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| **Problem Concept** | **Assessment** | **NANDA-I Nursing Diagnosis** |
| \*Perfusion/circulation | HR, BP, pulse strength, skin color & warmth, hair distribution, edema, shortness of breath, LOC | Decreased cardiac output, Ineffective tissue perfusion, Activity Intolerance, Risk for Ineffective: Tissue, Cardiac, or Cerebral tissue perfusion |
| \*Oxygenation | O2 sats, RR, LS, resp. effort, sputum, skin color, nail shape, accessory muscle use, LOC, & labs | Impaired Gas Exchange, Ineffective Breathing Pattern, Ineffective Airway Clearance, |
| \*Fluid/Electrolyte | Weight, HR, BP, Input/Output, Edema, pulse strength, skin, mucous membranes, cap refill, LS, RR, effort, LOC, | Risk for imbalanced fluid volume, excess fluid volume, Deficient fluid volume, Risk for ineffective renal perfusion, Risk for electrolyte imbalance |
| Elimination | Intake/Output, Urine color, consistency, amount, odor, frequency, abdominal pain or abnormalities, continence | Bowel incontinence, constipation, diarrhea, Impaired urinary elimination, urinary retention, Stress, urge or functional urinary incontinence, |
| Nutrition/Metabolism | Weight, dietary intake, activity, nausea, skin dryness, abdominal sounds, | Imbalanced Nutrition: Less or more than body requirements, Adult failure to thrive, Nausea, Risk for aspiration, Risk for unstable blood glucose, |
| Thermoregulation | Brain injury, Temp, HR, RR, Skin color & temperature, nail beds | Hyperthermia, hypothermia, Risk for imbalanced body temp |
| Infection | Exposure to pathogens, Fatigue, Temperature, HR, BP, RR, LS, skin integrity, hand hygiene, pulse strength, edema, redness, lymph nodes, breaks in primary defense | Risk for infection, Risk for infection (sepsis), |
| Sensory/Perception | Sensation, sensory aids, balance, muscle tone/coordination, environment | Risk for injury, Disturbed sensory perception, Self-care deficits, Unilateral neglect |
| Cognition | LOC, mood, memory, VS, PERRLA, | Acute/chronic confusion, impaired memory, |
| Mobility | VS, height/weight, body alignment, joint function, gait, muscle strength, activity tolerance, mobility restrictions, pain, injury, ROM, Functional Independence Measure. | Impaired physical, bed, or wheelchair mobility, impaired  Walking, Risk for injury |
| Skin Integrity | Wounds: location, size, characteristics, pain, age, mobility, sensation, nutrition, circulation, hydration, moisture, braden scale, color warmth, dry/wetness of skin | Impaired skin integrity, impaired tissue integrity,  Risk for bleeding, |
| Sleep & Rest | Hours of sleep, mood, day time activity | Disturbed sleep pattern, insomnia, Sleep deprivation |
| Pain | VS, Location, quality, Duration, Description, alleviating & aggravating factors, pain scale | Acute/Chronic pain, impaired comfort, self-neglect, Self-care deficit, |
| Hygiene | Overall appearance, odor, hygiene practices | Self-care deficit, disturbed body image, powerlessness, |
| Psychosocial | Mood, social interaction, | Social isolation, anxiety, fear |
| Spirituality | Religious belief system. Sources of hope, spiritual practices | Readiness for enhanced religiosity, moral distress, |
| Communication | Auditory or visual impairment, ability to speak, cognition, development | Readiness for enhanced communication. |
| Family | Support networks, mood, stress response, | Compromised family coping, ineffective coping, |
| Safety | Morse Fall Scale, Get up & go test, mobility, developmental stage, cognition, environment, medications, labs, sensory | Risk for falls, risk for injury, |

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NANDA International. *Nursing diagnoses: Definitions and classifications 2015-2017*. 10th ed*.* San Francisco: Wiley-Blackwell; 2014.