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ADVANCING PROFESSIONAL PRACTICE WITH NURSING DIAGNOSIS



PROGRAM SCHEDULE

MONDAY, MARCH 28 (Cont)

11:00 AM	11:30 AM	Break
12:15 PM	1:00 PM	**Nursing Diagnosis Internationally** Joyce Fitzpatrick, RN, PhD, Dean, College of Nursing, Case Western University
1:00 PM	2:00 PM	Lunch
2:00 PM	10:00 PM	Optional Tours

See tour information on back page for more details and optional choices.

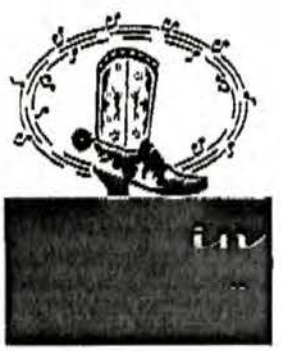
TUESDAY, MARCH 29

7:30 AM	8:30 AM	Continental Breakfast Meet the Candidates
7:30 AM	2:00 PM	Exhibits
8:30 AM	9:00 AM	Welcome/Introduction: Vici Cole Schonlau, Program Committee Member
9:00 AM	9:45 AM	**Nursing Diagnosis and Healthcare Reform** **Virginia Trotter-Betts, President, ANA**
9:45 AM	1:00 PM	Business Meeting
1:00 PM	2:00 PM	Lunch
2:00 PM	2:45 PM	**The Impact of Nursing Care** **Tipper Gore, Wife of the Vice President of the U.S.** (will confirm in Dec of 1993)
2:45 PM	3:30 PM	Break
3:30 PM	6:30 PM	Diagnosis Review Sessions
7:00 PM	11:30 PM	Optional Tour

See tour information on back page for more details and optional choices.

WEDNESDAY, MARCH 30

7:00 AM	8:00 AM	Continental Breakfast
7:30 AM	8:00 AM	Special Interest Groups
8:15 AM	8:30 AM	Welcome/Announcements: Angela Nicoletti, Program Committee Member
8:30 AM	9:30 AM	Critical Path Systems and Nursing Diagnosis: Issues and Controversies Kathleen A. Bower, RN, DNSc, The Center for Case Management, Inc., Mass.
9:30 AM	10:30 AM	**Advancing the Science of Nursing** Jean Jenny, RN, MS
10:30 AM	11:00 AM	Break
11:00 AM	Noon	Forum: Taxonomic Issues
Noon	12:30 PM	Lunch
12:30 PM	2:15 PM	Forum: Revising Current Diagnoses
2:15 PM	3:00 PM	**Closing Address:** **The Politics of Nursing Diagnosis** **Kristine Gebbie, National AIDS Policy Coordinator**
3:00 PM	3:30 PM	Finale
4:00 PM	Midnight	Sightseers Special: Optional Tour Country Music Hall of Fame/Pub Crawl



THE WHITE HOUSE

WASHINGTON

PRESS RELEASE

FOR IMMEDIATE RELEASE
FEBRUARY 7, 1994

FOR MORE INFORMATION:
JOHN PAUL GURROLA 202/632-1090
ANDREW BARRER 202/632-1090

FEDERAL AIDS BUDGET FOR 1995 INCREASES

WASHINGTON, D.C. -- Kristine M. Gebbie, President Clinton's National AIDS Policy Coordinator discussed the increases in the Federal budget on AIDS today. "In a time of over-all budget cuts and other budget-related program reductions, the President's continued commitment to HIV/AIDS is shown in a budget increase of nearly ten percent" Gebbie said. The Office of National AIDS Policy has three focus areas in its mission -- research, treatment/services and prevention. The budget requests for these three areas and the requests for the specific departments that are closely related to HIV/AIDS issues are described below.

The President's Budget proposes a 6% increase in NIH basic and preventive research for HIV and AIDS. This provides $1.379 billion for NIH AIDS research, a 29% increase since 1993. The President proposes an additional $231 million for AIDS research in other federal agencies, bringing the total federal investment to $1.61 billion.

This investment is combined with the Administration's commitment to improved management of AIDS research planning and budgeting at the NIH, and to enhancing government-wide and

private sector coordination.

HIV/AIDS treatment and care services are primarily funded through the Ryan White CARE Act. The Administration is recommending an increase in these treatment funds of 16.1% for a dollar increase of 93 million dollars. These funds will be split between the four titles of the Act as follows: Title I (cities) 39 million, Title II (states) 30 million, Title III (primary care systems) 19 million, Title IV (pediatric and maternity care centers) 5 million.

In FY 94 $1.1 billion was appropriated for block grants to states for substance abuse treatment, of which approximately $25 million were specifically earmarked for HIV related programs. The FY 95 budget shows an increase of $310 million for substance abuse treatment under the Substance Abuse and Mental Health Services Administration. This amount will go to the block grants given to states and will have direct impact on HIV prevention for persons with chronic substance abuse issues, including injecting drug users. This number will be adjusted based on the number of states that qualify in the coming weeks. Of the new amount, $15.5 million have been specifically earmarked for HIV prevention activities. Since drug abusers are at high risk for HIV transmission, we consider this budget line a significant part of our Federal AIDS prevention programs. HIV prevention activities under the Centers for Disease Control and Prevention will receive the same level of funding as in FY 94.

The Department of Health and Human Services, budget requests an increase of 592 million dollars over the 1994 level of spending. This raises the 1995 AIDS spending for HHS to nearly 6.0 billion. The increases within the Public Health Service include 93 million for the Ryan White AIDS services, 78 million for NIH and one million at AHCPR.

At the Department of Defense the 1995 budget request is divided between research, prevention and services/treatment money. $14 million is earmarked for research; $22 million for prevention and $63 million for treatment services for military members and their families.

The Department of Housing and Urban Development's (HUD) FY 95 budget requests $257 million towards the housing needs of people with HIV and AIDS. HUD funds can be used for a wide range of housing related services to prevent homelessness. Services can include emergency housing, transitional housing, and permanent housing arrangements; and the acquisition, rehabilitation and leasing of existing housing. Appropriate supportive services must be provided as part of HUD's HIV-related housing and include such activities as health and mental health services, permanent housing placement, chemical dependency treatment and counseling, day care, nutritional services, intensive care when required, and assistance in gaining access to local, state and federal government benefits and services. Housing Opportunities for People with AIDS remains stable at $156 million.

The Department of Veterans affairs, through its large system of hospitals, provides AIDS prevention education, performs research and provides treatment services to Veterans. The total VA budget request for FY 95 is increased by $18 M overall. Of the $349 M requested for FY 95, $312 M is earmarked for treatment services; $6 M for research and $31 M for prevention education.

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THE WHITE HOUSE

WASHINGTON

OFFICE OF NATIONAL AIDS POLICY
PUBLIC HEALTH SERVICE FY 95 BUDGET INFORMATION

Summary

The FY 1995 budget includes $2.7 billion in budget authority for the PHS for research, prevention and other related activities in the battle against AIDS and HIV infection. This is an increase of $177 million, or 7 percent, over the FY 1994 appropriations. The funds requested for HIV/AIDS activities are included in the budget for each of the PHS components. The tables below summarize the entire PHS-wide HIV/AIDS effort, both by PHS agency and by function.

For FY 1995, the President's Budget proposes a $93 million, or 16 percent, increase for HRSA's Ryan White AIDS health care services, and a $78 million, or 6 percent increase for NIH basic and preventive research on AIDS. (More detailed discussions of these program increases for AIDS are included in the individual agency sections.)

HIV/AIDS FUNDING BY PHS COMPONENT
(Dollars in millions)

	1993 Actual	1994 Approp.	1995 Request	+/-
FDA.....	$73	$72	$72	–
HRSA.....	390	608	701	+$93
IHS.....	3	4	4	–
CDC.....	498	543	543	–
NIH.....	1071	1301	1379	+78
SAMHSA.....	26	28	33	+5
AHCPR.....	10	11	12	+1
OASH.....	5	5	5	–
TOTAL, HIV/AIDS Budget Authority.....	2077	2572	2749	+177

SUBSTANCE ABUSE DOLLARS

In FY 94 $1.1 Billion was appropriated for block grants to states for substance abuse treatment. Through the efforts of the Office of the National Drug Control Policy Coordinator an additional $310 Million will be added to FY 95. This money is to be used by states for the most severe substance abuse cases, such as injecting drug abusers, who are at great risk for HIV transmission. $15.5 Million of the new money will be specifically earmarked for HIV-related substance abuse programs. Of the original $1.1 Billion, approximately 25 Million is also specifically earmarked for HIV related programs. (This number will be adjusted based on number of states that qualify in the coming weeks.) Because such abusers are at high risk for HIV transmission, this budget line is a significant part of federal AIDS prevention programs.

Office of National AIDS Policy

Federal HIV Funding

(In Millions of Dollars)

	FY 1994 Enacted	FY 1995 Budget	Dollar Increase FY 94 to FY 95	Percent Increase FY 94 to FY 95
Public Health Service	2,572	2,749	+177	+7%
Office of Civil Rights	3	3	+0	+0%
Veterans	331	349	+18	+5%
Defense	129	99	-30	-23%
Housing	253	257	+4	+2%
OPM-FEHB	193	213	+20	+10%
*Other	129	131	+2	+2%
Total Appropriations	***3610***	***3,801***	***+191***	***+5%***
Medicaid (Federal Share)	1,490	1,640	+150	+10%
Medicare	500	600	+100	+20%
Social Security	835	1,015	+180	+22%
Total Entitlement	***2,825***	***3,255***	***+430***	***+15%***
Total Spending	6,435	7,056	+621	+10%

* Includes USDAID, Bureau of Prisons, State, and Labor.

Note: Provided as draft by Office of Management and Budget 2/7/94.

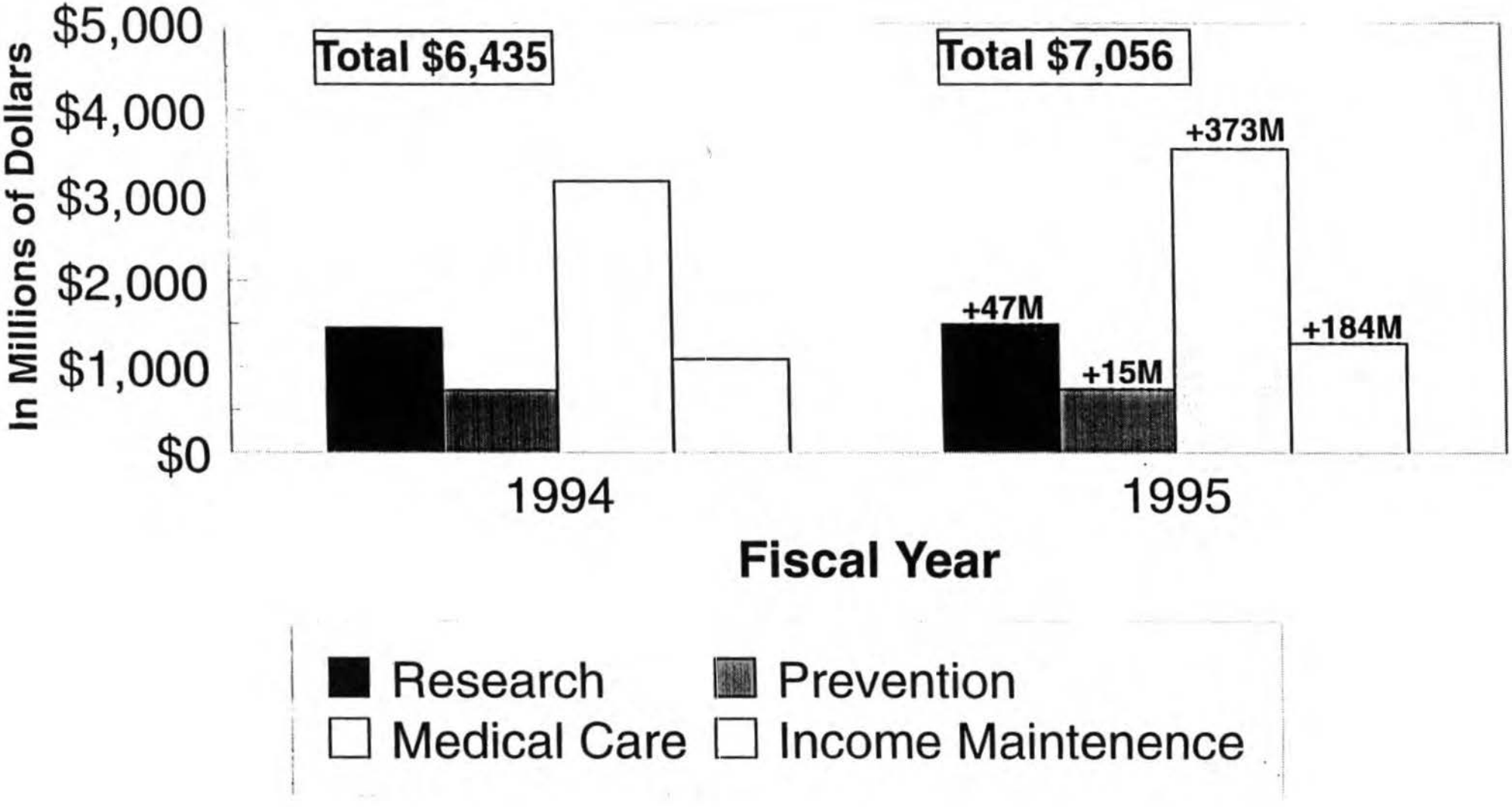
HHS HIV/AIDS Funding

(Dollars in thousands)

	1993	1994	1995		
				Chg. +/-	
	Enacted	Approp.	Pres. Budget	'94 Approp.	% Chg.
PUBLIC HEALTH SERVICE:					
FDA	$72,628	$72,399	$72,399	$0	0.0%
HRSA:					
Ryan White:					
Title I	$184,757	$325,500	$364,500	$39,000	12.0%
Title II	115,288	183,897	213,897	30,000	16.3%
Title III	47,968	47,968	66,968	19,000	39.6%
Title IV	--	22,000	27,000	5,000	22.7%
Sub, Ryan White	$348,013	$579,365	$672,365	$93,000	16.1%
Other HRSA AIDS	42,328	28,431	28,431	0	0.0%
Sub, HRSA	$390,341	$607,796	$700,796	$93,000	15.3%
IHS	$3,303	$3,556	$3,556	$0	0.0%
CDC	$498,253	$543,253	$543,253	$0	0.0%
NIH	$1,071,457	$1,301,045	$1,379,052	$78,007	6.0%
SAMHSA	$25,655	$28,111	$32,986	$4,875	17.3%
AHCPR	$9,624	$10,624	$12,000	$1,376	13.0%
OASH	$5,330	$5,323	$5,323	$0	0.0%
Subtotal, PHS	$2,076,591	$2,572,107	$2,749,365	$177,258	6.9%
ENTITLEMENTS:					
HCFA:					
Medicaid (Fed Share)	$1,290,000	$1,490,000	$1,640,000	$150,000	10.1%
Medicare	385,000	500,000	600,000	100,000	20.0%
Sub, HCFA	1,675,000	1,990,000	2,240,000	$250,000	12.6%
Social Security:					
DI	505,000	635,000	775,000	$140,000	22.0%
SSI	165,000	200,000	240,000	40,000	20.0%
Sub, Social Security	670,000	835,000	1,015,000	$180,000	21.6%
Subtotal, Entitlements	$2,345,000	$2,825,000	$3,255,000	$430,000	15.2%
OTHER:					
OS/Office for Civil Rights	$2,600	$2,600	$2,600	$0	0.0%
TOTAL, HHS	$4,424,191	$5,399,707	$6,006,965	$607,258	11.2%

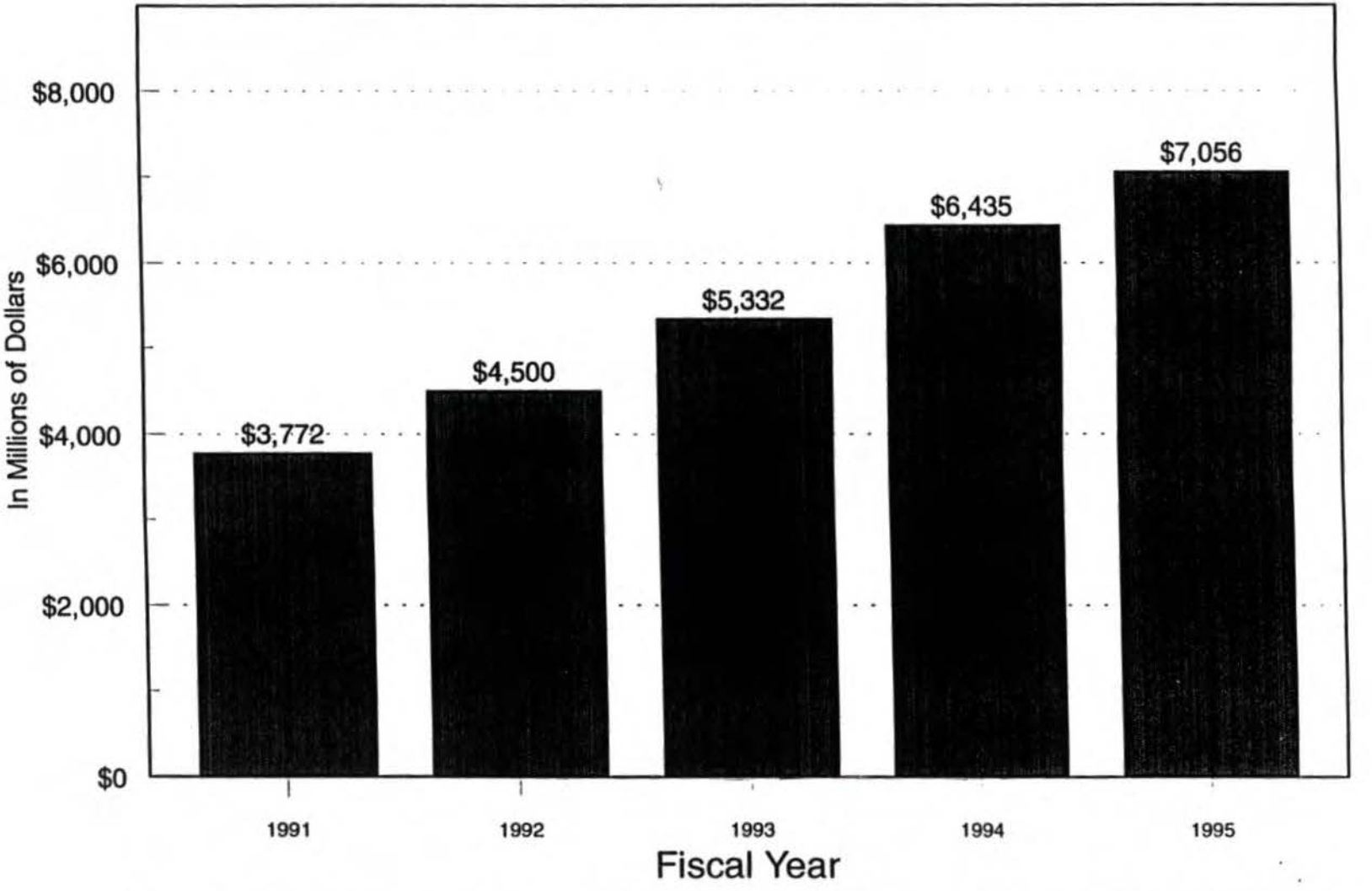
Office of Na ional AIDS Policy

Federal HIV Funding



Office of National AIDS Policy

Total Federal Spending for HIV/AIDS
1991 THRU 1995



FY95 includes an estimated $15.5 million in HIV/AIDS prevention services in the Hard Core DrugTreatment Initiative, an increase of approximately $6 million above previous HIV/AIDS programming in SAMSHA

HIV/AIDS

SURVEILLANCE REPORT — Third Quarter Edition

U.S. AIDS cases reported through September 1993 — **Issued October 1993, Vol. 5, No. 3**

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Acquired immunodeficiency syndrome (AIDS) is a specific group of diseases or conditions which are indicative of severe immunosuppression related to infection with the human immunodeficiency virus (HIV).

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Centers for Disease Control
and Prevention
National Center for Infectious Diseases
Division of HIV/AIDS
Atlanta, Georgia 30333

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

The *HIV/AIDS Surveillance Report* is published quarterly by the Division of HIV/AIDS, National Center for Infectious Diseases, Centers for Disease Control and Prevention (CDC), Atlanta, GA 30333. The year-end edition contains additional tables and graphs. All data contained in the *Report* are provisional.

Suggested Citation: Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report*, 1993;5(no. 3):[inclusive page numbers].

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Single copies of the *HIV/AIDS Surveillance Report* are available free from the CDC National AIDS Clearinghouse, P.O. Box 6003, Rockville, MD 20849-6003; telephone 1–800–458–5231. Individuals or organizations can be added to the mailing list by writing to Centers for Disease Control and Prevention, OD/OPS/MASO, 1/B49, Mailstop A-22, Atlanta, GA 30333. Confidential information, referrals, and educational material on AIDS are available from the CDC National AIDS Hotline: 1–800–342–2437, 1–800–344–7432 (Spanish access), and 1–800–243–7889 (TTY, deaf access).

Table 1. AIDS cases and annual rates per 100,000 population, by state, reported October 1991 through September 1992, October 1992 through September 1993;[1] and cumulative totals, by state and age group, through September 1993, United States[2]

State of residence	Oct. 1991-Sept. 1992		Oct. 1992-Sept. 1993		Cumulative totals		
	No.	Rate	No.	Rate	Adults/ adolescents	Children < 13 years old	Total
Alabama	465	11.4	705	17.0	2,275	43	2,318
Alaska	18	3.2	60	10.2	154	2	156
Arizona	408	10.9	1,202	31.3	3,059	14	3,073
Arkansas	237	10.0	420	17.5	1,239	21	1,260
California	8,641	28.4	17,474	56.4	62,201	356	62,557
Colorado	415	12.3	1,193	34.5	3,516	18	3,534
Connecticut	538	16.3	1,693	51.4	4,415	98	4,513
Delaware	126	18.5	346	49.9	830	7	837
District of Columbia	724	121.0	1,370	232.3	5,231	78	5,309
Florida	5,007	37.7	9,613	70.6	32,008	751	32,759
Georgia	1,348	20.4	2,597	38.4	9,255	87	9,342
Hawaii	175	15.4	324	27.9	1,250	10	1,260
Idaho	36	3.5	71	6.6	203	2	205
Illinois	1,842	16.0	3,005	25.8	10,522	140	10,662
Indiana	370	6.6	831	14.6	2,443	17	2,460
Iowa	86	3.1	196	7.0	577	6	583
Kansas	188	7.5	335	13.3	1,031	5	1,036
Kentucky	207	5.6	316	8.4	1,148	13	1,161
Louisiana	829	19.5	1,172	27.4	4,811	67	4,878
Maine	50	4.0	126	10.2	427	4	431
Maryland	1,096	22.6	2,353	47.6	7,187	152	7,339
Massachusetts	767	12.8	2,532	42.4	7,238	132	7,370
Michigan	784	8.4	1,752	18.6	4,904	62	4,966
Minnesota	237	5.3	624	13.9	1,829	13	1,842
Mississippi	231	8.9	468	17.9	1,483	20	1,503
Missouri	650	12.6	1,679	32.3	4,626	33	4,659
Montana	22	2.7	35	4.3	134	2	136
Nebraska	68	4.3	179	11.1	469	4	473
Nevada	235	18.3	601	44.0	1,641	15	1,656
New Hampshire	48	4.3	99	9.0	368	6	374
New Jersey	2,051	26.4	4,390	56.3	18,106	423	18,529
New Mexico	90	5.8	307	19.4	831	2	833
New York	8,232	45.6	16,031	88.4	63,660	1,321	64,981
North Carolina	648	9.6	1,059	15.5	3,735	75	3,810
North Dakota	4	0.6	4	0.6	32	—	32
Ohio	696	6.4	1,490	13.5	4,944	68	5,012
Oklahoma	228	7.2	716	22.3	1,795	15	1,810
Oregon	283	9.7	732	24.4	2,233	9	2,242
Pennsylvania	1,338	11.2	2,556	21.2	9,086	120	9,206
Rhode Island	102	10.2	305	30.3	842	9	851
South Carolina	347	9.7	1,395	38.4	3,022	38	3,060
South Dakota	8	1.1	23	3.2	57	2	59
Tennessee	442	8.9	967	19.2	2,734	26	2,760
Texas	2,944	17.0	7,164	40.4	23,572	213	23,785
Utah	145	8.2	270	14.9	818	20	838
Vermont	26	4.6	60	10.5	176	2	178
Virginia	606	9.6	1,590	24.9	4,710	82	4,792
Washington	573	11.4	1,459	28.2	4,765	18	4,783
West Virginia	61	3.4	78	4.3	359	5	364
Wisconsin	224	4.5	700	13.9	1,705	19	1,724
Wyoming	4	0.9	36	7.7	91	—	91
Subtotal	**44,900**	**17.8**	**94,703**	**37.0**	**323,747**	**4,645**	**328,392**
Guam	1	0.7	2	1.5	12	—	12
Pacific Islands, U.S.	—	—	—	—	2	—	2
Puerto Rico	1,796	50.5	2,621	73.1	10,436	256	10,692
Virgin Islands, U.S.	19	18.6	42	40.8	147	5	152
Total	**46,716**	**18.2**	**97,368**	**37.5**	**334,344**	**4,906**	**339,250**

[1]Includes 9 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.
[2]During the third quarter of 1993, CDC received reports of 23,664 cases and 9,951 deaths among adults/adolescents and 196 cases and 105 deaths among children.

Table 2. AIDS cases and annual rates per 100,000 population, by metropolitan area with 500,000 or more population, reported October 1991 through September 1992, October 1992 through September 1993;[1] and cumulative totals, by area and age group, through September 1993, United States

Metropolitan area of residence[2]	Oct. 1991–Sept. 1992		Oct. 1992–Sept. 1993		Cumulative totals		
	No.	Rate	No.	Rate	Adults/ adolescents	Children < 13 years old	Total
Akron, Ohio	36	5.4	46	6.9	214	—	214
Albany-Schenectady, N.Y.	106	12.2	217	24.7	672	14	686
Albuquerque, N.M.	58	9.6	186	30.2	490	1	491
Allentown, Pa.	32	5.3	122	20.0	314	4	318
Ann Arbor, Mich.	29	5.8	63	12.4	194	4	198
Atlanta, Ga.	956	31.3	1,773	56.4	6,836	43	6,879
Austin, Tex.	241	27.6	586	65.0	1,705	14	1,719
Bakersfield, Calif.	50	8.8	161	27.3	357	3	360
Baltimore, Md.	669	27.7	1,628	66.6	4,548	113	4,661
Baton Rouge, La.	92	17.1	135	24.7	469	7	476
Bergen-Passaic, N.J.	267	20.9	677	52.8	2,425	51	2,476
Birmingham, Ala.	116	13.7	259	30.2	716	11	727
Boston, Mass.	659	11.6	2,268	40.2	6,510	117	6,627
Buffalo, N.Y.	69	5.8	198	16.5	653	8	661
Charleston, S.C.	70	13.4	259	47.9	611	5	616
Charlotte, N.C.	118	9.9	245	20.1	747	10	757
Chicago, Ill.	1,614	21.5	2,619	34.5	9,251	125	9,376
Cincinnati, Ohio	112	7.3	230	14.7	768	11	779
Cleveland, Ohio	199	9.0	458	20.6	1,414	27	1,441
Columbus, Ohio	158	11.5	336	24.1	1,085	6	1,091
Dallas, Tex.	759	27.7	1,805	64.4	5,867	24	5,891
Dayton, Ohio	67	7.0	132	13.7	481	8	489
Denver, Colo.	335	20.1	1,010	58.9	2,918	13	2,931
Detroit, Mich.	606	14.1	1,233	28.7	3,484	45	3,529
El Paso, Tex.	46	7.5	116	18.3	303	1	304
Fort Lauderdale, Fla.	848	65.9	1,165	88.4	5,114	109	5,223
Fort Worth, Tex.	160	11.5	404	28.2	1,350	15	1,365
Fresno, Calif.	99	12.7	173	21.5	519	4	523
Gary, Ind.	47	7.7	78	12.6	240	2	242
Grand Rapids, Mich.	37	3.9	126	13.0	326	3	329
Greensboro, N.C.	128	12.0	151	14.0	631	11	642
Greenville, S.C.	62	7.4	255	29.8	521	2	523
Harrisburg, Pa.	46	7.7	78	12.9	313	6	319
Hartford, Conn.	167	14.8	565	50.2	1,397	17	1,414
Honolulu, Hawaii	124	14.6	256	29.6	946	6	952
Houston, Tex.	1,023	29.8	2,587	72.8	9,225	87	9,312
Indianapolis, Ind.	170	12.1	397	27.7	1,178	5	1,183
Jacksonville, Fla.	327	35.0	910	94.7	2,140	49	2,189
Jersey City, N.J.	313	56.6	619	111.8	2,933	68	3,001
Kansas City, Mo.	314	19.6	736	45.4	2,197	9	2,206
Knoxville, Tenn.	35	5.8	78	12.7	238	2	240
Las Vegas, Nev.	180	19.5	468	46.9	1,260	14	1,274
Little Rock, Ark.	82	15.8	171	32.6	485	9	494
Los Angeles, Calif.	3,327	37.1	5,557	61.1	21,704	146	21,850
Louisville, Ky.	90	9.4	166	17.2	509	8	517
Memphis, Tenn.	174	17.1	414	40.1	1,007	9	1,016
Miami, Fla.	1,324	67.0	2,423	120.1	9,303	260	9,563
Middlesex, N.J.	217	21.1	354	34.2	1,515	33	1,548
Milwaukee, Wis.	127	8.8	361	24.8	914	12	926
Minneapolis-Saint Paul, Minn.	204	7.9	550	20.9	1,619	10	1,629
Monmouth-Ocean City, N.J.	111	11.1	366	36.4	1,253	35	1,288
Nashville, Tenn.	125	12.5	269	26.3	844	10	854
Nassau-Suffolk, N.Y.	370	14.1	1,010	38.4	3,200	66	3,266
New Haven, Conn.	318	19.5	987	60.4	2,654	77	2,731
New Orleans, La.	476	36.8	612	46.9	2,868	37	2,905
New York, N.Y.	7,163	83.8	13,288	155.3	54,716	1,183	55,899
Newark, N.J.	838	43.8	1,540	80.6	7,229	184	7,413
Norfolk, Va.	105	7.2	325	21.9	1,006	22	1,028
Oakland, Calif.	563	26.7	1,225	57.2	4,138	26	4,164
Oklahoma City, Okla.	113	11.6	310	31.5	825	1	826
Omaha, Neb.	49	7.5	136	20.6	343	1	344
Orange County, Calif.	553	22.6	717	29.0	2,811	21	2,832

Table 2. AIDS cases and annual rates per 100,000 population, by metropolitan area with 500,000 or more population, reported October 1991 through September 1992, October 1992 through September 1993;[1] and cumulative totals, by area and age group, through September 1993, United States — Continued

Metropolitan area of residence[2]	Oct. 1991–Sept. 1992		Oct. 1992–Sept. 1993		Cumulative totals		
	No.	Rate	No.	Rate	Adults/ adolescents	Children < 13 years old	Total
Orlando, Fla.	331	26.1	870	66.3	2,249	42	2,291
Philadelphia, Pa.	1,005	20.3	2,110	42.5	7,082	87	7,169
Phoenix, Ariz.	292	12.8	863	36.9	2,236	9	2,245
Pittsburgh, Pa.	148	6.2	214	8.9	1,026	6	1,032
Portland, Oreg.	249	15.9	655	40.3	1,943	6	1,949
Providence, R.I.	96	10.5	285	31.1	791	8	799
Raleigh-Durham, N.C.	128	14.5	189	20.8	787	18	805
Richmond, Va.	140	15.9	385	42.9	1,006	13	1,019
Riverside-San Bernardino, Calif.	435	16.0	1,045	36.6	2,727	27	2,754
Rochester, N.Y.	76	7.1	243	22.4	742	8	750
Sacramento, Calif.	287	20.7	453	31.5	1,490	14	1,504
Saint Louis, Mo.	290	11.6	841	33.3	2,224	21	2,245
Salt Lake City, Utah	129	11.7	241	21.3	726	14	740
San Antonio, Tex.	217	16.1	426	31.1	1,591	14	1,605
San Diego, Calif.	631	24.8	1,474	56.7	4,877	32	4,909
San Francisco, Calif.	1,896	116.9	4,592	279.8	17,397	27	17,424
San Jose, Calif.	183	12.2	502	33.2	1,514	11	1,525
San Juan, P.R.	1,075	57.9	1,638	87.3	6,577	168	6,745
Sarasota, Fla.	90	18.0	148	28.9	570	12	582
Scranton, Pa.	26	4.1	54	8.4	188	3	191
Seattle, Wash.	424	20.4	1,043	49.1	3,536	10	3,546
Springfield, Mass.	92	15.3	210	35.0	574	15	589
Stockton, Calif.	34	6.9	109	21.6	307	8	315
Syracuse, N.Y.	71	9.5	168	22.2	497	6	503
Tacoma, Wash.	38	6.3	137	21.9	360	7	367
Tampa-Saint Petersburg, Fla.	535	25.5	1,421	66.6	3,781	53	3,834
Toledo, Ohio	33	5.4	90	14.6	271	4	275
Tucson, Ariz.	93	13.7	258	37.6	619	5	624
Tulsa, Okla.	70	9.7	236	32.1	549	5	554
Ventura, Calif.	73	10.8	130	19.0	378	1	379
Washington, D.C.	1,345	31.3	2,560	58.7	9,366	138	9,504
West Palm Beach, Fla.	529	59.7	787	86.5	2,916	107	3,023
Wichita, Kansas	62	12.6	96	19.2	276	2	278
Wilmington, Del.	93	17.8	261	49.1	617	6	623
Youngstown, Ohio	23	3.8	29	4.8	148	—	148
Metropolitan areas with 500,000 or more population	**39,112**	**24.8**	**81,352**	**50.9**	**284,441**	**4,131**	**288,572**
Metropolitan areas with 50,000 to 500,000 population	**4,821**	**10.5**	**10,306**	**22.0**	**31,977**	**485**	**32,462**
Non-metropolitan areas	**2,587**	**4.9**	**5,288**	**10.0**	**16,621**	**268**	**16,889**
Total[3]	**46,716**	**18.2**	**97,368**	**37.5**	**334,344**	**4,906**	**339,250**

[1]Includes 9 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.
[2]Based on Metropolitan Statistical Areas (MSA) revised June 1993. See technical notes.
[3]Totals include 1,327 persons whose area of residence is unknown.

Table 3. AIDS cases by age group, exposure category, and sex, reported October 1991 through September 1992, October 1992 through September 1993;[1] and cumulative totals, by age group and exposure category, through September 1993, United States

Adult/adolescent exposure category	Males				Females				Totals					
	Oct. 1991–Sept. 1992		Oct. 1992–Sept. 1993		Oct. 1991–Sept. 1992		Oct. 1992–Sept. 1993		Oct. 1991–Sept. 1992		Oct. 1992–Sept. 1993		Cumulative total[2]	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	24,334	(61)	46,025	(56)	—		—		24,334	(53)	46,025	(48)	183,344	(55)
Injecting drug use	8,621	(22)	19,142	(23)	2,815	(46)	6,891	(47)	11,436	(25)	26,033	(27)	80,713	(24)
Men who have sex with men and inject drugs	2,638	(7)	5,353	(7)	—		—		2,638	(6)	5,353	(6)	21,142	(6)
Hemophilia/coagulation disorder	317	(1)	990	(1)	6	(0)	27	(0)	323	(1)	1,017	(1)	2,963	(1)
Heterosexual contact:	1,613	(4)	3,328	(4)	2,588	(42)	5,545	(37)	4,201	(9)	8,873	(9)	24,358	(7)
Sex with injecting drug user	*703*		*1,102*		*1,474*		*2,474*		*2,177*		*3,576*		*11,750*	
Sex with bisexual male	—		—		*177*		*423*		*177*		*423*		*1,250*	
Sex with person with hemophilia	*3*		*10*		*20*		*61*		*23*		*71*		*193*	
Born in Pattern-II[3] country	*271*		*607*		*165*		*324*		*436*		*931*		*3,758*	
Sex with person born in Pattern-II country	*14*		*43*		*15*		*31*		*29*		*74*		*279*	
Sex with transfusion recipient with HIV infection	*18*		*59*		*49*		*101*		*67*		*160*		*456*	
Sex with HIV-infected person, risk not specified	*604*		*1,507*		*688*		*2,131*		*1,292*		*3,638*		*6,672*	
Receipt of blood transfusion, blood components, or tissue[4]	385	(1)	695	(1)	278	(5)	496	(3)	663	(1)	1,191	(1)	5,984	(2)
Other/risk not identified[5]	1,925	(5)	6,174	(8)	466	(8)	1,833	(12)	2,391	(5)	8,007	(8)	15,840	(5)
Adult/adolescent subtotal	39,833	(100)	81,707	(100)	6,153	(100)	14,792	(100)	45,986	(100)	96,499	(100)	334,344	(100)
Pediatric (< 13 years old) exposure category														
Hemophilia/coagulation disorder	23	(6)	18	(4)	—		—		23	(3)	18	(2)	202	(4)
Mother with/at risk for HIV infection:	329	(89)	397	(91)	347	(96)	417	(97)	676	(93)	814	(94)	4,328	(88)
Injecting drug use	*114*		*126*		*144*		*138*		*258*		*264*		*1,920*	
Sex with injecting drug user	*54*		*68*		*62*		*65*		*116*		*133*		*846*	
Sex with bisexual male	*7*		*5*		*8*		*4*		*15*		*9*		*88*	
Sex with person with hemophilia	*5*		*1*		*2*		*2*		*7*		*3*		*21*	
Born in Pattern-II country	*19*		*22*		*12*		*15*		*31*		*37*		*305*	
Sex with person born in Pattern-II country	*3*		*3*		*2*		*2*		*5*		*5*		*23*	
Sex with transfusion recipient with HIV infection	*1*		*1*		*3*		*2*		*4*		*3*		*19*	
Sex with HIV-infected person, risk not specified	*31*		*45*		*21*		*51*		*52*		*96*		*275*	
Receipt of blood transfusion, blood components, or tissue	*12*		*16*		*10*		*7*		*22*		*23*		*98*	
Has HIV infection, risk not specified	*83*		*110*		*83*		*131*		*166*		*241*		*733*	
Receipt of blood transfusion, blood components, or tissue	12	(3)	15	(3)	6	(2)	9	(2)	18	(2)	24	(3)	327	(7)
Risk not identified	5	(1)	7	(2)	8	(2)	6	(1)	13	(2)	13	(1)	49	(1)
Pediatric subtotal	369	(100)	437	(100)	361	(100)	432	(100)	730	(100)	869	(100)	4,906	(100)
Total	**40,202**		**82,144**		**6,514**		**15,224**		**46,716**		**97,368**		**339,250**	

[1]Includes 9 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.

[2]Includes 7 persons known to be infected with human immunodeficiency virus type 2 (HIV-2). See *JAMA* 1992;267:2775-9.

[3]See technical notes.

[4]Twenty-seven adults/adolescents and 2 children developed AIDS after receiving blood screened negative for HIV antibody. Six additional adults developed AIDS after receiving tissue or organs from HIV-infected donors. Three of the 6 received tissues or organs from a donor who was negative for HIV antibody at the time of donation. See *N Engl J Med* 1992;326:726-32.

[5]"Other" refers to 11 health-care workers who developed AIDS after occupational exposure to HIV-infected blood, as documented by evidence of seroconversion; to 4 patients who developed AIDS after exposure to HIV within the health-care setting, as documented by laboratory studies; to 1 person who acquired HIV infection perinatally and was diagnosed with AIDS after age 13; and to 1 person with intentional self-inoculation of blood from an HIV-infected person. "Risk not identified" refers to persons whose mode of exposure to HIV is unknown. This includes persons under investigation; persons who died, were lost to follow-up, or declined interview; and persons whose mode of exposure to HIV remains unidentified after investigation. See Figure 6.

Table 4. Male adult/adolescent AIDS cases by exposure category and race/ethnicity, reported October 1992 through September 1993,[1] and cumulative totals, through September 1993, United States

Exposure category	White, not Hispanic				Black, not Hispanic				Hispanic			
	Oct. 1992–Sept. 1993		Cumulative total		Oct. 1992–Sept. 1993		Cumulative total		Oct. 1992–Sept. 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	30,094	(73)	125,392	(78)	9,614	(37)	34,166	(42)	5,638	(42)	21,475	(45)
Injecting drug use	4,285	(10)	12,670	(8)	9,667	(37)	29,762	(36)	5,094	(38)	18,143	(38)
Men who have sex with men and inject drugs	3,001	(7)	11,959	(7)	1,568	(6)	5,974	(7)	712	(5)	3,021	(6)
Hemophilia/coagulation disorder	794	(2)	2,349	(1)	110	(0)	260	(0)	68	(1)	224	(0)
Heterosexual contact:	607	(1)	1,654	(1)	2,125	(8)	6,279	(8)	570	(4)	1,375	(3)
Sex with injecting drug user	*227*		*804*		*682*		*2,118*		*185*		*599*	
Sex with person with hemophilia	*6*		*13*		*1*		*4*		*2*		*4*	
Born in Pattern-II[2] country	*1*		*8*		*605*		*2,571*		—		*10*	
Sex with person born in Pattern-II country	*10*		*52*		*31*		*86*		*2*		*11*	
Sex with transfusion recipient with HIV infection	*25*		*72*		*26*		*51*		*6*		*28*	
Sex with HIV-infected person, risk not specified	*338*		*705*		*780*		*1,449*		*375*		*723*	
Receipt of blood transfusion, blood components, or tissue	431	(1)	2,519	(2)	157	(1)	606	(1)	91	(1)	385	(1)
Risk not identified[3]	2,032	(5)	4,380	(3)	2,807	(11)	5,127	(6)	1,234	(9)	2,728	(6)
Total	**41,244**	**(100)**	**160,923**	**(100)**	**26,048**	**(100)**	**82,174**	**(100)**	**13,407**	**(100)**	**47,351**	**(100)**

Exposure category	Asian/Pacific Islander				American Indian/Alaska Native				Cumulative totals[4]			
	Oct. 1992–Sept. 1993		Cumulative total		Oct. 1992–Sept. 1993		Cumulative total		Oct. 1992–Sept. 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	445	(74)	1,583	(79)	158	(63)	388	(63)	46,025	(56)	183,344	(62)
Injecting drug use	28	(5)	79	(4)	23	(9)	62	(10)	19,142	(23)	60,835	(21)
Men who have sex with men and inject drugs	22	(4)	57	(3)	42	(17)	107	(17)	5,353	(7)	21,142	(7)
Hemophilia/coagulation disorder	12	(2)	35	(2)	6	(2)	16	(3)	990	(1)	2,890	(1)
Heterosexual contact:	15	(2)	29	(1)	4	(2)	10	(2)	3,328	(4)	9,361	(3)
Sex with injecting drug user	*6*		*12*		*1*		*5*		*1,102*		*3,539*	
Sex with person with hemophilia	—		—		—		—		*10*		*22*	
Born in Pattern-II country	—		*3*		—		—		*607*		*2,597*	
Sex with person born in Pattern-II country	—		*1*		—		—		*43*		*150*	
Sex with transfusion recipient with HIV infection	*2*		*2*		—		—		*59*		*154*	
Sex with HIV-infected person, risk not specified	*7*		*11*		*3*		*5*		*1,507*		*2,899*	
Receipt of blood transfusion, blood components, or tissue	12	(2)	72	(4)	1	(0)	5	(1)	695	(1)	3,596	(1)
Risk not identified	69	(11)	152	(8)	15	(6)	26	(4)	6,174	(8)	12,474	(4)
Total	**603**	**(100)**	**2,007**	**(100)**	**249**	**(100)**	**614**	**(100)**	**81,707**	**(100)**	**293,642**	**(100)**

[1]Includes 9 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.
[2]See technical notes.
[3]"Risk not identified" refers to persons whose mode of exposure to HIV is unknown. This includes persons under investigation; persons who died, were lost to follow-up, or declined interview; and persons whose mode of exposure to HIV remains unidentified after investigation. See Figure 6.
[4]Includes 573 men whose race/ethnicity is unknown.

Table 5. Female adult/adolescent AIDS cases by exposure category and race/ethnicity, reported October 1992 through September 1993,[1] and cumulative totals, through September 1993, United States

Exposure category	White, not Hispanic				Black, not Hispanic				Hispanic			
	Oct. 1992–Sept. 1993		Cumulative total		Oct. 1992–Sept. 1993		Cumulative total		Oct. 1992–Sept. 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Injecting drug use	1,718	(46)	4,459	(43)	3,861	(48)	11,386	(52)	1,265	(44)	3,907	(47)
Hemophilia/coagulation disorder	14	(0)	48	(0)	7	(0)	15	(0)	5	(0)	9	(0)
Heterosexual contact:	1,387	(37)	3,595	(35)	2,884	(36)	7,864	(36)	1,192	(41)	3,377	(41)
Sex with injecting drug user	*586*		*1,703*		*1,191*		*4,101*		*667*		*2,337*	
Sex with bisexual male	*199*		*627*		*150*		*428*		*60*		*162*	
Sex with person with hemophilia	*50*		*140*		*9*		*21*		*1*		*7*	
Born in Pattern-II[2] country	*3*		*5*		*316*		*1,143*		*4*		*11*	
Sex with person born in Pattern-II country	*4*		*15*		*26*		*110*		*1*		*4*	
Sex with transfusion recipient with HIV infection	*49*		*176*		*27*		*63*		*17*		*51*	
Sex with HIV-infected person, risk not specified	*496*		*929*		*1,165*		*1,998*		*442*		*805*	
Receipt of blood transfusion, blood components, or tissue	223	(6)	1,398	(14)	167	(2)	571	(3)	88	(3)	349	(4)
Risk not identified[3]	398	(11)	793	(8)	1,089	(14)	1,892	(9)	327	(11)	631	(8)
Total	**3,740**	**(100)**	**10,293**	**(100)**	**8,008**	**(100)**	**21,728**	**(100)**	**2,877**	**(100)**	**8,273**	**(100)**

Exposure category	Asian/Pacific Islander				American Indian/Alaska Native				Cumulative totals[4]			
	Oct. 1992–Sept. 1993		Cumulative total		Oct. 1992–Sept. 1993		Cumulative total		Oct. 1992–Sept. 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Injecting drug use	15	(15)	34	(15)	17	(37)	52	(50)	6,891	(47)	19,878	(49)
Hemophilia/coagulation disorder	1	(1)	1	(0)	—		—		27	(0)	73	(0)
Heterosexual contact:	57	(58)	104	(45)	20	(43)	32	(31)	5,545	(37)	14,997	(37)
Sex with injecting drug user	*15*		*31*		*12*		*21*		*2,474*		*8,211*	
Sex with bisexual male	*13*		*28*		*1*		*3*		*423*		*1,250*	
Sex with person with hemophilia	—		*2*		*1*		*1*		*61*		*171*	
Born in Pattern-II country	*1*		*1*		—		—		*324*		*1,161*	
Sex with person born in Pattern-II country	—		—		—		—		*31*		*129*	
Sex with transfusion recipient with HIV infection	*8*		*11*		—		—		*101*		*302*	
Sex with HIV-infected person, risk not specified	*20*		*31*		*6*		*7*		*2,131*		*3,773*	
Receipt of blood transfusion, blood components, or tissue	16	(16)	59	(26)	2	(4)	8	(8)	496	(3)	2,388	(6)
Risk not identified	10	(10)	32	(14)	7	(15)	11	(11)	1,833	(12)	3,366	(8)
Total	**99**	**(100)**	**230**	**(100)**	**46**	**(100)**	**103**	**(100)**	**14,792**	**(100)**	**40,702**	**(100)**

[1]Includes 9 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.

[2]See technical notes.

[3]"Risk not identified" refers to persons whose mode of exposure to HIV is unknown. This includes persons under investigation; persons who died, were lost to follow-up, or declined interview; and persons whose mode of exposure to HIV remains unidentified after investigation. See Figure 6.

[4]Includes 75 women whose race/ethnicity is unknown.

Table 6. Pediatric AIDS cases by exposure category and race/ethnicity, reported October 1992 through September 1993, and cumulative totals, through September 1993, United States

Exposure category	White, not Hispanic				Black, not Hispanic				Hispanic			
	Oct. 1992–Sept. 1993		Cumulative total		Oct. 1992–Sept. 1993		Cumulative total		Oct. 1992–Sept. 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Hemophilia/coagulation disorder	13	(9)	141	(14)	1	(0)	24	(1)	4	(2)	33	(3)
Mother with/at risk for HIV infection:	118	(84)	663	(68)	489	(97)	2,556	(95)	197	(93)	1,074	(90)
Injecting drug use	*38*		*290*		*153*		*1,133*		*69*		*483*	
Sex with injecting drug user	*22*		*132*		*70*		*390*		*40*		*318*	
Sex with bisexual male	*4*		*39*		*2*		*28*		*3*		*20*	
Sex with person with hemophilia	*2*		*13*		—		*5*		*1*		*3*	
Born in Pattern-II[1] country	—		*3*		*37*		*300*		—		*2*	
Sex with person born in Pattern-II country	—		—		*5*		*22*		—		*1*	
Sex with transfusion recipient with HIV infection	*1*		*6*		*1*		*5*		*1*		*8*	
Sex with HIV-infected person, risk not specified	*10*		*45*		*57*		*148*		*27*		*77*	
Receipt of blood transfusion, blood components, or tissue	*6*		*29*		*12*		*43*		*5*		*25*	
Has HIV infection, risk not specified	*35*		*106*		*152*		*482*		*51*		*137*	
Receipt of blood transfusion, blood components, or tissue	9	(6)	167	(17)	6	(1)	74	(3)	7	(3)	76	(6)
Risk not identified[2]	1	(1)	9	(1)	8	(2)	29	(1)	4	(2)	11	(1)
Total	**141**	**(100)**	**980**	**(100)**	**504**	**(100)**	**2,683**	**(100)**	**212**	**(100)**	**1,194**	**(100)**

Exposure category	Asian/Pacific Islander				American Indian/Alaska Native				Cumulative totals[3]			
	Oct. 1992–Sept. 1993		Cumulative total		Oct. 1992–Sept. 1993		Cumulative total		Oct. 1992–Sept. 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Hemophilia/coagulation disorder	—		3	(14)	—		1	(7)	18	(2)	202	(4)
Mother with/at risk for HIV infection:	2	(50)	10	(45)	2	(100)	13	(93)	814	(94)	4,328	(88)
Injecting drug use	*1*		*3*		*1*		*6*		*264*		*1,920*	
Sex with injecting drug user	—		*2*		*1*		*2*		*133*		*846*	
Sex with bisexual male	—		*1*		—		—		*9*		*88*	
Sex with person with hemophilia	—		—		—		—		*3*		*21*	
Born in Pattern-II country	—		—		—		—		*37*		*305*	
Sex with person born in Pattern-II country	—		—		—		—		*5*		*23*	
Sex with transfusion recipient with HIV infection	—		—		—		—		*3*		*19*	
Sex with HIV-infected person, risk not specified	*1*		*1*		—		*2*		*96*		*275*	
Receipt of blood transfusion, blood components, or tissue	—		*1*		—		—		*23*		*98*	
Has HIV infection, risk not specified	—		*2*		—		*3*		*241*		*733*	
Receipt of blood transfusion, blood components, or tissue	2	(50)	9	(41)	—		—		24	(3)	327	(7)
Risk not identified	—		—		—		—		13	(1)	49	(1)
Total	**4**	**(100)**	**22**	**(100)**	**2**	**(100)**	**14**	**(100)**	**869**	**(100)**	**4,906**	**(100)**

[1]See technical notes.

[2]"Risk not identified" refers to persons whose mode of exposure to HIV is unknown. This includes persons under investigation; persons who died, were lost to follow-up, or declined interview; and persons whose mode of exposure to HIV remains unidentified after investigation. See Figure 6.

[3]Includes 13 children whose race/ethnicity is unknown.

Table 7. AIDS cases in adolescents and adults under age 25, by sex and exposure category, reported October 1991 through September 1992, October 1992 through September 1993,[1] and cumulative totals through September 1993, United States

	13-19 years old						20-24 years old					
	Oct. 1991–Sept. 1992		Oct. 1992–Sept. 1993		Cumulative total		Oct. 1991–Sept. 1992		Oct. 1992–Sept. 1993		Cumulative total	
Male exposure category	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	36	(35)	91	(28)	319	(33)	694	(63)	1,489	(60)	6,485	(64)
Injecting drug use	4	(4)	14	(4)	62	(6)	146	(13)	282	(11)	1,245	(12)
Men who have sex with men and inject drugs	5	(5)	8	(2)	45	(5)	110	(10)	204	(8)	1,063	(11)
Hemophilia/coagulation disorder	47	(46)	172	(52)	440	(45)	42	(4)	154	(6)	385	(4)
Heterosexual contact:	3	(3)	13	(4)	29	(3)	55	(5)	118	(5)	363	(4)
Sex with injecting drug user	*1*		*6*		*11*		*24*		*40*		*135*	
Sex with person with hemophilia	—		*1*		*1*		—		—		*1*	
Born in Pattern-II[2] country	—		*1*		*8*		*8*		*17*		*98*	
Sex with person born in Pattern-II country	—		—		*1*		—		*2*		*2*	
Sex with transfusion recipient with HIV infection	—		—		—		*1*		*4*		*9*	
Sex with HIV-infected person, risk not specified	*2*		*5*		*8*		*22*		*55*		*118*	
Receipt of blood transfusion, blood components, or tissue	5	(5)	12	(4)	42	(4)	6	(1)	22	(1)	85	(1)
Risk not identified[3]	2	(2)	19	(6)	40	(4)	53	(5)	220	(9)	445	(4)
Male subtotal	102	(100)	329	(100)	977	(100)	1,106	(100)	2,489	(100)	10,071	(100)
Female exposure category												
Injecting drug use	12	(20)	14	(8)	86	(20)	123	(32)	283	(30)	931	(35)
Hemophilia/coagulation disorder	1	(2)	1	(1)	5	(1)	1	(0)	4	(0)	9	(0)
Heterosexual contact:	34	(58)	105	(62)	236	(54)	206	(54)	483	(51)	1,329	(50)
Sex with injecting drug user	*20*		*37*		*127*		*118*		*233*		*754*	
Sex with bisexual male	*1*		*7*		*11*		*14*		*32*		*108*	
Sex with person with hemophilia	*2*		*1*		*6*		*2*		*7*		*27*	
Born in Pattern-II country	*1*		*4*		*11*		*5*		*11*		*64*	
Sex with person born in Pattern-II country	—		*1*		*2*		—		*1*		*12*	
Sex with transfusion recipient with HIV infection	—		*2*		*3*		—		*2*		*7*	
Sex with HIV-infected person, risk not specified	*10*		*53*		*76*		*67*		*197*		*357*	
Receipt of blood transfusion, blood components, or tissue	1	(2)	14	(8)	41	(9)	12	(3)	19	(2)	81	(3)
Risk not identified	11	(19)	36	(21)	67	(15)	40	(10)	167	(17)	291	(11)
Female subtotal	59	(100)	170	(100)	435	(100)	382	(100)	956	(100)	2,641	(100)
Total	**161**		**499**		**1,412**		**1,488**		**3,445**		**12,712**	

[1]Includes 9 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.
[2]See technical notes.
[3]"Risk not identified" refers to persons whose mode of exposure to HIV is unknown. This includes persons under investigation; persons who died, were lost to follow-up, or declined interview; and persons whose mode of exposure to HIV remains unidentified after investigation. See Figure 6.

Table 8. AIDS cases by sex, age at diagnosis, and race/ethnicity, reported through September 1993,[1] United States

Male	White, not Hispanic		Black, not Hispanic		Hispanic		Asian/Pacific Islander		American Indian/ Alaska Native		Total[2]	
Age at diagnosis (years)	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**
Under 5	329	(0)	1,167	(1)	478	(1)	8	(0)	8	(1)	1,992	(1)
5-12	248	(0)	183	(0)	155	(0)	7	(0)	1	(0)	594	(0)
13-19	473	(0)	299	(0)	186	(0)	11	(1)	11	(2)	980	(0)
20-24	4,735	(3)	3,282	(4)	1,938	(4)	75	(4)	23	(4)	10,071	(3)
25-29	23,298	(14)	12,067	(14)	7,742	(16)	267	(13)	123	(20)	43,576	(15)
30-34	37,653	(23)	19,017	(23)	11,723	(24)	420	(21)	173	(28)	69,100	(23)
35-39	35,879	(22)	19,483	(23)	10,671	(22)	443	(22)	126	(20)	66,742	(23)
40-44	25,717	(16)	13,213	(16)	7,088	(15)	346	(17)	85	(14)	46,548	(16)
45-49	15,223	(9)	6,869	(8)	3,793	(8)	218	(11)	34	(5)	26,191	(9)
50-54	8,173	(5)	3,800	(5)	2,012	(4)	108	(5)	17	(3)	14,140	(5)
55-59	4,671	(3)	2,121	(3)	1,174	(2)	62	(3)	9	(1)	8,066	(3)
60-64	2,775	(2)	1,155	(1)	587	(1)	20	(1)	10	(2)	4,551	(2)
65 or older	2,328	(1)	869	(1)	437	(1)	37	(2)	3	(0)	3,680	(1)
Male subtotal	161,502	(100)	83,525	(100)	47,984	(100)	2,022	(100)	623	(100)	296,231	(100)
Female												
Age at diagnosis (years)												
Under 5	320	(3)	1,143	(5)	455	(5)	1	(0)	5	(5)	1,933	(4)
5-12	81	(1)	189	(1)	106	(1)	6	(3)	—		384	(1)
13-19	102	(1)	262	(1)	68	(1)	1	(0)	1	(1)	435	(1)
20-24	672	(6)	1,347	(6)	594	(7)	12	(5)	10	(9)	2,641	(6)
25-29	1,875	(18)	3,801	(16)	1,699	(19)	23	(10)	23	(21)	7,430	(17)
30-34	2,455	(23)	5,618	(24)	2,126	(24)	48	(20)	34	(31)	10,300	(24)
35-39	1,918	(18)	5,094	(22)	1,707	(19)	38	(16)	14	(13)	8,792	(20)
40-44	1,093	(10)	2,826	(12)	988	(11)	37	(16)	9	(8)	4,961	(12)
45-49	594	(6)	1,187	(5)	472	(5)	21	(9)	5	(5)	2,286	(5)
50-54	359	(3)	706	(3)	273	(3)	14	(6)	2	(2)	1,356	(3)
55-59	344	(3)	381	(2)	168	(2)	8	(3)	1	(1)	903	(2)
60-64	249	(2)	248	(1)	87	(1)	12	(5)	3	(3)	599	(1)
65 or older	632	(6)	258	(1)	91	(1)	16	(7)	1	(1)	999	(2)
Female subtotal	10,694	(100)	23,060	(100)	8,834	(100)	237	(100)	108	(100)	43,019	(100)
Total	**172,196**		**106,585**		**56,818**		**2,259**		**731**		**339,250**	

[1]Includes 9 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.
[2]Includes 575 males and 86 females whose race/ethnicity is unknown.

Table 9. AIDS cases, case-fatality rates,[1] and deaths, by half-year and age group, through September 1993,[2] United States

Half-year	Adults/adolescents			Children <13 years old		
	Cases diagnosed during interval	Case-fatality rate	Deaths occurring during interval	Cases diagnosed during interval	Case-fatality rate	Deaths occurring during interval
Before 1981	92	81.5	30	6	66.7	1
1981 Jan.–June	98	89.8	37	11	81.8	2
July–Dec.	208	91.3	87	5	100.0	6
1982 Jan.–June	407	92.6	155	13	84.6	9
July–Dec.	707	91.1	290	16	81.3	5
1983 Jan.–June	1,312	93.2	526	32	100.0	13
July–Dec.	1,654	93.2	939	42	90.5	16
1984 Jan.–June	2,581	92.8	1,406	51	84.3	26
July–Dec.	3,408	92.8	1,981	62	87.1	22
1985 Jan.–June	4,970	92.0	2,825	99	76.8	45
July–Dec.	6,379	91.6	3,904	128	82.8	69
1986 Jan.–June	8,413	90.4	5,109	138	81.9	65
July–Dec.	10,026	88.3	6,568	189	70.9	91
1987 Jan.–June	13,115	88.6	7,613	218	72.0	117
July–Dec.	14,574	85.7	8,013	257	67.7	168
1988 Jan.–June	16,836	83.4	9,397	258	64.7	134
July–Dec.	17,425	83.1	10,764	338	61.2	174
1989 Jan.–June	20,096	78.7	12,379	352	60.2	171
July–Dec.	20,434	76.5	14,231	333	57.4	184
1990 Jan.–June	22,629	70.8	14,404	357	52.9	191
July–Dec.	22,128	66.3	15,265	377	43.0	190
1991 Jan.–June	25,769	58.7	15,902	357	42.3	163
July–Dec.	27,410	49.4	17,497	325	35.7	199
1992 Jan.–June	30,925	36.1	17,431	384	32.3	168
July–Dec.	31,177	23.4	17,555	318	27.0	197
1993 Jan.–June	27,847	11.4	14,787	213	18.3	161
July–Sept.	3,724	5.5	2,410	27	7.4	26
Total[3]	**334,344**	**60.3**	**201,775**	**4,906**	**53.3**	**2,615**

[1]Case-fatality rates are calculated for each half-year by date of diagnosis. Each 6-month case-fatality rate is the number of deaths ever reported among cases diagnosed in that period (regardless of the year of death), divided by the number of total cases diagnosed in that period, multiplied by 100. For example, during the interval January through June 1982, AIDS was diagnosed in 407 adults/adolescents. Through September 1993, 377 of these 407 were reported as dead. Therefore, the case fatality rate is 92.6 (377 divided by 407, multiplied by 100). The case-fatality rates shown here may be underestimates because of incomplete reporting of deaths. Reported deaths are not necessarily caused by HIV-related disease.

[2]Includes 9 months of data collected under the 1993 AIDS surveillance case defintions for adults and adolescents.

[3]Death totals include 270 adults/adolescents and 2 children known to have died, but whose dates of death are unknown.

Table 10. AIDS cases by year of diagnosis and definition category, diagnosed through September 1993,[1] United States

Definition category	Period of diagnosis: Before Sept. 1989 No.	(%)	Oct. 1989–Sept. 1990 No.	(%)	Oct. 1990–Sept. 1991 No.	(%)	Oct. 1991–Sept. 1992 No.	(%)	Oct. 1992–Sept. 1993 No.	(%)	Cumulative total No.	(%)
Pre-1987 definition	106,479	(79)	28,634	(64)	29,523	(58)	28,340	(47)	13,876	(29)	206,852	(61)
1987 definition	26,788	(20)	13,559	(30)	16,078	(31)	17,521	(29)	9,537	(20)	83,483	(25)
1993 definition[2]	1,610	(1)	2,402	(5)	5,467	(11)	15,032	(25)	24,404	(51)	48,915	(14)
Severe HIV-related immunosuppression[3]	*1,181*		*2,021*		*4,669*		*13,587*		*22,718*		*44,176*	
Pulmonary tuberculosis	*362*		*333*		*706*		*1,195*		*1,115*		*3,711*	
Recurrent pneumonia	*55*		*44*		*85*		*223*		*541*		*948*	
Invasive cervical cancer	*16*		*8*		*13*		*38*		*48*		*123*	
Total	**134,877**	**(100)**	**44,595**	**(100)**	**51,068**	**(100)**	**60,893**	**(100)**	**47,817**	**(100)**	**339,250**	**(100)**

[1]Includes 9 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.

[2]Persons who meet only the 1993 AIDS case definition and whose date of diagnosis is before January 1993 were diagnosed retrospectively. The sum of diagnoses listed for the four conditions under the 1993 definition do not equal the 1993 definition total because some persons have more than one diagnosis from the added conditions of pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer.

[3]Defined as CD4+ T-lymphocyte count of less than 200 cells/μL or a CD4+ percentage less than 14 in persons with laboratory confirmation of HIV infection.

Table 11. Health-care workers with documented and possible occupationally acquired AIDS/HIV infection, by occupation, reported through September 1993, United States[1]

Occupation	Documented occupational transmission[2] No.	Possible occupational transmission[3] No.
Dental worker, including dentist	—	6
Embalmer/morgue technician	—	3
Emergency medical technician/paramedic	—	8
Health aide/attendant	1	9
Housekeeper/maintenace worker	1	6
Laboratory technician, clinical	15	14
Laboratory technician, nonclinical	1	1
Nurse	13	15
Physician, nonsurgical	5	8
Physician, surgical	—	2
Respiratory therapist	1	2
Technician, dialysis	1	1
Technician, surgical	1	1
Technician/therapist, other than those listed above	—	3
Other health-care occupations	—	2
Total	**39**	**81**

[1]Health-care workers are defined as those persons, including students and trainees, who have worked in a health-care, clinical, or HIV laboratory setting at any time since 1978. See *MMWR* 1992;41:823-5.

[2]Health-care workers who had documented HIV seroconversion after occupational exposure: 34 had percutaneous exposure, 4 had mucocutaneous exposure, 1 had both percutaneous and mucocutaneous exposures. Thirty-six exposures were to blood from an HIV-infected person, 1 to visibly bloody fluid, 1 to an unspecified fluid, and 1 to a concentrated virus in a laboratory. Eleven of these health-care workers have developed AIDS.

[3]These health-care workers have been investigated and are without identifiable behavioral or transfusion risks; each reported percutaneous or mucocutaneous occupational exposures to blood or body fluids, or laboratory solutions containing HIV, but HIV seroconversion specifically resulting from an occupational exposure was not documented.

Table 12. Adult/adolescent AIDS cases by single and multiple exposure categories, reported through September 1993, United States

Exposure category	AIDS cases No.	(%)
Single mode of exposure		
Men who have sex with men	176,793	(53)
Injecting drug use	68,029	(20)
Hemophilia/coagulation disorder	2,212	(1)
Heterosexual contact	23,536	(7)
Receipt of transfusion[1]	5,978	(2)
Receipt of transplant of tissues/organs[2]	6	(0)
Other[3]	17	(0)
Single mode of exposure subtotal	**276,567**	**(83)**
Multiple modes of exposure		
Men who have sex with men; injecting drug use	18,885	(6)
Men who have sex with men; hemophilia/coagulation disorder	82	(0)
Men who have sex with men; heterosexual contact	3,718	(1)
Men who have sex with men; receipt of transfusion/transplant	2,554	(1)
Injecting drug use; hemophilia/coagulation disorder	88	(0)
Injecting drug use; heterosexual contact	11,003	(3)
Injecting drug use; receipt of transfusion/transplant	1,114	(0)
Hemophilia/coagulation disorder; heterosexual contact	29	(0)
Hemophilia/coagulation disorder; receipt of transfusion/transplant	704	(0)
Heterosexual contact; receipt of transfusion/transplant	822	(0)
Men who have sex with men; injecting drug use; hemophilia/coagulation disorder	20	(0)
Men who have sex with men; injecting drug use; heterosexual contact	1,764	(1)
Men who have sex with men; injecting drug use; receipt of transfusion/transplant	392	(0)
Men who have sex with men; hemophilia/coagulation disorder; heterosexual contact	4	(0)
Men who have sex with men; hemophilia/coagulation disorder; receipt of transfusion/transplant	27	(0)
Men who have sex with men; heterosexual contact; receipt of transfusion/transplant	163	(0)
Injecting drug use; hemophilia/coagulation disorder; heterosexual contact	20	(0)
Injecting drug use; hemophilia/coagulation disorder; receipt of transfusion/transplant	28	(0)
Injecting drug use; heterosexual contact; receipt of transfusion/transplant	421	(0)
Hemophilia/coagulation disorder; heterosexual contact; receipt of transfusion/transplant	18	(0)
Men who have sex with men; injecting drug use; hemophilia/coagulation disorder; heterosexual contact	4	(0)
Men who have sex with men; injecting druguse; hemophilia/coagulation disorder; receipt of transfusion/transplant	5	(0)
Men who have sex with men; injecting drug use; heterosexual contact; receipt of transfusion/transplant	71	(0)
Men who have sex with men; hemophilia/coagulation disorder; heterosexual contact; receipt of transfusion/transplant	3	(0)
Injecting drug use; hemophilia/coagulation disorder; heterosexual contact; receipt of transfusion/transplant	10	(0)
Men who have sex with men; injecting drug use; hemophilia/coagulation disorder; heterosexual contact; receipt of transfusion/transplant	1	(0)
Multiple modes of exposure subtotal	**41,950**	**(13)**
Risk not identified[4]	**15,823**	**(5)**
Total	**334,344**	**(100)**

[1]Includes 27 adult/adolescents and 2 children who developed AIDS after receiving blood screened negative for HIV antibody.

[2]Six adults developed AIDS after receiving tissue from HIV-infected donors. Three of the 6 received tissue or organs from a donor who was negative for HIV antibody at the time of donation. See *N Engl J Med* 1992;326:726-32.

[3]"Other" refers to 11 health-care workers who developed AIDS after occupational exposure to HIV-infected blood as documented by evidence of seroconversion; to 4 patients who developed AIDS after exposure to HIV within the health-care setting, as documented by laboratory studies; to 1 person who acquired HIV infection perinatally and was diagnosed with AIDS after age 13; and to 1 person with intentional self-inoculation of blood from an HIV-infected person.

4"Risk not identified" refers to persons whose mode of exposure to HIV is unknown. This includes persons under investigation; persons who died, were lost to follow-up, or declined interview; and persons whose mode of exposure to HIV remains unidentified after investigation. See Figure 6.

Figure 1. Male adult/adolescent AIDS annual rates per 100,000 population, for cases reported October 1992 through September 1993, United States

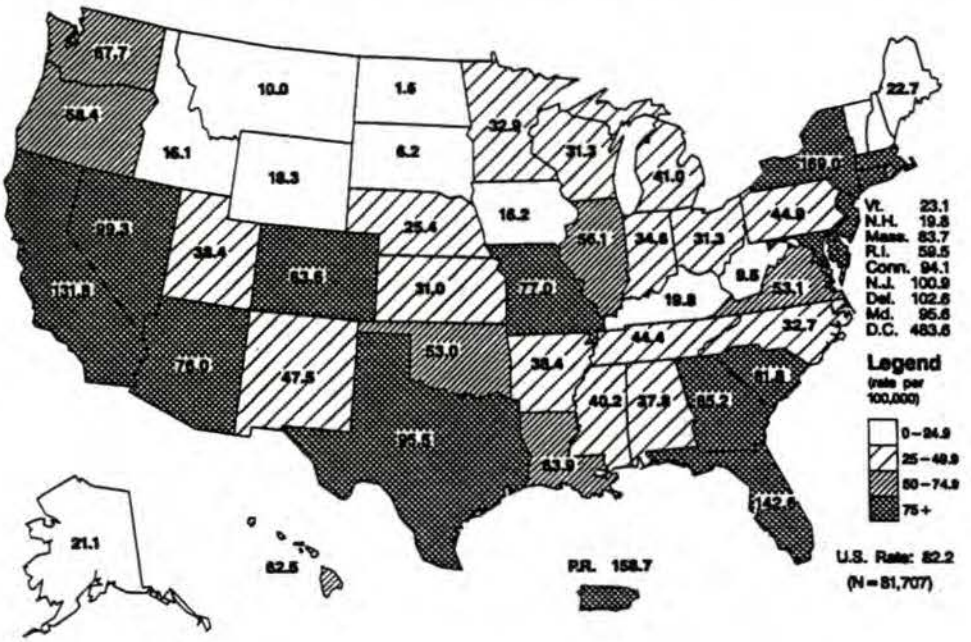


Figure 2. Female adult/adolescent AIDS annual rates per 100,000 population, for cases reported October 1992 through September 1993, United States

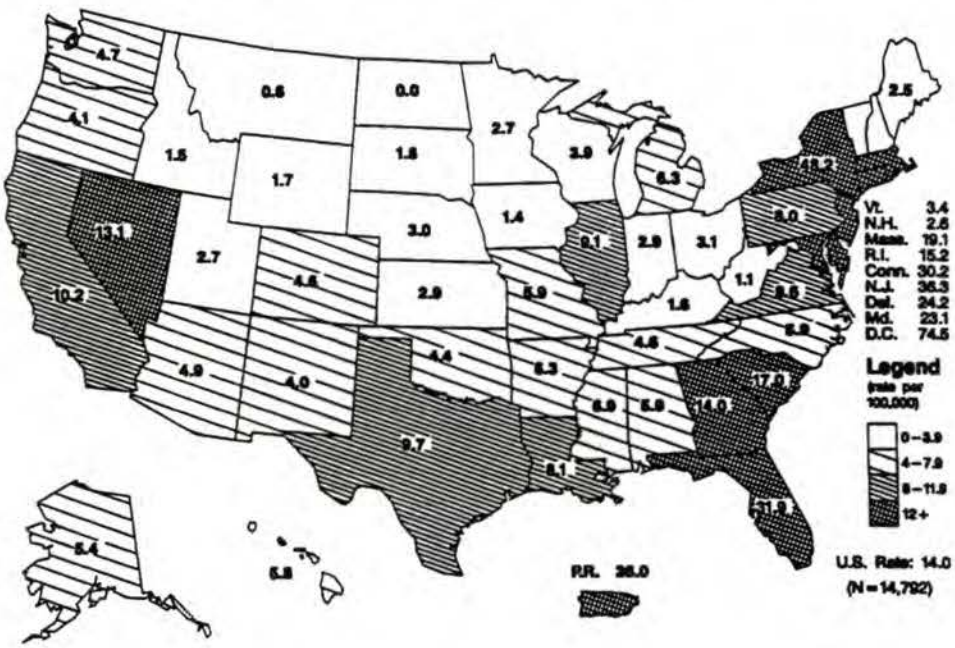


Figure 3. Male adult/adolescent AIDS cases reported October 1992 through September 1993, United States



Figure 4. Female adult/adolescent AIDS cases reported October 1992 through September 1993, United States

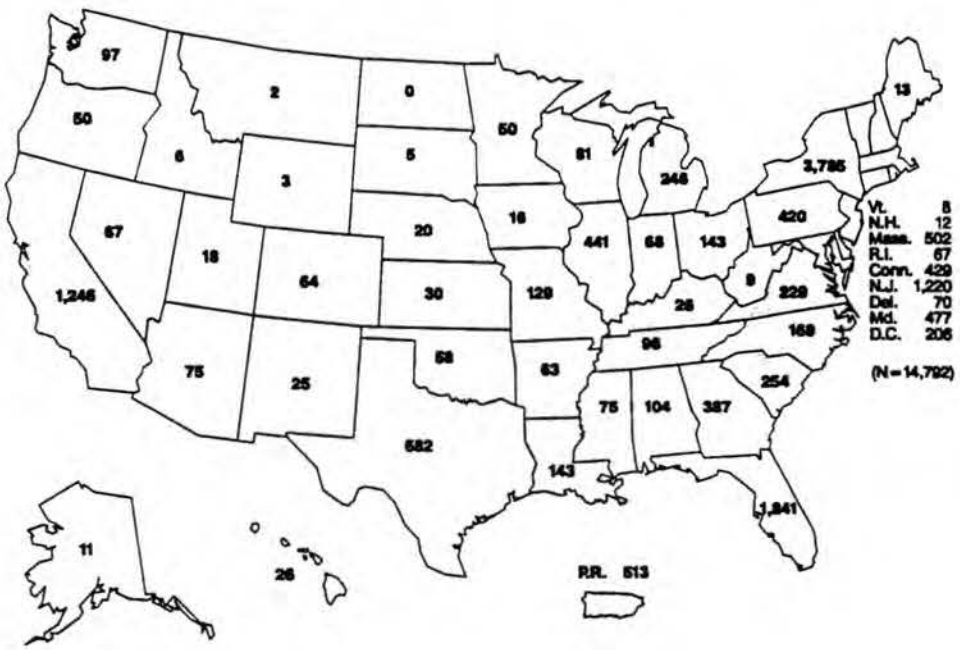


Figure 5. Pediatric AIDS cases reported October 1992 through September 1993, United States

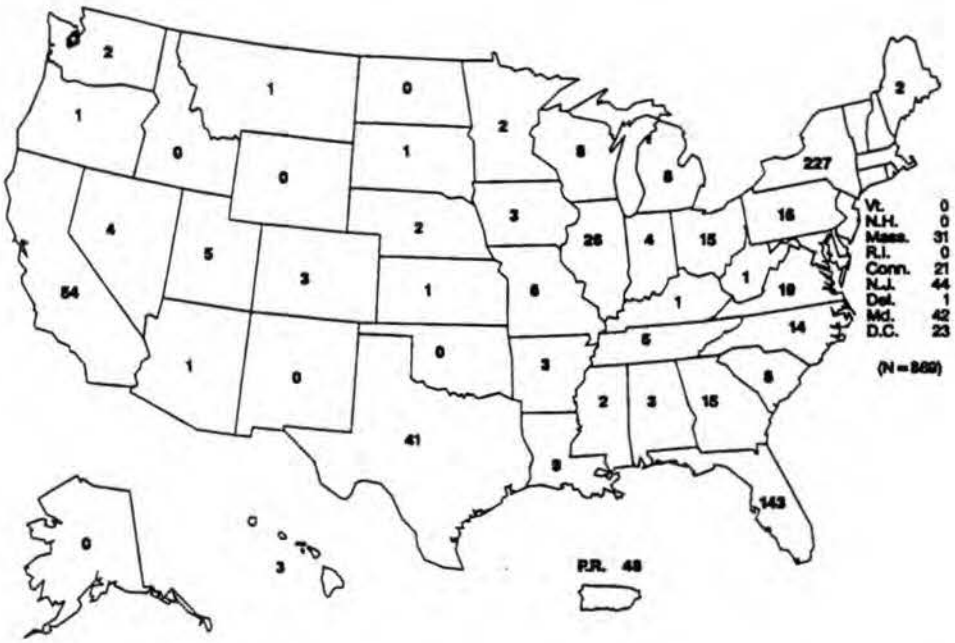
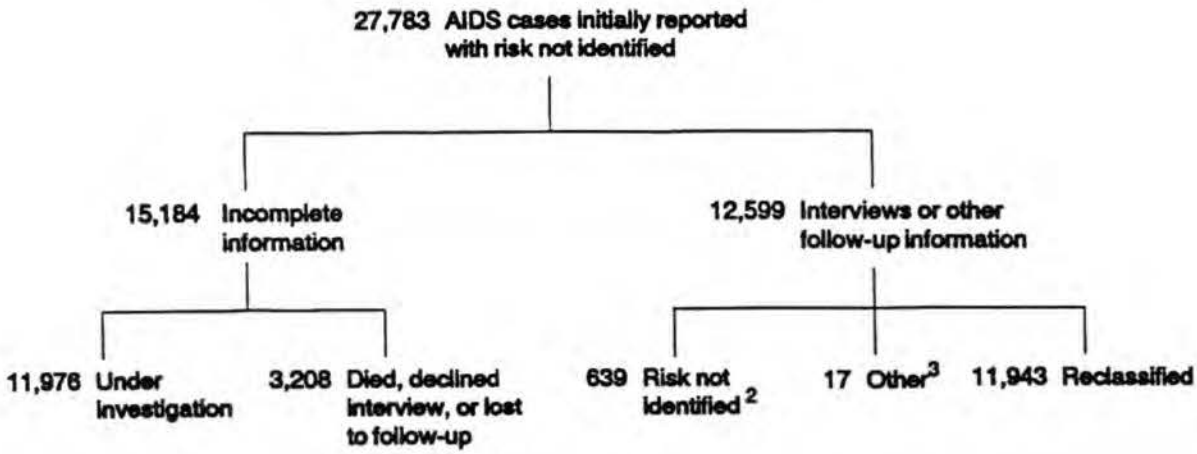


Figure 6. Results of investigations of adult/adolescent AIDS cases with risk not identified, reported through September 1993[1]



[1]Excludes 49 children under 13 years of age whose risk is not identified: 40 children who are under investigation and 9 who have died, declined interview, or were lost to follow-up. An additional 228 children who were initially reported with a risk not identified have been reclassified after investigation.

[2]Heterosexual transmission. 553 of the 639 persons who had no risk identified after follow-up responded to a standardized questionnaire: 185 (36%) of 511 persons responding to questions related to sexually transmitted diseases gave a history of such diseases and 123 (36%) of 342 interviewed men reported sexual contact with a prostitute. Some of these persons may represent unreported or unrecognized heterosexual transmission of HIV. See *MMWR*;38:423-4, 429-34.

[3]Eleven are health-care workers who developed AIDS after occupational exposure to HIV-infected blood, as documented by evidence of seroconversion; 4 are patients who developed AIDS after exposure to HIV within the health-care setting, as documented by laboratory studies; 1 is a person who acquired HIV infection perinatally and was diagnosed with AIDS after age 13; and 1 is a person with intentional self-inoculation of blood from an HIV-infected person.

Technical notes

Surveillance and reporting of AIDS

All 50 states, the District of Columbia, U.S. dependencies and possessions, and independent nations in free association with the United States[1] report AIDS cases to CDC using a uniform case definition and case report form. The original definition was modified in 1985 (*MMWR* 1985;34:373-5), in 1987 (*MMWR* 1987;36[suppl. no. 1S]:1S-15S), and again in 1993 (*MMWR* 1992;41[no. RR-17]:1-19). The revisions incorporated a broader range of AIDS-indicator diseases and conditions and used human immunodeficiency virus (HIV) diagnostic tests to improve the sensitivity and specificity of the definition.

For persons with laboratory-confirmed HIV infection, the 1987 revision incorporated HIV encephalopathy, wasting syndrome, and other indicator diseases that are diagnosed presumptively (i.e., without confirmatory laboratory evidence of the opportunistic disease). In addition to the 23 clinical conditions in the 1987 AIDS case definition, the 1993 expanded case definition for adults and adolescents includes HIV-infected persons with CD4+ T-lymphocyte counts of less than 200 cells/μL or a CD4+ percentage of less than 14, and persons diagnosed with pulmonary tuberculosis, recurrent pneumonia (more than 2 episodes in a 12-month period), and invasive cervical cancer. This expanded definition requires laboratory confirmation of HIV infection in a person with a CD4+ T-lymphocyte count of less than 200 cells/μL or with one of the added clinical conditions. Persons who meet the criteria for more than one definition category are classified hierarchically in the following order: pre-1987, 1987, and 1993. Persons in the 1993 definition category only meet the 1993 definition.

Each issue of this report includes information received and tabulated by CDC through the last day of the previous quarter. Data are tabulated by date of report to CDC unless otherwise noted. Data for U.S. dependencies and possessions and for associated independent nations are included in the totals.

Age group tabulations are based on the person's age at diagnosis of AIDS: adult/adolescent cases include persons 13 years of age and older; pediatric cases include children under 13 years of age.

Metropolitan areas with 500,000 or more population are included in this report. On December 31, 1992, the Office of Management and Budget announced new Metropolitan Statistical Area (MSA) definitions which reflect changes in the U.S. population determined by the 1990 census. These definitions were revised on June 30, 1993. The cities and counties which compose each metropolitan area in Table 2 are listed in the publication "Revised Statistical Definitions for Metropolitan Areas" (available from National Technical Information Service, accession no. PB93-505-824).

The metropolitan area definitions are the MSAs for all areas except the 6 New England states. For these states, the New England County Metropolitan Areas (NECMA) are used. Metropolitan areas are named for a central city in the MSA or NECMA, may include several cities and counties, and may cross state boundaries. For example, AIDS cases and annual rates presented for the District of Columbia in Table 1 include only persons residing within the geographic boundaries of the District. AIDS cases and annual rates for Washington, D.C., in Table 2 include persons residing within the metropolitan area, which includes counties in both Maryland and Virginia. State or metropolitan area data tabulations are based on the person's residence at diagnosis of the first AIDS-indicator disease(s).

Data in this report are provisional. Reporting delays (time between diagnosis and report to CDC) vary widely among exposure, geographic, racial/ethnic, and age categories, and have been as long as several years for some cases. About 55 percent of all cases are reported within 3 months of diagnosis, but about 20 percent are reported more than 1 year after diagnosis.

Although completeness of reporting of diagnosed cases varies by geographic region and population, studies conducted by state and local health departments indicate that reporting of AIDS cases in most areas of the United States is more than 85 percent complete (*J Acquir Immune Defic Syndr*, 1992;5:257-64; and *Am J Public Health* 1992;82:1495-9). In addition, multiple routes of exposure, opportunistic diseases diagnosed after the initial case report was submitted to CDC and vital status may not be deter-

[1]Included among the dependencies, possessions, and independent nations are Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, the Republic of Palau, the Republic of the Marshall Islands, the Commonwealth of the Northern Mariana Islands, and the Federated States of Micronesia. The latter 5 comprise the category "Pacific Islands, U.S." listed in Table 1.

mined or reported for all cases. Caution should be used in interpreting case-fatality rates because reporting of deaths is incomplete.

Exposure categories

For surveillance purposes, AIDS cases are counted only once in a hierarchy of exposure categories. Persons with more than one reported mode of exposure to HIV are classified in the category listed first in the hierarchy, except for men with both a history of sexual contact with other men and injecting drug use. They make up a separate category.

"Men who have sex with men" cases include men who report sexual contact with other men (i.e., homosexual contact) and men who report sexual contact with both men and women (i.e., bisexual contact). "Heterosexual contact" cases include persons who report either specific heterosexual contact with a person with (or at increased risk for) HIV infection (e.g., an injecting drug user), or persons presumed to have acquired HIV infection through heterosexual contact if they were born in countries with a distinctive pattern of transmission termed "Pattern II" by the World Health Organization (*MMWR* 1988;37:286-8, 293-5). Pattern-II transmission is observed in areas of sub-Saharan Africa and in some Caribbean countries. In these countries, most of the reported cases occur in heterosexuals and the male-to-female ratio is approximately 1:1. Injecting drug use and homosexual transmission either do not occur or occur rarely.

"Risk not identified" cases are persons with no reported history of exposure to HIV through any of the routes listed in the hierarchy of exposure categories. Risk not identified cases include persons who are currently under investigation by local health department officials; persons whose exposure history is incomplete because they died, declined to be interviewed, or were lost to follow-up; and persons who were interviewed or for whom other follow-up information was available and no exposure mode was identified. Persons who have an exposure mode identified at the time of follow-up are reclassified into the appropriate exposure category.

Rates

Rates are calculated on an annual basis per 100,000 population, based on U.S. Bureau of Census data from the 1990 census, and on extrapolations from the 1990 census and official Census Bureau estimates for 1991. Each 12-month rate is the number of cases for a 12-month period divided by the 1991 or 1992 population, multiplied by 100,000.

Case-fatality rates are calculated for each half-year by date of diagnosis. Each 6-month case-fatality rate is the number of deaths ever reported among cases diagnosed in that period (regardless of the year of death), divided by the number of total cases diagnosed in the period, multiplied by 100. Reported deaths are not necessarily caused by HIV-related disease.

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THE WHITE HOUSE

WASHINGTON

Health Care Reform and the HIV Epidemic
Top Ten Issues

For those infected with HIV, the assurance of comprehensive health insurance is an essential public health goal.

The Office of the National AIDS Policy Coordinator has provided advice on policy formulation during the development of the Health Security Act (HSA). These efforts were directed towards assuring adequate care and services for people with HIV/AIDS. As the Congress now debates the HSA, the Administration is making every effort to assure that modifications to the President's proposal maintain equity and sensitivity to the special needs of HIV-infected individuals.

Private insurance companies, like other businesses, seek to maximize profits by choosing only "acceptable" insurance risks. Under the HSA, universal coverage is guaranteed. Universal means everyone! What does Health Security mean to you?:

* **Universal coverage - HIV status or other health conditions do not prevent you from getting coverage.**
* **Community ratings prevent persons with HIV infection from being charged more for premiums.**
* **Prescription drugs will be covered.**
* **Ryan White CARE Act services will not be lost.**
* **Any form of discrimination is prohibited.**
* **Essential providers - specialists in treating HIV and AIDS will be available to all people who need them.**

Based on a series of focus groups with people with AIDS and HIV/AIDS service organizations, a list of "top ten" concerns for the HIV community were identified. Information regarding these concerns is attached for your review.

I hope this information will be helpful to you. If I can be of further assistance or provide any additional information, please contact me or Andrew E. Barrer, Ph.D. at (202) 632-1090. Thank you.

Kristine Gebbie

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator

Top Ten Issues

1. **Premium Financing and Risk Adjustment**

2. **Availability of and Assured Access to "Essential Providers"**

3. **Long-term and Home Care Coverage**

4. **Availability of Mental Health and Substance Abuse Services**

5. **Impact of the HSA on the Ryan White CARE Act**

6. **Medicaid and Medicare Funding and Program Transition Issues, especially as related to the Medicare and Medicaid programs**

7. **Confidentiality**

8. **Grievance Procedures**

9. **Effects of "State Options" on the HSA package of benefits**

10. **Funding for Public Health System Core Functions (e.g. Behavioral Research, Prevention Services, etc.)**

1. Premium Financing and Risk Adjustment

Issue: Will the risk adjustment mechanism prevent "redlining" for persons with HIV/AIDS or other life threatening illnesses?

Summary: Yes. Redlining, or any attempts to limit access to people with HIV or AIDS is clearly prohibited. The HSA provides mechanisms which require states to spread the financial risks associated with special communities by adjustments which would take into account such factors known to affect utilization of services, such as age, sex, health status and services to disadvantaged populations. The health plans have to meet specific rules on enrollment, community rating, information, and grievance procedures.

2. Availability of HIV Specialist, "Essential Providers"

Issue: Will HIV positive persons be able to continue using their local HIV medical specialist?

Summary: The Health Security Act establishes a special category of health care provider which is referred to as an "essential provider". Any health care provider or organization can make application to be certified as an essential provider. Within the HSA, a Ryan White grantee or subgrantee can be automatically certified as an essential provider. Each health plan must enter into a written agreement with each essential provider located within its service area.

3. Long-term Care and Home Health Care

Issue: Persons with HIV/AIDS often need home health care and long-term care services. Will the Health Security Act provide those needed services?

Summary: Home health care is included in the nationally guaranteed comprehensive benefits package. A new long-term care initiative will expand coverage of home and community-based care. This will make it possible for more elderly and disabled persons, including persons living with HIV/AIDS to live in their homes and communities while receiving long-term care. The Act will improve

Medicaid coverage for persons in nursing homes.

The HSA will improve the quality and reliability of private long-term care insurance and provide tax incentives for persons to buy it; and tax incentives to help individuals with disabilities work.

4. Availability of Mental Health and Substance Abuse Services

Issue: Mental health needs in the HIV/AIDS community tend to be greater than the average. What will HSA do to provide these services? Injecting drug users, at high risk of HIV infection and transmission, currently have inadequate treatment and preventive services available to them. Will adequate services be available to treat these individuals in order to ameliorate their additive disease and halt the epidemic?

Summary: A base level of mental health services will be provided to all persons through the Health Security Act. We know that viable mental health services are part of a good program of health care and especially beneficial to HIV infected persons.

In order to make a significant difference in the rate of new infections in the injecting drug use population and their sexual partners, the HSA will provide substance abuse treatment to everyone.

5. Health Care Reform and the Ryan White CARE Act

Issue: Will the financial restructuring of the health care system assure the delivery of health care services appropriate to the needs of vulnerable populations whose access problems go beyond lack of insurance?

Summary: The comprehensive benefits package provided by the HSA may not provide all essential services for persons with HIV/AIDS. Conversely, a variety of services currently provided by the CARE Act would be covered under the HSA benefits package. These would include primary care services, medications, assistance for health insurance coverage, home-based services, case management,

transportation, and outreach. It may be necessary to utilize Ryan White CARE Act funds "freed up" by the provision of these services under HSA to subsidize the supplemental and client's share of insurance premiums, co-payments, deductibles, and expenditures that exceed spending caps.

The CARE Act is not a "band-aid" that can be discarded after health care reform. The Act will serve as a critical resource to sustain health care delivery systems and insure the continued delivery of essential and comprehensive health and support services to those infected with HIV.

6. Medicaid and Medicare Funding and Program Transition Issues

Issue: What impact will the HSA have on funding for the Medicaid and Medicare programs? What programs will be available during the transition from the old system to the one provided under the HSA?

Summary: Under the HSA adult Medicaid recipients who now receive cash supplements (currently 9 million beneficiaries) would be enrolled in the new system, but would not have to pay premiums. Further, they would be entitled to join a new state and federally-matched program providing wrap-around services similar to those now available under the Medicaid program. Children less than 18 years of age who are currently eligible or would be Medicaid recipients, with eligibility for wrap-around services (primarily based on poverty level), would be provided those services through a new federally funded (but state administered) program, ***regardless of their cash assistance status.***

The Medicare program will be preserved and strengthened under the HSA, which will add new coverage for prescription drugs and expanded coverage of home and community-based care.

7. Health Security Act (HSA) and Confidentiality Issues

Issue: What safeguards are envisioned for the handling of health information on HIV affected persons under the Health Security Act ?

Summary: The HSA addresses the issue of how information will be handled and what penalties will be imposed for misusing information. The HSA will provide guidance level information on creation of the oversight board, users and uses of information, privacy standards, enrollee rights, outright prohibitions, training of information handlers, and comprehensive health information privacy protection. The development of the Comprehensive Health Information Privacy Protection Act will be implemented within two years from the date of passage.

8. Grievance Procedures

Issue: How can individuals ensure that their health plan will provide the health benefits and services they require?

Summary: The HSA is intended to provide adequate health care coverage for all citizens and legal residents of the United States. The Act requires States to approve each health plan before it can engage in providing health care under the Act. The law prohibits exclusions because of pre-existing conditions or through "red-lining," the practice of excluding a particular group of individuals because of perceived high risk.

The Health Security Act includes a comprehensive grievance process for any person aggrieved by acts or practices which result in denial or delay of benefits or payments. Individuals must work within the individual plan's grievance process before going to adjudication through the Complaint Review Offices set up in each state. If there is a question as to an individual's eligibility for a plan, subsidies or cost sharing, the individual may go directly to court and all costs can be reimbursed if the court finds for the individual.

The complaint office must rule in under 30 days, although a 24 hour appeal is available in cases of emergency. Appeals must be processed within 60 days. There are means of appealing, with the national board being the ultimate administrative appeal.

9. "State Options"

Issue: What impact will "State Options" have on coverage under the HSA? What impact will it have on services, availability, and affordability?

Summary: Some states cover additional services under federally matched Medicaid programs. Under the HSA, a number of programs will become available at each state's option. To assure that there is not a loss of services to the person with AIDS, Ryan White will continue to act as the safety net to assure needed services reach all people in need. The expanded use of case management, will help follow individual needs and assure services are provided.

10. Public Health System Core Functions

Issue: What is the nature of the funding for research on behavior, health services and Core Functions of Public Health Programs?

Summary: The Health Security Act will provide funding for AIDS specific research and public health initiatives that will have to be provided under the authority of the Public Health System. Behavioral research into those behaviors that may cause or contribute to disease will be conducted by the National Institutes of Health. The Act will also provide funding for strengthening the public health core function of states, including those components related to diseases of public health significance. This support will allow communities to maintain strong programs to prevent the spread of HIV, tuberculosis, and other conditions of public health importance.

Vanderbilt University Medical Center

School of Nursing | Office of the Dean | Direct Phone (615) 343-8876
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FAX TRANSMITTAL

TO: Steve (Kristine Gebbie's office)

FAX NUMBER: 202-632-1096

FROM: Colleen Conway-Welch

DATE: 12-29-93

Number of pages including this cover sheet: 4

REMARKS:

Telephone Dean's Office at (615) 343-8876 if there are any difficulties with this transmission.

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FAX TRANSMITTAL

TO: Kristine Gebbie

FAX NUMBER: 202 632-1096

FROM: Colleen Conway-Welch

DATE: Dec 29, 1993

Number of pages including this cover sheet: 1

REMARKS: Kris,

When you are speaking in Nashville on 3/30/94, I would love to take you out to dinner & to the airport. Please let me know if this plan will work for you.

Telephone Dean's Office at (615) 343-8876 if there are any difficulties with this transmission.

001 12:01 12/31/93

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March 29, 1994

TO: Steve Lee

FROM: Mary Clissold

RE: 3/30 lunch at Vanderbilt

The following people are members of the United Way of Middle Tennessee Community Aids Partnership.

1. Neil Diehl, Chairman
   Ingram Barge Company

2. Stephen Raffanti, MD
   Director, Comprehensive Care Clinic (Metro Aids Clinic)

3. Debbie Runions
   Tennessee Business Roundtable

4. Sam Coleman
   St. Thomas Hospital

5. Mary Baker
   Crittenton Services

6. Dan McEachern
   Lentz Public Health Center

7. Kyle Ridout
   General Director, Nashville Opera Association

8. Jerry Narramore
   CDC Director, Middle Tennessee Regional Office

9. Dan Bush
   Laurel Woods
   Communicable Disease Control
   Tennessee Department of Health and Environment

10. Dorothea Heiden
    President, United Way of Middle Tennessee

11. Kelly Kraft
    United Way of Middle Tennessee

12. Colleen Conway-Welch
    Vanderbilt School of Nursing

I have been unable to reach 2 others, but it looks like 14 people would be the maximum. Thanks for your help in coordinating everything.

ABSTRACTS

Paper Presentations

Saturday, March 26, 1994

ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

A BAYESIAN METHODOLOGICAL APPROACH TO VALIDATION OF A NURSING DIAGNOSIS: ACTIVITY INTOLERANCE

This was an exploratory methodological study which had as its purpose to demonstrate application of Bayesian statistical methods in nursing diagnosis validation research. Methodological research is indispensable in any scientific discipline and perhaps especially so when a field is relatively new and deals with highly complex, intangible concepts such as nursing diagnoses. One important aspect of methodological research is that it helps bring into focus the strengths and limitations of different ways of obtaining, organizing, and analyzing data.

The nursing diagnosis used for demonstration was the diagnosis, activity intolerance. Defining characteristics for the diagnosis were obtained through a review of the literature. The adequacy of operational definitions for defining characteristics was ascertained through consensual validation using Master's prepared clinical nurse specialists. Content validity for empirical indicants of defining characteristics was evaluated by surveying a panel of experts.

Data for the study were obtained through direct clinical observation of hospitalized adults (N=63). The subject pool included patients from the medical, surgical and oncology divisions of a large, urban teaching hospital.

Data were analyzed using Bayesian statistical methods. The most sensitive and specific defining characteristics included: (1) weakness during activity, (2) dizziness during activity, (3) dizziness three minutes after activity, (4) dyspnea during activity, (5) dyspnea three minutes after activity, (6) exertional fatigue, (7) a respiratory rate greater than or equal to 24 breaths per minute three minutes after activity, and (8) a pulse rate greater than or equal to 95 beats per minute three minutes after activity.

The predictive value positive for each defining characteristic and various clusters of defining characteristics was ascertained. The results suggested that weakness during activity was more predictive of the diagnosis than any other cue. Furthermore, cue clusters which included weakness during activity tended to be more predictive of the diagnosis than cue clusters that did not include weakness during activity.

This research provided only limited support for NANDA's theoretical model of activity intolerance. The implications of these findings are discussed relative to NANDA's theoretical model of activity intolerance and the current criteria by which defining characteristics are designated "major" or "minor". In addition, the strengths and limitations of Bayesian methods for validation research are identified and discussed.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

CONCEPTUAL DESCRIPTION OF THE NURSING DIAGNOSIS SPIRITUAL DISTRESS

The Diagnostic label Spiritual Distress represents an area where Nursing Science is making great strides. The Spiritual realm of patients is often a missing aspect in our health care system. Consumers of health care are realizing the importance of this realm, and are beginning to value spiritual interventions in ways similar to traditional measures. Although many nursing interventions directed at alleviation of Spiritual Distress are evolving through research and development, this realm of practice remains a mystery to many. An understanding of this diagnosis would foster the development and practice of spiritual nursing interventions. Descriptions of the concepts that make this diagnosis must be well understood in order to be integrated into assessments and interventions as well as evaluation. These conceptual descriptions are critical to perpetuate the progress of present and future research, and to enhance practice.

The author uses concept analysis and concept synthesis to develop the conceptual descriptions of the nursing diagnosis Spiritual Distress. The paper presents rationale and methods for the development of conceptual descriptions. Examples of clinical situations of Spiritual Distress are used.

Using scientific data from an extensive literature review and the authors clinical expertise the paper holistically describes the diagnosis using concepts from nursing, psychology, sociology, and Anthropology and Theology.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

Category for Wellness Diagnoses - A Proposal for a Trifocal Model of Nursing Diagnosis

The field of linguistics has long recognized the close tie between naming and perceiving. As noted by Sartori (1984), concepts unnamed go unnoticed. The ANA House of Delegates (1993) noted that the work of nursing is essentially invisible in health care databases due to lack of a unified nursing language system. The delegates charge nursing to name what we do, and thereby place nursing in a position to more effectively evaluate nursing outcomes, finance nursing services, and influence public policy. Allen (1989) noted that as we strive to name and classify the phenomena of concern to nursing, there has been a persistent omission of elements associated with wellness, prevention, and health promotion. Since health promotion and illness prevention are care components for which the nurse is accountable and responsible, it is essential that related phenomena be named and classified lest they go unnoticed. The definition of nursing diagnosis adopted by the NANDA membership at the Ninth Conference in 1990 (Carroll-Johnson, 1991) clearly intended to include wellness and prevention. The focus of clinical judgments was expanded beyond responses to health problems to include responses to life processes. But only a few wellness oriented nursing diagnoses have been submitted for review (e.g., effective breastfeeding). The long conceptual association of the term diagnosis with problem identification may lie at the root of the difficulty. Perhaps what is needed is a label more reflective of a wellness focus. In order for the health promotion and prevention component of nursing diagnosis and intervention to be valued, communicated, implemented, and recognized as important within and outside of nursing, more precise labeling is needed. The term "opportunity for enhancement" as a diagnostic term is proposed. Development of wellness diagnoses should be facilitated by having such a label which removes the problem-oriented sense long associated with "diagnosis." A trifocal classification model for nursing diagnosis is proposed, incorporating independent and collaborative, problem and wellness aspects from a client focused perspective. Use of this model should facilitate taxonomic classification and use of a wellness-illness axis. Clinical testing and refinement of the concepts presented is urged.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

CONSENSUAL VALIDATION OF INTERVENTIONS CATEGORIZED BY NURSING DIAGNOSES

This paper will present a research approach designed to determine content validity for nursing interventions listed on standards of care related to specific nursing diagnostic categories. The standards of care are an integral part of a Clinical Practice Model designed to support the practitioner in delivering high quality, cost effective, individualized professional nursing services. The data is based on an evolving, ten year old, validation effort that is presently taking place in 18 rural, community, and university hospitals across the country. These settings have collectively come together to clarify and mature the essence of professional nursing services. Practitioners and advanced practitioners use a descriptive validation survey to determine if the standard, based on their clinical expertise, is reflective, appropriate, and inclusive of knowledge and intervention patterns related to the diagnostic category. The content validity index, and percentages, along with an evaluation process for the suggested revisions and additions will be shared. A comparison of interventions on one standard, before and after the validation process, will be shared.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

NANDA Nursing Diagnoses Revisited:
Color Them DSM-IV Red

In 1982 a comparative study between the evolution of the diagnostic systems of the (then) Nursing Diagnosis Conference Group and that of the American Psychiatric Association (APA) was presented at the fifth biennial (now) NANDA conference. The APA Diagnostic and Statistical Manual IV (DSM-IV) is scheduled to be marketed in May, 1994. This presentation, NANDA Nursing Diagnoses Revisited, is a comparative study of the evolution of both systems from the period of the 1982 study to the present time. During the time frame from the first presentation to the present, the NANDA system has evolved from an alphabetized list of less than fifty nursing diagnoses to a Taxonomy of more than one hundred nursing diagnoses classified within nine Human Response Patterns. A revised system was submitted to the World Health Organization for inclusion in the International Classification of Diseases-10 (ICD-10). The American Nurses' Association (ANA), after financing a Task Force out of the Council of Psychiatric Nursing to develop a model system of psychiatric nursing diagnoses, had representation in the group that refined the NANDA system for ICD-10 consideration. Since 1989, the ANA has officially endorsed NANDA as the official group for the development and dissemination of Nursing Diagnoses. The APA has revised its Functional Assessment Scale, and has sent questionable diagnoses out for further clinical testing. The DSM-IV Task Force and its Work Groups have based all of their research aimed toward increased empiricism on three criteria: 1) a systematic review of literature; 2) a reanalysis of existing data; and, 3)clinical field trials. External funding was sought and received for the more than four years of scrutiny and revision of the DSM diagnostic system. Two pre-publication manuals, the DSM-IV Options Book and the DSM-IV Draft Criteria, have been published for dissemination and subsequent feedback from its users. As in 1982, this comparative study between the NANDA and APA systems will exemplify the evolution of representative diagnoses.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

Intervention Categories for Select Nursing Diagnoses and Related Factors

The purpose of this paper is to describe nursing intervention categories for six select nursing diagnoses and their most common Related Factors. These findings were part of a larger research project in which the relationships among the elements of the Nursing Minimum Data Set (NMDS) were examined (Ryan, Coenen, Devine, Werley, Sutton, & Kelber, 1993). The setting was an acute care public hospital in the Midwest, which had a nursing information system (NIS) that linked the elements of the NMDS and used the North American Diagnosis Association (NANDA) classification system. The sample included adult patients with the six most frequent nursing diagnoses who were hospitalized during 1991: pain (n = 4397), potential for injury (n = 2942), anxiety (n = 2474), decreased cardiac output (n = 1796), potential for infection (n = 1038), and knowledge deficit (n = 996). The mean age was 42 years. In general, there was an even distribution of men and women across nursing diagnostic categories. There were 60% Caucasians, 34% African Americans, and 6% Other Ethnicities. Using an American Standard Code for Information Interchange (ASCII) format, data were downloaded from the hospital NIS and transferred to a University mainframe computer for analysis. For each diagnostic label multiple Related Factors were identified in the NIS. In the sample, two or three Related Factors occurred frequently within each diagnostic category, additional Related Factors occurred with much less frequency. For example, with the diagnosis of anxiety the most frequent Related Factor, (unfamiliar surroundings/procedures/tests), occurred 49% of the time, the second (surgical procedure) 28%, the third (uncertain discharge plans) 4%, but the fourth (transferred to unfamiliar hospital) and fifth Related Factor (Hickman catheter) were used only 2% of the time. The prevalence of nursing interventions was examined according to the 16 category classification system proposed by the Task Force of the NMDS Conference Group (Werley & Lang, 1988). The intervention categories differed across Related Factors. In addition to the diagnostic label, the Related Factors clearly influenced the selection of interventions. For example in patients with anxiety, the intervention category of "emotional support" (46%) was used most frequently for the Related Factor of unfamiliar surroundings/procedures/tests; "teaching" (75%) was used most frequently with persons having surgery; and "coordination and collaboration" (68%) was most common with patients having uncertain discharge plans. It also was noted that although interventions in the teaching category were most frequent for all Related Factors within the diagnostic category of knowledge deficit, teaching interventions were provided to patients with diagnoses other than knowledge deficit. Further development of the NANDA classification system to include Related Factors is recommended. In addition, future efforts to link any classification system of nursing interventions with nursing diagnoses should include exploration of the relationships among interventions and Related Factors.

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Werley, H. H. & Lang, N. M. (1988). Identification of the Nursing Minimum Data Set. New York: Springer.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

THE THREE RESPIRATORY NURSING DIAGNOSES: DIFFERENTIAL DIAGNOSTIC VALIDATION OF THE DEFINING CHARACTERISTICS

The North American Nursing Diagnosis Association (NANDA) identifies three respiratory nursing diagnoses (RND's) - Impaired Gas Exchange (IGE), Ineffective Airway Clearance (IAC), and Ineffective Breathing Pattern (IBP) - and the defining characteristics for each. This is the second study by these investigators which addresses the RND's and the defining characteristics associated with each diagnosis.

A reliability study using a purposeful survey approach was utilized to determine which defining characteristics are used by professional nurses to identify the RND's and the degree to which each defining characteristic is indicative of a given RND. This design is the differential diagnostic validation (DDV) model described by Richard Fehring. To study if variance in defining characteristics of an RND is found between client age groups, adult and neonatal practitioners were surveyed. The sample consisted of baccalaureate and higher prepared professional nurses who had a minimum of one year, recent clinical experience in the care of adult or neonatal respiratory patients.

The Respiratory Nursing Diagnosis Scale II was developed for this study. Participants were asked to complete a 5-point Likert scale for each RND by rating the degree to which each of 30 potential defining characteristics is indicative of the given diagnosis. 4900 surveys were mailed and 558 acceptable surveys were returned.

Data analysis was consistent with Fehring's recommendations for the DDV model. Data were also analyzed to determine if variances in the defining characteristics of an RND were found between adult and neonatal practitioners. For IGE, adult and neonatal practitioners identified 3 major defining characteristics, compared to 7 by NANDA; for IAC, 2 characteristics were selected as major, compared to 4 by NANDA; and, for IBP, 4 major characteristics were named compared to 12 by NANDA.

This study not only identified a more limited number of major defining characteristics for each RND than NANDA, but the characteristics identified by the study participants were not always the same ones as those identified by NANDA. In addition, there were variances in the defining characteristics of all RND's when comparing adult and neonatal practitioners.

This study clarifies the need for further validation studies of the respiratory nursing diagnoses and suggests revision of NANDA's RND's and associated characteristics. In addition, there is a need to continue to differentiate defining characteristics for adults versus neonates.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

VALIDATION OF NURSING DIAGNOSES USING THE CASE-CONTROL DESIGN

The purpose of this presentation is to describe the case-control method and discuss its usefulness in the validation of nursing diagnoses. The case-control method is a retrospective design in which individuals with a condition (cases) are compared to individuals without the condition (controls). Cases and controls are compared by examining past and present exposures thought to be risk factors for the condition. To estimate relative risk from retrospective studies, all cases and controls must be representative of the same population being considered in respect to risk factors being evaluated (Kahn & Sempos, 1989).

The case-control method seems especially well suited for the validation of nursing diagnoses because prospective designs for validity would be impractical, impossible, or unethical. In this study, the researcher used the case-control method to validate the nursing diagnosis high risk for aspiration. Risk factors for aspiration were determined retrospectively from existing records. Ultimately, early recognition of these risk factors in patients and appropriate intervention can prevent the condition form occurring. Other advantages of the case-control design include: suitability for the study of rare diseases, practicality in terms of time and expense, minimal risk to subjects, and the opportunity to study multiple risk factors. Disadvantages include: reliance on records for information regarding exposures, difficulty selecting appropriate comparison groups, and inability to determine disease rates (Schlesselman, J.J., 1982).

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

The Wonder of Meaning: A Phenomenological Understanding of Spiritual Distress

The purpose of this study was to describe the phenomenon of spiritual distress as it is experienced by adults in the general population. This study focused on the key aspect of spiritual distress--concern about the meaning of life, death, and/or beliefs. In addition, this study sought to clarify the nursing diagnosis Spiritual Distress and evaluate the appropriateness and sufficiency of the defining characteristics for this diagnosis. Using phenomenological interview procedures, ten participants were asked to describe experiences of being concerned about the meaning of life, death, and/or their beliefs. All participants considered their beliefs to be very important, evaluated their health as good, and named a religious affiliation with which they identified.

A hermeneutical approach was used for data analysis. Data were analyzed within the dialogic process of a phenomenological research group in addition to the researcher's individual work. The thematic structure derived from the data describes the experiential themes of spiritual distress and their inter-relationships.

Participant narratives were grounded in the context of time. The thematic structure of the experience of spiritual distress was biphasic. The metaphor of the Web of Life, taken from the words of one participant, was used to describe both phases. Phase one was termed Breaking the Web, and occurred when an event broke the continuity of life. The three major themes and subthemes of this phase were: (1) Falling Apart (Pain, Instability), (2) Wondering (Questioning), and (3) Something Beyond (Feeling, Presence, Mystery). The second phase, during which participants found meaning in their experiences, was termed Rebuilding the Web. The four major themes and subthemes of this phase were: (1) Stability (Strength, Security), (2) Change and Growth (Self, Beliefs), (3) Wondering (No Answers, Accepting Limits to Knowing), and (4) Something Beyond.

The implications of the findings for the nursing diagnosis Spiritual Distress will be discussed and suggestions will be made for further research on spiritual distress.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

NURSING DIAGNOSIS AND CLINICAL GUIDELINES: A NEW PARADIGM FOR NURSING PRACTICE

Nurse educators, clinicians, and authors continue to struggle to identify the best approach to describing and labeling nursing practice. Educators ask students to develop lengthy nursing care plans that reflect the totality of a client's responses to a particular illness or health status using nursing diagnoses. Clinicians, faced with an ever increasing acuity and complexity of clients' problems, are asked to generate care plans, for which there is little time to address and perhaps less time to develop. Nurse authors strive to describe guidelines for caring for clients with a variety of medical conditions while at the same time identifying actual and potential nursing diagnoses and related nursing actions.

Multiple publications and lengthy discussions occur about what conflicts persist among definitions, nursing education, and today's practice realities. As clinicians, researchers, and educators have begun to explicate nurses' phenomenon of concern, confusion has evolved from: 1) attempts to label all nursing actions with a nursing diagnosis, 2) in the variations in the diagnosis and treatment of some health problems by the nurse as independent or collaborative nursing interventions, and 3) efforts to label expected or "usual" responses as a nursing diagnosis.

Carpenito (1993) addressed a "bifocal clinical practice model", looking at pathophysiologic, treatment-related, personal, environmental, and maturational issues that were among the collaborative responsibilities of the nurse. Wesorick (1990) explicated these responsibilities by describing a Clinical Practice Model. Within this model there was discussion of interdependent and independent clinical standards. However, there is not a consistent approach or languaging within practice and clinical settings.

Nurses must create a consensus and acknowledge that much of nursing is inter-dependent and that clinical practice guidelines for pathophysiologic, treatment-related, personal, environmental, and maturational conditions are the most appropriate approach for delivering nursing care. A consistent approach to discussing, teaching, and practicing nursing will enhance efforts to define and clarify the scope of nursing. We must end a trend in which nurses use labels like "alterations in endocrine function" or diagnose a problem when a condition is normal or an expected response. This paper will discuss a model for using nursing diagnoses and clinical practice guidelines as the basis for nursing practice and nursing education.

Within each guideline there should be decision-points where other interventions would be indicated or a nursing diagnosis should be made. Secondly, an intense effort should continue to explicate the phenomenon of concern and clarify in which practice settings certain nursing diagnoses can and should be made by the nurse. Additionally, selected responses, both normal or expected to health conditions should be identified and addressed with clinical practice guidelines.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

DIAGNOSES OF HUMAN RESPONSE PATTERN: COMMUNICATING

Accepting communication as a process and in view of theoretical considerations presented in the literatura, we analyzed communication patterns, impaired verbal communication diagnosis, its defining characteristics and related factors. We suggest that: the definitions of response patterns and of diagnosis be altered to contemplate other facets and not only verbal emission; introduction of new related factors (effects of medication, environmental barriers, absence of significant others, lack of information, stress, alteration of self-esteem and physical conditions); introduction of new defining characteristics associated with disturbances of actual communication (speech, language, hering, vision), anxiety, depression, dull facial expression, no eye contact, difficulty in accompanying usual communication patterns, impaired motor behaviors and verbalized feelings. We recommend validation of diagnoses resulting from subcategories of the referred pattern, already proposed in the literature.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

A MODEL FOR NURTURING UNDERGRADUATE THINKING (NUT)

Nursing education lacks a model for teaching thinking that is sensitive to the individual thinking differences of beginning students. A model is proposed for Nurturing Undergraduate Thinking (NUT). The NUT model emphasizes multiple modes of thinking as a way of cracking an older pattern of more limiting thinking (in which each nurse jumps to a conclusion that might not be the richest one). Traditional teaching models used with undergraduate students presuppose that students just pick up the thinking necessary to diagnose patient responses and use the nursing process along the path of learning the content of nursing. This assumption that thinking is acquired through osmosis does not work. What emerges is a multiple choice approach of picking diagnostic labels and matching standardized care plans. Picking a diagnostic label from a list has been accepted as thinking. Individualized patient care by undergraduate students becomes an unreachable ideal with traditional teaching models.

The proposed NUT model shows how higher order thinking can be taught to and learned by novice students. Assumptions of the model include: a) students are not blank slates; they come to nursing with existing thinking styles; b) most students are not aware of nor can they articulate their unique thinking styles; c) students must be taught to articulate, modify and enhance their existing thinking styles; d) higher order thinking (including critical thinking) is stifled by anxiety; e) openly practicing thinking requires risk-taking; f) the anxiety associated with risk-taking can be minimized; g) consistent role modeling of thinking speeds up the learning of thinking.

NUT teaching and learning strategies are aimed at helping students recognize and reflect upon their unique thinking styles in non-threatening situations. Numerous modes of thinking--recall, habits, inquiry, creativity and metacognition are explored through interactive learning approaches. Simple, but actual nursing situations that are understandable to beginning students are used to illustrate multiple modes of thinking.

The sooner each student understands her or his existing thinking pattern and practices multiple modes of thinking, the sooner s/he can move beyond basic multiple choice and matching styles of thinking. The NUT model promotes the higher level thinking skills required for quality nursing practice in today's health care arena.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

VALIDATION STUDY OF TWO NURSING DIAGNOSES: "INCREASED INTRACRANIAL PRESSURE" AND "HIGH RISK FOR INCREASED INTRACRANIAL PRESSURE"

Since the publication of the N.A.N.D.A. list of approved nursing diagnoses, there has been increased need voiced by clinical practitioners that the diagnostic labels need to be clarified for application in clinical practice. The study was designed to answer the following four research questions: 1) What are the defining characteristics that indicate the presence of the nursing diagnoses, "Increased intracranial pressure?", 2) What are the risk factors that indicate the presence of the nursing diagnoses, "High risk for increased intracranial pressure?", 3) What is the comparison of the diagnostic validation ratings among nurses at different education levels and, 4) What is the comparison of the diagnostic validation ratings among nurses in different clinical specialties.

The study was descriptive and retrospective in design. The tool, listing defining characteristics, risk factors, and operational definitions was pilot tested and assessed for test-retest reliability. (r=.69) The Diagnostic Content Validity (DCU) Model proposed by Fehring was adopted for the methodology and statistical analysis. Analysis of variance (A.N.O.V.A.) was also used. A sample of nurse experts, obtained from professional organizations were asked to respond to a mailed questionnaire. A cross section of nurses from critical care, oncology and pediatric units was used.

Lists of major and minor defining characteristics and risk factors were generated. Seventeen defining characteristics had a mean DCU score of .80 or greater, while 16 had scores between .50 and .80. No characteristic had a ratio less than .50. Based on the A.N.O.V.A., some interesting differences in clinical specialty areas were noted, indicating the need to develop universally meaningful diagnoses. Results of this study can serve as a framework for further study of these and other nursing diagnoses. Clarification of the major and minor defining characteristics and risk factors upon which nursing diagnoses are based can advance nursing by providing a standardized language.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

Do Clinicians Use Diagnostic Labels to Direct Intervention Selection?

Since 1973, nursing diagnoses have been developed to describe the work of nursing. A nursing diagnosis has been defined as "a clinical judgment about an individual, family, or community response to actual or potential health problems/life processes. Nursing diagnosis provides the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable (NANDA, 1991, p. 306)."

While much work has been done to name and validate nursing diagnoses and to delineate nursing interventions, there has not been a systematic study of the relationship between the selection of specific nursing diagnoses and specific nursing interventions. In actual practice, do clinicians use diagnostic labels to direct intervention selection?

As a beginning analysis of this problem, this research project examined the questions:

> Is there a relationship between accuracy in selecting diagnostic labels and accuracy in selecting nursing interventions?
>
> Is there a relationship between accuracy in selecting outcome statements and accuracy in selecting nursing interventions?

Method: This study used a descriptive correlational design. In Phase 1 we developed an instrument that produced scores for diagnostic accuracy, outcome setting accuracy, and interventional accuracy using case studies based on Leuner, Manton, Kelliher, Sullivan & Doherty (1990). Two scenarios were developed. Each had a list of nursing diagnoses, outcomes and interventions based on Taxonomy I (NANDA), Nursing Interventions Classification (McCloskey and Bulechek, 1992) and case specific outcomes developed by the researchers. Seventeen experts completed the instrument and used a Likert scale to rate each response. A scoring system was developed based on expert responses. Each respondent received a diagnosis, outcome and intervention score for each scenario. Correlations were measured among the scores and certain demographic variables.

Findings: Accuracy scores on diagnosis, outcome and intervention selection were normally distributed. For Case B, the correlation coefficient between scores on the outcome scale and the intervention scale was .6644 ($p<.01$). For this case, the correlation coefficient for diagnostic accuracy and intervention accuracy was only .0568. This supports the idea that outcome determination may have more impact on intervention selection than diagnostic labeling. The correlation coefficient between intervention selection accuracy for cases A and B was .5572, approaching significance ($p>.05$). The correlation coefficient between outcome selection for cases A and B was .5427, approaching significance. ($p>.05$). This suggests that the instrument is measuring common skills across cases.

Significance: During Phase 2, the instrument will be refined and administered to registered nurses practicing in adult health acute care settings. Nursing diagnoses are only useful if they support selection of nursing interventions that result in desired patient outcomes. This proposed research will provide a new way of examining the usefulness of nursing diagnoses to practicing nurses. Additionally, it will provide a useful tool to measure diagnostic and therapeutic decision-making.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

Sleep pattern disturbance: A nursing diagnosis

It is generally known that patients sleep poorly in hospitals. There is however, limited knowledge about the kind of sleep problems and what the determinants of these sleep problems are.

Problem statement: What kind of sleep problems patients experience in the hospital and what diagnoses do nurses formulate with respect to these sleep problems.

Methods: On surgical and medical wards of three general hospitals an inventarization of sleep problems, sleep quality and quantity, and possible related factors was conducted by means of patients interviews. 141 women between 30 and 70 years of age were interviewed. A secondary analysis was performed on the nursing reports of 3 experimental wards (1 surgical and 2 medical wards) during the posttest (5 to 6 weeks) of an intervention study on sleep. A total of 184 nursing reports were filled in of which 176 (96%) history forms and 140 (76%) nursing care plans. The information provided by the nursing reports during the pilot phase of the intervention study were transcribed and categorized which led to the development of a code book. Five care plans and history forms were coded by two independent raters and showed sufficient interrater-reliability ($r = .83$ and $r = .88$). During the posttest of the intervention study 120 patients were interviewed about their sleep quality and quantity in hospital. Of 76 patients data were available on their sleep reported by the nurses in the nursing care plans as well as self-reports.

Results:"Difficulty falling a sleep" and "frequent awakenings" were the most frequently reported sleep problems experienced by patients in the hospital. Environmental variables, personal characteristics and disease related variables were found to correlate with sleep quality in the hospital. It makes a difference whether the quality of sleep of a specific night or in general in hospital is studied. It seems that sleep quality in general can be explained by internal variables such as well-being and changes caused by hospital environment and routines explained the largest part of variance of sleep of a specific night. Comparing the patient interviews and the nursing care plans it became clear that only half of the problems patients report can be found in the nursing care plans. The sensitivity of the following nursing diagnoses varied between 37 and 74%: sleep latency (37%), awakenings (44%), sleep duration (68%) and sleep quality (74%). Specificity varied between 26 and 45%. 240 nursing diagnoses on sleep were reported in the 184 nursing care plans. The diagnoses reported most frequently were "poor sleep" and "potential sleep problems". One third of the nursing diagnoses were reported without mentioning the etiology of the problem. The etiologies mentioned most frequently were anxiety and pain.

Conclusions: Nurses are capable of detecting sleep problems but have problems in diagnosing sleep problems of patients accurately. Diagnoses are formulated poorly. Despite the fact that the diagnoses were formulated poorly the defining characteristics of the NANDA-approved nursing diagnosis "Sleep pattern disturbance" were all present. It is suggested that the defining characteristics, accepted by the NANDA, could be more appropriately used as nursing problems.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

Validation of four Nursing Diagnoses: Preliminary Report of a National Study in France

An nursing diagnosis expands to international use, there is a need for refinement beyond American culture and perspectives. In 1992, NANDA nursing diagnoses were included in the National Basic Nursing Program as well as in the legislation governing the practice of nursing in France. In line with these changes, the Ministry of Health in collaboration with AFEDI (Francophone European Nursing Diagnosis Association) decided to sponsor a multi-site study including nurses from public or private hospitals on a volunteer basis.

The purpose of the research was to involve nurses in the validation process of four diagnoses: Pain (P), Ineffective Airway Clearance (IAC), Altered Sleep Pattern (ASP) and High Risk of Self-Mutilation (HRSM). The research questions were as follows:

1. What are the critical and supporting defining characteristics associated with these four diagnoses?
2. What is the content validity for each of them?
3. What are the essential etiologies of P, IAC and ASP?
4. Are there relationships between major characteristics identified and professional or demographic characteristics of the nurses included in the sample?

The three actual diagnoses P, IAC and ASP were chosen because of their high prevalence in most hospital settings. HRSM was selected for psychiatric institutions and emergency units.

Instruments were developed, based on NANDA sources and review of the literature. The questionnaires were distributed to a convenience sample of nurses in hospitals, by on-site coordinators. Respondents rated each defining characteristic and etiologies on a 5-point Likert-type scale, regarding its representativeness of the diagnoses. Additional write-in characteristics which respondents had observed were also requested. According to Fehring's model (1987) weighted ratios were assigned to the scale choices and DCV determined.

Results and Implications:

Professional and demographic characteristics for the total sample of nurses will be discussed. Major and minor defining characteristics for the four diagnoses will be compared with similar studies from other countries. Implications for multinational validations of nursing diagnoses will be addressed.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

IMPAIRED ADJUSTMENT RELATED TO INAPPROPRIATE UTILIZATION OF RESOURCES 'A DOWN UNDER DIAGNOSIS'

In order to validate this diagnosis, the paper provides an overview and assessment of the literature describing the strategies used for the implementation of nursing diagnosis in Australian health care settings. The focus of this paper is on the adjustment required to achieve organizational change for effective implementation of nursing diagnosis.

In the discussion a range of further contributing factors to the diagnosis of Impaired Adjustment will be given and categorized then linked to the available resources.

In conclusion, plans and interventions will be suggested and recognition given to the value of nursing diagnoses as a diagnostic tool and a means of effective communication.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

VALIDATION OF THE NURSING DIAGNOSES: ACUTE AND CHRONIC PAIN

Pain is a phenomenon common to many medical-surgical patients. Several studies cite that patients are not being adequately managed for pain. In order for nurses to intervene effectively, nurses must first identify the nursing diagnosis of pain through appropriate assessment. Thus, the purpose of this study was to validate the critical indicators and minor defining characteristics of the nursing diagnosis: pain. Benner's adaptation of the Dreyfus Model of Skill Acquisition to nursing provided the contextual framework for this study. The research questions for this study included the following: (1) What are the critical indicators identified for acute and chronic pain by experienced staff nurses? (2) What are the minor defining characteristics identified for acute and chronic pain by experienced staff nurses?

This study is a descriptive design conducted to validate the nursing diagnoses of pain by the Differential Diagnostic Validation (DDV) model proposed by Fehring. The sample consisted of 150 registered nurses who have practiced nursing with various medical-surgical patients for over five years and are presently employed in a federal government hospital setting. A validation instrument was developed to include 55 clinical indicators of acute and chronic pain. These items were rated on a Likert-type scale from one to five indicating how characteristic the item was in determining the diagnosis of acute and chronic pain. Internal consistency analyses produced a Cronbach alpha of .95 for the instrument. The questionnaire packet consisting of two forms of the Pain Validation Tool and demographic items was distributed to the registered nurses.

The results identified one critical indicator for acute pain, communication of pain by the patient. No single critical indicator was identified for chronic pain. Multiple minor defining characteristics were identified for acute and chronic pain. Although there were six characteristics common to both, the majority of characteristics differentiated between acute and chronic pain. Thus, this study identifies the critical indicators and minor defining characteristics of these specific nursing diagnoses and adds to the knowledge base of nursing science related to acute and chronic pain. Recommendations will be made for future refinement of the diagnostic category of pain.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

High Risk for Impaired Skin Integrity:

Incorporation of the Risk Factors from the AHCPR Guidleines.

The diagnosis and care of patients with High Risk for Impaired Skin Integrity are clearly phenomena of concern to nursing. Nurses hold the primary responsibility for the prevention and treatment of pressure ulcers. However, due to NANDA's lengthy list of 18 risk factors for this diagnosis, nurses cannot effectively identify patients at risk for impaired skin integrity. The margin for diagnostic error from this list of unvalidated risk factors impacts on the effective use of this nursing diagnosis at the clinical level.

In 1992, an expert panel from the Agency for Health Care Policy and Research (AHCPR) convened to develop the clinical practice guidelines for the prediction and prevention of pressure ulcers in adults. This panel reviewed and evaluated 12,000 abstracts concerning pressure ulcers. As a result of this review, the panel identified one primary and three other risk factors:

1) immobility and limited activity levels (primary)

2) incontinence

3) nutritional factors (such as inadequate dietary intake, impaired nutritional status)

4) altered level of consciousness.

This is in stark contrast to the eighteen risk factors identified by NANDA and not supported by clinical research. This paper recommends the incorporation of these guidelines to refine the risk factors for High Risk for Impaired Skin Integrity.

The AHCPR guidelines have been incorporated into the hospital's standards of care and practice for the nursing diagnosis: High Risk for Impaired Skin Integrity. The clinical application of the standards has led to changes in assessment and staff education; which are both key components in preventing these debilitating patient problems.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

NURSING DIAGNOSES USED IN DISCHARGE PLANNING FOR PATIENTS WITH CANCER.

Efficient patient care management requires prompt identification of factors that predict potential discharge needs. Assessment of discharge planning factors such as nursing diagnoses can lead to early intervention that will result in timely and safe discharges with arrangement of resources needed in the community for continuity of care.

An explanatory, non-experimental research design was used to examine relationships among factors affecting discharge planning. Factors that were studied included nursing diagnoses, age, gender, race, economic status, hospital length of stay, marital status, caregiver availability, types of agencies needed in the community, and the services required. A convenience sample of the patients with cancer who received referrals to the community was gathered over one year (approximately 3,000 patients). The sample was described by the nursing diagnoses for different types of cancer and for the inpatient versus outpatient category. Using multiple regression, models were developed to predict the types of agencies needed (home care, hospice, nursing home, hospital, and medical equipment company), the services required (skilled nursing care, home health aide, social services, appliance and equipment supplies, nutritional supplement and equipment, chaplain, physical therapy, and respiratory therapy), and the amount of time taken to complete the referral. The level of significance for the variables was set at $p \leq 0.05$.

Implications for practice are the importance of recognizing factors that are predictors for discharge planning needs and the ability of these factors to describe resource needs for patients. The evaluation of nursing diagnoses as measures to describe and predict discharge planning needs may lead to more efficient use of health care resources.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

INSTRUMENT DEVELOPMENT: FACTORS CONTRIBUTING TO HEALTH-RELATED BEHAVIORS AND COMPLIANCE

The purpose of this research was to develop a valid and reliable instrument and to identify factors that contribute to health-related behaviors and compliance in the chronically ill adult clients.

The Unitary Man/Human framework was the conceptual framework and items were constructed from eighteen propositional statements within nine interactional patterns. The 68-item instrument was a Likert-type scale with scores ranging from 5=most of the time to 1=never. Content validity was established using fifteen expert panelists and a pilot study was conducted using thirty subjects. A criterion of 80% agreement among panelists was used for items to remain on the instrument. Cronbach's alpha for internal consistency reliability was .91 for the piloted questionnaire.

A non-probability sample of 200 chronically ill adult clients attending clinics in a Southeastern teaching institution participated. All subjects read and understood English, had a chronic illness for at least one year, were advised to alter diet and activities and had been taking at least one medication . The mean age was 52 and they were primarily female (68.5%), black (58.5%, married (35%, and unemployed (34%).

SPSSX was used for data analysis. The possible range of scores was 68 to 340 with high scores indicating a large number of factors contributing to health-related behaviors and compliance. In the sample the range of scores was from 208 to 336 with a mean of 272. T-tests were performed on sex, race, education, employment, income and illness and no significant differences were found except for education ($t=2.73$, $p=0.007$).

Cronbach's alpha for internal consistency reliability was 0.89.

An exploratory factor analysis using principal components extraction and varimax rotation isolated seven factors that explained 40.3% of the variance. The factors were named as follows: (1) trust, (2) confidence/reliance on the health care system, (3) perceptions and values, (4) independence/self-sufficiency, (5) social support, (6) self-concept/self-esteem, and (7) control/consistency.

The reliability of the subscales revealed that factors one through five were internally consistent with alphas ranging from 0.68-0.80. Factors six and seven had low alphas of 0.36 and 0.09 respectively.

A stepwise multiple regression analysis determined the relative importance of the factors and the first five factors explained 94% of the variance in the test scores (Beta=.3754, p=.00). The factors entered the analysis as follows: Factor 2, Factor 1, Factor 5, Factor 4, and Factor 3. Factors 6 and 7 combined explained only 4% of the variance.

Seven factors remained on the instrument for further testing.

Recommendations included confirmatory factor analysis and analysis of the findings in light of the development of the instrument from the nine interactional patterns of the Unitary Man/Human Framework. Since the nine patterns could not be confirmed, this poses questions for future instrument development using these patterns.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

Learned Helplessness: A More Discriminating Nursing Diagnosis

The purpose of this paper is to discuss a potentially new nursing diagnosis, Learned Helplessness (LH) and to demonstrate reasons for differentiating it from the current diagnosis of Powerlessness. Discrimination between the two is critical for a greater degree of accuracy in nursing diagnosis.

The current NANDA nursing diagnosis, Powerlessness, relies on the work of Miller (1993), who utilized the LH and Locus of Control Theories in the construct's theoretical development. Theoretically and logically a number of constructs may converge to explain powerlessness and thus convergent validity for the broader construct, powerlessness, in the diagnostic process is provided. It is also logical to consider the concepts that make up the powerlessness construct from a divergent perspective. The ability to diagnose LH in a client, sick or well, will sharpen divergent validity for the powerlessness construct, but more importantly, will allow for a greater degree of accuracy in the diagnostic process when an individual is manifesting LH behavioral deficits without the broader behaviors of powerlessness.

The literature provides a sound theoretical and research base for consideration of LH as an independent valid nursing diagnosis. LH can be measured directly with a reliable and valid tool, the Learned Helplessness Scale. Research demonstrates that even capable, healthy people do not practice levels of health promoting self-care to the degree to which they understand and can articulate the importance of such behaviors, even when environmental opportunities for self-care are optimal.

Attributional LH theory can account for active or absent LH behaviors which may be less accurately diagnosed under the powerlessness theory. A variety of causal attributions are possible for the healthy or chronically ill client. Causal attributions along personal-stable-global continua place a client at the most illness potentiating end of the health illness continuum and vigorous retrospective intervention strategies to unlearn cognitive noncontingency learning are indicated. Espousal to universal-unstable-specific continua indicate a transient time frame for LH and interventions should be preventive to avoid exacerbation of acute episodes of response-outcome noncontingency to a chronic LH mode of behavior. A 20 item, reliable and valid measure of LH is available. When test findings are correlated with health history data, nurses are better able to accurately diagnose whether the LH cognitive deficits are operant and thus develop a targeted plan of care rather than global interventions which are more appropriate for the diagnosis of Powerlessness.

The literature supports that chronic illness is the result of long-term failure to maintain healthy self-care behaviors. Current published and unpublished research indicates that even healthy people, who claim to maintain healthy lifestyle behaviors have a significant level of LH deficits (32% of the variance in one study). Primary care providers can assess for possible LH when overt behaviors such as smoking, obesity, alcoholism and noncompliance to health regimens are evident. When LH behaviors are evident, interventions must be directed to unlearning the cognitive deficit. Client health teaching, when LH is operant, is a moot nursing intervention.

Based on theory and descriptive, exploratory and clinical research, it is the thesis of this paper that LH deficit behaviors should and can effectively be measured and diagnosed independent of Powerlessness.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

Clinical Validation of Three Respiratory Nursing Diagnoses

Previous nurse validation studies demonstrated that three respiratory diagnoses, Ineffective Airway Clearance (IAC), Ineffective Breathing Pattern (IBP), and Impaired Gas Exchange (IGE), are frequently used in acute care settings. Clinical validation of the defining characteristics (DCs) of these diagnoses generates further knowledge for diagnostic decisions. This paper will report the findings of a clinical study done at two hospitals in New York City. Two purposes of the study were: to validate the three diagnoses with actual clinical cases and to differentiate nursing interventions for each of the diagnoses.

Methods for the study included (1) identification of DCs from available sources and development of an instrument to record these and other data, (2) validation of the instrument by nationally known experts (content validity = .96), (3) application of methods to estimate test-retest and interrater reliability, (4) conceptual analyses and descriptions of each of the three diagnoses, (5) development of conceptual and operational definitions for each of the defining characteristics, and (6) extensive training of six Master's prepared clinical specialists as raters for the study. The sample was 63 medical surgical patients in two hospitals, 49% female and 51% male with an average age of 55 years, who were identified as having one or more of the diagnoses by nurses. The diagnoses were verified through physical examination and health history. Informed consents and IRB approval were obtained.

Possible DCs were recorded on the instrument as Present or Absent and rated on a scale of 1 to 5 for degree that they were characteristic of a diagnosis. Nursing interventions were rated by each clinical expert for each clinical case on a scale of 1 to 5 for degree of importance to the identified diagnosis(es).

Data analyses, using Fehring's weighted ratios, revealed that only one DC reached the level of .80, i.e., "abnormal blood gases" for IGE. The number of DCs that reached the level of .50, considered as minimal for retention as a defining characteristic, were seven for IAC, three for IBP, and four for IGE. The DC "expresses fatigue" was retained for each of the three diagnoses. Alpha coefficients indicate that DCs consistently relate to one another. The meaning of the findings in relation to NANDA's DCs will be discussed. For each of the diagnoses, many nursing interventions, both direct care and teaching, were rated as at least "somewhat important" for treating the diagnoses, e.g., for direct care interventions, 12 were rated as at least somewhat important for IAC, 11 for IBP, and 10 for IGE. These data support NANDA approval of IAC, IBP, and IAC as nursing diagnoses.

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ABSTRACT
ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

Accuracy of Nurses' Diagnoses in Clinical Settings

The purpose of this study was to determine the accuracy of nurses' diagnoses of actual clinical situations. The theoretical framework was an integrated model of the diagnostic process in nursing. Concept development of accuracy of nursing diagnoses as a continuous variable served as a basis for measurement of accuracy of nurses' diagnoses.

The sample was 60 female staff nurses who met the delimitations of the study from three hospitals in the New York/New Jersey area, 20 from each hospital. Each subject diagnosed three clinical cases to yield 180 cases that were judged for accuracy, 60 in each hospital. The delimitations for the sample were: licensed registered nurses working as staff nurses on medical-surgical units, who had a minimum of one year's experience on the unit, with English as a first language, and educated in the United States. Master's prepared clinical experts in each hospital who were trained as raters judged the accuracy of nurses' diagnoses; two were required for each clinical situation to be diagnosed.

Subjects selected patients who were elective admissions, admitted within 36 hours. After selecting a patient, each nurse contacted a clinical expert to verify that two clinical experts would be able to diagnose the patient within 16 hours. Subjects were instructed to focus on an actual, rather than a potential, diagnosis in the psychosocial domain. This was to be the one diagnosis that was best supported by the data. The time period for data collection was limited to 15 to 30 minutes.

Two clinical experts simultaneously assessed and diagnosed the same patient within 16 hours of each staff nurse. One rater interviewed the patient, while the other rater observed, both using the same data base for diagnosis. On completion of data collection with each case, experts discussed the data to agree on the most accurate diagnosis on a seven-point scale of accuracy. Data collection is nearing completion.

Descriptive statistics will be computed for the study variables and demographic characteristics, e.g., accuracy scores of staff nurses as determined by two raters, two-rater averages of accuracy scores, accuracy scores of all subjects rated by each clinical expert, accuracy scores of nurses on specific clinical units. A validity index will be computed for the scoring method. Interrater reliability will be estimated. Data analyses will be completed by December 1993.

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The nursing process
A common thread...

The common thread uniting different types of nurses who work in varied areas is the **nursing process**—the essential core of how a registered nurse delivers holistic, patient-focused care.

Assessment

An RN uses a systematic, dynamic way to collect and analyze data about a client, the first step in delivering nursing care. Assessment includes not only physical data, but psychological, sociocultural, spiritual, economic, or life-style factors as well. For example, a nurse's assessment of a hospitalized patient in pain includes not only the physical causes and manifestations of pain, but the patient's *response*—inability to get out of bed, refusal to eat, withdrawal from family members, anger directed at hospital staff, fear, or request for more pain medication.

Diagnosis

The nursing **diagnosis** is the nurse's clinical judgment about the client's *response* to actual or potential health conditions or needs. The diagnosis reflects not only that the patient is in pain, but that the pain *has caused* other problems such as anxiety, poor nutrition, and conflict within the family, or *has the potential* to cause complications—for example, respiratory infection is a potential hazard to an immobilized patient. The diagnosis is the basis for the nurse's care plan.

Outcomes/Planning

Based on the assessment and diagnosis, the nurse sets measurable and achievable short- and long-range **goals** for this patient that might include moving from bed to chair at least three times per day; maintaining adequate nutrition by eating smaller, more frequent meals; resolving conflict through counseling, or managing pain through adequate medication. Assessment data, diagnosis, and goals are written in the patient's **care plan** so that nurses as well as other health professionals caring for the patient have access to it.

Implementation

Nursing care is **implemented** according to the care plan, so there is a continuity of care for the patient during hospitalization and in preparation for discharge. Care is documented in the patient's record.

Evaluation

Both the patient's status and the effectiveness of the nursing care must be continuously **evaluated,** and the care plan modified as needed.

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Nursing Facts

FROM THE AMERICAN NURSES ASSOCIATION

Registered Nurses: A Distinctive Health Care Profession

In 1992 alone, about 90,000 persons were licensed as registered nurses, joining 2.2 million other RNs in the nation's largest health care profession.

Each followed a distinct path of education to become a registered nurse, and after obtaining the RN license, increased his or her expertise as a direct health care provider in work settings ranging from acute care hospitals to home and community centers to corporate work sites.

From the basic education required of an RN to the advanced educational and clinical paths taken by more experienced nurses, the depth and breadth of the nursing profession is meeting different health care needs of the population.

What is nursing?

Florence Nightingale, in her *Notes on Nursing: What It Is and What It Is Not,* defined nursing as having "charge of the personal health of somebody...and what nursing has to do...is to put the patient in the best condition for nature to act upon him." The philosophy has been restated and refined since 1859, but the essence is the same. In the words of nursing theorist Virginia Henderson, nurses help people, sick or well, to do those things needed for health or a peaceful death that people would do on their own if they had the strength, will, or knowledge.

The human response...

What defines nursing and sets it apart from other health care professions, particularly medicine with which it has long been considered part and parcel? It is nurses' focus—in theory and practice—on the *response* of the individual and the family to actual or potential health problems. Nurses are educated to be attuned to the whole person, not just the unique presenting health problem. While a medical diagnosis of an illness may be fairly circumscribed, the human response to a health problem may be much more fluid and variable, and may have a great effect on the individual's ability to overcome the initial medical problem. It's often said that physicians *cure,* and nurses *care.* In what some describe as a blend of biology and psychology, nurses build on their understanding of the disease and illness process to promote the restoration and maintenance of health in their clients.

Nurses: Charting the course for a healthy nation.

Nurses' broad-based education and holistic focus positions them as the logical network of providers on which to build a true *health care* system for the future. With a growing realization that individuals have considerable responsibility for their personal health may come a recognition that there is a professional group whose focus in education and practice is to enable individuals to reach their fullest health potential—registered nurses.

Nursing education

To gain the RN title, an individual must graduate from a state-approved school of nursing—either a four-year university program, a two-year associate degree program, or a three-year diploma program—and pass a state RN licensing exam.

BSN

The four-year university-based **Bachelor of Science in Nursing** (BSN) degree provides the nursing theory, science, humanities, and behavioral science preparation necessary for the full scope of professional nursing responsibilities, and provides the knowledge base necessary for advanced education in specialized clinical practice, research, or primary health care. About 636 U.S. colleges and universities offer the BSN or advanced nursing degree.



Education of RN workforce, March 1992
*Master's or Doctorate

First two years: General preparation including psychology, human growth and development, biology, microbiology, organic chemistry, nutrition, and anatomy and physiology.

Final two years: Nursing curriculum such as adult acute and chronic disease; maternal/child health; pediatrics; psychiatric/mental health nursing; and community health nursing. Also, nursing theory, bioethics, management, research and statistics, health assessment, pharmacology, pathophysiology, and electives in complex nursing processes.

Supervised clinical practice is obtained during the last two years in hospitals, nursing homes, and community settings.

ADN

A two-year program granting an **Associate Degree in Nursing** (ADN) prepares individuals for a defined technical scope of practice. Set in the framework of general education, clinical and classroom preparation prepares ADN nurses for a wide range of nursing roles that require nursing theory and technical proficiency. Many RNs whose first degree is an ADN return to school during their working life to earn a bachelor's degree or higher.

Diploma

Usually associated with a hospital, the **Diploma in Nursing** program combines classroom and clinical instruction, usually over three years. Although once a common educational route for RNs, diploma programs have diminished steadily—to 10 percent of all basic RN education programs in 1990—as nursing education has shifted from hospitals to academic institutions.

Licensing

Upon graduation, an individual must pass the National Council Licensure Examination for Registered Nurses (NCLEX-RN) to obtain a license to practice registered nursing and use the RN title. State boards of nursing govern licensing requirements, set continuing education or competency requirements, and handle disciplinary actions against RNs.

So what is a licensed practical nurse?

A licensed practical nurse is not a registered nurse. Also called a licensed vocational nurse (LVN) in some states, an LPN has taken a 12–14 month post-high school educational course that focuses on basic nursing care. LPNs also must pass a licensing exam (the NCLEX-PN). In 1992, there were about 962,000 LPNs in the United States. About 655,000 were working at an average salary of $22,714. The membership of the American Nurses Association consists only of registered nurses (RNs).

Where do RNs work?

As members of the nation's largest health care profession, registered nurses practice wherever people need nursing care, including such common sites as hospitals, homes, schools, workplaces, and community centers, and uncommon areas such as children's camps, homeless shelters, and tourist sites. Nearly 1.9 million of the nation's 2.2 million RNs were employed in 1992, about one-third of them on a part-time basis.

About **66 percent** of nurses currently work in hospitals, including:

General units	449,000	Emergency room	76,000
Intensive care units	203,000	Labor and delivery	63,000
Operating/recovery room	128,000	Outpatient units	62,000
Stepdown unit	70,000		

The median salary of a staff nurse working full-time in hospitals in 1992 was **$33,278. Head nurses earned a median of $47,335.**

Other settings where registered nurses work include:

Community/public health	180,000	Nursing education	36,500
Ambulatory care	144,000	Insurance companies	20,000
Nursing homes	129,000	Occupational health	19,000
School health	51,000		

Advanced practice nurses

The advanced practice nurse (APN) is an umbrella term given to a registered nurse who has met advanced educational and clinical practice requirements, usually at the Master's level, beyond the basic nursing education and licensing required of all RNs. Under this umbrella fall four principal types of APNs:

Leading the way...

Nurse practitioner (NP)—Working in clinics, nursing homes, hospitals, or private offices, more than 49,000 nurse practitioners are qualified to provide a wide range of primary and preventive health care services, prescribe medication, and diagnose and treat common minor illnesses and injuries.

Certified nurse-midwife (CNM)—About 6,000 CNMs provide well-woman gynecological and low-risk obstetrical care. In 1990, CNMs delivered more than 148,000 babies, or about 3.6 percent of all U.S. births that year, in hospitals, birth centers, and homes.

Clinical nurse specialist (CNS)—Working in hospitals, clinics, nursing homes, private offices, and community-based settings, some 58,000 CNSs handle a wide range of physical and mental health problems, and also work in consultation, research, education, and administration.

Certified registered nurse anesthetists (CRNA)—The oldest of the advanced nursing specialties, CRNAs administer more than 65 percent of anesthetics given to patients each year, and are the sole providers of anesthetics in 85 percent of rural hospitals. There were about 25,000 CRNAs in practice in 1992.

To a healthier future...

There are more than 100,000 advanced practice nurses in the United States today, helping to bring needed primary health care services to the population and paving the way for increased use of such nurses in the future. Average salary of a nurse practitioner or nurse-midwife in 1992 was $43,500; a nurse anesthetist earned an average $77,500.

Baccalaureate and advanced education prepares nurses for the independent clinical judgment necessary in a more complex environment. While in 1977, only 18 percent of RNs had a bachelor's degree, by 1992, 30 percent of nurses had at least a BSN and nearly 40 percent of all new nursing students were enrolled in four-year programs. More than 117,000 students—11 percent of them men—enrolled in BSN programs in the 1992–1993 academic year.

Advanced practice nurses... a primary part of U.S. health care

The U.S. health care system is largely based on a "medical model" of care that relies on physicians to be the "gatekeepers" to services. As medical specialization has grown, there has been a parallel growth in sophisticated medical technology and treatment to the exclusion of needed basic primary health care services.

Advanced practice nurses are capable of providing much of that needed basic care. Most preventive and primary health care does not require the expensive specialization that characterizes physician education today. America's nurses believe that:

- the health care system must be restructured to focus on prevention and primary care rather than high-tech treatment and cure of disease.
- regulatory and legislative barriers to increased use of nurses as health care providers must be removed.
- basic health care services must be available to all citizens in convenient community locations.

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Nursing Facts

FROM THE AMERICAN NURSES ASSOCIATION

Advanced Practice Nursing: A New Age in Health Care

Innovative advances in health care make frequent headlines, but there is an equally innovative—if somewhat misunderstood—treatment for the cost and accessibility woes plaguing the U.S. health care system. More than 100,000 advanced practice nurses—and their numbers are growing—are carving out a new role in delivering timely, cost-effective, quality health care, especially to chronically underserved populations such as the elderly, the poor, and those in rural areas.

Some **60% to 80%** of primary and preventive care traditionally done by doctors can be done by a nurse for less money. This is not to say nurses work cheaper, but their cost-effectiveness reflects a variety of factors related to the employment setting, liability insurance, and the cost of education.

With an emphasis on health promotion and disease prevention and a proven record of providing excellent primary care in diverse settings, advanced practice nurses form a critical link in the solution to America's health care crisis. **Removing the barriers to advanced practice nursing would pay a healthy dividend now and in the future.**

Who are these nurses?

The advanced practice nurse (APN) is an umbrella term given to a registered nurse (RN) who has met advanced educational and clinical practice requirements beyond the 2-4 years of basic nursing education required of all RNs. Under this umbrella fall four principal types of APNs.

Nurse Practitioner (NP)

Number: 49,500.

Education: Most of the approximately 150 NP education programs in the United States today confer a master's degree. At least 36 states require NPs to be nationally certified by the ANA or a specialty nursing organization.

What do they do? Working in clinics, nursing homes, hospitals, or their own offices, NPs are qualified to handle a wide range of basic health problems. Most have a specialty—for example, adult, family, or pediatric health care. NPs conduct physical exams, take medical histories, diagnose and treat common acute minor illness or injuries, order and interpret lab tests and X-rays, and counsel and educate clients. In 39 states, they may prescribe medication according to state law. Some work as independent practitioners and can be reimbursed by Medicare or Medicaid for services rendered; others work for hospitals, HMOs, or private industry.

Average salary in 1992 was $43,600.

Certified Nurse-Midwife (CNM)

Number: about 6,000.

Education: An average one and one-half years of specialized education beyond nursing school, either in an accredited certificate program, or like NPs, increasingly at the master's level.

What they do: CNMs provide well-woman gynecological and low-risk obstetrical care including prenatal, labor and delivery, and post-partum care. In 1990, CNMs delivered 148,728 babies, or about 3.6 percent of all U.S. births that year, in hospitals, birth centers, and homes. An ANA meta-analysis of CNM care found that nurse-midwives performed fewer fetal monitors, episiotomies, and forceps deliveries, administered fewer IVs, delivered fewer low birthweight and premature infants, and had shorter patient hospital stays. CNMs have prescriptive authority in 33 states.

Average salary in 1992 was $43,600.

Clinical Nurse Specialist (CNS)

Number: about 58,000.

Education: Registered nurses with advanced nursing degrees—master's or doctoral—who are experts in a specialized area of clinical practice such as mental health, gerontology, cardiac or cancer care, and community or neonatal health.

What they do: CNSs work in hospitals, clinics, nursing homes, their own offices, and other community-based settings such as industry, home care and HMOs. Qualified to handle a wide range of physical and mental health problems, CNSs provide primary care and psychotherapy. They conduct health assessments, make diagnoses, deliver treatment, and develop quality control methods. Besides delivering direct patient care, CNSs work in consultation, research, education, and administration. Some work independently or in private practice and can be reimbursed by Medicare, Medicaid, CHAMPUS, and private insurers.

Salary range: $30,000 to $80,000, depending on experience and geographical location.

Certified Registered Nurse Anesthetist (CRNA)

Number: about 25,000.

Education: Registered nurses who complete 2-3 years higher education beyond the required four-year bachelor's degree, as well as meeting national certification and recertification requirements.

What they do: In this oldest of the advanced nursing specialties, CRNAs administer more than 65 percent of all anesthetics given to patients each year, and are the sole providers of anesthetics in 85 percent of rural hospitals. Working sometimes with an MD anesthesiologist, but frequently independently, these nurse specialists work in almost every setting in which anesthesia is given—operating rooms, dentist's offices, ambulatory surgical settings.

Average salary in 1992 was $77,500.

Advanced practice nurses are accessible. . .

They provide pre-employment physicals for employers, home health care to the elderly, health education in hospitals, schools, and community clinics, geriatric care in nursing homes, infectious disease control in prisons, pre- and post-natal care in inner-city and rural clinics, and psychotherapy in public and private practices.

Advanced practice nurses are cost-effective . . .

Advanced practice nurses aren't low-priced doctor substitutes. **They are first and foremost registered nurses, a profession with its own educational and licensing requirements, regulatory oversight by boards of nursing in all 50 states, and competency standards and continuing education requirements.** APNs are skilled in performing a wide range of initial, or primary, health services—especially screening and preventive services—that if ignored, can lead to far more serious and costly health problems down the line.

Advanced practice nurses deliver quality healthcare. . .

All advanced practice nurses must meet rigorous education, certification, and continuing education requirements.

Standards of practice are set and monitored by nursing professional organizations. Advanced practice nurses work collaboratively with physicians and other health professionals to coordinate health services for the best outcome for the patient.

Numerous studies attest to the value of APNs. . .

The Office of Technology Assessment, in a widely cited 1986 report, said NPs are "especially valuable in improving access to primary care and supplementary care in rural areas and in health programs for the poor, minorities and people without health insurance." OTA found the quality of NP care to be "as good as or better than care provided by physicians," and found NPs had "better communication, counseling and interviewing skills than physicians have."

The National Research Council of the National Academy of Sciences found no significant difference in the outcome of care provided by CRNAs and physician-anesthesiologists.

If advanced practice nurses are so accessible and affordable, why don't we use them to help provide care to 60 million uninsured and underinsured citizens?

A study published in the *Yale Journal on Regulation* by Barbara J. Safriet, associate dean of the Yale Law School, addressed that question.

"Unnecessary restrictions on their scope of practice, prescriptive authority, and eligibility for reimbursement actively impairs these providers' proven ability to safely meet the health care needs of many of our neediest citizens," Safriet said. "Removing these barriers would be an important first step to restoring the focus on health, and on care, that our system so desperately needs."

Nursing's Agenda for Health Care Reform

EXECUTIVE SUMMARY

America's nurses have long supported our nation's efforts to create a health care system that assures access, quality, and services at affordable costs. This document presents nursing's agenda for immediate health care reform. We call for a basic "core" of essential health care services to be available to everyone. We call for a restructured health care system that will focus on the consumers and their health, with services to be delivered in familiar, convenient sites, such as schools, workplaces, and homes. We call for a shift from the predominant focus on illness and cure to an orientation toward wellness and care. The basic components of nursing's "core of care" include:

- A restructured health care system which:
  - Enhances consumer access to services by delivering primary health care in community-based settings.
  - Fosters consumer responsibility for personal health, self care, and informed decision making in selecting health care services.
  - Facilitates utilization of the most cost-effective providers and therapeutic options in the most appropriate settings.

- A federally-defined standard package of essential health care services available to all citizens and residents of the United States, provided and financed through an integration of public and private plans and sources:
  - A public plan, based on federal guidelines and eligibility requirements, will provide coverage for the poor and create the opportunity for small businesses and individuals, particularly those at risk because of preexisting conditions an those potentially medically indigent, to buy into the plan.
  - A private plan will offer, at a minimum, the nationally standardized package of essential services. This standard package could be enriched as a benefit of employment or individuals could purchase additional services if they so choose. If employers do not offer private coverage, they must pay into the public plan for their employees.

- A phase-in of essential services, in order to be fiscally responsible:
  - Coverage of pregnant women and children is critical. This first step represents a cost-effective investment in the future health and prosperity of the nation.
  - One early step will be to design services specifically to assist vulnerable populations who have had limited access to our nation's health care system. A "Healthstart Plan" is proposed to improve the health status of these individuals.

- Planned change to anticipate health service needs that correlate with changing national demographics.

- Steps to reduce health care costs include:
  - Required usage of managed care in the public plan and encouraged in private plans.
  - Incentives for consumers and providers to utilize managed care arrangements.
  - Controlled growth of the health care system through planning and prudent resource allocation.
  - Incentives for consumers and providers to be more cost efficient in exercising health care options.
  - Development of health care policies based on effectiveness and outcomes research.
  - Assurance of direct access to a full range of qualified providers.
  - Elimination of unnecessary bureaucratic controls and administrative procedures.

- Case management will be required for those with continuing health care needs. Case management will reduce the fragmentation of the present system, promote consumers' active participation in decisions about their health, and create an advocate on their behalf.

- Provisions for long-term care, which include:
  - Public and private funding for services of short duration to prevent personal impoverishment.
  - Public funding for extended care if consumer resources are exhausted.
  - Emphasis on the consumers' responsibility to financially plan for their long-term care needs, including new personal financial alternatives and strengthened private insurance arrangements.

- Insurance reforms to assure improved access to coverage, including affordable premiums, reinsurance pools for catastrophic coverage, and other steps to protect both insurers and individuals against excessive costs.

- Access to services assured by no payment at the point of service and elimination of balance billing in both public and private plans.

- Establishment of public/private sector review -- operating under federal guidelines and including payers, providers, and consumers -- to determine resource allocation, cost reduction approaches, allowable insurance premiums, and fair and consistent reimbursement levels for providers. This review would progress in a climate sensitive to ethical issues.

Additional resources will be required to accomplish this plan. While significant dollars can be obtained through restructuring and other strategies, responsibility for any new funds must be shared by individuals, employers, and government, phased in over several years to minimize the impact.

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DIAGNOSIS REVIEW SESSION

Tuesday, March 29, 1994

PROPOSED NURSING DIAGNOSES

IMPAIRED URINARY FILTRATION SYNDROME

Definition: A state in which the individual is experiencing urinary filtration dysfunction. The urinary filtration syndrome is characterized by changes in glomerular permeability which allow the passage of particles into the urine resulting in compromised urinary function/filtration.

Defining Characteristics:

Major: Decreased urine output
Whaley and Wong, pg.867; Lippincott, pg.1362 & 1365.

Skin pale and stretched taut
Whaley and Wong, pg. 867; Pillitteri, pg. 1078.

Weight Gain
Whaley and Wong, pg.867; Lippincott, pg. 1362 & 1365

Proteinuria
Pillitteri, pg. 1074 & 1078; Whaley and Wong, pg. 866
Lippincott, pg.1362 & 1365.

Hypoalbuminemia
Pillittlei, pg 1074; Lippincott, pg. 1362 and 1365.

Increased BUN and Creatinine
Pillitteri, pg. 1074; Lippincott, pg.1362.

Hematuria
Pillitteri, pg. 1074; Lippincott, pg. 1362 and 1365.

Cloudy, brown (smokey) urine
Pillitteri, pg.1074; Whaley and Wong, pg. 871 and
Lippincott pg. 1362.

Urine sediment (WBC, epithelial cells, Hyaline, granular and RBC casts).
Pillitteri, pg. 1074; Lippincott, pg.1362 and 1365.

Oliguria (after initial urine changes)
Pillitteri, pg. 1074

Increased specific gravity
Pillitteri, pg. 1074; Lippincott, pg.1362.

Hypertension
Pillitteri, pg. 1074; Whaley and Wong, pg. 871;
Lippincott, pg. 1362 and 1365.

Hypervolemia
Pillitteri, pg. 1074

Edema (seen as periorbital edema to ascities)
Lippincott, pg. 1362 and 1365; Pillitteri, pg.1078;
Whaley and Wong, pg. 867 and 871.

Frothy Urine
Whaley and Wong, pg. 867

Azotemia
Whaley and Wong, pg. 871

Minor: Abdominal pain
Pillitteri, pg. 1074; Whaley and Wong, pg.871;
Lippincott, pg. 1365.

Low grade fever
Pillitteri, pg. 1074

Anorexia
Pillitteri, pg. 1074; Whaley and Wong, pg. 867 & 871;
Lippincott, pg. 1362 and 1365.

Vomiting
Pillitteri, pg. 1074 and 1078; Whaley and Wong,
pg. 871; Lippincott, pg. 1362 and 1365.

Headache
Pillitteri, pg. 1074 and 1078; Whaley and Wong,
pg. 871; Lippincott, pg. 1362 and 1365.

Congestive Heart Failure (cardiac enlargement and/or EKG changes)
Pillitteri, pg. 1074; Lippincott, pg. 1363.

Orthopnea
Pillitteri, pg. 1074 and 1078; Whaley and Wong,
pg. 867; Lippincott, pg. 1363.

Irritability, convulsions, lethargy
Pillitteri, pg. 1074 and 1078; Whaley and Wong,
pg. 867 and 871; Lippincott, pg. 1365.

Mild anemia
Pillitteri, pg. 1074.

ASO titer elevated
Pillitteri, pg. 1074; Whaley and Wong, pg. 871;
Lippincott, pg. 1363 and 1365.

Diarrhea
Pillitteri, pg. 1078; Whaley and Wong, pg. 867;
Lippincott, pg. 1365.

Increased clotting tendency
Pillitteri, pg. 1078.

Fatigue
Whaley and Wong, pg. 867.

Related Factors:

Pathophysiologic:

Infectious diseases, recent respiratory infection, impetigo,

strep throat, tonsillitis caused by streptococcal infection,

Otits media caused by streptococcal infection (PIllitteri, pg. 1074; Lippincott, pg. 1362; Whaley and Wong, pg. 871)

Poisoning from nephrotoxic agents (Lippincott, pg. 1365) pg. 865)

Systemic Lupus erythematousus, (Pillitteri, pg. 1074)

Sickle cell anemia, (Pillitteri, pg. 1074)

Syphilis, (Pillitteri, pg. 1074)

Post streptococcal glomerulohephritis, (Pillitteri, pg. 1074; Lippincott, pg. 1365.

Poisoning from chemical substances, toxemia of pregnancy,

Renal vein thrombosis, diabetic glomerulosclerosis, (Brunner and Suddarth, pg. 1047; Harkness Hood and Dincher, pg. 512).

Treatment related:

Blood transfusion with incompatible blood, Harkness Hood and Dincher, pg. 512.

Self Care Deficit: Medication Administration

Feeding related to (specify)
Bathing related to (specify)
Dressing related to (specify)
Toileting related to (specify)
Total related to (specify)
Medication Administration related to (specify)

Definition
Self care deficit: The state in which the individual experiences an impaired motor function or cognitive function, causing a decreased ability to feed, bathe, dress, toilet *and/or administer his/her own medications.*

Major (one of the following must be present)

1. Self feeding deficits
   Unable to cut food
   Unable to bring food to mouth

2. Self-bathing deficits (includes washing entire body, combing hair, brushing teeth, attending to skin and nail care, and applying makeup)
   Unable or unwilling to wash body or body parts
   Unable to obtain a water source
   Unable to regulate temperature or water flow

3. Self-dressing deficits (including donning regular or special clothing, not night-clothes)
   Impaired ability to put on or take off clothing
   Unable to fasten clothing
   Unable to groom self satisfactorily
   Unable to obtain or replace articles of clothing

4. Self-toileting deficits
   Unable or unwilling to get to toilet or commode
   Unable or unwilling to carry out proper hygiene
   Unable to transfer to and from toilet or commode
   Unable to handle clothing to accommodate toileting
   Unable to flush toilet or empty commode.

5. Total
   Unable to perform any self-care activities.

6. *Self Medication Administration*
   Unable to properly self administer medications

Etiological, Contributing, Risk Factors

Pathophysiological

Neuromuscular impairment
   Autoimmune alterations (arthritis, multiple sclerosis)
   Metabolic and endocrine alterations (diabetes mellitus, hypothyroidism)
   Nervous System disorders (Parkinsonism,myasthenia gravis, muscular dystrophy, Guillain Barre')
   Lack of coordination

Spasticity or flaccidity
Muscular weakness
Partial or total paralysis (spinal cord injury, stroke)
CNS tumors
Increased intracranial pressure
Cognitive impairment

Musculoskeletal disorders
Atrophy
Muscle contracture
Connective tissue diseases (systemic lupus erythematosus)
Edema (increased synovial fluid)

Visual disorders
Glaucoma
Cataracts
Diabetic/hypertensive retinopathy
Ocular histoplasmosis
Cranial nerve neuropathy
Visual field cuts

Treatment-related
External devices (casts, splints, bracts, IV equipment)
Surgical procedures
Fractures
Tracheotomy
Gastrostomy
Jejunostomy
Ileostomy
Colostomy
Complex medication regimen.
Number and types of prescriptions and non-prescription medications used

Situational (personal, environmental)
Immobility
Trauma
Nonfunctioning or missing limbs
Coma
Financial burden
Multiple prescribers
Inadequate or ambiguous instructions

Maturational
Elderly: Decreased visual and motor ability, muscle weakness, *physiological changes that alter responses to medications*

NEW NURSING DIAGNOSIS PROPOSAL FORM

REQUIRED:

1. Diagnosis Name: High Risk for Loneliness.

2. Diagnosis Definition: High Risk for Loneliness: A subjective state in which an individual is at risk of experiencing a vague dysphoria.

3. Diagnosis Risk Factors:

Patient Situations:

Affectional deprivation - lack of a person that provides support, intimacy and self-disclosure.

Physical isolation - lack of contact with one's familiar environment.

Cathectic deprivation - lack of contact with objects or things that are perceived as important or meaningful.

Social isolation - the sense of separation from family or friends after hospitalization.

4. Substantiating/Supportive Materials:

Affection deprivation

Loneliness has been linked to a variety of social and medical problems (Peplau and Perlman, 1982). Holmes's study (1961) of deaths among patients having lung pathology, found that the lack of close personal ties with others was the important variable distinguishing those who did and those who did not die. Studies, which control for baseline health status, show increased risks of death among persons with a low quantity, and sometimes low quality, of social relationships (House, Landis, and Unberson (1988).

Physical isolation

The environmental change resulting from hospitalization is a physical and psychosocial change that may be disruptive and stressful to patients (Hadley, 1969). Only two studies have documented the phenomenon of loneliness as a response to hospitalization in the adult (Francis, 1976; Odell, 1981).

Cathectic deprivation

A study by Francis (1976) of 133 non-intensive care, hospitalized, adult medical patients in two general, short term urban medical center hospitals demonstrated a direct relationship between secondary loneliness and cathectic investment. Cathectic investment is an individual's emotional attachment to specific persons and things. Francis defined secondary loneliness as a separation from persons and things in whom or in which the individual had a cathectic investment.

Odell (1981) conducted a study with 51 adults hospitalized on three medical and two surgical units in an acute care hospital using Schedules for the Measurement of Loneliness and Cathectic Investment developed by Francis (1976). A test-retest reliability coefficient for the loneliness items was r=0.980 and for the cathectic investment items was r=1.000. Twenty-eight (51%) of the subjects were determined to be lonely. Odell found that the intensity of loneliness increased during those times of the day when the patients were separated from meaningful persons or things.

Social isolation

Chappell and Badger, (1989) stated that the indicators of social isolation, such as living alone or having no family, are frequently assusmed to be indicative of emotional isolation, loneliness, or poor health. Health care personnel, in particular, are more likely to use such indicators of social isolation than to measure loneliness or psychological well-being directly.

Jones et al (1985) reported on the significance association between disability and loneliness ($p<0.001$). Schmidt and Kurdek (1985) concluded that lack of social support in poor health was particularly relevant for elderly women. No studies, focusing on loneliness as a response to hospitalization in only the elderly, were found. In a review of the literature on the effects of hospitalization on children, King and Ziegler (1981) cited 66 studies on responses to hospitalization in the child but none specifically focused on the tension of loneliness.

A two part study by Byrne and Proffitt (1988) of 30 hospitalized elderly patients in part I and 31 hospitalized elderly patients in part II demonstrated a high correlation between cathectic deprivation, social isolation, physical isolation, affectional deprivation and loneliness.

Proposal For a New Nursing Diagnosis of Spasticity

Section 1-Label

Spasticity

Section 2-Definition

Spasticity is the state in which an individual with an upper motor neuron injury experiences increased muscle tone and abnormal reflexes in response to internal or external stimuli which interfere with functional abilities such as mobility, hygiene, eating, dressing, and toileting.

Section 3-Defining Characteristics

Major Defining Characteristics

Decreased functional ability

Abnormal postures

Spasms

Decreased range of motion

Increased muscle tone

Minor Defining Characteristics

Loss of dexterity

Synergistic movement

Clonus

Clasp knife activity

Hyperactive tendon reflex

Muscle cramping

Impaired balance

Pain

Irradiation of reflex

Weakness

Related Factors

The following factors can precipitate the presence of or worsen the state of spasticity in a client: abnormal movement patterns, positioning/handling techniques, excessive effort, negative emotional state, decreased range of motion, pain, and noxious internal (physiologic) or external stimuli.

NEW NURSING DIAGNOSIS PROPOSAL FORM

REQUIRED:

1. Diagnosis Name: Parenting: Potential for growth: Parent/Infant Attachment

2. Diagnosis Definition: Actual/potential: Disruption of the interactive process between parent/significant other and infant that fosters the development of a protective and nurturing reciprocal relationship.

3. Diagnosis Defining Characteristics:

   a. Major

      1. Avoidance of, lack of, or inappropriate parent/infant interaction

   b. Minor

      1. Infrequent parent-initiated communication (e.g. phoning, yisitation)
      2. Parents verbalize belief that their infant does not love them
      3. Parents continue to search for infant abnormality, disregarding repeated negative findings
      4. Unrealistic parental expectations
      5. Parents unable to express or find anything positive about their baby
      6. Failure of parents to prepare for discharge
      7. Inappropriate response to infant's cues (over and under stimulation)
      8. Parents express
         - negative cognitions about self, child, or situation.
         - feeling that infant belongs to staff rather than parents.
         - fear that infant will die or become disabled.
         - feelings of helplessness and guilt.
         - fears of inadequacy and incompetence.
         - anger at infant or care-givers.
      9. Hesitant or unwilling to take an active role in the care of their child.
      10. Exaggerated parental revulsion by normal body fluids (stools, vomiting).

   a. Related Factors/Risk Factors:

      Personal
      Inability of parents to meet their personal needs
      Anxiety associated with the neonatal parental role
      Substance abuse
      Guilt
      Grieving loss of "dream or fantasized child"
      Fear of infant death or disability
      Insufficient time to accept pregnancy and prepare for infant
      Unwanted or unplanned pregnancy
      Feeling of failure
      Low self-esteem
      Sibling response (disruption in family routine)
      Multiple family stressors (financial; exhaustion; pre-existing conflicts)
      Previous pregnancy/child loss
      Lack of control
      Inadequate resources: support system, finances, transportation, communication barriers, e.g. language, phone access
      History of abuse/neglect
      Powerlessness
      Multiple birth
      Negative parental perception regarding infant's appearance/characteristic

PHYSIOLOGICAL

Ill or premature infant who is unable to effectively initiate parental contact due to altered behavioral organization

- autonomic system instability
- motor system instability
- state system instability
- self-regulatory system instability
- attentional/interactive system instability

Inadequate suck-swallow coordination (delayed breast or bottle feeding)
Developmental delays
Drug effects on infant (prenatal/postnatal)

ENVIRONMENTAL

Separation of baby from parent at birth
Inaccessibility to infant:

- Physical barriers (isolette, equipment)
- Physical separation (ill mother, distance)

Lack of privacy
Technological environment/medical terminology

TREATMENT RELATED

Unable to hold infant
Equipment, IV's, tubes, etc.
Parents unable to hear baby cry due to intubation
Prolonged hospitalization
Sedation/paralysis
Multiple surgeries/procedures

Submitted by:

Sally Deaver RN, BSN, Sharon Diehm RNC, Marie Quinn RN, BSN, Michelle Pietras RN, MSN, Kathy Wyngarden RN, MSN

KW/ej
NDP

#1) Proposal for a New Nursing Diagnosis

Category - Wellness Diagnosis

1. Label:

Potential for enhanced spiritual well-being

2. Definition:

Spiritual well being is the process of an individual's developing/unfolding of mystery through harmonious interconnectedness that springs from inner strengths.

3. Literature/clinical validation:

Care of the human spirit is a nursing activity often neglected in a world of technological, physiological and psychological care. Nurses interested in their commitment to holistic practice must attend to the human spirit as well as other dimensions of the person. A body of literature exists which defines the human spirit as involving traits of caring, love, honesty, wisdom and imagination. In addition, spirit is defined as a quality of trancendence, a guiding force, or something that goes beyond the individual nurse or client.

Support for a client's spiritual growth and/or development is a nursing function which promotes health and wellness. It has been shown that biobehavioral interventions such as prayer, relaxation, meditation, imagery, or music produce calming effects for an individual associated with parasympathetic responses (Rossi, 1986). Further, it is believed that the process of treating another human being with loving kindness will have a physiological effect related to autonomic nervous system responses (Benner & Wrubel, 1989; Dossey, 1988a; Dossey, 1988b; Dossey, 1988c).

To determine the appropriate nursing role related to the client's sprituality, Burkhardt (1989) completed a synthesis of 109 research studies and articles on the concept of spirit and spirituality. This work revealed three **defining characteristics** of spiritual well-being and the process of spiritual development -

1) *inner strengths* - a sense of awareness, self, consciousness, sacred source, unifying force, inner core, and transcendence;
2) *unfolding mystery* - one's experience about life's purpose and meaning, mystery, uncertainty, and struggles;
3) *harmonious interconnectedness* - relatedness, connectedness, harmony with self, others, higher power/God, and the environment.

PROPOSED NEW DIAGNOSIS

1. Label:

   Ineffective Coping
   (for use with communities)

2. Definition:

   A pattern of community activities for adaptation and problem solving that is unsatisfactory for meeting the demands or needs of the community.

3. Defining Characteristics:

   Major:

   . None identified

   Minor:

   . Community does not meet its own expectations
   . Deficits of community participation
   . Deficits in communication methods
   . Excessive community conflicts
   . Expressed difficulty in meeting demands for change
   . Expressed vulnerability
   . High illness rates
   . Stressors perceived as excessive

4. Related Factors:

   . Deficits in social support
   . Inadequate resources for problem solving
   . Powerlessness

5. Literature/ Clinical Validation

   See Lunney, M. (1991). Nursing diagnosis of community coping: Validation of ineffective coping. Paper submitted to the North American Nursing Diagnosis Association.

PROPOSED NEW DIAGNOSIS

1. Label:

Ineffective Management of Therapeutic Regimen
(for use with communities)

2. Definition:

A pattern of regulating and integrating into community processes programs for treatment of illness and the sequelae of illness that are unsatisfactory for meeting health-related goals.

3. Defining Characteristics:

a. Major:

. Number of health care resources are insufficient for the incidence/prevalence of illness(es)

b. Minor:

. Acceleration (expected or unexpected) of illness(es)
. Deficits in advocates for aggregate(s)
. Deficits in community activities for primary, secondary and tertiary prevention
. Deficits in persons and programs to be accountable for illness care of aggregate(s)
. Illness symptoms above the norm expected
. Unavailable resources for illness care

4. Related Factors:

Complexity of community/aggregate needs
Decreased communication (community/aggregate and society)
Decreased valuing of community/aggregate by members of society
Decreased valuing of health protection
Decreased valuing of self by community/aggregate
Disorganization of health care system
Economic factors, e.g., poor management of available finances
Excessive exposure to risk factors, e.g., toxic chemicals
Local, state, or national policies

5. Literature/ Clinical Validation:

Lunney, M. (1991). The concept of management of therapeutic regimen and validation of four nursing diagnoses. Paper submitted to the North American Nursing Diagnosis Association.

PROPOSED NEW DIAGNOSIS

1. Label:

Ineffective Management of Therapeutic Regimen
(for use with families)

2. Definition:

A pattern of regulating and integrating into family processes a program for treatment of illness and the sequelae of illness that is unsatisfactory for meeting specific health goals.

3. Defining Characteristics:

a. Major:

. Inappropriate family activities for meeting the goals of a treatment or prevention program

b. Minor:

. Acceleration (expected or unexpected) of illness symptoms of a family member
. Lack of attention to illness and its sequelae
. Verbalized desire to manage the treatment of illness and prevention of sequelae
. Verbalized difficulty with regulation/ integration of one or more prescribed regimens for treatment of illness and its effects or prevention of complications
. Verbalizes that family did not take action to reduce risk factors for progression of illness and sequelae

4. Related Factors:

Complexity of health care system
Complexity of therapeutic regimen
Decisional conflicts
Economic difficulties
Excessive demands made on individual or family
Family conflict
Family patterns of health care
Inadequate number and types of cues to action
Knowledge deficits
Mistrust of regimen and/or health care personnel
Perceived seriousness
Perceived susceptibility
Perceived barriers
Perceived benefits
Powerlessness
Social support deficits

TERMINAL ILLNESS RESPONSE: The state in which an individual with a terminal affliction attempts to deal with end of life decisions, the pending existential loss of loved ones, possessions, and his/her own body image, as well as the debilitating physical symptoms of dying. The family or caregiver are reciprocally affected, and sometimes if the patient is unconscious, they experience the phenomenon alone.

Goal: The patient, family, significant other or caregiver, will be prepared, supported, and cared for, as they reconcile to the pending death.

Defining characteristics:

Major:

Activity Intolerance
Alteration in Nutrition: Less Than Body Requirements
Anxiety
Family Processes Altered
Fear
Grieving, Anticipatory
Home Maintenance Impaired
Ineffective Family Coping
Ineffective Individual Coping
Knowledge Deficit
Pain
Powerlessness
Self Care Deficit
Social Isolation

Minor:

High Risk for Injury
Thought Processes Altered

Other Possible Characteristics:

Bowel Elimination Altered: Constipation
Fluid Volume Deficit
Gas Exchange Impaired
Incontinence: Functional
Noncompliance
Sleep Disturbance
Spiritual Distress

Related factors: Variables of social support, pain, age; cultural aspects; spiritual values; medical diagnosis of incurable disease; catastrophic injury; physical symptoms; grieving; notoriety of disease; medical profession's acceptance; role Strain; communication problems; feelings of loss; stages of grief: denial, anger, bargaining, depression, and acceptance; support system's acceptance of end of life decisions; unfamiliaritg with: legal, ethical, and financial aspects involved, cultural and spiritual rituals, funeral ceremonies, cemetary plots, monuments, and burial/ cremation planning or pre-arranging, as well as end of life decisions-- including advance directives (living will and durable power of attorney) to help others make decisions for the patient, if need be, concerning being kept alive by artificial means, such as CPR, artificial respiration, or feeding tubes.

References: 3, 12, 15, 25, 45, and 46

Actual Nursing Diagnosis:

Dysfunctional Alcohol Drinking Patterns

Definition:

Continuous or intermittent abuse of the beverage alcohol resulting in breakdown of social, emotional, spiritual or physical levels of health for the individual.

Defining Characteristics:

CAGE Screen Tool: Two or more of the following characteristics must be present.

Client has felt he or she should cut down on their drinking.

Client able to verbalize people have annoyed him or her by criticizing their drinking.

Client has felt bad or guilty about their drinking.

Client has used alcohol as an eye opener to steady nerves or get rid of hangover.

(Two or more positive response to CAGE questions)

Trauma Scale Screening Tool: For Emergency Room Use: Two or more of the following characteristics must be present.

Client has had fracture or dislocations to bones or joints.

Client has been injured in a traffic accident.

Client has had a head injury.

Client has been injured in an assault or fight (excluding athletic injuries).
Client has been injured after drinking alcohol.

Brief MAST Screening Tool: Three or more points

RELATED FACTORS:

Failed efforts to control drinking.

Clients family, significant other , etc. complains to care giver about clients alcohol use.

Client has used other drugs.

Disruption in relationships with other people, job, school, etc.

Family history of alcohol abuse.

Alcohol use related hospitalization, trauma.

Nutritional, self care deficit.

Social isolation.

Legal, social, financial complication.

Nursing Diagnosis

1. Label: Alteration in preservation/quality of life.

2. Definition:

Quality of life is that continuum for measuring how well one meets and takes care of one's own needs.

Preservation of life is the ability to prolong life naturally or on a life support system.

3. Defining characteristics:

Major Diagnostic Cues:

Patient is:

a. Terminal; and

b. Incurable; or

c. Diagnosed as a persistent vegetative state. (Right to a natural death, 1991)

In the judgement of the attending physician the patient suffers from a sustained loss of self-aware cognition and, without the use of extraordinary means or artificial nutrition or hydration, will succumb to death within a short period of time. (Right to a natural death, 1991)

Patient and/or family are facing decisions about preservation of life by extraordinary means (i.e. any medical procedure or intervention which in the judgement of the attending physician would serve only to postpone artificially the moment of death by sustaining, restoring, or supplanting a vital function. (Right to a natural death, 1991)

Prognosis is death.

Minor Diagnostic Cues:

Individuals have signed advance directives or have named someone a durable power of attorney.

Individuals are going through the grief and loss process of:

- Denial
- Anger
- Depression
- Bargaining
- Acceptance

4. Related Factors:

Individuals involved agree with proposed treatment and care.

Individuals involved understand why the care is being given and the consequences if stopped.

North American Nursing Diagnosis Association
Submission of Proposed Diagnosis

IMPAIRED ENVIRONMENTAL INTERPRETATION SYNDROME

I. Proposed Diagnosis:

Classification: Perceiving pattern (Taxonomy I, Revised)

II. Diagnostic Concept

Actual: nursing diagnosis:
Impaired Environmental Interpretation Syndrome
a human response to the condition of progressive and permanent memory loss in an individual.

III. Components of proposed diagnosis

LABEL: **Impaired Environmental Interpretation Syndrome**

Definition: Consistent lack of orientation to person, place, time or circumstances over more than three to six months necessitating a protective environment.

DEFINING CHARACTERISTICS:

Major:
Consistent disorientation in known and unknown environments (Katzman, 1986; Norris, 1986).
Chronic confusional states (Katzman, 1986).
Support see below

Minor:
Loss of occupation or social functioning from memory decline (Katzman, 1986).
Inability to follow simple directions/Instructions (Katzman, 1986).
Inability to reason (Katzman, 1986)
Loss of occupation or social functioning from intellectual and memory decline (Souder, 1992).
Inability to concentrate (Rasin, 1990: Foreman, 1990)
Slow in responding to questions (Eliopoulos, 1993)
Long-term memory may be intact but recent memory impaired (Hall, 1991,a; Eliopoulos, 1993)
Difficulty with abstraction, and impaired judgement (Matteson & McConnel, 1988).
Expressive aphasia (Souder, 1992)
Unable to respond to social cues (Miller, 1990).
Poor impulse control (Hall, 1991,a)
Expression of despair or depression (Miller, 1990).
Difficulty controlling emotions (Eliopoulos, 1993).

Sleep-wake cycle is fragmented (Foreman, & Grabowski, 1992; Norris, 1986)
Unable to locate bathroom (Matteson & McConnell, 1988).
Unable to do ADLs, e.g. bathing, dressing, grooming, toileting (Matteson & McConnell, 1988).
Inability to do ADLs, i.e. using phone, shopping, laundry (Matteson & McConnell, 1988).
Unable to prepare or locate food sources or prepare own food (Matteson & McConnell, 1988).
Unable to recognize caregiver over a period of time (Miller, 1990).
Unable to recognize family members or significant others over a period or time (Miller, 1990).

Related Factors:
A variety of health problems and situations can create favorable conditions that would contribute to the development of Impaired Environmental Interpretation Syndrome.

Pathophysiological:
Dementia (Hogstel, 1990)
Alzheimer's Disease (Hall, 1991; Souder, 1992)
Multi-infarct Dementia (Hogstel, 1990)
Pick's Disease (Souder, 1992)
Creutzfeldt-Jakob disease (Hogstel, 1990)
Parkinson's disease (Wilson & Kniesl, 1992)
Huntington's disease (Hogstel, 1990)
AIDS Dementia Complex (Johnson, 1993).
Post head trauma (Eliopoulos, 1993).
Down's Syndrome (Dick, 1992; Hogstel, 1990).
Normal pressure hydrocephalus (Miller, 1990)
Depression (Hogstel, 1990)

Situational (personal, environmental)
Alcoholism (Miller, 1990)
Heavy metal or carbon monoxide intoxication (Miller, 1990)
Severe folic acid & B-12 deficiency (Miller, 1990; Hall, 1991,a)

Risk Factors: (Factors which increase vulnerability of the individual)
Environmental change, change in location (Rasin, 1990).
Reported by family members to be negligent in self-care (Johnson, 1993).
Neurological Assessment reveal cognitive impairment (Hall, 1991,a).
Complex environment (Foreman, 1990; Hall, 1991;)
Medications--narcotics, phenothiazine, H2 antagonists, antiparkinson's agents (Andresen, 1992; Matteson & McConnel, 1988; Hogstel, 1990).
Infection (Rasin, 1990; Hogstel, 1990)
Dehydration (Rasin, 1990; Andresen, 1992)
Sudden change in environment (Foreman, 1990; Hogstel, 1990)

PROPOSAL FOR NEW NURSING DIAGNOSIS

RISK FOR DISORGANIZED BEHAVIOR: INFANT

I. Components of Proposed Diagnosis

A. Label:

Disorganized Behavior: Infant

B. Definition:

Risk for/alteration in integration and modulation of the physiological and behavioral sub-systems of functioning (i.e., autonomic, motor, state, organizational, self regulatory, and attentional-interactional systems) which impacts homeostasis and adaption.

C. Defining Characteristics:

Presence of risk factors (see Related/Risk Factors)

D. Related Factors Risk Factors:

Personal

- Pain 32, 49
- Hunger
- Fatigue 49, 71
- Oral/motor problems (e.g., swallowing, oral hypersensitivity) 25, 109, 199, 64
- Feeding intolerances 109
- Deficient ability to integrate sensory stimuli (e.g., lights, noise, touch, movement) 13, 43, 75
- Atypical self-stimulating patterns (e.g., muscle tension, arching) 61
- Disturbed sleep 50
- Sleep deprivation 1, 23, 24
- Social isolation during alert states & fussy periods 20
- Poor state organization (e.g., disorganized sleep/awake states, rapid state changes) 16, 23, 68
- Inconsistent parental involvement (e.g., maternal separation) 81
- Altered interactive patterns 31, 46
- Exposure to procedures without warning 49, 55
- Inconsistent motor organization/control (e.g., startles, tremors, jitters) 71
- Imbalanced extensor tone; less flexion and abduction of hips, less frequent hand- to-mouth behaviors 39
- Difficulty habituating to stimuli 107
- Deficient use self-regulatory strategies 107

Environmental

- Imbalance between task touch and consoling touch 58, 59, 63
- Multiple caregivers 59
- Exposure to procedures without warning 59
- Exposure to over stimulating environment [e.g., bright lights, visual clutter, prolonged noise > 60dB (monitor/IV alarms typically 80-90dB)] 24, 28, 59, 86
- Imbalance between technical noise & human voices 106, 111
- Exposed to inconsistent rhythmic patterns 105
- Handling when physiologically compromised 55
- Unable to see caregivers during care 106, 111
- Care non-contingent to infant state, behavioral cues, developmental level 106, 111
- Temperature variation 84
- Sensory deprivation 59

Physiological

- Prematurity (e.g., immature and/or altered central nervous system, cardiovascular respiratory systems)
- Pathology secondary to prematurity and/or hypoxic events (e.g., broncho-pulmonary dysplasia, apnea of prematurity, meconium aspiration, necrotizing entercolitis, hyperbilirubinemia, intracranial hemorrhage) 95
- Hyperbilirubinemia
- Infection/sepsis
- Nutritional/feeding problems 34
- Decreased oxygen saturation
- Congenital anomalies
- Hypoglycemia
- Prenatal exposure to drugs (e.g., alcohol, cocaine, multiple-use drugs)
- Reflux/emesis
- Colic 18, 34, 38 53, 62, 82, 95

Treatment Related

- Invasive/painful procedures (e.g., spinal/bladder taps, intubation, suctioning, heel sticks, surgical procedures)
- Chest physical therapy
- Restraints
- Equipment (e.g., bililights, tubes, tape)
- Medications 55, 116

PROPOSAL FOR NEW NURSING DIAGNOSIS

DISORGANIZED BEHAVIOR: INFANT

Components of Proposed Diagnosis

A. Label:
Disorganized Behavior: Infant

B. Definition:
Alteration in integration and modulation of the physiological and behavioral sub-systems of functioning (i.e., autonomic, motor, state, organizational, self regulatory, and attentional-interactional systems) which impacts with homeostasis and adaptation.

C. DEFINING CHARACTERISTICS:

Physiologic/Autonomic System

MAJOR:

Cardiopulmonary:
- Decrease oxygenation
- Tachycardia
- Bradycardia
- Respirations: irregular, respiratory pauses, apnea, tachypnea

Color fluctuations:
- Pink
- Pale
- Mottled
- Flushed/red
- Dusky

Neurological:
- Tremors/tremulous
- Startles (body/limbs)
- Twitches (body/limb),
- Jitteriness

Visceral:
- Gag
- Vomit
- Feeding intolerance/difficulties
- Relfux

6, 21,29, 54, 55, 57, 146

MINOR:

Respiratory:
- Hiccoughing
- Sneezing
- Coughing
- Nasal flaring

Visceral:
- Bowel straining and/or movement with stress

19, 29, 54, 57, 146

Motor System

MAJOR:

Posture:
- Exaggerated flexion and/or extension

Muscle Tone:

Hypertonicity:
- Hyperextensions truncal arching
- Arms:
  - Airplanes
  - Hand salutes
- Legs:
  - Sitting on air
  - Leg bracing
- Facial grimace

Hypotonicity:
- Extreme flaccidity trunk/arms/legs
- Lower face (e.g., gape face)

Fluctuating tone:
- Body squirms

Movement:
- Frantic extensions/flexions of arms/legs
- Uncoordinated
- Undifferentiated body movements
- Abnormal compensatory movements

MINOR:

Posture:
- Arching (e.g., neck/truck)
- Truncal extension/flexion (e.g., stretch down)
- Hyperflexion trunk (i.e., fetal tuck)

Movement:
- Slow, uncoordinated
- Abducted movements arms/legs

29, 57, 71

State System

MAJOR:

Range/Clarity:
- Lacks well differentiated states
- Diffuse/unclear sleep (e.g., frequent body movements, irregular respirations, whimpers)
- Diffuse/unclear awake (e.g., dull face, glassy/staring eyes, fussing)

Transition:

Rapid state transitions (i.e., difficulty moving from sleep to awake to alert states)

Ineffective habituation to stimuli (e.g., response repetitive stimuli)

MINOR:
- Hyper aroused wakefulness
- Unable to alert without disorganization to other systems
- Uses excessive sleep to habituate to stimuli

23, 29, 72, 110

Self-Regulatory System

MAJOR:

- Absent/limited/ineffective use self-regulatory behaviors to maintain and/or regain control (e.g., postural changes, hand to face/mouth, hand grasping/clasping, foot-leg/bracing, sucking fists/pacifier)
- Unable to regulate without facilitation by another
- Unable to be consoled by another
  12, 26, 30

Attentional/Interactional System

MAJOR:

- Displays imbalance of avoidance/withdrawal behaviors versus approach/engaging behaviors
- Deficient ability to orient and arouse to visual/auditory stimuli
- Deficient ability to attend to social stimuli with minimal disorganizations
- Avoids or does not engage in reciprocal social interactions
- Deficient interactive behaviors (e.g., averts attention away from external stimuli, frowning, anxious look, gaze avert)
- Difficult/unable to console (e.g., continued fussing after consoling attempts)

MINOR:

- Ineffective response to consoling (e.g., continued fussing after consoling attempts)
  7, 14, 16, 20, 24, 46

D. Related Factors Risk Factors:

Personal

- Pain 32, 49
- Hunger
- Fatigue 49, 71
- Oral/motor problems (e.g., swallowing, oral hypersensitivity) 25, 109, 199, 64
- Feeding intolerances 109
- Deficient ability to integrate sensory stimuli (e.g., lights, noise, touch, movement) 13, 43, 75
- Atypical self-stimulating patterns (e.g., muscle tension, arching) 61
- Disturbed sleep 50
- Sleep deprivation 1, 23, 24
- Social isolation during alert states & fussy periods 20
- Poor state organization (e.g., disorganized sleep/awake states, rapid state changes)
  16, 23, 68
- Inconsistent parental involvement (e.g., maternal separation) 81
- Altered interactive patterns 31, 46
- Exposure to procedures without warning 49, 55
- Inconsistent motor organization/control (e.g., startles, tremors, jitters) 71
- Imbalanced extensor tone; less flexion and abduction of hips, less frequent hand- to-mouth behaviors 39
- Difficulty habituating to stimuli 107
- Deficient use self-regulatory strategies 107

Environmental

- Imbalance between task touch and consoling touch 58, 59, 63
- Multiple caregivers 59
- Exposure to procedures without warning 59
- Exposure to over stimulating environment [e.g., bright lights, visual clutter, prolonged noise > 60dB (monitor/IV alarms typically 80-90dB)] 24, 28, 59, 86
- Imbalance between technical noise & human voices 106, 111
- Exposed to inconsistent rhythmic patterns 105
- Handling when physiologically compromised 55
- Unable to see caregivers during care 106, 111
- Care non-contingent to infant state, behavioral cues, developmental level 106, 111
- Temperature variation 84
- Sensory deprivation 59

Physiological

- Prematurity (e.g., immature and/or altered central nervous system, cardiovascular respiratory systems)
- Pathology secondary to prematurity and/or hypoxic events (e.g., broncho-pulmonary dysplasia, apnea of prematurity, meconium aspiration, necrotizing entercolitis, hyperbilirubinemia, intracranial hemorrhage) 95
- Hyperbilirubinemia
- Infection/sepsis
- Nutritional/feeding problems 34
- Decreased oxygen saturation
- Congenital anomalies
- Hypoglycemia
- Prenatal exposure to drugs (e.g., alcohol, cocaine, multiple-use drugs)
- Reflux/emesis
- Colic 18, 34, 38 53, 62, 82, 95

Treatment Related

- Invasive/painful procedures (e.g., spinal/bladder taps, intubation, suctioning, heel sticks, surgical procedures)
- Chest physical therapy
- Restraints
- Equipment (e.g., bililights, tubes, tape)
- Medications 55, 116

PROPOSAL FOR NEW NURSING DIAGNOSIS

POTENTIAL FOR ENHANCED ORGANIZED INFANT BEHAVIOR

I. Components of Proposed Diagnosis

A. Label:
Disorganized Behavior: Infant

B. Definition:
Integration and modulation of the physiological and neurobehavioral systems of functioning (i.e., physiologic/autonomic, motor, state, organizational, self regulatory and attentional-interactional systems).

C. DEFINING CHARACTERISTICS:

Physiologic/Autonomic System

Cardiopulmonary:
- Heart rate/respiration
- Stable
- Smooth
- Normal Fluctuations

Color:
- Stable (e.g., pink, without rapid changes)

Viscera:
- Smooth digestive functioning
- Feeding tolerance

Motor System

Posture
- Smooth
- Balanced
- Postural adjustments
- Active flexion

Muscle Tone
- Symmetrical
- Balance of flexion and extension without extensor tone

Movement
- Symmetrical
- Well differentiated
- Midline orientated
- Coordinated and purposeful
- Organized sucked-swallow and breath pattern

State System

Range:
- Well
- Differentiated full range of state

Clarity:
- Clear states from deep sleep
- To organized alertness and robust cry

Transition:
- Smooth, well defined sleep/wake changes

STATE VALUES (Brazelton 1973) 36 - 40 wks		UNCLEAR STATES
State I:	Quiet Sleep (non-REM)	< 32 weeks
State II:	Active Sleep (REM)	-Diffuse sleep
State III:	Drowsy-Transistion (fussy, semi-dosing)	-Diffuse awake
State IV:	Quiet Awake (organized alertness)	-Diffuse fuss
State V:	Active Awake (increase body movements)	
State VI:	Crying (> 15 seconds)	

Self-Regulatory System
- Displays balance of approach/engaging and avoidance/withdrawal behaviors
- Displays ability to orient and arouse to visual/auditory stimuli
- Displays ability to attend to social stimuli with minimal avoidance/defense behaviors
- Engages and interacts reciprocally with another in mutual adaptive way
- Displays variety of attachment/interactive (e.g., eye contact, mutual gazing, reaching toward, exploratory behaviors)
- Easily consoled by another

Attentional/Interactional System

MAJOR:
- Displays imbalance of avoidance/withdrawal behaviors versus approach/engaging behaviors
- Deficient ability to orient and arouse to visual/auditory stimuli
- Deficient ability to attend to social stimuli with minimal disorganizations
- Avoids or does not engage in reciprocal social interactions
- Difficult/unable to console (e.g., continued fussing after consoling attempts)
- Deficient interactive behaviors (e.g., averts attention away from external stimuli, frowning, anxious look, gaze avert)

MINOR:
- Ineffective response to consoling (e.g., continued fussing after consoling attempts) 7, 14, 16, 20, 24, 46

D. Related Factors Risk Factors:

Personal

- Pain 32, 49
- Hunger
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- Oral/motor problems (e.g., swallowing, oral hypersensitivity) 25, 109, 199, 64
- Feeding intolerances 109
- Deficient ability to integrate sensory stimuli (e.g., lights, noise, touch, movement) 13, 43, 75
- Atypical self-stimulating patterns (e.g., muscle tension, arching) 61
- Disturbed sleep 50
- Sleep deprivation 1, 23, 24
- Social isolation during alert states & fussy periods 20
- Poor state organization (e.g., disorganized sleep/awake states, rapid state changes) 16, 23, 68
- Inconsistent parental involvement (e.g., maternal separation) 81
- Altered interactive patterns 31, 46
- Exposure to procedures without warning 49, 55
- Inconsistent motor organization/control (e.g., startles, tremors, jitters) 71
- Imbalanced extensor tone; less flexion and abduction of hips, less frequent hand- to-mouth behaviors 39
- Difficulty habituating to stimuli 107
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Environmental

- Imbalance between task touch and consoling touch 58, 59, 63
- Multiple caregivers 59
- Exposure to procedures without warning 59
- Exposure to over stimulating environment [e.g., bright lights, visual clutter, prolonged noise > 60dB (monitor/IV alarms typically 80-90dB)] 24, 28, 59, 86
- Imbalance between technical noise & human voices 106, 111
- Exposed to inconsistent rhythmic patterns 105
- Handling when physiologically compromised 55
- Unable to see caregivers during care 106, 111
- Care non-contingent to infant state, behavioral cues, developmental level 106, 111
- Temperature variation 84
- Sensory deprivation 59

Potential for Enhanced Organized

Physiological

- Prematurity (e.g., immature and/or altered central nervous system, cardiovascular respiratory systems)
- Pathology secondary to prematurity and/or hypoxic events (e.g., broncho-pulmonary dysplasia, apnea of prematurity, meconium aspiration, necrotizing entercolitis, hyperbilirubinemia, intracranial hemorrhage) 95
- Hyperbilirubinemia
- Infection/sepsis
- Nutritional/feeding problems 34
- Decreased oxygen saturation
- Congenital anomalies
- Hypoglycemia
- Prenatal exposure to drugs (e.g., alcohol, cocaine, multiple-use drugs)
- Reflux/emesis
- Colic 18, 34, 38 53, 62, 82, 95

Treatment Related

- Invasive/painful procedures (e.g., spinal/bladder taps, intubation, suctioning, heel sticks, surgical procedures)
- Chest physical therapy
- Restraints
- Equipment (e.g., bililights, tubes, tape)
- Medications 55, 116

Label: High Risk for Impaired Skin Integrity: Pressure Ulcer

Taxonomy Placement: Exchanging

Definition: "a state in which the individual's skin is at risk of being adversely affected" (NANDA, 1991).

Risk Factors: External (environmental): pressure, shearing forces, friction.

Internal (somatic): dependent mobility status, bladder and bowel incontinence, comatose, confined to bed, chair, or paralysis, maceration, localized infection in pressure supporting areas, decreased circulation, skeletal prominence, loss of tissue, loss of muscle, cachexia/debilitation, dehydration, low serum albumin.

Literature/Clinical Validation: A study using the diagnostic content validity model (Fehring, 1986, Fehring, 1987) of the nursing diagnosis of Potential Impaired Skin Integrity: Pressure Ulcer was conducted by Sparks (1990). This diagnosis had been accepted for clinical testing by the North American Nursing Diagnosis Association in 1973, however, no substantial revisions of the risk factors has been made to date (see Appendix A for the chronological development of Potential Impaired Skin Integrity).

The sample for this study consisted of registered nurses who met selection criteria as being experts in the management of patients with skin integrity problems at the 280 facilities with inpatient rehabilitation units accredited by the Commission on the Accreditation of Rehabilitation Facilities (RU) on January 1, 1988 (CARF, 1988) and the 159 Veterans Administration Hospitals

Label: Idiopathic fecal incontinence

Definition

Idiopathic fecal incontinence is a change in an individual's pattern of elimination characterized by a loss of ability to voluntarily control the passage of feces/gas and occasional/frequent loss of normal stool.

Defining Characteristics

- Reported incidents of loss of normal stool
- Evidence of fecal soiling on undergarments
- Use of continence aids
- Lack of warning
- Perianal redness

Related Factors

- History of chronic/excessive straining during defecation
- History of severe constipation with impaction
- History of anorectal surgery, i.e., hemorrhoidectomy, anal fistula, or anal fissure
- Childbearing
- Traumatic disruption of puborectalis, internal or external anal sphincters during childbirth
- Rectal prolapse
- History of radiation

ACUTE CONFUSION

Definition

The abrupt onset of a cluster of global, transient changes and disturbances in attention, cognition, psychomotor activity, level of consciousness, and/or sleep-wake cycle (Foreman, 1986, 1990; Lipowski, 1990; McFarland, Wasli, & Gerety, In Press).

Major Defining Characteristics

Fluctuation in cognition (Foreman, 1989; Frances & Kapoor, 1990; Gomez & Gomez, 1987; Inouye, et al., 1990; Lipowski, 1990; Luna-Raines, 1989; Rasin, 1990; Wolanin & Phillips, 1981)

* orientation (time, place, person, date)
* attention (hypoalert or hyperalert)
* concentration (ability to shift, focus, and maintain attention)
* memory
* thought organization

Fluctuation in sleep-wake cycle (daytime drowsiness and napping and/or insomnia at night) (Lipowski, 1990; Wolanin & Phillip, 1981; Zimberg & Berenson, 1990)

Fluctuation in level of consciousness (Lipowski, 1990; Luna-Raines, 1989)

Fluctuation in psychomotor activity (hypoactivity or hyperactivity) (Lipowski, 1990)

Increased agitation or restlessness (Lipowski, 1990; Wolanin, 1981)

Misperceptions (illusions, misidentification of stimuli and the environment) (Lipowski, 1990; Luna-Raines, 1989; Williams, et al., 1985)

Lack of motivation to initiate and/or follow through with goal-directed or purposeful behavior (Lipowski, 1990; Luna-Raines 1989; Wolanin & Phillips, 1981)

Inability to follow directions (Lipowski, 1990; Wolanin & Phillips, 1981)

Inconsistent fluctuation in mood and emotional response (Lipowski, 1990; Wolanin & Phillips, 1981; Zimberg & Berenson, 1990)

Exacerbation of cognitive deficits at night (Lipowski, 1990)

Minor Defining Characteristics

Hallucinations (visual most common, followed by auditory and tactile) (Lipowski, 1990; Wolanin & Phillips, 1981)

Transient, poorly organized delusions (Lipowski, 1990)

Impaired perception of passage of time (Lipowski, 1990)

Impaired perception of spatial relationships (Lipowski, 1990)

Related Factors (Foreman, 1989, 1990; Francis, Martin, & Kapoor, 1990;Gomez & Gomez, 1987; Lipowski, 1990; Luna-Raines, 1989; Wise, 1987; Wolanin & Phillips, 1981; Zimberg & Berenson, 1990).

Predisposing Factors

Over 60 years of age

Demented elderly

Alcohol abuse

Drug abuse

Precipitating (organic) factors

Intoxication from medically prescribed drugs, e.g., anticholinergics, antihypertensives, antidepressants, antipsychotics, disulfiram, sedative-hypnotics, benzodiazepines, narcotics

Intoxication from illicit drugs, e.g., cocaine, amphetamines

Industrial poisons, e.g., carbon monoxide

Poisonous animals and plants

Ethyl and methyl alchohol

Withdrawal from alchohol

Withdrawal from sedatives or hypnotics

Withdrawal from illicit drugs

Infections

Epilepsy

Concussion or contusion to the head

Food allergies

Metabolic abnormalities, e.g., hypoxia, fluid and electrolyte disorders, hypoglycemia

Organ failure, e.g., uremia

Neoplasms

Extracranial neoplasms

Intracranial, space-occupying lesions

Cardiovascular disorders, e.g., myocardial infarction, cardiac arrhythmias

Cerebrovascular disorders, e.g., transient ischemic attacks, migraine headaches, hypertensive encephalopathy

Any type of severe anemia

Injury from physical agents, e.g., heat stroke, hypothermia, radiation damage

Facilitating Factors

Bereavement

Rapid, unplanned relocation to an unfamiliar environment

Sensory deprivation

Sensory overload

Immobilization

Sleep loss and deprivation

Extreme anxiety

WORK SHEETS

Diagnosis Review Session

Tuesday, March 29, 1994

High Risk for Loneliness

Submitters: Charlotte Profitt, MEd, MSN, RNC
Marjorie Byrne, MEd, MSN, RN

A subjective state in which an individual is at risk of experiencing vague dysphoria.

Impaired Environmental Interpretation Syndrome

Submitters: Judith W. Harmer, RN, MSN
Nancy K. English, RN, PhD

Consistent lack of orientation to person, place, time or circumstances over more than three to six months necessitating a protective environment.

High Risk for Impaired Skin Integrity: Pressure Ulcer

Submitter: Sheila M. Sparks, DNSc, RN, CS

A state in which the individual's skin is at risk of being adversely affected.

Terminal Illness Response (Resubmitted)

Submitter: Mary H. Lukkarila, BSN, RN

That time when a terminal illness develops or is diagnosed, and a patient tries to deal with the pending, permanent separation from loved ones, possessions, and his/her own body. If a patient is unconscious, the family, significant other, or caregiver may experience the phenomena alone.

Dysfunctional Alcohol Drinking Patterns

Submitters: Jane M. Curtis, RN, MSN

Continuous or intermittent abuse of the beverage alcohol resulting in breakdown of social, emotional, spiritual or physical levels of health for the individual.

Altered Family Processes: Addictive Behavior (Individual & Family)

Submitters: Marlene Lindeman, MSN, RN
Jean Krajiccek Bartek, PhD, RN, CARN
Jane Hokanson Hawks, MSN, RN, C

The state in which the psychosocial, spiritual, and physiological functions of a family unit are chronically disorganized, leading to conflict, denial of problems, resistance to change, ineffective problem-solving, and a series of self-perpetuating crises.

Alteration in Preservation/Quality of Life

Submitters: Paula Tutherow, RN

Quality of life is that continuum for measuring how well one meets and takes care of one's own needs. Preservation of life is the ability to prolong life naturally or on a life support system.

Potential for Enhanced Spiritual Well-Being

Submitters: Noreen Frisch, PhD, RN
Barbara Dossey, MS, RN
Margaret Burkhart, PhD, RN
Cathie Guzzetta, PhD, RN

The process of an individual's developing/unfolding of mystery through harmonious interconnectedness that springs from inner strengths.

Acute Confusion

Submitters: Elizabeth Kelchner Gerety, MS, RN, CS
Karen Inaba-Roland, MS, RN, CS

The abrupt onset of a cluster of global, transient changes and disturbances in attention cognition, psychomotor activity, level of consciousness, and/or sleep-wake cycle.

Spasticity

Submitter: Christine St. George, MSN, RN

The state in which an individual with an upper motor neuron injury experiences increased muscle tone and abnormal reflexes in response to internal or external stimuli which interfere with functional abilities such as mobility, hygiene, eating, dressing, and toileting.

Disorganized Behavior: Infant

Submitters: Mary DeWys, BS, RN
Kathy Wyngarden, MSN, RN

Alteration in integration and modulation of the physiological and behavioral systems of functioning (i.e., autonomic, motor, state, organizational, self regulatory, and attentional-interactional systems).

Altered Parent/Infant Attachment

Submitter: Kathy Wyngarden, MSN, RN

Disruption of the interactive process between parent/significant other and infant that fosters the development of a protective and nurturing reciprocal relationship.

Idiopathic Fecal Incontinence

Submitters: Audrey M. McLane, PhD, RN
Ruth E. McShane, PhD, RN

A change in an individual's pattern of elimination characterized by a loss of ability to voluntarily control the passage of feces/gas and occasional/frequent loss of normal stool.

Ineffective Coping (Communities)

Submitter: Margaret Lunney, PhD, RN

A pattern of community activities for adaption and problem solving that is unsatisfactory for meeting the demands or needs of the community.

Ineffective Management of Therapeutic Regimen (Families)

Submitter: Margaret Lunney, PhD, RN

A pattern of regulating and integrating into family processes a program for treatment of illness and the sequelae of illness that is unsatisfactory for meeting health goals.

Potential for Enhanced Coping (Communities)

Submitters: Margaret Lunney, PhD, RN

A pattern of community activities for adaption and problem solving that is satisfactory for meeting the demands or needs of the community but can be improved for management of current and future problems/stressors.

Labor Pain

Submitter: Angela Nicoletti, MS, RNC, OGNP

A subjective measure of an unpleasant sensation which lasts the duration of a contraction, and may linger between contractions. The feeling subsides with delivery of a fetus.

NORTH AMERICAN NURSING DIAGNOSIS ASSOCIATION

Proposed Rules for the 11th General Session

RULE #1 Attendance at the General Assembly is open to NANDA members and non-members. Only members can vote.

RULE #2 To obtain the floor, an individual shall go to a microphone; address the chair, give name and place of residence, state whether or not he/she is a voting member, and upon recognition by the chair, speaks.

RULE #3 A FOR or AGAINST card shall be raised by each person wishing to obtain the floor to speak to a motion/amendment. For and Against cards are provided on each table. The chair will alternate the floor to one speaking for a motion and one speaking against the motion. One person may not speak in debate more than twice to the same questions, or longer than three minutes, without permission of the Assembly granted by a two-thirds vote without debate. No one may speak more than once to a question if a member who has not spoken wishes to do so.

RULE #4 All motions shall be written on triplicate forms provided at each table. The original and 2nd copy is forwarded to the President and Secretary, respectively, by the page stationed at the mike at the time of the motion. The 3rd copy is retained by the individual making the motion.

RULE #5 If a member wishes to amend a motion, it may be done by one of the following methods: by striking out; by inserting; by striking out and inserting; by adding to; or by substitution. All amendments shall be written on triplicate forms provided at each table and handled as indicated in Rule #4.

RULE #6 Business interrupted by a recess of the meeting shall be resumed at the point where it was interrupted.

RULE #7 Only one substitute motion or paragraph amendment may be proposed at one time to any main motion. This will be the primary amendment. The substitute or paragraph amendment may have only one minor amendment applied to it at one time. This will be the secondary amendment. Each of the motions will be considered and voted on separately and in reverse order to their proposal.

RULE #8 Voting cards shall be utilized for voting. Green and pink cards are provided on each table. Members raise a green card to vote for a motion/amendment. Members raise a pink card to vote against a motion/amendment.

RULE #9 Emergency resolutions may be submitted to the NANDA Bylaws Committee in the NANDA headquarters before 5:00 P.M. of the first

day of the Conference, Sunday, April 26, 1992. These must be signed by an official representative of the group submitting the resolution.

Emergency resolutions are those that the significance could not have been apparent in sufficient time before the conference for submission to the Bylaws Committee and which because of the timeliness, require immediate attention. They may be:

a. Substantive - Resolutions which deal with issues, basic principles or policies of the association.

b. Commemorative - Resolutions which deal with the commemoration of important events or developments.

If the Bylaws Committee is in doubt about the emergency nature or advisability of a resolution which has been submitted in the prescribed manner, it is referred to the NANDA President, who may, in turn, refer it to the NANDA Board of Directors for a decision.

RULE #9 NO SMOKING is permitted during NANDA meetings thereby joining NANDA with the ranks of those truly committed to the achievement of maximal health for all people.

PURPOSE OF SPECIAL INTEREST GROUP MEETINGS

1. Share information not otherwise reported at Conference.

   A. Research:

   - completed
   - in progress
   - tool development
   - request assistance (subjects, co-investigators, location of tool, etc.)

   B. Implementation:

   - status of on-going use
   - plans for beginning
   - documentation methods
   - requests for assistance

   C. New Diagnoses

   - identified and developed or partially developed
   - title identified or suggested
   - requests for assistance in developing

2. Develop Networking in Area of Interest

   A. Report area or regional networking group

   B. Request participation in group to be formed

   C. Share recent literature in an area of interest

   d. Share conferences or workshops that will be forthcoming

ABSTRACTS

Featured Poster Presentations

March 27 to March 30, 1994

ABSTRACT
ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSIS

Title - Validation of Nursing Diagnoses Across Six Gerontological U-Diagnose Case Studies

Purpose - The purpose of this investigation was to determine if there are a set of nursing diagnoses used by gerontological clinical specialists.

Framework - The conceptual framework is the nursing process and writer's diagnostic reasoning model established in previous research. Diagnostic reasoning is defined by the writer as the decisions that occur during the assessment and planning steps of the nursing process.

Design - Six gerontoloical case studies were written to conform with the diagnostic reasoning protocols of diagnoses, objectives, criteria, interventions, rationale and outcomes. Each case study was developed by a master's prepared clinical specialist and based on their expertise in gerontological nursing. The developers used the North American Nursing Diagnosis Association (NANDA) listing to identify client problems. Three case studies were scenarios involving clients in acute care settings and the remaining three concerned clients within community settings.

Methodology - The NANDA problem listing and supporting data from the case studies and intervention plans were rated by the expert panels using a four point rating scale. Different expert panels were used for each case study, due to the content variation of the case studies. Two-way analysis of variance was used to calculate inter-rater reliability for each nursing diagnosis and intervention plan. A content validity index (CVI) was calculated using the ratings by expert panels for items within each nursing diagnosis. The occurrence of a nursing diagnosis within a case study was dependent on the nature of the case study.

Statistical Results - Thirty two nursing diagnoses were used within the six case studies. The incidence of a nursing diagnosis ranged from one to six. The mean inter-rater reliability results for nursing diagnoses was .736 and .762 for intervention plans. The mean content validity indices for nursing diagnoses was 77.7 and 79.2 for intervention plans. The expert panels varied in their degree of agreement for specific nursing diagnoses.

Conclusions/Implications - There was a moderate degree of agreement among the expert panels for the 32 NANDA diagnoses used within the six U-Diagnose case studies. A diagnostic reasoning model facilitated the identification of and validation of nursing diagnoses for gerontological clients.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

An Instrument for Nurses:
Diagnosing Noncompliance in Clients With Coronary Artery Disease

The purpose of this study was to develop and gather preliminary validity and reliability data on an instrument to measure nurses' perceptions of noncompliance in a cardiac population. Noncompliance was defined as, "nonadherence to a therapeutic recommendation following informed decision and expressed intention to attain therapeutic goals" (Gordon, 1991) and was conceptualized within the context of Gordon's eleven functional health patterns.

Thirty five items were generated and reviewed by a panel of five expert nurses for conceptual clarity and readability. A sample of 54 professional nurses provided the following preliminary validity and reliability evidence for the instrument: Cronbach's alpha of .92 and a four factor solution via principal component analysis and varimax rotation, accounting for 62% of the items' total variance.

The labels and alpha reliabilities for the four factors were: Health Perception/Health Management Pattern: Compliance (α=.96); Health Perception/Health Management Pattern: Noncompliance (α=.85); Role/Relationship Pattern: Compliance (α=.85); and Health Perception/Health Management Pattern: Noncompliance (α=.67). This study offers a new way to conceptualize noncompliance in the cardiac population.

Gordon, M. (1991). Manual of nursing diagnosis. St. Louis: Mosby Year Book.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

EFFECT OF CURRICULUM CHANGE ON STUDENT ANXIETY AND DIAGNOSTIC REASONING

Curriculum revision was undertaken to address student reported anxiety and faculty observed redundancy, overlap, and omissions in the curriculum. An additional aim of this revision was to improve diagnostic reasoning ability. This paper describes the effect of curriculum change on student anxiety and diagnostic reasoning ability.

An historical control/experimental group intervention design was used. The study intervention was the curriculum change. The control group was the Spring 1992 students in their last clinical courses and the experimental group was the Spring 1993 students in their last clinical course. The two groups were compared on state/trait anxiety and diagnostic reasoning ability.

Control group: A convenience sample of senior undergraduate students, Spring 1992, participated. Spielberger's State/Trait Anxiety Inventory revealed means of 42.08 (SD = 10.7) and 40.0 (SD = 8.1) respectively (n = 13). Gordon's Diagnostic Reasoning Questionnaire indicated a mean of 13.9 (SD = 1.3) of 20 correct on nursing diagnosis language, a mean of 6.5 (SD = 0.79) of 9 correct on nursing diagnosis concept (n = 12). Inferential ability statements showed a mean of 2.3 of 4 correct conclusions for each of 3 vignettes (n = 12).

Intervention group: A convenience sample of senior undergraduate students, Spring 1993, participated. Spielberger's State/Trait Anxiety Inventory revealed means of 34.04 (SD = 9.9) and 36.19 (SD = 8.0) respectively (n = 25). Gordon's Diagnostic Reasoning Questionnaire indicated a mean of 14.0 (SD = 1.9) of 20 correct on nursing diagnosis language, and a mean of 6.2 (SD = 1.5) of 9 correct on nursing diagnosis concept (n = 26). Inferential ability statements showed a mean of 2.6 of 4 correct conclusions of each of 3 vignettes (n = 26).

The effect of curriculum change was evaluated by comparing intervention and control group scores by t test. The intervention group students had significantly less state anxiety than the control students (t (36) = 2.31, p<.05). There was no significant difference between groups for trait anxiety. Additionally, the measures of both state and trait anxiety for the intervention group revealed lower means than the norms for college students (38.76 vs. 40.40).

There was no significant difference between groups in diagnostic reasoning ability of knowledge of nursing diagnosis language and knowledge of nursing diagnosis concepts. However, there was a significant difference in the inferential ability of the intervention group on one vignette (2.77 vs 2.08; t (36) = -2.54, p<.05).

Student anxiety and one aspect of diagnostic reasoning ability were significantly affected by curriculum change. In a time of curriculum revolution, these findings support the continued efforts of faculty to offer a curriculum that is anxiety reducing and that fosters the critical skill of diagnostic reasoning. Strategies for improving the teaching of diagnostic reasoning are suggested.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

The Prevalence of Nursing Diagnoses
in a Teaching Health Centre

While research and development of new nursing diagnoses continues, there is an ongoing need to review present utilization of NANDA approved diagnoses. The purpose of this study was to describe the prevalence of nursing diagnoses in a wide range of client populations. Secondarily, the utilization of collaborative problems and standard care plans were examined. Two hundred and twenty-nine charts were reviewed in a large urban teaching health centre in Southwestern Ontario. Client populations included surgery/paediatric, medicine/critical care, long term care, maternal-child/neonatal intensive care, rehabilitation, and psychiatry. Fifty-two percent of the charts had at least one nursing diagnosis present. Seventy-one percent of the statements were recognizable as nursing diagnoses. Eighty-eight standard care plans were initiated. Eighteen collaborative problems were documented. Pain was the most frequently used nursing diagnosis and was found on 15% of the charts. Continued development in the use of nursing diagnoses and standard care plans was recommended as well as examining the practice of writing collaborative problem statements. A communication plan for dissemination of the research results within the Health Centre will be developed and implications for nursing practice discussed.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

THE IDENTIFICATION OF DEPRESSION, ANXIETY, AND POWERLESSNESS IN MEDICAL PATIENTS

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Approximately 20% of medical inpatients experience clinical depression/anxiety which creates increased lengths of stay and higher rehospitalization rates. Unfortunately, depression/anxiety is seldom recognized or treated in medical patients due to lack of screening or screening tools that are long and tedious. Early identification of medical patients with depression/anxiety is essential for early nursing intervention. The hypothesis was that the percentage of medical patients identified with depression/anxiety will be consistent with previous studies which indicate that 20% of medical inpatients have depression/anxiety. One objective of this study was to identify stimuli and symptoms associated with depression/anxiety in order to initiate early nursing interventions. A second objective of this study was to look at the specificity and validity of the Screening Interview for Depression/Anxiety (SIDA) as compared to the previously validated, but longer Diagnostic Interview Schedule Tool (DIS). A prospective survey design was utilized with all patients on a general medicine division of a midwest university affiliated hospital admitted between Jan.-Sept. 1993. The study population consisted of adult patients admitted to the identified general medicine division, who have given informed consent, and who do not exhibit dementia/confusion. The theoretical basis for this study was the Roy Adaptation Model (1986). Patients meeting inclusion criteria received 1) DIS, 2) SIDA, and 3) Miller's Powerlessness Scale. Sixty-five patients were interviewed/screened by the researchers. Data collected was analyzed descriptively and statistically through a Chi Squared and logistic regression. Results indicated that 23% of the interviewed patients screened positive for depression and anxiety. The SIDA demonstrated 93% sensitivity and 97% specificity as compared to the DIS. In addition, the variables of age and past psychiatric history were significant predictor variables for the SIDA and DIS. In addition, the variable of powerlessness was a significant predictor variable for the SIDA. Implications for nursing are that early identification of depression/anxiety in medical patients will perhaps result in early intervention and, thereby possibly reducing length of hospital stay and treatment costs.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

CONSTRUCTION AND VALIDATION OF A TAXONOMY OF NURSING INTERVENTIONS

Efforts to standardize and classify nursing care are important because they make explicit what has previously been implicit, assumed, and unknown. Peplau has written that "science consists of systematized knowledge...the names of categories and items in a classification system identify, designate, define, provide clues to meaning, and serve as a common language for the profession and community." In May of 1992, the first comprehensive standardized language for nursing interventions, Nursing Interventions Classification (NIC), was published. NIC consists of 336 interventions each with a label, a definition, a set of activities that a nurse does to carry out the intervention, and a short list of background readings. NIC was five years in development by an experienced and diversified research team. Methods used to construct NIC included content analysis, expert survey, and focus group analysis. Since the publication of the alphabetical classification, the research team has continued work to develop a taxonomic structure which groups similar interventions. A three-level taxonomic structure consisting of six domains, 26 classes, and 357 interventions has been developed through application of hierarchical cluster analysis.

All of the interventions included in the NIC classification are meant to be clinically useful. No individual nurse could be expected to perform all of the interventions listed in the classification, but collectively they represent the total range of nursing practice. To help validate the content of NIC, two questionnaires were developed to determine the frequency with which nurses perform each of the 336 interventions. The first questionnaire was directed to specialty organizations who are members of the Nursing Organization Liaison Forum, and the second questionnaire went to individual nurses who are actively engaged in clinical practice. A third survey to evaluate the taxonomy structure has been directed to selected members of the Midwest Nursing Research Society. This research has been supported by a three-year grant (R01 NR02079) from the National Center for Nursing Research, which awarded an additional four years of continuation funding June 1, 1993. Objectives for the second grant include (1) develop and implement an expert review system to receive and evaluate feedback on NIC; (2) define and validate indirect care interventions; (3) develop a coding system that can be used for computerization, for articulation with other classifications, and for reimbursement; (4) construct an electronic version of NIC; (5) implement and evaluate the use of the classification in a nursing system in four agencies; and (6) establish mechanisms to build nursing knowledge through the analysis of electronically retrievable clinical nursing data.

This poster will overview the NIC project. Handouts describing NIC work will be available.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

Nursing diagnoses: strategy for formulation and validation.

The purposes of this study were to identify the nursing diagnoses co-occuring in adults with essencial hypertension, to validate the nursing diagnoses validated. The setting for this study was the nursing office at the ambulatory level in an University Hospital. The self-applied nursing history was utilized as a guideline for client interviewing and examination. The diagnostic process auxiliar instrument was utilized for registering the data related to the diagnostic process. Nursing diagnoses were formulated based on the presence of at least two cues. NANDA's Taxonomy I were used as guide in diagnostic labeling. The judge panel was asked to identify nursing diagnoses present in each client self-applied nursing history and to register them on the instrument. A content analysis of the nursing diagnoses generated by each nurse (researcher and panel) was done based on the diagnostic process rating scale. Criteria used to accept a diagnosis required eigth points as a mininum score. The results revealed that a total of eighty-two diagnoses were identified by the nurses in this sample of eight clients, but only forty-four diagnoses obtained a score above eigth. The researcher identified twenty-one diagnoses and nine (42.8%) had agreement with the panel and a score equal or superior to eight. These diagnoses accepted for fully meating the research criteria were knowledge deficit, anxiety, constipation, sexual dysfunction, and activity intolerance. The findings in this study support the need for replication of this research with a larger client sample size. The findings also support that accuracy of diagnoses requires the nurse's ability to define and identify a pattern of cues for each diagnostic label. The instruments presented in the study have implications for teaching and learning nursing diagnostic akills. Recommendations for future nursing research include the application of the diagnostic process auxiliar instrument and diagnostic process rating scale with a large sample size of students and professionals.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

CARD Project: An Innovative Strategy to Capture and Record Decisions

The purpose of this project was to design, implement, and evaluate strategies to improve skills in gathering and using data to support clinical nursing diagnosis. Based on the belief that the principle factors involved in 'maintaining' inadequate documentation were grounded in cognitive weaknesses related to application of knowledge, rather than the lack of knowledge, we drew heavily upon theory of knowledge utilization to guide our interventions. Goals of the project were: 1) full compliance with minimum expectations for clinical documentation; 2) progress notes reflecting continuity of care around patient problems, and 3) full involvement in long-term maintenance plans.

The sample consisted of approximately 1200 RN's currently employed on 48 inpatient units of a 1000 bed tertiary medical center. The project took place over a 2-year period, with five groups participating in staggered 'waves'.

Major project activities were organized into three phases. The Awareness phase focused on increasing the nurses' attention to documentation and nursing thought, individual assessment of performance and knowledge, and focused audit of discharge records. The Diffusion phase was marked by intensive educational programming at the unit and department level, individual feedback on clinical documentation, and focused audits of aggregate progress. The Maintenance phase involved gradual weaning from central supports, increased visibility and ownership of unit based-support, focused audits, and preparation of unit plans for continued activity.
Each nurse manager and clinical director identified key participants to champion the ideas and activities.

Findings compare aggregate baseline data to 6-month follow-up audit of between 300-400 patient records. Initial nursing assessments remained fairly stable at 80% and 87%. However, assessments reflecting a more complete database increased from 53% to 72%. Problem lists in the record increased from 45% to 80%, and use of a standardized nursing language increased from 42% to 65%. Problem-oriented progress notes increased from 41% to 82%. Identification of desired patient outcomes jumped from 20% to 79%, and progress notes focusing on outcome attainment increased from 39% to 59%.

We conclude that unit-based strategies based on individualized feedback, coupled with unit benchmarking, are successful approaches to improving documentation, particularly when combined with strengthening the skills of unit stakeholders. The area showing the least improvement is articulation of outcomes, which we suggest may be related to unclear language and minimal scientific evidence to support setting of diagnosis-based outcomes at this time.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

CONCEPTUAL MAPPING OF PERIOPERATIVE NURSING PRACTICE: A VALIDATION STUDY

Purpose: The purpose of this descriptive research is to identify current practices which will provide an empirical basis for work redesign. Phase 1 will focus on mapping the perioperative nursing work: 1) What activities comprise perioperative nursing work? 2) How frequently are the activities performed? 3) Are nursing activities grouped according to practice setting? 4) Do these activities validly and reliably represent perioperative nursing work?

Development of Nursing Activity List: We are committed to utilizing generic systems to describe the practice of perioperative nurses in order to enhance the external validity of the work and to strengthen the generalizability to other populations. Our preliminary work has focused on the development and alpha testing of the perioperative nursing activity list. We initially reviewed existing classification systems as source documents. The Nursing Intervention Classification (McCloskey & Bulechek, 1992) has been selected to provide the foundation. Assessment and physical examination activities are principally drawn from Gordon's Typology of Functional Health Patterns (1982). Administrative and indirect care behaviors are primarily derived from review of work-related studies (DHEW, 1978; Nelson & Hansen, 1985; Prescott et al, 1991). Alpha testing of this list has been completed. The final list contains 194 activities.

Sample/Setting: A two per cent random sample has been drawn from the current membership list of the Association of Operating Room Nurses. Approximately 500 nurses will be asked to indicate clinical relevance of the activities, while the second 500 nurses will be asked to comment on frequency. Allowing for nonrespondents, a final sample size of 300 in each group will provide sufficient stability for the analysis.

Technique for Data Collection: Procedure - A cover letter, nursing activity survey, demographic sheet, and return-addressed stamped envelope will be mailed to all subjects. Instrument - The activity list utilizes grouping terms or broader concepts to provide some focus for the subject so that like activities are adjacent. Several steps have been taken to ensure content validity. The activity list has been generated with much reliance on existing work. The list has been compared to other sources discussing perioperative nursing practice in order to identify gaps and to ensure that no major categories are missing. Focus groups have reviewed the lists in evolving phases, and a panel of national experts have commented on relevance. Reliability of measurement will be enhanced through use of terminology which has been developed through an iterative process. Focus groups have assisted through commenting on ambiguous terms and pointing out areas of overlap. Interviews were also conducted with each member of the focus group to review selected statements to ensure clarity. Similar ratings between the focus group and expert panel suggests reproducibility of results, another aspect of reliability. Issues of applicability of the instrument have been assessed through focus group and expert panel review. We have conducted multiple interviews with staff to assure relevance of the statements. Preliminary results suggest that 20% of the activities are common to all practice settings, while other activities are unique to one setting. These early findings are in the desired direction indicative of applicability.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

Use of an Innovation Diffusion Model to Disseminate Guidelines On Risk for Injury due to Slips and Falls

Problem and Objective: We designed clinical practice guidelines for assessment of risk for injury due to slips and falls (S/F). Between 40% to 60% of patients in this 1000 bed hospital were estimated to be at risk; a two year data base existed describing the number of falls and injuries and variation by clinical population.

Data and Methods: Using Havelock's linkage model of innovations transfer nurses in gerontology, neuroscience, and orthopaedics packaged research-based guidelines in formats designed to minimize cognitive complexity. The Practice Council served as the linker group for dissemination. Monitoring and review was integrated into the departmental quality assessment program.

Results and Conclusions: During a 12 month period there were 819 S/F: 35% from beds, 25% while walking, 15% from chairs, 3% from equipment, 22% unwitnessed. Risk factors (RF) ranged from none (19%), one (26%), two (19%), three (14%), and four (10%). Twelve percent had five or more RF. Falls from bed were associated ($p < .0001$) with higher number of RF. The most common RF were: impaired mobility, balance or gait (37%), confusion/agitation (35%), general weakness (33%), history of falls (21%), noncompliance (21%), and inability to follow directions (16%). We examined the three diagnostic criteria for risk for injury: Patients with a prior history of falls were generally diagnosed to be at risk during this hospitalization ($p < .0001$). However, of 289 confused or agitated patients only 113 (39%) were judged to be at risk, and 47% of the 450 patients with two or more RF were diagnosed at risk prior to actual S/F. Guidelines utilization was less than expected.

Implications for Audience: Although Havelock's linkage model is helpful to direct guideline dissemination and design feedback systems, our experience suggests that innovation diffusion theory may be insufficient to fully explain barriers to effective utilization of clinical guidelines by professionals.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

Research Methodologies in Nursing Diagnosis

In order to develop a standardized language for nursing, nursing diagnoses must be clearly conceptualized and validated by nurse experts and in clinical settings. The diagnoses, defining characteristics, and related factors must be clearly defined. These validated nursing diagnoses are the foundation for the development of effective, empirically based nursing interventions. This paper will present a three-stage approach to the validation of nursing diagnoses: concept analysis, expert validation, and clinical validation. The concept analysis approach used is that developed by Walker and Avant (1988); the expert and clinical validation strategies are those developed by Fehring (1988). Instrument development for clinical validation, based upon the results of concept analyses and expert validation, will be discussed. Exemplar research on anxiety and fear will be presented, as will use of both nurse and patient clinical data collection strategies. Results of the use of the three research strategies will be presented, including the integration of qualitative and quantitative data. Implications for nursing diagnosis research will be derived from the study.

This project is supported by the National Center for Nursing Research (Grant # 1 R15 NR02186-01A1).

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

STUDENT ATTITUDES TOWARD THE NURSING PROCESS AND PATIENT CARE PLANNING

Problem: Previous researchers indicated newly graduated nurse's attitudes toward the nursing process and its components are formed before the graduate nurse enters the nursing practice setting and that these developed attitudes are difficult to change. Daily discussions by nursing students and registered nurses regarding their attitudes toward the nursing process is a common occurrence. Research describing these attitudes and probable developmental influences is not well represented in the literature.

Purpose: The purpose of this longitudinal descriptive study is to measure the change in attitudes of baccalaureate nursing students toward the nursing process and patient care planning at different points in their academic program.

Methodology: An 18 item questionnaire was administered to 121 baccalaureate nursing students enrolled in a Southeastern state university. The items focused on the student's perception of how helpful the nursing process is in planning and implementing care and how specifically nursing diagnosis is viewed as a major component of the process of this nursing practice model. The questionnaire was administered six times at the completion of each adult health and specialty rotation.

Results: Significant difference (p .05) was found among the adult health and speciality groups' total mean scores. No significant difference (p .05) was found among speciality groups. Total mean scores ranged from 61.35 to 73.97 (maximum = 90). Coefficient of variation scores found the group continually becoming more homogenious in reported attitudes. T-tests performed on individual items found significance difference for several questions during speciality rotations. The repeated application of the instrument resulted in alpha coefficients ranging from 0.85 to 0.94.

Implications: Attitudes toward both nursing diagnosis and the nursing process did decrease as students progressed from the initial adult health to speciality courses. A positive attitude remained unchanged throughout the remaining speciality courses. Attitudes did change during speciality rotation to specific factors where care planning was found to be not a waste of time but rather a time safer. Future research should explore the rationales for the changes in attitudes in the specific speciality rotations. Also individual faculty's attitudes perceived by the students should be included in revisions of the questionnaire.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

A PSYCHIATRIC NURSING INSTRUMENT FOR ASSESSMENT OF MOOD: THE MANIA DEPRESSION SCALE

The Mania–Depression Scale (MD Scale) is a new instrument developed to assess mood states in psychiatric inpatients. Existing scales were found to be unsuitable for the purposes of a mood disorders unit due to various inadequacies. The scale provides for the rating of a patient's mood along a quantitative continuum ranging from –5 (depressive stupor) through 0 (euthymia) to +5 (full mania), with concrete behaviours listed as criteria for each rating point. The behavioural descriptors were based on DSM–III–R diagnostic criteria and nursing diagnostic criteria focusing on the cognitive–perceptual, affective, vegetative–physiological, and social domains. Provision was also made for the assessment of "mixed states" and idiosyncratic behaviour. Ratings on 53 patients were completed by nurses twice within a twenty–four hour period. Reliability and validity data and examples of clinical use of the scale in nursing are presented. MD Scale ratings appear to be sensitive to diurnal variation in mood, alternate states in bipolar patients, and longer term response to treatment. The initial use of the scale has proven to be a valuable adjunct in the identification and delineation of nursing diagnoses, interventions, and evaluation for discharge.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

VALIDATING DEFINING CHARACTERISTICS OF ALTERED SEXUALITY PATTERNS

Sexuality is a complex phenomenon, affecting and affected by physical, emotional, intellectual, and social dimensions and relationships. It is often difficult for nurses to diagnose the subjective experience of altered sexuality based on the current defining characteristics of this diagnosis. The purpose of this study was to identify defining characteristics specific to men and to women for the nursing diagnosis **altered sexuality patterns**, defined as "the state in which an individual expresses concern regarding his/her sexuality."

In this retrospective method study, data were collected from 100 randomly selected members of the North American Nursing Diagnosis Association (NANDA) and were analyzed by the Fehring method of diagnostic content validity (DVC). An investigator-developed survey tool, based on previous research; a review of the literature; and the current list of NANDA defining characteristics for this diagnostic category were used to collect data. Subjects were asked to rank the relevancy of 19 statements specific to altered sexuality patterns in women and 16 statements specific to altered sexuality patterns in men. All statements were evaluated as relevant by subjects; the total DVC was greater than 0.60 for both genders, and all statements had a weighted ratio greater than 0.50. Based on the weighted ratios, both major and minor defining characteristics were identified for the diagnosis of altered sexuality patterns in men and in women.

The results of this study contribute to the continued development of distinctive and measurable defining characteristics for the diagnostic category **altered sexuality patterns** that are gender-specific. The results also provide support for the refinement of diagnostic categories specific to sexuality into a single encompassing label of **altered sexuality patterns**.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

Assessment of Factors
Affecting the Use of Nursing Diagnosis

Nursing diagnosis has been taught in New Mexico for eight years and has recently been added to the Nursing Practice Act. Yet there is great variation in nurses' ability to diagnose and in clinical application of nursing diagnosis. In order to proceed with plans to change or provide nursing education/ continuing education programs, an assessment of factors affecting the use of nursing diagnosis in New Mexico was needed.

A survey was administered to 210 attendees at the September, 1993 Governor's Conference on Nursing held in Albuquerque, New Mexico. 166 participants completed the survey. Educational background of participants ranged from LPN to Doctorate, with 41% having a BSN and 31% having a MSN. Ten percent graduated from 1 to 5 years ago; 13 percent graduated from 5 to 10 years ago; and 68% graduated ten to more than 25 years ago. Thus, the largest group of those surveyed did not learn about nursing diagnosis in nursing school in New Mexico.

Forty-five percent of the participants were staff nurses; 26% were head nurses, supervisors or nurse administrators; 15% were faculty. The majority of participants (58%) worked in hospitals. All specialty areas were about equally represented.

Sixty-three percent of participants use NANDA nursing diagnoses often to always while 20% reported they use nursing diagnoses seldom to never. Seventy percent reported that nursing diagnoses are usually to always initiated on admission while 10% never initiate a nursing diagnosis. Among this group nursing diagnosis is quite commonly used.

Participants were asked to rate themselves on each step of the nursing process. There was statistical significance $<p0.001$ between participants' ability to collect a database and all other steps of the nursing process. This was not surprising as physical assessment has been a part of nursing practice in New Mexico almost twice as long as nursing diagnosis.

Participants indicated a need to learn how to select diagnostic cues from the database. It was interesting to note that a majority of the participants (47%) have no inservice education; 36% have some; while 5% have frequent inservice on the subject.

A t-test found statistical significance at the $p<0.001$ level, suggesting that if the employer uses nursing diagnosis the participant rates herself higher on the nursing process.

The most common problems in diagnosing were identified as lack of knowledge, institutional support, reference books, time, and confidence about its usefulness.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

Validation of Risk Factors for Disuse Syndrome

Registered nurses are often faced with challenging clinical practice situations involving immobilized patients. Nursing care focuses on preventing deterioration or disuse of major body systems and maintaining optimal functional ability. Disuse syndrome is the term used to describe secondary disability caused by immobilization. By identifying susceptible patients, such as persons with spinal cord injuries, permanent or temporary disability associated with immobility can be prevented or reduced. The purpose of this study was to obtain expert validation of the risk factors used to diagnose High Risk for Disuse Syndrome, to identify risk factors from the perspective of persons with spinal cord injuries, and to obtain registered nurses' judgments on the clarity and appropriateness of operational definitions for each risk factor. The Neuman Systems Model provides parameters for assessment of the client at risk for disuse syndrome. The risk factors validated in this study were identified by the North American Nursing Diagnosis Association (NANDA) and by the investigator through an extensive literature review. A descriptive survey design using Fehring's Diagnostic Content Validity (DCV) model was used. Subjects consisted of registered nurses and persons with spinal cord injuries meeting specific criteria. A sample of 300 master's prepared registered nurses were selected randomly as follows: 200 from the Association of Rehabilitation Nurses (ARN) and 100 from the American Association of Spinal Cord Injured Nurses (AASCIN). A sample of 30 volunteer subjects with spinal cord injuries were identified from an out-patient spinal cord injury clinic. Three investigator designed instruments were used to collect data from registered nurse subjects: Demographic Data Sheet; High Risk For Disuse Syndrome: Diagnostic Validation Tool (HRDS:DVT); High Risk For Disuse Syndrome: Operational Definition Tool (HRDS:ODT). One investigator designed instrument was used to collect data from subjects with spinal cord injuries: Persons with Spinal Cord Injuries: Structured Interview Guide (PSCI:SIG). Findings will be presented as well as conclusions and recommendations for future research. No studies have been reported on the validation of risk factors and the development of their operational definitions for the nursing diagnosis High Risk for Disuse Syndrome. The evidence provided by the DCV model will be strengthened and standardized if the meaning of risk factors are elucidated. This study will provide the knowledge base necessary to conduct future clinical validation research and correlational research. Obtaining the perspective of persons with spinal cord injuries on the risk factors for disuse syndrome is a new approach.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

Identification of Nursing Diagnostic Statements
From Videotaped Assessment Data

McFarland and McFarlane (1989) have identified nursing diagnosis as the critical link in the nursing process. This problem solving process used by nurses results in a nursing care plan designed to met the health care needs of the individual client. To effectively plan care for a client accurate nursing diagnoses must be identified from the data collected during the assessment phase.

A descriptive study was used to determine what nursing diagnostic statements would be identified from a videotaped health history interview of a young adult. A panel of ten experts established content validity of the material in the videotape and also created a criterion list of accurate nursing diagnostic statements. The four nursing diagnostic statements and their defining characteristics that were named by the panel were: 1) Altered nutrition, more than body requirement related to excessive intake versus lack of exercise; 2) Health Seeking Behaviors related to smoking, hypertension, diet, and exercise; 3) Ineffective individual coping related to situational crisis (stress); 4) Altered health maintenance related to insufficient knowledge of reduction of risk factors for hypertension. The convenience sample of 32 senior generic baccalaureate nursing students viewed the tape and were asked to list all the applicable nursing diagnostic statements based on the information presented in the videotape. They were supplied with an alphabetical list of approved nursing diagnosis. Their responses were compared with the criterion list of the expert panel and a Chi-square alysis was conducted. The results indicate that there is a significant relationship between the responses of the panel and the students. Of the four nursing diagnostic statements identified by the panel, two were identifed by the participants (Altered nutrition-six times and Ineffective individual coping-five times) and the remaining nursing diagnostic statements were not mentioned at all.

Findings indicate that the student nurses were unable to identify accurate nursing diagnostic statements from a videotaped health history interview on a consistent basis.

These findings are significant since health care workers must be able to accurately identify nursing diagnosis in order to implement interventions that will address the client's health care need.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

DIFFERENTIATING AND INTERFACING NURSING DIAGNOSTIC SERVICES AND MEDICAL DIAGNOSTIC SERVICES

There has never been a time when the wisdom of nursing has been so important. Our nation faces health care reform that will impact our children's children. If the profession of nursing does not advocate for health (body, mind, and spirit in balance) our humanity's fate will be narrowed to "absence of disease," the basis of our present struggling system. A health care model demands the merging of the medical diagnostic and nursing diagnostic framework. The services associated with the medical diagnostic process are well known to our society. There services associated with the nursing diagnostic process are not. This paper will address the process and outcomes of clearly delineating the unique services of nurses, showing those that relate to the medical diagnostic process and those that relate to the nursing diagnostic process. The development, consensual validation and use of interdependent (medical diagnostic) and independent (nursing diagnostic) standards of care will be presented. The outcomes of this differentiating and interfacing process is based on the collective experience of 20 rural, community, and university health care settings across the United States.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

MOVING NURSING DIAGNOSIS FROM THEORY INTO REALITY

This paper will present a systems thinking, Clinical Practice Model (CPM) designed to move nursing diagnosis from theory into clinical reality within the hospital setting. The majority of all nurses today practice in this setting. Hospital practice has historically been institutional, that is, nursing service evolves around tasks generated by medical orders, hospital policy and procedures. Shifting practice from institutional to professional nursing in which the service rendered by the nurse is driven by the person's human response, is a major paradigm shift. Common barriers for the nursing diagnostic process abound, such as, lack of precedent, knowledge, valuing, medical model, system design, and supportive practice arenas. The CPM creates a foundation that assures delivery of quality, cost effective professional nursing services. The systems thinking framework delineates the unique services of nursing, provides nursing diagnostic and medical diagnostic standards of care, and integrates them into every component of daily practice including the patient's story or admission assessment, discharge plan of care, documentation, professional exchange report, computerization and the continuous quality improvement program. The outcomes of implementing this innovative strategy in over 20 rural, community, and university health care settings across the United States will be shared.

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North American Nursing Diagnosis Association
1211 Locust Street, Philadelphia, PA 19107

Contact Hour Credit Statement

Name_____

Home Address_____

_____

Name of Program: 11th Biennial Conference on the Classification of Nursing Diagnoses: Advancing Professional Practice with Nursing Diagnosis

Location & Date: Stouffer Hotel, Nashville, TN March 26-30, 1994

Speakers or moderators will announce the verification number as you attend each session. Please keep careful track of the numbers announced.

CONTACT HOURS HAVE BEEN SUBMITTED TO THE PENNSYLVANIA NURSES ASSOCIATION FOR APPROVAL

Saturday, March 26, 1994

9:00 am - 2:00 pm Small Work Groups	_____	6 contact hours
3:00 pm - 3:30 pm Paper Presentation #1	_____	.6 contact hours
3:30 pm - 4:00 pm Paper Presentation #2	_____	.6 contact hours
4:00 pm - 4:30 pm Paper Presentation #3	_____	.6 contact hours
4:30 pm - 5:00 pm Paper Presentation #4	_____	.6 contact hours
Total for Saturday:	8.4 contact hours	

Sunday, March 27, 1994

9:00 am - 11:30 am Specialty Forum	_____	2.4 contact hours
1:00 pm - 3:45 pm Position Papers	_____	2.7 contact hours
3:45 pm - 5:15 pm Integrating Nursing Diagnosis	_____	1.8 contact hours
5:15 pm - 7:15 pm Poster Session	_____	2.4 contact hours
Total for Sunday:	9.3 contact hours	

Monday, March 28, 1994

7:15 am - 8:15 am Regional Meetings	_____	1.2 contact hours
9:00 am - 9:45 am International Nursing Practice	_____	.9 contact hours
10:15 am - 12:30 pm International Panel	_____	2.7 contact hours
12:30 pm - 1:00 pm Nursing Diagnosis Internationally	_____	.6 contact hours
Total for Monday:	5.4 contact hours	

Tuesday, March 28, 1994

9:00 am - 9:45 am Nursing Diagnosis/ Healthcare Reform	_____	.9 contact hours
2:30 pm - 6:30 pm DRC Sessions	_____	4.8 contact hours
Total for Tuesday:	5.7	

Wednesday, March 30, 1994

7:15 am - 8:15 am Special Interest Groups	_____	1.2 contact hours
8:30 am - 9:30 am Critical Path Systems	_____	1.2 contact hours
9:30 am - 10:15 am Advancing the Science of Nursing	_____	.9 contact hours
10:15 am - 10:45 am Advancing Professional Practice	_____	.9 contact hours
11:00 am - 12:00 pm Forum: Taxonomic Issues	_____	1.2 contact hours
1:00 pm - 2:15 pm Forum: Revising Current Diagnoses	_____	1.5 contact hours
2:15 pm - 3:00 pm Closing Address	_____	.9 contact hours
3:00 pm - 3:30 pm Finale	_____	.6 contact hours
Total for Wednesday:	8.4 contact hours	

A total of 37.2 contact hours have been submitted to the Pennsylvania Nurses Association for approval. The PNA is an accredited approver and provider of nursing continuing education by the American Nurses' Credentialing Center.

Registration List

11th NANDA Conference

March 26-30, 1994 Nashville,Tennessee

Registration List
11th NANDA Conference
March 26-30, 1994 Nashville, Tennessee

Abraham, Marilyn
Aloestet MO

Abrams, Sarah
Johnson City TN

Ackley, Betty
Jackson MI

Adams, Priscilla
Lincoln NE

Adams, Peggy
Redwood City CA

Aizenstein, Shirley
Skokee IL

Alfaro-LeFevre, Rosalinda
Malvern PA

Anderson, Linda
Pitman NJ

Antall, Gloria
Summit NJ

Arnold, Jean
Lake Hiawatha NJ

Arslan, Lidy
Paris France

Avant, Kay
Waco TX

Baker, Laurie
New York NY

Barkyoumb, Tammy
Framingham MA

Basque, Julia
Westborough MA

Bernocchi Losey, Donna
Redwood City CA

Bestard, Sue
London ON Canada

Beyea, Suzanne
Gilford NH

Blackmer, Virginia
Franklin NH

Boisvert, Cecile
St Aubin France

Bondy, Kathleen
Conway AR

Borkowski, Eleanor
Redlands CA

Bourdiau, Isabelle
St. Etienne FRANCE

Bourgin, Marie Odile
St. Etienne FRANCE

Bowers, Cathy
South Natick MA

Braden, Joseph
Philadelphia PA

Briley, Mary
Winterville NC

Briody, Margaret
Webster NY

Brodrick, Rhonda
Johnson City TN

Brown, Barbara
Wexford PA

Brown, Mary
New York NY

Browning, Marlene
Fall Branch TN

Brucker, Janet
Houston TX

Bryan, Beverley
London ON Canada

Bulechek, Gloria M.
Solon IA

Burke, Karen
Astoria OR

Burley, Joe
Gainesville FL

Byrne, Marge
Cincinnati OH

Capuano, Terry
Allentown PA

Carlson-Catalano, Judy
Staten Island NY

Carpenito, Richard
Mickleton NJ

Carpenito, Lynda
Mickleton NJ

Carroll, Diane
Beverly MA

Carroll-Johnson, Rose Mary
Valencia CA

Chandler, Nan
Bozeman MT

Chartier, Louise
Sherbrooke PQ Canada

Chase, Susan
Sudburg MA

Chisholm, Sheron
Traverse City MI

Clark, Carla
Phoenix AZ

Clayton, Greg
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Cleary, Patti
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Coenen, Amy
Milwaukee WI

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Coler, Marga
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Collins, Kelly
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Cox, Helen
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Cox, Karen
Beek Netherlands

Coyle Garwood, Jane
Gaithersburg MD

Creason, Nancy S.
Glen Carbon IL

Crosley, Mary
Babylon NY

Crosley, Joan
Babylon NY

Curtis, Jane
Santa Fe NM

DaCunha, Joanne
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Tarpon Springs FL

Davis Kipnis, Nancy
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De Carvalho, Emilia Campos
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Dennison, Brian
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Desharnais, Anna
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Ballina NS Australia

Emoto, Aiko
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Fendrich, LuAnne
Peoria IL

Fielding, Jane
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Figgins, Melba
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Frisch, Noreen
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Matthewman, Joscelyn
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McCourt, Ann
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McDermott, Mary Anne Nelson
Glen Ridge NJ

McFarlane, Elizabeth
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McLane, Audrey
Hendersonville NC

Mehmert, Peg
Davenport IA

Mercer, Margaret
Ames IA

Merriman, Carolyn
Jonesboro TN

Miers, Linda
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Pesut, Daniel
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Yoshiko, Inoue
Tokyo Japan

Yuguchi, Yoko
Hokkaido Japan

Zazworsky, Donna
Tuscon AZ

ABSTRACTS

General Poster Session

Sunday, March 27, 1994

ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

Determination of Content Validity and Reliability of an Instrument Developed to Identify the Defining Characteristics for the Nursing Diagnosis of Inability to Sustain Spontaneous Ventilation.

The purpose of this study was to determine the content validity and test-retest reliability of an instrument developed to validate the defining characteristics of Inability to Sustain Spontaneous Ventilation (ISSV). The subjects for this study were three groups of nurses who are considered to be experts in critical care nursing. In phase one of this study Lynn's (1986) model for determining content validity was utilized with the nurse subjects in groups one (Nurse Experts) and two (CCRN's). The 39 item Content Validity Index (CVI) was distributed and the subjects were asked to rank the items and the overall tool. In phase two the revised instrument, the 33 item Diagnostic Content Validity Scale (DCV), was administered to group three (critical care staff nurses) for evaluation of test-retest reliability and preliminary DCV score.
The overall rating of the CVI was 0.75 this was an agreement at the $p=0.05$ level of significance that the instrument is content valid. Six items were eliminated as being non-relavant ($p=>0.05$). Three items were retained with a $p=<0.05$ in one group. The DCV achieved a correlation of $r=0.85$ in the test-retest reliability phase. Preliminary DCV scores indicated that two items were critical defining characteristics, 22 were minor characteristics, and nine risk factors. The findings indicate that the instrument has content validity and demonstrated reliability using experienced critical care nurse subjects.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

High Risk Syndrome of Prostitution:

A potencial Nursing Syndrome

This paper explores the phenomenon of prostituition toward an end of proposing aggregate nursing diagnoses. The resultant diagnoses evolved from occupational risk factors found in a stratified sample of prostitutes in the State of Paraiba - Brazil. The case study was developed within an explorative framewwork through unstructured and semistrutured interviews. The consequential hig-risk aggregate nursing diagnoses suggest a **High Risk Syndrome of Prostitution.** The data show that prostitutes are at high risk for esposure to factors which alter the potential for the achievement of optimal health in the formol habitual, chronic and continual in cumulative doses over the years. The study demonstrates the importance of, and necessity for, identifyng aggregate nursing diagnoses which will guide nursing interventions in public health and its subspecialty epidemiology.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

THE NIC TAXONOMY STRUCTURE

With the publication of the Nursing Interventions Classification (NIC), systematic documentation and collection of standardized data about nursing interventions is possible. While the alphabetical classification is a good first step, users also need an organizing structure to help in the selection of appropriate interventions. An organizing structure also assists in identifying gaps in nursing knowledge and assists in nursing theory development. The purpose of this paper is to report the research to construct and evaluate the NIC taxonomy.

Seventeen nurses, all members of the Iowa Intervention Research Team, participated in a series of exercises to construct a taxonomy. The sample was used because the respondents were familiar with the NIC interventions, were trained in the use of the sorting technique, and were familiar with the task of concept development. Hierarchical cluster analysis was used to group related interventions into successively larger clusters on the basis of their similarities. All results from the statistical procedures were systematically reviewed to assure clinical relevance and clinical significance.

Team members first sorted each of the NIC interventions into similar groups. The first cluster analysis analyzed the resulting 57,970 pairs of interventions and resulted in 26 classes of interventions. A second analysis comparing similarity ratings of the classes resulted in six domains. A three-tiered taxonomic structure has been developed. The six domains at the topmost abstract level are entitled Physiological: Basic, Physiological: Complex, Behavioral, Family, Health System, and Safety. Moving to level two, each domain is composed of from two to eight classes. Each domain and class have a definition to help in intervention location and placement. Interventions consist of the third level of the taxonomy with some of the interventions located in more than one class.

Selected MNRS members were asked to help evaluate the taxonomy structure. Those who agreed to participate were mailed a taxonomy booklet and a questionnaire. The questionnaire asked the respondents to judge the six domains and 26 classes on five criteria: clarity; homogeneity, inclusiveness; mutual exclusiveness; and theory neutral. A five-point rating scale, from not at all characteristic to very characteristic, was used with each criteria. The ratings as well as written comments affirmed that the taxonomy structure was sound and that few revisions were needed.

Author(s): Iowa Intervention Project/Presenter: Gloria M. Bulechek, PhD, RN

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

INTERACTIVE CARE PLAN WORKSHEETS:
USAGE IN CLASSROOM PRESENTATIONS AND IN CLINICAL

Innovative educational strategies to assist in both the teaching and learning of the nursing process are always welcomed, since the varied aspects of individualized care plan construction can be difficult for the beginning student and the instructor. To assist both the educator and the student, fourteen of the original 30 Interactive Care Plan Worksheets (ICPW) designed by Burley (1993) are included in student's course material for the introductory concept course, NUR 3115 Conceptual Bases for Nursing Practice at the University of Florida, College of Nursing. The ICPW is used to provide the student with a linear approach in the presentation of the nursing process, care plan construction, and documentation. Each worksheet provides the student with information on a specific nursing diagnosis. The interactive construction of the worksheet allows the student to compare the data gathered about a client with the defining characteristics and related factors of selected nursing diagnoses. "TIME OUT" sections are included to challenge the decision making of the student. The back page of the ICPW contains areas related to the desired client outcome, nursing interventions and rationale, evaluation questions, and documentation. A section is also included for the instructor's comments. In a two-page worksheet the student is provided with guidance, feedback, and a mechanism for self-evaluation.

The ICPW can be adapted to existing course materials or reproduced for student usage, acting as a cognitive and a physical map to guide the student through the steps of the nursing process. In the classroom, the theoretical presentations of the steps of the nursing process can be followed using this structured approach of the ICPW. This structure also provides boundaries for the student with little or no actual clinical experience. The ICPW can assist the student in assessment as well as documentation of responses and outcome attainment. The need for accuracy in the establishment of an appropriate nursing diagnosis can be emphasized by the instructor when client data and established defining characteristics are in close proximity. The ICPW provides the clinical instructor with a tracking tool to measure the student's abilities to engage in critical thinking. The comments of our students and faculty after the initial incorporation of the ICPW have been favorable in relation to the ease of use and facilitation of the construction of individualized care plans.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

THE PROCESS OF DIAGNOSIS AND ITS TEACHING

The aquisition of the ability to diagnose is complex and is difficult to teach. Seeking to evaluate the use of strategies for the learning of this ability by students of the College of Nursing of Ribeirao Preto, Sao Paulo, Brazil, the steps proposed by Risner (1986) for Nursing Diagnosis were chosen. The two phases are: analysis and synthesis of data (steps: data are categorized; data gaps and incongruencies are identified; cues are clustered into patterns; appropriate theories, models, frameworks, concepts, norms and standards are applied and compared with patterns; health concerns and strengths are identified; etiological relationships are proposed) and the establishment of diagnoses (using Taxonomy I of Nursing Diagnoses, NANDA, 1990). A total of 106 Nursing Diagnoses were analyzed by the undergraduate students with the objective of verifying: the adequacy of data in each step in the analysis and synthesis phase; pertinence of assigning diagnostic categories to established inferences; the exactness of related factors and defining charaacteristics. From a comparison of Nursing Diagnoses with a validated index, the data showed that: 1) the content mentioned for each step of analysis and synthesis was pertinent for categorization (86.7%), gaps (75.4%), grouping (89.6%), comparison (66.9%), inference (68.8%) and relationship (55.6%); 2) The correct inferences produced 98.6% correct diagnostic categories; of the wrong inferences the students made correct diagnostic categories in 68.5% of the cases; 3) The correct relationships produced 76.2% of the related pertinent factors; in cases of wrong relationships, 72.3% of pertinent related factors were observed; 4) Correct groupings produced 80.8% of defining pertinent characteristics; of the incorrect groupings, the students established 72.7% of the defining pertinent characteristics.

When the analysis and synthesis step was correct there was a greater accuracy in the establishment of Nursing Diagnoses, reinforcing the use of selected strategy. It is important to note that the students established the Nursing Diagnoses, whether by process using data analysis/synthesis or from the taxonomy of NANDA.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

NURSING DIAGNOSIS IN RELATION TO NAUSEA AND VOMITING CAUSED BY CHEMOTHERAPY. Marijke de Hullu, MSN, RN. University Hospital Nijmegen, the Netherlands.

Nausea and vomiting (emesis) are one of the worst complications of the treatment with chemotherapy by cancer patients. It is having a great impact on the Quality of Life of the patient but even it is asking a lot of special care for the nurses. The mainpurpuse of this study is to design a measurement measuring aspects of care for AML (Acute Myeloid Leukemia) patients treated with chemotherapy who suffer from nausea and vomiting treated with an anti-emeticum. A subpurpose is to develop a measurement measuring care of heamatology patients treated with chemotherapy who suffer from emesis. Hypothese: There will be a significant difference in the given care for a patient who suffers from emesis related to the treatment with chemotherapy than a patient who doesn't suffer from emesis related to the treatment with chemotherapy.

During a preceding study of 12 months a measurement is developed based on nursing diagnosis (NANDA 1988). A four step study is designed to select nursing diagnosis which are significant for this group of patients by using three technics resp. Delphi-round, (17 nursing scientists of the Netherlands, 9 nurses of heamatology, oncology departments in the Netherlands) Depth interviews (40 nurses of a heamatology, oncology department) and Contentanalysis (of 15 dossiers). This combination of techniques is made because of the relative unfamiliarity with nursing diagnosis in the Netherlands. For this reason the emphasize was to give a lot of information about nursing diagnosis to the persons who were cooperating in this study to have a homogenous population as possible. All steps of the study were accompanied by a letter or a document with information about the nursing diagnosis. In the first step the categorysystem of M. Gordon is *translated* in dutch, containing 110 *nursing diagnosis*. In the second step a Delphi-round and Depth-interviews were done to select nursing diagnosis for patients who suffer from nausea and vomiting in relation to chemotherapy and to receive consensus about the formulation of *label, and defenition*. The Results were 22 nursing diagnosis: Health Management Deficit (specify), Health Management Deficit (total), Noncompliance, Alteration in Nutrition, Impaired Swallowing, Alteration in Oral Mucuous Membrane, Potential Fluid Volume Deficit, Fluid Volume Deficit, Potential Activity Intolerance, Total Selfcare Deficit, Total Self-care Deficit, Self-Bathing Hygiene Deficit, Self-Dressing Deficit, Self-toiletting Deficit, Diversional Activity Deficit, Fatigue, Sleep-pattern Disturbance, Anxiety, Anticipatory Anxiety, Hopelessness, Ineffective Coping, (and a new formulated diagnose) Nausea and Vomiting by chemotherapy. In step three again a Delphi-round and Depth-interviews were done to select the *defining characteristics and nursing interventions* (Bulecheck and Mc. Clofskey). In step four the final measurement is defined: 22 nursing diagnosis with label, defenition, defining characteristics and nursing interventions.

The nursing diagnosis and interventions were subject in the pilotstudy in June and July 1993. The population of the pilotstudy contained 130 heamatology patients and 35 nurses. The data of this study will be available in september 1993 and will be presented in the congress. Special interests in these data are: high frequency defining characteristics, low frequency defining characteristics, consistency of making a nursing diagnosis among the nurses involved in the pilotstudy. According to the results the measurement will be redifined and be subject to the next study. In november 1993 will be started with the nursing study in combination with a medical trial to measure nursing care for AML patients treated with chemotherapy and an anti-emeticum. In this study the population will contain 80 patients. The study will take 2 years.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

Critical Thinking Ability and the Use of Nursing Diagnoses
in Non-Traditional Students in Nursing

Critical thinking has been considered an essential component of professional nursing practice. Nurses are expected to think critically in order to engage in thoughtful, reflective decision making (White, Beardslee, Peters, and Supples, 1990). Faced with a vast expansion of knowledge regarding human response to illness, nurses must be responsive to patients and their needs in order to promote, maintain, and restore health within a rapidly changing health care arena. The complexity of patient care issues which confront the professional nurse today, only serves to highlight the importance of engaging in critical thought.

More than two decades ago, visionary nurse educators challenged the nursing community by creating educational programs that would admit non-nurse college graduates. This new student was typically older, had post secondary degree(s) and vast life experiences. The older student with life experience represents the changing demographics in society. This unique student population has been viewed as part of the solution to address the new opportunities and challenges facing the profession of nursing today.

Since 1984, nurse educators have come together to discuss the many reasons why changes are necessary in nursing education. In 1987, nurse educators mandated a curriculum revolution in nursing to transform nursing curricula from a training model to one that educates caring, critically thinking health care professionals (NLN, 1989). This revolution can be viewed as an opportunity to engage new student populations and teaching-learning strategies responsive to change.

The purpose of this study was to examine non-traditional students' critical thinking ability and their use of nursing diagnoses as students progress through a three year graduate program in nursing. A total of ninety-seven students participated in this study. Three cohort groups of students representing each year of graduate study were sampled. Each student completed the Watson-Glaser Critical Thinking Appraisal and the U-Diagnose Instrument, an evaluation tool for diagnostic reasoning. Other variables including GRE scores, years of education, presence or absence of a science background and GPA in nursing and non-nursing courses were assessed.

Descriptive and parametric statistics will be used for the data analysis.
Data analysis will be completed in September, 1993.

Currently, there are no studies which consider critical thinking and the use of nursing diagnoses in non-traditional students in nursing. The findings from this study will be compared with other studies which have assessed students in traditional nursing programs.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

ILLUMINATING THE DEFINING CHARACTERISTICS OF THE NURSING DIAGNOSIS OF FEAR:

AN APPLICATION TO TRANSIENT-DEVELOPMENTAL-FEAR IN CHILDREN

An interest in how nurses recognize the phenomenon of fear in children emerged from a unique clinical setting--a Cognitive Behavioral Inpatient Program for children with behavioral, interactional, and learning difficulties. When the children in the program encountered fear-eliciting-events, they were unable to take part in everyday program activities. During the original participant observation study--an integral component of conceptual analysis, using the hybrid model, designed by Schwartz-Barcott and Kim in 1986, support of the usefulness of specific NANDA defining characteristics was not apparent.

Analysis of data from 28 episodes of fear observed in fifteen 7-to-9-year-old children revealed that children did not readily identify the focus of fear. In addition, other defining characteristics were less discrete in this group of children.

Eighty-seven episodes of fear were observed in twenty-two 5-to-7-year-old children in a subsequent participant observation study. A check list consisting of several observable NANDA defining characteristics listed by Gordon in 1982 and additional observable response patterns identified by Barrios and Hartmann in 1988 was used to distinguish observable defining characteristics as well as observable response patterns as a basis for future study.

The data acquired thus far suggests a revision of the defining characteristics of fear as it relates to children. Further investigation of the utility of the indicators or defining characteristics of fear identified in this study is being planned.

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ABSTRACT

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COPING STRATEGIES AND HOME INFANT MONITORING

Sudden infant death represents 1.7 deaths per 1000 in France. The extensive preventative and follow-up measures after a sudden infant death or infant apnea episode have far reaching economic and psychosocial implications for both the family and the community.

Numerous studies have documented the problems faced by parents who must use home monitoring for a child at risk of sudden infant death. However, few studies have addressed coping strategies used by families. One wonders how these families manage in this situation which is challenging to their physical, financial and relational environment.

The purpose of this study is;

- to describe and analyze coping strategies in the above situation,
- to identify characteristics that lead to effective and ineffective coping.

A convenience sample for this study was drawn from infants/families who were followed in a home monitoring program of a large regional university hospital. Both quantitative and qualitative methods were used to collect the data. Taped interviews were undertaken with each family and analysed for major themes. The findings will be helpful to family nurses working in hospital and home-care settings in terms of assessment and intervention strategies.

This study was funded in part by AFEDI (Francophone European Nursing Diagnosis Association).

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ABSTRACT

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CLINICAL UTILIZATION OF ALTERED HEALTH MAINTENANCE

On a 30 bed medical-surgical unit at the Brockton/West Roxbury VA Medical center, West Roxbury Massachusetts, nursing staff address patient problems using NANDA approved diagnoses. The Medical center's Nursing Service have developed Standards of Care (SOC) and Standards of Practice (SOP) based on these approved diagnoses to facilitate the identification, interventions and client outcomes to actual or potential health problems and life processes.

The nursing staff on this unit practice in a team nursing delivery care system. Prevalent surgical interventions include, but are not limited to,abdominal and vascular, with an emphasis on cancer related procedures. Short stays also characterize this client population with the average length of stay being six (6) days. Compounding this is the client's numerous co-morbidities; alcholism, diabetes, chronic obstructive pulmonary disease, warrenting a varied and creative time-limited approach to these dynamic presentations.

The Nursing Service policy clearly defines the professional nurse's responsibilities as they relate to the diagnostic process; client assessment with-in eight (8) hours of admission and the identification of an initial nursing diagnosis complete with interventions and client outcomes. A more comprehensive assessment, using a Functional Health Patterns format, is to be completed with-in forty-eight (48) hours. Subsequent nursing diagnoses based upon dysfunctional patterns are then to be identified and addressed.

This mandate at times was difficult to meet, given the short stays, level of acuity of the client and team nursing approach. Therefore, the staff considered the use of a prevailing nursing diagnosis with individualize etilogies that would both direct the interventions and address most if not all of the client's responses. Furthermore, having one diagnosis to review for client care activities made it an attractive and pragmatic vehicle to assure comprehensive care.

It was decided that the nursing diagnosis, *Altered Health Maintenance* would be a viable strategy to meet these mandates. This diagnosis was chosen because the multi-faceted etilogies with which the client presents could be addressed and that the belief staff hold; that most of their clients surgeries were symptoms of their greater needs.

This working diagnosis, *Altered Health Maintenance*, has been in use for the past year. Staff response has been favorable in utilizing this diagnosis for the majority of their clients. Future plans are to formulate hypotheses for scientific study, identify cause and effect relationships, validate efficacy of interventions, thereby eliminating and or resolving client's actual or potential health problems and life processes.

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ABSTRACT

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The Standardized Progress Note was developed to utilize the nursing process with outpatients who are treated consistently by the same nurse therapist. It was prompted by the trend towards higher caseloads, the shift in emphasis to treat the more acutely ill as outpatients and a desire to better concentrate treatment on the problems identified in concert with the client.

The form includes areas for the necessary patient data, samples of verbalizations, non-verbal observations and the general content or focus of the session.

The unique feature is found in the assessment portion where the therapist can choose from 16 different potential problems which are derived from and correspond with the NANDA diagnosis (ie. Social Isolation, Anxiety, High Risk for Self-harm etc.) Each nursing diagnosis has an accompaning scale which describes the behavioural responses along a quantitative continiuum In this way, each client has their unique constellation of "tracked areas", that can be used to plan and evaluate the nursing care.

Not only has this tool proven to be an efficient use of time, but it has also effectively permitted consistent, objective assessments and tended to focus treatment more on the identified nursing diagnoses. Non-nursing clinicians have also found this tool useful in their practice as pertinent information is readily available.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

Correlates of Nursing Diagnoses Among Seriously Ill Psychiatric Patients

This purposes of this study were to identify the nursing diagnoses occurring among a group of psychiatric inpatients with serious mental illness and to examine the relationships between nursing diagnoses and selected other variables. The convenience sample consisted of 41 patients with diagnoses of schizophrenia, schizoaffective disorder, or bipolar disorder admitted to the inpatient psychiatric unit of a veteran's administration hospital. Thirteen of the patients (37%) were dually diagnosed with a substance abuse problem. The ages of the patients ranged between 28 and 62 with a mean of 41 (SD = 7). The patients were primarily African-American (66%) and male (92%) and they had had a mean of 14 prior hospitalizations. Data were analyzed with frequencies, chi-squares, Pearson and point-biserial correlations, as appropriate. There were no significant associations between psychiatric symptoms as assessed with the Problem Appraisal Scale (PAS) and the nursing diagnoses assigned. Adequate inter-rater reliability of the PAS was established; however, nursing diagnoses used were those assigned by admitting staff. The most common nursing diagnoses in descending order were: Alteration in Thought Process, Ineffective Individual Coping, and Potential for Violence (directed toward others). Nursing diagnosis of Potential for Violence and Alteration in Thought Process were negatively correlated. Potential for violence was negatively correlated with the CNS's assessment of the patient's current level of functioning and to family involvement with the patient. Impaired thought process, however, was significantly more frequent among patients who did not have a family member participating in the study than it was among those who did have a family member participating. The cross-sectional nature of the study does not permit conclusive interpretation of findings and instead the findings suggest needs for additional study. For example, the lack of relationship between nursing diagnoses and the PAS could be explained as due to questionable reliability or validity of the measure of nursing diagnoses or it is possible that nursing diagnoses are capturing independent qualities that are not redundant with psychiatric assessment. Similarly, findings related to family involvement and the nursing diagnosis of Potential for Violence may indicate that family involvement reduces patient violence or it may be that families reduce their involvement with patients who are violent. Since violence is associated with readmission decisions and families are increasingly expected to assume responsibilities for mentally ill family members, the direction of this relationship has potentially important policy and clinical implications.

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ABSTRACT

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TITLE:

Development of a psychiatric nursing assessment tool utilizing functional health patterns.

It is by no accident that the initial step of the nursing process is assessment. This is reinforced by the fact that the American Nurses Association's first standard of nursing practice, defines the need for the organized and systematic collection of data that are accessible to health care providers.

The development of this psychiatric nursing assessment tool and protocol utilizing Gordon's functional health patterns, provides a solid foundation for the organized systematic collection of the clients physiological, sociological, spiritual and psychological states. The development of a accurate and complete knowledge base facilitates the identification of accurate nursing diagnosis, client outcomes, implementation of nursing orders and the evaluation of nursing interventions. As Sir Martin Roth notes in his discussion of "The psychiatric disorders of later life", "precise diagnosis is an essential precondition for appropriate treatment and rehabilitation..."

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ABSTRACT

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Title: A Study of the professional use of nursing diagnosis related to the perceived effectiveness of orientation to the Nursing Diagnosis System, the real and perceived ability to utilize the Nursing Diagnosis System effectively, and overall effect on job satisfaction.

The purpose of the study is to evaluate the effectiveness of an orientation program on the ability of the home care RN to utilize nursing diagnoses in directing clinical practice, to promote job satisfaction at a professional level, to meet the needs of the client, and to meet the documentation requirements of the home care agency and regulators.

Common themes of the orientation program were the use of nursing process to make decisions about nursing diagnosis and the selection of expected outcomes. The documentation requirements of the home care agency and regulators is incorporated into the presentation on the use of nursing process in the home care setting.

Data is gathered through the utilization of a questionnaire to nurses who underwent the orientation concerning job satisfaction, use of the Nursing Diagnosis System, and perceived effectiveness of the orientation program. A computer program is used to compare patient assessment data and nursing diagnoses and expected outcomes selected by the nurses, and to survey the ability of the nurses to use the nursing process model in decision making when selecting nursing diagnosis and expected outcomes.

Anticipated findings are that the nurses perceived the orientation program to be effective, that it enhanced their ability to use the Nursing Diagnosis System effectively, and that it increased job satisfaction at a professional level.

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ABSTRACT

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Psychometric Evaluation of a Client Outcome Measure

The purpose of this study was to assess the content and criterion validity of the Problem Rating Scale for Outcomes (PRSO), an instrument designed to measure community health clients' problem-specific progress. The PRSO was inductively developed from practice and provides the outcome component of the nursing process. It is comprised of Knowledge, Behavior, and Status subscales.

Reliability was assessed in two different phases, and the results indicate that the PRSO subscales possess adequate to very good reliability. Content validity was assessed by experts who rated the appropriateness and generalizability of the subscales. The Behavior and Knowledge subscales were found to possess a reasonable level of content validity, while the ratings for the Status subscale were lower.

Criterion validity of the Knowledge subscale was assessed by examining the relationship between that scale and an objective test of knowledge. Criterion validity of the Behavior and Status subscales was evaluated by correlating the nurses' ratings on the PRSO with client self-reports of appropriate behaviors and problem-specific status. The study provided evidence for validity of the Knowledge and Behavior subscales, while the Status subscale results were less impressive. The study supports the validity of the PRSO and encourages use by practicing nurses to document and quantify the impact of their services.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

Diagnostic Content Validation for Anxiety, Hopelessness, and Ineffective Airway Clearance on ICU in Japan

Now, nursing diagnosis is expanding to use in Japan, and Japanese Nursing Diagnosis Society has been founded in 1991. However, NANDA's nursing diagnoses are written in English and born in North American Culture. So,we Japanese have some task to use NANDA's nursing diagnoses, which are Japanese translation and validation for each diagnosis in Japan.

Wake,M.M.,et al already tested *Anxiety, Hopelessness*, and *Ineffective Airway Clearance* on ICU multinationally, where were Belgium, Canada, Columbia, England, France and United States.

The purpose of this study is to add Japanese Validation to Wake's survey for *Anxiety*, *Hopelessness*, and *Ineffective Airway Clearance*.

【Methods】

Subjects: 49 ICU nurses working at 3 hospitals who had more than 1 year clinical & ICU experiences and learned about nursing diagnosis. Instrument: Japanese translated Validation Scale according to Fehring DCV (Diagnostic Content Validation) model

【Results and Discussion】

1. Sample characteristics: (1)Clinical experience years; 7.4±4.2 (2) ICU experience years; 4.4±2.4 (3) Highest nursing education; %AD or diploma 100 (4) %Use nursing diagnosis; 95.0 (5) %Conference session on nursing diagnosis; 65.3 (6) %Read about nursing diagnosis; 98.0 (7) Self-rated knowledge of nursing diagnosis (1-5 scales); 2.5 (mean)

2. Frequency to occur of 3 diagnoses: % answered very & quite often : (1)*Ineffective Airway Clearance*; 81.3 (2)*Anxiety*; 79.6 (3)*Hopelessness*; 20.9

3. Major defining characteristics: (1)***Ineffective Airway Clearance***; The critical defining characteristics identified were copious secretions, ineffective cough, tenacious secretions in Japan, it showed a similar characteristics as U.S.. (2)***Anxiety***; identified panic, overexcited, distressed, insomnia. Similar critical characteristic to U.S. were only panic and distressed. But tearful, rattled, restlessness which identified in U.S. were not identified in Japan. It may due to that Japanese do not express their emotion to the limit. (3)***Hopelessness***; The only critical characteristic was verbal cue of despondency. Also passivity is major characteristic according to NANDA, and was 0.799 by DCV score in U.S.. But Japan showed lower frequency to occur than U.S.. As American primarily values on independency or autonomy, they may be easy to get hopelessness when they are not independent. On the other hand, Japanese patients are primarily passive to medical worker and easy to accept the situation. So, hopelessness in Japan may get less than U.S..

Therefore, it suggests that the defining characteristics for psychological diagnoses are different with each culture.

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CANCER AND PAIN: ALTERATIONS IN HUMAN RESPONSE PATTERNS

The ambulatory acting in oncological pain created the need in knowing the demand of patients' care received there. The belief that the nursing diagnoses, proposed by North American Nursing Diagnosis Association, bring perspectives to the phenomenon delimitations which the nurse manages, that these must be tested and the results must be shown to be adaptated to Brazil, justified the choose of this framework.

Intending to know the care's demands a study was elaborated and the objectives were: identify the most frequents nursing diagnoses and the human response patterns (HRP) alterated in patients with cancer in treatment in a pain ambulatory. The preliminary results refer to a sample of ten male patients, with an average of 58,2% year old (minimum 29 and maximum 78 years). Based on the collected datas in interview diagnoses were made taking as criterion the consensus between the authors and the evidence with at least one defining characteristic.

Ninety diagnoses were formulated with an average of 9 per patient (minimum 6 and maximum 13) distributed in 28 differents categories. The most frequent diagnoses were: chronic pain (100%), knowledge deficit (90%), impaired physical mobility (70%), alterated nutrition: less than body requerements (60%), activity intolerance (60%), constipation (60%), sleep pattern disturbance (50%), ineffective individual coping (40%), potencial for infection (40%). Five categories were formulated to 30% of the patients, four to 20% and ten to 10%. Alteration was found in every HRP, excepting the valuing pattern. Through the frequency diagnoses analisis formulated in each pattern, the most alterated were: changing (32,2%), moving (21,1%), feeling (12,2%), knowing (11,1%) and perceiving (10%).

The datas show the oncological illness and the pain carry alterations in the physiological domain, in the interpersonal life, in the daily life activities and in the persons' affection, bringing the commitement to qualify of life and creating an extensive nursing care demand. Researches describing, explaining and stabilishing basis on these phenomenons will be the foundation to these patients' care.

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NURSING DIAGNOSES OF PATIENTS WITH CHRONIC CARDIAC CHAGAS' DISEASE

The undertaking of an interview and physical examination in 30 in-hospital patients with chronic cardiac chagas' disease taking into account the health funcional approach patterns proposed by Gordon led us to data for the making up a total of 233 nursing diagnoses, with a mean of 7,7 per patient and 24 differents categories whose frequencies were: potential decreased cardiac output (100%); alteration in role performance (73,3%); potential activity intolerance (70,0%); knowledge deficit (63,3%); altered sexuality patterns (53,3%); health maintenance alateration (46,7%); potencial fluid volume excess (46,7%); sleep-pattern distrubance (43,3%); noncompliance (treatment) (40%); diversional activity deficit (33,3%); activity intolerance (30%); colonic constipation (26,7%); potential for infection (26,7%); self-care deficit (hygiene, dressing, toileting) (13,3%); impaired physical mobility (13,3%); altered nutrition: less than body requirements (10,0%); ineffective coping (10%); fear (10%); impaired swallowing (10%); alteration in self-steem (6,7%); excess fluid volume (3,3%); social isolation (33,3%); potential impaired skin integrity (3,3%). The making up of these diagnoses expressed the alterations of ten health functional patterns out of the eleven proposed by **Gordon**. We have not identified alteration only in the value-belief pattern. The results herein express the complexity of the patients' actual and potential health problems, making the qualified nursing care for them a challenge.

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ABSTRACT

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The purpose of this presentation is to demonstrate a computer aided instruction (CAI) system for nursing diagnosis which the authors have developed.

The CAI system for nursing diagnosis, which was named "ARUKAS" by the authors, was developed to help nurses make accurate nursing diagnoses. Since the diagnostic process is a cycle of cognitive activities such as decision making, inference, and judgment, it is very difficult for a student and or a novice to label a client's health problem.

"ARUKAS", the CAI system for nursing diagnosis, is composed of three parts: I) decision making to generate appropriate diagnoses, 2) drawing a diagram to relate and prioritize those diagnoses, and 3) subsequent nursing planning. By using this system, even a beginner of nursing diagnosis is able to identify the appropriate focus of nursng care. The authors believe that "ARUKAS", the CAI system for nursing diagnosis, will not only improve the diagnostic inference ability of a nurse, but also facilitate the development of computerized nursing information system to facilitate exchange of patients' data between medical centers and the nursing care facilities in a given community.

DEVELOPMENT OF A COMPUTER AIDED INSTRUCTION SYSTEM FOR NURSING DIAGNOSIS

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

NURSING PROCESS APPLIED TO A EPILEPTIC PATIENT: ADOPTION OF HORTA'S THEORETICAL MODEL AND NANDA'S REVISED TAXONOMY I.

This study presents the utilization of nursing process based in HORTA's theoretical framework (1979) and NANDA'S Revised Taxonomy I, which instrument for data collection is based on human basic needs as: psychobiological, psychosocial and psycho spiritual. A case study was done with a client with epilepsy in a Mental Health Ambulatory with the following goals: to use the methodology of nursing assistance to an epileptic client to investigate teaching-learning strategies to him, and to evaluate the results obtained. Many nursing diagnoses constituted the data. Those data were selected in a hierarchical order according to the client needs as: fatigue and sleep patterns disturbance and a teaching-learning strategy was chosen in the planning stage relating to the objectives and goals settled, followed by the evaluation stage. The introduction of NANDA's Taxonomy I for the identification of nursing diagnoses substituting HORTA's proposed model showed to be feasible and gave guidelines to nursing care planning.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

SEXUALITY IN WOMEN WITH EPILEPSY: NURSING DIAGNOSES

Using the content analysis technique, social representations about the sexuality in women with epilepsy were apprehended. Basing themselves in the content analysis technique, the authors grouped context units related to defining characteristics of the nursing diagnoses for sexual disfunction and altered sexual pattern, mentioned in Taxonomy I of NANDA. The subjects of the study were seven epilepsy patients followed-up in the Neurology Ambulatory of a hospital-school in the city of Joao Pessoa, Paraiba, Brazil.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

UTILIZATION OF CONTENT ANALYSIS TECHNIQUE FOR IDENTIFICATION OF NURSING DIAGNOSES IN EPILEPTIC PATIENTS

The objective of the study was to test the operationalization of the content analysis technique for the identification of the psychosocial effects of epilepsy , and subsequently for the identification of nursing diagnoses in epileptic patients. Semistructured interviews were held with a random sample of 15 epileptic patients attending the Neurology and Mental Health Outpatient Clinic of a teaching hospital in João Pessoa, Paraíba, Brazil. The data obtained were submitted to the content analysis technique - transcription and a detailed reading of the interviews; coding and classification of speech segments; selection and grouping of "analysis units" that might belong to the category of psychosocial effects of epilepsy; inferring interpretation of the manifest and latent contents of the analysis units subdivided into emotions/feelings and thoughts-attitudes categories; regrouping of the analysis units around characteristics that define the nursing diagnoses; denomination of the diagnoses. The technique employed permitted the identification of six nursing diagnoses for the clientele: Social isolation; Sexual dysfunction; Defensive resolution strategies; Self-esteem disorders; Impotence; Anxiety. We conclude that the use of the content analysis technique may be useful for the study of nursing diagnoses as long as it is applied to different patient populations to confirm the efficacy obtained in the present study.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

MODEL FOR ANALYSIS OF THE NURSE-PATIENT INTERACTIVE PROCESS (MAPI) IN THE IMPLEMENTATION OF PSYCHOSOCIAL DIAGNOSES

In the interpersonal relationship, the nurses aim to therapeutically actuate helping people with some kind of problem. The comprehensive help occurs in a non-directive way, emphasizing the nurses' attention to listen to the patients through a communication contributive to the nurses' actions, which will be implemented according to the expressed needs. Content analysis is a methodological resource which helps the professional in the psychosocial diagnoses search and in the nursing actions. This analysis, later than the interaction of the overt and latent contents, does not interfere in the relationship, however offers elements to evaluate what happened, pointing out wrong and right actions as far as therapy is concerned, offering elements to plan the continuation of the interactive process. Thus, the diagnoses achieved through this study will guide the professionals in further actions of the interactive process.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

Nursing Diagnosis in Long Term Spinal Cord Injury

What nursing diagnoses are most frequently identified in long term Spinal Cord Injury (SCI)? Is there a common pattern or cluster of nursing diagnoses that characterizes the nursing care of this patient population?

This study used a convenience sample of 62 long term SCI patients (60 males, 2 females). The average length of stay was 9.3 years (range 1-29). The average age was 63.5 years (range 38-99), and the average length of time since SCI was 23.4 years (range 2-50).

The diagnosticians were 18 staff RN's (7 BSN, 7 AD, 4 Diploma). These RN's maintained monthly Nursing Care Plan Evaluations (NCPE) on the sample patients. While 8 RN's were each responsible for 4 NCPE, part timers were responsible for only 1 NCPE, and still other RN's (due to patient turnover) were responsible for up to 6 NCPE.

NCPE's were analyzed for 26 months over a period of three years. During this time 49 different NANDA diagnoses were selected for a total of 6668 diagnoses. The most frequently occurring diagnoses were:

1. Self Care Deficit
2. Altered Patterns of Urinary Elimination
3. Impaired Skin Integrity
4. Bowel Incontinence
5. Pain
6. Impaired Physical Mobility
7. High Risk for Injury
8. Altered Thought Processes

The average number of diagnoses per patient (dx/pt) was 7.5. While BSN's used an average of 7.0 dx/pt, AD's used an average of 8.2 dx/pt and diploma RN's used an average of 6.8 dx/pt. Overall, the average number of dx/pt reached a peak in September 1991 of 8.9 and has slowly declined to a low of 6.3 in Nov. 1993, the most recent month evaluated.

This decline in dx/pt was attributed to the use of two "umbrella" diagnoses, Self Care Deficit and Impaired Physical Mobility. These diagnoses included information previously placed under other diagnoses. RN's that use umbrella diagnoses are said to be minimizers because they use as few as 2 diagnoses. In contrast, a few RN's, the maximizers, continue to add new diagnoses frequently, and have used as many as 12 diagnoses.

Based on the list of frequently occurring diagnoses an assessment tool for outpatients was developed.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

Articulating the Practice of Emergency Department Nurses: An Implementation Plan

PROBLEM - In a review of records in the Emergency Department of a large urban hospital, there was insufficient evidence that documentation accurately reflected practice. Although staff recognized the problems in articulating focused assessment, progress toward outcomes and continuity of care, they did not know how to adapt the clinical process to their practice of high volume and rapid turnover of complex patients. To refine the use of nursing diagnosis in this setting a large scale implementation plan using diagnostic reasoning as a framework was undertaken. Special emphasis was placed on developing a plan that assessed the abilities of nurses individually as well as collectively.

STRATEGIES - Based on the conceptual framework of knowledge utilization, the following strategies were employed: Defining Standards - Articulating the expectations for documentation in the Emergency Department; Disseminating Standards - Raising awareness around expectations now defined; Auditing Records - Assessing the abilities of each nurse individually
Providing Individualized Written Feedback - Providing each nurse with individual written feedback on their performance; Continued Examination of Data - Auditing to document individual progress.

METHODOLOGY - Standards for Emergency Department Documentation were developed over a three month period by expert staff and leadership. The standards were disseminated by staff representatives via staff meetings and one on one communication. This study utilized a retrospective record review for data collection. A record audit focused on four major areas of the clinical process: 1) Focused Assessment, 2) Problem Identification, 3) Outcomes and Interventions and 4) Reassessment and Evaluation. For reliability of response, each record was reviewed by two nurses with expertise in the diagnostic process. Following this baseline record audit each nurse was given an individual plan for developing areas of weakness in their abilities. Individualized written feedback on their documentation of actual patients was given by peers seen as credible from a diagnostic as well as experiential perspective. Continued examination of data identical to the baseline audit will be conducted 3 months following implementation of individual feedback.

SAMPLE - Data related to each nurses ability to engage in the diagnostic process as well as to accurately utilize nursing diagnosis was obtained from a convenience sample of 198 patient records. Three records were reviewed for each of the 66 Emergency Room nurses. Records were reflective of four specialty areas of emergency nursing practice.

RESULTS - Baseline audit results from 198 patient records is as follows: 1) Focused Assessment of presenting problem articulated - 42%, 2) nurses were able to identify a nursing problem - 55%,
3) progress towards outcomes articulated - 12%, 4) Reassessment and Evaluation - On discharge from the Emergency Department, Problems resolved - 8%, Problems unresolved and referred for follow-up - 40%. Analysis is currently underway to examine variability within each nurses' record.

CURRENT STATUS - Follow up audit results are pending. Nurses who have received individual feedback about their documentation and have participated in the audit process, have begun to demonstrate an ability to integrate these concepts into their practice. This positive response gives reason to be optimistic about follow up audit results.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

VALIDATION OF NURSING MANAGEMENT DIAGNOSES

Theories of nursing and organizational decision making relate to the practice of nursing management and provide frameworks for enhancing the effectiveness of that practice. Within the discipline of management science, Simon's Decision Theory identifies four steps to solving problems: identification of disequilibrium, diagnosis and definition of the problem, determination of alternatives, and implementation of chosen solutions. Within the discipline of nursing, the nursing process has been widely used in nursing practice and nursing education, but only recently been used in nursing management for decision making. The second step of both processes, diagnosis and definition of the problem, is critical to effective decision making in management as well as nursing. Nurse managers play a pivotal role in diagnosing organizational problems and making decisions to solve those problems to achieve the goals of nursing.

The focus of the North American Nursing Diagnosis Association's diagnoses are individuals and groups with physical, psychosocial, and spiritual health problems/needs. The focus of organizational diagnosis is a specific organizational unit. Nursing management diagnosis is a judgment about nursing organizational problems that provide a basis for nurse manager interventions to achieve outcomes for which the nurse manager is accountable. A nursing organizational problem is a discrepancy between what should be happening and what is actually happening that prevents the goals of nursing from being accomplished in the organization.

In a previous study, 72 nursing management diagnoses were identified from problems described by practicing nurse managers. The purposes of this study are to validate those diagnoses according to the definition of nursing management diagnosis, to identify the frequency of occurrence of the organizational problem, and to identify the level of disruption the nursing organizational problem causes in attaining nursing's goals in organizations.

A questionnaire was developed using the 72 previously identified nursing management diagnoses and pilot tested with a group of 24 practicing nurse managers. A revised questionnaire was mailed to 700 randomly selected members of the Council of Nurse Managers of the American Organization of Nurse Executives. Data were analyzed using descriptive statistics. Nursing management diagnoses with at least 70 % "yes" responses to the question of fit with the definition of nursing management diagnoses were considered valid. Frequency of occurrence and level of disruption responses were analyzed by mean scores of 5 point Likert scales. Student t scores were computed to correlate frequency and level of disruption.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

VALIDATION OF THE DEFINING CHARACTERISTICS OF POTENTIAL FOR VIOLENCE

There is a high incidence of violence in contemporary society which is reflected in the violence exhibited by psychiatric patients. The recognition and early intervention in the management of violence is necessary to maintain a therapeutic environmnet in psychiatric facilities. If violence potential is unrecognized and occurs, it can have a negative effect on all the patients and staff. While many factors can potentiate violence, the purpose of this study was to validate the behavioral cues of the violent patient.

The study utilized a Diagnostic Content Validity model. The instrument used to validate the defining characteristics was developed by the investigators for this study. The instrument consisted of the defining characteristics of Potential for Violence identified by NANDA, and six additional characteristics. The characteristics were to be rated on a Likert scale by nurses who had expertise in caring for patients with a history of violence.

Members of the Psychiatric/Mental Health Special Interest Group surveyed a convenience sample of 125 registered nurses at eight hospitals. The respondents were asked to rate the importance of each of the characteristics to making the diagnosis of Potential for Violence by selecting from a scale of 1 to 5 with 5-extremely important; 4-very important; 3-important; 2-somewhat important; and 1-not important. At the end of the rating scale the nurses were asked to list any other behaviors that did not appear on the list that might be deemed essential. Included with the instrument was a demographic for to be completed by each respondent.

The data were analyzed quantitatively by assigning a weight to each response and then dividing by the total number of responses. The assigned weights were as follows: 5=1; 4=0.75; 3=0.50; 2=0.25; 1=0. Defining characteristics with a combined score of 0.80 or better were considered major, those with a score of 0.50-0.79 were considered minor characteristics and those with a score below 0.50 were deleted as defining characteristics. Nine characteristics were identified as major defining characteristics, 20 characteristics were identified as minor defining characteristics, and 10 characteristics were determined not to be defining characteristics.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

Strategies to avoid premature closure of the diagnostic process

This research was done to evaluate the effect of teaching cognitive and metacognitive strategies for each phase of the diagnostic process to avoid the premature closure of this process which is a main learning difficulty. The work of others in cognitive psychology, on information processing theory, and in nursing, on the diagnostic process, particularly the model of Carnevali et al. (1984) constitutes the theorical framework.

The model of Carnevali et al (1984) has helped to gain an understanding of the problem of premature closure. These authors distinguish six phases in the diagnostic process: 1. Pre-encounter patient data, 2. Entry to the data field, 3. Hypothesis activation, 4. Guided search, 5. Hypothesis evaluation, 6. Definitive diagnosis. This study shows that students go rapidly from phase 3 to phase 6 without taking time with phases 4 and 5. This could be explained by the fact that students are novices in diagnostic reasoning (Benner, 1984) because, first, their domain-specific knowledge is less developed in quantity and in quality in long term memory and, second, the diagnostic abilities are not always taught as such (Lunney et Svitlik, 1988).

In this work, a learner's guide was written to explain the six phases of the diagnostic process, the more efficient strategies to apply in each phase and to provide self-monitoring strategies of the process. The guide was supported mainly by the work of Carnevali et al. (1984), Gordon (1987) and Ziegler et al. (1986). We formulate the following hypothesis: *Teaching both cognitive and metacognitive strategies of the diagnostic process, with the help of a learner's guide, enhance the nursing students's capability of making a complete and adequate diagnostic process.*

The experimentation was addresed to third year nursing students. Three volunteers participated in this trial. The experimental protocol included a pretest, an intervention and a post-test. Four written case histories were used as support material. The use of a videotaped thinking aloud protocol allowed an understanding of the students'cognitive processes and a measure of the evolution of their learning. A written feed-back followed each case history. The experimentation was carried out over a two- month period and each case history analysis lasted one hour per student.

Results demonstrate a significant increase in each subject's ability to perform a complete diagnostic process. Detailed qualitative analyses of each subject's results show both the elements acquired and those on the way to so-being as well as the evolution of their metacognitive skills. This research indicates the importance of teaching cognitive and metacognitive strategies for each phase of the diagnostic process in avoiding premature closure and, consequently, in enhancing accurate nursing diagnosis.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

Relationship between Attitudes Toward the Elderly and the Diagnostic Reasoning Ability of Baccalaureate Nursing Students

This study's purpose was to determine the relationship between attitudes toward the elderly held by generic baccalaureate nursing students and their ability to use diagnostic reasoning skills to identify health problems of the elderly.

It was predicted that the more favorable the attitude toward the elderly, and the more contact that the student had with the elderly, the greater the number of accurate nursing diagnostic statements and supporting defining characteristics that would be identified.

A correlational design was used to described the relationship between the independent variables, attitudes toward the elderly as measured by the Robb "Behavioral Intentions Toward the Elderly" Questionnaire and contact with the elderly as measured by a researcher-created instrument, and the dependent variable, the nursing diagnostic statements with their supporting defining characteristice recorded on the response sheet after viewing a videotaped health history interview with an elderly person. Critical thinking skills, a control variable, wqas measured by the Watson-Glaser Critical Thinking Appraisal.

The convenience sample was 36 senior baccalaureate generic nursing students who voluntarily attended two data collection sessions.

Data was analyzed by Pearson's Product Moment Correlation and partial correlation. Significance was set at the $p < .05$ level. The findings did not support the relationship between favorable attitudes toward the elderly and the ability to write accurate nursing diagnostic statements but did support the relationship between the attitudes toward the elderly and the number of correct defining charactertics listed for each nursing diagnostic statement. The findings did not support the relationship between the more contact that the studnets had with the elderly and their ability to write accurate nuring diagnostic statements and supporting defining characteristics. This significant findings seems to indicate that the students are able to select the defining characteristics from assessment material but are not able to use information processing theory to cluster the information into meaninful patterns and to label them as nursing diagnostic statements.

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ABSTRACT

ELEVENTH CONFERENCE ON CLASSIFICATION OF NURSING DIAGNOSES

Development Of A High Risk For Falls Care Plan In A Psychiatric Setting

Study Objectives: – The objectives for this descriptive study was threefold. First, the incidences, the nature of the falls and the characteristics of the patients and settings that contributed to the falls were determined. Secondly, significant risk factors associated with the falls were identified. Thirdly, a high risk for falls level II standardized care plan was developed.

Method: – A fall report instrument was developed from an extensive literature review which highlighted risk factors associated with falls. The content validity of the instrument was established based on a critical examination of the literature on falls. The adolescent unit, the rehabilitation unit, the mood disorders unit, a psychogeriatric unit, an admission unit, and an intermediate unit were chosen to represent a cross-section of patient populations. Each area was given an inservice on the purpose, the rationale and the guidelines for completing the fall report instrument. Data was collected on eighty patients over a six month period.

Summary of Results: – Descriptive statistics were computed to determine significant risk factors related to the falls. Findings revealed that age, history of falls, inadequate footwear, incontinence, mobility, balance, and gait problems, disorientation, poly pharmacy, diagnosis of depression or psychosis are high risk patient characteristics. Falls occurred most frequently during the day shift and in the patient's room.

Conclusion: – This study furnished our institution with a database which complemented the literature and which allowed us to develop a standardized care plan on high risk for falls. Further investigation can be initiated to determine the correlation between risk factors and severity of falls.

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NORTH AMERICAN NURSING DIAGNOSIS ASSOCIATION

11th Biennial Conference on Nursing Diagnosis

CRITICAL PATH SYSTEMS AND NURSING DIAGNOSIS: ISSUES AND CONTROVERSIES

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CRITICAL PATH/CareMap AND CASE MANAGEMENT SYSTEMS: AN OVERVIEW

CareMap™ TOOL: A cause and effect grid which identifies expected patient/family and staff behaviors against a timeline for a case type or otherwise defined homogeneous population. The four essential parts of a CareMap™ tool are a Timeline, an Index of Problems with Intermediate and Outcome Criteria, a Critical Path, and Variance Record. A CareMap™ tool reflects the best practice patterns of the clinicians of all key disciplines and departments who author the CareMap™ tool. They are used to coordinate, plan, deliver, monitor, document, and review care concurrently by individuals from all disciplines. Data from each Variance Record can be used retrospectively in aggregate form for Continuous Quality Improvement.

CareMap™ SYSTEM: (Coordinate Care) A CareMap™ Systems includes the six components (CareMap™ tools, Variance Management, CQI, Communication, Case Consultation, Health Care Team Meetings) used around the clock to coordinate, organize, and sequence the care-giving process at the direct patient-care level. Because all disciplines and departments use the CareMap™ tools as a guide, provider-controlled managed care is established.

CASE MANAGEMENT: A clinical system that focuses on the accountability of an identified individual or group for coordinating a patient's care (or group of patients) across a continuum of care; insuring and facilitating the achievement of quality, clinical and cost outcomes; negotiating, procuring and coordinating services and resources needed by the patient/family; intervening at key points (and/or at significant variances) for individual patients; addressing and resoling patterns in aggregate variances that have a negative quality-cost impact; and creating opportunities and systems to enhance outcomes.

GOALS OF CRITICAL PATH/CareMap™ AND CASE MANAGEMENT SYSTEMS:

1. The achievement of realistic, desirable patient and family outcomes.
2. An appropriate length of stay.
3. Appropriate utilization of resources.
4. Satisfaction and involvement of patients and their families, clinical staff (including nurses, physicians, and other members of the health care team), and administrative staff.

AVAILABLE OPTIONS:

1. CareMap™ System (Coordinated Care) only;
2. Case Management only;
3. CareMap™ System and Case Management;
4. Neither

CASE MANAGEMENT AND CareMap™ SYSTEMS ARE NOT SUBSTITUTES FOR:

1. Poor management.
2. Poor basic patient care.
3. Lack of accountability systems.

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RELATIONSHIP BETWEEN CASE MANAGEMENT, CAREMAP® AND CARE DELIVERY SYSTEMS

UNIT/DEPARTMENT/DISCIPLINE BASED CARE COORDINATION (100%)

(CASE MANAGEMENT)

CONTINUUM BASED CARE COORDINATION (<20%)

(60-80%)
TOOLS & SYSTEMS FOR CARE COORDINATION

CAREMAP® SYSTEM
VARIANCE MANAGEMENT
REFOCUSED COMMUNICATION

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Expanding Scope of Accountability



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CRITICAL PATH/CareMap® SYSTEMS: AN OVERVIEW

A Critical Path/CareMap® system is a clinical system that organizes and sequences the care giving process at the client-provider level to better achieve quality and cost outcomes. It is a cyclical process organized for specific case types by all related departments.

Critical Path/CareMap® systems:

1. Are based on the process of anticipating and describing in advance the care patients within the specific case types require and then comparing the actual status of the patient to that anticipated.
2. Consider the entire episode of illness and should outline the care requirements for each area within which the patient population receives care.
3. Do not change staffing requirements.
4. Can be used with any nursing care delivery system.
5. Facilitate continuity of plan.
6. Are not synonymous with Case Management.

The components of a Critical Path/CareMap® system include:

1. Critical Path/CareMap® tools
2. Variance management
3. Quality Improvement
4. Restructured communication systems, including intershift report and rounds
5. Case Consultation
6. Health Care Team Meetings

Critical Paths/CareMaps® are generally targeted for 60-80% or more of the patient population as a long term goal. Initial case types are often selected on the basis of high volume and patternability of the care required by the case type. Case types in which there is high interest among the participants should also be considered.

Critical Paths/CareMaps® can be developed for various categories of patient populations including:

1. Diagnoses (eg., Myocardial Infarction, Congestive Heart Failure)
2. Procedures (eg., Total Hip Replacement, Coronary Artery Bypass Graft, PTCA)
3. Conditions or symptoms (eg., Ventilator Dependent patients, Boarder Babies)

Both qualitative and quantative factors are important in selecting case types for Critical Path/CareMap® development.

GENERAL INFORMATION

... Identify or reflect patterns of care for the usual patient within a case type or other grouping.

... Lead to outcomes within a pre-established timeframe.

... Focus care givers on "what day is it?"

... Promote continuity of plan.

... Are collaboratively developed by members of the health care team who are usually involved in the care of the identified patient population (eg., physicians, nurses, Social Service, Physical Therapy, pharmacy, etc)

... Are used in all geographic areas. The time frame will need to be adjusted to "fit" that of the area. For example, the time frame for an Emergency Department will probably be hours while that in ambulatory care may be months or visits.

... Are not standing orders unless so designated by the individual institution or agency.

... Their inclusion as a permanent part of the patient record is a decision made by the individual institution. An institution may initially decide to include the CareMap®/Critical Path component in the permanent record but not the variance tracking record.

SPECIFIC ISSUES OR SITUATIONS

... Multiple diagnoses or presenting problems may necessitate "merging" the appropriate CareMaps® involved in the patient's care.

... Multiple physicians caring for one case type may necessitate the development of physician specific CareMaps® if the practice patterns vary widely and consensus cannot be reached.

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Figure 1
CareMap™: Congestive Heart Failure

	Day 1	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6
	Benchmark Quality Criteria						
Location	ER 1–4 hours	Floor Telemetry or CCU 6–24 hours	Floor	Floor	Floor	Floor	Floor
Problem							
1) Alteration in gas exchange/perfusion and fluid balance due to decreased cardiac output, excess fluid volume	Reduced pain from admission or pain free Uses pain scale O_2 sat. improves over admission baseline on O_2 therapy	Responsive, equal to or less than on admission	O_2 sat > 90 Resp 20–22 Vital signs stable Crackles at lung bases, less shortness of breath with activity	Does not require O_2 Vital signs stable Crackles at base Respirations 20–22 Less shortness of breath with activity	Does not require O_2 O_2 sat. on room air 90%) Vital signs stable Crackles at base Respirations 20–22 Completes activities with no increase in respirations, no edema	Can lie in bed at baseline position Chest X-ray clear or at baseline	No dyspnea
2) Potential for shock	No signs/symptoms of shock	No signs/symptoms of shock	No signs/symptoms of shock	No signs/symptoms of shock Normal lab values	No signs/symptoms of shock	No signs/symptoms of shock	No signs/symptoms of shock
3) Potential for alteration/risk of immobility and decreased activity/skin breakdown, DVT	No redness at pressure points No falls	No redness at pressure points No falls	Tolerates chair, ambulating, eating, and sleeping	Has dental improvement Up in room and bathroom with assist	Up as tolerated for short periods	Activity increased to level used at home without shortness of breath	Activity increased to level used at home without shortness of breath
4) Alteration in nutritional intake due to nausea and vomiting, bowel		No anorexia No vomiting Taking liquids as offered	Eating solids Takes in 50% each meal	Taking 50% each meal	Taking 50% each meal Weight 2 lbs from patient's normal baseline	Taking 75% each meal	Taking 75% each meal
5) Potential for arrhythmias due to decreased cardiac output, decreased oxygen flow, supply pressures, decreased gas exchange	No evidence of arrhythmias	Normal sinus rhythm with benign ectopy	EKG(s) Benign or no arrhythmias	Digoxin level OHL Benign or no arrhythmias	Digoxin level WHL Benign or no arrhythmias	Digoxin level WHL Benign or no arrhythmias	Digoxin level WHL Benign or no arrhythmias
6) Potentially requires its future treatment & hospitalization	Patient/family expressing concerns Following directions of staff	Patient/family expressing concerns Following directions of staff	Patient/family expressing concerns Following directions of staff	States reasons for and demonstrates with med periods Patient begins to assess own knowledge and ability to care for CHF at home	Patient discuss whether he/she wants discussion with physician about advanced directives	States plan for 1–2 days, pneumovaccine as to meds, diet, activity, follow-up appointments Expresses reasons to having CHF	Reviews plans Shares signs and symptoms to notify physician/ER Signs discharge consent
7) Individual problems							
Staff Tasks							
Assessments/Consults	Vital signs q 15 min Nursing assessments Notes on lung sounds, edema, color, pain, allergies, regular med diversion Cardiac monitor Arterial line if needed Swan Ganz Intake & output	Vital signs q 15 min–1 hr Repeat nursing assessments Cardiac monitor Arterial line Swan Ganz Daily weight Intake & output	Vital signs q 4 hrs Repeat nursing assessments D/C cardiac monitor (if in) D/C arterial and Swan Ganz Daily weight Intake & output	Vital signs q 6 hrs Repeat nursing assessments Daily weight Intake & output	Vital signs q 6 hrs Repeat nursing assessments Daily weight Intake & output Hydration consult	Vital signs q 6 hrs Repeat nursing assessments Daily weight Intake & output	Vital signs q 6 hrs Repeat nursing assessments Daily weight Intake & output
Specimens/Tests	Cardiac TSH studies Chest X-ray EKG CPK q 8 hr x 3 ABG if pulse Ox. (benign) Lytes, Mg, K, Cl, CO_2, Glucose, BUN, Creatinine Digoxin (benign)	BNS	Evaluate for ECHO Lytes, BUN, Creatinine			Chest X-ray Lytes, BUN, Creatinine	
Treatments	O_2 or nebulizer IV or Heparin lock	O_2 IV or Heparin lock	IV or Heparin lock	D/C pulse Ox if stable D/C IV or Heparin lock			
Medications	Evaluate for Digoxin Morphine or peptic Diuretics IV Evaluate for arrhythmias Evaluate for anxiety/meds	Evaluate for Digoxin Morphine or peptic Diuretics IV Evaluate for pre-hospitalization medications K supplements Stool softeners	D/C Intravitrix or peptic Diuretics IV or PO K supplements Stool softeners Evaluate for morphine perph	Change to PO Digoxin PO diuretics K supplements Stool softeners Morphine perph if present	PO diuretics K supplements Stool softeners Morphine perph if present	PO diuretics K supplements Stool softeners Morphine perph if present	PO diuretics K supplements Stool softeners Morphine perph if present
Nutrition	Hold	Clear liquids	Cardiac, low-salt diet	Cardiac, low-salt diet	Cardiac, low-salt diet	Cardiac, low-salt diet	
Safety/Activity	Commode Bedrest with head elevated Reposition patient q 2 hrs Bedrails up Call light available	Commode Bedrest with head elevated Dangle Reposition patient q 2 hrs Evaluate need portable Bedrails up Call light available	Commode Evaluate need portable Chair with assist 1–2 hr with less one-assist Bedrails up Call light available	Bedrest/up privileges Chair x 3 Bedrails up Call light available	Ambulation in hall x 3 Up as tolerated need permits Bedrails up Call light available	Encourage ADLs that strengthen activities at home Bedrails up Call light available	Encourage ADLs that strengthen activities at home Bedrails up Call light available
Teaching	Explain procedures Teach chest pain scale and importance of reporting	Explain source, need for energy conservation Orient to unit and routine	Clarify CHF Dx and future teaching needs Orient to unit and routine Schedule need periods Begin medication teaching	Importance of weighing self every day Provide smoking cessation information Review energy conservation schedule	Continue review level as indicated by pertest Provide smoking cessation information Dietary teaching	Review CHF discussion material with patient	Reinforce CHF teaching
Transfer/Discharge Coordination	Assess home situation; notify significant other if no arrhythmias or chest pain, transfer to floor Observed transfer to ICU	Screen for discharge needs Transfer to floor	Consider Home Health Care referral		Evaluate needs for diet and anti-smoking classes Physician share discussion appointments for advanced directives	Appointment and arrangement for follow-up care with Home Health Care nurses Consult VNA	Reinforce follow-up appointments

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CRITICAL PATHS/CareMap® TOOLS: ELEMENTS FOR SUCCESS

DESIGN

* Is the format functional for the staff using them?
* What does the Critical Path/CareMap® tool replace?
* Is the format consistent within the organization?
* Does the format include the Critical Path/CareMap® tool and a tool for variance documentation?

CONTENT

* Has the content been developed within a multidisciplinary forum?
* Does the content reflect a realistic compromise between current and desired practice?

ACCOUNTABILITY

* Has accountability for using the Critical Path/CareMap® tool in the management of patient care been clearly delineated?
* Has accountability for managing the systems associated with the Critical Path/CareMap® tool been clearly delineated?

OBSERVATIONS

* Of the three elements, accountability is the most important and the most difficult to comprehensively and consistently execute.
* An organization can have a functional design and state of the art content but have an ineffective system if the accountability structures are not securely in place.

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The Center for Case Management

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6 Pleasant Street
South Natick, MA 01760

ANATOMY OF A CareMap® TOOL

GENERAL PATIENT INFORMATION

This section outlines key data regarding the patient and may include:

Patient Name	Location(s)
Allergies	Physician
Religion	Advanced Directive

Who to contact in emergency

INDEX OF PROBLEMS/ISSUES USUALLY ASSOCIATED WITH THE DIAGNOSIS OR CASE TYPE

This section contains 5-6 critical actual or potential problems related to the presenting diagnosis or case type. Space should be provided for listing problems or issues that are specific to the individual patients.

The index of problems is developed in an interdisciplinary forum. The problems may be stated in Nursing Diagnostic language.

INTERMEDIATE GOALS AND DISCHARGE OUTCOMES ASSOCIATED WITH EACH PROBLEM/ISSUE LISTED IN THE INDEX

Intermediate goals are those benchmarks that indicate progress is being made towards the long term or discharge outcomes.

Discharge or long term outcomes describe the desired condition of the patient at discharge or other prescribed time.

Both intermediate goals and discharge/long term outcomes should be stated in terms that are:

* Patient focused (statements begin with "The patient...".
* Framed by an active verb
* Realistic
* Measurable
* Behavioral

CRITICAL PATH

A Critical Path is a cause and effect grid of interventions to be provided by members of a multidisciplinary team to move patients towards desired outcomes within an estimated length of stay.

TIMELINE

The timeline in a CareMap® tool is a measure of clinical progression. It may be stated in time (ie., days, hours, weeks) or in clinical phases.

The timeframes or phases outlined are applicable to both the interventions and the intermediate goals and discharge outcomes.

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VARIANCE MANAGEMENT: GENERAL INFORMATION

VARIANCE DEFINED

VARIANCE is a deviation from the patient care activities outlined on the Critical Path/CareMap™ tool which may alter the anticipated discharge date, the expected cost, or the expected outcomes. It may be helpful to think of variance in terms of detours from the CareMap™.

TYPES OF VARIANCE

Variance can be **positive** or **negative**. Positive variances occur when patients progress towards the anticipated outcomes or discharge faster than anticipated. Negative variances contribute to prolonging the length of stay or to interruptions in reaching the anticipated outcomes.

Variances are collected concurrently for individual patients and are identified by the care givers during the course of care. Individual patient variance is identified and documented,with a corrective plan developed and initiated when appropriate. Because this is a concurrent process, it is often possible to reverse or avoid negative variance. When the individual patients are discharged the variance data is pooled with that from other patients within the same case type. The pooled variance data is then aggregated and addressed retrospectively.

WORKING WITH VARIANCE DATA RETROSPECTIVELY: THREE STEPS

AGGREGATE. In this step, the data about variances and variance sources from individual patients are coded or clustered in an organized way. The incidence of each code is then summed. Aggregate data is generally identified by case type or other patient grouping.

Three major categories of aggregate variance causes have been identified and can be used as an approach to coding data. They are:

1. Patient/Family: Those deviations that originate due to factors related to the patients and/or their families such as:

Patient/Family (continued)
   a. Age
   b. Lack of social support
   c. Patient condition, including extreme pain or fatigue, complications or comorbidities.

2. Clinician: Those deviations that originate due to factors related to the staff involved with the patient such as:
   a. Care giver omission or commission
   b. Health care team decision
   c. Delay in initiating teaching or discharge planning.

3. System: Those deviations which originate due to the system within which patient care is given. There are two sub-groupings of system variance: internal (institutional) and external (community).

   a. External or community variances include:
      * Extended care placement not available
      * Home care not available
      * Third party reimbursers do not provide coverage for the services required.

   b. Internal or institutional variances include:
      * Appropriate bed or appointment time not available
      * Department is overbooked or closed
      * Equipment breakdown
      * Turnaround time for lab results or equipment.

ANALYZE. Analyzing variance data involves examining the aggregated data for trends and patterns and then assessing the significance of those patterns or single episode variances. It may be useful to consider the similarity of this step to the plotting of a scatter diagram. Scatter diagrams seek to identify patterns in data once it is plotted on a graph.

ADDRESS. In this step, a corrective plan is developed, implemented and evaluated for significant variance patterns or significant single episode variances. In general, single episode variances or patterns that are not significant are not addressed.

By using these three steps, variance analysis is directly related to Quality Improvement strategies.

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TIPS FOR WORKING WITH VARIANCE

1. Keep in mind that sometimes variance data doesn't tell the complete story. It may just point to where additional data is needed.

2. Design the analysis and action phases to be highly inter-disciplinary. Maintain a high level of staff involvement. This may be accomplished by using the CareMap™/Critical Path teams that were involved in writing the content.

3. Remember that data analysis is not always an innate skill. Staff will need to be taught, coached, and facilitated in this process.

4. Don't plan to respond to every piece of variance data. Focus on the important patterns and trends, especially those that will produce the most beneficial results. Use the 20/80 principle in deciding which data to address via an action plan.

5. Don't analyze data too frequently. There probably won't be enough data to make it worthwhile. In addition, staff and managers will not have time to truly plan, implement, and evaluate meaningful action plans.

6. Maintain a log of identified significant trends, the actions taken, and the results. Quantify the results when possible.

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LINKING CRITICAL PATHS/CareMaps™ AND CQI

PLAN

* Identify case types for CareMap development.
* Collect baseline data to confirm appropriateness.
* Select, orient and facilitate a CareMap team (analogy: CQI team).
* Draft/finalize CareMap team.
* Revise CareMap based on variance data.

DO

* Use the CareMap as a guide while providing care.

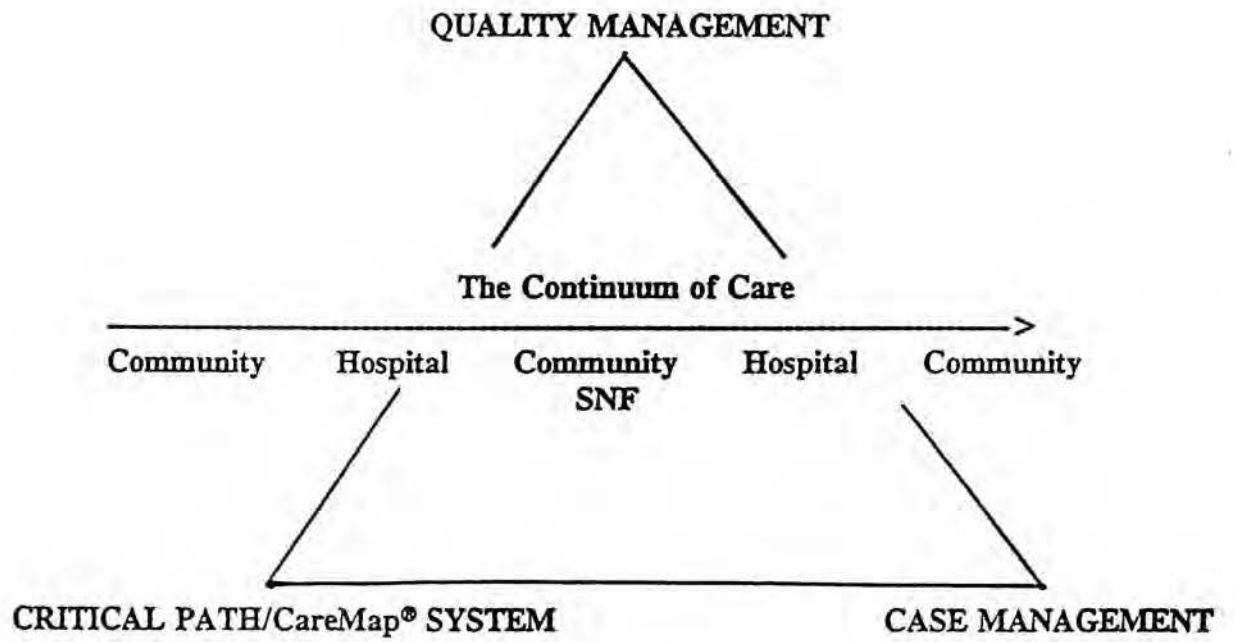
CHECK

* Identify, document variances from the CareMap.
* Aggregate variance data.
* Analyze variance data.
* Develop an action plan to address selected variance trends.

ACT

* Implement the action plan.
* Evaluate the results of the action plan.
* Modify the plan based on the evaluation.
* Teach new skills to staff

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