I- What is a Nursing Diagnosis?

A **nursing diagnosis** is a clinical judgment concerning 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 the selection of nursing interventions to achieve outcomes for which the nurse has accountability. **Nursing diagnoses** are developed based on data obtained during the nursing assessment and enable the nurse to develop the care plan.

II- Purposes of Nursing Diagnosis

The purpose of the nursing diagnosis is as follows:

- Helps identify nursing priorities and help direct nursing interventions based on identified priorities.
- Helps the formulation of expected outcomes for quality assurance requirements of third-party payers.
- Nursing diagnoses help identify how a client or group responds to actual or potential health and life processes and knowing their available resources of strengths that can be drawn upon to prevent or resolve problems.
- Provides a common language and forms a basis for communication and understanding between nursing professionals and the healthcare team.
- Provides a basis of evaluation to determine if nursing care was beneficial to the client and cost-effective.
- For nursing students, nursing diagnoses are an effective teaching tool to help sharpen their problem-solving and critical thinking skills.

III- Nursing Process

The five stages of the nursing process are assessment, diagnosing, planning, implementation, and evaluation. In the diagnostic process, the nurse is required to have critical thinking. Apart from the understanding of nursing diagnoses and their definitions, the nurse promotes awareness of defining characteristics and behaviors of the diagnoses, related factors to the selected nursing diagnoses, and the interventions suited for treating the diagnoses.

1- Assessment

What data is collected? The first step of the nursing process is called assessment. When the nurse first encounters a patient, the former is expected to perform an assessment to identify the patient's health problems as well as the physiological, psychological, and emotional state. The most common approach to gathering important information is through an interview. Physical examinations, referencing a patient's health history, obtaining a patient's family history, and general observation can also be used to collect assessment data.

2- Diagnosis

What is the problem? Once the assessment is completed, the second step of the nursing process is where the nurse will take all the gathered information into consideration and diagnose the patient's condition and medical needs. Diagnosing involves a nurse making an educated judgment about a potential or actual health problem with a patient. More than one diagnoses are sometimes made for a single patient.

3- Planning

How to manage the problem? When the nurse, any supervising medical staff, and the patient agree on the diagnosis, the nurse will plan a course of treatment that takes into account short- and long-term goals. Each problem is committed to a clear, measurable goal for the expected beneficial outcome.

4- Implementation

Putting the plan into action. The implementation phase of the nursing process is when the nurse put the treatment plan into effect. This typically begins with the medical staff conducting any needed medical interventions. Interventions should be specific to each patient and focus on achievable outcomes. Actions associated in a nursing care plan include monitoring the patient for signs of change or improvement, directly caring for the patient or conducting important medical tasks, educating and guiding the patient about further health management, and referring or contacting the patient for a follow-up.

5- Evaluation

Did the plan work? Once all nursing intervention actions have taken place, the team now learns what works and what does not by evaluating what was done beforehand. The possible patient outcomes are generally explained under three terms: the patient's condition improved, the patient's condition stabilized, and the patient's condition worsened. Accordingly, evaluation is the last, but if goals were not sufficed, the nursing process begins again from the first step.

IV- Types of Nursing Diagnoses

The five types of nursing diagnoses are:

1- Actual diagnosis (Problem-Focused diagnosis)
2- Possible diagnosis
3- Risk diagnosis
4- Wellness diagnosis (health promotion diagnosis)
5- Syndrome diagnosis

1- Actual Diagnosis

A **problem-focused diagnosis** (also known as **actual diagnosis**) is a client problem that is present at the time of the nursing assessment. These diagnoses are based on the presence of associated signs and symptoms. Actual nursing diagnosis should not be viewed as more important than risk diagnoses. There are many instances where a risk diagnosis can be the diagnosis with the highest priority for a patient.

Examples of actual nursing diagnosis are:

- **Ineffective Breathing Pattern** related to pain as evidenced by pursed-lip breathing, reports of pain during inhalation, use of accessory muscles to breathe
- **Anxiety** related to stress as evidenced by increased tension, apprehension, and expression of concern regarding upcoming surgery
- **Acute Pain** related to decreased myocardial flow as evidenced by grimacing, expression of pain, guarding behavior.

- **Impaired Skin Integrity** related to pressure over bony prominence as evidenced by pain, bleeding, redness, wound drainage.

2- Possible Nursing Diagnosis

A possible nursing diagnosis is not a type of diagnosis as are actual, risk, health promotion, and syndrome. Possible nursing diagnoses are statements describing a suspected problem for which additional data are needed to confirm or rule out the suspected problem. It provides the nurse with the ability to communicate with other nurses that a diagnosis may be present but additional data collection is indicated to rule out or confirm the diagnosis.

Examples include

- *Possible Chronic Low Self-Esteem*
- *Possible Social Isolation*.

3- Risk Nursing Diagnosis

The second type of nursing diagnosis is called **risk nursing diagnosis.** These are clinical judgment that a problem does not exist, but the presence of risk factors indicates that a problem is likely to develop unless nurses intervene. The individual (or group) is **more susceptible** to develop the problem than others in the same or a similar situation because of risk factors. For example, an elderly client with diabetes and vertigo has difficulty walking refuses to ask for assistance during ambulation may be appropriately diagnosed with risk for injury.

Examples of risk nursing diagnosis are:

- **Risk for Falls** *as evidenced by* muscle weakness
- **Risk for Injury** *as evidenced by* altered mobility
- **Risk for Infection** *as evidenced by* immunosuppression

4- Health Promotion Diagnosis

Health promotion diagnosis (also known as **wellness diagnosis**) is a clinical judgment about motivation and desire to increase well-being. Health promotion diagnosis is concerned in the individual, family, or community transition from a specific level of wellness to a higher level of wellness.

Components of a health promotion diagnosis generally include only the diagnostic label or a one-part-statement. Examples of health promotion diagnosis:

- Readiness for Enhanced Spiritual Well Being

- Readiness for Enhanced Family Coping
- Readiness for Enhanced Parenting

5- Syndrome Diagnosis

A syndrome diagnosis is a clinical judgment concerning with a cluster of problem or risk nursing diagnoses that are predicted to present because of a certain situation or event.

Examples of a syndrome nursing diagnosis are:

- Chronic Pain Syndrome
- Post-trauma Syndrome