Chapter 4

NANDA-I Nursing Diagnosis with Current Updates

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Abstract

Today, nursing classification systems have a key role in creating a common language among nurses all over the world. Nursing diagnosis, which is one of the classification systems and the first step of the nursing process, provides a basis for the selection of nursing interventions necessary to achieve results that are within the authority and competence of the nurse. Successful resolution of the individual's problem depends on the correct determination of the nursing diagnosis. Successful resolution of the individual's problem depends on the correct determination of the nursing diagnosis. The North American Nursing Diagnosis Association, now NANDA International (NANDA-I), began a formal effort to classify nursing diagnoses in 1973. NANDA-I continues to meet biennially to review proposed new nursing diagnoses and to examine the use of nursing diagnoses in research, education, and clinical practice. NANDA-I has also published Nursing Diagnoses: Definitions and Classification 2021-2023, the complete list of nursing diagnoses, definitions, and defining characteristics. Today, NANDA-I members continue to work to make regular updates on the ANA and International Council of Nursing classification systems. Creating a care plan based on carefully selected nursing diagnoses and their use in conjunction with the critical pathway will enable us to provide our patients with collaborative, high-quality care that includes a strong nursing component. In this context, it is very important to follow the updates in NANDA-I nursing diagnoses.

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1. Introduction

The use of a common language in nursing care based on a model with an individualized and holistic approach is extremely important in managing care, determining and documenting the quality of care. The most effective method in the use of middle language in nursing is classification systems. With classification systems, it can be easier to classify and name patient problems, appropriate nursing interventions for these problems, and the contributions of interventions to patient outcomes.

1.1. Nursing Process

The nursing process provides the framework for providing the best care and providing the best care, a critical thought process in professional nursing practice. The nursing process is parallel to scientific problem-solving steps. The components of the nursing process consist of identification-situation evaluation, making a nursing diagnosis, planning, implementation and evaluation where the goal and expected outcome criteria (patient results) are determined (Ackley et al., 2017; Hardiker et al., 2019; Makic et al., 2022).

1.2. Nursing Diagnosis

It is the second stage of the nursing process and in this stage, the nurse brings together the information in the patient's history and makes an assessment of the patient's health status. An appropriate nursing diagnosis can only be made after thoroughly analyzing information by combining clues, scanning, organizing and clustering information. This process called clinical reasoning; It is a cognitive process in which formal or informal thought strategies are used to collect and analyze patient data, evaluate the importance of these data, and identify alternative practices.

Nursing diagnosis provides a basis for the selection of nursing interventions necessary to achieve results that are within the nurse's authority and competence. Successful resolution of the individual's problem depends on the correct determination of the nursing diagnosis. For example, does the nurse have the authority to intervene in a diagnosis of "pneumonia" or "hypertension"? The nursing officer is not responsible for both the diagnosis and treatment of pneumonia. However, nurses are responsible for describing the individual's physiological, social, psychological and spiritual reactions to pneumonia and how they are affected by the situation; It is responsible for facilitating the individual's adaptation to the situation (Ellis et al., 2000; Maas & Delaney, 2004).

Nursing diagnosis and medical diagnoses can often be confused. However, medical diagnoses diagnose trauma or disease. A medical pathology (hypertension…), diagnostic studies (e.g. bronchoscopy), equipment e.g. Medical diagnoses can be used in cases such as NG tube, urinary catheter), signs and symptoms, treatments (e.g. cortisone treatment, decubitus care), surgical procedures (e.g. tracheostomy). However, nursing diagnosis appears as a stimulus that activates nursing action. For example; "Deterioration in skin integrity due to tissue irritation secondary to nasogastric tube insertion is an example of a nursing diagnosis.

Nursing diagnosis is created in various ways based on data collected about the patient. For example; Let's assume that a patient whose diet and metabolic status are being evaluated cannot eat due to nausea due to medication. In such a patient, it would be appropriate to make a nursing diagnosis of "change in nutrition: malnutrition" in the field of nutrition and metabolic status. Nursing diagnoses are formulated by analyzing and interpreting data (Maas & Delaney, 2004; Muller-Staub et al., 2006).

1.2.1. History of Nursing Process and Nursing Diagnoses

Classification in nursing started with Florence Nightingale in 1857. During her services during the Crimean War, Nightingale identified nursing-related problems such as nutritional deficiencies, risk of infection, and delayed recovery. And he gave great importance to observation, which is one of the diagnostic methods. The nursing process which was developed by Ida Jean Orlando in 1958. Virgina Fry, an important nurse leader, talked about the concept of nursing diagnosis as a first step of the nursing process in the 1950s (Di Giulio, 1992; Rabelo-Silva et al., 2021; Somantri et al., 2021).

When the nursing process was first defined, it only included the steps of data collection, planning, implementation and evaluation. In addition, in the last 30 years, some important developments have contributed to the addition of the "diagnosis" step, which is a different part of the nursing process. In the Nursing Practice Standards of the American Nurses Association (ANA) (1973), nursing diagnosis is defined as; "A separate and identifiable action performed by a licensed practical nurse. A group of nurse educators, theorists, and clinicians initially identified 37 nursing diagnoses. In 1991, the ANA published revised clinical practice standards that listed nursing diagnoses as a distinct step of the nursing process. Each state has approved in its nursing practice act the diagnoses listed as part of the nurse's legal responsibility.

The North American Nursing Diagnosis Association, now NANDA International (NANDA-I), began a formal effort to classify nursing diagnoses in 1973. NANDA-I continues to meet biennially to review proposed new nursing diagnoses and to examine the use of nursing diagnoses in research, education, and clinical practice. NANDA-I has also published Nursing Diagnoses: Definitions and Classification 2021-2023, the complete list of nursing diagnoses, definitions, and defining characteristics. Today, NANDA-I members continue their work to make periodic updates on the ANA and International Council of Nursing classification systems (Paans et al., 2010; Ackley, 2019; De Groot et al., 2019).

1.2.2. Types of Nursing Diagnoses

Holistic evaluation of the patient is the most fundamental element in making the appropriate nursing diagnosis. For example; If during the evaluation of the patient, imbalance and balance disorder are encountered in the patient's gait and the patient verbally expresses such as "I am afraid of falling while going down the stairs", but there is no history of falling before, we can diagnose such a patient as falling risk (Tastan et al., 2014; Harrington, 2019; Rabelo-Silva et al. 2021).

1.2.2.1. Actual Diagnosis

This diagnosis, also called problem-focused nursing diagnosis, is a clinical judgment about an undesirable human response to a health condition or health process that occurs in the individual, family, or society. Associated factors are an integral part of all problem-focused diagnoses. These are etiologies, conditions, factors, or influences that are associated with nursing diagnoses. For example, excessive weight; Excessive food intake in connection with metabolic requirements, food intake being concentrated at the end of the day, and weight being 20% more than the skeleton and height. An actual nursing diagnosis describes a clinical decision that the nurse validates due to the presence of major defining features. These are the problems encountered in the patient during the nurse's assessment of the situation. Pain, distortion of body image, excessive nutrition, and hyperthermia are other examples of existing nursing diagnoses (Muller-Staub et al., 2006; Ackley, et al., 2019).

1.2.2.2. Risk Diagnosis

A risk nursing diagnosis is a clinical judgment regarding the vulnerability of an individual, family, or community to develop undesirable reactions to life processes or health conditions. Risk diagnosis is supported by the presence of risk factors that increase the individual, family, or community's vulnerability

to an unhealthy condition. In other words, risk nursing diagnoses are a clinical decision about whether an individual, family, or community is more likely to develop problems than others in the same or similar situation. Risk nursing diagnoses are used to express problems that may arise if precautions are not taken. In summary, the problem in risk nursing diagnoses has not yet emerged. It is supported by the presence of risk factors that increase the vulnerability of the individual, family or community to an unhealthy situation. Risk of obesity, risk of deterioration in skin integrity due to immobility due to hip fracture, risk of trauma, risk of deterioration in skin integrity, etc. (Bahrudin et al., 2019; Doenges et al., 2022).

1.2.2.3. Well-Being Diagnosis

It defines the reaction of the individual/family/society who is in a good state and ready to strengthen this state of well-being, increasing their willingness to reach the level of well-being. In other words; It is a clinical judgment regarding motivation and desire to increase well-being and activate human health potential. It can also be expressed as readiness to improve a specific health behavior or health condition. The health promotion response can occur in the individual, family, group or community. Promoting health is different from preventing problems. Health promotion focuses on being as healthy as possible, as opposed to preventing a disease or problem. The difference between promoting health and preventing disease is that health behavior must always be positive. With a health promotion diagnosis, outcomes and interventions should focus on further improving health. Readiness to become stronger in nutrition and readiness to become stronger in parenting are examples of well-being diagnoses (Ackley, et al., 2019; Doenges et al., 2022).

1.2.2.4. Syndrome Diagnosis

Syndrome diagnoses occur by clustering and combining other diagnoses. A syndrome diagnosis includes a group of current or at-risk nursing diagnoses that are predicted to occur due to a specific situation or event. When you look at the literature, it can be seen that this type of diagnosis is not used much in the educational or clinical field. It is thought that this situation is due to the lack of knowledge about nursing diagnoses and syndrome diagnosis type in this field. Rape trauma syndrome is an example of one of the syndrome diagnoses (Muller-Staub et al., 2006; Ackley, et al., 2019; Herdman et al., 2021).

1.2.3. Nursing Diagnosis - Medical Diagnosis

1.2.3.1. Collaborative Diagnosis

Collaborative diagnoses are problems that the nurse cannot solve alone. It requires collaboration with other members of the team to solve the problem. Change in urinary excretion, functional incontinence, and decicus ulcers are examples of this type of diagnosis.

Nursing diagnoses require an independent nursing approach. Collaborative diagnoses, on the other hand, require a semi-dependent nursing approach because they require other members of the team. Multidisciplinary approach is the most fundamental element for common diagnoses (Ackley, et al., 2019; Herdman et al., 2021).

1.2.4. Formulating Nursing Diagnostic Statements

After collecting patient data, symptoms of reaction to existing or potential health problems should be identified from the data obtained and the appropriate nursing diagnosis should be selected in line with clinical interpretation skills. In this context; relevant symptoms are highlighted or underlined (descriptive features). Is this normal when reviewing cookies? Is this a desired situation? Is this a problem for the patient? The questions are verified with the patient. Symptoms are listed, similar symptoms are classified, symptoms are analyzed (what do these symptoms mean?, do the symptoms make sense when put together?). In the analysis of symptoms, subjective and objective symptoms need to be interpreted. In the final stage of the formulation, the nursing diagnosis in the appropriate NANDA-I taxonomy II field is selected from the list (Doenges et al., 2022; Ardila Suárez et al., 2023).

1.2.4.1. Related Factors

They are relevant factors that show some stereotypical associations with nursing diagnosis. These; These are the elements that relate to, contribute to, or direct the situation before the situation. There may be causal or contributing factors such as pathophysiological and psychological changes, developmental period, and cultural or environmental conditions. Etiology is another expression used for related conditions. Although it is not a medical diagnosis, it is not a problem that a nurse can treat independently without a physician's request.To give an example of related situations; The etiology for decreased activity tolerance may be the imbalance between oxygen requirement and supply (Moser et al., 2018; Bağrıaçık & Bostanoğlu, 2022).

1.2.4.2. Defining Characteristics

Symptoms, signs and findings of individuals constitute defining characteristics. Descriptive features are, in a sense, evidence that leads the nurse to a nursing diagnosis. Therefore, collecting data in a systematic, holistic and comprehensive manner ensures both accurate identification of descriptive features and accurate and complete nursing diagnoses. Findings such as bad taste in the mouth, bleeding, rusty tongue, faded gums, and oral lesions are defining features for the nursing diagnosis of change in the oral mucous membrane (Ackley, et al., 2019; Herdman et al., 2021).

1.2.5 PES Format in the Formulation of Nursing Diagnose

Problem-Etiology-Symptom (PES) format is a way used in existing nursing diagnoses, one of the types of nursing diagnoses.

(P) Problem Name of nursing diagnosis

(E) Etiology Associated factor (contributing factors)

(S) Signs and symptoms Defining characteristics

According to the PES format, the nursing diagnosis of "Dysfunction in Ventilator Weaning Response: Adult" indicates the problem; Abnormal breathing sounds, audible airway secretions, decreased oxygen saturation, low pH, and sweating are examples of defining characteristics, while abnormal breathing sounds, audible airway secretions, decreased oxygen saturation, low pH, sweating, and cyanosis are examples of etiology (Ackley, 2019; Bağrıaçık & Bostanoğlu, 2022; Ardila Suárez & Escalada-Hernández, 2023).

1.3. The Importance of Nursing Diagnoses

Critical paths are being used in an increasing number of healthcare settings to guide a patient's care process. It can be especially helpful for nursing students and new graduates to use a critical path. Responsibility for caregiving may be assigned for only a day or two for a particular patient. Seeing the entire pathway and examining the outcomes the patient is expected to achieve will help us gain a broader clinical perspective on care. Using the critical path as a guide to providing care does not eliminate the need to formulate and use nursing diagnoses. Nursing diagnoses continue to define nursing's primary responsibility to diagnose and treat an individual's response to actual or potential health problems. It is not possible to document/record all care needs of any patient in a critical way. When using a road; We should always keep in mind that the patient may need nursing intervention beyond what is stated on the critical path. Creating a care plan

based on carefully selected nursing diagnoses and using it together with the critical path will enable us to provide our patients with collaborative and high-quality care that includes a strong nursing component (Erdemir et al., 2017; Herdman et al., 2021; Miguel et al., 2022).

1.4. New 2021-2023 NANDA-I Taxonomy II Nursing Diagnoses

NANDA-I updates nursing diagnoses every four years. The most current list of nursing diagnoses by field is as follows (Herdman et al., 2021).

1.4.1. Health Promotion

- Risk for elopement attempt (00290)
- Readiness for enhanced exercise engagement (00307)
- Ineffective health maintenance behaviors (00292)*
- Ineffective health self-management (00276)*
- Readiness for enhanced health self-management (00293)*
- Ineffective family health self-management (00294)*
- Ineffective home maintenance behaviors (00300)*
- Risk for ineffective home maintenance behaviors (00308)
- Readiness for enhanced home maintenance behaviors (00309)

1.4.2. Nutrition

- Ineffective infant suck-swallow response (00295)*
- Risk for metabolic syndrome (00296)*

1.4.3. Elimination and Exchange

- Disability-associated urinary incontinence (00297)*
- Mixed urinary incontinence (00310)
- Risk for urinary retention (00322)
- Impaired bowel continence (00319)*

1.4.4. Activity/ Rest

- Decreased activity tolerance (00298)*
- Risk for decreased activity tolerance (00299)*
- Risk for impaired cardiovascular function (00311)

- Ineffective lymphedema self-management (00278)
- Risk for ineffective lymphedema self-management (00281)
- Risk for thrombosis (00291)
- Dysfunctional adult ventilatory weaning response (00318)

1.4.5. Perception / Cognition

- Disturbed thought process (00279)

1.4.6. Role -Relationship

- Disturbed family identity syndrome (00283)
- Risk for disturbed family identity syndrome (00284)

1.4.7. Coping/ Stress Tolerance

- Maladaptive grieving (00301)*
- Risk for maladaptive grieving (00302)*
- Readiness for enhanced grieving (00285)

1.4.8. Safety / Protection

- Ineffective dry eye self-management (00277)
- Risk for adult falls (00303)*
- Risk for child falls (00306)
- Nipple-areolar complex injury (00320)
- Risk for nipple-areolar complex injury (00321)
- Adult pressure injury (00312)
- Risk for adult pressure injury (00304)*
- Child pressure injury (00313)
- Risk for child pressure injury (00286)
- Neonatal pressure injury (00287)
- Risk for neonatal pressure injury (00288)
- Risk for suicidal behavior (00289)*
- Neonatal hypothermia (00280)
- Risk for neonatal hypothermia (00282)

1.4.9. Growth / Development

- Delayed child development (00314)
- Risk for delayed child development (00305)*
- Delayed infant motor development (00315)
- Risk for delayed infant motor development (00316)

1.5. Diagnoses removed from NANDA-I nursing diagnoses, 2021–2023

Twenty-three of the 52 diagnoses were revised and deleted from the NANDA-I nursing diagnosis list 2021-2023. The diagnoses that have been removed from the classification are listed in Table 1.

Table 1. Removed NANDA-I Nursing Diagnoses in 2021-2023 Version

Domain	Class	Diagnosis label	Code
1	2	Ineffective health maintenance	00099
	2	Ineffective health management	00078
	2	Readiness for enhanced health management	00162
	2	Ineffective family health management	00080
2	1	Ineffective infant feeding pattern	00107
	4	Risk for metabolic imbalance syndrome	00263
3	1	Functional urinary incontinence	00020
	1	Overflow urinary incontinence	00176
	1	Reflex urinary incontinence	00018
	2	Bowel incontinence	00014
4	4	Activity intolerance	00092
	4	Risk for activity intolerance	00094
	5	Impaired home maintenance	00098
9	2	Grieving	00136
	2	Complicated grieving	00135
	2	Risk for complicated grieving	00172
	3	Decreased intracranial adaptive capacity	00049
11	2	Risk for falls	00155
	2	Risk for pressure ulcer	00249
	2	Risk for venous thromboembolism	00268
	3	Risk for suicide	00150
	5	Latex allergy reaction	00041
13	2	Risk for delayed development	00112

Herdman, T., Kamitsuru, S., Lopes, C.T. (2021). Nursing diagnoses - Definitions and classification 2021-2023. New York: Thieme.

1.6. Nursing Diagnoses with Changed Diagnosis Label

Seventeen nursing diagnoses' labels were revised to confirm whether the diagnostic label was consistent with current literature or not. The changes are demonstrated in Table 2.

Table 2. Revisions in Nursing Diagnosis Labels in 2021-2023 Version (Herdman et al., 2021)

Domain	Previous diagnosis label	New diagnosis label
1. Health promotion	Ineffective health maintenance (00099)	Ineffective health maintenance behaviors (00292)
	Ineffective health management (00078)	Ineffective health self-management (00276)
	Readiness for enhanced health management (00162)	Readiness for enhanced health self-management (00293)
	Ineffective family health management (00080)	Ineffective family health self-management (00294)
	Impaired home maintenance (00098)*	Ineffective home maintenance behaviors (00300)
2. Nutrition	Ineffective infant feeding pattern (00107)	Ineffective infant suck-swallow response (00295)
	Risk for metabolic imbalance syndrome (00263)	Risk for metabolic syndrome (00296)
3. Elimination and exchange	Functional urinary incontinence (00020)	Disability-associated urinary incontinence (00297)
	Bowel incontinence (00014)	Impaired bowel continence (00319)
4. Activity/rest	Activity intolerance (00092)	Decreased activity tolerance (00298)
	Risk for activity intolerance (00094)	Risk for decreased activity tolerance (00299)
9. Coping/stress tolerance	Complicated grieving (00135)	Maladaptive grieving (00301)
	Risk for complicated grieving (00172)	Risk for maladaptive grieving (00302)
11. Safety/ protection	Risk for falls (00155)	Risk for adult falls (00303)
	Risk for pressure ulcer (00249)	Risk for adult pressure injury (00304)
	Risk for suicide (00150)	Risk for suicidal behavior (00289)
13. Growth/ development	Risk for delayed development (00112)	Risk for delayed child development (00305)

Herdman, T., Kamitsuru, S., Lopes, C.T. (2021). Nursing diagnoses - Definitions and classification 2021-2023. New York: Thieme.

1.7. Conclusion

Creating a care plan based on carefully selected nursing diagnoses and their use in conjunction with the critical pathway will enable us to provide our patients with collaborative, high-quality care that includes a strong nursing component. In this context, it is very important to follow the updates in NANDA-I nursing diagnoses.

1.8. References

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