FACULTY TEXTBOOK TOOL: SHIFTING FROM NURSING DIAGNOSES

FACULTY NOTE: This tool was created in response to requests for strategies to move away from nursing diagnoses. Some illustrations are inserted <u>within this document</u> from Alfaro-LeFevre (2020). *Critical Thinking, Clinical Reasoning, and Clinical Judgment: A Practical Approach.* Additional content is suggested the form of <u>page references from the text.</u> For information on how to request faculty review copies, click here: http://alfaroteachsmart.com/books.html

Permission to make copies for nonprofit faculty use is granted (for other use — or for questions and comments — email TeachSmartAlfaro@aol.com). Additional tools are being developed and can be found at http://alfaroteachsmart.com/textbooktools.html

PURPOSE: This tool summarizes why nursing diagnosis and North American Nursing Diagnoses International (NANDA-I) terms are no longer used and gives strategies for moving ahead.

BACKGROUND: While efforts to focus on nursing diagnosis were worthwhile and embraced by many — including myself — the language, rules, lack of evidence, advent of electronic health records, and exorbitant NANDA fees has caused their demise. The below bullets summarize some of the issues:

❑   NANDA used volunteers to develop the work. The terms evolved with little evidence to support their *clinical* use. Conference participants repeatedly stated their concern about clinical relevance, but we saw little, if any, change. When I reviewed the NANDA taxonomy book in 2010, there were very few references for each diagnosis (the ones that *were* there were old and esoteric). The current NANDA taxonomy book is published with NO references. Yet, because the terms appeared in many textbooks, many believed they were evidence-based. Seizing opportunity, Wiley (NANDA publisher) began to charge large permission fees for use of their terms.

❑   While the goal was to have consistent language, many of the terms were "morphed" by schools and clinical organizations to fit their particular needs (consistency was not achieved). Many of the diagnoses were not understood. Many clinicians resisted the nursing diagnosis language and concept. Many never learned. There was little consensus and a lot of "renaming" of medical diagnoses to make them nursing diagnoses (e.g. *dehydration* became *fluid volume deficit*).

❑   Rules of nursing diagnosis statements (e.g., "two or three part statements") were problematic. Problems rarely fall neatly into two or three part statements. Many believe that these rules actually impede reasoning (too much thinking about the rules).

❑   NCLEX never adopted nursing diagnoses. Approximately 80% current NCLEX items focus on nursing management of <u>medical problems</u>.

❑   Many nurses tried to make every problem a nurse manages "fit" into nursing diagnosis terms (they don't).

❑   Today's interprofessional clinical practice, focus on *priority problems* (rather than all possible), and electronic health records (EHR), increase the need to use terms that are *understood by all professions*. As EHR have evolved, only *priority nursing diagnoses* have been retained; these are usually labeled *priority problems* or *priority nursing problems.*

❑   Many textbooks have already removed nursing diagnoses. They now use the terms *problems* and *potential complications*, just as clinical organizations do. Nursing diagnoses have not been addressed in journal articles for over a decade (except in the NANDA journal).

❑   Nursing roles and accountability for managing priority problems is becoming clearer through analytics gleaned from EHR. EHR guide what MUST be documented — therefore they guide what MUST be done (the opposite of what many of us have taught for a long time).

FACULTY TEXTBOOK TOOL: SHIFTING FROM NURSING DIAGNOSES

STRATEGIES

❑ Recognize that it takes an initial shift in thinking from old nursing diagnosis habits, but once you do it, it totally makes sense.

❑ Replace the term *nursing diagnosis* with *priority nursing and medical problems that the nurse must manage (*see pages 3-5 of this document). Use the terms used on NCLEX and in local EHR and decision support tools. If the problems are not clearly defined, use the term *issue*. Here's an example of 4 priority problems a patient may have that require nursing management, in addition to the standard priorities (e.g., safety, infection control, medication management, patient participation, communication, immobility, and monitoring for and signs and symptoms of potential complications):

> ➢ pneumonia, dehydration risk, fatigue, pain.

Note that reason for admission is always a priority, while others may change daily, based on individual patient needs. Interventions aimed at treating pneumonia include treating many of the old nursing diagnoses, such as *Ineffective Airway Clearance.*

❑ Make safety, infection control, and medication reconciliation first priority in every patient situation (teach these on day ONE). Note that medication reconciliation is a priority issue, but not a nursing diagnosis. See Quick Priority Assessment, textbook pages 106 - 107.

❑ Be sure learners know how to determine their own scope of practice (page 6 of this document), as well as their roles and responsibilities in relation to specific problems (see *Nursing Accountability — What Do Nurses Do*, textbook pages 84-89). NCSBN stresses that not knowing scope of practice is no excuse for errors. It doesn't matter whether the problem is a nursing or medical diagnosis; what matters is nursing accountability for each patient problem.

❑ Make identification of potential complications a requirement (pages 3-5 of this document).

❑ Focus on prevention and health promotion (see *Predict, Prevent, Manage, Promote* Model, textbook pages 105-107)

❑ Ensure that learners identify all the factors contributing to the priority problems, both medical and nursing. (see "Systematic Problem Analysis Worksheet" on textbook page 162)

❑ Focus on QSEN and JCAHO standards and priorities. For example, patient communication, education, and satisfaction; error prevention and teamwork.

❑ Stress assessment and monitoring role. A major priority must be to identify *signs and symptoms (cues*) that indicate need for more expert evaluation.

❑ Teach problem-focused assessment and intervention: What is the nursing management of the problems listed on pages 3-5 of this document? Giving them the big picture, as on pages 3-5 is similar to giving them the NANDA list of diagnoses.

❑ If you use concept-based curriculum, consider whether your concepts may replace some of the nursing diagnoses (e.g., "The priority patient issues were oxygenation and mobility").

❑ Teach *principles* of clinical reasoning (textbook pages 80-83)

❑ Pay attention to how technology influences clinical judgment (see free 30 minute webinar http://alfaroteachsmart.com/textbooktools.html)

❑ Use a *map* to ensure holistic assessment (see textbook page 91; also at http://alfaroteachsmart.com/textbooktools.html)

❑ *Keep* what you know is working. For example, *Gordon's Functional Health Patterns* remain useful for holistic nursing assessment. Maslow is helpful for setting priorities. Remember that if you're using only *one* approach, you are probably not thinking critically. It takes several approaches. Telling students something like, "here's another way of looking at this" is good.

❑ Finally: Help your students become critical thinkers (it's the foundation for building reasoning skills and helps them deal with the constant change they will experience in school and the clinical setting. Chapter 2, *Becoming a Critical Thinker*, is devoted to this.

FACULTY TEXTBOOK TOOL: SHIFTING FROM NURSING DIAGNOSES

Textbook page 87 (inserting textbook image was problematic; this is my handout).

Common Priority Nursing Problems (Alphabetical List)

NOTE: Depending on problem complexity and nurse qualifications, nurses are accountable for consulting with primary care providers before determining a plan of care. This is a partial list; adapt as needed.

- Activity Intolerance / Mobility problems
- Airway and breathing problems
- Behavioral problems management
- Comfort / pain management
- Constipation, diarrhea, and other bowel elimination problems
- Dehydration risks
- Health promotion
- Infection / safety / fall risk management
- Medication and other treatment management
- Nutrition problems
- Oral hygiene †

- Urinary elimination problems
- Patient education
- Pressure ulcer/impaired skin integrity risk management
- Self-care problems (feeding, bathing, dressing, toileting, other ADLs)
- Sleep problems
- Smoking cessation,
- Spiritual Concerns
- Surveillance (monitoring to detect reportable signs and symptoms)
- Violence or self-harm risks
- Weight management

† Linked with pneumonia incidence

FACULTY TEXTBOOK TOOL: SHIFTING FROM NURSING DIAGNOSES

Textbook page 88 (inserting textbook image was problematic; this is my handout).

COMMON MEDICAL PROBLEMS AND THEIR POTENTIAL COMPLICATIONS*

ANGINA / MYOCARDIAL INFARCTION

Dysrhythmias
Congestive Heart Failure / Pulmonary Edema
Shock (cardiogenic, hypovolemic)
Infarction, infarction extension
Thrombi / emboli formation (pulmonary emboli, stroke)
Hypoxemia
Electrolyte imbalance
Acid-base imbalance
Pericarditis
Cardiac tamponade
Cardiac arrest
   See also Kidney Disease

LUNG DISEASES (ASTHMA, COPD, ETC.)

Hypoxemia
Acid-base and electrolyte imbalance
Respiratory Failure
Infection
   See also Pneumonia and Angina / Myocardial Infarction

PNEUMONIA

Respiratory Failure
Dehydration
Sepsis / septic shock
Pulmonary embolus
Pulmonary hypertension
   See also Angina / Myocardial Infarction

DIABETES

Hypoglycemia (Diabetic Shock)
Hyperglycemia (Diabetic Coma)
Compromised Circulation – Pressure and leg ulcers
Delayed wound healing
Hypertension
Eye problems (retinal hemorrhage)
Infection
Dehydration
   See also Angina / Myocardial Infarction and Kidney Failure

HYPERTENSION

Stroke (Cerebrovascular accident-CVA)
Transient ischemic attacks (TIAs)
Hypertensive crisis
   See also Angina / Myocardial infarction and Kidney Failure

KIDNEY DISEASE

Congestive Heart Failure
Kidney Failure
Edema
Hyperkalemia
Electrolyte / acid-base imbalance
Anemia
   See also Hypertension and Urinary Tract Infection

URINARY TRACT INFECTION (UTI)

Septic shock
Kidney Failure

HIV AND IMMUNOSUPRESSION

Opportunistic infections (TB, herpes,
   intestinal organisms, etc)
Severe diarrhea
   See also lung diseases and pneumonia

FRACTURES

Bleeding (internal or external)
Bone fragment displacement
Edema / pressure points
Compromised circulation
Nerve compression
Compartment syndrome
Thrombus / embolus formation
Infection

HEAD TRAUMA

Respiratory depression
Airway occlusion
Aspiration
Bleeding (internal or external)
Shock
Brain swelling
Increased intracranial pressure
Seizures-Coma
Hyper / hypothermia
Infection

OTHER TRAUMA

See Anesthesia / Surgical invasive procedures, next box.

DEPRESSION / PSYCHIATRIC DISORDERS

Reality distortion
Dehydration - Malnutrition
Suicide
Violence (against self or others)
Self-protection problems
Trauma-death
Medication side effects

FACULTY TEXTBOOK TOOL: SHIFTING FROM NURSING DIAGNOSES

Textbook page 89 (inserting textbook image was problematic; this is my handout)

COMMON COMPLICATIONS RELATED TO TREATMENTS AND INVASIVE PROCEDURES

ANESTHESIA – SURGICAL PROCEDURES

Respiratory depression
Airway management problems
Aspiration
Atelectasis-pneumonia
Bleeding (internal or external)
Hypovolemia / shock
Infection / septic shock
Fluid/electrolyte imbalance
Thrombus / embolus
Paralytic ileus
Urinary retention
Incision complications (infection, poor healing, dehiscence/evisceration)
   See also Angina / Myocardial Infarction, previous box.

CARDIAC CATHETERIZATION-INVASIVE MONITORING:

Bleeding (internal or at insertion site)
Hemo-pneumothorax
Thrombus / embolus formation
Stroke
Infection / sepsis

See also Angina/Myocardial Infarction, previous box

CHEST TUBES - THORACENTESIS

Bleeding (internal or at insertion site)
Hemo-pneumothorax
Atelectasis
Chest tube malfunction/blockage
Infection / sepsis

.

FOLEY CATHETER

Infection / sepsis
Catheter malfunction/blockage
Bladder spasms

IV THERAPY

Bleeding (internal or at insertion site)
Air embolus
Phlebitis / thrombophlebitis
Infiltration / extravasation / tissue necrosis
Fluid overload
Infection / sepsis

MEDICATIONS

Adverse reactions (allergic response, exaggerated response, side effects)
Drug interactions
Overdose / toxicity

NASOGASTRIC SUCTION

Electrolyte imbalance
Tube malfunction/blockage
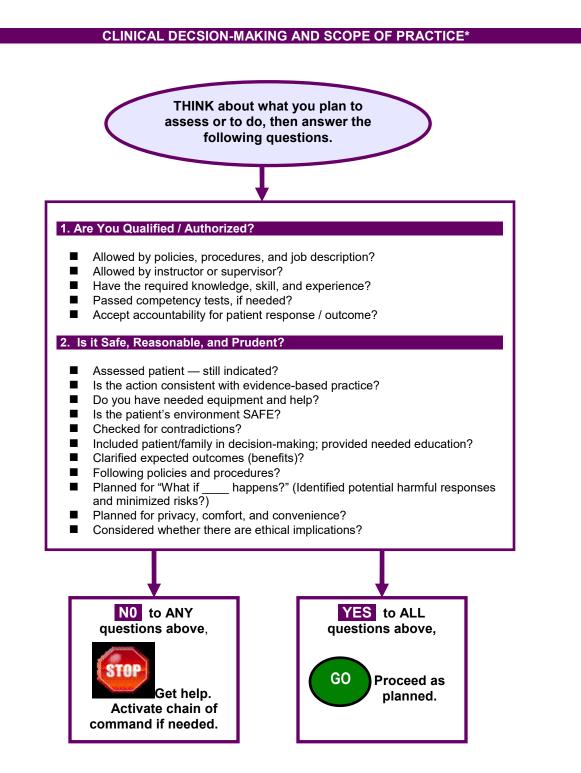Aspiration
Bleeding

PARACENTESIS

Bleeding (internal or at insertion site)
Paralytic ileus
Infection / sepsis

SKELETAL TRACTION / CASTS

See fractures, previous box

FACULTY TEXTBOOK TOOL: SHIFTING FROM NURSING DIAGNOSES

Textbook page 93 (inserting textbook image was problematic; this is my handout)

CLINICAL DECSION-MAKING AND SCOPE OF PRACTICE*

THINK about what you plan to assess or to do, then answer the following questions.

1. Are You Qualified / Authorized?

- Allowed by policies, procedures, and job description?
- Allowed by instructor or supervisor?
- Have the required knowledge, skill, and experience?
- Passed competency tests, if needed?
- Accept accountability for patient response / outcome?

2. Is it Safe, Reasonable, and Prudent?

- Assessed patient — still indicated?
- Is the action consistent with evidence-based practice?
- Do you have needed equipment and help?
- Is the patient's environment SAFE?
- Checked for contradictions?
- Included patient/family in decision-making; provided needed education?
- Clarified expected outcomes (benefits)?
- Following policies and procedures?
- Planned for "What if _____ happens?" (Identified potential harmful responses and minimized risks?)
- Planned for privacy, comfort, and convenience?
- Considered whether there are ethical implications?

N0 to ANY questions above,

STOP

Get help. Activate chain of command if needed.

YES to ALL questions above,

GO **Proceed as planned.**

* Scope of practice varies from state to state, depending on state practice acts and State Board of Nursing (SBN) rules and regulations**.** When in doubt, ask your clinical educator, supervisor, or check with your SBN.