Foundations

American Nurses Association
Social Policy Statement

• Definition of nursing includes—the diagnosis and treatment of human responses to health, illness, or life processes (ANA, 2003)
Standards of Practice

• Standard #2: Diagnosis: The registered nurse analyzes the assessment data to determine the diagnoses or issues. (ANA, 2004)
Measurement Criteria

1. Derives the diagnoses

2. Validates the diagnoses

3. Documents diagnoses
Advanced Practice

1. Compares and contrasts findings

2. Utilizes complex data

3. Assists staff
Nursing Diagnosis

- Verb: the process
- Noun: a label
NANDA-I Definition

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

- is as correct as the data allow
- mirrors current situation
- reflects changes as they occur
- are time dependent
- may change
Culture Shift

- Unlike medical diagnoses
- Nursing diagnoses change with the patient
DIAGNOSTIC REASONING

ANALYZING THE Patient DATABASE
Step 1: Problem-Sensing

• Data are reviewed and analyzed
Step 2: Rule-Out Process

- Alternative explanations considered
Step 3: Synthesizing Data

- View of the data as a whole
Step 4: Confirming the Hypothesis

• Review the NANDA-I diagnosis

• Compare the possible etiology

• Compare the patient cues
Step 5: List Patient’s Needs

- Finalize the diagnostic statement
Patient Diagnostic Statement

• Outcome of the diagnostic process

• A three-part statement
PES Format

• Problem or need (NANDA-I label)

• Etiology (Related Factors)

• Signs/Symptoms (Defining Characteristics)
Step 6: Re-evaluate Patient Problem List

- Prioritize
- Classify
Prioritize Needs

Kalish’s Hierarchy of Needs
Survival Needs
- (air, food, drink, warmth, sleep, elimination, pain avoidance)

Stimulation Needs
- (sex, activity, exploration, manipulation, novelty)

Esteem—Self-Esteem

Love—Belonging—Closeness

Safety Needs
- (safety, security, protection)

Self-actualization
- (personal growth and fulfilment)

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Evaluation Tools

Self-Monitoring of Accuracy Using the Integrated Model
Pre-encounter Data

• Amount of data collected

• How data was interpreted

• The individual’s biases
Pre-encounter Data-2

- Clustering of cues
- Hypotheses named
- Data connected with hypotheses
**Shaping Data Gathering**

- Effect of seeing the patient
- Interpretation of data
- Effect of student’s behavior
Data Gathering-2

- Arranging clusters
- Data collected for hypotheses
Clustering the Cues

• Need for further data collection

• Validity and reliability assigned to the data
Clustering the Cues-2

- Validating clusters
- Agreement of peers
Activating Possible Diagnostic Explanations

• Supporting the hypotheses

• Judgment of relevance

• Consistency of judgment
Activating Possible Diagnostic Explanations-2

- Diagnostic hypotheses supported by the clusters

- Considering important hypotheses
Hypothesis-directed Searching

- Identifying high-priority diagnoses
- Considering conflicting hypotheses
Hypothesis-directed Searching-2

- Use of clusters
- Diagnostic concepts considered relevant for testing
Testing Goodness of Fit

- Cues used to test the goodness of fit
- Interpretations derived from legitimate sources
Goodness of Fit - 2

- Sufficient development of clusters
- Appropriateness of diagnostic label
Evaluation Tools-2

Lunney's Ordinal Scale for Degrees of Accuracy of a Nursing Diagnosis
Criteria /Value +5

- Diagnosis is consistent with all of the cues, supported by highly relevant cues, and precise.
Criteria / Value +4

• Diagnosis is consistent with most or all of the cues and supported by relevant cues but fails to reflect one or a few highly relevant cues.
Criteria / Value +3

- Diagnosis is consistent with many of the cues but fails to reflect the specificity of available cues.
Criteria / Value +2

- Diagnosis is indicated by some of the cues but there are insufficient cues relevant to the diagnosis, and/or the diagnosis is lower priority than other diagnoses.
Criteria/Value +1

- Diagnosis is suggested by only one or a few cues.
Criteria /Value 0

- Diagnosis is not indicated by any of the cues.
- No diagnosis is stated when there are sufficient cues to state a diagnosis.
- The diagnosis cannot be rated.
Criteria /Value -1

• Diagnosis is indicated by more than one cue but should be rejected based on the presence of at least two disconfirming cues.
Planning Care

- Creating outcomes
- Choosing interventions
Final Product

Patient Plan of Care
References


References


References
