Recommendations when using diagnoses with limited or no related/risk factors.

As the NANDA-I terminology has evolved over the years, so has our thinking. Educators and instructors have emphasized that to remove the underlying cause of the problem-focused nursing diagnosis, nursing intervention should be aimed at related (etiological) factors, or to prevent the risk nursing diagnosis, nursing intervention should be aimed at risk factors that increase the vulnerability. However, until the current edition (2018 – 2020 edition), diagnoses included many related/risk factors that are not amenable to independent nursing intervention. This has caused serious confusion among students, educators and clinical nurses over the years.

After much review and discussion, it was determined that many of the factors categorized as related/risk factors were important for clinical reasoning (they help us diagnose accurately), but nursing intervention could not remove or change them. To be clinically useful, and to meet the goal of identifying etiological factors, this needed to change. Therefore, we have created two new categories: *at risk populations* and *associated conditions*.

The lists of related/risk factors were reviewed, and only those factors that could be removed or improved by nursing intervention were retained. After separating out related/risk factors from the tenth edition of the terminology into the two new categories, we see there are many diagnoses with few or no related/risk factors. We are now facing another new challenge! Therefore, during this next cycle, we will be focusing on developing more clinically useful related/risk factors on which nurses could intervene. We appreciate your understanding and cooperation, and we encourage you to participate in this process by recommending evidence-based factors which are amenable to independent nursing intervention.

Finally, it is very important to understand that the NANDA-I terminology is not a completed or finished product, rather, it will always be evolving as our knowledge base increases. When users find the phrase "to be developed", or when there is a very limited list of related factors or risk factors, we encourage you to think critically and logically. Practically, you need to consider appropriate related/risk factor(s) for your patient based on theories, literature, supporting research, expert opinion, and your own clinical experience. Remember that those factors you choose to use must be things that a nurse can improve or remove through independent nursing intervention. At the same time, we

ask you to submit these newly identified related/risk factors to NANDA-I for diagnosis revision, so that your work can help support clinical reasoning of others using our terminology.

How do we write the Problem – Etiology – Signs/Symptoms (PES) Statement?

NANDA-I does not require, nor does it endorse, the PES statement. We acknowledge that it may be a very helpful method for students to learn to think critically, and provide faculty members with a way to evaluate clinical reasoning. However, we are also aware that ***no other discipline*** uses a "statement" when identifying or documenting a diagnosis. Many nursing faculty members introduce the PES statement early in the nursing curriculum, but move to sole use of the diagnosis label by the end of the program. Obviously, students should be able to justify the diagnosis by reference to their assessment, but it is not necessary to continue to write the full statement. Others simply require the diagnosis label, and ask students to identify the diagnostic indicators they used to diagnose the patient, but don't require the PES statement itself.

It is also a reality that many electronic health records (EHRs) do not have the capability of supporting the PES statement within the clinical documentation system; rather, only the diagnosis label is identified. Thus, NANDA-I's position is that it is perfectly appropriate to document the ***label only***, because the related factors and defining characteristics (or the risk factors) can be found within the nursing assessment, nursing notes, or plan of care sections within the patient record.

However, since we released the 11th edition of the book, we have had questions as to how the statement would be written in the case of diagnoses without current related or risk factors.

Let's review the statement:

DIAGNOSIS related to **ETIOLOGICAL FACTOR** as evidenced by **DEFINING CHARACTERISTICS**

GRIEVING related to _____ as evidenced by *anger*, *blaming*, *despair*, *psychological distress*.

What do we use for a related factor here? If we look at the current definition, we see that grieving is defined as a normal, complex process that includes emotional, physical, spiritual, social and intellectual responses and behaviors by which individuals incorporate an actual, anticipated or perceived loss into their daily lives.

It is likely that we need to reconceptualize the *diagnosis label* – nurses cannot prevent the grief from occurring (nor would we want to, as it is a normal process) – but what we can do is to support the patient and help in managing its sequelae. For example, we do support patients/families by helping them to understand that grief is normal, and discussing the way grief can manifest in different individuals. We can work with them to enhance their coping skills, to find ways to express their grief that are healthy and healing, and to identify social support structures. However, we cannot remove (or improve) the causative factor of the grief – the loss itself. Perhaps the labels should be *effective grief management*, *ineffective grief management*, and *readiness for enhanced grief management*. We could then focus on the factors that support or prevent an individual from successfully incorporating the loss into his/her daily life: things nurses do every day that are independent nursing interventions.

Thus, we might have:
INEFFECTIVE GRIEF MANAGEMENT related to *fear of separation*, *insufficient emotional support*, *insufficient resilience*, as evidenced by *alteration in sleep pattern*, *debilitating psychological distress*, *violence*.

Ok, but what do we do today?
First, remember that the terminology – just as with nursing science – is evolving. It is not "fixed in stone", so we need to use our own clinical reasoning and critical thinking skills.

With the current terminology, we might use:
GRIEVING related to *fear of separation*, *insufficient emotional support*, *insufficient resilience*, as evidenced by *alteration in sleep pattern*, *psychological distress*, *anger, blaming*.

- The related factors aren't found in the 11th edition of the NANDA-I terminology, but we ***can*** find them in the literature, and/or we may have experienced them in our clinical practice.
- The defining characteristics would be found in our clinical assessment of the patient (and are found in the 11th edition).

It is, we believe, important to explain to students that nursing language is evolving as our concepts evolve – and we cannot always keep up! This has been true in medicine, which has had to deal with diagnoses that were named for the individual(s) who identified the disease rather than reflecting the disease state itself. It has taken years to rename and reconceptualize many medical diagnoses, and refinement continues as an ongoing process. So it is within nursing! This shows that our discipline is constantly evolving, and that they will need to commit to lifelong learning to maintain currency in our field of study.