relocation stress syndrome
Risk for relocation stress syndrome
Family processes, interrupted
Dysfunctional family processes: alcoholism
Risk for impaired parenting
Impaired parenting
Risk for impaired parent/infant/child attachment
Parental role conflict
Caregiver role strain
Risk for caregiver role strain
Impaired verbal communication
Risk for violence, directed at self
Risk for violence, directed at others

SEXUALITY-REPRODUCTIVE
Sexual dysfunction
Ineffective sexuality patterns
Rape Trauma syndrome
Rape-Trauma syndrome: compound reaction
Rape-Trauma syndrome: silent reaction

COPING-STRESS TOLERANCE PATTERN
Ineffective coping
Defensive coping
Community coping, ineffective
Community coping, readiness for enhanced
Ineffective denial
Impaired adjustment
Post-Trauma syndrome
Risk for post-trauma syndrome
Family coping: readiness for enhanced
Ineffective family coping: compromised
Ineffective family coping: disabling
Risk for violence, directed at self
Risk for violence, directed at others
Risk for suicide
Self-mutilation
Risk for self-mutilation

VALUE-BELIEF PATTERN
Spiritual distress
Risk for spiritual distress
Spiritual Well-Being, readiness for enhanced

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EIGHTH EDITION

Marilynn E. Doenges, RN, BSN, MA, CS, APN
Clinical Specialist
Adult Psychiatric/Mental Health Nursing, Retired
Adjunct Faculty
Beth-El College of Nursing and Health Sciences CU-Springs
Colorado Springs, Colorado

Mary Frances Moorhouse, RN, BSN, CRRN, CLNC
Nurse Consultant
TNT-RN Enterprises
Colorado Springs, Colorado

Alice Geissler-Murr, RN, BSN, CLNC
Contract Practitioner
Legal Nurse Consultant
Colorado Springs, Colorado

F.A. Davis Company • Philadelphia

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This book is dedicated to:

Our families, who helped with the mundane activities of daily living that allowed us to write this book and who provide us with love and encouragement in all our endeavors.

Our friends, who support us in our writing, put up with our memory lapses, and love us still.

Bob Martone, Publisher, Nursing, who asks questions that stimulate thought and discussion, and who maintains good humor throughout.

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Robert H. Craven, Jr., and the F. A. Davis family.

And last and most important:

The nurses we are writing for, to those who have found the previous edition of the *Pocket Guide* helpful, and to other nurses who are looking for help to provide quality nursing care in a period of transition and change, we say, "Nursing Diagnosis is the way."

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A special acknowledgment to Marilynn's friend, the late Diane Camillone, who provoked an awareness of the role of the patient and continues to influence our thought about the importance of quality nursing care, and our late colleague, Mary Jeffries, who introduced us to nursing diagnosis.

To our colleagues in NANDA who continue to formulate and refine nursing diagnosis to provide nursing with the tools to enhance and promote the growth of the profession.

Marilynn E. Doenges
Mary Frances Moorhouse
Alice Geissler-Murr

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Contents

Disorder/Health Problems with Associated Nursing Diagnoses appear on pages 576–680.

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 patient care supports the growing awareness that nursing care is a key factor in patient 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 patient 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 the North American Nursing Diagnosis Association (NANDA). These interventions are the activities needed to implement and document care provided to the individual patient 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, 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: Guidelines for Planning and Documenting Patient Care,* ed. 6 (Doenges, Moorhouse, Geissler, 2002); *Psychiatric Care Plans: Guidelines for Planning and Documenting Client Care,* ed. 3 (Doenges, Townsend, Moorhouse, 1998); *Maternal/Newborn Plans of Care: Guidelines for Planning and Documenting Client Care,* ed. 3 (Doenges, Moorhouse, 1999).

Nursing diagnoses are listed alphabetically in Chapter 4 for ease of reference and include the diagnoses accepted for use by NANDA through 2001. Each approved diagnosis 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 patient. **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. It is 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, 105 classes and 155 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 of "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 SNOWMED for inclusion in their international coding system. Today, research data from around the world are validating nursing diagnoses in support for resubmission and acceptance in future additions. Therefore, the originally proposed ICD version of NANDA's Taxonomy I R is presented here for information only (Appendix 3).

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 initial assessment. The Diagnostic Division label is included following the Taxonomic label under each nursing diagnosis heading.

Desired Outcomes/Evaluation Criteria are identified to assist the nurse in formulating individual patient 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 Breastfeeding, ineffective; Infant Behavior, disorganized; and Parent/Infant/Child Attachment, risk for impaired. For example, when addressing Fluid Volume Deficit, isotonic (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 in order 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 publications by Joanne C. McCloskey and Marion Johnson for more in-depth information.

Chapter 5 presents approximately 300 disorders/health conditions reflecting all specialty areas, with associated nursing

diagnoses written as patient diagnostic statements that include the "related to" and "evidenced by" components. This section will facilitate and help validate the assessment and problem 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 patients. As new nursing diagnoses are developed, it is important that the data they encompass are added to the current data base. 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: North American Nursing Diagnosis Association, 1211 Locust Street, Philadelphia, PA 19107; e-mail: nanda@nursecominc.com.

CHAPTER 1

The Nursing Process

Many years ago, the nursing profession identified a problem-solving process that "combines the most desirable elements of the art of nursing with the most relevant elements of systems theory, using the scientific method" (Shore, 1988). The term *nursing process* was introduced in the 1950s and has gained national acceptance as the basis for providing effective nursing care. It is now included in the conceptual framework of all nursing curricula and is accepted in the legal definition of nursing in the nurse practice acts of most states. This nursing process is central to nursing actions in any setting, because it is an efficient method of organizing thought processes for clinical decision making and problem solving.

Nursing process requires the skills of (1) assessment (systematic collection of data relating to patients and their problems), (2) problem identification (analysis of data), (3) planning (setting goals, choice of solutions), (4) implementation (putting the plan into action), and (5) evaluation (assessing the effectiveness of the plan and changing the plan as indicated by the current needs). Although these skills are presented as separate, individual activities, they are interrelated and form a continuous circle of thought and action.

To use this process, the nurse must demonstrate fundamental abilities of knowledge, creativity, adaptability, commitment, trust, and leadership. In addition, intelligence and interpersonal and technical skills are important. Because decision making is crucial to each step of the process, the following assumptions are important for the nurse to consider:

- The patient is a human being who has worth and dignity.
- There are basic human needs that must be met, and when they are not, problems arise, requiring interventions by another person until and if the individual can resume responsibility for self.
- Patients have a right to quality health and nursing care delivered with interest, compassion, competence, and a focus on wellness and prevention of illness.
- The therapeutic nurse-patient relationship is important in this process.

Nurses have struggled for years to define nursing by identifying the parameters of nursing with the goal of attaining professional

status. To this end, nurses meet, discuss, and conduct research to identify and label patient problems and responses that fall within the scope of nursing practice (in both the national and international arenas). Changes in healthcare delivery and reimbursement methods, the advent of health maintenance organizations (HMOs), and alternative healthcare settings (home health, extended-care facilities, and the like) continue to increase the need for a commonality of communication to ensure continuity of care for the patient who moves from one setting/area to another. Evaluation and improvement of provided services are an important part of this process, and both providers and users of care benefit from accurate documentation of the care provided and the patient's response.

The use of nursing diagnosis (ND) provides nurses with a common language for identifying patient problems, aids in the choice of nursing interventions, and provides guidance for evaluation. It promotes improved communication among nurses, shifts, units, other healthcare providers, and alternative care settings. This language further provides a base for clinicians, educators, and researchers to document, validate, and/or alter the process. The American Nurses Association (ANA) Social Policy Statements (1980/1995) and the ANA Standards of Practice (1973/1991) have provided impetus and support for the use of nursing diagnosis in the practice setting.

Currently, there are differing definitions of nursing diagnosis. The North American Nursing Diagnosis Association (NANDA) has accepted the following definition:

> Nursing diagnosis is a clinical judgment about individual, family, or community responses to actual and potential health problems/life processes. Nursing diagnoses provide the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable.

Although it continues to evolve, the current NANDA list provides diagnostic labels and information for appropriate use. Nurses need to become familiar with the parameters of the diagnoses, identifying strengths and weaknesses, thus promoting research and further development. Although nursing practice is more than nursing diagnosis, the use of NDs can help to define and to refine the profession. Also, NDs can be used within many existing conceptual frameworks because they are a generic approach adaptable to all.

Whereas nursing actions were once based on variables such as signs and symptoms, diagnostic tests, and medical diagnosis, NDs are a uniform way of identifying, focusing on, and dealing with specific patient problems/needs. The accurate nursing

diagnosis of a patient problem can set a standard for nursing practice, thus leading 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 patient as well as the family/significant other(s) (SO[s]). This relationship also extends to all disciplines that have contact with the individual/family. Although nurses work within the medical and psychosocial domains, nursing's phenomena of concern are the patterns of human response, not disease processes. Therefore, nursing diagnoses usually do not parallel or mimic medical/psychiatric diagnoses but do involve independent nursing activities as well as collaborative roles and actions. Thus, the written plan of care contains more than actions initiated by medical orders. It contains a combination of the orders and plans of care of all involved disciplines. The nurse is responsible for seeing that these different activities are pulled together into a functional plan to provide holistic care for the individual/family.

Summary

In using ND 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 and/or restoration of health (or relief of pain and discomfort when a return to health is not possible). Because the nursing process is the basis of all nursing actions, it is the essence of nursing. The process is flexible and yet sufficiently structured so as to provide the base for nursing actions. It can be applied in any healthcare or educational setting, in any theoretical or conceptual framework, and within the context of any nursing philosophy.

Subsequent chapters help the nurse apply the nursing process to become more familiar with the current NANDA-approved list of NDs, their definitions, related/risk factors (etiology), and defining characteristics. Coupled with desired outcomes and the most commonly used interventions, the nurse can write, implement, and document an individualized plan of care.

CHAPTER 2

Application of the Nursing Process

Because of their hectic schedules, many nurses believe that time spent in writing plans of care is time taken away from patient care. Plans of care have been viewed as "busy work" to satisfy accreditation requirements or the whims of supervisors. In reality, however, quality patient care must be planned and coordinated. Properly written and used plans of care can provide direction and continuity of care by facilitating communication among nurses and other caregivers. They also provide guidelines for documentation and a tool for evaluating the care provided.

The components of a plan of care are based on the nursing process. Creating a plan of care begins with the collection of data (assessment). The patient database consists of subjective and objective information encompassing the various concerns reflected in the current NANDA list of NDs (Table 2–1). Subjective data are those that are reported by the patient (and SOs) in the individual's own words. This information includes the individual's perceptions and what he or she wants to share. It is important to accept what is reported because the patient is the "expert" in this area. Objective data are those that are observed or described (quantitatively or qualitatively) and include diagnostic testing and physical examination findings. Analysis of the collected data leads to the identification of problems or areas of concern/need. These problems/needs are expressed as NDs.

A nursing diagnosis is a decision about a problem/need that requires nursing intervention and management. The problem may be anything that interferes with the quality of life the patient is used to and/or desires. It includes concerns of the patient, SOs, and/or nurse. The ND focuses attention on a physical or behavioral response, either a current problem or one at risk for developing. When the ND label is combined with the individual's specific related/risk factors and defining characteristics (as appropriate), a patient diagnostic statement is created. This provides direction for nursing care, and its affective tone can shape expectations of the patient's response and/or influence the nurse's behavior toward the patient.

The key to accurate diagnosis is collection and analysis of data. In Chapter 3, the NDs have been categorized into divisions (Diagnostic Divisions: Nursing Diagnoses Organized According to a Nursing Focus, Section 2) and an assessment tool designed to assist the nurse to identify appropriate NDs as the data are collected. Nurses may feel at risk in committing themselves to documenting a nursing diagnosis for fear they might be wrong. However, unlike medical diagnoses, NDs can change as the patient progresses through various stages of illness/maladaptation to resolution of the problem.

Desired outcomes are formulated to give direction to, as well as to evaluate, the care provided. These outcomes emerge from the diagnostic statement and are what the patient hopes to achieve. They serve as the guidelines to evaluate progress toward resolution of problems/needs, providing impetus for revising the plan as appropriate. In this book, outcomes are stated in general terms to permit the practitioner to individualize them by adding timelines and other data according to specific patient circumstances. Outcome terminology needs to be concise, realistic, measurable, and stated in words the patient can understand. Beginning the outcome statement with an action verb provides measurable direction, for example, "Verbalizes relationship between diabetes mellitus and circulatory changes in feet within 2 days" or "Correctly performs procedure of home glucose monitoring within 48 hours."

Interventions are the action steps taken to achieve desired outcomes and, because they are communicated to others, they must be clearly stated. A solid nursing knowledge base is vital to this process because the rationale for interventions needs to be sound and feasible with the intention of providing effective individualized care. The actions may be independent or collaborative and may encompass specific orders from nursing, medicine, and other disciplines. Written interventions that guide ongoing patient care need to be dated and signed. To facilitate the planning process, specific nursing priorities have been identified in this text to provide a general ranking of interventions. This ranking would be altered according to individual patient situations. The seasoned practitioner may choose to use these as broad-based interventions. The student or beginning practitioner may need to develop a more detailed plan of care by including the appropriate interventions listed under each nursing priority. Finally, as each patient usually has a perception of the problems he or she faces and an expectation of what needs to be done about the problems, the plan of care must be congruent with the patient's reality or it will fail.

The plan of care documents patient care in areas of accountability, quality assurance, and liability. The nurse needs to plan

care with the patient, inasmuch as both are accountable for that care and for achieving the desired outcomes.

Summary

Healthcare providers have a responsibility for planning with the patient and family for continuation of care to the eventual outcome of an optimal state of wellness or a dignified death. Planning, setting goals, and choosing appropriate interventions are essential to the construction of a plan of care as well as to delivery of quality nursing care. These nursing activities comprise the planning phase of the nursing process and are documented in the plan of care for a particular patient. As a part of the patient's permanent record, the plan of care not only provides a means for the nurse who is actively caring for the patient to be aware of the patient's needs (NDs), goals, and actions to be taken, but it also substantiates the care provided for review by third-party payors and accreditation agencies, while meeting legal requirements.

Table 2–1. NURSING DIAGNOSES

ACCEPTED FOR USE AND RESEARCH (2001–2002)

Activity Intolerance [specify level]
Activity Intolerance, risk for
Adjustment, impaired
Airway Clearance, ineffective
Allergy Response, latex
Allergy Response, risk for latex
Anxiety [specify level]
Anxiety, death
Aspiration, risk for
Attachment, risk for impaired parent/infant/child
Autonomic Dysreflexia
Autonomic Dysreflexia, risk for

Body Image, disturbed
Body Temperature, risk for imbalanced
Bowel Incontinence
Breastfeeding, effective
Breastfeeding, ineffective
Breastfeeding, interrupted
Breathing Pattern, ineffective

Cardiac Output, decreased
Caregiver Role Strain
Caregiver Role Strain, risk for
Communication, impaired verbal

Conflict, decisional (specify)
Confusion, acute
Confusion, chronic
Constipation
Constipation, perceived
Constipation, risk for
Coping, defensive
Coping, ineffective
Coping, community, ineffective
Coping, community, readiness for enhanced
Coping, family: compromised
Coping, family: disabled
Coping, family: readiness for enhanced

Denial, ineffective
Dentition, impaired
Development, risk for delayed
Diarrhea
Disuse Syndrome, risk for
Diversional Activity, deficient

Energy Field, disturbed
Environmental Interpretation Syndrome, impaired

Failure to Thrive, adult
*Falls, risk for
Family Processes, dysfunctional: alcoholism
Family Processes, interrupted
Fatigue
Fear
[Fluid Volume, deficient hyper/hypotonic]
Fluid Volume, deficient [isotonic]
Fluid Volume, excess
Fluid Volume, risk for deficient
Fluid Volume, risk for imbalanced

Gas Exchange, impaired
Grieving, anticipatory
Grieving, dysfunctional
Growth, risk for disproportionate
Growth and Development, delayed

Health Maintenance, ineffective
Health-Seeking Behaviors (specify)
Home Maintenance, impaired
Hopelessness
Hyperthermia
Hypothermia

Infant Behavior, disorganized
Infant Behavior, risk for disorganized

Table 2-1. NURSING DIAGNOSES (*Continued*)

Infant Behavior, readiness for enhanced, organized
Infant Feeding Pattern, ineffective
Infection, risk for
Injury, risk for
Injury, risk for, perioperative positioning
Intracranial Decreased Adaptive Capacity

Knowledge, deficient [Learning Need] (specify)

Loneliness, risk for

Memory, impaired
Mobility, impaired bed
Mobility, impaired physical
Mobility, impaired wheelchair

Nausea
Noncompliance, [Adherence Ineffective] [specify]
Nutrition: imbalanced, less than body requirements
Nutrition: imbalanced, more than body requirements
Nutrition: imbalanced, risk for more than body requirements

Oral Mucous Membrane, impaired

Pain, acute
Pain, chronic
Parental Role Conflict
Parenting, impaired
Parenting, risk for impaired
Peripheral Neurovascular Dysfunction, risk for
Poisoning, risk for
Post-Trauma Syndrome
Post-Trauma Syndrome, risk for
Powerlessness
*Powerlessness, risk for
Protection, ineffective

Rape-Trauma Syndrome
Rape-Trauma Syndrome: compound reaction
Rape-Trauma Syndrome: silent reaction
Relocation Stress Syndrome
*Relocation Stress Syndrome, risk for
Role Performance, ineffective

Self-Care Deficit: bathing/hygiene
Self-Care Deficit: dressing/grooming
Self-Care Deficit: feeding
Self-Care: toileting

Self Esteem, chronic low
Self Esteem, situational low
*Self Esteem, risk for situational low
*Self-Mutilation
Self-Mutilation, risk for
Sensory/Perception, disturbed (specify: visual, auditory, kinesthetic, gustatory, tactile, olfactory)
Sexual Dysfunction
Sexuality Patterns, ineffective
Skin Integrity, impaired
Skin Integrity, risk for impaired
Sleep Deprivation
Sleep Pattern, disturbed
Social Interaction, impaired
Social Isolation
Sorrow, chronic
Spiritual Distress
Spiritual Distress, risk for
Spiritual Well-Being, readiness for enhanced
Suffocation, risk for
*Suicide, risk for
Surgical Recovery, delayed
Swallowing, impaired

Therapeutic Regimen: Community, ineffective management
Therapeutic Regimen: Family, ineffective management
Therapeutic Regimen: effective management
Therapeutic Regimen: ineffective management
Thermoregulation, ineffective
Thought Processes, disturbed
Tissue Integrity, impaired
Tissue Perfusion, ineffective (specify type: renal, cerebral, cardiopulmonary, gastrointestinal, peripheral)
Transfer Ability, impaired
Trauma, risk for

Urinary Elimination, impaired
Urinary Incontinence, functional
Urinary Incontinence, reflex
Urinary Incontinence, stress
Urinary Incontinence, total
Urinary Incontinence, urge
Urinary Incontinence, risk for urge
Urinary Retention [acute/chronic]

Ventilation, Impaired Spontaneous
Ventilatory Weaning Response, dysfunctional
Violence, [actual/] risk for other-directed
Violence, [actual/] risk for self-directed

Walking, impaired
*Wandering [specify sporadic or continuous]

*New to the 14th Conference.

[ ] Information that appears in brackets has been added by the authors to clarify and enhance the use of NDs.

Please also see the NANDA diagnoses grouped according to Gordon's Functional Health Patterns on the inside front cover.

CHAPTER 3

Putting Theory into Practice: Sample Assessment Tools, Plan of Care, and Documentation

The patient assessment is the foundation on which identification of individual needs, responses, and problems is based. To facilitate the steps of assessment and diagnosis in the nursing process, an assessment tool (Assessment Tools for Choosing Nursing Diagnoses, Section 1) has been constructed using a nursing focus instead of the medical approach of "review of systems." This has the advantage of identifying and validating NDs as opposed to medical diagnoses.

To achieve this nursing focus, we have grouped the NANDA NDs into related categories titled Diagnostic Divisions (Section 2), which reflect a blending of theories, primarily Maslow's Hierarchy of Needs and a self-care philosophy. These divisions serve as the framework or outline for data collection/clustering that focuses attention on the nurse's phenomena of concern—the human responses to actual and potential health problems—and directs the nurse to the most likely corresponding NDs.

Because the divisions are based on human responses and needs and not specific "systems," information may be recorded in more than one area. For this reason, the nurse is encouraged to keep an open mind, to pursue all leads, and to collect as much data as possible before choosing the ND label that best reflects the patient's situation. For example, when the nurse identifies the cue of restlessness in a patient, the nurse may infer that the patient is anxious, assuming that the restlessness is psychologically based and overlooking the possibility that it is physiologically based.

From the specific data recorded in the database, an individualized patient diagnostic statement can be formulated using the problem, etiology, signs/symptoms (PES) format to accurately represent the patient's situation. For example, the diagnostic

statement may read, "Deficient knowledge regarding diabetic care, related to misinterpretation of information and/or lack of recall, evidenced by inaccurate follow-through of instructions and failure to recognize signs and symptoms of hyperglycemia."

Desired patient outcomes are identified to facilitate choosing appropriate interventions and to serve as evaluators of both nursing care and patient response. These outcomes also form the framework for documentation.

Interventions are designed to specify the action of the nurse, the patient, and/or SOs. Interventions need to promote the patient's movement toward health/independence in addition to the achievement of physiological stability. This requires involvement of the patient in his or her own care, including participation in decisions about care activities and projected outcomes.

Section 3, "Patient Situation and Prototype Plan of Care," contains a sample plan of care formulated on data collected in the nursing model assessment tool. Individualized patient diagnostic statements and desired patient outcomes (with timelines added to reflect anticipated length of stay and individual patient/nurse expectations) have been identified. Interventions have been chosen based on concerns/needs identified by the patient and nurse during data collection, as well as by physician orders.

Although not normally included in a written plan of care, rationales are included in this sample for the purpose of explaining or clarifying the choice of interventions to enhance the nurse's learning.

Finally, to complete the learning experience, samples of documentation based on the patient situation are presented in Section 4, "Documentation Techniques". The plan of care provides documentation of the planning process and serves as a framework/outline for charting of administered care. The primary nurse needs to periodically review the patient's progress and the effectiveness of the treatment plan. Persons then are able to read the notes and have a clear picture of what occurred with the patient in order to make appropriate judgments regarding patient management. The best way to ensure the clarity of progress notes is through the use of descriptive (or observational) statements. Observations of patient behavior and response to therapy provide invaluable information. Through this communication, it can be determined if the patient's current desired outcomes or interventions need to be eliminated or altered and if the development of new outcomes or interventions is warranted. Progress notes are an integral component of the overall medical record and should include all significant events that occur in the daily life of the patient. They reflect implementation of the treatment plan and document

that appropriate actions have been carried out, precautions taken, and so forth. It is important that both the implementation of interventions and progress toward the desired outcomes be documented. The notes need to be written in a clear and objective fashion, specific as to date and time, and signed by the person making the entry.

Use of clear documentation helps the nurse to individualize patient care. Providing a picture of what has happened and is happening promotes continuity of care and facilitates evaluation. This reinforces each person's accountability and responsibility for using nursing process to provide individually appropriate and cost-effective patient care.

SECTION 1

ASSESSMENT TOOLS FOR CHOOSING NURSING DIAGNOSES

This is a suggested guide/tool to create a database reflecting a nursing focus. Although the Diagnostic Divisions are alphabetized here for ease of presentation, they can be prioritized or rearranged in any manner to meet individual needs. In addition, the assessment tool can be adapted to meet the needs of specific patient populations. Excerpts of assessment tools adapted for psychiatric and obstetric settings are included at the end of this section.

ADULT MEDICAL/SURGICAL ASSESSMENT TOOL

General Information

Name: _____
Age: _____ DOB: _____ Gender: _____ Race: _____
Admission Date: _____ Time: _____ From: _____
Source of Information: _____
Reliability (1–4 with 4 = very reliable): _____

Activity/Rest

SUBJECTIVE (REPORTS)

Occupation: _____ Usual activities: _____
Leisure time activities/hobbies: _____
Limitations imposed by condition: _____
Sleep: Hours: _____ Naps: _____ Aids: _____
  Insomnia: _____ Related to: _____
  Rested on awakening: _____
  Excessive grogginess: _____
Feelings of boredom/dissatisfaction: _____

OBJECTIVE (EXHIBITS)

Observed response to activity: Cardiovascular: _____
  Respiratory: _____
Mental status (i.e., withdrawn/lethargic): _____
Neuro/muscular assessment:
  Muscle mass/tone: _____
  Posture: _____ Tremors: _____
  ROM: _____ Strength: _____ Deformity: _____

Circulation

SUBJECTIVE (REPORTS)

History of:
  Hypertension: _____ Heart trouble: _____
  Rheumatic fever: _____ Ankle/leg edema: _____
  Phlebitis: _____ Slow healing: _____
  Claudication: _____
  Dysreflexia: _____
  Bleeding tendencies/episodes: _____
  Palpitations: _____ Syncope: _____
Extremities: Numbness: _____ Tingling: _____
Cough/hemoptysis: _____
Change in frequency/amount of urine: _____

OBJECTIVE (EXHIBITS)

BP: R and L: Lying/sit/stand: _____
Pulse pressure: _____ Auscultatory gap: _____
Pulses (palpation): Carotid: _____ Temporal: _____
Jugular: _____ Radial: _____ Femoral: _____
Popliteal: _____ Post-tibial: _____ Dorsalis pedis: _____
Cardiac (palpation): Thrill: _____ Heaves: _____
Heart sounds: Rate: _____ Rhythm: _____ Quality: _____
Friction rub: _____ Murmur: _____
Vascular bruit: _____ Jugular vein distention: _____
Breath sounds: _____
Extremities: Temperature: _____ Color: _____
Capillary refill: _____
Homans' sign: _____ Varicosities: _____
Nail abnormalities: _____ Edema: _____
Distribution/quality of hair: _____
Trophic skin changes: _____
Color: General: _____
Mucous membranes: _____ Lips: _____
Nailbeds: _____ Conjunctiva: _____ Sclera: _____
Diaphoresis: _____

Ego Integrity

SUBJECTIVE (REPORTS)

Stress factors: _____
Ways of handling stress: _____
Financial concerns: _____
Relationship status: _____
Cultural factors/ethnic ties: _____
Religion: _____ Practicing: _____
Lifestyle: _____ Recent changes: _____
Sense of connectedness/harmony with self: _____
Feelings of: Helplessness: _____ Hopelessness: _____
Powerlessness: _____

OBJECTIVE (EXHIBITS)

Emotional status (check those that apply):
Calm: _____ Anxious: _____ Angry: _____
Withdrawn: _____ Fearful: _____ Irritable: _____
Restive: _____ Euphoric: _____
Observed physiological response(s): _____
Changes in energy field:
Temperature: _____ Color: _____ Distribution: _____
Movement: _____
Sounds: _____

Elimination

SUBJECTIVE (REPORTS)

Usual bowel pattern: _____
Laxative use: _____
Character of stool: _____ Last BM: _____
Diarrhea: _____ Constipation: _____
History of bleeding: _____ Hemorrhoids: _____
Usual voiding pattern: _____
Incontinence/when: _____ Urgency: _____
Frequency: _____ Retention: _____
Character of urine: _____
Pain/burning/difficulty voiding: _____
History of kidney/bladder disease: _____
Diuretic use: _____

OBJECTIVE (EXHIBITS)

Abdomen: Tender: _____ Soft/firm: _____
Palpable mass: _____ Size/girth: _____
Bowel sounds: Location: _____ Type: _____
Hemorrhoids: _____ Stool guaiac: _____
Bladder palpable: _____ Overflow voiding: _____
CVA tenderness: _____

Food/Fluid

SUBJECTIVE (REPORTS)

Usual diet (type): _____
Carbohydrate/Protein/Fat intake: g/d _____
Vitamin/food supplement use: _____
Food preferences: _____ Prohibitions: _____
No. of meals daily: _____
Dietary pattern/content: B: _____ L: _____ D: _____
Last meal/intake: _____
Loss of appetite: _____ Nausea/vomiting: _____
Heartburn/indigestion: _____
Related to: _____ Relieved by: _____
Allergy/food intolerance: _____
Mastication/swallowing problems: _____
Dentures: _____
Usual weight: _____ Changes in weight: _____
Diuretic use: _____

OBJECTIVE (EXHIBITS)

Current weight: _____ Height: _____ Body build: _____
Skin turgor: _____ Mucous membranes moist/dry: _____
Breath sounds: Crackles: _____ Wheezes: _____

Edema: General: _____ Dependent: _____
Periorbital: _____ Ascites: _____
Jugular vein distention: _____
Thyroid enlarged: _____
Condition of teeth/gums: _____
Appearance of tongue: _____
Mucous membranes: _____ Halitosis: _____
Bowel sounds: _____
Hernia/masses: _____
Urine S/A or Chemstix: _____
Serum glucose (glucometer): _____

Hygiene

SUBJECTIVE REPORTS

Activities of daily living: Independent/dependent (level):
Mobility: _____ Feeding: _____
Hygiene: _____ Dressing/Grooming: _____ Toileting: _____
Preferred time of personal care/bath: _____
Equipment/prosthetic devices required: _____
Assistance provided by: _____

OBJECTIVE (EXHIBITS)

General appearance: _____
Manner of dress: _____ Personal habits: _____
Body odor: _____ Condition of scalp: _____
Presence of vermin: _____

Neurosensory

SUBJECTIVE (REPORTS)

Fainting spells/dizziness: _____
Headaches: Location: _____ Frequency: _____
Tingling/numbness/weakness (location): _____
Stroke/brain injury (residual effects): _____
Seizures: Type: _____ Aura: _____
Frequency: _____ Postictal state: _____
How controlled: _____
Eyes: Vision loss: _____ Last examination: _____
Glaucoma: _____ Cataract: _____
Ears: Hearing loss: _____ Last examination: _____
Sense of smell: _____ Epistaxis: _____

OBJECTIVE (EXHIBITS)

Mental status (note duration of change):
Oriented/disoriented: Time: _____ Place: _____
Person: _____ Situation: _____

Check all that apply:
Alert: _____ Drowsy: _____ Lethargic: _____
Stuporous: _____ Comatose: _____
Cooperative: _____ Combative: _____
Delusions: _____ Hallucinations: _____
Affect (describe): _____
Memory: Recent: _____ Remote: _____
Glasses: _____ Contacts: _____ Hearing aids: _____
Pupil: Shape: _____ Size/reaction: R/L: _____
Facial droop: _____ Swallowing: _____
Handgrasp/release, R/L: _____
Posturing: _____
Deep tendon reflexes: _____ Paralysis: _____

Pain/Discomfort

SUBJECTIVE (REPORTS)

Primary focus: _____ Location: _____
Intensity (0-10 with 10 = most severe): _____
Frequency: _____ Quality: _____
Duration: _____ Radiation: _____
Precipitating/aggravating factors: _____
How relieved: _____
Associated symptoms: _____
Effect on activities: _____
Relationships: _____
Additional focus: _____

OBJECTIVE (EXHIBITS)

Facial grimacing: _____ Guarding affected area: _____
Posturing: _____ Behaviors: _____
Emotional response: _____ Narrowed focus: _____
Change in BP: _____ Pulse: _____

Respiration

SUBJCTIVE (REPORTS)

Dyspnea/related to: _____
Cough/sputum: _____
History of: Bronchitis: _____ Asthma: _____
Tuberculosis: _____ Emphysema: _____
Recurrent pneumonia: _____
Exposure to noxious fumes: _____
Smoker: _____ pk/day: _____ No. of pk-yrs: _____
Use of respiratory aids: _____ Oxygen: _____

OBJECTIVE (EXHIBITS)

Respiratory: Rate: _____ Depth: _____ Symmetry: _____
Use of accessory muscles: _____ Nasal flaring: _____
Fremitus: _____
Breath sounds: _____ Egophony: _____
Cyanosis: _____ Clubbing of fingers: _____
Sputum characteristics: _____
Mentation/restlessness: _____

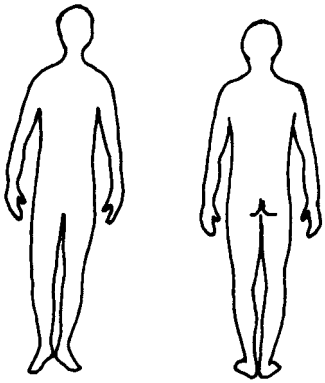
Safety

SUBJECTIVE (REPORTS)

Allergies/sensitivity: _____ Reaction: _____
Exposure to infectious diseases: _____
Previous alteration of immune system: _____
  Cause: _____
History of sexually transmitted disease (date/type): _____
  Testing: _____ High-risk behaviors: _____
Blood transfusion/number: _____ When: _____
  Reaction: _____ Describe: _____
Geographic areas lived in/visited: _____
Seat belt/helmet use: _____
History of accidental injuries: _____
  Fractures/dislocations: _____
Arthritis/unstable joints: _____
Back problems: _____
Changes in moles: _____ Enlarged nodes: _____
Delayed healing: _____
Cognitive limitations: _____
  Impaired vision/hearing: _____
Prosthesis: _____ Ambulatory devices: _____

OBJECTIVE (EXHIBITS)

Temperature: _____ Diaphoresis: _____
Skin integrity (mark location on diagram): _____
  Scars: _____ Rashes: _____ Lacerations: _____
  Ulcerations: _____ Ecchymoses: _____ Blisters: _____
  Burns (degree/percent): _____
  Drainage: _____
General strength: _____ Muscle tone: _____
  Gait: _____ ROM: _____
  Paresthesia/paralysis: _____
Results of cultures: _____ Immune system testing: _____
  Tuberculosis testing: _____



Sexuality (Component of Ego Integrity and Social Interactions)

SUBJECTIVE (REPORTS)

Sexually active: _____ Use of condoms: _____
Birth control method: _____
Sexual concerns/difficulties: _____
Recent change in frequency/interest: _____

OBJECTIVE (EXHIBITS)

Comfort level with subject matter: _____

***FEMALE:* SUBJECTIVE (REPORTS)**

Age at menarche: _____ Length of cycle: _____
Duration: _____ No. of pads used/day: _____
Last menstrual period: _____ Pregnant now: _____
Bleeding between periods: _____
Menopause: _____ Vaginal lubrication: _____
Vaginal discharge: _____
Surgeries: _____
Hormonal therapy/calcium use: _____
Practices breast self-examination: _____
Last mammogram: _____ Pap smear: _____

OBJECTIVE (EXHIBITS)

Breast examination: _____
Genital warts/lesions: _____ Discharge: _____

MALE: SUBJECTIVE (REPORTS)

Penile discharge: _____ Prostate disorder: _____
Circumcised: _____ Vasectomy: _____
Practice self-examination: Breast: _____ Testicles: _____
Last proctoscopic/prostate examination: _____

OBJECTIVE (EXHIBITS)

Breast: _____ Penis: _____ Testicles: _____
Genital warts/lesions: _____ Discharge: _____

Social Interactions

SUJECTIVE (REPORTS)

Marital status: _____ Years in relationship: _____
Perception of relationship: _____
  Living with: _____
  Concerns/stresses: _____
Extended family: _____
  Other support person(s): _____
Role within family structure: _____
Perception of relationships with family members: _____
Feelings of: Mistrust: _____ Rejection: _____
  Unhappiness: _____
  Loneliness/isolation: _____
Problems related to illness/condition: _____
Problems with communication: _____
Genogram: _____

OBJECTIVE (EXHIBITS)

Speech: Clear: _____ Slurred: _____
  Unintelligible: _____ Aphasic: _____
  Unusual speech pattern/impairment: _____
  Use of speech/communication aids: _____
  Laryngectomy present: _____
Verbal/nonverbal communication with family/SO(s): _____
  Family interaction (behavioral) pattern: _____

Teaching/Learning

SUBJECTIVE (REPORTS)

Dominant language (specify): _____ Second language: _____
  Literate: _____ Education level: _____
  Learning disabilities (specify): _____
  Cognitive limitations: _____
Where born: _____ If immigrant, how long in this country? _____

Health and illness beliefs/practices/customs: _____
Presence of Advance Directives/Durable Medical Power of Attorney: _____
_____
Special healthcare concerns (e.g., impact of religious/cultural practices): _____
Health goals: _____
Familial risk factors (indicate relationship):
Diabetes: _____ Thyroid (specify): _____
Tuberculosis: _____ Heart disease: _____
Strokes: _____ High BP: _____
Epilepsy: _____ Kidney disease: _____
Cancer: _____ Mental illness: _____
Other: _____
Prescribed medications:
Drug: _____
Dose: _____ Times (circle last dose): _____
Take regularly: _____ Purpose: _____
Side effects/problems: _____
Nonprescription drugs: OTC drugs: _____
Street drugs: _____ Tobacco: _____
Smokeless tobacco: _____
Alcohol (amount/frequency): _____
Use of herbal supplements (specify): _____
Admitting diagnosis per provider: _____
Reason per patient: _____
History of current complaint: _____
Patient expectations of this hospitalization: _____
Previous illnesses and/or hospitalizations/surgeries: _____
Evidence of failure to improve: _____
Last complete physical examination: _____

Discharge Plan Considerations

DRG projected mean length of stay: _____
Date information obtained: _____
Anticipated date of discharge: _____
Resources available: Persons: _____
Financial: _____ Community: _____
Support groups: _____
Socialization: _____
Areas that may require alteration/assistance:
Food preparation: _____ Shopping: _____
Transportation: _____ Ambulation: _____
Medication/IV therapy: _____ Treatments: _____
Wound care: _____ Supplies: _____
Self-care (specify): _____
Homemaker/maintenance (specify): _____

Physical layout of home (specify): _____
Anticipated changes in living situation after discharge: _____
_____
Living facility other than home (specify): _____
Referrals (date, source, services):
Social services: _____ Rehab services: _____
Dietary: _____ Home care: _____
Resp/O_2: _____ Equipment: _____
Supplies: _____
Other: _____

EXCERPT FROM PSYCHIATRIC ASSESSMENT TOOL

Ego Integrity

SUBJECTIVE (REPORTS)

What kind of person are you (positive/negative, etc.)? _____
What do you think of your body? _____
How would you rate your self-esteem (1-10 with 10 highest)? _____
What are your problematic moods? Depressed: _____
Guilty: _____ Sad: _____
Unreal: _____ Ups/downs: _____
Apathetic: _____ Detached: _____
Separated from the world: _____
Are you a nervous person? _____
Are your feelings easily hurt? _____
Report of stress factors: _____
Previous patterns of handling stress: _____
Financial concerns: _____
Relationship status: _____
Work history/Military service: _____
Cultural factors: _____
Religion: _____ Practicing: _____
Lifestyle: _____ Recent changes: _____
Significant losses/changes (date): _____
Stages of grief/manifestations of loss: _____
Feelings of: Helplessness: _____
Hopelessness: _____ Powerlessness: _____

OBJECTIVE (EXHIBITS)

Emotional status (check those that apply):
Calm: ___ Friendly: ____ Cooperative: ____ Evasive: ____
Anxious: _____ Angry/hostile: _____ Withdrawn: _____
Fearful: ____ Irritable: ____ Restive: ____ Passive: ____
Dependent: _____ Euphoric: _____ Other (specify): _____
Defense mechanisms:
Projection: _____ Denial: _____ Undoing: _____
Rationalization: _____ Repression: _____
Passive-aggressive: _____ Sublimation: _____
Intellectualization: _____ Somatization: _____
Regression: _____ Identification: _____
Introjection: _____ Reaction formation: _____
Isolation: _____ Displacement: _____ Substitution: _____
Consistency of behavior:
Verbal: _____ Nonverbal: _____

Characteristics of speech: _____
Slow/rapid/volume: _____ Pressured: _____
Impairments: _____ Aphasia: _____
Motor activity/behaviors: _____ Posturing: _____
Restless: _____ Under/overactive: _____
Stereotypic: _____ Tics/tremors: _____
Gait patterns: _____ Coping strategies: _____
Observed physiological response(s): _____

Neurosensory

SUBJECTIVE (REPORTS)

Dreamlike states: _____ Walking in sleep: _____
Automatic writing: _____
Believe/feel you are another person: _____
Perception different than others: _____
Ability to follow directions: _____
Perform calculations: _____
Accomplish ADLs: _____
Fainting spells/dizziness: _____
Blackouts: _____
Seizures: _____

OBJECTIVE (EXHIBITS)

Mental status (note duration of change): _____
Oriented/disoriented: Time: _____
Place: _____ Person: _____
Check all that apply:
Alert: ____ Drowsy: ____ Lethargic: ____ Stuporous: ____
Comatose: _____ Cooperative: _____ Combative: _____
Delusions: ___ Hallucinations: ___ Affect (describe): ____
Memory: Immediate: _____ Recent: _____ Remote: _____
Comprehension: _____
Thought processes (assessed through speech): Patterns of speech (e.g., spontaneous/sudden silences): _____
Content: _____ Change in topic: _____
Delusions: _____ Hallucinations: _____ Illusions: _____
Rate or flow: _____
Clear, logical progression: _____
Expression: _____
Flight of ideas: _____
Ability to concentrate: _____ Attention span: _____
Mood: _____
Affect: _____ Appropriateness: _____ Intensity: _____
Range: _____
Insight: _____ Misperceptions: _____

Attention/calculation skills: _____
Judgment: _____
Ability to follow directions: _____
Problem solving: _____
Impulse control: Aggression: ___ Hostility: ___ Affection: ___
Sexual feelings: _____

EXCERPT FROM PRENATAL ASSESSMENT TOOL

Safety

SUBJECTIVE (REPORTS)

Allergies/sensitivity: _____
Reaction: _____
Previous alteration of immune system: _____
Cause: _____
History of sexually transmitted diseases/gynecologic infections (date/type): _____ Testing: _____
High-risk behaviors: _____
Blood transfusion/number: _____ When: _____
Reaction: _____ Describe: _____
Childhood diseases: _____
Immunization history: _____
Recent exposure to German measles: _____
Other viral infections: _____ X ray/radiation: _____
House pets: _____
Previous ob/gyn problems: PIH: _____ Kidney: _____
Hemorrhage: _____ Cardiac: _____
Diabetes: _____ Infection/UTI: _____
ABO/Rh sensitivity: _____ Uterine surgery: _____
Anemia: _____
Length of time since last pregnancy: _____
Type of previous delivery: _____
Health status of living children: _____
History of accidental injuries: _____
Fractures/dislocations: _____ Physical abuse: _____
Arthritis/unstable joints: _____
Back problems: _____
Changes in moles: _____ Enlarged nodes: _____
Impaired vision: _____ Hearing: _____
Prosthesis: _____ Ambulatory devices: _____

OBJECTIVE (EXHIBITS)

Temperature: _____ Diaphoresis: _____
Skin integrity: _____ Scars: _____
Rashes: _____ Sores: _____ Ecchymoses: _____
Vaginal warts/lesions: _____
General strength: _____ Muscle tone: _____
Gait: _____ ROM: _____ Paresthesia/paralysis: _____
Fetal: Heart rate: _____ Location: _____
Method of auscultation: _____ Fundal height: _____
Estimated gestation: _____
Movement: _____ Ballottement: _____

Results of fetal testing: Date: _____ Test: _____ Result: _____
Results of cultures, cervical/rectal: _____
Immune system _____
testing: _____ Blood type: Maternal: _____ Paternal: _____
Screenings: Serology: _____ Syphilis: _____ Sickle Cell: ____
Rubella: _____ Hepatitis: _____ HIV: _____ AFP: _____

Sexuality (Component of Ego Integrity and Social Interactions)

SUBJECTIVE (REPORTS)

Sexual concerns: _____
Menarche: _____ Length of cycle: _____
Duration: _____
First day of last menstrual period: _____
Amount: _____
Bleeding/cramping since LMP: _____
Vaginal discharge: _____
Client's belief of when conception occurred: _____
Estimated date of delivery: _____
Practices breast self-examination (Y/N): _____
Last Pap smear: _____ Results: _____
Recent contraceptive method: _____
OB history (GPTPAL): Gravida: _____ Para: _____
Term: _____ Preterm: _____ Abortions: _____
Living: _____ Multiple births: _____
Delivery history: Year: _____ Place of delivery: _____
Length of gestation: _____ Length of labor: _____
Type of delivery: _____
Born (alive or dead): _____
Weight: _____ Apgar scores: _____
Complications (maternal/fetal): _____

OBJECTIVE (EXHIBITS)

Pelvic: Vulva: _____ Perineum: _____
Vagina: _____ Cervix: _____
Uterus: _____ Adnexal: _____
Diagonal conjugate: _____
Transverse diameter: _____ Outlet (cm): _____
Shape of sacrum: _____ Arch: _____
Coccyx: _____ SS Notch: _____
Ischial spines: _____
Adequacy of inlet: _____
Mid: _____ Outlet: _____
Prognosis for delivery: _____
Breast examination: _____ Nipples: _____
Pregnancy test: _____ Serology test (date): _____
Pap smear date/results: _____

EXCERPT FROM INTRAPARTAL ASSESSMENT TOOL

Pain/Discomfort

SUBJECTIVE (REPORTS)

Uterine contractions began: _____
Became regular: _____ Character: _____
Frequency: _____ Duration: _____
Location of contractile pain:
Front: _____ Sacral area: _____
Degree of discomfort: Mild: _____ Moderate: _____
Severe: _____
How relieved: Breathing/relaxation techniques: _____
Positioning: _____ Sacral rubs: _____
Effleurage: _____

OBJECTIVE (EXHIBITS)

Facial expression: _____ Narrowed focus: _____
Body movement: _____
Change in blood pressure: _____ Pulse: _____

Safety

SUBJECTIVE (REPORTS)

Allergies/Sensitivity: _____
Reaction (specify): _____
History of STD (date/type): _____
Month of first prenatal visit: _____
Previous/current obstetric problems/treatment:
PIH: _____ Kidney: _____ Hemorrhage: _____
Cardiac: _____ Diabetes: _____
Infection/UTI: _____ ABO/Rh sensitivity: _____
Uterine surgery: _____ Anemia: _____
Length of time since last pregnancy: _____
Type of previous delivery: _____
Health status of living children: _____
Blood transfusion: _____ When: _____
Reaction (describe): _____
Maternal stature/build: _____
Fractures/dislocations: _____
Pelvis: _____
Arthritis/Unstable joints: _____
Spinal problems/deformity: Kyphosis: _____
Scoliosis: _____ Trauma: _____
Surgery: _____
Prosthesis/ambulatory devices: _____

OBJECTIVE (EXHIBITS)

Temperature: _____
Skin integrity: _____ Rashes: _____
Sores: _____ Bruises: _____Scars: _____
Paresthesia/Paralysis: _____
Fetal status: Heart rate: _____ Location: _____
Method of auscultation: _____
Fundal height: _____ Estimated gestation: _____
Activity/movement: _____
Fetal assessment testing (Y/N): _____
Date: _____ Test: _____ Results: _____
Labor status: Cervical dilation: _____ Effacement: _____
Fetal descent: _____ Engagement: _____
Presentation: _____ Lie: _____
Position: _____
Membranes: Intact: _____ Ruptured/time: _____
Nitrazine test: _____ Amount of drainage: _____
Character: _____
Blood type/Rh: Maternal: _____ Paternal: _____
Screens: Sickle cell: _____ Rubella: _____
Hepatitis: _____ HIV: _____ Tuberculosis: _____
Serology: Syphilis: Pos _____ Neg _____
Cervical/Rectal culture: Pos _____ Neg _____
Vaginal warts/lesions: _____
Perineal varicosities: _____

SECTION 2

DIAGNOSTIC DIVISIONS: NURSING DIAGNOSES ORGANIZED ACCORDING TO A NURSING FOCUS

After data are collected and areas of concern/need identified, the nurse is directed to the Diagnostic Divisions to review the list of nursing diagnoses that fall within the individual categories. This will assist the nurse in choosing the specific diagnostic label to accurately describe the data. Then, with the addition of etiology or related/risk factors (when known) and signs and symptoms, or cues (defining characteristics), the patient diagnostic statement emerges.

ACTIVITY/REST—Ability to engage in necessary/desired activities of life (work and leisure), and to obtain adequate sleep/rest

Activity intolerance
Activity intolerance, risk for
Disuse Syndrome, risk for
Diversional Activity, deficient
Fatigue
Mobility, impaired bed
Mobility, impaired wheelchair
Sleep Deprivation
Sleep Pattern, disturbed
Transfer Ability, impaired
Walking, impaired

CIRCULATION—Ability to transport oxygen and nutrients necessary to meet cellular needs

Autonomic Dysreflexia
Autonomic Dysreflexia, risk for
Cardiac Output, decreased
Intracranial, decreased adaptive capacity
Tissue perfusion, ineffective (specify type: renal, cerebral, cardiopulmonary, gastrointestinal, peripheral)

EGO INTEGRITY—Ability to develop and use skills and behaviors to integrate and manage life experiences

Adjustment, impaired
Anxiety [specify level]
Anxiety, death
Body Image, disturbed
Conflict, decisional (specify)
Coping, defensive
Coping, ineffective
Denial, ineffective
Energy Field, disturbed
Fear
Grieving, anticipatory
Grieving, dysfunctional
Hopelessness
Personal Identity, disturbed
Post-Trauma Syndrome
Post-Trauma Syndrome, risk for
Powerlessness
Powerlessness, risk for
Rape-Trauma Syndrome
Rape-Trauma Syndrome: compound reaction
Rape-Trauma Syndrome: silent reaction
Relocation Stress Syndrome
Relocation Stress Syndrome, risk for
Self-Esteem, chronic low
Self-Esteem, situational low
Self-Esteem, risk for situational low
Sorrow, chronic
Spiritual Distress
Spiritual Distress, risk for
Spiritual Well-Being, readiness for enhanced

ELIMINATION—Ability to excrete waste products

Bowel Incontinence
Constipation
Constipation, perceived
Constipation, risk for
Diarrhea
Urinary Elimination, impaired
Urinary Incontinence, functional
Urinary Incontinence, reflex
Urinary Incontinence, stress
Urinary Incontinence, total
Urinary Incontinence, urge
Urinary Incontinence, risk for urge
Urinary Retention [acute/chronic]

FOOD/FLUID—Ability to maintain intake of and utilize nutrients and liquids to meet physiologic needs

Breastfeeding, effective
Breastfeeding, ineffective
Breastfeeding, interrupted
Dentition, impaired
Failure to Thrive, adult
[Fluid Volume, deficient hyper/hypotonic]
Fluid Volume, deficient [isotonic]
Fluid Volume, excess
Fluid Volume, risk for deficient
Fluid Volume, risk for imbalanced
Infant Feeding Pattern, ineffective
Nausea
Nutrition: imbalanced, less than body requirements
Nutrition: imbalanced, more than body requirements
Nutrition: imbalanced, risk for more than body requirements
Oral Mucous Membrane, impaired
Swallowing, impaired

HYGIENE—Ability to perform activities of daily living

Self-Care Deficit: bathing/hygiene
Self-Care Deficit: dressing/grooming
Self-Care Deficit: feeding
Self-Care Deficit: toileting

NEUROSENSORY—Ability to perceive, integrate, and respond to internal and external cues

Confusion, acute
Confusion, chronic
Infant Behavior, disorganized
Infant Behavior, risk for disorganized
Infant Behavior, readiness for enhanced, organized
Memory, impaired
Peripheral Neurovascular Dysfunction, risk for
Sensory Perception, disturbed (specify: visual, auditory, kinesthetic, gustatory, tactile, olfactory)
Thought Processes, disturbed
Unilateral Neglect

PAIN/DISCOMFORT—Ability to control internal/external environment to maintain comfort

Pain, acute
Pain, chronic

RESPIRATION—Ability to provide and use oxygen to meet physiologic needs

Airway Clearance, ineffective
Aspiration, risk for
Breathing Pattern, ineffective
Gas Exchange, impaired
Ventilation, impaired spontaneous
Ventilatory Weaning Response, dysfunctional

SAFETY—Ability to provide safe, growth-promoting environment

Allergy Response, latex
Allergy Response, risk for latex
Body Temperature, risk for imbalanced
Environmental Interpretation Syndrome, impaired
Falls, risk for
Health Maintenance, ineffective
Home Maintenance, impaired
Hyperthermia
Hypothermia
Infection, risk for
Injury, risk for
Injury, risk for, perioperative positioning
Mobility, impaired physical
Poisoning, risk for
Protection, ineffective
Self Mutilation
Self-Mutilation, risk for
Skin Integrity, impaired
Skin Integrity, risk for impaired
Suffocation, risk for
Suicide, risk for
Surgical Recovery, delayed
Thermoregulation, ineffective
Tissue Integrity, impaired
Trauma, risk for
Violence, [actual/] risk for other-directed
Violence, [actual/] risk for self-directed
Wandering [specify sporadic or continual]

SEXUALITY—[Component of Ego Integrity and Social Interaction] Ability to meet requirements/characteristics of male/female role

Sexual Dysfunction
Sexuality Patterns, ineffective

SOCIAL INTERACTION—Ability to establish and maintain relationships

Attachment, risk for impaired parent/infant/child
Caregiver Role Strain
Caregiver Role Strain, risk for
Communication, impaired verbal
Coping, community, ineffective
Coping, community, readiness for enhanced
Coping, family: compromised
Coping, family: disabled
Coping, family: readiness for enhanced
Family Processes, dysfunctional: alcoholism
Family Processes, interrupted
Loneliness, risk for
Parental Role Conflict
Parenting, impaired
Parenting, risk for impaired
Role Performance, ineffective
Social Interaction, impaired
Social Isolation

TEACHING/LEARNING—Ability to incorporate and use information to achieve healthy lifestyle/optimal wellness

Development, risk for delayed
Growth, risk for disproportionate
Growth and Development, delayed
Health-Seeking Behaviors (specify)
Knowledge, deficient (specify)
Noncompliance [Adherence, ineffective] [specify]
Therapeutic Regimen: Community, ineffective management
Therapeutic Regimen: Family, ineffective management
Therapeutic Regimen: effective management
Therapeutic Regimen: ineffective management

SECTION 3

PATIENT SITUATION AND PROTOTYPE PLAN OF CARE

Patient Situation

Mr. R.S., a type 2 diabetic patient (non–insulin-dependent) for 5 years, presented to his physician's office with a nonhealing ulcer of 3 weeks' duration on his left foot. Screening studies done in the doctor's office revealed blood glucose of 356/fingerstick and urine Chemstix of 2%. Because of distance from medical provider and lack of local community services, he is admitted to the hospital.

ADMITTTING PHYSICIANS'S ORDERS

Culture/sensitivity and Gram's stain of foot ulcer
Random blood glucose on admission and fingerstick BG qid
CBC, electrolytes, serum lipid profile, glycosylated Hb in AM
Chest x ray and ECG in AM
Diabeta 10 mg, PO bid
Glucophage 500 mg, PO qd to start—will increase gradually
Humulin N 10 U SC q AM and hs. Begin insulin instruction for postdischarge self-care if necessary
Dicloxacillin 500 mg PO q6h, start after culture obtained
Darvocet-N 100 mg PO q4h prn pain
Diet—2400 calories, 3 meals with 2 snacks
Up in chair ad lib with feet elevated
Foot cradle for bed
Irrigate lesion L foot with NS tid, then cover with wet to dry sterile dressing
Vital signs qid

PATIENT ASSESSMENT DATABASE

Name: R.S. Informant: Patient
Reliability (Scale 1–4): 3
Age: 69 DOB: 5/3/31 Race: Caucasian Gender: M
Adm. date: 6/28/2000 Time: 7 PM From: home

Activity/Rest

SUBJECTIVE (REPORTS)

Occupation: farmer

Usual activities/hobbies: reading, playing cards. "Don't have time to do much. Anyway, I'm too tired most of the time to do anything after the chores."
Limitations imposed by illness: "Have to watch what I order if I eat out."
Sleep: Hours: 6 to 8 h/night Naps: no Aids: no
Insomnia: "Not unless I drink coffee after supper."
Usually feels rested when awakens at 4:30 AM

OBJECTIVE (EXHIBITS)

Observed response to activity: limps, favors L foot when walking
Mental status: alert/active
Neuro/muscular assessment: Muscle mass/tone: bilaterally equal/firm Posture: erect
ROM: full Strength: equal 4 extremities/(favors L foot currently)

Circulation

SUBJECTIVE (REPORTS)

History of slow healing: lesion L foot, 3 weeks' duration
Extremities: Numbness/tingling: "My feet feel cold and tingly like sharp pins poking the bottom of my feet when I walk the quarter mile to the mailbox."
Cough/character of sputum: occ./white
Change in frequency/amount of urine: yes/voiding more lately

OBJECTIVE (EXHIBITS)

Peripheral pulses: radials 3+; popliteal, dorsalis, post-tibial/pedal, all 1+
BP: R: Lying: 146/90 Sit: 140/86 Stand: 138/90
L: Lying: 142/88 Sit: 138/88 Stand: 138/84
Pulse: Apical: 86 Radial: 86 Quality: strong
Rhythm: regular
Chest auscultation: few wheezes clear with cough, no murmurs/rubs
Jugular vein distention: 0
Extremities:
Temperature: feet cool bilaterally/legs warm
Color: Skin: legs pale
Capillary refill: slow both feet (approx. 5 seconds)
Homans' sign: 0
Varicosities: few enlarged superficial veins both calves
Nails: toenails thickened, yellow, brittle

Distribution and quality of hair: coarse hair to midcalf, none on ankles/toes
Color:
General: ruddy face/arms
Mucous membranes/lips: pink
Nailbeds: blanch well
Conjunctiva and sclera: white

Ego Integrity

SUBJECTIVE (REPORTS)

Report of stress factors: "Normal farmer's problems: weather, pests, bankers, etc."
Ways of handling stress: "I get busy with the chores and talk things over with my livestock. They listen pretty good."
Financial concerns: no insurance; needs to hire someone to do chores while here
Relationship status: married
Cultural factors: rural/agrarian, eastern European descent, "American," no ethnic ties
Religion: Protestant/practicing
Lifestyle: middle class/self-sufficient farmer
Recent changes: no
Feelings: "I'm in control of most things, except the weather and this diabetes now."
Concerned re possible therapy change "from pills to shots."

OBJECTIVE (EXHIBITS)

Emotional status: generally calm, appears frustrated at times
Observed physiological response(s): occasionally sighs deeply/frowns, fidgeting with coin, shoulders tense/shrugs shoulders, throws up hands

Elimination

SUBJECTIVE (REPORTS)

Usual bowel pattern: almost every PM
Last BM: last night Character of stool: firm/brown
Bleeding: 0 Hemorrhoids: 0 Constipation: occ.
Laxative used: hot prune juice on occ.
Urinary: no problems Character of urine: pale yellow

OBJECTIVE (EXHIBITS)

Abdomen tender: no Soft/Firm: soft Palpable mass: none
Bowel sounds: active all 4 quads

Food/Fluid

SUBJECTIVE (REPORTS)

Usual diet (type): 2400 calorie (occ. "cheats" with dessert; "My wife watches it pretty closely.")
No. of meals daily: 3/1 snack
Dietary pattern:
B: fruit juice/toast/ham/decaf coffee
L: meat/potatoes/veg/fruit/milk
D: meat sandwich/soup/fruit/decaf coffee
Snack: milk/crackers at hs. Usual beverage: skim milk, 2 to 3 cups decaf coffee, drinks "lots of water"—several quarts
Last meal/intake: Dinner: roast beef sandwich, vegetable soup, pear with cheese, decaf coffee
Loss of appetite: "Never, but lately I don't feel as hungry as usual."
Nausea/Vomiting: 0 Food allergies: none
Heartburn/food intolerance: cabbage causes gas, coffee after supper causes heartburn
Mastication/swallowing problems: no
Dentures: partial upper plate—fits well
Usual weight: 175 lb Recent changes: has lost about 5 lb this month
Diuretic therapy: no

OBJECTIVE (EXHIBITS)

Wt: 171 lb Ht: 5 ft 10 in Build: stocky
Skin turgor: good/leathery
Appearance of tongue: midline, pink
Mucous membranes: pink, intact
Condition of teeth/gums: good, no irritation/bleeding noted
Breath sounds: few wheezes cleared with cough
Bowel sounds: active all 4 quads
Urine Chemstix: 2% Fingerstick: 356 (Dr. office) 450 adm, random BG drawn on adm

Hygiene

SUBJECTIVE (REPORTS)

Activities of daily living: independent in all areas
Preferred time of bath: PM

OBJECTIVE (EXHIBITS)

General appearance: clean, shaven, short-cut hair; hands rough and dry; skin on feet dry, cracked and scaly
Scalp and eyebrows: scaly white patches
No body odor

Neurosensory

SUBJECTIVE (REPORTS)

Headache: "Occasionally behind my eyes when I worry too much."
Tingling/numbness: feet, once or twice a week (as noted)
Eyes: Vision loss, far-sighted, "seems a little blurry now" Examination: 2 yr ago
Ears: Hearing loss R: "some" L: no (has not been tested)
Nose: Epistaxis: 0 Sense of smell: "No problem"

OBJECTIVE (EXHIBITS)

Mental status: alert, oriented to time, place, person, situation
Affect: concerned Memory: Remote/Recent: clear and intact
Speech: clear/coherent, appropriate
Pupil reaction: PERLA/small
Glasses: reading Hearing aid: no
Handgrip/release: strong/equal

Pain/Discomfort

SUBJECTIVE (REPORTS)

Primary problem focus: Location: medial aspect, heel of L foot Intensity (0–10): 4 to 5 Quality: dull ache with occ. sharp stabbing sensation
Frequency/Duration: "seems like all the time." Radiation: no
Precipitating factors: shoes, walking How relieved: ASA, not helping
Other complaints: sometimes has back pain following chores/heavy lifting, relieved by ASA/liniment rubdown

OBJECTIVE (EXHIBITS)

Facial grimacing: when lesion border palpated
Guarding affected area: pulls foot away
Narrowed focus: no
Emotional response: tense, irritated

Respiration

SUBJECTIVE (REPORTS)

Dyspnea: 0 Cough: occ. morning cough, white sputum
Emphysema: 0 Bronchitis: 0 Asthma: 0 Tuberculosis: 0
Smoker: filters pk/day: ½ No. pk-yrs: 25+
Use of respiratory aids: 0

OBJECTIVE (EXHIBITS)

Respiratory rate: 22 Depth: good Symmetry: equal, bilateral
Auscultation: few wheezes, clear with cough
Cyanosis: 0 Clubbing of fingers: 0
Sputum characteristics: none to observe
Mentation/restlessness: alert/oriented/relaxed

Safety

SUBJECTIVE (REPORTS)

Allergies: 0 Blood transfusions: 0
Sexually transmitted disease: none
Fractures/dislocations: L clavicle, 1966, fell getting off tractor
Arthritis/unstable joints: "I think I've got some in my knees."
Back problems: occ. lower back pain
Vision impaired: requires glasses for reading
Hearing impaired: slightly (R), compensates by turning "good ear" toward speaker

OBJECTIVE (EXHIBITS)

Temperature: 99.4°F (37.4°C) tympanic
Skin integrity: impaired L foot Scars: R inguinal, surgical
Rashes: 0 Bruises: 0 Lacerations: 0 Blisters: 0
Ulcerations: medial aspect L heel, 2.5-cm diameter, approx. 3 mm deep, draining small amount cream-color/pink-tinged matter, no odor noted
Strength (general): equal all extremities Muscle tone: firm
ROM: good Gait: favors L foot Paresthesia/Paralysis: 0

Sexuality: Male

SUBJECTIVE (REPORTS)

Sexually active: yes Use of condoms: no (monogomous)
Recent changes in frequency/interest: "I've been too tired lately."
Penile discharge: 0 Prostate disorder: 0 Vasectomy: 0
Last proctoscopic examination: 2 yr ago Prostate examination: 1 yr ago
Practice self-examination: Breast/testicles: No
Problems/complaints: "I don't have any problems, but you'd have to ask my wife if there are any complaints."

OBJECTIVE (EXHIBITS)

Examination: Breast: no masses Testicles: deferred Prostate: deferred

Social Interactions

SUBJECTIVE (REPORTS)

Marital status: married 45 yr Living with: wife
Report of problems: none
Extended family: 1 daughter lives in town (30 miles away); 1 daughter married/grandson, living out of state
Other: several couples, he and wife play cards/socialize with 2 to 3 times/mo
Role: works farm alone; husband/father/grandfather
Report of problems related to illness/condition: none until now
Coping behaviors: "My wife and I have always talked things out. You know the 11th commandment is 'Thou shalt not go to bed angry.' "

OBJECTIVE (EXHIBITS)

Speech: clear, intelligible
Verbal/nonverbal communication with family/SO(s): speaks quietly with wife, looking her in the eye; relaxed posture
Family interaction patterns: wife sitting at bedside, relaxed, both reading paper, making occasional comments to each other

Teaching/Learning

SUBJECTIVE (REPORTS)

Dominant language: English Second language: 0
Literate: yes
Education level: 2-yr college
Health and illness/beliefs/practices/customs: "I take care of the minor problems and see the doctor only when something's broken."
Familial risk factors/relationship:
Diabetes: maternal uncle
Tuberculosis: brother died age 27
Heart disease: father died, age 78, heart attack
Strokes: mother died, age 81
High BP: mother
Prescribed medications:
Drug: Diabeta Dose: 10 mg bid
Schedule: 8 AM/6 PM, last dose 6 PM today
Purpose: control diabetes
Takes medications regularly? yes
Home urine/glucose monitoring: "Stopped several months ago when I ran out of TesTape. It was always negative, anyway."
Nonprescription (OTC) drugs: occ. ASA
Use of alcohol (amount/frequency): socially, occ. beer

Tobacco: ½ pk/day
Admitting diagnosis (physician): hyperglycemia with nonhealing lesion L foot
Reason for hospitalization (patient): "Sore on foot and the doctor is concerned about my blood sugar, and says I'm supposed to learn this fingerstick test now."
History of current complaint: "Three weeks ago I got a blister on my foot from breaking in my new boots. It got sore so I lanced it but it isn't getting any better."
Patient's expectations of this hospitalization: "Clear up this infection and control my diabetes."
Other relevant illness and/or previous hospitalizations/surgeries: 1969, R inguinal hernia repair
Evidence of failure to improve: lesion L foot, 3 wk
Last physical examination: complete 1 yr ago, office follow-up 3 mo ago

Discharge Considerations (as of 6/28)

Anticipated discharge: 7/1/00 (3 days)
Resources: self, wife Financial: "If this doesn't take too long to heal, we got some savings to cover things."
Community supports: diabetic support group (has not participated)
Anticipated lifestyle changes: become more involved in management of condition
Assistance needed: may require farm help for several days
Teaching: learn new medication regimen and wound care, review diet; encourage smoking cessation
Referral: Supplies: Downtown Pharmacy or AARP
Equipment: Glucometer-AARP
Follow-up: primary care provider 1 wk after discharge to evaluate wound healing and potential need for additional changes in diabetic regimen

PLAN OF CARE FOR PATIENT WITH DIABETES MELLITUS

Patient Diagnostic Statement:

Skin Integrity, Impaired related to pressure, altered metabolic state, circulatory impairment and decreased sensation, as evidenced by draining wound L foot.

Outcome: Blood Glucose Control (NOC) Indicators: Patient Will:

Demonstrate correction of metabolic state as evidenced by FBS less than 120 mg/dL within 36 hr (6/30 0700).

Outcome: Wound Healing: Secondary Intention (NOC) Indicators: Patient Will:

Be free of purulent drainage within 48 hr (6/30 1900).
Display signs of healing with wound edges clean/pink within 60 hr (7/1 0700).

ACTIONS/INTERVENTIONS	RATIONALE
Wound Care (NIC)	
Irrigate wound with room temperature sterile NS tid.	Cleans wound without harming delicate tissues.
Assess wound with each dressing change. Obtain wound tracing on adm and at discharge.	Provides information about effectiveness of therapy and identifies additional needs.
Apply wet to dry sterile dressing. Use paper tape.	Keeps wound clean/minimizes cross contamination. Adhesive tape may be abrasive to fragile tissues.
Infection Control (NIC)	
Follow wound precautions.	Use of gloves and proper handling of contaminated dressings reduces likelihood of spread of infection.
Obtain sterile specimen of wound drainage on admission.	Culture/sensitivity identifies pathogens and therapy of choice.
Administer dicloxacillin 500 mg PO q6h, starting 10 PM. Observe for signs of hypersensitivity (i.e., pruritus, urticaria, rash).	Treatment of infection/prevention of complications. Food interferes with drug absorption, requiring scheduling around meals.

ACTIONS/INTERVENTIONS	RATIONALE
	Although no prior history of penicillin reaction, it may occur at any time.
Administer antidiabetic medications: 10 U Humulin N insulin SC q AM/hs after fingerstick BG; Diabeta 10 mg PO bid; Glucophage 500 mg PO qd. Note onset of side effects.	Treats underlying metabolic dysfunction, reducing hyperglycemia and promoting healing. Glucophage lowers serum glucose levels by improving insulin sensitivity, increasing glucose utilization in the muscles. By using in conjunction with Diabeta, patient may be able to discontinue insulin once target dosage is achieved (e.g., 2000 mg/day). Increase of 1 tablet per week is necessary to limit side effects of diarrhea, abdominal cramping, vomiting, possibly leading to dehydration and prerenal azotemia.

Patient Diagnostic Statement:

Pain, Acute related to physical agent (open would L foot), as evidenced by verbal report of pain and guarding behavior.

Outcome: Pain Control (NOC) Indicators: Patient Will:

Report pain is minimized/relieved within 1 hr of analgesic administration (ongoing).
Report absence or control of pain by discharge (7/1).

Outcome: Pain Disruptive Effects (NOC) Indicators: Patient Will:

Ambulate normally, full weight bearing by discharge (7/1).

ACTIONS/INTERVENTIONS	RATIONALE
Pain Management (NIC)	
Determine pain characteristics through patient's description.	Establishes baseline for assessing improvement/changes.

Place foot cradle on bed, encourage use of loose-fitting slipper when up.	Avoids direct pressure to area of injury, which could result in vasoconstriction/ increased pain.
Administer Darvocet-N 100 mg PO q4h as needed. Document effectiveness.	Provides relief of discomfort when unrelieved by other measures.

Patient Diagnostic Statement:

Tissue Perfusion, Ineffective (Peripheral) related to decreased arterial flow evidenced by decreased pulses, pale/cool feet; thick, brittle nails; numbness/tingling of feet "when walks ¼ mile."

Outcome: Knowledge: Diabetes Management (NOC) Indicators: Patient Will:

Verbalize understanding of relationship between chronic disease (diabetes mellitus) and circulatory changes within 48 hr (6/30 1900).

Demonstrate awareness of safety factors/proper foot care within 48 hr (6/30 1900).

Maintain adequate level of hydration to maximize perfusion, as evidenced by balanced intake/output, moist skin/mucous membranes, adequate capillary refill less than 4 seconds (ongoing).

ACTIONS/INTERVENTIONS	RATIONALE
Circulatory Care: Arterial Insufficiency (NIC)	
Elevate feet when up in chair. Avoid long periods with feet dependent.	Minimizes interruption of blood flow, reduces venous pooling.
Assess for signs of dehydration. Monitor intake/output. Encourage oral fluids.	Glycosuria may result in dehydration with consequent reduction of circulating volume and further impairment of peripheral circulation.
Instruct patient to avoid constricting clothing/socks and ill-fitting shoes.	Compromised circulation and decreased pain sensation may precipitate or aggravate tissue breakdown
Reinforce safety precautions regarding use of heating pads, hot water bottles/soaks.	Heat increases metabolic demands on compromised tissues. Vascular insufficiency alters pain sensation, increasing risk of injury.

ACTIONS/INTERVENTIONS	RATIONALE
Recommended cessation of smoking.	Vascular constriction associated with smoking and diabetes impairs peripheral circulation.
Discuss complications of disease that result from vascular changes (i.e., ulceration, gangrene, muscle or bony structure changes).	Although proper control of diabetes mellitus may not prevent complications, severity of effect may be minimized. Diabetic foot complications are the leading cause of non-traumatic lower extremity amputations. **Note:** Skin dry, cracked, scaly; feet cool; pain when walking a distance suggest mild to medium vascular disease (autonomic neuropathy) that can limit response to infection, impair wound healing, and increase risk of bony deformities.
Review proper foot care as outlined in teaching plan.	Altered perfusion of lower extremities may lead to serious/persistent complications at the cellular level.

Patient Diagnostic Statement:

Learning Need regarding diabetic condition related to misinterpretation of information and/or lack of recall as evidenced by inaccurate follow-through of instructions regarding home glucose monitoring and foot care, and failure to recognize signs/symptoms of hyperglycemia.

Outcome: Knowledge: Diabetes Management (NOC) Indicators: Patient Will:

Perform procedure of home glucose monitoring correctly within 36 hr (6/30 0700).
Verbalize basic understanding of disease process and treatment within 38 hr (6/30 0900).
Explain reasons for actions within 28 hr (6/30 0900).
Perform insulin administration correctly within 60 hr (7/1 0700).

ACTIONS/INTERVENTIONS	RATIONALE
Teaching: Disease Process (NIC)	
Determine patient's level of knowledge, priorities of learning needs, desire/need for including wife in instruction.	Establishes baseline and direction for teaching/planning. Involvement of wife, if desired, will provide additional resource for recall/understanding and may enhance patient's follow through.
Provide teaching guide, "Understanding Your Diabetes," 6/29 AM. Show film "Living with Diabetes" 6/29 4 PM, when wife is visiting. Include in group teaching session 6/30 AM. Review information and obtain feedback from patient/wife.	Provides different methods for accessing/reinforcing information and enhances opportunity for learning/understanding.
Discuss factors related to/altering diabetic control (e.g., stress, illness, exercise).	Drug therapy/diet may need to be altered in response to both short-term and long-term stressors.
Review signs/symptoms of hyperglycemia (e.g., fatigue, nausea/vomiting, polyuria/polydipsia). Discuss how to prevent and evaluate this situation and when to seek medical care. Have patient identify appropriate interventions.	Recognition/understanding of these signs/symptoms and timely intervention will aid patient in avoiding recurrences and preventing complications.
Review and provide information about necessity for routine examination of feet and proper foot care (e.g., daily inspection for injuries, pressure areas, corns, calluses; proper nail cutting; daily washing, application of good moisturizing lotion [e.g., Eucerin, Keri, Nivea] bid). Recommend wearing loose-fitting socks and properly	Reduces risk of tissue injury, promotes understanding and prevention of stasis ulcer formation and wound healing difficulties.

ACTIONS/INTERVENTIONS	RATIONALE
fitting shoes (break new shoes in gradually) and avoiding going barefoot. If foot injury/skin break occurs, wash with soap/dermal cleanser and water, cover with sterile dressing, inspect wound and change dressing daily; report redness, swelling, or presence of drainage.	
Instruct regarding prescribed insulin therapy:	May be a temporary treatment of hyperglycemia with infection or may be permanent replacement of oral hypoglycemic agent.
Humulin N Insulin, SC;	Intermediate-acting insulin generally lasts 18–28 hr, with peak effect 6–12 hr.
Keep vial in current use at room temperature (if used within 30 days);	Cold insulin is poorly absorbed.
Store extra vials in refrigerator;	Refrigeration prevents wide fluctuations in temperature, prolonging the drug shelflife.
Roll bottle and invert to mix, or shake gently;	Vigorous shaking may create foam, which can interfere with accurate dose withdrawal and may damage the insulin molecule. **Note:** New research suggests that shaking the vial may be more effective in mixing suspension.
Choice of injection sites (e.g., across lower abdomen in Z pattern).	Provides for steady absorption of medication. Site is easily visualized and accessible by patient, and Z pattern minimizes tissue damage.
Demonstrate, then observe patient drawing insulin into syringe, reading syringe markings, and administering dose. Assess for accuracy.	May require several instruction sessions and practice before patient/wife feel comfortable drawing up and injecting medication.

Instruct in signs/symptoms of insulin reaction/hypoglycemia (i.e., fatigue, nausea, headache, hunger, sweating, irritability, shakiness, anxiety, difficulty concentrating).	Knowing what to watch for and appropriate treatment (such as ½ cup of grape juice for immediate response and snack within ½ hr [e.g., 1 slice bread with peanut butter or cheese, fruit, and slice of cheese for sustained effect]) may prevent/minimize complications.
Review "Sick Day Rules" (e.g., call the doctor if too sick to eat normally/stay active), take insulin as ordered. Keep record as noted in Sick Day Guide.	Understanding of necessary actions in the event of mild/severe illness promotes competent self-care and reduces risk of hyper/hypoglycemia.
Instruct patient/wife in fingerstick glucose monitoring to be done 4 × /d until stable, then bid rotating times (e.g., FBS, before dinner; before lunch and hs). Observe return demonstrations of the procedure.	Fingerstick monitoring provides accurate and timely information regarding diabetic status. Return demonstration verifies correct learning.
Recommend patient maintain record/log of fingerstick testing, antidiabetic medication, and insulin dosage/site, unusual physiological response, dietary intake. Outline desired goals (e.g., FBS 80–120, premeal 80–140).	Provides accurate record for review by caregivers for assessment of therapy effectiveness/needs.
Schedule consultation with dietitian to restructure meal plan and evaluate food choices.	Calories are unchanged on new orders but have been redistributed to 3 meals and 2 snacks. Dietary choices (e.g., increased vitamin C) may enhance healing.
Discuss other healthcare issues such as smoking habits, self-monitoring for cancer (breasts/testicles), and reporting changes in general well-being.	Encourages patient involvement, awareness, and responsibility for own health; promotes wellness. **Note:** Smoking tends to increase patient's resistance to insulin.

SECTION 4

DOCUMENTATION TECHNIQUES: SOAP AND FOCUS CHARTING®

Several charting formats are currently used for documentation. These include block notes, with a single entry covering an entire shift (e.g., 7 AM to 3 PM), narrative timed notes (e.g., "8:30 AM, ate breakfast well"), and the problem-oriented medical record system (POMR or PORS) using SOAP/SOAPIER approach, to name a few. The latter can provide thorough documentation; however, the SOAP/SOAPIER charting system was designed by physicians for episodic care and requires that the entries be tied to a problem identified from a problem list. (See Example 1.)

The Focus Charting® system (Example 2) has been designed by nurses for documentation of frequent/repetitive care and to encourage viewing the patient from a positive rather than a negative (problem only) perspective. Charting is focused on patient and nursing concerns, with the focal point of patient status and the associated nursing care. A *Focus* is usually a patient problem/concern or nursing diagnosis but is not a medical diagnosis or a nursing task/treatment (e.g., wound care, indwelling catheter insertion, tube feeding).

Recording of assessment, interventions, and evaluation using Data, Action, and Response (DAR) categories facilitates tracking what is happening to the patient at any given moment. Thus, the four components of this charting system are:

(1) **Focus:** Nursing diagnosis, patient problem/concern, signs/symptoms of potential importance (e.g., fever, dysrhythmia, edema), a significant event or change in status or specific standards of care/agency policy.
(2) **Data:** Subjective/objective information describing and/or supporting the Focus.
(3) **Action:** Immediate/future nursing actions based on assessment and consistent with/complementary to the goals and nursing action recorded in the patient plan of care.
(4) **Response:** Describes the effects of interventions and whether or not the goal was met.

The following charting examples are based on the data within the patient situation of Mr. R.S. in Chapter 3, Section 3, pages **–**.

Example 1. SAMPLE SOAP/IER CHARTING FOR PROTOTYPE PLAN OF CARE

S = Subjective I = Implementation O = Objective
E = Evaluation A = Analysis R = Revision P = Plan

DATE	TIME	NUMBER/PROBLEM*	NOTE
6/30/00	1600	No. 1 (Skin Integrity, Impaired)	S: "That hurts" (when tissue surrounding wound palpated). O: Scant amount serous drainage on dressing Wound borders pink. No odor present. A: Wound shows early signs of healing, free of infection. P: Continue skin care per plan of care.
To document more of the nursing process, some institutions have added the following: Implementation, Evaluation, and Revision (if plan was ineffective).			
			I: NS soaks as ordered. Applied sterile wet dressing with paper tape. E: Wound clean, no drainage present. R: None required. Signed: E. Moore, RN
6/28/00	2100	No. 2 (Pain, Acute)	S: "Dull, throbbing pain in left foot." States there is no radiation to other areas. O: Muscles tense. Moving about bed, appears uncomfortable. A: Persistent pain. P: Foot cradle placed on bed. Signed: M. Siskin, RN
	2200		E: Reports pain relieved. Appears relaxed. Signed: M. Siskin, RN
6/30/00	1100	No. 3 (Learning Need, Diabetic Care)	S: "My wife and I have some questions and concerns we wish to discuss."

Example 1. SAMPLE SOAP/IER CHARTING FOR PROTOTYPE PLAN OF CARE (*Continued*)

O: Copy of list of questions attached to teaching plan.
A: R.S. and wife need review of information and practice for insulin administration.
P: Attended group teaching session with wife and read "Understanding Your Diabetes." To meet with dietitian.
I: R.S. demonstrated insulin administration techniques for wife to observe. Procedure handout sheet for future reference provided to couple. Scheduled meeting for them with dietitian at 1300 today to discuss remaining questions.
E: R.S. More confident in demonstration, performed activity cor rectly without hesitation or hand tremors. R.S. explained steps of procedure and reasons for actions to wife. Couple identified resources to contact if questions/problems arise.
Signed: B. Briner, RN

*As noted on Plan of Care.

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CHAPTER 4

Nursing Diagnoses in Alphabetical Order

Activity intolerance
[specify level]

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

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]

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

Functional Level Classification (Gordon, 1987):

Level I: Walk, regular pace, on level indefinitely; one flight or more but more short of breath than normally
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—Patient 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 patient'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, etc.)
- Evaluate current limitations/degree of deficit in light of usual status. **(Provides comparative baseline.)**
- Note patient 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 patient 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.
- 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 patient. (**Helps to minimize frustration, rechannel energy.**)
- Encourage expression of feelings contributing to/resulting from condition.
- Involve patient/SOs in planning of activities as much as possible.
- Assist with activities and provide/monitor patient's use of assistive devices (crutches, walker, wheelchair, oxygen tank, and so on) **to protect patient from injury.**
- Promote comfort measures and provide for relief of pain **to enhance ability to participate in activities.** (Refer to ND Pain, acute or Pain, chronic.)
- 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 patient's ability.
- Review expectations of patient/SO(s)/providers **to establish individual goals.** Explore conflicts/differences **to reach agreement for the most effective plan.**
- Instruct patient/SOs 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 patient tolerates.
- Give patient information that provides evidence of daily/weekly progress **to sustain motivation.**
- Assist patient to learn and demonstrate 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).

- Encourage patient 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 Diversional Activity, deficient.)

Documentation Focus

ASSESSMENT/REASSESSMENT

- Level of activity as noted in Functional Level Classification.
- Causative/precipitating factors.
- Patient 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

Activity intolerance, risk for

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

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

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

Risk Factors

History of previous intolerance
Presence of circulatory/respiratory problems
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—Patient 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 patient'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 patient and other team members (e.g., physical and/or occupational therapist, exercise/rehabilitation physiologist). **Coordination of program enhances likelihood of success.**

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

- Promote/implement conditioning program and support inclusion in exercise/activity groups **to prevent/limit deterioration.**
- Instruct patient in unfamiliar activities and in alternate ways of doing familiar activities **to conserve energy and promote safety.**

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 patient/SO with planning for changes that may become necessary.
- Identify and discuss symptoms for which patient 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

Adjustment, impaired

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

[Diagnostic Division: Ego Integrity]

Nursing Diagnosis Extension and Classification (NDEC) Revision 1998

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

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—Patient 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 present life situations.
- Identify and use appropriate support systems.

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

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 present condition.**
- Listen to the patient's perception of inability/reluctance to adapt to situations that are occurring at present.
- Survey (with the patient) past and present significant support systems (family, church, groups, and organizations) **to identify helpful resources.**
- Explore the expressions of emotions signifying impaired adjustment by patient/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 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 patient's perception of the factors leading to the present impairment, noting onset, duration, presence/absence of physical complaints, social withdrawal.
- Review with patient previous life situations and role changes **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 of SOs, consultants' notes). **In situations of great stress, physical and/or emotional, the patient may not accurately assess occurrences leading to the present situation.**

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

- Organize a team conference (including patient and ancillary services) **to focus on contributing factors of impaired adjustment and plan for management of the situation.**
- Acknowledge patient's efforts to adjust: "Have done your best." **Avoids 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 patient in adapting to changes in other life situations (e.g., vocational rehabilitation, employment experiences, psychosocial support services).
- Develop a plan of action with patient **to meet immediate needs** (e.g., physical safety and hygiene, emotional support of professionals and SOs) 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.**
- Explore previously used coping skills and application to current situation. Refine/develop new strategies as appropriate.
- Identify and problem-solve with the patient 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 patient perceives in present 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 patient/SO(s) to see appropriate alternatives and potential changes in locus of control.
- Assist SOs to learn methods of managing present needs. (Refer to NDs specific to patient's deficits.)
- Pace and time learning sessions **to meet patient's needs,** providing for 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.
- Patient'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

- Patient 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 patient and SO(s) and referrals that are made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Acceptance: Health Status
NIC—Coping Enhancement

Airway Clearance, ineffective

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

[Diagnostic Division: Respiration]

Nursing Diagnosis Extension and Classification (NDEC) Revision 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

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

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

Desired Outcomes/Evaluation Criteria—Patient 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 patient 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 anatomical 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 liquify secretions.** 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 patient 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 patient'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.
- Include breathing exercises, effective cough, use of adjunct devices (e.g., IPPB or incentive spirometer) in preoperative teaching.
- 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.**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Related Factors for individual patient.
- 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

- Patient'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 CLASSIFICATION (NOC/NIC)

NOC—Respiratory Status: Airway Patency
NIC—Airway Management

Allergy Response, latex

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

[Diagnostic Division: Safety]

Definition: An allergic response to natural latex rubber products

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—Patient Will:

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

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

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 urologic conditions requiring frequent surgeries and/or catheterizations (e.g., extrophy of the bladder).
- 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 patient with a history of type I reaction.**

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

- Ascertain patient'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, and avoidance of latex). Inform patient 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 patient's file. Encourage patient to wear medical ID bracelet and to inform care providers.
- Survey and routinely monitor patient'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 patient/family/SO about signs of reaction and emergency treatment. **Promotes awareness of problem and facilitates timely intervention.**
- 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

Allergy Response, latex, risk for

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

[Diagnostic Division: Safety]

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

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)

Desired Outcomes/Evaluation Criteria—Patient 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 urologic conditions requiring frequent surgeries and/or catheterizations.
- Ascertain if patient 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.**

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

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

- Discuss necessity of avoiding latex exposure. Recommend/assist patient/family to survey environment and remove any medical or household products containing latex.
- Substitute nonlatex products, such as natural rubber gloves, PCV IV tubing, latex-free tape, thermometers, electrodes, oxygen cannulas, and so forth.
- Obtain lists of latex-free products and supplies for patient/care provider.
- Ascertain that facilities have established policies and procedures to address safety and reduce risk to workers and patients.
- 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 patient/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 **(appearance of hives, itching, reddened areas indicates 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 [mild, moderate, severe, panic]

Taxonomy II: Coping/Stress Tolerance-Class 2 Coping Responses (00146)

[Diagnostic Division: Ego Integrity]

Revised 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, and so on]

Defining Characteristics

SUBJECTIVE

Behavioral
Expressed concerns due to change in life events

Affective
Regretful; scared; rattled; distressed; apprehension; uncertainty; fearful; feelings of inadequacy; anxious; jittery; [sense of impending doom]; [hopelessness]

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

Cognitive
Fear of unspecific consequences; awareness of physiological symptoms

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

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

p = parasympathetic nervous system; s = sympathetic nervous system

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, substance abuse).
- Identify patient's perception of the threat represented by the situation.
- 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 patient'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 patient 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 (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 (patient 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 patient to identify feelings and begin to deal with problems:

- Establish a therapeutic relationship, conveying empathy and unconditional positive regard.
- Be available to patient for listening and talking.
- Encourage patient to acknowledge and to express feelings, for example, crying (sadness), laughing (fear, denial), swearing (fear, anger).
- Assist patient to develop self-awareness of verbal and nonverbal behaviors.
- Clarify meaning of feelings/actions by providing feedback and checking meaning with the patient.
- Acknowledge anxiety/fear. Do not deny or reassure patient that everything will be all right.
- Provide accurate information about the situation. **Helps patient 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.**
- Manage environmental factors such as harsh lighting and high traffic flow, which may be confusing/stressful to older individuals.
- Accept patient as is. (**The patient 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 patient; do not respond personally **because this may escalate the situation.**
- Assist patient to use anxiety for coping with the situation if helpful. (**Moderate anxiety heightens awareness and permits the patient to focus on dealing with problems.**)

Panic State

- Stay with patient, 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 patient to develop acceptable ways of dealing with anxiety. **Note:** Staff may need to provide safe controls/environment until patient regains control.
- Gradually increase activities/involvement with others as anxiety is decreased.
- Use cognitive therapy **to focus on/correct faulty catastrophic interpretations of physical symptoms.**
- Give antianxiety medications (antianxiety agents/sedatives) as ordered.

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

- Assist patient to learn precipitating factors and new methods of coping with disabling anxiety.
- Review happenings, thoughts, and feelings preceding the anxiety attack.
- Identify things the patient 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 patient 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.** (**Note:** 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.

IMPLEMENTATION/EVALUATION

- Patient 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

Anxiety, death

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

[Diagnostic Division: Ego Integrity]

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

Related Factors

To be developed by NANDA

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

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

Negative death images or unpleasant thought 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
Concern 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

OBJECTIVE

Deep sadness
(Refer to ND Grieving, anticipatory.)

Desired Outcomes/Evaluation Criteria—Patient 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 patient 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 patient's role in family constellation. Observe patterns of communication in family and response of family/SO to patient's situation and concerns. **In addition to identifying areas of need/concern, also reveals strengths useful in addressing the concerns.**
- Assess impact of patient 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 patient'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 patient.
- Note use of drugs (including alcohol), presence of insomnia, excessive sleeping, avoidance of interactions with others.
- Note patient's religious/spiritual orientation, involvement in religious/church activities, presence of conflicts regarding spiritual beliefs.
- Listen to patient/SO reports/expressions of anger/concern, 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 patient to deal with situation:

- Provide open and trusting relationship.
- Use therapeutic communication skills of Active-listening, silence, acknowledgment. Respect patient 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 patient 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 philosophical issues/questions about spiritual impact of illness/situation.
- Review past life experiences of loss and use of coping skills, noting patient strengths and successes.
- Provide calm, peaceful setting and privacy as appropriate. **Promotes relaxation and ability to deal with situation.**
- Assist patient 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 patient to move forward toward resolution.**
- Refer to therapists, spiritual advisors, counselors **to facilitate grief work.**
- Refer to community agencies/resources **to assist patient/SO for planning for eventualities (legal issues, funeral plans, etc.).**

NURSING PRIORITY NO. 3. To promote independence:

- Support patient's efforts to develop realistic steps to put plans into action.
- Direct patient's thoughts beyond present state to enjoyment of each day and the future when appropriate.
- Provide opportunities for patient to make simple decisions. **Enhances sense of control.**
- Develop individual plan using patient's locus of control **to assist patient/family through the process.**
- Treat expressed decisions and desires with respect and convey to others as appropriate.
- Assist with completion of Advance Directives and cardiopulmonary resuscitation (CPR) instructions.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings, including patient's fears and signs/symptoms being exhibited.
- Responses/actions of family/SOs.
- Availability/use of resources.

PLANNING

- Plan of care and who is involved in planning.

IMPLEMENTATION/EVALUATION

- Patient'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—Fear Control
NIC—Dying Care

Aspiration, risk for

Taxonomy II: Safety/Protection—Class 2 Physical Injury (00039)
[Diagnostic Division: Respiration]

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
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 over-inflation 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—Patient 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.

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

- Evaluate presence of neuromuscular weakness, noting muscle groups involved, degree of impairment, and whether acute or of a 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, patient 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 drugs; **can affect awareness and muscles of gag/swallow.**

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

- Monitor use of oxygen masks in patients at risk for vomiting. Refrain from using oxygen masks for comatose individuals.
- Keep wire cutters/scissors with patient 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 patient who is coughing frequently or not coughing at all; ventilator patient being tube-fed) **to determine presence of secretions/silent aspiration.**
- Elevate patient to highest or best possible position for eating and drinking and during tube feedings.
- Feed slowly, instruct patient 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 Swallowing, impaired.
- Train patient to suction self or train family members in suction techniques (especially if patient 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

- Patient's responses to interventions/teaching and actions performed.
- Foods/fluids patient 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

Attachment, risk for impaired parent/infant/child

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

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

Risk Factors

Inability of parents to meet the 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.

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

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 parent's 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 parent regarding child growth and development, addressing parental perceptions. **Helps clarify realistic expectations.**
- 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-patient 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).
- 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—Parenting
NIC—Attachment Promotion

Autonomic Dysreflexia

Taxonomy II: Coping/Stress Tolerance-Class 3 Neurobehavioral Stress (00009)

[Diagnostic Division: Circulation]

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
Lack of patient 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)

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

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—Patient/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 patient from and/or instruct to avoid environmental temperature extremes/drafts.
- Monitor closely during procedures/diagnostics that manipulate bladder or bowel.

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 **to block excessive autonomic nerve transmission, normalize heart rate, and reduce hypertension**

as required. Administer and carefully adjust dosage of antihypertensive medications for child. (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 patient/SO(s).
- Instruct patient/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 patient/family in identifying emergency referrals (e.g., physician, rehabilitation nurse/home care supervisor). Place phone number(s) in prominent place.
- Refer to ND Autonomic Dysreflexia, risk for.

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

- Patient'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

Autonomic Dysreflexia, risk for

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 patients with injuries at T7 and T8)

Risk Factors

MUSCULO-SKELETAL—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

UROLOGIC STIMULI

Bladder distention/spasm
Detrusor sphincter dysynergia
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)

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

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

Desired Outcomes/Evaluation Criteria—Patient 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 urologic (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.**
- 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 patient 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 patient/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 patient/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

- Patient'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—Risk Control
NIC—Dysreflexia Management

Body Image, disturbed

Taxonomy II: Self-perception—Class 3 Body Image (00118)
[Diagnostic Division: Ego Integrity]
Revised 1998 by small group work 1996

Definition: Confusion in mental picture of one's physical self

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

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 lifestyle
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
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]

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

Desired Outcomes/Evaluation Criteria—Patient 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 Pain, chronic; 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 Attachment, risk for impaired parent/infant/child when child is effected.)
- Assess mental/physical influence of illness/condition on the patient's emotional state (e.g., diseases of the endocrine system, use of steroid therapy, and so on).
- Evaluate level of patient's knowledge of and anxiety related to situation. Observe emotional changes.
- Recognize behavior indicative of overconcern with body and its processes.
- Have patient describe self, noting what is positive and what is negative. Be aware of how patient believes others see self.
- Discuss meaning of loss/change to patient. **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

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

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 **in order 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 patient 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 patient's current level of adaptation and progress.
- Listen to patient'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 Denial, ineffective.)
- 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 patient and SO(s) to deal with/accept issues of self-concept related to body image:
- Establish therapeutic nurse-patient relationship conveying an attitude of caring and developing a sense of trust.
- Visit patient frequently and acknowledge the individual as someone who is worthwhile. **Provides opportunities for listening to concerns and questions.**
- 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 patient's self-concept without moral judgments regarding patient'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 patient facing surgery or potentially poor outcome of procedure/illness, **in order 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 patient 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 patient's appearance is affected.**
- Encourage family members to treat patient normally and not as an invalid.
- Encourage patient to look at/touch affected body part **to begin to incorporate changes into body image.**
- Allow patient to use denial without participating (e.g., patient 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 patient 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 patient 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 patient 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.**
- Provide information at patient's level of acceptance and in small pieces **to allow for easier assimilation.** Clarify misconceptions. Reinforce explanations given by other health team members.
- Include patient in decision-making process and problem-solving activities.
- Assist patient 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 patient 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 patient.
- Support systems available (e.g., SOs, friends, groups).

PLANNING

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

IMPLEMENTATION/EVALUATION

- Patient'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

Body Temperature, risk for imbalanced

Taxonomy II: Safety/Protection—Class 6 Thermoregulation (00005)

[Diagnostic division: Safety]

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

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

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—Patient 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 patient'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.

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.**

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

- Monitor core body temperature. (Tympanic temperature may be preferred, **as it is the most accurate noninvasive method.**)
- Restore/maintain core temperature within patient'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 patient/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 patient 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 need and who is responsible for actions.
- Specific referrals made.

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]

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—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

Desired Outcomes/Evaluation Criteria—Patient Will:

- Verbalize understanding of causative/controlling factors.
- Identify individually appropriate interventions.

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

- 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 patient or SO to record times at which incontinence occurs, **to note relationship to meals, activity, patient'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 patient 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 patient/caregiver in providing diet high in bulk/fiber and adequate fluids (minimum of 2000–2400 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 patient 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) **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

- Patient'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.

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

Breastfeeding, effective [Learning Need]*

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

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
Regular and sustained suckling/swallowing at the breast [e.g., 8–10 times/24 h]
Appropriate infant weight patterns for age
Effective mother/infant communication pattern (infant cues, maternal interpretation and response)

*This 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.

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

Signs and/or symptoms of oxytocin release (letdown 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—Patient 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 suggests adequate hydration).**
- Encourage mother/other family members to express feelings/concerns, and Active-listen **to determine nature of concerns.**
- 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.

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

- 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 Establishment: Maternal
NIC—Lactation Counseling

Breastfeeding, ineffective

Taxonomy II: Role Relationships—Class 3 Role Performance (00104)

[Diagnostic Division: Food/Fluid]

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

Related Factors

Prematurity; infant anomaly; poor infant sucking reflex
Infant receiving [numerous or repeated] supplemental feedings with artificial nipple

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

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—Patient 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 patient knowledge about breastfeeding and extent of instruction that has been given.
- Encourage discussion of current/previous breastfeeding experience(s).

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

- 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 letdown 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.

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 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/letdown 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 letdown 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 letdown 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 letdown:** Use relaxation techniques before nursing (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 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 together and 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.**

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—Knowledge Breastfeeding
NIC—Breastfeeding Assistance

Breastfeeding, interrupted

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

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 that appears in brackets has been added by the 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—Patient 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 patient 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 **because they may affect milk production/letdown 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.

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

- Referrals, plan for follow-up and who is responsible.
- Specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Breastfeeding Maintenance
NIC—Lactation Counseling

Breathing Pattern, ineffective

Taxonomy II: Activity/Rest—Class 4 Cardiovascular/Pulmonary Responses (00032)
[Diagnostic Division: Respiration]
Nursing Diagnosis Extension and Classification (NDEC) Revision 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 patient's normal O_2:CO_2 ratio (e.g., O_2 therapy in COPD)]

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

Defining Characteristics

SUBJECTIVE

Shortness of breath

OBJECTIVE

Dyspnea; orthopnea

Respiratory rate:

Adults (age 14 or greater)	<11 or [>]24
Children 1–4 yr	<20 or >30
5–14 yr	<15 or >25
Infants 0–12 mo	<25 or >60

Depth of breathing:
AdultsVT 500 mL at rest
Infants 6–8 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—Patient Will:

- Establish a normal/effective respiratory pattern.
- Be free of cyanosis and other signs/symptoms of hypoxia with ABGs within patient'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.**

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

- Review chest x-rays as indicated **for severity of acute/chronic conditions.**
- Review laboratory data, for example, ABGs (degree of oxygenation, CO_2 retention); drug screens; and pulmonary function studies (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:

- Administer oxygen at lowest concentration indicated for underlying pulmonary condition, respiratory distress, or cyanosis.
- Suction airway **to clear secretions** as needed.
- 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 patient in "taking control" of the situation.**
- Have patient breathe into a paper bag **to correct hyperventilation.**
- Maintain calm attitude while dealing with patient and SOs **to limit level of anxiety.**
- Assist patient 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 patient 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 ND Pain, acute or Pain, chronic.)
- 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 patient to learn breathing exercises: diaphragmatic, abdominal breathing, inspiratory resistive, and pursed-lip as indicated.
- Recommend energy conservation techniques and pacing of activities.
- Encourage adequate rest periods between activities **to limit fatigue.**
- Discuss relationship of smoking to respiratory function.
- Encourage patient/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 Assistances

Cardiac Output, decreased

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

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 changes

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

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]

Behavorial/Emotional: Restlessness

Desired Outcomes/Evaluation Criteria—Patient 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 patients 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 Autonomic Dysreflexia, risk for.)
- 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/

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

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:

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, central venous pressure—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 patient 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 patient.
- Avoid the use of restraints whenever possible if patient 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 patient to breathe deeply in/out during activities that increase risk of Valsalva effect.
- Alter environment/bed linens **to maintain body temperature in near-normal range.**
- Provide psychological support. Maintain calm attitude but admit concerns if questioned by the patient. **Honesty can be reassuring when so much activity and "worry" are apparent to the patient.**
- Provide information about testing procedures and patient 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 Tissue Perfusion, ineffective.

NURSING PRIORITY NO. **4.** To promote venous return:

POSTACUTE/CHRONIC PHASE

- Provide for adequate rest, positioning patient 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, dizziness, 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 of 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.
- Teach 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; Diversional Activity, deficient; Coping, ineffective and Coping, family: compromised; Sexual Dysfunction; Pain, acute/chronic; Nutrition, imbalanced; Fluid Volume, deficient/excess, 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

- Patient'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.
- 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]

Nursing Diagnosis Extension and Classification (NDEC) Revision 1998/Revised 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 codependency of care receiver

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

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 codependency

SOCIOECONOMIC

Competing role commitments
Alienation from family, friends, and coworkers; isolation from others
Insufficient recreation

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

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

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)
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—Caregiver 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.

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 patient 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.
- Determine current knowledge of the situation, noting misconceptions, lack of information. **May interfere with caregiver/care receiver's 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 codependency needs/enabling behaviors of caregiver.
- Determine availability/use of support systems and resources.
- Identify presence/degree of conflict between caregiver/care receiver/family.
- Determine preillness/current behaviors that may be interfering with the care/recovery of the care receiver.

NURSING PRIORITY NO. **3** To assist caregiver to identify feelings and begin 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.
- Identify available 12-step program when indicated **to provide tools to deal with enabling/codependent 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's/receiver's 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

Caregiver Role Strain, risk for

Taxonomy II: Role Relationships—Class 1 Caregiving Roles (00062)
[Diagnostic Division: Social Interaction]

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

Risk Factors

Illness severity of the care receiver; psychological or cognitive problems in care receiver; addiction or codependency
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)

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

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
Past 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—Caregiver 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.

Actions/Interventions

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

- Note presence of high risk situations (e.g., elderly patient 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 codependency 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, assist with problem solving.**
- Provide information and/or demonstrate techniques for dealing with acting out/violent or disoriented behavior.
- Assist caregiver to recognize codependent behaviors (i.e., doing things for others that others are able to do for themselves) and how these behaviors affect the situation.

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

Communication, impaired verbal

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

[Diagnostic Division: Social Interaction]

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 CNS; weakening of the musculoskeletal system
Psychological barriers (e.g., psychosis, lack of stimuli); emotional conditions [depression, panic, anger]; stress
Environmental barriers
Cultural difference

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

Lack of information
Side effects of medication
Alteration of self-esteem or self-concept
Altered perceptions
Absence of SOs

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)
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—Patient 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).

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

- 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).
- 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 patient to establish a means of communication to express needs, wants, ideas, and questions:

- Determine ability to read/write. Evaluate musculoskeletal states, 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 patient to learn to use and adjust to aids.
- Establish relationship with the patient, listening carefully and attending to patient's verbal/nonverbal expressions.
- Maintain eye contact, preferably at patient's level. Be aware of cultural factors that may preclude eye contact (e.g., Native-American).

- Keep communication simple, using all modes for accessing information: visual, auditory, and kinesthetic.
- Maintain a calm, unhurried manner. Provide sufficient time for patient 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 patient 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 patients relearn 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.
- 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-patient 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 patient/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: patient's name, address, telephone number, type of airway, and that emergency assistance is immediately required.
- Use and assist patient/SOs 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 Coping, ineffective; Coping, family: disabled (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 patient 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.

DISCHARGE PLANNING

- Discharge needs/referrals made, additional resources available.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Communication Ability
NIC—Communication Enhancement: Speech Deficit

Conflict, decisional [specify]

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

[Diagnostic Division: Ego Integrity]

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

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

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

[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; and so on)

Desired Outcomes/Evaluation Criteria—Patient Will:

- Verbalize awareness of positive and negative aspect 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, availability/involvement of support persons (e.g., lack of/conflicting advice). Ascertain dependency of other(s) on patient and/or issues of codependency.
- Active-listen/identify reason for indecisiveness **to help patient to clarify problem.**

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

- 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 patient to develop/effectively use problem-solving skills:

- Promote safe and hopeful environment, as needed, while patient regains inner control.
- Encourage verbalization of conflicts/concerns.
- Accept verbal expressions of anger/guilt, setting limits on maladaptive behavior **to promote patient 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 patient to view it as a learning opportunity **to develop new and creative solutions.**
- Correct misperceptions patient may have and provide factual information. **Provides for better decision making.**
- Provide opportunities for patient 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 patient 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 Family Processes, interrupted; Family Processes, dysfunctional: alcoholism; Coping, family: compromised.
- Practice use of problem-solving process with current situation/decision.
- Discuss/clarify spiritual concerns, accepting patient'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 patient 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 patient.**
- Support patient 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

- Patient'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

Confusion, acute

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

[Diagnostic Division: Neurosensory]

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—Patient Will:

- Regain/maintain usual reality orientation and level of consciousness.

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

- Verbalize understanding of causative factors when known as able.
- Initiate lifestyle/behavior changes to prevent or minimize recurrence of problem.

Actions/Interventions

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

- Identify factors present, including substance abuse, seizure history, recent ETC therapy, episodes of fever/pain, presence of acute infection (especially urinary tract infection in elderly patient), 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 signs of poor tissue perfusion** (i.e., hypotension, tachycardia, tachypnea).
- Determine current medications/drug use—especially antianxiety agents, barbiturates, lithium, methyldopa, 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, dioxin + 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 Sleep Pattern, disturbed as appropriate.

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

- Talk with SOs **to determine historical baseline, observed changes, and onset/recurrence of changes.**
- 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 patient oriented during daylight hours but confused during night.)**
- Determine threat to safety of patient/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).

- Monitor/adjust medication regimen and note response. Eliminate nonessential drugs as appropriate.
- Orient patient 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 patient to use vision/hearing aids when needed.
- Give simple directions. Allow sufficient time for patient 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 patient 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).

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

Confusion, chronic

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

[Diagnostic Division: Neurosensory]

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
Cerebral vascular accident
Head injury

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

Defining Characteristics

OBJECTIVE

Clinical evidence of organic impairment
Altered interpretation/response to stimuli
Progressive/long-standing cognitive impairment
No change in level of consciousness
Impaired socialization
Impaired memory (short-term, long-term)
Altered personality

Desired Outcome/Evaluation Criteria—Patient Will:

- Remain safe and free from harm.

Family/SO Will:

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

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 communications.
- 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 patient.
- 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 (clocks, calendars, personal items, seasonal decorations). Encourage participation in resocialization groups.
- Allow patient 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 patient'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 Caregiver Role Strain, risk for.

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 patient'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

Constipation

Taxonomy II: Elimination—Class 2 Gastrointestinal System (00011)
[Diagnostic Division: Elimination]
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

FUNCTIONALS

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

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

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

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—Patient 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).
- 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 patient has "lived with" or a postsurgical event that causes great distress) **as patient'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 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., patient 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 glycerine suppositories and digital stimulation as appropriate **when long-term or permanent bowel dysfunction is present.**

NURSING PRIORITY NO. 5. 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 patient 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 patient'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.
- Recommendations for follow-up care.
- Specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Bowel Elimination
NIC—Constipation/Impaction Management

Constipation, perceived

Taxonomy II: Elimination—Class 2 Gastrointestinal System (00012)
[Diagnostic Division: Elimination]

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 overuse of laxatives, enemas, and suppositories
Expected passage of stool at same time every day

Desired Outcomes/Evaluation Criteria—Patient Will:

- Verbalize understanding of physiology of bowel function.

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

- 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 patient's understanding of a "normal" bowel pattern.
- Compare with patient's current bowel functioning.
- Identify interventions used by patient 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 patient's concerns/fears.
- Encourage use of stress reduction activities/refocusing of attention while patient works to establish individually appropriate pattern.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings/patient'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

- Patient'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

Constipation, risk for

Taxonomy II: Elimination—Class 2 Gastrointestinal System (00015)
[Diagnostic Division: Elimination]
Nursing Diagnosis Extension and Classification (NDEC) Submission 1998

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

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

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

Desired Outcomes/Evaluation Criteria—Patient Will:

- Maintain usual pattern of bowel functioning.
- Verbalize understanding of risk factors and appropriate interventions/solutions related to individual situation.
- 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 patient'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 above).
- 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., patient 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. 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.
- Review appropriate use of medications.
- Encourage patient to maintain elimination diary if appropriate **to help monitor bowel pattern.**
- Refer to NDs Constipation; Constipation, perceived.

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

Coping, defensive

Taxonomy II: Coping/Stress Tolerance—Class 2 Coping Responses (00071)

[Diagnostic Division: Ego Integrity]

Definition: Repeated projection of falsely positive self-evaluation based on a self-protective pattern that defends against underlying perceived threats to positive self-regard.

Related Factors

To be developed by NANDA
[Refer to ND Coping, ineffective.]

Defining Characteristics

SUBJECTIVE

Denial of obvious problems/weaknesses
Projection of blame/responsibility
Hypersensitive to slight/criticism
Grandiosity
Rationalizes failures
[Refuses or rejects assistance]

OBJECTIVE

Superior attitude toward others
Difficulty establishing/maintaining relationships, [avoidance of intimacy]
Hostile laughter or ridicule of others, [aggressive behavior]
Difficulty in reality testing perceptions
Lack of follow-through or participation in treatment or therapy
[Attention-seeking behavior]

Desired Outcomes/Evaluation Criteria—Patient Will:

- Verbalize understanding of own problems/stressors.
- Identify areas of concern/problems.
- Demonstrate acceptance of responsibility for own actions, successes, and failures.
- Participate in treatment program/therapy.
- Maintain involvement in relationships.

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

Actions/Interventions

- Refer to ND Coping, ineffective for additional interventions.

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

- Assess ability to comprehend current situation, developmental level of functioning.
- Determine level of anxiety and effectiveness of current coping mechanisms.
- Determine coping mechanisms used (e.g., projection, avoidance, rationalization) and purpose of coping strategy (e.g., may mask low self-esteem) **to note how these behaviors affect current situation.**
- Assist patient to identify/consider need to address problem differently.
- Describe all aspects of the problem through the use of therapeutic communication skills such as Active-listening.
- Observe interactions with others **to note difficulties/ability to establish satisfactory relationships.**
- Note expressions of grandiosity in the face of contrary evidence (e.g., "I'm going to buy a new car" when the individual has no job or available finances).

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

- Provide explanation of the rules of the treatment setting and consequences of lack of cooperation.
- Set limits on manipulative behavior; be consistent in enforcing consequences when rules are broken and limits tested.
- Develop therapeutic relationship **to enable patient to test new behaviors in a safe environment.** Use positive, nonjudgmental approach and "I" language **to promote sense of self-esteem.**
- Encourage control in all situations possible, include patient in decisions, planning, **to preserve autonomy.**
- Acknowledge individual strengths and incorporate awareness of personal assets/strengths in plan.
- Convey attitude of acceptance and respect (unconditional positive regard) **to avoid threatening patient's self-concept, preserve existing self-esteem.**
- Encourage identification and expression of feelings.
- Provide healthy outlets for release of hostile feelings (e.g., punching bags, pounding boards). Involve in outdoor recreation program when available.
- Provide opportunities for patient to interact with others in a positive manner, **promoting self-esteem.**

- Assist patient with problem-solving process. Identify and discuss responses to situation, maladaptive coping skills. Suggest alternative responses to situation, **to help patient select more adaptive strategies for coping.**
- Use confrontation judiciously **to help patient begin to identify defense mechanisms (e.g., denial/projection) that are hindering development of satisfying relationships.**

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

- Encourage patient to learn relaxation techniques, use of guided imagery, and positive affirmation of self in order **to incorporate and practice new behaviors.**
- Promote involvement in activities/classes where patient can practice new skills and develop new relationships.
- Refer to additional resources (e.g., substance rehabilitation, family/marital therapy) as indicated.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings/presenting behaviors.
- Patient perception of the present situation and usual coping methods/degree of impairment.

PLANNING

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

IMPLEMENTATION/EVALUATION

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

DISCHARGE PLANNING

- Referrals and follow-up program.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Self-Esteem
NIC—Self-Awareness Enhancement

Coping, ineffective

Taxonomy II: Coping/Stress Tolerance—Class 2 Coping Responses (00069)

[Diagnostic Division: Ego Integrity]

Nursing Diagnosis Extension and Classification (NDEC) Revision 1998

Definition: Inability to form a valid appraisal of the stressors, inadequate choices of practiced responses, and/or inability to use available resources

Related Factors

Situational/maturational crises
High degree of threat
Inadequate opportunity to prepare for stressor; disturbance in pattern of appraisal of threat
Inadequate level of confidence in ability to cope/perception of control; uncertainty
Inadequate resources available; inadequate social support created by characteristics of relationships
Disturbance in pattern of tension release; inability to conserve adaptive energies
Gender differences in coping strategies
[Work overload, no vacations, too many deadlines; little or no exercise]
[Impairment of nervous system; cognitive/sensory/perceptual impairment, memory loss]
[Severe/chronic pain]

Defining Characteristics

SUBJECTIVE

Verbalization of inability to cope or inability to ask for help
Sleep disturbance; fatigue
Abuse of chemical agents
[Reports of muscular/emotional tension, lack of appetite]

OBJECTIVE

Lack of goal-directed behavior/resolution of problem, including inability to attend to and difficulty with organizing information; [lack of assertive behavior]

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

Use of forms of coping that impede adaptive behavior [including inappropriate use of defense mechanisms, verbal manipulation]
Inadequate problem solving
Inability to meet role expectations/basic needs
Decreased use of social supports
Poor concentration
Change in usual communication patterns
High illness rate [including high blood pressure, ulcers, irritable bowel, frequsent headaches/neckaches]
Risk taking
Destructive behavior toward self or others [including overeating, excessive smoking/drinking, overuse of prescribed/OTC medications, illicit drug use]
[Behavioral changes, e.g., impatience, frustration, irritability, discouragement]

Desired Outcomes/Evaluation Criteria—Patient Will:

- Assess the current situation accurately.
- Identify ineffective coping behaviors and consequences.
- Verbalize awareness of own coping abilities.
- Verbalize feelings congruent with behavior.
- Meet psychological needs as evidenced by appropriate expression of feelings, identification of options, and use of resources.

Actions/Interventions

NURSING PRIORITY NO. **1.** To determine degree of impairment:

- Evaluate ability to understand events, provide realistic appraisal of situation.
- Identify developmental level of functioning. (**People tend to regress to a lower developmental stage during illness/crisis.**)
- Assess current functional capacity and note how it is affecting the individual's coping ability.
- Determine alcohol intake, drug use, smoking habits, sleeping and eating patterns.
- Ascertain impact of illness on sexual needs/relationship.
- Assess level of anxiety and coping on an ongoing basis.
- Note speech and communication patterns.
- Observe and describe behavior in objective terms. Validate observations.

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

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

- Ascertain patient's understanding of current situation and its impact.
- Active-listen and identify patient's perceptions of what is happening.
- Evaluate patient's decision-making ability.
- Determine previous methods of dealing with life problems **to identify successful techniques that can be used in current situation.**

NURSING PRIORITY NO. 3. To assist patient to deal with current situation:

- Call patient by name. Ascertain how patient prefers to be addressed. **Using patient's name enhances sense of self and promotes individuality/self-esteem.**
- Encourage communication with staff/SOs.
- Use reality orientation (e.g., clocks, calendars, bulletin boards) and make frequent references to time, place as indicated. Place needed/familiar objects within sight **for visual cues.**
- Provide for continuity of care with same personnel taking care of the patient as often as possible.
- Explain disease process/procedures/events in a simple, concise manner. Devote time for listening; **may help patient to express emotions, grasp situation, and feel more in control.**
- Provide for a quiet environment/position equipment out of view as much as possible **when anxiety is increased by noisy surroundings.**
- Schedule activities so periods of rest alternate with nursing care. Increase activity slowly.
- Assist patient in use of diversion, recreation, relaxation techniques.
- Stress positive body responses to medical conditions, but do not negate the seriousness of the situation (e.g., stable blood pressure during gastric bleed or improved body posture in depressed patient).
- Encourage patient to try new coping behaviors and gradually master situation.
- Confront patient when behavior is inappropriate, pointing out difference between words and actions. **Provides external locus of control, enhancing safety.**
- Assist in dealing with change in concept of body image as appropriate. (Refer to ND Body Image, disturbed.)

NURSING PRIORITY NO. 4. To provide for meeting psychological needs:

- Treat the patient with courtesy and respect. Converse at patient's level, providing meaningful conversation while performing care. (**Enhances therapeutic relationship.**) Take advantage of teachable moments.

- Allow patient to react in own way without judgment by staff. Provide support and diversion as indicated.
- Encourage verbalization of fears and anxieties and expression of feelings of denial, depression, and anger. Let the patient know that these are normal reactions.
- Provide opportunity for expression of sexual concerns.
- Help patient to set limits on acting-out behaviors and learn ways to express emotions in an acceptable manner. (**Promotes internal locus of control.**)

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

- Give updated/additional information needed about events, cause (if known), and potential course of illness as soon as possible. **Knowledge helps reduce anxiety/fear, allows patient to deal with reality.**
- Provide and encourage an atmosphere of realistic hope.
- Give information about purposes and side effects of medications/treatments.
- Stress importance of follow-up care.
- Encourage and support patient in evaluating lifestyle, occupation, and leisure activities.
- Assess effects of stressors (e.g., family, social, work environment, or nursing/healthcare management) and ways to deal with them.
- Provide for gradual implementation and continuation of necessary behavior/lifestyle changes. **Enhances commitment to plan.**
- Discuss/review anticipated procedures and patient concerns, as well as postoperative expectations when surgery is recommended.
- Refer to outside resources and/or professional therapy as indicated/ordered.
- Determine need/desire for religious representative/spiritual counselor and make arrangements for visit.
- Provide information, privacy, or consultation as indicated for sexual concerns.
- Refer to other NDs as indicated (e.g., Pain; Anxiety; Communication, impaired verbal; Violence, [actual/] risk for other-directed and Violence, [actual/] risk for self-directed).

Documentation Focus

ASSESSMENT/REASSESSMENT

- Baseline findings, degree of impairment, and patient's perceptions of situation.
- Coping abilities and previous ways of dealing with life problems.

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

PLANNING

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

IMPLEMENTATION/EVALUATION

- Patient's responses to interventions/teaching and actions performed.
- Medication dose, time, and patient's response.
- Attainment/progress toward desired outcome(s).
- Modifications to plan of care.

DISCHARGE PLANNING

- Long-term needs and actions to be taken.
- Support systems available, specific referrals made, and who is responsible for actions to be taken.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Coping
NIC—Coping Enhancement

Coping, community, ineffective

Taxonomy II: Coping/Stress Tolerance—Class 2 Coping Responses (00077)

[Diagnostic Division: Social Interaction]

Nursing Diagnosis Extension and Classification (NDEC) Revision 1998

Definition: Pattern of community activities (for adaptation and problem solving) that is unsatisfactory for meeting the demands or needs of the community

Related Factors

Deficits in social support services and resources
Inadequate resources for problem solving
Ineffective or nonexistent community systems (e.g., lack of emergency medical system, transportation system, or disaster planning systems)
Natural or human-made disasters

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

Defining Characteristics

SUBJECTIVE

Community does not meet its own expectations
Expressed vulnerability; community powerlessness
Stressors perceived as excessive

OBJECTIVE

Deficits of community participation
Excessive community conflicts
High illness rates
Increased social problems (e.g., homicide, vandalism, arson, terrorism, robbery, infanticide, abuse, divorce, unemployment, poverty, militance, mental illness)

Desired Outcomes/Evaluation Criteria—Community Will:

- Recognize negative and positive factors affecting community's ability to meet its own demands or needs.
- Identify alternatives to inappropriate activities for adaptation/problem solving.
- Report a measurable increase in necessary/desired activities to improve community functioning.

Actions/Interventions

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

- Evaluate community activities **as related to meeting collective needs within the community itself and between the community and the larger society.**
- Note community reports of community functioning including areas of weakness or conflict.
- Identify effects of Related Factors on community activities.
- Determine availability and use of resources.
- Identify unmet demands or needs of the community.

NURSING PRIORITY NO. 2. To assist the community to reactivate/develop skills to deal with needs:

- Determine community strengths.
- Identify and prioritize community goals.
- Encourage community members/groups to engage in problem-solving activities.
- Develop a plan jointly with community **to deal with deficits in support to meet identified goals.**

NURSING PRIORITY NO. 3. To promote wellness as related to community health:

- Create plans managing interactions within the community itself and between the community and the larger society **to meet collective needs.**
- Assist the community to form partnerships within the community and between the community and the larger society. **Promotes long-term development of the community to deal with current and future problems.**
- Provide channels for dissemination of information to the community as a whole, for example, print media; radio/television reports and community bulletin boards; speakers' bureau; reports to committees, councils, advisory boards on file and accessible to the public.
- Make information available in different modalities and geared to differing educational levels/cultures of the community.
- Seek out and evaluate underserved populations.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings, including perception of community members regarding problems.

PLANNING

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

IMPLEMENTATION/EVALUATION

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

DISCHARGE PLANNING

- Long-range plans and who is responsible for actions to be taken.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Community Health Status
NIC—Community Health Development

Coping, community, readiness for enhanced

Taxonomy II: Coping/Stress Tolerance—Class 2 Coping Responses (00076)

[Diagnostic Division: Social Interaction]

Definition: Pattern of community activities for adaptation and problem solving that is satisfactory for meeting the demands or needs of the community but can be improved for management of current and future problems/stressors

Related Factors

Social supports available
Resources available for problem solving
Community has a sense of power to manage stressors

Defining Characteristics

SUBJECTIVE

Agreement that community is responsible for stress management

OBJECTIVE

Deficits in one or more characteristics that indicate effective coping
Active planning by community for predicted stressors
Active problem solving by community when faced with issues
Positive communication among community members
Positive communication between community/aggregates and larger community
Programs available for recreation and relaxation
Resources sufficient for managing stressors

Desired Outcomes/Evaluation Criteria—Community Will:

- Identify positive and negative factors affecting management of current and future problems/stressors.
- Have an established plan in place to deal with problems/stressors.

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

- Describe management of deficits in characteristics that indicate effective coping.
- Report a measurable increase in ability to deal with problems/stressors.

Actions/Interventions

NURSING PRIORITY NO. 1. To determine existence of and deficits or weaknesses in management of current and future problems/stressors:

- Review community plan for dealing with problems/stressors.
- Assess effects of Related Factors on management of problems/stressors.
- Determine community's strengths and weaknesses.
- Identify limitations in current pattern of community activities that can be improved through adaptation and problem solving.
- Evaluate community activities as related to management of problems/stressors within the community itself and between the community and the larger society.

NURSING PRIORITY NO. 2. To assist the community in adaptation and problem solving for management of current and future needs/stressors:

- Define and discuss current needs and anticipated or projected concerns. **Agreement on scope/parameters of needs is essential for effective planning.**
- Prioritize goals **to facilitate accomplishment.**
- Identify available resources (e.g., persons, groups, financial, governmental, as well as other communities).
- Make a joint plan with the community to deal with adaptation and problem solving **for management of problems/stressors.**
- Seek out and involve underserved/at-risk groups within the community. **Supports communication and commitment of community as a whole.**

NURSING PRIORITY NO. 3. To promote well-being of community:

- Assist the community to form partnerships within the community and between the community and the larger society **to promote long-term developmental growth of the community.**
- Support development of plans for maintaining these interactions.
- Establish mechanism for self-monitoring of community needs and evaluation of efforts. **Facilitates proactive rather than reactive responses by the community.**

- Use multiple formats, for example, TV, radio, print media, billboards and computer bulletin boards, speakers' bureau, reports to community leaders/groups on file and accessible to the public, **to keep community informed regarding plans, needs, outcomes.**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings and community's perception of situation.
- Identified areas of concern, community strengths/weaknesses.

PLANNING

- Plan of care and who is involved and responsible for each action.
- Teaching plan.

IMPLEMENTATION/EVALUATION

- Response of community entities to the actions performed.
- Attainment/progress toward desired outcomes.
- Modifications to plan of care.

DISCHARGE PLANNING

- Short-range and long-range plans to deal with current, anticipated, and potential problems and who is responsible for follow-through.
- Specific referrals made, coalitions formed.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Community Competence
NIC—Program Development

Coping, family: compromised

Taxonomy II: Coping/Stress Tolerance—Class 2 Coping Responses (00074)

[Diagnostic Division: Social Interaction]

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

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

Related Factors

Inadequate or incorrect information or understanding by a primary person
Temporary preoccupation by a significant person who is trying to manage emotional conflicts and personal suffering and is unable to perceive or act effectively in regard to client's needs
Temporary family disorganization and role changes
Other situational or developmental crises or situations the significant person may be facing
Little support provided by client, in turn, for primary person
Prolonged disease or disability progression that exhausts the supportive capacity of SO(s)
[Unrealistic expectations of client/SOs or each other]
[Lack of mutual decision-making skills]
[Diverse coalitions of family members]

Defining Characteristics

SUBJECTIVE

Client expresses or confirms a concern or complaint about SO's response to his or her health problem
SO describes preoccupation with personal reaction (e.g., fear, anticipatory grief, guilt, anxiety) to client's illness/disability, or other situational or developmental crises
SO describes or confirms an inadequate understanding or knowledge base that interferes with effective assistive or supportive behaviors

OBJECTIVE

SO attempts assistive or supportive behaviors with less than satisfactory results
SO withdraws or enters into limited or temporary personal communication with the client at the time of need
SO displays protective behavior disproportionate (too little or too much) to the client's abilities or need for autonomy
[SO displays sudden outbursts of emotions/shows emotional lability or interferes with necessary nursing/medical interventions]

Desired Outcomes/Evaluation Criteria-Family Will

- Identify/verbalize resources within themselves to deal with the situation.

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

- Interact appropriately with the patient, providing support and assistance as indicated.
- Provide opportunity for patient to deal with situation in own way.
- Verbalize knowledge and understanding of illness/disability/disease.
- Express feelings honestly.
- Identify need for outside support and seek such.

Actions/Interventions

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

- Identify underlying situation(s) that may contribute to the inability of family to provide needed assistance to the patient. **Circumstances may have preceded the illness and now have a significant effect (e.g., patient had a heart attack during sexual activity, mate is afraid of repeating).**
- Note the length of illness such as cancer, multiple sclerosis, and/or other long-term situations that may exist.
- Assess information available to and understood by the family/SO(s).
- Discuss family perceptions of situation. **Expectations of patient and family members may/may not be realistic.**
- Identify role of the patient in family and how illness has changed the family organization.
- Note other factors besides the patient's illness that are affecting abilities of family members **to provide needed support.**

NURSING PRIORITY NO. **2** To assist family to reactivate/develop skills to deal with current situation:

- Listen to patient's/SO's comments, remarks, and expression of concern(s). Note nonverbal behaviors and/or responses and congruency.
- Encourage family members to verbalize feelings openly/clearly.
- Help family **to understand and accept/deal with patient behaviors** by discussing underlying reasons.
- Assist the family and patient to understand "who owns the problem" and who is responsible for resolution. Avoid placing blame or guilt.
- Encourage patient and family to develop problem-solving skills **to deal with the situation.**

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

- Provide information for family/SO(s) about specific illness/condition.
- Involve patient and family in planning care as often as possible. **Enhances commitment to plan.**
- Promote assistance of family in providing patient care as appropriate. **Identifies ways of demonstrating support while maintaining patient's independence (e.g., providing favorite foods, engaging in diversional activities).**
- Refer to appropriate resources for assistance as indicated (e.g., counseling, psychotherapy, financial, spiritual).
- Refer to NDs Fear; Anxiety/Anxiety, death; Coping, ineffective; Coping, family: readiness for enhanced; Coping, family: disabled; Grieving, anticipatory as appropriate.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings, including current/past coping behaviors, emotional response to situation/stressors, support systems available.

PLANNING

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

IMPLEMENTATION/EVALUATION

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

DISCHARGE PLANNING

- Long-range plan and who is responsible for actions.
- Specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATION (NOC/NIC)

NOC—Family Coping
NIC—Family Involvement Promotion

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

Coping, family: disabled

Taxonomy II: Coping/Stress Tolerance—Class 2 Coping Responses (00073)

[Diagnostic Division: Social Interaction]

Definition: Behavior of SO (family member or other primary person) that disables his/her capacities and the client's capacity to effectively address tasks essential to either person's adaptation to the health challenge

Related Factors

Significant person with chronically unexpressed feelings of guilt, anxiety, hostility, despair, and so forth
Dissonant discrepancy of coping styles for dealing with adaptive tasks by the significant person and client or among significant people
Highly ambivalent family relationships
Arbitrary handling of a family's resistance to treatment that tends to solidify defensiveness as it fails to deal adequately with underlying anxiety
[High-risk family situations, such as single or adolescent parent, abusive relationship, substance abuse, acute/chronic disabilities, member with terminal illness]

Defining Characteristics

SUBJECTIVE

[Expresses despair regarding family reactions/lack of involvement]

OBJECTIVE

Intolerance, rejection, abandonment, desertion
Psychosomaticism
Agitation, depression, aggression, hostility
Taking on illness signs of client
Neglectful relationships with other family members
Carrying on usual routines disregarding client's needs
Neglectful care of the client in regard to basic human needs and/or illness treatment
Distortion of reality regarding the client's health problem, including extreme denial about its existence or severity
Decisions and actions by family that are detrimental to economic or social well-being

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

Impaired restructuring of a meaningful life for self, impaired individualization, prolonged overconcern for client
Client's development of helpless, inactive dependence

Desired Outcomes/Evaluation Criteria—Family Will:

- Verbalize more realistic understanding and expectations of the patient.
- Visit/contact patient regularly.
- Participate positively in care of patient, within limits of family's abilities and patient's needs.
- Express feelings and expectations openly and honestly as appropriate.

Actions/Interventions

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

- Ascertain preillness behaviors/interactions of the family. **Provides comparative baseline.**
- Identify current behaviors of the family members (e.g., withdrawal—not visiting, brief visits, and/or ignoring patient when visiting; anger and hostility toward patient and others; ways of touching between family members, expressions of guilt).
- Discuss family perceptions of situation. **Expectations of patient and family members may/may not be realistic.**
- Note other factors that may be stressful for the family (e.g., financial difficulties or lack of community support, as when illness occurs when out of town). **Provides opportunity for appropriate referrals.**
- Determine readiness of family members to be involved with care of the patient.

NURSING PRIORITY NO. 2. To provide assistance to enable family to deal with the current situation:

- Establish rapport with family members who are available. **Promotes therapeutic relationship and support for problem-solving solutions.**
- Acknowledge difficulty of the situation for the family. **Reduces blaming/guilt feelings.**
- Active-listen concerns, note both overconcern/lack of concern, which may interfere with ability to resolve situation.
- Allow free expression of feelings, including frustration, anger, hostility, and hopelessness. Place limits on acting-out/inappropriate behaviors **to minimize risk of violent behavior.**
- Give accurate information to SO(s) from the beginning.
- Be liaison between family and healthcare providers, **to provide explanations and clarification of treatment plan.**

- Provide brief, simple explanations about use and alarms when equipment (such as a ventilator) is involved. Identify appropriate professional(s) **for continued support/problem solving.**
- Provide time for private interaction between patient/family.
- Include SO(s) in the plan of care; provide instruction **to assist them to learn necessary skills to help patient**.
- Accompany family when they visit **to be available for questions, concerns, and support**.
- Assist SO(s) to initiate therapeutic communication with patient.
- Refer patient to protective services as necessitated by risk of physical harm. **Removing patient from home enhances individual safety and may reduce stress on family to allow opportunity for therapeutic intervention.**

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

- Assist family to identify coping skills being used and how these skills are/are not helping them deal with situation.
- Answer family's questions patiently and honestly. Reinforce information provided by other providers.
- Reframe negative expressions into positive whenever possible. (**A positive frame contributes to supportive interactions and can lead to better outcomes.**)
- Respect family needs for withdrawal and intervene judiciously. **Situation may be overwhelming and time away can be beneficial to continued participation.**
- Encourage family to deal with the situation in small increments rather than the whole picture.
- Assist the family to identify familiar things that would be helpful to the patient (e.g., a family picture on the wall) **to reinforce/maintain orientation.**
- Refer family to appropriate resources as needed (e.g., family therapy, financial counseling, spiritual advisor).
- Refer to ND Grieving, anticipatory as appropriate.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings, current/past behaviors including family members who are directly involved and support systems available.
- Emotional response(s) to situation/stressors.

PLANNING

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

IMPLEMENTATION/EVALUATION

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

DISCHARGE PLANNING

- Ongoing needs/resources/other follow-up recommendations and who is responsible for actions.
- Specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Family Normalization
NIC—Family Therapy

Coping, family: readiness for enhanced

Taxonomy II: Coping/Stress Tolerance—Class 2 Coping Responses (00075)

[Diagnostic Division: Social Interaction]

Definition: Effective managing of adaptive tasks by family member involved with the client's health challenge, who now exhibits desire and readiness for enhanced health and growth in regard to self and in relation to the client

Related Factors

Needs sufficiently gratified and adaptive tasks effectively addressed to enable goals of self-actualization to surface [Developmental stage, situational crises/supports]

Defining Characteristics

SUBJECTIVE

Family member attempting to describe growth impact of crisis on his or her own values, priorities, goals, or relationships

Individual expressing interest in making contact on a one-to-one basis or on a mutual-aid group basis with another person who has experienced a similar situation

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

OBJECTIVE

Family member moving in direction of health-promoting and enriching lifestyle that supports and monitors maturational processes, audits and negotiates treatment programs, and generally chooses experiences that optimize wellness

Desired Outcomes/Evaluation Criteria—Family Will:

- Express willingness to look at own role in the family's growth.
- Verbalize desire to undertake tasks leading to change.
- Report feelings of self-confidence and satisfaction with progress being made.

Actions/Interventions

NURSING PRIORITY NO. **1.** To assess situation and adaptive skills being used by the family members:

- Determine individual situation and stage of growth family is experiencing/demonstrating.
- Observe communication patterns of family. Listen to family's expressions of hope, planning, effect on relationships/life.
- Note expressions such as "Life has more meaning for me since this has occurred" **to identify changes in values.**

NURSING PRIORITY NO. **2.** To assist family to develop/strengthen potential for growth:

- Provide time to talk with family **to discuss their view of the situation.**
- Establish a relationship with family/patient **to foster growth.**
- Provide a role model with which the family may identify.
- Discuss importance of open communication and of not having secrets.
- Demonstrate techniques such as Active-listening, I-messages, and problem solving **to facilitate effective communication.**

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

- Assist family to support the patient in meeting own needs within ability and/or constraints of the illness/situation.
- Provide experiences for the family **to help them learn ways of assisting/supporting patient.**
- Identify other patients/groups with similar conditions and assist patient/family to make contact (groups such as Reach for Recovery, CanSurmount, Al-Anon, and so on). **Provides ongoing support for sharing common experiences, problem solving, and learning new behaviors.**

- Assist family members to learn new, effective ways of dealing with feelings/reactions.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Adaptive skills being used, stage of growth.
- Family communication patterns.

PLANNING

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

IMPLEMENTATION/EVALUATION

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

DISCHARGE PLANNING

- Identified needs/referrals for follow-up care, support systems.
- Specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Family Participation in Professional Care
NIC—Normalization Promotion

Denial, ineffective

Taxonomy II: Coping/Stress Tolerance—Class 2 Coping Responses (00072)
[Diagnostic Division: Ego Integrity]

Definition: Conscious or unconscious attempt to disavow the knowledge or meaning of an event to reduce anxiety/fear, but leading to the detriment of health

Related Factors

To be developed by NANDA
[Personal vulnerability; unmet self-needs]

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

[Presence of overwhelming anxiety-producing feelings/situation; reality factors that are consciously intolerable]
[Fear of consequences, negative past experiences]
[Learned response patterns, e.g., avoidance]
[Cultural factors, personal/family value systems]

Defining Characteristics

SUBJECTIVE

Minimizes symptoms; displaces source of symptoms to other organs
Unable to admit impact of disease on life pattern
Displaces fear of impact of the condition
Does not admit fear of death or invalidism

OBJECTIVE

Delays seeking or refuses healthcare attention to the detriment of health
Does not perceive personal relevance of symptoms or danger
Makes dismissive gestures or comments when speaking of distressing events
Displays inappropriate affect
Uses home remedies (self-treatment) to relieve symptoms

Desired Outcomes/Evaluation Criteria—Patient Will

- Acknowledge reality of situation/illness.
- Express realistic concern/feelings about symptoms/illness.
- Seek appropriate assistance for presenting problem.
- Display appropriate affect.

Actions/Interventions

NURSING PRIORITY NO. **1.** To assess causative/contributing factors:
- Identify situational crisis/problem and patient's perception of the situation.
- Determine stage and degree of denial.
- Compare patient's description of symptoms/conditions to reality of clinical picture.
- Note patient's comments about impact of illness/problem on lifestyle.

NURSING PRIORITY NO. **2.** To assist patient to deal appropriately with situation:
- Develop trusting nurse-patient relationship. Use therapeutic communication skills of Active-listening and I-messages.

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

- Provide safe, nonthreatening environment.
- Encourage expressions of feelings, accepting patient's view of the situation without confrontation. Set limits on maladaptive behavior **to promote safety.**
- Present accurate information as appropriate, without insisting that the patient accept what has been presented. **Avoids confrontation, which may further entrench patient in denial.**
- Discuss patient's behaviors in relation to illness (e.g., diabetes, alcoholism) and point out the results of these behaviors.
- Encourage patient to talk with SO(s)/friends. **May clarify concerns and reduce isolation and withdrawal.**
- Involve in group sessions **so patient can hear other views of reality and test own perceptions.**
- Avoid agreeing with inaccurate statements/perceptions **to prevent perpetuating false reality.**
- Provide positive feedback for constructive moves toward independence **to promote repetition of behavior.**

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

- Provide written information about illness/situation **for patient and family to refer to as they consider options.**
- Involve family members/SO(s) in long-range planning for meeting individual needs.
- Refer to appropriate community resources (e.g., Diabetes Association, Multiple Sclerosis Society, Alcoholics Anonymous) **to help patient with long-term adjustment.**
- Refer to ND Coping, ineffective.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings, degree of personal vulnerability/denial.
- Impact of illness/problem on lifestyle.

PLANNING

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

IMPLEMENTATION/EVALUATION

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

DISCHARGE PLANNING

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Acceptance: Health Status
NIC—Anxiety Reduction

Dentition, impaired

Taxonomy II: Safety/Protection—Class 2 Physical Injury (00048)

[Diagnostic Division: Food/Fluid]

Nursing Diagnosis Extension and Classification (NDEC) Submission 1998

Definition: Disruption in tooth development/eruption patterns or structural integrity of individual teeth

Related Factors

Dietary habits; nutritional deficits
Selected prescription medications; chronic use of tobacco, coffee or tea, red wine
Ineffective oral hygiene, sensitivity to heat or cold; chronic vomiting
Lack of knowledge regarding dental health; excessive use of abrasive cleaning agents/intake of fluorides
Barriers to self-care; access or economic barriers to professional care
Genetic predisposition; premature loss of primary teeth; bruxism
[Traumatic injury/surgical intervention]

Defining Characteristics

SUBJECTIVE

Toothache

OBJECTIVE

Halitosis
Tooth enamel discoloration; erosion of enamel; excessive plaque
Worn down or abraded teeth; crown or root caries; tooth fracture(s); loose teeth; missing teeth or complete absence
Premature loss of primary teeth; incomplete eruption for age (may be primary or permanent teeth)
Excessive calculus
Malocclusion or tooth misalignment; asymmetrical facial expression

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

Desired Outcomes/Evaluation Criteria—Patient Will:

- Display healthy gums, mucous membranes and teeth in good repair.
- Report adequate nutritional/fluid intake.
- Verbalize and demonstrate effective dental hygiene skills.
- Follow through on referrals for appropriate dental care.

Action/Interventions

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

- Note presence/absence of teeth and/or dentures and ascertain its significance in terms of nutritional needs and aesthetics.
- Evaluate current status of dental hygiene and oral health.
- Document presence of factors affecting dentition (e.g., chronic use of tobacco, coffee, tea; bulimia/chronic vomiting; abscesses, tumors, braces, bruxism/chronic grinding of teeth) **to evaluate for possible interventions and/or treatment needs.**
- Note current factors impacting dental health (e.g., presence of ET intubation, facial fractures, chemotherapy) **that require special mouth care activities.**

NURSING PRIORITY NO. 2. To treat/manage dental care needs:

- Administer saline rinses, diluted alcohol-free mouthwashes.
- Provide gentle gum massage with soft toothbrush.
- Assist with/encourage brushing and flossing **when patient is unable to do self-care.**
- Provide appropriate diet for optimal nutrition, considering patient's ability to chew (e.g., liquids or soft foods).
- Increase fluids as needed **to enhance hydration and general well-being of oral mucous membranes.**
- Reposition ET tubes and airway adjuncts routinely, carefully padding/protecting teeth/prosthetics. Suction with care when indicated.
- Avoid thermal stimuli when teeth are sensitive. Recommend use of specific toothpaste designed **to reduce sensitivity of teeth.**
- Document (photo) facial injuries before treatment **to provide "pictorial baseline" for future comparison/evaluation.**
- Maintain good jaw/facial alignment when fractures are present.
- Administer antibiotics as needed **to treat oral/gum infections.**
- Recommend use of analgesics and topical analgesics as needed **when dental pain is present.**
- Administer antibiotic therapy prior to dental procedures in susceptible individuals (e.g., prosthetic heart valve patients)

and/or ascertain that bleeding disorders or coagulation deficits are not present **to prevent excess bleeding.**
- Refer to appropriate care providers (e.g., dental hygienists, dentists, oral surgeon, etc.)

NURSING PRIORITY NO. 3. To promote wellness (Teaching/Discharge Considerations):
- Instruct patient/caregiver in home-care interventions **to treat condition and/or prevent further complications.**
- Review resources that are needed for the patient to perform adequate dental hygiene care (e.g., toothbrush/paste, clean water, referral to dental care providers, access to financial assistance, personal care assistant).
- Encourage cessation of tobacco, especially smokeless, enrolling in smoking cessation classes.
- Discuss advisability of dental checkup and/or care prior to instituting chemotherapy or radiation **to minimize oral/dental/tissue damage.**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including individual factors influencing dentition problems.
- Baseline photos/description of oral cavity/structures.

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 outcome(s).
- 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—Knowledge: Health
NIC—Oral Health Maintenance

Development, risk for delayed

Taxonomy II: Growth/Development—Class 2 Development (00112)

[Diagnostic Division: Teaching/Learning]

Nursing Diagnosis Extension and Classification (NDEC) Submission 1998

Definition: At risk for delay of 25% or more in one or more of the areas of social or self-regulatory behavior, or cognitive, language, gross or fine motor skills

Risk Factors

PRENATAL

Maternal age <15 or >35 years
Unplanned or unwanted pregnancy; lack of, late, or poor prenatal care
Inadequate nutrition; poverty; illiteracy
Genetic or endocrine disorders; infections; substance abuse

INDIVIDUAL

Prematurity; congenital or genetic disorders
Vision/hearing impairment or frequent otitis media
Failure to thrive, inadequate nutrition; chronic illness
Brain damage (e.g., hemorrhage in postnatal period, shaken baby, abuse, accident); seizures
Positive drug screening test; substance abuse
Lead poisoning; chemotherapy; radiation therapy
Foster or adopted child
Behavior disorders
Technology dependent
Natural disaster

ENVIRONMENTAL

Poverty
Violence

CAREGIVER

Mental retardation or severe learning disability
Abuse
Mental illness

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

Desired Outcomes/Evaluation Criteria—Patient Will:

- Perform motor, social, self-regulatory behavior, cognitive and language skills appropriate for age within scope of present capabilities.

Caregiver Will

- Verbalize understanding of age-appropriate development/expectations
- Identify individual risk factors for developmental delay/deviation and plan(s) for prevention.

Actions/Interventions

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

- Identify condition(s) that could contribute to developmental deviations, for example, prematurity, extremes of maternal age, substance abuse, brain injury/damage, chronic severe illness, mental illness, poverty, shaken baby syndrome abuse, violence, failure to thrive, inadequate nutrition, (and/or others) as listed in Risk Factors.
- Ascertain nature of caregiver required activities and abilities to perform needed activities.
- Note severity/pervasiveness of situation (e.g., potential for long-term stress leading to abuse/neglect, versus situational disruption during period of crisis or transition).
- Evaluate environment in which long-term care will be provided.

NURSING PRIORITY NO. 2. To assist in preventing and/or limiting developmental delays:

- Avoid blame when discussing contributing factors. **Blame engenders negative feelings and does nothing to contribute to solution of the situation.**
- Note chronological age **to help determine developmental expectations.**
- Review expected skills/activities, using authoritative text (e.g., Gesell, Musen/Congor) or assessment tools (e.g., Draw-a-Person, Denver Developmental Screening Test, Bender's Visual Motor Gestalt test). **Provides guide for comparative measurement as child/individual progresses.**
- Consult professional resources (e.g., occupational/rehabilitation/speech therapists, special education teacher, job counselor) **to formulate plan and address specific individual needs.**
- Encourage setting of short-term realistic goals for achieving developmental potential. **Small incremental steps are often easier to deal with.**

- Identify equipment needs (e.g., adaptive/growth-stimulating computer programs, communication devices).

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

- Provide information regarding normal development, as appropriate, including pertinent reference materials.
- Encourage attendance at appropriate educational programs (e.g., parenting classes, infant stimulation sessions, seminars on life stresses, aging process).
- Identify available community resources as appropriate (e.g., early intervention programs, seniors' activity/support groups, gifted and talented programs, sheltered workshop, crippled children's services, medical equipment/supplier). **Provides additional assistance to support family efforts in treatment program.**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings/individual needs including developmental level.
- Caregiver's understanding of situation and individual role.

PLANNING

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

IMPLEMENTATION/EVALUATION

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

DISCHARGE PLANNING

- Identified long-range needs and who is responsible for actions to be taken.
- Specific referrals made, sources for assistive devices, educational tools.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Child Development: [specify age]
NIC—Developmental Enhancement: Child

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

Diarrhea

Taxonomy II: Elimination—Class 2 Gastrointestinal System (0013)

[Diagnostic Division: Elimination]

Nursing Diagnosis Extension and Classification (NDEC) Revision 1998

Definition: Passage of loose, unformed stools

Related Factors

PSYCHOLOGICAL

High stress levels and anxiety

SITUATIONAL

Laxative/alcohol abuse; toxins; contaminants
Adverse effects of medications; radiation
Tube feedings
Travel

PHYSIOLOGICAL

Inflammation; irritation
Infectious processes; parasites
Malabsorption

Defining Characteristics

SUBJECTIVE

Abdominal pain
Urgency, cramping

OBJECTIVE

Hyperactive bowel sounds
At least three loose liquid stools per day

Desired Outcomes/Evaluation Criteria—Patient Will:

- Reestablish and maintain normal pattern of bowel functioning.
- Verbalize understanding of causative factors and rationale for treatment regimen.
- Demonstrate appropriate behavior to assist with resolution of causative factors (e.g., proper food preparation or avoidance of irritating foods).

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

Actions/Interventions

NURSING PRIORITY NO. **1.** To assess causative factors/etiology:

- Ascertain onset and pattern of diarrhea, noting whether acute or chronic.
- Observe and record frequency, characteristics, amount, time of day, and precipitating factors related to occurrence of diarrhea.
- Note reports of pain associated with episodes.
- Auscultate abdomen **for presence, location, and characteristics of bowel sounds.**
- Observe for presence of associated factors, such as fever/chills, abdominal pain/cramping, emotional upset, physical exertion, and so forth.
- Evaluate diet history and note nutritional/fluid and electrolyte status.
- Review medications, noting side effects, possible interactions; note new prescriptions—particularly antibiotics **which often cause changes in bowel habits, especially in children.**
- Determine recent exposure to different/foreign environments, change in drinking water/food intake, similar illness of others **that may help identify causative environmental factors.**
- Note history of recent gastrointestinal surgery; concurrent/chronic illnesses/treatment; food/drug allergies, lactose intolerance.
- Review results of laboratory testing on stool specimens (for fat, blood, infections, and so on).
- Assess for fecal impaction **that may be accompanied by diarrhea.**

NURSING PRIORITY NO. **2.** To eliminate causative factors:

- Restrict solid food intake as indicated **to allow for bowel rest/reduced intestinal workload.**
- Provide for changes in dietary intake **to avoid foods/substances that precipitate diarrhea.**
- Limit caffeine and high-fiber foods; avoid milk and fruits as appropriate.
- Adjust strength/rate of enteral tube feedings; change formula as indicated **when diarrhea is associated with tube feedings.**
- Recommend change in drug therapy as appropriate (e.g., choice of antacid).
- Promote the use of relaxation techniques (e.g., progressive relaxation exercise, visualization techniques) **to decrease stress/anxiety.**

NURSING PRIORITY NO. **3.** To maintain hydration/electrolyte balance:

- Assess baseline hydration, note presence of postural hypotension, tachycardia, skin hydration/turgor, and condition of mucous membranes.

- Weigh infant's diapers **to determine amount of output and fluid replacement needs.**
- Review laboratory work for abnormalities.
- Administer antidiarrheal medications as indicated **to decrease gastrointestinal motility and minimize fluid losses.**
- Encourage oral intake of fluids containing electrolytes, such as juices, bouillon, or commercial preparations as appropriate.
- Administer enteral and IV fluids as indicated.

NURSING PRIORITY NO. **4.** To maintain skin integrity:

- Assist as needed with pericare after each bowel movement.
- Provide prompt diaper change and gentle cleansing because skin breakdown can occur quickly when diarrhea occurs.
- Apply lotion/ointment skin barrier as needed.
- Provide dry linen as necessary.
- Expose perineum/buttocks to air/use heat lamp if needed to keep area dry.
- Refer to ND Skin Integrity, impaired.

NURSING PRIORITY NO. **5.** To promote return to normal bowel functioning:

- Increase oral fluid intake and return to normal diet as tolerated.
- Encourage intake of nonirritating liquids.
- Discuss possible change in infant formula. **Diarrhea may be result of/aggravated by intolerance to specific formula.**
- Recommend products such as natural fiber, plain natural yogurt, Lactinex **to restore normal bowel flora.**
- Give medications as ordered **to treat infectious process, decrease motility, and/or absorb water.**

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

- Review causative factors and appropriate interventions **to prevent recurrence.**
- Evaluate and identify individual stress factors and coping behaviors.
- Review food preparation, emphasizing adequate cooking time and proper refrigeration/storage **to prevent bacterial growth/contamination.**
- Discuss possibility of dehydration and the importance of fluid replacement.
- Respond to call for assistance promptly.
- Place bedpan in bed with patient (if desired) or commode chair near bed **to provide quick access/reduce need to wait for assistance of others.**
- Provide privacy and psychological support as necessary.
- Discuss use of incontinence pads **to protect bedding/furniture,** depending on the severity of the problem.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings, including characteristics/pattern of elimination.

PLANNING

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

IMPLEMENTATION/EVALUATION

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

DISCHARGE PLANNING

- Recommendations for follow-up care.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Bowel Elimination
NIC—Diarrhea Management

Disuse Syndrome, risk for

Taxonomy II: Activity/Rest—Class 2 Activity/Exercise (00040)
[Diagnostic Division: Activity/Rest]

Definition: At risk for deterioration of body systems as the result of prescribed or unavoidable musculoskeletal inactivity

NOTE: NANDA-identified complications from immobility can include pressure ulcer, constipation, stasis of pulmonary secretions, thrombosis, urinary tract infection/retention, decreased strength/endurance, orthostatic hypotension, decreased range of joint motion, disorientation, body image disturbance, and powerlessness.

Risk Factors

Severe pain, [chronic pain]
Paralysis, [other neuromuscular impairment]

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

Mechanical or prescribed immobilization
Altered level of consciousness
[Chronic physical or mental illness]

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—Patient Will:

- Display intact skin/tissues or achieve timely wound healing.
- Maintain/reestablish effective elimination patterns.
- Be free of signs/symptoms of infectious processes.
- Demonstrate adequate peripheral perfusion with stable vital signs, skin warm and dry, palpable peripheral pulses.
- Maintain usual reality orientation.
- Maintain/regain optimal level of cognitive, neurosensory, and musculoskeletal functioning.
- Express sense of control over the present situation and potential outcome.
- Recognize and incorporate change into self-concept in accurate manner without negative self-esteem.

Actions/Interventions

NURSING PRIORITY NO. **1.** To evaluate probability of developing complications:

- Identify specific and potential concerns including patient's age, use of wheelchair, restraints. (**Ageist perspective of care provider may result in reluctance to engage in early mobilization of older patient.**)
- Ascertain availability and use of support systems.
- Determine if patient's condition is acute/short-term or whether it may be a long-term/permanent condition.
- Evaluate patient's/family's understanding and ability to manage care for long period.

NURSING PRIORITY NO. **2.** To identify individually appropriate preventive/corrective interventions:

SKIN

- Monitor skin over bony prominences.
- Reposition frequently as individually indicated **to relieve pressure.**
- Provide skin care daily and prn, drying well and using gentle massage and lotion **to stimulate circulation.**

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

- Initiate use of pressure-reducing devices (e.g., egg-crate/gel/water/air mattress or cushions).
- Review nutritional status and monitor nutritional intake.
- Provide/reinforce teaching regarding dietary needs, position changes, cleanliness.
- Refer to ND Skin or Tissue Integrity.

ELIMINATION

- Encourage balanced diet, including fruits and vegetables high in fiber and with adequate fluids **for optimal stool consistency and to facilitate passage through colon.** Include 8 oz/day of cranberry juice cocktail **to reduce risk of urinary infections.**
- Maximize mobility at earliest opportunity, using assistive devices as individually appropriate.
- Evaluate need for stool softeners, bulk-forming laxatives.
- Implement consistent bowel management/bladder training programs as indicated.
- Monitor urinary output/characteristics. Observe for signs of infection.
- Refer to NDs Constipation; Diarrhea; Bowel Incontinence; Urinary Elimination, impaired; Urinary Retention.

RESPIRATION

- Monitor breath sounds and characteristics of secretions **for early detection of complications (e.g., pneumonia).**
- Reposition, cough, deep-breathe on a regular schedule **to facilitate clearing of secretions/prevent atelectasis.**
- Suction as indicated **to clear airways.**
- Encourage use of incentive spirometry.
- Demonstrate techniques/assist with postural drainage.
- Assist with/instruct family and caregivers in quad coughing techniques/diaphragmatic weight training **to maximize ventilation in presence of SCI.**
- Discourage smoking. Involve in smoking cessation program as indicated.
- Refer to NDs Airway Clearance/Breathing Pattern, ineffective.

VASCULAR (TISSUE PERFUSION)

- Determine core and skin temperature. Investigate development of cyanosis, changes in mentation **to identify changes in oxygenation status.**
- Routinely evaluate circulation/nerve function of affected body parts. Note changes in temperature, color, sensation, and movement.
- Institute peripheral vascular support measures (e.g., elastic hose, Ace wraps, sequential compression devices—SCDs) **to enhance venous return.**

- Monitor blood pressure before, during and after activity—sitting, standing, and lying if possible **to ascertain response to/tolerance of activity.**
- Assist with position changes as needed. Raise head gradually. Institute use of tilt table where appropriate. **Injury may occur as a result of orthostatic hypotension.**
- Maintain proper body position; avoid use of constricting garments/restraints **to prevent vascular congestion.**
- Refer to NDs Tissue Perfusion, ineffective; Peripheral Neurovascular Dysfunction, risk for.

MUSCULOSKELETAL (MOBILITY/RANGE OF MOTION, STRENGTH/ENDURANCE)

- Perform range of motion exercises and involve patient in active exercises with physical/occupational therapy (e.g., muscle strengthening).
- Maximize involvement in self-care.
- Pace activities as possible **to increase strength/endurance.**
- Apply functional positioning splints as appropriate.
- Evaluate role of pain in mobility problem.
- Implement pain management program as individually indicated.
- Limit/monitor closely the use of restraints, and immobilize patient as little as possible. Remove restrains periodically, and assist with range of motion exercises.
- Refer to NDs Activity Intolerance; Mobility, impaired physical; Pain, acute; Pain, chronic.

SENSORY-PERCEPTION

- Orient patient as necessary to time, place, person, and so forth. Provide cues for orientation (e.g., clock, calendar).
- Provide appropriate level of environmental stimulation (e.g., music, TV/radio, clock, calendar, personal possessions, and visitors).
- Encourage participation in recreational/diversional activities and regular exercise program (as tolerated).
- Promote use of sleep aids/usual presleep rituals **to promote normal sleep/rest.**
- Refer to NDs Sensory Perception, disturbed; Sleep Pattern, disturbed; Social Isolation; Diversional Activity, deficient.

SELF-ESTEEM, POWERLESSNESS

- Explain/review all care procedures.
- Provide for/assist with mutual goal setting, involving SO(s). **Promotes sense of control and enhances commitment to goals.**
- Provide consistency in caregivers whenever possible.
- Ascertain that patient can communicate needs adequately (e.g., call light, writing tablet, picture/letter board, interpreter).

- Encourage verbalization of feelings/questions.
- Refer to NDs Powerlessness; Communication, impaired verbal; Self-Esteem [specify]; Role Performance, ineffective.

BODY IMAGE

- Orient to body changes through verbal description, written information; encourage looking at and discussing changes **to promote acceptance.**
- Promote interactions with peers and normalization of activities within individual abilities.
- Refer to NDs Body Image, disturbed; Self-Esteem, situational low; Social Isolation; Personal Identity, disturbed.

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

- Provide/review information about individual needs/areas of concern.
- Encourage involvement in regular exercise program including isometric/isotonic activities, active or assistive ROM **to limit consequences of disuse and maximize level of function.**
- Review signs/symptoms requiring medical evaluation/follow-up **to promote timely interventions.**
- Identify community support services (e.g., financial, home maintenance, respite care, transportation).
- Refer to appropriate rehabilitation/home-care resources.
- Note sources for assistive devices/necessary equipment.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings, noting individual areas of concern, functional level, degree of independence, support systems/available resources.

PLANNING

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

IMPLEMENTATION/EVALUATION

- Patient's response to interventions/teaching and actions performed.
- Changes in level of functioning.
- Attainment/progress toward desired outcome(s).
- Modifications to plan of care.

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

DISCHARGE PLANNING

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Immobility Consequences: Physiological
NIC—Energy Management

Diversional Activity, deficient

Taxonomy II: Activity/Rest—Class 2 Activity/Exercise (00097)
[Diagnostic Division: Activity/Rest]

Definition: Decreased stimulation from (or interest or engagement in) recreational or leisure activities [**Note**: Internal/external factors may or may not be beyond the individual's control.]

Related Factors

Environmental lack of diversional activity as in long-term hospitalization; frequent, lengthy treatments, [home-bound]
[Physical limitations, bedridden, fatigue, pain]
[Situational, developmental problem, lack of sources]
[Psychological condition, such as depression]

Defining Characteristics

SUBJECTIVE

Patient's statement regarding the following:
Boredom; wish there were something to do, to read, and so on
Usual hobbies cannot be undertaken in hospital [home or other care setting]
[Changes in abilities/physical limitations]

OBJECTIVE

[Flat affect; disinterest, inattentiveness]
[Restlessness; crying]
[Lethargy; withdrawal]
[Hostility]
[Overeating or lack of interest in eating; weight loss or gain]

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

Desired Outcomes/Evaluation Criteria—Patient Will

- Recognize own psychological response (e.g., hopelessness and helplessness, anger, depression) and initiate appropriate coping actions.
- Engage in satisfying activities within personal limitations.

Actions/Interventions

NURSING PRIORITY NO. 1. To assess precipitating/etiological factors:

- Validate reality of environmental deprivation.
- Note impact of disability/illness on lifestyle. Compare with previous/normal activity level.
- Determine ability to participate/interest in activities that are available. **Presence of depression, problems of mobility, protective isolation, or sensory deprivation may interfere with desired activity.**

NURSING PRIORITY NO. 2. To motivate and stimulate patient involvement in solutions:

- Acknowledge reality of situation and feelings of the patient **to establish therapeutic relationship.**
- Review history of activity/hobby preferences and possible modifications.
- Institute appropriate actions to deal with concomitant conditions such as depression, immobility, and so forth.
- Provide for physical as well as mental diversional activities.
- Encourage mix of desired activities/stimuli (e.g., music; news program; educational presentations—TV/tapes, reading materials or "living" books; visitors; games; crafts; and hobbies interspersed with rest/quiet periods as appropriate). **Activities need to be personally meaningful for patient to derive the most enjoyment.**
- Participate in decisions about timing and spacing of lengthy treatments to promote relaxation/reduce sense of boredom.
- Encourage patient to assist in scheduling required and optional activity choices. For example, patient may want to watch favorite TV show at bathtime; if bath can be rescheduled later, **patient's sense of control is enhanced.**
- Refrain from making changes in schedule without discussing with patient. **It is important for staff to be responsible in making and following through on commitments to patient.**
- Provide change of scenery (indoors and out where possible).
- Identify requirements for mobility (wheelchair/walker/van/volunteers, and the like).
- Provide for periodic changes in the personal environment when the patient is confined. Use the individual's input in

creating the changes (e.g., seasonal bulletin boards, color changes, rearranging furniture, pictures).
- Suggest activities such as bird feeders/baths for bird-watching, a garden in a window box/terrarium, or a fish bowl/aquarium **to stimulate observation as well as involvement and participation in activity, such as identification of birds, choice of seeds, and so forth.**
- Accept hostile expressions while limiting aggressive acting-out behavior. (**Permission to express feelings of anger, hopelessness allows for beginning resolution. However, destructive behavior is counterproductive to self-esteem and problem solving.**)
- Involve occupational therapist as appropriate **to help identify and procure assistive devices, and/or gear specific activities to individual situation.**

NURSING PRIORITY NO. 3. To promote wellness (Teaching/Discharge Considerations):
- Explore options for useful activities using the person's strengths/abilities.
- Make appropriate referrals to available support groups, hobby clubs, service organizations.
- Refer to NDs Powerlessness; Social Isolation.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Specific assessment findings, including blocks to desired activities.
- Individual choices for activities.

PLANNING

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

IMPLEMENTATION/EVALUATION

- Patient'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 actions to be taken.
- Referrals/community resources.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Leisure Participation
NIC—Recreation Therapy

Energy Field, disturbed

Taxonomy II: Activity/Rest—Class 3 Energy Balance (00050)

[Diagnostic Division: Ego Integrity]

Definition: Disruption of the flow of energy [aura] surrounding a person's being that results in a disharmony of the body, mind and/or spirit

Related Factors

To be developed by NANDA
[Block in energy field]
[Depression]
[Increased state anxiety]
[Impaired immune system]
[Pain]

Defining Characteristics

OBJECTIVE

Temperature change (warmth/coolness)
Visual changes (image/color)
Disruption of the field (vacant/hold/spike/bulge)
Movement (wave/spike/tingling/dense/flowing)
Sounds (tone/words)

Desired Outcomes/Evaluation Criteria—Patient Will

- Acknowledge feelings of anxiety and distress.
- Verbalize sense of relaxation/well-being.
- Display reduction in severity/frequency of symptoms.

Actions/Interventions

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

- Develop therapeutic nurse-patient relationship, initially accepting role of healer/guide as patient desires.
- Provide opportunity for patient to talk about illness, concerns, past history, emotional state, or other relevant information. Note body gestures, tone of voice, words chosen to express feelings/issues.
- Determine patient's motivation/desire for treatment.

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

- Note use of medications, other drug use (e.g., alcohol).
- Use testing as indicated, such as the State-Trait Anxiety Inventory (STAI) or the Affect Balance Scale, **to provide measures of the patient's anxiety.**

NURSING PRIORITY NO. **2.** To evaluate energy field:

- Place patient in sitting or supine position with legs/arms uncrossed. Place pillows or other supports **to enhance comfort and relaxation.**
- Center self physically and psychologically **to quiet mind and turn attention to the healing intent.**
- Move hands slowly over the patient at level of 2 to 3 inches above skin **to assess state of energy field and flow of energy within the system.**
- Identify areas of imbalance or obstruction in the field (i.e., areas of asymmetry; feelings of heat/cold, tingling, congestion or pressure).

NURSING PRIORITY NO. **3.** To provide therapeutic intervention:

- Explain the process of Therapeutic Touch (TT) and answer questions as indicated **to prevent unrealistic expectation. Fundamental focus of TT is on healing and wholeness, not curing signs/symptoms of disease.**
- Discuss findings of evaluation with patient.
- Assist patient with exercises **to promote "centering" and increase potential to self-heal, enhance comfort, reduce anxiety.**
- Perform unruffling process, keeping hands 2 to 3 inches from patient's body **to dissipate impediments to free flow of energy within the system and between nurse and patient.**
- Focus on areas of disturbance identified, holding hands over or on skin, and/or place one hand in back of body with other hand in front, allowing patient's body to pull/repattern energy as needed. At the same time, concentrate on the intent to help the patient heal.
- Shorten duration of treatment as appropriate. Children and elderly individuals are generally more sensitive to therapeutic intervention.
- Make coaching suggestions in a soft voice **for enhancing feelings of relaxation** (e.g., pleasant images/other visualizations, deep breathing).
- Use hands-on massage/apply pressure to acupressure points as appropriate during process.
- Pay attention to changes in energy sensations as session progresses. Stop when the energy field is symmetrical and there is a change to feelings of peaceful calm.

- Hold patient's feet for a few minutes at end of session **to assist in "grounding" the body energy.**
- Provide patient time for a period of peaceful rest following procedure.

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

- Allow period of patient dependency, as appropriate, **for patient to strengthen own inner resources.**
- Encourage ongoing practice of the therapeutic process.
- Instruct in use of stress-reduction activities (e.g., centering/meditation, relaxation exercises) **to promote harmony between mind-body-spirit.**
- Discuss importance of integrating techniques into daily activity plan, **for sustaining/enhancing sense of well-being.**
- Have patient practice each step and demonstrate the complete TT process following the session as patient displays readiness to assume responsibilities for self-healing.
- Promote attendance at a support group **where members can help each other practice and learn the techniques of TT.**
- Refer to other resources as identified (e.g., psychotherapy, clergy, medical treatment of disease processes, hospice) **for the individual to address total well-being/facilitate peaceful death.**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings, including characteristics and differences in the energy field.
- Patient's perception of problem/need for treatment.

PLANNING

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

IMPLEMENTATION/EVALUATION

- Changes in energy field.
- Patient's response 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 for actions to be taken.
- Specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Well-Being
NIC—Therapeutic Touch

Environmental Interpretation Syndrome, impaired

Taxonomy II: Perception/Cognition—Class 2 Orientation (00127)

[Diagnostic Division: Safety]

Definition: Consistent lack of orientation to person, place, time, or circumstances over more than 3 to 6 months, necessitating a protective environment

Related Factors

Dementia (Alzheimer's disease, multi-infarct dementia, Pick's disease, AIDS dementia)
Parkinson's disease
Huntington's disease
Depression
Alcoholism

Defining Characteristics

SUBJECTIVE

[Loss of occupation or social functioning from memory decline]

OBJECTIVE

Consistent disorientation in known and unknown environments
Chronic confusional states
Inability to follow simple directions, instructions
Inability to reason; to concentrate; slow in responding to questions
Loss of occupation or social functioning from memory decline

Desired Outcomes/Evaluation Criteria—Patient Will

• Be free of harm.

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

Caregiver Will

- Identify individual patient safety concerns/needs.
- Modify activities/environment to provide for safety.

Actions/Interventions

NURSING PRIORITY NO. **1.** To assess causative/precipitating factors:

- Discuss history and progression of condition. Note length of time since onset, future expectations, and incidents of injury/accidents.
- Review patient's behavioral changes with SOs, **to note difficulties/problems,** as well as additional impairments (e.g., decreased agility, reduced ROM of joints, loss of balance, decline in visual acuity).
- Identify potential environmental dangers and patient's level of awareness (if any) of threat.
- Review results of cognitive screening tests.

NURSING PRIORITY NO. **2.** To provide/promote safe environment:

- Provide consistent caregivers as much as possible.
- Include SO(s)/caregivers in planning process. **Enhances commitment to plan.**
- Identify previous/usual patterns for activities, such as sleeping, eating, self-care, and so on **to include in plan of care.**
- Promote and structure activities and rest periods.
- Limit number of decisions/choices patient needs to make at one time **to conserve emotional energy.**
- Keep communication/questions simple. Use concrete terms.
- Limit number of visitors patient interacts with at one time.
- Provide simple orientation measures, such as one-number calendar, holiday lights, and so on.
- Provide for safety/protection against hazards, such as to lock doors to unprotected areas/stairwells, discourage/supervise smoking, monitor ADLs (e.g., use of stove/sharp knives, choice of clothing in relation to environment/season), lock up medications/poisonous substances.
- Distract/redirect patient's attention when behavior is agitated or dangerous.
- Use symbols instead of words when hearing/other impaired **to improve communication.**
- Use identity tags in clothes/belongings, bracelet/necklace (**provides identification if patient wanders away/gets lost**).
- Incorporate information from results of cognitive testing into care planning.
- Refer to NDs Trauma, risk for; Confusion, chronic.

NURSING PRIORITY NO. 3. To assist caregiver to deal with situation:

- Determine family's ability to care for patient at home on an ongoing basis relative to individual responsibilities and availability.
- Discuss need for time for self away from patient. (Refer to ND Caregiver Role Strain.)

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

- Provide specific information about disease process/prognosis and patient's particular needs.
- Discuss need for/appropriatness of genetic counseling for family members.
- Promote/plan for continuing care as appropriate. Identify resources for respite care needs.
- Refer to appropriate outside resources such as adult day care, homemaker services, support groups. **Provides assistance, promotes problem solving.**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings, including degree of impairment.

PLANNING

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

IMPLEMENTATION/EVALUATION

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

DISCHARGE PLANNING

- Long-range needs, who is responsible for actions to be taken.
- Specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Cognitive Ability
NIC—Reality Orientation

Failure to Thrive, adult

Taxonomy II: Growth/Development—Class 1 Growth (00101)

[Diagnostic Division: Food/Fluid]

Definition: Progressive functional deterioration of a physical and cognitive nature. The individual's ability to live with multisystem diseases, cope with ensuing problems, and manage his or her care are remarkably diminished

Related Factors

Depression; apathy
Fatigue
[Major disease/degenerative condition]
[Aging process]

Defining Characteristics

SUBJECTIVE

States does not have an appetite, not hungry, or "I don't want to eat"
Expresses loss of interest in pleasurable outlets, such as food, sex, work, friends, family, hobbies, or entertainment
Difficulty performing simple self-care tasks
Altered mood state—expresses feelings of sadness, being low in spirit
Verbalizes desire for death

OBJECTIVE

Inadequate nutritional intake—eating less than body requirements; consumes minimal to none of food at most meals (i.e., consumes less than 75% of normal requirements at each or most meals); anorexia—does not eat meals when offered
Weight loss (decreased body mass from baseline weight)—5% unintentional weight loss in 1 month, 10% unintentional weight loss in 6 months
Physical decline (decline in bodily function)—evidence of fatigue, dehydration, incontinence of bowel and bladder
Cognitive decline (decline in mental processing)—as evidenced by problems with responding appropriately to environmental stimuli; demonstrates difficulty in reasoning, decision making, judgment, memory, concentration; decreased perception

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

Apathy as evidenced by lack of observable feeling or emotion in terms of normal ADLs and environment
Decreased participation in ADLs that the older person once enjoyed; self-care deficit—no longer looks after or takes charge of physical cleanliness or appearance; neglects home environment and/or financial responsibilities
Decreased social skills/social withdrawal—noticeable decrease from usual past behavior in attempts to form or participate in cooperative and interdependent relationships (e.g., decreased verbal communication with staff, family, friends)
Frequent exacerbations of chronic health problems such as pneumonia or UTIs

Desired Outcomes/Evaluation Criteria—Patient Will:

- Acknowledge presence of factors affecting well-being.
- Identify corrective/adaptive measures for individual situation.
- Demonstrate behaviors/lifestyle changes necessary to promote improved status.

Actions/Interventions

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

- Assess patient's perception of factors leading to present condition, noting onset, duration, presence/absence of physical complaints, social withdrawal.
- Review with patient previous and current life situations, including role changes, losses, and so on **to identify stressors affecting current situation.**
- Determine presence of malnutrition and factors contributing to failure to eat (e.g., chronic nausea, loss of appetite, no access to food or cooking, poorly fitting dentures, financial problems).
- Determine patient's cognitive and perceptual status and effect on self-care ability.
- Evaluate level of adaptive behavior, knowledge, and skills about health maintenance, environment, and safety.
- Ascertain safety and effectiveness of home environment, persons providing care, and potential for/presence of neglectful/abusive situations.

NURSING PRIORITY NO. **2.** To assess degree of impairment:

- Perform physical and/or psychosocial assessment **to determine the extent of limitations affecting ability to thrive.**
- Active-listen patient's/caregiver's perception of problem.
- Survey past and present availability/use of support systems.

NURSING PRIORITY NO. 3. To assist patient to achieve/maintain general well-being:

- Develop plan of action with patient/caregiver to meet immediate needs (physical safety, hygiene, nutrition, emotional support) and assist in implementation of plan.
- Explore previously used successful coping skills and application to current situation. Refine/develop new strategies as appropriate.
- Assist patient to develop goals for dealing with life/illness situation. Involve SO in long-range planning. **Promotes commitment to goals and plan, maximizing outcomes.**

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

- Refer to other resources (e.g., social worker, occupational therapy, home care, assistive care, placement services, spiritual advisor). **Enhances coping, assists with problem solving, and may reduce risks to patient and caregiver.**
- Promote socialization within individual limitations. **Provides additional stimulation, reduces sense of isolation.**
- Help patient find a reason for living or begin to deal with end-of-life issues and provide support for grieving. **Enhances sense of control.**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including current weight, dietary pattern, perceptions of self, food and eating, motivation for loss, support/feedback from SOs.
- Ability to perform ADLs/participate in care, meet own needs.

PLANNING

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

IMPLEMENTATION/EVALUATION

- Responses to interventions and actions performed, general well-being, weekly weight.
- 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.
- Community resources/support groups.
- Specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Will to Live
NIC—Mood Management

Falls, risk for

Taxonomy II: Safety/Protection—Class 2 Physical Injury (00155)
[Diagnostic Division: Safety] Submitted 2000

Definition: Increased susceptibility to falling that may cause physical harm

Risk Factors

Adults
- History of falls
- Wheelchair use; use of assistive devices (e.g., walker, cane)
- Age 65 or over; female (if elderly)
- Lives alone
- Lower limb prosthesis

Physiological
- Presence of acute illness; postoperative conditions
- Visual/hearing difficulties
- Arthritis
- Orthostatic hypotension; faintness when turning or extending neck
- Sleeplessness
- Anemias; vascular disease
- Endoplasms (i.e., fatigue/limited mobility)
- Urgency and/or incontinence; diarrhea
- Postprandial blood sugar changes
- Impaired physical mobility; foot problems; decreased lower extremity strength
- Impaired balance; difficulty with gait; proprioceptive deficits (e.g., unilateral neglect)
- Neuropathy

Cognitive
- Diminished mental status (e.g., confusion, delirium, dementia, impaired reality testing)
- Medications; antihypertensive agents; ACE inhibitors; diuretics; tricyclic antidepressants; antianxiety agents; hypnotics or tranquilizers

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

Alcohol use; narcotics
Environment
Restraints
Weather conditions (e.g., wet floors/ice)
Cluttered environment; throw/scatter rugs; no antislip material in bath and/or shower
Unfamiliar, dimly lit room
Children
2 years of age; male gender when <1 year of age
Lack of gate on stairs; window guards; auto restraints
Unattended infant on bed/changing table/sofa; bed located near window
Lack of parental supervision

Desired Outcomes/Evaluation Criteria—Patient/Caregivers Will:

- Verbalize understanding of individual risk factors that contribute to possibility of falls and take steps to correct situation(s).
- Demonstrate behaviors, lifestyle changes to reduce risk factors and protect self from injury.
- Modify environment as indicated to enhance safety.
- Be free of injury.

Actions/Interventions

NURSING PRIORITY NO. 1. To evaluate source/degree of risk:

- Note age and sex (child, young adult, elderly women are at greater risk).
- Evaluate developmental level, decision-making ability, level of cognition and competence. **Infants, young children, and elderly are at greatest risk because of developmental issues and weakness. Individuals with physical injuries or cognitive impairments are also at risk for falls caused by immobility, use of assistive aids, environmental hazards, or inability to recognize danger.**
- Assess muscle strength, gross and fine motor coordination. Note individual's general health status, determining what physical factors may affect safety, such as use of oxygen, chronic or debilitating conditions.
- Evaluate patient's cognitive status. **Affects ability to perceive own limitations and risk for falling.**
- Assess mood, coping abilities, personality styles. **Individual's temperament, typical behavior, stressors and level of self-esteem can affect attitude toward safety issues, resulting in carelessness or increased risk-taking without consideration of consequences.**

- Ascertain knowledge of safety needs/injury prevention and motivation to prevent injury. **Patient/caregivers may not be aware of proper precautions or may not have the knowledge, desire, or resources to attend to safety issues in all settings.**
- Note socioeconomic status/availability and use of resources in other circumstances. **Can affect current coping abilities.**

NURSING PRIORITY NO. 2. To assist patient/caregiver to reduce or correct individual risk factors:

- Provide information regarding patient's disease/condition(s) that may result in increased risk of falls.
- Identify needed interventions and safety devices to promote safe environment and individual safety.
- Review consequences of previously determined risk factors (e.g., falls caused by failure to make provisions for impairments caused by physical, cognitive or environmental factors).
- Review medication regimen and how it affects patient. Instruct in monitoring of effects/side effects. **Use of pain medications may contribute to weakness and confusion; multiple medications and combinations of medications affecting blood pressure or cardiac function may contribute to dizziness or loss of balance.**
- Discuss importance of monitoring conditions that **contribute to occurrence of injury** (e.g., fatigue, objects that block traffic patterns, lack of sufficient light, attempting tasks that are too difficult for present level of functioning, lack of ability to contact someone when help is needed).
- Determine caregiver's expectations of children, cognitively impaired and/or elderly family members and compare with actual abilities. **Reality of patient's abilities and needs may be different than perception or desires of caregivers.**
- Discuss need for and sources of supervision (e.g., babysitters, before and after school programs, elderly day care, personal companions, etc).
- Plan for home visit when appropriate. Determine that home safety issues are addressed, including supervision, access to emergency assistance, and patient's ability to manage self care in the home. **May be needed to adequately determine patient's needs and available resources.**
- Refer to physical or occupational therapist as appropriate. **May require exercises to improve strength or mobility, improve/relearn ambulation, or identify and obtain appropriate assistive devices for mobility, bathroom safety, or home modification.**

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

- Refer to other resources as indicated. **Patient/caregivers may need financial assistance, home modifications, referrals for counseling, homecare, sources for safety equipment, or placement in extended care facility.**
- Provide written resources **for later review/reinforcement of learning.**
- Promote education geared to increasing individual's awareness of safety measures and available resources.
- Promote community awareness about the problems of design of buildings, equipment, transportation, and work-place accidents that contribute to falls.
- Connect patient/family with community resources, neighbors, friends to assist elderly/handicapped individuals in providing such things as structural maintenance, clearing of snow, gravel or ice from walks and steps, etc.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual risk factors noting current physical findings (e.g., bruises, cuts, anemia, and use of alcohol, drugs and prescription medications).
- Patient's/caregiver's understanding of individual risks/safety concerns.

PLANNING

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

IMPLEMENTATION/EVALUATION

- Individual responses to interventions/teaching and actions performed.
- Specific actions and changes that are made.
- Attainment/progress toward desired outcomes.
- Modifications to plan of care.

DISCHARGE PLANNING

- Long-range plans for discharge needs, lifestyle, home setting and community changes, and who is responsible for actions to be taken.
- Specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Safety Behavior: Fall Prevention
NIC—Fall Prevention

Family Processes, dysfunctional: alcoholism

Taxonomy II: Role Relationships—Class 2 Family Relationships (00063)
[Diagnostic Division: Social Interaction]

Definition: Psychosocial, spiritual, and physiological functions of the family unit are chronically disorganized, which leads to conflict, denial of problems, resistance to change, ineffective problem solving, and a series of self-perpetuating crises

Related Factors

Abuse of alcohol; resistance to treatment
Family history of alcoholism
Inadequate coping skills; addictive personality; lack of problem-solving skills
Biochemical influences; genetic predisposition

Defining Characteristics

SUBJECTIVE

Feelings
Anxiety/tension/distress; decreased self-esteem/worthlessness; lingering resentment
Anger/suppressed rage; frustration; shame/embarrassment; hurt; unhappiness; guilt
Emotional isolation/loneliness; powerlessness; insecurity; hopelessness; rejection
Responsibility for alcoholic's behavior; vulnerability; mistrust
Depression; hostility; fear; confusion; dissatisfaction; loss; repressed emotions
Being different from other people; misunderstood
Emotional control by others; being unloved; lack of identity
Abandonment; confused love and pity; moodiness; failure

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

Roles and Relationships
Family denial; deterioration in family relationships/disturbed family dynamics; ineffective spouse communication/marital problems; intimacy dysfunction
Altered role function/disruption of family roles; inconsistent parenting/low perception of parental support; chronic family problems
Lack of skills necessary for relationships; lack of cohesiveness; disrupted family rituals
Family unable to meet security needs of its members
Pattern of rejection; economic problems; neglected obligations

OBJECTIVE

Roles and Relationships
Closed communication systems
Triangulating family relationships; reduced ability of family members to relate to each other for mutual growth and maturation
Family does not demonstrate respect for individuality and autonomy of its members

Behaviors
Expression of anger inappropriately; difficulty with intimate relationships; impaired communication; ineffective problem-solving skills; inability to meet emotional needs of its members; manipulation; dependency; criticizing; broken promises; rationalization/denial of problems
Refusal to get help/inability to accept and receive help appropriately; blaming
Loss of control of drinking; enabling to maintain drinking [substance use]; alcohol [substance] abuse; inadequate understanding or knowledge of alcoholism [substance abuse]
Inability to meet spiritual needs of its members
Inability to express or accept wide range of feelings; orientation toward tension relief rather than achievement of goals; escalating conflict
Lying; contradictory, paradoxical communication; lack of dealing with conflict; harsh self-judgment; isolation; difficulty having fun; self-blaming; unresolved grief
Controlling communication/power struggles; seeking approval and affirmation
Lack of reliability; disturbances in academic performance in children; disturbances in concentration; chaos; failure to accomplish current or past developmental tasks/difficulty with life-cycle transitions

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

Verbal abuse of spouse or parent; agitation; diminished physical contact

Family special occasions are alcohol-centered; nicotine addiction; inability to adapt to change; immaturity; stress-related physical illnesses; inability to deal with traumatic experiences constructively; substance abuse other than alcohol

Desired Outcomes/Evaluation Criteria—Family Will:

- Verbalize understanding of dynamics of codependence.
- Participate in individual/family treatment programs.
- Identify ineffective coping behaviors/consequences.
- Demonstrate/plan for necessary lifestyle changes.
- Take action to change self-destructive behaviors/alter behaviors that contribute to patient's drinking/substance use.

Actions/Interventions

NURSING PRIORITY NO. 1. To assess contributing factors/underlying problem(s):

- Assess current level of functioning of family members.
- Ascertain family's understanding of current situation; note results of previous involvement in treatment.
- Review family history, explore roles of family members and circumstances involving substance use.
- Determine history of accidents/violent behaviors within family and safety issues.
- Discuss current/past methods of coping.
- Determine extent of enabling behaviors being evidenced by family members.
- Identify sabotage behaviors of family members. **Issues of secondary gain (conscious or unconscious) may impede recovery.**
- Note presence/extent of behaviors of family, patient, and self that might be "too helpful," such as frequent requests for help, excuses for not following through on agreed-on behaviors, feelings of anger/irritation with others. **Enabling behaviors can complicate acceptance and resolution of problem.**

NURSING PRIORITY NO. 2. To assist family to change destructive behaviors:

- Mutually agree on behaviors/responsibilities for nurse and patient. **Maximizes understanding of what is expected.**
- Confront and examine denial and sabotage behaviors used by family members. **Helps individuals move beyond blocks to recovery.**
- Discuss use of anger, rationalization and/or projection and ways in which these interfere with problem resolution.

- Encourage family to deal with anger **to prevent escalation to violence.** Problem-solve concerns.
- Determine family strengths, areas for growth, individual/family successes.
- Remain nonjudgmental in approach to family members and to member who uses alcohol/drugs.
- Provide information regarding effects of addiction on mood/personality of the involved person. **Helps family members understand and cope with negative behaviors without being judgmental or reacting angrily.**
- Distinguish between destructive aspects of enabling behavior and genuine motivation to aid the user.
- Identify use of manipulative behaviors and discuss ways to avoid/prevent these situations.

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

- Provide factual information to patient/family about the effects of addictive behaviors on the family and what to expect after discharge.
- Provide information about enabling behavior, addictive disease characteristics for both user and nonuser who is codependent.
- Discuss importance of restructuring life activities, work/leisure relationships. **Previous lifestyle/relationships supported substance use requiring change to prevent relapse.**
- Encourage family to refocus celebrations excluding alcohol use **to reduce risk of relapse.**
- Provide support for family members; encourage participation in group work.
- Encourage involvement with/refer to self-help groups, Al-Anon, AlaTeen, Narcotics Anonymous, family therapy groups **to provide ongoing support and assist with problem solving.**
- Provide bibliotherapy as appropriate.
- In addition, refer to NDs Family Processes, interrupted; Coping, family: compromised/disabled as appropriate.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings, including history of substance(s) that have been used, and family risk factors/safety concerns.
- Family composition and involvement.
- Results of prior treatment involvement.

PLANNING

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

IMPLEMENTATION/EVALUATION

- Responses of family members to treatment/teaching and actions performed.
- Attainment/progress toward desired outcome(s).
- Modifications to plan of care.

DISCHARGE PLANNING

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Family Environment: Internal
NIC—Substance Use Treatment

Family Processes, interrupted

Taxonomy II: Role Relationships—Class 2 Family Relationships (00060)

[Diagnostic Division: Social Interactions]

Nursing Diagnosis Extension and Classification (NDEC) Revision 1998

Definition: Change in family relationships and/or functioning

Related Factors

Situational transition and/or crises [e.g., economic, change in roles, illness, trauma, disabling/expensive treatments]
Developmental transition and/or crises [e.g., loss or gain of a family member, adolescence, leaving home for college]
Shift in health status of a family member
Family roles shift; power shift of family members
Modification in family finances, family social status
Informal or formal interaction with community

Defining Characteristics

SUBJECTIVE

Changes in: power alliances; satisfaction with family; expressions of conflict within family; effectiveness in completing assigned tasks; stress-reduction behaviors; expressions of

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

conflict with and/or isolation from community resources; somatic complaints

[Family expresses confusion about what to do; verbalizes they are having difficulty responding to change]

OBJECTIVE

Changes in: assigned tasks; participation in problem solving/decision making; communication patterns; mutual support; availability for emotional support/affective responsiveness and intimacy; patterns and rituals

Desired Outcomes/Evaluation Criteria—Family Will:

- Express feelings freely and appropriately.
- Demonstrate individual involvement in problem-solving processes directed at appropriate solutions for the situation/crisis.
- Direct energies in a purposeful manner to plan for resolution of the crisis.
- Verbalize understanding of illness/trauma, treatment regimen, and prognosis.
- Encourage and allow member who is ill to handle situation in own way, progressing toward independence.

Actions/Interventions

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

- Determine pathophysiology, illness/trauma, developmental crisis present.
- Identify family developmental stage (e.g., marriage, birth of a child, children leaving home).
- Note components of family: parent(s), children, male/female, extended family available.
- Observe patterns of communication in this family. Are feelings expressed? Freely? Who talks to whom? Who makes decisions? For whom? Who visits? When? What is the interaction between family members? (**Not only identifies weakness/areas of concern to be addressed, but also strengths that can be used for resolution of problem.**)
- Assess boundaries of family members. Do members share family identity and have little sense of individuality? Do they seem emotionally distant, not connected with one another?

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

- Ascertain role expectations of family members. Who is the ill member (e.g., nurturer, provider)? How does the illness affect the roles of others?
- Determine "Family Rules." For example, adult concerns (finances, illness, and so on) are kept from the children.
- Identify parenting skills and expectations.
- Note energy direction. Are efforts at resolution/problem solving purposeful or scattered?
- Listen for expressions of despair/helplessness (e.g., "I don't know what to do") **to note degree of distress.**
- Note cultural and/or religious factors **that may affect perceptions/expectations of family members.**
- Assess support systems available outside of the family.

NURSING PRIORITY NO. **2.** To assist family to deal with situation/crisis:

- Deal with family members in warm, caring, respectful way.
- Acknowledge difficulties and realities of the situation. **Reinforces that some degree of conflict is to be expected and can be used to promote growth.**
- Encourage expressions of anger. Avoid taking them personally. **Maintains boundaries between nurse and family.**
- Stress importance of continuous, open dialogue between family members **to facilitate ongoing problem solving.**
- Provide information as necessary, verbal and written. Reinforce as necessary.
- Assist family to identify and encourage their use of previously successful coping behaviors.
- Recommend contact by family members on a regular, frequent basis.
- Arrange for/encourage family participation in multidisciplinary team conference/group therapy as appropriate.
- Involve family in social support and community activities of their interest and choice.

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

- Encourage use of stress-management techniques (e.g., appropriate expression of feelings, relaxation exercises).
- Provide educational materials and information **to assist family members in resolution of current crisis.**
- Refer to classes (e.g., Parent Effectiveness, specific disease/disability support groups, self-help groups, clergy, psychological counseling/family therapy as indicated).
- Assist family to identify situations that may lead to fear/anxiety. (Refer to NDs Fear; Anxiety.)
- Involve family in planning for future and mutual goal setting. **Promotes commitment to goals/continuation of plan.**

- Identify community agencies (e.g., Meals on Wheels, visiting nurse, trauma support group, American Cancer Society, Veterans Administration) **for both immediate and long-term support.**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings including family composition, developmental stage of family, and role expectations.
- Family communication patterns.

PLANNING

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

IMPLEMENTATION/EVALUATION

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

DISCHARGE PLANNING

- Long-range needs, noting who is responsible for actions to be taken.
- Specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Family Functioning
NIC—Family Process Maintenance

Fatigue

Taxonomy II: Activity/Rest—Class 3 Energy Balance (00093)
[Diagnostic Division: Activity/Rest]
Nursing Diagnosis Extension and Classification (NDEC) Revision 1998

Definition: An overwhelming sustained sense of exhaustion and decreased capacity for physical and mental work at usual level

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

Related Factors

PSYCHOLOGICAL

Stress; anxiety; boring lifestyle; depression

ENVIRONMENTAL

Noise; lights; humidity; temperature

SITUATIONAL

Occupation; negative life events

PHYSIOLOGICAL

Increased physical exertion; sleep deprivation
Pregnancy; disease states; malnutrition; anemia
Poor physical condition
[Altered body chemistry (e.g., medications, drug withdrawal, chemotherapy)]

Defining Characteristics

SUBJECTIVE

Verbalization of an unremitting and overwhelming lack of energy; inability to maintain usual routines/level of physical activity
Perceived need for additional energy to accomplish routine tasks; increase in rest requirements
Tired; inability to restore energy even after sleep
Feelings of guilt for not keeping up with responsibilities
Compromised libido
Increase in physical complaints

OBJECTIVE

Lethargic or listless; drowsy
Compromised concentration
Disinterest in surroundings/introspection
Decreased performance, [accident-prone]

Desired Outcomes/Evaluation Criteria—Patient Will:

- Report improved sense of energy.
- Identify basis of fatigue and individual areas of control.
- Perform ADLs and participate in desired activities at level of ability.
- Participate in recommended treatment program.

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

Actions/Interventions

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

- Review medication regimen/use (e.g., β-blockers with fatigue as a side effect, cancer chemotherapy).
- Identify presence of physical and/or psychological disease states (e.g., multiple sclerosis, lupus, chronic pain, hepatitis, AIDS, major depressive disorder, anxiety states).
- Note stage of disease process, nutrition state, fluid balance.
- Determine ability to participate in activities/level of mobility.
- Assess presence/degree of sleep disturbances.
- Note lifestyle changes, expanded responsibilities/demands of others, job-related conflicts.
- Assess psychological and personality factors that may affect reports of fatigue level.
- Note patient's belief about what is causing the fatigue and what relieves it.
- Evaluate aspect of "learned helplessness" that may be manifested by giving up. **Can perpetuate a cycle of fatigue, impaired functioning, and increased anxiety and fatigue.**

NURSING PRIORITY NO. 2. To determine degree of fatigue/impact on life:

- Use a scale such as Piper Fatigue Self-Report Scale/Nail's General Fatigue Scale, as appropriate. **Can help determine manifestation, intensity, duration, and emotional meaning of fatigue.**
- Note daily energy patterns (i.e., peaks/valleys). **Helpful in determining pattern/timing of activity.**
- Discuss lifestyle changes/limitations imposed by fatigue state.
- Interview parent/care provider regarding specific changes observed in child/elder. (**These individuals may not be able to verbalize feelings or relate meaningful information.**)
- Review availability and current use of support systems/resources.
- Evaluate need for individual assistance/assistive devices.
- Measure physiological response to activity (e.g., changes in blood pressure or heart/respiratory rate).

NURSING PRIORITY NO. 3. To assist patient to cope with fatigue and manage within individual limits of ability:

- Accept reality of patient reports of fatigue and do not underestimate effect on quality of life the patient experiences (**e.g., patients with MS are prone to more frequent/severe fatigue following minimal energy expenditure and require longer recovery period; post-polio patients often display a cumulative effect if they fail to pace themselves and rest when early signs of fatigue are encountered**).

- Establish realistic activity goals with patient. **Enhances commitment to promoting optimal outcomes.**
- Plan care to allow individually adequate rest periods. Schedule activities for periods when patient has the most energy, to maximize participation.
- Involve patient/SO(s) in schedule planning.
- Encourage patient to do whatever possible (e.g., self-care, sit up in chair, walk). Increase activity level as tolerated.
- Instruct in methods to conserve energy (e.g., sit instead of stand during activities/shower; plan steps of activity before beginning so that all needed materials are at hand).
- Assist with self-care needs; keep bed in low position and travelways clear of furniture, assist with ambulation as indicated.
- Provide environment conducive to relief of fatigue. **Temperature and level of humidity are known to affect exhaustion (especially in patients with MS).**
- Provide diversional activities. Avoid overstimulation/understimulation (cognitive and sensory). **Impaired concentration can limit ability to block competing stimuli/distractions**.
- Discuss routines to promote restful sleep. (Refer to ND Sleep Pattern, disturbed.)
- Instruct in stress-management skills of visualization, relaxation, and biofeedback when appropriate.
- Refer to physical/occupational therapy for programmed daily exercises and activities **to maintain/increase strength and muscle tone and to enhance sense of well-being.**

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

- Discuss therapy regimen relating to individual causative factors (e.g., physical and/or psychological illnesses) and help patient/SO(s) to understand relationship of fatigue to illness.
- Assist patient/SO(s) to develop plan for activity and exercise within individual ability. Stress necessity of allowing sufficient time to finish activities.
- Instruct patient in ways to monitor responses to activity and significant signs/symptoms that **indicate the need to alter activity level.**
- Promote overall health measures (e.g., nutrition, adequate fluid intake, appropriate vitamin/iron supplementation).
- Provide supplemental oxygen as indicated. **Presence of anemia/hypoxemia reduces oxygen available for cellular uptake and contributes to fatigue.**
- Encourage patient to develop assertiveness skills, prioritizing goals/activities, learning to say "No." Discuss burnout syndrome when appropriate and actions patient can take to change individual situation.

- Assist patient to identify appropriate coping behaviors. **Promotes sense of control and improves self-esteem.**
- Identify support groups/community resources.
- Refer to counseling/psychotherapy as indicated.
- Obtain resources to assist with routine needs (e.g., Meals on Wheels, homemaker/housekeeper services, yard care).

Documentation Focus

ASSESSMENT/REASSESSMENT

- Manifestations of fatigue and other assessment findings.
- Degree of impairment/effect on lifestyle.
- Expectations of patient/SO relative to individual abilities/specific condition.

PLANNING

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

IMPLEMENTATION/EVALUATION

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

DISCHARGE PLANNING

- Discharge needs/plan, actions to be taken, and who is responsible.
- Specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Endurance
NIC—Energy Management

Fear [specify focus]

Taxonomy II: Coping/Stress Tolerance—Class 2 Coping Responses (00148)

[Diagnostic Division: Ego Integrity] Revised 2000

Definition: Response to perceived threat [real or imagined] that is consciously recognized as a danger

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

Related Factors

Natural/innate origin (e.g., sudden noise, height, pain, loss of physical support); innate releasers (neurotransmitters); phobic stimulus
Learned response (e.g., conditioning, modeling from identification with others)
Unfamiliarity with environmental experiences
Separation from support system in potentially stressful situation (e.g., hospitalization, hospital procedures [/treatments])
Language barrier; sensory impairment

Defining Characteristics

SUBJECTIVE

Cognitive: Identifies object of fear; stimulus believed to be a threat
Physiological: Anorexia, nausea, fatigue, dry mouth, [palpitations]
Apprehension; excitement; being scared; alarm; panic; terror; dread
Decreased self-assurance
Increased tension; jitteriness

OBJECTIVE

Cognitive: Diminished productivity, learning ability, problem-solving
Behaviors: Increased alertness; avoidance[/flight] or attack behaviors; impulsiveness; narrowed focus on "it" (e.g., the focus of the fear)
Physiological: Increased pulse; vomiting; diarrhea; muscle tightness; increased respiratory rate and shortness of breath; increased systolic blood pressure; pallor; increased perspiration; pupil dilation

Desired Outcomes/Evaluation Criteria—Patient Will:

- Acknowledge and discuss fears, recognizing healthy versus unhealthy fears.
- Verbalize accurate knowledge of/sense of safety related to current situation.

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

- Demonstrate understanding through use of effective coping behaviors (e.g., problem solving) and resources.
- Display appropriate range of feelings and lessened fear.

Actions/Interventions

NURSING PRIORITY NO. **1.** To assess degree of fear and reality of threat perceived by the patient:

- Ascertain patient/SO(s) perception of what is occurring and how this affects life.
- Note degree of incapacitation (e.g., "frozen with fear," inability to engage in necessary activities).
- Compare verbal/nonverbal responses, **to note congruencies or misperceptions of situation.**
- Be alert to signs of denial/depression.
- Identify sensory deficits that may be present, such as hearing impairment. **Affects sensory reception and interpretation.**
- Note degree of concentration, focus of attention.
- Investigate patient's reports of subjective experiences (may be delusions/hallucinations).
- Be alert to and evaluate potential for violence.
- Measure vital signs/physiological responses to situation.
- Assess family dynamics. (Refer to other NDs such as Family Processes, interrupted; Coping, family: readiness for enhanced; Coping, family: compromised/disabled; Anxiety.)

NURSING PRIORITY NO. **2.** To assist patient/SOs in dealing with fear/situation:

- Stay with the patient or make arrangements to have someone else be there. **Sense of abandonment can exacerbate fear.**
- Listen to, Active-listen patient concerns.
- Provide information in verbal and written form. Speak in simple sentences and concrete terms. **Facilitates understanding and retention of information.**
- Acknowledge normalcy of fear, pain, despair, and give "permission" to express feelings appropriately/freely.
- Provide opportunity for questions and answer honestly. **Enhances sense of trust and nurse-patient relationship.**
- Present objective information when available and allow patient to use it freely. Avoid arguing about patient's perceptions of the situation. **Limits conflicts when fear response may impair rational thinking.**
- Promote patient control where possible and help patient identify and accept those things over which control is not possible. (**Strengthens internal locus of control.**)
- Encourage contact with a peer who has successfully dealt with a similarly fearful situation. **Provides a role model, and patient is more likely to believe others who have had similar experience(s).**

NURSING PRIORITY NO. 3. To assist patient in learning to use own responses for problem solving:

- Acknowledge usefulness of fear for taking care of self.
- Identify patient's responsibility for the solutions. (Reinforce that the nurse will be available for help.) **Enhances sense of control.**
- Determine internal/external resources for help (e.g., awareness/use of effective coping skills in the past; SOs who are available for support).
- Explain procedures within level of patient's ability to understand and handle. (Be aware of how much information patient wants **to prevent confusion/overload**.)
- Explain relationship between disease and symptoms if appropriate.
- Review use of antianxiety medications and reinforce use as prescribed.

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

- Support planning for dealing with reality.
- Assist patient to learn relaxation/visualization and guided imagery skills.
- Encourage and assist patient to develop exercise program (within limits of ability). **Provides a healthy outlet for energy generated by feelings and promotes relaxation.**
- Provide for/deal with sensory deficits in appropriate manner (e.g., speak clearly and distinctly, use touch carefully as indicated by situation).
- Refer to support groups, community agencies/organizations as indicated. **Provides ongoing assistance for individual needs.**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings, noting individual factors contributing to current situation.
- Manifestations of fear.

PLANNING

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

IMPLEMENTATION/EVALUATION

- Patient's responses to treatment plan/interventions 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—Anxiety Control
NIC—Anxiety Reduction

[Fluid volume, deficient hyper/hypotonic]

NOTE: NANDA has restricted Fluid Volume, Deficient to address only isotonic dehydration. For patient needs related to dehydration associated with alterations in sodium, the authors have provided this second diagnostic category.

[Diagnostic Division: Food/Fluid]

Definition: [Decreased intravascular, interstitial, and/or intracellular fluid. This refers to dehydration with changes in sodium.]

Related Factors

[Hypertonic dehydration: uncontrolled diabetes mellitus/insipidus, HHNC, increased intake of hypertonic fluids/IV therapy, inability to respond to thirst reflex/inadequate free water supplementation (high-osmolarity enteral feeding formulas), renal insufficiency/failure]
[Hypotonic dehydration: chronic illness/malnutrition, excessive use of hypotonic IV solutions (e.g., D_5W), renal insufficiency]

Defining Characteristics

SUBJECTIVE

[Reports of fatigue, nervousness, exhaustion]
[Thirst]

OBJECTIVE

[Increased urine output, dilute urine (initially) and/or decreased output/oliguria]
[Weight loss]

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

[Decreased venous filling]
[Hypotension (postural)]
[Increased pulse rate; decreased pulse volume and pressure]
[Decreased skin turgor]
[Change in mental status (e.g., confusion)]
[Increased body temperature]
[Dry skin/mucous membranes]
[Hemoconcentration; altered serum sodium]

Desired Outcomes/Evaluation Criteria—Patient Will:

- Maintain fluid volume at a functional level as evidenced by individually adequate urinary output, stable vital signs, moist mucous membranes, good skin turgor.
- Verbalize understanding of causative factors and purpose of individual therapeutic interventions and medications.
- Demonstrate behaviors to monitor and correct deficit as indicated when condition is chronic.

Actions/Interventions

NURSING PRIORITY NO. **1.** To assess causative/precipitating factors:

- Note possible medical diagnoses/disease processes that may lead to deficits (e.g., chronic renal failure with loss of sodium, diuretic therapy, increased respiratory losses secondary to acidosis, hyperglycemia).
- Determine effects of age. **(Elderly individuals often have a decreased thirst reflex and may not be aware of additional water needs.)**
- Evaluate nutritional status, noting current intake, weight changes, problems with oral intake, use of supplements/tube feedings. Measure subcutaneous fat/muscle mass.

NURSING PRIORITY NO. **2.** To evaluate degree of fluid deficit:

- Assess vital signs; note strength of peripheral pulses.
- Measure blood pressure (lying/sitting/standing) when possible and monitor invasive hemodynamic parameters as indicated (e.g., CVP, PAP/PCWP).
- Note presence of physical signs (e.g., dry mucous membranes, poor skin turgor, delayed capillary refill).
- Observe urinary output, color, and measure amount and specific gravity.
- Review laboratory data (e.g., Hb/Hct, electrolytes, total protein/albumin).

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

NURSING PRIORITY NO. 3. To correct/replace fluid losses to reverse pathophysiological mechanisms:

- Establish 24-hour replacement needs and routes to be used (e.g., IV/PO). **Prevents peaks/valleys in fluid level.**
- Note patient preferences concerning fluids and foods with high fluid content.
- Provide nutritious diet via appropriate route; give adequate free water with enteral feedings.
- Administer IV fluids as appropriate.
- Maintain accurate intake and output (I/O), calculate 24-hour fluid balance, and weigh daily.

NURSING PRIORITY NO. 4. To promote comfort and safety:

- Bathe less frequently using mild cleanser/soap and provide optimal skin care with suitable emollients **to maintain skin integrity and prevent excessive dryness.**
- Provide frequent oral care, eye care **to prevent injury from dryness.**
- Change position frequently.
- Provide for safety measures when patient is confused.
- Replace electrolytes as ordered.
- Administer medications (e.g., insulin, antidiuretic hormone—ADH, vasopressin—Pitressin therapy) as indicated by contributing disease process.
- Correct acidosis (e.g., administration of sodium bicarbonate or changes in mechanical ventilation as appropriate).

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

- Discuss factors related to occurrence of deficit as individually appropriate.
- Identify, and instruct in ways to meet specific nutritional needs.
- Instruct patient/SO(s) in how to measure and record I/O.
- Identify actions (if any) patient may take to correct deficiencies.
- Review/instruct in medication regimen and administration and interactions/side effects.
- Instruct in signs and symptoms indicating need for immediate/further evaluation and follow-up.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including factors affecting ability to manage (regulate) body fluids and degree of deficit.
- I/O, fluid balance, changes in weight, urine specific gravity, and vital signs.
- Results of diagnostic testing/laboratory studies.

PLANNING

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

IMPLEMENTATION/EVALUATION

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

DISCHARGE PLANNING

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Fluid Balance
NIC—Fluid/Electrolyte Management

Fluid Volume, deficient [isotonic]

NOTE: This diagnosis has been structured to address isotonic dehydration (hypovolemia) excluding states in which changes in sodium occur. For patient needs related to dehydration associated with alterations in sodium, refer to Fluid Volume, Deficient [hyper/hypotonic].

Taxonomy II: Nutrition—Class 5 Hydration (00027)
[Diagnostic Division: Food/Fluid]

Definition: Decreased intravascular, interstitial and/or intracellular fluid. This refers to dehydration, water loss alone without change in sodium.

Related Factors

Active fluid volume loss [e.g., hemorrhage, gastric intubation, diarrhea, wounds; abdominal cancer; burns, fistulas, ascites (third spacing); use of hyperosmotic radiopaque contrast agents]
Failure of regulatory mechanisms [e.g., fever/thermoregulatory response, renal tubule damage]

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

Defining Characteristics

SUBJECTIVE

Thirst
Weakness

OBJECTIVE

Decreased urine output; increased urine concentration
Decreased venous filling; decreased pulse volume/pressure
Sudden weight loss (except in third spacing)
Decreased BP; increased pulse rate/body temperature
Decreased skin/tongue turgor; dry skin/mucous membranes
Change in mental state
Elevated Hct

Desired Outcomes/Evaluation Criteria—Patient Will:

- Maintain fluid volume at a functional level as evidenced by individually adequate urinary output with normal specific gravity, stable vital signs, moist mucous membranes, good skin turgor, and prompt capillary refill, resolution of edema (e.g., ascites)
- Verbalize understanding of causative factors and purpose of individual therapeutic interventions and medications.
- Demonstrate behaviors to monitor and correct deficit as indicated.

Actions/Interventions

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

- Note possible diagnoses that may create a fluid volume deficit (e.g., ulcerative colitis, burns, cirrhosis of the liver, abdominal cancer); other factors, such as laryngectomy/tracheostomy tubes, drainage from wounds/fistulas or suction devices; water deprivation/fluid restrictions; decreased level of consciousness; vomiting, hemorrhage, dialysis; hot/humid climate, prolonged exercise; increased metabolic rate secondary to fever; increased caffeine/alcohol.
- Determine effects of age. (**Elderly individuals are at higher risk because of decreasing response/effectiveness of compensatory mechanisms, e.g., kidneys are less efficient in conserving sodium and water. Infants and children have a relatively low percentage of total body water and are less able to control their fluid intake.**)

NURSING PRIORITY NO. 2. To evaluate degree of fluid deficit:

- Estimate traumatic/procedural fluid losses and note possible routes of insensible fluid losses.
- Assess vital signs; note strength of peripheral pulses.

- Note physical signs of dehydration (e.g., concentrated urine, dry mucous membranes, delayed capillary refill, poor skin turgor, confusion).
- Determine customary and current weight.
- Measure abdominal girth when ascites or third spacing of fluid occurs. Assess for peripheral edema formation.
- Review laboratory data (e.g., Hb/Hct, electrolytes, total protein/albumin, BUN/Cr).

NURSING PRIORITY NO. 3. To correct/replace losses to reverse pathophysiological mechanisms:

- Stop blood loss (e.g., gastric lavage with room temperature or cool saline solution, drug administration, prepare for surgical intervention).
- Establish 24-hour fluid replacement needs and routes to be used. **Prevents peaks/valleys in fluid level.**
- Note patient preferences regarding fluids and foods with high fluid content.
- Keep fluids within patient's reach and encourage frequent intake as appropriate.
- Administer IV fluids as indicated. Replace blood products/plasma expanders as ordered.
- Control humidity and ambient air temperature as appropriate, especially when major burns are present, or increase/decrease in presence of fever. Reduce bedding/clothes, provide tepid sponge bath. Assist with hypothermia when ordered **to decrease severe fever and elevated metabolic rate.** (Refer to ND Hyperthermia.)
- Maintain accurate I/O and weigh daily. Monitor urine specific gravity.
- Monitor vital signs (lying/sitting/standing) and invasive hemodynamic parameters as indicated (e.g., CVP, PAP/PCWP).

NURSING PRIORITY NO. 4. To promote comfort and safety:

- Change position frequently.
- Bathe every other day, provide optimal skin care with emollients.
- Provide frequent oral care as well as eye care **to prevent injury from dryness.**
- Change dressings frequently/use adjunct appliances as indicated for draining wounds **to protect skin and monitor losses**.
- Provide for safety measures when patient is confused.
- Administer medications (e.g., antiemetics, antidiarrheals **to limit gastric/intestinal losses;** antipyretics **to reduce fever**).
- Refer to ND Diarrhea.

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

- Discuss factors related to occurrence of dehydration.
- Assist patient/SO(s) to learn to measure own I/O.

- Identify actions patient may take to correct deficiencies.
- Recommend restriction of caffeine, alcohol as indicated.
- Review medications and interactions/side effects.
- Note signs/symptoms indicating need for emergent/further evaluation and follow-up.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings, including degree of deficit and current sources of fluid intake.
- I/O, fluid balance, changes in weight/edema, urine specific gravity, and vital signs.

PLANNING

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

IMPLEMENTATION/EVALUATION

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

DISCHARGE PLANNING

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Hydration
NIC—Hypovolemia Management

Fluid Volume, excess

Taxonomy II: Nutrition—Class 5 Hydration (00026)
[Diagnostic division: Food/Fluid]

Definition: Increased isotonic fluid retention

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

Related Factors

Compromised regulatory mechanism [e.g., syndrome of inappropriate antidiuretic hormone—SIADH—or decreased plasma proteins as found in conditions such as malnutrition, draining fistulas, burns, organ failure]
Excess fluid intake
Excess sodium intake
[Drug therapies such as chlorpropamide, tolbutamide, vincristine, triptylines, carbamazepine]

Defining Characteristics

SUBJECTIVE

Shortness of breath, orthopnea
Anxiety

OBJECTIVE

Edema, may progress to anasarca; weight gain over short period of time
Intake exceeds output; oliguria
Abnormal breath sounds (rales or crackles), changes in respiratory pattern, dyspnea
Increased CVP; jugular vein distention; positive hepatojugular reflex
S_3 heart sound
Pulmonary congestion, pleural effusion, pulmonary artery pressure changes; BP changes
Change in mental status; restlessness
Specific gravity changes
Decreased Hb/Hct, azotemia, altered electrolytes

Desired Outcomes/Evaluation Criteria—Patient Will:

- Stabilize fluid volume as evidenced by balanced I/O, vital signs within patient's normal limits, stable weight, and free of signs of edema.
- Verbalize understanding of individual dietary/fluid restrictions.
- Demonstrate behaviors to monitor fluid status and reduce recurrence of fluid excess.
- List signs that require further evaluation.

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

Actions/Interventions

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

- Be aware of risk factors (e.g., cardiac failure, cerebral lesions, renal/adrenal insufficiency, psychogenic polydipsia, acute stress, surgical/anesthetic procedures, excessive or rapid infusion of IV fluids, decrease or loss of serum proteins).
- Note amount/rate of fluid intake from all sources: PO, IV, ventilator, and so forth.
- Review intake of sodium (dietary, drug, IV) and protein.

NURSING PRIORITY NO. 2. To evaluate degree of excess:

- Compare current weight with admission and/or previously stated weight.
- Measure vital signs and invasive hemodynamic parameters (e.g., CVP, PAP/PCWP) if available.
- Auscultate breath sounds **for presence of crackles/congestion.**
- Record occurrence of dyspnea (exertional, nocturnal, and so on).
- Auscultate heart tones **for S_3, ventricular gallop.**
- Assess for presence of neck vein distention/hepatojugular reflux.
- Note presence of edema (puffy eyelids, dependent swelling ankles/feet if ambulatory or up in chair; sacrum and posterior thighs when recumbent), anasarca.
- Measure abdominal girth **for changes that may indicate increasing fluid retention/edema.**
- Note patterns and amount of urination (e.g., nocturia, oliguria).
- Evaluate mentation **for confusion, personality changes.**
- Assess neuromuscular reflexes.
- Assess appetite; note presence of nausea/vomiting.
- Observe skin and mucous membranes (**prone to decubitus/ulceration**).
- Note fever (**at increased risk of infection**).
- Review laboratory data (e.g., BUN/Cr, Hb/Hct, serum albumin, proteins, and electrolytes; urine specific gravity/osmolality/sodium excretion) and chest x-ray.

NURSING PRIORITY NO. 3. To promote mobilization/elimination of excess fluid:

- Restrict sodium and fluid intake as indicated.
- Record I/O accurately; calculate fluid balance (plus/minus).
- Set an appropriate rate of fluid intake/infusion throughout 24-hour period **to prevent peaks/valleys in fluid level.**
- Weigh daily or on a regular schedule, as indicated. **Provides a comparative baseline.**
- Administer medications (e.g., diuretics, cardiotonics, steroid replacement, plasma or albumin volume expanders).

- Evaluate edematous extremities, change position frequently **to reduce tissue pressure and risk of skin breakdown.**
- Place in semi-Fowler's position as appropriate **to facilitate movement of diaphragm improving respiratory effort.**
- Promote early mobility.
- Provide quiet environment, limiting external stimuli.
- Use safety precautions if confused/debilitated.
- Assist with procedures as indicated (e.g., thoracentesis, dialysis).

NURSING PRIORITY NO. 4. To maintain integrity of skin and oral mucous membranes:

- Refer to NDs Skin Integrity, impaired/risk for impaired and Oral Mucous Membrane, impaired.

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

- Review dietary restrictions and safe substitutes for salt (e.g., lemon juice or spices such as oregano).
- Discuss importance of fluid restrictions and "hidden sources" of intake (such as foods high in water content).
- Instruct patient/family in use of voiding record, I/O.
- Consult dietitian as needed.
- Suggest interventions such as frequent oral care, chewing gum/hard candy, use of lip balm **to reduce discomforts of fluid restrictions.**
- Review drug regimen/side effects.
- Stress need for mobility and/or frequent position changes **to prevent stasis and reduce risk of tissue injury.**
- Identify "danger" signs requiring notification of healthcare provider **to ensure timely evaluation/intervention.**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings, noting existing conditions contributing to and degree of fluid retention (vital signs, amount, presence and location of edema, and weight changes).
- I/O, fluid balance.

PLANNING

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

IMPLEMENTATION/EVALUATION

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

DISCHARGE PLANNING

- Long-range needs, noting who is responsible for actions to be taken.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Fluid Balance
NIC—Hypervolemia Management

Fluid Volume, risk for deficient

Taxonomy II: Nutrition—Class 5 Hydration (00028)
[Diagnostic Division: Food/Fluid]

Definition: At risk for experiencing vascular, cellular, or intracellular dehydration

Risk Factors

Extremes of age and weight
Loss of fluid through abnormal routes (e.g., indwelling tubes)
Knowledge deficiency related to fluid volume
Factors influencing fluid needs (e.g., hypermetabolic states)
Medications (e.g., diuretics)
Excessive losses through normal routes (e.g., diarrhea)
Deviations affecting access, intake, or absorption of fluids (e.g., physical immobility)

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—Patient Will:

- Identify individual risk factors and appropriate interventions.
- Demonstrate behaviors or lifestyle changes to prevent development of fluid volume deficit.

Actions/Interventions

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

- Note patient's age, level of consciousness/mentation.

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

- Assess other etiologic factors present (e.g., availability of fluids, mobility, presence of fever).

NURSING PRIORITY NO. 2. To prevent occurrence of deficit:

- Weigh patient and compare with recent weight history.
- Establish individual fluid needs/replacement schedule.
- Encourage oral intake (e.g., offer fluids between meals, provide water with drinking straw) **to maximize intake.**
- Provide supplemental fluids (tube feed, IV) as indicated. Distribute fluids over 24-hour period. **Prevents peaks/valleys in fluid level.**
- Monitor I/O balance being aware of insensible losses **to ensure accurate picture of fluid status.**
- Perform serial weights, **to note trends.**
- Note changes in vital signs (e.g., orthostatic hypotension, tachycardia, fever).
- Assess skin turgor/oral mucous membranes.
- Review laboratory data (e.g., Hb/Hct, electrolytes, BUN/Cr).
- Administer medications as indicated (e.g., antiemetics, antidiarrheals, antipyretics).

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

- Discuss individual risk factors/potential problems and specific interventions.
- Review appropriate use of medication.
- Encourage patient to maintain diary of food/fluid intake; number and amount of voidings and stools, and so forth.
- Refer to NDs [Fluid Volume, deficient hyper/hypotonic] or [isotonic].

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including individual factors influencing fluid needs/requirements.
- Baseline weight, vital signs.
- Specific patient preferences for fluids.

PLANNING

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

IMPLEMENTATION/EVALUATION

- Responses to interventions/teaching and actions performed.

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

- Attainment/progress toward desired outcome(s).
- 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—Fluid Balance
NIC—Fluid Monitoring

Fluid Volume, risk for imbalanced

Taxonomy II: Nutrition—Class 5 Hydration (00025)
[Diagnostic Division: Food/Fluid]

Definition: At risk for a decrease, an increase, or a rapid shift from one to the other of intravascular, interstitial, and/or intracellular fluid. This refers to body fluid loss, gain, or both.

Risk Factors

Scheduled for major invasive procedures
[Rapid/sustained loss, e.g., hemorrhage, burns, fistulas]
[Rapid fluid replacement]
Other risk factors to be determined

Desired Outcomes/Evaluation Criteria—Patient Will:

- Demonstrate adequate fluid balance as evidenced by stable vital signs, palpable pulses/good quality, normal skin turgor, moist mucous membranes; individual appropriate urinary output; lack of excessive weight fluctuation (loss/gain), and no edema present.

Actions/Interventions

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

- Note potential sources of fluid loss/intake; presence of conditions such as diabetes insipidus, hyperosmolar nonketotic

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

syndrome; need for major invasive procedures, medications (e.g., diuretics); use of IV fluids and delivery device, administration of total parenteral nutrition (TPN).
- Note patient's age, current level of hydration, and mentation. **Provides information regarding ability to tolerate fluctuations in fluid level and risk for creating or failing to respond to problem (e.g., confused patient may have inadequate intake, disconnect tubings, or readjust IV flow rate).**

NURSING PRIORITY NO. 2. To prevent fluctuations/imbalances in fluid levels:
- Measure and record I/O. Monitor urine output (hourly as needed), noting amount, color, time of day, diuresis.
- Note presence of vomiting, liquid stool; inspect dressing(s), drainage devices **to include losses in output calculations.**
- Calculate fluid balance (intake > output or output > intake).
- Auscultate BP, calculate pulse pressure. (**PP widens before systolic BP drops in response to fluid loss.**)
- Monitor BP responses to activities (e.g., **BP/heart and respiratory rate often increases when either fluid deficit or excess is present**).
- Weigh daily or as indicated and evaluate changes **as they relate to fluid status.**
- Assess for clinical signs of dehydration (hypotension, dry skin/mucous membranes, delayed capillary refill) or fluid excess (e.g., peripheral/dependent edema, adventitious breath sounds, distended neck veins).
- Note increased lethargy, hypotension, muscle cramping. (**Electrolyte imbalances may be present.**)
- Review laboratory data, chest x-ray **to determine changes indicative of electrolyte and/or fluid imbalance.**
- Establish fluid oral intake, incorporating beverage preferences when possible.
- Maintain fluid/sodium restrictions when needed.
- Administer IV fluids as prescribed using infusion pumps **to promote fluid management.**
- Tape tubing connections longitudinally **to reduce risk of disconnection and loss of fluids.**
- Administer diuretics, antiemetics, as prescribed.
- Assist with rotating tourniquet phlebotomy, dialysis or ultrafiltration **to correct fluid overload situation.**

NURSING PRIORITY NO. 3. To promote wellness (Teaching/Discharge Considerations):
- Discuss individual risk factors/potential problems and specific interventions.
- Instruct patient/SO in how to measure and record I/O as appropriate.

- Review/instruct in medication/TPN regimen.
- Identify signs and symptoms indicating need for prompt evaluation/follow-up.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including individual factors influencing fluid needs/requirements.
- Baseline weight, vital signs.
- Specific patient preferences for fluids.

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 outcome(s).
- 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—Fluid Balance
NIC—Fluid Monitoring

Gas Exchange, impaired

Taxonomy II: Elimination—Class 4 Pulmonary System (00030)

[Diagnostic Division: Respiration]

Nursing Diagnosis Extension and Classification (NDEC) Revision 1998

Definition: Excess or deficit in oxygenation and/or carbon dioxide elimination at the alveoli-capillary membrane [This may be an entity of its own but also may be an end result of other pathology with an interrelatedness between airway clearance and/or breathing pattern problems.]

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

Related Factors

Ventilation perfusion imbalance [as in the following: altered blood flow (e.g., pulmonary embolus, increased vascular resistance), vasospasm, heart failure, hypovolemic shock]
Alveolar-capillary membrane changes (e.g., acute adult respiratory distress syndrome); chronic conditions such as restrictive/obstructive lung disease, pneumoconiosis, respiratory depressant drugs, brain injury, asbestosis/silicosis
[Altered oxygen supply (e.g., altitude sickness)]
[Altered oxygen-carrying capacity of blood (e.g., sickle cell/other anemia, carbon monoxide poisoning)]

Defining Characteristics

SUBJECTIVE

Dyspnea
Visual disturbances
Headache upon awakening
[Sense of impending doom]

OBJECTIVE

Confusion; [decreased mental acuity]
Restlessness; irritability; [agitation]
Somnolence; [lethargy]
Abnormal ABGs/arterial pH; hypoxia/hypoxemia; hypercapnia; hypercarbia; decreased carbon dioxide
Cyanosis (in neonates only); abnormal skin color (pale, dusky)
Abnormal rate, rhythm, depth of breathing; nasal flaring
Tachycardia [development of dysrhythmias]
Diaphoresis
[Polycythemia]

Desired Outcomes/Evaluation Criteria—Patient Will:

- Demonstrate improved ventilation and adequate oxygenation of tissues by ABGs within patient's normal limits and absence of symptoms of respiratory distress (as noted in Defining Characteristics).
- Verbalize understanding of causative factors and appropriate interventions.
- Participate in treatment regimen (e.g., breathing exercises, effective coughing, use of oxygen) within level of ability/situation.

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

Actions/Interventions

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

- Note presence of factors listed in Related Factors. Refer to NDs Airway Clearance, ineffective and Breathing Pattern, ineffective as appropriate.

NURSING PRIORITY NO. 2. To evaluate degree of compromise:

- Note respiratory rate, depth; use of accessory muscles, pursed-lip breathing; note areas of pallor/cyanosis; for example, peripheral (nailbeds) versus central (circumoral) or general duskiness.
- Auscultate breath sounds, note areas of decreased/adventitious breath sounds as well as fremitus.
- Assess level of consciousness and mentation changes. Note somnolence, restlessness, reports of headache on arising.
- Monitor vital signs and cardiac rhythm.
- Evaluate pulse oximetry **to determine oxygenation;** evaluate vital capacity **to assess respiratory insufficiency.**
- Review pertinent laboratory data (e.g., ABGs, CBC); chest x-rays.
- Assess energy level and activity tolerance.
- Note effect of illness on self-esteem/body image.

NURSING PRIORITY NO. 3. To correct/improve existing deficiencies:

- Elevate head of bed/position patient appropriately, provide airway adjuncts and suction as indicated **to maintain airway.**
- Encourage frequent position changes and deep-breathing/coughing exercises. Use incentive spirometer, chest physiotherapy, IPPB, and so forth as indicated. **Promotes optimal chest expansion and drainage of secretions.**
- Provide supplemental oxygen at lowest concentration indicated by laboratory results and patient symptoms/situation.
- Monitor for carbon dioxide narcosis e.g., change in level of consciousness, changes in O_2 and CO_2 blood gas levels, flushing, decreased respiratory rate and headaches **which may occur in patients receiving long-term oxygen therapy.**
- Maintain adequate I/O **for mobilization of secretions,** but avoid fluid overload.
- Use sedation judiciously **to avoid depressant effects on respiratory functioning.**
- Ensure availability of proper emergency equipment including ET/trach set and suction catheters appropriate for age and size of infant/child/adult. Avoid use of face mask in elderly emaciated patient.
- Encourage adequate rest and limit activities to within patient tolerance. Promote calm/restful environment. **Helps limit oxygen needs/consumption.**
- Provide psychological support, listening to questions/concerns.

- Administer medications as indicated (e.g., corticosteroids, antibiotics, bronchodilators, expectorants, heparin) **to treat underlying conditions.**
- Monitor therapeutic and adverse effects as well as interactions of drug therapy.
- Minimize blood loss from procedures (e.g., tests, hemodialysis).
- Assist with procedures as individually indicated (e.g., transfusion, phlebotomy, bronchoscopy) **to improve respiratory function/oxygen-carrying capacity.**
- Monitor/adjust ventilator settings (e.g., FIO_2, tidal volume, inspiratory/expiratory ratio, sigh, positive end-expiratory pressure—PEEP) as indicated when mechanical support is being used.
- Keep environment allergen/pollutant free **to reduce irritant effect on airways.**

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

- Review risk factors, particularly environmental/employment-related **to promote prevention/management of risk.**
- Discuss implications of smoking related to the illness/condition.
- Encourage patient and SO(s) to stop smoking, attend cessation programs as necessary **to improve lung function.**
- Discuss reasons for allergy testing when indicated. Review individual drug regimen and ways of dealing with side effects.
- Instruct in the use of relaxation, stress-reduction techniques as appropriate.
- Reinforce need for adequate rest, while encouraging activity within patient's limitations.
- Review oxygen-conserving techniques (e.g., sitting instead of standing to perform tasks, eating small meals; performing slower, purposeful movements).
- Review job description/work activities **to identify need for job modifications/vocational rehabilitation.**
- Discuss home oxygen therapy and safety measures as indicated when home oxygen implemented.
- Identify specific supplier for supplemental oxygen/necessary respiratory devices, as well as other individually appropriate resources, such as home-care agencies, Meals on Wheels, and so on, **to facilitate independence.**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings, including respiratory rate, character of breath sounds; frequency, amount, and appearance of secretions; presence of cyanosis, laboratory findings, and mentation level.
- Conditions that may interfere with oxygen supply.

PLANNING

- Plan of care/interventions and who is involved in the planning.
- Ventilator settings, liters of supplemental oxygen.
- Teaching plan.

IMPLEMENTATION/EVALUATION

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

DISCHARGE PLANNING

- Long-range needs, identifying who is responsible for actions to be taken.
- Community resources for equipment/supplies postdischarge.
- Specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Respiratory Status: Gas Exchange
NIC—Respiratory Monitoring

Grieving, anticipatory

Taxonomy II: Coping/Stress Tolerance—Class 2 Coping Responses (00136)

[Diagnostic Division: Ego Integrity]

Definition: Intellectual and emotional responses and behaviors by which individuals, families, communities work through the process of modifying self-concept based on the perception of potential loss [**Note:** May be a healthy response requiring interventions of support and information giving.]

Related Factors

To be developed by NANDA
[Perceived potential loss of SO, physiological/psychosocial well-being (body part/function, social role), lifestyle/personal possessions]

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

Defining Characteristics

SUBJECTIVE

Sorrow, guilt, anger, [choked feelings]
Denial of potential loss; denial of the significance of the loss
Expression of distress at potential loss, [ambivalence, sense of unreality]; bargaining
Alteration in activity level; sleep/dream patterns; eating habits; libido

OBJECTIVE

Potential loss of significant object (e.g., people, job, status, home, ideals, part and processes of the body)
Altered communication patterns
Difficulty taking on new or different roles
Resolution of grief prior to the reality of loss
[Altered affect]
[Crying]
[Social isolation, withdrawal]

Desired Outcomes/Evaluation Criteria—Patient Will:

- Identify and express feelings (e.g., sadness, guilt, fear) freely/effectively.
- Acknowledge impact/effect of the grieving process (e.g., physical problems of eating, sleeping) and seek appropriate help.
- Look toward/plan for future, one day at a time.

Actions/Interventions

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

- Determine patient's perception of anticipated loss and meaning to him or her. "What are your concerns?" "What are your fears? Your greatest fear?" "How do you see this affecting you/your lifestyle?"
- Ascertain response of family/SO(s) to patient's situation/concerns.

NURSING PRIORITY NO. 2. To determine current response to anticipated loss:

- Note emotional responses, such as withdrawal, angry behavior, crying.
- Observe patient's body language and check out meaning with the patient. Note congruency with verbalizations.

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

- Note cultural factors/expectations that may impact patient's responses **to assess how the patient is responding to the situation.**
- Identify problems with eating, activity level, sexual desire, role performance (e.g., work, parenting).
- Note family communication/interaction patterns.
- Determine use/availability of community resources/support groups.

NURSING PRIORITY NO. **3.** To assist patient to deal with situation:

- Provide open environment and trusting relationship. **Promotes a free discussion of feelings and concerns.**
- Use therapeutic communication skills of Active-listening, silence, acknowledgment. Respect patient desire/request not to talk.
- Provide puppets or play therapy for toddlers/young children. (**May help express grief and deal with loss.**)
- Permit appropriate expressions of anger, fear. Note hostility toward/feelings of abandonment by spiritual power. (Refer to appropriate NDs.)
- Provide information about normalcy of individual grief reaction.
- Be honest when answering questions, providing information. **Enhances sense of trust and nurse-patient relationship.**
- Provide assurance to child that cause for situation is not patient's own doing, bearing in mind age and developmental level. **May lessen sense of guilt and affirm there is no need to assign blame to any family member.**
- Provide hope within parameters of individual situation. Do not give false reassurance.
- Review past life experiences/previous loss(es), role changes, and coping skills, noting strengths/successes. **Useful in dealing with current situation and problem solving existing needs.**
- Discuss control issues, such as what is in the power of the individual to change and what is beyond control. **Recognition of these factors helps patient focus energy for maximal benefit/outcome.**
- Incorporate family/SO(s) in problem solving. **Encourages family to support/assist patient to deal with situation while meeting needs of family members.**
- Determine patient's status and role in family (e.g., parent, sibling, child, and address loss of family member role).
- Instruct in use of visualization and relaxation techniques.
- Use sedatives/tranquilizers with caution. **May retard passage through the grief process.**

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

- Give information that feelings are OK and are to be expressed appropriately. **Expression of feelings can facilitate the grieving process, but destructive behavior can be damaging.**
- Encourage continuation of usual activities/schedule and involvement in appropriate exercise program.
- Identify/promote family and social support systems.
- Discuss and assist with planning for future/funeral as appropriate.
- Refer to additional resources such as pastoral care, counseling/psychotherapy, community/organized support groups as indicated for both patient and family/SO **to meet ongoing needs and facilitate grief work.**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings, including patient's perception of anticipated loss and signs/symptoms that are being exhibited.
- Responses of family/SOs.
- Availability/use of resources.

PLANNING

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

IMPLEMENTATION/EVALUATION

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

DISCHARGE PLANNING

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Grief Resolution
NIC—Grief Work Facilitation

Grieving, dysfunctional

Taxonomy II: Coping/Stress Tolerance—Class 2 Coping Responses (00135)

[Diagnostic Division: Ego Integrity]

Definition: Extended, unsuccessful use of intellectual and emotional responses by which individuals, families, and communities attempt to work through the process of modifying self-concept based on the perception of loss

Related Factors

Actual or perceived object loss (e.g., people, possessions, job, status, home, ideals, parts and processes of the body [e.g., amputation, paralysis, chronic/terminal illness])
[Thwarted grieving response to a loss, lack of resolution of previous grieving response]
[Absence of anticipatory grieving]

Defining Characteristics

SUBJECTIVE

Expression of distress at loss; denial of loss
Expression of guilt; anger; sadness; unresolved issues; [hopelessness]
Idealization of lost object (e.g., people, possessions, job, status, home, ideals, parts and processes of the body)
Reliving of past experiences with little or no reduction (diminishment) of intensity of the grief
Alterations in eating habits, sleep/dream patterns, activity level, libido, concentration and/or pursuit of tasks

OBJECTIVE

Onset or exacerbation of somatic or psychosomatic responses
Crying; labile affect
Difficulty in expressing loss
Prolonged interference with life functioning; developmental regression
Repetitive use of ineffectual behaviors associated with attempts to reinvest in relationships
[Withdrawal; isolation]

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

Desired Outcomes/Evaluation Criteria—Patient Will:

- Acknowledge presence/impact of dysfunctional situation.
- Demonstrate progress in dealing with stages of grief at own pace.
- Participate in work and self-care/ADLs as able.
- Verbalize a sense of progress toward resolution of the grief and hope for the future.

Actions/Interventions

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

- Identify loss that is present. Look for cues of sadness (e.g., sighing, faraway look, unkempt appearance, inattention to conversation).
- Identify stage of grief being expressed: denial, isolation, anger, bargaining, depression, acceptance.
- Determine level of functioning, ability to care for self.
- Note availability/use of support systems and community resources.
- Be aware of avoidance behaviors (e.g., anger, withdrawal, long periods of sleeping or refusing to interact with family).
- Identify cultural factors and ways individual has dealt with previous loss(es) **to determine how the individual is expressing self.**
- Ascertain response of family/SO(s) to patient's situation. Assess needs of SO(s).
- Refer to ND Grieving, anticipatory as appropriate.

NURSING PRIORITY NO. **2.** To assist patient to deal appropriately with loss:

- Encourage verbalization without confrontation about realities **(helpful in beginning resolution and acceptance).**
- Encourage patient to talk about what the patient chooses and do not try to force the patient to "face the facts."
- Active-listen feelings and be available for support/assistance. Speak in soft, caring voice.
- Encourage expression of anger/fear and anxiety. Refer to appropriate NDs.
- Permit verbalization of anger with acknowledgment of feelings and setting of limits regarding destructive behavior. **(Enhances patient safety and promotes resolution of grief process).**
- Acknowledge reality of feelings of guilt/blame, including hostility toward spiritual power. (Refer to ND Spiritual Distress.) Assist patient to take steps toward resolution.
- Respect the patient's needs and wishes for quiet, privacy, talking, or silence.

- Give "permission" to be at this point when the patient is depressed.
- Provide comfort and availability as well as caring for physical needs.
- Reinforce use of previously effective coping skills. Instruct in/encourage use of visualization and relaxation techniques.
- Assist SOs to cope with patient's response. (**Family/SO[s] may not be dysfunctional but may be intolerant.**) Include age-specific interventions.
- Include family/SO(s) in setting realistic goals for meeting needs of family members.

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

- Discuss with patient healthy ways of dealing with difficult situations.
- Have patient identify familial, religious, and cultural factors that have meaning for him or her. **May help bring loss into perspective and promote grief resolution.**
- Encourage involvement in usual activities, exercise, and socialization within limits of physical ability, and psychological state.
- Discuss and assist with planning for future/funeral as appropriate.
- Refer to other resources (e.g., pastoral care, counseling, psychotherapy, organized support groups). **Provides additional help when needed to resolve situation, continues grief work.**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings, including meaning of loss to the patient, current stage of the grieving process, and responses of family/SOs.
- Availability/use of resources.

PLANNING

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

IMPLEMENTATION/EVALUATION

- Patient's response to interventions/teaching and actions performed.

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

- 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—Grief Resolution
NIC—Grief Work Facilitation

Growth, risk for disproportionate

Taxonomy II: Growth/Development—Class 1 Growth (00113)

[Diagnostic Division: Teaching/Learning]

Nursing Diagnosis Extension and Classification (NDEC) Submission 1998

Definition: At risk for growth above the 97th percentile or below the 3rd percentile for age, crossing two percentile channels; disproportionate growth

Risk Factors

PRENATAL

Maternal nutrition; multiple gestation
Substance use/abuse; teratogen exposure
Congenital/genetic disorders [e.g., dysfunction of endocrine gland, tumors]

INDIVIDUAL

Organic (e.g., pituitary tumors) and inorganic factors
Prematurity
Malnutrition; caregiver and/or individual maladaptive feeding behaviors; insatiable appetite; anorexia; [impaired metabolism, greater-than-normal energy requirements]
Infection; chronic illness [e.g., chronic inflammatory diseases]
Substance [use]/abuse [including anabolic steroids]

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

ENVIRONMENTAL

Deprivation; poverty
Violence; natural disasters
Teratogen; lead poisoning

CAREGIVER

Abuse
Mental illness/retardation, severe learning disability

Desired Outcomes/Evaluation Criteria—Patient Will:

- Receive appropriate nutrition as indicated by individual needs.
- Demonstrate weight/growth stabilizing or progress toward age-appropriate size.
- Participate in plan of care as appropriate for age/ability.

Caregiver Will:

- Verbalize understanding of growth delay/deviation and plans for intervention.

Actions/Interventions

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

- Determine factors/condition(s) existing that could contribute to growth deviation as listed in Risk Factors, including familial history of pituitary tumors, Marfan's syndrome, genetic anomalies, and so forth.
- Identify nature and effectiveness of parenting/caregiving activities (e.g., inadequate, inconsistent, unrealistic/insufficient expectations; lack of stimulation, limit setting, responsiveness).
- Note severity/pervasiveness of situation (e.g., individual/showing effects of long-term physical/emotional abuse/neglect versus individual experiencing recent onset situational disruption or inadequate resources during period of crisis or transition).
- Assess significant stressful events, losses, separation and environmental changes (e.g., abandonment, divorce, death of parent/sibling, aging, move).
- Assess cognition, awareness, orientation, behavior (e.g., withdrawal/aggression) reaction to environment and stimuli.
- Active-listen concerns about body size, ability to perform competitively (e.g., sports, body building) **to ascertain the potential for use of anabolic steroids/other drugs.**

NURSING PRIORITY NO. 2. To prevent/limit deviation from growth norms:

- Note chronological age, familial factors (body build/stature), **to determine growth expectations.** Note reported losses/ alterations in functional level. **Provides comparative baseline.**
- Identify present growth age/stage. Review expectations for current height/weight percentiles and degree of deviation.
- Investigate increase in height/weight especially exceeding 3 standard deviations (SDs) above the mean in prepubertal patients. Note presence of headache and other neurological changes. (**May indicate giganitsm due to pituitary tumor.**)
- Note reports of pregressive increase in hat/glove/ring/shoe size in adults, especially after age 40. **Elongation of facial features, hands and feet suggests acromeagaly.**
- Review results of x-rays **to determine bone age/extent of bone and soft-tissue overgrowth,** laboratory studies **to measure hormone levels,** and diagnostic scans **to identify pathology.**
- Assist with therapy to treat/correct underlying conditions (e.g., Crohn's disease, cardiac problems, or renal disease); endocrine problems (e.g., hypothyroidism, type 1 diabetes mellitus, growth hormone abnormalities); genetic/intrauterine growth retardation; infant feeding problems, nutritional deficits. Refer to ND Nutrition, imbalanced [specify].
- Include nutritionist and other specialists (e.g., physical/occupational therapist) in developing plan of care.
- Determine need for medications (e.g., appetite stimulants or antidepressants, growth hormones, etc.).
- Discuss consequences of substance use/abuse.
- Monitor growth periodically. **Aids in evaluating effectiveness of interventions/promotes early identification of need for additional actions.**

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

- Provide information regarding normal growth as appropriate, including pertinent reference materials.
- Discuss appropriateness of appearance, grooming, touching, language, and other associated developmental issues. Refer to NDs Growth and Development, delayed and Self-Care deficit [specify].
- Recommend involvement in regular exercise/sports medicine program **to enhance muscle tone/strength and appropriate body building.**

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

- Discuss actions to take to prevent/avoid preventable complications.
- Identify available community resources as appropriate (e.g., public health programs, such as WIC; medical equipment supplies; nutritionists; substance abuse programs; specialists in endocrine problems/genetics).

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings/individual needs, including current growth status, and trends.
- Caregiver's understanding of situation and individual role.

PLANNING

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

IMPLEMENTATION/EVALUATION

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

DISCHARGE PLANNING

- Identified long-range needs and who is responsible for actions to be taken.
- Specific referrals made, sources for assistive devices, educational tools.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Child Development: [specify age group]
NIC—Nutritional Monitoring

Growth and Development, delayed

Taxonomy II: Growth/Development—Class 2 Development (00111)

[Diagnostic Division: Teaching/Learning]

Definition: Deviations from age-group norms

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

Related Factors

Inadequate caretaking, [physical/emotional neglect or abuse]
Indifference, inconsistent responsiveness, multiple caretakers
Separation from SOs
Environmental and stimulation deficiencies
Effects of physical disability [handicapping condition]
Prescribed dependence [insufficient expectations for self-care]
[Physical/emotional illness (chronic, traumatic), e.g., chronic inflammatory disease, pituitary tumors, impaired nutrition/metabolism, greater-than-normal energy requirements; prolonged/painful treatments; prolonged/repeated hospitalizations]
[Sexual abuse]
[Substance use/abuse]

Defining Characteristics

SUBJECTIVE

Inability to perform self-care or self-control activities appropriate for age

OBJECTIVE

Delay or difficulty in performing skills (motor, social, or expressive) typical of age group; [loss of previously acquired skills, precocious or accelerated skill attainment]
Altered physical growth
Flat affect, listlessness, decreased responses
[Sleep disturbances, negative mood/response]

Desired Outcomes/Evaluation Criteria—Patient Will:

- Perform motor, social, and/or expressive skills typical of age group within scope of present capabilities.
- Perform self-care and self-control activities appropriate for age.
- Demonstrate weight/growth stabilization or progress toward age-appropriate size.

Parents/Caregivers Will:

- Verbalize understanding of growth/developmental delay/deviation and plan(s) for intervention.

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

Actions/Interventions

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

- Determine existing condition(s) contributing to growth/developmental deviation, such as limited intellectual capacity, physical disabilities, accelerated physical growth, early puberty, chronic illness, tumors, genetic anomalies, substance use/abuse, multiple birth (e.g., twins)/minimal length of time between pregnancies.
- Determine nature of parenting/caretaking activities (e.g., inadequate, inconsistent, unrealistic/insufficient expectations; lack of stimulation, limit setting, responsiveness).
- Note severity/pervasiveness of situation (e.g., long-term physical/emotional abuse versus situational disruption or inadequate assistance during period of crisis or transition).
- Assess significant stressful events, losses, separation and environmental changes (e.g., abandonment, divorce; death of parent/sibling; aging; unemployment, new job; moves; new baby/sibling, marriage, new stepparent).
- Active-listen concerns about body size, ability to perform competitively (e.g., sports, body building). Determine use of drugs, which may affect body growth.
- Evaluate hospital/institutional environment for adequate stimulation, diversional or play activities.

NURSING PRIORITY NO. 2. To determine degree of deviation from growth/developmental norms:

- Note chronological age, familial factors including body build/stature **to determine individual expectations.**
- Carefully record height/weight over time **to determine trends.**
- Note findings of psychological evaluation of patient and family. (**Extreme emotional deprivation may retard physical growth by hypothalamic inhibition of growth hormone, as in failure to thrive or dwarfism.**)
- Identify present developmental age/stage. Note reported losses in functional level/evidence of precocious development. **Provides comparative baseline.**
- Review expected skills/activities, using authoritative text (e.g., Gesell, Musen/Congor) or assessment tools (e.g., Draw-a-Person, Denver Developmental Screening Test, Bender's Visual Motor Gestalt Test).
- Note degree of individual deviation, multiple skills affected (e.g., speech, motor activity, socialization versus one area of difficulty, such as toileting).
- Note whether difficulty is temporary or permanent (e.g., setback or delay versus irreversible condition such as brain damage, stroke, Alzheimer's disease).

- Investigate sexual acting-out behaviors inappropriate for age. **May indicate sexual abuse.**
- Note signs of sexual maturation (e.g., development of pubic/axillary hair, breast enlargement, presence of body odor, acne, rapid linear growth, and adolescent-type behavior, with or without maturation of gonads. (**Precocious puberty in females before age 8 or males before age 10 may occur because of lesions of hypothalamus/intracranial tumors).**

NURSING PRIORITY NO. 3. To correct/minimize growth deviations and associated complications:

- Review medication regimen given to stimulate/suppress growth as appropriate, or possibly to shrink tumor when present.
- Stress necessity of not stopping medications without approval of healthcare provider.
- Prepare for surgical interventions/radiation therapy **to treat tumor.**
- Discuss appropriateness and potential complications of bone-lengthening procedures.
- Discuss consequences of substance use/abuse.
- Include nutritionist and other specialists (e.g., physical/occupational therapists) in developing plan of care.
- Monitor growth periodically. **Aids in evaluating effectiveness of interventions/promotes early identification of need for additional actions.**
- Review use of medication to suppress pituitary secretions **to halt precocious puberty and possibility of surgical removal of tumor.**

NURSING PRIORITY NO. 4. To assist patient (and/or caregivers) to prevent, minimize, or overcome delay/regressed or precocious development:

- Consult appropriate professional resources (e.g., occupational/rehabilitation/speech therapists, special education teacher, job counselor) **to address specific individual needs.**
- Encourage recognition that deviation/behavior is appropriate for a specific age level (e.g., 14-year-old is functioning at level of 6-year-old or 9-year-old is displaying pubertal changes). **Promotes acceptance of patient as presented and helps shape expectations reflecting actual situation.**
- Avoid blame when discussing contributing factors.
- Maintain positive, hopeful attitude. Support self-actualizing nature of the individual and attempts to maintain or return to optimal level of self-control or self-care activities.
- Refer family/patient for counseling/psychotherapy **to deal with issues of abuse/neglect.**
- Encourage setting of short-term, realistic goals for achieving developmental potential.

- Involve patient in opportunities to practice new behaviors (e.g., role play, group activities). **Strengthens learning process.**
- Identify equipment needs (e.g., adaptive/growth-stimulating computer programs, communication devices).
- Evaluate progress on continual basis **to increase complexity of tasks/goals as indicated.**
- Provide positive feedback for efforts/successes and adaptation while minimizing failures. **Encourages continuation of efforts, improving outcome.**
- Assist patient/caregivers to accept and adjust to irreversible developmental deviations (e.g., Down syndrome is not currently correctable).
- Provide support for caregiver during transitional crises (e.g., residential schooling, institutionalization).

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

- Provide information regarding normal growth and development process as appropriate. Suggest genetic counseling for family/patient dependent on causative factors.
- Determine reasonable expectations for individual without restricting potential (i.e., set realistic goals that, if met, can be advanced). **Promotes continued personal growth.**
- Discuss appropriateness of appearance, grooming, touching, language, and other associated developmental issues. Refer to ND Self-Care deficit [specify].
- Recommend involvement in regular exercise/sport medicine program **to enhance muscle tone/strength and appropriate body building.**
- Discuss actions to take to avoid preventable complications (e.g., periodic laboratory studies **to monitor hormone levels/nutritional status**).
- Recommend wearing medical alert bracelet when taking replacement hormones.
- Encourage attendance at appropriate educational programs (e.g., parenting classes, infant stimulation sessions, seminars on life stresses, aging process).
- Provide pertinent reference materials and pamphlets. **Enhances learning at own pace.**
- Discuss community responsibilities (e.g., services required to be provided to school-age child). Include social worker/special education team in process of planning **for meeting educational, physical, psychological, and monitoring needs of child.**

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

- Identify community resources as appropriate: public health programs such as Women, Infants, and Children (WIC), nutritionist, substance abuse programs; early intervention programs, seniors' activity/support groups, gifted and talented programs, Sheltered Workshop, crippled children's services, medical equipment/supplier. **Provides additional assistance to support family efforts in treatment program.**
- Evaluate/refer to social services **to determine safety of patient and consideration of placement in foster care.**
- Refer to the NDs Parenting, impaired; Family Processes, interrupted.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings/individual needs including current growth status/trends and developmental level/evidence of regression.
- Caregiver's understanding of situation and individual role.
- Safety of individual/need for placement.

PLANNING

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

IMPLEMENTATION/EVALUATION

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

DISCHARGE PLANNING

- Identified long-range needs and who is responsible for actions to be taken.
- Specific referrals made; sources for assistive devices, educational tools.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Child Development: [specify age group]
NIC—Developmental Enhancement: Child

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

Health Maintenance, ineffective

Taxonomy II: Health Promotion—Class 2 Health Management (00099)

[Diagnostic Division: Safety]

Definition: Inability to identify, manage, and/or seek out help to maintain health [This diagnosis contains components of other NDs. We recommend subsuming health maintenance interventions under the "basic" nursing diagnosis when a single causative factor is identified (e.g., Knowledge, deficient (Specify); Therapeutic Regimen, ineffective management; Confusion, chronic; Communication, impaired verbal; Thought Process, disturbed; Coping, ineffective; Coping, family: compromised; Growth and Development, delayed).]

Related Factors

Lack of or significant alteration in communication skills (written, verbal, and/or gestural)
Unachieved developmental tasks
Lack of ability to make deliberate and thoughtful judgments
Perceptual or cognitive impairment (complete or partial lack of gross and/or fine motor skills)
Ineffective individual coping; dysfunctional grieving; disabling spiritual distress
Ineffective family coping
Lack of material resource; [lack of psychosocial supports]

Defining Characteristics

SUBJECTIVE

Expressed interest in improving health behaviors
Reported lack of equipment, financial and/or other resources; impairment of personal support systems
Reported inability to take the responsibility for meeting basic health practices in any or all functional pattern areas
[Reported compulsive behaviors]

OBJECTIVE

Demonstrated lack of knowledge regarding basic health practices
Observed inability to take the responsibility for meeting basic health practices in any or all functional pattern areas; history of lack of health-seeking behavior

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

Demonstrated lack of adaptive behaviors to internal/external environmental changes
Observed impairment of personal support system; lack of equipment, financial and/or other resources
[Observed compulsive behaviors]

Desired Outcomes/Evaluation Criteria—Patient Will:

- Identify necessary health maintenance activities.
- Verbalize understanding of factors contributing to current situation.
- Assume responsibility for own healthcare needs within level of ability.
- Adopt lifestyle changes supporting individual healthcare goals.

SO/Caregiver Will:

- Verbalize ability to cope adequately with existing situation, provide support/monitoring as indicated.

Actions/Interventions

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

- Determine level of dependence/independence and type/presence of developmental disabilities. **May range from complete dependence (dysfunctional) to partial or relative independence.**
- Assess communication skills/ability/need for interpreter.
- Note whether impairment is a progressive illness/long-term health problem, exacerbation or complication of chronic illness. **May require more intensive/long-lasting intervention.**
- Evaluate for substance use/abuse (e.g., alcohol, narcotics).
- Note desire/level of ability to meet health maintenance needs, as well as self-care ADLs.
- Note setting where patient lives (e.g., long-term care facility, homebound, or homeless).
- Ascertain recent changes in lifestyle (e.g., man whose wife dies and he has no skills for taking care of his own/family's health needs).
- Determine level of adaptive behavior, knowledge, and skills about health maintenance, environment, and safety.
- Evaluate environment **to note individual adaptation needs (e.g., supplemental humidity, air purifier, change in heating system).**
- Note patient's use of professional services and resources (e.g., appropriate or inappropriate/nonexistent).

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

NURSING PRIORITY NO. 2. To assist patient/caregiver(s) to maintain and manage desired health practices:

- Develop plan with patient/SO(s) for self-care. **Allows for incorporating existing disabilities, adapting and organizing care as necessary.**
- Provide time to listen to concerns of patient/SO(s).
- Provide anticipatory guidance **to maintain and manage effective health practices during periods of wellness, and identify ways patient can adapt when progressive illness/long-term health problems occur.**
- Encourage socialization and personal involvement **to prevent regression.**
- Provide for communication and coordination between the healthcare facility team and community healthcare providers **to provide continuation of care.**
- Involve comprehensive specialty health teams when available/indicated (e.g., pulmonary, psychiatric, enterostomal, IV therapy, nutritional support, substance abuse counselors).
- Monitor adherence to prescribed medical regimen **to alter the care plan as needed.**

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

- Provide information about individual healthcare needs.
- Limit amount of information presented at one time, especially when dealing with elderly patient. Present new material through self-paced instruction when possible. **Allows patient time to process and store new information.**
- Help patient/SO(s) develop healthcare goals. Provide a written copy to those involved in planning process **for future reference/revision as appropriate.**
- Assist patient/SO(s) to develop stress management skills.
- Identify ways to adapt exercise program **to meet patient's changing needs/abilities and environmental concerns.**
- Identify signs and symptoms requiring further evaluation and follow-up.
- Make referral as needed for community support services (e.g., homemaker/home attendant, Meals on Wheels, skilled nursing care, Well-Baby Clinic, senior citizen healthcare activities).
- Refer to social services as indicated **for assistance with financial, housing, or legal concerns (e.g., conservatorship).**
- Refer to support groups as appropriate (e.g., senior citizens, Red Cross, Alcoholics or Narcotics Anonymous).
- Arrange for hospice service for patient with terminal illness.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings, including individual abilities; family involvement, and support factors/availability of resources.

PLANNING

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

IMPLEMENTATION/EVALUATION

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

DISCHARGE PLANNING

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Health Promoting Behavior
NIC—Health System Guidance

Health-Seeking Behaviors (specify)

Taxonomy 1 R: Choosing (5.4)
[Diagnostic Division: Teaching/Learning]

Definition: Active seeking (by a person in stable health) of ways to alter personal health habits and/or the environment in order to move toward a higher level of health (**Note:** Stable health is defined as achievement of age-appropriate illness-prevention measures; client reports good or excellent health, and signs and symptoms of disease, if present, are controlled.)

Related Factors

To be developed by NANDA
[Situational/maturational occurrence precipitating concern about current health status]

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

Defining Characteristics

SUBJECTIVE

Expressed desire to seek a higher level of wellness
Expressed desire for increased control of health practice
Expression of concern about current environmental conditions on health status
Stated unfamiliarity with wellness community resources
[Expressed desire to modify codependent behaviors]

OBJECTIVE

Observed desire to seek a higher level of wellness
Observed desire for increased control of health practice
Demonstrated or observed lack of knowledge in health promotion behaviors, unfamiliarity with wellness community resources

Desired Outcomes/Evaluation Criteria—Patient Will:

- Express desire to change specific habit/lifestyle patterns to achieve/maintain optimal health.
- Participate in planning for change.
- Seek community resources to assist with desired change.

Actions/Interventions

NURSING PRIORITY NO. 1. To assess specific concerns/habits/issues patient desires to change:

- Discuss concerns with patient and Active-listen **to identify underlying issues (e.g., physical and/or emotional stressors; and/or external factors such as environmental pollutants or other hazards).**
- Review knowledge base and note coping skills that have been used previously to change behavior/habits.
- Use testing as indicated and review results with patient/SO(s) **to help with development of plan of action.**
- Identify behaviors associated with health habits/poor health practices and measures may need to change.

NURSING PRIORITY NO. 2. To assist patient to develop plan for improving health:

- Explore with patient/SO(s) areas of health over which each individual has control.
- Problem-solve options for change. **Helps identify actions to be taken to achieve desired improvement.**

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

- Provide information about conditions/health risk factors or concerns in written and audio/video tape forms as appropriate. **Use of multiple modalities enhances acquisition/retention of information.**
- Discuss assertive behaviors and provide opportunity for patient to practice new behaviors.
- Use therapeutic communication skills **to provide support for desired changes.**

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

- Acknowledge patient's strengths in present health management and build on in planning for future.
- Encourage use of relaxation skills, medication, visualization, and guided imagery **to assist in management of stress.**
- Instruct in individually appropriate wellness behaviors (e.g., breast self-examination, immunizations, regular medical and dental examinations, healthy diet, exercise program).
- Identify and refer child/family member to health resources for immunizations, basic health services, and to learn health promotion/monitoring skills (e.g., monitoring hydration, measuring fever). **May facilitate long-term attention to health issues.**
- Refer to community resources (e.g., dietitian/weight control program, smoking cessation groups, Alcoholics Anonymous, codependency support groups, assertiveness training/Parent Effectiveness classes, clinical nurse specialists/psychiatrists) **to address specific concerns.**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings including individual concerns/risk factors.
- Patient's request for change.

PLANNING

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

IMPLEMENTATION/EVALUATION

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

DISCHARGE PLANNING

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Health Seeking Behavior
NIC—Self-Modification Assistance

Home Maintenance, impaired

Taxonomy II: Health Promotion—Class 2 Health Management (00098)
[Diagnostic Division: Safety]

Definition: Inability to independently maintain a safe growth-promoting immediate environment

Related Factors

Individual/family member disease or injury
Insufficient family organization or planning
Insufficient finances
Impaired cognitive or emotional functioning
Lack of role modeling
Unfamiliarity with neighborhood resources
Lack of knowledge
Inadequate support systems

Defining Characteristics

SUBJECTIVE

Household members express difficulty in maintaining their home in a comfortable [safe] fashion
Household requests assistance with home maintenance
Household members describe outstanding debts or financial crises

OBJECTIVE

Accumulation of dirt, food, or hygienic wastes
Unwashed or unavailable cooking equipment, clothes, or linen
Overtaxed family members (e.g., exhausted, anxious)
Repeated hygienic disorders, infestations, or infections
Disorderly surroundings; offensive odors
Inappropriate household temperature
Lack of necessary equipment or aids
Presence of vermin or rodents

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

Desired Outcomes/Evaluation Criteria—Patient/Caregiver Will:

- Identify individual factors related to difficulty in maintaining a safe environment.
- Verbalize plan to eliminate health and safety hazards.
- Adopt behaviors reflecting lifestyle changes to create and sustain a healthy/growth-promoting environment.
- Demonstrate appropriate, effective use of resources.

Actions/Interventions

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

- Determine reason for and degree of disability.
- Assess level of cognitive/emotional/physical functioning.
- Identify lack of knowledge/misinformation.
- Discuss home environment **to determine ability to care for self and to identify potential health and safety hazards.**
- Identify support systems available to patient/SO(s).
- Determine financial resources to meet needs of individual situation.

NURSING PRIORITY NO. **2.** To help patient/SO(s) to create/maintain a safe, growth-promoting environment:

- Coordinate planning with multidisciplinary team.
- Arrange for home visit/evaluation as needed.
- Assist patient/SO(s) to develop plan for maintaining a clean, healthful environment (e.g., sharing of household tasks/repairs between family members, contract services, exterminators, trash removal).
- Assist patient/SO(s) to identify and acquire necessary equipment (e.g., lifts, commode chair, safety grab bar, cleaning supplies) **to meet individual needs.**
- Identify resources available for appropriate assistance (e.g., visiting nurse, budget counseling, homemaker, Meals on Wheels, physical/occupational therapy, social services).
- Identify options for financial assistance.

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

- Identify environmental hazards **that may negatively affect health.** Discuss long-term plan for taking care of environmental needs.
- Provide information necessary for the individual situation.
- Plan opportunities for family members/caregivers to have respite from care of patient. **Prevents burnout/role strain.**
- Identify community resources and support systems (e.g., extended family, neighbors).

- Refer to NDs Knowledge, deficient (Specify); Self-Care deficit [specify]; Coping, ineffective; Coping, family: compromised Injury, risk for.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings include individual/environmental factors, presence and use of support systems.

PLANNING

- Plan of care and who is involved in planning; support systems and community resources identified.
- Teaching plan.

IMPLEMENTATION/EVALUATION

- Patient's/SO'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 actions to be taken.
- Specific referrals made, equipment needs/resources.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Self-Care: Instrumental Activities of Daily Living (IADL)
NIC—Home Maintenance Assistance

Hopelessness

Taxonomy II: Self-Perception—Class 1 Self-Concept (00124)

[Diagnostic Division: Ego Integrity]

Definition: Subjective state in which an individual sees limited or no alternatives or personal choices available and is unable to mobilize energy on own behalf

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

Related Factors

Prolonged activity restriction creating isolation
Failing or deteriorating physiological condition
Long-term stress; abandonment
Lost belief in transcendent values/God

Defining Characteristics

SUBJECTIVE

Verbal cues (despondent content, "I can't," sighing); [believes things will not change/problems will always be there]

OBJECTIVE

Passivity, decreased verbalization
Decreased affect
Lack of initiative
Decreased response to stimuli, [depressed cognitive functions, problems with decisions, thought processes; regression]
Turning away from speaker; closing eyes; shrugging in response to speaker
Decreased appetite, increased/decreased sleep
Lack of involvement in care/passively allowing care
[Withdrawal from environs]
[Lack of involvement/interest in SOs (children, spouse)]
[Angry outbursts]

Desired Outcomes/Evaluation Criteria—Patient Will:

- Recognize and verbalize feelings.
- Identify and use coping mechanisms to counteract feelings of hopelessness.
- Involve self in and control (within limits of the individual situation) own self-care and ADLs.
- Set progressive short-term goals to develop/foster/sustain behavioral changes/outlook.
- Participate in diversional activities of own choice.

Actions/Interventions

NURSING PRIORITY NO. 1. To identify causative/contributing factors:
- Review familial/social history and physiological history for problems, such as history of poor coping abilities, disorder of familial relating patterns, emotional problems, language/

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

cultural barriers (**leading to feelings of isolation**), recent or long-term illness of patient or family member, multiple social and/or physiological traumas to individual or family members.
- Note current familial/social/physical situation of patient (e.g., newly diagnosed with chronic/terminal disease, language/cultural barriers, lack of support system, recent job loss, loss of spiritual/religious faith, recent multiple traumas).
- Determine coping behaviors and defense mechanisms displayed.

NURSING PRIORITY NO. 2. To assess level of hopelessness:
- Note behaviors indicative of hopelessness. (Refer to Defining Characteristics.)
- Determine coping behaviors previously used and patient's perception of effectiveness then and now.
- Evaluate/discuss use of defense mechanisms (useful or not), such as increased sleeping, use of drugs, illness behaviors, eating disorders, denial, forgetfulness, daydreaming, ineffectual organizational efforts, exploiting own goal setting, regression.

NURSING PRIORITY NO. 3. To assist patient to identify feelings and to begin to cope with problems as perceived by the patient:
- Establish a therapeutic/facilitative relationship showing positive regard for the patient. **Patient may then feel safe to disclose feelings and feel understood and listened to.**
- Explain all tests/procedures thoroughly. Involve patient in planning schedule for care. Answer questions truthfully. **Enhances trust and therapeutic relationship.**
- Encourage patient to verbalize and explore feelings and perceptions (e.g., anger, helplessness, powerlessness, confusion, despondency, isolation, grief).
- Provide opportunity for children to "play out" feelings (e.g., puppets or art for preschooler, peer discussions for adolescents). **Provides insight into perceptions and may give direction for coping strategies.**
- Express hope to patient and encourage SOs and other health-team members to do so. **Patient may not identify positives in own situation.**
- Assist patient to identify short-term goals. Promote activities to achieve goals, and facilitate contingency planning. **Promotes dealing with situation in manageable steps, enhancing chances for success and sense of control.**
- Discuss current options and list actions that may be taken to gain some control of situation. Correct misconceptions expressed by the patient.
- Endeavor to prevent situations that might lead to feelings of isolation or lack of control in patient's perception.

- Promote patient control in establishing time, place, and frequency of therapy sessions. Involve family members in the therapy situation as appropriate.
- Help patient recognize areas in which he or she has control versus those that are not within his or her control.
- Encourage risk taking in situations in which the patient can succeed.
- Help patient begin to develop coping mechanisms that can be learned and used effectively **to counteract hopelessness.**
- Encourage structured/controlled increase in physical activity. **Enhances sense of well-being.**
- Demonstrate and encourage use of relaxation exercises, guided imagery.

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

- Provide positive feedback for actions taken to deal with and overcome feelings of hopelessness. **Encourages continuation of desired behaviors.**
- Assist patient/family to become aware of factors/situations leading to feelings of hopelessness. **Provides opportunity to avoid/modify situation.**
- Discuss initial signs of hopelessness (e.g., procrastination, increasing need for sleep, decreased physical activity, and withdrawal from social/familial activities).
- Facilitate patient's incorporation of personal loss. **Enhances grief work and promotes resolution of feelings.**
- Encourage patient/family to develop support systems in the immediate community.
- Help patient to become aware of, nurture, and expand spiritual self. (Refer to ND Spiritual Distress.)
- Introduce the patient into a support group before the individual therapy is terminated **for continuation of therapeutic process.**
- Refer to other resources for assistance as indicated (e.g., clinical nurse specialist, psychiatrist, social services, spiritual advisor).

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings, including degree of impairment, use of coping skills and support systems.

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 outcome(s).
- Modifications to plan of care.

DISCHARGE PLANNING

- Identified long-range needs/patient's goals for change and who is responsible for actions to be taken.
- Specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Depression Control
NIC—Hope Instillation

Hyperthermia

Taxonomy II: Safety/Protection—Class 6 Thermoregulation (00007)
[Diagnostic Division: Safety]

Definition: Body temperature elevated above normal range

Related Factors

Exposure to hot environment; inappropriate clothing
Vigorous activity; dehydration
Inability or decreased ability to perspire
Medications or anesthesia
Increased metabolic rate; illness or trauma

Defining Characteristics

SUBJECTIVE

[Headache]

OBJECTIVE

Increase in body temperature above normal range
Flushed skin; warm to touch
Increased respiratory rate, tachycardia; [unstable BP]
Seizures or convulsions; [muscle rigidity/fasciculations]
[Confusion]

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

Desired Outcomes/Evaluation Criteria—Patient Will:

- Maintain core temperature within normal range.
- Be free of complications such as irreversible brain/neurological damage, and acute renal failure.
- Identify underlying cause/contributing factors and importance of treatment, as well as signs/symptoms requiring further evaluation or intervention.
- Demonstrate behaviors to monitor and promote normothermia.
- Be free of seizure activity.

Actions/Interventions

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

- Identify underlying cause (e.g., excessive heat production such as hyperthyroid state, malignant hyperpyrexia; impaired heat dissipation such as heatstroke, dehydration; autonomic dysfunction as occurs with spinal cord transection; hypothalamic dysfunction such as CNS infection, brain lesions, drug overdose; infection).
- Note chronological and developmental age of patient (**children are more susceptible to heatstroke, elderly or impaired individuals may not be able to recognize and/or act on symptoms of hyperthermia).**

NURSING PRIORITY NO. **2.** To evaluate effects/degree of hyperthermia:

- Monitor core temperature. **Note:** Rectal and tympanic temperatures most closely approximate core temperature; however, abdominal temperature monitoring may be done in the premature neonate.
- Assess neurological response, noting level of consciousness and orientation, reaction to stimuli, reaction of pupils, presence of posturing or seizures.
- Monitor BP and invasive hemodynamic parameters if available (e.g., mean arterial pressure—MAP, CVP, PAP, PCWP). **Central hypertension or peripheral/postural hypotension can occur.**
- Monitor heart rate and rhythm. **Dysrhythmias and ECG changes are common due to electrolyte imbalance, dehydration, specific action of catecholamines, and direct effects of hyperthermia on blood and cardiac tissue.**
- Monitor respirations. **Hyperventilation may initially be present, but ventilatory effort may eventually be impaired by seizures, hypermetabolic state (shock and acidosis).**
- Auscultate breath sounds, noting adventitious sounds such as crackles (rales).

- Monitor/record all sources of fluid loss such as urine (**oliguria and/or renal failure may occur due to hypotension, dehydration, shock, and tissue necrosis**); vomiting and diarrhea, wounds/fistulas, and insensible losses (**potentiates fluid and electrolyte losses**).
- Note presence/absence of sweating as body attempts to increase heat loss by evaporation, conduction, and diffusion. **Evaporation is decreased by environmental factors of high humidity and high ambient temperature as well as body factors producing loss of ability to sweat or sweat gland dysfunction (e.g., spinal cord transection, cystic fibrosis, dehydration, vasoconstriction).**
- Monitor laboratory studies such as ABGs, electrolytes, cardiac and liver enzymes (**may reveal tissue degeneration**); glucose; urinalysis (**myoglobinuria, proteinuria, and hemoglobinuria can occur as products of tissue necrosis**); and coagulation profile (**for presence of disseminated intravascular coagulation—DIC**).

NURSING PRIORITY NO. 3. To assist with measures to reduce body temperature/restore normal body/organ function:

- Administer antipyretics, orally/rectally (e.g., aspirin, acetaminophen), as ordered.
- Promote surface cooling by means of undressing (**heat loss by radiation and conduction**); cool environment and/or fans (**heat loss by convection**); cool/tepid sponge baths or immersion (**heat loss by evaporation and conduction**); local ice packs, especially in groin and axillae (**areas of high blood flow**); and/or use of hypothermia blanket. (**Note:** In pediatric patients, tepid water is preferred. **Alcohol sponges are no longer used because they can increase peripheral vascular constriction and CNS depression; cold-water sponges/ immersion can increase shivering, producing heat.**) In presence of malignant hyperthermia, lavage of body cavities with cold water may be used **to promote core cooling.**
- Administer medications (e.g., chlorpromazine or diazepam) as ordered, **to control shivering and seizures.**
- Wrap extremities with bath towels when hypothermia blanket is used, **to minimize shivering.**
- Turn off hypothermia blanket when core temperature is within 1° to 3° of desired temperature **to allow for downward drift.**
- Promote patient safety (e.g., maintain patent airway, padded siderails, skin protection from cold such as when hypothermia blanket is used, observation of equipment safety measures).
- Provide supplemental oxygen **to offset increased oxygen demands and consumption.**

- Administer medications as indicated **to treat underlying cause,** such as antibiotics **(for infection),** dantrolene **(for malignant hyperthermia),** β-blockers **(for thyroid storm).**
- Administer replacement fluids and electrolytes **to support circulating volume and tissue perfusion.**
- Maintain bedrest **to reduce metabolic demands/oxygen consumption.**
- Provide high-calorie diet, tube feedings, or parenteral nutrition **to meet increased metabolic demands.**

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

- Review specific cause such as underlying disease process (thyroid storm); environmental factors (heatstroke); reaction to anesthesia (malignant hyperthermia).
- Identify those factors that patient can control (if any), such as correction of underlying disease process (e.g., thyroid control medication); ways to protect oneself from excessive exposure to environmental heat (e.g., proper clothing, restriction of activity, scheduling outings during cooler part of day); and understanding of family traits (e.g., malignant hyperthermia reaction to anesthesia is often familial).
- Discuss importance of adequate fluid intake **to prevent dehydration.**
- Review signs/symptoms of hyperthermia (e.g., flushed skin, increased body temperature, increased respiratory/heart rate). **Indicates need for prompt intervention.**
- Recommend avoidance of hot tubs/saunas as appropriate **(e.g., patients with cardiac conditions, pregnancy that may affect fetal development or increase maternal cardiac workload).**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Temperature and other assessment findings, including vital signs and state of mentation.

PLANNING

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

IMPLEMENTATION/EVALUATION

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

DISCHARGE PLANNING

- Referrals that are made, those responsible for actions to be taken.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Thermoregulation
NIC—Temperature Regulation

Hypothermia

Taxonomy II: Safety/Protection—Class 6 Thermoregulation (00006)
[Diagnostic Division: Safety]

Definition: Body temperature below normal range

Related Factors

Exposure to cool or cold environment [prolonged exposure, e.g., homeless, immersion in cold water/near drowning; induced hypothermia/cardiopulmonary bypass]
Inadequate clothing
Evaporation from skin in cool environment
Inability or decreased ability to shiver
Aging [or very young]
[Debilitating] illness or trauma, damage to hypothalamus
Malnutrition; decreased metabolic rate, inactivity
Consumption of alcohol; medications[/drug overdose] causing vasodilation

Defining Characteristics

OBJECTIVE

Reduction in body temperature below normal range
Shivering; piloerection
Cool skin
Pallor
Slow capillary refill; cyanotic nailbeds
Hypertension; tachycardia
[Core temperature 95°F/35°C: increased respirations, poor judgment, shivering]
[Core temperature 95° to 93.2°F/35° to 34°C: bradycardia or tachycardia, myocardial irritability/dysrhythmias, muscle rigidity, shivering, lethargic/confused, decreased coordination]
[Core temperature 93.2° to 86°F/34° to 30°C: hypoventilation, bradycardia, generalized rigidity, metabolic acidosis, coma]

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

[Core temperature below 86°F/30°C: no apparent vital signs, heart rate unresponsive to drug therapy, comatose, cyanotic, dilated pupils, apneic, areflexic, no shivering (appears dead)]

Desired Outcomes/Evaluation Criteria—Patient Will:

- Display core temperature within normal range.
- Be free of complications such as cardiac failure, respiratory infection/failure, thromboembolic phenomena.
- Identify underlying cause/contributing factors that are within patient control.
- Verbalize understanding of specific interventions to prevent hypothermia.
- Demonstrate behaviors to monitor and promote normothermia.

Actions/Interventions

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

- Note underlying cause (e.g., exposure to cold weather, cold water immersion, preparation for surgery, open wounds/exposed viscera, multiple rapid transfusions of banked blood, treatment for hyperthermia).
- Note contributing factors: age of patient (e.g., premature neonate, child, elderly person); concurrent/coexisting medical problems (e.g., brainstem injury, near drowning, sepsis, hypothyroidism, alcohol intoxication); nutrition status; living condition/relationship status (e.g., aged/cognitive impaired patient living alone).

NURSING PRIORITY NO. **2.** To prevent further decrease in body temperature:

- Remove wet clothing. Prevent pooling of antiseptic/irrigating solutions under patient in operating room.
- Wrap in warm blankets, extra clothing; cover skin areas outside of operative field.
- Avoid use of heat lamps or hot water bottles. (**Surface rewarming can result in rewarming shock due to surface vasodilation.**)
- Provide warm liquids if patient can swallow.
- Warm blood transfusions as appropriate.
- Prevent drafts in room.

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

NURSING PRIORITY NO. 3. To evaluate effects of hypothermia:

- Measure core temperature with low register thermometer (measuring below 94°F/34°C).
- Assess respiratory effort (**rate and tidal volume are reduced when metabolic rate decreases and respiratory acidosis occurs**).
- Auscultate lungs, noting adventitious sounds (**pulmonary edema, respiratory infection, and pulmonary embolus are possible complications of hypothermia**).
- Monitor heart rate and rhythm. **Cold stress reduces pacemaker function, and bradycardia (unresponsive to atropine), atrial fibrillation, atrioventricular blocks, and ventricular tachycardia can occur. Ventricular fibrillation occurs most frequently when core temperature is 82°F/28°C or below.**
- Monitor BP, noting hypotension. **Can occur due to vasoconstriction, and shunting of fluids as a result of cold injury effect on capillary permeability.**
- Measure urine output (**oliguria/renal failure can occur due to low flow state and/or following hypothermic osmotic diuresis**).
- Note CNS effects (e.g., mood changes, sluggish thinking, amnesia, complete obtundation); and peripheral CNS effects (e.g., paralysis—87.7°F/31°C, dilated pupils—below 86°F/30°C, flat EEG—68°F/20°C).
- Monitor laboratory studies such as ABGs (respiratory and metabolic acidosis); electrolytes; CBC (increased hematocrit, decreased white blood cell count); cardiac enzymes (**myocardial infarct may occur owing to electrolyte imbalance, cold stress catecholamine release, hypoxia, or acidosis**); coagulation profile; glucose; pharmacological profile (**for possible cumulative drug effects**).

NURSING PRIORITY NO. 4. To restore normal body temperature/organ function:

- Assist with measures to normalize core temperature such as warmed IV solutions and warm solution lavage of body cavities (gastric, peritoneal, bladder) or cardiopulmonary bypass if indicated.
- Rewarm no faster than 1° to 2°/h **to avoid sudden vasodilation, increased metabolic demands on heart, and hypotension (rewarming shock).**
- Assist with surface warming by means of warmed blankets, warm environment/radiant heater, electronic warming devices. Cover head/neck and thorax, leaving extremities uncovered as appropriate **to maintain peripheral vasoconstriction. Note:** Do not institute surface rewarming prior to

core rewarming in severe hypothermia (**causes afterdrop of temperature by shunting cold blood back to heart in addition to rewarming shock as a result of surface vasodilation**).
- Protect skin/tissues by repositioning, applying lotion/lubricants, and avoiding direct contact with heating appliance/blanket. (**Impaired circulation can result in severe tissue damage.**)
- Keep patient quiet; handle gently **to reduce potential for fibrillation in cold heart.**
- Provide CPR as necessary, with compressions initially at one-half normal heart rate (**severe hypothermia causes slowed conduction, and cold heart may be unresponsive to medications, pacing, and defibrillation**).
- Maintain patent airway. Assist with intubation if indicated.
- Provide heated, humidified oxygen when used.
- Turn off warming blanket when temperature is within 1° to 3° of desired temperature **to avoid hyperthermia situation.**
- Administer IV fluids with caution **to prevent overload as the vascular bed expands (cold heart is slow to compensate for increased volume).**
- Avoid vigorous drug therapy (**as rewarming occurs, organ function returns, correcting endocrine abnormalities, and tissues become more receptive to the effects of drugs previously administered). Note:** Iloprost IV may help control blood viscosity—**enhancing circulation and reducing risk of gangrene.**
- Immerse hands/feet in warm water/apply warm soaks once body temperature is stabilized. Place sterile cotton between digits and wrap hands/feet with a bulky gauze wrap.
- Perform range-of-motion exercises, provide support hose, reposition, do coughing/deep-breathing exercises, avoid restrictive clothing/restraints **to reduce circulatory stasis.**
- Provide well-balanced, high-calorie diet/feedings **to replenish glycogen stores and nutritional balance.**

NURSING PRIORITY NO. 5. To promote wellness (Teaching/Discharge Considerations):
- Inform patient/SO(s) of procedures being used to rewarm patient.
- Review specific cause of hypothermia.
- Discuss signs/symptoms of early hypothermia (e.g., changes in mentation, somnolence, impaired coordination, slurred speech) **to facilitate recognition of problem and timely intervention.**
- Identify factors that patient can control (if any), such as protection from environment, potential risk for future hypersensitivity to cold, and so forth.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Findings, noting degree of system involvement, respiratory rate, ECG pattern, capillary refill, and level of mentation.
- Graph temperature.

PLANNING

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

IMPLEMENTATION/EVALUATION

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

DISCHARGE PLANNING

- Long-term needs, identifying who is responsible for each action.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Thermoregulation
NIC—Hypothermia Treatment

Infant Behavior, disorganized

Taxonomy II: Coping/Stress Tolerance—Class 3 Neurobehavioral Stress (00116)

[Diagnostic Division: Neurosensory]

Nursing Diagnosis Extension and Classification (NDEC) Revision 1998

Definition: Disintegrated physiological and neurobehavioral responses to the environment

Related Factors

PRENATAL

Congenital or genetic disorders; teratogenic exposure; [exposure to drugs]

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

POSTNATAL

Prematurity; oral/motor problems; feeding intolerance; malnutrition
Invasive/painful procedures; pain

INDIVIDUAL

Gestational/postconceptual age; immature neurological system
Illness; [infection]; [hypoxia/birth asphyxia]

ENVIRONMENTAL

Physical environment inappropriateness
Sensory inappropriateness/overstimulation/deprivation
[Lack of containment/boundaries]

CAREGIVER

Cue misreading/cue knowledge deficit
Environmental stimulation contribution

Defining Characteristics

OBJECTIVE

Regulatory Problems
Inability to inhibit [e.g., "locking in"—inability to look away from stimulus]; irritability

State-Organization System
Active-awake (fussy, worried gaze); quiet-awake (staring, gaze aversion)
Diffuse/unclear sleep, state-oscillation
Irritable or panicky crying

Attention-Interaction System
Abnormal response to sensory stimuli (e.g., difficult to soothe, inability to sustain alert status)

Motor System
Increased, decreased, or limp tone
Finger splay, fisting or hands to face; hyperextension of arms and legs
Tremors, startles, twitches; jittery, jerky, uncoordinated movement
Altered primitive reflexes

Physiological
Bradycardia, tachycardia, or arrhythmias; bradypnea, tachypnea, apnea

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

Pale, cyanotic, mottled, or flushed color
"Time-out signals" (e.g., gaze, grasp, hiccough, cough, sneeze, sigh, slack jaw, open mouth, tongue thrust)
Oximeter desaturation
Feeding intolerances (aspiration or emesis)

Desired Outcomes/Evaluation Criteria—Infant Will:

- Exhibit organized behaviors that allow the achievement of optimal potential for growth and development as evidenced by modulation of physiological, motor, state, and attentional-interactive functioning.

Parent/Caregiver Will:

- Recognize individual infant cues.
- Identify appropriate responses (including environmental modifications) to infant's cues.
- Verbalize readiness to assume caregiving independently.

Actions/Interventions

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

- Determine infant's chronological and developmental age; note length of gestation.
- Observe for cues suggesting presence of situations that may result in pain/discomfort.
- Determine adequacy of physiological support.
- Evaluate level/appropriateness of environmental stimuli.
- Ascertain parents' understanding of infant's needs/abilities.
- Listen to parent's concerns about their capabilities to meet infant's needs.

NURSING PRIORITY NO. **2.** To assist parents in providing co-regulation to the infant:

- Provide a calm, nurturant physical and emotional environment.
- Encourage parents to hold infant, including skin-to-skin contact as appropriate.
- Model gentle handling of baby and appropriate responses to infant behavior. **Provides cues to parent.**
- Support and encourage parents to be with infant and participate actively in all aspects of care. **Situation may be overwhelming and support may enhance coping.**
- Discuss infant growth/development, pointing out current status and progressive expectations as appropriate. **Augments parent knowledge of co-regulation.**

- Incorporate the parents' observations and suggestions into plan of care. **Demonstrates valuing of parents' input and encourages continued involvement.**

NURSING PRIORITY NO. **3.** To deliver cares within the infant's stress threshold:

- Provide a consistent caregiver. **Facilitates recognition of infant cues/changes in behavior.**
- Identify infant's individual self-regulatory behaviors, e.g., sucking, mouthing; grasp, hand-to-mouth, face behaviors; foot clasp, brace; limb flexion, trunk tuck; boundary seeking.
- Support hands to mouth and face; offer pacifier or non-nutritive sucking at the breast with gavage feedings. **Provides opportunities for infant to suck.**
- Avoid aversive oral stimulation, such as routine oral suctioning; suction ET tube only when clinically indicated.
- Use oxy-hood large enough to cover the infant's chest so arms will be inside the hood. **Allows for hand-to-mouth activities during this therapy.**
- Provide opportunities for infant to grasp.
- Provide boundaries and/or containment during all activities. Use swaddling, nesting, bunting, caregiver's hands as indicated.
- Allow adequate time/opportunities to hold infant. Handle infant very gently, move infant smoothly, slowly and contained, avoiding sudden/abrupt movements.
- Maintain normal alignment, position infant with limbs softly flexed, shoulders and hips adducted slightly. Use appropriate-sized diapers.
- Evaluate chest for adequate expansion, placing rolls under trunk if prone position indicated.
- Avoid restraints, including at IV sites. If IV board is necessary, secure to limb positioned in normal alignment.
- Provide a sheepskin, egg-crate mattress, water bed, and/or gel pillow/mattress for infant who does not tolerate frequent position changes. **Minimizes tissue pressure, lessens risk of tissue injury.**
- Visually assess color, respirations, activity, invasive lines without disturbing infant. Assess with "hands on" every 4 hours as indicated and prn. **Allows for undisturbed rest/quiet periods.**
- Schedule daily activities, time for rest, and organization of sleep/wake states **to maximize tolerance of infant.** Defer routine care when infant in quiet sleep.
- Provide care with baby in sidelying position. Begin by talking softly to the baby, then placing hands in containing hold on

baby, **allow baby to prepare.** Proceed with least invasive manipulations first.
- Respond promptly to infant's agitation or restlessness. Provide "time out" when infant shows early cues of overstimulation. Comfort and support the infant after stressful interventions.
- Remain at infant's bedside for several minutes after procedures/caregiving **to monitor infant's response and provide necessary support.**
- Administer analgesics as individually appropriate.

NURSING PRIORITY NO. **4.** To modify the environment to provide appropriate stimulation:
- Introduce stimulation as a single mode and assess individual tolerance.

LIGHT/VISION

- Reduce lighting perceived by infant; introduce diurnal lighting (and activity) when infant achieves physiological stability. (Day light levels of 20 to 30 candles and night light levels of less than 10 candles are suggested.) Change light levels gradually **to allow infant time to adjust.**
- Protect the infant's eyes from bright illumination during examinations/procedures, as well as from indirect sources such as neighboring phototherapy treatments, **to prevent retinal damage.**
- Deliver phototherapy (when required) with Biliblanket devices if available **(alleviates need for eye patches).**
- Provide caregiver face (preferably parent's) as visual stimulus when infant shows readiness (awake, attentive).

SOUND

- Identify sources of noise in environment and eliminate or reduce (e.g., speak in a low voice, reduce volume on alarms/telephones to safe but not excessive volume, pad metal trash can lids, open paper packages such as IV tubing and suction catheters slowly and at a distance from bedside, conduct rounds/report away from bedside, place soft/thick fabric such as blanket rolls and toys near infant's head **to absorb sound**).
- Keep all incubator portholes closed, closing with two hands **to avoid loud snap with closure and associated startle response.**
- Do not play musical toys or tape players inside incubator.
- Avoid placing items on top of incubator; if necessary to do so, pad surface well.

- Conduct regular decibel checks of interior noise level in incubator (recommended not to exceed 60 dB).
- Provide auditory stimulation **to console, support infant before and through handling or to reinforce restfulness.**

OLFACTORY

- Be cautious in exposing infant to strong odors (such as alcohol, Betadine, perfumes), **as olfactory capability of the infant is very sensitive.**
- Place a cloth or gauze pad scented with milk near the infant's face during gavage feeding. **Enhances association of milk with act of feeding/gastric fullness.**
- Invite parents to leave a handkerchief that they have scented by wearing close to their body near infant. **Strengthens infant recognition of parents.**

VESTIBULAR

- Move and handle the infant slowly and gently. Do not restrict spontaneous movement.
- Provide vestibular stimulation **to console, stabilize breathing/heart rate, or enhance growth.** Use a water bed (with or without oscillation), a motorized/moving bed or cradle, or rocking in the arms of a caregiver.

GUSTATORY

- Dip pacifier in milk and offer to infant for sucking and tasting during gavage feeding.

TACTILE

- Maintain skin integrity and monitor closely. Limit frequency of invasive procedures.
- Minimize use of chemicals on skin (e.g., alcohol, Betadine, solvents) and remove afterward with warm water **because skin is very sensitive/fragile.**
- Limit use of tape and adhesives directly on skin. Use DuoDerm under tape **to prevent dermal injury.**
- Touch infant with a firm containing touch, avoid light stroking. Provide a sheepskin, soft linen. **Note: Tactile experience is the primary sensory mode of the infant.**
- Encourage frequent parental holding of infant (including skin-to-skin). Supplement activity with extended family, staff, volunteers.

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

- Evaluate home environment **to identify appropriate modifications.**

- Identify community resources (e.g., early stimulation program, qualified child-care facilities/respite care, visiting nurse, home-care support, specialty organizations).
- Determine sources for equipment/therapy needs.
- Refer to support/therapy groups as indicated **to provide role models, facilitate adjustment to new roles/responsibilities, and enhance coping.**
- Provide contact number, as appropriate (e.g., primary nurse) **to support adjustment to home setting.**
- Refer to additional NDs such as Attachment, risk for impaired parent/infant/child; Coping, family: compromised/disabled/readiness for enhanced; Growth and Development, delayed; Caregiver Role Strain, risk for.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Findings, including infant's cues of stress, self-regulation, and readiness for stimulation; chronological/developmental age.
- Parent's concerns, level of knowledge.

PLANNING

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

IMPLEMENTATION/EVALUATION

- Infant's responses to interventions/actions performed.
- Parents' participation and response to interactions/teaching.
- Attainment/progress toward desired outcome(s).
- Modifications of 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—Neurological Status
NIC—Environmental Management

Infant Behavior, risk for disorganized

Taxonomy II: Coping/Stress Tolerance—Class 3 Neurobehavioral Stress (00115)
[Diagnostic Division: Neurosensory]

Definition: Risk for alteration in integration and modulation of the physiological and behavioral systems of functioning (i.e., autonomic, motor, state, organizational, self-regulatory, and attentional-interactional systems)

Risk Factors

Pain
Oral/motor problems
Environmental overstimulation
Lack of containment/boundaries
Invasive/painful procedures
Prematurity; [immaturity of the CNS; genetic problems that alter neurological and/or physiological functioning, conditions resulting in hypoxia and/or birth asphyxia]
[Malnutrition; infection; drug addiction]
[Environmental events or conditions such as separation from parents, exposure to loud noise, excessive handling, bright lights]

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—Infant Will:

- Exhibit organized behaviors that allow the achievement of optimal potential for growth and development as evidenced by modulation of physiological, motor, state, and attentional-interactive functioning.

Parent/Caregiver Will:

- Identify cues reflecting infant's stress threshold and current status.
- Develop/modify responses (including environment) to promote infant adaptation and development.
- Verbalize readiness to assume caregiving independently. Refer to ND Infant Behavior, disorganized for Actions/Interventions and Documentation Focus.

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Neurological Status
NIC—Environmental Management

Infant Behavior, readiness for enhanced, organized

Taxonomy II: Coping/Stress Tolerance—Class 3 Neurobehavioral (00117)
[Diagnostic Division: Neurosensory]

Definition: A pattern of modulation of the physiological and behavioral systems of functioning (i.e., autonomic, motor, state-organizational, self-regulators, and attentional-interactional systems) in an infant that is satisfactory but that can be improved resulting in higher levels of integration in response to environmental stimuli

Related Factors

Prematurity
Pain

Defining Characteristics

OBJECTIVE

Stable physiological measures
Definite sleep-wake states
Use of some self-regulatory behaviors
Response to visual/auditory stimuli

Desired Outcomes/Evaluation Criteria—Infant Will:

- Continue to modulate physiological and behavioral systems of functioning.
- Achieve higher levels of integration in response to environmental stimuli.

Parent/Caregiver Will:

- Identify cues reflecting infant's stress threshold and current status.

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

- Develop/modify responses (including environment) to promote infant adaptation and development.

Actions/Interventions

NURSING PRIORITY NO. **1.** To assess infant status and parental skill level:

- Determine infant's chronological and developmental age; note length of gestation.
- Identify infant's individual self-regulatory behaviors: suck, mouth; grasp, hand-to-mouth, face behaviors; foot clasp, brace; limb flexion, trunk tuck; boundary seeking.
- Observe for cues suggesting presence of situations that may result in pain/discomfort.
- Evaluate level/appropriateness of environmental stimuli.
- Ascertain parents' understanding of infant's needs/abilities.
- Listen to parents' perceptions of their capabilities to promote infant's development.

NURSING PRIORITY NO. **2.** To assist parents to enhance infant's integration:

- Review infant growth/development, pointing out current status and progressive expectations. Identify cues reflecting infant stress.
- Discuss possible modifications of environmental stimuli/activity schedule, sleep and pain control needs.
- Incorporate parents' observations and suggestions into plan of care. **Demonstrates valuing of parents' input and enhances sense of ability to deal with situation.**

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

- Identify community resources (e.g., visiting nurse, home care support, child care).
- Refer to support group/individual role model **to facilitate adjustment to new roles/responsibilities.**
- Refer to additional NDs, for example, Coping, family: readiness for enhanced.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Findings, including infant's self-regulation and readiness for stimulation; chronological/developmental age.
- Parents' concerns, level of knowledge.
- Plan of care and who is involved in the planning.
- Teaching plan.

IMPLEMENTATION/EVALUATION

- Infant's responses to interventions/actions performed.
- Parents' participation and response to interactions/teaching.
- Attainment/progress toward desired outcome(s).
- Modifications of 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—Neurological Status
NIC—Developmental Care

Infant Feeding Pattern, ineffective

Taxonomy II: Nutrition—Class 1 Ingestion (00107)
[Diagnostic Division: Food/Fluid]

Definition: Impaired ability to suck or coordinate the suck–swallow response

Related Factors

Prematurity
Neurological impairment/delay
Oral hypersensitivity
Prolonged NPO
Anatomic abnormality

Defining Characteristics

SUBJECTIVE

[Caregiver reports infant is unable to initiate or sustain an effective suck]

OBJECTIVE

Inability to initiate or sustain an effective suck
Inability to coordinate sucking, swallowing, and breathing

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

Desired Outcomes/Evaluation Criteria—Patient Will:

- Display adequate output as measured by sufficient number of wet diapers daily.
- Demonstrate appropriate weight gain.
- Be free of aspiration.

Actions/Interventions

NURSING PRIORITY NO. 1. To identify contributing factors/degree of impaired function:

- Assess developmental age, structural abnormalities (e.g., cleft lip/palate), mechanical barriers (e.g., ET tube, ventilator).
- Determine level of consciousness, neurological damage, seizure activity, presence of pain.
- Note type/scheduling of medications. (**May cause sedative effect/impair feeding activity.**)
- Compare birth and current weight/length measurements.
- Assess signs of stress when feeding (e.g., tachypnea, cyanosis, fatigue/lethargy).
- Note presence of behaviors indicating continued hunger after feeding.

NURSING PRIORITY NO. 2. To promote adequate infant intake:

- Determine appropriate method for feeding (e.g., special nipple/feeding device, gavage/enteral tube feeding) and choice of formula/breast milk to meet infant needs.
- Demonstrate techniques/procedures for feeding. Note proper positioning of infant, "latching-on" techniques, rate of delivery of feeding, frequency of burping.
- Monitor caregiver's efforts. Provide feedback and assistance as indicated. **Enhances learning, encourages continuation of efforts.**
- Refer mother to lactation specialist **for assistance and support in dealing with unresolved issues (e.g., teaching infant to suck).**
- Emphasize importance of calm/relaxed environment during feeding.
- Adjust frequency and amount of feeding according to infant's response. **Prevents infant's frustration associated with under/overfeeding.**
- Advance diet, adding solids or thickening agent as appropriate for age and infant needs.
- Alternate feeding techniques (e.g., nipple and gavage) according to infant's ability and level of fatigue.

- Alter medication/feeding schedules as indicated **to minimize sedative effects.**

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

- Instruct caregiver in techniques to prevent/alleviate aspiration.
- Discuss anticipated growth and development goals for infant, corresponding caloric needs.
- Suggest monitoring infant's weight and nutrient intake periodically.
- Recommend participation in classes as indicated (e.g., first aid, infant CPR).

Documentation Focus

ASSESSMENT/REASSESSMENT

- Type and route of feeding, interferences to feeding and reactions.
- Infant's measurements.

PLANNING

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

IMPLEMENTATION/EVALUATION

- Infant's response to interventions (e.g., amount of intake, weight gain, response to feeding) and actions performed.
- Caregiver's involvement in infant care, participation in activities, response to teaching.
- Attainment of/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—Swallowing Status: Oral Phase
NIC—Nutritional Monitoring

Infection, risk for

Taxonomy II: Safety/Protection—Class 1 Infection (00004)

[Diagnostic Division: Safety]

Definition: At increased risk for being invaded by pathogenic organisms

Risk Factors

Inadequate primary defenses (broken skin, traumatized tissue, decrease in ciliary action, stasis of body fluids, change in pH secretions, altered peristalsis)
Inadequate secondary defenses (e.g., decreased hemoglobin, leukopenia, suppressed inflammatory response) and immunosuppression
Inadequate acquired immunity; tissue destruction and increased environmental exposure; invasive procedures
Chronic disease, malnutrition, trauma
Pharmaceutical agents [including antibiotic therapy]
Rupture of amniotic membranes
Insufficient knowledge to avoid exposure to pathogens

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—Patient Will:

- Verbalize understanding of individual causative/risk factor(s).
- Identify interventions to prevent/reduce risk of infection.
- Demonstrate techniques, lifestyle changes to promote safe environment.
- Achieve timely wound healing; be free of purulent drainage or erythema; be afebrile.

Actions/Interventions

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

- Note risk factors for occurrence of infection (e.g., compromised host, skin integrity, environmental exposure).
- Observe for localized signs of infection at insertion sites of invasive lines, sutures, surgical incisions/wounds.

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

- Assess and document skin conditions around insertions of pins, wires, and tongs, noting inflammation and drainage.
- Note signs and symptoms of sepsis (systemic infection): fever, chills, diaphoresis, altered level of consciousness, positive blood cultures.
- Obtain appropriate tissue/fluid specimens for observation and culture/sensitivities testing.

NURSING PRIORITY NO. 2. To reduce/correct existing risk factors:

- Stress proper handwashing techniques by all caregivers between therapies/patients. **A first-line defense against nosocomial infections/cross-contamination.**
- Monitor visitors/caregivers **to prevent exposure of patient.**
- Provide for isolation as indicated (e.g., wound/skin, reverse). **Reduces risk of cross-contamination.**
- Perform/instruct in preoperative body shower/scrubs when indicated (e.g., orthopedic, plastic surgery).
- Maintain sterile technique for invasive procedures (e.g., IV, urinary catheter, pulmonary suctioning).
- Cleanse incisions/insertion sites daily and prn with povidone-iodine or other appropriate solution.
- Change dressings as needed/indicated.
- Separate touching surfaces when skin is excoriated, such as in herpes zoster. Use gloves when caring for open lesions **to minimize autoinoculation/transmission of viral diseases (e.g., herpes simplex virus, hepatitis, AIDS).**
- Cover dressings/casts with plastic when using bedpan **to prevent contamination when wound is in perineal/pelvic region.**
- Encourage early ambulation, deep breathing, coughing, position change **for mobilization of respiratory secretions.**
- Monitor/assist with use of adjuncts (e.g., respiratory aids such as incentive spirometry) **to prevent pneumonia.**
- Maintain adequate hydration, stand/sit to void, and catheterize if necessary **to avoid bladder distention.**
- Provide regular catheter/perineal care. **Reduces risk of ascending UTI.**
- Assist with medical procedures (e.g., wound/joint aspiration, incision and drainage of abscess, bronchoscopy) as indicated.
- Administer/monitor medication regimen (e.g., antimicrobials, drip infusion into osteomyelitis, subeschar clysis, topical antibiotics) and note patient's response **to determine effectiveness of therapy/presence of side effects.**
- Administer prophylactic antibiotics and immunizations as indicated.

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

- Review individual nutritional needs, appropriate exercise program, and need for rest.
- Instruct patient/SO(s) in techniques to protect the integrity of skin, care for lesions, and prevention of spread of infection.
- Emphasize necessity of taking antibiotics as directed (e.g., dosage and length of therapy). **Premature discontinuation of treatment when patient begins to feel well may result in return of infection.**
- Discuss importance of not taking antibiotics/using "leftover" drugs unless specifically instructed by healthcare provider. **Inappropriate use can lead to development of drug-resistant strains/secondary infections.**
- Discuss the role of smoking in respiratory infections.
- Promote safer-sex practices and report sexual contacts of infected individuals **to prevent the spread of sexually transmitted disease.**
- Involve in community education programs geared to increasing awareness of spread/prevention of communicable diseases.
- Promote childhood immunization program. Encourage adults to update immunizations as appropriate.
- Include information in preoperative teaching about ways to reduce potential for postoperative infection (e.g., respiratory measures to prevent pneumonia, wound/dressing care, avoidance of others with infection).
- Review use of prophylactic antibiotics if appropriate (e.g., prior to dental work for patients with history of rheumatic fever).
- Identify resources available to the individual (e.g., substance abuse/rehabilitation or needle exchange program as appropriate; available/free condoms, and so on).
- Refer to NDs Disuse Syndrome, risk for; Home Maintenance, Impaired; Health Maintenance, ineffective.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual risk factors that are present including recent/current antibiotic therapy.
- Wound and/or insertion sites, character of drainage/body secretions.
- Signs/symptoms of infectious process

PLANNING

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

IMPLEMENTATION/EVALUATION

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

DISCHARGE PLANNING

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Immune Status
NIC—Infection Protection

Injury, risk for

Taxonomy II: Safety/Protection—Class 2 Physical Injury (00035)

[Diagnostic Division: Safety]

Definition: At risk of injury as a result of environmental conditions interacting with the individual's adaptive and defensive resources

Risk Factors

INTERNAL

Biochemical, regulatory function (e.g., sensory disfunction)
Integrative or effector dysfunction; tissue hypoxia; immune/autoimmune dysfunction; malnutrition; abnormal blood profile (e.g., leukocytosis/leukopenia, altered clotting factors, thrombocytopenia, sickle cell, thalassemia, decreased hemoglobin)
Physical (e.g., broken skin, altered mobility); developmental age (physiological, psychosocial)
Psychological (affective, orientation)

EXTERNAL

Biological (e.g., immunization level of community, microorganism)

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

Chemical (e.g., pollutants, poisons, drugs, pharmaceutical agents, alcohol, caffeine, nicotine, preservatives, cosmetics, dyes); nutrients (e.g., vitamins, food types)
Physical (e.g., design, structure, and arrangement of community, building, and/or equipment), mode of transport or transportation
People/provider (e.g., nosocomial agent, staffing patterns; cognitive, affective, and psychomotor factors).

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—Patient/Caregivers Will:

- Verbalize understanding of individual factors that contribute to possibility of injury and take steps to correct situation(s).
- Demonstrate behaviors, lifestyle changes to reduce risk factors and protect self from injury.
- Modify environment as indicated to enhance safety.
- Be free of injury.

Actions/Interventions

In reviewing this ND, it is apparent there is much overlap with other diagnoses. We have chosen to present generalized interventions. Although there are commonalities to injury situations, we suggest that the reader refer to other primary diagnoses as indicated, such as Poisoning, Suffocation, Trauma, and Falls, risk for; Wandering; Mobility, impaired physical; Thought Processes, disturbed; Confusion, acute or chronic; Sensory Perception, disturbed; Home Maintenance, ineffective; Nutrition: imbalanced, less than body requirements; Skin Integrity, impaired/risk for impaired; Gas Exchange, impaired; Tissue Perfusion, ineffective; Cardiac Output, decreased; Infection, risk for; Violence, risk for other-directed/self-directed; Parenting, impaired/risk for impaired.

NURSING PRIORITY NO. **1.** To evaluate degree/source of risk inherent in the individual situation:

- Note age and sex **(children, young adults, elderly persons, and men are at greater risk).**
- Evaluate developmental level, decision-making ability, level of cognition and competence.

- Assess mood, coping abilities, personality styles (i.e., temperament, aggression, impulsive behavior, level of self-esteem) **that may result in careless/increased risk taking without consideration of consequences.**
- Evaluate individual's response to violence in surroundings (e.g., neighborhood, TV, peer group). **May enhance disregard for own/others' safety.**
- Ascertain knowledge of safety needs/injury prevention and motivation to prevent injury in home, community, and work setting.
- Determine potential for abusive behavior by family members/SO(s)/peers.
- Note socioeconomic status/availability and use of resources.
- Assess muscle strength, gross and fine motor coordination.
- Observe for signs of injury and age (e.g., old/new bruises, history of fractures, frequent absences from school/work).

NURSING PRIORITY NO. 2. To assist patient/caregiver to reduce or correct individual risk factors:

- Provide information regarding disease/condition(s) that may result in increased risk of injury (e.g., osteoporosis).
- Identify interventions/safety devices **to promote safe physical environment and individual safety.** Refer to physical or occupational therapist as appropriate.
- Review consequences of previously determined risk factors (e.g., increase in oral cancer among teenagers using smokeless tobacco; occurrence of spontaneous abortion, fetal alcohol syndrome/neonatal addiction in prenatal women using tobacco, alcohol, and other drugs).
- Demonstrate/encourage use of techniques to reduce/manage stress and vent emotions such as anger, hostility.
- Discuss importance of self-monitoring of conditions/emotions that can contribute to occurrence of injury (e.g., fatigue, anger, irritability).
- Encourage participation in self-help programs, such as assertiveness training, positive self-image **to enhance self-esteem.**
- Review expectations caregivers have of children, cognitively impaired, and/or elderly family members.
- Discuss need for and sources of supervision (e.g., before and after school programs, elderly day care).
- Discuss concerns about child care, discipline practices.

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

- Refer to other resources as indicated (e.g., counseling/psychotherapy, budget counseling, parenting classes).
- Provide bibliotherapy/written resources **for later review and self-paced learning.**

- Promote community education programs geared to increasing awareness of safety measures and resources available to the individual.
- Promote community awareness about the problems of design of buildings, equipment, transportation, and workplace practices that contribute to accidents.
- Identify community resources/neighbors/friends to assist elderly/handicapped individuals in providing such things as structural maintenance, snow and ice removal from walks and steps, and so forth.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual risk factors, noting current physical findings (e.g., bruises, cuts).
- Patient's/caregiver's understanding of individual risks/safety concerns.

PLANNING

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

IMPLEMENTATION/EVALUATION

- Individual responses to interventions/teaching and actions performed.
- Specific actions and changes that are made.
- Attainment/progress toward desired outcome(s).
- Modifications to plan of care.

DISCHARGE PLANNING

- Long-range plans for discharge needs, lifestyle and community changes, and who is responsible for actions to be taken.
- Specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Safety Behavior: Personal
NIC—Surveillance: Safety

Injury, risk for perioperative positioning

Taxonomy II: Safety/Protection—Class 2 Physical Injury (00087)

[Diagnostic Division: Safety]

Definition: At risk for injury as a result of the environmental conditions found in the perioperative setting

Risk Factors

Disorientation; sensory/perceptual disturbances due to anesthesia
Immobilization, muscle weakness; [preexisting musculoskeletal conditions]
Obesity; emaciation; edema
[Elderly]

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—Patient Will:

- Be free of injury related to perioperative disorientation.
- Be free of untoward skin and tissue injury or changes lasting beyond 24 to 48 hours postprocedure.
- Report resolution of localized numbness, tingling, or changes in sensation related to positioning within 24 to 48 hours as appropriate.

Actions/Interventions

NURSING PRIORITY NO. **1.** To identify individual risk factors/needs:

- Note anticipated length of procedure and customary position **to increase awareness of potential complications (e.g., supine position may cause low back pain and skin pressure at heels/elbows/sacrum; lateral chest position can cause shoulder and neck pain plus eye and ear injury on the patient's downside).**

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

- Review patient's history, noting age, weight/height, nutritional status, physical limitations/preexisting conditions. **May affect choice of position and skin/tissue integrity during surgery (e.g., elderly person with no subcutaneous padding, arthritis; thoracic outlet/cubital tunnel syndrome, diabetes, obesity, presence of abdominal stoma, peripheral vascular disease, level of hydration, temperature of extremities).**
- Assess the individual's responses to preoperative sedation/medication, noting level of sedation and/or adverse effects (e.g., drop in BP) and report to surgeon as indicated.
- Evaluate environmental conditions/safety issues surrounding the sedated patient (e.g., patient holding area, siderails up on bed/cart, someone with the patient, etc.).

NURSING PRIORITY NO. 2. To position patient to provide protection for anatomic structures and to prevent patient injury:

- Lock cart/bed in place, provide body and limb support for patient during transfers, using adequate numbers of personnel.
- Place safety strap strategically **to secure patient for specific procedure.** Avoid pressure on extremities when securing straps.
- Maintain body alignment as much as possible, using pillows, padding, safety straps **to secure position.**
- Protect body from contact with metal parts of the operating table, **which could produce burns.**
- Position extremities **to facilitate periodic evaluation of safety, circulation, nerve pressure, and body alignment, especially when moving table attachments.**
- Apply and reposition padding of pressure points of bony prominences (e.g., arms, ankles) and neurovascular pressure points (e.g., breasts, knees) **to maintain position of safety.**
- Place legs in stirrups simultaneously, adjusting stirrup height to patient's legs, maintaining symmetrical position (when lithotomy position used). Pad popliteal space as indicated.
- Check peripheral pulses and skin color/temperature periodically **to monitor circulation.**
- Reposition slowly at transfer and in bed (especially halothane-anesthetized patient) **to prevent severe drop in BP, dizziness, or unsafe transfer.**
- Protect airway and facilitate respiratory effort following extubation.
- Determine specific position reflecting procedure guidelines (e.g., head of bed elevated following spinal anesthesia, turn to unoperated side following pneumonectomy).

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

- Provide perioperative teaching relative to patient safety issues including not crossing legs during procedures performed under local or light anesthesia; postoperative needs/limitations, and signs/symptoms requiring medical evaluation.
- Inform patient and postoperative caregivers of expected/transient reactions (such as low backache, localized numbness, and reddening or skin indentations, all of which should disappear in 24 hours).
- Assist with therapies/nursing actions including skin care measures, application of elastic stockings, early mobilization **to promote skin and tissue integrity.**
- Encourage/assist with frequent range-of-motion exercises, especially when joint stiffness occurs.
- Identify potential hazards in the surgical suite and implement corrections as appropriate.
- Refer to appropriate resources as needed.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Findings, including individual risk factors for problems in the perioperative setting/need to modify routine activities or positions.
- Periodic evaluation of monitoring activities.

PLANNING

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

IMPLEMENTATION/EVALUATION

- Response to interventions 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.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Risk Control
NIC—Positioning: Intraoperative

Intracranial, decreased adaptive capacity

Taxonomy II: Coping/Stress Tolerance—Class 3 Neurobehavioral Stress (00049)

[Diagnostic Division: Circulation]

Definition: Intracranial fluid dynamic mechanisms that normally compensate for increases in intracranial volume are compromised, resulting in repeated disproportionate increases in intracranial pressure (ICP) in response to a variety of noxious and non-noxious stimuli

Related Factors

Brain injuries
Sustained increase in ICP = 10 to 15 mm Hg
Decreased cerebral perfusion pressure ≤ 50 to 60 mm Hg
Systemic hypotension with intracranial hypertension

Defining Characteristics

OBJECTIVE

Repeated increases in ICP of >10 mm Hg for more than 5 minutes following a variety of external stimuli
Disproportionate increase in ICP following single environmental or nursing maneuver stimulus
Elevated P_2 ICP waveform
Volume pressure response test variation (volume-pressure ratio 2, pressure-volume index <10)
Baseline ICP equal to or greater than 10 mm Hg
Wide amplitude ICP waveform
[Altered level of consciousness—coma]
[Changes in vital signs, cardiac rhythm]

Desired Outcomes/Evaluation Criteria—Patient Will:

- Demonstrate stable ICP as evidenced by normalization of pressure waveforms/response to stimuli.
- Display improved neurological signs.

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

Actions/Interventions

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

- Determine factors related to individual situation (e.g., cause for coma)
- Monitor/document changes in ICP waveform and corresponding event (e.g., suctioning, position change, monitor alarms, family visit) **in order to alter care appropriately.**

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

- Assess eye opening and position/movement, pupils (size, shape, equality, light reactivity), and consciousness/mental status.
- Note purposeful and nonpurposeful motor response (posturing and so on), comparing right/left sides.
- Test for presence/absence of reflexes (e.g., blink, cough, gag, Babinski's reflex), nuchal rigidity.
- Monitor vital signs and cardiac rhythm before/during/after activity. **Helps determine parameters for "safe" activity.**

NURSING PRIORITY NO. 3. To minimize/correct causative factors/maximize perfusion:

- Elevate head of bed (HOB) 15 to 45 degrees (30 degrees for child), as individually appropriate.
- Maintain head/neck in neutral position, support with small towel rolls or pillows to maximize venous return. Avoid placing head on large pillow or causing hip flexion of 90 degrees or more.
- Decrease extraneous stimuli/provide comfort measures (e.g., quiet environment, soft voice, tapes of familiar voices played through earphones, back massage, gentle touch as tolerated) **to reduce central nervous system (CNS) stimulation and promote relaxation.**
- Limit painful procedures (e.g., venipunctures, redundant neurological evaluations) to those that are absolutely necessary.
- Provide rest periods between care activities and limit duration of procedures. Lower lighting/noise level, schedule and limit activities **to provide restful environment and promote regular sleep patterns** (i.e., day/night pattern).
- Limit/prevent activities that increase intrathoracic/abdominal pressures (e.g., coughing, vomiting, straining at stool). Avoid/limit use of restraints. **These factors markedly increase ICP.**
- Suction with caution—only when needed—and limited to 2 passes of 10 seconds each with negative pressure no more than 120 mm Hg. Suction just beyond end of endo/tracheal tube without touching tracheal wall or carina. Administer lidocaine intratracheally **(reduces cough reflex),** hyperoxygenate before suctioning as appropriate **to minimize hypoxia.**

- Maintain patency of urinary drainage system **to reduce risk of hypertension, increased ICP, associated dysreflexia if spinal cord injury is also present, and spinal cord shock is past.** (Refer to ND Autonomic Dysreflexia.)
- Weigh as indicated. Calculate fluid balance every shift/daily **to determine fluid needs/maintain hydration and prevent fluid overload.**
- Restrict fluid intake as necessary, administer IV fluids via pump/control device **to prevent inadvertent vascular bolus or overload.**
- Regulate environmental temperature/bed linens, use cooling blanket as indicated **to decrease metabolic and O_2 needs when fever present.**
- Investigate increased restlessness **to determine causative factors and initiate corrective measures early or as indicated.**
- Provide appropriate safety measures/initiate treatment for seizures **to prevent injury/increase of ICP/hypoxia.**
- Administer supplemental oxygen; hyperventilate as indicated when on mechanical ventilation. Monitor arterial blood gases (ABGs), particularly CO_2 and Pao_2 levels. **$Paco_2$ level of 28 to 30 mm Hg decreases cerebral blood flow while maintaining adequate cerebral oxygenation, while a Pao_2 of less than 65 mm Hg may cause cerebral vascular dilation.**
- Administer medications (e.g., antihypertensives, diuretics, analgesics/sedatives, antipyretics, vasopressors, antiseizure drugs, neuromuscular blocking agents, and corticosteroids) as appropriate **to maintain homeostasis.**
- Prepare patient for surgery as indicated (e.g., evacuation of hematoma/space-occupying lesion) **to reduce ICP/enhance circulation.**

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

- Discuss with caregivers specific situations (e.g., if patient choking or experiencing pain, needing to be repositioned, constipated, blocked urinary flow) and review appropriate interventions **to prevent/limit episodic increases in ICP.**
- Identify signs/symptoms suggesting increased ICP (in patient at risk without an ICP monitor), for example, restlessness, deterioration in neurological responses. Review appropriate interventions.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Neurological findings noting right/left sides separately (such as pupils, motor response, reflexes, restlessness, nuchal rigidity).

- Response to activities/events (e.g., changes in pressure waveforms/vital signs).
- Presence/characteristics of seizure activity.

PLANNING

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

IMPLEMENTATION/EVALUATION

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

DISCHARGE PLANNING

- Future needs, plan for meeting them, and determining who is responsible for actions.
- Referrals as identified.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Neurological Status
NIC—Cerebral Edema Management

Knowledge, Deficient (specify) [Learning Need]

Taxonomy II: Perception/Cognition—Class 4 Cognition (00126)

[Diagnostic Division: Teaching/Learning]

Definition: Absence or deficiency of cognitive information related to specific topic [Lack of specific information necessary for patients/SO(s) to make informed choices regarding condition/treatment/lifestyle changes]

Related Factors

Lack of exposure
Information misinterpretation
Unfamiliarity with information resources
Lack of recall
Cognitive limitation
Lack of interest in learning

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

[Patient's request for no information]
[Inaccurate/incomplete information presented]

Defining Characteristics

SUBJECTIVE

Verbalization of the problem
[Request for information]
[Statements reflecting misconceptions]

OBJECTIVE

Inaccurate follow-through of instruction
Inadequate performance of test
Inappropriate or exaggerated behaviors (e.g., hysterical, hostile, agitated, apathetic)
[Development of preventable complication]

Desired Outcomes/Evaluation Criteria—Patient Will:

- Participate in learning process.
- Identify interferences to learning and specific action(s) to deal with them.
- Exhibit increased interest/assume responsibility for own learning and begin to look for information and ask questions.
- Verbalize understanding of condition/disease process and treatment.
- Identify relationship of signs/symptoms to the disease process and correlate symptoms with causative factors.
- Perform necessary procedures correctly and explain reasons for the actions.
- Initiate necessary lifestyle changes and participate in treatment regimen.

Actions/Interventions

NURSING PRIORITY NO. **1.** To assess readiness to learn and individual learning needs:

- Ascertain level of knowledge, including anticipatory needs.
- Determine patient's ability to learn. (**May not be physically, emotionally, or mentally capable at this time.**)
- Be alert to signs of avoidance. **May need to allow patient to suffer the consequences of lack of knowledge before patient is ready to accept information.**
- Identify support persons/SO(s) requiring information.

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

NURSING PRIORITY NO. 2. To determine other factors pertinent to the learning process:

- Note personal factors (e.g., age, sex, social/cultural influences, religion, life experiences, level of education, sense of powerlessness).
- Determine blocks to learning: language barriers (e.g., can't read, speaks/understands only nondominant language); physical factors (e.g., sensory deficits, such as aphasia, dyslexia); physical stability (e.g., acute illness, activity intolerance); difficulty of material to be learned.
- Assess the level of the patient's capabilities and the possibilities of the situation. **(May need to help SO[s] and/or caregivers to learn.)**

NURSING PRIORITY NO. 3. To assess the patient's/SO(s') motivation:

- Identify motivating factors for the individual.
- Provide information relevant to the situation.
- Provide positive reinforcement. **(Encourages continuation of efforts.)** Avoid use of negative reinforcers (e.g., criticism and threats).

NURSING PRIORITY NO. 4. To establish priorities in conjunction with patient:

- Determine patient's most urgent need from both patient's and nurse's viewpoint. **Identifies starting point.**
- Discuss patient's perception of need. Relate information to patient's personal desires/needs and values/beliefs.
- Differentiate "critical" content from "desirable" content. **Identifies information that can be addressed at a later time.**

NURSING PRIORITY NO. 5. To establish the content to be included:

- Identify information that needs to be remembered (cognitive).
- Identify information having to do with emotions, attitudes, and values (affective).
- Identify psychomotor skills that are necessary for learning.

NURSING PRIORITY NO. 6. To develop learner's objectives:

- State objectives clearly in learner's terms **to meet learner's (not instructor's) needs.**
- Identify outcomes (results) to be achieved.
- Recognize level of achievement, time factors, and short-term and long-term goals.
- Include the affective goals (e.g., reduction of stress).

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

NURSING PRIORITY NO. 7. To identify teaching methods to be used:

- Determine patient's method of accessing information (visual, auditory, kinesthetic, gustatory/olfactory) and include in teaching plan **to facilitate learning.**
- Involve the patient/SO(s) by using programmed books, questions/dialogue, audio/visual materials.
- Involve with others who have same problems/needs/concerns (e.g., group presentations, support groups). **Provides role model and sharing of information.**
- Provide mutual goal setting and learning contracts. **(Clarifies expectations of teacher and learner.)**
- Use team and group teaching as appropriate.

NURSING PRIORITY NO. 8. To facilitate learning:

- Provide written information/guidelines for patient to refer to as necessary. **Reinforces learning process.**
- Pace and time learning sessions and learning activities to individual's needs. Involve and evaluate with patient.
- Provide an environment that is conducive to learning.
- Be aware of factors related to teacher in the situation: Vocabulary, dress, style, knowledge of the subject, and ability to impart information effectively.
- Begin with information the patient already knows and move to what the patient does not know, progressing from simple to complex. **Limits sense of being overwhelmed.**
- Deal with the patient's anxiety. Present information out of sequence, if necessary, dealing first with material that is most anxiety-producing when the anxiety is interfering with the patient's learning process.
- Provide active role for patient in learning process, **promotes sense of control over situation.**
- Provide for feedback (positive reinforcement) and evaluation of learning/acquisition of skills.
- Be aware of informal teaching and role modeling that takes place on an ongoing basis (e.g., answering specific questions/reinforcing previous teaching during routine care).
- Assist patient to use information in all applicable areas (e.g., situational, environmental, personal).

NURSING PRIORITY NO. 9. To promote wellness (Teaching/Discharge Considerations):

- Provide phone number of contact person **to answer questions/validate information postdischarge.**
- Identify available community resources/support groups.
- Provide information about additional learning resources (e.g., bibliography, tapes). **May assist with further learning/promote learning at own pace.**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings/learning style and identified needs, presence of learning blocks (e.g., hostility, inappropriate behavior).

PLANNING

- Plan for learning, methods to be used, and who is involved in the planning.
- Teaching plan.

IMPLEMENTATION/EVALUATION

- Responses of the patient/SO(s) to the learning plan and actions performed. How the learning is demonstrated.
- Attainment/progress toward desired outcome(s).
- Modifications to plan of care.

DISCHARGE PLANNING

- Additional learning/referral needs.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Knowledge: [specify—25 choices]
NIC—Teaching: [specify—14 choices]

Loneliness, risk for

Taxonomy II: Self-perception—Class 1 Self-Concept (00054)

[Diagnostic Division: Social Interaction]

Definition: At risk for experiencing vague dysphoria

Risk Factors

Affectional deprivation
Physical isolation
Cathectic deprivation
Social isolation

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

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

Desired Outcomes/Evaluation Criteria—Patient Will:

- Identify individual difficulties and ways to address them.
- Engage in social activities.
- Report involvement in interactions/relationship patient views as meaningful.

Actions/Interventions

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

- Differentiate between ordinary loneliness and a state of constant sense of dysphoria. Note patient's age and duration of problem, that is, situational (such as leaving home for college) or chronic. **Elderly individuals incur multiple losses associated with aging, loss of spouse, decline in physical health, and changes in roles intensifying feelings of loneliness.**
- Determine degree of distress, tension, anxiety, restlessness present. Note history of frequent illnesses, accidents, crises.
- Note presence/proximity of family, SO(s).
- Determine how individual perceives/deals with solitude.
- Review issues of separation from parents as a child, loss of SO(s)/spouse.
- Assess sleep/appetite disturbances, ability to concentrate.
- Note expressions of "yearning" for an emotional partnership.

NURSING PRIORITY NO. 2. To assist patient to identify feelings and situations in which he or she experiences loneliness:

- Establish nurse-patient relationship in which patient feels free to talk about feelings.
- Discuss individual concerns about feelings of loneliness and relationship between loneliness and lack of SOs. Note desire/willingness to change situation. **Motivation can impede—or facilitate—achieving desired outcomes.**
- Support expression of negative perceptions of others and whether patient agrees. **Provides opportunity for patient to clarify reality of situation, recognize own denial.**
- Accept patient's expressions of loneliness as a primary condition and not necessarily as a symptom of some underlying condition.

NURSING PRIORITY NO. 3. To assist patient to become involved:

- Discuss reality versus perceptions of situation.
- Discuss importance of emotional bonding (attachment) between infants/young children, parents/caregivers as appropriate.
- Involve in classes such as assertiveness, language/communication, social skills **to address individual needs/enhance socialization.**
- Role-play situations **to develop interpersonal skills.**

- Discuss positive health habits, including personal hygiene, exercise activity of patient's choosing.
- Identify individual strengths, areas of interest **that provide opportunities for involvement with others.**
- Encourage attendance at group activities to meet individual needs (e.g., therapy, separation/grief, religion).
- Help patient establish plan for progressive involvement, beginning with a simple activity (e.g., call an old friend, speak to a neighbor) and leading to more complicated interactions/activities.
- Provide opportunities for interactions in a supportive environment (e.g., have patient accompanied as in a "buddy system") during initial attempts to socialize. **Helps reduce stress, provides positive reinforcement, and facilitates successful outcome.**

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

- Encourage involvement in special-interest groups (computers, bird watchers); charitable services (serving in a soup kitchen, youth groups, animal shelter).
- Suggest volunteering for church committee or choir; attending community events with friends and family; becoming involved in political issues/campaigns; enrolling in classes at local college/continuing education programs.
- Refer to appropriate counselors for help with relationships and so on.
- Refer to NDs Hopelessness, Anxiety, Social Isolation.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings, including patient's perception of problem, availability of resources/support systems.
- Patient's desire/commitment to change.

PLANNING

- Plan of care 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

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Loneliness
NIC—Socialization Enhancement

Memory, impaired

Taxonomy II: Perception/Cognition—Class 4 Cognition (00131)
[Diagnostic Division: Neurosensory]

Definition: Inability to remember or recall bits of information or behavioral skills (Impaired memory may be attributed to physiopathological or situational causes that are either temporary or permanent)

Related Factors

Acute or chronic hypoxia
Anemia
Decreased cardiac output
Fluid and electrolyte imbalance
Neurological disturbances [e.g., brain injury/concussion]
Excessive environmental disturbances; [manic state, fugue, traumatic event]
[Substance use/abuse; effects of medications]
[Age]

Defining Characteristics

SUBJECTIVE

Reported experiences of forgetting
Inability to recall recent or past events, factual information, [or familiar persons, places, items]

OBJECTIVE

Observed experiences of forgetting
Inability to determine if a behavior was performed
Inability to learn or retain new skills or information
Inability to perform a previously learned skill
Forget to perform a behavior at a scheduled time

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

Desired Outcomes/Evaluation Criteria—Patient Will:

- Verbalize awareness of memory problems.
- Establish methods to help in remembering essential things when possible.
- Accept limitations of condition and use resources effectively.

Actions/Interventions

NURSING PRIORITY NO. 1. To assess causative factor(s)/degree of impairment:

- Determine physical/biochemical factors that may be related to loss of memory.
- Assist with/review results of cognitive testing.
- Evaluate skill proficiency levels including self-care activities and driving ability.
- Ascertain how patient/family view the problem (e.g., practical problems of forgetting and/or role and responsibility impairments related to loss of memory and concentration) **to determine significance/impact of problem.**

NURSING PRIORITY NO. 2. To maximize level of function:

- Implement appropriate memory retraining techniques, such as keeping calendars, writing lists, memory cue games, mnemonic devices, using computers, and so forth.
- Assist in/instruct patient and family in associate-learning tasks such as practice sessions recalling personal information, reminiscing, locating a geographic location (Stimulation Therapy).
- Encourage ventilation of feelings of frustration, helplessness, and so forth. Refocus attention to areas of control and progress **to lessen feelings of powerlessness/hopelessness.**
- Provide for/emphasize importance of pacing learning activities and having appropriate rest **to avoid fatigue.**
- Monitor patient's behavior and assist in use of stress-management techniques **to reduce frustration.**
- Structure teaching methods and interventions to patient's level of functioning and/or potential for improvement.
- Determine patient's response to/effects of medications prescribed to improve attention, concentration, memory processes and to lift spirits/modify emotional responses. **Helpful in deciding whether quality of life is improved when considering side effects/cost of drugs.**

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

- Assist patient/SO(s) to establish compensation strategies **to improve functional lifestyle and safety,** such as menu

planning with a shopping list, timely completion of tasks on a daily planner, checklists at the front door to ascertain that lights and stove are off before leaving.
- Refer to/encourage follow-up with counselors, rehabilitation programs, job coaches, social/financial support systems **to help deal with persistent/difficult problems.**
- Assist patient to deal with functional limitations (such as loss of driving privileges) and identify resources to meet individual needs, **maximizing independence.**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, testing results, and perceptions of significance of problem.
- Actual impact on lifestyle and independence.

PLANNING

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

IMPLEMENTATION/EVALUATION

- 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 actions to be taken.
- Specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Memory
NIC—Memory Training

Mobility, impaired bed

Taxonomy II: Activity/Rest—Class 2 Activity/Exercise (00091)

[Diagnostic Division: Safety]

Definition: Limitation of independent movement from one bed position to another

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

Related Factors

To be developed by NANDA
[Neuromuscular impairment]
[Pain/discomfort]

Defining Characteristics

SUBJECTIVE

[Reported difficulty performing activities]

OBJECTIVE

Impaired ability to: turn side to side, move from supine to sitting or sitting to supine, "scoot" or reposition self in bed, move from supine to prone or prone to supine, from supine to long-sitting or long-sitting to supine

Desired Outcomes/Evaluation Criteria—Patient/Caregiver Will:

- Verbalize willingness to/and participate in repositioning program.
- Verbalize understanding of situation/risk factors, individual therapeutic regimen, and safety measures.
- Demonstrate techniques/behaviors that enable safe repositioning.
- Maintain position of function and skin integrity as evidenced by absence of contractures, footdrop, decubitus, and so forth.
- Maintain or increase strength and function of affected and/or compensatory body part.

Actions/Interventions

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

- Determine diagnoses that contribute to immobility (e.g., MS, arthritis, parkinsonism, hemi/para/tetraplegia, fractures/multiple trauma, mental illness, depression).
- Note individual risk factors and current situation, such as surgery, casts, amputation, traction, pain, age/weakness/debilitation, severe depression, aggravating immobility, head injury, dementia, burns, SCI.
- Determine degree of perceptual/cognitive impairment and/or ability to follow directions.

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

NURSING PRIORITY NO. 2. To assess functional ability:

- Determine functional level classification 1 to 4 (1 = requires use of equipment or device, 2 = requires help from another person for assistance, 3 = requires help from another person and equipment device, 4 = dependent, does not participate in activity).
- Note emotional/behavioral responses to problems of immobility.
- Note presence of complications related to immobility.

NURSING PRIORITY NO. 3. To promote optimal level of function and prevent complications:

- Include physical and occupational therapists in creating exercise program and identifying assistive devices.
- Turn frequently, reposition in good body alignment, using appropriate support.
- Instruct caregivers in methods of moving patient relative to specific situations.
- Observe skin for reddened areas/shearing. Provide regular skin care as appropriate.
- Assist on/off bedpan and into sitting position when possible. **Facilitates elimination.**
- Administer medication prior to activity as needed **for pain relief to permit maximal effort/involvement in activity.**
- Observe for change in strength to do more or less self-care **to adjust care as indicated.**
- Assist with activities of hygiene, toileting, feeding.
- Provide diversional activities as appropriate.
- Ensure call bell is within reach.
- Provide individually appropriate methods to communicate adequately with patient.
- Provide extremity protection (padding, exercises, etc.).

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

- Involve patient/SO in determining activity schedule. **Promotes commitment to plan, maximizing outcomes.**
- Encourage continuation of exercises **to maintain/enhance gains in strength/muscle control.**
- Obtain/identify sources for assistive devices. Demonstrate safe use and proper maintenance.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including level of function/ability to participate in specific/desired activities.

PLANNING

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

IMPLEMENTATION/EVALUATION

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

DISCHARGE PLANNING

- Discharge/long-range needs, noting who is responsible for each action to be taken.
- Specific referrals made.
- Sources of/maintenance for assistive devices.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Body Position: Self-Initiated
NIC—Bed Rest Care

Mobility, impaired physical

Taxonomy II: Activity/Rest—Class 2 Activity/Exercise (00085)

[Diagnostic Division: Safety]

Nursing Diagnosis Extension and Classification (NDEC) Revision 1998

Definition: Limitation in independent, purposeful physical movement of the body or of one or more extremities

Related Factors

Sedentary lifestyle, disuse or deconditioning; limited cardiovascular endurance
Decreased muscle strength, control and/or mass; joint stiffness or contracture; loss of integrity of bone structures
Intolerance to activity/decreased strength and endurance
Pain/discomfort
Neuromuscular/musculoskeletal impairment
Sensoriperceptual/cognitive impairment; developmental delay
Depressive mood state or anxiety

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

Selective or generalized malnutrition; altered cellular metabolism; body mass index above 75th age-appropriate percentile
Lack of knowledge regarding value of physical activity; cultural beliefs regarding age-appropriate activity; lack of physical or social environmental supports
Prescribed movement restrictions; medications
Reluctance to initiate movement

Defining Characteristics

SUBJECTIVE

[Report of pain/discomfort on movement]

OBJECTIVE

Limited range of motion; limited ability to perform gross fine/motor skills; difficulty turning
Slowed movement; uncoordinated or jerky movements, decreased [sic]reaction time
Gait changes (e.g., decreased walking speed; difficulty initiating gait, small steps, shuffles feet; exaggerated lateral postural sway)
Postural instability during performance of routine ADLs
Movement-induced shortness of breath/tremor
Engages in substitutions for movement (e.g., increased attention to other's activity, controlling behavior, focus on preillness/disability activity)

Suggested Functional Level Classification:

0—Completely independent
1—Requires use of equipment or device
2—Requires help from another person for assistance, supervision, or teaching
3—Requires help from another person and equipment device
4—Dependent, does not participate in activity

Desired Outcomes/Evaluation Criteria—Patient Will:

- Verbalize willingness to and demonstrate participation in activities.
- Verbalize understanding of situation/risk factors and individual treatment regimen and safety measures.

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

- Demonstrate techniques/behaviors that enable resumption of activities.
- Maintain position of function and skin integrity as evidenced by absence of contractures, footdrop, decubitus, and so forth.
- Maintain or increase strength and function of affected and/or compensatory body part.

Actions/Interventions

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

- Determine diagnosis that contributes to immobility (e.g., MS, arthritis, parkinsonism, hemiplegia/paraplegia, depression).
- Note situations such as surgery, fractures, amputation, tubings (chest, catheter, and so on) that may restrict movement.
- Assess degree of pain, listening to patient's description.
- Ascertain patient's perception of activity/exercise needs.
- Note decreased motor agility related to age.
- Determine degree of perceptual/cognitive impairment and ability to follow directions.
- Assess nutritional status and energy level.

NURSING PRIORITY NO. 2. To assess functional ability:

- Determine degree of immobility in relation to previously suggested scale.
- Observe movement when patient is unaware of observation **to note any incongruencies with reports of abilities.**
- Note emotional/behavioral responses to problems of immobility. **Feelings of frustration/powerlessness may impede attainment of goals.**
- Determine presence of complications related to immobility (e.g., pneumonia, elimination problems, contractures, decubitus, anxiety). Refer to ND Disuse Syndrome, risk for.

NURSING PRIORITY NO. 3. To promote optimal level of function and prevent complications:

- Assist/have patient reposition self on a regular schedule as dictated by individual situation (including frequent shifting of weight when patient is wheelchair-bound).
- Instruct in use of siderails, overhead trapeze, roller pads **for position changes/transfers.**
- Support affected body parts/joints using pillows/rolls, foot supports/shoes, air mattress, water bed, and so forth **to maintain position of function and reduce risk of pressure ulcers.**
- Assist with treatment of underlying condition causing pain and/or dysfunction.
- Administer medications prior to activity as needed **for pain relief to permit maximal effort/involvement in activity.**

- Provide regular skin care to include pressure area management.
- Schedule activities with adequate rest periods during the day **to reduce fatigue.** Provide patient with ample time to perform mobility-related tasks.
- Encourage participation in self-care, occupational/diversional/recreational activities. **Enhances self-concept and sense of independence.**
- Identify energy-conserving techniques for ADLs. **Limits fatigue, maximizing participation.**
- Discuss discrepancies in movement when patient aware/unaware of observation and methods for dealing with identified problems.
- Provide for safety measures as indicated by individual situation, including environmental management/fall prevention.
- Consult with physical/occupational therapist as indicated **to develop individual exercise/mobility program and identify appropriate adjunctive devices.**
- Encourage adequate intake of fluids/nutritious foods. **Promotes well-being and maximizes energy production.**

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

- Encourage patient's/SO(s') involvement in decision making as much as possible. **Enhances commitment to plan, optimizing outcomes.**
- Assist patient to learn safety measures as individually indicated (e.g., use of heating pads, locking wheelchair before transfers, removal or securing of scatter/area rugs).
- Involve patient and SO(s) in care, assisting them to learn ways of managing problems of immobility.
- Demonstrate use of adjunctive devices (e.g., walkers, braces, prosthetics). Identify appropriate resources for obtaining and maintaining appliances/equipment. **Promotes independence and enhances safety.**
- Review individual dietary needs. Identity appropriate vitamin/herbal supplements.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including level of function/ability to participate in specific/desired activities.

PLANNING

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

IMPLEMENTATION/EVALUATION

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

DISCHARGE PLANNING

- Discharge/long-range needs, noting who is responsible for each action to be taken.
- Specific referrals made.
- Sources of/maintenance for assistive devices.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Mobility Level
NIC—Exercise Therapy: Muscle Control

Mobility, impaired wheelchair

Taxonomy II: Activity/Rest—Class 2 Activity/Exercise (00089)

[Diagnostic Division: Safety]

Definition: Limitation of independent operation of wheelchair within environment

Related Factors

To be developed by NANDA

Defining Characteristics

Impaired ability to operate manual or power wheelchair on even or uneven surface, on an incline or decline, on curbs

Note: Specify level of independence (Refer to ND Mobility, impaired physical)

Desired Outcomes/Evaluation Criteria—Patient Will:

- Be able to move safely within environment, maximizing independence.
- Identify and use resources appropriately.

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

Caregiver Will:

- Provide safe mobility within environment and community.

Actions/Interventions

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

- Determine diagnosis that contributes to immobility (e.g., amyotrophic lateral sclerosis—ALS, spinal cord injury—SCI, spastic cerebral palsy, brain injury) and patient's functional level/individual abilities.
- Identify factors in environments frequented by the patient that contribute to inaccessibility (e.g., uneven floors/surfaces, lack of ramps, steep incline/decline, narrow doorways/spaces).
- Ascertain access to and appropriateness of public and/or private transportation.

NURSING PRIORITY NO. 2. To promote optimal level of function and prevent complications:

- Ascertain that wheelchair provides the base mobility to maximize function.
- Provide for patient's safety while in a wheelchair (e.g., supports for all body parts, repositioning and transfer assistive devices, and height adjustment).
- Note evenness of surfaces patient would need to negotiate and refer to appropriate sources for modifications. Clear pathways of obstructions.
- Recommend/arrange for alterations to home/work or school/recreational settings frequented by patient.
- Determine need for and capabilities of assistive persons. Provide training and support as indicated.
- Monitor patient's use of joystick, sip and puff, sensitive mechanical switches, and so forth **to provide necessary equipment if condition/capabilities change.**
- Monitor patient for adverse effects of immobility (e.g., contractures, muscle atrophy, DVT, pressure ulcers).

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

- Identify/refer to medical equipment suppliers **to customize patient's wheelchair for size, positioning aids, and electronics suited to patient's ability (e.g., sip and puff, head movement, sensitive switches, etc.).**
- Encourage patient's/SO(s') involvement in decision making as much as possible. **Enhances commitment to plan, optimizing outcomes.**
- Involve patient/SO in care, assisting them in managing immobility problems. **Promotes independence.**

- Demonstrate/provide information regarding individually appropriate safety measures.
- Refer to support groups relative to specific medical condition/disability; independence/political action groups. **Provides role modeling, assistance with problem solving.**
- Identify community resources **to provide ongoing support.**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including level of function/ability to participate in specific/desired activities.

PLANNING

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

IMPLEMENTATION/EVALUATION

- Responses to interventions/teaching and actions performed.

DISCHARGE PLANNING

- Discharge/long-range needs, noting who is responsible for each action to be taken.
- Specific referrals made.
- Sources of/maintenance for assistive devices.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Ambulation: Wheelchair
NIC—Positioning: Wheelchair

Nausea

Taxonomy II: Comfort—Class 1 Physical Comfort (00134)
[Diagnostic Division: Food/Fluid]

Definition: Unpleasant, wavelike sensation in the back of the throat, epigastrium, or throughout the abdomen that may or may not lead to vomiting

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

Related Factors

Postsurgical anesthesia
Stimulation of neuropharmacological mechanisms; chemotherapy; [radiation therapy]
Irritation to the gastrointestinal (GI) system

Defining Characteristics

SUBJECTIVE

Reports "nausea" or "sick to stomach"

OBJECTIVE

Usually precedes vomiting, but may be experienced after vomiting or when vomiting does not occur
Accompanied by swallowing movement affected by skeletal muscles; pallor, cold and clammy skin, increased salivation, tachycardia, gastric stasis, and diarrhea

Desired Outcomes/Evaluation Criteria—Patient Will:

- Be free of nausea.
- Manage chronic nausea, as evidenced by acceptable level of dietary intake.
- Maintain/regain weight as appropriate.

Actions/Interventions

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

- Assess for presence of conditions of the GI tract (e.g., peptic ulcer disease, cholecystitis, gastritis, ingestion of "problem" foods).
- Note systemic conditions that may result in nausea (e.g., pregnancy, cancer treatment, myocardial infarction—MI, hepatitis, systemic infections, drug toxicity, presence of neurogenic causes-stimulation of the vestibular system, CNS trauma/tumor).
- Identify situations that patient perceives as anxiety inducing, threatening, or distasteful (e.g., "this is nauseating").
- Note psychological factors, including those that are culturally determined (e.g., eating certain foods considered repulsive in one's own culture).

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

- Determine if nausea is potentially self-limiting and/or mild (e.g., first trimester of pregnancy, 24-hour GI viral infection) or is severe and prolonged (e.g., cancer treatment, hyperemesis gravidarum). **Indicates degree of effect on fluid/electrolyte balance and nutritional status.**

NURSING PRIORITY NO. 2. To promote comfort and enhance intake:

- Administer/monitor response to medications that prevent or relieve nausea.
- Have patient try dry foods such as toast, crackers, dry cereal before arising when nausea occurs in the morning, or throughout the day as appropriate.
- Advise patient to drink liquids before or after meals, instead of with meals.
- Provide diet and snacks with substitutions of preferred foods when available **to improve nutrient intake.** Include bland beverages, gelatin, sherbet. Avoid overly sweet, fried and fatty foods.
- Instruct patient to avoid large meals **so stomach does not feel too full.** Eat small meals spaced throughout the day.
- Instruct patient to eat and drink slowly, chewing food well **for easier digestion.**
- Provide clean, pleasant smelling, quiet environment. Avoid offending odors such as cooking smells, smoke, perfumes, mechanical emissions when possible.
- Provide frequent oral care **to cleanse mouth and minimize "bad tastes."**
- Advise patient to suck on ice cubes, tart or hard candies; drink cool, clear liquids, such as light-colored sodas. **Can provide some fluid/nutrient intake.**
- Encourage deep, slow breathing **to promote relaxation.**
- Use distraction with music, chatting with family/friends, watching TV **to limit dwelling on unpleasant sensation.**
- Administer antiemetic on regular schedule before/during and after administration of antineoplastic agents.
- Investigate use of acupressure point therapy (e.g., elastic band worn around wrist with small, hard bump that presses against acupressure point). **Some individuals with chronic nausea report this to be helpful and without sedative effect of medication.**
- Time chemotherapy doses **for least interference with food intake.**

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

- Review individual factors causing nausea and ways to avoid problem.
- Advise patient to prepare and freeze meals in advance **for days when nausea is severe or cooking is impossible.**
- Discuss potential complications and possible need for medical follow-up or alternative therapies. **Timely recognition and intervention may limit severity of complications (e.g., dehydration).**
- Review signs of dehydration and stress importance of replacing fluids and/or electrolytes (with products such as Gatorade or Pedialyte).

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including individual factors causing nausea.
- Baseline weight, vital signs.
- Specific patient preferences for nutritional intake.

PLANNING

- Plan of care 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

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Symptom Severity
NIC—Nausea Management

Noncompliance [Adherence, ineffective] [specify]

Taxonomy II: Choosing (5.2.1.1)
[Diagnostic Division: Teaching/Learning]
Revised 1998 by small group work 1996

Definition: Behavior of person and/or caregiver that fails to coincide with a health-promoting or therapeutic plan agreed on by the person (and/or family and/or community) and healthcare professional; in the presence of an agreed-on health-promoting or therapeutic plan, person's or caregiver's behavior is fully or partially adherent or nonadherent and may lead to clinically ineffective, partially ineffective outcomes

Related Factors

HEALTHCARE PLAN

Duration
SOs; cost; intensity; complexity

INDIVIDUAL FACTORS

Personal and developmental abilities; knowledge and skill relevant to the regimen behavior; motivational forces
Individual's value system; health beliefs, cultural influences, spiritual values
[Altered thought processes such as depression, paranoia]
[Difficulty changing behavior, as in addictions]
[Issues of secondary gain]

HEALTH SYSTEM

Individual health coverage; financial flexibility of plan
Credibility of provider; client-provider relationships; provider continuity and regular follow-up; provider reimbursement of teaching and follow-up; communication and teaching skills of the provider
Access and convenience of care; satisfaction with care

NETWORK

Involvement of members in health plan; social value regarding plan
Perceived beliefs of SOs' communication and teaching skills

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

Defining Characteristics

SUBJECTIVE

Statements by patient or SO(s) of failure to adhere; [does not perceive illness/risk to be serious, does not believe in efficacy of therapy, unwilling to follow treatment regimen or accept side effects/limitations]

OBJECTIVE

Behavior indicative of failure to adhere (by direct observation)
Objective tests (e.g., physiological measures, detection of physiologic markers)
Failure to progress
Evidence of development of complications/exacerbation of symptoms
Failure to keep appointments
[Inability to set or attain mutual goals]
[Denial]

Desired Outcomes/Evaluation Criteria—Patient Will:

- Participate in the development of mutually agreeable goals and treatment plan.
- Verbalize accurate knowledge of condition and understanding of treatment regimen.
- Make choices at level of readiness based on accurate information.
- Access resources appropriately.
- Demonstrate progress toward desired outcomes/goals.

Actions/Interventions

NURSING PRIORITY NO. 1. To determine reason for alteration/disregard of therapeutic regimen/instructions:

- Discuss with patient/SO(s) their perception/understanding of the situation (illness/treatment).
- Listen to/Active-listen patient's complaints, comments.
- Note language spoken, read, and understood.
- Be aware of developmental level as well as chronological age of patient.
- Assess level of anxiety, locus of control, sense of powerlessness, and so forth.

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

- Note length of illness. (**Patients tend to become passive and dependent in long-term, debilitating illnesses.**)
- Clarify value system: cultural/religious values, health/illness beliefs of the patient/SO(s).
- Determine social characteristics, demographic and educational factors, as well as personality of the patient.
- Verify psychological meaning of the behavior (e.g., may be denial). Note issues of secondary gain—**family dynamics, school/workplace issues, involvement in legal system may unconsciously affect patient's decision.**
- Assess availability/use of support systems and resources.
- Be aware of nurses'/healthcare providers' attitudes and behaviors toward the patient. (Do they have an investment in the patient's compliance/recovery? What is the behavior of the patient and nurse when patient is labeled "noncompliant"?) **Some care providers may be enabling patient whereas others' judgmental attitudes may impede treatment progress.**

NURSING PRIORITY NO. 2. To assist patient/SO(s) to develop strategies for dealing effectively with the situation:

- Develop therapeutic nurse-patient relationship. **Promotes trust, provides atmosphere in which patient/SO(s) can freely express views/concerns.**
- Explore patient involvement in or lack of mutual goal setting. (**Patient will be more likely to follow through on goals he or she participated in developing.**)
- Review treatment strategies. Identify which interventions in the plan of care are most important in meeting therapeutic goals and which are least amenable to compliance. **Sets priorities and encourages problem solving areas of conflict.**
- Contract with the patient for participation in care. **Enhances commitment to follow-through.**
- Encourage patient to maintain self-care, providing for assistance when necessary. Accept patient's evaluation of own strengths/limitations while working with patient to improve abilities.
- Provide for continuity of care in and out of the hospital/care setting, including long-range plans. **Supports trust, facilitates progress toward goals.**
- Provide information and help patient to know where and how to find it on own. **Promotes independence and encourages informed decision making.**
- Give information in manageable amounts, using verbal, written, and audiovisual modes at level of patient's ability. **Facilitates learning.**

- Have patient paraphrase instructions/information heard. **Helps validate patient's understanding and reveals misconceptions.**
- Accept the patient's choice/point of view, even if it appears to be self-destructive. Avoid confrontation regarding beliefs **to maintain open communication.**
- Establish graduated goals or modified regimen as necessary (e.g., patient with COPD who smokes a pack of cigarettes a day may be willing to reduce that amount). **May improve quality of life, encouraging progression to more advanced goals.**

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

- Stress importance of the patient's knowledge and understanding of the need for treatment/medication, as well as consequences of actions/choices.
- Develop a system for self-monitoring **to provide a sense of control and enable the patient to follow own progress and assist with making choices.**
- Provide support systems **to reinforce negotiated behaviors.** Encourage patient to continue positive behaviors, especially if patient is beginning to see benefit.
- Refer to counseling/therapy and/or other appropriate resources.
- Refer to NDs Coping, ineffective; Coping, family: compromised; Knowledge, deficient (specify); Anxiety.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings/deviation from prescribed treatment plan and patient's reasons in own words.
- Consequences of actions to date.

PLANNING

- Plan of care 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

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Compliance Behavior
NIC—Mutual Goal Setting

Nutrition: imbalanced, less than body requirements

Taxonomy II: Nutrition—Class 1 Ingestion (00002)
[Diagnostic Division: Food/Fluid]

Definition: Intake of nutrients insufficient to meet metabolic needs

Related Factors

Inability to ingest or digest food or absorb nutrients because of biological, psychological, or economic factors
[Increased metabolic demands, e.g., burns]
[Lack of information, misinformation, misconceptions]

Defining Characteristics

SUBJECTIVE

Reported inadequate food intake less than recommended daily allowances (RDA)
Reported lack of food
Aversion to eating; reported altered taste sensation; satiety immediately after ingesting food
Abdominal pain with or without pathological condition; abdominal cramping
Lack of interest in food; perceived inability to digest food
Lack of information, misinformation, misconceptions [Note: The authors view this as a related factor rather than a defining characteristic.]

OBJECTIVE

Body weight 20% or more under ideal [for height and frame]
Loss of weight with adequate food intake
Evidence of lack of [available] food
Weakness of muscles required for swallowing or mastication

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

Sore, inflamed buccal cavity
Poor muscle tone
Capillary fragility
Hyperactive bowel sounds; diarrhea and/or steatorrhea
Pale conjunctiva and mucous membranes
Excessive loss of hair [or increased growth of hair on body (lanugo)]; [cessation of menses]
[Decreased subcutaneous fat/muscle mass]
[Abnormal laboratory studies (e.g., decreased albumin, total proteins; iron deficiency; electrolyte imbalances)]

Desired Outcomes/Evaluation Criteria—Patient Will:

- Demonstrate progressive weight gain toward goal.
- Display normalization of laboratory values and be free of signs of malnutrition as reflected in Defining Characteristics.
- Verbalize understanding of causative factors when known and necessary interventions.
- Demonstrate behaviors, lifestyle changes to regain and/or maintain appropriate weight.

Actions/Interventions

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

- Identify patients at risk for malnutrition (e.g., intestinal surgery, hypermetabolic states, restricted intake, prior nutritional deficiencies).
- Determine ability to chew, swallow, taste; denture fit; presence of mechanical barriers; lactose intolerance, cystic fibrosis, pancreatic disease (**factors that can affect ingestion and/or digestion of nutrients).**
- Ascertain understanding of individual nutritional needs **to determine what information to provide patient/SO.**
- Note availability/use of financial resources and support systems. Determine ability to acquire and store various types of food.
- Discuss eating habits, including food preferences, intolerances/aversions **to appeal to patients likes/desires.**
- Assess drug interactions, disease effects, allergies, use of laxatives, diuretics. (**These factors may be affecting appetite, food intake, or absorption.**)
- Determine psychological factors, cultural or religious desires/influences **that may affect food choices.**

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

- Perform psychological assessment as indicated, **to assess body image and congruency with reality.**
- Note occurrence of amenorrhea, tooth decay, swollen salivary glands, and report of constant sore throat **(may be signs of bulimia/affect ability to eat).**
- Review usual activities/exercise program noting repetitive activities (e.g., constant pacing)/inappropriate exercise (e.g., prolonged jogging). **May reveal obsessive nature of weight-control measures.**

NURSING PRIORITY NO. **2.** To evaluate degree of deficit:

- Assess weight, age, body build, strength, activity/rest level, and so forth. **Provides comparative baseline.**
- Note total daily intake. Maintain diary of calorie intake, patterns and times of eating **to reveal changes that should be made in patient's dietary intake.**
- Calculate basal energy expenditure (BEE) using Harris-Benedict formula and estimate energy and protein requirements.
- Measure/calculate subcutaneous fat and muscle mass via triceps skin fold and midarm muscle circumference or other anthropometric measurements **to establish baseline parameters.**
- Auscultate bowel sounds. Note characteristics of stool (color, amount, frequency, and so on).
- Review indicated laboratory data (e.g., serum albumin/prealbumin, transferrin, amino acid profile, iron, BUN, nitrogen balance studies, glucose, liver function, electrolytes, total lymphocyte count, indirect calorimetry).
- Assist with diagnostic procedures (e.g., Schilling's test, D-xylose test, 72-hour stool fat, GI series).

NURSING PRIORITY NO. **3.** To establish a nutritional plan that meets individual needs:

- Assist in developing regimen **to correct/control underlying causative factors (e.g., cancer, malabsorption syndrome, anorexia).**
- Consult dietitian/nutritional team as indicated **to implement interdisciplinary team management.**
- Provide diet modifications as indicated. For example:
  - Increase protein, carbohydrates, calories
  - Use sauces, butters, creams, or oils in food/beverage, if fat well tolerated
  - Small feedings with snacks (easily digested snack at hs)
  - Mechanical soft or blenderized tube feedings
  - Appetite stimulants (e.g., wine) if indicated
  - Dietary supplements

Formula tube feedings; parenteral nutrition infusion
- Administer pharmaceutical agents as indicated:
  Digestive drugs/enzymes
  Vitamin/mineral (iron) supplements
  Medications (e.g., antacids, anticholinergics, antiemetics, antidiarrheals)
- Determine whether patient prefers/tolerates more calories in a particular meal.
- Use flavoring agents (e.g., lemon and herbs) if salt is restricted, **to enhance food satisfaction and stimulate appetite.**
- Encourage use of sugar/honey in beverages if carbohydrates are tolerated well.
- Encourage patient to choose foods that are appealing, **to stimulate appetite.**
- Avoid foods that cause intolerances/increase gastric motility (e.g., gas-forming foods, hot/cold, spicy, caffeinated beverages, milk products, and the like), according to individual needs.
- Limit fiber/bulk if indicated, because **it may lead to early satiety.**
- Promote pleasant, relaxing environment, including socialization when possible **to enhance intake.**
- Prevent/minimize unpleasant odors/sights. **May have a negative effect on appetite/eating.**
- Provide oral care before/after meals and PM.
- Encourage use of lozenges and so forth **to stimulate salivation when dryness is a factor.**
- Promote adequate/timely fluid intake. **(Limiting fluids 1 hour prior to meal decreases possibility of early satiety.)**
- Weigh weekly and prn **to monitor effectiveness of efforts.**
- Develop individual strategies when problem is mechanical (e.g., wired jaws or paralysis following stroke). Consult occupational therapist **to identify appropriate assistive devices**, or speech therapist **to enhance swallowing ability.** (Refer to ND Swallowing, impaired.)
- Develop structured (behavioral) program of nutrition therapy (e.g., document time/length of eating period, then put food in blender and tube-feed food not eaten), **particularly when problem is anorexia nervosa or bulimia.**
- Recommend/support hospitalization **for controlled environment as indicated in severe malnutrition/life-threatening situations.**

NURSING PRIORITY NO. 4. To promote wellness (Teaching/Discharge Considerations):
- Emphasize importance of well-balanced, nutritious intake. Provide information regarding individual nutritional needs and ways to meet these needs within financial constraints.

- Develop behavior modification program with patient involvement appropriate to specific needs.
- Provide positive regard, love, and acknowledgment of "voice within" guiding patient with eating disorder.
- Develop consistent, realistic weight gain goal.
- Weigh weekly and document results **to monitor effectiveness of dietary plan.**
- Consult with dietitian/nutritional support team as necessary **for long-term needs.**
- Develop regular exercise/stress reduction program.
- Review drug regimen, side effects, and potential interactions with other medications/over-the-counter drugs.
- Review medical regimen and provide information/assistance as necessary.
- Assist patient to identify/access resources such as food stamps, budget counseling, Meals on Wheels, community food banks, and/or other appropriate assistance programs.
- Refer for dental hygiene/professional care, counseling/psychiatric care, family therapy as indicated.
- Provide/reinforce patient teaching regarding preoperative and postoperative dietary needs when surgery is planned.
- Assist patient/SO(s) to learn how to blenderize food and/or perform tube feeding.
- Refer to home health resources and so on **for initiation/supervision of home nutrition therapy when used.**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Baseline and subsequent assessment findings to include signs/symptoms as noted in Defining Characteristics and laboratory diagnostic findings.
- Caloric intake.
- Individual cultural/religious restrictions, personal preferences.
- Availability/use of resources.
- Personal understanding/perception of problem.

PLANNING

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

IMPLEMENTATION/EVALUATION

- Patient's responses to interventions/teaching and actions performed.
- Results of weekly weigh-in.
- Attainment/progress toward desired outcome(s).
- Modifications to plan of care.

DISCHARGE PLANNING

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Nutritional Status
NIC—Nutrition Management

Nutrition: imbalanced, more than body requirements

Taxonomy II: Nutrition—Class 1 Ingestion (00001)
[Diagnostic Division: Food/Fluid]

Definition: Intake of nutrients that exceeds metabolic needs

Related Factors

Excessive intake in relationship to metabolic need

[NOTE: Underlying cause is often complex and may be difficult to diagnose/treat.]

Defining Characteristics

SUBJECTIVE

Reported dysfunctional eating patterns:
Pairing food with other activities
Eating in response to external cues such as time of day, social situation
Concentrating food intake at end of day
Eating in response to internal cues other than hunger, for example, anxiety
Sedentary activity level

OBJECTIVE

Weight 20% over ideal for height and frame [obese]
Triceps skin fold greater than 15 mm in men and 25 mm in women

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

Weight 10% over ideal for height and frame [overweight]
Observed dysfunctional eating patterns [as noted in subjective]
[Percentage of body fat greater than 22% for trim women and 15% for trim men]

Desired Outcomes/Evaluation Criteria—Patient Will:

- Verbalize a more realistic self-concept/body image (congruent mental and physical picture of self).
- Demonstrate acceptance of self as is rather than an idealized image.
- Demonstrate appropriate changes in lifestyle and behaviors, including eating patterns, food quantity/quality, and exercise program.
- Attain desirable body weight with optimal maintenance of health.

Actions/Interventions

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

- Assess knowledge of nutritional needs and amount of money spent/available for purchasing food.
- Ascertain how patient perceives food and the act of eating.
- Review diary of foods/fluids ingested, times and patterns of eating, activities/place, whether alone or with other(s); and feelings before, during, and after eating.
- Calculate total calorie intake.
- Ascertain previous dieting history.
- Discuss patient's view of self, including what being fat does for the patient. **Active cultural practices may place high importance on food and intake as well as large body size (e.g., Samoan).** Note negative/positive monologues (self-talk) of the individual.
- Obtain body drawing. (Patient draws self on wall with chalk, then stands against it and actual body is drawn to determine difference between the two). **Determines whether patient's view of self-body image is congruent with reality.**
- Ascertain occurrence of negative feedback from SO(s). **May reveal control issues, impact motivation for change**.
- Review daily activity and exercise program **to identify areas for modification.**

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

NURSING PRIORITY NO. 2. To establish weight reduction program:

- Discuss patient's motivation for weight loss (e.g., for own satisfaction/self-esteem, or to gain approval from another person). **Helps patient determine realistic motivating factors for individual situation (e.g., acceptance of self "as is," improvement of health status).**
- Obtain commitment for weight loss **if contracting is implemented.**
- Record height, weight, body build, gender, and age.
- Calculate calorie requirements based on physical factors and activity.
- Provide information regarding specific nutritional needs. (**Obese individual may be deficient in needed nutrients.**) Assist patient in determining type of diet to be used within physician/dietitian guidelines.
- Work with dietitian **to assist in creating/evaluating nutritional program.**
- Set realistic goals for weekly weight loss.
- Discuss eating behaviors (e.g., eating over sink, "nibbling," kinds of activities associated with eating) and identify necessary modifications. Develop appetite reeducation plan **to support continuation of behavioral changes.**
- Stress need for adequate fluid intake.
- Encourage involvement in planned activity program of patient's choice and within physical abilities.
- Monitor individual drug regimen (e.g., appetite suppressants, hormone therapy, vitamin/mineral supplements).
- Provide positive reinforcement/encouragement for efforts as well as actual weight loss. **Enhances commitment to program.**

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

- Discuss myths patient/SO(s) may have about weight and weight loss.
- Assist patient to choose nutritious foods that reflect personal likes, meet individual needs, and are within financial budget.
- Identify ways to manage stress/tension during meals. **Promotes relaxation to permit focus on act of eating and awareness of satiety.**
- Review and discuss strategies to deal appropriately with feelings **instead of overeating.**
- Encourage variety and moderation in dietary plan **to decrease boredom.**
- Advise to plan for special occasions (birthday/holidays) by reducing intake before event and/or eating "smart" **to redistribute/reduce calories and allow for participation.**

- Discuss importance of an occasional treat by planning for inclusion in diet, **to avoid feelings of deprivation arising from self-denial.**
- Recommend patient weigh only once per week, same time/clothes, and graph on chart. Measure/monitor body fat when possible **(more accurate measure).**
- Discuss normalcy of ups and downs of weight loss: plateauing, set point (at which weight is not being lost), hormonal influences, and so forth. **Prevents discouragement when progress stalls.**
- Encourage buying personal items/clothing as a reward for weight loss or other accomplishments. Suggest disposing of "fat clothes" **to encourage positive attitude of permanent change and remove "safety valve" of having wardrobe available "just in case" weight is regained.**
- Involve SO(s) in treatment plan as much as possible **to provide ongoing support and increase likelihood of success.**
- Refer to community support groups/psychotherapy as indicated.
- Provide contact number for dietitian **to address ongoing nutrition/dietary needs.**
- Refer to NDs Body Image, disturbed; Coping, ineffective.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including current weight, dietary pattern; perceptions of self, food, and eating; motivation for loss, support/feedback from SO(s).

PLANNING

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

IMPLEMENTATION/EVALUATION

- Responses to interventions, weekly weight, 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—Weight Control
NIC—Weight Reduction Assistance

Nutrition: imbalanced, risk for more than body requirements

Taxonomy II: Nutrition—Class 1 Ingestion (00003)
[Diagnostic Division: Food/Fluid]

Definition: At risk for an intake of nutrients that exceeds metabolic needs

Risk Factors

Reported/observed obesity in one or both parents[/spouse; hereditary predisposition]
Rapid transition across growth percentiles in infants or children, [adolescents]
Reported use of solid food as major food source before 5 months of age
Reported/observed higher baseline weight at beginning of each pregnancy, [frequent, closely spaced pregnancies]
Dysfunctional eating patterns:
    Pairing food with other activities
Eating in response to external cues such as time of day, social situation
Concentrating food intake at end of day
Eating in response to internal cues other than hunger (such as anxiety)
Observed use of food as reward or comfort measure
[Frequent/repeated dieting]
[Socially/culturally isolated; lacking other outlets]
[Alteration in usual activity patterns/sedentary lifestyle]
[Alteration in usual coping patterns]
[Majority of foods consumed are concentrated, high-calorie/fat sources]
[Significant/sudden decline in financial resources, lower socioeconomic status]

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

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—Patient Will:

- Verbalize understanding of body and energy needs.
- Identify lifestyle/cultural factors that predispose to obesity.
- Demonstrate behaviors, lifestyle changes to reduce risk factors.
- Acknowledge responsibility for own actions and need to "act, not react" to stressful situations.
- Maintain weight at a satisfactory level for height, body build, age, and gender.

Actions/Interventions

NURSING PRIORITY NO. 1. To assess potential factors for undesired weight gain:

- Note presence of factors as listed in Risk Factors. (**A high correlation exists between obesity in parents and children. When one parent is obese, 40% of the children may be overweight; when both are obese, the proportion may be as high as 80%.**)
- Determine age and activity level/exercise patterns.
- Calculate growth percentiles in infants/children.
- Review laboratory data **for indicators of endocrine/metabolic disorders.**
- Determine weight change patterns, lifestyle, and cultural factors that may predispose to weight gain. **Socioeconomic group, amount of money available for purchasing food, proximity of grocery store, and available storage space for food are all factors that may impact food choices and intake.**
- Assess eating patterns in relation to risk factors.
- Determine patterns of hunger and satiety. (**Patterns differ in those who are predisposed to weight gain. Skipping meals decreases the metabolic rate.**)
- Note history of dieting/kinds of diets used. Determine whether yo-yo dieting or bulimia is a factor.
- Identify personality characteristics that may indicate potential for obesity: for example, rigid thinking patterns, external locus of control, negative body image/self-concept, negative monologues (self-talk), dissatisfaction with life.
- Determine psychological significance of food to the patient.
- Listen to concerns and assess motivation to prevent weight gain.

NURSING PRIORITY NO. 2. To assist patient to develop preventive program to avoid weight gain:

- Provide information on balancing calorie intake and energy expenditure.
- Help patient develop new eating patterns/habits (e.g., eat slowly, eat when hungry, stop when full, do not skip meals).
- Discuss importance/help patient develop a program of exercise and relaxation techniques. **Encourages patient to incorporate into lifestyle.**
- Assist the patient to develop strategies for reducing stressful thinking/actions. **Promotes relaxation, reduces likelihood of stress/comfort eating.**

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

- Review individual risk factors and provide information **to assist the patient with motivation and decision making.**
- Consult with dietitian about specific nutrition/dietary issues.
- Provide information for new mothers about nutrition for developing babies.
- Encourage the patient to make a decision to lead an active life and control food habits.
- Assist patient in learning to be in touch with own body and to identify feelings that may provoke "comfort eating," such as anger, anxiety, boredom, sadness.
- Develop a system for self-monitoring **to provide a sense of control and enable the patient to follow own progress and assist with making choices.**
- Refer to support groups and appropriate community resources for behavior modification as indicated.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Findings related to individual situation, risk factors, current caloric intake/dietary pattern.

PLANNING

- Plan of care and who is involved in the 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

- Long-range needs, noting who is responsible for actions to be taken.
- Specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Weight Control
NIC—Weight Management

Oral Mucous Membrane, impaired

Taxonomy II: Safety/Protection—Class 2 Physical Injury (00045)

[Diagnostic Division: Food/Fluid]

Nursing Diagnosis Extension and Classification (NDEC) Revision 1998

Definition: Disruption of the lips and soft tissue of the oral cavity

Related Factors

Pathological conditions—oral cavity (radiation to head or neck); cleft lip or palate; loss of supportive structures
Trauma
Mechanical (e.g., ill-fitting dentures; braces; tubes [ET, nasogastric], surgery in oral cavity)
Chemical (e.g., alcohol, tobacco, acidic foods, regular use of inhalers)
Chemotherapy; immunosuppression/compromised; decreased platelets; infection; radiation therapy
Dehydration, malnutrition or vitamin deficiency
NPO for more than 24 hours
Lack of/impaired or decreased salivation; mouth breathing
Ineffective oral hygiene; barriers to oral self-care/professional care
Medication side effects
Stress; depression
Diminished hormone levels (women); aging-related loss of connective, adipose, or bone tissue

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

Defining Characteristics

SUBJECTIVE

Xerostomia (dry mouth)
Oral pain/discomfort
Self-report of bad/diminished or absent taste; difficulty eating or swallowing

OBJECTIVE

Coated tongue; smooth atrophic, sensitive tongue; geographic tongue
Gingival or mucosal pallor
Stomatitis; hyperemia; bleeding gingival hyperplasia; macroplasia; vesicles, nodules, or papules
White patches/plaques, spongy patches or white curdlike exudate, oral lesions or ulcers; fissures; cheilitis; desquamation; mucosal denudation
Edema
Halitosis, [carious teeth]
Gingival recession, pockets deeper than 4 mm
Purulent drainage or exudates; presence of pathogens
Enlarged tonsils beyond what is developmentally appropriate
Red or bluish masses (e.g., hemangiomas)
Difficult speech

Desired Outcomes/Evaluation Criteria—Patient Will:

- Verbalize understanding of causative factors.
- Identify specific interventions to promote healthy oral mucosa.
- Demonstrate techniques to restore/maintain integrity of oral mucosa.
- Report/demonstrate a decrease in symptoms/complaints as noted in Defining Characteristics.

Actions/Interventions

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

- Note presence of illness/disease/trauma (e.g., herpes simplex, gingivitis, facial fractures, cancer or cancer therapies, as well as generalized debilitating conditions).

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

- Determine nutrition/fluid intake and reported changes.
- Note use of tobacco (including smokeless) and alcohol.
- Observe for chipped or sharp-edged teeth. Note fit of dentures or other prosthetic devices when used.
- Assess medication use and possibility of side effects **affecting health or integrity of oral mucous membranes.**
- Determine allergies to food/drugs, other substances.
- Evaluate patient's ability to provide self-care and availability of necessary equipment/assistance.
- Review oral hygiene practices: frequency and type (brush/floss/Water Pik); professional dental care.

NURSING PRIORITY NO. **2.** To correct identified/developing problems:

- Routinely inspect oral cavity for sores, lesions, and/or bleeding. Recommend patient establish regular schedule, such as when performing oral care activities.
- Encourage adequate fluids **to prevent dehydration.**
- Provide for increased humidity, if indicated, by vaporizer or room humidifier.
- Avoid irritating foods/fluids, temperature extremes. Provide soft or pureed diet as required.
- Recommend avoiding alcohol, smoking/chewing tobacco, **which may further irritate mucosa.**
- Encourage use of chewing gum, hard candy, and so forth **to stimulate saliva.**
- Lubricate lips and provide commercially prepared oral lubricant solution.
- Use lemon/glycerine swabs with caution; **may be irritating if mucosa is injured.**
- Provide frequent oral care (including after meals/at bedtime) with mouthwash (especially before meals). May use dilute hydrogen peroxide or 2% sodium perborate (if infection present), sodium chloride, sodium bicarbonate, or alkaline solutions, depending on cause of condition.
- Use soft-bristle brush or sponge/cotton-tip applicators to cleanse teeth and tongue **(limits mucosal/gum irritation).**
- Provide anesthetic lozenges or analgesics such as Stanford solution, viscous lidocaine (Xylocaine), hot pepper (capsaicin) candy, as indicated **to reduce oral discomfort/pain.**
- Administer antibiotics, as ordered, when infection is present.
- Change position of ET tube/airway q8h and prn **to minimize pressure on tissues.**
- Provide adequate nutritional intake when malnutrition is a factor.

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

- Review current oral hygiene patterns and provide information as required/desired **to correct deficiencies/encourage proper care.**
- Instruct parents in oral hygiene techniques and proper dental care for infants/children (e.g., safe use of pacifier, brushing of teeth and gums, avoidance of sweet drinks and candy, recognition and treatment of thrush). **Encourages early initiation of good oral health practices and timely intervention for treatable problems.**
- Discuss special mouth care required during and after illness/trauma, or following surgical repair (e.g., cleft lip/palate) **to facilitate healing.**
- Identify need for/demonstrate use of special "appliances" **to perform own oral care.**
- Listen to concerns about appearance and provide accurate information about possible treatments/outcomes. Discuss effect of condition on self-esteem/body image, noting withdrawal from usual social activities/relationships, and/or expressions of powerlessness.
- Review information regarding drug regimen, use of local anesthetics.
- Promote general health/mental health habits. (**Altered immune response can affect the oral mucosa.**)
- Provide nutritional information **to correct deficiencies, reduce irritation/gum disease, prevent dental caries.**
- Stress importance of limiting night time regimen of bottle of milk for infant in bed. Suggest pacifier or use of water during night **to prevent bottle syndrome with decaying of teeth.**
- Recommend regular dental checkups/care.
- Identify community resources (e.g., low-cost dental clinics, Meals on Wheels/food stamps, home care aide).

Documentation Focus

ASSESSMENT/REASSESSMENT

- Condition of oral mucous membranes, routine oral care habits and interferences.

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 outcome(s).
- Modifications to plan of care.

DISCHARGE PLANNING

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Oral Health
NIC—Oral Health Restoration

Pain, acute

Taxonomy II: Comfort—Class 1 Physical Comfort (00132)
[Diagnostic Division: Pain/Comfort]

Definition: Unpleasant sensory and emotional experience arising from actual or potential tissue damage or described in terms of such damage (International Association for the Study of Pain); sudden or slow onset of any intensity from mild to severe with an anticipated or predictable end and a duration of less than 6 months

Related Factors

Injuring agents (biological, chemical, physical, psychological)

Defining Characteristics

SUBJECTIVE

Verbal or coded report [may be less from patients younger than age 40, men, and some cultural groups]
Changes in appetite and eating
[Pain unrelieved and/or increased beyond tolerance]

OBJECTIVE

Guarded/protective behavior; antalgic position/gestures
Facial mask; sleep disturbance (eyes lack luster, "hecohe [beaten] look," fixed or scattered movement, grimace)
Expressive behavior (restlessness, moaning, crying, vigilance, irritability, sighing)
Distraction behavior (pacing, seeking out other people and/or activities, repetitive activities)
Autonomic alteration in muscle tone (may span from listless [flaccid] to rigid)

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Autonomic responses (diaphoresis; blood pressure, respiration, pulse change; pupillary dilation)
Self-focusing
Narrowed focus (altered time perception, impaired thought process, reduced interaction with people and environment)
[Fear/panic]

Desired Outcomes/Evaluation Criteria—Patient Will:

- Report pain is relieved/controlled.
- Follow prescribed pharmacological regimen.
- Verbalize methods that provide relief.
- Demonstrate use of relaxation skills and diversional activities as indicated for individual situation.

Actions/Interventions

NURSING PRIORITY NO. **1.** To assess etiology/precipitating contributory factors:

- Perform a comprehensive assessment of pain to include location, characteristics, onset/duration, frequency, quality, severity (0-10 or faces scale), and precipitating/aggravating factors.
- Determine possible pathophysiological/psychological causes of pain (e.g., inflammation, fractures, neuralgia, surgery, influenza, pleurisy, angina, cholecystitis, burns, headache, herniated disc, grief, fear/anxiety).
- Note location of surgical procedures, **as this can influence the amount of postoperative pain experienced; for example, vertical/diagonal incisions are more painful than transverse or S-shaped. Presence of known/unknown complication(s) may make the pain more severe than anticipated.**
- Assess patient's perceptions, along with behavioral and physiological responses. Note patient's attitude toward pain and use of specific pain medications, including any history of substance abuse.
- Note patient's locus of control (internal/external). **Individuals with external locus of control may take little or no responsibility for pain management.**
- Assist in thorough diagnosis, including neurological and psychological factors (pain inventory, psychological interview) as appropriate when pain persists.

NURSING PRIORITY NO. **2.** To evaluate patient's response to pain:

- Perform pain assessment each time pain occurs. Note and investigate changes from previous reports **to rule out**

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worsening of underlying condition/development of complications.
- Accept patient's description of pain. (**Pain is a subjective experience and cannot be felt by others.**) Acknowledge the pain experience and convey acceptance of patient's response to pain.
- Note cultural and developmental influences affecting pain response. (**Verbal/behavioral cues may have no direct relationship to the degree of pain perceived [e.g., stoic versus exaggerated].**)
- Observe nonverbal cues (e.g., how patient walks, holds body, sits; facial expression; cool fingertips/toes, which can mean constricted vessels) and other objective Defining Characteristics as noted, especially in persons who cannot communicate verbally. **Observations may/may not be congruent with verbal reports indicating need for further evaluation**.
- Assess for referred pain, as appropriate **to help determine possibility of underlying condition or organ dysfunction requiring treatment**.
- Monitor vital signs—**usually altered in acute pain**.
- Ascertain patient's knowledge of and expectations about pain management.
- Review patient's previous experiences with pain and methods found either helpful or unhelpful for pain control in the past.

NURSING PRIORITY NO. 3. To assist patient to explore methods for alleviation/control of pain:
- Work with patient to prevent pain. Use flow sheet to document pain, therapeutic interventions, response, and length of time before pain recurs. Instruct patient to report pain as soon as it begins **as timely intervention is more likely to be successful in alleviating pain.**
- Determine patient's acceptable level of pain on a 0 to 10 or faces scale.
- Encourage verbalization of feelings about the pain.
- Provide quiet environment, calm activities.
- Provide comfort measures (e.g., back rub, change of position, use of heat/cold) **to provide nonpharmacological pain management.**
- Instruct in/encourage use of relaxation exercises, such as focused breathing, commercial or individualized tapes (e.g., "white" noise, music, instructional).
- Encourage diversional activities (e.g., TV/radio, socialization with others).
- Review procedures/expectations and tell patient when treatment will hurt, use puppets to demonstrate procedure for

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child **to reduce concern of the unknown and associated muscle tension.**
- Suggest parent be present during procedures to comfort child.
- Identify ways of avoiding/minimizing pain (e.g., splinting incision during cough; firm mattress, and/or proper supporting shoes for low back pain, good body mechanics).
- Administer analgesics as indicated to maximal dosage as needed **to maintain "acceptable" level of pain.** Notify physician if regimen is inadequate to meet pain control goal.
- Demonstrate/monitor use of self-administration/patient-controlled analgesia (PCA).
- Assist patient to alter drug regimen, based on individual needs. **Increasing/decreasing dosage, stepped program to switch from injection to oral route, increased time span as pain lessens helps in self-management of pain.**
- Note when pain occurs (e.g., only with ambulation, every evening) **in order to medicate prophylactically as appropriate.**
- Instruct patient in use of transcutaneous electrical stimulation (TENS) unit when ordered.
- Assist in treatment of underlying disease processes causing pain. Evaluate effectiveness of periodic therapies (e.g., cortisone injections for joint inflammation).

NURSING PRIORITY NO. **4.** To promote wellness (Teaching/Discharge Considerations):
- Encourage adequate rest periods **to prevent fatigue.**
- Review ways to lessen pain, including techniques such as Therapeutic Touch (TT), biofeedback, self-hypnosis, and relaxation skills.
- Discuss impact of pain on lifestyle/independence and ways to maximize level of functioning.
- Provide for individualized physical therapy/exercise program that can be continued by the patient when discharged. **(Promotes active, not passive role.)**
- Discuss with SO(s) ways in which they can assist patient and reduce precipitating factors that may cause or increase pain (e.g., participating in household tasks following abdominal surgery).
- Identify specific signs/symptoms and changes in pain requiring medical follow-up.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual assessment findings, including patient's description of response to pain, specifics of pain inventory, expectations of pain management, and acceptable level of pain.
- Prior medication use; substance abuse.

PLANNING

- Plan of care 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

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Pain Level
NIC—Pain Management

Pain, chronic

Taxonomy II: Comfort—Class 1 Physical Comfort (00133)
[Diagnostic Division: Pain/Discomfort]

Definition: Unpleasant sensory and emotional experience arising from actual or potential tissue damage or described in terms of such damage (International Association for the Study of Pain); sudden or slow onset of any intensity from mild to severe, constant or recurring without an anticipated or predictable end and a duration of greater than 6 months

[Pain is a signal that something is wrong. Chronic pain can be recurrent and periodically disabling (e.g., migraine headaches) or may be unremitting. While chronic pain syndrome includes various learned behaviors, psychological factors become the primary contribution to impairment. It is a complex entity, combining elements from other NDs, e.g., Powerlessness; Diversional Activity, deficient; Family Processes, interrupted; Self-Care deficit; and Disuse Syndrome, risk for.]

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

Related Factors

Chronic physical/psychosocial disability

Defining Characteristics

SUBJECTIVE

Verbal or coded report
Fear of reinjury
Altered ability to continue previous activities
Changes in sleep patterns; fatigue
[Changes in appetite]
[Preoccupation with pain]
[Desperately seeks alternative solutions/therapies for relief/control of pain]

OBJECTIVE

Observed evidence of: protective/guarding behavior; facial mask; irritability; self-focusing; restlessness; depression
Reduced interaction with people
Anorexia, weight changes
Atrophy of involved muscle group
Sympathetic mediated responses (temperature, cold, changes of body position, hypersensitivity)

Desired Outcomes/Evaluation Criteria—Patient Will:

- Verbalize and demonstrate (nonverbal cues) relief and/or control of pain/discomfort.
- Verbalize recognition of interpersonal/family dynamics and reactions that affect the pain problem.
- Demonstrate/initiate behavioral modifications of lifestyle and appropriate use of therapeutic interventions.

Family/SO(s) Will:

- Cooperate in pain management program. (Refer to ND Coping, family: readiness for enhanced.)

Actions/Interventions

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

- Identify factors as outlined for ND Pain, acute.
- Assist in thorough diagnosis, including neurological, psychological evaluation (Minnesota Multiphasic Personality Inventory—MMPI, pain inventory, psychological interview).

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

- Assess for phantom limb pain when amputation has occurred.
- Evaluate emotional/physical components of individual situation. Note codependent components, enabling behaviors of caregivers/family members **that support continuation of the status quo.**
- Determine cultural factors for the individual situation (e.g., how expression of pain is accepted—moaning aloud or enduring in stoic silence; magnification of symptoms in order to convince others of reality of pain).
- Note sex and age of patient. **Current literature suggests there may be differences between women and men as to how they perceive and/or respond to pain. Sensitivity to pain is likely to decline as one gets older.**
- Discuss use of nicotine, sugar, caffeine, white flour as appropriate (**some holistic practitioners believe these items need to be eliminated from the patient's diet**).
- Evaluate current and past analgesic/narcotic drug use (including alcohol).
- Determine issues of secondary gain for the patient/SO(s) (e.g., financial/insurance, marital/family concern, work issues). **May interfere with progress in pain management/resolution of situation.**
- Make home visit when possible, observing such factors as safety equipment, adequate room, colors, plants, family interactions. Note impact of home environment on the patient.

NURSING PRIORITY NO. 2. To determine patient response to chronic pain situation:

- Evaluate pain behavior. (**May be exaggerated because patient's perception of pain is not believed or because patient believes caregivers are discounting reports of pain.**)
- Determine individual patient threshold for pain (physical examination, pain profile, and the like).
- Ascertain duration of pain problem, who has been consulted, and what drugs and therapies (including alternative/complementary) have been used.
- Note lifestyle effects of pain (e.g., decreased activity, weight loss or gain, sleep difficulties).
- Assess degree of personal maladjustment of the patient such as isolationism, anger, irritability, loss of work time/job.
- Note availability/use of personal and community resources.
- Acknowledge and assess pain matter-of-factly, avoiding undue expressions of concern.

NURSING PRIORITY NO. 3. To assist patient to deal with pain:

- Include patient and SO(s) in establishing pattern of discussing pain for specified length of time **to limit focusing on pain.**

- Use interventions from ND Pain, acute as appropriate (e.g., heat/cold, splinting or exercises, hydrotherapy, electrical stimulation/TENS unit).
- Review patient expectations versus reality, because **pain may not be resolved but can be significantly lessened or managed.**
- Discuss the physiological dynamics of tension/anxiety and how this affects the pain.
- Investigate and use nonpharmacological methods of pain control (e.g., visualization, guided imagery, Therapeutic Touch (TT), progressive muscle relaxation, biofeedback, massage).
- Assist patient to learn breathing techniques (e.g., diaphragmatic breathing) **to assist in muscle and generalized relaxation.**
- Encourage patient to use positive affirmations: "I am healing." "I am relaxed." "I love this life." Have patient be aware of internal-external dialogue. Say "cancel" when negative thoughts develop.
- Use tranquilizers, narcotics, and analgesics sparingly **(these drugs are physically and psychologically addicting and promote sleep disturbances, especially interference with deep REM—rapid eye movement—sleep).** Patient may need to be detoxified if many medications are currently used. Note: Antidepressants have an additional benefit of analgesic effects **because perception of pain decreases as depression is lessened.**
- Encourage right-brain stimulation with activities such as love, laughter, and music **to release endorphins enhancing sense of well-being.**
- Encourage use of subliminal tapes to bypass logical part of the brain by saying: "I am becoming a more relaxed person." "It is all right for me to relax."
- Assist family in developing a program of positive reinforcement, encouraging patient to use own control and diminishing attention given to pain behavior.
- Be alert to changes in pain. **May indicate a new physical problem.**

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

- Assist patient and SO(s) to learn how to heal by developing sense of internal control, by being responsible for own treatment, and by obtaining the information and tools to accomplish this.
- Discuss potential for developmental delays in child with chronic pain. Identify current level of function and review appropriate expectations for individual child.
- Review safe use of medications, side effects requiring medical evaluation.

- Assist patient to learn to change pain behavior to wellness behavior. "Act as if you are well."
- Encourage and assist family member/SO(s) to learn massage techniques.
- Recommend that patient and SO(s) take time for themselves. **Provides opportunity to re-energize and refocus on tasks at hand.**
- Identify and discuss potential hazards of unproved and/or nonmedical therapies/remedies.
- Identify community support groups/resources to meet individual needs (e.g., yard care, home maintenance, alternative transportation). **Proper use of resources may reduce negative pattern of "overdoing" heavy activities, then spending several days in bed recuperating.**
- Refer for counseling and/or marital therapy, Parent Effectiveness classes, and so forth as needed. **Presence of chronic pain affects all relationship/family dynamics.**
- Refer to NDs Coping, ineffective; Coping, family: compromised.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including duration of problem/specific contributing factors, previously/currently used interventions.
- Perception of pain, effects on lifestyle, and expectations of therapeutic regimen.
- Family's/SO's response to patient, and support for change.

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 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—Pain Control
NIC—Pain Management

Parental Role Conflict

Taxonomy II: Role Relationships—Class 1 Role Performance (00064)

[Diagnostic Division: Social Interaction]

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
Expresses concern about perceived loss of control over decisions relating to child
Verbalizes 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.

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

- Express feelings about child's illness/situation and effect on family life.
- 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 patient'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.**
- 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 Parenting, impaired, 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

Parenting, impaired

Taxonomy II: Role Relationships—Class 1 Caregiving Roles (00056)

[Diagnostic Division: Social Interaction]

Nursing Diagnosis Extension and Classification (NDEC) Revision 1998

Definition: Inability of the primary caretaker to create, maintain, or regain an environment that promotes the optimum growth and development of the child (Note: It is important to reaffirm that adjustment to parenting in general is a normal maturational process that elicits nursing behaviors to prevent potential problems and to promote health.)

Related Factors

SOCIAL

Presence of stress (e.g., financial, legal, recent crisis, cultural move [e.g., from another country/cultural group within same country]); unemployment or job problems; financial difficulties; relocations; poor home environments

Lack of family cohesiveness; marital conflict, declining satisfaction; change in family unit

Role strain or overload; single parents; father of child not involved

Unplanned or unwanted pregnancy; lack of, or poor, parental role model; low self-esteem

Low socioeconomic class; poverty; lack of resources, access to resources, social support networks, transportation

Inadequate child-care arrangements; lack of value of parenthood; inability to put child's needs before own

Poor problem-solving skills; maladaptive coping strategies

Social isolation

History of being abusive/being abused; legal difficulties

KNOWLEDGE

Lack of knowledge about child health maintenance, parenting skills, child development; inability to recognize and act on infant cues

Unrealistic expectation for self, infant, partner

Low educational level or attainment; limited cognitive functioning; lack of cognitive readiness for parenthood

Poor communication skills

Preference for physical punishment

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

PHYSIOLOGICAL

Physical illness

INFANT OR CHILD

Premature birth; multiple births; unplanned or unwanted child; not gender desired
Illness; prolonged separation from parent/separation at birth
Difficult temperament; lack of goodness of fit (temperament) with parental expectations
Handicapping condition or developmental delay; altered perceptual abilities; attention-deficit hyperactivity disorder

PSYCHOLOGICAL

Young age, especially adolescent
Lack of, or late, prenatal care; difficult labor and/or delivery; multiple births; high number or closely spaced pregnancies
Sleep deprivation or disruption; depression
Separation from infant/child
History of substance abuse or dependencies
Disability; history of mental illness

Defining Characteristics

SUBJECTIVE

Parental
Statements of inability to meet child's needs; cannot control child
Negative statements about child
Verbalization of role inadequacy frustration

OBJECTIVE

Infant or Child
Frequent accidents/illness; failure to thrive
Poor academic performance/cognitive development
Poor social competence; behavioral disorders
Incidence of physical and psychological trauma or abuse
Lack of attachment; separation anxiety
Runaway

Parental
Maternal-child interaction deficit; poor parent-child interaction; little cuddling; insecure or lack of attachment to infant
Inadequate child health maintenance; unsafe home environment; inappropriate child-care arrangements; inappropriate visual, tactile, auditory stimulation
Poor or inappropriate caretaking skills; inconsistent care/behavior management
Inflexibility to meet needs of child, situation

High punitiveness; rejection or hostility to child; child abuse; child neglect; abandonment

Desired Outcomes/Evaluation Criteria—Patient Will:

- Verbalize realistic information and expectations of parenting role.
- Verbalize acceptance of the individual situation.
- Identify own strengths, individual needs, and methods/resources to meet them.
- Demonstrate appropriate attachment/parenting behaviors.

Actions/Interventions

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

- Note family constellation; two-parent, single, extended family, or child living with other relative such as grandparent.
- Determine developmental stage of the family (e.g., new child, adolescent, child leaving/returning home).
- Assess family relationships and identify needs of individual members. Report and take necessary actions as legally/professionally indicated if child's safety is a concern.
- Assess parenting skill level, taking into account the individual's intellectual, emotional, and physical strengths and weaknesses. **(Parents with significant impairments may need more education/assistance.)**
- Observe attachment behaviors between parental figure and child. (Refer to ND Attachment, risk for impaired parent/infant/child.)
- Note presence of factors in the child (e.g., birth defects, hyperactivity) that may affect attachment and caretaking needs.
- Evaluate physical challenges/limitations. **Might affect the parent's ability to care for a child (e.g., visual/hearing impairment, quadriplegia, severe depression).**
- Determine presence/effectiveness of support systems, role models, extended family, and community resources available to the parent(s).
- Note absence from home setting/lack of child supervision by parent (e.g., working long hours/out of town, multiple responsibilities such as working and attending educational classes).

NURSING PRIORITY NO. **2.** To foster development of parenting skills:

- Create an environment in which relationships can be developed and needs of each individual met. **(Learning is more effective when individuals feel safe.)**
- Make time for listening to concerns of the parent(s).

- Emphasize positive aspects of the situation, maintaining a hopeful attitude toward the parent's capabilities and potential for improving the situation.
- Note staff attitudes toward parent/child and specific problem/disability; for example, needs of disabled parent(s) to be seen as an individual and evaluated apart from a stereotype. **Negative attitudes are detrimental to promoting positive outcomes.**
- Encourage expression of feelings, such as helplessness, anger, frustration. Set limits on unacceptable behaviors.
- Acknowledge difficulty of situation and normalcy of feelings. **Enhances feelings of acceptance.**
- Recognize stages of grieving process when the child is disabled or other than anticipated (e.g., girl instead of boy, misshapen head/prominent birthmark). Allow time for parents to express feelings and deal with the "loss."
- Encourage attendance at skill classes (e.g., Parent Effectiveness) **to assist in developing communication and problem-solving techniques.**
- Emphasize parenting functions rather than mothering/fathering skills. **By virtue of gender, each person brings something to the parenting role; however, nurturing tasks can be done by both parents.**

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

- Involve all available members of the family in learning.
- Provide information appropriate to the situation, including time management, limit setting, and stress-reduction techniques. **Facilitates satisfactory implementation of plan/new behaviors.**
- Develop support systems appropriate to the situation (e.g., extended family, friends, social worker, home care services).
- Assist parent to plan time and conserve energy in positive ways. **Enables individual to cope effectively with difficulties as they arise.**
- Encourage parents to identify positive outlets for meeting their own needs (e.g., going out for dinner, making time for their own interests and each other/dating). **Promotes general well-being, helps reduce burnout.**
- Refer to appropriate support/therapy groups as indicated.
- Identify community resources (e.g., child-care services) **to assist with individual needs to provide respite and support.**
- Refer to NDs such as Coping, ineffective; Coping, family: compromised; Violence, risk for [specify]; Self-Esteem [specify]; Family Processes, interrupted, and so on.

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

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including parenting skill level, deviations from normal parenting expectations, family makeup and developmental stages.
- Availability/use of support systems and community resources.

PLANNING

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

IMPLEMENTATION/EVALUATION

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

DISCHARGE PLANNING

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Role Performance
NIC—Parenting Promotion

Parenting, risk for impaired

Taxonomy II: Role Relationships—Class 1 caregiving Roles (00057)

[Diagnostic Division: Social Interaction]

Nursing Diagnosis Extension and Classification (NDEC) Revision 1998

Definition: Risk for inability of the primary caretaker to create, maintain, or regain an environment that promotes the optimum growth and development of the child. (**Note**: It is important to reaffirm that adjustment to parenting in general is a normal maturational process that elicits nursing behaviors to prevent potential problems and to promote health.)

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

Risk Factors

Lack of role identity; lack of available role model, ineffective role model

SOCIAL

Stress [e.g., financial, legal, recent crisis, cultural move (e.g., from another country/cultural group within same country)]; unemployment or job problems; financial difficulties; relocations; poor home environments
Lack of family cohesiveness; marital conflict, declining satisfaction; change in family unit
Role strain/overload; single parents; father of child not involved
Unplanned or unwanted pregnancy; lack of, or poor, parental role model; low self-esteem
Low socioeconomic class; poverty; lack of: [resources], access to resources, social support networks, transportation
Inadequate child-care arrangements; lack of value of parenthood; inability to put child's needs before own
Poor problem-solving skills; maladaptive coping strategies
Social isolation
History of being abusive/being abused; legal difficulties

KNOWLEDGE

Lack of knowledge about child health maintenance, parenting skills, child development; inability to recognize and act on infant cues
Unrealistic expectation of child
Low educational level or attainment; low cognitive functioning; lack of cognitive readiness for parenthood
Poor communication skills
Preference for physical punishment

PHYSIOLOGICAL

Physical illness

INFANT OR CHILD

Premature birth; multiple births; unplanned or unwanted child; not gender desired
Illness; prolonged separation from parent/separation at birth
Difficult temperament; lack of goodness of fit (temperament) with parental expectations
Handicapping condition or developmental delay; altered perceptual abilities; attention-deficit hyperactivity disorder

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

PSYCHOLOGICAL

Young age, especially adolescent
Lack of, or late, prenatal care; difficult labor and/or delivery; multiple births; high number or closely spaced pregnancies
Sleep deprivation or disruption; depression
Separation from infant/child
History of substance abuse or dependencies
Disability; history of mental illness

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—Patient Will:

- Verbalize awareness of individual risk factors.
- Identify own strengths, individual needs, and methods/resources to meet them.
- Demonstrate behavior/lifestyle changes to reduce potential for development of problem or reduce/eliminate effects of risk factors.
- Participate in activities, classes to promote growth.

Refer to Parenting, impaired or Attachment, risk for impaired parent/infant/child, interventions and documentation focus.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Parenting
NIC—Parenting Promotion

Personal Identity, disturbed

Taxonomy II: Selp-Perception—Class 1 Self-Concept (00121)
[Diagnostic Division: Ego Integrity]

Definition: Inability to distinguish between self and nonself

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

Related Factors

To be developed by NANDA
[Organic brain syndrome]
[Poor ego differentiation, as in schizophrenia]
[Panic/dissociative states]
[Biochemical body change]

Defining Characteristics

To be developed by NANDA

SUBJECTIVE

[Confusion about sense of self, purpose or direction in life, sexual identification/preference]

OBJECTIVE

[Difficulty in making decisions]
[Poorly differentiated ego boundaries]
[See ND Anxiety for additional characteristics]

Desired Outcomes/Evaluation Criteria—Patient Will:

- Acknowledge threat to personal identity.
- Integrate threat in a healthy, positive manner (e.g., state anxiety is reduced, make plans for the future).
- Verbalize acceptance of changes that have occurred.
- State ability to identify and accept self (long-term outcome).

Actions/Interventions

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

- Ascertain patient's perception of the extent of the threat to self and how patient is handling the situation.
- Determine speed of occurrence of threat. **An event that has happened quickly may be more threatening.**
- Define disturbed body image. **(Body image is the basis of personal identity.)**
- Be aware of physical signs of panic state. (Refer to ND Anxiety.)
- Note age of patient. **An adolescent may struggle with the developmental task of personal/sexual identity, whereas an older person may have more difficulty accepting/dealing with a threat to identity, such as progressive loss of memory.**

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

- Assess availability and use of support systems. Note response of family/SO(s).
- Note withdrawn/automatic behavior, regression to earlier developmental stage, general behavioral disorganization, or display of self-mutilation behaviors in adolescent or adult; delayed development, preference for solitary play, display of self-stimulation in child.
- Determine presence of hallucinations/delusions, distortions of reality.

NURSING PRIORITY NO. 2. To assist patient to manage/deal with threat:

- Make time to listen to patient, encouraging appropriate expression of feelings, including anger and hostility.
- Provide calm environment.
- Use crisis-intervention principles **to restore equilibrium when possible.**
- Assist patient to develop strategies to cope with threat to identity. **Helps reduce anxiety and promotes self-awareness and self-esteem.**
- Engage patient in activities to help in identifying self as an individual (e.g., use of mirror for visual feedback, tactile stimulation).
- Provide for simple decisions, concrete tasks, calming activities.
- Allow patient to deal with situation in small steps because **may be unable to cope with larger picture when in stress overload.**
- Assist patient in developing/participating in an individualized exercise program (walking is an excellent beginning program).
- Provide concrete assistance as needed (e.g., help with ADLs, providing food).
- Take advantage of opportunities to promote growth. Realize that patient will have difficulty learning while in a dissociative state.
- Maintain reality orientation without confronting patient's irrational beliefs. **Patient may become defensive, blocking opportunity to look at other possibilities.**
- Use humor judiciously when appropriate.
- Discuss options for dealing with issues of sexual gender (e.g., therapy/gender-change surgery when patient is a transsexual).
- Refer to NDs Body Image, disturbed; Self-Esteem [specify]; Spiritual Distress.

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

- Provide accurate information about threat to and potential consequences for individual.

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

- Assist patient and SO(s) to acknowledge and integrate threat into future planning (e.g., wearing ID bracelet when prone to mental confusion; change of lifestyle to accommodate change of gender for transsexual patient).
- Refer to appropriate support groups (e.g., day-care program, counseling/psychotherapy, gender identity).

Documentation Focus

ASSESSMENT/REASSESSMENT

- Findings, noting degree of impairment.
- Nature of and patient's perception of the threat.

PLANNING

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

IMPLEMENTATION/EVALUATION

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

DISCSHARGE PLANNING

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Identity
NIC—Self-Esteem Enhancement

Peripheral Neurovascular Dysfunction, risk for

Taxonomy II: Safety/Protection—Class 2 Physical Injury (00086)

[Diagnostic Division: Neurosensory]

Definition: At risk for disruption in circulation, sensation, or motion of an extremity

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

Risk Factors

Fractures
Mechanical compression (e.g., tourniquet, cast, brace, dressing, or restraint)
Orthopedic surgery; trauma
Immobilization
Burns
Vascular obstruction

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—Patient Will:

- Maintain function as evidenced by sensation/movement within normal range for the individual.
- Identify individual risk factors.
- Demonstrate/participate in behaviors and activities to prevent complications.
- Relate signs/symptoms that require medical reevaluation.

Actions/Interventions

NURSING PRIORITY NO. 1. To determine significance/degree of potential for compromise:

- Note individual risk factors, such as history of previous problems in extremity(ies), immobility/paralysis, duration/progression of condition.
- Assess presence, location, and degree of swelling/edema formation. Measure affected extremity and compare with unaffected extremity.
- Note position/location of casts, braces, traction apparatus.
- Review recent/current drug regimen, noting use of anticoagulants and vasoactive agents.

NURSING PRIORITY NO. 2. To prevent deterioration/maximize circulation of affected limb(s):

- Remove jewelry from affected limb.
- Limit/avoid use of restraints. Pad limb and evaluate status frequently, if restraints are required.
- Monitor entire length of injured extremity for swelling/edema formation. Note appearance, spread of hematoma.
- Monitor presence/quality of peripheral pulse distal to injury or impairment via palpation/Doppler. **Occasionally a pulse may be palpated even though circulation is blocked by a soft clot through which pulsations may be felt; or perfusion**

through larger arteries may continue after increased compartment pressure has collapsed the arteriole/venule circulation in the muscle.

- Assess capillary return, skin color, and warmth in the limb(s) at risk and compare with unaffected extremities. **Peripheral pulses, capillary refill, skin color, and sensation may be normal even in the presence of compartmental syndrome, because superficial circulation is usually not compromised.**
- Perform neurovascular assessments, noting changes in motor/sensory function. Ask patient to localize pain/discomfort, and to report numbness and tingling; presence of pain with exercise or rest (atherosclerotic changes). Refer to ND Tissue Perfusion, ineffective (specify type: renal, cerebral, cardiopulmonary, gastrointestinal, peripheral), as appropriate.
- Test sensation of peroneal nerve by pinch/pinprick in the dorsal web between first and second toe, and assess ability to dorsiflex toes if indicated (e.g., presence of leg fracture).
- Inspect tissues around cast edges for rough places, pressure points. Investigate reports of "burning sensation" under cast.
- Observe position/location of supporting ring of splints/sling. Readjust as indicated.
- Maintain elevation of injured extremity(ies) unless contraindicated by confirmed presence of compartment syndrome. **In presence of increased compartment pressure, elevation of extremity actually impedes arterial flow, decreasing perfusion.**
- Apply ice bags around injury/fracture site as indicated.
- Investigate sudden signs of limb ischemia (e.g., decreased skin temperature, pallor, increased pain), reports of pain that is extreme for type of injury, increased pain on passive movement of extremity, development of paresthesia, muscle tension/tenderness with erythema, change in pulse quality distal to injury. Place limb in neutral position, avoiding elevation. Report symptoms to physician at once **to provide for timely intervention.**
- Split/bivalve cast, reposition traction/restraints as appropriate **to release pressure.**
- Assist with measurements of/monitor intracompartmental pressures as indicated. **Provides for early intervention/evaluates effectiveness of therapy.**
- Prepare for surgical intervention (e.g., fibulectomy/fasciotomy) as indicated **to relieve pressure/restore circulation.**
- Use techniques such as repositioning/padding **to relieve pressure.**
- Encourage patient to routinely exercise digits/joints distal to injury. Encourage ambulation as soon as possible.

- Evaluate for tenderness, swelling, pain on dorsiflexion of foot (positive Homans' sign).
- Keep linens off affected extremity with bed cradle.
- Apply antiembolic hose/sequential pressure device as indicated.
- Monitor Hb/Hct, coagulation studies (e.g., prothrombin time).
- Administer IV fluids, blood products as needed **to maintain circulating volume/tissue perfusion.**
- Administer anticoagulants as indicated **for thrombotic vascular obstructions.**

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

- Review proper body alignment, elevation of limbs as appropriate.
- Discuss necessity of avoiding constrictive clothing, sharp angulation of legs/crossing legs.
- Demonstrate proper use of antiembolic hose.
- Review safe use of heat/cold therapy as indicated.
- Instruct patient/SO(s) to check shoes, socks for proper fit and/or wrinkles, and so on.
- Demonstrate/recommend continuation of exercises **to maintain function and circulation of limbs.**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Specific risk factors, nature of injury to limb.
- Assessment findings, including comparison of affected/unaffected limb, characteristics of pain in involved area.

PLANNING

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

IMPLEMENTATION/EVALUATION

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

DISCHARGE PLANNING

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Tissue Perfusion: Peripheral
NIC—Peripheral Sensation Management

Poisoning, risk for

Taxonomy II: Safety/Protection—Class 4 Environmental Hazards (00037)
[Diagnostic Division: Safety]

Definition: At accentuated risk of accidental exposure to or ingestion of drugs or dangerous products in doses sufficient to cause poisoning [or the adverse effects of prescribed medication/drug use]

Risk Factors

INTERNAL (INDIVIDUAL)

Reduced vision
Lack of safety or drug education
Lack of proper precaution; [unsafe habits, disregard for safety measures, lack of supervision]
Insufficient finances
Verbalization of occupational setting without adequate safeguards
Cognitive or emotional difficulties; [behavioral]
[Age (e.g., young child, elderly person)]
[Chronic disease state, disability]
[Cultural or religious beliefs/practices]

EXTERNAL (ENVIRONMENTAL)

Large supplies of drugs in house
Medicines stored in unlocked cabinets accessible to children or confused persons
Availability of illicit drugs potentially contaminated by poisonous additives
Flaking, peeling paint or plaster in presence of young children
Dangerous products placed or stored within the reach of children or confused persons
Unprotected contact with heavy metals or chemicals

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

Paint, lacquer, and so forth in poorly ventilated areas or without effective protection
Chemical contamination of food and water
Presence of poisonous vegetation
Presence of atmospheric pollutants, [proximity to industrial chemicals/pattern of prevailing winds]
[Therapeutic margin of safety of specific drugs (e.g., therapeutic versus toxic level, half-life, method of uptake and degradation in body, adequacy of organ function)]
[Use of multiple herbal supplements or megadosing]

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—Patient Will:

- Verbalize understanding of dangers of poisoning.
- Identify hazards that could lead to accidental poisoning.
- Correct environmental hazards as identified.
- Demonstrate necessary actions/lifestyle changes to promote safe environment.

Actions/Interventions

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

- Determine presence of internal/external risk factors in patient's environment, including presence of allergens/pollutants that may affect patient's condition.
- Assess patient's knowledge of safety hazards of drugs/herbal supplements/environment and ability to respond to potential threat.
- Determine use of legal/illegal drugs, for example, alcohol, marijuana, heroin, prescription/OTC drugs. Review results of laboratory tests/toxicology screening as indicated.

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

- Discuss safety cap and/or lockup of medicines, cleaning products, paint/solvents, and so forth.
- Administer children's medications as drugs, not candy. Recap medication containers immediately after obtaining current dosage. **Open containers increase risk of accidental ingestion.**

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

- Stress importance of supervising infant/child or individuals with cognitive limitations.
- Code medicines for the visually impaired.
- Have responsible SO(s)/home health nurse supervise medication regimen/prepare medications for the cognitively or visually impaired, or obtain prefilled med box from pharmacy.
- Encourage discarding outdated/unused drug safely (disposing in hazardous waste collection areas, not down drain/toilet).
- Refer identified health/safety violations to the appropriate resource (e.g., health department, Occupational Safety and Health Administration—OSHA).
- Repair/replace/correct unsafe household items/situations (e.g., storage of solvents in soda bottles, flaking/peeling paint or plaster).

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

- Institute community programs **to assist individuals to identify and correct risk factors in own environment.**
- Review drug side effects/potential interactions with patient/SO(s). Discuss use of OTC drugs/herbal supplements and possibilities of misuse, drug interactions, and overdosing as with vitamin megadosing, and so on.
- Educate patient to outdoor hazards, both local and vacation, for example, vegetation (poison ivy), ticks, and bees. Encourage susceptible person to carry kit with a prefilled syringe of epinephrine and an epinephrine nebulizer **for immediate use when necessary.**
- Encourage periodic inspection of well water/tap water **to identify possible contaminants.**
- Review sources of possible water contamination (e.g., sewage disposal, agricultural/industrial runoff).
- Review pertinent job-related health department/OSHA regulations.
- Refer to resources that provide information about air quality (e.g., pollen index, "bad air days").
- Provide list of emergency numbers placed by telephone **for use if poisoning occurs.**
- Encourage parent to place safety stickers on drugs/chemicals **to warn children of harmful contents.**
- Instruct in first aid measures or ascertain that patient/SO has access to written literature when potential exists for accidents/trauma.
- Suggest purchase of ipecac syrup **to have available for home use on advice of emergency service/physician.**
- Refer substance abuser to detoxification programs, inpatient/outpatient rehabilitation, counseling, support groups, and psychotherapy.

- Encourage emergency measures, awareness and education (e.g., CPR/first aid class, community safety programs, ways to access emergency medical personnel).

Documentation Focus

ASSESSMENT/REASSESSMENT

- Identified risk factors noting internal/external concerns.

PLANNING

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

IMPLEMENTATION/EVALUATION

- Response to interventions/teaching and actions performed.
- Attainment/progress toward desired outcome(s).
- Modification 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—Risk Control: Drug Use
NIC—Environmental Management: Safety

Post-Trauma Syndrome [specify stage]

Taxonomy II: Coping/Stress Tolerance—Class 1 Post-Trauma Responses (00141)
[Diagnostic Division: Ego Integrity]
Nursing Diagnosis Extension and Classification (NDEC) Revision 1998

Definition: Sustained maladaptive response to a traumatic, overwhelming event

Related Factors

Events outside the range of usual human experience
Serious threat or injury to self or loved ones; serious accidents; industrial and motor vehicle accidents

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

Physical and psychosocial abuse; rape
Witnessing mutilation, violent death, or other horrors; tragic occurrence involving multiple deaths
Natural and/or man-made disasters; sudden destruction of one's home or community; epidemics
Wars; military combat; being held prisoner of war or criminal victimization (torture)

Defining Characteristics

SUBJECTIVE

Intrusive thoughts/dreams; nightmares; flashbacks
Palpitations; headaches; [loss of interest in usual activities, loss of feeling of intimacy/sexuality]
Hopelessness; shame
[Excessive verbalization of the traumatic event, verbalization of survival guilt or guilt about behavior required for survival]
Gastric irritability; [changes in appetite; sleep disturbance/insomnia; chronic fatigue/easy fatigability]

OBJECTIVE

Anxiety; fear
Hypervigilant; exaggerated startle response; neurosensory irritability; irritability
Grief; guilt
Difficulty in concentrating; depression
Anger and/or rage; aggression
Avoidance; repression; alienation; denial; detachment; psychogenic amnesia; numbing
Altered mood states; [poor impulse control/irritability and explosiveness]; panic attacks; horror
Substance abuse; compulsive behavior
Enuresis (in children)
[Difficulty with interpersonal relationships; dependence on others; work/school failure]
[**Stages**:
ACUTE SUBTYPE: Begins within 6 months and does not last longer than 6 months.
CHRONIC SUBTYPE: Lasts more than 6 months.
DELAYED SUBTYPE: Period of latency of 6 months or more before onset of symptoms.]

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

Desired Outcomes/Evaluation Criteria—Patient Will:

- Express own feelings/reactions, avoiding projection.
- Verbalize a positive self-image.
- Report reduced anxiety/fear when memories occur.
- Demonstrate ability to deal with emotional reactions in an individually appropriate manner.
- Demonstrate appropriate changes in behavior/lifestyle (e.g., share experiences with others, seek/get support from SO(s) as needed, change in job/residence).
- Report absence of physical manifestations (such as pain, chronic fatigue).
- Refer to ND Rape-Trauma Syndrome for additional outcomes when trauma is the result of rape.

Actions/Interventions

NURSING PRIORITY NO. 1. To assess causative factor(s) and individual reaction:

ACUTE

- Observe for and elicit information about physical or psychological injury and note associated stress-related symptoms such as "numbness," headache, tightness in chest, nausea, pounding heart, and so forth.
- Identify psychological responses: anger, shock, acute anxiety, confusion, denial. Note laughter, crying; calm or agitated, excited (hysterical) behavior; expressions of disbelief and/or self-blame, lability of emotional changes.
- Assess patient's knowledge of and anxiety related to the situation. Note ongoing threat to self (e.g., contact with perpetrator and/or associates).
- Identify social aspects of trauma/incident (e.g., disfigurement, chronic conditions/permanent disabilities).
- Ascertain ethnic, background/cultural and religious perceptions and beliefs about the occurrence (e.g., retribution from God).
- Determine degree of disorganization.
- Identify whether incident has reactivated preexisting or coexisting situations (physical/psychological). **Affects how the patient views the trauma.**
- Determine disruptions in relationships (e.g., family, friends, coworkers, SOs). **Support persons may not know how to deal with patient/situation (e.g., be oversolicitous or withdraw).**
- Note withdrawn behavior, use of denial, and use of chemical substances or impulsive behaviors (e.g., chain-smoking, overeating).

- Be aware of signs of increasing anxiety (e.g., silence, stuttering, inability to sit still). **Increasing anxiety may indicate risk for violence.**
- Note verbal/nonverbal expressions of guilt or self-blame when patient has survived trauma in which others died.
- Assess signs/stage of grieving for self and others.
- Identify development of phobic reactions to ordinary articles (e.g., knives); situations (e.g., walking in groups of people, strangers ringing doorbell).

CHRONIC PHASE (IN ADDITION TO ABOVE ASSESSMENT)

- Evaluate continued somatic complaints (e.g., gastric irritation, anorexia, insomnia, muscle tension, headache). Investigate reports of new/changes in symptoms.
- Note manifestations of chronic pain or pain symptoms in excess of degree of physical injury.
- Be aware of signs of severe/prolonged depression; note presence of flashbacks, intrusive memories, and/or nightmares.
- Assess degree of dysfunctional coping (e.g., use of chemical substances/substance abuse) and consequences.

NURSING PRIORITY NO. 2. To assist patient to deal with situation that exists:

ACUTE PHASE

- Provide a calm, safe environment. **Promotes sense of trust and safety.**
- Assist with documentation for police report, as indicated, and stay with the patient.
- Listen to/investigate physical complaints. **Emotional reactions may limit patient's ability to recognize physical injury.**
- Identify supportive persons for this individual.
- Remain with patient, listen as patient recounts incident/concerns—possibly repeatedly. (If patient does not want to talk, accept silence.) **Provides psychological support.**
- Provide environment in which patient can talk freely about feelings, fear (including concerns about relationship with/response of SO), and experiences/sensations (e.g., loss of control, "near-death experience").
- Help child to express feelings about event using techniques appropriate to developmental level (e.g., play for young child, stories/puppets for preschooler, peer group for adolescent). **Children are more likely to express in play what they may not be able to verbalize directly.**
- Assist with practical realities (e.g., temporary housing, money, notifications of family members, or other needs).

- Be aware of and assist patient to use ego strengths in a positive way by acknowledging ability to handle what is happening. **Enhances self-concept, reduces sense of helplessness.**
- Allow the patient to work through own kind of adjustment. If the patient is withdrawn or unwilling to talk, do not force the issue.
- Listen for expressions of fear of crowds and/or people.

CHRONIC PHASE

- Continue listening to expressions of concern. **May need to continue to talk about the incident.**
- Permit free expression of feelings (may continue from the crisis phase). Do not rush patient through expressions of feelings too quickly and do not reassure inappropriately. **Patient may believe pain and/or anguish is misunderstood and may be depressed. Statements such as "You don't understand" or "You weren't there" are a defense, a way of pushing others away.**
- Encourage patient to talk out experience, expressing feelings of fear, anger, loss/grief. (Refer to ND Grieving, dysfunctional).
- Ascertain/monitor sleep pattern of children as well as adults. Sleep disturbances/nightmares may develop delaying resolution, impairing coping abilities.
- Encourage patient to become aware of and accepting of own feelings and reactions when identified.
- Acknowledge reality of loss of self, which existed before the incident. Assist patient to move toward an acceptance of the potential for growth that exists within patient.
- Continue to allow patient to progress at own pace.
- Give "permission" to express/deal with anger at the assailant/situation in acceptable ways.
- Keep discussion on practical and emotional level rather than intellectualizing the experience, **which allows patient to avoid dealing with feelings.**
- Assist in dealing with practical concerns and effects of the incident, such as court appearances, altered relationships with SO(s), employment problems.
- Provide for sensitive, trained counselors/therapists and engage in therapies such as psychotherapy in conjunction with medications, Implosive Therapy (flooding), hypnosis, relaxation, Rolfing, memory work, cognitive restructuring, Eye Movement Desensitization and Reprocessing (EMDR), physical and occupational therapies.
- Discuss use of medication (e.g., antidepressants). **Lithium may be used to reduce explosiveness; low-dose psychotropics may be used when loss of contact with reality is a problem.**

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

- Assist patient to identify and monitor feelings while therapy is occurring.
- Provide information about what reactions patient may expect during each phase. Let patient know these are common reactions. Be sure to phrase in neutral terms of "You may or you may not. . . ." **Helps reduce fear of the unknown.**
- Assist patient to identify factors that may have created a vulnerable situation and that he or she may have power to change **to protect self in the future.**
- Avoid making value judgments.
- Discuss lifestyle changes patient is contemplating and how they may contribute to recovery. **Helps patient evaluate appropriateness of plans.**
- Assist with learning stress-management techniques.
- Discuss recognition of and ways to manage "anniversary reactions," letting patient know normalcy of recurrence of thoughts and feelings at this time.
- Suggest support group for SO(s) **to assist with understanding of and ways to deal with patient.**
- Encourage psychiatric consultation, especially if patient is unable to maintain control, is violent, is inconsolable, or does not seem to be making an adjustment. Participation in a group may be helpful.
- Refer to family/marital counseling if indicated.
- Refer to NDs Powerlessness; Coping, ineffective; Grieving, anticipatory/dysfunctional.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, noting current dysfunction and behavioral/emotional responses to the incident.
- Specifics of traumatic event.
- Reactions of family/SO(s).

PLANNING

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

IMPLEMENTATION/EVALUATION

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

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Fear Control
NIC—Support System Enhancement

Post-Trauma Syndrome, risk for

Taxonomy II: Coping/Stress Tolerance—Class 1 Post-Trauma Responses (00145)

[Diagnostic Division: Ego Integrity]

Nursing Diagnosis Extension and Classification (NDEC) Submission 1998

Definition: At risk for sustained maladaptive response to a traumatic, overwhelming event

Risk Factors

Occupation (e.g., police, fire, rescue, corrections, emergency room staff, mental health worker, [and their family members])
Perception of event; exaggerated sense of responsibility; diminished ego strength
Survivor's role in the event
Inadequate social support; nonsupportive environment; displacement from home
Duration of the event

Desired Outcomes/Evaluation Criteria—Patient Will:

- Be free of severe anxiety.
- Demonstrate ability to deal with emotional reactions in an individually appropriate manner.
- Report absence of physical manifestations (pain, nightmares/flashbacks, fatigue) associated with event.

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

Actions/Interventions

NURSING PRIORITY NO. **1.** To assess contributing factors and individual reaction:

- Note occupation (e.g., police, fire, emergency room, etc.), as listed in Risk Factors.
- Assess patient's knowledge of and anxiety related to potential or recurring situations.
- Identify how patient's past experiences may affect current situation.
- Listen for comments of taking on responsibility (e.g., "I should have been more careful/gone back to get her").
- Evaluate for life factors/stressors currently or recently occurring, such as displacement from home due to catastrophic event (e.g., illness/injury, fire/flood/violent storm/earthquake).
- Identify patient's coping mechanisms.
- Determine availability/usefulness of patient's support systems, family, social, community, and so forth. (Note: Family members can also be at risk.)

NURSING PRIORITY NO. **2.** To assist patient to deal with situation that exists:

- Educate high-risk persons/families about signs/symptoms of post-trauma response, especially if it is likely to occur in their occupation/life.
- Identify and discuss patient's strengths (e.g., very supportive family, usually copes well with stress, etc.) as well as vulnerabilities (e.g., patient tends toward alcohol/other drugs for coping, patient has witnessed a murder, etc.)
- Discuss how individual coping mechanisms have worked in past traumatic events.
- Evaluate patient's perceptions of events and personal significance (e.g., policeman/parent investigating death of a child).
- Provide emotional and physical presence **to strengthen patient's coping abilities.**
- Encourage expression of feelings. Note whether feelings expressed appear congruent with events the patient experienced. **Incongruency may indicate deeper conflict and can impede resolution.**
- Observe for signs and symptoms of stress responses, such as nightmares, reliving an incident, poor appetite, irritability, numbness and crying, family/relationship disruption. **These responses are normal in the early postincident time frame. If prolonged and persistent, the patient may be experiencing post-traumatic stress disorder.**

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

- Provide a calm, safe environment **in which patient can deal with disruption of life.**
- Encourage patient to identify and monitor feelings on an ongoing basis. **Promotes awareness of changes in ability to deal with stressors.**
- Encourage learning stress-management techniques **to help with resolution of situation.**
- Recommend participation in debriefing sessions that may be provided following major events. **Dealing with the stressor promptly may facilitate recovery from event/prevent exacerbation.**
- Identify employment, community resource groups. **Provides opportunity for ongoing support to deal with recurrent stressors.**
- Refer for individual/family counseling as indicated.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Identified risk factors noting internal/external concerns.
- Patient's perception of event and personal significance.

PLANNING

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

IMPLEMENTATION/EVALUATION

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

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—Grief Resolution
NIC—Crisis Intervention

Powerlessness [specify level]

Taxonomy II: Self-perception—Class 1 Self-Concept (00125)
[Diagnostic Division: Ego Integrity]

Definition: Perception that one's own action will not significantly affect an outcome; a perceived lack of control over a current situation or immediate happening

Related Factors

Healthcare environment [e.g., loss of privacy, personal possessions, control over therapies]
Interpersonal interaction [e.g., misuse of power, force; abusive relationships]
Illness-related regimen [e.g., chronic/debilitating conditions]
Lifestyle of helplessness [e.g., repeated failures, dependency]

Defining Characteristics

SUBJECTIVE

Severe
Verbal expressions of having no control or influence over situation, outcome, or self-care
Depression over physical deterioration that occurs despite patient compliance with regimens

Moderate
Expressions of dissatisfaction and frustration over inability to perform previous tasks and/or activities
Expression of doubt regarding role performance
Reluctance to express true feelings; fear of alienation from caregivers

Low
Expressions of uncertainty about fluctuating energy levels

OBJECTIVE

Severe
Apathy [withdrawal, resignation, crying]
[Anger]

Moderate
Does not monitor progress
Nonparticipation in care or decision making when opportunities are provided

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

Dependence on others that may result in irritability, resentment, anger, and guilt
Inability to seek information regarding care
Does not defend self-care practices when challenged
Passivity

Low
Passivity

Desired Outcomes/Evaluation Criteria—Patient Will:

- Express sense of control over the present situation and future outcome.
- Make choices related to and be involved in care.
- Identify areas over which individual has control.
- Acknowledge reality that some areas are beyond individual's control.

Actions/Interventions

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

- Identify situational circumstances (e.g., strange environment, immobility, diagnosis of terminal/chronic illness, lack of support system(s), lack of knowledge about situation).
- Determine patient's perception/knowledge of condition and treatment plan.
- Ascertain patient response to treatment regimen. Does patient see reason(s) and understand it is in the patient's interest or is patient compliant and helpless?
- Identify patient locus of control: internal (expressions of responsibility for self and ability to control outcomes—"I didn't quit smoking") or external (expressions of lack of control over self and environment—"Nothing ever works out"; "What bad luck to get lung cancer").
- Assess degree of mastery patient has exhibited in life.
- Determine if there has been a change in relationships with SO(s).
- Note availability/use of resources.
- Investigate caregiver practices. Do they support patient control/responsibility?

NURSING PRIORITY NO. 2. To assess degree of powerlessness experienced by the patient/SO(s):

- Listen to statements patient makes: "They don't care"; "It won't make any difference"; "Are you kidding?"
- Note expressions that indicate "giving up," such as "It won't do any good."

- Note behavioral responses (verbal and nonverbal) including expressions of fear, interest or apathy, agitation, withdrawal.
- Note lack of communication, flat affect, and lack of eye contact.
- Identify the use of manipulative behavior and reactions of patient and caregivers. (**Manipulation is used for management of powerlessness because of distrust of others, fear of intimacy, search for approval, and validation of sexuality.**)

NURSING PRIORITY NO. **3.** To assist patient to clarify needs relative to ability to meet them:

- Show concern for patient as a person.
- Make time to listen to patient's perceptions and concerns and encourage questions.
- Accept expressions of feelings, including anger and hopelessness.
- Avoid arguing or using logic with hopeless patient. **Patient will not believe it can make a difference.**
- Express hope for the patient. (**There is always hope of something.**)
- Identify strengths/assets and past coping strategies that were successful. **Helps patient to recognize own ability to deal with difficult situation.**
- Assist patient to identify what he or she can do for self. Identify things the patient can/cannot control.
- Encourage patient to maintain a sense of perspective about the situation.

NURSING PRIORITY NO. **4.** To promote independence:

- Use patient's locus of control to develop individual plan of care (e.g., for patient with internal control, encourage patient to take control of own care and for those with external control, begin with small tasks and add as tolerated).
- Develop contract with patient specifying goals agreed on. **Enhances commitment to plan, optimizing outcomes.**
- Treat expressed decisions and desires with respect. (Avoid critical parenting behaviors.)
- Provide patient opportunities to control as many events as energy and restrictions of care permit.
- Discuss needs openly with patient and set up agreed-on routines for meeting identified needs. **Minimizes use of manipulation.**
- Minimize rules and limit continuous observation to the degree that safety permits **to provide sense of control for the patient.**
- Support patient efforts to develop realistic steps to put plan into action, reach goals, and maintain expectations.
- Provide positive reinforcement for desired behaviors.

- Direct patient's thoughts beyond present state to future when appropriate.
- Schedule frequent brief visits to check on patient, deal with patient needs, and let patient know someone is available.
- Involve SO(s) in patient care as appropriate.

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

- Instruct in/encourage use of anxiety and stress-reduction techniques.
- Provide accurate verbal and written information about what is happening and discuss with patient/SO(s). Repeat as often as necessary.
- Assist patient to set realistic goals for the future.
- Assist patient to learn/use assertive communication skills.
- Facilitate return to a productive role in whatever capacity possible for the individual. Refer to occupational therapist/vocational counselor as indicated.
- Encourage patient to think productively and positively and take responsibility for choosing own thoughts.
- Problem-solve with patient/SO(s).
- Suggest periodic review of own needs/goals.
- Refer to support groups, counseling/therapy, and so forth as indicated.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, noting degree of powerlessness, locus of control, individual's perception of the situation.

PLANNING

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

IMPLEMENTATION/EVALUATION

- Responses to interventions/teaching and actions performed.
- Specific goals/expectations.
- 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—Health Beliefs: Perceived Control
NIC—Self-Responsibility Facilitation

Powerlessness, risk for

Taxonomy II: Self-Perception—Class 1 Self-Concept (00125)
[Diagnostic Division: Ego Integrity]
Submitted 2000

Definition: At risk for perceived lack of control over a situation and/or one's ability to significantly affect an outcome

Risk Factors

Physiological
- Chronic or acute illness (hospitalization, intubation, ventilator, suctioning); dying
- Acute injury or progressive debilitating disease process (e.g., spinal cord injury, multiple sclerosis)
- Aging (e.g., decreased physical strength, decreased mobility)

Psychosocial
- Lack of knowledge of illness or healthcare system
- Lifestyle of dependency with inadequate coping patterns
- Absence of integrality (e.g., essence of power)
- Decreased self-esteem; low or unstable body image

Desired Outcomes/Evaluation Criteria—Patient Will:

- Express sense of control over the present situation and hopefulness about future outcomes.
- Make choices related to and be involved in care.
- Identify areas over which individual has control.
- Acknowledge reality that some areas are beyond individual's control.

Actions/Interventions

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

- Identify situational circumstances (e.g., acute illness, sudden hospitalization, diagnosis of terminal or debilitating/chronic illness, very young or aging with decreased physical strength and mobility, lack of knowledge about illness, healthcare system).

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

- Determine patient's perception/knowledge of condition and proposed treatment plan.
- Identify patient's locus of control: Internal (expressions of responsibility for self and environment) or external (expressions of lack of control over self and environment).
- Assess patient's self-esteem and degree of mastery patient has exhibited in life situations.
- Note availability and use of resources.
- Listen to statements patient makes which might indicate feelings of powerlessness (e.g., "They don't care," "It won't make a difference," "It won't do any good").
- Observe behavioral responses (verbal and nonverbal) for expressions of fear, disinterest or apathy, or withdrawal.
- Be alert for signs of manipulative behavior and note reactions of patient and caregivers. **(Manipulation may be used for management of powerlessness because of fear and distrust.)**

NURSING PRIORITY NO. **2.** To assist patient to clarify needs and ability to meet them:

- Show concern for patient as a person. Encourage questions.
- Make time to listen to patient's perceptions of the situation as well as concerns.
- Accept expressions of feelings, including anger and reluctance to try to work things out.
- Express hope for patient and encourage review of past experiences with successful strategies.
- Assist patient to identify what he or she can do to help self and what situations can/cannot be controlled.

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

- Encourage patient to be active in own health care management and to take responsibility for choosing own actions and reactions.
- Plan and problem-solve with patient and SOs.
- Support patient efforts to develop realistic steps to put plan into action, reach goals, and maintain expectations.
- Provide accurate verbal and written instructions about what is happening and what realistically might happen.
- Suggest periodic review of own needs/goals.
- Refer to support groups or counseling/therapy as appropriate.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, noting potential for powerlessness, locus of control, individual's perception of the situation.

PLANNING

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

IMPLEMENTATION/EVALUATION

- Responses to interventions/teaching and actions performed.
- Specific goals/expectations.
- 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—Health Beliefs: Perceived Control
NIC—Self-Responsibility Facilitation

Protection, ineffective

Taxonomy II: Safety/Protection—Class 2 Physical Injury (00043)

[Diagnostic Division: Safety]

Definition: Decrease in the ability to guard self from internal or external threats such as illness or injury

Related Factors

Extremes of age
Inadequate nutrition
Alcohol abuse
Abnormal blood profiles (e.g., leukopenia, thrombocytopenia, anemia, coagulation)
Drug therapies (e.g., antineoplastic, corticosteroid, immune, anticoagulant, thrombolytic)
Treatments (e.g., surgery, radiation)
Diseases, such as cancer and immune disorders

Defining Characteristics

SUBJECTIVE

Neurosensory alterations
Chilling

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

Itching
Insomnia; fatigue; weakness
Anorexia

OBJECTIVE

Deficient immunity
Impaired healing; altered clotting
Maladaptive stress response
Perspiring [inappropriately]
Dyspnea; cough
Restlessness; immobility
Disorientation
Pressure sores

Authors' note: The purpose of this diagnosis seems to combine multiple NDs under a single heading for ease of planning care when a number of variables may be present. Outcomes/evaluation criteria and interventions are specifically tied to individual related factors that are present, such as:

- **Extremes of age**: Concerns may include body temperature/thermoregulation or thought process/sensory-perceptual alterations, as well as risk for trauma, suffocation, or poisoning; and fluid volume imbalances.
- **Inadequate nutrition**: Brings up issues of nutrition, less than body requirements; infection, altered thought processes, trauma, ineffective coping, and altered family processes.
- **Alcohol abuse**: May be situational or chronic with problems ranging from ineffective breathing patterns, decreased cardiac output, and fluid volume deficit to nutritional problems, infection, trauma, altered thought processes, and coping/family process difficulties.
- **Abnormal blood profile**: Suggests possibility of fluid volume deficit, decreased tissue perfusion, impaired gas exchange, activity intolerance, or risk for infection.
- **Drug therapies, treatments, and disease concerns**: Would include risk for infection, fluid volume imbalances, altered skin/tissue integrity, pain, nutritional problems, fatigue, and emotional responses.

It is suggested that the user refer to specific NDs based on identified related factors and individual concerns for this patient in order to find appropriate outcomes and interventions.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Cognitive Orientation
NIC—Postanesthesia Care

Rape-Trauma Syndrome [specify]

Taxonomy II: Coping/Stress Tolerance—Class 1 Self-Concept (see A, B, C, following)
[Diagnostic Division: Ego Integrity]

Definition: Sustained maladaptive response to a forced, violent sexual penetration against the victim's will and consent. Note: This syndrome includes the following three subcomponents: [A] Rape-Trauma; [B] Compound Reaction; and [C] Silent Reaction.

NOTE: Although attacks are most often directed toward women, men also may be victims.

Related Factors

Rape [actual/attempted forced sexual penetration]

Defining Characteristics

[A] RAPE-TRAUMA—TAXONOMY II (00142)

NURSING DIAGNOSIS EXTENSION AND CLASSIFICATION (NDEC) REVISION 1998

SUBJECTIVE

Embarrassment; humiliation; shame; guilt; self-blame
Loss of self-esteem; helplessness; powerlessness
Shock; fear; anxiety; anger; revenge
Nightmare and sleep disturbances
Change in relationships; sexual dysfunction

OBJECTIVE

Physical trauma (e.g., bruising, tissue irritation); muscle tension and/or spasms
Confusion; disorganization; inability to make decisions
Agitation; hyperalertness; aggression
Mood swings; vulnerability; dependence; depression
Substance abuse; suicide attempts
Denial; phobias; paranoia; dissociative disorders

[B] COMPOUND REACTION—TAXONOMY II (00143)

The trauma syndrome that develops from this attack or attempted attack includes an acute phase of disorganization of the victim's lifestyle and a long-term process of reorganization of lifestyle.

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

Related Factors

To be developed by NANDA

Defining Characteristics

ACUTE PHASE. Emotional reactions (e.g., anger, embarrassment, fear of physical violence and death, humiliation, self-blame, revenge)
Multiple physical symptoms (e.g., gastrointestinal irritability, genitourinary discomfort, muscle tension, sleep pattern disturbance)
Reactivated symptoms of such previous conditions (i.e., physical/psychiatric illness); reliance on alcohol and/or drugs
LONG-TERM PHASE. Changes in lifestyle (e.g., changes in residence, dealing with repetitive nightmares and phobias, seeking family/social network support)

[C] SILENT REACTION—TAXONOMY II (00141)

Related Factors

To be developed by NANDA

Defining Characteristics

Abrupt changes in relationships with men
Increase in nightmares
Increasing anxiety during interview (i.e., blocking of associations, long periods of silence; minor stuttering, physical distress)
Pronounced changes in sexual behavior
No verbalization of the occurrence of rape
Sudden onset of phobic reactions

Desired Outcomes/Evaluation Criteria—Patient Will:

- Deal appropriately with emotional reactions as evidenced by behavior and expression of feelings.
- Report absence of physical complications, pain, and discomfort.
- Verbalize a positive self-image.
- Verbalize recognition that incident was not of own doing.
- Identify behaviors/situations within own control that may reduce risk of recurrence.
- Deal with practical aspects (e.g., court appearances).
- Demonstrate appropriate changes in lifestyle (e.g., change in job/residence) as necessary and seek/obtain support from SO(s) as needed.
- Interact with individuals/groups in desired and acceptable manner.

Actions/Interventions

NURSING PRIORITY NO. **1.** To assess trauma and individual reaction, noting length of time since occurrence of event:

- Observe for and elicit information about physical injury and assess stress-related symptoms such as numbness, headache, tightness in chest, nausea, pounding heart, and so forth.
- Identify psychological responses: anger, shock, acute anxiety, confusion, denial. Note laughter, crying, calm or agitated, excited (hysterical) behavior, expressions of disbelief and/or self-blame.
- Note signs of increasing anxiety (e.g., silence, stuttering, inability to sit still).
- Determine degree of disorganization.
- Identify whether incident has reactivated preexisting or coexisting situations (physical/psychological). **Can affect how the patient views the trauma.**
- Determine disruptions in relationships with men and with others (e.g., family, friends, coworkers, SO[s]).
- Identify development of phobic reactions to ordinary articles (e.g., knives) and situations (e.g., walking in groups of people, strangers ringing doorbell).
- Note degree of intrusive repetitive thoughts, sleep disturbances.
- Assess degree of dysfunctional coping (e.g., use of alcohol, other drugs, suicidal/homicidal ideation, marked change in sexual behavior).

NURSING PRIORITY NO. **2.** To assist patient to deal with situation that exists:

- Explore own feeling (nurse/caregiver) regarding rape/incest issue prior to interacting with the patient. **Need to recognize own biases to prevent imposing them on the patient.**

ACUTE PHASE

- Stay with the patient/do not leave child unattended. **Provides reassurance/sense of safety.**
- Involve rape response team when available. Provide same sex examiner when appropriate.
- Evaluate infant/child/adolescent as dictated by age, sex, and developmental level.
- Assist with documentation of incident for police/child-protective services reports, maintain sequencing and collection of evidence (chain of evidence), label each specimen, and store/package properly.
- Provide environment in which patient can talk freely about feelings and fears, including concerns about relationship with/response of SO(s), pregnancy, sexually transmitted diseases.

- Provide psychological support by listening and remaining with patient. If patient does not want to talk, accept silence. **May indicate Silent Reaction to the occurrence.**
- Listen to/investigate physical complaints. Assist with medical treatments as indicated. **Emotional reactions may limit patient's ability to recognize physical injury.**
- Assist with practical realities (e.g., safe temporary housing, money, or other needs).
- Be aware of patient's ego strengths and assist patient to use them in a positive way by acknowledging patient's ability to handle what is happening.
- Identify supportive persons for this individual.

POSTACUTE PHASE

- Allow the patient to work through own kind of adjustment. May be withdrawn or unwilling to talk; do not force the issue.
- Listen for expressions of fear of crowds, men, and so forth. **May reveal developing phobias.**
- Discuss specific concerns/fears. Identify appropriate actions (e.g., diagnostic testing for pregnancy, sexually transmitted diseases) and provide information as indicated.
- Include written instructions that are concise and clear regarding medical treatments, crisis support services, and so on. **Reinforces teaching, provides opportunity to deal with information at own pace.**

LONG-TERM PHASE

- Continue listening to expressions of concern. **May need to continue to talk about the assault.** Note persistence of somatic complaints (e.g., nausea, anorexia, insomnia, muscle tension, headache).
- Permit free expression of feelings (may continue from the crisis phase). Do not rush patient through expressions of feelings too quickly and do not reassure inappropriately. **Patient may believe pain and/or anguish is misunderstood and depression may limit responses.**
- Acknowledge reality of loss of self that existed before the incident. Assist patient to move toward an acceptance of the potential for growth that exists within individual.
- Continue to allow patient to progress at own pace.
- Give "permission" to express/deal with anger at the perpetrator/situation in acceptable ways. Set limits on destructive behaviors. **Facilitates resolution of feelings without diminishing self-concept.**
- Keep discussion on practical and emotional level rather than intellectualizing the experience, **which allows patient to avoid dealing with feelings.**

- Assist in dealing with ongoing concerns about and effects of the incident, such as court appearance, pregnancy, sexually transmitted disease, relationship with SO(s), and so forth.
- Provide for sensitive, trained counselors, considering individual needs. (**Male/female counselors may be best determined on an individual basis as counselor's gender may be an issue for some patients, affecting ability to disclose.**)

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

- Provide information about what reactions patient may expect during each phase. Let patient know these are common reactions. Be sure to phrase in neutral terms of "You may or may not. . . ." (Be aware that, although male rape perpetrators are usually heterosexual, the male victim may be concerned about his own sexuality and may exhibit a homophobic response.)
- Assist patient to identify factors that may have created a vulnerable situation and that she or he may have power to change **to protect self in the future.**
- Avoid making value judgments.
- Discuss lifestyle changes patient is contemplating and how they will contribute to recovery. **Helps patient evaluate appropriateness of plans.**
- Encourage psychiatric consultation if patient is violent, inconsolable, or does not seem to be making an adjustment. Participation in a group may be helpful.
- Refer to family/marital counseling as indicated.
- Refer to NDs Powerlessness; Coping, ineffective; Grieving, anticipatory/dysfunctional; Anxiety; Fear.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including nature of incident, individual reactions/fears, degree of trauma (physical/emotional), effects on lifestyle.
- Reactions of family/SO(s).
- Samples gathered for evidence and disposition/storage (chain of evidence).

PLANNING

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

IMPLEMENTATION/EVALUATION

- 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 actions to be taken.
- Specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATION (NOC/NIC)—RAPE-TRAUMA SYNDROME

NOC—Abuse Recovery: Emotional
NIC—Rape Trauma Treatment

COMPOUND REACTION

NOC—Coping
NIC—Crises Intervention

SILENT REACTION

NOC—Abuse Recovery: Sexual
NIC—Counseling

Relocation Stress Syndrome

Taxonomy II: Coping/Stress Tolerance—Class 1 Post-Trauma Responses (00114)
[Diagnostic Division: Ego Integrity]
Revised 2000

Definition: Physiological and/or psychosocial disturbance following transfer from one environment to another

Related Factors

Past, concurrent, and recent losses
Feeling of powerlessness
Lack of adequate support system; lack of predeparture counseling; unpredictability of experience
Isolation from family/friends; language barrier
Impaired psychosocial health; passive coping
Decreased health status

Defining Characteristics

SUBJECTIVE

Anxiety (e.g., separation); anger
Insecurity; worry; fear

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

Loneliness; depression
Unwillingness to move, or concern over relocation
Sleep disturbance

OBJECTIVE

Temporary or permanent move; voluntary/involuntary move
Increased [frequency of] verbalization of needs
Pessimism; frustration
Increased physical symptoms/illness (e.g., gastrointestinal disturbances; weight change)
Withdrawal; aloneness; alienation; [hostile behavior/outbursts]
Loss of identity, self-worth, or self-esteem; dependency
[Increased confusion/cognitive impairment]

Desired Outcomes/Evaluation Criteria—Patient Will:

- Verbalize understanding of reason(s) for change.
- Demonstrate appropriate range of feelings and lessened fear.
- Participate in routine and special/social events as able.
- Verbalize acceptance of situation.
- Experience no catastrophic event.

Actions/Interventions

NURSING PRIORITY NO. **1.** To assess degree of stress as perceived/experienced by patient and determine issues of safety:

- Ascertain patient's perceptions about change(s) and expectations for the future, noting patient's age. **(Children can be traumatized by transfer to new school/loss of peers; elderly persons may be affected by loss of long-term home/neighborhood setting and support persons.)**
- Monitor behavior, noting presence of suspiciousness/paranoia, irritability, defensiveness. Compare with SO(s')/staff's description of customary responses. **May temporarily exacerbate mental deterioration (cognitive inaccessibility) and further impair communication (social inaccessibility).**
- Note signs of increased stress, reports of "new" physical discomfort/pain, or presence of fatigue.
- Determine involvement of family/SO(s). Note availability/use of support systems and resources.
- Determine presence of cultural and/or religious concerns/conflicts.

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

NURSING PRIORITY NO. 2. To assist patient to deal with situation/changes:

- Encourage visit to new surroundings prior to transfer when possible. **Provides opportunity to "get acquainted" with new situation, reducing fear of unknown.**
- Orient to surroundings/schedules. Introduce to staff members, roommate/residents. Provide clear, honest information about actions/events.
- Encourage free expression of feelings. Acknowledge reality of situation and maintain hopeful attitude regarding move/change.
- Identify strengths/successful coping behaviors the individual has used previously. **Incorporating these into problem solving builds on past successes.**
- Encourage individual/family to personalize area with pictures, own belongings, and the like as appropriate. **Enhances sense of belonging/personal space.**
- Determine patient's usual schedule of activities and incorporate into facility routine as possible. **Reinforces sense of importance of individual.**
- Introduce diversional activities, such as art therapy, music, and so on. **Involvement increases opportunity to interact with others, decreasing isolation.**
- Place in private room, if appropriate, and include SO(s)/family into care activities, meal time, and so on.
- Encourage hugging and use of touch unless patient is paranoid or agitated at the moment. **Human connection reaffirms acceptance of individual.**
- Deal with aggressive behavior by imposing calm, firm limits. Control environment and protect others from patient's disruptive behavior. **Promotes safety for patient/others.**
- Remain calm, place in a quiet environment, providing time-out, **to prevent escalation into panic state and violent behavior.**

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

- Involve patient in formulating goals and plan of care when possible. **Supports independence and commitment to achieving outcomes.**
- Discuss benefits of adequate nutrition, rest, and exercise **to maintain physical well-being.**
- Involve in anxiety- and stress-reduction activities as able to enhance psychological well-being.
- Encourage participation in activities/hobbies/personal interactions as appropriate. **Promotes creative endeavors, stimulating the mind.**
- Support self-responsibility and coping strategies to foster sense of control and self-worth.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings, individual's perception of the situation/changes, specific behaviors.
- Safety issues.

PLANNING

- Note plan of care, who is involved in planning, and who is responsible for proposed actions.
- Teaching plan.

IMPLEMENTATION/EVALUATION

- Response to interventions (especially time-out/seclusion)/teaching and actions performed.
- Sentinel events.
- 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—Psychosocial Adjustment: Life Change
NIC—Coping Enhancement

Relocation Stress Syndrome, risk for

Taxonomy II: Coping/Stress Tolerance—Class 1 Post-Trauma Responses (00149)

[Diagnostic Division: Ego Integrity]

Submitted 2000

Definition: At risk for physiological and/or psychosocial disturbance following transfer from one environment to another

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

Risk Factors

Moderate to high degree of environmental change (e.g., physical, ethnic, cultural)
Temporary and/or permanent moves; voluntary/involuntary move
Lack of adequate support system/group; lack of predeparture counseling
Passive coping; feelings of powerlessness
Moderate mental competence (e.g., alert enough to experience changes)
Unpredictability of experiences
Decreased psychosocial or physical health status
Past, current, recent losses

Desired Outcomes/Evaluation Criteria—Patient Will:

- Verbalize understanding of reason(s) for change.
- Express feelings and concerns openly and appropriately.
- Experience no catastrophic event.

Actions/Interventions

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

- Evaluate patient for current and potential losses related to relocation, noting age, developmental level, role in family, and physical/emotional health status.
- Ascertain patient's perception about change(s) and expectations for the future, noting patient's age. (**Transfer to new school/loss of peers can traumatize children; elderly individuals may be affected by loss of long-term home/neighborhood setting and support persons.**)
- Note whether relocation will be temporary (e.g., extended care for rehabilitation therapies) or long-term/permanent (e.g., move from home of many years, placement in nursing home).
- Evaluate patient/caregiver's resources and coping abilities. Determine family/SO degree of involvement and willingness to be involved.
- Determine issues of safety that may be involved.

NURSING PRIORITY NO. **2.** To prevent/minimize adverse response to change: Refer to Relocation Stress Syndrome for additional Action/Interventions and Documentation Focus.

Role Performance, ineffective

Taxonomy II: Role Relationships—Class 3 Role Performance (00055)

[Diagnostic Division: Social Interaction]

Revised 1998

Definition: Patterns of behavior and self-expression that do not match the environmental context, norms, and expectations. Note: There is a typology of roles: sociopersonal (friendship, family, marital, parenting, community), home management, intimacy (sexuality, relationship building), leisure/exercise/recreation, self-management, socialization (developmental transitions), community contributor, and religious.

Related Factors

SOCIAL

Inadequate role socialization (e.g., role model, expectations, responsibilities)
Young age, developmental level
Lack of resources; low socioeconomic status; poverty
Stress and conflict; job schedule demands
Family conflict; domestic violence
Inadequate support system; lack of rewards
Inadequate or inappropriate linkage with the healthcare system

KNOWLEDGE

Lack of knowledge about role/role skills; lack of or inadequate role model
Inadequate role preparation (e.g., role transition, skill, rehearsal, validation); lack of opportunity for role rehearsal
Education attainment level; developmental transitions
Role transition
Unrealistic role expectations

PHYSIOLOGICAL

Health alterations (e.g., physical health, body image, self-esteem, mental health, psychosocial health, cognition, learning style, neurological health); fatigue; pain; low self-esteem; depression
Substance abuse
Inadequate/inappropriate linkage with healthcare system

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

Defining Characteristics

SUBJECTIVE

Altered role perceptions/change in self-perception of role/usual patterns of responsibility/capacity to resume role/other's perception of role
Inadequate opportunities for role enactment
Role dissatisfaction; overload; denial
Discrimination [by others]; powerlessness

OBJECTIVE

Inadequate knowledge; role competency and skills; adaptation to change or transition; inappropriate developmental expectations
Inadequate confidence; motivation; self-management; coping
Inadequate opportunities/external support for role enactment
Role strain; conflict; confusion; ambivalence; [failure to assume role]
Uncertainty; anxiety or depression; pessimistic
Domestic violence; harassment; system conflict

Desired Outcomes/Evaluation Criteria—Patient Will:

- Verbalize realistic perception and acceptance of self in changed role.
- Verbalize understanding of role expectations/obligations.
- Talk with family/SO(s) about situation and changes that have occurred and limitations imposed.
- Develop realistic plans for adapting to new role/role changes.

Actions/Interventions

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

- Identify type of role dysfunction, for example, developmental (adolescent to adult); situational (husband to father, gender identity); health-illness transitions.
- Determine patient role in family constellation.
- Identify how patient sees self as a man/woman in usual lifestyle/role functioning.
- Ascertain patient's view of sexual functioning (e.g., loss of childbearing ability following hysterectomy).
- Identify cultural factors relating to individual's sexual roles.
- Determine patient's perceptions/concerns about current situation. **May believe current role is more appropriate for the opposite sex (e.g., passive role of the patient may be somewhat less threatening for women).**
- Interview SO(s) regarding their perceptions and expectations.

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

- Discuss perceptions and significance of the situation as seen by patient.
- Maintain positive attitude toward the patient.
- Provide opportunities for patient to exercise control over as much as possible. **Enhances self-concept and promotes commitment to goals.**
- Offer realistic assessment of situation and communicate hope.
- Discuss and assist the patient/SO(s) to develop strategies for dealing with changes in role related to past transitions, cultural expectations, and value/belief challenges. **Helps those involved deal with differences between individuals (e.g., adolescent task of separation in which parents clash with child's choices).**
- Acknowledge reality of situation related to role change and help patient to express feelings of anger, sadness, and grief. Encourage celebration of positive aspects of change and expressions of feelings.
- Provide open environment for patient to discuss concerns about sexuality. **Embarrassment can block discussion of sensitive subject.** (Refer to NDs Sexual Dysfunction; Sexuality Patterns, ineffective.)
- Identify role model for the patient. Educate about role expectations using written and audiovisual materials.
- Use the techniques of role rehearsal to help the patient develop new skills **to cope with changes.**

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

- Make information available for patient to learn about role expectations/demands that may occur. **Provides opportunity to be proactive in dealing with changes.**
- Accept patient in changed role. Encourage and give positive feedback for changes and goals achieved. **Provides reinforcement and facilitates continuation of efforts.**
- Refer to support groups, employment counselors, Parent Effectiveness classes, counseling/psychotherapy as indicated by individual need(s). **Provides ongoing support to sustain progress.**
- Refer to NDs Self-Esteem [specify] and the Parenting diagnoses.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including specifics of predisposing crises/situation, perception of role change.
- Expectations of SO(s).

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

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 outcome(s).
- Modifications of 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—Role Performance
NIC—Role Enhancement

Self-Care deficit: bathing/hygiene, dressing/grooming, feeding, toileting

Taxonomy II: Activity/Rest—Class 2 Activity/Exercise (Bathing/Hygiene 00108, Dressing/Grooming 00109, Feeding 00102, Toileting 00110)

[Diagnostic Division: Hygiene]

Nursing Diagnosis Extension and Classification (NDEC) Revision 1998

Definition: Impaired ability to perform feeding, bathing/hygiene, dressing and grooming, or toileting activities for oneself [on a temporary, permanent, or progressing basis] [**Note:** Self-care also may be expanded to include the practices used by the patient to promote health, the individual responsibility for self, a way of thinking. Refer to NDs Home Maintenance, impaired; Health Maintenance, ineffective.]

Related Factors

Weakness or tiredness; decreased or lack of motivation
Neuromuscular/musculoskeletal impairment
Environmental barriers
Severe anxiety

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

Pain, discomfort
Perceptual or cognitive impairment
Inability to perceive body part or spatial relationship [bathing/hygiene]
Impaired transfer ability (self-toileting)
Impaired mobility status (self-toileting)
[Mechanical restrictions such as cast, splint, traction, ventilator]

Defining Characteristics

SELF-FEEDING DEFICIT*

Inability to:
- Prepare food for ingestion; open containers
- Handle utensils; get food onto utensil safely; bring food from a receptacle to the mouth
- Ingest food safely; manipulate food in mouth; chew/swallow food
- Pick up cup or glass
- Use assistive device
- Ingest sufficient food; complete a meal
- Ingest food in a socially acceptable manner

SELF-BATHING/HYGIENE DEFICIT*

Inability to:
- Get bath supplies
- Wash body or body parts
- Obtain or get to water source; regulate temperature or flow of bath water
- Get in and out of bathroom [tub]
- Dry body

SELF-DRESSING/GROOMING DEFICIT*

Inability to choose clothing, pick up clothing, use assistive devices
Impaired ability to obtain or replace articles of clothing; put on or take off necessary items of clothing on upper/lower body; fasten clothing/use zippers; put on socks/shoes
Inability to maintain appearance at a satisfactory level

SELF-TOILETING DEFICIT*

Inability to:
- Get to toilet or commode
- Manipulate clothing

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

* [Refer to ND Mobility, impaired physical, for suggested functional level classification.]

Sit on or rise from toilet or commode
Carry out proper toilet hygiene
Flush toilet or [empty] commode

Desired Outcomes/Evaluation Criteria—Patient Will:

- Identify individual areas of weakness/needs.
- Verbalize knowledge of healthcare practices.
- Demonstrate techniques/lifestyle changes to meet self-care needs.
- Perform self-care activities within level of own ability.
- Identify personal/community resources that can provide assistance.

Actions/Interventions

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

- Determine existing conditions/extremes of age/developmental level affecting ability of individual to care for own needs: CVA, MS, Alzheimer's, and so forth.
- Note concomitant medical problems that may be factors for care (e.g., high BP, heart disease, malnutrition, pain, and/or medications patient is taking).
- Note other etiologic factors present, including language barriers, speech impairment, visual acuity/hearing problem, emotional stability/ability.
- Assess barriers to participation in regimen (e.g., lack of information, insufficient time for discussion; psychological and/or intimate family problems that may be difficult to share; fear of appearing stupid or ignorant; social/economic; work/home environment problems).

NURSING PRIORITY NO. **2.** To assess degree of disability:

- Identify degree of individual impairment/functional level according to scale (noted in ND Mobility, impaired physical).
- Assess memory/intellectual functioning. Note developmental level to which patient has regressed/progressed.
- Determine individual strengths and skills of the patient.
- Note whether deficit is temporary or permanent, should decrease or increase with time.

NURSING PRIORITY NO. **3.** To assist in correcting/dealing with situation:

- Establish "contractual" partnership with patient/SO(s).

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

- Promote patient/SO participation in problem identification and decision making. **Enhances commitment to plan, optimizing outcomes.**
- Develop plan of care appropriate to individual situation, scheduling activities to conform to patient's normal schedule.
- Plan time for listening to the patient/SO(s) **to discover barriers to participation in regimen.**
- Provide for communication among those who are involved in caring for/assisting the patient. **Enhances coordination and continuity of care.**
- Establish remotivation/resocialization programs when indicated.
- Assist with rehabilitation program **to enhance capabilities.**
- Provide privacy during personal care activities.
- Allow sufficient time for patient to accomplish tasks to fullest extent of ability. Avoid unnecessary conversation/interruptions.
- Assist with necessary adaptations **to accomplish ADLs.** Begin with familiar, easily accomplished tasks **to encourage patient and build on successes.**
- Arrange for assistive devices as necessary (e.g., raised toilet seat/grab bars, button hook, modified eating utensils).
- Identify energy-saving behaviors (e.g., sitting instead of standing when possible).
- Implement bowel or bladder training/retraining programs as indicated.
- Encourage food and fluid choices reflecting individual likes and abilities that meet nutritional needs. Provide assistive devices/alternate feeding methods as appropriate.
- Assist with medication regimen as necessary, noting potential for/presence of side effects.
- Make home visit **to assess environmental/discharge needs.**

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

- Assist the patient to become aware of rights and responsibilities in health/healthcare and to assess own health strengths—physical, emotional, and intellectual.
- Support patient in making health-related decisions and assist in developing self-care practices and goals that promote health.
- Provide for ongoing evaluation of self-care program, identifying progress and needed changes.
- Review/modify program periodically to accommodate changes in patient's abilities. **Assists patient to adhere to plan of care to fullest extent.**
- Encourage keeping a journal of progress.

- Review safety concerns. Modify activities/environment **to reduce risk of injury.**
- Refer to home care provider, social services, physical/occupational therapy, rehabilitation and counseling resources as indicated.
- Identify additional community resources (e.g., senior services, Meals on Wheels).
- Review instructions from other members of the healthcare team and provide written copy. **Provides clarification, reinforcement, and periodic review by patient/caregivers.**
- Give family information about respite/other care options. **Allows them free time away from the care situation to renew themselves.**
- Assist/support family with alternative placements as necessary. **Enhances likelihood of finding individually appropriate situation to meet patient's needs.**
- Be available for discussion of feelings about situation (e.g., grieving, anger).
- Refer to NDs Injury/Trauma, risk for; Coping, ineffective; Coping, family: compromised; Self-Esteem, situational low; Constipation; Bowel Incontinence; Urinary Elimination, impaired; Mobility, impaired physical; Activity intolerance; Powerlessness.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, functional level, and specifics of limitation(s).
- Needed resources/adaptive devices.

PLANNING

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

IMPLEMENTATION/EVALUATION

- 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 to be taken.
- Type of and source for assistive devices.
- Specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

BATHING/HYGIENE DEFICIT

NOC—Self-Care Bathing
NIC—Self-Care Assistance: Bathing/Hygiene

DRESSING/GROOMING DEFICIT

NOC—Self-Care Dressing
NIC—Self-Care Assistance: Dressing/Grooming

FEEDING DEFICIT

NOC—Self-Care Eating
NIC—Self-Care Assistance: Feeding

TOILETING DEFICIT

NOC—Self-Care Toileting
NIC—Self-Care Assistance: Toileting

Self-Esteem, chronic low

Taxonomy II: Self-Perception—Class 2 Self-Esteem (00119)
[Diagnostic Division: Ego Integrity]

Definition: Long-standing negative self-evaluation/feelings about self or self-capabilities

Related Factors

To be developed by NANDA
[Fixation in earlier level of development]
[Continual negative evaluation of self/capabilities from childhood]
[Personal vulnerability]
[Life choices perpetuating failure; ineffective social/occupational functioning]
[Feelings of abandonment by SO; willingness to tolerate possibly life-threatening domestic violence]
[Chronic physical/psychiatric conditions; antisocial behaviors]

Defining Characteristics

SUBJECTIVE

(Long-standing or chronic:)
Self-negating verbalization

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

Expressions of shame/guilt
Evaluates self as unable to deal with events
Rationalizes away/rejects positive feedback and exaggerates negative feedback about self

OBJECTIVE

Hesitant to try new things/situations (long-standing or chronic)
Frequent lack of success in work or other life events
Overly conforming, dependent on others' opinions
Lack of eye contact
Nonassertive/passive; indecisive
Excessively seeks reassurance

Desired Outcomes/Evaluation Criteria—Patient Will:

- Verbalize understanding of negative evaluation of self and reasons for this problem.
- Participate in treatment program to promote change in self-evaluation.
- Demonstrate behaviors/lifestyle changes to promote positive self-esteem.
- Verbalize increased sense of self-esteem in relation to current situation.
- Participate in family/group/community activities to enhance change.

Actions/Interventions

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

- Determine factors of low self-esteem related to current situation (e.g., family crises, physical disfigurement, social isolation), noting age and developmental level of individual.
- Assess content of negative self-talk. Note patient's perceptions of how others view him or her.
- Determine availability/quality of family/SO(s) support.
- Identify family dynamics, present and past.
- Note nonverbal behavior (e.g., nervous movements, lack of eye contact). **Incongruencies between verbal/nonverbal communication requires clarification.**
- Determine degree of participation and cooperation with therapeutic regimen (e.g., maintaining scheduled medications such as antidepressants/antipsychotics).
- Note willingness to seek assistance, motivation for change.
- Be alert to patient concept of self in relation to cultural/religious ideal(s).

NURSING PRIORITY NO. 2. To promote patient sense of self-esteem in dealing with situation:

- Develop therapeutic relationship. Be attentive, validate patient's communication, provide encouragement for efforts, maintain open communication, use skills of Active-listening and I-messages. **Promotes trusting situation in which patient is free to be open and honest with self and therapist.**
- Address presenting medical/safety issues.
- Accept patient's perceptions/view of situation. Avoid threatening existing self-esteem.
- Be aware that people are not programmed to be rational. They must seek information—choosing to learn; to think rather than merely accepting/reacting—**in order to have respect for self, facts, honesty, and to develop positive self-esteem.**
- Discuss patient perceptions of self related to what is happening; confront misconceptions and negative self-talk. Address distortions in thinking, such as self-referencing (belief that others are focusing on individual's weaknesses/limitations), filtering (focusing on negative and ignoring positive), catastrophizing (expecting the worst outcomes). **Addressing these issues openly provides opportunity for change.**
- Emphasize need to avoid comparing self with others. Encourage patient to focus on aspects of self that can be valued.
- Have patient list current/past successes and strengths.
- Use positive I-messages rather than praise. **Assists patient to develop internal sense of self-esteem.**
- Discuss what behavior does for patient (positive intention). What options are available to the patient/SO(s)?
- Assist patient to deal with sense of powerlessness. Refer to ND Powerlessness.
- Set limits on aggressive or problem behaviors such as acting out, suicide preoccupation, or rumination. Put self in patient's place (empathy not sympathy).
- Give reinforcement for progress noted. **Positive words of encouragement support development of coping behaviors.**
- Allow patient to progress at own rate. **Adaptation to a change in self-concept depends on its significance to individual, disruption to lifestyle, and length of illness/debilitation.**
- Assist patient to recognize and cope with events, alterations, and sense of loss of control by incorporating changes accurately into self-concept.
- Involve in activities/exercise program, promote socialization. **Enhances sense of well-being/can help energize patient.**

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

- Discuss inaccuracies in self-perception with patient/SO(s).
- Prepare patient for events/changes that are expected, when possible.
- Provide structure in daily routine/care activities.
- Emphasize importance of grooming and personal hygiene. Assist in developing skills as indicated (e.g., makeup classes, dress for success). **People feel better about themselves when they present a positive outer appearance.**
- Assist patient to identify goals that are personally achievable. Provide positive feedback for verbal and behavioral indications of improved self-view. **Increases likelihood of success and commitment to change.**
- Refer to vocational/employment counselor, educational resources as appropriate. **Assists with development of social/vocational skills.**
- Encourage participation in classes/activities/hobbies that patient enjoys or would like to experience.
- Reinforce that this therapy is a brief encounter in overall life of the patient/SO(s), with continued work and ongoing support being necessary to sustain behavior changes/personal growth.
- Refer to classes **to assist with new learning skills to promote self-esteem** (e.g., assertiveness training, positive self-image, communication skills).
- Refer to counseling/therapy, mental health, and special needs support groups as indicated.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including early memories of negative evaluations (self and others), subsequent/precipitating failure events.
- Effects on interactions with others/lifestyle.
- Specific medical/safety issues.
- Motivation for/willingness to change.

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 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—Self-Esteem
NIC—Self-Esteem Enhancement

Self-Esteem, situational low

Taxonomy II: Self-Perception—Class 2 Self-Esteem (00120)

[Diagnostic Division: Ego Integrity]

Revised 2000

Definition: Development of a negative perception of self-worth in response to a current situation (specify)

Related Factors

Developmental changes (specify); [maturational transitions, adolescence, aging]
Functional impairments; disturbed body image
Loss (specify)[e.g., loss of health status, body part, independent functioning; memory deficit/cognitive impairment]
Social role changes (specify)
Failures/rejections; lack of recognition/rewards; [feelings of abandonment by SO]
Behavior inconsistent with values

Defining Characteristics

SUBJECTIVE

Reports current situational challenge to self-worth
Expressions of helplessness and uselessness
Evaluation of self as unable to deal with situations or events

OBJECTIVE

Self-negating verbalizations
Indecisive, nonassertive behavior

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

Desired Outcomes/Evaluation Criteria—Patient Will:

- Verbalize understanding of individual factors that precipitated current situation.
- Identify feelings and underlying dynamics for negative perception of self.
- Express positive self-appraisal.
- Demonstrate behaviors to restore positive self-esteem.
- Participate in treatment regimen/activities to correct factors that precipitated crisis.

Actions/Interventions

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

- Determine individual situation (e.g., family crisis, physical disfigurement) related to low self-esteem in the present circumstances.
- Identify basic sense of self-esteem of patient, image patient has of self—existential, physical, psychological.
- Assess degree of threat/perception of patient in regard to crisis.
- Be aware of sense of control patient has (or perceives to have) over self and situation.
- Determine patient's awareness of own responsibility for dealing with situation, personal growth, and so forth.
- Assess family/SO(s) dynamics and support of patient.
- Be alert to patient's concept of self in relation to cultural/religious ideals.
- Note patient's locus of control (internal/external).
- Determine past coping skills in relation to current episode.
- Assess negative attitudes and/or self-talk.
- Note nonverbal body language. **Incongruencies between verbal/nonverbal communication requires clarification.**
- Assess for self-destructive/suicidal behavior. (Refer to ND Suicide, risk for as appropriate.)
- Identify previous adaptations to illness/disruptive events in life. (**May be predictive of current outcome.**)

NURSING PRIORITY NO. 2. To assist patient to deal with loss/change and recapture sense of positive self-esteem:

- Assist with treatment of underlying condition when possible. **For example, cognitive restructuring and improved concentration in mild brain injury often result in restoration of positive self-esteem.**
- Encourage expression of feelings, anxieties. Facilitate grieving the loss.

- Active-listen patient's concerns/negative verbalizations without comment or judgment.
- Identify individual strengths/assets and aspects of self that remain intact, can be valued. Reinforce positive traits, abilities, self-view.
- Help patient identify own responsibility and control or lack of control in situation.
- Assist patient to problem-solve situation, developing plan of action and setting goals to achieve desired outcome. **Enhances commitment to plan, optimizing outcomes.**
- Convey confidence in patient's ability to cope with current situation.
- Mobilize support systems.
- Provide opportunity for patient to practice alternative coping strategies, including progressive socialization opportunities.
- Encourage use of visualization, guided imagery, and relaxation **to promote positive sense of self.**
- Provide feedback of patient's self-negating remarks/behavior, using I-messages **to allow the patient to experience a different view.**
- Encourage involvement in decisions about care when possible.

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

- Encourage patient to set long-range goals for achieving necessary lifestyle changes. **Supports view that this is an ongoing process.**
- Support independence in ADLs/mastery of therapeutic regimen. **Individuals who are confident are more secure and positive in self-appraisal.**
- Promote attendance in therapy/support group as indicated.
- Involve extended family/SO(s) in treatment plan. **Increases likelihood they will provide appropriate support to patient.**
- Provide information to assist patient in making desired changes.
- Suggest participation in group/community activities (e.g., assertiveness classes, volunteer work, support groups).

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, noting precipitating crisis, patient's perceptions, effects on desired lifestyle/interaction with others.

PLANNING

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

IMPLEMENTATION/EVALUATION

- Responses to interventions/teaching, actions performed, and changes that may be indicated.
- Attainment/progress toward desired outcome(s).
- Modifications to plan of care.

DISCHARGE PLANNING

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Self-Esteem
NIC—Self-Esteem Enhancement

Self-Esteem, risk for situational low

Taxonomy II: Self-Perception—Class 2 Self-Esteem (00153)
[Diagnostic Division: Ego Integrity]
Submitted 2000

Definition: At risk for developing negative perception of self-worth in response to a current situation (specify)

Risk Factors

Developmental changes (specify)
Disturbed body image; functional impairment (specify); loss (specify)
Social role changes (specify)
History of learned helplessness; neglect, or abandonment
Unrealistic self-expectations
Behavior inconsistent with values
Lack of recognition/rewards; failures/rejections
Decreased power/control over environment
Physical illness (specify)

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

Desired Outcomes/Evaluation Criteria—Patient Will:

- Acknowledge factors that lead to possibility of feelings of low self-esteem.
- Verbalize view of self as a worthwhile, important person who functions well both interpersonally and occupationally.
- Demonstrate self-confidence by setting realistic goals and actively participating in life situation.

Actions/Interventions

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

- Determine individual factors that may contribute to diminished self-esteem.
- Identify basic sense of self-worth of patient, image patient has of self—existential, physical, psychological.
- Note patient's perception of threat to self in current situation.
- Be aware of sense of control patient has (or perceives to have) over self and situation.
- Determine patient awareness of own responsibility for dealing with situation, personal growth, and so forth.
- Assess family/SO(s) dynamics and support of patient.
- Note patient concept of self in relation to cultural/religious ideals.
- Assess negative attitudes and/or self-talk. **Contributes to view of situation as hopeless, difficult.**
- Listen for self-destructive/suicidal verbalizations, noting behaviors that indicate these thoughts.
- Note nonverbal body language. **Incongruencies between verbal/nonverbal communication require clarification.**
- Identify previous adaptations to illness/disruptive events in life. **May be predictive of current outcome.**

Refer to NDs, Self-Esteem, situational low, and Self-Esteem, chronic low, as appropriate for additional nursing priorities/interventions.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including individual expressions of lack of self-esteem, effects on interactions with others/lifestyle.
- Underlying dynamics and duration (situational or situational exacerbating chronic).

PLANNING

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

IMPLEMENTATION/EVALUATION

- Responses to interventions/teaching, actions performed, and changes that may be indicated.
- Attainment/progress toward desired outcome(s).
- Modifications to plan of care.

DISCHARGE PLANNING

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Self-Esteem
NIC—Self-Esteem Enhancement

Self-Mutilation

Taxonomy II: Safety/Protection—Class 3 Violence (00151)
[Diagnostic Division: Safety]
Submitted 2000

Definition: Deliberate self-injurious behavior causing tissue damage with the intent of causing nonfatal injury to attain relief of tension

Related Factors

History of self-injurious behavior; family history of self-destructive behaviors
Feelings of depression, rejection, self-hatred, separation anxiety, guilt, depersonalization
Low or unstable self-esteem/body image; labile behavior (mood swings); feels threatened with actual or potential loss of significant relationship (e.g., loss of parent/parental relationship)

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

Perfectionism; emotionally disturbed; battered child; substance abuse; eating disorders; sexual identity crisis; childhood illness or surgery; childhood sexual abuse
Adolescence; peers who self-mutilate; isolation from peers
Family divorce; family alcoholism; violence between parental figures
History of inability to plan solutions or see long-term consequences; inadequate coping
Mounting tension that is intolerable; needs quick reduction of stress; impulsivity; irresistible urge to cut/damage self
Use of manipulation to obtain nurturing relationship with others; chaotic/disturbed interpersonal relationships; poor parent-adolescent communication; lack of family confidant
Experiences dissociation or depersonalization; psychotic state (command hallucinations); character disorders; borderline personality disorders; developmentally delayed or autistic individuals
Foster, group, or institutional care; incarceration

Defining Characteristics

SUBJECTIVE

Self-inflicted burns (e.g., eraser, cigarette)
Ingestion/inhalation of harmful substances/objects

OBJECTIVE

Cuts/scratches on body
Picking at wounds
Biting; abrading; severing
Insertion of object(s) into body orifice(s)
Hitting
Constricting a body part

Desired Outcomes/Evaluation Criteria—Patient Will:

- Verbalize understanding of reasons for occurrence of behavior.
- Identify precipitating factors/awareness of arousal state that occurs prior to incident.
- Express increased self-concept/self-esteem.
- Seeks help when feeling anxious and having thoughts of harming self.

Actions/Interventions

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

- Determine underlying dynamics of individual situation as listed in Related Factors. Note previous episodes of self-mutilation behavior. **Although some body piercing (e.g., ears) is generally accepted as decorative, piercing of multiple sites often is an attempt to establish individuality, addressing issues of separation and belonging.**
- Identify previous history of self-mutilative behavior and relationship to stressful events.
- Determine presence of inflexible, maladaptive personality traits that reflect personality/character disorder (e.g., impulsive, unpredictable, inappropriate behaviors, intense anger or lack of control of anger).
- Evaluate history of mental illness (e.g., borderline personality, identity disorder).
- Note use/abuse of addicting substances.
- Review laboratory findings (e.g., blood alcohol, polydrug screen, glucose, and electrolyte levels). **Drug use may affect behavior.**

NURSING PRIORITY NO. **2.** To structure environment to maintain patient safety:

- Assist patient to identify feelings leading up to desire for self-mutilation. **Early recognition of recurring feelings provides opportunity to seek other ways of coping.**
- Provide external controls/limit setting. **May decrease the opportunity to self-mutilate.**
- Include patient in development of plan of care. **Commitment to plan promotes likelihood of adherence.**
- Encourage appropriate expression of feelings. **Identifies feelings and promotes understanding of what leads to development of tension.**
- Note feelings of healthcare providers/family, such as frustration, anger, defensiveness, need to rescue. **Patient may be manipulative, evoking defensiveness and conflict. These feelings need to be identified, recognized, and dealt with openly with staff and patient.**
- Provide care for patient's wounds, when self-mutilation occurs, in a manner-of-fact manner. Do not offer sympathy or additional attention **that could provide reinforcement for maladaptive behavior and may encourage its repetition. A manner-of-fact approach can convey empathy/concern.**

NURSING PRIORITY NO. 3. To promote movement toward positive changes:

- Involve patient in developing plan of care. **Enhances commitment to goals, optimizing outcomes.**
- Develop a contract between patient and counselor to enable the patient to stay physically safe, such as "I will not cut or harm myself for the next 8 hours." Renew contract on a regular basis and have both parties sign and date each contract.
- Provide avenues of communication **for times when patient needs to talk to avoid cutting or damaging self.**
- Assist patient to learn assertive behavior. Include the use of effective communication skills, focusing on developing self-esteem by replacing negative self-talk with positive comments.
- Use interventions that help the patient to reclaim power in own life (e.g., experiential and cognitive).

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

- Discuss commitment to safety and ways in which patient will deal with precursors to undesired behavior.
- Promote the use of healthy behaviors, identifying the consequences and outcomes of current actions.
- Identify support systems.
- Discuss living arrangements when patient is discharged. **May need assistance with transition to changes required to avoid recurrence of self-mutilating behaviors.**
- Involve family/SO(s) in planning for discharge and involve in group therapies as appropriate. **Promotes coordination and continuation of plan, commitment to goals.**
- Provide information and discuss the use of medication as appropriate. **Antidepressant medications may be useful, but they need to be weighed against the potential for overdosing.**
- Refer to NDs Anxiety; Social Interaction, impaired; Self-Esteem, (specify).

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including risk factors present, underlying dynamics, prior episodes.

PLANNING

- Plan of care 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

- Long-range needs and who is responsible for actions to be taken.
- Community resources, referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Self-Mutilation Restraint
NIC—Behavior Management: Self-Harm

Self-Mutilation, risk for

Taxonomy II: Safety/Protection—Class 3 Violence (00139)
[Diagnostic Division: Safety]
Revised 2000

Definition: At risk for deliberate self-injurious behavior causing tissue damage with the intent of causing nonfatal injury to attain relief of tension

Risk Factors

Feelings of depression, rejection, self-hatred, separation anxiety, guilt, and depersonalization
Low or unstable self-esteem/body image
Adolescence; isolation from peers; peers who self-mutilate
Perfectionism; childhood illness or surgery; eating disorders; substance abuse; sexual identity crisis
Emotionally disturbed and/or battered children; childhood sexual abuse; developmentally delayed or autistic individual
Inadequate coping; loss of control over problem-solving situations; history of inability to plan solutions or see long-term consequences
Experiences mounting tension that is intolerable; inability to express tension verbally; needs quick reduction of stress

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

Experiences irresistible urge to cut/damage self; history of self-injurious behavior
Chaotic/disturbed interpersonal relationships; use of manipulation to obtain nurturing relationship with others
Family alcoholism; divorce; history of self-destructive behaviors; violence between parental figures
Loss of parent/parental relationships; feels threatened with actual or potential loss of significant relationship
Character disorders; borderline personality disorders; experiences dissociation or depersonalization; psychotic state (command hallucinations)
Foster, group, or institutional care; incarceration

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—Patient Will:

- Verbalize understanding of reasons for occurrence of behavior.
- Identify precipitating factors/awareness of arousal state that occurs prior to incident.
- Express increased self-concept/self-esteem.
- Demonstrate self-control as evidenced by lessened (or absence of) episodes of self-mutilation.
- Engage in use of alternative methods for managing feelings/individuality.

Actions/Interventions

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

- Determine underlying dynamics of individual situation as listed in Risk Factors. Note previous episodes of self-mutilating behavior (e.g., cutting, scratching, bruising, unconventional body piercings). **Although some body piercing (e.g., ears) is generally accepted as decorative, piercing of multiple sites often is an attempt to establish individuality, addressing issues of separation and belonging.**
- Identify conditions that may interfere with ability to control own behavior (e.g., psychotic state, mental retardation, autism).
- Note beliefs, cultural/religious practices that may be involved in choice of behavior.
- Determine use/abuse of addictive substances.
- Assess presence of inflexible, maladaptive personality traits **that reflect personality/character disorder** (e.g., impulsive,

unpredictable, inappropriate behaviors, intense anger or lack of control of anger).
- Note degree of impairment in social and occupational functioning. **May dictate treatment setting (e.g., specific outpatient program, short-stay inpatient).**
- Review laboratory findings (e.g., blood alcohol, polydrug screen, glucose, electrolyte levels).

NURSING PRIORITY NO. 2. To structure environment to maintain patient safety:
- Assist patient to identify feelings and behaviors that precede desire for self-mutilation. **Early recognition of recurring feelings provides patient opportunity to seek other ways of coping.**
- Provide external controls/limit setting **to decrease the need to self-mutilate.**
- Include patient in development of plan of care **to reestablish ego boundaries, strengthen commitment to goals and participation in therapy.**
- Encourage patient to recognize and appropriately express feelings verbally.
- Keep patient in continuous staff view and do special observation checks **to promote safety.**
- Develop schedule of alternative healthy, success-oriented activities, as in groups such as Overeaters Anonymous (OA) or similar 12-step program based on individual needs, self-esteem activities including positive affirmations, visiting with friends, and exercise.
- Structure inpatient milieu to maintain positive, clear, open communication among staff and patients, with an understanding that "secrets are not tolerated" and will be confronted.
- Note feelings of healthcare providers/family, such as frustration, anger, defensiveness, distraction, despair and powerlessness, need to rescue. **Patient may be manipulating/splitting providers/family members, which evokes defensiveness and resultant conflict. These feelings need to be identified, recognized, and dealt with openly with staff and patient.**

NURSING PRIORITY NO. 3. To promote movement toward positive actions:
- Encourage patient involvement in developing plan of care. **Enhances commitment to goals, optimizing outcomes.**
- Assist patient to learn assertive behavior rather than nonassertive/ aggressive behavior. Include use of effective communication skills, focusing on developing self-esteem by replacing negative self-talk with positive comments.
- Develop a contract between patient and counselor **to enable the patient to stay physically safe,** such as "I will not cut or harm myself for the next 8 hours." Contract is renewed on a regular basis

and signed and dated by both parties. Contingency arrangements need to be made **so patient can talk to counselor as needed.**
- Discuss with patient/family normalcy of adolescent task of separation and ways of achieving.
- Promote the use of healthy behaviors, identifying the consequences and outcomes of current actions: "Does this get you what you want?" "How does this behavior help you achieve your goals?"
- Use interventions that help the patient to reclaim power in own life (e.g., experiential and cognitive).
- Involve patient/family in group therapies as appropriate.

NURSING PRIORITY NO. 4. To promote wellness (Teaching/Discharge Considerations):
- Discuss commitment to safety and ways in which patient will deal with precursors to undesired behavior.
- Mobilize support systems.
- Identify living circumstances patient will be going to once discharged. **May need assistance with transition to changes required to avoid recurrence of self-mutilating behaviors.**
- Arrange for continued involvement in group therapy(ies).
- Involve family/SO(s) in planning for discharge. **Promotes coordination and continuation of plan, commitment to goals.**
- Discuss and provide information about the use of medication as appropriate. **Antidepressant medications may be useful, but use needs to be weighed against potential for overdosing.**
- Refer to NDs Anxiety; Social Interaction, impaired; Self-Esteem (specify).

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including risk factors present, underlying dynamics, prior episodes.

PLANNING

- Plan of care 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

- Long-range needs and who is responsible for actions to be taken.
- Community resources, referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Self-Mutilation Restraint
NIC—Behavior Management: Self-Harm

Sensory Perception, disturbed (specify: visual, auditory, kinesthetic, gustatory, tactile, olfactory)

Taxonomy II: Perception/Cognition—Class 3 Sensation/Perception (00122)

[Diagnostic Division: Neurosensory]

Revised 1998 by small group work in 1996

Definition: Change in the amount or patterning of incoming stimuli accompanied by a diminished, exaggerated, distorted, or impaired response to such stimuli

Related Factors

Excessive/insufficient environmental stimuli
[Therapeutically restricted environments (e.g., isolation, intensive care, bedrest, traction, confining illnesses, incubator)]
[Socially restricted environment (e.g., institutionalization, homebound, aging, chronic/terminal illness, infant deprivation); stigmatized (e.g., mentally ill/retarded/handicapped); bereaved]
[Excessive noise level such as work environment, patient's immediate environment (ICU with support machinery and the like)]
Altered sensory reception, transmission, and/or integration:
[Neurological disease, trauma, or deficit]
[Altered status of sense organs]
[Inability to communicate, understand, speak, or respond]
[Sleep deprivation]
[Pain, (phantom limb)]
Biochemical imbalances; electrolyte imbalance; biochemical imbalances for sensory distortion (e.g., illusions, hallucinations)[elevated BUN, elevated ammonia, hypoxia]; [drugs, e.g., stimulants or depressants, mind-altering drugs]
Psychological stress [narrowed perceptual fields caused by anxiety]
Altered sensory perception

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

Defining Characteristics

SUBJECTIVE

Reported change in sensory acuity [e.g., photosensitivity, hypoesthesias/hyperesthesias, diminished/altered sense of taste, inability to tell position of body parts (proprioception)]
Visual/auditory distortions
[Distortion of pain, e.g., exaggerated, lack of]

OBJECTIVE

Measured change in sensory acuity
Change in usual response to stimuli, [rapid mood swings, exaggerated emotional responses, anxiety/panic state, motor incoordination, altered sense of balance/falls (e.g., Ménierè's syndrome)]
Change in problem-solving abilities; poor concentration
Disoriented in time, in place, or with people
Altered communication patterns
Change in behavior pattern
Restlessness, irritability
Hallucinations; [illusions]; [bizarre thinking]

Desired Outcomes/Evaluation Criteria—Patient Will:

- Regain/maintain usual level of cognition.
- Recognize and correct/compensate for sensory impairments.
- Verbalize awareness of sensory needs and presence of overload and/or deprivation.
- Identify/modify external factors that contribute to alterations in sensory/perceptual abilities.
- Use resources effectively and appropriately.
- Be free of injury.

Actions/Interventions

NURSING PRIORITY NO. 1. To assess causative/contributing factors and degree of impairment:

- Identify underlying reason for alterations in sensory perception, as noted in Related Factors.
- Be aware of patients at risk for loss/alterations in sensory/perceptual senses (e.g., increased intraocular pressure after eye surgery), drug toxicity side effects (e.g., halos around lights, ringing in ears), middle-ear disturbances (altered sense of balance).

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

- Review laboratory values (e.g., electrolytes, chemical profile, ABGs, serum drug levels).
- Assess ability to speak and respond to simple commands.
- Evaluate sensory awareness: Stimulus of hot/cold, dull/sharp; awareness of motion, and location of body parts, visual acuity and hearing. Investigate reports of feeling cold—**may indicate decrease in peripheral circulation/cellular catabolism.**
- Determine response to painful stimuli, **to note whether response is appropriate to stimulus, immediate, or delayed.**
- Observe for behavioral responses (e.g., illusions/hallucinations, delusions, withdrawal, hostility, crying, inappropriate affect, confusion/disorientation).
- Ascertain patient's perception of problem/changes.
- Interview SO(s) regarding his or her observations of changes that have occurred/responses of patient to changes.

NURSING PRIORITY NO. 2. To promote normalization of response to stimuli:

- Note degree of alteration/involvement (single/multiple senses).
- Listen to and respect patient's expressions of deprivation. Take these into consideration in planning care.
- Provide means of communication as indicated.
- Provide a stable environment with continuity of care by same personnel as much as possible. Have personnel wear name tags/reintroduce self as appropriate.
- Avoid isolation of patient, physically or emotionally, **to prevent sensory deprivation/limit confusion.**
- Provide feedback to assist patient to separate reality from fantasy/altered perception.
- Reorient to time, place, staff, and events as necessary (especially when vision is impaired).
- Explain procedures/activities, expected sensations, and outcomes.
- Minimize discussion of negatives (e.g., patient and personnel problems) within patient's hearing. **Patient may misinterpret and believe references are to himself/herself.**
- Eliminate extraneous noise/stimuli, including nonessential equipment, alarms/audible monitor signals when possible.
- Provide undisturbed rest/sleep periods.
- Arrange bed, personal articles, and food trays to take advantage of functional vision. **Enhances independence and safety.**
- Describe food when patient cannot see, and assist as necessary.
- Speak to visually impaired or unresponsive patient during care **to provide auditory stimulation and prevent startle reflex.**
- Provide tactile stimulation as care is given. **Communicates presence/connection with other human being, because touching is an important part of caring and a deep psychological need.**

- Provide sensory stimulation, including familiar smells/sounds, tactile stimulation with a variety of objects, changing of light intensity and other cues (e.g., clocks, calendars).
- Encourage SO(s) to bring in familiar objects, talk to, and touch the patient frequently.
- Provide diversional activities as able (e.g., TV/radio, conversation, large print or talking books). (Refer to ND Diversional Activity, deficient.)
- Involve other health-team members in providing stimulating modalities such as music therapy, sensory training, remotivation therapy.
- Identify and encourage use of resources/prosthetic devices (e.g., hearing aids, computerized visual aid/glasses with a level-plumbline for balance). **Useful for augmenting senses.**
- Limit/carefully monitor use of sedation, especially in older population.

NURSING PRIORITY NO. **3.** To prevent injury/complications:

- Place call bell within reach and be sure patient knows where it is/how to use it.
- Provide safety measures (e.g., siderails, bed in low position, ambulate with assistance). Protect from thermal injury (e.g., monitor use of heating pads/lights, ice packs). Note perceptual deficit on chart **so caregivers are aware.**
- Position doors and furniture so they are out of travel path for patient with impaired vision, or strategically place items/grab bars **to aid in maintaining balance.**
- Ambulate with assistance/devices **to enhance balance.**
- Describe where affected areas of body are when moving the patient.
- Limit activities that may increase intraocular pressure when indicated: Avoid sudden movement of the head, rubbing eyes, bending/stooping, use of bedpan (**may be more strain than getting up to the bathroom**).
- Monitor drug regimen postsurgically (e.g., antiemetics, miotics, sympathomimetics, ß-blockers) **to prevent increase in or to reduce intraocular pressure.**
- Refer to NDs Injury, risk for; Trauma, risk for.

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

- Assist patient/SO(s) to learn effective ways of coping with and managing sensory disturbances, anticipating safety needs according to patient's sensory deficits and developmental level.
- Identify alternative ways of dealing with perceptual deficits (e.g., compensation techniques).

- Provide explanations of and plan care with patient, involving SO(s) as much as possible. **Enhances commitment to and continuation of plan, optimizing outcomes.**
- Review home safety measures pertinent to deficits.
- Discuss drug regimen, noting possible toxic side effects of both prescription and OTC drugs. **Prompt recognition of side effects allows for timely intervention/change in drug regimen.**
- Demonstrate use/care of sensory prosthetic devices. **Identify resources/community programs for acquiring and maintaining devices.**
- Promote meaningful socialization. (Refer to ND Social Isolation.)
- Encourage out-of-bed/out-of-room activities.
- Refer to appropriate helping resources such as Society for the Blind, Self-Help for the Hard of Hearing (SHHH), or local support groups, screening programs, and so forth.
- Refer to additional NDs Anxiety; Thought Processes, disturbed; Unilateral Neglect; Confusion, acute/chronic, as appropriate.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, noting specific deficit/associated symptoms, perceptions of patient/SO(s).
- Assistive device needs.

PLANNING

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

IMPLEMENTATION/EVALUATION

- 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 actions to be taken.
- Available resources; specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

AUDITORY

NOC—Hearing Compensation Behavior
NIC—Communication Enhancement: Hearing Deficit

VISUAL

NOC—Vision Compensation Behavior
NIC—Communication Enhancement: Visual Deficit

GUSTATORY/OLFACTORY

NOC—Distorted Thought Control
NIC—Nutrition Management

KINESTHETIC

NOC—Balance
NIC—Body Mechanics Promotion

TACTILE

NOC—Sensory Function: Cutaneous
NIC—Peripheral Sensation Management

Sexual Dysfunction

Taxonomy II: Sexuality—Class 2 Sexual Function (00059)
[Diagnostic Division: Sexuality]

Definition: Change in sexual function that is viewed as unsatisfying, unrewarding, inadequate

Related Factors

Biopsychosocial alteration of sexuality:
- Ineffectual or absent role models; lack of SO
- Vulnerability
- Misinformation or lack of knowledge
- Physical abuse; psychosocial abuse (e.g., harmful relationships)
- Values conflict
- Lack of privacy
- Altered body structure or function (pregnancy, recent childbirth, drugs, surgery, anomalies, disease process, trauma, [paraplegia/quadriplegia], radiation, [effects of aging])

Defining Characteristics

SUBJECTIVE

Verbalization of problem [e.g., loss of sexual desire, disruption of sexual response patterns such as premature ejaculation, dyspareunia, vaginismus]

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

Actual or perceived limitation imposed by disease and/or therapy
Inability to achieve desired satisfaction
Alterations in achieving perceived sex role
Conflicts involving values
Alterations in achieving sexual satisfaction
Seeking confirmation of desirability

OBJECTIVE

Alteration in relationship with SO
Change of interest in self and others

Desired Outcomes/Evaluation Criteria—Patient Will:

- Verbalize understanding of sexual anatomy/function and alterations that may affect function.
- Verbalize understanding of individual reasons for sexual problems.
- Identify stressors in lifestyle that may contribute to the dysfunction.
- Identify satisfying/acceptable sexual practices and some alternative ways of dealing with sexual expression.
- Discuss concerns about body image, sex role, desirability as a sexual partner with partner/SO.

Actions/Interventions

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

- Obtain sexual history including usual pattern of functioning and level of desire. Note vocabulary used by the individual **to maximize communication/understanding.**
- Have patient describe problem in own words.
- Determine importance of sex to individual/partner and patient's motivation for change.
- Be alert to comments of patient **as sexual concerns are often disguised as humor, sarcasm, and/or offhand remarks.**
- Assess knowledge of patient/SO regarding sexual anatomy/function and effects of current situation/condition.
- Determine preexisting problems that may be factors in current situation (e.g., marital/job stress, role conflicts).
- Identify current stress factors in individual situation. **These factors may be producing enough anxiety to cause depression or other psychological reaction(s) that would cause physiological symptoms.**
- Discuss cultural/religious value factors or conflicts present.

- Determine pathophysiology, illness/surgery/trauma involved, and impact on (perception of) individual/SO.
- Review medication regimen/drug use (prescription, OTC, illegal, alcohol) and cigarette use. **Antihypertensives may cause erectile dysfunction; MAO inhibitors and tricyclics can cause erection/ejaculation problems and anorgasmia in women; narcotics/alcohol produce impotence and inhibit orgasm; smoking creates vasoconstriction and may be a factor in erectile dysfunction.**
- Observe behavior/stage of grieving when related to body changes or loss of a body part (e.g., pregnancy, obesity, amputation, mastectomy).
- Assist with diagnostic studies to determine cause of erectile dysfunction. (**More than half of the cases have a physical cause such as diabetes, vascular problems, and so on.**) Monitor penile tumescence during REM sleep **to assist in determining physical ability.**
- Explore with patient the meaning of patient's behavior. (**Masturbation, for instance, may have many meanings/purposes, such as for relief of anxiety, sexual deprivation, pleasure, a nonverbal expression of need to talk, way of alienating.**)
- Avoid making value judgments **as they do not help the patient to cope with the situation. Note:** Nurse needs to be aware of and be in control of own feelings and response to patient expressions and/or concerns.

NURSING PRIORITY NO. 2. To assist patient/SO(s) to deal with individual situation:

- Establish therapeutic nurse-patient relationship **to promote treatment and facilitate sharing of sensitive information/feelings.**
- Assist with treatment of underlying medical conditions, including changes in medication regimen, weight management, cessation of smoking, and so forth.
- Provide factual information about individual condition involved. **Promotes informed decision making.**
- Determine what patient wants to know **to tailor information to patient needs. Note:** Information affecting patient safety/consequences of actions may need to be reviewed/reinforced.
- Encourage and accept expressions of concern, anger, grief, fear.
- Assist patient to be aware/deal with stages of grieving for loss/change.
- Encourage patient to share thoughts/concerns with partner and to clarify values/impact of condition on relationship.

- Provide for/identify ways to obtain privacy **to allow for sexual expression for individual and/or between partners without embarrassment and/or objections of others.**
- Assist patient/SO(s) to problem-solve alternative ways of sexual expression.
- Provide information about availability of corrective measures such as medication (e.g., papaverine or sildenafil—Viagra—for erectile dysfunction) or reconstructive surgery (e.g., penile/breast implants) when indicated.
- Refer to appropriate resources as need indicates (e.g., healthcare coworker with greater comfort level and/or knowledgeable clinical nurse specialist or professional sex therapist, family counseling).

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

- Provide sex education, explanation of normal sexual functioning when necessary.
- Provide written material appropriate to individual needs (include list of books related to patient's needs) **for reinforcement at patient's leisure/readiness to deal with sensitive materials.**
- Encourage ongoing dialogue and take advantage of teachable moments that occur.
- Demonstrate and assist patient to learn relaxation and/or visualization techniques.
- Assist patient to learn regular self-examination as indicated (e.g., breast/testicular examinations).
- Identify community resources for further assistance (e.g., Reach for Recovery, CanSurmount, Ostomy Association).
- Refer for further professional assistance concerning relationship difficulties, low sexual desire/other sexual concerns (such as premature ejaculation, vaginismus, painful intercourse).
- Identify resources for assistive devices/sexual "aids."

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings including nature of dysfunction, predisposing factors, perceived effect on sexuality/relationships.
- Response of SO(s).
- Motivation for change.

PLANNING

- Plan of care 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

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Sexual Functioning
NIC—Sexual Counseling

Sexuality Patterns, ineffective

Taxonomy II: Sexuality—Class 2 Sexual Function (00065)
[Diagnostic Division: Sexuality]

Definition: Expressions of concern regarding own sexuality

Related Factors

Knowledge/skill deficit about alternative responses to health-related transitions, altered body function or structure, illness or medical treatment
Lack of privacy
Impaired relationship with a SO; lack of SO
Ineffective or absent role models
Conflicts with sexual orientation or variant preferences
Fear of pregnancy or of acquiring a sexually transmitted disease

Defining Characteristics

SUBJECTIVE

Reported difficulties, limitations, or changes in sexual behaviors or activities
[Expressions of feeling alienated, lonely, loss, powerless, angry]

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

Desired Outcomes/Evaluation Criteria—Patient Will:

- Verbalize understanding of sexual anatomy and function.
- Verbalize knowledge and understanding of sexual limitations, difficulties, or changes that have occurred.
- Verbalize acceptance of self in current (altered) condition.
- Demonstrate improved communication and relationship skills.
- Identify individually appropriate method of contraception.

Actions/Interventions

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

- Obtain sexual history, as indicated, including perception of normal function, use of vocabulary (assessing basic knowledge). Note comments/concerns about sexual identity.
- Determine importance of sex and a description of the problem in the patient's own words. Be alert to comments of patient/SO (e.g., discount of overt or covert sexual expressions such as "He's just a dirty old man"). **Sexual concerns are often disguised as sarcasm, humor, or in offhand remarks.**
- Note cultural/religious value factors and conflicts that may exist.
- Assess stress factors in patient's environment that might cause anxiety or psychological reactions (power issues involving SO, adult children, aging, employment, loss of prowess).
- Explore knowledge of effects of altered body function/limitations precipitated by illness and/or medical treatment of alternative sexual responses and expressions (e.g., undescended testicle in young male, gender change/reassignment procedure, mutilating cancer surgery).
- Review substance use history (prescription medication, OTC drugs, alcohol, and illicit drugs).
- Explore issues and fears associated with sex (pregnancy, sexually transmitted diseases, trust/control issues, inflexible beliefs, preference confusion, altered performance).
- Determine patient's interpretation of the altered sexual activity or behavior (e.g., a way of controlling, relief of anxiety, pleasure, lack of partner). **These behaviors (when related to body changes, including pregnancy or weight loss/gain, or loss of body part) may reflect a stage of grieving.**
- Assess life-cycle issues, such as adolescence, young adulthood, menopause, aging.
- Avoid value judgments—**they do not help the patient to cope with the situation. Note:** Nurse needs to be aware of and in control of own feelings and responses to the patient's expressions and/or concerns.

NURSING PRIORITY NO. 2. To assist patient/SO to deal with individual situation:

- Provide atmosphere in which discussion of sexual problems is encouraged/permitted. **Sense of trust/comfort enhances ability to discuss sensitive matters.**
- Provide information about individual situation, determining patient needs and desires.
- Encourage discussion of individual situation with opportunity for expression of feelings without judgment.
- Provide specific suggestions about interventions directed toward the identified problems.
- Identify alternative forms of sexual expression that might be acceptable to both partners.
- Discuss ways to manage individual devices/appliances (e.g., ostomy bag, breast prostheses, urinary collection device) when change in body image/medical condition is involved.
- Provide anticipatory guidance about losses that are to be expected (e.g., loss of known self when transsexual surgery is planned).
- Introduce patient to individuals who have successfully managed a similar problem. **Provides positive role model, support for problem solving.**

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

- Provide factual information about problem(s) as identified by the patient.
- Engage in ongoing dialogue with the patient and SO(s) as situation permits.
- Discuss methods/effectiveness/side effects of contraceptives if indicated.
- Refer to community resources (e.g., planned parenthood, gender identity clinic, social services, others) as indicated.
- Refer for intensive individual/group psychotherapy, which may be combined with couple/family and/or sex therapy, as appropriate.
- Refer to NDs Sexual Dysfunction; Body Image, disturbed; Self-Esteem (specify).

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including nature of concern, perceived difficulties/limitations or changes, specific needs/desires.
- Response of SO(s).

PLANNING

- Plan of care and who is involved in the 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

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Sexual Identity: Acceptance
NIC—Teaching: Sexuality

Skin Integrity, impaired

Taxonomy II: Safety/Protection—Class 2 Physical Injury (00046)

[Diagnostic Division: Safety]

Revised 1998 by small group work 1996

Definition: Altered epidermis and/or dermis [The integumentary system is the largest multifunctional organ of the body.]

Related Factors

EXTERNAL

Hyperthermia or hypothermia
Chemical substance; radiation; medications
Physical immobilization
Humidity; moisture; [excretions/secretions]
Altered fluid status
Mechanical factors (e.g., shearing forces, pressure, restraint), [trauma: injury/surgery]
Extremes in age

INTERNAL

Altered nutritional state (e.g., obesity, emaciation); metabolic state; fluid status
Skeletal prominence; alterations in turgor (change in elasticity); [presence of edema]

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

Altered circulation; sensation; pigmentation
Developmental factors
Immunological deficit
[Psychogenic]

Defining Characteristics

SUBJECTIVE

[Reports of itching, pain, numbness of affected/surrounding area]

OBJECTIVE

Disruption of skin surface (epidermis)
Destruction of skin layers (dermis)
Invasion of body structures

Desired Outcomes/Evaluation Criteria—Patient Will:

Display timely healing of skin lesions/wounds/pressure sores without complication.
Maintain optimal nutrition/physical well-being.
Participate in prevention measures and treatment program.
Verbalize feelings of increased self-esteem and ability to manage situation.

Actions/Interventions

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

- Identify underlying condition/pathology involved (e.g., skin and other cancers, burns, scleroderma, lupus, psoriasis, acne, diabetes, occupational hazards, steroid therapy, familial history, trauma, surgical incision/amputation, radiation therapy, communicable diseases).
- Note general debilitation, reduced mobility, changes in skin/muscle mass associated with aging/chronic disease, presence of incontinence/problems with self-care.
- Assess blood supply and sensation (nerve damage) of affected area.
- Determine nutritional status and areas at risk for injury because of malnutrition (e.g., pressure points on emaciated and/or elderly patient).
- Evaluate risks for injury (e.g., the use of restraints, long-term immobility).

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

- Note laboratory results pertinent to causative factors (e.g., studies such as Hb/Hct, blood glucose, albumin/protein).

NURSING PRIORITY NO. 2. To assess extent of involvement/injury:

- Obtain a history of condition, including age at onset, date of first episode, how long it lasted, original site, characteristics of lesions, and any changes that have occurred.
- Note changes in skin color, texture, and turgor. Assess areas of least pigmentation for color changes (e.g., sclera, conjunctiva, nailbeds, buccal mucosa, tongue, palms, and soles of feet).
- Palpate skin lesions for size, shape, consistency, texture, temperature, and hydration.
- Determine depth of injury/damage to integumentary system (epidermis, dermis, and/or underlying issues).
- Measure length, width, depth of ulcers. Note extent of tunneling/undermining, if present.
- Inspect surrounding skin for erythema, induration, maceration.
- Photograph lesion(s) as appropriate **to document status/provide visual baseline for future comparisons.**
- Note odors emitted from the skin/area of injury.
- Classify ulcer using tool such as Wagner Ulcer Classification System. **Provides consistent terminology for documentation.**

NURSING PRIORITY NO. 3. To determine impact of condition:

- Ascertain attitudes of individual/SO(s) about condition (e.g., cultural values, stigma). Note misconceptions.
- Obtain psychological assessment of patient's emotional status, noting potential or sexual problems arising from presence of condition.
- Note presence of compromised vision, hearing, or speech. **Skin is a particularly important avenue of communication for these people and, when compromised, may affect responses.**

NURSING PRIORITY NO. 4. To assist patient with correcting/minimizing condition and promote optimal healing:

- Inspect skin on a daily basis, describing lesions and changes observed.
- Periodically remeasure/photograph wound and observe for complications (e.g., infection, dehiscence) to monitor progress of wound healing.
- Keep the area clean/dry, carefully dress wounds, support incision (e.g., use of Steri-Strips, splinting when coughing), prevent infection, and stimulate circulation to surrounding areas, **to assist body's natural process of repair.**
- Assist with débridement/enzymatic therapy as indicated (e.g., burns, severe pressures sores).
- Use appropriate barrier dressings, wound coverings, drainage appliances, and skin-protective agents for open/

draining wounds and stomas to protect the wound and/or surrounding tissues. Expose lesions/ulcer to air and light as indicated.
- Limit/avoid use of plastic material (e.g., rubber sheet, plastic-backed linen savers). Remove wet/wrinkled linens promptly. **Moisture potentiates skin breakdown.**
- Develop repositioning schedule for patient, involving patient in reasons for and decisions about times and positions in conjunction with other activities **to enhance understanding and cooperation.**
- Use appropriate padding devices (e.g., air/water mattress, sheepskin) when indicated **to reduce pressure on/enhance circulation to compromised tissues.**
- Encourage early ambulation/mobilization. **Promotes circulation and reduces risks associated with immobility.**
- Calculate ankle-brachial index for patients with potential for/actual impairment of circulation to lower extremities. **Result <0.9 indicates need for close monitoring/more aggressive intervention (e.g., tighter blood glucose and weight control in diabetic patient).**
- Obtain specimen from draining wounds when appropriate for culture/sensitivities/Gram's stain **to determine appropriate therapy.**
- Provide optimum nutrition and increased protein intake **to provide a positive nitrogen balance to aid in healing and to maintain general good health.**
- Monitor periodic laboratory studies relative to general well-being and status of specific problem.
- Consult with wound specialist as indicated **to assist with developing plan of care for problematic or potentially serious wounds.**

NURSING PRIORITY NO. 5. To promote wellness (Teaching/Discharge Considerations):
- Review importance of skin and measures to maintain proper skin functioning.
- Discuss importance of early detection of skin changes and/or complications.
- Assist the patient/SO(s) in understanding and following medical regimen and developing program of preventive care and daily maintenance. **Enhances commitment to plan, optimizing outcomes.**
- Review measures to avoid spread/reinfection of communicable disease/conditions.
- Emphasize importance of proper fit of clothing/shoes, use of specially lined shock-absorbing socks or pressure-reducing insoles for shoes **in presence of reduced sensation/circulation.**

- Identify safety factors for use of equipment/appliances (e.g., heating pad, ostomy appliances, padding straps of braces).
- Encourage patient to verbalize feelings and discuss how/if condition affects self-concept/self-esteem. (Refer to NDs Body Image, disturbed, Self-Esteem, situational low.)
- Assist patient to work through stages of grief and feelings associated with individual condition.
- Lend psychological support and acceptance of patient, using touch, facial expressions, and tone of voice.
- Assist patient to learn stress reduction and alternate therapy techniques **to control feelings of helplessness and deal with situation.**
- Refer to dietitian or certified diabetes educator as appropriate **to enhance healing, reduce risk of recurrence of diabetic ulcers.**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Characteristics of lesion(s)/condition, ulcer classification.
- Causative/contributing factors.
- Impact of condition.

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 outcome(s).
- Modifications to plan of care.

DISCHARGE PLANNING

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Tissue Integrity: Skin & Mucous Membranes
NIC—Skin Care: Topical Treatments

Skin Integrity, risk for impaired

Taxonomy II: Safety/Protection—Class 2 Physical Injury (00047)

[Diagnostic Division: Safety]

Revised 1998 by small group work 1996

Definition: At risk for skin being adversely altered;
Note: Risk should be determined by the use of a risk assessment tool (e.g., Braden Scale)

Risk Factors

EXTERNAL

Chemical substance; radiation
Hypothermia or hyperthermia
Physical immobilization
Excretions and/or secretions; humidity; moisture
Mechanical factors (e.g., shearing forces, pressure, restraint)
Extremes of age

INTERNAL

Medication
Alterations in nutritional state (e.g., obesity, emaciation), metabolic state, [fluid status]
Skeletal prominence; alterations in skin turgor (change in elasticity); [presence of edema]
Altered circulation, sensation, pigmentation
Developmental factors
Psychogenic
Immunologic

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—Patient Will:

- Identify individual risk factors.
- Verbalize understanding of treatment/therapy regimen.
- Demonstrate behaviors/techniques to prevent skin breakdown.

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

Actions/Interventions

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

- Note general debilitation, reduced mobility, changes in skin and muscle mass associated with aging, poor nutritional status or chronic diseases, incontinence and/or problems of self-care and/or medication/therapy, and so forth.
- Note laboratory results pertinent to causative factors (e.g., Hg/Hct, blood glucose, albumin/total protein).
- Calculate ankle-brachial index as appropriate (diabetic patients or others with impaired circulation to lower extremities). **Result <0.9 indicates need for more aggressive preventive interventions (e.g., closer blood glucose and weight control).**

NURSING PRIORITY NO. 2. To maintain skin integrity at optimal level:

- Handle infant (especially premature infants) gently. **Epidermis of infants and very young children is thin and lacks subcutaneous depth that will develop with age.**
- Maintain strict skin hygiene, using mild nondetergent soap, drying gently and thoroughly and lubricating with lotion or emollient as indicated.
- Massage bony prominences gently and avoid friction when moving patient.
- Change position in bed/chair on a regular schedule. Encourage participation with active and assistive range-of-motion exercises.
- Provide adequate clothing/covers; protect from drafts **to prevent vasoconstriction.**
- Keep bed clothes dry, use nonirritating materials, and keep bed free of wrinkles, crumbs, and so forth.
- Provide protection by use of pads, pillows, foam mattress, water bed, and so forth **to increase circulation and alter/eliminate excessive tissue pressure.**
- Inspect skin surfaces/pressure points routinely.
- Observe for reddened/blanched areas and institute treatment immediately. **Reduces likelihood of progression to skin breakdown.**
- Provide for safety measures during ambulation and other therapies that might cause dermal injury (e.g., properly fitting hose/footwear, use of heating pads/lamps, restraints).

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

- Provide information to patient/SO(s) about the importance of regular observation and effective skin care in preventing problems.

- Emphasize importance of adequate nutritional/fluid intake **to maintain general good health and skin turgor.**
- Encourage continuation of regular exercise program (active/assistive) **to enhance circulation.**
- Recommend elevation of lower extremities when sitting **to enhance venous return and reduce edema formation.**
- Encourage restriction/abstinence from tobacco, **which can cause vasoconstriction.**
- Suggest use of ice, colloidal bath, lotions **to decrease irritable itching.**
- Recommend keeping nails short or wearing gloves **to reduce risk of dermal injury when severe itching is present.**
- Discuss importance of avoiding exposure to sunlight in specific conditions (e.g., systemic lupus, tetracycline/psychotropic drug use, radiation therapy) as well as potential for development of skin cancer.
- Counsel diabetic and neurologically impaired patient about importance of skin care, especially of lower extremities.
- Perform periodic assessment using a tool such as Braden Scale **to determine changes in risk status and need for alterations in the plan of care.**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including individual risk factors.

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 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—Pressure Management

Sleep Deprivation

Taxonomy II: Activity/Rest—Class 1 Sleep/Rest (00096)
[Diagnostic Division: Activity/Rest]
Nursing Diagnosis Extension and Classification (NDEC) Submission 1998

Definition: Prolonged periods of time without sleep (sustained natural, periodic suspension of relative consciousness)

Related Factors

Sustained environmental stimulation; unfamiliar or uncomfortable sleep environment
Inadequate daytime activity; sustained circadian asynchrony; aging-related sleep stage shifts; non-sleep-inducing parenting practices
Sustained inadequate sleep hygiene; prolonged use of pharmacological or dietary antisoporifics
Prolonged physical/psychological discomfort; periodic limb movement (e.g., restless leg syndrome, nocturnal myoclonus); sleep-related: enuresis; painful erections
Nightmares; sleepwalking; sleep terror
Sleep apnea
Sundowner's syndrome; dementia
Idiopathic CNS hypersomnolence; narcolepsy; familial sleep paralysis

Defining Characteristics

SUBJECTIVE

Daytime drowsiness; decreased ability to function
Malaise; tiredness; lethargy
Anxious
Perceptual disorders (e.g., disturbed body sensation, delusions, feeling afloat); heightened sensitivity to pain

OBJECTIVE

Restlessness; irritability
Inability to concentrate; slowed reaction
Listlessness; apathy
Mild, fleeting nystagmus; hand tremors
Acute confusion; transient paranoia; agitated or combative; hallucinations

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

Desired Outcomes/Evaluation Criteria—Patient Will:

- Identify individually appropriate interventions to promote sleep.
- Verbalize understanding of sleep disorders.
- Adjust lifestyle to accommodate chronobiological rhythms.
- Report improvement in sleep/rest pattern.

Family Will:

- Deal appropriately with parasomnias.

Actions/Interventions

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

- Determine presence of physical or psychological stressors, including night-shift working hours, pain, advanced age, current/recent illness, death of a spouse.
- Note medical diagnoses that affect sleep (e.g., dementia, encephalitis, brain injury, narcolepsy, depression, asthma, sleep-induced respiratory disorders/obstructive sleep apnea, nocturnal myoclonus).
- Evaluate for use of medications and/or other drugs affecting sleep (e.g., diet pills, antidepressives, antihypertensives, alcohol, stimulants, sedatives, diuretics, narcotics).
- Note environmental factors affecting sleep (e.g., unfamiliar or uncomfortable sleep environment, excessive noise and light, uncomfortable temperature, roommate irritations/actions—e.g., snoring, watching TV late at night).
- Determine presence of parasomnias: nightmares/terrors or somnambulism (e.g., sitting, sleepwalking, or other complex behavior during sleep).
- Note reports of terror, brief periods of paralysis, sense of body being disconnected from the brain. **Occurrence of sleep paralysis, though not widely recognized in the United States, has been well documented elsewhere and may result in feelings of fear/reluctance to go to sleep.**

NURSING PRIORITY NO. **2.** To assess degree of impairment:

- Determine patient's usual sleep pattern and expectations. **Provides comparative baseline.**
- Ascertain duration of current problem and effect on life/functional ability.
- Listen to subjective reports of sleep quality.
- Observe physical signs of fatigue (e.g., restlessness, reports of feeling not rested or being exhausted, irritability, changes in behavior/performance, disorientation, frequent yawning).

- Determine interventions patient has tried to date. **Helps identify appropriate options.**
- Distinguish patient's beneficial bedtime habits from detrimental ones (e.g., drinking late evening milk versus drinking late evening coffee).
- Instruct patient and/or bed partner to keep a sleep-wake log **to document symptoms and identify factors that are interfering with sleep.**
- Do a chronological chart **to determine peak performance rhythms.**

NURSING PRIORITY NO. **3.** To assist patient to establish optimal sleep pattern:

- Encourage patient to develop plan to restrict caffeine, alcohol, and other stimulating substances from late afternoon/evening intake, and avoid eating large evening/late-night meals. **These factors are known to disrupt sleep patterns.**
- Recommend bedtime snack (protein, simple carbohydrate, and low fat) for young children 15 to 30 minutes before retiring. **Sense of fullness and satiety promotes sleep and reduces likelihood of gastric upset.**
- Promote adequate physical exercise activity during day. **Enhances expenditure of energy/release of tension so that patient feels ready for sleep/rest.**
- Review medications being taken and their effect on sleep, suggesting modifications in regimen, **if medications are found to be interfering.**
- Suggest abstaining from daytime naps **because they impair ability to sleep at night.**
- Investigate anxious feelings **to help determine basis and appropriate anxiety-reduction techniques.**
- Recommend quiet activities such as reading/listening to soothing music in the evening **to reduce stimulation so patient can relax.**
- Instruct in relaxation techniques, music therapy, meditation, and so forth **to decrease tension, prepare for rest/sleep.**
- Limit evening fluid intake if nocturia is present **to reduce need for nighttime elimination.**
- Discuss/implement effective age appropriate bedtime rituals (e.g., going to bed at same time each night, drinking warm milk, rocking, story reading, cuddling, favorite blanket/toy) **to enhance patient's ability to fall asleep, reinforce that bed is a place to sleep, and promote sense of security for child.**
- Provide calm, quiet environment and manage controllable sleep-disrupting factors (e.g., noise, light, room temperature).

- Administer sedatives/other sleep medications when indicated, noting patient's response. Time pain medications for peak effect/duration **to reduce need for redosing during prime sleep hours.**
- Instruct patient to get out of bed, leave bedroom, engage in relaxing activities if unable to fall asleep, and not return to bed until feeling sleepy.
- Review with the patient the physician's recommendations for medications or surgery (alteration of facial structures/tracheotomy) and/or apneic oxygenation therapy—continuous positive airway pressure (CPAP) such as Respironics—**when sleep apnea is severe as documented by sleep disorder studies.**

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

- Review possibility of next-day drowsiness/"rebound" insomnia and temporary memory loss **that may be associated with prescription sleep medications.**
- Discuss use/appropriateness of OTC sleep medications/herbal supplements. Note possible side effects and drug interactions.
- Refer to support group/counselor to help deal with psychological stressors (e.g., grief, sorrow). Refer to NDs Grieving, dysfunctional; Sorrow, chronic.
- Encourage family counseling **to help deal with concerns arising from parasomnias.**
- Refer to sleep specialist/laboratory **when problem is unresponsive to interventions.**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings, including specifics of sleep pattern (current and past) and effects on lifestyle/level of functioning.
- Medications/interventions, previous therapies.
- Family history of similar problem.

PLANNING

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

IMPLEMENTATION/EVALUATION

- Patient'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—Sleep
NIC—Sleep Enhancement

Sleep Pattern, disturbed

Taxonomy II: Activity/Rest—Class 1 Sleep/Rest (00095)
[Diagnostic Division: Activity/Rest]
Nursing Diagnosis Extension and Classification (NDEC) Revision 1998

Definition: Time-limited disruption of sleep (natural, periodic suspension of consciousness) amount and quality

Related Factors

PSYCHOLOGICAL

Daytime activity pattern; fatigue; dietary; body temperature
Social schedule inconsistent with chronotype; shift work; daylight/darkness exposure
Frequently changing sleep-wake schedule/travel across time zones; circadian asynchrony
Childhood onset; aging-related sleep shifts; periodic gender-related hormonal shifts
Inadequate sleep hygiene; maladaptive conditioned wakefulness
Ruminative presleep thoughts; anticipation; thinking about home
Preoccupation with trying to sleep; fear of insomnia
Biochemical agents; medications; sustained use of antisleep agents
Temperament; loneliness; grief; anxiety; fear; boredom; depression
Separation from SOs; loss of sleep partner, life change
Delayed or advanced sleep phase syndrome

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

ENVIRONMENTAL

Excessive stimulation; noise; lighting; ambient temperature, humidity; noxious odors; sleep partner
Unfamiliar sleep furnishings
Interruptions for therapeutics, monitoring, laboratory tests; other-generated awakening
Physical restraint
Lack of sleep privacy/control

PARENTAL

Mother's sleep–wake pattern/emotional support
Parent-infant interaction

PHYSIOLOGICAL

Position
Gastroesophageal reflux; nausea
Shortness of breath; stasis of secretions; fever
Urinary urgency, incontinence

Defining Characteristics

SUBJECTIVE

Verbal complaints [reports] of difficulty falling asleep/not feeling well rested; dissatisfaction with sleep
Sleep onset greater than 30 minutes
Three or more nighttime awakenings; prolonged awakenings
Awakening earlier or later than desired; early morning insomnia
Decreased ability to function; [falling asleep during activities]

OBJECTIVE

Less than age-normed total sleep time
Increased proportion of stage 1 sleep
Decreased proportion of stages 3 and 4 sleep (e.g., hyporesponsiveness, excess sleepiness, decreased motivation)
Decreased proportion of REM sleep (e.g., REM rebound, hyperactivity, emotional lability, agitation and impulsivity, atypical polysomnographic features)
Sleep maintenance insomnia
Self-induced impairment of normal pattern
[Changes in behavior and performance (increasing irritability, disorientation, listlessness, restlessness, lethargy)]
[Physical signs (mild fleeting nystagmus, ptosis of eyelid, slight hand tremor, expressionless face, dark circles under eyes, changes in posture, frequent yawning)]

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

Desired Outcomes/Evaluation Criteria—Patient Will:

- Verbalize understanding of sleep disturbance
- Identify individually appropriate interventions to promote sleep.
- Adjust lifestyle to accommodate chronobiological rhythms.
- Report improvement in sleep/rest pattern.
- Report increased sense of well-being and feeling rested.

Actions/Interventions

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

- Identify presence of factors as listed in Related Factors, including factors that can contribute to insomnia (such as chronic pain); metabolic diseases (such as hyperthyroidism and diabetes); prescribed/OTC drug use; aging (**a high percentage of elderly are affected by sleep problems**).
- Assess sleep pattern disturbances that are associated with specific underlying illnesses (e.g., nocturia occurring with benign prostatic hypertrophy).
- Observe parent-infant interactions/provision of emotional support. Note mother's sleep-wake pattern. **Lack of knowledge of infant cues/problem relationships may create tension interfering with sleep. Structured sleep routines based on adult schedules may not meet child's needs.**
- Ascertain presence/frequency of enuresis.
- Review psychological assessment, noting individual and personality characteristics.
- Determine recent traumatic events in patient's life (e.g., a death in family, loss of job).
- Evaluate use of caffeine and alcoholic beverages (**overindulgence interferes with REM sleep**).
- Assist with diagnostic testing (e.g., EEG, sleep studies).

NURSING PRIORITY NO. **2.** To evaluate sleep pattern and dysfunction(s):

- Observe and/or obtain feedback from patient/SO(s) regarding usual bedtime, rituals/routines, number of hours of sleep, time of arising, and environmental needs **to determine usual sleep pattern and provide comparative baseline.**
- Determine patient's/SO's expectations of adequate sleep. **Provides opportunity to address misconceptions/unrealistic expectations.**
- Investigate whether patient snores and in what position(s) this occurs.
- Listen to subjective reports of sleep quality.
- Identify circumstances that interrupt sleep and frequency.

- Note alteration of habitual sleep time such as change of work pattern/rotating shifts, change in normal bedtime (hospitalization).
- Observe physical signs of fatigue (e.g., restlessness, hand tremors, thick speech).
- Do a chronological chart **to determine peak performance rhythm.**
- Graph "circadian" rhythms of individual's biological internal chemistry per protocol as indicated. (**Note: Studies have shown sleep cycles are affected by body temperature at onset of sleep.**)

NURSING PRIORITY NO. 3. To assist patient to establish optimal sleep/rest patterns:

- Arrange care to provide for uninterrupted periods for rest, especially allowing for longer periods of sleep at night when possible. Do as much care as possible without waking patient.
- Explain necessity of disturbances for monitoring vital signs and/or other care when patient is hospitalized.
- Provide quiet environment and comfort measures (e.g., back rub, washing hands/face, cleaning and straightening sheets) in preparation for sleep.
- Discuss/implement effective age appropriate bedtime rituals (e.g., going to bed at same time each night, drinking warm milk, rocking, story reading, cuddling, favorite blanket/toy) **to enhance patient's ability to fall asleep, reinforce that bed is a place to sleep, and promote sense of security for child.**
- Recommend limiting intake of chocolate and caffeine/alcoholic beverages, especially prior to bedtime.
- Limit fluid intake in evening if nocturia is a problem **to reduce need for nighttime elimination.**
- Explore other sleep aids (e.g., warm bath/milk, protein intake before bedtime).
- Administer pain medications (if required) 1 hour before sleep **to relieve discomfort and take maximum advantage of sedative effect.**
- Monitor effects of drug regimen—amphetamines or stimulants (e.g., Methylphenidate—Ritalin used in narcolepsy).
- Use barbiturates and/or other sleeping medications sparingly. **Research indicates long-term use of these medications can actually induce sleep disturbances.**
- Develop behavioral program for insomnia:
  Establish routine bedtime and arising.
  Think relaxing thoughts when in bed.
  Do not nap in the daytime.
  Do not read in bed; get out of bed if not asleep in 15 minutes.
  Limit sleep to 7 hours a night.
  Get up the same time each day—even on weekends/days off.

- Assure patient that occasional sleeplessness should not threaten health.

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

- Assist patient to develop individual program of relaxation. Demonstrate techniques (e.g., biofeedback, self-hypnosis, visualization, progressive muscle relaxation).
- Encourage participation in regular exercise program during day **to aid in stress control/release of energy. Exercise at bedtime may stimulate rather than relax patient and actually interfere with sleep.**
- Recommend inclusion of bedtime snack (e.g., milk or mild juice, crackers, protein source such as cheese/peanut butter) in dietary program **to reduce sleep interference from hunger/hypoglycemia.**
- Suggest that bed/bedroom be used only for sleep, not for working, watching TV.
- Provide for child's (or impaired individual's) sleep time safety (e.g., infant placed on back, bedrails/bed in low position, nonplastic sheets).
- Investigate use of aids to block out light/noise, such as sleep mask, darkening shades/curtains, earplugs, monotonous sounds such as low-level background noise (white noise).
- Participate in program to "reset" the body's sleep clock (chronotherapy) when patient has delayed sleep-onset insomnia.
- Assist individual to develop schedules that take advantage of peak performance times as identified in chronobiological chart.
- Recommend midmorning nap if one is required. **Napping, especially in the afternoon, can disrupt normal sleep patterns.**
- Assist patient to deal with grieving process when loss has occurred. (Refer to ND Grieving, dysfunctional.)
- Refer to sleep specialist/laboratory for treatment when indicated.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings, including specifics of sleep pattern (current and past) and effects on lifestyle/level of functioning.
- Medications/interventions, previous therapies

PLANNING

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

IMPLEMENTATION/EVALUATION

- Patient'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—Sleep
NIC—Sleep Enhancement

Social Interaction, impaired

Taxonomy II: Role Relationship—Class 3 Role Performance (00052)

[Diagnostic Division: Social Interaction]

Definition: Insufficient or excessive quantity or ineffective quality of social exchange

Related Factors

Knowledge/skill deficit about ways to enhance mutuality
Communication barriers [including head injury, stroke, other neurological conditions affecting ability to communicate]
Self-concept disturbance
Absence of available SO(s) or peers
Limited physical mobility [e.g., neuromuscular disease]
Therapeutic isolation
Sociocultural dissonance
Environmental barriers
Altered thought processes

Defining Characteristics

SUBJECTIVE

Verbalized discomfort in social situations

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

Verbalized inability to receive or communicate a satisfying sense of belonging, caring, interest, or shared history
Family report of change of style or pattern of interaction

OBJECTIVE

Observed discomfort in social situations
Observed inability to receive or communicate a satisfying sense of belonging, caring, interest, or shared history
Observed use of unsuccessful social interaction behaviors
Dysfunctional interaction with peers, family, and/or others

Desired Outcomes/Evaluation Criteria—Patient Will:

- Verbalize awareness of factors causing or promoting impaired social interactions.
- Identify feelings that lead to poor social interactions.
- Express desire/be involved in achieving positive changes in social behaviors and interpersonal relationships.
- Give self positive reinforcement for changes that are achieved.
- Develop effective social support system; use available resources appropriately.

Actions/Interventions

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

- Review social history with patient/SO(s) and go back far enough in time to note when changes in social behavior or patterns of relating occurred/began, for example, loss or long-term illness of loved one; failed relationships; loss of occupation, financial, or political (power) position; change in status in family hierarchy (job loss, aging, illness); poor coping/adjustment to developmental stage of life, as with marriage, birth/adoption of child, or children leaving home.
- Ascertain ethnic/cultural or religious implications for the patient **because these impact choice of behaviors.**
- Review medical history noting stressors of physical/long-term illness (e.g., stroke, cancer, MS, head injury, Alzheimer's disease), mental illness (e.g., schizophrenia), medications/drugs, debilitating accidents.
- Review family patterns of relating and social behaviors. Explore possible family scripting of behavioral expectations in the children and how the patient was affected. **(May result in conforming or rebellious behaviors.)**
- Observe patient while relating to family/SO(s) and note observations of prevalent patterns.

- Encourage patient to verbalize feeling of discomfort about social situations. Note any causative factors, recurring precipitating patterns, and barriers to using support systems.
- Note effects of changes on socioeconomic level, ethnic/religious practices.

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

- Encourage patient to verbalize problems and perceptions of reasons for problems. Active-listen to note indications of hopelessness, powerlessness, fear, anxiety, grief, anger, feeling unloved or unlovable; problems with sexual identity; hate (directed or not).
- Observe and describe social/interpersonal behaviors in objective terms, noting speech patterns, body language (a) in the therapeutic setting and (b) in normal areas of daily functioning (if possible): family, job, social/entertainment settings.
- Determine patient's use of coping skills and defense mechanisms. **(Affects ability to be involved in social situations.)**
- Evaluate possibility of patient being the victim of or using destructive behaviors against self or others. (Refer to ND Violence, [actual/]risk for other-directed/self-directed.)
- Interview family, SO(s), friends, spiritual leaders, coworkers, as appropriate, **to obtain observations of patient's behavioral changes.**

NURSING PRIORITY NO. 3. To assist patient/SO(s) to recognize/make positive changes in impaired social and interpersonal interactions:

- Establish therapeutic relationship using positive regard for the person, Active-listening, and providing safe environment for self-disclosure.
- Have patient list behaviors that cause discomfort. **Once recognized, patient can choose to change.**
- Have family/SO(s) list patient's behaviors that are causing discomfort for them.
- Review/list negative behaviors observed previously by caregivers, coworkers, and so forth.
- Compare lists and validate reality of perceptions. Help patient prioritize those behaviors needing change.
- Explore with patient and role-play means of making changes in social interactions/behaviors (as determined earlier).
- Role-play random social situations in therapeutically controlled environment with "safe" therapy group. Have group note behaviors, both positive and negative, and discuss these and any changes needed.

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

- Role-play changes and discuss impact. Include family/SO(s) as indicated. **Enhances comfort with new behaviors.**
- Provide positive reinforcement for improvement in social behaviors and interactions. **Encourages continuation of desired behaviors/efforts for change.**
- Participate in multidisciplinary patient-centered conferences **to evaluate progress.** Involve everyone associated with patient's care, family members, SO(s), and therapy group.
- Work with the patient to alleviate underlying negative self-concepts **because they often impede positive social interactions.**
- Involve neurologically impaired patient in individual and/or group interactions as situation allows.
- Refer for family therapy as indicated **because social behaviors and interpersonal relationships involve more than the individual.**

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

- Encourage patient to keep a daily journal in which social interactions of each day can be reviewed and the comfort/discomfort experienced noted with possible causes/precipitating factors. **Helps patient to identify responsibility for own behavior(s).**
- Assist the patient to develop positive social skills through practice of skills in real social situations accompanied by a support person. Provide positive feedback during interactions with patient.
- Seek community programs for patient involvement that promote positive behaviors the patient is striving to achieve. Encourage classes, reading materials, community support groups, and lectures for self-help in alleviating negative self-concepts that lead to impaired social interactions.
- Encourage ongoing family or individual therapy as long as it is promoting growth and positive change. (Be alert to possibility of therapy being used as a crutch.)
- Provide for occasional follow-up **for reinforcement of positive behaviors after professional relationship has ended.**
- Refer to/involve psychiatric clinical nurse specialist for additional assistance when indicated.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including factors affecting interactions, nature of social exchanges, specifics of individual behaviors.
- Perceptions/response of others.

PLANNING

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

IMPLEMENTATION/EVALUATION

- 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 actions to be taken.
- Community resources, specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Social Interaction Skills
NIC—Socialization Enhancement

Social Isolation

Taxonomy II: Comfort—Class 3 Social Comfort (00053)
[Diagnostic Division: Social Interaction]

Definition: Aloneness experienced by the individual and perceived as imposed by others and as a negative or threatened state

Related Factors

Factors contributing to the absence of satisfying personal relationships (e.g., delay in accomplishing developmental tasks); immature interests
Alterations in physical appearance/mental status
Altered state of wellness
Unaccepted social behavior/values
Inadequate personal resources
Inability to engage in satisfying personal relationships
[Traumatic incidents or events causing physical and/or emotional pain]

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

Defining Characteristics

SUBJECTIVE

Expresses feelings of aloneness imposed by others
Expresses feelings of rejection
Expresses values acceptable to the subculture but unacceptable to the dominant cultural group
Inability to meet expectations of others
Experiences feelings of difference from others
Inadequacy in or absence of significant purpose in life
Expresses interests inappropriate to developmental age/stage
Insecurity in public

OBJECTIVE

Absence of supportive SO(s)—family, friends, group
Sad, dull affect
Inappropriate or immature interests/activities for developmental age/stage
Hostility projected in voice, behavior
Evidence of physical/mental handicap or altered state of wellness
Uncommunicative; withdrawn; no eye contact
Preoccupation with own thoughts; repetitive meaningless actions
Seeking to be alone or existing in a subculture
Showing behavior unaccepted by dominant cultural group

Desired Outcomes/Evaluation Criteria—Patient Will:

- Identify causes and actions to correct isolation.
- Verbalize willingness to be involved with others.
- Participate in activities/programs at level of ability/desire.
- Express increased sense of self-worth.

Actions/Interventions

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

- Determine presence of factors as listed in Related Factors and other concerns (e.g., elderly; female; adolescent; ethnic/racial minority; economically/educationally disadvantaged).
- Identify blocks to social contacts (e.g., physical immobility, sensory deficits, housebound, incontinence).
- Assess factors in patient's life that may contribute to sense of helplessness (e.g., loss of spouse/parent).

- Listen to comments of patient regarding sense of isolation. Differentiate isolation from solitude and loneliness that may be acceptable or by choice.
- Assess patient's feelings about self, sense of ability to control situation, sense of hope, and coping skills.
- Identify support systems available to the patient including presence of/relationship with extended family.
- Determine drug use (legal/illicit).
- Identify behavior response of isolation (e.g., excessive sleeping/daydreaming, substance use), **which also may potentiate isolation.**
- Review history and elicit information about traumatic events that may have occurred. (Refer to ND Post-Trauma Syndrome.)

NURSING PRIORITY NO. 2. To alleviate conditions that contribute to patient's sense of isolation:

- Establish therapeutic nurse-patient relationship. **Promotes trust, allowing patient to feel free to discuss sensitive matters.**
- Note onset of physical/mental illness and where recovery is anticipated or condition is chronic/progressive.
- Spend time visiting with patient, and identify other resources available (e.g., volunteer, social worker, chaplain).
- Develop plan of action with patient: Look at available resources; support risk-taking behaviors, financial planning, appropriate medical care/self-care, and so forth.
- Introduce patient to those with similar/shared interests and other supportive people. **Provides role models, encourages problem solving.**
- Provide positive reinforcement when patient makes move(s) toward other(s). **Encourages continuation of efforts.**
- Provide for placement in sheltered community when necessary.
- Assist patient to problem-solve solutions to short-term/imposed isolation (e.g., communicable disease measures, including compromised host).
- Encourage open visitation when possible and/or telephone contacts **to maintain involvement with others.**
- Provide environmental stimuli (e.g., open curtains, pictures, TV, and radio).
- Promote participation in recreational/special interest activities in setting that patient views as safe.
- Identify foreign language resources such as interpreter, newspaper, radio programming, as appropriate.

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

- Assist patient to learn skills (e.g., problem solving, communication, social skills, self-esteem, ADLs).
- Encourage and assist patient to enroll in classes as needed (e.g., assertiveness, vocational, sex education).
- Help patient differentiate between isolation and loneliness/aloneness and not slip into an undesired state.
- Involve patient in programs directed to correction and prevention of identified causes of problem (e.g., senior citizen services, daily telephone contact, house sharing, pets, day-care centers, church resources).
- Refer to therapists as appropriate **to facilitate grief work, relationship building, and so on.**
- Involve children and adolescents in programs/activities **to promote socialization skills and peer contact.**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including precipitating factors, effect on lifestyle/relationships, and functioning.
- Patient's perception of situation.

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 outcome(s).
- 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—Social Involvement
NIC—Social Enhancement

Sorrow, chronic

Taxonomy II: Coping/Stress Tolerance—Class 2 Coping Responses (00137)

[Diagnostic Division: Ego Integrity]

Definition: Cyclical, recurring, and potentially progressive pattern of pervasive sadness experienced (by a parent or caregiver, individual with chronic illness or disability) in response to continual loss, throughout the trajectory of an illness or disability

Related Factors

Death of a loved one
Experiences chronic physical or mental illness or disability (e.g., mental retardation, MS, prematurity, spina bifida or other birth defects, chronic mental illness, infertility, cancer, Parkinson's disease); one or more trigger events (e.g., crises in management of the illness, crises related to developmental stages, missed opportunities or milestones that bring comparisons with developmental, social, or personal norms)
Unending caregiving as a constant reminder of loss

Defining Characteristics

SUBJECTIVE

Expresses one or more of the following feelings: anger, being misunderstood, confusion, depression, disappointment, emptiness, fear, frustration, guilt/self-blame, helplessness, hopelessness, loneliness, low self-esteem, recurring loss, overwhelmed
Client expresses periodic, recurrent feelings of sadness

OBJECTIVE

Feelings that vary in intensity, are periodic, may progress and intensify over time, and may interfere with the client's ability to reach his or her highest level of personal and social well-being

Desired Outcomes/Evaluation Criteria—Patient Will:

- Acknowledge presence/impact of sorrow.
- Demonstrate progress in dealing with grief.
- Participate in work and/or self-care ADLs as able.

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

- Verbalize a sense of progress toward resolution of sorrow and hope for the future.

Actions/Interventions

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

- Determine current/recent events or conditions contributing to patient's state of mind, as listed in Related Factors (e.g., death of loved one, chronic physical or mental illness or disability, etc.).
- Look for cues of sadness (e.g., sighing, faraway look, unkempt appearance, inattention to conversation, refusing food, etc.).
- Determine level of functioning, ability to care for self.
- Be aware of avoidance behaviors (e.g., anger, withdrawal, denial).
- Identify cultural factors/religious conflicts.
- Ascertain response of family/SO's to patient's situation. Assess needs of family/SO.
- Refer to Grieving, dysfunctional; Caregiver Role Strain; Coping, ineffective, as appropriate.

NURSING PRIORITY NO. 2. To assist patient to move through sorrow:

- Encourage verbalization about situation **(helpful in beginning resolution and acceptance).** Active-listen feelings and be available for support/assistance.
- Encourage expression of anger/fear/anxiety. Refer to appropriate NDs.
- Acknowledge reality of feelings of guilt/blame, including hostility toward spiritual power. (Refer to ND Spiritual Distress.) **Helps patient to take steps toward resolution.**
- Provide comfort and availability as well as caring for physical needs.
- Discuss ways individual has dealt with previous losses. Reinforce use of previously effective coping skills.
- Instruct/encourage use of visualization and relaxation skills.
- Assist SO to cope with patient response. **(Family/SO may not be dysfunctional, but may be intolerant.)**
- Include family/SO in setting realistic goals for meeting individual needs.

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

- Discuss healthy ways of dealing with difficult situations.
- Have patient identify familial, religious, and cultural factors that have meaning for him or her. **May help bring loss or distressing situation into perspective and promote grief/sorrow resolution.**
- Encourage involvement in usual activities, exercise, and socialization within limits of physical and psychological state.

- Introduce concept of mindfulness (living in the moment). **Promotes feelings of capability and belief that this moment can be dealt with.**
- Refer to other resources (e.g., pastoral care, counseling, psychotherapy, respite care providers, support groups). **Provides additional help when needed to resolve situation, continue grief work.**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including nature of sorrow, effects on participation in treatment regimen.
- Physical/emotional response to conflict.
- Reactions of family/SO.

PLANNING

- Plan of care 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

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Depression Level
NIC—Hope Instillation

Spiritual Distress

Taxonomy II: Life Principles—Class 3 Value/Belief/Action Congruence (00066)

[Diagnostic Division: Ego Integrity]

Definition: Disruption in the life principle that pervades a person's entire being and that integrates and transcends one's biological and psychosocial nature

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

Related Factors

Separation from religious/cultural ties
Challenged belief and value system (e.g., due to moral/ethical implications of therapy, due to intense suffering)

Defining Characteristics

SUBJECTIVE

Expresses concern with meaning of life/death and/or belief systems
Verbalizes inner conflict about beliefs; concern about relationship with deity; [does not experience that God is forgiving]
Angry toward God [as defined by the person]; displacement of anger toward religious representatives
Questions meaning of suffering; own existence
Questions moral/ethical implications of therapeutic regimen
Seeks spiritual assistance
Unable to [or chooses not to] participate in usual religious practices
Description of nightmares/sleep disturbances
[Regards illness/situation as punishment]
[Unable to accept self; engages in self-blame]
[Describes somatic symptoms]

OBJECTIVE

Alteration in behavior/mood evidenced by anger, crying, withdrawal, preoccupation, anxiety, hostility, apathy, etc
Gallows humor

Desired Outcomes/Evaluation Criteria—Patient Will:

- Verbalize increased sense of self-concept and hope for future.
- Demonstrate ability to help self/participate in care.
- Participate in activities with others, actively seek relationships.
- Discuss beliefs/values about spiritual issues.
- Verbalize acceptance of self as not deserving illness/situation, "no one is to blame."

Actions/Interventions

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

- Determine patient's religious/spiritual orientation, current involvement, presence of conflicts.

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

- Listen to patient/SO(s') reports/expressions of anger/concern, alienation from God, belief that illness/situation is a punishment for wrongdoing, and so forth.
- Determine sense of futility, feelings of hopelessness and helplessness, lack of motivation to help self.
- Note expressions of inability to find meaning in life, reason for living. Evaluate suicidal ideation.
- Note alterations in behavior (e.g., as listed in Defining Characteristics).
- Ascertain drug use/abuse.
- Assess sense of self-concept, worth, ability to enter into loving relationships.
- Observe behavior indicative of poor relationships with others (e.g., manipulative, nontrusting, demanding).
- Determine support systems available to patient/SO(s).
- Be aware of influence of caregiver's belief system. (**It is still possible to be helpful to patient while remaining neutral/not espousing own beliefs.**)
- Ascertain if there are spiritual practices/restrictions that will affect patient care/personal needs or create conflict between spiritual beliefs and treatment.

NURSING PRIORITY NO. **2.** To assist patient/SO(s) to deal with feelings/situation:

- Develop therapeutic nurse-patient relationship. Ask how you can be most helpful. Convey acceptance of patient's spiritual beliefs/concerns. **Promotes trust and comfort, encouraging patient to be open about sensitive matters.**
- Problem-solve solutions/identify areas for compromise if conflicts occur.
- Establish environment that promotes free expression of feelings and concerns.
- Provide calm, peaceful setting when possible.
- Set limits on acting-out behavior that is inappropriate/destructive. **Promotes safety for patient/others and helps prevent loss of self-esteem.**
- Make time for nonjudgmental discussion of philosophic issues/questions about spiritual impact of illness/situation and/or treatment regimen.
- Involve patient in refining healthcare goals and therapeutic regimen as appropriate. **Enhances commitment to plan, optimizing outcomes.**
- Discuss difference between grief and guilt and help patient to identify and deal with each, assuming responsibility for own actions, expressing awareness of the consequences of acting out of false guilt.
- Use therapeutic communication skills of reflection and Active-listening. **Helps patient find own solutions to concerns.**

- Provide role model (e.g., nurse, individual experiencing similar situation/disease). **sharing of experiences/hope assists patient to deal with situation.**
- Suggest use of journaling. **Can assist in clarifying values/ideas, recognizing and resolving feelings/situation.**
- Assist patient to learn use of meditation/prayer and forgiveness **to heal past hurts.** Provide information that anger with God is a normal part of the grieving process.
- Monitor physical care when undergoing withdrawal from drugs.
- Provide time and privacy to engage in spiritual growth/religious activities (e.g., prayer, meditation, scripture reading).
- Provide play therapy for child that encompasses spiritual data.
- Abide by parents' wishes in discussing and implementing child's spiritual support.
- Refer to appropriate resources for help (e.g., pastoral/parish nurse or religious counselor, crisis counselor, hospice; psychotherapy; Alcoholics/Narcotics Anonymous).
- Refer to NDs Coping, ineffective; Powerlessness; Self-Esteem (specify); Social Isolation.

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

- Assist patient to develop goals for dealing with life/illness situation. **Enhances commitment to goal, optimizing outcomes.**
- Help patient find a reason for living. **Promotes sense of hope and willingness to continue efforts to improve situation.**
- Assist in developing coping skills to deal with stressors of illness/necessary changes in lifestyle.
- Assist patient to identify SO(s) and people who could provide support as needed.
- Assist patient to identify spiritual resources that could be helpful (e.g., contact spiritual advisor who has qualifications/experience in dealing with specific problems such as death/dying, relationship problems, substance abuse, suicide).

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including nature of spiritual conflict, effects of participation in treatment regimen.
- Physical/emotional responses to conflict.

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 outcome(s).
- Modifications to plan of care.

DISCHARGE PLANNING

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Spiritual Well-Being
NIC—Spiritual Support

Spiritual Distress, risk for

Taxonomy II: Life Principles—Class 3 Value/Belief/Action Congruence (00067)

[Diagnostic Division: Ego Integrity]

Nursing Diagnosis Extension and Classification (NDEC) Submission 1998

Definition: At risk for an altered sense of harmonious connectedness with all of life and the universe in which dimensions that transcend and empower the self may be disrupted

Risk Factors

Physical or psychological stress; energy-consuming anxiety; physical/mental illness
Situation/maturational losses; loss of loved one
Blocks to self-love; low self-esteem; poor relationships; inability to forgive
Substance abuse
Natural disasters

Desired Outcomes/Evaluation Criteria—Patient Will:

- Identify meaning and purpose in one's life that reinforces hope, peace, and contentment.

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

- Verbalize acceptance of self as being worthy, not deserving of illness/situation, and so forth.
- Identify and use resources appropriately.

Actions/Interventions

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

- Ascertain current situation (e.g., natural disaster, death of a spouse, personal injustice).
- Listen to patient's/SO(s') reports/expressions of anger/concern, belief that illness/situation is a punishment for wrongdoing, and so forth.
- Note reason for living and whether it is directly related to situation (e.g., home and business washed away in a flood, parent whose only child is terminally ill).
- Determine patient's religious/spiritual orientation, current involvement, presence of conflicts, especially in current circumstances.
- Assess sense of self-concept, worth, ability to enter into loving relationships.
- Observe behavior indicative of poor relationships with others (e.g., manipulative, nontrusting, demanding).
- Determine support systems available to and used by patient/SO(s).
- Ascertain substance use/abuse. (**Affects ability to deal with problems in a positive manner.**)

NURSING PRIORITY NO. 2. To assist patient/SO(s) to deal with feeling/situation:

- Establish environment that promotes free expression of feelings and concerns.
- Have patient identify and prioritize current/immediate needs. **Helps patient focus on what needs to be done and identify manageable steps to take.**
- Make time for nonjudgmental discussion of philosophical issues/questions about spiritual impact of illness/situation and/or treatment regimen.
- Discuss difference between grief and guilt and help patient to identify and deal with each, assuming responsibility for own actions, expressing awareness of the consequences of acting out of false guilt.
- Use therapeutic communication skills of reflection and Active-listening. **Helps patient find own solutions to concerns.**
- Review coping skills used and their effectiveness in current situation. **Identifies strengths to incorporate into plan and techniques needing revision.**
- Provide role model (e.g., nurse, individual experiencing similar situation/disease). **Sharing of experiences/hope assists patient to deal with reality.**

- Suggest use of journaling. **Can assist in clarifying values/ideas, recognizing and resolving feelings/situation.**
- Refer to appropriate resources for help (e.g., crisis counselor, governmental agencies; pastoral/parish nurse or spiritual advisor who has qualifications/experience dealing with specific problems such as death/dying, relationship problems, substance abuse, suicide; hospice, psychotherapy, Alcoholics/Narcotics Anonymous).

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

- Role-play new coping techniques **to enhance integration of new skills/necessary changes in lifestyle.**
- Assist patient to identify SO(s) and individuals/support groups who could provide ongoing support **because this is a daily need requiring lifelong commitment.**
- Abide by parents' wishes in discussing and implementing child's spiritual support.
- Discuss benefit of family counseling as appropriate. **Issues of this nature (e.g., situational losses, natural disasters, difficult relationships) affect family dynamics.**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including risk factors, nature of current distress.
- Physical/emotional responses to distress.
- Access to/use of resources.

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 outcome(s).
- Modifications to plan of care.

DISCHARGE PLANNING

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Spiritual Well-Being
NIC—Spiritual Support

Spiritual Well-Being, readiness for enhanced

Taxonomy II: Life Principles—Class 2 Beliefs (00068)
[Diagnostic Division: Ego Integrity]

Definition: Process of developing/unfolding of mystery through harmonious interconnectedness that springs from inner strengths [Spiritual well-being is the ability to invest meaning, value, and purpose in one's life that gives harmony, peace, and contentment. This provides for life-affirming relationships with deity, self, community, and environment.]

Related Factors

To be developed by NANDA

Defining Characteristics

SUBJECTIVE

Inner strengths: sense of awareness, self-consciousness, sacred source, unifying force, inner core, and transcendence
Unfolding mystery: one's experience about life's purpose and meaning, mystery, uncertainty, and struggles
Harmonious interconnectedness: relatedness/connectedness/harmony with self, others, higher power/God, and the environment

Desired Outcomes/Evaluation Criteria—Patient Will:

- Acknowledge the stabilizing and strengthening forces in one's life needed for balance and well-being of the whole person.
- Identify meaning and purpose in one's life that reinforces hope, peace, and contentment.
- Verbalize a sense of peace/contentment and comfort of spirit.
- Demonstrate behavior congruent with verbalizations that lend support and strength for daily living.

Actions/Interventions

NURSING PRIORITY NO. 1. To determine spiritual state/motivation for growth:

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

- Review religious/spiritual history, activities/rituals and frequency of participation. (**Provides basis to build on for growth/change.**)
- Explore meaning/interpretation and relationship of spirituality, life/death, and illness to life's journey. Ascertain patient's perception of current state.
- Determine relational values of support systems to one's spiritual centeredness.
- Discuss life's/God's plan for the individual.
- Validate the meaning of one's spiritual beliefs/religious practice and rituals to daily living.
- Explore ways that spirituality/religious practices have affected one's life and given meaning and value to daily living. Note consequences as well as benefits.

NURSING PRIORITY NO. 2. To assist patient to integrate values and beliefs to achieve a sense of wholeness and optimum balance in daily living:

- Explore ways beliefs give meaning and value to daily living. **Provides support for dealing with current/future concerns.**
- Clarify reality/appropriateness of patient's self-perceptions and expectations. **Necessary to provide firm foundation for growth.**
- Discuss the importance and value of spiritual ritual/prayer to one's daily life.
- Identify ways to achieve connectedness or harmony with self, others, nature, higher power (e.g., meditation, prayer, talking/sharing one's self with others; being out in nature/gardening/walking; attending religious activities). **This is a highly individual and personal decision, and no action is too trivial to be considered.**

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

- Identify ways for spiritual/religious expression.
- Encourage patient to take time to be introspective in the search for peace and harmony. Discuss use of relaxation/meditative activities (e.g., yoga, tai chi, prayer).
- Encourage participation in the practices that validate one's beliefs in an external way that supports and strengthens the inner self (e.g., participation in desired religious activities, contact with minister/spiritual advisor).
- Discuss and role-play, as necessary, ways to deal with alternative view/conflict that may occur with family/SO(s)/society or cultural group. **Provides opportunity to try out different behaviors in a safe environment and be prepared for potential eventualities.**
- Suggest attendance/involvement in dream-sharing group **to develop/enhance learning** of the characteristics of spiritual awareness and facilitate the individual's growth.

- Suggest use of bibliotherapy, providing list of relevant resources **for later reference/self-paced learning.**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings, including patient perception of needs and desire/expectations for change.

PLANNING

- Plan of care 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

- Long-range needs/expectations and plan of action.
- Specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATION (NOC/NIC)

NOC—Spiritual Well-Being
NIC—Spiritual Growth Facilitation

Suffocation, risk for

Taxonomy II: Safety/Protection—Class 2 Physical Injury (00036)
[Diagnostic Division: Safety]

Definition: Accentuated risk of accidental suffocation (inadequate air available for inhalation)

Risk Factors

INTERNAL (INDIVIDUAL)

Reduced olfactory sensation
Reduced motor abilities
Lack of safety education, precautions

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

Cognitive or emotional difficulties [e.g., altered consciousness/mentation]
Disease or injury process

EXTERNAL (ENVIRONMENTAL)

Pillow/propped bottle placed in an infant's crib
Pacifier hung around infant's head
Children playing with plastic bag or inserting small objects into their mouths or noses
Children left unattended in bathtubs or pools
Discarded or unused refrigerators or freezers without removed doors
Vehicle warming in closed garage [/faulty exhaust system]; use of fuel-burning heaters not vented to outside
Household gas leaks; smoking in bed
Low-strung clothesline
Person who eats large mouthfuls [or pieces] of food

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—Patient Will:

- Verbalize knowledge of hazards in the environment.
- Identify interventions appropriate to situation.
- Correct hazardous situations to prevent/reduce risk of suffocation.
- Demonstrate CPR skills and how to access emergency assistance.

Actions/Interventions

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

- Note presence of internal/external factors in individual situation (e.g., seizure activity, inadequate supervision of small children, comatose patient).
- Determine patient's/SO's knowledge of safety factors/hazards present in the environment.
- Identify level of concern/awareness and motivation of patient/SO(s) to correct safety hazards and improve individual situation.
- Assess neurological status and note factors that have potential to compromise airway or affect ability to swallow (e.g., stroke, cerebral palsy, MS, ALS).

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

- Determine use of antiepileptics and how well epilepsy is controlled.
- Note reports of sleep disturbance and fatigue; **may be indicative of sleep apnea (airway obstruction).**

NURSING PRIORITY NO. 2. To reverse/correct contributing factors:

- Identify/encourage safety measures (such as seizure precautions; not smoking in bed, propping baby bottle, or running automobile in closed garage) **to prevent/minimize injury.**
- Recommend storing plastic bags out of reach of infants/young children. Avoid use of plastic mattress or crib covers, comforter or fluffy pillows in cribs **to reduce risk of accidental suffocation.**
- Use proper positioning, suctioning, use of adjuncts as indicated for comatose patient **to protect/maintain airway.** (Tracheotomy may be necessary.)
- Provide diet modifications as indicated by degree of swallowing disability, cognition **to reduce risk of aspiration.**
- Monitor medication regimen (e.g., anticonvulsants, analgesics, sedatives), noting potential for interaction and oversedation.
- Discuss with patient/SO(s) identified environmental safety hazards and problem-solve methods for resolution.
- Emphasize importance of periodic evaluation and repair of gas appliances/furnace, automobile exhaust system **to prevent exposure to carbon monoxide.**

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

- Review safety factors identified in individual situation and methods for remediation.
- Develop plan with patient/caregiver for long-range management of situation to avoid injuries. **Enhances commitment to plan, optimizing outcomes.**
- Review importance of chewing carefully, taking small amounts of food, using caution when talking or drinking while eating. Discuss possibility of choking **because of throat muscle relaxation and impaired judgment when drinking alcohol and eating.**
- Emphasize the importance of getting help when beginning to choke; instead of leaving table, remain calm and make gesture across throat, making sure someone recognizes the emergency.
- Promote public education in techniques for clearing blocked airways, Heimlich maneuver, CPR.
- Assist individuals to learn to read package labels and identify safety hazards such as toys with small parts.
- Promote pool safety and use of approved flotation equipment.
- Discuss safety measures regarding use of heaters, household gas appliances, old/discarded appliances.
- Refer to NDs Airway Clearance, ineffective; Aspiration, risk for; Breathing Pattern, ineffective; Sleep Pattern, disturbed; Parenting, impaired.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual risk factors including individual's cognitive status and level of knowledge.
- Level of concern/motivation for change.
- Equipment/airway adjunct needs.

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 outcome(s).
- Modifications to plan of care.

DISCHARGE PLANNING

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Risk Control
NIC—Airway Management

Suicide, risk for

Taxonomy II: Safety/Protection—Class 3 Violence (00150)
[Diagnostic Division: Safety]
Submitted 2000

Definition: At risk for self-inflicted, life-threatening injury

Risk Factors/[Indicators]

BEHAVIORAL

History of prior suicide attempt
Buying a gun; stockpiling medicines
Making or changing a will; giving away possessions
Sudden euphoric recovery from major depression

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

Impulsiveness; marked changes in behavior, attitude, school performance

VERBAL

Threats of killing oneself; states desire to die/end it all

SITUATIONAL

Living alone; retired; relocation, institutionalization; economic instability
Presence of gun in home
Adolescents living in nontraditional settings (e.g., juvenile detention center, prison, half-way house, group home)

PSYCHOLOGICAL

Family history of suicide; abuse in childhood
Alcohol and substance use/abuse
Psychiatric illness/disorder (e.g., depression, schizophrenia, bipolar disorder)
Guilt
Gay or lesbian youth

DEMOGRAPHIC

Age: elderly, young adult males, adolescents
Race: Caucasian, Native American
Gender: male
Divorced, widowed

PHYSICAL

Physical/terminal illness; chronic pain

SOCIAL

Loss of important relationship; disrupted family life; poor support systems; social isolation
Grief, bereavement; loneliness
Hopelessness; helplessness
Legal or disciplinary problem
Cluster suicides

Desired Outcomes/Evaluation Criteria—Patient Will:

- Acknowledge difficulties perceived in current situation.
- Identify current factors that can be dealt with.
- Be involved in planning course of action to correct existing problems.

Actions/Interventions

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

- Identify degree of risk/potential for suicide and seriousness of threat. Use a scale of 1–10 and prioritize according to severity of threat, availability of means. (**Risk of suicide is greater in teens and the elderly, but there is a rising awareness of risk in early childhood.**)
- Note behaviors indicative of intent (e.g., gestures, presence of means such as guns, threats, giving away possessions, previous attempts, and presence of hallucinations or delusions).
- Ask directly if person is thinking of acting on thoughts/feelings **to determine intent.**
- Reevaluate potential for suicide periodically at key times (e.g., mood changes, increasing withdrawal), as well as when patient is feeling better and discharge planning becomes active. **The highest risk is when the patient has both suicidal ideation and sufficient energy with which to act.**
- Determine presence of SO(s)/friends who are available for support.
- Note withdrawal from usual activities, lack of social interactions.
- Identify conditions such as acute/chronic brain syndrome; panic state; hormonal imbalance (e.g., PMS, postpartum psychosis, drug-induced) **that may interfere with ability to control own behavior.**
- Review laboratory findings (e.g., blood alcohol, blood glucose, ABGs, electrolytes, renal function tests), **to identify factors that may affect reasoning ability.**
- Assess physical complaints (e.g., sleeping difficulties, lack of appetite).
- Note family history of suicidal behavior. (**Individual risk is increased.**)
- Assess coping behaviors presently used. Note: Patient may believe there is no alternative except suicide.
- Determine drug use, involvement with judicial system.

NURSING PRIORITY NO. **2.** To assist patients to accept responsibility for own behavior and prevent suicide:

- Develop therapeutic nurse-patient relationship, providing consistent caregiver. **Promotes sense of trust, allowing individual to discuss feelings openly.**
- Maintain straightforward communication **to avoid reinforcing manipulative behavior.**
- Explain concern for safety and willingness to help patient stay safe.
- Encourage expression of feelings and make time to listen to concerns. **Acknowledges reality of feelings and that they are OK.**

Helps individual sort out thinking and begin to develop understanding of situation.

- Give permission to express angry feelings in acceptable ways and let patient know someone will be available to assist in maintaining control. **Promotes acceptance and sense of safety.**
- Acknowledge reality of suicide as an option. Discuss consequences of actions if they follow through on intent. Ask how it will help individual to resolve problems. **Helps to focus on consequences of actions and possibility of other options.**
- Maintain observation of patient and check environment for hazards that could be used to commit suicide **to increase patient safety/reduce risk of impulsive behavior.**
- Help patient identify more appropriate solutions/behaviors (e.g., motor activities/exercise) **to lessen sense of anxiety and associated physical manifestations.**
- Provide directions for actions patient can take, avoiding negative statements, such as "do nots." **Promotes a positive attitude.**

NURSING PRIORITY NO. 3. To assist patient to plan course of action to correct/deal with existing situation:

- Gear interventions to individual involved (e.g., age, relationship, and current situation).
- Negotiate contract with patient regarding willingness not to do anything lethal for a stated period of time. Specify what caregiver will be responsible for and what client responsibilities are.
- Specify alternative actions necessary if patient is unwilling to negotiate contract.
- Discuss losses patient has experienced and meaning of those losses. **Unresolved issues may be contributing to thoughts of hopelessness.**

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

- Promote development of internal control by helping patient look at new ways to deal with problems.
- Assist with learning problem solving, assertiveness training, and social skills.
- Engage in physical activity programs. **Promotes feelings of self-worth and improves sense of well-being.**
- Determine nutritional needs and help patient to plan for meeting them.
- Involve family/SO in planning **to improve understanding and support.**
- Refer to formal resources as indicated (e.g., individual/group/marital psychotherapy, substance abuse treatment program, and social services).

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including nature of concern (e.g., suicidal/behavioral risk factors and level of impulse control, plan of action/means to carry out plan.)
- Patient's perception of situation, motivation for change.

PLANNING

- Plan of care and who is involved in the planning.
- Details of contract regarding suicidal ideation/plans.
- Teaching plan.

IMPLEMENTATION/EVALUATION

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

DISCHARGE PLANNING

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Suicide Self-Restraint
NIC—Suicide Prevention

Surgical Recovery, delayed

Taxonomy II: Activity/Rest—Class 2 Activity/Exercise (00100)

[Diagnostic Division: Safety]

Definition: Extension of the number of postoperative days required to initiate and perform activities that maintain life, health, and well-being

Related Factors

To be developed by NANDA

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

Defining Characteristics

SUBJECTIVE

Perception more time needed to recover
Report of pain/discomfort; fatigue
Loss of appetite with or without nausea
Postpones resumption of work/employment activities

OBJECTIVE

Evidence of interrupted healing of surgical area (e.g., red, indurated, draining, immobile)
Difficulty in moving about; requires help to complete self-care

Desired Outcomes/Evaluation Criteria—Patient Will:

- Display complete healing of surgical area.
- Be able to perform desired self-care activities.
- Report increased energy, able to participate in usual (work/employment) activities.

Actions/Interventions

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

- Determine extent of injury/damage to tissues and general state of health.
- Identify underlying condition/pathology involved (e.g., skin/other cancers, burns, diabetes, steroid therapy, multiple trauma, infections, radiation therapy), **which may affect healing/recovery.**
- Note odors emitted from wound, presence of fever, or other signs **suggesting localized/systemic infections.**
- Assess circulation and sensation in affected area **(possible loss of blood flow/nerve damage).**
- Determine nutritional status and current intake.
- Ascertain attitudes of individual about condition (e.g., cultural values, stigma regarding condition, lack of motivation to return to usual role/activities).

NURSING PRIORITY NO. 2. To determine impact of delayed recovery:

- Note length of hospitalization to date and compare with expected length of stay for procedure and situation.
- Determine energy level and current participation in ADLs. Compare with usual level of function.
- Ascertain whether patient usually requires assistance in home setting and who provides it/current availability and capability.
- Obtain psychological assessment of patient's emotional status, noting potential problems arising from current situation.

NURSING PRIORITY NO. 3. To promote optimal recovery:

- Inspect incisions/wounds routinely, describing changes (e.g., deepening or healing wound measurements, presence/type of drainage, development of necrosis).
- Observe for complications (e.g., infection, dehiscence).
- Assist with wound care as indicated (e.g., débridement, barrier dressings, wound coverings, skin-protective agents for open/draining wounds).
- Include wound care specialist/stomal therapist as appropriate **to problem-solve healing difficulties.**
- Limit/avoid use of plastics or latex materials. (**Patient may be sensitive.**)
- Provide optimal nutrition and adequate protein intake **to provide a positive nitrogen balance aiding in healing and to achieve general good health.**
- Encourage ambulation, regular exercise **to promote circulation, improve strength, and reduce risks associated with immobility.**
- Recommend alternating activity with adequate rest periods **to prevent fatigue.**
- Administer medications as indicated (e.g., patient may be experiencing stubborn infection requiring IV antibiotics or management of chronic pain).
- Encourage patient to adhere to medical regimen and follow-up care **to monitor healing process and provide for timely intervention as needed.**

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

- Discuss reality of recovery process and patient's/SO's expectations. **Individuals are often unrealistic regarding energy and time required for healing and own abilities/responsibilities to facilitate process.**
- Involve patient/SO(s) in setting incremental goals. **Enhances commitment to plan and reduces likelihood of frustration blocking progress.**
- Refer to physical/occupational therapists as indicated **to identify assistive devices to facilitate independence in ADLs.**
- Identify suppliers for dressings/wound care items and assistive devices as needed.
- Consult dietitian for individual dietary plan **to meet increased nutritional needs that reflect personal situation/resources.**
- Determine home situation (e.g., lives alone, bedroom/bathroom on second floor, availability of assistance). **Identifies necessary adjustments, such as moving bedroom to first floor, arranging for commode during recovery, obtaining a Life-line emergency call system.**

- Discuss alternative placement (e.g., convalescent/rehabilitation center as appropriate).
- Identify community resources (e.g., visiting nurse, home healthcare agency, Meals on Wheels, respite care). **Facilitates adjustment to home setting.**
- Refer for counseling/support. **May need additional help to overcome feelings of discouragement, deal with changes in life.**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings, including individual concerns, family involvement, and support factors/availability of resources.

PLANNING

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

IMPLEMENTATION/EVALUATION

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

DISCHARGE PLANNING

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Self-Care: Activities of Daily Living (ADL)
NIC—Self-Care Assistance

Swallowing, impaired

Taxonomy II: Nutrition—Class 1 Ingestion (00103)
[Diagnostic Division: Food/Fluid]
Nursing Diagnosis Extension and Classification (NDEC) Revision 1998

Definition: Abnormal functioning of the swallowing mechanism associated with deficits in oral, pharyngeal, or esophageal structure or function

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

Related Factors

CONGENITAL DEFICITS

Upper airway anomalies; mechanical obstruction (e.g., edema, tracheostomy tube, tumor); history of tube feeding
Neuromuscular impairment (e.g., decreased or absent gag reflex, decreased strength or excursion of muscles involved in mastication, perceptual impairment, facial paralysis); conditions with significant hypotonia; cranial nerve involvement
Respiratory disorders; congenital heart disease
Behavioral feeding problems; self-injurious behavior
Failure to thrive or protein energy malnutrition

NEUROLOGICAL PROBLEMS

External/internal traumas; acquired anatomic defects
Nasal or nasopharyngeal cavity defects
Oral cavity or oropharynx abnormalities
Upper airway/laryngeal anomalies; tracheal, laryngeal, esophageal defects
Gastroesophageal reflux disease; achalasia
Premature infants; traumatic head injury; developmental delay; cerebral palsy

Defining Characteristics

SUBJECTIVE

Esophageal Phase Impairment
Complaints [reports] of "something stuck"; odynophagia
Food refusal or volume limiting
Heartburn or epigastric pain
Nighttime coughing or awakening

OBJECTIVE

Oral Phase Impairment
Weak suck resulting in inefficient nippling
Slow bolus formation; lack of tongue action to form bolus; premature entry of bolus
Incomplete lip closure; food pushed out of/falls from mouth
Lack of chewing
Coughing, choking, gagging before a swallow
Piecemeal deglutition; abnormality in oral phase of swallow study

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

Inability to clear oral cavity; pooling in lateral sulci; nasal reflux; sialorrhea or drooling
Long meals with little consumption

Pharyngeal Phase Impairment
Food refusal
Altered head positions; delayed/multiple swallows; inadequate laryngeal elevation; abnormality in pharyngeal phase by swallow study
Choking, coughing, or gagging; nasal reflux; gurgly voice quality
Unexplained fevers; recurrent pulmonary infections

Esophageal Phase Impairment
Observed evidence of difficulty in swallowing (e.g., stasis of food in oral cavity, coughing/choking); abnormality in esophageal phase by swallow study
Hyperextension of head, arching during or after meals
Repetitive swallowing or ruminating; bruxism
Unexplained irritability surrounding mealtime
Acidic smelling breath; regurgitation of gastric contents or wet burps; vomitus on pillow; vomiting; hematemesis

Desired Outcomes/Evaluation Criteria—Patient Will:

- Verbalize understanding of causative/contributing factors.
- Identify individually appropriate interventions/actions to promote intake and prevent aspiration.
- Demonstrate feeding methods appropriate to the individual situation.
- Pass food and fluid from mouth to stomach safely.
- Maintain adequate hydration as evidenced by good skin turgor, moist mucous membranes, and individually appropriate urine output.
- Achieve and/or maintain desired body weight.

Caregiver/SO(s) Will:

- Demonstrate emergency measures in the event of choking.

Actions/Interventions

NURSING PRIORITY NO. 1. To assess causative/contributing factors and degree of impairment:

- Assess sensory-perceptual status (sensory awareness, orientation, concentration, motor coordination).
- Inspect oropharyngeal cavity for edema, inflammation, altered integrity of oral mucosa, adequacy of oral hygiene.
- Ascertain presence and strength of cough and gag reflex.

- Evaluate ability to swallow using crushed ice or small sips of water.
- Auscultate breath sounds **to evaluate the presence of aspiration.**
- Assess strength and excursion of muscles involved in mastication and swallowing.
- Verify proper fit of dentures.
- Record current weight/recent changes.
- Prepare for/assist with diagnostic testing of swallowing activity.

NURSING PRIORITY NO. 2. To prevent aspiration and maintain airway patency:

- Identify individual factors that can precipitate aspiration/compromise airway.
- Raise head to a 90-degree angle with head in anatomic alignment and slightly flexed forward during feeding. Keep HOB elevated for 30 to 45 minutes after feeding, if possible.
- Position patient on the unaffected side, placing food in this side of mouth and having patient use the tongue to assist with managing the food when one side of the mouth is affected by the condition (e.g., hemiplegia).
- Suction oral cavity prn. Teach patient self-suction when appropriate. **Promotes independence/sense of control.**

NURSING PRIORITY NO. 3. To enhance swallowing ability to meet fluid and caloric body requirements:

- Refer to gastroenterologist as indicated. (**Esophageal dilatation may be necessary when impaired sphincter function or esophageal strictures impede swallowing.**)
- Refer to speech therapist **to identify specific techniques to enhance patient efforts/safety measures as indicated.**
- Provide cognitive cues (e.g., remind patient to chew/swallow as indicated) **to enhance concentration and performance of swallowing sequence.**
- Encourage a rest period before meals **to minimize fatigue.**
- Provide analgesics prior to feeding as indicated **to enhance comfort,** but be cautious **to avoid decreasing awareness/sensory perception.**
- Focus attention on feeding/swallowing activity and decreasing environmental stimuli, **which may be distracting during feeding.**
- Determine food preferences of patient **to incorporate as possible.** Present foods in an appealing, attractive manner.
- Ensure temperature (hot or cold versus tepid) of foods/fluid, **which will stimulate sensory receptors.**
- Provide a consistency of food/fluid that is most easily swallowed (can be formed into a bolus before swallowing), such as

gelatin desserts prepared with less water than usual, pudding, and custard; thickened liquids (addition of thickening agent, or yogurt, cream soups prepared with less water); thinned purees (hot cereal with water added); or thick drinks such as nectars; fruit juices that have been frozen into "slush" consistency (**thin fluids are most difficult to control);** medium-soft boiled or scrambled eggs; canned fruit; soft-cooked vegetables. Avoid milk products and chocolate, **which may thicken oral secretions.**

- Feed one consistency and/or texture of food at a time.
- Place food midway in oral cavity; provide medium-sized bites (about 15 mL) **to adequately trigger the swallowing reflex.**
- Instruct to chew food on unaffected side as appropriate.
- Massage the laryngopharyngeal musculature (sides of trachea and neck) gently **to stimulate swallowing.**
- Observe oral cavity after each bite and have patient check around cheeks with tongue for remaining food. Remove food if unable to swallow.
- Incorporate patient's eating style and pace when feeding **to avoid fatigue and frustration with process.**
- Allow ample time for eating (feeding).
- Remain with patient during meal **to reduce anxiety and offer assistance.**
- Use a glass with a nose cutout **to avoid posterior head tilting while drinking.** Never pour liquid into the mouth. Avoid "washing food down" with liquid.
- Monitor intake, output, and body weight **to evaluate adequacy of fluid and caloric intake.**
- Provide positive feedback for patient's efforts.
- Provide oral hygiene following each feeding.
- Consider tube feedings/parenteral solutions as indicated **for the patient unable to achieve adequate nutritional intake.**
- Consult with dysphagia specialist/rehabilitation team as indicated.

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

- Consult with dietitian **to establish optimum dietary plan.**
- Place medication in gelatin, jelly, or puddings. Consult with pharmacist to determine if pills may be crushed or if liquids/capsules are available.
- Assist patient and/or SO in learning specific feeding techniques and swallowing exercises.
- Instruct patient and/or SO in emergency measures in event of choking.
- Encourage continuation of facial exercise program **to maintain/improve muscle strength.**

- Establish routine schedule for monitoring weight.
- Refer to ND Nutrition: imbalanced, risk for less than body requirements.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including degree/characteristics of impairment, current weight/recent changes.
- Effects on lifestyle/socialization and nutritional status.

PLANNING

- Plan of care 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

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Swallowing Status
NIC—Swallowing Therapy

Therapeutic Regimen: Community, ineffective management

Taxonomy II: Health Promotion—Class 2 Health Management (0081)
[Diagnostic Division: Teaching/Learning]

Definition: Pattern of regulating and integrating into community processes programs for treatment of illness and the sequelae of illness that are unsatisfactory for meeting health-related goals

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

Related Factors

To be developed by NANDA
[Lack of safety for community members]
[Economic insecurity]
[Health care not available]
[Unhealthy environment]
[Education not available for all community members]
[Does not possess means to meet human needs for recognition, fellowship, security, and membership]

Defining Characteristics

SUBJECTIVE

[Community members/agencies verbalize inability to meet therapeutic needs of all members]
[Community members/agencies verbalize overburdening of resources for meeting therapeutic needs of all members]

OBJECTIVE

Deficits in people and programs to be accountable for illness care of aggregates
Deficits in advocates for aggregates
Deficit in community activities for [primary medical care/prevention]/secondary and tertiary prevention
Illness symptoms above the norm expected for the number and type of population; unexpected acceleration of illness(es)
Number of healthcare resources insufficient[/unavailable] for the incidence or prevalence of illness(es)
[Deficits in community for collaboration and development of coalitions to address programs for treatment of illness and the sequelae of illness]

Desired Outcomes/Evaluation Criteria—Community Will:

- Identify both negative and positive factors affecting community treatment programs for meeting health-related goals.
- Participate in problem solving of factors interfering with regulating and integrating community programs.
- Report illness symptoms moving toward norm expected for the incidence or prevalence of illness(es).

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

Actions/Interventions

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

- Evaluate community healthcare resources for illness/sequelae of illness.
- Note reports from members of the community regarding ineffective/inadequate community functioning.
- Investigate unexpected acceleration of illness in the community.
- Identify strengths/limitations of community resources and community commitment to change.
- Ascertain effect of related factors on community activities.
- Determine knowledge/understanding of treatment regimen.

NURSING PRIORITY NO. **2.** To assist community to develop strategies to improve community functioning/management:

- Foster cooperative spirit of community without negating individuality of members/groups.
- Involve community in determining healthcare goals and prioritize them **to facilitate planning process.**
- Plan together with community health and social agencies **to problem-solve solutions to identified and anticipated problems/needs.**
- Identify specific populations at risk or underserved **to actively involve them in process.**
- Create teaching plan/form speakers' bureau **to disseminate information to community members regarding value of treatment/preventive programs.**

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

- Assist community to develop a plan for continuing assessment of community needs/functioning and effectiveness of plan. **Promotes proactive approach.**
- Encourage community to form partnerships within the community and between the community and the larger society **to aid in long-term planning for anticipated/projected needs/concerns.**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings, including members' perceptions of community problems.

PLANNING

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

IMPLEMENTATION/EVALUATION

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

DISCHARGE PLANNING

- Long-range goals and who is responsible for actions to be taken.
- Specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Community Competence
NIC—Community Health Development

Therapeutic Regimen, effective management

Taxonomy II: Health Promotion—Class 2 Health Management (00082)
[Diagnostic Division: Teaching/Learning]

Definition: Pattern of regulating and integrating into daily living a program for treatment of illness and its sequelae that is satisfactory for meeting specific health goals

Related Factors

To be developed by NANDA
[Complexity of healthcare management; therapeutic regimen]
[Added demands made on individual or family]
[Adequate social supports]

Defining Characteristics

SUBJECTIVE

Verbalized desire to manage the treatment of illness and prevention of sequelae
Verbalized intent to reduce risk factors for progression of illness and sequelae

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

OBJECTIVE

Appropriate choices of daily activities for meeting the goals of a treatment or prevention program
Illness symptoms are within a normal range of expectation

Desired Outcomes/Evaluation Criteria—Individual Will:

- Verbalize understanding of therapeutic regimen for illness/condition.
- Demonstrate effective problem solving in integration of therapeutic regimen into lifestyle.
- Identify/use available resources.
- Remain free of preventable complications/progression of illness and sequelae.

Actions/Interventions

NURSING PRIORITY NO. **1.** To assess situation and individual needs:

- Ascertain patient's knowledge/understanding of condition and treatment needs. Note specific health goals.
- Identify individual's perceptions of adaptation to treatment/anticipated changes.
- Note treatments added to present regimen and patient/SO(s) associated learning needs.
- Discuss present resources used by patient, **to note whether changes need to be arranged (e.g., increased hours of home care assistance; access to case manager to support complex/long-term program).**

NURSING PRIORITY NO. **2.** To assist patient/SO(s) in developing strategies to meet increased demands of therapeutic regimen:

- Identify steps necessary to reach desired health goal(s).
- Accept patient's evaluation of own strengths/limitations while working together to improve abilities. **Promotes sense of self-esteem and confidence to continue efforts.**
- Provide information/bibliotherapy and help patient/SO(s) identify and evaluate resources they can access on their own. **When referencing the Internet or nontraditional/unproven resources, the individual must exercise some restraint and determine the reliability of the source/information provided before acting on it.**
- Acknowledge individual efforts/capabilities **to reinforce movement toward attainment of desired outcomes.**

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

- Promote patient/caregiver choices and involvement in planning and implementing added tasks/responsibilities.

- Provide for follow-up contact/home visit as appropriate.
- Assist in implementing strategies for monitoring progress/responses to therapeutic regimen. **Promotes proactive problem solving.**
- Mobilize support systems, including family/SO(s), social, financial, and so on.
- Refer to community resources as needed/desired.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Findings, including dynamics of individual situation.
- Individual strengths/additional needs.

PLANNING

- Plan of care 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

- Short-range and long-range needs and who is responsible for actions.
- Available resources, specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Symptom Control
NIC—Health System Guidance

Therapeutic Regimen: Family, ineffective management

Taxonomy II: Health Promotion—Class 2 Health Management (00080)
[Diagnostic Division: Teaching/Learning]

Definition: Pattern of regulating and integrating into family processes a program for treatment of illness and the sequelae of illness that is unsatisfactory for meeting specific health goals

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

Related Factors

Complexity of healthcare system
Complexity of therapeutic regimen
Decisional conflicts
Economic difficulties
Excessive demands made on individual or family
Family conflicts

Defining Characteristics

SUBJECTIVE

Verbalized difficulty with regulation/integration of one or more effects or prevention of complication; [inability to manage treatment regimen]
Verbalized desire to manage the treatment of illness and prevention of the sequelae
Verbalizes that family did not take action to reduce risk factors for progression of illness and sequelae

OBJECTIVE

Inappropriate family activities for meeting the goals of a treatment or prevention program
Acceleration (expected or unexpected) of illness symptoms of a family member
Lack of attention to illness and its sequelae

Desired Outcomes/Evaluation Criteria—Family Will:

- Identify individual factors affecting regulation/integration of treatment program.
- Participate in problem solving of factors.
- Verbalize acceptance of need/desire to change actions to achieve agreed-on outcomes or goals of treatment or prevention program.
- Demonstrate behaviors/changes in lifestyle necessary to maintain therapeutic regimen.

Actions/Interventions

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

- Ascertain family's perception of efforts to date.
- Evaluate family activities as related to appropriate family functioning/activities—looking at frequency/effectiveness of family communication, promotion of autonomy, adaptation to

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

meet changing needs, health of home environment/lifestyle, problem-solving abilities, ties to community.
- Note family health goals and agreement of individual members. (**Presence of conflict interferes with problem solving.**)
- Determine understanding of and value of the treatment regimen to the family.
- Identify availability and use of resources.

NURSING PRIORITY NO. 2. To assist family to develop strategies to improve management of therapeutic regimen:
- Provide information **to aid family in understanding the value of the treatment program.**
- Assist family members to recognize inappropriate family activities. Help the members identify both togetherness and individual needs and behavior, **so that effective interactions can be enhanced and perpetuated.**
- Make a plan jointly with family members to deal with complexity of healthcare regimen/system and other related factors. **Enhances commitment to plan, optimizing outcomes.**
- Identify community resources as needed using the three strategies of education, problem solving, and resource linking **to address specific deficits.**

NURSING PRIORITY NO. 3. To promote wellness as related to future health of family members:
- Help family identify criteria to promote ongoing self-evaluation of situation/effectiveness and family progress. **Provides opportunity to be proactive in meeting needs.**
- Make referrals to and/or jointly plan with other health/social and community resources. **Problems often are multifaceted, requiring involvement of numerous providers/agencies.**
- Provide contact person/case manager for one-to-one assistance as needed **to coordinate care, provide support, assist with problem solving, and so forth.**
- Refer to NDs Caregiver Role Strain; Therapeutic Regimen: ineffective management, as indicated.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including nature of problem/degree of impairment, family values/health goals, and level of participation and commitment of family members.
- Availability and use of resources.

PLANNING

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

IMPLEMENTATION/EVALUATION

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

DISCHARGE PLANNING

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Family Participation in Professional Care
NIC—Family Involvement Promotion

Therapeutic Regimen, ineffective management

Taxonomy II: Health Promotion—Class 2 Health Management (00078)

[Diagnostic Division: Teaching/Learning]

Definition: Pattern of regulating and integrating into daily living a program for treatment of illness and the sequelae of illness that is unsatisfactory for meeting specific health goals

Related Factors

Complexity of healthcare system/therapeutic regimen
Decisional conflicts
Economic difficulties
Excessive demands made on individual or family
Family conflict
Family patterns of healthcare
Inadequate number and types of cues to action
Knowledge deficits
Mistrust of regimen and/or healthcare personnel
Perceived seriousness/susceptibility/barriers/benefits
Powerlessness
Social support deficits

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

Defining Characteristics

SUBJECTIVE

Verbalized desire to manage the treatment of illness and prevention of sequelae
Verbalized difficulty with regulation/integration of one or more prescribed regimens for treatment of illness and its effects or prevention of complications
Verbalized that did not take action to include treatment regimens in daily routines/reduce risk factors for progression of illness and sequelae

OBJECTIVE

Choice of daily living ineffective for meeting the goals of a treatment or prevention program
Acceleration (expected or unexpected) of illness symptoms

Desired Outcomes/Evaluation Criteria—Patient Will:

- Verbalize acceptance of need/desire to change actions to achieve agreed-on outcomes.
- Verbalize understanding of factors/blocks involved in individual situation.
- Participate in problem solving of factors interfering with integration of therapeutic regimen.
- Demonstrate behaviors/changes in lifestyle necessary to maintain therapeutic regimen.
- Identify/use available resources.

Actions/Interventions

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

- Ascertain patient's knowledge/understanding of condition and treatment needs.
- Determine patient's/family's health goals and patterns of health care.
- Identify individual perceptions and expectations of treatment regimen.
- Note availability/use of resources for assistance, caregiving/respite care.

NURSING PRIORITY NO. **2.** To assist patient/SO(s) to develop strategies to improve management of therapeutic regimen:

- Use therapeutic communication skills **to assist patient to problem-solve solution(s).**
- Explore patient involvement in or lack of mutual goal setting.

- Identify steps necessary to reach desired goal(s).
- Contract with the patient for participation in care.
- Accept patient's evaluation of own strengths/limitations while working together to improve abilities. State belief in patient's ability to cope and/or adapt to situation.
- Provide positive reinforcement for efforts **to encourage continuation of desired behaviors.**
- Provide information as well as help patient to know where and how to find it on own. Reinforce previous instructions and rationale, using a variety of learning modalities, including role playing, demonstration, written materials, and so forth.

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

- Emphasize importance of patient knowledge and understanding of the need for treatment/medication as well as consequences of actions/choices.
- Promote patient/caregiver/SO(s) participation in planning and evaluating process. **Enhances commitment to plan, optimizing outcomes.**
- Assist patient to develop strategies for monitoring therapeutic regimen. **Promotes early recognition of changes, allowing proactive response.**
- Mobilize support systems, including family/SO(s), social, financial, and so on.
- Refer to counseling/therapy (group and individual) as indicated.
- Identify home and community-based nursing services **for assessment, follow-up care, and education in patient's home.**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Findings including underlying dynamics of individual situation, patient's perception of problem/needs.
- Family involvement/needs.
- Individual strengths/limitations.
- Availability/use of resources.

PLANNING

- Plan of care 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

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Treatment Behavior: Illness or Injury
NIC—Self-Modification Assistance

Thermoregulation, ineffective

Taxonomy II: Safety/Protection—Class 6 Thermoregulation (00008)
[Diagnostic Division: Safety]

Definition: Temperature fluctuation between hypothermia and hyperthermia

Related Factors

Trauma or illness [e.g., cerebral edema, CVA, intracranial surgery, or head injury]
Immaturity, aging [e.g., loss/absence of brown adipose tissue]
Fluctuating environmental temperature
[Changes in hypothalamic tissue causing alterations in emission of thermosensitive cells and regulation of heat loss/production]
[Changes in metabolic rate/activity; changes in level/action of thyroxine and catecholamines]
[Chemical reactions in contracting muscles]

Defining Characteristics

OBJECTIVE

Fluctuations in body temperature above or below the normal range
Tachycardia
Reduction in body temperature below normal range; cool skin; pallor (moderate); shivering (mild); piloerection; cyanotic nailbeds; slow capillary refill; hypertension
Warm to touch; flushed skin; increased respiratory rate; seizures/convulsions

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

Desired Outcomes/Evaluation Criteria—Patient/Caregiver Will:

- Verbalize understanding of individual factors and appropriate interventions.
- Demonstrate techniques/behaviors to correct underlying condition/situation.
- Maintain body temperature within normal limits.

Actions/Interventions

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

- Assist with measures to identify causative factor(s)/underlying condition (e.g., obtaining history concerning present symptoms, correlation with past history/family history, diagnostic studies).

NURSING PRIORITY NO. 2. To assist with measures to correct/treat underlying cause:

- Refer to NDs Hypothermia and Hyperthermia **to restore/maintain body temperature within normal range.**
- Administer fluids, electrolytes, and medications as indicated **to restore or maintain body/organ function.**
- Prepare patient for/assist with procedures (e.g., surgical intervention, neoplastic agent, antibiotics), **to treat underlying cause of hypothermia or hyperthermia.**

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

- Review causative/related factors, if appropriate, with patient/SO(s).
- Provide information concerning disease processes, current therapies, and postdischarge precautions as appropriate to situation.
- Refer to teaching in NDs Hypothermia; Hyperthermia.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including nature of problem, degree of impairment/fluctuations in temperature.

PLANNING

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

IMPLEMENTATION/EVALUATION

- Responses to interventions/teaching 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—Thermoregulation
NIC—Temperature Regulation

Thought Processes, disturbed

Taxonomy II: Perception/Cognition—Class 4 Cognition (00130)

[Diagnostic Division: Neurosensory]

Definition: Disruption in cognitive operations and activities

Related Factors

To be developed by NANDA
[Physiological changes, aging, hypoxia, head injury, malnutrition, infections]
[Biochemical changes, medications, substance abuse]
[Sleep deprivation]
[Psychological conflicts, emotional changes, mental disorders]

Defining Characteristics

SUBJECTIVE

[Ideas of reference, hallucinations, delusions]

OBJECTIVE

Inaccurate interpretation of environment
Inappropriate/nonreality-based thinking
Memory deficit/problems, [disorientation to time, place, person, circumstances and events, loss of short-term/remote memory]
Hypervigilance or hypovigilance
Cognitive dissonance, [decreased ability to grasp ideas, make decisions, problem-solve, use abstract reasoning or conceptualize, calculate; disordered thought sequencing]
Distractibility, [altered attention span]
Egocentricity

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

[Confabulation]
[Inappropriate social behavior]

Desired Outcomes/Evaluation Criteria—Patient Will:

- Recognize changes in thinking/behavior.
- Verbalize understanding of causative factors when known/able.
- Identify interventions to deal effectively with situation.
- Demonstrate behaviors/lifestyle changes to prevent/minimize changes in mentation.
- Maintain usual reality orientation.

Actions/Interventions

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

- Identify factors present, for example, acute/chronic brain syndrome (recent CVA/Alzheimer's); increased intracranial pressure; infections; malnutrition; sensory deprivation; delirium.
- Determine drug use (prescription/OTC/illicit). **May have side and/or cumulative effects that alter thought processes and sensory-perception.**
- Note schedule of drug administration (**may be significant when evaluating cumulative effects**).
- Assess dietary intake/nutritional status.
- Monitor laboratory values for abnormalities such as metabolic alkalosis, hypokalemia, anemia, elevated ammonia levels, and signs of infection.

NURSING PRIORITY NO. **2.** To assess degree of impairment:

- Evaluate mental status according to age and developmental capacity, noting extent of impairment in thinking ability, memory (remote/recent), orientation to person/place/time, insight and judgment.
- Assess attention span/distractibility and ability to make decisions or problem-solve. (**Determines ability to participate in planning/executing care.**)
- Note discrepancies in child's age and mastery of developmental milestones.
- Test ability to receive, send, and appropriately interpret communications.
- Note behavior such as untidy personal habits; slowing and/or slurring of speech.
- Note occurrence of paranoia and delusions, hallucinations.

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

- Interview SO(s) to determine usual thinking ability, changes in behavior, length of time problem has existed, and other pertinent information, **to provide baseline for comparison.**
- Assess patient's anxiety level in relation to situation.
- Assist with in-depth testing of specific functions as appropriate.

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

- Assist with treatment for underlying problems such as anorexia (nervosa/other), increased intracranial pressure, sleep disorders, biochemical imbalances. (**Cognition often improves with correction of medical problems.**)
- Establish alternate means for self-expression if unable to communicate verbally.
- Monitor and document vital signs periodically as appropriate.
- Perform neurological assessments as indicated and compare with baseline. Note changes in level of consciousness and cognition, such as increased lethargy, confusion, drowsiness, irritability; changes in ability to communicate. **Early recognition of changes promotes proactive modifications to plan of care.**
- Reorient to time/place/person as needed. (**Inability to maintain orientation is a sign of deterioration.**)
- Have patient write name periodically; keep this record for comparison and report differences.
- Note behavior that may be indicative of potential for violence and take appropriate actions.
- Provide safety measures (e.g., siderails, padding as necessary; close supervision, seizure precautions) as indicated.
- Schedule structured activity and rest periods. **Provides stimulation without undue fatigue.**
- Monitor medication regimen. Ascertain that physician is informed of all medications patient is taking, noting possible interactions/cumulative effects.
- Encourage family/SO(s) to participate in reorientation and provide ongoing input (e.g., current news and family happening).
- Refer to appropriate rehabilitation providers (e.g., cognitive retraining program, speech therapist, psychosocial resources, biofeedback, counselor).

NURSING PRIORITY NO. 4. To create therapeutic milieu and assist patient/SO(s) to develop coping strategies (especially when condition is irreversible):

- Provide opportunities for SO(s) to ask questions and obtain information.
- Maintain a pleasant, quiet environment and approach in a slow, calm manner. **Patient may respond with anxious or aggressive behaviors if startled or overstimulated.**

- Give simple directions, using short words and simple sentences.
- Listen with regard **to convey interest and worth to individual.**
- Maintain reality-oriented relationship and environment (clocks, calendars, personal items, seasonal decorations).
- Present reality concisely and briefly and do not challenge illogical thinking—**defensive reactions may result.**
- Reduce provocative stimuli, negative criticism, arguments, and confrontations **to avoid triggering fight/flight responses.**
- Refrain from forcing activities and communications. **Patient may feel threatened and may withdraw or rebel.**
- Respect individuality and personal space.
- Use touch judiciously, respecting personal needs, but keeping in mind physical and psychological importance of touch.
- Provide for nutritionally well-balanced diet incorporating patient's preferences as able. Encourage patient to eat. Provide pleasant environment and allow sufficient time to eat. **Enhances intake and general well-being.**
- Allow more time for patient to respond to questions/comments and make simple decisions.
- Assist patient/SO(s) with grieving process for loss of self/abilities as in Alzheimer's disease.
- Encourage participation in resocialization activities/groups when available.

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

- Assist in identifying ongoing treatment needs/rehabilitation program for the individual **to maintain gains and continue progress if able.**
- Stress importance of cooperation with therapeutic regimen.
- Promote socialization within individual limitations.
- Identify problems related to aging that are remediable and assist patient/SO(s) to seek appropriate assistance/access resources. **Encourages problem solving to improve condition rather than accept the status quo.**
- Help patient/SO(s) develop plan of care when problem is progressive/long-term.
- Refer to community resources (e.g., day-care programs, support groups, drug/alcohol rehabilitation).
- Refer to NDs Confusion, acute; Self-Care deficit; Grieving, anticipatory/dysfunctional; Sensory Perception, disturbed; Tissue Perfusion, ineffective.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including nature of problem, current and previous level of function, effect on independence and lifestyle.

PLANNING

- Plan of care 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

- 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—Distorted Thought Control
NIC—Dementia Management

Tissue Integrity, impaired

Taxonomy II: Safety/Protection—Class 2 Physical Injury (00044)

[Diagnostic Division: Safety]

Revised 1998 by small group work in 1996

Definition: Damage to mucous membrane, corneal, integumentary, or subcutaneous tissues

Related Factors

Altered circulation
Nutritional deficit/excess; [metabolic, endocrine dysfunction]
Fluid deficit/excess
Knowledge deficit
Impaired physical mobility
Irritants, chemical (including body excretions, secretions, medications); radiation (including therapeutic radiation)
Thermal (temperature extremes)
Mechanical (e.g., pressure, shear, friction), [surgery]
Knowledge deficit
[Infection]

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

Defining Characteristics

OBJECTIVE

Damaged or destroyed tissue (e.g., cornea, mucous membrane, integumentary, or subcutaneous)

Desired Outcomes/Evaluation Criteria—Patient Will:

- Verbalize understanding of condition and causative factors.
- Identify interventions appropriate for specific condition.
- Demonstrate behaviors/lifestyle changes to promote healing and prevent complications/recurrence.
- Display progressive improvement in wound/lesion healing.

Actions/Interventions

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

- Review history for possible causes: occupational, sports, and ADL hazards; familial history, illness, use of prosthetic devices (false limbs/eye, contacts, dentures, tracheal airways, indwelling catheters, esophageal dilators, and so on).
- Note poor health practices (e.g., lack of cleanliness, frequent use of enemas, poor nutrition, unsafe sexual practices, poor dental hygiene); emotional/psychological problems; cultural/religious practices.
- Assess environmental location of home/work in past and present as well as recent travel. (**Some areas of a country or city seem to be more susceptible to certain disease entities/environmental pollutants.**)
- Note race/ethnic background for genetic/sociocultural factors.
- Note evidence of other organ/tissue involvement (e.g., draining fistula through the integumentary and subcutaneous tissue may involve a bone infection).
- Assess adequacy of blood supply and innervation of the affected tissue.

NURSING PRIORITY NO. **2.** To assess degree of impairment:

- Obtain history of condition: characteristics of previous episode(s), if any; when occurred, how many episodes, sites of past episodes; how episode starts/ends; other symptoms that have accompanied episodes; characteristics of lesions and changes/differences between lesions/episodes; duration this episode.
- Record size (depth, width), color, smell, location, temperature, texture, consistency of wounds/lesions if possible. **Provides comparative baseline.** (Note: Full extent of lesions of mucous membranes or subcutaneous tissue may not be discernible.)

- Observe for other distinguishing characteristics of inflamed tissue (e.g., exudate; granulation; cyanosis/pallor; tight, shiny skin).
- Assist with diagnostic procedures (e.g., cultures, oscopy, scans, biopsies); **may be necessary to determine extent of impairment.**
- Determine psychological effects of condition on the patient and family.

NURSING PRIORITY NO. 3. To assist patient to correct/minimize impairment and to promote healing:

- Modify/eliminate factors contributing to condition, if possible. Assist with treatment of underlying condition(s) as appropriate.
- Inspect lesions/wounds daily for changes (e.g., signs of infection/complications or healing). **Promotes timely intervention/revision of plan of care.**
- Promote good nutrition with adequate protein and calorie intake, and vitamin/mineral supplements as indicated **to facilitate healing.**
- Encourage adequate periods of rest and sleep, including uninterrupted periods of sufficient duration; meeting comfort needs; limiting/avoiding use of caffeine/alcohol and medications affecting REM sleep.
- Promote early mobility. Provide position changes, active/passive and assistive exercises **to promote circulation and prevent excessive tissue pressure.**
- Provide devices such as eye pads/protective goggles, humidifiers, padding, air/water mattresses, splints, dressings, oral rinses, and so on **to aid in comfort/healing.**
- Practice aseptic technique for cleansing/dressing/medicating lesions. **Reduces risk of cross-contamination.**
- Obtain specimens of culture exudate/lesions for repeat cultures, sensitivity and Gram's stain when appropriate.
- Monitor laboratory studies (e.g., CBC, electrolytes, glucose, cultures) **for changes indicative of healing/infection/complications.**
- Provide safe environment when vision is affected.

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

- Encourage verbalizations of feelings and expectations regarding present condition.
- Help patient and family to identify effective coping mechanisms and to begin to implement them.
- Discuss importance of early detection and reporting of changes in condition or any unusual physical discomforts/changes. **Promotes early detection of developing complications.**
- Emphasize need for adequate nutritional/fluid intake.

- Instruct in aseptic/clean techniques for dressing changes and proper disposal of soiled dressings **to prevent spread of infectious agent.**
- Review medical regimen (e.g., proper use of topical sprays, creams, ointments, soaks, or irrigations).
- Identify required changes in lifestyle, occupation, or environment **necessitated by limitations imposed by condition or to avoid causative factors.**
- Refer to community/governmental resources as indicated (e.g., Public Health Department, OSHA, National Association for the Prevention of Blindness).
- Refer to NDs dependent on individual situation (e.g., Skin Integrity, impaired; Oral Mucous Membrane, impaired; Injury, risk for perioperative positioning; Mobility, impaired physical; Sensory Perception, disturbed: visual; Tissue Perfusion, ineffective; Trauma, risk for; Infection, risk for).

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including history of condition, characteristics of wound/lesion, evidence of other organ/tissue involvement.
- Impact on functioning/lifestyle.

PLANNING

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

IMPLEMENTATION/EVALUATION

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

DISCHARGE PLANNING

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Tissue Integrity: Skin & Mucous Membranes
NIC—Wound Care

Tissue Perfusion, ineffective (specify type: renal, cerebral, cardiopulmonary, gastrointestinal, peripheral)

Taxonomy II: Activity/Rest—Class 4 Cardiovascular/Pulmonary Responses (00024)

[Diagnostic Division: Circulation]

Revised 1998 by small group work in 1996

Definition: Decrease in oxygen resulting in the failure to nourish the tissues at the capillary level [Tissue perfusion problems can exist without decreased cardiac output; however, there may be a relationship between cardiac output and tissue perfusion.]

Related Factors

Interruption of flow—arterial, venous
Exchange problems
Hypervolemia, hypovolemia
Mechanical reduction of venous and/or arterial blood flow
Decreased Hb concentration in blood
Altered affinity of hemoglobin for O_2; enzyme poisoning
Impaired transport of the O_2 across alveolar and/or capillary membrane
Mismatch of ventilation with blood flow
Hypoventilation

Defining Characteristics

RENAL

Objective
Altered blood pressure outside of acceptable parameters
Oliguria or anuria; hematuria
Arterial pulsations, bruits
Elevation in BUN/Cr ratio

CEREBRAL

Objective
Altered mental status; speech abnormalities
Behavioral changes; [restlessness]; changes in motor response; extremity weakness or paralysis
Changes in pupillary reactions
Difficulty in swallowing

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

CARDIOPULMONARY

Subjective
Chest pain
Dyspnea
Sense of "impending doom"

Objective
Dysrhythmias
Capillary refill >3 sec
Altered respiratory rate outside of acceptable parameters
Use of accessory muscles; chest retraction; nasal flaring
Bronchospasms
Abnormal ABGs
[Hemoptysis]

GASTROINTESTINAL

Subjective
Nausea
Abdominal pain or tenderness

Objective
Hypoactive or absent bowel sounds
Abdominal distention
[Melena]

PERIPHERAL

Subjective
Claudication

Objective
Altered skin characteristics (hair, nails, moisture)
Skin temperature changes
Skin discolorations; color diminished; color pale on elevation, color does not return on lowering the leg
Altered sensations
BP changes in extremities; weak or absent pulses; diminished arterial pulsations; bruits
Edema
Delayed healing
Positive Homans' sign

Desired Outcomes/Evaluation Criteria—Patient Will:

- Verbalize understanding of condition, therapy regimen, side effects of medications, and when to contact healthcare provider.

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

- Demonstrate behaviors/lifestyle changes to improve circulation (e.g., cessation of smoking, relaxation techniques, exercise/dietary program).
- Demonstrate increased perfusion as individually appropriate (e.g., skin warm/dry, peripheral pulses present/strong, vital signs within patient's normal range, alert/oriented, balanced intake/output, absence of edema, free of pain/discomfort).

Actions/Interventions

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

- Determine factors related to individual situation, for example, previous history of/at risk for formation of thrombus or emboli, fractures, diagnosis of Raynaud's or Buerger's disease. In addition, note situations that can affect all body systems (e.g., SLE, the glucocorticoids in Addison's disease, congestive heart failure, pheochromocytoma/other endocrine imbalances, and sepsis).
- Identify changes related to systemic and/or peripheral alterations in circulation (e.g., altered mentation, vital signs, postural BPs, pain, changes in skin/tissue/organ function, signs of metabolic imbalances).
- Evaluate for signs of infection especially when immune system is compromised.
- Observe for signs of pulmonary emboli: sudden onset of chest pain, cyanosis, respiratory distress, hemoptysis, diaphoresis, hypoxia, anxiety, restlessness.

NURSING PRIORITY NO. 2. To note degree of impairment/organ involvement:

- Determine duration of problem/frequency of recurrence, precipitating/aggravating factors.
- Note customary baseline data (e.g., usual BP, weight, mentation, ABGs, and other appropriate laboratory study values). **Provides comparison with current findings.**
- Ascertain impact on functioning/lifestyle.

RENAL

- Ascertain usual voiding pattern; compare with current situation.
- Note characteristics of urine; measure specific gravity.
- Review laboratory studies (e.g., BUN/Cr levels, proteinuria, specific gravity, serum electrolytes).
- Note mentation (**may be altered by increased BUN/Cr).**
- Auscultate BP, ascertain patient's usual range (**decreased glomerular filtration rate—GFR—may increase renin and raise BP).**
- Note presence, location, intensity, duration of pain.
- Observe for dependent/generalized edema.

CEREBRAL

- Determine presence of visual, sensory/motor changes, headache, dizziness, altered mental status, personality changes.
- Note history of brief/intermittent periods of confusion/blackout. (**Suggests transient ischemic attacks—TIAs.**)
- Interview SO(s) regarding their perception of situation.

CARDIOPULMONARY

- Investigate reports of chest pain/angina; note precipitating factors, changes in characteristics of pain episodes.
- Note presence/degree of dyspnea, cyanosis, hemoptysis.
- Determine cardiac rhythm, presence of dysrhythmias.
- Review baseline ABGs, electrolytes, BUN/Cr, cardiac enzymes.

GASTROINTESTINAL

- Note reports of nausea/vomiting, location/type/intensity of pain.
- Auscultate bowel sounds; measure abdominal girth; ascertain patient's customary waist size/belt length; note changes in stool/presence of blood.
- Observe for symptoms of peritonitis, ischemic colitis, abdominal angina.

PERIPHERAL

- Ascertain history/characteristics of pain, for example, with/without activity, temperature/color changes, paresthesia, time (day/night), precipitated by heat, and so forth.
- Measure circumference of extremities as indicated. (**Useful in identifying edema in involved extremity.**)
- Assess lower extremities, noting skin texture, presence of edema, ulcerations.
- Measure capillary refill; palpate for presence/absence and quality of pulses.
- Auscultate for systolic/continuous bruits below obstruction in extremities.
- Check for calf tenderness (Homans' sign), swelling and redness, **which may indicate thrombus formation.**
- Review laboratory studies (e.g., clotting times, Hb/Hct).
- Observe for signs of shock/sepsis. Note presence of bleeding or signs of DIC.

NURSING PRIORITY NO. 3. To maximize tissue perfusion:

RENAL

- Monitor vital signs.
- Measure urine output on a regular schedule. (Intake may be calculated against output.) Weigh daily.

- Administer medication (e.g., anticoagulants in presence of thrombosis, steroids in membranous nephropathy).
- Provide for diet restrictions, as indicated, while providing adequate calories to meet the body's needs. **(Restriction of protein helps limit BUN.)**
- Provide psychological support for patient/SO(s), especially when progression of disease and resultant treatment (dialysis) may be long term.

CEREBRAL

- Elevate HOB (e.g., 10 degrees) and maintain head/neck in midline or neutral position **to promote circulation/venous drainage.**
- Administer medications (e.g., steroids/diuretics may be used to decrease edema, anticoagulants).
- Assist with/monitor hypothermia therapy, **which may be used to decrease metabolic and O_2 needs.**
- Prepare patient for surgery as indicated (e.g., carotid endarterectomy, evacuation of hematoma/space-occupying lesion).
- Refer to ND Intracranial, decreased adaptive capacity.

CARDIOPULMONARY

- Monitor vital signs, hemodynamics, heart sounds, and cardiac rhythm.
- Encourage quiet, restful atmosphere. **Conserves energy/lowers tissue O_2 demands.**
- Caution patient to avoid activities that increase cardiac workload (e.g., straining at stool). Review ways of avoiding constipation.
- Administer medications (e.g., antidysrhythmics, fibrinolytic agents).
- Note signs of ischemia secondary to drug effects.
- Refer to ND Cardiac Output, decreased.

GASTROINTESTINAL

- Maintain gastric/intestinal decompression and measure output periodically.
- Provide small/easily digested food and fluids when tolerated.
- Encourage rest after meals **to maximize blood flow to stomach.**
- Prepare patient for surgery as indicated. (May be a surgical emergency, for example, resection, bypass graft, mesenteric endarterectomy.)
- Refer to ND Nutrition: imbalanced, less than body requirements.

PERIPHERAL

- Perform assistive/active range of motion exercises (Buerger and Buerger-Allen).

- Encourage early ambulation when possible. **Enhances venous return.**
- Discourage sitting/standing for long periods, wearing constrictive clothing, crossing legs.
- Elevate the legs when sitting, but avoid sharp angulation of the hips or knees.
- Avoid use of knee gatch on bed; elevate entire foot as indicated.
- Provide air mattress, sheepskin padding, bed/foot cradle **to protect the extremities.**
- Elevate HOB at night **to increase gravitational blood flow.**
- Apply antithromboembolic hose/Ace bandages to lower extremities before arising from bed **to prevent venous stasis.**
- Use paper tape instead of adhesive.
- Avoid massaging the leg **when at risk for embolus.**
- Exercise caution in use of hot water bottles or heating pads; **tissues may have decreased sensitivity due to ischemia. (Heat also increases the metabolic demands of already compromised tissues.)**
- Monitor circulation above/below casts; apply ice and elevate limb as appropriate **to reduce edema.**
- Encourage patient to limit/quit smoking.
- Assist with/prepare for medical procedures (e.g., sympathectomy, vein graft) **to improve peripheral circulation.**
- Monitor closely for signs of shock when sympathectomy is done **(result of unmediated vasodilation).**
- Administer medications with caution (e.g., vasodilators, papaverine, antilipemics, anticoagulants). **Drug response, half-life, toxic levels may be altered by decreased tissue perfusion.**
- Monitor for signs of bleeding during use of fibrinolytic agents.

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

- Discuss the risk factors and potential outcomes of atherosclerosis. **(Information necessary for patient to make informed choices and commit to lifestyle changes as appropriate.)**
- Encourage discussion of feelings regarding prognosis/long-term effects of condition.
- Identify necessary changes in lifestyle and assist patient to incorporate disease management into ADLs.
- Encourage patient to quit smoking, join Smoke-out, other stop-smoking programs. **(Smoking causes vasoconstriction and may further compromise perfusion.)**
- Demonstrate/encourage use of relaxation techniques, exercises/techniques **to decrease tension level.** Establish regular exercise program.
- Review specific dietary changes/restrictions with patient (e.g., reduction of cholesterol and triglycerides, high or low in protein, avoidance of rye in Buerger's disease).

- Discuss care of dependent limbs, body hygiene, foot care when circulation is impaired.
- Recommend avoidance of vasoconstricting drugs.
- Discourage massaging of calf in presence of varicose veins/thrombophlebitis **to prevent embolization.**
- Emphasize importance of avoiding use of aspirin, some OTC drugs, vitamins containing potassium, mineral oil, or alcohol when taking anticoagulants.
- Review medical regimen and appropriate safety measures (e.g., use of electric razor when taking anticoagulants).
- Discuss preventing exposure to cold, dressing warmly and use of natural fibers **to retain heat more efficiently.**
- Provide preoperative teaching appropriate for the situation.
- Refer to specific support groups, counseling as appropriate.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, noting nature/extent and duration of problem, effect on independence/lifestyle.
- Characteristics of pain, precipitators, and what relieves pain.
- Vital signs, cardiac rhythm/dysrhythmias.
- Pulses/BP, including above/below suspected lesion as appropriate.
- I/O and weight as indicated.

PLANNING

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

IMPLEMENTATION/EVALUATION

- Response to interventions/teaching, 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.
- Available resources, specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

CARDIOPULMONARY

NOC—Tissue Perfusion: Cardiac
NIC—Cardiac Care

CEREBRAL

NOC—Tissue Perfusion: Cerebral
NIC—Cerebral Perfusion Promotion

RENAL

NOC—Urinary
NIC—Fluid/Electrolyte Management

GASTROINTESTINAL

NOC—Tissue Perfusion: Abdominal Organ
NIC—Nutrition Management

PERIPHERAL

NOC—Tissue Perfusion: Peripheral
NIC—Circulatory Care: Arterial Insufficiency

Transfer Ability, impaired

Taxonomy II: Activity/Rest—Class 2 Activity/Exercise (00090)
[Diagnostic Division: Activity/Rest]

Definition: Limitation of independent movement between two nearby surfaces

Related Factors

To be developed by NANDA
[Conditions that result in poor muscle tone]
[Cognitive impairment]
[Fractures, trauma, spinal cord injury]

Defining Characteristics

SUBJECTIVE OR OBJECTIVE

Impaired ability to transfer: from bed to chair and chair to bed, chair to car or car to chair, chair to floor or floor to chair, standing to floor or floor to standing; on or off a toilet or commode; in and out of tub or shower, between uneven levels
Specify level of independence—[refer to ND Mobility, impaired physical, for suggested functional level classification]

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

Desired Outcomes/Evaluation Criteria—Patient/Caregiver Will:

- Verbalize understanding of situation and appropriate safety measures.
- Master techniques of transfer successfully.
- Make desired transfer safely.

Actions/Interventions

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

- Determine diagnosis that contributes to transfer problems (e.g., MS, fractures, back injuries, quadriplegia/paraplegia, agedness, dementias, brain injury, etc.).
- Note current situations such as surgery, amputation, contractures, traction apparatus, mechanical ventilation, multiple tubings that restrict movement.

NURSING PRIORITY NO. 2. To assess functional ability:

- Evaluate degree of impairment using 0 to 4 functional level classification.
- Note emotional/behavioral responses of patient/SO to problems of immobility.
- Determine presence/degree of perceptual/cognitive impairment and ability to follow directions.

NURSING PRIORITY NO. 3. To promote optimal level of movement:

- Assist with treatment of underlying condition causing dysfunction.
- Consult with PT/OT/rehabilitation team **in developing mobility aids and adjunctive devices.**
- Instruct in use of siderails, overhead trapeze, safety grab bars, cane walker, devices on the bed/chair that protect patient (e.g., call light, bed-positioning switch in easy reach), wheelchair, crutches, assisting as necessary.
- Provide instruction/reinforce information for patient and caregivers regarding positioning to improve/maintain balance when transferring.
- Monitor body alignment and balance and encourage wide base of support when standing to transfer.
- Use full-length mirror as needed **to facilitate patient's view of own postural alignment.**
- Demonstrate/reinforce safety measures as indicated, such as transfer board, gait belt, supportive footwear, good lighting, clearing floor of clutter, and so forth **to avoid possibility of fall and subsequent injury.**

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

- Assist patient/caregivers to learn safety measures as individually indicated (e.g., locking wheelchair before transfer, having scatter rugs removed from floor, using properly placed Hoyer lift, etc.).
- Refer to appropriate community resources for evaluation and modification of environment (e.g., shower/tub, uneven floor surfaces/steps, use of ramps/standing tables/lifts, etc.).

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including level of function/ability to participate in desired transfers.

PLANNING

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

IMPLEMENTATION/EVALUATION

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

DISCHARGE PLANNING

- Discharge/long-range needs, noting who is responsible for each action to be taken.
- Specific referrals made.
- Sources of/maintenance for assistive devices.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Transfer Performance
NIC—Transport

Trauma, risk for

Taxonomy II: Safety/Protection—Class 2 Physical Injury (00038)

[Diagnostic Division: Safety]

Definition: Accentuated risk of accidental tissue injury (e.g., wound, burn, fracture)

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

Risk Factors

INTERNAL (INDIVIDUAL)

Weakness; balancing difficulties; reduced large or small muscle coordination, hand/eye coordination
Poor vision
Reduced temperature and/or tactile sensation
Lack of safety education/precautions
Insufficient finances to purchase safety equipment or to effect repairs
Cognitive or emotional difficulties
History of previous trauma

EXTERNAL (ENVIRONMENTAL) [INCLUDES BUT IS NOT LIMITED TO]:

Slippery floors (e.g., wet or highly waxed; unanchored rug; litter or liquid spills on floors or stairways; snow or ice collected on stairs, walkways)
Bathtub without handgrip or antislip equipment
Use of unsteady ladder or chairs
Obstructed passageways; entering unlighted rooms
Unsturdy or absent stair rails; children playing without gates at top of stairs
Unanchored electric wires
High beds; inappropriate call-for-aid mechanisms for bed-resting client
Unsafe window protection in homes with young children
Pot handles facing toward front of stove; bathing in very hot water (e.g., unsupervised bathing of young children)
Potential igniting gas leaks; delayed lighting of gas burner or oven
Unscreened fires or heaters; wearing plastic apron or flowing clothing around open flames; highly flammable children's toys or clothing
Smoking in bed or near O_2; grease waste collected on stoves
Children playing with matches, candles, cigarettes
Playing with fireworks or gunpowder; guns or ammunition stored unlocked
Experimenting with chemical or gasoline; inadequately stored combustibles or corrosives (e.g., matches, oily rags, lye; contact with acids or alkalis)
Overloaded fuse boxes; faulty electrical plugs, frayed wires, or defective appliances; overloaded electrical outlets
Exposure to dangerous machinery; contact with rapidly moving machinery, industrial belts, or pulleys
Sliding on coarse bed linen or struggling within bed[/chair] restraints

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Contact with intense cold; overexposure to sun, sunlamps, radiotherapy
Use of thin or worn-out pot holders [or mitts]
Use of cracked dishware or glasses
Knives stored uncovered; children playing with sharp-edged toys
Large icicles hanging from roof
High-crime neighborhood and vulnerable clients
Driving a mechanically unsafe vehicle; driving at excessive speeds; driving without necessary visual aids
Driving after partaking of alcoholic beverages or [other] drugs
Children riding in the front seat of car, nonuse or misuse of seat restraints/[unrestrained infant/child riding in car]
Misuse [or nonuse] of necessary headgear for motorized cyclists or young children carried on adult bicycles
Unsafe road or road-crossing conditions; playing or working near vehicle pathways (e.g., driveways, lanes, railroad tracks)

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—Patient/Caregiver Will:

- Identify and correct potential risk factors in the environment.
- Demonstrate appropriate lifestyle changes to reduce risk of injury.
- Identify resources to assist in promoting a safe environment.
- Recognize need for/seek assistance to prevent accidents/injuries.

Actions/Interventions

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

- Determine factors related to individual situation and extent of risk/injuries sustained.
- Note age of individual, mentation, agility, impairment of mobility.
- Evaluate environment (home/work/transportation) for safety hazards.
- Assess interest and knowledge of the patient/caregivers regarding safety needs.
- Note history of accidents during given period, noting circumstances of the accident (e.g., time of day that falls occur, activities going on, who was present).

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- Assess influence of stress on potential for injury.
- Review potential risk factors (e.g., noise level/use of headphones, various inhalants and length of exposure time).
- Review laboratory studies and observe for signs/symptoms of endocrine/electrolyte imbalances **that may result in/exacerbate conditions, such as confusion, tetany, pathological fractures, and so on.**
- Determine presence/potential for hypothermia or hyperthermia, for example, induced (coma therapy/surgery) or accidental.

NURSING PRIORITY NO. 2. To promote safety measures required by individual situation:

- Orient patient to environment.
- Make arrangement for call system for bedridden patient in home and in hospital setting. Demonstrate use and place call bell/light within patient's reach.
- Keep bed in low position or place mattress on floor as appropriate.
- Use and pad siderails as indicated.
- Provide seizure precautions.
- Lock wheels on bed/movable furniture. Clear travel paths. Provide adequate area lighting.
- Assist with activities and transfers as needed.
- Provide well-fitting, nonskid footwear.
- Demonstrate/monitor use of assistive devices, such as cane, walker, crutches, wheelchair, safety bars.
- Provide supervision while patient is smoking.
- Provide for appropriate disposal of potentially injurious items (e.g., needles, scalpel blades).
- Apply/monitor use of restraints when required (e.g., vest, limb, belt, mitten).
- Refer to specific NDs as appropriate (e.g., Hypothermia; Mobility, impaired physical; Skin Integrity, impaired; Sensory Perception, disturbed; Thought Processes, disturbed; Body Temperature, risk for imbalanced; Home Maintenance, impaired).

NURSING PRIORITY NO. 3. To treat underlying medical/psychiatric condition:

- Provide positioning as required by situation (e.g., postcorneal lens surgery, immobilization of fractures).
- Assist with treatments for endocrine/electrolyte imbalance conditions. (**May improve cognition/muscle tone and general well-being.**)
- Provide quiet environment and reduced stimulation as indicated. **Helps limit confusion or overstimulation for patients at risk for such conditions as seizures, tetany, autonomic hyperreflexia.**

- Rewarm patient gradually when hypothermia is present. (Refer to ND Hypothermia.)
- Refer to counseling/psychotherapy, as need indicates, especially when individual is "accident-prone"/self-destructive behavior is noted. (Refer to NDs Violence, [actual/] risk for other-directed/self-directed.)

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

- Stress importance of changing position slowly and obtaining assistance when weak and when problems of balance, coordination, or postural hypotension are present **to reduce risk of syncope/falls.**
- Encourage use of warm-up/stretching exercises before engaging in athletic activity **to prevent muscle injuries.**
- Recommend use of seat belts, fitted helmets for cyclists, approved infant seat; avoidance of hitchhiking.
- Refer to accident prevention programs (e.g., driver training, parenting classes, firearms safety, and so forth).
- Develop fire safety program (e.g., family fire drills; use of smoke detectors; yearly chimney cleaning; purchase of fire-retardant clothing, especially children's nightwear; fireworks safety).
- Problem-solve with patient/parent to provide adequate child supervision after school, during working hours, and on school holidays.
- Discuss necessary environmental changes (e.g., decals on glass doors to show when they are closed, lowering temperature on hot water heater, adequate lighting of stairways) **to prevent/reduce risk of accidents.**
- Identify community resources (e.g., financial to **assist with necessary corrections/improvements/purchases).**
- Recommend involvement in community self-help programs such as Neighborhood Watch, Helping Hand.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual risk factors, past/recent history of injuries, awareness of safety needs.

PLANNING

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

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

IMPLEMENTATION/EVALUATION

- Responses to interventions/teaching, 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.
- Available resources, specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Safety Status: Physical Injury
NIC—Environmental Management: Safety

Unilateral Neglect

Taxonomy II: Perception/Cognition—Class 1 Attention (00123)
[Diagnostic Division: Neurosensory]

Definition: Lack of awareness and attention to one side of the body

Related Factors

Effects of disturbed perceptual abilities (e.g., [homonymous] hemianopsia, one-sided blindness; [or visual inattention])
Neurological illness or trauma
[Impaired cerebral blood flow]

Defining Characteristics

SUBJECTIVE

[Reports feeling that part does not belong to own self]

OBJECTIVE

Consistent inattention to stimuli on an affected side
Inadequate self-care [inability to satisfactorily perform ADLs]
[Lack of] positioning and/or safety precautions in regard to the affected side
Does not look toward affected side; [does not touch affected side]
Leaves food on plate on the affected side
[Failure to use the affected side of the body without being reminded to do so]

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

Desired Outcomes/Evaluation Criteria—Patient Will:

- Acknowledge presence of sensory-perceptual impairment.
- Verbalize positive realistic perception of self incorporating the current dysfunction.
- Identify adaptive/protective measures for individual situation.
- Perform self-care within level of ability.
- Demonstrate behaviors, lifestyle changes necessary to promote physical safety.

Actions/Interventions

NURSING PRIORTIY NO. **1.** To assess the extent of altered perception and the related degree of disability:

- Measure visual acuity and field of vision.
- Assess sensory awareness (e.g., response to stimulus of hot/cold, dull/sharp); note problems with awareness of motion and proprioception.
- Observe patient's behavior **to determine the extent of impairment.**
- Assess ability to distinguish between right and left.
- Note physical signs of neglect (e.g., disregard for position of affected limb(s), skin irritation/injury).
- Observe ability to function within limits of impairment. Compare with patient's perception of own abilities.
- Explore and encourage verbalization of feelings **to identify meaning of loss/dysfunction/change to the patient and impact it may have on assuming ADLs.**

NURSING PRIORITY NO. **2.** To promote optimal comfort and safety for the patient in the environment:

- Approach patient from the unaffected side during acute phase. Explain to patient that one side is being neglected; repeat as needed.
- Orient to physical environment.
- Remove excess stimuli from the environment when working with the patient.
- Encourage patient to turn head and eyes in full rotation and "scan" the environment **to compensate for visual field loss.**
- Position bedside table and objects (such as call bell, tissues) within functional field of vision.
- Position furniture and equipment so travel path is not obstructed. Keep doors wide open or completely closed.
- Remove articles in the environment that may create a safety hazard (e.g., footstool, throw rug).
- Ensure adequate lighting in the environment.

- Monitor affected body part(s) for positioning/anatomic alignment, pressure points/skin irritation/injury, and dependent edema. (**Increased risk of injury/ulcer formation necessitates close observation and timely intervention.**)
- Protect affected body part(s) from pressure/injury/burns, and help patient learn to assume this responsibility.

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

- Increase the amount of touch in providing patient care.
- Encourage the patient to look at and handle affected side **to stimulate awareness.**
- Bring the affected limb across the midline **for the patient to visualize during care.**
- Provide tactile stimuli to the affected side by touching/manipulating, stroking, and communicating about the affected side by itself rather than stimulating both sides simultaneously.
- Provide objects of various weight, texture, and size for the patient to handle.
- Assist the patient to position the affected extremity carefully and teach to routinely visualize placement of the extremity. Remind with visual cues. If the patient completely ignores one side of the body, use positioning to improve perception (e.g., position patient facing/looking at the affected side).
- Encourage patient to accept affected limb/side as part of self even when it no longer feels like it belongs.
- Use a mirror to help the patient adjust position **by visualizing both sides of the body.**
- Use descriptive terms to identify body parts rather than "left" and "right"; for example, "Lift this leg" (point to leg) or "Lift your affected leg."
- Describe where affected areas of body are when moving the patient.
- Acknowledge and accept feelings of despondency, grief, and anger. (**When feelings are openly expressed, patient can deal with them and move forward.**)
- Reinforce to patient the reality of the dysfunction and need to compensate.
- Avoid participating in the patient's use of denial.
- Encourage family members and SO(s) to treat patient normally and not as an invalid, including patient in family activities.
- Assist with ADLs, maximizing self-care potential. Help patient to bathe, apply lotion, and so forth to affected side.
- Place nonessential items (e.g., TV, pictures, hairbrush) on affected side during postacute phase once patient begins to cross midline **to encourage continuation of behavior.**

- Refer to/encourage patient to use rehabilitative services **to enhance independence in functioning.**
- Identify additional resources to meet individual needs (e.g., Meals on Wheels, home-care services) **to maximize independence, allow patient to return to community setting.**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including extent of altered perception, degree of disability, effect on independence/participation in ADLs.

PLANNING

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

IMPLEMENTATION/EVALUATION

- Responses to intervention/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.
- Available resources, specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Self—Care: Activities of Daily Living (ADL)
NIC—Unilateral Neglect Management

Urinary Elimination, impaired

Taxonomy II: Elimination—Class 1 Urinary System (00016)
[Diagnostic Division: Elimination]

Definition: Disturbance in urine elimination

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

Related Factors

Multiple causality; sensory motor impairment; anatomical obstruction; UTI; [mechanical trauma; fluid/volume states; psychogenic factors; surgical diversion]

Defining Characteristics

SUBJECTIVE

Frequency; urgency
Hesitancy
Dysuria
Nocturia, [enuresis]

OBJECTIVE

Incontinence
Retention

Desired Outcomes/Evaluation Criteria—Patient Will:

- Verbalize understanding of condition.
- Identify causative factors. (Refer to specific NDs for incontinence/retention as appropriate.)
- Achieve normal elimination pattern or participate in measures to correct/compensate for defects.
- Demonstrate behaviors/techniques to prevent urinary infection.
- Manage care of urinary catheter, or stoma and appliance following urinary diversion.

Actions/Interventions

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

- Identify physical diagnoses that may be involved such as surgery (including urinary diversion); neurological deficits such as MS, paraplegia/tetraplegia; mental/emotional dysfunction; prostate disease; recent/multiple pregnancies; cardiovascular disease; pelvic trauma; use of penile clamps (**may result in urethral trauma**).
- Determine whether problem is due to loss of neurological functioning or disorientation (e.g., Alzheimer's disease).
- Determine pathology of bladder dysfunction relative to medical diagnosis identified. (**For example, in neurological/demyelinating diseases such as MS, problem may be failure to store urine, empty bladder, or both.**)

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

- Inspect stoma of urinary diversion for edema, scarring, presence of congealed mucus.
- Review drug regimen. Note use of drugs that may be nephrotoxic (e.g., aminoglycosides, tetracyclines), especially in patients who are immunosuppressed. Also note those that may result in retention (e.g., atropine, belladonna).
- Note age and sex of patient. **(UTIs are more prevalent in women and older men.)**
- Rule out gonorrhea in men when urethritis with a penile discharge is present and there are no bacteria in the urine.
- Assist with antibody-coated bacteria assay **to diagnose bacterial infection of the kidney or prostate.**
- Review laboratory tests for hyperparathyroidism, changes in renal function, presence of infection.
- Strain all urine for calculi and describe stones expelled and/or send to laboratory for analysis.

NURSING PRIORITY NO. **2.** To assess degree of interference/disability:

- Determine patient's previous pattern of elimination and compare with current situation. Note reports of frequency, urgency, burning, incontinence, nocturia/enuresis, size and force of urinary stream.
- Palpate bladder **to assess retention.**
- Investigate pain, noting location, duration, intensity; presence of bladder spasms, back or flank pain, and so forth.
- Determine patient's usual daily fluid intake (both amount and beverage choices/use of caffeine). Note condition of skin and mucous membranes, color of urine **to help determine level of hydration.**

NURSING PRIORITY NO. **3.** To assist in treating/preventing urinary alteration:

- Refer to specific NDs Incontinence (specify), Urinary Retention.
- Encourage fluid intake up to 3000 to 4000 mL/day (within cardiac tolerance), including cranberry juice, **to help maintain renal function, prevent infection and formation of urinary stones, avoid encrustation around catheter, or to flush urinary diversion appliance.**
- Assist with developing toileting routines as appropriate.
- Encourage patient to void in sitz bath after surgical procedures of the perineal area. **(Warm water helps relax muscles and soothe sore tissues, facilitating voiding.)**
- Observe for signs of infection—cloudy, foul odor; bloody urine. Send urine (midstream clean-voided specimen) for culture and sensitivities as indicated.
- Encourage patient to verbalize fear/concerns (e.g., disruption in sexual activity, inability to work). **Open expression allows patient to deal with feelings and begin problem solving.**

- Monitor medication regimen, antimicrobials (single-dose is frequently being used for UTI), sulfonamides, antispasmodics, and so on, **to note patient's response, need to modify treatment.**
- Discuss surgical procedures and review medical regimen for patient with benign prostatic hypertrophy bladder/prostatic cancer, and so forth.

NURSING PRIORITY NO. **4.** To assist in management of long-term urinary alterations:

- Keep bladder deflated by use of an indwelling catheter connected to closed drainage. Investigate alternatives when possible (e.g., intermittent catheterization, surgical interventions, urinary drugs, voiding maneuvers, condom catheter).
- Provide latex-free catheter and care supplies **to reduce risk of latex sensitivity.**
- Check frequently for bladder distention and observe for overflow **to reduce risk of infection and/or autonomic hyperreflexia.**
- Maintain acidic environment of the bladder by the use of agents such as vitamin C, Mandelamine when appropriate **to discourage bacterial growth.**
- Adhere to a regular bladder/diversion appliance emptying schedule **to avoid accidents.**
- Provide for routine diversion appliance care, and assist patient to recognize and deal with problems such as alkaline salt encrustation, ill-fitting appliance, malodorous urine, infection, and so forth.

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

- Emphasize importance of keeping area clean and dry **to reduce risk of infection and/or skin breakdown.**
- Instruct female patients with UTI to drink large amounts of fluid, void immediately after intercourse, wipe from front to back, promptly treat vaginal infections, and take showers rather than tub baths **to limit risk/avoid reinfection.**
- Encourage SO(s) who participate in routine care to recognize complications (including latex allergy) necessitating medical interventions.
- Instruct in proper application and care of appliance for urinary diversion. Encourage liberal fluid intake, avoidance of foods/medications that produce strong odor, use of white vinegar or deodorizer in pouch **to promote odor control.**
- Identify sources for supplies, programs/agencies providing financial assistance to obtain needed equipment.
- Recommend avoidance of gas-forming foods in presence of ureterosigmoidostomy **as flatus can cause urinary incontinence.**

- Recommend use of silicone catheter when permanent/long-term catheterization is required.
- Demonstrate proper positioning of catheter drainage tubing and bag **to facilitate drainage/prevent reflux.**
- Refer patient/SO(s) to appropriate community resources such as ostomy specialist, support group, sex therapist, psychiatric clinical nurse specialist, and so on **to deal with changes in body image/function when indicated.**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including previous and current pattern of voiding, nature of problem, effect on desired lifestyle.

PLANNING

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

IMPLEMENTATION/EVALUATION

- Response to interventions/teaching, 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.
- Available resources/specific referrals made.
- Individual equipment needs and sources.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Urinary Elimination
NIC—Urinary Elimination Management

Urinary Incontinence, functional

Taxonomy II: Elimination—Class 1 Urinary System (00020)
[Diagnostic Division: Elimination]
Nursing Diagnosis Extension and Classification (NDEC) Revision 1998

Definition: Inability of usually continent person to reach toilet in time to avoid unintentional loss of urine

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

Related Factors

Altered environmental factors [e.g., poor lighting or inability to locate bathroom]
Neuromuscular limitations
Weakened supporting pelvic structures
Impaired vision/cognition
Psychological factors; [reluctance to use call light or bedpan]
[Increased urine production]

Defining Characteristics

SUBJECTIVE

Senses need to void
[Voiding in large amounts]

OBJECTIVE

Loss of urine before reaching toilet; amount of time required to reach toilet exceeds length of time between sensing urge and uncontrolled voiding
Able to completely empty bladder
May only be incontinent in early morning

Desired Outcomes/Evaluation Criteria—Patient Will:

- Verbalize understanding of condition and identify interventions to prevent incontinence.
- Alter environment to accommodate individual needs.
- Report voiding in individually appropriate amounts.
- Urinate at acceptable times and places.

Actions/Interventions

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

- Determine if patient is voluntarily postponing urination.
- Review history for disease, use of medication/substances known to increase urine output and/or alter bladder tone (e.g., diabetes mellitus, prolapsed bladder, diuretics, alcohol, caffeine).
- Test urine with Chemstix to note presence of glucose, **which can cause polyuria and result in overdistention of the bladder.**
- Determine the difference between the time it takes to get to the bathroom/remove clothing and the time between urge and involuntary loss of urine.

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

- Review disease process and medications. **Could affect mental status/orientation to place, recognition of urge to void, and/or its significance.**
- Identify environmental conditions that interfere with timely access to bathroom/successful toileting process. **Factors such as unfamiliar surroundings, dexterity problems, poor lighting, improperly fitted chair walker, low toilet seat, absence of safety bars, and travel distance to toilet may affect self-care ability.**

NURSING PRIORITY NO. **2.** To assess degree of interference/disability:

- Assist patient to keep voiding diary. Determine the frequency and timing of continent/incontinent voids.
- Measure/estimate amount of urine voided or lost with incontinence.
- Examine urine for signs of bacteriuria (e.g., cloudy/hazy).
- Ascertain effect on lifestyle (including socialization and sexuality) and self-esteem.

NURSING PRIORITY NO. **3.** To assist in treating/preventing incontinence:

- Administer prescribed diuretics in the morning **to lessen nighttime voidings.**
- Reduce or eliminate use of hypnotics if possible, **as patient may be too sedated to recognize/respond to urge to void.**
- Provide means of summoning assistance (e.g., call light or bell).
- Adapt clothes for quick removal: Velcro fasteners, full skirts, crotchless panties or no panties, suspenders or elastic waists instead of belts on pants. **Facilitates toileting once urge to void is noted.**
- Use night-lights **to mark bathroom location.**
- Provide cues such as adequate room lighting, signs, color coding of door, **to assist patient who is disoriented to find the bathroom.**
- Remove throw rugs, excess furniture in travel path to bathroom.
- Raise chair and/or toilet seat.
- Provide bedside commode, urinal, or bedpan as indicated.
- Schedule voiding for every 3 hours **to minimize bladder pressure.**
- Restrict fluid intake 2 to 3 hours before bedtime **to reduce voiding during the night.**
- Instruct in pelvic floor strengthening exercises as appropriate.
- Implement bladder training program as indicated.
- Include physical/occupational therapist in determining ways to alter environment, appropriate assistive devices to meet patient's individual needs.

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

- Discuss need to respond immediately to urge to void.
- Suggest limiting intake of coffee, tea, and alcohol **because of diuretic effect and impact on voiding pattern.**
- Review use/intake of foods, fluids, and supplements containing potassium. **Potassium deficiency can negatively affect bladder tone.**
- Emphasize importance of perineal care following voiding.
- Maintain positive regard **to reduce embarrassment associated with incontinence, need for assistance, use of bedpan.**
- Promote participation in developing long-term plan of care.
- Refer to NDs Urinary Incontinence, reflex; Urinary Incontinence, stress; Urinary Incontinence, total; Urinary Incontinence, urge.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Current elimination pattern/assessment findings and effect on lifestyle and self-esteem.

PLANNING

- Plan of care 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

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Urinary Continence
NIC—Prompted Voiding

Urinary Incontinence, reflex

Taxonomy II: Elimination—Class 1 Urinary System (00018)
[Diagnostic Division: Elimination]
Nursing Diagnosis Extension and Classification (NDEC) Revision 1998

Definition: Involuntary loss of urine at somewhat predictable intervals when a specific bladder volume is reached

Related Factors

Tissue damage from radiation cystitis, inflammatory bladder conditions, or radical pelvic surgery
Neurological impairment above level of sacral or pontine micturition center

Defining Characteristics

SUBJECTIVE

No sensation of bladder fullness/urge to void/voiding
Sensation of urgency without voluntary inhibition of bladder contraction
Sensations associated with full bladder such as sweating, restlessness, and abdominal discomfort

OBJECTIVE

Predictable pattern of voiding
Inability to voluntarily inhibit or initiate voiding
Complete emptying with [brain] lesion above pontine micturition center
Incomplete emptying with [spinal cord] lesion above sacral micturition center

Desired Outcomes/Evaluation Criteria—Patient Will:

- Verbalize understanding of condition/contributing factors.
- Establish bladder regimen appropriate for individual situation.
- Demonstrate behaviors/techniques to control condition and prevent complications.
- Urinate at acceptable times and places.

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

Actions/Interventions

NURSING PRIORITY NO. 1. To assess degree of interference/disability:

- Note causative/disease process as listed in Related Factors.
- Evaluate for concomitant urinary retention.
- Assess ability to sense bladder fullness, awareness of incontinence.
- Review voiding diary if available or record frequency and time of urination. Compare timing of voidings, particularly in relation to liquid intake and medications.
- Measure amount of each voiding **because incontinence often occurs once a specific bladder volume is achieved.**
- Evaluate ability to manipulate/use urinary collection device or catheter.
- Refer to urologist/appropriate specialist for testing of sphincter control and volumes.

NURSING PRIORITY NO. 2. To assist in managing incontinence:

- Encourage minimum of 1500 to 2000 mL of fluid intake daily. Regulate liquid intake at prescheduled times (with and between meals) **to promote predictable voiding pattern.**
- Restrict fluids 2 to 3 hours before bedtime **to reduce voiding during sleep.**
- Instruct patient, or take to toilet before the expected time of incontinence, **in an attempt to stimulate the reflex for voiding.**
- Instruct in measures such as pouring warm water over perineum, running water in sink, stimulating/massaging skin of lower abdomen, thighs, and so on **to stimulate voiding reflexes.**
- Set alarm to awaken during night **to maintain schedule,** or use external catheter as appropriate.
- Demonstrate application of external collection device or intermittent self-catheterization using small-lumen straight catheter if condition indicates.
- Establish intermittent catheterization schedule based on patient's activity schedule as indicated.
- Measure postvoid residuals/catheterization volumes. **Determines frequency for emptying bladder.**

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

- Encourage continuation of regular toileting program.
- Suggest use of incontinence pads/pants during day and social contact, if appropriate, dependent on patient's activity level, amount of urine loss, manual dexterity, and cognitive ability.
- Stress importance of perineal care following voiding and frequent changing of incontinence pads if used.
- Encourage limited intake of coffee, tea, and alcohol **because of diuretic effect, which may affect predictability of voiding pattern.**

- Instruct in proper care of catheter and clean techniques **to reduce risk of infection.**
- Review signs/symptoms of urinary complications and need for medical follow-up.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Findings/degree of disability and effect on lifestyle.

PLANNING

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

IMPLEMENTATION/EVALUATION

- Responses to treatment plan/interventions 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.
- Available resources, equipment needs/sources.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Urinary Continence
NIC—Urinary Bladder Training

Urinary Incontinence, stress

Taxonomy II: Elimination—Class 1 Urinary System (00017)
[Diagnostic Division: Elimination]

Definition: Loss of less than 50 mL of urine occurring with increased abdominal pressure

Related Factors

Degenerative changes in pelvic muscles and structural supports associated with increased age [e.g., poor closure of urethral sphincter, estrogen deficiency]

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

High intra-abdominal pressure (e.g., obesity, gravid uterus)
Incompetent bladder outlet; overdistention between voidings
Weak pelvic muscles and structural supports [e.g., straining with chronic constipation]
[Neural degeneration, vascular deficits, surgery, radiation therapy]

Defining Characteristics

SUBJECTIVE

Reported dribbling with increased abdominal pressure [e.g., coughing, sneezing, lifting, impact aerobics, changing position]
Urinary urgency; frequency (more often than every 2 hours)

OBJECTIVE

Observed dribbling with increased abdominal pressure

Desired Outcomes/Evaluation Criteria—Patient Will:

- Verbalize understanding of condition and interventions for bladder conditioning.
- Demonstrate behaviors/techniques to strengthen pelvic floor musculature.
- Remain continent even with increased intra-abdominal pressure.

Actions/Interventions

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

- Identify physiological causes of increased intra-abdominal pressure (e.g., obesity, gravid uterus). Note contributing history such as multiple births, bladder or pelvic trauma/repairs.
- Assess for urine loss with coughing or sneezing, relaxed pelvic musculature and support, noting inability to start/stop stream while voiding, bulging of perineum when bearing down. Refer to urologic specialists **for sphincter weakness or hypermobility testing.**
- Catheterize as indicated **to rule out the possibility of postvoid residuals.**

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

NURSING PRIORITY NO. 2. To assess degree of interference/disability:

- Observe voiding patterns, time and amount voided, and stimulus provoking incontinence. Review voiding diary if available.
- Prepare for/assist with appropriate testing (e.g., cystoscopy, cystometrogram).
- Determine effect on lifestyle (including socialization and sexuality) and self-esteem.
- Ascertain methods of self-management (e.g., limiting liquid intake, using undergarment protection).
- Assess for concomitant urge or functional incontinence, noting whether bladder irritability, reduced bladder capacity, or voluntary overdistention is present. (Refer to appropriate NDs.)

NURSING PRIORITY NO. 3. To assist in treating/preventing incontinence:

- Assist with medical treatment of underlying urological condition as indicated (surgery, medications, biofeedback, and so on).
- Suggest starting and stopping stream 2 or 3 times during voiding **to isolate muscles involved in voiding process for exercise training.**
- Encourage regular pelvic floor strengthening exercises (Kegel exercises or use of vaginal cones). Combine activity with biofeedback as appropriate **to enhance training.**
- Incorporate "bent-knee sit-ups" into exercise program **to increase abdominal muscle tone.**
- Suggest that patient urinate at least every 3 hours during the day **to reduce bladder pressure.** Recommend consciously delaying voiding as appropriate **to slowly achieve desired 3- to 4-hour intervals between voids.**
- Restrict intake 2 to 3 hours prior to bedtime **to decrease incontinence during sleep.**

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

- Encourage limiting use of coffee/tea and alcohol **because of diuretic effect, which may lead to bladder distention, increasing likelihood of incontinence.**
- Suggest use of incontinence pads/pants as needed. Consider patient's activity level, amount of urine loss, physical size, manual dexterity, and cognitive ability **to determine specific product choices best suited to individual situation and needs.**
- Stress importance of perineal care following voiding and frequent changing of incontinence pads **to prevent irritation and infection.** Recommend application of oil-based emollient **to protect skin from irritation.**
- Avoid/limit participation in activities such as heavy lifting, impact aerobics **that increase intra-abdominal pressure.** Substitute swimming, bicycling, or low-impact exercise.

- Refer to weight-loss program/support group **when obesity is a contributing factor.**
- Review use of sympathomimetic drugs, if prescribed, **to improve resting tone of the bladder neck and proximal urethra.**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Findings/pattern of incontinence and physical factors present.
- Effect on lifestyle and self-esteem.
- Patient understanding of condition.

PLANNING

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

IMPLEMENTATION/EVALUATION

- Responses to interventions/teaching, actions performed, and changes that are identified.
- Attainment/progress toward desired outcome(s).
- Modifications to plan of care.

DISCHARGE PLANNING

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Urinary Continence
NIC—Pelvic Muscle Exercise

Urinary Incontinence, total

Taxonomy II: Elimination—Class 1 Urinary System (00021)
[Diagnostic Division: Elimination]

Definition: Continuous and unpredictable loss of urine

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

Related Factors

Neuropathy preventing transmission of reflex [signals to the reflex arc] indicating bladder fullness
Neurological dysfunction [e.g., cerebral lesions] causing triggering of micturition at unpredictable times
Independent contraction of detrusor reflex due to surgery
Trauma or disease affecting spinal cord nerves [destruction of sensory or motor neurons below the injury level]
Anatomic (fistula)

Defining Characteristics

SUBJECTIVE

Constant flow of urine at unpredictable times without uninhibited bladder contractions/spasm or distention
Nocturia
Lack of perineal or bladder filling awareness
Unawareness of incontinence

OBJECTIVE

Unsuccessful incontinence refractory treatments

Desired Outcomes/Evaluation Criteria—Patient/Caregiver Will:

- Verbalize awareness of causative/contributing factors.
- Establish bladder regimen for individual situation.
- Demonstrate behaviors, techniques to manage condition and to prevent complications.
- Manage incontinence so that social functioning is regained/maintained.

Actions/Interventions

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

- Determine if patient is aware of incontinence.
- Be aware of/note effect of medical history of global neurological impairment, neuromuscular trauma after surgery/radiation therapy, or presence of fistula.
- Determine concomitant chronic retention (e.g., palpate bladder, ultrasound scan/catheterize for residual).
- Carry out/assist with procedures/tests (e.g., cystoscopy, cystogram) **to establish diagnosis/identify appropriateness of surgical repair.**

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

NURSING PRIORITY NO. 2. To assess degree of interference/disability:

- Toilet patient every 2 hours and note time of voiding and incontinence **to determine pattern of urination.**
- Ascertain effect of condition on lifestyle and self-esteem.
- Inspect skin **for areas of erythema/excoriation.**
- Review history for past interventions regarding alterations in urinary elimination.

NURSING PRIORITY NO. 3. To assist in preventing/managing incontinence:

- Encourage at least 1500 to 2000 mL liquid intake per day. Regulate liquid intake at prescheduled times (with and between meals) **to promote predictable voiding pattern.**
- Restrict intake 2 to 3 hours before bedtime **to reduce voiding during sleep.**
- Establish voiding schedule by toileting at same time as recorded voidings and 30 minutes earlier than recorded time of incontinence.
- Encourage measures such as pouring warm water over perineum, running water in sink, massaging lower abdomen **to stimulate voiding.** (**Note:** This may not be successful if reflex is not intact.)
- Adjust schedule, once continent, by increasing voiding time in 30-minute increments **to achieve desired 3- to 4-hour intervals between voids.**
- Use condom catheter or female cone during the day and pad the bed during the night if external device is not tolerated.
- Establish intermittent catheterization schedule if condition requires.

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

- Assist patient to identify regular period of time for voiding **to establish elimination program.**
- Suggest use of adult briefs as indicated (e.g., during social contacts) **for extra protection and to enhance confidence.**
- Stress importance of pericare after each voiding (using alcohol-free products) and application of oil-based emollient **to protect the skin from irritation.**
- Demonstrate techniques of clean intermittent self-catheterization (CISC) using small-lumen straight catheter (or Mitrofanoff continent urinary channel for patients not able to catheterize themselves) as indicated.
- Instruct in proper care of catheter and clean technique **to prevent infection.**
- Recommend use of silicone catheter when long-term/continuous placement is indicated after other measures/bladder training have failed.

- Encourage self-monitoring of catheter patency and avoidance of reflux of urine. **Reduces risk of infection.**
- Suggest intake of acidifying juices **to discourage bacterial growth/adherence to bladder wall.**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Current elimination pattern.
- Assessment findings including effect on lifestyle and self-esteem.

PLANNING

- Plan of care/interventions, including 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 plan/long-term needs and who is responsible for actions to be taken.
- Specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Urinary Continence
NIC—Urinary Incontinence Care

Urinary Incontinence, urge

Taxonomy II: Elimination—Class 1 Urinary System (00019)

[Diagnostic Division: Elimination]

Definition: Involuntary passage of urine occurring soon after a strong sense of urgency to void

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

Related Factors

Decreased bladder capacity (e.g., history of pelvic inflammatory disease—PID, abdominal surgeries, indwelling urinary catheter)
Irritation of bladder stretch receptors causing spasm (e.g., bladder infection, [atrophic urethritis, vaginitis]; alcohol, caffeine, increased fluids; increased urine concentration; overdistention of bladder
[Medication use, such as diuretics, sedatives, anticholinergic agents]
[Constipation/stool impaction]
[Restricted mobility; psychological disorder such as depression, change in mentation/confusional state, e.g., stroke, dementia, Parkinson's disease]

Defining Characteristics

SUBJECTIVE

Urinary urgency
Frequency (voiding more often than every 2 hours)
Bladder contracture/spasm
Nocturia (more than 2 times per night)

OBJECTIVE

Inability to reach toilet in time
Voiding in small amounts (<100 cc) or in large amounts (>550 cc)

Desired Outcomes/Evaluation Criteria—Patient Will:

- Verbalize understanding of condition.
- Demonstrate behaviors/techniques to control/correct situation.
- Report increase in interval between urge and involuntary loss of urine.
- Void every 3 to 4 hours in individually appropriate amounts.

Actions/Interventions

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

- Assess for signs and symptoms of bladder infection (e.g., cloudy, odorous urine; bacteriuria).
- Determine use/presence of bladder irritants (e.g., significant intake of alcohol or caffeine, resulting in increased output or concentrated urine).

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

- Determine whether there is a history of long-standing habits or medical conditions that may reduce bladder capacity (e.g., severe PID, abdominal surgeries, recent/lengthy use of indwelling urinary catheter, or frequent voluntary voiding).
- Note factors that may affect ability to respond to urge to void (e.g., impaired mobility, use of sedation).
- Clinitest urine for glucose. **Presence of glucose in urine causes polyuria, resulting in overdistention of the bladder.**
- Assess for concomitant functional incontinence. Refer to ND Urinary Incontinence, functional.
- Palpate bladder for overdistention. Rule out high postvoid residuals via palpation/catheterization.
- Prepare for/assist with appropriate testing (e.g., urinalysis, cystometrogram).

NURSING PRIORITY NO. 2. To assess degree of interference/disability:

- Measure amount of urine voided, especially noting amounts less than 100 cc or greater than 550 cc.
- Record frequency and degree of urgency.
- Note length of warning time between initial urge and loss of urine.
- Ascertain effect on lifestyle (including socialization and sexuality) and self-esteem.

NURSING PRIORITY NO. 3. To assist in treating/preventing incontinence:

- Increase fluid intake to 1500 to 2000 mL/day.
- Regulate liquid intake at prescheduled times (with and between meals) **to promote predictable voiding pattern.**
- Provide assistance/devices as indicated for patients who are mobility impaired (e.g., provide means of summoning assistance; place bedside commode, urinal, or bedpan within patient's reach).
- Establish schedule for voiding (habit training) based on patient's usual voiding pattern.
- Instruct patient to tighten pelvic floor muscles before arising from bed. **Helps prevent loss of urine as abdominal pressure changes.**
- Suggest starting and stopping stream two or more times during voiding **to isolate muscles involved in voiding process for exercise training.**
- Encourage regular pelvic floor strengthening exercise (Kegel exercises or use of vaginal cones). Combine activity with biofeedback as appropriate **to enhance effectiveness of training.**
- Set alarm to awaken during night if indicated, **to continue voiding schedule.**
- Recommend consciously delaying voiding **to gradually increase intervals between voiding to every 2 to 4 hours.**

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

- Suggest limiting intake of coffee/tea and alcohol **because of irritating effect on the bladder.**
- Recommend use of incontinence pads/pants if necessary, considering patient's level of activity, amount of urine loss, physical size, manual dexterity, and cognitive ability.
- Suggest wearing loose-fitting or especially adapted clothing **to facilitate response to voiding urge.**
- Emphasize importance of perineal care after each voiding **to prevent skin irritation.**
- Identify signs/symptoms indicating urinary complications and need for medical follow-up.
- Review use of anticholinergics, if prescribed, **to increase warning time by blocking impulses within the sacral reflex arc.**
- Discuss possible surgical intervention or use of electronic stimulation therapy **to induce bladder contraction/inhibit detrusor overactivity as appropriate.**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including pattern of incontinence, effect on lifestyle and self-esteem.

PLANNING

- Plan of care/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 and who is responsible for actions to be taken.
- Specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Urinary Continence
NIC—Urinary Habit Training

Urinary Incontinence, risk for urge

Taxonomy II: Elimination—Class 1 Urinary System (00022)
[Diagnostic Division: Elimination]
Nursing Diagnosis Extension and Classification (NDEC) Submission 1998

Definition: At risk for an involuntary loss of urine associated with a sudden, strong sensation or urinary urgency

Risk Factors

Effects of medications; caffeine; alcohol
Detrusor hyperreflexia from cystitis, urethritis, tumors, renal calculi, CNS disorders above pontine micturition center
Detrusor muscle instability with impaired contractility; involuntary sphincter relaxation
Ineffective toileting habits
Small bladder capacity

Desired Outcomes/Evaluation Criteria—Patient Will:

- Identify individual risk factors and appropriate interventions.
- Demonstrate behaviors or lifestyle changes to prevent development of problem.

Actions/Interventions

NURSING PRIORITY NO. **1.** To assess potential for developing incontinence:

- Determine use/presence of bladder irritants (e.g., significant intake of alcohol or caffeine, resulting in increased output or concentrated urine).
- Review history for long standing habits or medical conditions that may reduce bladder capacity, (e.g., impaired mobility, use of sedation).
- Note factors that may affect ability to respond to urge to void (e.g., impaired mobility, use of sedation).
- Prepare for/assist with appropriate testing (e.g., urinalysis, cystometrogram) **to evaluate voiding pattern, identify pathology.**

NURSING PRIORITY NO. **2.** To prevent occurrence of problem:

- Measure amount of urine voided, especially noting amounts less than 100 mL or greater than 550 mL.

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

- Record intake and frequency/degree of urgency of voiding.
- Ascertain patient's awareness/concerns about developing problem and whether lifestyle is affected (e.g., socialization, sexual patterns).
- Regulate liquid intake at prescheduled times (with and between meals) **to promote predictable voiding pattern.**
- Establish schedule for voiding (habit training) based on patient's usual voiding pattern.
- Provide assistance/devices as indicated for patients who are mobility impaired (e.g., provide means of summoning assistance; place bedside commode, urinal, or bedpan within patient's reach).
- Instruct patient to tighten pelvic floor muscles before arising from bed. **Helps prevent loss of urine as abdominal pressure changes.**
- Suggest starting and stopping stream two or more times during voiding **to isolate muscles involved in voiding process for exercise training.**
- Encourage regular pelvic floor strengthening exercise (Kegel exercises or use of vaginal cones). Combine activity with biofeedback, as appropriate, **to enhance effectiveness of training.**

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

- Recommend limiting intake of coffee/tea and alcohol **because of their irritating effect on the bladder.**
- Suggest wearing loose-fitting or especially adapted clothing **to facilitate response to voiding urge.**
- Emphasize importance of perineal care after each voiding **to reduce risk of ascending infection.**
- Discuss use of hormone (conjugated estrogens—Premarin) creme vaginally **to strengthen urethral tissues as appropriate.**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including specific risk factors and pattern of voiding.

PLANNING

- Plan of care/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 and who is responsible for actions to be taken.
- Specific referrals made.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Urinary Continence
NIC—Urinary Habit Training

Urinary Retention [acute/chronic]

Taxonomy II: Elimination—Class 1 Urinary System (00023)
[Diagnostic Division: Elimination]

Definition: Incomplete emptying of the bladder

Related Factors

High urethral pressure caused by weak[/absent] detrusor
Inhibition of reflex arc
Strong sphincter; blockage [e.g., benign prostatic hypertrophy-BPH, perineal swelling]
[Habituation of reflex arc]
[Infections]
[Neurological diseases/trauma]
[Use of medications with side effect of retention (e.g., atropine, belladonna, psychotropics, antihistamines, opiates)]

Defining Characteristics

SUBJECTIVE

Sensation of bladder fullness
Dribbling
Dysuria

OBJECTIVE

Bladder distention
Small, frequent voiding or absence of urine output

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

Residual urine [150 mL or more]
Overflow incontinence
[Reduced stream]

Desired Outcomes/Evaluation Criteria—Patient Will:

- Verbalize understanding of causative factors and appropriate interventions for individual situation.
- Demonstrate techniques/behaviors to alleviate/prevent retention.
- Void in sufficient amounts with no palpable bladder distention; experience no postvoid residuals greater than 50 mL; have no dribbling/overflow.

Actions/Interventions

ACUTE

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

- Note presence of pathological conditions (**e.g., neurological disease, infection, stone formation**).
- Assess for effects of medication, such as psychotropics, anesthesia, opiates, sedatives, antihistamines.
- Determine anxiety level (e.g., **patient may be too embarrassed to void in presence of others**).
- Examine for fecal impaction, surgical site swelling, postpartal edema, vaginal or rectal packing, enlarged prostate or other "mechanical" factors **that may produce a blockage of the urethra.**
- Evaluate general hydration status.

NURSING PRIORITY NO. **2.** To determine degree of interference/disability:

- Determine if there has been any significant urine output in the last 6 to 8 hours.
- Palpate height of the bladder.
- Note recent amount/type of fluid intake.
- Ascertain whether patient has sensation of bladder fullness, level of discomfort.

NURSING PRIORITY NO. **3.** To assist in treating/preventing retention:

- Relieve pain by administering appropriate medications and measures **to reduce swelling/treat underlying cause.**
- Sit upright on bedpan/commode or stand **to provide functional position of voiding.**
- Provide privacy.

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

- Use ice techniques, spirits of wintergreen, stroking inner thigh, running water in sink or warm water over perineum **to stimulate reflex arc.**
- Remove blockage if possible (e.g., vaginal packing, bowel impaction). Prepare for more aggressive intervention (e.g., surgery/prostatectomy).
- Catheterize with intermittent or indwelling catheter **to resolve acute retention.**
- Drain bladder slowly with straight catheter in increments of 200 mL at a time **to prevent possibility of occurrence of hematuria, syncope.**
- Observe for signs of infection/send urine to laboratory for culture as indicated.
- Reduce recurrences by controlling causative/contributing factors when possible (e.g., ice to perineum, use of stool softeners/laxatives, change of medication/dosage).

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

- Encourage patient to report problems immediately **so treatment can be instituted promptly.**
- Emphasize need for adequate fluid intake.

CHRONIC

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

- Review medical history for diagnoses such as prostatic hypertrophy, scarring, recurrent stone formation **that may suggest detrusor muscle atrophy and/or chronic overdistention because of outlet obstruction.**
- Determine presence of weak or absent sensory and/or motor impulses (as with CVAs, spinal injury, or diabetes).
- Evaluate customary fluid intake.
- Assess for effects of psychotropics, antihistamines, atropine, belladonna, and so forth.
- Strain urine **for presence of stones/calculi.**

NURSING PRIORITY NO. **2.** To determine degree of interference/disability:

- Measure amount voided and postvoid residuals.
- Determine frequency and timing of dribbling and/or voiding.
- Note size and force of urinary stream.
- Palpate height of bladder.
- Determine presence of bladder spasms.
- Ascertain effect of condition on functioning/lifestyle.

NURSING PRIORITY NO. 3. To assist in treating/preventing retention:

- Recommend patient void on timed schedule.
- Demonstrate and instruct patient/SO(s) in use of Credé's maneuver **to facilitate emptying of the bladder.**
- Encourage patient to use Valsalva's maneuver if appropriate **to increase intra-abdominal pressure.**
- Establish regular voiding/self-catheterization program **to prevent reflux and increased renal pressures.**

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

- Establish regular schedule for bladder emptying whether voiding or using catheter.
- Stress need for adequate fluid intake, including use of acidifying fruit juices or ingestion of vitamin C/Mandelamine **to discourage bacterial growth and stone formation.**
- Instruct patient/SO(s) in clean intermittent catheterization (CIC) techniques.
- Review signs/symptoms of complications requiring medical evaluation/intervention.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including nature of problem, degree of impairment, and whether patient is incontinent.

PLANNING

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

IMPLEMENTATION/EVALUATION

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

DISCHARGE PLANNING

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Urinary Elimination
NIC—Urinary Retention Care

Ventilation, impaired spontaneous

Taxonomy II: Activity/Rest—Class 2
Cardiovascular/Pulmonary Response (00033)
[Diagnostic Division: Respiration]

Definition: Decreased energy reserves results in an individual's inability to maintain breathing adequate to support life

Related Factors

Metabolic factors; [hypermetabolic state (e.g., infection), nutritional deficits/depletion of energy stores]
Respiratory muscle fatigue
[Airway size/resistance; problems with secretion management]

Defining Characteristics

SUBJECTIVE

Dyspnea
Apprehension

OBJECTIVE

Increased metabolic rate
Increased heart rate
Increased restlessness
Decreased cooperation
Increased use of accessory muscles
Decreased tidal volume
Decreased Po_2; Sao_2
Increased Pco_2

Desired Outcomes/Evaluation Criteria—Patient Will:

- Reestablish/maintain effective respiratory pattern via ventilator with absence of retractions/use of accessory muscles, cyanosis, or other signs of hypoxia; and with ABGs/Sao_2 within acceptable range.
- Participate in efforts to wean (as appropriate) within individual ability.

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

Caregiver Will:

- Demonstrate behaviors necessary to maintain respiratory function.

Actions/Interventions

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

- Investigate etiology of respiratory failure **to determine patient's future capabilities, ventilation needs, and most appropriate type of ventilatory support.**
- Assess spontaneous respiratory pattern, noting rate, depth, rhythm, symmetry of chest movement, use of accessory muscles **to measure work of breathing.**
- Auscultate breath sounds, noting presence/absence and equality of breath sounds, adventitious breath sounds.
- Obtain ABGs, pulmonary function studies as appropriate.
- Review chest x-ray and magnetic resonance imaging/computed tomography (MRI/CT) scan results if done.
- Note response to respiratory therapy (e.g., bronchodilators, supplemental oxygen, IPPB treatments).

NURSING PRIORITY NO. 2. To provide/maintain ventilatory support:

- Observe overall breathing pattern, distinguishing between spontaneous respirations and ventilator breaths.
- Administer sedation as required **to synchronize respirations and reduce work of breathing/energy expenditure.**
- Count patient's respirations for 1 full minute and compare to desired/ventilator set rate.
- Verify that patient's respirations are in phase with the ventilator. **Decreases work of breathing, maximizes O_2 delivery.**
- Inflate tracheal/endotracheal tube cuff properly using minimal leak/occlusive technique. Check cuff inflation every 4 to 8 hours and whenever cuff is deflated/reinflated **to prevent risk associated with under/overinflation.**
- Check tubing for obstruction (e.g., kinking or accumulation of water). Drain tubing as indicated; avoid draining toward the patient, or back into the reservoir **resulting in contamination/providing medium for growth of bacteria.**
- Check ventilator alarms for proper functioning. Do not turn off alarms, even for suctioning. Remove from ventilator and ventilate manually if source of ventilator alarm cannot be quickly identified and rectified. Verify that alarms can be heard in the nurses' station by care providers.
- Assess ventilator settings routinely and readjust as indicated according to patient's primary disease and results of diagnostic testing.

- Verify that oxygen line is in proper outlet/tank; monitor inline oxygen analyzer or perform periodic oxygen analysis.
- Note tidal volume (10 to 15 mL/kg). Verify proper function of spirometer, bellows, or computer readout of delivered volume. Note alterations from desired volume delivery **to determine alteration in lung compliance or leakage through machine/around tube cuff (if used).**
- Monitor airway pressure **for developing complications/equipment problems.**
- Monitor inspiratory and expiratory (I:E) ratio.
- Promote maximal ventilation of alveoli; check sigh rate intervals (usually 1½ to 2 times tidal volume). **Reduces risk of atelectasis, helps mobilize secretions.**
- Note inspired humidity and temperature; maintain hydration **to liquefy secretions facilitating removal.**
- Auscultate breath sounds periodically. Note frequent crackles or rhonchi that do not clear with coughing/suctioning **because they may indicate developing complications (atelectasis, pneumonia, acute bronchospasm, pulmonary edema).**
- Suction as needed **to clear secretions.**
- Note changes in chest symmetry. **May indicate improper placement of ET tube, development of barotrauma.**
- Keep resuscitation bag at bedside and ventilate manually whenever indicated (e.g., if patient is removed from ventilator or troubleshooting equipment problems).
- Administer and monitor response to medications that promote airway patency and gas exchange.

NURSING PRIORITY NO. 3. To prepare for/assist with weaning process if appropriate:

- Determine physical/psychological readiness to wean, including specific respiratory parameters; presence/absence of infection, cardiac failure, nutritional status.
- Explain weaning activities/techniques, individual plan and expectations. **Reduces fear of unknown.**
- Elevate head of bed/place in orthopedic chair if possible, or position **to alleviate dyspnea and to facilitate oxygenation.**
- Assist patient in "taking control" of breathing if weaning is attempted or ventilatory support is interrupted during procedure/activity.
- Coach patient to take slower, deeper breaths, practice abdominal/pursed-lip breathing, assume position of comfort, and use relaxation techniques **to maximize respiratory function.**
- Assist patient to practice effective coughing, secretion management.
- Provide quiet environment, calm approach, undivided attention of nurse. **Promotes relaxation decreasing energy/oxygen requirements.**

- Involve family/SO(s) as appropriate. Provide diversional activity. **Helps patient focus on something other than breathing.**
- Instruct patient in use of energy-saving techniques during care activities, **to limit oxygen consumption/fatigue.**
- Acknowledge and provide ongoing encouragement for patient's efforts. Communicate hope for successful weaning response (even partial). **Enhances commitment to continue activity, maximizing outcomes.**

NURSING PRIORITY NO. **4.** To prepare for discharge on ventilator when indicated:

- Ascertain plan for discharge placement (e.g., return home, short-term/permanent placement in long-term care—LTC).
- Determine specific equipment needs. Identify resources for equipment needs/maintenance and arrange for delivery prior to patient discharge.
- Review layout of home, noting size of rooms, doorways; placement of furniture, number/type of electrical outlets **to identify necessary changes.**
- Obtain no-smoking signs to be posted in home. Encourage family members to refrain from smoking.
- Have family/SO(s) notify utilities company and fire department of presence of ventilator in home.
- Review and provide written materials regarding proper ventilator management, maintenance, and safety **for reference in home setting, enhancing patient's/SO's level of comfort.**
- Demonstrate airway management techniques and proper equipment cleaning practices.
- Instruct SO(s)/care provider in other pulmonary physiotherapy measures as indicated (e.g., chest physiotherapy—CPT).
- Allow sufficient opportunity for SO(s)/family to practice new skills. Role-play potential crisis situations **to enhance confidence in ability to handle patient's needs.**
- Identify signs/symptoms requiring prompt medical evaluation/intervention. **Timely treatment may prevent progression of problem.**
- Provide positive feedback and encouragement for efforts of SO(s)/family. **Promotes continuation of desired behaviors.**
- List names and phone numbers for identified contact persons/resources. Refer to individual(s) who have managed home ventilation. **Round-the-clock availability reduces sense of isolation and enhances likelihood of obtaining appropriate information when needed.**

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

- Discuss impact of specific activities on respiratory status and problem-solve solutions **to maximize weaning effort.**
- Engage patient in specialized exercise program **to enhance respiratory muscle strength and general endurance.**
- Protect patient from sources of infection (e.g., monitor health of visitors, roommate, staff involved in care).
- Recommend involvement in support group; introduce to individuals dealing with similar problems **to provide role models, assistance for problem solving.**
- Encourage time-out for care providers **so they may attend to personal needs, wellness, and growth.**
- Provide opportunities for patient/SO(s) to discuss termination of therapy/end-of-life decisions.
- Identify ventilator-dependent individuals who are successfully managing condition **to encourage hope for the future.**
- Refer to additional resources (e.g., spiritual advisor, counselor).

Documentation Focus

ASSESSMENT/REASSESSMENT

- Baseline findings, subsequent alterations in respiratory function.
- Results of diagnostic testing.
- Individual risk factors/concerns.

PLANNING

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

IMPLEMENTATION/EVALUATION

- Patient's/other's responses to interventions, teaching, and actions performed.
- Skill level/assistance needs of SO(s)/family.
- Attainment, progress toward desired outcome(s).
- Modifications to plan of care.

DISCHARGE PLANNING

- Discharge plan, including appropriate referrals, action taken, and who is responsible for each action.
- Equipment needs and source.
- Resources for support persons/home care providers.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Respiratory Status: Ventilation
NIC—Mechanical Ventilation

Ventilatory Weaning Response, dysfunctional

Taxonomy II: Activity/Rest—Class 4 Cardiovascular/Pulmonary Responses (00034)
[Diagnostic Division: Respiration]

Definition: Inability to adjust to lowered levels of mechanical ventilator support that interrupts and prolongs the weaning process

Related Factors

PHYSICAL

Ineffective airway clearance
Sleep pattern disturbance
Inadequate nutrition
Uncontrolled pain or discomfort
[Muscle weakness/fatigue, inability to control respiratory muscles; immobility]

PSYCHOLOGICAL

Knowledge deficit of the weaning process, patient's role
Patient's perceived inefficacy about the ability to wean
Decreased motivation
Decreased self-esteem
Anxiety (moderate, severe); fear; insufficient trust in the nurse
Hopelessness; powerlessness
[Unprepared for weaning attempt]

SITUATIONAL

Uncontrolled episodic energy demands or problems
Inappropriate pacing of diminished ventilator support
Inadequate social support
Adverse environment (noisy, active environment, negative events in the room, low nurse-patient ratio; extended nurse absence from bedside, unfamiliar nursing staff)
History of ventilator dependence >1 week
History of multiple unsuccessful weaning attempts

Defining Characteristics

Responds to lowered levels of mechanical ventilator support with:

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

MILD DVWR

Subjective
Expressed feelings of increased need for O_2; breathing discomfort; fatigue, warmth
Queries about possible machine malfunction

Objective
Restlessness
Slight increased respiratory rate from baseline
Increased concentration on breathing

MODERATE DVWR

Subjective
Apprehension

Objective
Slight increase from baseline blood pressure (<20 mm Hg)
Slight increase from baseline heart rate (<20 beats/min)
Baseline increase in respiratory rate (<5 breaths/min)
Hypervigilance to activities
Inability to respond to coaching/cooperate
Diaphoresis
Eye widening, "wide-eyed look"
Decreased air entry on auscultation
Color changes; pale, slight cyanosis
Slight respiratory accessory muscle use

SEVERE DVWR

Objective
Agitation
Deterioration in ABGs from current baseline
Increase from baseline BP (>20 mm Hg)
Increase from baseline heart rate (>20 beats/min)
Respiratory rate increases significantly from baseline
Profuse diaphoresis
Full respiratory accessory muscle use; shallow, gasping breaths; paradoxical abdominal breathing
Discoordinated breathing with the ventilator
Decreased level of consciousness
Adventitious breath sounds, audible airway secretions
Cyanosis

Desired Outcomes/Evaluation Criteria—Patient Will:

- Actively participate in the weaning process.
- Reestablish independent respiration with ABGs within patient's normal range and be free of signs of respiratory failure.

- Demonstrate increased tolerance for activity/participate in self-care within level of ability.

Actions/Interventions

NURSING PRIORITY NO. 1. To identify contributing factors/degree of dysfunction:

- Note length of ventilator dependence. Review previous episodes of dependence/weaning.
- Assess physical factors involved in weaning (e.g., stability of vital signs, hydration status, presence of fever/pain; nutritional intake and muscle strength).
- Ascertain patient's understanding of weaning process, expectations, and concerns.
- Determine psychological readiness, presence/degree of anxiety.
- Review laboratory studies reflecting number/integrity of red blood cells (O_2 transport) and nutritional status (sufficient energy to meet demands of weaning).
- Review chest x-ray/pulse oximetry and ABGs.

NURSING PRIORITY NO. 2. To support weaning process:

- Consult with dietitian, nutritional support team for adjustments of composition of diet **to prevent excessive production of CO_2, which could alter respiratory drive.**
- Explain weaning techniques, e.g., T-piece, SIMV, CPAP, pressure support. Discuss individual plan and expectations. **Reduces fear of unknown, enhances sense of trust.**
- Introduce patient to individual who has shared similar experiences with successful outcome.
- Provide undisturbed rest/sleep periods. Avoid stressful procedures/situations or nonessential activities.
- Time medications during weaning efforts **to minimize sedative effects.**
- Provide quiet room; calm approach, undivided attention of nurse. **Enhances relaxation, conserving energy.**
- Involve SO(s)/family as appropriate (e.g., sit at bedside, provide encouragement, and help monitor patient status).
- Provide diversional activity (e.g., watching TV, reading aloud) **to focus attention away from breathing.**
- Note response to activity/patient care during weaning and limit as indicated **to prevent excessive O_2 consumption/demand with increased possibility of failure.**
- Auscultate breath sounds periodically; suction airway as indicated.
- Acknowledge and provide ongoing encouragement for patient's efforts.

- Minimize setbacks, focus patient attention on gains and progress to date **to reduce frustration that may further impair progress.**
- Suspend weaning (take a "holiday") periodically as individually appropriate (e.g., initially may "rest" 45 or 50 minutes each hour, progressing to a 20-minute rest every 4 hours, then weaning during daytime and resting during night).

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

- Discuss impact of specific activities on respiratory status and problem-solve solutions to maximize weaning effort.
- Engage in rehabilitation program **to enhance respiratory muscle strength and general endurance.**
- Teach patient/SO(s) how to protect patient from sources of infection (e.g., monitor health of visitors, persons involved in care; avoid crowds during flu season).
- Identify conditions requiring immediate medical intervention **to prevent respiratory failure.**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Baseline findings and subsequent alterations.
- Results of diagnostic testing/procedures.
- Individual risk factors.

PLANNING

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

IMPLEMENTATION/EVALUATION

- Patient response to interventions.
- Attainment of/progress toward desired outcome(s).
- Modifications to plan of care.

DISCHARGE PLANNING

- Status at discharge, long-term needs and referrals, indicating who is to be responsible for each action.
- Equipment needs/supplier.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Respiratory Status: Ventilation
NIC—Mechanical Ventilatiory Weaning

NANDA has separated the diagnosis of Violence into its two elements: "directed at others" and "self-directed." However, the interventions in general address both situations and have been left in one block following the definition and supporting data of the two diagnoses.

Violence, [actual/] risk for other-directed

Taxonomy II: Safety/Protection—Class 3 Violence (00138) [Diagnostic Division: Safety]

Definition: At risk for behaviors in which an individual demonstrates that he/she can be physically, emotionally, and/or sexually harmful to others

Risk Factors/[Indicators]*

History of violence:
- Against others (e.g., hitting, kicking, scratching, biting or spitting, or throwing objects at someone; attempted rape, rape, sexual molestation; urinating/defecating on a person)
- Threats (e.g., verbal threats against property/person, social threats, cursing, threatening notes/letters or gestures, sexual threats)
- Antisocial behavior (e.g., stealing, insistent borrowing, insistent demands for privileges, insistent interruption of meetings; refusal to eat or to take medication, ignoring instructions)
- Indirect (e.g., tearing off clothes, urinating/defecating on floor, stamping feet, temper tantrum; running in corridors, yelling, writing on walls, ripping objects off walls, throwing objects, breaking a window, slamming doors; sexual advances).

Other factors:
- Neurological impairment (e.g., positive EEG, CT, or MRI; head trauma; positive neurological findings; seizure disorders, [temporal lobe epilepsy])
- Cognitive impairment (e.g., learning disabilities, attention deficit disorder, decreased intellectual functioning); [organic brain syndrome]

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

*__Note:__ Although a risk diagnosis does not have defining characteristics (signs and symptoms), the factors identified here can be used to denote an actual diagnosis or as indicators of risk for/escalation of violence.

History of childhood abuse/witnessing family violence, [negative role modeling]; cruelty to animals; firesetting
Prenatal and perinatal complications/abnormalities
History of drug/alcohol abuse; pathological intoxication, [toxic reaction to medication]
Psychotic symptomatology (e.g., auditory, visual, command hallucinations; paranoid delusions; loose, rambling, or illogical thought processes); [panic states; rage reactions; catatonic/manic excitement]
Motor vehicle offenses (e.g., frequent traffic violations, use of motor vehicle to release anger)
Suicidal behavior; impulsivity; availability and/or possession of weapon(s)
Body language: rigid posture, clenching of fists and jaw, hyperactivity, pacing, breathlessness, threatening stances)
[Hormonal imbalance (e.g., premenstrual syndrome—PMS, postpartal depression/psychosis)]
[Expressed intent/desire to harm others directly or indirectly]
[Almost continuous thoughts of violence]

Violence, [actual/] risk for self-directed

Taxonomy II: Safety/Protection—Class 3 Violence (00140)
[Diagnostic Division: Safety]

Definition: At risk for behaviors in which an individual demonstrates that he/she can be physically, emotionally, and/or sexually harmful to self

Risk Factors/[Indicators]*

Ages 15 to 19; over age 45
Marital status (single, widowed, divorced)
Employment (unemployed, recent job loss/failure); occupation (executive, administrator/owner of business, professional, semiskilled worker)
Conflictual interpersonal relationships
Family background (chaotic or conflictual, history of suicide)
Sexual orientation: bisexual (active), homosexual (inactive)
Physical health (hypochondriac, chronic or terminal illness)

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

* **Note:** Although a risk diagnosis does not have defining characteristics (signs and symptoms), the factors identified here can be used to denote an actual diagnosis or as indicators of risk for/escalation of violence.

Mental health (severe depression, psychosis, severe personality disorder, alcoholism, or drug abuse)
Emotional status (hopelessness, [lifting of depressed mood], despair, increased anxiety, panic, anger, hostility); history of multiple suicide attempts; suicidal ideation (frequent, intense prolonged); suicide plan (clear and specific; lethality, method and availability of destructive means)
Personal resources (poor achievement, poor insight, affect unavailable and poorly controlled)
Social resources (poor rapport, socially isolated, unresponsive family)
Verbal clues (e.g., talking about death, "better off without me," asking questions about lethal dosages of drugs)
Behavioral clues (e.g., writing forlorn love notes, directing angry messages at an SO who has rejected the person, giving away personal items, taking out a large life insurance policy), people who engage in autoerotic sexual acts [e.g., asphyxiation]

Desired Outcomes/Evaluation Criteria [for directed at others/self-directed]—Patient Will:

- Acknowledge realities of the situation.
- Verbalize understanding of why behavior occurs.
- Identify precipitating factors.
- Express realistic self-evaluation and increased sense of self-esteem.
- Participate in care and meet own needs in an assertive manner.
- Demonstrate self-control as evidenced by relaxed posture, nonviolent behavior.
- Use resources and support systems in an effective manner.

Actions/Interventions

(Address both "directed at others" and "self-directed")

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

- Determine underlying dynamics as listed in the Risk Factors.
- Ascertain patient's perception of self/situation. Note use of defense mechanisms (e.g., denial, projection).
- Observe/listen for early cues of distress/increasing anxiety (e.g., irritability, lack of cooperation, demanding behavior, body posture/expression).
- Identify conditions such as acute/chronic brain syndrome; panic state; hormonal imbalance (e.g., PMS, postpartal

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

psychosis, drug-induced, postsurgical/postseizure confusion; psychomotor seizure activity) **that may interfere with ability to control own behavior.**
- Review laboratory findings (e.g., blood alcohol, blood glucose, ABGs, electrolytes, renal function tests).
- Observe for signs of suicidal/homicidal intent (e.g., perceived morbid or anxious feeling while with the patient; warning from the patient, "It doesn't matter," "I'd/They'd be better off dead"; mood swings; "accident-prone"/self-destructive behavior; suicidal attempts, possession of alcohol and/or other drug(s) in known substance abuser).
- Note family history of suicidal/homicidal behavior.
- Ask directly if the person is thinking of acting on thoughts/feelings **to determine violent intent.**
- Determine availability of suicidal/homicidal means.
- Assess patient coping behaviors already present. (**Note:** Patient believes there are no alternatives other than violence.)
- Identify risk factors and assess for indicators of child abuse/neglect: unexplained/frequent injuries, failure to thrive, and so forth.

NURSING PRIORITY NO. 2. To assist patient to accept responsibility for impulsive behavior and potential for violence:
- Develop therapeutic nurse-patient relationship. Provide consistent caregiver when possible. **Promotes sense of trust, allowing patient to discuss feelings openly.**
- Maintain straightforward communication **to avoid reinforcing manipulative behavior.**
- Note motivation for change (e.g., failing relationships, job loss, involvement with judicial system). **Crisis situation can provide impetus for change, but requires timely therapeutic intervention to sustain efforts.**
- Help patient recognize that own actions may be in response to own fear (**may be afraid of own behavior, loss of control**), dependency, and feeling of powerlessness.
- Make time to listen to expressions of feelings. Acknowledge reality of patient's feelings and that feelings are OK. (Refer to ND Self-Esteem, specify.)
- Confront patient's tendency to minimize situation/behavior.
- Identify factors (feelings/events) involved in precipitating violent behavior.
- Discuss impact of behavior on others/consequences of actions.
- Acknowledge reality of suicide/homicide as an option. Discuss consequences of actions if they were to follow through on intent. Ask how it will help patient to resolve problems.
- Accept patient's anger without reacting on emotional basis. Give permission to express angry feelings in acceptable ways and let

patient know that staff will be available to assist in maintaining control. **Promotes acceptance and sense of safety.**
- Help patient identify more appropriate solutions/behaviors (e.g., motor activities/exercise) **to lessen sense of anxiety and associated physical manifestations.**
- Provide directions for actisons patient can take, avoiding negatives, such as "do nots."

NURSING PRIORITY NO. 3. To assist patient in controlling behavior:
- Contract with patient regarding safety of self/others.
- Give patient as much control as possible within constraints of individual situation. **Enhances self-esteem, promotes confidence in ability to change behavior.**
- Be truthful when giving information and dealing with patient. **Builds trust, enhancing therapeutic relationship.**
- Identify current/past successes and strengths. Discuss effectiveness of coping techniques used and possible changes. (Refer to ND Coping, ineffective.) **Patient is often not aware of positive aspects of life, and once recognized, they can be used as a basis for change.**
- Assist patient to distinguish between reality and hallucinations/delusions.
- Approach in positive manner, acting as if the patient has control and is responsible for own behavior. Be aware, though, that the patient may not have control, especially if under the influence of drugs (including alcohol).
- Maintain distance and do not touch patient when situation indicates patient does not tolerate such closeness (e.g., posttrauma response).
- Remain calm and state limits on inappropriate behavior (including consequences) in a firm manner.
- Direct patient to stay in view of staff.
- Administer prescribed medications (e.g., antianxiety/antipsychotic), taking care not to oversedate patient.
- Monitor for possible drug interactions, cumulative effects of drug regimen (e.g., anticonvulsants/antidepressants).
- Give positive reinforcement for patient's efforts. **Encourages continuation of desired behaviors.**
- Explore death fantasies when expressed (e.g., "I'll look down and watch them suffer; they'll be sorry," "They'll be glad to get rid of me") or the idea that death is not final (e.g., "I can come back").

NURSING PRIORITY NO. 4. To assist patient/SO(s) to correct/deal with existing situation:
- Gear interventions to individual(s) involved, based on age, relationship, and so forth.
- Maintain calm, matter-of-fact, nonjudgmental attitude. **Decreases defensive response.**

- Notify potential victims in the presence of serious homicidal threat **in accordance with legal/ethical guidelines.**
- Discuss situation with abused/battered person, providing accurate information about choices and effective actions that can be taken.
- Assist individual to understand that angry, vengeful feelings are appropriate in the situation, need to be expressed and not acted on. (Refer to ND Post-Trauma Syndrome, as psychological responses may be very similar.)
- Identify resources available for assistance (e.g., battered women's shelter, social services).

NURSING PRIORITY NO. **5.** To promote safety in event of violent behavior:

- Provide a safe, quiet environment and remove items from the patient's environment that could be used to inflict harm to self/others.
- Maintain distance from patient who is striking out/hitting and take evasive/controlling actions as indicated.
- Call for additional staff/security personnel.
- Approach aggressive/attacking patient from the front, just out of reach, in a commanding posture with palms down.
- Tell patient to stop. **This may be sufficient to help patient control own actions.**
- Maintain direct/constant eye contact when appropriate.
- Speak in a low, commanding voice.
- Provide patient with a sense that caregiver is in control of the situation **to provide feeling of safety.**
- Maintain clear route for staff and patient and be prepared to move quickly.
- Hold patient, using restraints or seclusion when necessary until patient regains self-control. Administer medication as indicated.

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

- Promote patient involvement in planning care within limits of situation, allowing for meeting own needs for enjoyment. **Individuals often believe they are not entitled to pleasure and good things in their lives and need to learn how to meet these needs.**
- Assist patient to learn assertive rather than manipulative, nonassertive/aggressive behavior.
- Discuss reasons for patient's behavior with SO(s). Determine desire/commitment of involved parties to sustain current relationships.
- Develop strategies to help parents learn more effective parenting skills (e.g., parenting classes, appropriate ways of dealing with frustrations).

- Identify support systems (e.g., family/friends, clergy).
- Refer to formal resources as indicated (e.g., individual/group psychotherapy, substance abuse treatment program, social services, safe house facility).
- Refer to NDs Parenting, impaired; Coping, family [specify]; Post-Trauma Syndrome.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including nature of concern (e.g., suicidal/homicidal), behavioral risk factors and level of impulse control, plan of action/means to carry out plan.
- Patient's perception of situation, motivation for change.

PLANNING

- Plan of care and who is involved in the planning.
- Details of contract regarding violence to self/others.
- Teaching Plan.

IMPLEMENTATION/EVALUATION

- Actions taken to promote safety, including notification of parties at risk.
- Response to interventions/teaching and actions performed.
- Attainment/progress toward desired outcome(s).
- Modifications to plan of care.

DISCHARGE PLANNING

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Aggression Control
NIC—Anger Control Assistance

Walking, impaired

Taxonomy II: Activity/Rest—Class 2 Activity/Exercise (00088)

[Diagnostic Division: Activity/Rest]

Definition: Limitation of independent movement within the environment on foot

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

Related Factors

To be developed by NANDA
[Condition affecting muscles/joints impairing ability to walk]

Defining Characteristics

SUBJECTIVE OR OBJECTIVE

Impaired ability to walk required distances, walk on an incline/decline, or on uneven surfaces, to navigate curbs, climb stairs
[Specify level of independence—refer to ND Mobility, impaired physical, for suggested functional level classification]

Desired Outcomes/Evaluation Criteria—Patient Will:

- Be able to move about within environment as needed/desired within limits of ability or with appropriate adjuncts.
- Verbalize understanding of situation/risk factors and safety measures.

Actions/Interventions

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

- Identify condition/diagnoses that contribute to difficulty walking (e.g., advanced age, acute illness, weakness/chronic illness, recent surgery, trauma, arthritis, brain injury, vision impairments, pain, fatigue, cognitive dysfunction).
- Determine ability to follow directions, and note emotional/behavioral responses that may be affecting the situation.

NURSING PRIORITY NO. 2. To assess functional ability:

- Determine degree of impairment in relation to suggested functional scale (0 to 4), noting that impairment can be either temporary or permanent.
- Note emotional/behavioral responses of patient/SO to problems of mobility.

NURSING PRIORITY NO. 3. To promote safe, optimal level of independence in walking:

- Assist with treatment of underlying condition causing dysfunction as needed/indicated by individual situation.
- Consult with PT/OT **to develop individual mobility/walking program and identify appropriate adjunctive devices.**
- Demonstrate use of adjunctive devices (e.g., walker, cane, crutches, prosthesis).

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

- Schedule walking/exercise activities interspersed with adequate rest periods **to reduce fatigue.** Provide ample time to perform mobility-related tasks. Advance levels of exercise as able.
- Provide safety measures as indicated, including environmental management/fall prevention.

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

- Involve patient/SO in care, assisting them to learn ways of managing deficits **to enhance safety for patient and SO/caregivers.**
- Identify appropriate resources for obtaining and maintaining appliances, equipment, and environmental modifications **to promote mobility.**
- Instruct patient/SO in safety measures as individually indicated (e.g., maintaining safe travel pathway, proper lighting/handrails on stairs, etc.) **to reduce risk of falls.**

Documentation Focus

ASSESSMENT/REASSESSMENT

- Individual findings, including level of function/ability to participate in specific/desired activities.

PLANNING

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

IMPLEMENTATION/EVALUATION

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

DISCHARGE PLANNING

- Discharge/long-range needs, noting who is responsible for each action to be taken.
- Specific referrals made.
- Sources of/maintenance for assistive devices.

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Ambulation: Walking
NIC—Exercise Therapy: Ambulation

Wandering [specify sporadic or continual]

Taxonomy II: Activity/Rest—Class 2 Activity/Exercise (00154)

[Diagnostic Division: Safety]

Submitted 2000

Definition: Meandering, aimless, or repetitive locomotion that exposes the individual to harm; frequently incongruent with boundaries, limits, or obstacles

Related Factors

Cognitive impairment, specifically memory and recall deficits, disorientation, poor visuoconstructive (or visuospatial) ability, language (primarily expressive) defects
Cortical atrophy
Premorbid behavior (e.g., outgoing, sociable personality; premorbid dementia)
Separation from familiar people and places
Emotional state, especially frustration, anxiety, boredom, or depression (agitation)
Physiological state or need (e.g., hunger/thirst, pain, urination, constipation)
Over/understimulating social or physical environment; sedation
Time of day

Defining Characteristics

OBJECTIVE

Frequent or continuous movement from place to place, often revisiting the same destinations
Persistent locomotion in search of "missing" or unattainable people or places; scanning, seeking, or searching behaviors
Haphazard locomotion; fretful locomotion or pacing; long periods of locomotion without an apparent destination
Locomotion into unauthorized or private spaces; trespassing
Locomotion resulting in unintended leaving of a premise
Inability to locate significant landmarks in a familiar setting; getting lost
Locomotion that cannot be easily dissuaded or redirected; following behind or shadowing a caregiver's locomotion
Hyperactivity
Periods of locomotion interspersed with periods of nonlocomotion (e.g., sitting, standing, sleeping)

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

Desired Outcomes/Evaluation Criteria—Patient Will:

- Be free of injury, or unplanned exits.

Caregiver(s) Will:

- Modify environment as indicated to enhance safety.
- Provide for maximal independence of patient.

Actions/Interventions

NURSING PRIORITY NO. 1. To assess degree of impairment/stage of disease process:

- Ascertain history of patient's memory loss and cognitive changes.
- Note results of diagnostic testing, confirming diagnosis and type of dementia.
- Evaluate patient's mental status during daytime and nighttime, noting when patient's confusion is most pronounced, and when patient sleeps.
- Monitor patient's use/need for assistive devices such as glasses, hearing aids, cane, etc.
- Assess frequency and pattern of wandering behavior **to determine individual risks/safety needs.**
- Identify patient's reason for wandering if possible (e.g., looking for lost item, desire to go home, boredom, need for activity, hunger, thirst, or discomfort).
- Ascertain if patient has delusions due to shadows, lights, and noises.

NURSING PRIORITY NO. 2. To assist patient/caregiver to deal with situations:

- Provide a structured daily routine. **Decreases wandering behavior and minimizes caregiver stress.**
- Encourage participation in family activities and familiar routines such as folding laundry, listening to music, walking outdoors. **Activities and exercises may reduce anxiety and restlessness.**
- Bring patient to bathroom on a regular schedule.
- Provide safe place for patient to wander, away from safety hazards (e.g., hot water/kitchen stove, open stairway) and other noisy patients. Arrange furniture and other items **to accommodate wandering.**
- Make sure that doors have alarms and that alarms are turned on. Provide door and window locks that are not easily opened **to prevent unsafe exits.**
- Provide 24-hour reality orientation. (**Patient can be awake at any time and fail to recognize day/night routines.**)

- Sit with patient and talk. Provide TV/radio/music.
- Avoid overstimulation from activities or new partners/roommate during rest periods when patient is in a facility.
- Use pressure-sensitive bed/chair alarms **to alert caregivers of movement.**
- Avoid using physical or chemical restraints (sedatives) to control wandering behavior. **May increase agitation, sensory deprivation, and falls, and may contribute to wandering behavior.**
- Provide consistent staff as much as possible.
- Provide room near monitoring station; check patient location on frequent basis.

NURSING PRIORITY NO. 3. To Promote Wellness (Teaching/Discharge Considerations):

- Identify problems that are remediable and assist patient/SO to seek appropriate assistance and access resources. (**Encourages problem solving to improve condition rather than accept the status quo.**)
- Notify neighbors about patient's condition and request that they contact patient's family or local police if they see patient outside alone. **Community awareness can prevent/reduce risk of patient being lost or hurt.**
- Use community resources such as Alzheimer's Association Safe Return Program **to assist in identification, location, and safe return of individual with wandering behaviors.**
- Help patient/SO develop plan of care when problem is progressive.
- Refer to community resources such as day care programs, support groups, etc.
- Refer to NDs: Confusion, acute; Sensory Perception, disturbed (specify: visual, auditory, kinesthetic, gustatory, tactile, olfactory); Injury, risk for; Falls, risk for.

Documentation Focus

ASSESSMENT/REASSESSMENT

- Assessment findings, including individual concerns, family involvement, and support factors/availability of resources.

PLANNING

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

IMPLEMENTATION/EVALUATION

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

DISCHARGE PLANNING

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

SAMPLE NURSING OUTCOMES & INTERVENTIONS CLASSIFICATIONS (NOC/NIC)

NOC—Risk Control
NIC—Elopement Precautions

CHAPTER 5

Disorders/Health Problems with Associated Nursing Diagnoses

This chapter presents approximately 300 disorders/health conditions reflecting all specialty areas, with associated nursing diagnoses written as patient problem 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 problems 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 147 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 disorders and nursing diagnoses, the disorders have been listed alphabetically and coded to identify nursing specialty areas.

MS: Medical-Surgical
PED: Pediatric
OB: Obstetric
CH: Community
PSY: Psychiatric

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.

Abortion, spontaneous termination **OB**

Fluid Volume, deficient [isotonic] may be related to excessive blood loss, possibly evidenced by decreased pulse volume and pressure, delayed capillary refill, or changes in sensorium.

Spiritual Distress, risk for: risk factors may include need to adhere to personal religious beliefs/practices, blame for loss directed at self or God.

Knowledge, deficient [Learning Need] regarding cause of abortion, self-care, contraception/future pregnancy may be related to lack of familiarity with new self/healthcare needs, sources for support, possibly evidenced by requests for information and statement of concern/misconceptions, development of preventable complications.

Grieving, anticipatory related to perinatal loss, possibly evidenced by crying, expressions of sorrow, or changes in eating habits/sleep patterns.

Sexuality patterns, risk for ineffective risk factors may include increasing fear of pregnancy and/or repeat loss, impaired relationship with SO(s), self-doubt regarding own femininity.*

Abruptio placentae — OB

Fluid Volume, deficient [isotonic] may be related to excessive blood loss, possibly evidenced by hypotension, increased heart rate, decreased pulse volume and pressure, delayed capillary refill, or changes in sensorium.

Fear related to threat of death (perceived or actual) to fetus/self, possibly evidenced by verbalization of specific concerns, increased tension, sympathetic stimulation.

Pain, acute may be related to collection of blood between uterine wall and placenta, possibly evidenced by verbal reports, abdominal guarding, muscle tension, or alterations in vital signs.

Gas Exchange, impaired fetal may be related to altered uteroplacental O_2 transfer, possibly evidenced by alterations in fetal heart rate and movement.

Abscess, brain (acute) — MS

Pain, acute may be related to inflammation, edema of tissues, possibly evidenced by reports of headache, restlessness, irritability, and moaning.

Hyperthermia risk factors may include inflammatory process/hypermetabolic state and dehydration.*

Confusion, acute may be related to physiological changes (e.g., cerebral edema/altered perfusion, fever), possibly evidenced by fluctuation in cognition/level of consciousness, increased agitation/restlessness, hallucinations.

Suffocation/Trauma, risk for: risk factors may include development of clonic/tonic muscle activity and changes in consciousness (seizure activity).*

Achalasia — MS

Swallowing, impaired may be related to neuromuscular impairment, possibly evidenced by observed difficulty in swallowing or regurgitation.

Nutrition: imbalanced, less than body requirements may be related to inability and/or reluctance to ingest adequate nutrients to meet metabolic demands/nutritional needs, possibly evidenced by reported/observed inadequate intake, weight loss, and pale conjunctiva and mucous membranes.

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

Pain, acute may be related to spasm of the lower esophageal sphincter, possibly evidenced by reports of substernal pressure, recurrent heartburn, or gastric fullness (gas pains).

Anxiety [specify level]/Fear may be related to recurrent pain, choking sensation, altered health status, possibly evidenced by verbalizations of distress, apprehension, restlessness, or insomnia.

Aspiration, risk for: risk factors may include regurgitation/spillover of esophageal contents.*

Knowledge, deficient [Learning Need] regarding condition, prognosis, self-care and treatment needs may be related to lack of familiarity with pathology and treatment of condition, possibly evidenced by requests for information, statement of concern, or development of preventable complications.

Acidosis, metabolic — MS

(Refer to Diabetic Ketoacidosis)

Addison's disease — MS

[Fluid Volume, deficient hyper/hypotonic] may be related to vomiting, diarrhea, increased renal losses, possibly evidenced by delayed capillary refill, poor skin turgor, dry mucous membranes, report of thirst.

Cardiac Output, decreased may be related to hypovolemia and altered electrical conduction (dysrhythmias) and/or diminished cardiac muscle mass, possibly evidenced by alterations in vital signs, changes in mentation, and irregular pulse or pulse deficit.

CH

Fatigue may be related to decreased metabolic energy production, altered body chemistry (fluid, electrolyte, and glucose imbalance), possibly evidenced by unremitting overwhelming lack of energy, inability to maintain usual routines, decreased performance, impaired ability to concentrate, lethargy, and disinterest in surroundings.

Body Image, disturbed may be related to changes in skin pigmentation, mucous membranes, loss of axillary/pubic hair, possibly evidenced by verbalization of negative feelings about body and decreased social involvement.

Mobility, risk for impaired physical risk factors may include neuromuscular impairment (muscle wasting/weakness) and dizziness/syncope.*

Nutrition: imbalanced, less than body requirements may be related to glucocorticoid deficiency; abnormal fat, protein, and carbohydrate metabolism; nausea, vomiting, anorexia, possibly evidenced by weight loss, muscle wasting, abdominal cramps, diarrhea, and severe hypoglycemia.

Home Maintenance, risk for impaired risk factors may include effects of disease process, impaired cognitive functioning, and inadequate support systems.*

Adenoidectomy — PED/MS

Anxiety [specify level]/Fear may be related to separation from supportive others, unfamiliar surroundings, and perceived threat of

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

injury/abandonment, possibly evidenced by crying, apprehension, trembling, and sympathetic stimulation (pupil dilation, increased heart rate).

Airway Clearance, risk for ineffective risk factors may include sedation, collection of secretions/blood in oropharynx, and vomiting.*

Fluid Volume, risk for deficient risk factors may include operative trauma to highly vascular site/hemorrhage.*

Pain, acute may be related to physical trauma to oronasopharynx, presence of packing, possibly evidenced by restlessness, crying, and facial mask of pain.

Adrenalectomy MS

Tissue Perfusion, ineffective (specify type) may be related to hypovolemia and vascular pooling (vasodilation), possibly evidenced by diminished pulse, pallor/cyanosis, hypotension, and changes in mentation.

Infection, risk for: risk factors may include inadequate primary defenses (incision, traumatized tissues), suppressed inflammatory response, invasive procedures.*

Knowledge, deficient [Learning Need] regarding condition, prognosis, self-care and treatment needs may be related to unfamiliarity with long-term therapy requirements, possibly evidenced by request for information and statement of concern/misconceptions.

Adult respiratory distress syndrome (ARDS) MS

Airway Clearance, ineffective may be related to loss of ciliary action, increased amount and viscosity of secretions, and increased airway resistance, possibly evidenced by presence of dyspnea, changes in depth/rate of respiration, use of accessory muscles for breathing, wheezes/crackles, cough with or without sputum production.

Gas Exchange, impaired may be related to changes in pulmonary capillary permeability with edema formation, alveolar hypoventilation and collapse, with intrapulmonary shunting; possibly evidenced by tachypnea, use of accessory muscles, cyanosis, hypoxia per arterial blood gases (ABGs)/oximetry; anxiety and changes in mentation.

Fluid Volume, risk for deficient risk factors may include active loss from diuretic use and restricted intake.*

Cardiac Output, risk for decreased risk factors may include alteration in preload (hypovolemia, vascular pooling, diuretic therapy, and increased intrathoracic pressure/use of ventilator/positive end-expiratory pressure—PEEP).*

Anxiety [specify level]/Fear may be related to physiological factors (effects of hypoxemia); situational crisis, change in health status/threat of death; possibly evidenced by increased tension, apprehension, restlessness, focus on self, and sympathetic stimulation.

Injury, risk for barotrauma risk factors may include increased airway pressure associated with mechanical ventilation (PEEP).*

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

Affective disorder **PSY**

(Refer to Bipolar Disorder; Depressive Disorders, major)

AIDS (acquired immunodeficiency syndrome) **MS**

Infection, risk for progression to sepsis/onset of new opportunistic infection risk factors may include depressed immune system, use of antimicrobial agents, inadequate primary defenses; broken skin, traumatized tissue; malnutrition and chronic disease processes.*

Fluid Volume, risk for deficient risk factors may include excessive losses: copious diarrhea, profuse sweating, vomiting, hypermetabolic state or fever; and restricted intake (nausea, anorexia; lethargy).*

Pain, acute/chronic may be related to tissue inflammation/destruction: infections, internal/external cutaneous lesions, rectal excoriation, malignancies, necrosis, peripheral neuropathies, myalgias and arthralgias, possibly evidenced by verbal reports, self-focusing/narrowed focus, alteration in muscle tone, paresthesias, paralysis, guarding behaviors, changes in vital signs (acute), autonomic responses, and restlessness.

CH

Nutrition: imbalanced, less than body requirements may be related to altered ability to ingest, digest, and/or absorb nutrients (nausea/vomiting, hyperactive gag reflex, intestinal disturbances); increased metabolic activity/nutritional needs (fever, infection), possibly evidenced by weight loss, decreased subcutaneous fat/muscle mass; lack of interest in food/aversion to eating, altered taste sensation; abdominal cramping, hyperactive bowel sounds, diarrhea, sore and inflamed buccal cavity.

Fatigue may be related to decreased metabolic energy production, increased energy requirements (hypermetabolic state), overwhelming psychological/emotional demands; altered body chemistry (side effects of medication, chemotherapy), possibly evidenced by unremitting/overwhelming lack of energy, inability to maintain usual routines, decreased performance; impaired ability to concentrate, lethargy/restlessness, and disinterest in surroundings.

Protection, ineffective may be related to chronic disease affecting immune and neurological systems, inadequate nutrition, drug therapies, possibly evidenced by deficient immunity, impaired healing, neurosensory alterations, maladaptive stress response, fatigue, anorexia, disorientation.

PSY

Social Isolation may be related to changes in physical appearance/mental status, state of wellness, perceptions of unacceptable social or sexual behavior/values, physical isolation, phobic fear of others (transmission of disease); possibly evidenced by expressed feelings of aloneness/rejection, absence of supportive SO(s), and withdrawal from usual activities.

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

Thought Processes, disturbed/Confusion, chronic may be related to physiological changes (hypoxemia, central nervous system—CNS—infection by HIV, brain malignancies, and/or disseminated systemic opportunistic infection); altered drug metabolism/excretion, accumulation of toxic elements (renal failure, severe electrolyte imbalance, hepatic insufficiency), possibly evidenced by clinical evidence of organic impairment, altered attention span, distractibility, memory deficit, disorientation, cognitive dissonance, delusional thinking, impaired ability to make decisions/problem-solve, inability to follow complex commands/mental tasks, loss of impulse control and altered personality.

Aldosteronism, primary — MS

Fluid Volume, deficient [isotonic] may be related to increased urinary losses, possibly evidenced by dry mucous membranes, poor skin turgor, dilute urine, excessive thirst, weight loss.

Mobility, impaired physical may be related to neuromuscular impairment, weakness, and pain, possibly evidenced by impaired coordination, decreased muscle strength, paralysis, and positive Chvostek's and Trousseau's signs.

Cardiac Output, risk for decreased risk factors may include hypovolemia and altered electrical conduction/dysrhythmias.*

Alzheimer's disease — CH

(Also refer to Dementia, presenile/senile)

Injury/Trauma, risk for: risk factors may include inability to recognize/identify danger in environment, disorientation, confusion, impaired judgment, weakness, muscular incoordination, balancing difficulties, and altered perception.

Confusion, chronic 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.

Sensory Perception, disturbed (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.

Sleep Pattern, disturbed 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.

Health Maintenance, ineffective may be related to deterioration affecting ability in all areas including coordination/communication,

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

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.

PSY

Coping, family: compromised/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 patient, and withdrawal from interaction with patient/social contacts.

Relocation Stress Syndrome, risk for: 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.*

Amputation MS

Tissue Perfusion, risk for ineffective: peripheral risk factors may include reduced arterial/venous blood flow; tissue edema, hematoma formation; hypovolemia.*

Pain, acute 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.

Mobility, impaired physical 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.

Body Image, disturbed 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.

Amyotrophic lateral sclerosis (ALS) MS

Mobility, impaired physical may be related to muscle wasting/weakness, possibly evidenced by impaired coordination, limited range of motion, and impaired purposeful movement.

Breathing Pattern, ineffective/Ventilation, impaired spontaneous 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.

Swallowing, impaired 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

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

expressions of frustration about inability to care for self and depression over physical deterioration.

Grieving, anticipatory may be related to perceived potential loss of self/physiopsycosocial well-being, possibly evidenced by sorrow, choked feelings, expression of distress, changes in eating habits/sleeping patterns, and altered communication patterns/libido.

CH

Communication, impaired verbal may be related to physical barrier (neuromuscular impairment), possibly evidenced by impaired articulation, inability to speak in sentences, and use of nonverbal cues (changes in facial expression).

Caregiver Role Strain, risk for: risk factors may include illness severity of care receiver, complexity and amount of home-care needs, duration of caregiving required, caregiver is spouse, family/caregiver isolation, lack of respite/recreation for caregiver.*

Anemia CH

Activity Intolerance [specify level] may be related to imbalance between O_2 supply (delivery) and demand, possibly evidenced by reports of fatigue and weakness, abnormal heart rate or blood pressure (BP) response, decreased exercise/activity level, and exertional discomfort or dyspnea.

Nutrition: imbalanced, less than body requirements may be related to failure to ingest/inability to digest food or absorb nutrients necessary for formation of normal red blood cells (RBCs); possibly evidenced by weight loss/weight below normal for age, height, body build; decreased triceps skinfold measurement, changes in gums/oral mucous membranes; decreased tolerance for activity, weakness, and loss of muscle tone.

Knowledge, deficient [Learning Need] regarding condition, prognosis, self-care and treatment needs may be related to inadequate understanding or misinterpretation of dietary/physiological needs, possibly evidenced by inadequate dietary intake, request for information, and development of preventable complications.

Anemia, sickle cell MS

Gas Exchange, impaired may be related to decreased O_2-carrying capacity of blood, reduced RBC life span, abnormal RBC structure, increased blood viscosity, predisposition to bacterial pneumonia/pulmonary infarcts, possibly evidenced by dyspnea, use of accessory muscles, cyanosis/signs of hypoxia, tachycardia, changes in mentation, and restlessness.

Tissue Perfusion, ineffective (specify type) may be related to stasis, vasoocclusive nature of sickling, inflammatory response, atrioventricular (AV) shunts in pulmonary and peripheral circulation, myocardial damage (small infarcts, iron deposits, fibrosis), possibly evidenced by signs and symptoms dependent on system involved, for example: renal: decreased specific gravity and pale urine in face of

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

dehydration; cerebral: paralysis and visual disturbances; peripheral: distal ischemia, tissue infarctions, ulcerations, bone pain; cardiopulmonary: angina, palpitations.

CH

Pain, acute/chronic may be related to intravascular sickling with localized vascular stasis, occlusion, infarction/necrosis and deprivation of O_2 and nutrients, accumulation of noxious metabolites, possibly evidenced by reports of localized, generalized, or migratory joint and/or abdominal/back pain; guarding and distraction behaviors (moaning, crying, restlessness), facial grimacing, narrowed focus, and autonomic responses.

Knowledge, deficient [Learning Need] regarding disease process, genetic factors, prognosis, self-care and treatment needs may be related to lack of exposure/recall, misinterpretation of information, unfamiliarity with resources, possibly evidenced by questions, statement of concern/misconceptions, exacerbation of condition, inadequate follow-through of therapy instructions, and development of preventable complications.

Growth and Development, delayed may be related to effects of physical condition, possibly evidenced by altered physical growth and delay/difficulty performing skills typical of age group.

Coping, family: compromised may be related to chronic nature of disease/disability, family disorganization, presence of other crises/situations impacting significant person/parent, lifestyle restrictions, possibly evidenced by significant person/parent expressing preoccupation with own reaction and displaying protective behavior disproportionate to patient's ability or need for autonomy.

Angina pectoris — MS

Pain, acute may be related to decreased myocardial blood flow, increased cardiac workload/O_2 consumption, possibly evidenced by verbal reports, narrowed focus, distraction behaviors (restlessness, moaning), and autonomic responses (diaphoresis, changes in vital signs).

Cardiac Output, decreased may be related to inotropic changes (transient/prolonged myocardial ischemia, effects of medications), alterations in rate/rhythm and electrical conduction, possibly evidenced by changes in hemodynamic readings, dyspnea, restlessness, decreased tolerance for activity, fatigue, diminished peripheral pulses, cool/pale skin, changes in mental status, and continued chest pain.

Anxiety [specify level] may be related to situational crises, change in health status and/or threat of death, negative self-talk possibly evidenced by verbalized apprehension, facial tension, extraneous movements, and focus on self.

CH

Activity intolerance may be related to imbalance between O_2 supply and demand, possibly evidenced by exertional dyspnea, abnormal pulse/BP response to activity, and electrocardiogram (ECG) changes.

Knowledge, deficient [Learning Need] regarding condition, prognosis, self-care and treatment needs may be related to lack of exposure, inaccurate/misinterpretation of information, possibly evidenced by questions, request for information, statement of concern, and inaccurate follow-through of instructions.

Adjustment, risk for/impaired risk factors may include condition requiring long-term therapy/change in lifestyle, assault to self-concept, and altered locus of control.*

Anorexia nervosa MS

Nutrition: imbalanced, less than body requirements may be related to psychological restrictions of food intake and/or excessive activity, self-induced vomiting, laxative abuse, possibly evidenced by weight loss, poor skin turgor/muscle tone, denial of hunger, unusual hoarding or handling of food, amenorrhea, electrolyte imbalance, cardiac irregularities, hypotension.

Fluid Volume, risk for deficient risk factors may include inadequate intake of food and liquids, chronic/excessive laxative or diuretic use, self-induced vomiting.*

PSY

Thought Processes, disturbed may be related to severe malnutrition/electrolyte imbalance, psychological conflicts; possibly evidenced by impaired ability to make decisions, problem-solve, nonreality-based verbalizations, ideas of reference, altered sleep patterns, altered attention span/distractibility; perceptual disturbances with failure to recognize hunger, fatigue, anxiety, and depression.

Body Image, disturbed/Self-Esteem, chronic low may be related to altered perception of body, perceived loss of control in some aspect of life, unmet dependency needs, personal vulnerability, dysfunctional family system, possibly evidenced by negative feelings, distorted view of body, use of denial, feeling powerless to prevent/make changes, expressions of shame/guilt, overly conforming, dependent on others' opinions.

Family Processes, interrupted may be related to ambivalent family relationships and ways of transacting issues of control, situational/maturational crises possibly evidenced by enmeshed family, dissonance among family members, family developmental tasks not being met, family members acting as enablers.

Anxiety disorder, generalized PSY

Anxiety [specify level]/Powerlessness may be related to real or perceived threat to physical integrity or self-concept (may or may not be able to identify the threat), unconscious conflict about essential values/beliefs and goals of life, unmet needs, negative self-talk, possibly evidenced by sympathetic stimulation, extraneous movements (foot shuffling, hand/arm fidgeting, rocking movements, restlessness), persistent feelings of apprehension and uneasiness, a general anxious feeling that patient has difficulty alleviating, poor eye contact, focus on self, impaired functioning, free-floating anxiety, impaired functioning, and nonparticipation in decision making.

Coping, ineffective may be related to level of anxiety being experienced by the patient, personal vulnerability; unmet expectations/unrealistic perceptions, inadequate coping methods and/or support systems

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possibly evidenced by verbalization of inability to cope/problem-solve, excessive compulsive behaviors (e.g., smoking, drinking), and emotional/muscle tension, alteration in societal participation, high rate of accidents.

Sleep Pattern, disturbed may be related to psychological stress, repetitive thoughts, possibly evidenced by reports of difficulty in falling asleep/awakening earlier or later than desired, reports of not feeling rested, dark circles under eyes, and frequent yawning.

Coping, family: risk for compromised risk factors may include inadequate/incorrect information or understanding by a primary person, temporary family disorganization and role changes, prolonged disability that exhausts the supportive capacity of SO(s).*

Social Interaction, impaired/Social Isolation may be related to low selfconcept, inadequate personal resources, misinterpretation of internal/external stimuli, hypervigilance possibly evidenced by discomfort in social situations, withdrawal from or reported change in pattern of interactions, dysfunctional interactions; expressed feelings of difference from others; sad, dull affect.

Aortic stenosis — MS

Cardiac Output, decreased may be related to structural changes of heart valve, left ventricular outflow obstruction, alteration of afterload (increased left ventricular end-diastolic pressure and systemic vascular resistance—SVR), alteration in preload/increased atrial pressure and venous congestion, alteration in electrical conduction, possibly evidenced by fatigue, dyspnea, changes in vital signs/hemodynamic parameters, and syncope.

Gas Exchange, risk for impaired risk factors may include alveolar-capillary membrane changes/congestion.*

CH

Pain, acute risk factors may include episodic ischemia of myocardial tissues and stretching of left atrium.*

Activity intolerance may be related to imbalance between O_2 supply and demand (decreased/fixed cardiac output), possibly evidenced by exertional dyspnea, reported fatigue/weakness, and abnormal blood pressure or ECG changes/dysrhythmias in response to activity.

Appendicitis — MS

Pain, acute may be related to distention of intestinal tissues by inflammation, possibly evidenced by verbal reports, guarding behavior, narrowed focus, and autonomic responses (diaphoresis, changes in vital signs).

Fluid Volume, risk for deficient risk factors may include nausea, vomiting, anorexia, and hypermetabolic state.*

Infection, risk for: risk factors may include release of pathogenic organisms into peritoneal cavity.*

Arrhythmia, cardiac — MS/CH

(Refer to Dysrhythmia, cardiac)

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Arthritis, juvenile rheumatoid — PED/CH

(Also refer to Arthritis, rheumatoid)

Development, risk for delayed risk factors may include effects of physical disability and required therapy.

Social Isolation, risk for: risk factors may include delay in accomplishing developmental task, altered state of wellness, and changes in physical appearance.*

Arthritis, rheumatoid — CH

Pain, acute/chronic may be related to accumulation of fluid/inflammatory process, degeneration of joint, and deformity, possibly evidenced by verbal reports, narrowed focus, guarding/protective behaviors, and physical and social withdrawal.

Mobility, impaired physical may be related to musculoskeletal deformity, pain/discomfort, decreased muscle strength, possibly evidenced by limited range of motion, impaired coordination, reluctance to attempt movement, and decreased muscle strength/control and mass.

Self-Care deficit [specify] may be related to musculoskeletal impairment, decreased strength/endurance and range of motion, pain on movement, possibly evidenced by inability to manage activities of daily living (ADLs).

Body Image, disturbed/Role Performance, ineffective may be related to change in body structure/function, impaired mobility/ability to perform usual tasks, focus on past strength/function/appearance, possibly evidenced by negative self-talk, feelings of helplessness, change in lifestyle/physical abilities, dependence on others for assistance, decreased social involvement.

Arthroplasty — MS

Infection, risk for: risk factors may include breach of primary defenses (surgical incision), stasis of body fluids at operative site, and altered inflammatory response.*

Fluid Volume, risk for deficient risk factors may include surgical procedure/trauma to vascular area.*

Mobility, impaired physical may be related to decreased strength, pain, musculoskeletal changes, possibly evidenced by impaired coordination and reluctance to attempt movement.

Pain, acute may be related to tissue trauma, local edema, possibly evidenced by verbal reports, narrowed focus, guarded movement, and autonomic responses (diaphoresis, changes in vital signs).

Arthroscopy — MS

Knowledge, deficient [Learning Need] regarding procedure/outcomes and self-care needs may be related to unfamiliarity with information/resources, misinterpretations, possibly evidenced by questions and requests for information, misconceptions.

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Asthma **MS**

(Also refer to Emphysema)

Airway Clearance, ineffective may be related to increased production/retained pulmonary secretions, bronchospasm, decreased energy/fatigue, possibly evidenced by wheezing, difficulty breathing, changes in depth/rate of respirations, use of accessory muscles, and persistent ineffective cough with or without sputum production.

Gas Exchange, impaired may be related to altered delivery of inspired O_2/air trapping, possibly evidenced by dyspnea, restlessness, reduced tolerance for activity, cyanosis, and changes in ABGs and vital signs.

Anxiety [specify level] may be related to perceived threat of death, possibly evidenced by apprehension, fearful expression, and extraneous movements.

CH

Activity intolerance may be related to imbalance between O_2 supply and demand, possibly evidenced by fatigue and exertional dyspnea.

Athlete's foot **CH**

Skin Integrity, impaired may be related to fungal invasion, humidity, secretions, possibly evidenced by disruption of skin surface, reports of painful itching.

Infection, risk for spread risk factors may include multiple breaks in skin, exposure to moist/warm environment.*

Autistic disorder **PED/PSY**

Social Interaction, impaired may be related to abnormal response to sensory input/inadequate sensory stimulation, organic brain dysfunction; delayed development of secure attachment/trust, lack of intuitive skills to comprehend and accurately respond to social cues, disturbance in self-concept, possibly evidenced by lack of responsiveness to others, lack of eye contact or facial responsiveness, treating persons as objects, lack of awareness of feelings in others, indifference/aversion to comfort, affection, or physical contact; failure to develop cooperative social play and peer friendships in childhood.

Communication, impaired verbal may be related to inability to trust others, withdrawal into self, organic brain dysfunction, abnormal interpretation/response to and/or inadequate sensory stimulation, possibly evidenced by lack of interactive communication mode, no use of gestures or spoken language, absent or abnormal nonverbal communication; lack of eye contact or facial expression; peculiar patterns of speech (form, content, or speech production), and impaired ability to initiate or sustain conversation despite adequate speech.

Self-Mutilation, risk for: risk factors may include organic brain dysfunction, inability to trust others, disturbance in self-concept, inadequate sensory stimulation or abnormal response to sensory input (sensory overload); history of physical, emotional, or sexual abuse; and response to demands of therapy, realization of severity of condition.*

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Personal Identity, disturbed may be related to organic brain dysfunction, lack of development of trust, maternal deprivation, fixation at presymbiotic phase of development, possibly evidenced by lack of awareness of the feelings or existence of others, increased anxiety resulting from physical contact with others, absent or impaired imitation of others, repeating what others say, persistent preoccupation with parts of objects, obsessive attachment to objects, marked distress over changes in environment; autoerotic/ritualistic behaviors, self-touching, rocking, swaying.

Coping, family: compromised/disabled may be related to family members unable to express feelings; excessive guilt, anger, or blaming among family members regarding child's condition; ambivalent or dissonant family relationships, prolonged coping with problem exhausting supportive ability of family members, possibly evidenced by denial of existence or severity of disturbed behaviors, preoccupation with personal emotional reaction to situation, rationalization that problem will be outgrown, attempts to intervene with child are achieving increasingly ineffective results, family withdraws from or becomes overly protective of child.

Battered child syndrome — PED/CH

Trauma, risk for: risk factors may include dependent position in relationship(s), vulnerability (e.g., congenital problems/chronic illness), history of previous abuse/neglect, lack/nonuse of support systems by caregiver(s).*

Family Processes, interrupted/Parenting, impaired may be related to poor role model/identity, unrealistic expectations, presence of stressors, and lack of support, possibly evidenced by verbalization of negative feelings, inappropriate caretaking behaviors, and evidence of physical/psychological trauma to child.

PSY

Self-Esteem, chronic low may be related to deprivation and negative feedback of family members, personal vulnerability, feelings of abandonment, possibly evidenced by lack of eye contact, withdrawal from social contacts, discounting own needs, nonassertive/passive, indecisive, or overly conforming behaviors.

Post-Trauma Syndrome may be related to sustained/recurrent physical or emotional abuse; possibly evidenced by acting-out behavior, development of phobias, poor impulse control, and emotional numbness.

Coping, ineffective may be related to situational or maturational crisis, overwhelming threat to self, personal vulnerability, inadequate support systems, possibly evidenced by verbalized concern about ability to deal with current situation, chronic worry, anxiety, depression, poor self-esteem, inability to problem-solve, high illness rate, destructive behavior toward self/others.

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Benign prostatic hypertrophy CH/MS

Urinary Retention [acute/chronic] may be related to mechanical obstruction (enlarged prostate), decompensation of detrusor musculature, inability of bladder to contract adequately, possibly evidenced by frequency, hesitancy, inability to empty bladder completely, incontinence/dribbling, bladder distention, residual urine.

Pain, acute may be related to mucosal irritation, bladder distention, colic, urinary infection, and radiation therapy, possibly evidenced by verbal reports (bladder/rectal spasm), narrowed focus, altered muscle tone, grimacing, distraction behaviors, restlessness, and autonomic responses.

Fluid Volume, risk for deficient risk factors may include postobstructive diuresis, endocrine/electrolyte imbalances.*

Fear/Anxiety [specify level] may be related to change in health status (possibility of surgical procedure/malignancy); embarrassment/loss of dignity associated with genital exposure before, during, and after treatment, and concern about sexual ability, possibly evidenced by increased tension, apprehension, worry, expressed concerns regarding perceived changes, and fear of unspecific consequences.

Bipolar disorder PSY

Violence, risk for other-directed risk factors may include irritability, impulsive behavior; delusional thinking; angry response when ideas are refuted or wishes denied; manic excitement, with possible indicators of threatening body language/verbalizations, increased motor activity, overt and aggressive acts; hostility.*

Nutrition: imbalanced, less than body requirements may be related to inadequate intake in relation to metabolic expenditures, possibly evidenced by body weight 20% or more below ideal weight, observed inadequate intake, inattention to mealtimes, and distraction from task of eating; laboratory evidence of nutritional deficits/imbalances.

Poisoning, risk for lithium toxicity risk factors may include narrow therapeutic range of drug, patient's ability (or lack of) to follow through with medication regimen and monitoring, and denial of need for information/therapy.*

Sleep Pattern, disturbed may be related to psychological stress, lack of recognition of fatigue/need to sleep, hyperactivity, possibly evidenced by denial of need to sleep, interrupted nighttime sleep, one or more nights without sleep, changes in behavior and performance, increasing irritability/restlessness, and dark circles under eyes.

Sensory Perception, disturbed (specify) [overload] may be related to decrease in sensory threshold, endogenous chemical alteration, psychological stress, sleep deprivation, possibly evidenced by increased distractibility and agitation, anxiety, disorientation, poor concentration, auditory/visual hallucination, bizarre thinking, and motor incoordination.

Family Processes, interrupted may be related to situational crises (illness, economics, change in roles); euphoric mood and grandiose ideas/actions of patient, manipulative behavior and limit

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testing, patient's refusal to accept responsibility for own actions, possibly evidenced by statements of difficulty coping with situation, lack of adaptation to change or not dealing constructively with illness; ineffective family decision-making process, failure to send and to receive clear messages, and inappropriate boundary maintenance.

Borderline personality disorder PSY

Violence, risk for self-directed/other-directed/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.

Self-Esteem, chronic low/Personal Identity, disturbed 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.

Brain tumor MS

Pain, acute 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).

Thought Processes, disturbed 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.

Sensory Perception, disturbed (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.

Fluid Volume, risk for deficient risk factors may include recurrent vomiting from irritation of vagal center in medulla and decreased intake.*

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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 ADLs.

Bronchitis CH

Airway Clearance, ineffective may be related to excessive, thickened mucous secretions, possibly evidenced by presence of rhonchi, tachypnea, and ineffective cough.

Activity intolerance [specify level] may be related to imbalance between O_2 supply and demand, possibly evidenced by reports of fatigue, dyspnea, and abnormal vital sign response to activity.

Pain, acute 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.

Bronchopneumonia MS/CH

(Also refer to Bronchitis)

Airway Clearance, ineffective may be related to tracheal bronchial inflammation, edema formation, increased sputum production, pleuritic pain, decreased energy, fatigue, possibly evidenced by changes in rate/depth of respirations, abnormal breath sounds, use of accessory muscles, dyspnea, cyanosis, effective/ineffective cough—with or without sputum production.

Gas Exchange, impaired may be related to inflammatory process, collection of secretions affecting O_2 exchange across alveolar membrane, and hypoventilation, possibly evidenced by restlessness/changes in mentation, dyspnea, tachycardia, pallor, cyanosis, and ABGs/oximetry evidence of hypoxia.

Infection, risk for spread risk factors may include decreased ciliary action, stasis of secretions, presence of existing infection.*

Burn (dependent on type, degree, and severity of the injury) MS/CH

Fluid Volume, risk for deficient risk factors may include loss of fluids through wounds, capillary damage and evaporation, hypermetabolic state, insufficient intake, hemorrhagic losses.*

Airway Clearance, ineffective risk factors may include mucosal edema and loss of ciliary action (smoke inhalation), direct upper airway injury by flame, steam, chemicals.*

Infection, risk for: risk factors may include loss of protective dermal barrier, traumatized/necrotic tissue, decreased hemoglobin, suppressed inflammatory response, environmental exposure/invasive procedures.*

Pain, acute/chronic may be related to destruction of/trauma to tissue and nerves, edema formation, and manipulation of impaired tissues, possibly evidenced by verbal reports, narrowed focus, distraction and guarding behaviors, facial mask of pain, and autonomic responses (changes in vital signs).

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Nutrition: imbalanced, risk for less than body requirements risk factors may include hypermetabolic state in response to burn injury/stress, inadequate intake, protein catabolism.*

Post-Trauma Syndrome may be related to life-threatening event, possibly evidenced by reexperiencing the event, repetitive dreams/nightmares, psychic/emotional numbness, and sleep disturbance.

Protection, ineffective may be related to extremes of age, inadequate nutrition, anemia, impaired immune system, possibly evidenced by impaired healing, deficient immunity, fatigue, anorexia.

PED

Diversional Activity, deficient may be related to long-term hospitalization, frequent lengthy treatments, and physical limitations, possibly evidenced by expressions of boredom, restlessness, withdrawal, and requests for something to do.

Development, risk for delayed risk factors may include effects of physical disability, separation from SO(s), and environmental deficiencies.*

Bursitis — CH

Pain, acute/chronic may be related to inflammation of affected joint, possibly evidenced by verbal reports, guarding behavior, and narrowed focus.

Mobility, impaired physical may be related to inflammation and swelling of joint, and pain, possibly evidenced by diminished range of motion, reluctance to attempt movement, and imposed restriction of movement by medical treatment.

Calculus, urinary — MS/CH

Pain, acute may be related to increased frequency/force of ureteral contractions, tissue trauma and edema formation, possibly evidenced by reports of sudden, severe, colicky pains; guarding and distraction behaviors, and autonomic responses.

Urinary Elimination, impaired may be related to stimulation of the bladder by calculi, renal or ureteral irritation, mechanical obstruction of urinary flow, inflammation possibly evidenced by urgency and frequency; oliguria (retention); hematuria.

Infection, risk for: risk factors may include stasis of urine.*

Knowledge, deficient [Learning Need] regarding condition, prognosis, self-care and treatment needs may be related to lack of exposure/recall and information misinterpretation, possibly evidenced by requests for information, statements of concern, and recurrence/development of preventable complications.

Cancer — MS

(Also refer to Chemotherapy)

Fear/Anxiety, death may be related to situational crises, threat to/change in health/socioeconomic status, role functioning, interaction patterns; threat of death, separation from family, interpersonal

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transmission of feelings, possibly evidenced by expressed concerns, feelings of inadequacy/helplessness, insomnia; increased tension, restlessness, focus on self, sympathetic stimulation.

Grieving, anticipatory may be related to potential loss of physiological well-being (body part/function), perceived separation from SO(s)/lifestyle (death), possibly evidenced by anger, sadness, withdrawal, choked feelings, changes in eating/sleep patterns, activity level, libido, and communication patterns.

Pain, acute/chronic may be related to the disease process (compression of nerve tissue, infiltration of nerves or their vascular supply, obstruction of a nerve pathway, inflammation), or side effects of therapeutic agents, possibly evidenced by verbal reports, self-focusing/narrowed focus, alteration in muscle tone, facial mask of pain, distraction/guarding behaviors, autonomic responses, and restlessness.

Fatigue may be related to decreased metabolic energy production, increased energy requirements (hypermetabolic state), overwhelming psychological/emotional demands, and altered body chemistry (side effects of medications, chemotherapy), possibly evidenced by unremitting/overwhelming lack of energy, inability to maintain usual routines, decreased performance, impaired ability to concentrate, lethargy/listlessness, and disinterest in surroundings.

Home Maintenance, impaired may be related to debilitation, lack of resources, and/or inadequate support systems, possibly evidenced by verbalization of problem, request for assistance, and lack of necessary equipment or aids.

PED

Coping, family: compromised/disabled may be related to chronic nature of disease and disability, ongoing treatment needs, parental supervision, and lifestyle restrictions, possibly evidenced by expression of denial/despair, depression, and protective behavior disproportionate to patient's abilities or need for autonomy.

Coping, family: readiness for enhanced may be related to the fact that the individual's needs are being sufficiently gratified and adaptive tasks effectively addressed, enabling goals of self-actualization to surface, possibly evidenced by verbalizations of impact of crisis on own values, priorities, goals, or relationships.

Cardiac surgery — MS/PED

Anxiety [specify level]/Fear may be related to change in health status and threat to self-concept/of death, possibly evidenced by sympathetic stimulation, increased tension, and apprehension.

Cardiac Output, risk for decreased risk factors may include decreased preload (hypovolemia), depressed myocardial contractility, changes in SVR (afterload), and alterations in electrical conduction (dysrhythmias).*

Fluid Volume, deficient [isotonic] may be related to intraoperative bleeding with inadequate blood replacement; bleeding related to

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insufficient heparin reversal, fibrinolysis, or platelet destruction; or volume depletion effects of intraoperative/postoperative diuretic therapy, possibly evidenced by increased pulse rate, decreased pulse volume/pressure, decreased urine output, hemoconcentration.

Breathing Pattern, ineffective/Gas Exchange, risk for impaired risk factors may include inadequate ventilation (pain/muscle weakness), diminished oxygen-carrying capacity (blood loss), decreased lung expansion (atelectasis or hemo/pneumothorax), inadequate function or premature discontinuation of chest tubes.*

Pain, acute/[Discomfort] may be related to tissue inflammation/trauma, edema formation, intraoperative nerve trauma, and myocardial ischemia, possibly evidenced by reports of incisional discomfort/pain in chest and donor site; paresthesia/pain in hand, arm, shoulder, anxiety, restlessness, irritability; distraction behaviors, and autonomic responses.

Skin/Tissue Integrity, impaired related to mechanical trauma (surgical incisions, puncture wounds) and edema evidenced by disruption of skin surface/tissues.

Carpal tunnel syndrome CH/MS

Pain, acute/chronic may be related to pressure on median nerve, possibly evidenced by verbal reports, reluctance to use affected extremity, guarding behaviors, expressed fear of reinjury, altered ability to continue previous activities.

Mobility, impaired physical may be related to neuromuscular impairment and pain, possibly evidenced by decreased hand strength, weakness, limited range of motion, and reluctance to attempt movement.

Peripheral Neurovascular Dysfunction, risk for: risk factors may include mechanical compression (e.g., brace, repetitive tasks/motions), immobilization.*

Knowledge, deficient [Learning Need] regarding condition, prognosis and treatment/safety needs may be related to lack of exposure/recall, information misinterpretation, possibly evidenced by questions, statements of concern, request for information, inaccurate follow-through of instructions/development of preventable complications.

Casts CH/MS

(Also refer to Fractures)

Peripheral Neurovascular dysfunction, risk for: risk factors may include presence of fracture(s), mechanical compression (cast), tissue trauma, immobilization, vascular obstruction.*

Skin Integrity, risk for impaired risk factors may include pressure of cast, moisture/debris under cast, objects inserted under cast to relieve itching, and/or altered sensation/circulation.*

Self-Care Deficit [specify] may be related to impaired ability to perform self-care tasks, possibly evidenced by statements of need for assistance and observed difficulty in performing activities of daily living.

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Cataract — CH

Sensory Perception, disturbed: visual may be related to altered sensory reception/status of sense organs, and therapeutically restricted environment (surgical procedure, patching), possibly evidenced by diminished acuity, visual distortions, and change in usual response to stimuli.

Trauma, risk for: risk factors may include poor vision, reduced hand/eye coordination.*

Anxiety [specify level]/Fear may be related to alteration in visual acuity, threat of permanent loss of vision/independence, possibly evidenced by expressed concerns, apprehension, and feelings of uncertainty.

Knowledge, deficient [Learning Need] regarding ways of coping with altered abilities, therapy choices, lifestyle changes may be related to lack of exposure/recall, misinterpretation, or cognitive limitations, possibly evidenced by requests for information, statement of concern, inaccurate follow-through of instructions/development of preventable complications.

Cat scratch disease — CH

Pain, acute may be related to effects of circulating toxins (fever, headache, and lymphadenitis), possibly evidenced by verbal reports, guarding behavior, and autonomic response (changes in vital signs).

Hyperthermia may be related to inflammatory process, possibly evidenced by increased body temperature, flushed warm skin, tachypnea and tachycardia.

Cerebrovascular accident — MS

Tissue Perfusion, ineffective: cerebral may be related to interruption of blood flow (occlusive disorder, hemorrhage, cerebral vasospasm/edema), possibly evidenced by altered level of consciousness, changes in vital signs, changes in motor/sensory responses, restlessness, memory loss; sensory, language, intellectual, and emotional deficits.

Mobility, impaired physical may be related to neuromuscular involvement (weakness, paresthesia, flaccid/hypotonic paralysis, spastic paralysis), perceptual/cognitive impairment, possibly evidenced by inability to purposefully move involved body parts/limited range of motion; impaired coordination, and/or decreased muscle strength/control.

Communication, impaired verbal [and/or written] may be related to impaired cerebral circulation, neuromuscular impairment, loss of facial/oral muscle tone and control; generalized weakness/fatigue, possibly evidenced by impaired articulation, does not/cannot speak (dysarthria); inability to modulate speech, find and/or name words, identify objects and/or inability to comprehend written/spoken language; inability to produce written communication.

Self-Care deficit [specify] may be related to neuromuscular impairment, decreased strength/endurance, loss of muscle control/coordination, perceptual/cognitive impairment, pain/discomfort, and depression, possibly evidenced by stated/observed inability to perform ADLs, requests for assistance, disheveled appearance, and incontinence.

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Swallowing, risk for impaired risk factors may include muscle paralysis and perceptual impairment.*

Unilateral Neglect risk factors may include sensory loss of part of visual field with perceptual loss of corresponding body segment.*

CH

Home Maintenance, impaired may be related to condition of individual family member, insufficient finances/family organization or planning, unfamiliarity with resources, and inadequate support systems, possibly evidenced by members expressing difficulty in managing home in a comfortable manner/requesting assistance with home maintenance, disorderly surroundings, and overtaxed family members.

Self-Esteem, situational low/Body image, disturbed/Role performance, ineffective may be related to biophysical, psychosocial, and cognitive/perceptual changes, possibly evidenced by actual change in structure and/or function, change in usual patterns of responsibility/physical capacity to resume role; and verbal/nonverbal response to actual or perceived change.

Cesarean birth, unplanned — OB

Knowledge, deficient [Learning Need] regarding underlying procedure, pathophysiology, and self-care needs may be related to incomplete/inadequate information, possibly evidenced by request for information, verbalization of concerns/misconceptions and inappropriate/exaggerated behavior.

Anxiety [specify level] may be related to actual/perceived threat to mother/fetus, emotional threat to self-esteem, unmet needs/expectations, interpersonal transmission, possibly evidenced by increased tension, apprehension, feelings of inadequacy, sympathetic stimulation, and narrowed focus, restlessness.

Self-Esteem, risk for situational low risk factors may include perceived "failure" at life event.*

Pain, risk for acute risk factors may include increased/prolonged contractions, psychological reaction.*

Infection, risk for: risk factors may include invasive procedures, rupture of amniotic membranes, break in skin, decreased hemoglobin, exposure to pathogens.*

Chemotherapy — MS/CH

(Also refer to Cancer)

Fluid Volume, risk for deficient risk factors may include gastrointestinal losses (vomiting), interference with adequate intake (stomatitis/anorexia), losses through abnormal routes (indwelling tubes, wounds, fistulas), hypermetabolic state.*

Nutrition: imbalanced, less than body requirements may be related to inability to ingest adequate nutrients (nausea, stomatitis, and fatigue), hypermetabolic state, possibly evidenced by weight loss (wasting), aversion to eating, reported altered taste sensation, sore, inflamed buccal cavity; diarrhea and/or constipation.

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Oral Mucous Membrane, impaired may be related to side effects of therapeutic agents/radiation, dehydration, and malnutrition, possibly evidenced by ulcerations, leukoplakia, decreased salivation, and reports of pain.

Body Image, disturbed may be related to anatomical/structural changes; loss of hair and weight, possibly evidenced by negative feelings about body, preoccupation with change, feelings of helplessness/ hopelessness, and change in social environment.

Protection, ineffective may be related to inadequate nutrition, drug therapy/radiation, abnormal blood profile, disease state (cancer), possibly evidenced by impaired healing, deficient immunity, anorexia, fatigue.

Cholecystectomy MS

Pain, acute may be related to interruption in skin/tissue layers with mechanical closure (sutures/staples) and invasive procedures (including T-tube/nasogastric—NG—tube), possibly evidenced by verbal reports, guarding/distraction behaviors, and autonomic responses (changes in vital signs).

Breathing Pattern, ineffective may be related to decreased lung expansion (pain and muscle weakness), decreased energy/fatigue, ineffective cough, possibly evidenced by fremitus, tachypnea, and decreased respiratory depth/vital capacity.

Fluid Volume, risk for deficient risk factors may include vomiting/NG aspiration, medically restricted intake, altered coagulation.*

Cholelithiasis CH

Pain, acute may be related to inflammation and distortion of tissues, ductal spasm, possibly evidenced by verbal reports, guarding/distraction behaviors, and autonomic responses (changes in vital signs).

Nutrition: imbalanced, less than body requirements may be related to inability to ingest/absorb adequate nutrients (food intolerance/pain, nausea/vomiting, anorexia), possibly evidenced by aversion to food/decreased intake and weight loss.

Knowledge, deficient [Learning Need] regarding pathophysiology, therapy choices, and self-care needs may be related to lack of information, misinterpretation, possibly evidenced by verbalization of concerns, questions, and recurrence of condition.

Chronic obstructive lung disease CH/MS

(Also refer to Asthma: Emphysema)

Gas Exchange, impaired may be related to altered O_2 delivery (obstruction of airways by secretions/bronchospasm, air trapping) and alveoli destruction, possibly evidenced by dyspnea, restlessness, confusion, abnormal ABG values, and reduced tolerance for activity.

Airway Clearance, ineffective may be related to bronchospasm, increased production of tenacious secretions, retained secretions, and decreased energy/fatigue, possibly evidenced by presence of wheezes, crackles, tachypnea, dyspnea, changes in depth of respirations, use of accessory muscles, cough (persistent), and chest x-ray findings.

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Activity intolerance may be related to imbalance between O_2 supply and demand, and generalized weakness, possibly evidenced by verbal reports of fatigue, exertional dyspnea, and abnormal vital sign response.

Nutrition: imbalanced, less than body requirements may be related to inability to ingest adequate nutrients (dyspnea, fatigue, medication side effects, sputum production, anorexia), possibly evidenced by weight loss, reported altered taste sensation, decreased muscle mass/subcutaneous fat, poor muscle tone, and aversion to eating/lack of interest in food.

Infection, risk for: risk factors may include decreased ciliary action, stasis of secretions, and debilitated state/malnutrition.*

Cirrhosis MS/CH

(Also refer to Substance dependence/abuse rehabilitation; Hepatitis, acute viral)

Nutrition: imbalanced, less than body requirements may be related to inability to ingest/absorb nutrients (anorexia, nausea, indigestion, early satiety), abnormal bowel function, impaired storage of vitamins, possibly evidenced by aversion to eating, observed lack of intake, muscle wasting, weight loss, and imbalances in nutritional studies.

Fluid Volume, excess may be related to compromised regulatory mechanism (e.g., syndrome of inappropriate antidiuretic hormone—SIADH, decreased plasma proteins/malnutrition) and excess sodium/fluid intake, possibly evidenced by generalized or abdominal edema, weight gain, dyspnea, BP changes, positive hepatojugular reflex, change in mentation, altered electrolytes, changes in urine specific gravity, and pleural effusion.

Skin Integrity, risk for impaired risk factors may include altered circulation/metabolic state, poor skin turgor, skeletal prominence, and presence of edema/ascites, accumulation of bile salts in skin.*

Confusion, risk for acute risk factors may include alcohol abuse, increased serum ammonia level, and inability of liver to detoxify certain enzymes/drugs.*

Self-Esteem, situational low/Body Image, disturbed may be related to biophysical changes/altered physical appearance, uncertainty of prognosis, changes in role function, personal vulnerability, self-destructive behavior (alcohol-induced disease), possibly evidenced by verbalization of changes in lifestyle, fear of rejection/reaction of others, negative feelings about body/abilities, and feelings of helplessness/hopelessness/powerlessness.

Injury, risk for hemorrhage risk factors may include abnormal blood profile (altered clotting factors), portal hypertension/development of esophageal varices.*

Cocaine hydrochloride poisoning, acute MS

(Also refer to Substance dependence/abuse rehabilitation)

Breathing Pattern, ineffective may be related to pharmacological effects on respiratory center of the brain, possibly evidenced by tachypnea, altered depth of respiration, shortness of breath, and abnormal ABGs.

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Cardiac Output, risk for decreased risk factors may include drug effect on myocardium (degree dependent on drug purity/quality used), alterations in electrical rate/rhythm/conduction, preexisting myocardiopathy.*

CH

Nutrition: imbalanced, less than body requirements may be related to anorexia, insufficient/inappropriate use of financial resources, possibly evidenced by reported inadequate intake, weight loss/less than normal weight gain; lack of interest in food, poor muscle tone, signs/laboratory evidence of vitamin deficiencies.

Infection, risk for: risk factors may include injection techniques, impurities of drugs; localized trauma/nasal septum damage, malnutrition, altered immune state.*

PSY

Coping, ineffective may be related to personal vulnerability, negative role modeling, inadequate support systems; ineffective/inadequate coping skills with substitution of drug, possibly evidenced by use of harmful substance despite evidence of undesirable consequences.

Sensory Perception, disturbed (specify) may be related to exogenous chemical, altered sensory reception/transmission/integration (hallucination), altered status of sense organs, possibly evidenced by responding to internal stimuli from hallucinatory experiences, bizarre thinking, anxiety/panic changes in sensory acuity (sense of smell/taste).

Coccidioidomycosis (San Joaquin/Valley Fever) CH

Pain, acute may be related to inflammation, possibly evidenced by verbal reports, distraction behaviors, and narrowed focus.

Fatigue may be related to decreased energy production; states of discomfort, possibly evidenced by reports of overwhelming lack of energy, inability to maintain usual routine, emotional lability/irritability, impaired ability to concentrate, and decreased endurance/libido.

Knowledge, deficient [Learning Need] regarding nature/course of disease, therapy and self-care needs may be related to lack of information, possibly evidenced by statements of concern and questions.

Colitis, ulcerative MS

Diarrhea may be related to inflammation or malabsorption of the bowel, presence of toxins and/or segmental narrowing of the lumen, possibly evidenced by increased bowel sounds/peristalsis, urgency, frequency/watery stools (acute phase), changes in stool color, and abdominal pain/cramping.

Pain, acute/chronic may be related to inflammation of the intestines/hyperperistalsis and anal/rectal irritation, possibly evidenced by verbal reports, guarding/distraction behaviors.

Fluid Volume, risk for deficient risk factors may include continued GI losses (diarrhea, vomiting, capillary plasma loss), altered intake, hypermetabolic state.*

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CH

Nutrition: imbalanced, less than body requirements may be related to altered intake/absorption of nutrients (medically restricted intake, fear that eating may cause diarrhea) and hypermetabolic state, possibly evidenced by weight loss, decreased subcutaneous fat/muscle mass, poor muscle tone, hyperactive bowel sounds, steatorrhea, pale conjunctiva and mucous membranes, and aversion to eating.

Coping, ineffective may be related to chronic nature and indefinite outcome of disease, multiple stressors (repeated over time), personal vulnerability, severe pain, inadequate sleep, lack of/ineffective support systems, possibly evidenced by verbalization of inability to cope, discouragement, anxiety; preoccupation with physical self, chronic worry, emotional tension; depression, and recurrent exacerbation of symptoms.

Powerlessness, risk for: risk factors may include unresolved dependency conflicts, feelings of insecurity/resentment, repression of anger and aggressive feelings, lacking a sense of control in stressful situations, sacrificing own wishes for others, and retreat from aggression or frustration.*

Colostomy

MS

Skin Integrity, risk for impaired risk factors may include absence of sphincter at stoma and chemical irritation from caustic bowel contents, reaction to product/removal of adhesive, and improperly fitting appliance.*

Diarrhea/Constipation, risk for: risk factors may include interruption/alteration of normal bowel function (placement of ostomy), changes in dietary/fluid intake, and effects of medication.*

CH

Knowledge, deficient [Learning Need] regarding changes in physiological function and self-care/treatment needs may be related to lack of exposure/recall, information misinterpretation, possibly evidenced by questions, statement of concern, and inaccurate follow-through of instruction/development of preventable complications.

Body Image, disturbed may be related to biophysical changes (presence of stoma; loss of control of bowel elimination) and psychosocial factors (altered body structure, disease process/associated treatment regimen, e.g., cancer, colitis), possibly evidenced by verbalization of change in perception of self, negative feelings about body, fear of rejection/reaction of others, not touching/looking at stoma, and refusal to participate in care.

Social Interaction, impaired may be related to fear of embarrassing situation secondary to altered bowel control with loss of contents, odor, possibly evidenced by reduced participation and verbalized/observed discomfort in social situations.

Sexual Dysfunction, risk for: risk factors may include altered body structure/function, radical resection/treatment procedures, vulnerability/

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psychological concern about response of SO(s), and disruption of sexual response pattern (e.g., erectile difficulty).*

Coma, diabetic **MS**

(Refer to Diabetic Ketoacidosis)

Concussion of brain **CH**

Pain, acute may be related to trauma to/edema of cerebral tissue, possibly evidenced by reports of headache, guarding/distraction behaviors, and narrowed focus.

Fluid Volume, risk for deficient risk factors may include vomiting, decreased intake, and hypermetabolic state (fever).*

Thought Processes, risk for disturbed risk factors may include trauma to/edema of cerebral tissue.

Knowledge, deficient* [Learning Need] regarding condition, treatment/safety needs, and potential complications may be related to lack of recall, misinterpretation, cognitive limitation, possibly evidenced by questions/statement of concerns, development of preventable complications.

Conduct disorder (childhood, adolescence) **PSY/PED**

Violence, risk for self-directed/other-directed risk factors may include retarded ego development, antisocial character, poor impulse control, dysfunctional family system, loss of significant relationships, history of suicidal/acting-out behaviors.

Coping, defensive may be related to inadequate coping strategies, maturational crisis, multiple life changes/losses, lack of control of impulsive actions, and personal vulnerability, possibly evidenced by inappropriate use of defense mechanisms, inability to meet role expectations, poor self-esteem, failure to assume responsibility for own actions, hypersensitivity to slight or criticism, and excessive smoking/drinking/drug use.

Thought Processes, disturbed may be related to physiological changes, lack of appropriate psychological conflict, biochemical changes, as evidenced by tendency to interpret the intentions/actions of others as blaming and hostile; deficits in problem-solving skills, with physical aggression the solution most often chosen.

Self-Esteem, chronic low may be related to life choices perpetuating failure, personal vulnerability, possibly evidenced by self-negating verbalizations, anger, rejection of positive feedback, frequent lack of success in life events.

CH

Coping, family: compromised/disabled may be related to excessive guilt, anger, or blaming among family members regarding child's behavior; parental inconsistencies; disagreements regarding discipline, limit setting, and approaches; and exhaustion of parental resources (prolonged coping with disruptive child), possibly evidenced by unrealistic parental expectations, rejection or overprotection of child; and exaggerated expressions of anger, disappointment, or despair regarding child's behavior or ability to improve or change.

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Social Interaction, impaired may be related to retarded ego development, developmental state (adolescence), lack of social skills, low self-concept, dysfunctional family system, and neurological impairment, possibly evidenced by dysfunctional interaction with others (difficulty waiting turn in games or group situations, not seeming to listen to what is being said), difficulty playing quietly and maintaining attention to task or play activity, often shifting from one activity to another and interrupting or intruding on others.

Congestive heart failure — MS

(Refer to Heart failure, chronic)

Conn's syndrome — MS/CH

(Refer to Aldosteronism, primary)

Constipation — CH

Constipation may be related to weak abdominal musculature, GI obstructive lesions, pain on defecation, diagnostic procedures, pregnancy, possibly evidenced by change in character/frequency of stools, feeling of abdominal/rectal fullness or pressure, changes in bowel sounds, abdominal distention.

Pain, acute may be related to abdominal fullness/pressure, straining to defecate, and trauma to delicate tissues, possibly evidenced by verbal reports, reluctance to defecate, and distraction behaviors.

Knowledge, deficient [Learning Need] regarding dietary needs, bowel function, and medication effect may be related to lack of information/misconceptions, possibly evidenced by development of problem and verbalization of concerns/questions.

Coronary artery bypass surgery — MS

(Also refer to Cardiac surgery)

Cardiac Output, risk for decreased risk factors may include decreased myocardial contractility, diminished circulating volume (preload), alterations in electrical conduction, and increased SVR (afterload).*

Pain, acute may be related to direct chest tissue/bone trauma, invasive tubes/lines, donor site incision, tissue inflammation/edema formation, intraoperative nerve trauma, possibly evidenced by verbal reports, autonomic responses (changes in vital signs), and distraction behaviors/(restlessness), irritability.

Sensory Perception, disturbed (specify) may be related to restricted environment (postoperative/acute), sleep deprivation, effects of medications; continuous environmental sounds/activities, and psychological stress of procedure, possibly evidenced by disorientation, alterations in behavior, exaggerated emotional responses, and visual/auditory distortions.

CH

Role Performance, ineffective may be related to situational crises (dependent role)/recuperative process, uncertainty about future, possibly evidenced by delay/alteration in physical capacity to resume role, change in usual role or responsibility, change in self/others' perception of role.

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Crohn's disease **MS/CH**

(Also refer to Colitis, ulcerative)

Nutrition: imbalanced, less than body requirements may be related to intestinal pain after eating; and decreased transit time through bowel, possibly evidenced by weight loss, aversion to eating, and observed lack of intake.

Diarrhea may be related to inflammation of small intestines, presence of toxins, particular dietary intake, possibly evidenced by hyperactive bowel sounds, cramping, and frequent loose liquid stools.

Knowledge, deficient [Learning Need] regarding condition, nutritional needs, and prevention of recurrence may be related to insufficient information/misinterpretation, unfamiliarity with resources, possibly evidenced by statements of concern/questions, inaccurate follow-through of instructions, and development of preventable complications/exacerbation of condition.

Croup **PED/CH**

Airway Clearance, ineffective may be related to presence of thick, tenacious mucus and swelling/spasms of the epiglottis, possibly evidenced by harsh/brassy cough, tachypnea, use of accessory breathing muscles, and presence of wheezes.

Fluid Volume, deficient [isotonic] may be related to decreased ability/aversion to swallowing, presence of fever, and increased respiratory losses, possibly evidenced by dry mucous membranes, poor skin turgor, and scanty/concentrated urine.

Croup membranous **PED/CH**

(Also refer to Croup)

Suffocation, risk for: risk factors may include inflammation of larynx with formation of false membrane.*

Anxiety [specify level]/Fear may be related to change in environment, perceived threat to self (difficulty breathing), and transmission of anxiety of adults, possibly evidenced by restlessness, facial tension, glancing about, and sympathetic stimulation.

Cushing's syndrome **CH/MS**

Fluid Volume, excess risk factors may include compromised regulatory mechanism (fluid/sodium retention).

Infection, risk for: risk factors may include immunosuppressed inflammatory response, skin and capillary fragility, and negative nitrogen balance.*

Nutrition: imbalanced, less than body requirements may be related to inability to utilize nutrients (disturbance of carbohydrate metabolism), possibly evidenced by decreased muscle mass and increased resistance to insulin.

Self-Care deficit [specify] may be related to muscle wasting, generalized weakness, fatigue, and demineralization of bones, possibly evidenced by statements of/observed inability to complete or perform ADLs.

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Body Image, disturbed may be related to change in structure/appearance (effects of disease process, drug therapy), possibly evidenced by negative feelings about body, feelings of helplessness, and changes in social involvement.

Sexual Dysfunction may be related to loss of libido, impotence, and cessation of menses, possibly evidenced by verbalization of concerns and/or dissatisfaction with and alteration in relationship with SO.

Trauma, risk for fractures risk factors may include increased protein breakdown, negative protein balance, demineralization of bones.*

Cystic fibrosis — CH/PED

Airway Clearance, ineffective may be related to excessive production of thick mucus and decreased ciliary action, possibly evidenced by abnormal breath sounds, ineffective cough, cyanosis, and altered respiratory rate/depth.

Infection, risk for: risk factors may include stasis of respiratory secretions and development of atelectasis.*

Nutrition: imbalanced, less than body requirements may be related to impaired digestive process and absorption of nutrients, possibly evidenced by failure to gain weight, muscle wasting, and retarded physical growth.

Knowledge, deficient [Learning Need] regarding pathophysiology of condition, medical management, and available community resources may be related to insufficient information/misconceptions, possibly evidenced by statements of concern, questions; inaccurate follow-through of instructions, development of preventable complications.

Coping, family: compromised may be related to chronic nature of disease and disability, inadequate/incorrect information or understanding by a primary person, and possibly evidenced by significant person attempting assistive or supportive behaviors with less than satisfactory results, protective behavior disproportionate to patient's abilities or need for autonomy.

Cystitis — CH

Pain, acute may be related to inflammation and bladder spasms, possibly evidenced by verbal reports, distraction behaviors, and narrowed focus.

Urinary Elimination, impaired may be related to inflammation/irritation of bladder, possibly evidenced by frequency, nocturia, and dysuria.

Knowledge, deficient [Learning Need] regarding condition, treatment, and prevention of recurrence may be related to inadequate information/misconceptions, possibly evidenced by statements of concern and questions; recurrent infections.

Cytomegalic inclusion disease — CH

(Refer to Herpes Infections)

Dehiscence (abdominal) — MS

Skin Integrity, impaired may be related to altered circulation, altered nutritional state (obesity/malnutrition), and physical stress on incision,

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possibly evidenced by poor/delayed wound healing and disruption of skin surface/wound closure.

Infection, risk for: risk factors may include inadequate primary defenses (separation of incision, traumatized intestines, environmental exposure).*

Tissue Integrity, risk for impaired risk factors may include exposure of abdominal contents to external environment.*

Fear/Anxiety [severe] may be related to crises, perceived threat of death, possibly evidenced by fearfulness, restless behaviors, and sympathetic stimulation.

Knowledge, deficient [Learning Need] regarding condition/prognosis and treatment needs may be related to lack of information/recall and misinterpretation of information, possibly evidenced by development of preventable complication, requests for information, and statement of concern.

Dehydration PED

Fluid Volume, deficient [specify] may be related to etiology as defined by specific situation, possibly evidenced by dry mucous membranes, poor skin turgor, decreased pulse volume/pressure, and thirst.

Oral Mucous Membrane, risk for impaired risk factors may include dehydration and decreased salivation.*

Knowledge, deficient [Learning Need] regarding fluid needs may be related to lack of information/misinterpretation, possibly evidenced by questions, statement of concern, and inadequate follow-through of instructions/development of preventable complications.

Delirium tremens (acute alcohol withdrawal) MS/PSY

Anxiety [severe/panic]/Fear may be related to cessation of alcohol intake/physiological withdrawal, threat to self-concept, perceived threat of death, possibly evidenced by increased tension, apprehension, fear of unspecified consequences; identifies object of fear.

Sensory Perception, disturbed (specify) may be related to exogenous (alcohol consumption/sudden cessation)/endogenous (electrolyte imbalance, elevated ammonia and blood urea nitrogen—BUN) chemical alterations, sleep deprivation, and psychological stress, possibly evidenced by disorientation, restlessness, irritability, exaggerated emotional responses, bizarre thinking, and visual and auditory distortions/hallucinations.

Cardiac Output, risk for decreased risk factors may include direct effect of alcohol on heart muscle, altered SVR, presence of dysrhythmias.*

Trauma, risk for: risk factors may include alterations in balance, reduced muscle coordination, cognitive impairment, and involuntary clonic/tonic muscle activity.*

Nutrition: imbalanced, less than body requirements may be related to poor dietary intake, effects of alcohol on organs involved in digestion, interference with absorption/metabolism of nutrients and amino acids, possibly evidenced by reports of inadequate food intake, altered taste sensation, lack of interest in food, debilitated state, decreased

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subcutaneous fat/muscle mass, signs of mineral/electrolyte deficiency including abnormal laboratory findings.

Dementia, presenile/senile CH/PSY

(Also refer to Alzheimer's disease)

Memory, impaired may be related to neurological disturbances, possibly evidenced by observed experiences of forgetting, inability to determine if a behavior was performed, inability to perform previously learned skills, inability to recall factual information or recent/past events.

Fear may be related to decreases in functional abilities, public disclosure of disabilities, further mental/physical deterioration possibly evidenced by social isolation, apprehension, irritability, defensiveness, suspiciousness, aggressive behavior.

Self-Care deficit [specify] may be related to cognitive decline, physical limitations, frustration over loss of independence, depression, possibly evidenced by impaired ability to perform ADLs.

Trauma, risk for: risk factors may include changes in muscle coordination/balance, impaired judgment, seizure activity.*

Caregiver Role Strain, risk for: risk factors may include illness severity of care receiver, duration of caregiving required, care receiver exhibiting deviant/bizarre behavior; family/caregiver isolation, lack of respite/ recreation, spouse is caregiver.*

Depressive disorders, major depression, dysthymia PSY

Violence, risk for self-directed risk factors may include depressed mood and feeling of worthlessness and hopelessness.*

Anxiety [moderate to severe]/Thought Processes, disturbed may be related to psychological conflicts, unconscious conflict about essential values/goals of life, unmet needs, threat to self-concept, sleep deprivation, interpersonal transmission/contagion, possibly evidenced by reports of nervousness or fearfulness, feelings of inadequacy; agitation, angry/tearful outbursts, rambling/discoordinated speech, restlessness, hand rubbing or wringing, tremulousness; poor memory/concentration, decreased ability to grasp ideas, inability to follow/impaired ability to make decisions, numerous/repetitious physical complaints without organic cause, ideas of reference, hallucinations/delusions.

Sleep Pattern, disturbed may be related to biochemical alterations (decreased serotonin), unresolved fears and anxieties, and inactivity, possibly evidenced by difficulty in falling/remaining asleep, early morning awakening/awakening later than desired, reports of not feeling rested, physical signs (e.g., dark circles under eyes, excessive yawning); hypersomnia (using sleep as an escape).

Social Isolation/Social Interaction, impaired may be related to alterations in mental status/thought processes (depressed mood), inadequate personal resources, decreased energy/inertia, difficulty engaging in satisfying personal relationships, feelings of worthlessness/low self-concept, inadequacy in or absence of significant

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purpose in life, and knowledge/skill deficit about social interactions, possibly evidenced by decreased involvement with others, expressed feelings of difference from others, remaining in home/room/bed, refusing invitations/suggestions of social involvement, and dysfunctional interaction with peers, family, and/or others.

Family Processes, interrupted may be related to situational crises of illness of family member with change in roles/responsibilities, developmental crises (e.g., loss of family member/relationship), possibly evidenced by statements of difficulty coping with situation, family system not meeting needs of its members, difficulty accepting or receiving help appropriately, ineffective family decision-making process, and failure to send and to receive clear messages.

Injury, risk for [effects of electroconvulsive therapy—ECT] risk factors may include effects of therapy on the cardiovascular, respiratory, musculoskeletal, and nervous systems; and pharmacological effects of anesthesia.*

Dermatitis seborrheic — CH

Skin Integrity, impaired may be related to chronic inflammatory condition of the skin, possibly evidenced by disruption of skin surface with dry or moist scales, yellowish crusts, erythema, and fissures.

Diabetes mellitus — CH/PED

Knowledge, deficient [Learning Need] regarding disease process/treatment and individual care needs may be related to unfamiliarity with information/lack of recall, misinterpretation, possibly evidenced by requests for information, statements of concern/misconceptions, inadequate follow-through of instructions, and development of preventable complications.

Nutrition: imbalanced, less than body requirements may be related to inability to utilize nutrients (imbalance between intake and utilization of glucose) to meet metabolic needs, possibly evidenced by change in weight, muscle weakness, increased thirst/urination, and hyperglycemia.

Adjustment, risk for impaired risk factors may possibly include all-encompassing change in lifestyle, self-concept requiring lifelong adherence to therapeutic regimen and internal/altered locus of control.*

Infection, risk for: risk factors may include decreased leukocyte function, circulatory changes, and delayed healing.*

Sensory Perception, risk for disturbed (specify) risk factors may include endogenous chemical alteration (glucose/insulin and/or electrolyte imbalance).*

Coping, family: compromised may be related to inadequate or incorrect information or understanding by primary person(s), other situational/developmental crises or situations the significant person(s) may be facing, lifelong condition requiring behavioral changes impacting family, possibly evidenced by family expressions of confusion about what to do, verbalizations that they are having difficulty coping with situation; family does not meet physical/emotional

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needs of its members; SO(s) preoccupied with personal reaction (e.g., guilt, fear), display protective behavior disproportionate (too little/too much) to patient's abilities or need for autonomy.

Diabetic ketoacidosis CH/MS

Fluid Volume, deficient [specify] may be related to hyperosmolar urinary losses, gastric losses and inadequate intake, possibly evidenced by increased urinary output/dilute urine; reports of weakness, thirst; sudden weight loss, hypotension, tachycardia, delayed capillary refill, dry mucous membranes, poor skin turgor.

Nutrition: imbalanced, less than body requirements that may be related to inadequate utilization of nutrients (insulin deficiency), decreased oral intake, hypermetabolic state, possibly evidenced by recent weight loss, reports of weakness, lack of interest in food, gastric fullness/abdominal pain, and increased ketones, imbalance between glucose/insulin levels.

Fatigue may be related to decreased metabolic energy production, altered body chemistry (insufficient insulin), increased energy demands (hypermetabolic state/infection), possibly evidenced by overwhelming lack of energy, inability to maintain usual routines, decreased performance, impaired ability to concentrate, listlessness.

Infection, risk for: risk factors may include high glucose levels, decreased leukocyte function, stasis of body fluids, invasive procedures, alteration in circulation/perfusion.*

Dialysis, general CH

(Also refer to Dialysis, peritoneal; hemodialysis)

Nutrition: imbalanced, less than body requirements may be related to inadequate ingestion of nutrients (dietary restrictions, anorexia, nausea/vomiting, stomatitis), loss of peptides and amino acids (building blocks for proteins) during procedure, possibly evidenced by reported inadequate intake, aversion to eating, altered taste sensation, poor muscle tone/weakness, sore/inflamed buccal cavity, pale conjunctiva/mucous membranes.

Grieving, anticipatory may be related to actual or perceived loss, chronic and/or fatal illness, and thwarted grieving response to a loss, possibly evidenced by verbal expression of distress/unresolved issues, denial of loss; altered eating habits, sleep and dream patterns, activity levels, libido; crying, labile affect; feelings of sorrow, guilt, and anger.

Body Image, disturbed/Self-Esteem, situational low may be related to situational crisis and chronic illness with changes in usual roles/body image, possibly evidenced by verbalization of changes in lifestyle, focus on past function, negative feelings about body, feelings of helplessness/powerlessness, extension of body boundary to incorporate environmental objects (e.g., dialysis setup), change in social involvement, overdependence on others for care, not taking responsibility for self-care/lack of follow-through, and self-destructive behavior.

Self-Care deficit [specify] may be related to perceptual/cognitive impairment (accumulated toxins); intolerance to activity, decreased

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strength and endurance; pain/discomfort, possibly evidenced by reported inability to perform ADLs, disheveled/unkempt appearance, strong body odor.

Powerlessness may be related to illness-related regimen and healthcare environment, possibly evidenced by verbal expression of having no control, depression over physical deterioration, nonparticipation in care, anger, and passivity.

Coping, family: compromised/disabled may be related to inadequate or incorrect information or understanding by a primary person, temporary family disorganization and role changes, patient providing little support in turn for the primary person, and prolonged disease/disability progression that exhausts the supportive capacity of significant persons, possibly evidenced by expressions of concern or reports about response of SO(s)/family to patient's health problem, preoccupation of SO(s) with own personal reactions, display of intolerance/rejection, and protective behavior disproportionate (too little or too much) to patient's abilities or need for autonomy.

Dialysis, peritoneal — MS/CH

(Also refer to Dialysis, general)

Fluid Volume, risk for excess risk factors may include inadequate osmotic gradient of dialysate, fluid retention (dialysate drainage problems/inappropriate osmotic gradient of solution, bowel distention), excessive PO/IV intake.*

Trauma, risk for: risk factors may include improper placement during insertion or manipulation of catheter.

Pain, acute may be related to procedural factors (catheter irritation, improper catheter placement), presence of edema/abdominal distention, inflammation, or infection, rapid infusion/infusion of cold or acidic dialysate, possibly evidenced by verbal reports, guarding/distraction behaviors, and self-focus.

Infection, risk for peritonitis risk factors may include contamination of catheter/infusion system, skin contaminants, sterile peritonitis (response to composition of dialysate).*

Breathing Pattern, risk for ineffective risk factors may include increased abdominal pressure with restricted diaphragmatic excursion, rapid infusion of dialysate, pain/discomfort, inflammatory process (e.g., atelectasis/pneumonia).*

Diarrhea — PED/CH

Knowledge, deficient [Learning Need] regarding causative/contributing factors and therapeutic needs may be related to lack of information/misconceptions, possibly evidenced by statements of concern, questions, and development of preventable complications.

Fluid Volume, risk for deficient risk factors may include excessive losses through GI tract, altered intake.*

Pain, acute may be related to abdominal cramping and irritation/excoriation of skin, possibly evidenced by verbal reports, facial grimacing, and autonomic responses.

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Skin Integrity, impaired may be related to effects of excretions on delicate tissues, possibly evidenced by reports of discomfort and disruption of skin surface/destruction of skin layers.

Digitalis toxicity MS/CH

Cardiac Output, decreased may be related to altered myocardial contractility/electrical conduction, properties of digitalis (long half-life and narrow therapeutic range), concurrent medications, age/general health status and electrolyte/acid-base balance, possibly evidenced by changes in rate/rhythm/conduction (development/worsening of dysrhythmias), changes in mentation, worsening of heart failure, elevated serum drug levels.

Fluid Volume, risk for deficient/excess risk factors may include excessive losses from vomiting/diarrhea, decreased intake/nausea, decreased plasma proteins, malnutrition, continued use of diuretics; excess sodium/fluid retention.*

Knowledge, deficient [Learning Need] regarding condition/therapy and self-care needs may be related to information misinterpretation and lack of recall, possibly evidenced by inaccurate follow-through of instructions and development of preventable complications.

Thought Processes, risk for disturbed risk factors may include physiological effects of toxicity/reduced cerebral perfusion.*

Dilation and curettage (D and C) OB/GYN

(Also refer to Abortion, spontaneous termination)

Knowledge, deficient [Learning Need] regarding surgical procedure, possible postprocedural complications, and therapeutic needs may be related to lack of exposure/unfamiliarity with information, possibly evidenced by requests for information and statements of concern/misconceptions.

Disseminated intravascular coagulation (DIC) MS

Fluid Volume, risk for deficient risk factors may include failure of regulatory mechanism (coagulation process) and active loss/hemorrhage.*

Tissue Perfusion, ineffective (specify type) may be related to alteration of arterial/venous flow (microemboli throughout circulatory system, and hypovolemia), possibly evidenced by changes in respiratory rate and depth, changes in mentation, decreased urinary output, and development of acral cyanosis/focal gangrene.

Anxiety [specify level]/Fear may be related to sudden change in health status/ threat of death, interpersonal transmission/contagion, possibly evidenced by sympathetic stimulation, restlessness, focus on self, and apprehension.

Gas Exchange, risk for impaired risk factors may include reduced oxygen-carrying capacity, development of acidosis, fibrin deposition in microcirculation, and ischemic damage of lung parenchyma.*

Pain, acute may be related to bleeding into joints/muscles, with hematoma formation, and ischemic tissues with areas of acral

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cyanosis/focal gangrene, possibly evidenced by verbal reports, narrowed focus, alteration in muscle tone, guarding/distraction behaviors, restlessness, autonomic responses.

Dissociative disorders PSY

Anxiety [severe/panic]/Fear may be related to a maladaptation or ineffective coping continuing from early life, unconscious conflict(s), threat to self-concept, unmet needs, or phobic stimulus, possibly evidenced by maladaptive response to stress (e.g., dissociating self/fragmentation of the personality), increased tension, feelings of inadequacy, and focus on self, projection of personal perceptions onto the environment.

Violence, risk for self-directed/other-directed risk factors may include dissociative state/conflicting personalities, depressed mood, panic states, and suicidal/homicidal behaviors.*

Personal Identity, disturbed may be related to psychological conflicts (dissociative state), childhood trauma/abuse, threat to physical integrity/self-concept, and underdeveloped ego, possibly evidenced by alteration in perception or experience of the self, loss of one's own sense of reality/the external world, poorly differentiated ego boundaries, confusion about sense of self, purpose or direction in life; memory loss, presence of more than one personality within the individual.

Coping, family: compromised may be related to multiple stressors repeated over time, prolonged progression of disorder that exhausts the supportive capacity of significant person(s), family disorganization and role changes, high-risk family situation possibly evidenced by family/SO(s) describing inadequate understanding or knowledge that interferes with assistive or supportive behaviors; relationship and marital conflict.

Diverticulitis CH

Pain, acute may be related to inflammation of intestinal mucosa, abdominal cramping, and presence of fever/chills, possibly evidenced by verbal reports, guarding/distraction behaviors, autonomic responses, and narrowed focus.

Diarrhea/Constipation may be related to altered structure/function and presence of inflammation, possibly evidenced by signs and symptoms dependent on specific problem (e.g., increase/decrease in frequency of stools and change in consistency).

Knowledge, deficient [Learning Need] regarding disease process, potential complications, therapeutic and self-care needs may be related to lack of information/misconceptions, possibly evidenced by statements of concern, request for information, and development of preventable complications.

Powerlessness, risk for: risk factors may include chronic nature of disease process and recurrent episodes despite cooperation with medical regimen.*

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

Down syndrome **PED/CH**

(Also refer to Mental retardation)

Growth and Development, delayed may be related to effects of physical/mental disability, possibly evidenced by altered physical growth; delay/inability in performing skills and self-care/self-control activities appropriate for age.

Trauma, risk for: risk factors may include cognitive difficulties and poor muscle tone/coordination, weakness.*

Nutrition, imbalanced, less than body requirements may be related to poor muscle tone and protruding tongue, possibly evidenced by weak and ineffective sucking/swallowing and observed lack of adequate intake with weight loss/failure to gain.

Family Processes, interrupted may be related to situational/maturational crises requiring incorporation of new skills into family dynamics, possibly evidenced by confusion about what to do, verbalized difficulty coping with situation, unexamined family myths.

Grieving, risk for dysfunctional risk factors may include loss of "the perfect child," chronic condition requiring long-term care, and unresolved feelings.*

Attachment, risk for impaired parent/infant/child risk factors may include ill infant/child who is unable to effectively initiate parental contact due to altered behavioral organization, inability of parents to meet the personal needs.*

Social Isolation risk factors may include withdrawal from usual social interactions and activities, assumption of total child care, and becoming overindulgent/overprotective.*

Drug overdose, acute (depressants) **MS/PSY**

(Also refer to Substance dependence/abuse rehabilitation)

Breathing Pattern, ineffective/Gas Exchange, impaired may be related to neuromuscular impairment/CNS depression, decreased lung expansion, possibly evidenced by changes in respirations, cyanosis, and abnormal ABGs.

Trauma/Suffocation/Poisoning, risk for: risk factors may include CNS depression/agitation, hypersensitivity to the drug(s), psychological stress.

Violence, risk for self-directed/other-directed risk factors may include suicidal behaviors, toxic reactions to drug(s).*

Infection, risk for: risk factors may include drug injection techniques, impurities in injected drugs, localized trauma; malnutrition, altered immune state.*

Dysmenorrhea **GYN**

Pain, acute may be related to exaggerated uterine contractibility, possibly evidenced by verbal reports, guarding/distraction behaviors, narrowed focus, and autonomic responses (changes in vital signs).

Activity intolerance, risk for: risk factors may include severity of pain and presence of secondary symptoms (nausea, vomiting, syncope, chills), depression.*

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

Coping, ineffective may be related to chronic, recurrent nature of problem; anticipatory anxiety, and inadequate coping methods, possibly evidenced by muscular tension, headaches, general irritability, chronic depression, and verbalization of inability to cope, report of poor self-concept.

Dysrhythmia, cardiac — MS

Cardiac Output, risk for decreased risk factors may include altered electrical conduction and reduced myocardial contractility.*

Anxiety [specify level] may be related to perceived threat of death, possibly evidenced by increased tension, apprehension, and expressed concerns.

Knowledge, deficient [Learning Need] regarding medical condition/therapy needs may be related to lack of information/ misinterpretation and unfamiliarity with information resources, possibly evidenced by questions, statement of misconception, failure to improve on previous regimen, and development of preventable complications.

Activity intolerance, risk for: risk factors may include imbalance between myocardial O_2 supply and demand, and cardiac depressant effects of certain drugs (β-blockers, antidysrhythmics).*

Poisoning, risk for digitalis toxicity risk factors may include limited range of therapeutic effectiveness, lack of education/proper precautions, reduced vision/cognitive limitations.

Eclampsia — OB

(Refer to Pregnancy-Induced Hypertension)

Ectopic pregnancy (tubal) — OB

(Also refer to Abortion, spontaneous termination)

Pain, acute may be related to distention/rupture of fallopian tube, possibly evidenced by verbal reports, guarding/distraction behaviors, facial mask of pain, and autonomic responses (diaphoresis, changes in vital signs).

Fluid Volume, risk for deficient risk factors may include hemorrhagic losses and decreased/restricted intake.*

Anxiety [specify level]/Fear may be related to threat of death and possible loss of ability to conceive, possibly evidenced by increased tension, apprehension, sympathetic stimulation, restlessness, and focus on self.

Eczema (dermatitis) — CH

Pain[Discomfort] may be related to cutaneous inflammation and irritation, possibly evidenced by verbal reports, irritability, and scratching.

Infection, risk for: risk factors may include broken skin and tissue trauma.*

Social Isolation may be related to alterations in physical appearance, possibly evidenced by expressed feelings of rejection and decreased interaction with peers.

Edema, pulmonary — MS

Fluid Volume, excess may be related to decreased cardiac functioning, excessive fluid/sodium intake, possibly evidenced by dyspnea, presence of crackles (rales), pulmonary congestion on x-ray, restlessness,

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anxiety, and increased central venous pressure (CVP)/pulmonary pressures.

Gas Exchange, impaired may be related to altered blood flow and decreased alveolar/capillary exchange (fluid collection/shifts into interstitial space/alveoli), possibly evidenced by hypoxia, restlessness, and confusion.

Anxiety [specify level]/Fear may be related to perceived threat of death (inability to breathe), possibly evidenced by responses ranging from apprehension to panic state, restlessness, and focus on self.

Emphysema — CH/MS

Gas Exchange, impaired may be related to alveolar capillary membrane changes/destruction, possibly evidenced by dyspnea, restlessness, changes in mentation, abnormal ABG values.

Airway Clearance, ineffective may be related to increased production/retained tenacious secretions, decreased energy level, and muscle wasting, possibly evidenced by abnormal breath sounds (rhonchi), ineffective cough, changes in rate/depth of respirations, and dyspnea.

Activity intolerance may be related to imbalance between O_2 supply and demand, possibly evidenced by reports of fatigue/weakness, exertional dyspnea, and abnormal vital sign response to activity.

Nutrition: imbalanced, less than body requirements may be related to inability to ingest food (shortness of breath, anorexia, generalized weakness, medication side effects), possibly evidenced by lack of interest in food, reported altered taste, loss of muscle mass and tone, fatigue, and weight loss.

Infection, risk for: risk factors may include inadequate primary defenses (stasis of body fluids, decreased ciliary action), chronic disease process, and malnutrition.*

Powerlessness may be related to illness-related regimen and healthcare environment, possibly evidenced by verbal expression of having no control, depression over physical deterioration, nonparticipation in therapeutic regimen, anger, and passivity.

Encephalitis — MS

Tissue Perfusion, risk for ineffective: cerebral risk factors may include cerebral edema altering/interrupting cerebral arterial/venous blood flow, hypovolemia, exchange problems at cellular level (acidosis).*

Hyperthermia may be related to increased metabolic rate, illness, and dehydration, possibly evidenced by increased body temperature, flushed/warm skin, and increased pulse and respiratory rates.

Pain, acute may be related to inflammation/irritation of the brain and cerebral edema, possibly evidenced by verbal reports of headache, photophobia, distraction behaviors, restlessness, and autonomic response (changes in vital signs).

Trauma/Suffocation, risk for: risk factors may include restlessness, clonic/tonic activity, altered sensorium, cognitive impairment; generalized weakness, ataxia, vertigo.*

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Endocarditis **MS**

Cardiac Output, risk for decreased risk factors may include inflammation of lining of heart and structural change in valve leaflets.*

Anxiety [specify level] may be related to change in health status and threat of death, possibly evidenced by apprehension, expressed concerns, and focus on self.

Pain, acute may be related to generalized inflammatory process and effects of embolic phenomena, possibly evidenced by verbal reports, narrowed focus, distraction behaviors, and autonomic responses (changes in vital signs).

Activity intolerance, risk for: risk factors may include imbalance between O_2 supply and demand, debilitating condition.

Tissue Perfusion, risk for ineffective (specify) risk factors may include embolic interruption of arterial flow (embolization of thrombi/valvular vegetations).*

Endometriosis **GYN**

Pain, acute/chronic may be related to pressure of concealed bleeding/formation of adhesions, possibly evidenced by verbal reports (pain between/with menstruation), guarding/distraction behaviors, and narrowed focus.

Sexual Dysfunction may be related to pain secondary to presence of adhesions, possibly evidenced by verbalization of problem, and altered relationship with partner.

Knowledge, deficient [Learning Need] regarding pathophysiology of condition and therapy needs may be related to lack of information/misinterpretations, possibly evidenced by statements of concern and misconceptions.

Enteritis **MS/CH**

(Refer to Colitis, ulcerative; Crohn's disease)

Epididymitis **MS**

Pain, acute may be related to inflammation, edema formation, and tension on the spermatic cord, possibly evidenced by verbal reports, guarding/distraction behaviors (restlessness), and autonomic responses (changes in vital signs).

Infection, risk for spread risk factors may include presence of inflammation/infectious process, insufficient knowledge to avoid spread of infection.*

Knowledge, deficient [Learning Need] regarding pathophysiology, outcome, and self-care needs may be related to lack of information/misinterpretations, possibly evidenced by statements of concern, misconceptions, and questions.

Epilepsy **CH**

Knowledge, deficient [Learning Need] regarding condition and medication control may be related to lack of information/misinterpretations, scarce financial resources, possibly evidenced by questions,

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statements of concern/misconceptions, incorrect use of anticonvulsant medication, recurrent episodes/uncontrolled seizures.

Self-Esteem [specify]/Personal Identity, disturbed may be related to perceived neurological functional change/weakness, perception of being out of control, stigma associated with condition, possibly evidenced by negative feelings about "brain"/self, change in social involvement, feelings of helplessness, and preoccupation with perceived change or loss.

Social Interaction, impaired may be related to unpredictable nature of condition and self-concept disturbance, possibly evidenced by decreased self-assurance, verbalization of concern, discomfort in social situations, inability to receive/communicate a satisfying sense of belonging/caring, and withdrawal from social contacts/activities.

Trauma/Suffocation, risk for: risk factors may include weakness, balancing difficulties, cognitive limitations/altered consciousness, loss of large-or small-muscle coordination (during seizure).*

Failure to thrive PED

Nutrition, imbalanced, less than body requirements may be related to inability to ingest/digest/absorb nutrients (defects in organ function/metabolism, genetic factors), physical deprivation/psychosocial factors, possibly evidenced by lack of appropriate weight gain/weight loss, poor muscle tone, pale conjunctiva, and laboratory tests reflecting nutritional deficiency.

Growth and Development, delayed may be related to inadequate caretaking (physical/emotional neglect or abuse); indifference, inconsistent responsiveness, multiple caretakers; environmental and stimulation deficiencies, possibly evidenced by altered physical growth, flat affect, listlessness, decreased response; delay or difficulty in performing skills or self-control activities appropriate for age group.

Parenting, risk for impaired risk factors may include lack of knowledge, inadequate bonding, unrealistic expectations for self/infant, and lack of appropriate response of child to relationship.*

Knowledge, deficient [Learning Need] regarding pathophysiology of condition, nutritional needs, growth/development expectations, and parenting skills may be related to lack of information/misinformation or misinterpretation, possibly evidenced by verbalization of concerns, questions, misconceptions; or development of preventable complications.

Fetal alcohol syndrome PED

Injury, risk for CNS damage risk factors may include external chemical factors (alcohol intake by mother), placental insufficiency, fetal drug withdrawal in utero/postpartum and prematurity.*

Infant Behavior, disorganized may be related to prematurity, environmental overstimulation, lack of containment/boundaries, possibly evidenced by change from baseline physiological measures; tremors, startles, twitches, hyperextension of arms/legs, deficient self-regulatory behaviors, deficient response to visual/auditory stimuli.

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Parenting, risk for impaired risk factors may include mental and/or physical illness, inability of mother to assume the overwhelming task of unselfish giving and nurturing, presence of stressors (financial/legal problems), lack of available or ineffective role model, interruption of bonding process, lack of appropriate response of child to relationship.*

PSY

Coping, ineffective [Mother] may be related to personal vulnerability, low self-esteem, inadequate coping skills, and multiple stressors (repeated over period of time), possibly evidenced by inability to meet basic needs/fulfill role expectations/problem-solve, and excessive use of drug(s).

Family Processes, dysfunctional: alcoholism may be related to lack of/insufficient support from others, mother's drug problem and treatment status, together with poor coping skills, lack of family stability/overinvolvement of parents with children and multigenerational addictive behaviors, possibly evidenced by abandonment, rejection, neglectful relationships with family members, and decisions and actions by family that are detrimental.

Fetal demise — OB

Grieving, anticipatory may be related to death of fetus/infant (wanted or unwanted), possibly evidenced by verbal expressions of distress, anger, loss; crying; alteration in eating habits or sleep pattern.

Self-Esteem, situational low may be related to perceived "failure" at a life event, possibly evidenced by negative self-appraisal in response to life event, verbalization of negative feelings about the self (helplessness, uselessness), difficulty making decisions.

Spiritual Distress, risk for: risk factors may include loss of loved one, low self-esteem, poor relationships, challenged belief and value system (birth is supposed to be the beginning of life, not of death) and intense suffering.*

Fractures — MS/CH

(Also refer to Casts; Traction)

Trauma, risk for additional injury risk factors may include loss of skeletal integrity/movement of skeletal fragments, use of traction apparatus, and so on.*

Pain, acute may be related to muscle spasms, movement of bone fragments, tissue trauma/edema, traction/immobility device, stress, and anxiety, possibly evidenced by verbal reports, distraction behaviors, self-focusing/narrowed focus, facial mask of pain, guarding/protective behavior, alteration in muscle tone, and autonomic responses (changes in vital signs).

Peripheral Neurovascular dysfunction, risk for: risk factors may include reduction/interruption of blood flow (direct vascular injury, tissue trauma, excessive edema, thrombus formation, hypovolemia).*

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Mobility, impaired physical may be related to neuromuscular/skeletal impairment, pain/discomfort, restrictive therapies (bedrest, extremity immobilization), and psychological immobility, possibly evidenced by inability to purposefully move within the physical environment, imposed restrictions, reluctance to attempt movement, limited range of motion, and decreased muscle strength/control.

Gas Exchange, risk for impaired risk factors may include altered blood flow, blood/fat emboli, alveolar/capillary membrane changes (interstitial/pulmonary edema, congestion).*

Knowledge, deficient [Learning Need] regarding healing process, therapy requirements, potential complications, and self-care needs may be related to lack of exposure, misinterpretation of information, possibly evidenced by statements of concern, questions, and misconceptions.

Frostbite — MS/CH

Tissue Integrity, impaired may be related to altered circulation and thermal injury, possibly evidenced by damaged/destroyed tissue.

Pain, acute may be related to diminished circulation with tissue ischemia/necrosis and edema formation, possibly evidenced by verbal reports, guarding/distraction behaviors, narrowed focus, and autonomic responses (changes in vital signs).

Infection, risk for: risk factors may include traumatized tissue/tissue destruction, altered circulation, and compromised immune response in affected area.*

Gallstone — CH

(Refer to Cholelithiasis)

Gangrene, dry — MS

Tissue Perfusion, ineffective: peripheral may be related to interruption in arterial flow, possibly evidenced by cool skin temperature, change in color (black), atrophy of affected part, and presence of pain.

Pain, acute may be related to tissue hypoxia and necrotic process, possibly evidenced by verbal reports, guarding/distraction behaviors, narrowed focus, and autonomic responses (changes in vital signs).

Gas, lung irritant — MS/CH

Airway Clearance, ineffective may be related to irritation/inflammation of airway, possibly evidenced by marked cough, abnormal breath sounds (wheezes), dyspnea, and tachypnea.

Gas Exchange, risk for impaired risk factors may include irritation/inflammation of alveolar membrane (dependent on type of agent, and length of exposure).*

Anxiety [specify level] may be related to change in health status and threat of death, possibly evidenced by verbalizations, increased tension, apprehension, and sympathetic stimulation.

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Gastritis, acute — MS

Pain, acute may be related to irritation/inflammation of gastric mucosa, possibly evidenced by verbal reports, guarding/distraction behaviors, and autonomic responses (changes in vital signs).

Fluid Volume, risk for deficient risk factors may include excessive losses through vomiting and diarrhea, continued bleeding, reluctance to ingest/restrictions of oral intake.*

Gastritis, chronic — CH

Nutrition: imbalanced, less than body requirements risk factors may include inability to ingest adequate nutrients (prolonged nausea/vomiting, anorexia, epigastric pain).*

Knowledge, deficient [Learning Need] regarding pathophysiology, psychological factors, therapy needs, and potential complications may be related to lack of information/misinterpretation, possibly evidenced by verbalization of concerns, questions, misconceptions, and continuation of problem.

Gastroenteritis — MS

(Refer to Gastritis, chronic; Enteritis)

Gender identity disorder — PSY

(For individuals experiencing persistent and marked distress regarding uncertainty about issues relating to personal identity, e.g., sexual orientation and behavior.)

Anxiety [specify level] may be related to unconscious/conscious conflicts about essential values/beliefs (ego-dystonic gender identification), threat to self-concept, unmet needs, possibly evidenced by increased tension, helplessness, hopelessness, feelings of inadequacy, uncertainty, insomnia and focus on self, and impaired daily functioning.

Role Performance, ineffective/Personal Identity, disturbed may be related to crisis in development in which person has difficulty knowing/accepting to which sex he or she belongs or is attracted, sense of discomfort and inappropriateness about anatomic sex characteristics, possibly evidenced by confusion about sense of self, purpose or direction in life, sexual identification/preference, verbalization of desire to be/insistence that person is the opposite sex, change in self-perception of role, and conflict in roles.

Sexuality Patterns, ineffective may be related to ineffective or absent role models and conflict with sexual orientation and/or preferences, lack of/impaired relationship with an SO, possibly evidenced by verbalizations of discomfort with sexual orientation/role, and lack of information about human sexuality.

Coping, family: compromised/disabled risk factors may include inadequate/incorrect information or understanding, SO unable to perceive or to act effectively in regard to patient's needs, temporary family disorganization and role changes, and patient providing little support in turn for primary person.*

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Coping, family: readiness for enhanced may be related to individual's basic needs being sufficiently gratified and adaptive tasks effectively addressed to enable goals of self-actualization to surface, possibly evidenced by family member(s) attempts to describe growth/impact of crisis on own values, priorities, goals, or relationships; family member(s) is moving in direction of health-promoting and enriching lifestyle that supports patient's search for self; and choosing experiences that optimize wellness.

Glaucoma — CH

Sensory Perception, disturbed: visual may be related to altered sensory reception and altered status of sense organ (increased intraocular pressure/atrophy of optic nerve head), possibly evidenced by progressive loss of visual field.

Anxiety [specify level] may be related to change in health status, presence of pain, possibility/reality of loss of vision, unmet needs, and negative self-talk, possibly evidenced by apprehension, uncertainty, and expressed concern regarding changes in life event.

Glomerulonephritis — PED

Fluid Volume, excess may be related to failure of regulatory mechanism (inflammation of glomerular membrane inhibiting filtration), possibly evidenced by weight gain, edema/anasarca, intake greater than output, and blood pressure changes.

Pain, acute may be related to effects of circulating toxins and edema/distention of renal capsule, possibly evidenced by verbal reports, guarding/distraction behaviors, and autonomic responses (changes in vital signs).

Nutrition: imbalanced, less than body requirements may be related to anorexia and dietary restrictions, possibly evidenced by aversion to eating, reported altered taste, weight loss, and decreased intake.

Diversional activity, deficient may be related to treatment modality/restrictions, fatigue, and malaise, possibly evidenced by statements of boredom, restlessness, and irritability.

Growth, risk for disproportionate risk factors may include infection, malnutrition, chronic illness.

Gonorrhea — CH

(Also refer to Sexually transmitted disease—STD)

Infection, risk for dissemination/bacteremia risk factors may include presence of infectious process in highly vascular area and lack of recognition of disease process.*

Pain, acute may be related to irritation/inflammation of mucosa and effects of circulating toxins, possibly evidenced by verbal reports of genital or pharyngeal irritation, perineal/pelvic pain, guarding/distraction behaviors.

Knowledge, deficient [Learning Need] regarding disease cause/transmission, therapy, and self-care needs may be related to lack of information/misinterpretation, denial of exposure, possibly evidenced

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by statements of concern, questions, misconceptions, and inaccurate follow-through of instructions/development of preventable complications.

Gout CH

Pain, acute may be related to inflammation of joint(s), possibly evidenced by verbal reports, guarding/distraction behaviors, and autonomic responses (changes in vital signs).

Mobility, impaired physical may be related to joint pain/edema, possibly evidenced by reluctance to attempt movement, limited range of motion, and therapeutic restriction of movement.

Knowledge, deficient [Learning Need] regarding cause, treatment, and prevention of condition may be related to lack of information/misinterpretation, possibly evidenced by statements of concern, questions, misconceptions, and inaccurate follow-through of instructions.

Guillain-Barré syndrome (acute polyneuritis) MS

Breathing Pattern/Airway Clearance, risk for ineffective risk factors may include weakness/paralysis of respiratory muscles, impaired gag/swallow reflexes, decreased energy/fatigue.*

Sensory Perception, disturbed (specify) may be related to altered sensory reception/transmission/integration (altered status of sense organs, sleep deprivation), therapeutically restricted environment, endogenous chemical alterations (electrolyte imbalance, hypoxia), and psychological stress, possibly evidenced by reported or observed change in usual response to stimuli, altered communication patterns, and measured change in sensory acuity and motor coordination.

Mobility, impaired physical may be related to neuromuscular impairment, pain/discomfort, possibly evidenced by impaired coordination, partial/complete paralysis, decreased muscle strength/control.

Anxiety [specify level]/Fear may be related to situational crisis, change in health status/threat of death, possibly evidenced by increased tension, restlessness, helplessness, apprehension, uncertainty, fearfulness, focus on self, and sympathetic stimulation.

Disuse Syndrome, risk for: risk factors include paralysis and pain.*

Hay fever CH

Pain [Discomfort] may be related to irritation/inflammation of upper airway mucous membranes and conjunctiva, possibly evidenced by verbal reports, irritability, and restlessness.

Knowledge, deficient [Learning Need] regarding underlying cause, appropriate therapy, and required lifestyle changes may be related to lack of information, possibly evidenced by statements of concern, questions, and misconceptions.

Heart failure, chronic MS

Cardiac Output, decreased may be related to altered myocardial contractility/inotropic changes; alterations in rate, rhythm, and electrical conduction; and structural changes (valvular defects, ventricular aneurysm), possibly evidenced by tachycardia/

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dysrhythmias, changes in blood pressure, extra heart sounds, decreased urine output, diminished peripheral pulses, cool/ashen skin, orthopnea, crackles; dependent/generalized edema and chest pain.

Fluid Volume, excess may be related to reduced glomerular filtration rate/increased antidiuretic hormone (ADH) production, and sodium/water retention, possibly evidenced by orthopnea and abnormal breath sounds, S_3 heart sound, jugular vein distention, positive hepatojugular reflex, weight gain, hypertension, oliguria, generalized edema.

Gas Exchange, risk for impaired risk factors may include alveolar-capillary membrane changes (fluid collection/shifts into interstitial space/alveoli).*

CH

Activity intolerance may be related to imbalance between O_2 supply/demand, generalized weakness, and prolonged bedrest/sedentary lifestyle, possibly evidenced by reported/observed weakness, fatigue; changes in vital signs, presence of dysrhythmias; dyspnea, pallor, and diaphoresis.

Knowledge, deficient [Learning Need] regarding cardiac function/disease process, therapy and self-care needs may be related to lack of information/misinterpretation, possibly evidenced by questions, statements of concern/misconceptions; development of preventable complications or exacerbations of condition.

Heatstroke — MS

Hyperthermia may be related to prolonged exposure to hot environment/vigorous activity with failure of regulating mechanism of the body, possibly evidenced by high body temperature (greater than 105°F/40.6°C), flushed/hot skin, tachycardia, and seizure activity.

Cardiac Output, decreased may be related to functional stress of hypermetabolic state, altered circulating volume/venous return, and direct myocardial damage secondary to hyperthermia, possibly evidenced by decreased peripheral pulses, dysrhythmias/tachycardia, and changes in mentation.

Hemodialysis — MS/CH

(Also refer to Dialysis, general)

Injury, risk for loss of vascular access risk factors may include clotting/thrombosis, infection, disconnection/hemorrhage.*

Fluid Volume, risk for deficient risk factors may include excessive fluid losses/shifts via ultrafiltration, hemorrhage (altered coagulation/disconnection of shunt), and fluid restrictions.*

Fluid Volume, risk for excess risk factors may include excessive fluid intake; rapid IV, blood/plasma expanders/saline given to support BP during procedure.*

Protection, ineffective may be related to chronic disease state, drug therapy, abnormal blood profile, inadequate nutrition, possibly evidenced by altered clotting, impaired healing, deficient immunity, fatigue, anorexia.

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Hemophilia **PED**

Fluid Volume, risk for deficient risk factors may include impaired coagulation/hemorrhagic losses.*

Pain, acute/chronic risk factors may include nerve compression from hematomas, nerve damage or hemorrhage into joint space.*

Mobility, risk for impaired physical risk factors may include joint hemorrhage, swelling, degenerative changes, and muscle atrophy.*

Protection, ineffective may be related to abnormal blood profile, possibly evidenced by altered clotting.

Coping, family: compromised may be related to prolonged nature of condition that exhausts the supportive capacity of significant person(s), possibly evidenced by protective behaviors disproportionate to patient's abilities/need for autonomy.

Hemorrhoidectomy **MS/CH**

Pain, acute may be related to edema/swelling and tissue trauma, possibly evidenced by verbal reports, guarding/distraction behaviors, focus on self, and autonomic responses (changes in vital signs).

Urinary Retention, risk for [acute] risk factors may include perineal trauma, edema/swelling, and pain.*

Knowledge, deficient [Learning Need] regarding therapeutic treatment and potential complications may be related to lack of information/misconceptions, possibly evidenced by statements of concern and questions.

Hemorrhoids **CH/OB**

Pain, acute may be related to inflammation and edema of prolapsed varices, possibly evidenced by verbal reports, and guarding/distraction behaviors.

Constipation may be related to pain on defecation and reluctance to defecate, possibly evidenced by frequency, less than usual pattern and hard, formed stools.

Hemothorax **MS**

(Also refer to Pneumothorax)

Trauma/Suffocation, risk for: risk factors may include concurrent disease/injury process, dependence on external device (chest drainage system), and lack of safety education/precautions.*

Anxiety [specify level] may be related to change in health status and threat of death, possibly evidenced by increased tension, restlessness, expressed concern, sympathetic stimulation, and focus on self.

Hepatitis, acute viral **MS/CH**

Fatigue may be related to decreased metabolic energy production and altered body chemistry, possibly evidenced by reports of lack of energy/inability to maintain usual routines, decreased performance, and increased physical complaints.

Nutrition: imbalanced, less than body requirements may be related to inability to ingest adequate nutrients (nausea, vomiting, anorexia); hypermetabolic state, altered absorption and metabolism, possibly

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evidenced by aversion to eating/lack of interest in food, altered taste sensation, observed lack of intake, and weight loss.

Pain, acute/[Discomfort] may be related to inflammation and swelling of the liver, arthralgias, urticarial eruptions, and pruritus, possibly evidenced by verbal reports, guarding/distraction behaviors, focus on self, and autonomic responses (changes in vital signs).

Infection, risk for: risk factors may include inadequate secondary defenses and immunosuppression, malnutrition, insufficient knowledge to avoid exposure to pathogens/spread to others.

Skin/Tissue Integrity, risk for impaired risk factors may include bile salt accumulation in the tissues.

Home Maintenance, risk for impaired risk factors may include debilitating effects of disease process and inadequate support systems (family, financial, role model).*

Knowledge, deficient [Learning Need] regarding disease process/transmission, treatment needs, and future expectations may be related to lack of information/recall, misinterpretation, unfamiliarity with resources, possibly evidenced by questions, statement of concerns/misconceptions, inaccurate follow-through of instructions, and development of preventable complications.

Hernia, hiatal — CH

Pain, chronic may be related to regurgitation of acidic gastric contents, possibly evidenced by verbal reports, facial grimacing, and focus on self.

Knowledge, deficient [Learning Need] regarding pathophysiology, prevention of complications and self-care needs may be related to lack of information/misconceptions, possibly evidenced by statements of concern, questions, and recurrence of condition.

Herniated nucleus pulposus (ruptured intervertebral disk) — CH/MS

Pain, acute/chronic may be related to nerve compression/irritation and muscle spasms, possibly evidenced by verbal reports, guarding/distraction behaviors, preoccupation with pain, self/narrowed focus, and autonomic responses (changes in vital signs when pain is acute), altered muscle tone/function, changes in eating/sleeping patterns and libido, physical/social withdrawal.

Mobility, impaired physical may be related to pain (muscle spasms), therapeutic restrictions (e.g., bedrest, traction/braces), muscular impairment, and depression, possibly evidenced by reports of pain on movement, reluctance to attempt/difficulty with purposeful movement, decreased muscle strength, impaired coordination, and limited range of motion.

Diversional Activity, deficient may be related to length of recuperation period and therapy restrictions, physical limitations, pain and depression, possibly evidenced by statements of boredom, disinterest, "nothing to do," and restlessness, irritability, withdrawal.

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Herpes, herpes simplex **CH**

Pain, acute may be related to presence of localized inflammation and open lesions, possibly evidenced by verbal reports, distraction behaviors, and restlessness.

Infection, risk for secondary risk factors may include broken/traumatized tissue, altered immune response, and untreated infection/treatment failure.*

Sexuality Patterns, ineffective risk factors may include lack of knowledge, values conflict, and/or fear of transmitting the disease.*

Herpes zoster (shingles) **CH**

Pain, acute may be related to inflammation/local lesions along sensory nerve(s), possibly evidenced by verbal reports, guarding/distraction behaviors, narrowed focus, and autonomic responses (changes in vital signs).

Knowledge, deficient [Learning Need] regarding pathophysiology, therapeutic needs, and potential complications may be related to lack of information/misinterpretation, possibly evidenced by statements of concern, questions, and misconceptions.

HIV positive **CH**

(Also refer to AIDS)

Adjustment, impaired may be related to life-threatening, stigmatizing condition/disease; assault to self-esteem, altered locus of control, inadequate support systems, incomplete grieving, medication side effects (fatigue/depression), possibly evidenced by verbalization of nonacceptance/denial of diagnosis, nonexistent or unsuccessful involvement in problem solving/goal setting; extended period of shock and disbelief or anger; lack of future-oriented thinking.

Knowledge, deficient [Learning Need] regarding disease, prognosis, and treatment needs may be related to lack of exposure/recall, information misinterpretation, unfamiliarity with information resources, or cognitive limitation, possibly evidenced by statement of misconception/request for information, inappropriate/exaggerated behaviors (hostile, agitated, hysterical, apathetic), inaccurate follow-through of instructions/development of preventable complications.

Hodgkin's disease **CH/MS**

(Also refer to Cancer; Chemotherapy)

Anxiety [specify level]/Fear may be related to threat of self-concept and threat of death, possibly evidenced by apprehension, insomnia, focus on self, and increased tension.

Knowledge, deficient [Learning Need] regarding diagnosis, pathophysiology, treatment, and prognosis may be related to lack of information/misinterpretation, possibly evidenced by statements of concern, questions, and misconceptions.

Pain, acute/[Discomfort] may be related to manifestations of inflammatory response (fever, chills, night sweats) and pruritus, possibly evidenced by verbal reports, distraction behaviors, and focus on self.

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

Breathing Pattern/Airway Clearance, risk for ineffective risk factors may include tracheobronchial obstruction (enlarged mediastinal nodes and/or airway edema).*

Hydrocephalus PED/MS

Tissue Perfusion, ineffective: cerebral may be related to decreased arterial/venous blood flow (compression of brain tissue), possibly evidenced by changes in mentation, restlessness, irritability, reports of headache, pupillary changes, and changes in vital signs.

Sensory Perception, disturbed: visual may be related to pressure on sensory/motor nerves, possibly evidenced by reports of double vision, development of strabismus, nystagmus, pupillary changes, and optic atrophy.

Mobility, risk for impaired physical risk factors may include neuromuscular impairment, decreased muscle strength, and impaired coordination.*

Intracranial, risk for decreased adaptive capacity risk factors may include brain injury, changes in perfusion pressure/intracranial pressure.*

CH

Infection, risk for: risk factors may include invasive procedure/presence of shunt.*

Knowledge, deficient [Learning Need] regarding condition, prognosis, and long-term therapy needs/medical follow-up may be related to lack of information/misperceptions, possibly evidenced by questions, statement of concern, request for information, and inaccurate follow-through of instruction/development of preventable complications.

Hyperbilirubinemia PED

Injury, risk for CNS involvement risk factors may include prematurity, hemolytic disease, asphyxia, acidosis, hyponatremia, and hypoglycemia.*

Injury, risk for effects of treatment risk factors may include physical properties of phototherapy and effects on body regulatory mechanisms, invasive procedure (exchange transfusion), abnormal blood profile, chemical imbalances.*

Knowledge, deficient [Learning Need] regarding condition prognosis, treatment/safety needs may be related to lack of exposure/recall and information misinterpretation, possibly evidenced by questions, statement of concern, and inaccurate follow-through of instructions/development of preventable complications.

Hyperemesis gravidarum OB

Fluid Volume, deficient [isotonic] may be related to excessive gastric losses and reduced intake, possibly evidenced by dry mucous membranes, decreased/concentrated urine, decreased pulse volume and pressure, thirst, and hemoconcentration.

Nutrition: imbalanced, less than body requirements may be related to inability to ingest/digest/absorb nutrients (prolonged vomiting), possibly evidenced by reported inadequate food intake, lack of interest in food/aversion to eating, and weight loss.

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

Coping, risk for ineffective risk factors may include situational/maturational crisis (pregnancy, change in health status, projected role changes, concern about outcome).*

Hypertension CH

Knowledge, deficient [Learning Need] regarding condition, therapeutic regimen, and potential complications may be related to lack of information/recall, misinterpretation, cognitive limitations, and/or denial of diagnosis, possibly evidenced by statements of concern/questions, and misconceptions, inaccurate follow-through of instructions, and lack of BP control.

Adjustment, impaired may be related to condition requiring change in lifestyle, altered locus of control, and absence of feelings/denial of illness, possibly evidenced by verbalization of nonacceptance of health status change and lack of movement toward independence.

Sexual Dysfunction, risk for: risk factors may include side effects of medication.*

MS

Cardiac Output, risk for decreased risk factors may include increased afterload (vasoconstriction), fluid shifts/hypovolemia, myocardial ischemia, ventricular hypertrophy/rigidity.*

Pain, acute headache may be related to increased cerebrovascular pressure, possibly evidenced by verbal reports (throbbing pain located in suboccipital region, present on awakening and disappearing spontaneously after being up and about), reluctance to move head, avoidance of bright lights and noise, increased muscle tension.

Hyperthyroidism CH

(Also refer to Thyrotoxicosis)

Fatigue may be related to hypermetabolic imbalance with increased energy requirements, irritability of CNS, and altered body chemistry, possibly evidenced by verbalization of overwhelming lack of energy to maintain usual routine, decreased performance, emotional lability/irritability, and impaired ability to concentrate.

Anxiety [specify level] may be related to increased stimulation of the CNS (hypermetabolic state, pseudocatecholamine effect of thyroid hormones), possibly evidenced by increased feelings of apprehension, overexcitement/distress, irritability/emotional lability, shakiness, restless movements, tremors.

Nutrition: imbalanced, risk for less than body requirements risk factors may include inability to ingest adequate nutrients for hypermetabolic rate/constant activity, impaired absorption of nutrients (vomiting/diarrhea), hyperglycemia/relative insulin insufficiency.*

Tissue Integrity, risk for impaired risk factors may include altered protective mechanisms of eye related to periorbital edema, reduced ability to blink, eye discomfort/dryness, and development of corneal abrasion/ulceration.*

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

Hypoglycemia CH

Thought Processes, disturbed may be related to inadequate glucose for cellular brain function and effects of endogenous hormone activity, possibly evidenced by irritability, changes in mentation, memory loss, altered attention span, and emotional lability.

Nutrition: imbalanced, risk for less than body requirements risk factors may include inadequate glucose metabolism and imbalance of glucose/insulin levels.*

Knowledge, deficient [Learning Need] regarding pathophysiology of condition and therapy/self-care needs may be related to lack of information/recall, misinterpretations, possibly evidenced by development of hypoglycemia and statements of questions/misconceptions.

Hypoparathyroidism (acute) MS

Injury, risk for: risk factors may include neuromuscular excitability/tetany and formation of renal stones.*

Pain, acute may be related to recurrent muscle spasms and alteration in reflexes, possibly evidenced by verbal reports, distraction behaviors, and narrowed focus.

Airway Clearance, risk for ineffective risk factors may include spasm of the laryngeal muscles.*

Anxiety [specify level] may be related to threat to, or change in, health status, physiological responses.

Hypothermia (systemic) CH

(Also refer to Frostbite)

Hypothermia may be related to exposure to cold environment, inadequate clothing, age extremes (very young/elderly), damage to hypothalamus, consumption of alcohol/medications causing vasodilation, possibly evidenced by reduction in body temperature below normal range, shivering, cool skin, pallor.

Knowledge, deficient [Learning Need] regarding risk factors, treatment needs, and prognosis may be related to lack of information/recall, misinterpretation, possibly evidenced by statement of concerns/misconceptions, occurrence of problem, and development of complications.

Hypothyroidism CH

(Also refer to Myxedema)

Mobility, impaired physical may be related to weakness, fatigue, muscle aches, altered reflexes, and mucin deposits in joints and interstitial spaces, possibly evidenced by decreased muscle strength/control and impaired coordination.

Fatigue may be related to decreased metabolic energy production, possibly evidenced by verbalization of unremitting/overwhelming lack of energy, inability to maintain usual routines, impaired ability to concentrate, decreased libido, irritability, listlessness, decreased performance, increase in physical complaints.

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Sensory Perception, disturbed (specify) may be related to mucin deposits and nerve compression, possibly evidenced by paresthesias of hands and feet or decreased hearing.

Constipation may be related to decreased peristalsis/physical activity, possibly evidenced by frequency less than usual pattern, decreased bowel sounds, hard dry stools, and development of fecal impaction.

Hysterectomy GYN/MS

Pain, acute may be related to tissue trauma/abdominal incision, edema/hematoma formation, possibly evidenced by verbal reports, guarding/distraction behaviors, and autonomic responses (changes in vital signs).

Urinary Elimination, risk for impaired/Urinary Retention [acute] risk factors may include mechanical trauma, surgical manipulation, presence of localized edema/hematoma, or nerve trauma with temporary bladder atony.*

Sexuality Patterns, risk for ineffective/Sexual Dysfunction risk factors may include concerns regarding altered body function/structure, perceived changes in femininity, changes in hormone levels, loss of libido, and changes in sexual response pattern.*

Ileocolitis MS/CH

(Refer to Colitis, ulcerative)

Ileostomy MS/CH

(Refer to Colostomy)

Ileus MS

Pain, acute may be related to distention/edema and ischemia of intestinal tissue, possibly evidenced by verbal reports, guarding/distraction behaviors, narrowed focus, and autonomic responses (changes in vital signs).

Diarrhea/Constipation may be related to presence of obstruction/changes in peristalsis, possibly evidenced by changes in frequency and consistency or absence of stool, alterations in bowel sounds, presence of pain, and cramping.

Fluid Volume, risk for deficient risk factors may include increased intestinal losses (vomiting and diarrhea), and decreased intake.*

Impetigo PED/CH

Skin Integrity, impaired may be related to presence of infectious process and pruritus, possibly evidenced by open/crusted lesions.

Pain, acute may be related to inflammation and pruritus, possibly evidenced by verbal reports, distraction behaviors, and self-focusing.

Infection, risk for secondary risk factors may include broken skin, traumatized tissue, altered immune response, and virulence/contagious nature of causative organism.*

Infection, risk for transmission risk factors may include virulent nature of causative organism, insufficient knowledge to prevent infection of others.*

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Influenza — CH

Pain [Discomfort] may be related to inflammation and effects of circulating toxins, possibly evidenced by verbal reports, distraction behaviors, and narrowed focus.

Fluid Volume, risk for deficient risk factors may include excessive gastric losses, hypermetabolic state, and altered intake.*

Hyperthermia may be related to effects of circulating toxins and dehydration, possibly evidenced by increased body temperature, warm/flushed skin, and tachycardia.

Breathing Pattern, risk for ineffective risk factors may include response to infectious process, decreased energy/fatigue.

Insulin shock — MS/CH

(Refer to Hypoglycemia)

Intestinal obstruction — MS

(Refer to Ileus)

Kawasaki disease — PED

Hyperthermia may be related to increased metabolic rate and dehydration, possibly evidenced by increased body temperature greater than normal range, flushed skin, increased respiratory rate, and tachycardia.

Pain, acute may be related to inflammation and edema/swelling of tissues, possibly evidenced by verbal reports, restlessness, guarding behaviors, and narrowed focus.

Skin Integrity, impaired may be related to inflammatory process, altered circulation, and edema formation, possibly evidenced by disruption of skin surface including macular rash and desquamation.

Oral Mucous Membrane, impaired may be related to inflammatory process, dehydration, and mouth breathing, possibly evidenced by pain, hyperemia, and fissures of lips.

Cardiac Output, risk for decreased risk factors may include structural changes/inflammation of coronary arteries and alterations in rate/rhythm or conduction.*

Labor, induced/augmented — OB

Knowledge, deficient [Learning Need] regarding procedure, treatment needs, and possible outcomes may be related to lack of exposure/recall, information misinterpretation, and unfamiliarity with information resources, possibly evidenced by questions, statement of concern/misconception, and exaggerated behaviors.

Injury, risk for maternal risk factors may include adverse effects/response to therapeutic interventions.*

Gas Exchange, risk for impaired fetal risk factors may include altered placental perfusion/cord prolapse.*

Pain, acute may be related to altered characteristics of chemically stimulated contractions, psychological concerns, possibly evidenced by verbal reports, increased muscle tone, distraction/guarding behaviors, and narrowed focus.

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Labor, stage I (active phase) **OB**

Pain, acute/[Discomfort] may be related to contraction-related hypoxia, dilation of tissues, and pressure on adjacent structures combined with stimulation of both parasympathetic and sympathetic nerve endings, possibly evidenced by verbal reports, guarding/distraction behaviors (restlessness), muscle tension, and narrowed focus.

Urinary Elimination, impaired may be related to altered intake/dehydration, fluid shifts, hormonal changes, hemorrhage, severe intrapartal hypertension, mechanical compression of bladder, and effects of regional anesthesia, possibly evidenced by changes in amount/frequency of voiding, urinary retention, slowed progression of labor, and reduced sensation.

Coping, risk for ineffective [individual/couple] risk factors may include situational crises, personal vulnerability, use of ineffective coping mechanisms, inadequate support systems, and pain.*

Labor, stage II (expulsion) **OB**

Pain, acute may be related to strong uterine contractions, tissue stretching/dilation and compression of nerves by presenting part of the fetus, and bladder distention, possibly evidenced by verbalizations, facial grimacing, guarding/distraction behaviors (restlessness), narrowed focus, and autonomic responses (diaphoresis).

Cardiac Output, [fluctuation] may be related to changes in SVR, fluctuations in venous return (repeated/prolonged Valsalva's maneuvers, effects of anesthesia/medications, dorsal recumbent position occluding the inferior vena cava and partially obstructing the aorta), possibly evidenced by decreased venous return, changes in vital signs (BP, pulse), urinary output, fetal bradycardia.

Gas Exchange, risk for impaired fetal risk factors may include mechanical compression of head/cord, maternal position/prolonged labor affecting placental perfusion, and effects of maternal anesthesia, hyperventilation.*

Skin/Tissue Integrity, risk for impaired risk factors may include untoward stretching/lacerations of delicate tissues (precipitous labor, hypertonic contractile pattern, adolescence, large fetus) and application of forceps.*

Fatigue risk factors may include pregnancy, stress, anxiety, sleep deprivation, increased physical exertion, anemia, humidity/temperature, lights.

Laminectomy (lumbar) **MS**

Tissue Perfusion, ineffective (specify type) may be related to diminished/interrupted blood flow (dressing, edema/hematoma formation), hypovolemia, possibly evidenced by paresthesia, numbness; decreased range of motion, muscle strength.

Trauma, risk for spinal risk factors may include temporary weakness of spinal column, balancing difficulties, changes in muscle tone/coordination.*

Pain, acute may be related to traumatized tissues, localized inflammation, and edema, possibly evidenced by altered muscle tone, verbal reports, and distraction/guarding behaviors, autonomic changes.

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Mobility, impaired physical may be related to imposed therapeutic restrictions, neuromuscular impairment, and pain, possibly evidenced by limited range of motion, decreased muscle strength/control, impaired coordination, and reluctance to attempt movement.

Urinary Retention, risk for [acute] risk factors may include pain and swelling in operative area and reduced mobility/restrictions of position.*

Laryngectomy — MS

(Also refer to Cancer; Chemotherapy)

Airway Clearance, ineffective may be related to partial/total removal of the glottis, temporary or permanent change to neck breathing, edema formation, and copious/thick secretions, possibly evidenced by dyspnea/difficulty breathing, changes in rate/depth of respiration, use of accessory respiratory muscles, weak/ineffective cough, abnormal breath sounds, and cyanosis.

Skin/Tissue Integrity, impaired may be related to surgical removal of tissues/grafting, effects of radiation or chemotherapeutic agents, altered circulation/reduced blood supply, compromised nutritional status, edema formation, and pooling/continuous drainage of secretions, possibly evidenced by disruption of skin/tissue surface and destruction of skin/tissue layers.

Oral Mucous Membrane, impaired may be related to dehydration/absence of oral intake, poor/inadequate oral hygiene, pathological condition (oral cancer), mechanical trauma (oral surgery), decreased saliva production, difficulty swallowing and pooling/drooling of secretions, and nutritional deficits, possibly evidenced by xerostomia (dry mouth), oral discomfort, thick/mucoid saliva, decreased saliva production, dry and crusted/coated tongue, inflamed lips, absent teeth/gums, poor dental health and halitosis.

CH

Communication, impaired verbal may be related to anatomic deficit (removal of vocal cords), physical barrier (tracheostomy tube), and required voice rest, possibly evidenced by inability to speak, change in vocal characteristics, and impaired articulation.

Aspiration, risk for: risk factors may include impaired swallowing, facial/neck surgery, presence of tracheostomy/feeding tube.*

Laryngitis — CH/PED

(Refer to Croup)

Lead poisoning, acute — PED/CH

(Also refer to Lead poisoning, chronic)

Trauma, risk for: risk factors may include loss of coordination, altered level of consciousness, clonic or tonic muscle activity, neurological damage.*

Fluid Volume, risk for deficient risk factors may include excessive vomiting, diarrhea, or decreased intake.*

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Knowledge, deficient [Learning Need] regarding sources of lead and prevention of poisoning may be related to lack of information/misinterpretation, possibly evidenced by statements of concern, questions, and misconceptions.

Lead poisoning, chronic **CH**

(Also refer to Lead Poisoning, acute)

Nutrition: imbalanced, less than body requirements may be related to decreased intake (chemically induced changes in the GI tract), possibly evidenced by anorexia, abdominal discomfort, reported metallic taste, and weight loss.

Thought Processes, disturbed may be related to deposition of lead in CNS and brain tissue, possibly evidenced by personality changes, learning disabilities, and impaired ability to conceptualize and reason.

Pain, chronic may be related to deposition of lead in soft tissues and bone, possibly evidenced by verbal reports, distraction behaviors, and focus on self.

Leukemia, acute **MS**

(Also refer to Chemotherapy)

Infection, risk for: risk factors may include inadequate secondary defenses (alterations in mature white blood cells, increased number of immature lymphocytes, immunosuppression and bone marrow suppression), invasive procedures, and malnutrition.*

Anxiety [specify level]/Fear may be related to change in health status, threat of death, and situational crisis, possibly evidenced by sympathetic stimulation, apprehension, feelings of helplessness, focus on self, and insomnia.

Activity intolerance [specify level] may be related to reduced energy stores, increased metabolic rate, imbalance between O_2 supply and demand, therapeutic restrictions (bedrest)/effect of drug therapy, possibly evidenced by generalized weakness, reports of fatigue and exertional dyspnea; abnormal heart rate or BP response.

Pain, acute may be related to physical agents (infiltration of tissues/organs/CNS, expanding bone marrow) and chemical agents (antileukemic treatments), possibly evidenced by verbal reports (abdominal discomfort, arthralgia, bone pain, headache); distraction behaviors, narrowed focus, and autonomic responses (changes in vital signs).

Fluid Volume, risk for deficient risk factors may include excessive losses (vomiting, hemorrhage, diarrhea), decreased intake (nausea, anorexia), increased fluid need (hypermetabolic state/fever), predisposition for kidney stone formation/tumor lysis syndrome.*

Long-term care **CH**

(Also refer to condition requiring/contributing to need for facility placement)

Anxiety [specify level]/Fear may be related to change in health status, role functioning, interaction patterns, socioeconomic status, environment;

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unmet needs, recent life changes, and loss of friends/SO(s), possibly evidenced by apprehension, restlessness, insomnia, repetitive questioning, pacing, purposeless activity, expressed concern regarding changes in life events, and focus on self.

Grieving, anticipatory may be related to perceived/actual or potential loss of physiopsychosocial well-being, personal possessions and SO(s); as well as cultural beliefs about aging/debilitation, possibly evidenced by denial of feelings, depression, sorrow, guilt; alterations in activity level, sleep patterns, eating habits, and libido.

Poisoning, risk for drug toxicity risk factors may include effects of aging (reduced metabolism, impaired circulation, precarious physiological balance, presence of multiple diseases/organ involvement) and use of multiple prescribed/OTC drugs.*

Thought Processes, disturbed may be related to physiological changes of aging (loss of cells and brain atrophy, decreased blood supply); altered sensory input, pain, effects of medications, and psychological conflicts (disrupted life pattern), possibly evidenced by slower reaction times, memory loss, altered attention span, disorientation, inability to follow, altered sleep patterns, and personality changes.

Sleep Pattern, disturbed may be related to internal factors (illness, psychological stress, inactivity) and external factors (environmental changes, facility routines), possibly evidenced by reports of difficulty in falling asleep/not feeling rested, interrupted sleep/awakening earlier than desired; change in behavior/performance, increasing irritability, and listlessness.

Sexuality Patterns, risk for ineffective risk factors may include biopsychosocial alteration of sexuality; interference in psychological/physical well-being, self-image, and lack of privacy/SO.*

Relocation Stress Syndrome, risk for: risk factors may include multiple losses, feeling of powerlessness, lack of/inappropriate use of support system, changes in psychosocial/physical health status.*

Lupus erythematosus, systemic (SLE) CH

Fatigue may be related to inadequate energy production/increased energy requirements (chronic inflammation), overwhelming psychological or emotional demands, states of discomfort, and altered body chemistry (including effects of drug therapy), possibly evidenced by reports of unremitting and overwhelming lack of energy/inability to maintain usual routines, decreased performance, lethargy, and decreased libido.

Pain, acute may be related to widespread inflammatory process affecting connective tissues, blood vessels, serosal surfaces and mucous membranes, possibly evidenced by verbal reports, guarding/distraction behaviors, self-focusing, and autonomic responses (changes in vital signs).

Skin/Tissue Integrity, impaired may be related to chronic inflammation, edema formation, and altered circulation, possibly evidenced by presence of skin rash/lesions, ulcerations of mucous membranes and photosensitivity.

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Body Image, disturbed may be related to presence of chronic condition with rash, lesions, ulcers, purpura, mottled erythema of hands, alopecia, loss of strength, and altered body function, possibly evidenced by hiding body parts, negative feelings about body, feelings of helplessness, and change in social involvement.

Lyme disease — CH/MS

Pain, acute/chronic may be related to systemic effects of toxins, presence of rash, urticaria, and joint swelling/inflammation, possibly evidenced by verbal reports, guarding behaviors, autonomic responses, and narrowed focus.

Fatigue may be related to increased energy requirements, altered body chemistry, and states of discomfort evidenced by reports of overwhelming lack of energy/inability to maintain usual routines, decreased performance, lethargy, and malaise.

Cardiac Output, risk for decreased risk factors may include alteration in cardiac rate/rhythm/conduction.*

Mallory-Weiss syndrome — MS

(Also refer to Achalasia)

Fluid Volume, risk for deficient risk factors may include excessive vascular losses, presence of vomiting, and reduced intake.*

Knowledge, deficient [Learning Need] regarding causes, treatment, and prevention of condition may be related to lack of information/misinterpretation, possibly evidenced by statements of concern, questions, and recurrence of problem.

Mastectomy — MS

Skin/Tissue Integrity, impaired may be related to surgical removal of skin/tissue, altered circulation, drainage, presence of edema, changes in skin elasticity/sensation, and tissue destruction (radiation), possibly evidenced by disruption of skin surface and destruction of skin layers/subcutaneous tissues.

Mobility, impaired physical may be related to neuromuscular impairment, pain, and edema formation, possibly evidenced by reluctance to attempt movement, limited range of motion, and decreased muscle mass/strength.

Self-Care Deficit: bathing/hygiene/dressing/grooming may be related to temporary loss/altered action of one or both arms, possibly evidenced by statements of inability to perform/complete self-care tasks.

Body Image, disturbed may be related to loss of body part denoting femininity, possibly evidenced by not looking at/touching area, negative feelings about body, preoccupation with loss, and change in social involvement/relationship.

Mastitis — OB/GYN

Pain, acute may be related to erythema and edema of breast tissues, possibly evidenced by verbal reports, guarding/distraction behaviors, self-focusing, autonomic responses (changes in vital signs).

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Infection, risk for spread/abscess formation risk factors may include traumatized tissues, stasis of fluids, and insufficient knowledge to prevent complications.*

Knowledge, deficient [Learning Need] regarding pathophysiology, treatment, and prevention may be related to lack of information/misinterpretation, possibly evidenced by statements of concern, questions, and misconceptions.

Breastfeeding, risk for ineffective risk factors may include inability to feed on affected side/interruption in breastfeeding.

Mastoidectomy PED/MS

Infection, risk for spread risk factors may include preexisting infection, surgical trauma, and stasis of body fluids in close proximity to brain.*

Pain, acute may be related to inflammation, tissue trauma, and edema formation, possibly evidenced by verbal reports, distraction behaviors, restlessness, self-focusing, and autonomic responses (changes in vital signs).

Sensory Perception, disturbed: auditory may be related to presence of surgical packing, edema, and surgical disturbance of middle ear structures, possibly evidenced by reported/tested hearing loss in affected ear.

Measles CH/PED

Pain, acute may be related to inflammation of mucous membranes, conjunctiva, and presence of extensive skin rash with pruritus, possibly evidenced by verbal reports, distraction behaviors, self-focusing, and autonomic responses (changes in vital signs).

Hyperthermia may be related to presence of viral toxins and inflammatory response, possibly evidenced by increased body temperature, flushed/warm skin, and tachycardia.

Infection, risk for secondary risk factors may include altered immune response and traumatized dermal tissues.*

Knowledge, deficient [Learning Need] regarding condition, transmission, and possible complications may be related to lack of information/misinterpretation, possibly evidenced by statements of concern, questions, misconceptions, and development of preventable complications.

Meningitis, acute meningococcal MS

Infection, risk for spread risk factors may include hematogenous dissemination of pathogen, stasis of body fluids, suppressed inflammatory response (medication-induced), and exposure of others to pathogens.*

Tissue Perfusion, ineffective: cerebral risk factors may include cerebral edema altering/interrupting cerebral arterial/venous blood flow, hypovolemia, exchange problems at cellular level (acidosis).*

Hyperthermia may be related to infectious process (increased metabolic rate) and dehydration, possibly evidenced by increased body temperature, warm/flushed skin, and tachycardia.

Pain, acute may be related to inflammation/irritation of the meninges with spasm of extensor muscles (neck, shoulders, and back), possibly

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evidenced by verbal reports, guarding/distraction behaviors, narrowed focus, photophobia, and autonomic responses (changes in vital signs).

Trauma/Suffocation, risk for: risk factors may include alterations in level of consciousness, possible development of clonic/tonic muscle activity (seizures), and generalized weakness/prostration, ataxia, vertigo.*

Meniscectomy MS/CH

Walking, impaired may be related to pain, joint instability, and imposed medical restrictions of movement, possibly evidenced by impaired ability to move about environment as needed/desired.

Knowledge, deficient [Learning Need] regarding postoperative expectations, prevention of complications, and self-care needs may be related to lack of information, possibly evidenced by statements of concern, questions, and misconceptions.

Mental retardation CH

(Also refer to Down syndrome)

Communication, impaired verbal may be related to developmental delay/impairment of cognitive and motor abilities, possibly evidenced by impaired articulation, difficulty with phonation, and inability to modulate speech/find appropriate words (dependent on degree of retardation).

Self-Care, risk for deficit [specify] risk factors may include impaired cognitive ability and motor skills.*

Nutrition: imbalanced, risk for more than body requirements risk factors may include decreased metabolic rate coupled with impaired cognitive development, dysfunctional eating patterns, and sedentary activity level.*

Social Interaction, impaired may be related to impaired thought processes, communication barriers, and knowledge/skill deficit about ways to enhance mutuality, possibly evidenced by dysfunctional interactions with peers, family, and/or SO(s), and verbalized/observed discomfort in social situation.

Coping, family: compromised may be related to chronic nature of condition and degree of disability that exhausts supportive capacity of SO(s), other situational or developmental crises or situations SO(s) may be facing, unrealistic expectations of SO(s), possibly evidenced by preoccupation of SO with personal reaction, SO(s) withdraw(s) or enter(s) into limited interaction with individual, protective behavior disproportionate (too much or too little) to patient's abilities or need for autonomy.

Home Maintenance, impaired may be related to impaired cognitive functioning, insufficient finances/family organization or planning, lack of knowledge, and inadequate support systems, possibly evidenced by requests for assistance, expression of difficulty in maintaining home, disorderly surroundings, and overtaxed family members.

Sexual Dysfunction, risk for: risk factors may include biopsychosocial alteration of sexuality, ineffectual/absent role models, misinformation/lack of knowledge, lack of SO(s), and lack of appropriate behavior control.*

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Mitral stenosis **MS/CH**

Activity intolerance may be related to imbalance between O_2 supply and demand, possibly evidenced by reports of fatigue, weakness, exertional dyspnea, and tachycardia.

Gas Exchange, impaired may be related to altered blood flow, possibly evidenced by restlessness, hypoxia, and cyanosis (orthopnea/paroxysmal nocturnal dyspnea).

Cardiac Output, decreased may be related to impeded blood flow as evidenced by jugular vein distention, peripheral/dependent edema, orthopnea/paroxysmal nocturnal dyspnea.

Knowledge, deficient [Learning Need] regarding pathophysiology, therapeutic needs, and potential complications may be related to lack of information/recall, misinterpretation, possibly evidenced by statements of concern, questions, inaccurate follow-through of instructions, and development of preventable complications.

Mononucleosis, infectious **CH**

Fatigue may be related to decreased energy production, states of discomfort, and increased energy requirements (inflammatory process), possibly evidenced by reports of overwhelming lack of energy, inability to maintain usual routines, lethargy, and malaise.

Pain [Discomfort] may be related to inflammation of lymphoid and organ tissues, irritation of oropharyngeal mucous membranes, and effects of circulating toxins, possibly evidenced by verbal reports, distraction behaviors, and self-focusing.

Hyperthermia may be related to inflammatory process, possibly evidenced by increased body temperature, warm/flushed skin, and tachycardia.

Knowledge, deficient [Learning Need] regarding disease transmission, self-care needs, medical therapy, and potential complications may be related to lack of information/misinterpretation, possibly evidenced by statements of concern, misconceptions, and inaccurate follow-through of instructions.

Mood disorders **PSY**

(Refer to Depressive disorders)

Multiple personality **PSY**

(Refer to Dissociative disorders)

Multiple sclerosis **CH**

Fatigue may be related to decreased energy production/increased energy requirements to perform activities, psychological/emotional demands, pain/discomfort, medication side effects, possibly evidenced by verbalization of overwhelming lack of energy, inability to maintain usual routine, decreased performance, impaired ability to concentrate, increase in physical complaints.

Sensory Perception, disturbed: visual, kinesthetic, tactile may be related to delayed/interrupted neuronal transmission, possibly evidenced

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by impaired vision, diplopia, disturbance of vibratory or position sense, paresthesias, numbness, and blunting of sensation.

Mobility, impaired physical may be related to neuromuscular impairment, discomfort/pain, sensoriperceptual impairments, decreased muscle strength, control and/or mass, deconditioning, possibly evidenced by limited ability to perform motor skills, limited range of motion, gait changes/postural instability.

Powerlessness/Hopelessness may be related to illness-related regimen and lifestyle of helplessness, possibly evidenced by verbal expressions of having no control or influence over the situation, depression over physical deterioration that occurs despite patient compliance with regimen, nonparticipation in care or decision making when opportunities are provided, passivity, decreased verbalization/affect.

Home Maintenance, impaired may be related to effects of debilitating disease, impaired cognitive and/or emotional functioning, insufficient finances, and inadequate support systems, possibly evidenced by reported difficulty, observed disorderly surroundings, and poor hygienic conditions.

Coping, family: compromised/disabled may be related to situational crises/temporary family disorganization and role changes, patient providing little support in turn for SO(s), prolonged disease/disability progression that exhausts the supportive capacity of SO(s), feelings of guilt, anxiety, hostility, despair, and highly ambivalent family relationships, possibly evidenced by patient expressing/confirming concern or report about SO(s) response to patient's illness, SO(s) preoccupied with own personal reactions, intolerance, abandonment, neglectful care of the patient, and distortion of reality regarding patient's illness.

Mumps PED/CH

Pain, acute may be related to presence of inflammation, circulating toxins, and enlargement of salivary glands, possibly evidenced by verbal reports, guarding/distraction behaviors, self-focusing, and autonomic responses (changes in vital signs).

Hyperthermia may be related to inflammatory process (increased metabolic rate) and dehydration, possibly evidenced by increased body temperature, warm/flushed skin, and tachycardia.

Fluid Volume, risk for deficient risk factors may include hypermetabolic state and painful swallowing, with decreased intake.*

Muscular dystrophy (Duchenne's) PED/CH

Mobility, impaired physical may be related to musculoskeletal impairment/weakness, possibly evidenced by decreased muscle strength, control, and mass; limited range of motion; and impaired coordination.

Growth and Development, delayed may be related to effects of physical disability, possibly evidenced by altered physical growth and altered ability to perform self-care/self-control activities appropriate to age.

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

Nutrition: imbalanced, risk for more than body requirements risk factors may include sedentary lifestyle and dysfunctional eating patterns.*

Coping, family: compromised may be related to situational crisis/emotional conflicts around issues about hereditary nature of condition and prolonged disease/disability that exhausts supportive capacity of family members, possibly evidenced by preoccupation with personal reactions regarding disability and displaying protective behavior disproportionate (too little/too much) to patient's abilities/need for autonomy.

Myasthenia gravis — MS

Breathing Pattern/Airway Clearance, ineffective may be related to neuromuscular weakness and decreased energy/fatigue, possibly evidenced by dyspnea, changes in rate/depth of respiration, ineffective cough, and adventitious breath sounds.

Communication, impaired verbal may be related to neuromuscular weakness, fatigue, and physical barrier (intubation), possibly evidenced by facial weakness, impaired articulation, hoarseness, and inability to speak.

Swallowing, impaired may be related to neuromuscular impairment of laryngeal/pharyngeal muscles and muscular fatigue, possibly evidenced by reported/observed difficulty swallowing, coughing/choking, and evidence of aspiration.

Anxiety [specify level]/Fear may be related to situational crisis, threat to self-concept, change in health/socioeconomic status or role function, separation from support systems, lack of knowledge, and inability to communicate, possibly evidenced by expressed concerns, increased tension, restlessness, apprehension, sympathetic stimulation, crying, focus on self, uncooperative behavior, withdrawal, anger, and noncommunication.

CH

Knowledge, deficient [Learning Need] regarding drug therapy, potential for crisis (myasthenic or cholinergic) and self-care management may be related to inadequate information/misinterpretation, possibly evidenced by statements of concern, questions, and misconceptions; development of preventable complications.

Mobility, impaired physical may be related to neuromuscular impairment, possibly evidenced by reports of progressive fatigability with repetitive/prolonged muscle use, impaired coordination, and decreased muscle strength/control.

Sensory Perception, disturbed: visual may be related to neuromuscular impairment, possibly evidenced by visual distortions (diplopia) and motor incoordination.

Myocardial infarction — MS

(Also refer to Myocarditis)

Pain, acute may be related to ischemia of myocardial tissue, possibly evidenced by verbal reports, guarding/distraction behaviors

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(restlessness), facial mask of pain, self-focusing, and autonomic responses (diaphoresis, changes in vital signs).

Anxiety [specify level]/Fear may be related to threat of death, threat of change of health status/role functioning and lifestyle, interpersonal transmission/contagion, possibly evidenced by increased tension, fearful attitude, apprehension, expressed concerns/uncertainty, restlessness, sympathetic stimulation, and somatic complaints.

Cardiac Output, risk for decreased risk factors may include changes in rate and electrical conduction, reduced preload/increased SVR, and altered muscle contractility/depressant effects of some medications, infarcted/dyskinetic muscle, structural defects.

Tissue Perfusion, risk for ineffective risk factors may include reduction/interruption of blood flow (e.g., vasoconstriction, hypervolemia/shunting, and thromboembolic formation).*

Myocarditis — MS

(Also refer to Myocardial risk for infarction)

Activity, risk for intolerance may be related to imbalance in O_2 supply and demand (myocardial inflammation/damage) cardiac depressant effects of certain drugs, and enforced bedrest, possibly evidenced by reports of fatigue, exertional dyspnea, tachycardia/palpitations in response to activity, ECG changes/dysrhythmias, and generalized weakness.

Cardiac Output, risk for decreased risk factors may include degeneration of cardiac muscle.*

Knowledge, deficient [Learning Need] regarding pathophysiology of condition/outcomes, treatment, and self-care needs/lifestyle changes may be related to lack of information/misinterpretation, possibly evidenced by statements of concern, misconceptions, inaccurate follow-through of instructions, and development of preventable complications.

Myringotomy — PED/MS

(Refer to Mastoidectomy)

Myxedema — CH

(Also refer to Hypothyroidism)

Body Image, disturbed may be related to change in structure/function (loss of hair/thickening of skin, masklike facial expression, enlarged tongue, menstrual and reproductive disturbances), possibly evidenced by negative feelings about body, feelings of helplessness, and change in social involvement.

Nutrition: imbalanced, more than body requirements may be related to decreased metabolic rate and activity level, possibly evidenced by weight gain greater than ideal for height and frame.

Cardiac Output, risk for decreased risk factors may include altered electrical conduction and myocardial contractility.*

Neonatal, normal newborn — PED

Gas Exchange, risk for impaired risk factors may include prenatal or intrapartal stressors, excess production of mucus, or cold stress.*

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Body Temperature, risk for imbalanced risk factors may include large body surface in relation to mass, limited amounts of insulating subcutaneous fat, nonrenewable sources of brown fat and few white fat stores, thin epidermis with close proximity of blood vessels to the skin, inability to shiver, and movement from a warm uterine environment to a much cooler environment.*

Attachment, risk for impaired parent/infant/child risk factors may include developmental transition (gain of a family member), anxiety associated with the parent role, lack of privacy (intrusive family/visitors).*

Nutrition: imbalanced, less than body requirements risk factors may include rapid metabolic rate, high-caloric requirement, increased insensible water losses through pulmonary and cutaneous routes, fatigue, and a potential for inadequate or depleted glucose stores.*

Infection, risk for: risk factors may include inadequate secondary defenses (inadequate acquired immunity, e.g., deficiency of neutrophils and specific immunoglobulins), and inadequate primary defenses (e.g., environmental exposure, broken skin, traumatized tissues, decreased ciliary action).*

Neonatal, premature newborn PED

Gas Exchange, impaired may be related to alveolar-capillary membrane changes (inadequate surfactant levels), altered blood flow (immaturity of pulmonary arteriole musculature), altered O_2 supply (immaturity of central nervous system and neuromuscular system, tracheobronchial obstruction), altered O_2-carrying capacity of blood (anemia), and cold stress, possibly evidenced by respiratory difficulties, inadequate oxygenation of tissues, and acidemia.

Breathing Pattern, ineffective may be related to immaturity of the respiratory center, poor positioning, drug-related depression and metabolic imbalances, decreased energy/fatigue, possibly evidenced by dyspnea, tachypnea, periods of apnea, nasal flaring/use of accessory muscles, cyanosis, abnormal ABGs, and tachycardia.

Thermoregulation, risk for ineffective risk factors may include immature CNS development (temperature regulation center), decreased ratio of body mass to surface area, decreased subcutaneous fat, limited brown fat stores, inability to shiver or sweat, poor metabolic reserves, muted response to hypothermia, and frequent medical/nursing manipulations and interventions.*

Fluid Volume, risk for deficient risk factors may include extremes of age and weight, excessive fluid losses (thin skin, lack of insulating fat, increased environmental temperature, immature kidney/failure to concentrate urine).*

Infant Behavior, risk for disorganized risk factors may include prematurity (immaturity of CNS system, hypoxia), lack of containment/boundaries, pain, overstimulation, separation from parents.*

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Nephrectomy MS

Pain, acute may be related to surgical tissue trauma with mechanical closure (suture), possibly evidenced by verbal reports, guarding/distraction behaviors, self-focusing, and autonomic responses (changes in vital signs).

Fluid Volume, risk for deficient risk factors may include excessive vascular losses and restricted intake.*

Breathing Pattern, ineffective may be related to incisional pain with decreased lung expansion, possibly evidenced by tachypnea, fremitus, changes in respiratory depth/chest expansion, and changes in ABGs.

Constipation may be related to reduced dietary intake, decreased mobility, GI obstruction (paralytic ileus), and incisional pain with defecation, possibly evidenced by decreased bowel sounds, reduced frequency/amount of stool, and hard/formed stool.

Nephrotic syndrome MS/CH

Fluid Volume, excess may be related to compromised regulatory mechanism with changes in hydrostatic/oncotic vascular pressure and increased activation of the renin-angiotensin-aldosterone system, possibly evidenced by edema/anasarca, effusions/ascites, weight gain, intake greater than output, and BP changes.

Nutrition: imbalanced, less than body requirements may be related to excessive protein losses and inability to ingest adequate nutrients (anorexia), possibly evidenced by weight loss/muscle wasting (may be difficult to assess due to edema), lack of interest in food, and observed inadequate intake.

Infection, risk for risk factors may include chronic disease and steroidal suppression of inflammatory responses.*

Skin Integrity, risk for impaired risk factors may include presence of edema and activity restrictions.*

Neuralgia, trigeminal CH

Pain, acute may be related to neuromuscular impairment with sudden violent muscle spasm, possibly evidenced by verbal reports, guarding/distraction behaviors, self-focusing, and autonomic responses (changes in vital signs).

Knowledge, deficient [Learning Need] regarding control of recurrent episodes, medical therapies, and self-care needs may be related to lack of information/recall and misinterpretation, possibly evidenced by statements of concern, questions, and exacerbation of condition.

Neuritis CH

Pain, acute/chronic may be related to nerve damage usually associated with a degenerative process, possibly evidenced by verbal reports, guarding/distraction behaviors, self-focusing, and autonomic responses (changes in vital signs).

Knowledge, deficient [Learning Need] regarding underlying causative factors, treatment, and prevention may be related to lack of information/

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misinterpretation, possibly evidenced by statements of concern, questions, and misconceptions.

Obesity — CH/PSY

Nutrition: imbalanced, more than body requirements may be related to excessive intake in relation to metabolic needs, possibly evidenced by weight 20% greater than ideal for height and frame, sedentary activity level, reported/observed dysfunctional eating patterns, and excess body fat by triceps skin fold/other measurements.

Body Image, disturbed/Self-Esteem, chronic low may be related to view of self in contrast to societal values, family/subcultural encouragement of overeating; control, sex, and love issues; possibly evidenced by negative feelings about body, fear of rejection/reaction of others, feeling of hopelessness/powerlessness, and lack of follow-through with treatment plan.

Activity intolerance may be related to imbalance between oxygen supply and demand, and sedentary lifestyle, possibly evidenced by fatigue or weakness, exertional discomfort, and abnormal heart rate/BP response.

Social Interaction, impaired may be related to verbalized/observed discomfort in social situations, self-concept disturbance, possibly evidenced by reluctance to participate in social gatherings, verbalization of a sense of discomfort with others, feelings of rejection, absence of/ineffective supportive SO(s).

Osteoarthritis (degenerative joint disease) — CH

(Refer to Arthritis, rheumatoid)

(Although this is a degenerative process versus the inflammatory process of rheumatoid arthritis, nursing concerns are the same.)

Osteomyelitis — MS/CH

Pain, acute may be related to inflammation and tissue necrosis, possibly evidenced by verbal reports, guarding/distraction behaviors, self-focus, and autonomic responses (changes in vital signs).

Hyperthermia may be related to increased metabolic rate and infectious process, possibly evidenced by increased body temperature and warm/flushed skin.

Tissue Perfusion, ineffective: bone may be related to inflammatory reaction with thrombosis of vessels, destruction of tissue, edema, and abscess formation, possibly evidenced by bone necrosis, continuation of infectious process, and delayed healing.

Walking, risk for impaired risk factors may include inflammation and tissue necrosis, pain, joint instability.

Knowledge, deficient [Learning Need] regarding pathophysiology of condition, long-term therapy needs, activity restriction, and prevention of complications may be related to lack of information/misinterpretation, possibly evidenced by statements of concern, questions, and misconceptions, and inaccurate follow-through of instructions.

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Osteoporosis — CH

Trauma, risk for: risk factors may include loss of bone density/integrity increasing risk of fracture with minimal or no stress.*

Pain, acute/chronic may be related to vertebral compression on spinal nerve/muscles/ligaments, spontaneous fractures, possibly evidenced by verbal reports, guarding/distraction behaviors, self-focus, and changes in sleep pattern.

Mobility, impaired physical may be related to pain and musculoskeletal impairment, possibly evidenced by limited range of motion, reluctance to attempt movement/expressed fear of reinjury, and imposed restrictions/limitations.

Palsy, cerebral (spastic hemiplegia) — PED/CH

Mobility, impaired physical may be related to muscular weakness/hypertonicity, increased deep tendon reflexes, tendency to contractures, and underdevelopment of affected limbs, possibly evidenced by decreased muscle strength, control, mass; limited range of motion, and impaired coordination.

Coping, family: compromised may be related to permanent nature of condition, situational crisis, emotional conflicts/temporary family disorganization, and incomplete information/understanding of patient's needs, possibly evidenced by verbalized anxiety/guilt regarding patient's disability, inadequate understanding and knowledge base, and displaying protective behaviors disproportionate (too little/too much) to patient's abilities or need for autonomy.

Growth and Development, delayed may be related to effects of physical disability, possibly evidenced by altered physical growth, delay or difficulty in performing skills (motor, social, expressive), and altered ability to perform self-care/self-control activities appropriate to age.

Pancreatitis — MS

Pain, acute may be related to obstruction of pancreatic/biliary ducts, chemical contamination of peritoneal surfaces by pancreatic exudate/autodigestion, extension of inflammation to the retroperitoneal nerve plexus, possibly evidenced by verbal reports, guarding/distraction behaviors, self-focusing, grimacing, autonomic responses (changes in vital signs), and alteration in muscle tone.

Fluid Volume, risk for deficient risk factors may include excessive gastric losses (vomiting, nasogastric suctioning), increase in size of vascular bed (vasodilation, effects of kinins), third-space fluid transudation, ascites formation, alteration of clotting process, hemorrhage.*

Nutrition: imbalanced, less than body requirements may be related to vomiting, decreased oral intake as well as altered ability to digest nutrients (loss of digestive enzymes/insulin), possibly evidenced by reported inadequate food intake, aversion to eating, reported altered taste sensation, weight loss, and reduced muscle mass.

Infection, risk for: risk factors may include inadequate primary defenses (stasis of body fluids, altered peristalsis, change in pH secretions),

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immunosuppression, nutritional deficiencies, tissue destruction, and chronic disease.*

Paranoid personality disorder PSY

Violence, risk for self-directed/other-directed risk factors may include perceived threats of danger, paranoid delusions, and increased feelings of anxiety.*

Anxiety [severe] may be related to inability to trust (has not mastered tasks of trust versus mistrust), possibly evidenced by rigid delusional system (serves to provide relief from stress that justifies the delusion), frightened of other people and own hostility.

Powerlessness may be related to feelings of inadequacy, lifestyle of helplessness, maladaptive interpersonal interactions (e.g., misuse of power, force; abusive relationships), sense of severely impaired self-concept, and belief that individual has no control over situation(s), possibly evidenced by paranoid delusions, use of aggressive behavior to compensate, and expressions of recognition of damage paranoia has caused self and others.

Thought Processes, disturbed may be related to psychological conflicts, increased anxiety, and fear, possibly evidenced by difficulties in the process and character of thought, interference with the ability to think clearly and logically, delusions, fragmentation, and autistic thinking.

Coping, family: compromised may be related to temporary or sustained family disorganization/role changes, prolonged progression of condition that exhausts the supportive capacity of SO(s), possibly evidenced by family system not meeting physical/emotional/spiritual needs of its members, inability to express or to accept wide range of feelings, inappropriate boundary maintenance; SO(s) describe(s) preoccupation with personal reactions.

Paraplegia MS/CH

(Also refer to Quadriplegia)

Transfer Ability, impaired may be related to loss of muscle function/control, injury to upper extremity joints (overuse).

Sensory Perception, disturbed: kinesthetic, tactile may be related to neurological deficit with loss of sensory reception and transmission, psychological stress, possibly evidenced by reported/measured change in sensory acuity and loss of usual response to stimuli.

Urinary Incontinence, reflex/Urinary Elimination, ineffective may be related to loss of nerve conduction above the level of the reflex arc, possibly evidenced by lack of awareness of bladder filling/fullness, absence of urge to void, uninhibited bladder contraction, urinary tract infections (UTIs), kidney stone formation.

Body Image, disturbed/Role Performance, ineffective may be related to loss of body functions, change in physical ability to resume role, perceived loss of self/identity, possibly evidenced by negative feelings about body/self, feelings of helplessness/powerlessness, delay in taking responsibility for self-care/participation in therapy, and change in social involvement.

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Sexual Dysfunction may be related to loss of sensation, altered function, and vulnerability, possibly evidenced by seeking of confirmation of desirability, verbalization of concern, alteration in relationship with SO, and change in interest in self/others.

Parathyroidectomy — MS

Pain, acute may be related to presence of surgical incision and effects of calcium imbalance (bone pain, tetany), possibly evidenced by verbal reports, guarding/distraction behaviors, self-focus, and autonomic responses (changes in vital signs).

Fluid Volume, risk for excess risk factors may include preoperative renal involvement, stress-induced release of ADH, and changing calcium/electrolyte levels.*

Airway Clearance, risk for ineffective risk factors may include edema formation and laryngeal nerve damage.*

Knowledge, deficient [Learning Need] regarding postoperative care/complications and long-term needs may be related to lack of information/recall, misinterpretation, possibly evidenced by statements of concern, questions, and misconceptions.

Parkinson's disease — CH

Walking, impaired may be related to neuromuscular impairment (muscle weakness, tremors, bradykinesia) and musculoskeletal impairment (joint rigidity), possibly evidenced by inability to move about the environment as desired, increased occurrence of falls.

Swallowing, impaired may be related to neuromuscular impairment/muscle weakness, possibly evidenced by reported/observed difficulty in swallowing, drooling, evidence of aspiration (choking, coughing).

Communication, impaired verbal may be related to muscle weakness and incoordination, possibly evidenced by impaired articulation, difficulty with phonation, and changes in rhythm and intonation.

Caregiver Role Strain may be related to illness, severity of care receiver, psychological/cognitive problems in care receiver, caregiver is spouse, duration of caregiving required, lack of respite/recreation for caregiver, possibly evidenced by feeling stressed, depressed, worried; lack of resources/support, family conflict.

Pelvic inflammatory disease — OB/GYN/CH

Infection, risk for spread risk factors may include presence of infectious process in highly vascular pelvic structures, delay in seeking treatment.*

Pain, acute may be related to inflammation, edema, and congestion of reproductive/pelvic tissues, possibly evidenced by verbal reports, guarding/distraction behaviors, self-focus, and autonomic responses (changes in vital signs).

Hyperthermia may be related to inflammatory process/hypermetabolic state, possibly evidenced by increased body temperature, warm/flushed skin, and tachycardia.

Self-Esteem, risk for situational low risk factors may include perceived stigma of physical condition (infection of reproductive system).

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Knowledge, deficient [Learning Need] regarding cause/complications of condition, therapy needs, and transmission of disease to others may be related to lack of information/misinterpretation, possibly evidenced by statements of concern, questions, misconceptions, and development of preventable complications.

Periarteritis nodosa MS/CH

(Refer to Polyarteritis [nodosa])

Pericarditis MS

Pain, acute may be related to tissue inflammation and presence of effusion, possibly evidenced by verbal reports of pain affected by movement/position, guarding/distraction behaviors, self-focus, and autonomic responses (changes in vital signs).

Activity intolerance may be related to imbalance between O_2 supply and demand (restriction of cardiac filling/ventricular contraction, reduced cardiac output), possibly evidenced by reports of weakness/fatigue, exertional dyspnea, abnormal heart rate or BP response, and signs of heart failure.

Cardiac Output, risk for decreased risk factors may include accumulation of fluid (effusion) restricted cardiac filling/contractility.*

Anxiety [specify level] may be related to change in health status and perceived threat of death, possibly evidenced by increased tension, apprehension, restlessness, and expressed concerns.

Peripheral vascular disease (atherosclerosis) CH

Tissue Perfusion, ineffective: peripheral may be related to reduction or interruption of arterial/venous blood flow, possibly evidenced by changes in skin temperature/color, lack of hair growth, BP/pulse changes in extremity, presence of bruits, and reports of claudication.

Activity intolerance may be related to imbalance between O_2 supply and demand, possibly evidenced by reports of muscle fatigue/weakness and exertional discomfort (claudication).

Skin/Tissue Integrity, impaired risk factors may include altered circulation with decreased sensation and impaired healing.*

Peritonitis MS

Infection, risk for spread/septicemia risk factors may include inadequate primary defenses (broken skin, traumatized tissue, altered peristalsis), inadequate secondary defenses (immunosuppression), and invasive procedures.*

Fluid Volume, deficient [mixed] may be related to fluid shifts from extracellular, intravascular, and interstitial compartments into intestines and/or peritoneal space, excessive gastric losses (vomiting, diarrhea, NG suction), hypermetabolic state, and restricted intake, possibly evidenced by dry mucous membranes, poor skin turgor, delayed capillary refill, weak peripheral pulses, diminished urinary output, dark/concentrated urine, hypotension, and tachycardia.

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

Pain, acute may be related to chemical irritation of parietal peritoneum, trauma to tissues, accumulation of fluid in abdominal/peritoneal cavity, possibly evidenced by verbal reports, muscle guarding/rebound tenderness, distraction behaviors, facial mask of pain, self-focus, autonomic responses (changes in vital signs).

Nutrition: imbalanced, risk for less than body requirements risk factors may include nausea/vomiting, intestinal dysfunction, metabolic abnormalities, increased metabolic needs.*

Pheochromocytoma MS

Anxiety [specify level] may be related to excessive physiological (hormonal) stimulation of the sympathetic nervous system, situational crises, threat to/change in health status, possibly evidenced by apprehension, shakiness, restlessness, focus on self, fearfulness, diaphoresis, and sense of impending doom.

Fluid Volume, deficient [mixed] may be related to excessive gastric losses (vomiting/diarrhea), hypermetabolic state, diaphoresis, and hyperosmolar diuresis, possibly evidenced by hemoconcentration, dry mucous membranes, poor skin turgor, thirst, and weight loss.

Cardiac Output, decreased/Tissue Perfusion, ineffective (specify type) may be related to altered preload/decreased blood volume, altered SVR, and increased sympathetic activity (excessive secretion of catecholamines), possibly evidenced by cool/clammy skin, change in BP (hypertension/postural hypotension), visual disturbances, severe headache, and angina.

Knowledge, deficient [Learning Need] regarding pathophysiology of condition, outcome, preoperative and postoperative care needs may be related to lack of information/recall, possibly evidenced by statements of concern, questions, and misconceptions.

Phlebitis CH

(Refer to Thrombophlebitis)

Phobia PSY

(Also refer to Anxiety Disorder, generalized)

Fear may be related to learned irrational response to natural or innate origins (phobic stimulus), unfounded morbid dread of a seemingly harmless object/situation, possibly evidenced by sympathetic stimulation and reactions ranging from apprehension to panic, withdrawal from/total avoidance of situations that place individual in contact with feared object.

Social Interaction, impaired may be related to intense fear of encountering feared object/activity or situation and anticipated loss of control, possibly evidenced by reported change of style/pattern of interaction, discomfort in social situations, and avoidance of phobic stimulus.

Placenta previa OB

Fluid Volume, risk for deficient risk factors may include excessive vascular losses (vessel damage and inadequate vasoconstriction).*

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

Gas Exchange, impaired fetal may be related to altered blood flow, altered oxygen carrying capacity of blood (maternal anemia), and decreased surface area of gas exchange at site of placental attachment, possibly evidenced by changes in fetal heart rate/activity and release of meconium.
Fear may be related to threat of death (perceived or actual) to self or fetus, possibly evidenced by verbalization of specific concerns, increased tension, sympathetic stimulation.
Diversional Activity, risk for deficient risk factors may include imposed activity restrictions/bedrest.*

Pleurisy **CH**

Pain, acute may be related to inflammation/irritation of the parietal pleura, possibly evidenced by verbal reports, guarding/distraction behaviors, self-focus, and autonomic responses (changes in vital signs).
Breathing Pattern, ineffective may be related to pain on inspiration, possibly evidenced by decreased respiratory depth, tachypnea, and dyspnea.
Infection, risk for pneumonia risk factors may include stasis of pulmonary secretions, decreased lung expansion, and ineffective cough.*

Pneumonia **CH/MS**

(Refer to Bronchitis; Bronchopneumonia)

Pneumothorax **MS**

(Also refer to Hemothorax)
Breathing Pattern, ineffective may be related to decreased lung expansion (fluid/air accumulation), musculoskeletal impairment, pain, inflammatory process, possibly evidenced by dyspnea, tachypnea, altered chest excursion, respiratory depth changes, use of accessory muscles/nasal flaring, cough, cyanosis, and abnormal ABGs.
Cardiac Output, risk for decreased risk factors may include compression/displacement of cardiac structures.*
Pain, acute may be related to irritation of nerve endings within pleural space by foreign object (chest tube), possibly evidenced by verbal reports, guarding/distraction behaviors, self-focus, and autonomic responses (changes in vital signs).

Polyarteritis (nodosa) **MS/CH**

Tissue Perfusion, ineffective (specify type) may be related to reduction/interruption of blood flow, possibly evidenced by organ tissue infarctions, changes in organ function, and development of organic psychosis.
Hyperthermia may be related to widespread inflammatory process, possibly evidenced by increased body temperature and warm/flushed skin.
Pain, acute may be related to inflammation, tissue ischemia, and necrosis of affected area, possibly evidenced by verbal reports, guarding/distraction behaviors, self-focus, and autonomic responses (changes in vital signs).

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

Grieving, anticipatory may be related to perceived loss of self, possibly evidenced by expressions of sorrow and anger, altered sleep and/or eating patterns, changes in activity level, and libido.

Polycythemia vera CH

Activity intolerance may be related to imbalance between O_2 supply and demand, possibly evidenced by reports of fatigue/weakness.

Tissue Perfusion, ineffective (specify type) may be related to reduction/interruption of arterial/venous blood flow (insufficiency, thrombosis, or hemorrhage), possibly evidenced by pain in affected area, impaired mental ability, visual disturbances, and color changes of skin/mucous membranes.

Polyradiculitis MS

(Refer to Guillain-Barré Syndrome)

Postoperative recovery period MS

Breathing Pattern, ineffective may be related to neuromuscular and perceptual/cognitive impairment, decreased lung expansion/energy, and tracheobronchial obstruction, possibly evidenced by changes in respiratory rate and depth, reduced vital capacity, apnea, cyanosis, and noisy respirations.

Body Temperature, risk for imbalanced risk factors may include exposure to cool environment, effect of medications/anesthetic agents, extremes of age/weight, and dehydration.*

Sensory Perception, disturbed (specify)/Thought Processes, disturbed may be related to chemical alteration (use of pharmaceutical agents, hypoxia), therapeutically restricted environment, excessive sensory stimuli and physiological stress, possibly evidenced by changes in usual response to stimuli, motor incoordination; impaired ability to concentrate, reason, and make decisions; and disorientation to person, place, and time.

Fluid Volume, risk for deficient risk factors may include restriction of oral intake, loss of fluid through abnormal routes (indwelling tubes, drains) and normal routes (vomiting, loss of vascular integrity, changes in clotting ability), extremes of age and weight.*

Pain, acute may be related to disruption of skin, tissue, and muscle integrity, musculoskeletal/bone trauma, and presence of tubes and drains, possibly evidenced by verbal reports, alteration in muscle tone, facial mask of pain, distraction/guarding behaviors, narrowed focus, and autonomic responses.

Skin/Tissue Integrity, impaired may be related to mechanical interruption of skin/tissues, altered circulation, effects of medication, accumulation of drainage, and altered metabolic state, possibly evidenced by disruption of skin surface/layers and tissues.

Infection, risk for: risk factors may include broken skin, traumatized tissues, stasis of body fluids, presence of pathogens/contaminants, environmental exposure, and invasive procedures.*

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

Postpartal period **OB/CH**

Attachment, risk for impaired parent/infant/child/Parenting, risk for impaired risk factors may include lack of support between/from SO(s), ineffective or no role model, anxiety associated with the parental role, unrealistic expectations, presence of stressors (e.g., financial, housing, employment).

Fluid Volume, risk for deficient risk factors may include excessive blood loss during delivery, reduced intake/inadequate replacement, nausea/vomiting, increased urine output, and insensible losses.*

Pain acute/[Discomfort] may be related to tissue trauma/edema, muscle contractions, bladder fullness, and physical/psychological exhaustion, possibly evidenced by reports of cramping (afterpains), self-focusing, alteration in muscle tone, distraction behaviors, and autonomic responses (changes in vital signs).

Urinary Elimination, impaired may be related to hormonal effects (fluid shifts/continued elevation in renal plasma flow), mechanical trauma/tissue edema, and effects of medication/anesthesia, possibly evidenced by frequency, dysuria, urgency, incontinence, or retention.

Constipation may be related to decreased muscle tone associated with diastasis recti, prenatal effects of progesterone, dehydration, excess analgesia or anesthesia, pain (hemorrhoids, episiotomy, or perineal tenderness), prelabor diarrhea and lack of intake, possibly evidenced by frequency less than usual pattern, hard-formed stool, straining at stool, decreased bowel sounds, and abdominal distention.

Sleep Pattern, disturbed may be related to pain/discomfort, intense exhilaration/excitement, anxiety, exhausting process of labor/delivery, and needs/demands of family members, possibly evidenced by verbal reports of difficulty in falling asleep/not feeling well-rested, interrupted sleep, frequent yawning, irritability, dark circles under eyes.

Post-traumatic stress disorder **PSY**

Post-Trauma Syndrome related to having experienced a traumatic life event, possibly evidenced by reexperiencing the event, somatic reactions, psychic/emotional numbness, altered lifestyle, impaired sleep, self-destructive behaviors, difficulty with interpersonal relationships, development of phobia, poor impulse control/irritability, and explosiveness.

Violence, risk for other-directed risk factors may include startle reaction, an intrusive memory causing a sudden acting out of a feeling as if the event were occurring; use of alcohol/other drugs to ward off painful effects and produce psychic numbing, breaking through the rage that has been walled off, response to intense anxiety or panic state, and loss of control.*

Coping, ineffective may be related to personal vulnerability, inadequate support systems, unrealistic perceptions, unmet expectations, overwhelming threat to self, and multiple stressors repeated over a period of time, possibly evidenced by verbalization of inability to cope or difficulty asking for help, muscular tension/headaches, chronic worry, and emotional tension.

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

Grieving, dysfunctional may be related to actual/perceived object loss (loss of self as seen before the traumatic incident occurred as well as other losses incurred in/after the incident), loss of physiopsychosocial well-being, thwarted grieving response to a loss, and lack of resolution of previous grieving responses, possibly evidenced by verbal expression of distress at loss, anger, sadness, labile affect; alterations in eating habits, sleep/dream patterns, libido; reliving of past experiences, expression of guilt, and alterations in concentration.

Family Processes, interrupted may be related to situational crisis, failure to master developmental transitions, possibly evidenced by expressions of confusion about what to do and that family is having difficulty coping, family system not meeting physical/emotional/spiritual needs of its members, not adapting to change or dealing with traumatic experience constructively, and ineffective family decision-making process.

Pregnancy (prenatal period) OB/CH

Nutrition: imbalanced, risk for less than body requirements risk factors may include changes in appetite, insufficient intake (nausea/vomiting, inadequate financial resources and nutritional knowledge); meeting increased metabolic demands (increased thyroid activity associated with the growth of fetal and maternal tissues).*

Pain, acute/[Discomfort] may be related to hormonal influences, physical changes, possibly evidenced by verbal reports (nausea, breast changes, leg cramps, hemorrhoids, nasal stuffiness), alteration in muscle tone, restlessness, and autonomic responses (changes in vital signs).

Injury, risk for fetal risk factors may include environmental/hereditary factors and problems of maternal well-being that directly affect the developing fetus (e.g., malnutrition, substance use).*

Cardiac Output, [maximally compensated] may be related to increased fluid volume/maximal cardiac effort and hormonal effects of progesterone and relaxin (places the patient at risk for hypertension and/or circulatory failure), and changes in peripheral resistance (afterload), possibly evidenced by variations in BP and pulse, syncopal episodes, presence of pathological edema.

Coping, family: readiness for enhanced may be related to situational/maturational crisis with anticipated changes in family structure/roles, needs sufficiently met and adaptive tasks effectively addressed to enable goals of self-actualization to surface, as evidenced by movement toward health-promoting and enriching lifestyle, choosing experiences that optimize pregnancy experience/wellness.

Constipation, risk for: risk factors may include changes in dietary/fluid intake, smooth muscle relaxation, decreased peristalsis, and effects of medications (e.g., iron).*

Fatigue/Sleep Pattern, disturbed may be related to increased carbohydrate metabolism, altered body chemistry, increased energy requirements to perform ADLs, discomfort, anxiety, inactivity, possibly evidenced by reports of overwhelming lack of energy/inability to maintain usual routines, difficulty falling asleep/not feeling well-rested, interrupted sleep, irritability, lethargy, and frequent yawning.

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Role Performance, risk for ineffective risk factors may include maturational crisis, developmental level, history of maladaptive coping, absence of support systems.*

Knowledge, deficient [Learning Need] regarding normal physiological/psychological changes and self-care needs may be related to lack of information/recall and misinterpretation of normal physiological/psychological changes and their impact on the client/family, possibly evidenced by questions, statements of concern, misconceptions and inaccurate follow-through of instructions/development of preventable complications.

Pregnancy, adolescent OB/CH

(Also refer to Pregnancy—prenatal period)

Family Processes, interrupted may be related to situational/developmental transition (economic, change in roles/gain of a family member), possibly evidenced by family expressing confusion about what to do, unable to meet physical/emotional/spiritual needs of the members, family inability to adapt to change or to deal with traumatic experience constructively; does not demonstrate respect for individuality and autonomy of its members, ineffective family decision-making process, and inappropriate boundary maintenance.

Social Isolation may be related to alterations in physical appearance, perceived unacceptable social behavior, restricted social sphere, stage of adolescence, and interference with accomplishing developmental tasks, possibly evidenced by expressions of feelings of aloneness/rejection/difference from others, uncommunicative, withdrawn, no eye contact, seeking to be alone, unacceptable behavior, and absence of supportive SO(s).

Body Image, disturbed/Self-Esteem [specify] may be related to situational/maturational crisis, biophysical changes, and fear of failure at life events, absence of support systems, possibly evidenced by self-negating verbalizations, expressions of shame/guilt, fear of rejection/reaction of other, hypersensitivity to criticism, and lack of follow-through/nonparticipation in prenatal care.

Knowledge, deficient [Learning Need] regarding pregnancy, developmental/individual needs, future expectations may be related to lack of exposure, information misinterpretation, unfamiliarity with information resources, lack of interest in learning, possibly evidenced by questions, statement of concern/misconception, sense of vulnerability/denial of reality, inaccurate follow-through of instruction, and development of preventable complications.

Parenting, risk for impaired may be related to chronological age/developmental stage, unmet social/emotional/maturational needs of parenting figures, unrealistic expectation of self/infant/partner, ineffective role model/social support, lack of role identity, and presence of stressors (e.g., financial, social).*

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Pregnancy-induced hypertension (preeclampsia) OB/CH

Fluid Volume, deficient [isotonic] may be related to a plasma protein loss, decreasing plasma colloid osmotic pressure allowing fluid shifts out of vascular compartment, possibly evidenced by edema formation, sudden weight gain, hemoconcentration, nausea/vomiting, epigastric pain, headaches, visual changes, decreased urine output.

Cardiac Output, decreased may be related to hypovolemia/decreased venous return, increased SVR, possibly evidenced by variations in BP/hemodynamic readings, edema, shortness of breath, change in mental status.

Tissue Perfusion, ineffective [uteroplacental] may be related to vasospasm of spiral arteries and relative hypovolemia, possibly evidenced by changes in fetal heart rate/activity, reduced weight gain, and premature delivery/fetal demise.

Knowledge, deficient [Learning Need] regarding pathophysiology of condition, therapy, self-care/nutritional needs, and potential complications may be related to lack of information/recall, misinterpretation, possibly evidenced by statements of concern, questions, misconceptions, inaccurate follow-through of instructions/development of preventable complications.

Premenstrual tension syndrome (PMS) GYN/CH/PSY

Pain, acute/chronic maybe related to cyclic changes in female hormones affecting other systems (e.g., vascular congestion/spasms), vitamin deficiency, fluid retention, possibly evidenced by increased tension, apprehension, jitteriness, verbal reports, distraction behaviors, somatic complaints, self-focusing, physical and social withdrawal.

Fluid Volume, excess may be related to abnormal alterations of hormonal levels, possibly evidenced by edema formation, weight gain, and periodic changes in emotional status/irritability.

Anxiety [specify level] may be related to cyclic changes in female hormones affecting other systems, possibly evidenced by feelings of inability to cope/loss of control, depersonalization, increased tension, apprehension, jitteriness, somatic complaints, and impaired functioning.

Knowledge, deficient [Learning Need] regarding pathophysiology of condition and self-care/treatment needs may be related to lack of information/misinterpretation, possibly evidenced by statements of concern, questions, misconceptions, and continuation of condition, exacerbating symptoms.

Pressure ulcer or sore CH

(Also refer to Ulcer, decubitus)

Tissue Perfusion, ineffective: peripheral may be related to reduced/interrupted blood flow, possibly evidenced by presence of inflamed, necrotic lesion.

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Knowledge, deficient [Learning Need] regarding cause/prevention of condition and potential complications may be related to lack of information/misinterpretation, possibly evidenced by statements of concern, questions, misconceptions, and inaccurate follow-through of instructions.

Preterm labor **OB/CH**

Activity intolerance may be related to muscle/cellular hypersensitivity, possibly evidenced by continued uterine contractions/irritability.

Poisoning, risk for: risk factors may include dose-related toxic/side effects of tocolytics.*

Injury, risk for fetal risk factors may include delivery of premature/immature infant.*

Anxiety [specify level] may be related to situational crisis, perceived or actual threats to self/fetus and inadequate time to prepare for labor, possibly evidenced by increased tension, restlessness, expressions of concern, and autonomic responses (changes in vital signs).

Knowledge, deficient [Learning Need] regarding preterm labor treatment needs and prognosis may be related to lack of information and misinterpretation, possibly evidenced by questions, statements of concern, misconceptions, inaccurate follow-through of instruction, and development of preventable complications.

Prostatectomy **MS**

Urinary Elimination, impaired may be related to mechanical obstruction (blood clots, edema, trauma, surgical procedure, pressure/irritation of catheter/balloon) and loss of bladder tone, possibly evidenced by dysuria, frequency, dribbling, incontinence, retention, bladder fullness, suprapubic discomfort.

Fluid Volume, risk for deficient risk factors may include trauma to highly vascular area with excessive vascular losses, restricted intake, postobstructive diuresis.*

Pain, acute may be related to irritation of bladder mucosa and tissue trauma/edema, possibly evidenced by verbal reports (bladder spasms), distraction behaviors, self-focus, and autonomic responses (changes in vital signs).

Body Image, disturbed may be related to perceived threat of altered body/sexual function, possibly evidenced by preoccupation with change/loss, negative feelings about body, and statements of concern regarding functioning.

CH

Sexual Dysfunction, risk for: risk factors may include situational crisis (incontinence, leakage of urine after catheter removal, involvement of genital area) and threat to self-concept/change in health status.*

Pruritus **CH**

Pain, acute may be related to cutaneous hyperesthesia and inflammation, possibly evidenced by verbal reports, distraction behaviors, and self-focus.

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Skin Integrity, risk for impaired risk factors may include mechanical trauma (scratching) and development of vesicles/bullae that may rupture.*

Psoriasis CH

Skin Integrity, impaired may be related to increased epidermal cell proliferation and absence of normal protective skin layers, possibly evidenced by scaling papules and plaques.

Body Image, disturbed may be related to cosmetically unsightly skin lesions, possibly evidenced by hiding affected body part, negative feelings about body, feelings of helplessness, and change in social involvement.

Pulmonary embolus MS

Breathing Pattern, ineffective may be related to tracheobronchial obstruction (inflammation, copious secretions or active bleeding), decreased lung expansion, inflammatory process, possibly evidenced by changes in depth and/or rate of respiration, dyspnea/use of accessory muscles, altered chest excursion, abnormal breath sounds (crackles, wheezes), and cough (with or without sputum production).

Gas Exchange, impaired may be related to altered blood flow to alveoli or to major portions of the lung, alveolar-capillary membrane changes (atelectasis, airway/alveolar collapse, pulmonary edema/effusion, excessive secretions/active bleeding), possibly evidenced by profound dyspnea, restlessness, apprehension, somnolence, cyanosis, and changes in ABGs/pulse oximetry (hypoxemia and hypercapnia).

Tissue Perfusion, ineffective: cardiopulmonary may be related to interruption of blood flow (arterial/venous), exchange problems at alveolar level or at tissue level (acidotic shifting of the oxyhemoglobin curve), possibly evidenced by radiology/laboratory evidence of ventilation/perfusion mismatch, dyspnea, and central cyanosis.

Fear/Anxiety [specify level] may be related to severe dyspnea/inability to breathe normally, perceived threat of death, threat to/change in health status, physiological response to hypoxemia/acidosis, and concern regarding unknown outcome of situation, possibly evidenced by restlessness, irritability, withdrawal or attack behavior, sympathetic stimulation (cardiovascular excitation, pupil dilation, sweating, vomiting, diarrhea), crying, voice quivering, and impending sense of doom.

Purpura, idiopathic thrombocytopenic CH

Protection, ineffective may be related to abnormal blood profile, drug therapy (corticosteroids or immunosuppressive agents), possibly evidenced by altered clotting, fatigue, deficient immunity.

Activity intolerance may be related to decreased oxygen-carrying capacity/imbalance between O_2 supply and demand, possibly evidenced by reports of fatigue/weakness.

Knowledge, deficient [Learning Need] regarding therapy choices, outcomes, and self-care needs may be related to lack of information/misinterpretation, possibly evidenced by statements of concern, questions, and misconceptions.

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Pyelonephritis MS

Pain, acute may be related to acute inflammation of renal tissues, possibly evidenced by verbal reports, guarding/distraction behaviors, self-focus, and autonomic responses (changes in vital signs).

Hyperthermia may be related to inflammatory process/increased metabolic rate, possibly evidenced by increase in body temperature, warm/flushed skin, tachycardia, and chills.

Urinary Elimination, impaired may be related to inflammation/irritation of bladder mucosa, possibly evidenced by dysuria, urgency, and frequency.

Knowledge, deficient [Learning Need] regarding therapy needs and prevention may be related to lack of information/misinterpretation, possibly evidenced by statements of concern, questions, misconceptions, and recurrence of condition.

Quadriplegia (Tetraplegia) MS/CH

(Also refer to Paraplegia)

Breathing Pattern, ineffective may be related to neuromuscular impairment (diaphragm and intercostal muscle function), reflex abdominal spasms, gastric distention, possibly evidenced by decreased respiratory depth, dyspnea, cyanosis, and abnormal ABGs.

Trauma, risk for additional spinal injury risk factors may include temporary weakness/instability of spinal column.*

Grieving, anticipatory may be related to perceived loss of self, anticipated alterations in lifestyle and expectations, and limitation of future options/choices, possibly evidenced by expressions of distress, anger, sorrow; choked feelings; and changes in eating habits, sleep, communication patterns.

Self-Care deficit [total] related to neuromuscular impairment, evidenced by inability to perform self-care tasks.

Mobility, impaired bed/wheelchair may be related to loss of muscle function/control.

Autonomic, dysreflexia, risk for: risk factors may include altered nerve function (spinal cord injury at T6 or above), bladder/bowel/skin stimulation (tactile, pain, thermal).*

Home Maintenance, impaired may be related to permanent effects of injury, inadequate/absent support systems and finances, and lack of familiarity with resources, possibly evidenced by expressions of difficulties, requests for information and assistance, outstanding debts/financial crisis, and lack of necessary aids and equipment.

Rape CH

Knowledge, deficient [Learning Need] regarding required medical/legal procedures, prophylactic treatment for individual concerns (STDs, pregnancy), community resources/supports may be related to lack of information, possibly evidenced by statements of concern, questions, misconceptions, and exacerbation of symptoms.

Rape-Trauma Syndrome (acute phase) related to actual or attempted sexual penetration without consent, possibly evidenced by wide range

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of emotional reactions, including anxiety, fear, anger, embarrassment, and multisystem physical complaints.

Tissue Integrity, impaired risk factors may include forceful sexual penetration and trauma to fragile tissues.*

PSY

Coping, ineffective may be related to personal vulnerability, unmet expectations, unrealistic perceptions, inadequate support systems/coping methods, multiple stressors repeated over time, overwhelming threat to self, possibly evidenced by verbalizations of inability to cope or difficulty asking for help, muscular tension/headaches, emotional tension, chronic worry.

Sexual Dysfunction may be related to biopsychosocial alteration of sexuality (stress of post-trauma response), vulnerability, loss of sexual desire, impaired relationship with SO, possibly evidenced by alteration in achieving sexual satisfaction, change in interest in self/others, preoccupation with self.

Raynaud's phenomenon CH

Pain, acute/chronic may be related to vasospasm/altered perfusion of affected tissues and ischemia/destruction of tissues, possibly evidenced by verbal reports, guarding of affected parts, self-focusing, and restlessness.

Tissue Perfusion, ineffective: peripheral may be related to periodic reduction of arterial blood flow to affected areas, possibly evidenced by pallor, cyanosis, coolness, numbness, paresthesia, slow healing of lesions.

Knowledge, deficient [Learning Need] regarding pathophysiology of condition, potential for complications, therapy/self-care needs may be related to lack of information/misinterpretation, possibly evidenced by statements of concern, questions, and misconceptions; development of preventable complications.

Reflex sympathetic dystrophy (RSD) CH

Pain, acute/chronic may be related to continued nerve stimulation, possibly evidenced by verbal reports, distraction/guarding behaviors, narrowed focus, changes in sleep patterns, and altered ability to continue previous activities.

Tissue Perfusion, ineffective: peripheral may be related to reduction of arterial blood flow (arteriole vasoconstriction), possibly evidenced by reports of pain, decreased skin temperature and pallor, diminished arterial pulsations, and tissue swelling.

Sensory Perception, disturbed: tactile may be related to altered sensory reception (neurological deficit, pain), possibly evidenced by change in usual response to stimuli/abnormal sensitivity of touch, physiological anxiety, and irritability.

Role Performance, ineffective risk factors may include situational crisis, chronic disability, debilitating pain.*

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Coping, family: compromised risk factors may include temporary family disorganization and role changes and prolonged disability that exhausts the supportive capacity of SO(s).*

Renal failure, acute MS

Fluid Volume, excess may be related to compromised regulatory mechanisms (decreased kidney function), possibly evidenced by weight gain, edema/anasarca, intake greater than output, venous congestion, changes in BP/CVP, and altered electrolyte levels.

Nutrition: imbalanced, less than body requirements may be related to inability to ingest/digest adequate nutrients (anorexia, nausea/vomiting, ulcerations of oral mucosa, and increased metabolic needs) in addition to therapeutic dietary restrictions, possibly evidenced by lack of interest in food/aversion to eating, observed inadequate intake, weight loss, loss of muscle mass.

Infection, risk for risk factors may include depression of immunological defenses, invasive procedures/devices, and changes in dietary intake/malnutrition.*

Thought Processes, disturbed may be related to accumulation of toxic waste products and altered cerebral perfusion, possibly evidenced by disorientation, changes in recent memory, apathy, and episodic obtundation.

Renal transplantation MS

Fluid Volume, excess risk factors may include compromised regulatory mechanism (implantation of new kidney requiring adjustment period for optimal functioning).*

Body Image, disturbed may be related to failure and subsequent replacement of body part and medication-induced changes in appearance, possibly evidenced by preoccupation with loss/change, negative feelings about body, and focus on past strength/function.

Fear may be related to potential for transplant rejection/failure and threat of death, possibly evidenced by increased tension, apprehension, concentration on source, and verbalizations of concern.

Infection, risk for: risk factors may include broken skin/traumatized tissue, stasis of body fluids, immunosuppression, invasive procedures, nutritional deficits, and chronic disease.*

CH

Coping, [individual/]family: risk for compomised risk factors may include situational crises, family disorganization and role changes, prolonged disease exhausting supportive capacity of SO/family, therapeutic restrictions/long-term therapy needs.*

Respiratory distress syndrome (premature infant) PED

(Also refer to Neonatal, premature newborn)

Gas Exchange, impaired may be related to alveolar/capillary membrane changes (inadequate surfactant levels), altered oxygen supply

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(tracheobronchial obstruction, atelectasis), altered blood flow (immaturity of pulmonary arteriole musculature), altered oxygen-carrying capacity of blood (anemia), and cold stress, possibly evidenced by tachypnea, use of accessory muscles/retractions, expiratory grunting, pallor or cyanosis, abnormal ABGs, and tachycardia.

Ventilation, impaired spontaneous may be related to respiratory muscle fatigue and metabolic factors, possibly evidenced by dyspnea, increased metabolic rate, restlessness, use of accessory muscles, and abnormal ABGs.

Infection, risk for: risk factors may include inadequate primary defenses (decreased ciliary action, stasis of body fluids, traumatized tissues), inadequate secondary defenses (deficiency of neutrophils and specific immunoglobulins), invasive procedures, and malnutrition (absence of nutrient stores, increased metabolic demands).*

Tissue Perfusion, risk for ineffective gastrointestinal risk factors may include persistent fetal circulation and exchange problems.*

Attachment, risk for impaired parent/infant risk factors may include premature/ill infant who is unable to effectively initiate parental contact (altered behavioral organization), separation, physical barriers, anxiety associated with the parental role/demands of infant.*

Retinal detachment — CH

Sensory Perception, disturbed: visual related to decreased sensory reception, possibly evidenced by visual distortions, decreased visual field, and changes in visual acuity.

Knowledge, deficient [Learning Need] regarding therapy, prognosis, and self-care needs may be related to lack of information/misconceptions, possibly evidenced by statements of concern and questions.

Home Maintenance, impaired risk factors may include visual limitations/activity/restrictions.*

Reye's syndrome — PED

Fluid Volume, deficient [isotonic] may be related to failure of regulatory mechanism (diabetes insipidus), excessive gastric losses (pernicious vomiting), and altered intake, possibly evidenced by increased/dilute urine output, sudden weight loss, decreased venous filling, dry mucous membranes, decreased skin turgor, hypotension, and tachycardia.

Tissue Perfusion, ineffective: cerebral may be related to diminished arterial/venous blood flow and hypovolemia, possibly evidenced by memory loss, altered consciousness, and restlessness/agitation.

Trauma, risk for: risk factors may include generalized weakness, reduced coordination, and cognitive deficits.*

Breathing Pattern, ineffective may be related to decreased energy and fatigue, cognitive impairment, tracheobronchial obstruction, and inflammatory process (aspiration pneumonia), possibly evidenced by tachypnea, abnormal ABGs, cough, and use of accessory muscles.

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Rheumatic fever — PED

Pain, acute may be related to migratory inflammation of joints, possibly evidenced by verbal reports, guarding/distraction behaviors, self-focus, and autonomic responses (changes in vital signs).

Hyperthermia may be related to inflammatory process/hypermetabolic state, possibly evidenced by increased body temperature, warm/flushed skin, and tachycardia.

Activity intolerance may be related to generalized weakness, joint pain, and medical restrictions/bedrest, possibly evidenced by reports of fatigue, exertional discomfort, and abnormal heart rate in response to activity.

Cardiac Output, risk for decreased risk factors may include cardiac inflammation/enlargement and altered contractility.*

Rickets (osteomalacia) — PED

Growth and Development, delayed may be related to dietary deficiencies/indiscretions, malabsorption syndrome, and lack of exposure to sunlight, possibly evidenced by altered physical growth and delay or difficulty in performing motor skills typical for age.

Knowledge, deficient [Learning Need] regarding cause, pathophysiology, therapy needs and prevention may be related to lack of information, possibly evidenced by statements of concern, questions, misconceptions, and inaccurate follow-through of instructions.

Ringworm, tinea — CH

(Also refer to Athlete's Foot)

Skin Integrity, impaired may be related to fungal infection of the dermis, possibly evidenced by disruption of skin surfaces/presence of lesions.

Knowledge, deficient [Learning Need] regarding infectious nature, therapy, and self-care needs may be related to lack of information/misinformation, possibly evidenced by statements of concern, questions, and recurrence/spread.

Rubella — PED/CH

Pain, acute/[Discomfort] may be related to inflammatory effects of viral infection and presence of desquamating rash, possibly evidenced by verbal reports, distraction behaviors/restlessness.

Knowledge, deficient [Learning Need] regarding contagious nature, possible complications, and self-care needs may be related to lack of information/misinterpretations, possibly evidenced by statements of concern, questions, and inaccurate follow-through of instructions.

Scabies — CH

Skin Integrity, impaired may be related to presence of invasive parasite and development of pruritus, possibly evidenced by disruption of skin surface and inflammation.

Knowledge, deficient [Learning Need] regarding communicable nature, possible complications, therapy, and self-care needs may be related to lack of information/misinterpretation, possibly evidenced by questions and statements of concern about spread to others.

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Scarlet fever **PED**

Hyperthermia may be related to effects of circulating toxins, possibly evidenced by increased body temperature, warm/flushed skin, and tachycardia.

Pain [Discomfort] may be related to inflammation of mucous membranes and effects of circulating toxins (malaise, fever), possibly evidenced by verbal reports, distraction behaviors, guarding (decreased swallowing), and self-focus.

Fluid Volume, risk for deficient risk factors may include hypermetabolic state (hyperthermia) and reduced intake.*

Schizophrenia (schizophrenic disorders) **PSY/CH**

Thought Processes, disturbed may be related to disintegration of thinking processes, impaired judgment, presence of psychological conflicts, disintegrated ego-boundaries, sleep disturbance, ambivalence and concomitant dependence, possibly evidenced by impaired ability to reason/problem-solve, inappropriate affect, presence of delusional system, command hallucinations, obsessions, ideas of reference, cognitive dissonance.

Social Isolation may be related to alterations in mental status, mistrust of others/delusional thinking, unacceptable social behaviors, inadequate personal resources, and inability to engage in satisfying personal relationships, possibly evidenced by difficulty in establishing relationships with others; dull affect, uncommunicative/withdrawn behavior, seeking to be alone, inadequate/absent significant purpose in life, and expression of feelings of rejection.

Health Maintenance, ineffective/Home Maintenance, impaired may be related to impaired cognitive/emotional functioning, altered ability to make deliberate and thoughtful judgments, altered communication, and lack/inappropriate use of material resources, possibly evidenced by inability to take responsibility for meeting basic health practices in any or all functional areas and demonstrated lack of adaptive behaviors to internal or external environmental changes, disorderly surroundings, accumulation of dirt/unwashed clothes, repeated hygienic disorders.

Violence, risk for self-directed/other-directed risk factors may include disturbances of thinking/feeling (depression, paranoia, suicidal ideation), lack of development of trust and appropriate interpersonal relationships, catatonic/manic excitement, toxic reactions to drugs (alcohol).*

Coping, ineffective may be related to personal vulnerability, inadequate support system(s), unrealistic perceptions, inadequate coping methods, and disintegration of thought processes, possibly evidenced by impaired judgment/cognition and perception, diminished problem-solving/decision-making capacities, poor self-concept, chronic anxiety, depression, inability to perform role expectations, and alteration in social participation.

Family Processes, interrupted/Coping, family: disabled may be related to ambivalent family system/relationships, change of roles, and

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difficulty of family member in coping effectively with patient's maladaptive behaviors, possibly evidenced by deterioration in family functioning, ineffective family decision-making process, difficulty relating to each other, patient's expressions of despair at family's lack of reaction/involvement, neglectful relationships with patient, extreme distortion regarding patient's health problem including denial about its existence/severity or prolonged overconcern.

Self-Care deficit [specify] may be related to perceptual and cognitive impairment, immobility (withdrawal/isolation and decreased psychomotor activity), and side effects of psychotropic medications, possibly evidenced by inability or difficulty in areas of feeding self, keeping body clean, dressing appropriately, toileting self, and/or changes in bowel/bladder elimination.

Sciatica CH

Pain, acute/chronic may be related to peripheral nerve root compression, possibly evidenced by verbal reports, guarding/distraction behaviors, and self-focus.

Mobility, impaired physical may be related to neurological pain and muscular involvement, possibly evidenced by reluctance to attempt movement and decreased muscle strength/mass.

Scleroderma CH

(Also refer to Lupus Erythematosus, Systemic—SLE)

Mobility, impaired physical may be related to musculoskeletal impairment and associated pain, possibly evidenced by decreased strength, decreased range of motion, and reluctance to attempt movement.

Tissue Perfusion, ineffective (specify type) may be related to reduced arterial blood flow (arteriolar vasoconstriction), possibly evidenced by changes in skin temperature/color, ulcer formation, and changes in organ function (cardiopulmonary, GI, renal).

Nutrition: imbalanced, less than body requirements may be related to inability to ingest/digest/absorb adequate nutrients (sclerosis of the tissues rendering mouth immobile, decreased peristalsis of esophagus/small intestines, atrophy of smooth muscle of colon), possibly evidenced by weight loss, decreased intake/food, and reported/observed difficulty swallowing.

Adjustment, impaired may be related to disability requiring change in lifestyle, inadequate support systems, assault to self-concept, and altered locus of control, possibly evidenced by verbalization of nonacceptance of health status change and lack of movement toward independence/future-oriented thinking.

Body Image, disturbed may be related to skin changes with induration, atrophy, and fibrosis, loss of hair, and skin and muscle contractures, possibly evidenced by verbalization of negative feelings about body, focus on past strength/function or appearance, fear of rejection/ reaction by others, hiding body part, and change in social involvement.

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Scoliosis **PED**

Body Image, disturbed may be related to altered body structure, use of therapeutic device(s), and activity restrictions, possibly evidenced by negative feelings about body, change in social involvement, and preoccupation with situation or refusal to acknowledge problem.

Knowledge, deficient [Learning Need] regarding pathophysiology of condition, therapy needs, and possible outcomes may be related to lack of information/misinterpretation, possibly evidenced by statements of concern, questions, misconceptions, and inaccurate follow-through of instructions.

Adjustment, impaired may be related to lack of comprehension of long-term consequences of behavior, possibly evidenced by failure to adhere to treatment regimen/keep appointments and evidence of failure to improve.

Seizure Disorder **CH**

(Refer to Epilepsy)

Sepsis, puerperal **OB**

(Also refer to Septicemia)

Infection, risk for spread/septic shock risk factors may include presence of infection, broken skin, and/or traumatized tissues, rupture of amniotic membranes, high vascularity of involved area, stasis of body fluids, invasive procedures, and/or increased environmental exposure, chronic disease (e.g., diabetes, anemia, malnutrition), altered immune response, and untoward effect of medications (e.g., opportunistic/secondary infection).*

Hyperthermia may be related to inflammatory process/hypermetabolic state, possibly evidenced by increase in body temperature, warm/flushed skin, and tachycardia.

Attachment, risk for impaired parent/infant/child risk factors may include interruption in bonding process, physical illness, perceived threat to own survival.

Tissue Perfusion, risk for ineffective: peripheral risk factors may include interruption/reduction of blood flow (presence of infectious thrombi).*

Septicemia **MS**

(Also refer to Sepsis, puerperal)

Tissue Perfusion, ineffective (specify type) may be related to changes in arterial/venous blood flow (selective vasoconstriction, presence of microemboli) and hypovolemia, possibly evidenced by changes in skin temperature/color, changes in blood/pulse pressure; changes in sensorium, and decreased urinary output.

Fluid Volume, risk for deficient risk factors may include marked increase in vascular compartment/massive vasodilation, vascular shifts to interstitial space, and reduced intake.*

Cardiac Output, risk for decreased risk factors may include decreased preload (venous return and circulating volume), altered afterload

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(increased SVR), negative inotropic effects of hypoxia, complement activation, and lysosomal hydrolase.*

Serum sickness **CH**

Pain, acute may be related to inflammation of the joints and skin eruptions, possibly evidenced by verbal reports, guarding/distraction behaviors, and self-focus.

Knowledge, deficient [Learning Need] regarding nature of condition, treatment needs, potential complications, and prevention of recurrence may be related to lack of information/misinterpretation, possibly evidenced by statements of concern, questions, misconceptions, and inaccurate follow-through of instructions.

Sexually transmitted disease (STD) **GYN/CH**

Infection, risk for transmission risk factors may include contagious nature of infecting agent and insufficient knowledge to avoid exposure to/transmission of pathogens.*

Skin/Tissue Integrity, impaired may be related to invasion of/irritation by pathogenic organism(s), possibly evidenced by disruptions of skin/tissue and inflammation of mucous membranes.

Knowledge, deficient [Learning Need] regarding condition, prognosis/complications, therapy needs, and transmission may be related to lack of information/misinterpretation, lack of interest in learning, possibly evidenced by statements of concern, questions, misconceptions; inaccurate follow-through of instructions, and development of preventable complications.

Shock **MS**

(Also refer to Shock, cardiogenic; Shock, hypovolemic/hemorrhagic)

Tissue Perfusion, ineffective (specify type) may be related to changes in circulating volume and/or vascular tone, possibly evidenced by changes in skin color/temperature and pulse pressure, reduced blood pressure, changes in mentation, and decreased urinary output.

Anxiety [specify level] may be related to change in health status and threat of death, possibly evidenced by increased tension, apprehension, sympathetic stimulation, restlessness, and expressions of concern.

Shock, cardiogenic **MS**

(Also refer to Shock)

Cardiac Output, decreased may be related to structural damage, decreased myocardial contractility, and presence of dysrhythmias, possibly evidenced by ECG changes, variations in hemodynamic readings, jugular vein distention, cold/clammy skin, diminished peripheral pulses, and decreased urinary output.

Shock, hypovolemic/hemorrhagic **MS**

(Also refer to Shock)

Fluid Volume, deficient [isotonic] may be related to excessive vascular loss, inadequate intake/replacement, possibly evidenced by hypotension,

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tachycardia, decreased pulse volume and pressure, change in mentation, and decreased/concentrated urine.

Shock, septic

(Refer to Septicemia)

Sick sinus syndrome MS

(Also refer to Dysrhythmia, cardiac)

Cardiac Output, decreased may be related to alterations in rate, rhythm, and electrical conduction, possibly evidenced by ECG evidence of dysrhythmias, reports of palpitations/weakness, changes in mentation/consciousness, and syncope.

Trauma, risk for: risk factors may include changes in cerebral perfusion with altered consciousness/loss of balance.*

Snow blindness CH

Sensory Perception, disturbed: visual 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.

Pain, acute 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

Coping, ineffective 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.

Pain, chronic 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.

Sensory Perception, disturbed (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).

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Social Interaction, impaired 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 MS/CH

(Refer to Paraplegia: Quadriplegia)

Sprain of ankle or foot CH

Pain, acute 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).

Walking, impaired 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

Trauma, risk for: risk factors may include increased middle-ear pressure with displacement of prosthesis and balancing difficulties/dizziness.*

Infection, risk for: risk factors may include surgically traumatized tissue, invasive procedures, and environmental exposure to upper respiratory infections.*

Pain, acute may be related to surgical trauma, edema formation, and presence of packing, possibly evidenced by verbal reports, guarding/distraction behaviors, and self-focus.

Substance dependence/abuse rehabilitation PSY/CH

(following acute detoxification)

Denial/Coping, ineffective 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 recovery, 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.

Nutrition: imbalanced, less than body requirements may be related to insufficient dietary intake to meet metabolic needs for psychological/physiological/economical 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

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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.

Family Processes, dysfunctional: 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.

Surgery, general — MS

(Also refer to Postoperative Recovery Period)

Knowledge, deficient [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 increased tension, apprehension, decreased self-assurance, fear of unspecific consequences, focus on self, sympathetic stimulation, and restlessness.

Injury, risk for perioperative positioning risk factors may include disorientation, immobilization, muscle weakness, obesity/edema.*

Breathing Pattern, risk for ineffective risk factors may include chemically induced muscular relaxation, perception/cognitive impairment, decreased energy.*

Fluid Volume, risk for deficient risk factors may include preoperative fluid deprivation, blood loss, and excessive GI losses (vomiting/gastric suction).*

Synovitis (knee) — CH

Pain, acute 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).

Walking, impaired may be related to pain and decreased strength of joint, possibly evidenced by reluctance to attempt movement, inability to move about environment as desired.

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Syphilis, congenital — PED

(Also refer to Sexually transmitted disease—STD)

Pain, acute 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).

Skin/Tissue Integrity, impaired may be related to exposure to pathogens during vaginal delivery, possibly evidenced by disruption of skin surfaces and rhinitis.

Growth and Development, delayed may be related to effect of infectious process, possibly evidenced by altered physical growth and delay or difficulty performing skills typical of age group.

Knowledge, deficient [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

Sensory Perception, disturbed (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.

Mobility, impaired physical may be related to neuromuscular and sensory impairment, possibly evidenced by decreased muscle strength, control, and mass; and impaired coordination.

Self-Care deficit [specify] may be related to neuromuscular and sensory impairments, possibly evidenced by statement of inability to perform care tasks.

Tay-Sachs disease — PED

Growth and Development, delayed may be related to effects of physical condition, possibly evidenced by altered physical growth, loss of/failure to acquire skills typical of age, flat affect, and decreased responses.

Sensory Perceptual, disturbed: visual may be related to neurological deterioration of optic nerve, possibly evidenced by loss of visual acuity.

CH

Grieving, anticipatory [family] may be related to expected eventual loss of infant/child, possibly evidenced by expressions of distress, denial, guilt, anger, and sorrow; choked feelings; changes in sleep/eating habits; and altered libido.

Powerlessness [family] may be related to absence of therapeutic interventions for progressive/fatal disease, possibly evidenced by verbal expressions of having no control over situation/outcome and depression over physical/mental deterioration.

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Spiritual Distress, risk for: risk factors may include challenged belief and value system by presence of fatal condition with racial/religious connotations and intense suffering.*

Coping, family: compromised may be related to situational crisis, temporary preoccupation with managing emotional conflicts and personal suffering, family disorganization, and prolonged/progressive disease, possibly evidenced by preoccupations with personal reactions, expressed concern about reactions of other family members, inadequate support of one another, and altered communication patterns.

Thrombophlebitis CH/MS/OB

Tissue Perfusion, ineffective: peripheral may be related to interruption of venous blood flow, venous stasis, possibly evidenced by changes in skin color/temperature over affected area, development of edema, pain, diminished peripheral pulses, slow capillary refill.

Pain, acute/[Discomfort] may be related to vascular inflammation/irritation and edema formation (accumulation of lactic acid), possibly evidenced by verbal reports, guarding/distraction behaviors, restlessness, and self-focus.

Mobility, risk for impaired physical risk factors may include pain and discomfort and restrictive therapies/safety precautions.*

Knowledge, deficient [Learning Need] regarding pathophysiology of condition, therapy/self-care needs, and risk of embolization may be related to lack of information/misinterpretation, possibly evidenced by statements of concern, questions, inaccurate follow-through of instructions, and development of preventable complications.

Thrombosis, venous MS

(Refer to Thrombophlebitis)

Thyroidectomy MS

(Also refer to Hyperthyroidism; Hypoparathyroidism, Hypothyroidism)

Airway Clearance, risk for ineffective risk factors may include hematoma/edema formation with tracheal obstruction, laryngeal spasms.*

Communication, impaired verbal may be related to tissue edema, pain/discomfort, and vocal cord injury/laryngeal nerve damage, possibly evidenced by impaired articulation, does not/cannot speak, and use of nonverbal cues/gestures.

Injury, risk for tetany risk factors may include chemical imbalance/excessive CNS stimulation.*

Trauma, risk for head/neck risk factors may include loss of muscle control/support and position of suture line.*

Pain, acute may be related to presence of surgical incision/manipulation of tissues/muscles, postoperative edema, possibly evidenced by verbal reports, guarding/distraction behaviors, narrowed focus, and autonomic responses (changes in vital signs).

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Thyrotoxicosis **MS**

(Also refer to Hyperthyroidism)

Cardiac Output, decreased risk factors may include uncontrolled hypermetabolic state increasing cardiac workload, changes in venous return and SVR; and alterations in rate, rhythm, and electrical conduction.*

Anxiety [specific level] may be related to physiological factors/CNS stimulation (hypermetabolic state and pseudocatecholamine effect of thyroid hormones), possibly evidenced by increased feelings of apprehension, shakiness, loss of control, panic, changes in cognition, distortion of environmental stimuli, extraneous movements, restlessness, and tremors.

Thought Processes, disturbed risk factors may include physiological changes (increased CNS stimulation/accelerated mental activity) and altered sleep patterns.*

Knowledge, deficient [Learning Needs] regarding condition, treatment needs, and potential for complications/crisis situation may be related to lack of information/recall, misinterpretation, possibly evidenced by statements of concern, questions, misconceptions; and inaccurate follow-through of instructions.

Tic douloureux **CH**

(Refer to Neuralgia, trigeminal)

Tonsillectomy **PED/MS**

(Refer to Adenoidectomy)

Tonsillitis **PED**

Pain, acute may be related to inflammation of tonsils and effects of circulating toxins, possibly evidenced by verbal reports, guarding/distraction behaviors, reluctance/refusal to swallow, self-focus, and autonomic responses (changes in vital signs).

Hyperthermia may be related to presence of inflammatory process/hypermetabolic state and dehydration, possibly evidenced by increased body temperature, warm/flushed skin, and tachycardia.

Knowledge, deficient [Learning Need] regarding cause/transmission, treatment needs, and potential complications may be related to lack of information/misinterpretation, possibly evidenced by statements of concern, questions, inaccurate follow-through of instructions, and recurrence of condition.

Total joint replacement **MS**

Infection, risk for: risk factors may include inadequate primary defenses (broken skin, exposure of joint), inadequate secondary defenses/immunosuppression (long-term corticosteroid use), invasive procedures/surgical manipulation, implantation of foreign body, and decreased mobility.*

Mobility, impaired physical may be related to pain and discomfort, musculoskeletal impairment, and surgery/restrictive therapies, possibly

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evidenced by reluctance to attempt movement, difficulty purposefully moving within the physical environment, reports of pain/discomfort on movement, limited range of motion, and decreased muscle strength/control.

Tissue Perfusion, risk for ineffective: peripheral risk factors may include reduced arterial/venous blood flow, direct trauma to blood vessels, tissue edema, improper location/dislocation of prosthesis, and hypovolemia.*

Pain, acute may be related to physical agents (traumatized tissues/surgical intervention, degeneration of joints, muscle spasms) and psychological factors (anxiety, advanced age), possibly evidenced by verbal reports, guarding/distraction behaviors, self-focus, and autonomic responses (changes in vital signs).

Toxemia of pregnancy — OB

(Refer to Pregnancy-Induced Hypertension)

Toxic shock syndrome — MS

(Also refer to Septicemia)

Hyperthermia may be related to inflammatory process/hypermetabolic state and dehydration, possibly evidenced by increased body temperature, warm/flushed skin, and tachycardia.

Fluid Volume, deficient [isotonic] may be related to increased gastric losses (diarrhea, vomiting), fever/hypermetabolic state, and decreased intake, possibly evidenced by dry mucous membranes, increased pulse, hypotension, delayed venous filling, decreased/concentrated urine, and hemoconcentration.

Pain, acute may be related to inflammatory process, effects of circulating toxins, and skin disruptions, possibly evidenced by verbal reports, guarding/distraction behaviors, self-focus, and autonomic responses (changes in vital signs).

Skin/Tissue Integrity, impaired may be related to effects of circulating toxins and dehydration, possibly evidenced by development of desquamating rash, hyperemia, and inflammation of mucous membranes.

Traction — MS

(Also refer to Casts; Fractures)

Pain, acute may be related to direct trauma to tissue/bone, muscle spasms, movement of bone fragments, edema, injury to soft tissue, traction/immobility device, anxiety, possibly evidenced by verbal reports, guarding/distraction behaviors, self-focus, alteration in muscle tone, and autonomic responses (changes in vital signs).

Mobility, impaired physical may be related to neuromuscular/skeletal impairment, pain, psychological immobility, and therapeutic restrictions of movement, possibly evidenced by limited range of motion, inability to move purposefully in environment, reluctance to attempt movement, and decreased muscle strength/control.

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Infection, risk for: risk factors may include invasive procedures (including insertion of foreign body through skin/bone), presence of traumatized tissue, and reduced activity with stasis of body fluids.*

Diversional Activity, deficient may be related to length of hospitalization/therapeutic intervention and environmental lack of usual activity, possibly evidenced by statements of boredom, restlessness, and irritability.

Trichinosis CH

Pain, acute may be related to parasitic invasion of muscle tissues, edema of upper eyelids, small localized hemorrhages, and development of urticaria, possibly evidenced by verbal reports, guarding/distraction behaviors (restlessness), and autonomic responses (changes in vital signs).

Fluid Volume, deficient [isotonic] may be related to hypermetabolic state (fever, diaphoresis); excessive gastric losses (vomiting, diarrhea); and decreased intake/difficulty swallowing, possibly evidenced by dry mucous membranes, decreased skin turgor, hypotension, decreased venous filling, decreased/concentrated urine, and hemoconcentration.

Breathing Pattern, ineffective may be related to myositis of the diaphragm and intercostal muscles, possibly evidenced by resulting changes in respiratory depth, tachypnea, dyspnea, and abnormal ABGs.

Knowledge, deficient [Learning Need] regarding cause/prevention of condition, therapy needs, and possible complications may be related to lack of information, misinterpretation, possibly evidenced by statements of concern, questions, and misconceptions.

Tuberculosis (pulmonary) CH

Infection, risk for spread/reactivation risk factors may include inadequate primary defenses (decreased ciliary action/stasis of secretions, tissue destruction/extension of infection), lowered resistance/suppressed inflammatory response, malnutrition, environmental exposure, insufficient knowledge to avoid exposure to pathogens, or inadequate therapeutic intervention.*

Airway Clearance, ineffective may be related to thick, viscous or bloody secretions; fatigue/poor cough effort, and tracheal/pharyngeal edema, possibly evidenced by abnormal respiratory rate, rhythm, and depth; adventitious breath sounds (rhonchi, wheezes), stridor and dyspnea.

Gas Exchange, risk for impaired risk factors may include decrease in effective lung surface, atelectasis, destruction of alveolar-capillary membrane, bronchial edema; thick, viscous secretions.*

Activity intolerance may be related to imbalance between O_2 supply and demand, possibly evidenced by reports of fatigue, weakness, and exertional dyspnea.

Nutrition: imbalanced, less than body requirements may be related to inability to ingest adequate nutrients (anorexia, effects of drug therapy, fatigue, insufficient financial resources), possibly evidenced by weight loss, reported lack of interest in food/altered taste sensation, and poor muscle tone.

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Therapeutic Regimen: risk for ineffective management risk factors may include complexity of therapeutic regimen, economic difficulties, family patterns of health care, perceived seriousness/benefits (especially during remission), side effects of therapy.*

Tympanoplasty MS

(Refer to Stapedectomy)

Typhus (tick-borne/Rocky Mountain spotted fever) CH/MS

Hyperthermia may be related to generalized inflammatory process (vasculitis), possibly evidenced by increased body temperature, warm/flushed skin, and tachycardia.

Pain, acute may be related to generalized vasculitis and edema formation, possibly evidenced by verbal reports, guarding/distraction behaviors, self-focus, and autonomic responses (changes in vital signs).

Tissue Perfusion, ineffective (specify type) may be related to reduction/interruption of blood flow (generalized vasculitis/thrombi formation), possibly evidenced by reports of headache/abdominal pain, changes in mentation, and areas of peripheral ulceration/necrosis.

Ulcer, decubitus CH/MS

Skin/Tissue Integrity, impaired may be related to altered circulation, nutritional deficit, fluid imbalance, impaired physical mobility, irritation of body excretions/secretions, and sensory impairments, evidenced by tissue damage/destruction.

Pain, acute may be related to destruction of protective skin layers and exposure of nerves, possibly evidenced by verbal reports, distraction behaviors, and self-focus.

Infection, risk for: risk factors may include broken/traumatized tissue, increased environmental exposure, and nutritional deficits.*

Ulcer, peptic (acute) MS/CH

Fluid Volume, deficient [isotonic] may be related to vascular losses (hemorrhage), possibly evidenced by hypotension, tachycardia, delayed capillary refill, changes in mentation, restlessness, concentrated/decreased urine, pallor, diaphoresis, and hemoconcentration.

Tissue Perfusion, risk for ineffective (specify type) risk factors may include hypovolemia.*

Fear/Anxiety may be related to change in health status and threat of death, possibly evidenced by increased tension, restlessness, irritability, fearfulness, trembling, tachycardia, diaphoresis, lack of eye contact, focus on self, verbalization of concerns, withdrawal, and panic or attack behavior.

Pain, acute may be related to caustic irritation/destruction of gastric tissues, possibly evidenced by verbal reports, distraction behaviors, self-focus, and autonomic responses (changes in vital signs).

Knowledge, deficient [Learning Need] regarding condition, therapy/self-care needs, and potential complications may be related to lack of information/recall, misinterpretation, possibly evidenced by

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statements of concern, questions, misconceptions; inaccurate follow-through of instructions, and development of preventable complications/recurrence of condition.

Unconsciousness (coma) MS

Suffocation, risk for: risk factors may include cognitive impairment/loss of protective reflexes and purposeful movement.*

Fluid Volume, risk for deficient/Nutrition: imbalanced, risk for less than body requirements risk factors may include inability to ingest food/fluids, increased needs/hypermetabolic state.*

Self-Care Deficit [total] may be related to cognitive impairment and absence of purposeful activity, evidenced by inability to perform ADLs.

Tissue Perfusion, risk for ineffective: cerebral risk factors may include reduced or interrupted arterial/venous blood flow (direct injury, edema formation, space-occupying lesions), metabolic alterations, effects of drug/alcohol overdose, hypoxia/anoxia.*

Infection, risk for: risk factors may include stasis of body fluids (oral, pulmonary, urinary), invasive procedures, and nutritional deficits.*

Urinary diversion MS/CH

Skin Integrity, risk for impaired risk factors may include absence of sphincter at stoma, character/flow of urine from stoma, reaction to product/chemicals, and improperly fitting appliance or removal of adhesive.*

Body Image, disturbed related factors may include biophysical factors, (presence of stoma, loss of control of urine flow), and psychosocial factors (altered body structure, disease process/associated treatment regimen, such as cancer), possibly evidenced by verbalization of change in body image, fear of rejection/reaction of others, negative feelings about body, not touching/looking at stoma, refusal to participate in care.

Pain, acute may be related to physical factors (disruption of skin/tissues, presence of incisions/drains), biological factors (activity of disease process, such as cancer, trauma), and psychological factors (fear, anxiety), possibly evidenced by verbal reports, self-focusing, guarding/distraction behaviors, restlessness, and autonomic responses (changes in vital signs).

Urinary Elimination, impaired may be related to surgical diversion, tissue trauma, and postoperative edema, possibly evidenced by loss of continence, changes in amount and character of urine, and urinary retention.

Urolithiasis (urinary calculi) MS/CH

Pain, acute may be related to distention, trauma, and edema formation in sensitive tissue or cellular ischemia, possibly evidenced by verbal reports, guarding/distraction behaviors, self-focus, and autonomic responses (changes in vital signs).

Urinary Elimination, impaired may be related to edema formation and irritation/inflammation of ureteral and bladder tissues, possibly evidenced by urgency, frequency, retention, and hematuria.

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Fluid Volume, risk for deficient risk factors may include stimulation of renal-intestinal reflexes causing nausea, vomiting, and diarrhea; changes in urinary output, postoperative diuresis; and decreased intake.*

Uterine bleeding, abnormal GYN/MS

Anxiety [specify level] may be related to perceived change in health status and unknown etiology, possibly evidenced by apprehension, uncertainty, fear of unspecified consequences, expressed concerns, and focus on self.

Activity intolerance may be related to imbalance between oxygen supply and demand/decreased oxygen-carrying capacity of blood (anemia), possibly evidenced by reports of fatigue/weakness.

Uterus, rupture of, in pregnancy OB

Fluid Volume, deficient [isotonic] may be related to excessive vascular losses, possibly evidenced by hypotension, increased pulse rate, decreased venous filling, and decreased urine output.

Cardiac Output, decreased may be related to decreased preload (hypovolemia), possibly evidenced by cold/clammy skin, decreased peripheral pulses, variations in hemodynamic readings, tachycardia, and cyanosis.

Pain, acute may be related to tissue trauma and irritation of accumulating blood, possibly evidenced by verbal reports, guarding/distraction behaviors, self-focus, and autonomic responses (changes in vital signs).

Anxiety [specify level] may be related to threat of death of self/fetus, interpersonal contagion, physiological response (release of catecholamines), possibly evidenced by fearful/scared affect, sympathetic stimulation, stated fear of unspecified consequences, and expressed concerns.

Vaginismus GYN/CH

Pain, acute may be related to muscle spasm and hyperesthesia of the nerve supply to vaginal mucous membrane, possibly evidenced by verbal reports, distraction behaviors, and self-focus.

Sexual Dysfunction may be related to physical and/or psychological alteration in function (severe spasms of vaginal muscles), possibly evidenced by verbalization of problem, inability to achieve desired satisfaction, and alteration in relationship with SO.

Vaginitis GYN/CH

Tissue Integrity, impaired may be related to irritation/inflammation and mechanical trauma (scratching) of sensitive tissues, possibly evidenced by damaged/destroyed tissue, presence of lesions.

Pain, acute may be related to localized inflammation and tissue trauma, possibly evidenced by verbal reports, distraction behaviors, and self-focus.

Knowledge, deficient [Learning Need] regarding hygienic/therapy needs and sexual behaviors/transmission of organisms may be related to lack of information/misinterpretation, possibly evidenced by statements of concern, questions, and misconceptions.

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Varices, esophageal **MS**

(Also refer to Ulcer, peptic [acute])

Fluid Volume, deficient [isotonic] may be related to excessive vascular loss, reduced intake, and gastric losses (vomiting), possibly evidenced by hypotension, tachycardia, decreased venous filling, and decreased/concentrated urine.

Anxiety [specify level]/Fear may be related to change in health status and threat of death, possibly evidenced by increased tension/apprehension, sympathetic stimulation, restlessness, focus on self, and expressed concerns.

Varicose veins **CH**

Pain, chronic may be related to venous insufficiency and stasis, possibly evidenced by verbal reports.

Body Image, disturbed may be related to change in structure (presence of enlarged, discolored tortuous superficial leg veins) possibly evidenced by hiding affected parts and negative feelings about body.

Skin/Tissue Integrity, risk for impaired risk factors may include altered circulation/venous stasis and edema formation.*

Venereal disease **CH**

(Refer to Sexually transmitted disease-STD)

Wilms' tumor **PED**

(Also refer to Cancer; Chemotherapy)

Anxiety [specify level]/Fear may be related to change in environment and interaction patterns with family members and threat of death with family transmission and contagion of concerns, possibly evidenced by fearful/scared affect, distress, crying, insomnia, and sympathetic stimulation.

Injury, risk for: risk factors may include nature of tumor (vascular, mushy with very thin covering) with increased danger of metastasis when manipulated.*

Family Processes, interrupted may be related to situational crisis of life-threatening illness, possibly evidenced by a family system that has difficulty meeting physical, emotional, and spiritual needs of its members, and inability to deal with traumatic experience effectively.

Diversional Activity, deficient may be related to environmental lack of age-appropriate activity (including activity restrictions) and length of hospitalization/treatment, possibly evidenced by restlessness, crying, lethargy, and acting-out behavior.

Wound, bullet **MS**

(Depends on site and speed/character of bullet)

Fluid Volume, risk for deficient risk factors may include excessive vascular losses, altered intake/restrictions.*

Pain, acute may be related to destruction of tissue (including organ and musculoskeletal), surgical repair, and therapeutic interventions,

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possibly evidenced by verbal reports, guarding/distraction behaviors, self-focus, and autonomic responses (changes in vital signs).

Tissue Integrity, impaired may be related to mechanical factors (yaw of projectile and muzzle blast), possibly evidenced by damaged or destroyed tissue.

Infection, risk for: risk factors may include tissue destruction and increased environmental exposure, invasive procedures, and decreased hemoglobin.*

CH

Post-Trauma Syndrome, risk for: risk factors may include nature of incident (catastrophic accident, assault, suicide attempt) and possibly injury/death of other(s) involved.*

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APPENDIX 1

NANDA's Taxonomy II

The 13 domains and their classes are:

Domain 1 Health Promotion: The awareness of well-being or normality of function and the strategies used to maintain control of and enhance that well-being or normality of function

- Class 1 Health Awareness: Recognition of normal function and well-being
- Class 2 Health Management: Identifying, controlling, performing, and integrating activities to maintain health and well-being

Domain 2 Nutrition: The activities of taking in, assimilating, and using nutrients for the purposes of tissue maintenance, tissue repair, and the production of energy

- Class 1 Ingestion: Taking food or nutrients into the body
- Class 2 Digestion: The physical and chemical activities that convert foodstuffs into substances suitable for absorption and assimilation
- Class 3 Absorption: The act of taking up nutrients through body tissues
- Class 4 Metabolism: The chemical and physical processes occurring in living organisms and cells for the development and use of protoplasm production of waste and energy, with the release of energy for all vital processes
- Class 5 Hydration: The taking in and absorption of fluids and electrolytes

Domain 3 Elimination: Secretion and excretion of waste products from the body

- Class 1 Urinary System: The process of secretion and excretion of urine
- Class 2 Gastrointestinal System: Excretion and expulsion of waste products from the bowel
- Class 3 Integumentary System: Process of secretion and excretion through the skin
- Class 4 Pulmonary System: Removal of byproducts of metabolic products, secretions, and foreign material from the lung or bronchi

Domain 4 Activity/Rest: The production, conservation, expenditure, or balance of energy resources
- Class 1 Sleep/Rest: Slumber, repose, ease, or inactivity
- Class 2 Activity/Exercise: Moving parts of the body (mobility), doing work, or performing actions often (but not always) against resistance
- Class 3 Energy Balance: A dynamic state of harmony between intake and expenditure of resources
- Class 4 Cardiovascular/Pulmonary Responses: Cardiopulmonary mechanisms that support activity/rest

Domain 5 Perception/Cognition: The human information processing system including attention, orientation, sensation, perception, cognition, and communication
- Class 1 Attention: Mental readiness to notice or observe
- Class 2 Orientation: Awareness of time, place, and person
- Class 3 Sensation/Perception: Receiving information through the senses of touch, taste, smell, vision, hearing, and kinesthesia and the comprehension of sense data resulting in naming, associating, and/or pattern recognition
- Class 4 Cognition: Use of memory, learning, thinking, problem solving, abstraction, judgement, insight, intellectual capacity, calculation, and language
- Class 5 Communication: Sending and receiving verbal and nonverbal information

Domain 6 Self-Perception: Awareness about the self
- Class 1 Self-Concept: The perception(s) about the total self
- Class 2 Self-Esteem: Assessment of one's own worth, capability, significance, and success
- Class 3 Body Image: A mental image of one's own body

Domain 7 Role Relationships: The positive and negative connections or associations between persons or groups of persons and the means by which those connections are demonstrated
- Class 1 Caregiving Roles: Socially expected behavior patterns by persons providing care who are not health care professionals
- Class 2 Family Relationships: Associations of people who are biologically related or related by choice
- Class 3 Role Performance: Quality of functioning in socially expected behavior patterns

Domain 8 Sexuality: Sexual identity, sexual function, and reproduction

Class 1 Sexual Identity: The state of being a specific person in regard to sexuality and/or gender
Class 2 Sexual Function: The capacity or ability to participate in sexual activities
Class 3 Reproduction: Any process by which new individuals (people) are produced

Domain 9 Coping/Stress Tolerance: Contending with life events/life processes

Class 1 Post-Trauma Responses: Reactions occurring after physical or psychological trauma
Class 2 Coping Responses: The process of managing environmental stress
Class 3 Neurobehavioral Stress: Behavioral responses reflecting nerve and brain function

Domain 10 Life Principles: Principles underlying conduct, thought, and behavior about acts, customs, or institutions viewed as being true or having intrinsic worth

Class 1 Values: The identification and ranking of preferred mode of conduct or end states
Class 2 Beliefs: Opinions, expectations, or judgments about acts, customs, or institutions viewed as being true or having intrinsic worth
Class 3 Value/Belief/Action Congruence: The correspondence or balance achieved between values, beliefs, and actions

Domain 11 Safety/Protection: Freedom from danger, physical injury, or immune system damage; preservation from loss; and protection of safety and security

Class 1 Infection: Host responses following pathogenic invasion
Class 2 Physical Injury: Bodily harm or hurt
Class 3 Violence: The exertion of excessive force or power so as to cause injury or abuse
Class 4 Environmental Hazards: Sources of danger in the surroundings
Class 5 Defensive Processes: The processes by which the self protects itself from the nonself
Class 6 Thermoregulation: The physiologic process of regulating heat and energy within the body for purposes of protecting the organism

Domain 12 Comfort: Sense of mental, physical, or social well-being or ease

Class 1 Physical Comfort: Sense of well-being or ease
Class 2 Environmental Comfort: Sense of well-being or ease in/with one's environment
Class 3 Social Comfort: Sense of well-being or ease with one's social situations

Domain 13 Growth/Development: Age-appropriate increases in physical dimensions, organ systems, and/or attainment of developmental milestones

Class 1 Growth: Increases in physical dimensions or maturity of organ systems

Class 2 Development: Attainment, lack of attainment, or loss of developmental milestones

APPENDIX 2

Definitions of Taxonomy II Axes

Axis 1 The Diagnostic Concept: Defined as the principal element or the fundamental and essential part, the root, of the diagnostic statement.

Axis 2 Time: Defined as the duration of a period or interval.

Acute: Less than 6 months

Chronic: More than 6 months

Intermittent: Stopping or starting again at intervals, periodic, cyclic

Continuous: Uninterrupted, going on without stops

Axis 3 The Unit of Care: Defined as the distinct population for which a nursing diagnosis is determined. Values are:

Individual: A single human being distinct from others, a person

Family: Two or more people having continuous or sustained relationships, perceiving reciprocal obligations, sensing common meaning, and sharing certain obligations toward others; related by blood or choice

Group: Individuals gathered, classified, or acting together

Community: "'A group of people living in the same locale under the same government.' Examples include neighborhoods, cities, census tracts, and populations at risk." (Craft Rosenberg, 1999, p. 127)

When the unit of care is not explicitly stated, it becomes the individual by default.

Axis 4 Age: Defined as the length of time or interval during which an individual has existed. Values are:

Fetus	Adolescent
Neonate	Young adult
Infant	Middle-age adult
Toddler	Young-old adult
Pre-school child	Middle-old adult
School-age child	Old-old adult

Axis 5 Health Status: Defined as the position or rank on the health continuum. Values are:

Wellness: The quality or state of being healthy, especially as a result of deliberate effort

Risk: Vulnerability, especially as a result of exposure to factors that increase the chance of injury or loss
Actual: Existing in fact or reality, existing at the present time.

Axis 6 Descriptor: Defined as a judgment that limits or specifies the meaning of a nursing diagnosis. Values are:

Ability: Capacity to do or act
Anticipatory: To realize beforehand, foresee
Balance: State of equilibrium
Compromised: To make vulnerable to threat
Deficient: Inadequate in amount, quality, or degree; not sufficient; incomplete
Delayed: To postpone, impede, and retard
Depleted: Emptied wholly or in part, exhausted of
Disabling: To make unable or unfit, to incapacitate
Disorganized: To destroy the systematic arrangement
Disproportionate: Not consistent with a standard
Disturbed: Agitated or interrupted, interfered with
Dysfunctional: Abnormal, incomplete functioning
Effective: Producing the intended or expected effect
Excessive: Characterized by the amount or quantity that is greater than necessary, desirable, or useful
Functional: Normal, complete functioning
Imbalanced: State of disequilibrium
Impaired: Made worse, weakened, damaged, reduced, deteriorated
Inability: Incapacity to do or act
Increased: Greater in size, amount, or degree
Ineffective: Not producing the desired effect
Interrupted: To break the continuity or uniformity
Organized: To form as into a systematic arrangement
Perceived: To become aware of by means of the senses; assignment of meaning
Readiness for enhanced (for use with wellness diagnoses): To make greater, to increase in quality, to attain the more desired

Axis 7 Topology: Consists of parts/regions of the body—all tissues, organs, anatomical sites, or structures. Values are:

Auditory	Oral
Bowel	Olfactory
Cardiopulmonary	Peripheral neurovascular
Cerebral	Peripheral vascular

(NANDA: Nursing Diagnoses: Definitions & Classification 2001–2002, Philadelphia, 2001.)

Gastrointestinal
Gustatory
Intracranial
Urinary
Mucous membranes
Renal
Skin
Tactile
Visual

APPENDIX 3

Proposed ICD-10 Version of NANDA's Taxonomy Revised Submitted 1989

Work is ongoing with the American Nurses Association to have nursing diagnoses included in the World Health Organization International Classification of Diseases (ICD).

"Conditions That Necessitate Nursing Care"

HUMAN RESPONSE PATTERN: CHOOSING

Y00. Family Coping, Impaired
Y00.0. Compromised
Y00.1. Disabled

Y01. [Health Seeking Behavior]
Y01.0–9. Health Seeking Behaviors (Specify)

Y02. Individual Coping, Impaired
Y02.0. Adjustment, Impaired
Y02.1. Conflict: Decisional
Y02.2. Coping, Defensive
Y02.3. Denial, Impaired
Y02.4. Noncompliance

HUMAN RESPONSE PATTERN: COMMUNICATING

Y10. Communication, Impaired
Y10.0. Verbal

HUMAN RESSPONSE PATTERN: EXCHANGING

Y20. [Bowel Elimination, Altered]
Y20.0. Bowel Incontinence
Y20.1. Constipation: Colonic
Y20.2. Constipation: Perceived
Y20.3. Diarrhea

Y21. Cardiac Output, Altered

Y22. [**Fluid Volume, Altered**]
Y22.0. Deficit
Y22.1. Deficit: Risk
Y22.2. Excess

Y23. **Injury, Risk**
Y23.0. Aspiration
Y23.1. Disuse Syndrome
Y23.2. Poisoning
Y23.3. Suffocation
Y23.4. Trauma

Y24. [**Nutrition, Altered**]
Y24.0. Less Than Body Requirement
Y24.1. More Than Body Requirement
Y24.2. More Than Body Requirement: Risk

Y25. [**Physical Regulation, Altered**]
Y25.0. Dysreflexia
Y25.1. Hyperthermia
Y25.2. Hypothermia
Y25.3. Infection, Risk
Y25.4. Thermoregulation, Impaired

Y26. [**Respiration, Altered**]
Y26.0. Airway Clearance, Impaired
Y26.1. Breathing Pattern, Impaired
Y26.2. Gas Exchange, Impaired

Y27. **Tissue Integrity, Altered**
Y27.0. Oral Mucous Membrane, Impaired
Y27.1. Skin Integrity, Impaired
Y27.2. Skin Integrity, Impaired: Risk

Y28. **Tissue Perfusion, Altered**
Y28.0. Cardiopulmonary
Y28.1. Cerebral
Y28.2. Gastrointestinal
Y28.3. Peripheral
Y28.4. Renal

Y29. **Urinary Elimination, Altered**
Y29.0. Incontinence: Functional
Y29.1. Incontinence: Reflex
Y29.2. Incontinence: Stress
Y29.3. Incontinence: Urge
Y29.4. Incontinence: Total
Y29.5. Retention

HUMAN RESPONSE PATTERN: FEELING

Y30. Anxiety

Y31. [Comfort, Altered]
Y31.0. Pain, Acute
Y31.1. Pain, Chronic

Y32. Fear

Y33. [Grieving]
Y33.0. Anticipatory
Y33.1. Dysfunctional

Y34. Post-Trauma Response
Y34.0. Rape-Trauma Syndrome
Y34.1. Rape-Trauma Syndrome: Compound Reaction
Y34.2. Rape-Trauma Syndrome: Silent Reaction

Y35. Violence, Risk

HUMAN RESPONSE PATTERN: KNOWING

Y40. [Knowledge, Deficit]
Y40.0–9. Knowledge, Deficit (Specify)

Y41. Thought Processes, Altered

HUMAN RESPONSE PATTERN: MOVING

Y50. [Activity, Altered]
Y50.0. Activity Intolerance
Y50.1. Activity Intolerance: Risk
Y50.2. Diversional Activity, Deficit
Y50.3. Fatigue
Y50.4. Physical Mobility, Impaired
Y50.5. Sleep Pattern, Disturbance

Y51. Bathing/Hygiene Deficit

Y52. Dressing/Grooming Deficit

Y53. Feeding Deficit
Y53.0. Breastfeeding, Impaired
Y53.1. Swallowing, Impaired

Y54. Growth and Development, Altered

Y55. Health Maintenance, Altered

Y56. Home Maintenance Management, Impaired

Y57. Toileting Deficit

HUMAN RESPONSE PATTERN: PERCEIVING

Y60. [Meaningfulness, Altered]
Y60.0. Hopelessness
Y60.1. Powerlessness

Y61. [Self Concept, Altered]
Y61.0. Body Image, Disturbance
Y61.1. Personal Identity, Disturbed
Y61.2. Self-Esteem Disturbance: Chronic Low
Y61.3. Self-Esteem Disturbance: Situational Low

Y62. Sensory Perception, Altered
Y62.0. Auditory
Y62.1. Gustatory
Y62.2. Kinesthetic
Y62.3. Olfactory
Y62.4. Tactile
Y62.5. Visual
Y62.6. Unilateral Neglect

HUMAN RESPONSE PATTERN: RELATING

Y70. Family Processes, Altered

Y71. Role Performance, Altered
Y71.0. Parental Role Conflict
Y71.1. Parenting, Altered
Y71.2. Parenting, Altered: Risk
Y71.3. Sexual Dysfunction

Y72. Sexuality Patterns, Altered

Y73. [Socialization, Altered]
Y73.0. Social Interaction, Impaired
Y73.1. Social Isolation

HUMAN RESPONSE PATTERN: VALUING

Y80. [Spiritual State, Altered]
Y80.0. Spiritual Distress

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