

Understanding the NANDA Nursing Diagnosis List with Examples

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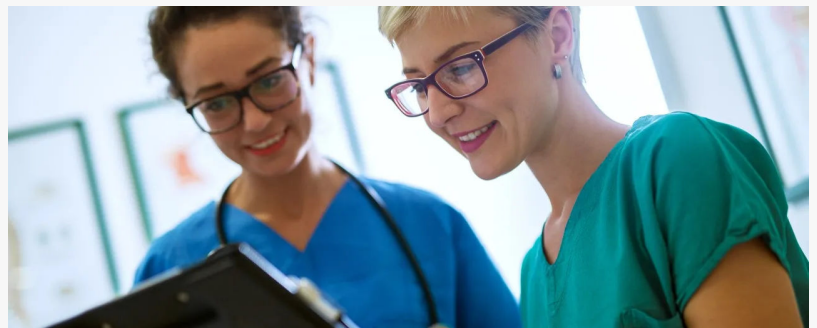
BOUNTIFUL, UTAH, UNITED STATES, May 20, 2024 /EINPresswire.com/ -- □The information for this article was primarily sourced from [NANDA International, Inc.](#), an authority on standardized nursing diagnostic terminology, and the American Nurses Association, an organization whose mission is shaping the future of nursing and healthcare.

What Is a Nursing Diagnosis?

A nursing diagnosis is an essential step of the nursing process and is crucial to ensure quality of care. Nurses initiate the nursing diagnosis, which describes a response to the medical diagnosis.

According to the North American Nursing Diagnosis Association (NANDA), a nursing diagnosis is:

“a clinical judgment concerning a human response to health conditions/life processes, or a vulnerability for that response, by an individual, family, group or community. A nursing diagnosis provides the basis for selecting nursing interventions to achieve outcomes for which the nurse



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has accountability.”

What Are Some of the Most Common Nursing Diagnoses?

One of the most common nursing diagnoses is chronic pain.

A few of the more common nursing diagnoses include the following:

Impaired gas exchange

Acute pain

Risk for infection

Ineffective airway clearance

Activity intolerance

Acute confusion

Anxiety

Chronic pain

Impaired skin integrity

Decreased cardiac output

Diarrhea

Ineffective breathing pattern

What Is a Medical Diagnosis?

A healthcare provider creates a medical diagnosis after assessing the signs and symptoms present and then identifies a condition, injury, or disease.

To create a nursing diagnosis, a medical diagnosis must first be present. Keep reading to learn more about nursing practice, a nursing diagnosis, and how to write or create one.

What Is the Nursing Process?

Regardless of a nurse’s work setting, their role revolves around implementing the five steps of the nursing process:

Assessment: The first step of the nursing process is collecting and analyzing patient data, including physiological, psychological, sociocultural, lifestyle, economic, and spiritual information. Read more about the [complete head-to-toe nursing assessment](#).

Diagnosis: The next step of the process is making a diagnosis based on a clinical judgment of the patient’s medical condition. This diagnosis becomes the basis of the nursing care plan.

Outcomes/Planning: Based on the previous steps, nurses set goals for the patient and include them in the treatment plan in order to achieve the desired outcome.

Implementation: In this step, nurses implement and document nursing interventions according to the care plan. This may include administering medications, educating the patient, monitoring vital signs, etc.

Evaluation: Throughout the nursing process, nurses evaluate the patient’s status and the impact of the care they provide, which can lead to modifications in the care plan.

Nursing vs. Medical Diagnoses: What’s the Difference?

The most evident difference between a medical and a nursing diagnosis is the healthcare professional who makes the diagnosis. Whereas physicians, physician's assistants (PAs), and advanced nurse practitioners (ANPs) make medical diagnoses—registered nurses (RNs) are responsible for nursing diagnoses. They also educate patients on these diagnoses.

However, the healthcare provider's credentials are not the only distinction. Medical diagnoses focus on diseases or other medical problems; nursing diagnoses deal with the human response to health conditions and life processes.

The nursing diagnosis contemplates the level of pain a patient reports, whether they are experiencing mental health conditions as a result of their physical illness, their attitudes, challenges, resources, etc. Therefore, two patients with the same medical diagnosis, such as pneumonia, diabetes, or hypertension, can have different nursing diagnoses.

For example, the nursing diagnosis of a patient with chronic obstructive pulmonary disease (COPD) may address the patient's feelings of depression, hopelessness, and pessimism, commonly observed behaviors among patients with this disease.

Original Article contains [The 7 Diagnostic Axes](#)

How to Write a Nursing Diagnosis

According to NANDA recommendations, a nursing diagnosis is a statement that includes both the diagnosis itself and related factors seen through defining characteristics. Nurses should also try to link the defining characteristics, associated factors, and risk factors discovered during the patient's assessment.

A nursing diagnosis should include the following components:

Diagnosis label: This is the name for a diagnosis and reflects the diagnostic focus and the nursing judgment. It is a term or phrase representing a pattern of related signs and symptoms.

Definition: This clear description helps set the diagnosis apart from other diagnoses.

Defining characteristics: These are all the observable signs and symptoms that cluster to indicate a problem-focused or health-promotion nursing diagnosis or a syndrome. These signs and symptoms may be perceived through any of the senses (sight, touch, smell, etc.) or communicated by the patient or family members.

Risk factors: These are only part of risk diagnoses; they increase an individual's, family's, group's, or community's vulnerability to experiencing an unhealthy event. They may be environmental, physiological, psychological, genetic, or chemical.

Related factors: These factors appear to be related to the nursing diagnosis. Nurses may describe these factors as being antecedent to, associated with, related to, contributing to, or abetting. Problem-focused nursing diagnoses and syndromes must have related factors, whereas health-promotion diagnoses only include related factors if they help to clarify the diagnosis.

Nurse writing notes from her tablet

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Aren't sure where to start? First, registered nurses must analyze patients' subjective and objective data and identify patterns.

Then, nurses develop hypotheses based on how these patterns correlate with defining characteristics of a nursing diagnosis.

Nurses must also include the cause—or related factors—of a patient's problem. If possible, nursing care plans created based on these diagnoses should modify or remove the associated factors that cause the problem identified in the nursing diagnosis.

As with any part of the nursing process, if a nursing diagnosis was not documented, it didn't happen. Thankfully with modern charting technology, most of the nursing diagnoses are now digitally created after one documents their assessments, and they are automatically added to the plan of care.

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