Chapter 2

From Assessment to Diagnosis

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Assessment is the first and the most critical step in the nursing process. If this step is not handled well, nurses will lose control over the subsequent steps of the nursing process. Without proper nursing assessment, there can be no nursing diagnosis, and without nursing diagnosis, there can be no independent nursing interventions. Assessment should not be performed merely to fill in the blank spaces on a form or computer screen. If this rings a bell for you, it’s time to take a new look at the purpose of assessment!

What Happens during Nursing Assessment?

During the assessment and diagnosis steps of the nursing process, nurses collect data from a patient (or family/group/community), process that data into information, and then organize that information into meaningful categories of knowledge, also known as nursing diagnoses. Assessment provides the best opportunity for nurses to establish an effective therapeutic relationship with the patient. In other words, assessment is both an intellectual and an interpersonal activity.

As you can see in Figure 2.1, assessment involves multiple steps, with the goal being to diagnose and prioritize these diagnoses, which then become the basis for nursing treatment. Now, this probably sounds like a long, involved process and, frankly, who has time for all of that? In the real world, however, some of these steps happen in the blink of an eye. For instance, if a nurse sees a patient who is holding her lower abdomen and grimacing, he might immediately suspect that the patient is experiencing acute pain (00132). Thus, the movement from data collection (observation of the patient’s behavior) to determining potential diagnoses (e.g., acute pain) occurs in a split second. However, this
quickly determined diagnosis might not be the right one – or it may not be the highest priority for your patient. Getting there does take time.

So, how do you accurately diagnose? Only by continuing to the further step of in-depth assessment – and the proper use of the data collected during that assessment – can you ensure accuracy in diagnosis. The patient may indeed be experiencing acute pain, but without in-depth assessment, there is no way for the nurse to know that the pain is related to intestinal cramping and diarrhea. This chapter provides foundational knowledge for what to do with all of that data you have collected. After all, why bother collecting it if you aren’t going to use it?

In the next section, we will go through each of the steps in the process that takes us from assessment to diagnosis. But first, let’s spend a few minutes discussing the purpose – because assessment is not simply a task that nurses complete, we need to really understand its purpose so we can understand how it applies to our professional role as nurses.

**Why Do Nurses Assess?**

Nurses need to assess patients from the viewpoint of the nursing discipline to diagnose accurately and to provide effective care. What is the “nursing discipline”? Simply put, it is the body of knowledge that comprises the science of nursing. Diagnosing a patient based on his/her medical diagnosis or medical information is neither a recommended nor a safe diagnostic process. Such an overly simplified conclusion could lead to inappropriate interventions, prolonged length of stay, and unnecessary readmissions.

Remember that nurses diagnose actual or potential human responses to health conditions/life processes, or a vulnerability for that response – the focus here is “human responses.” Human beings are complicated – we just don’t all respond to one situation in the same way. Those responses are based on many factors: genetics, physiology, health condition, and past experience with illness/injury. However, they are also influenced by the patient’s culture, ethnicity, religion/spiritual beliefs, gender, and family upbringing. This means that human responses
are not so easily identified. If we simply assume that every patient with a particular medical diagnosis will respond in a certain way, we may treat conditions (and therefore use the nurse’s time and other resources) that do not exist while missing others that truly need our attention.

It is possible that there may be close relationships between some nursing diagnoses and medical conditions; however, to date we do not have sufficient scientific evidence to definitively link all nursing diagnoses to particular medical diagnoses. For instance, there is no way to identify the patient’s ability for independent daily living or the availability/quality of family support, based on a medical diagnosis of myocardial infarction or osteoporosis. Nor can one assume that every patient with a medical diagnosis will respond in the same way: every patient who has experienced a mastectomy does not experience disturbed body image (00118), for example. Therefore, nursing assessment and diagnosis should be driven from the viewpoint of the nursing discipline.

Unfortunately, in your practice, you will probably observe nurses who assign or “pick” a diagnosis before they have assessed the patient. What is wrong with this pathway to diagnosis? As an example, a nurse may begin to complete a plan of care based on the nursing diagnosis of anxiety (00146) for a patient undergoing surgery, before the patient has even arrived on the unit or been evaluated. Nurses working in surgical units encounter many preoperative patients, and those patients are often very anxious. Those nurses may know that preoperative teaching is an effective intervention in reducing anxiety.

So, assuming a relationship between preoperative patients and anxiety could be useful in practice. However, the statement “preoperative patients have anxiety” may not apply to every patient (it is a hypothesis), and so it must be validated with each and every patient. This is especially true because anxiety is a subjective experience – although we may think the patient seems anxious, or we may expect him to be anxious, only he can really tell us if he feels anxious. In other words, the nurse can understand how the patient feels only if the patient tells the nurse about his feelings, so anxiety is a problem-focused nursing diagnosis which requires subjective data from the patient. What appears to be anxiety may actually be fear (00148) or ineffective coping (00069); we simply cannot know until we assess and validate our findings. Thus, before nurses diagnose a patient, a thorough assessment is absolutely necessary.

The Screening Assessment

There are two types of assessment: screening and in-depth assessment. While both require data collection, they serve different purposes. The screening assessment is the initial data collection step, and is probably...
the easiest to complete. The in-depth assessment is more focused, enabling the nurse to explore information that was identified in the initial screening assessment, and to search for additional cues that might support or refute potential nursing diagnoses.

*Not a Simple Matter of “Filling in the Blanks”*

Most schools and healthcare organizations provide nurses with a standardized form – on paper or in the electronic health record – that must be completed for each patient within a specified period of time. For example, patients who are admitted to the hospital may need to have this assessment completed within 24 hours of admission. Patients seen in an ambulatory clinic may have a required assessment prior to being seen by the primary care provider (a physician or nurse practitioner, for example). Some organizations will have tools that enable completion of an assessment based on a particular nursing theory or model (e.g., Roy Adaptation Model), body system review, or some other method of organizing the data to be collected.

The performance of the screening assessment requires specific competences for the accurate completion of various procedures to obtain data, and it requires a high level of skill in interpersonal communication. Patients must feel safe and trust the nurse before they will feel comfortable answering personal questions or providing answers, especially if they feel that their responses might not be “normal” or “accepted.”

We say that the initial screening assessment may be the easiest step because, in some ways, it is initially a process of “filling in the blanks.” The form requires the patient’s temperature, so the nurse takes the temperature and inputs that data into the assessment form. The form requires that information is collected about the patient’s cardiac system, and the nurse completes all of the blank spaces on the form that deal with this system (heart rate, rhythm, presence of a murmur, pedal pulses, etc.).

However, appropriate nursing assessment requires far more than this initial screening. Obviously, when the nurse reviews data collected during her assessment, and starts to recognize potential diagnoses, she will need to collect further data that can help her determine if there are other human responses occurring that are of concern, that indicate risks for the patient, or that suggest health promotion opportunities. The nurse will also want to identify the etiology or precipitating factors of areas of concern. It is quite possible that these in-depth questions are not included in the organization’s assessment form, because there is simply no way to include every possible question that might need to be asked for every possible human response!
Assessment Framework

Let’s take a moment to consider the type of framework that supports a thorough nursing assessment. An evidence-based assessment framework should be used for accurate nursing diagnosis as well as safe patient care. It should also represent the discipline of the professional using it: in this case, the assessment form should represent knowledge from the nursing discipline.

Should we use the NANDA-I taxonomy as an assessment framework?

There is sometimes confusion over the difference between the NANDA-I Taxonomy II of nursing diagnoses and Gordon’s Functional Health Patterns (FHP) assessment framework (1994). The NANDA-I taxonomy was developed based on Gordon’s work; that is why the two frameworks look similar. However, their purposes and functions are entirely different. (See Chapters 3 and 4 for more specific information on the NANDA-I taxonomy.)

The NANDA-I Taxonomy serves its intended purpose of sorting/categorizing nursing diagnoses. Each domain and class is defined, so the framework helps nurses to locate a nursing diagnosis within the taxonomy. On the other hand, the FHP framework was scientifically developed to standardize the structure for nursing assessment (Gordon, 1994). It guides the history-taking and physical examination by nurses, providing items to assess and a structure for organizing assessment data. In addition, the sequence of 11 patterns provides an efficient and effective flow for the nursing assessment.

As stated in the NANDA-I Position Statement (2010), use of an evidence-based assessment framework, such as Gordon’s FHP, is highly recommended for accurate nursing diagnosis and safe patient care. It is not intended that the NANDA-I Taxonomy should be used as an assessment framework.

Data Analysis

The second step in the process is the conversion of data to information. Its purpose is to help us to consider what the data we collected in the screening assessment might mean, or to help us identify additional data that need to be collected. The terms “information” and “data” are sometimes used interchangeably, but the actual characteristics of data and information are quite different. In order to have a better understanding of assessment and nursing diagnosis, it is useful to take a moment to differentiate data from information.
• Objective data
  • 15-year-old girl
  • 5 ft 9” tall (175.26 cm)
  • 105 pounds (47.63 kg)
  • Weighed 145 pounds / 65.77 kg at last visit, 11 months ago
    (5 ft 7”/170.18 cm at that time)

• Subjective data
  • States she is afraid she will regain weight
  • States she needs to lose 5 more pounds (2.3 kg) to reach her goal weight
  • Complains of frequent headaches and stomach pain

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Figure 2.2 Converting Data to Information: The Case of Caroline, a 14-year-old Female Seen in Ambulatory Clinic

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Nursing knowledge

• Weight abnormal: underweight
  • 1st percentile for body mass index (BMI) (CDC, 2014)
  • Anxious about body weight
  • Elevated stress levels (body image, fear of gaining weight, headaches, stomach pain)

Information

Data collection

• Nutritional requirements for adolescent females
• Self-esteem, body image theories
• Stress and coping theories
Data are the raw facts collected by nurses through their observations. Nurses collect data from a patient (or family/group/community) and then, using their nursing knowledge, they transform those data into information. Information can be seen as data with an assigned judgment or meaning, such as “high” or “low,” “normal” or “abnormal,” and “important” or “unimportant.” Figure 2.2 provides an example of how objective and subjective data can be converted to information through the application of nursing knowledge.

It is important to note that the same data can be interpreted differently depending on the context, or the gathering of new data. For example, let’s suppose that a nurse checks the body temperature of Mr. W who was just admitted to the hospital with an infected surgical wound and difficulty breathing. The thermometer indicates his temperature is 37.5°C/99.5°F, via the axillary route. This plain fact is given meaning by comparing it to accepted normal values, as the nurse processes data into information: Mr. W has a slight fever. However, what if the nurse learns that when Mr. W was seen in the ambulatory clinic two hours ago, his temperature was 39.0°C/102.2°F? With this new piece of data, the current temperature data can be reinterpreted: Mr. W’s temperature has decreased (it is improving).

When documenting assessment, therefore, it is important to include both data and information. Information cannot be validated by others if original data are not provided. For example, simply indicating “Mr. W had a fever” is not clinically useful. How severe was the fever? How were data gathered (oral, axillary, core temperature)? Documentation that shows that Mr. W had a fever of 37.5°C/ 99.5°F, via the axillary method, enables another nurse to compare new temperature readings against the previous ones, and to identify if the patient is improving.

**Subjective versus Objective Data**

Nurses collect and document two types of data related to a patient: subjective and objective data. While physicians value objective over subjective data for medical diagnoses, nurses value both types of data for nursing diagnoses (Gordon, 2008).

What is the difference between subjective and objective data? The dictionary (Merriam-Webster, 2014) defines *subjective* as “based on feelings or opinions rather than facts”; *objective* means “based on facts rather than feelings or opinions.” One thing you should be careful of here is that when these terms are used in the context of nursing assessment, they have a slightly different meaning from this general dictionary definition. Although the basic idea remains the same, “subjective” does not mean the nurse’s feelings or opinions, but that of the subject of nursing care: the patient/family/group/community.
Moreover, “objective” signifies those facts observed by the nurse or other healthcare professionals.

In other words, the subjective data come from verbal reports from the patient regarding perceptions and thoughts on his/her health, daily life, comfort, relationships, and so on. For instance, a patient may report “I have had severe back pain for a week,” or “I don’t have anyone in my life with whom I can share my feelings.” Sometimes, however, the patient is unable to provide subjective data, and so we must rely on other sources, such as family members/close friends. Parents may provide useful information about their child’s behavior based on their daily observations and knowledge. An example might be a parent telling the nurse that “She usually curls up in a ball and rocks herself when she hurts.” Nurses can use this information to validate the baby’s behavior, and such behavior can be used as subjective data.

Nurses collect these subjective data through the process of history-taking or interview. History-taking is not merely asking the patient one question after another using a routine format. In order to obtain accurate data from a patient, nurses must incorporate active listening skills, and use open-ended questions as much as possible, especially as follow-up questions when potentially abnormal data are identified.

The objective data are those things that nurses observe about the patient. Objective data are collected through physical examinations and diagnostic test results. Here, “to observe” does not only mean the use of eyesight: it requires the use of all senses. For example, nurses look at the patient’s general appearance, listen to his lung sounds, they may smell foul wound drainage, and feel the skin temperature using touch. Additionally, nurses use various instruments and tools with the patient to collect numerical data (e.g., body weight, blood pressure, oxygen saturation, pain level). In order to obtain reliable and accurate objective data, nurses must have appropriate knowledge and skills to perform physical assessment and to use standardized tools or monitoring devices.

Ask yourself: Do these data signify:
- A problem?
- A strength?
- A vulnerability?

Clustering of Information/Seeing a Pattern

Once the nurse has collected data and transformed it into information, the next step is to begin to answer the question: What are my patient’s human responses (nursing diagnoses)? This requires the knowledge of
a variety of theories and models from nursing as well as several related disciplines. It also requires knowledge about the concepts that underlie the nursing diagnoses themselves. Do you remember the modified nursing process diagram introduced in Chapter 1 (Figure 1.2)? In this diagram, Herdman (2013) identifies the importance of theory/nursing science underlying nursing concepts. Assessment techniques are meaningless if we do not know how to use the data!

If the nurse who assessed the adolescent, Caroline (Figure 2.3), did not know the normal BMIs in that age group, he might not have been able to interpret that patient’s weight as being underweight. If he did not understand theories related to child development, self-esteem, body image, stress, and coping in this age group, then he might not identify other vulnerabilities or problem responses exhibited by Caroline.

**Identifying Potential Nursing Diagnoses**  
(Diagnostic Hypotheses)

At this step in the process, the nurse looks at the information that is coming together to form a pattern; it provides him with a way of seeing what human responses the patient may be experiencing. Initially, the
nurse considers all potential diagnoses that may come to mind. In the expert nurse, this can happen in seconds – for novice or student nurses, it may take support from more expert nurses or faculty members to guide their thinking.

Ask yourself, now that you have collected your assessment data and converted it into information, how do you know what’s important and what’s irrelevant for this particular patient?

Seeing patterns in the data requires an understanding of the concept that supports each diagnosis. For example, if you have assessed Ms. K and you note that she is having difficulty breathing, her pulse oximeter shows her oxygenation is 88%, she is using accessory muscles to breathe, and she has supraclavicular retractions, what does this tell you? Unless you have a good understanding of normal breathing patterns, normal gas exchange, and ventilation, it may not tell you very much at all. You may know that Ms. K has some problem with her breathing, but not enough to know what you should look for to identify a cause (related factors) or even what other data (defining characteristics) you should look for to determine an accurate diagnosis. This situation can lead to the nurse just “picking a diagnosis” from a list, or trying to use the medical diagnosis as the basis for the nursing diagnosis. Conceptual knowledge of each nursing diagnosis allows the nurse to give accurate meanings to the data collected from the patient, and prepares her to perform the in-depth assessment.

When you have this conceptual knowledge, you will begin to look at the data you collected in a different way. You will turn that data into information, and start to observe how that information starts to group together to form patterns, or to “paint a picture” of what might be happening with your patient. Take another look at Figure 2.2. With conceptual nursing knowledge of nutrition, self-esteem, stress, coping, and adolescent development, you might begin to see the information as possible nursing diagnoses, such as:

- Imbalanced nutrition, less than body requirements (00002)
- Disturbed body image (00118)
- Situational low self-esteem (00120).

Unfortunately, this step is often where nurses stop: they develop a list of diagnoses and either launch directly into action (determining interventions), or they simply “pick” one of the diagnoses that sounds most appropriate, based on the diagnosis label, and then move on to selecting interventions for those diagnoses. This is, quite simply, the wrong thing to do. For diagnoses to be accurate, they must be validated – and that requires additional, in-depth assessment to confirm or to refute, or “rule out,” a diagnosis.

By combining basic nursing knowledge and nursing diagnosis knowledge, the nurse can now move from identifying potential diagnoses
based on the screening assessment to an in-depth assessment, and then to determining the accurate nursing diagnosis(es).

**In-Depth Assessment**

At this stage, you have reviewed the information resulting from the screening assessment to determine if it was normal or abnormal, or if it represented a risk (vulnerability) or a strength. Those items that were not considered normal, or were seen as a vulnerability, should have been considered in relation to a problem-focused or risk diagnosis. Areas in which the patient indicated a desire to improve something (for example, to enhance nutrition) should be considered as a potential health promotion diagnosis.

If some data are interpreted as abnormal, further in-depth assessment is crucial in order to diagnose the patient accurately. However, if nurses simply collect data without paying much attention to them, critical data may be overlooked. Take another look at Figure 2.2. The nurse could have stopped his assessment here, and simply moved on to a diagnosis of *impaired nutrition, less than body requirements* (00002). He could have provided education about proper nutrition and normal weight ranges for Caroline’s age and height. He could have developed a nutrition plan or made a referral to a dietitian. However, while all of those things might be appropriate, he would have neglected to identify some major issues that are probably significant, which, if not addressed, will lead to continued issues with Caroline’s weight and nutritional status.

Through the in-depth assessment, however, Caroline’s nurse was able to identify peer pressure, bullying, and high stress levels regarding school performance, her desire to “fit in” at school, her goal of attending a top university, and the need to win an academic scholarship to afford tuition (Figure 2.4). He learned that Caroline had vulnerabilities consistent with a stressful social environment (peers who focused on weight/appearance, threat of bullying, and a best friend with self-injurious behavior). However, he also identified that Caroline had a strength in the support she received from her parents and brother – a very important thing to build in to any plan of care. So, with this additional in-depth assessment, the nurse could now revise his potential diagnoses:

- Imbalanced nutrition, less than body requirements (00002)
- Stress overload (00177)
- Ineffective coping (00069)
- Anxiety (00146)
- Disturbed body image (00118)
- Situational low self-esteem (00120)
Figure 2.4 In-Depth Assessment: The Case of Caroline, a 14-year-old Female Seen in Ambulatory Clinic

- **Objective data**
  - 15-year-old girl
  - 5 ft 9" tall (175.26 cm)
  - 105 pounds (47.63 kg)
  - Weighed 145 pounds / 65.77 kg at last visit, 11 months ago (5 ft 7"/170.18 cm at that time)

- **Subjective data**
  - States she is afraid she will regain weight
  - States she needs to lose 5 more pounds (2.3 kg) to reach her goal weight
  - Complains of frequent headaches and stomach pain

- **Nutritional requirements for adolescent females**
- **Self-esteem, body image theories**

- **Weight abnormal: underweight**
  - 1st percentile for body mass index (BMI) (CDC, 2014)
  - Anxious about body weight
  - Elevated stress levels (body image, fear of gaining weight, headaches/stomach pain)

- **Imbalanced nutrition, less than body requirements (00002)**
- **Disturbed body image (00118)**
- **Situational low self-esteem (00120)**

- **In-depth assessment**
  - States she was bullied at school for two years due to weight, which has now stopped.
  - Wants to lose 5 more pounds (2.3 kg)
  - Weighs herself 1–2 times/day
  - Strictly monitors caloric intake
  - States “you don’t understand, people don’t like you if you are fat!” when weight norms are discussed.
  - Notes peer approval very important—strong desire to “fit in”
  - Very concerned about school performance, wants to attend a top university
  - College placement exams in near future; says she studies 4 hours/night and more on weekends, & is taking preparatory course for exams
  - States she is intelligent, but needs a scholarship to attend a good college because of the cost
  - States parents and younger brother are strong supports for her
  - Notes peers are very concerned with their weight/appearance
  - States school is very competitive
  - Her best friend has been exhibiting self-injurious (cutting) behavior
  - Indicates difficulty getting to sleep and awakens without feeling rested
  - States she is “a strong person—when I put my mind to something, I know I can do it!” Smiles when she talks about the strength of her determination.

- Potential diagnoses
  - States parents and younger brother are strong supports for her
Confirming/Refuting Potential Nursing Diagnoses

Whenever new data are collected and processed into information, it is time to reconsider previous potential or determined diagnoses. In this step, there are three primary things to consider:

- Did the in-depth assessment provide new data that would rule out or eliminate one or more of your potential diagnoses?
- Did the in-depth assessment point toward new diagnoses that you had not previously considered?
- How can you differentiate between similar diagnoses?

It is also important to remember that other nurses will need to be able to continue to validate the diagnosis you make, and to understand how you arrived at your diagnosis. It is for this reason that it is important to use standardized terms, such as the NANDA-I nursing diagnoses, which provide not only a label (e.g., ineffective coping (00069)), but also a definition and assessment criteria (defining characteristics and related factors, or risk factors), so that other nursing professionals can continue to validate – or perhaps refute – the diagnosis as new data become available for the patient. Terms that are simply constructed by nurses at the bedside, without these validated definitions and assessment criteria, have no consistent meaning and cannot be clinically validated or confirmed. When a NANDA-I nursing diagnosis does not exist that fits a pattern you identify in a patient, it is safer to describe the condition in detail rather than to make up a term that will have different meanings to different nurses. Remember that patient safety depends on good communication – so use only standardized terms that have clear definitions and assessment criteria so that they can be easily validated.

Eliminating Possible Diagnoses

One of the goals of in-depth assessment is to eliminate, or “rule out,” one or more of the potential diagnoses you were considering. You do this by reviewing the information you have obtained and comparing it to what you know about the diagnoses. It is critical that the assessment data support the diagnosis(es). Diagnoses that are not well supported through the assessment criteria provided by NANDA-I (defining characteristics, related factors, or risk factors) and/or that are not supported by etiological factors (causes or contributors to the diagnoses) are not appropriate for a patient.
As we look at Figure 2.4 and consider the potential diagnoses that Caroline’s nurse identified, we can begin to eliminate some of these as valid diagnoses. Sometimes it is helpful to do a side-to-side comparison of the diagnoses, focusing on those defining characteristics and related factors that were identified throughout the assessment and patient history (Table 2.1).

For example, after reflection, Caroline’s nurse quickly eliminates from consideration the diagnosis, *situational low self-esteem*. The definition of this diagnosis simply does not fit Caroline’s confidence in her intelligence, her ability to achieve what she puts her mind to, and her pride in her strength of determination. Although she does have some related factors for this diagnosis, she does not have the signs/symptoms of someone with this diagnosis and, in fact, she has strengths that are quite contrary to it. The nurse also eliminates *anxiety*. Although Caroline does have some defining characteristics and related factors for this diagnosis, she does not refer to herself as anxious, nor does she identify a feeling of dread or apprehension. Rather, she clearly states stressors that exist in her life, and sees these as a challenge to be overcome.

**Potential New Diagnoses**

It is very possible, such as in the case of Caroline (Figure 2.4), that new data will lead to new information and, in turn, to new diagnoses. The same questions that you used to eliminate potential diagnoses should be used as you consider these diagnoses.

**Differentiating between Similar Diagnoses**

It is helpful to narrow down your potential diagnoses by considering those that are very similar, but that have a distinctive feature making one more relevant to the patient than the other. Let’s take another
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<th>Table 2.1</th>
<th>The Case of Caroline: A Comparison of Identified Defining Characteristics and Related Factors</th>
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<tr>
<td><strong>Imbalanced nutrition, less than body requirements (00002)</strong></td>
<td><strong>Definition</strong></td>
<td>Intake of nutrients insufficient to meet metabolic needs</td>
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<td><strong>Stress overload (00177)</strong></td>
<td><strong>Defining characteristics</strong></td>
<td>Body weight 20% or more below ideal weight range</td>
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<td>Food intake less than recommended daily allowance (RDA)</td>
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<td></td>
<td>Misperception</td>
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<td><strong>Ineffective coping (00069)</strong></td>
<td><strong>Definition</strong></td>
<td>Excessive amounts and types of demands that require action</td>
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<td></td>
<td><strong>Defining characteristics</strong></td>
<td>Excessive stress</td>
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<td>Negative impact from stress</td>
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<td>Tension</td>
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<td><strong>Anxiety (00146)</strong></td>
<td><strong>Definition</strong></td>
<td>Inability to form a valid appraisal of the stressors, inadequate choices of practiced responses, and/or inability to use available resources</td>
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<td><strong>Defining characteristics</strong></td>
<td>Alteration in sleep pattern</td>
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<td></td>
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<td>Ineffective coping strategies</td>
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<td><strong>Disturbed body image (00118)</strong></td>
<td><strong>Definition</strong></td>
<td>Vague, uneasy feeling of discomfort or dread accompanied by an autonomic response (the source is often nonspecific or unknown to the individual); a feeling of apprehension caused by anticipation of danger. It is an alerting sign that warns of impending danger and enables the individual to take measures to deal with that threat</td>
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<td><strong>Defining characteristics</strong></td>
<td>Alteration in view of one’s body</td>
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<td><strong>Situational low self-esteem (00120)</strong></td>
<td><strong>Definition</strong></td>
<td>Confusion in mental picture of one’s physical self</td>
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<td><strong>Defining characteristics</strong></td>
<td>Development of a negative perception of self-worth in response to a current situation</td>
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<th>Related factors</th>
<th>Imbalanced nutrition, less than body requirements (00002)</th>
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<th>Anxiety (00146)</th>
<th>Disturbed body image (00118)</th>
<th>Situational low self-esteem (00120)</th>
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<td>Insufficient dietary intake</td>
<td>Excessive stress</td>
<td>Gender differences in coping strategies</td>
<td>Maturational crisis</td>
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look at our patient, Caroline. After the in-depth assessment, the nurse had six potential diagnoses; two diagnoses were eliminated, leaving four potential diagnoses. One way to start the process of differentiation is to look at where the diagnoses are located within the NANDA-I taxonomy. This gives you a clue about how the diagnoses are grouped together into the broad area of nursing knowledge (domain) and the subcategories, or group of diagnoses with similar attributes (class).

A quick review of Table 2.2 shows only one diagnosis within the nutrition domain, and one within the self-perception domain. However, two diagnoses are found within the coping/stress tolerance domain; these diagnoses are also located in the same class, that of coping responses. This suggests that some differentiation could support a narrowing of potential diagnoses within those sharing similar attributes.

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Domain</th>
<th>Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>Imbalanced nutrition, less than body</td>
<td>Nutrition</td>
<td>Ingestion</td>
</tr>
<tr>
<td>requirements (00002)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stress overload (00177)</td>
<td>Coping/stress tolerance</td>
<td>Coping responses</td>
</tr>
<tr>
<td>Ineffective coping (00069)</td>
<td>Coping/stress tolerance</td>
<td>Coping responses</td>
</tr>
<tr>
<td>Disturbed body image (00118)</td>
<td>Self-perception</td>
<td>Body image</td>
</tr>
</tbody>
</table>

Ask Yourself: When I look at the patient information in light of similar nursing diagnoses:

- Do the diagnoses share a similar focus, or is it different?
- If the diagnoses share a similar focus, is one more focused/specific than the other?
- Does one diagnosis potentially lead to another that I have identified? That is, could it be the causative factor of that other diagnosis?

As the nurse considers what he knows about Caroline, he can look at the coping responses he identified as potential diagnoses in light of these questions. The diagnoses do not share a similar diagnostic focus: one focuses on stress and one focuses on coping. Stress overload is fairly specific: there are excessive amounts and types of demands requiring
action by the patient. Caroline has clearly identified stressors (bullying, peer pressure, desire to “fit in,” college entrance exams, need for a scholarship to attend college, a good friend exhibiting cutting behavior, etc.). Ineffective coping looks at how the individual evaluates stressors, and the choices she makes to respond to them, and/or how she accesses available resources to respond to them.

It is easy to see how stress overload could lead to ineffective coping: elimination of stressors, or a reframing of how Caroline perceives those stressors, could then have an impact how the patient copes with the situation. The nurse might take some time to consider if it is possible for the patient to eliminate or reframe the stressors, or if the priority is to focus on the ineffective coping in response to the stressors. This should, if possible, be a discussion and a decision that are made together with the patient. After all, Caroline is the one living this experience, so her focus and prioritization should help drive the nurse’s plan of care.

A thinking tool (Figure 2.5) used by our colleagues in medicine can be useful as a review prior to determining your final diagnosis(es): it uses the acronym SEA TOW (Rencic, 2011). This tool can easily be adapted for nursing diagnosis, too.

It is always a good idea to ask a colleague, or an expert, for a second opinion if you are unsure of the appropriate diagnosis. Is the diagnosis you are considering the result of a “Eureka” moment? Did you recognize a pattern in the data from your assessment and patient interview? Did you confirm this pattern by reviewing the diagnostic indicators (defining characteristics, related factors or risk factors)? Did you collect anti-evidence: data that seem to refute this diagnosis? Can you justify the diagnosis even with these data, or do the data suggest you need to look deeper? Think about your thinking: was it logical, reasoned, built on your knowledge of nursing science and the human response that you are diagnosing? Do you need additional information about the response before you are ready to confirm it? Are you overconfident? This can
happen when you are accustomed to patients presenting with particular diagnoses, and so you “jump” to a diagnosis, rather than truly applying clinical reasoning skills. Finally, what else could be missing? Are there other data you need to collect or review in order to validate, confirm, or rule out a potential nursing diagnosis? Use of the SEA TOW acronym can help you validate your clinical reasoning process and increase the likelihood of accurate diagnosis.

Making a Diagnosis/Prioritizing

The final step is to determine the diagnosis(es) that will drive nursing intervention for your patient. After reviewing everything he learned about his patient, Caroline, the nurse may have determined three key diagnoses, one of which is new:

- Imbalanced nutrition, less than body requirements (00002)
- Disturbed body image (00118)
- Readiness for enhanced coping (00158)

The imbalanced nutrition diagnosis must be addressed to prevent potential consequences of malnutrition, especially during Caroline’s phase of adolescence (puberty) in which she needs to ensure good nutrition for growth and healthy development. This may be the primary, or high priority, diagnosis. Disturbed body image continues as a diagnosis, because Caroline currently feels that she needs to be “really thin,” and despite the fact that she is underweight, she continues to express the desire to lose additional weight. Her consistent reference to her history of being overweight, her daily or twice daily monitoring of her weight, and her fear of gaining weight all indicate that this issue must be addressed together with the nutrition diagnosis in order for the intervention to be successful.

In discussion with Caroline, the stressors she is experiencing are real and probably cannot be modified; unfortunately, bullying and the cultural pressure in adolescence regarding weight are very real. For Caroline, her desire for a university education places stress on her to perform well on entrance exams and in her high school courses in order to have the possibility for financial support through an academic scholarship. Therefore, a focus on stress overload might not be effective for this patient. However, as the nurse talked with her about the concerns with how she coped with these stresses, Caroline indicated a desire to enhance her own knowledge of stress management techniques, to better manage the stressors in her life, and to learn to reach out to others to enhance her social support. This further data showed the nurse that, in regard to coping strategies, there was a health promotion
opportunity for Caroline, and so readiness for enhanced coping was a more appropriate diagnosis for Caroline than ineffective coping.

Remember that the nursing process, which includes evaluation of the diagnosis, is an ongoing process and as more data become available, or as the patient’s condition changes, the diagnosis(es) may also change – or the prioritization may change. Think back for a moment to the initial screening assessment that the nurse performed on Caroline. Do you see that, without further follow-up, he would have missed the health promotion opportunity for Caroline (readiness for enhanced coping), and he might have designed a plan to address self-esteem issues that would not have been appropriate for her?

Can you see why the idea of just “picking” a nursing diagnosis to go along with the medical diagnosis simply isn’t the way to go? The in-depth, ongoing assessment provided so much more information about Caroline, which can be used to determine not only the appropriate diagnoses, but realistic outcomes and interventions that will best meet her individual needs.

Summary

Assessment is a critical role of professional nurses, and requires an understanding of nursing concepts on which nursing diagnoses are developed. Collecting data for the sole purpose of completing some mandatory form or computer screen is a waste of time, and it certainly does not support individualized care for our patients. Collecting data with the intent of identifying critical information, considering nursing diagnoses, and then driving in-depth assessment to validate and prioritize diagnosis – this is the hallmark of professional nursing.

So, although it may seem to be a simple way to proceed, standardizing nursing diagnoses without assessment can and often does lead to inaccurate diagnoses, inappropriate outcomes, and ineffective and/or unnecessary interventions for diagnoses that are not relevant to the patient – and may lead to completely missing the most important nursing diagnosis for your patient.

References

