Nursing Diagnosis:
A statement that describes a client’s actual or potential **health problems** that a nurse can identify and for which she can order nursing interventions to maintain the health status, to reduce, eliminate or prevent alterations/changes.
Is the problem statement that the nurse makes regarding a client’s condition which she uses to communicate professionally.

It uses the critical-thinking skills analysis and synthesis in order to identify client strengths & health problems that can be resolves/prevented by collaborative and independent nursing interventions.

Nursing Diagnosing

Is the 2nd step of the nursing process.

The process of reasoning or the clinical act of identifying problems.

Purpose: To identify health care needs

To diagnose in nursing: it means to analyze assessment information and derive meaning from this analysis.
NANDA – North American Nursing Diagnosis Association

- Identifies nursing functions
- Creates classification system
- Establishes diagnostic labels
- Purpose: “to develop, refine, and promote a taxonomy of nursing diagnostic terminology of general use for professional nurses”.

NURSING DIAGNOSIS:

Eg.
- Problem: Fever → nursing diagnosis: Alteration in thermoregulatory function: or hyperthermia related to inflammatory process.
3 activities in Diagnosing:

- **DIAGNOSING** =
  - Data Analysis +
  - Problem Identification +
  - Formulation of Nsg Diagnosis
Components of a nursing diagnosis: PES or PE

- Problem statement/diagnostic label/definition = P
- Etiology/related factors/causes = E
- Defining characteristics/signs and symptoms = S

Characteristics of Nursing Diagnosis

- It states a clear and concise health problem.
- It is derived from existing evidences about the client.
- It is potentially amenable to nursing therapy.
- It is the basis for planning and carrying out nursing care.
TYPES OF NURSING DIAGNOSES

- 1. Actual nursing diagnosis
- 2. Risk nursing diagnosis
- 3. Possible nursing diagnosis
- 4. Wellness nursing diagnosis
- 5. Syndrome nursing diagnosis

Actual Nursing Diagnosis

- a client problem that is present at the time of the nursing assessment. It is based on the presence of signs and symptoms.

Examples:
- Imbalanced Nutrition: Less than body requirements r/t decreased appetite nausea as manifested by decreas body weight.
- Ineffective airway clearance r/t to viscous secretions as manifested by productive coph
- Acute Pain (Chest) r/t cough 2nrdary to pneumonia AMB client verbalization
- Activity Intolerance r/t general weakness AMB client verbalization
Potential Nursing diagnosis

- one in which evidence about a health problem is incomplete or unclear therefore requires more data to support or reject it; or the causative factors are unknown but a problem is only considered possible to occur.
- Examples:
  - Possible nutritional deficit RT nausea
  - Possible low self-esteem r/t loss job
  - Possible altered thought processes r/t unfamiliar surroundings

Risk Nursing diagnosis

- is a clinical judgment that a problem does not exist, therefore no S/S are present, but the presence of RISK FACTORS is indicates that a problem is only is likely to develop unless nurse intervene or do something about it.
- No subjective or objective cues are present therefore the factors that cause the client to be more vulnerable to the problem is the etiology of a risk nursing diagnosis.
- Examples:
  - Risk for Impaired skin integrity (left ankle) r/t decrease peripheral circulation in diabetes.
  - Risk for Constipation r/t inactivity and insufficient fluid intake
  - Risk for infection r/t compromised immune system.
  - Risk for injury r/t decreased vision after cataract surgery.
Wellness nursing diagnosis

- clinical judgment about an individual, family and community in transition from a specific level of wellness to a higher level of wellness
  - E.g. Knowledge deficit regarding breast feeding RT first time.
  - E.g. Readiness for + higher level of wellness
  - Rudeness for enhance family coping.

Syndrome nursing diagnosis

- comprises of a cluster of problems
  - Format: 1 part statement E.g -:
    - rape trauma syndrome)
    - risk for disuse syndrome.
Formula in writing nursing diagnosis: PES or PE

- Actual nursing diagnosis
  - □ = Patient problem + Etiology – replace the (+) symbol with the words “RELATED TO” abbreviated as r/t.
  - □ = Problem + Etiology + S/S
- Risk Nursing diagnosis = Problem + Risk Factors
- Possible nursing diagnosis = Problem + Etiology

Etiology (Related/ Risk Factors) → the probable cause of the health problem; may include client’s behavior, environmental factors or the interaction of the two;

NANDA-“related to” to describe the etiology or likely cause

Example:
- Activity intolerance related to decreased cardiac output.
- Ineffective breast-feeding related to first-time experience
- Altered bowel elimination; constipation related to insufficient fluid intake.
Problem Statement → describes the client’s health problem or response for which nursing therapy is given

Qualifiers → added words to give additional meaning to the diagnostic statement
- Altered → change from baseline
- Impaired → made worse, weakened, damaged
- Decreased → smaller in size, amount or degree
- Ineffective → not producing the desired effect
- Acute → severe or of short duration
- Chronic → lasting a long time

Activities during diagnosis
- Compare data against standards
- Cluster or group data
- Data analysis after comparing with standards
- Identify gaps and inconsistencies in data
- Determine the client’s health problems, health risks, strengths
- Formulate Nursing Diagnosis – prioritize nursing diagnosis based on what problem endangers the client’s life
Nursing diagnosis

**Risk nursing diagnosis**

= Problem + Etiology (risk factor)

- **Risk for infection** r/t surgical procedure.
- The client will demonstrate no signs or symptoms of infection.