VALIDATION STUDY OF NURSING DIAGNOSES

by

Margaret Deeter McComb, R.N., M.A.

A Thesis

Presented to
The University of Oregon Health Sciences Center
School of Nursing
and the Graduate Council of the
University of Oregon Health Sciences Center
in partial fulfillment
of the requirements for the degree of
Master of Nursing

June 8, 1980

APPROVED:

[redacted]

Florence Hardesty, Ph.D., Associate Professor, Thesis Advisor

[redacted]

Mary C. King, M.Ed., Assistant Professor, First Reader

[redacted]

Carol Lindeman, Ph.D., Professor, Second Reader

[redacted]

Susan Will, M.S.N., Assistant Professor, Third Reader

ACKNOWLEDGEMENT

My thanks to Kristine M. Gebbie – teacher, mentor, friend – whose advice and support throughout this project were invaluable.

This study was supported in part by a United States
Public Health Service Traineeship from
Grant Number 5A11 NU 00250-03 and
Grant Number 5A11 NU 00250-04

TABLE OF CONTENTS

TABLE OF CONTENTS (Continued)

TABLE OF CONTENTS (Continued)

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1

INTRODUCTION

Statement of the Problem

There is increasing professional agreement that the conclusions nurses reach as a result of patient assessment may be called nursing diagnoses (Gebbie, 1976a). The terminology entered nursing literature in the 1950s (Fry, 1953; Hornung, 1956) and has appeared since with increasing regularity despite the proposals for alternative terminology which have been offered (Bloch, 1974; Levine, 1965). The 1973 American Nurses Association Standards of Nursing Practice specifically incorporates nursing diagnosis in Standard II: "Nursing diagnoses are derived from the data about the health status of the patient/client" and Standard III: "The plan of nursing care includes goals derived from nursing diagnoses" (Standards of Nursing Practice, 1973). Increasingly, state nurse practice acts are explicitly including nursing diagnoses as part of nursing practice (Bullough, 1978).

However, the profession lacks a standardized or commonly accepted set of labels for the diagnoses nurses make. The development of a standardized nomenclature and classification of nursing diagnoses has been the work of three National Conferences on the Classification of Nursing Diagnoses. The first conference in 1973 was composed of 100 nurses in education and clinical practice who met in small task groups to identify nursing diagnoses. The diagnostic labels were then presented to the

total group where a majority vote of acceptance was viewed as validation of the diagnosis. The first conference generated some 30 diagnoses--labels for 30 patient or client conditions that nurses diagnose from within nursing knowledge (Gebbie & Lavin, 1974). A study done between the first and second conferences generated 2338 diagnoses and their defining characteristics, identified by nurses in 28 agencies, which are widely distributed geographically. The study results and the work of the first conference were used by participants at the Second National Conference to generate 35 diagnostic labels, each with a list of no more than 15 signs and symptoms. An additional 19 labels were listed as "diagnoses 'to be considered'" since time constraints prevented their refinement at that conference (Gebbie, 1976b).

Subsequently, at a series of regional workshops and conferences, the diagnoses were further developed and refined. The resulting data were collected centrally at the St. Louis-based National Clearinghouse for Classification of Nursing Diagnoses and used to plan the Third National Conference. Participants received copies of the work done by the regional groups well in advance of the conference and decided in advance which diagnostic labels they wished to work to perfect or enlarge. They were encouraged to bring supporting literature and materials. The task groups not only worked to refine the diagnoses and identifying characteristics, but also were requested to identify common etiological factors for the diagnoses and to identify literature to support their work. The groups also were requested to indicate the "degree of independent nursing therapy commonly involved in preventing, treating, or resolving the health problem" (Working Papers, 1978).

Appendix I is a list of the diagnoses developed at the first, second, and third conferences.

At the fourth conference in April 1980 groups considered all diagnoses submitted or developed and accepted since 1973. For each a decision was made to delete, accept without change, retain and change or further develop the diagnosis (Working Papers, 1980).

Standardization of nursing diagnosis offers clear communication of patient conditions and nurses' concerns to nursing colleagues in education, research, and practice; those concerned with storage and retrieval of information; third party payers; legislators; and consumers. That the profession is increasingly interested is indicated by the resolution passed at the 1976 American Nurses' Association (ANA) Convention that supports "the identification of nomenclature and development of a classification system of nursing diagnoses" (ANA Convention, 1976). More recently, the ANA National Conference on Evaluation Research: Assessment of Nursing identified the development of "a classification and nomenclature system, part of a general nursing taxonomy" as one of four priorities for an ongoing plan for evaluation research in nursing (Conference Names, 1979).

One method for standardization of the diagnostic labels is establishing consensual validity of the labels and their defining characteristics. This is what has been done by the sample of nurse-participants at each of the National Conferences when they accept or reject the work of the task groups.

The work of the National Conference group has produced the initial steps toward the definition of phenomena encountered in clinical

practice. The development of the diagnostic labels and their defining characteristics may be viewed as operationalizing of definitions of the basic concepts from which theories and research questions will be developed (Kritek, 1978). The number of nurses who have participated in this definition process is relatively small. Before moving beyond this phase, then, it is important to further validate the diagnostic labels and their characteristics.

Validity is used, in this case, to describe the confirmation, or substantiation, of evidence (Powers, 1964). This is much the same as the need to corroborate the data obtained in surveys and polls. Parten (1950) states that the validity of results is indicated by the extent to which the results agree with some criterion that is regarded as an acceptable measure of the phenomenon. The difficulty often encountered in the validation of survey results is present in the validation of the diagnoses in that an acceptable outside criterion, or "true score," is not available (Campbell & Katona, 1953). At the present stage of development, nurses must use essentially the same criteria as used by the American Psychiatric Association Task Force on Nomenclature and Statistics in preparing the third edition of the Diagnostic and Statistical Manual of Mental Disorders.

> If there is general agreement among clinicians who would be expected to encounter the condition that there are a significant number of patients who have it and that its identification is important in their clinical work, it has been included. (Task Force, American Psychiatric Association, 1978, p. viii)

Newly defined terms were included in the classification with the expectation that they would be critically examined in the field trials, critiques by clinicians, and research studies to be done using the new

classification.

Thus, the initial criteria for comparison are the clinical knowledge and experience of practitioners. Castles (1976) and Gordon (1979) use the term consensual validation to describe this process. Angell (1964) defines consensus as "that general agreement which tends to produce order where there was disorder. Such general agreement may be accompanied by differences of view on detail" (p. 128). The term implies both former disagreement and the sharing of sentiment as well as rational agreement in resolution (Angell, 1964).

Gordon and Sweeney (1979) term the identification process used at the National Conferences a "retrospective identification 'model'" and state the the diagnoses so developed can be validated using a different sample of nurses. Therefore, the present study was developed to present the labels and defining characteristics to a sample of nurses to establish consensual validation for those diagnoses. The retrospective identification and validation of diagnoses need to be followed by many sorts of investigations. The ideal situation would be for entire agencies to make the commitment to be involved as has been done with the field trials of the Diagnostic and Statistical Manual of Mental Disorders, third edition. Several research models for such studies are suggested by Gordon and Sweeney (1979). This work, however, must be preceded by the development of an initial list of nursing diagnoses, each operationalized by a list of defining characteristics.

It was the intention of this investigator to survey a group of nurses to determine the degree of their consensus regarding 14 of the diagnoses and identifying characteristics that emerged from the Third

National Conference on the Classification of Nursing Diagnoses.

Review of the Literature

The review of recent literature is divided into five categories: (a) definitions and concepts; (b) publications about nursing diagnoses; (c) relationship to theory; (d) research and implementation experiences; and (e) the implications for the profession. The review is focused on the development of the concept of nursing diagnosis and of the work towards developing a nomenclature.

Definitions and concepts. The definitions of nursing diagnosis abound, increasing as various writers operationalize the concept. Roy (1975) uses "the summary statement or judgement made by the nurse about data she [sic] has gathered in her [sic] nursing assessment." The definition that guided the work of the First National Conference was "the logical end-product of nursing assessment" (Gebbie & Lavin, 1975). "A statement of a client condition which is identified from nursing knowledge and which nurses have a legal right to treat" is Castles' definition in a research project (1976). Gordon (1976) emphasizes the three parts of the nursing diagnosis: (a) the problem or category label; (b) the probable cause of the problem; and (c) the signs and symptoms, calling this the P-E-S (Problem-Etiology-Sign) format. Nurse theorists at the Third National Conference used the definition "a concise phrase or term summarizing a cluster of empirical indicators representing patterns of unitary man" (Gordon, 1979). Jones (1979) uses "the statement of a person's response to a situation or illness, which is actually or potentially unhealthful, and which nursing intervention can help to

change in the direction of health." The definition used for this study is similar : a client/patient condition which is actually or potentially unhealthful and which nursing intervention can help to change in the direction of health.

While most authors recommend the use of the qualifier "nursing" to differentiate the diagnoses made by nurses from the diagnostic labels of other disciplines, particularly medicine, one cannot simply say that medical diagnoses are only made by physicians and nursing diagnoses by nurses. The modifier indicates the area of expertise or conceptual framework from which the diagnosis is made and intervention is planned (Gebbie, 1976; Soares, 1978).

The names, or labels, assigned to nursing diagnoses make up a nomenclature, the system of terms used in any science or art and part of the development of a taxonomy, or classification system (Castles, 1976; Gebbie & Lavin, 1975; Jones, 1979). Classification is the "arrangement of objects into groups or sets on the basis of their relationships." Taxonomy is defined as "the theoretical study of classification" (Sokal, 1963). A taxonomy is "a set of classifications which are ordered and arranged on the basis of a single principle or on the basis of a single set of principles" (Bloom, 1956). The taxonomy determines the principles by which the terms or diagnoses will be ordered into groups.

The clinical beginning of the development of the proposed taxonomy, then, is the identification of all the items (diagnoses) to be classified and followed by the application of a standardized set of labels to the items. Then the items must be organized into groups and subgroups along some organizing principle. Lastly, coding by numbers or

abbreviations will allow storage and retrieval of nursing data by complex data systems (Gebbie, 1974). The National Conferences on Nursing Diagnoses have begun the work with the generation of diagnostic labels and their defining characteristics. The diagnoses now tend to be of differing levels of abstraction and it seems probable that as categories are developed, some diagnostic labels presently in use will become category labels while others will remain diagnoses or evolve as etiologies. At the present stage of development, all are considered nursing diagnoses, to be changed as nurses collectively use and evaluate them.

While the ultimate goal is the creation of a taxonomy for nursing diagnoses, this study is concerned with the need to standardize the nomenclature, or terms.

Review of publications. In the 1950s the term nursing diagnosis was used by Fry (1953) without definition as a part of the "creative approach to nursing." Hornung (1956) advocated the use of the term nursing diagnosis to correspond with the responsibility the nurse assumes in patient care and to end vague descriptions of patient conditions.

In the 1960s authors described the diagnostic process and sought acceptance for both the concept and the term nursing diagnosis. Chambers (1962) defines nursing diagnosis as a process: "a careful investigation of the facts to determine the nature of a nursing problem." Komorita (1963) urged the use of the term nursing diagnosis and compared it to the terms problem and needs. Durand and Prince (1966) described the diagnostic process as the statement of a conclusion reached after investigation of a patient and recognition of a pattern. Rothberg (1967) advocated nursing diagnosis because nursing's emphasis on the individual

means that care based on nursing diagnosis will focus on the whole person. Discomfort with the term nursing diagnosis is reflected in Bloch's (1974) choice of problem definition instead of diagnosis and intervention over treatment to avoid confusion with medicine. Similarly, Levine (1965) proposed the term trophicognosis.

The proceedings of each of the three national conferences, the lists of the approved diagnoses, related conceptual materials, and research reports have been published after each conference (Gebbie, 1978; Gebbie, 1980; Gebbie & Lavin, 1975). Participants in the first conference described the conference and its work in various journals (Bircher, 1975; Gebbie & Lavin, 1974; Gordon, 1976; Roy, 1975a, 1975b). The possible impact on medical records systems was discussed by Puder (1975).

Other nurses wrote elaborating on the concept of nursing diagnosis. Gordon (1976) defined nursing diagnosis as having conceptual, structural, and competency components. Brown (1974) reinforced the need for a standard nomenclature and taxonomy so that the epidemiological approach can be applied to the study of nursing diagnoses. Soares (1978) presents a careful conceptual differentiation between medical and nursing diagnosis. The use of the nursing diagnosis concept and the development of a taxonomy are discussed in relation to the problem-oriented system (Carnevali & Little, 1976; Gebbie, 1976a). Mundinger and Jauron (1975) discuss implementation of a nursing diagnostic statement as part of primary nursing.

Also concerned with implementation of nursing diagnosis, a study of 187 nurses revealed an inability of some to reach a diagnostic conclusion (Aspinall, 1976). Campbell (1978) has used students' data to generate a

list of nursing diagnoses and interventions, published in a cross-referenced, indexed volume. However, there is some controversy regarding her identification as nursing diagnoses some "signs, symptoms, and processes" which have heretofore been viewed as within the domain of medicine (Gordon, 1979).

More recently, publication relative to implementation of the diagnostic labels has occurred. Haines and Rossi (1979) discussed a complex of diagnoses they hypothesize to be associated with the medical diagnosis 'myocardial infarction'. This could represent the direction for a research project. A series of papers from the Second Northeastern Regional Conference on Nursing Diagnoses concerned various facets of implementation of nursing diagnosis. In all the articles, nursing diagnosis is viewed in the context of the nursing process and as an asset to communication about client problems. Change processes and strategies involved in implementation of nursing diagnosis are discussed by Field (1979). Bruce (1979) told of the implementation plan in a large private psychiatric hospital. Using nursing diagnoses in a discharge planning program was found helpful since the largest number of referrals is for nursing services for specific nursing problems (McKeehan, 1979). The implementation of nursing diagnoses in a home health care setting where the major service provided is nursing, helped focus care and more adequately predict the service needs of clients (Dalton, 1979). Weber (1979) discussed the advantages of using nursing diagnoses in private practice.

There has been relatively little published research related to the development of nursing diagnoses. A research project of some scope was

begun by members of the Task Force established by the planners of the First National Conference on Nursing Diagnoses. The first of three phases tests a method of consensual validation for the standardization of nursing diagnoses (Castles, 1976). The data are being analyzed from that study. Gordon and Sweeney (1979) identify types of studies needed to develop a classification and give three models of appropriate research design. Jones (1979) describes a clinical project in progress where diagnostic statements have been generated in client encounters. A model for the formulation of nursing diagnoses was developed and then tested in a validation study reported by Avant (1979). Guzzetta and Forsyth (1979) report a project to test a typology of stress as observed in acute illness, using myocardial infarction patients in an ICU setting. Gordon et al. (1980) report a study of the use of the accepted nursing diagnoses in a population of obstetrical/gynecological patients using the nursing diagnoses recorded on the form one hospital uses to refer patients to home health agencies.

Relationship to nursing theory. The inductive process of beginning the classification of nursing's domain from the definition of the many specific aspects of nursing is in counterbalance with the work of nurses involved in designing conceptual models and theories of nursing. For the nurse theorist, classification begins deductively with the definition of the nature and scope of the profession. The categories and subsets are then deduced and labeled according to the model chosen (Gebbie, 1976a; Roy, 1975).

The identification of nursing diagnoses with lists of defining characteristics represents the inductive development of operational

definitions, the most basic work in constructing nursing theories or nursing research and defining the scope of nursing. The work of the National Conferences has exemplified the feeling that both induction and deduction can be used effectively in the development of a taxonomy, despite the differences of opinion and debate that will probably result. Just as each theorist has a concept of the definition of the nature of nursing and its scope, so does each practitioner. A taxonomy of nursing diagnoses must represent the consensus of nurses from both vantage points to be relevant for both clinicans and theorists. Nurse theorists have been involved in the process of developing a standardized nomenclature since the First National Conference. At the Third National Conference, as task groups worked on refining diagnostic categories, a group of theorists met to develop a conceptual framework for a classification system (Working Papers, 1978). The theorists continued their work on the framework and presented a further development of the suggested framework at the Fourth National Conference in 1980. At this conference theorists met with other conferees, using the framework to analyze case study material and attempting to generate nursing diagnoses deductively (Working Papers, 1980).

McKay (1978), in discussing the relationship between theory and the development and use of a taxonomy, deals with the effort to develop a taxonomy of nursing diagnoses as one of a number of possible taxonomies of nursing. The relationship between developing a nomenclature and taxonomy, and nursing theory are discussed by Henderson (1978) and Kritek (1978, 1979). Both writers assert that the present developments represent theory-building activity at the factor-isolating level (Dickoff,

James, & Weidenbach, 1968) and at the first level described by Jacox (1974). Kritek (1978) contends that in the desire to create theory at the highest level (situation-producing), nursing has neglected necessary preliminary work and suggests that classification of nursing diagnoses is a prelude to higher level nursing theory.

Implications for professional nursing. The development of a classification of nursing diagnoses has significant implications for all areas of nursing. The nurse in clinical practice can communicate patient problems more clearly to peers in the practice setting or in another agency. As part of the nursing process, the diagnoses, with the etiological component, lead directly to planning intervention. The diagnoses give the administrator tools for evaluating quality of nursing care or for estimating nursing service needs. For the nurse researcher, the nomenclature facilitates the communication of research designs, increases the ability to generalize findings, suggests new areas of research, and facilitates the communication of findings to practitioners. The nurse educator can use diagnostic categories in planning curriculum (Fredette & O'Connor, 1979; Roy, 1975). The nurse theorist will be facilitated in theory-building by the naming and classifying of basic concepts.

Nursing data can be stored and retrieved according to the diagnoses, a potential aid to all professional areas, but perhaps with most impact in research and quality assurance. When records are stored by medical diagnosis, retrieval of nursing data is dependent on being able to guess with which medical diagnoses a given nursing diagnosis might be associated--an inefficient and likely inaccurate process. The ability to name the problems nurses treat will enhance communication with other health

care professionals, third party payers, legislators, and clients, and potentially clarify the scope of the profession (Gebbie, 1976a; Gordon, 1976; Roy, 1975).

Purpose of the Study

The development of a standardized nomenclature, the first step in the inductive process of developing a taxonomy, represents a significant effort. The immediate goal of this study was to contribute to that effort by helping to define some of the items (diagnoses) to be classified. The specific purposes of the study were to:

1. Establish validation of each label with its cluster of defining characteristics as representing a nursing diagnosis as defined in the study.

2. Establish validation of each of the defining characteristics of each diagnostic label.

3. Identify alternative labels nurses may currently attach to that cluster of "symptoms."

4. Identify the perceived importance of that label in the subjects' own practice and for the profession.

This was to be done by surveying a group of Oregon nurses regarding 15 nursing diagnoses from the Third National Conference. The number of diagnoses was limited for the convenience of the nurses participating. The results will add to the refinement and/or elaboration of the diagnostic labels and provide new data to assist in refining the diagnoses as the group works toward the goal of a classification of nursing diagnoses. The validation of the diagnoses developed by the National

Conferences would also validate the process of the Conferences in developing the diagnoses. The longer-range goal of the study is to participate in the preliminary steps of nursing theory development by involvement in the definition of the phenomena of the field.

Nurses participating in the study may not receive direct benefits from their activity but may incidentally develop a greater awareness of nursing diagnoses and the work of the National Conference group. This may be enhanced for those who as individuals or whose agencies have requested follow-up reports of the results of the study.

CHAPTER 2

METHODS

Research Design

This descriptive study had three purposes. The first, similar to the retrospective model suggested by Gordon (1979), was to establish further consensual validation of the diagnostic labels and their defining characteristics, initially validated at the Third National Conference on Nursing Diagnoses. It was retrospective in that the subjects validated the diagnoses against their accumulated past experiences in nursing. The second descriptive purpose was that of identifying the perceived usefulness of the diagnoses in the subjects' own practice area as well as for the profession as a whole. A third and fourth purpose were to identify alternative labels that individual nurses may give to the same clinical phenomenon and to identify the perceived importance of the diagnoses in the subjects' practice and for the profession.

A survey research design using a self-administered questionnaire was chosen because of its flexibility and applicability to the descriptive and exploratory goals of the study (Babbie, 1973; Polit & Hungler, 1978). The intent was not to generalize about the probable response of all nurses to these questions, but to add to the weight of consensus for these diagnoses and to provide new or additional data useful to the National Clearinghouse in assigning the next National Conference's tasks or developing of nursing diagnosis research that can be conducted on a larger scale.

Subjects

Fifty-three Oregon nurses at least half-time employed in direct patient care (20 hours/week) were recruited for the study. The arbitrary half-time criterion was chosen to establish that the subjects would be primarily clinicians. It was decided not to recruit subjects only among nurses with advanced preparation. While some investigators have so restricted samples in the belief that only nurses with advanced clinical skills can identify diagnoses (Jones, 1979), the Castles study (1976) was not limited to advanced clinicians and the initial data for Campbell's work (1978) were nursing problems identified by students. Sample selection in this study reflects the goal of further validating the work of the National Conferences, where subjects drawn from the clinical practice area are not limited to clinical specialists. It is the investigator's belief that nurses who plan and record nursing care must find the diagnoses useful and usable.

The assumption was made that nurses in practice settings where medically-directed or dependent nursing functions are less predominant make many independent nursing decisions, whether they use nursing diagnosis labels or not. Such nurses were presumed to have more clinical nursing experience against which the diagnoses could be validated. Nurses were actively recruited by contacting agency administrators in home health and community setting, rehabilitation facilities, psychiatric services, correctional facilities, and long-term care settings. Nurse practitioners were recruited through the Oregon Nurses' Association, Nurse Practitioner Special Interest Group, and a local group, Psychiatric Nurses in Advanced Practice.

Because the desired sample consisted of nurses with fairly specific traits and the researcher's time and financial support were limited, a specific accidental sample, the sample of convenience, was used (Polit & Hungler, 1978).

Data Collection Instruments

Informed consent. Informed consent was obtained from each subject using the form presented in Appendix B.

Inventory of subjects' professional characteristics. This information was collected for the purpose of describing the sample and to facilitate post hoc analysis of results. The items included reflect the possibility that factors such as education and experience, clinical background and practice setting, as well as the amount and kind of contact with concepts regarding nursing diagnoses could influence reliability and validity (Gordon, 1979). Therefore, the sample was surveyed as to:

1. Age.
2. County in which employed.
3. Educational level.
4. Type of nursing education, basic and planned.
5. Years in practice.
6. Present practice setting and years in it.
7. Specialty area, years in it, and special preparation.
8. Previous exposure to nursing diagnosis concepts.

9. Extent of use of nursing diagnosis in own practice.

10. Agency requirements for use of nursing diagnosis.

(Appendix C)

Nursing diagnosis questionnaire. The subjects were asked to evaluate a group of the diagnoses identified at the Third National Conference on Classification of Nursing Diagnoses. A questionnaire was designed that incorporated both structured and open-ended questions, reflecting the purposes of evaluating existing data as well as generating new data. A series of five questions was directed to each diagnosis (see Appendices D and E).

Question 1 has two parts. Part 1a is to ascertain the acceptability of the particular diagnostic label. A structured question using a dichotomous response format and a "don't know" alternative was chosen.

Question 1b is to describe the degree of acceptability or agreement on the several defining characteristics of a single diagnosis. A structured question with a matrix (checklist) response format was chosen. "Agreement" in question 1b is indicated by a response to any of three gradations of agreement or disagreement ("somewhat," "moderately," or "strongly"). Numerical values were assigned to each response: from 1 for "strongly disagree" to 6 for "strongly agree."

Question 2 has an open-ended form since the goal is to generate new data in the form of alternative labels that nurses use for the same cluster of observations.

Questions 3 and 4 are to assess the respondent's perception of the utility or importance of the particular diagnostic label. The structured questions have a graphic rating scale requiring the expression of opinion

along a continuum (Polit & Hungler, 1978). The responses were scores 1 for "not at all" to 5 for "extremely."

Question 5 represents an open-ended opportunity to make any comment regarding the diagnoses.

Two individuals who have been involved with the planning of three of the National Conferences on the Classification of Nursing Diagnoses and who have written and/or conducted research in the area were asked to evaluate the content of the questionnaire. No major changes were required in the questionnaire after their evaluation.

Instructions. Instructions preceded the inventory and the questionaire, briefly restating the purpose of the study, then giving general directions for the entire questionnaire (see Appendix F). Specific directions accompanied each question since several different types of questions were used within the same questionnaire (Babbie, 1973).

Diagnoses. The Third National Conference identified more than 15 diagnoses. However, the number was limited for the convenience of the subjects. Diagnoses with extremely long and/or complicated defining characteristics were eliminated because it would require too great an amount of time for the subjects to consider each carefully. In addition, the attempt was made to choose diagnoses that have relevance in multiple practice settings.

The 15 diagnoses chosen for the study were:

Mobility, impairment of

Body image, alterations in

Grieving

Alteration in nutrition: more than body requirements

Alteration in nutrition: less than body requirements

Alteration in comfort: pain

Functional performance, variations in self care

Functional performance, variations in home maintenance management

Alterations in patterns of sexuality

Non-compliance

Fluid volume deficit, potential

Fluid volume deficit, active loss

Parenting, alterations in

Altered levels of consciousness

Sensory-perceptual alterations

The source for the content of the questionnaire (the diagnostic labels and defining characteristics) was the investigator's personal working papers from the Third National Conference.

Some assumptions were made about the difficulty of the task and the diagnoses were arranged so that subjects could become more familiar with the format of the questionnaire as the validation task became more difficult. Thus, the last 2 diagnoses included are quite abstract with considerable overlap and would seem to present the greatest difficulty to the subject, while the first 2 diagnoses seem more clearly stated.

Pretesting the Instruments

Pretesting was done to estimate the time required to complete the questionnaire and to evaluate the clarity of the instructions and the questions (Polit & Hungler, 1978). The pretest sample included two graduate students, one staff nurse, and one undergraduate nursing student.

Each was asked to complete the questionnaire and then to complete a form entitled "Questions for Pretest Participants" (see Appendices G and H). None of the pretesters was using these diagnostic labels or any nursing diagnoses in practice at that time. Three of the four had never seen them before. All felt that the general directions were clear. Three mentioned specific questions that were problematic, but in regard to personal information deficits: one person could not define a specific medical term used as a defining characteristic, another felt unable to remember "specifics" about fluid volume deficit, a third had difficulty with several of the terms. The fourth had considerable difficulty with question 1b throughout ("Please consider each of the characteristics . . . listed. To what extent do you think each represents a defining characteristic of the diagnosis?"). She had interpreted this to mean: "to what extent does each of these fit the definition of a nursing diagnosis?" When specifically asked if changing the directions could have clarified this for her, this pretester felt it would not; nor, in retrospect, could she perceive the source of her confusion. Thus, this question was left unchanged with the investigator planning that completed questionnaires be specifically examined for evidence of unusual responses or patterns of responses that might indicate subjects' having problems with this question. An additional protection was that the instructions included encouragement to contact the investigator about problems related to completing the questionnaire.

Times required to complete the questionnaire ranged from 35 to 90 minutes with an average time of 57.5 minutes. It was this investigator's assumption that if completion of the questionnaire were excessively time

consuming, subjects would become less discriminating in answering or unwilling to finish the questions. One of the diagnoses, Fluid volume deficit, active loss, was dropped from the list with the intention of bringing the completion time for the majority of subjects to between 35 and 45 minutes.

Procedure

Nurse subjects were approached both individually and through their agencies. Nurse practitioners affiliated with the Oregon Nurses Association Nurse Practitioner Special Interest Group were sent a recruitment letter with a post card enclosed on which nurses could indicate an interest in participating, a request for more information, or a request to receive the results of the study (see Appendices I and J). Ninety-three such letters were sent. Twenty-six affirmative replies were received within three weeks. Eleven responses indicated interest in participation but a need for additional information. Thirteen cards were returned with notes regarding ineligibility, and with seven requests for the results of the study. A packet containing a questionnaire identified only by a random number, a consent form, return postage, and a return address label was sent to each nurse practitioner agreeing to participate. The identifying random number was marked on the post card having the subject's name and address, and stored in a master file.

The participation of psychiatric nurses in advanced practice was solicited at a special interest group meeting. The same packet plus a blank post card were given to volunteer subjects to be returned by mail. Questionnaires were also returned by mail by subjects who were solicited

by telephone contact.

Other subjects were solicited through their employing agencies. These included two rehabilitation nursing units, two home health agencies in the greater Portland area, and two facilities in another urban part of Oregon. In each case, a supervisor assisted with volunteer recruitment. Completed questionnaires were returned to a central location in the agency and picked up by the investigator. Subjects' names and addresses were placed on the recruitment post cards and their questionnaires also were only identifiable by assigned numbers.

Ninety questionnaires were distributed in the manner described. At the conclusion of the data collection, fifty-three had been returned. Some nine additional questionnaires were returned after the data analysis was completed and were not included in the study.

Data Analysis

The data generated were analyzed using descriptive statistics. The percentage of respondents accepting (agreeing with) the diagnostic label was calculated. The criterion for acceptance of a diagnosis at the National Conferences has been 51% and this standard was applied to the data generated in question 1a to determine the validation of a diagnosis.

In question 1b, the mean of the agreement scores for each defining characteristic was calculated. The characteristics are listed in a chart form with each diagnostic label according to the "Mean Agreement Score."

Questions 3 and 4 had scores ranging from 1 to 5; a mean "utility" score and "importance" score was computed and displayed in chart form

with the data for each diagnosis.

Responses to open-ended questions (2 and 5) were categorized and are presented in summary in the text and in total in Appendix L.

CHAPTER 3

RESULTS

The results of the study will be presented in the following order: (a) sample, (b) results related to the total group of diagnoses, and (c) results related to 4 of the 14 diagnoses. The results of only 4 diagnoses will be presented and discussed in the text. However, the complete results from the Inventory are in Appendix K and the complete results from the Nursing Diagnosis Questionnaire are in Appendix L.

Sample

The sample consisted of fifty-three registered nurses in Oregon. Data were collected to describe the sample regarding their preparation and experience in nursing. In addition, three questions were directed to the subjects' exposure to information about nursing diagnosis and the use of nursing diagnosis in practice. The results are summarized here. Complete data are in Appendix L.

Age. The subjects' age ranged from 24 to 56 years. The mean age was 34.5 years. The distribution is shown in Figure 1.

Preparation in nursing. The subjects were asked to give their basic preparation in nursing as well as the highest degree or certificate held. Basic preparation at the associate degree, baccalaureate and master's levels, as well as diploma programs were included. No subjects claimed doctoral level basic preparation. The largest group (56%) had entered practice with baccalaureate degrees. (See Figure 2.)

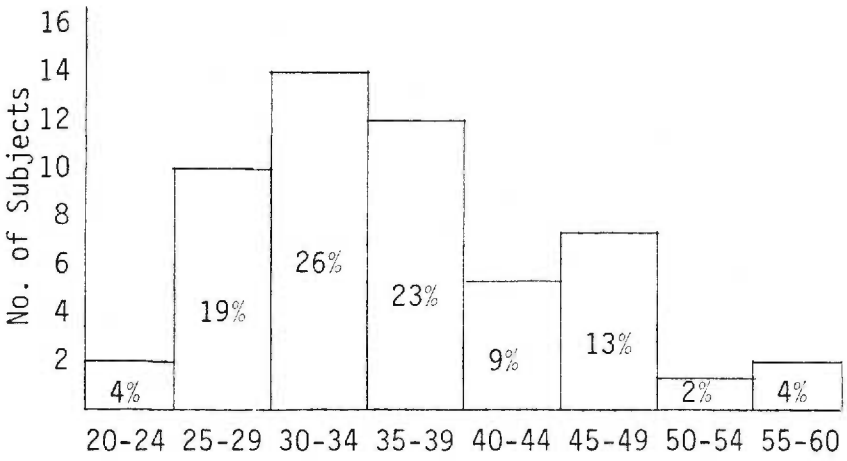


Figure 1. Age of participants.

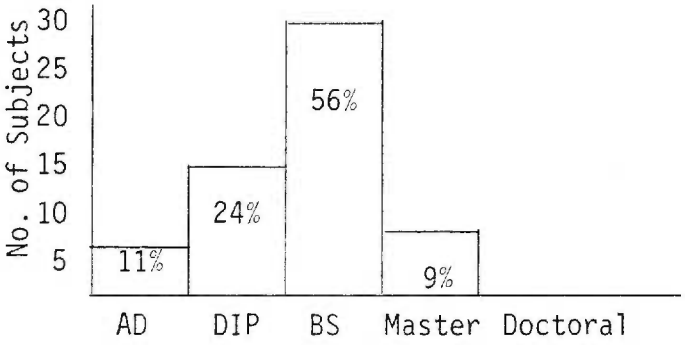


Figure 2. Subjects' basic preparation in nursing.

Subjects indicated their highest degree or certificate at all possible levels of nursing preparation, except doctoral. Baccalaureate and Master's preparation in non-nursing areas were indicated as well. Of the thirty-two subjects, 56% had the baccalaureate in nursing as the highest degree held. (Table 1) Twenty-five subjects responded that they had advanced preparation in a clinical specialty. Family practice, psychiatry/mental health, and gerontology were most often named (28%). The complete list of specialty areas is contained in Appendix K.

Table 1

Highest Degree or Certificate Held by Subjects

Degree or certificate	n	%
Baccalaureate degree in nursing	32	60
Non-degree nurse practitioner program	8	15
Diploma from hospital school of nursing	5	9
Associate arts degree in nursing	3	6
Master's degree in nursing	2	4
Baccalaureate degree, non-nursing	2	4
Master's degree, non-nursing	1	2
Doctoral degree in nursing	0	0
Associate arts degree, non-nursing	0	0
Doctoral degree, non-nursing	0	0

Current practice setting and specialty area. Subjects practice in in-patient and out-patient settings of various sorts. The largest groups were in ambulatory care (21%) and home health care (36%). (Table 2.) All specialty areas on the questionnaire were represented.

The largest single specialty area represented was community nursing (41%). Table 3 shows the specialty areas of the nurses in the sample.

Experience in nursing. Three questions were asked about the nurses' experience in nursing: (a) the number of years in the present practice setting, (b) the number of years in the claimed specialty area, and (c) the number of years in practice. While the largest number were new to their present practice area, the nurses were experienced in both the specialty area and in nursing (Figures 3a, 3b, and 3c).

Table 2

Current Practice Setting of Subjects

Practice setting		n	%
Hospital		4	7
Long-term care facility		5	9
Ambulatory care*		11	21
Home health care		19	36
Private practice		6	11
Other:	schools	2	4
	corrections	4	7
	mental health emergency unit	3	6
	ER	1	2

*Several subjects separately listed clinic, college health service, health maintenance organization, and community mental health center. These areas have been included as ambulatory care settings.

Table 3

Nursing Specialty Area of Subjects

Area		n	%
Maternity		2	4
Children		3	6
Mental Health		9	16
Medical		6	11
Surgical		3	6
Community		22	41
Geriatric		6	11
Oncology		1	2
Other:	Rehabilitation	2	4
	Pain unit	1	2
	Adult health	2	4
	Family practice	3	6
	OB/GYN	1	2
	College health	1	2

*Subjects indicated more than 1 response each.

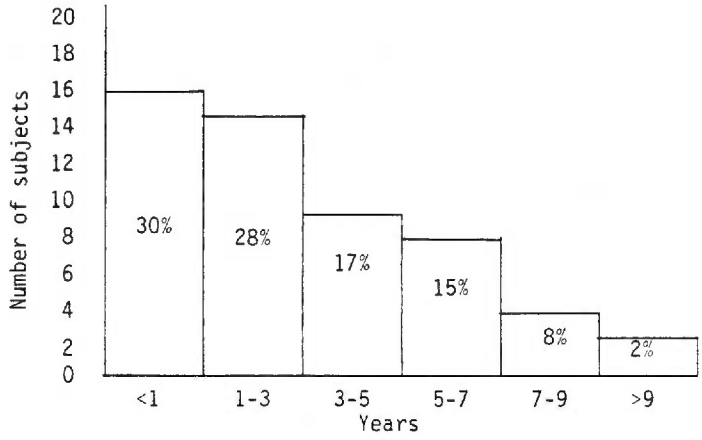


Figure 3a. Number of years in present practice setting.

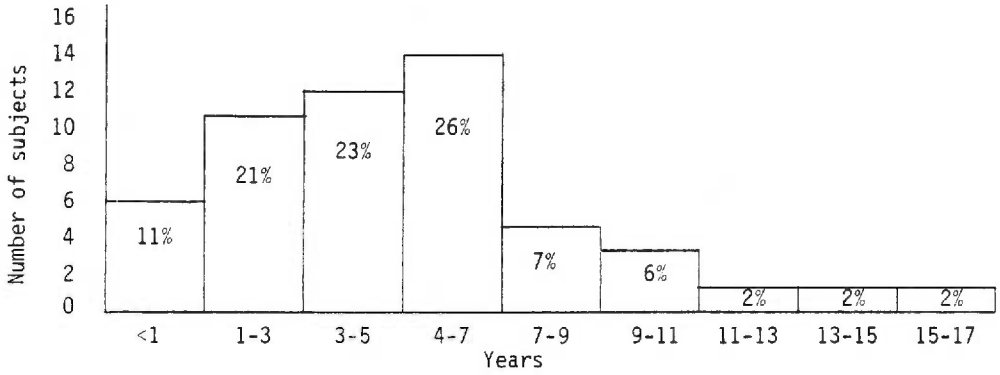


Figure 3b. Number of years in specialty area.

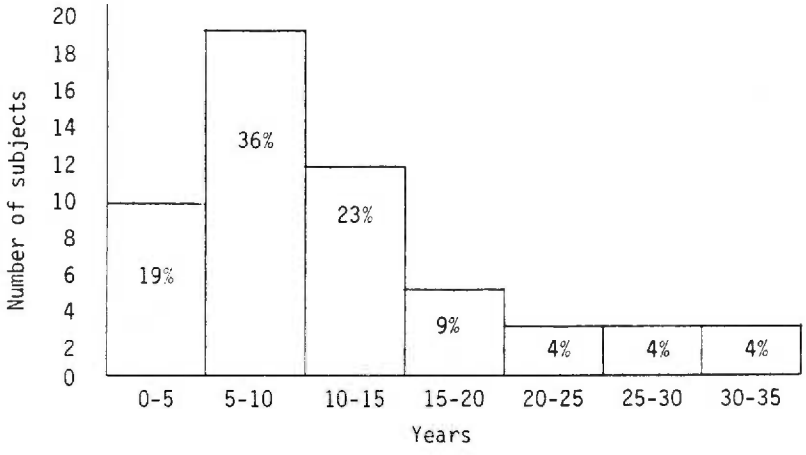


Figure 3c. Number of years in practice.

Finally, the nurses indicated a familiarity with the area of nursing diagnosis through inservice education, undergraduate or graduate nursing programs. Of the subjects, 74% use and chart their own nursing diagnoses occasionally or frequently, 21% always; 44% indicated they chart from a list of diagnostic labels; 26% said they are required to use and chart nursing diagnoses in their practice. The complete data are in Appendix K.

Validation of the Diagnostic Labels as Nursing Diagnoses

Validation was seen as more than 51% of the sample agreeing that the diagnostic label with its defining characteristics constituted a nursing diagnosis as defined in the study. As previously stated, this is consistent with the methodology of the National Conferences. All 14 of the diagnoses in the study were so validated. Of the diagnoses, 4 received 100% validation. The lowest percent score was 83%. The validation of each diagnosis can be seen in Table 4.

Validation of Defining Characteristics

The highest possible agreement score for the characteristics was 6. The highest mean agreement score for any characteristic was 5.92. The lowest was 3.94, the only mean score below 4.00. The characteristics have been re-ordered under each diagnosis in Appendix L so that those with strongest agreement are at the top and those with lowest agreement are at the bottom of the list. Participants omitted occasional items in this area, in some cases marking "don't know" in the questionnaire, but more often without comment. One subject omitted the entire section under a diagnosis. In one diagnosis (Fluid volume deficit, potential) one item was omitted four times, another three times, and two items were

Table 4

Validation of Diagnosis

Diagnostic Label	Percent		
	Yes	No	Don't Know
1. Mobility, impairment of	100	-	-
2. Body image, alteration in	100	-	-
3. Grieving	98	-	2
4. Alteration in nutrition, more than body requirements	90	4	6
5. Alteration in nutrition, less than body requirements	94	4	2
6. Alteration in comfort, pain	98	-	2
7. Functional performance, variations in self care	92	4	4
8. Functional performance, variations in home maintenance management	83	8	9
9. Alterations in patterns of sexuality	88	6	6
10. Non-compliance	92	4	-
11. Fluid volume deficit, potential	96	4	-
12. Parenting, alterations in	86	8	6
13. Altered levels of consciousness	100	-	-
14. Sensory-perceptual alterations	100	-	-

omitted once each. Complete data are available in Appendix L.

Identification of Alternative Labels

Alternative labels were given for each diagnosis. In many cases respondents used this question to indicate that another label would be

desirable, but did not and/or could not offer an alternative. These comments were added to the comments list so that only specific alternative labels were listed. A complete list of alternative labels proposed for each diagnosis is included in Appendix L with the data related to that diagnosis. A summary of proposed alternative labels will be included in the discussion of the 4 specific diagnoses which follows.

Perceived Utility and Importance

Participants were asked to indicate their perception of the utility of the diagnosis in their own practice and then for the profession of nursing. The highest score possible was 5.0. Of the diagnoses, 13% received a mean score between 3.00 and 4.00 ("moderately" to "quite" useful). The highest was 3.98 for Alterations in comfort, pain; the lowest, 2.98 given to Parenting, alterations in. In the second area, mean scores ranged from 3.58 (Alterations in sexuality) to 4.57 (Alterations in comfort, pain). The scores for each diagnosis are shown in Table 5.

Comments

Some comments were made about each diagnosis, although not by every participant. Comments largely fell into the following categories:

1. Explanations of responses to the label or characteristics.
2. Opinions of the label.
3. Observations or suggestions regarding the characteristics.
4. Observations about the diagnosis itself.

The comments are listed with the diagnoses in Appendix L.

Table 5

Mean Scores of Perceived Utility/Importance

Diagnosis	Own Practice	For Profession	
1. Mobility	3.85	4.23	53
2. Body image, alteration in	3.57	4.15	53
3. Grieving	3.87	4.25	53
4. Alteration in nutrition, more than body requirements	3.26	3.68	53
5. Alteration in nutrition, less than body requirements	3.55	3.85	53
6. Alteration in comfort, pain	3.98	4.57	53
7. Functional performance, variations in self care	3.60	4.06	53
8. Functional performance, variations in home maintenance management	3.35	3.65	53
9. Alterations in patterns of sexuality	3.09	3.58	53
10. Non-compliance	3.88	4.08	52
11. Fluid volume deficit, potential	3.45	3.92	53
12. Parenting, alterations in	2.89	3.96	53
13. Altered levels of consciousness	3.68	4.21	52
14. Sensory/perceptual alterations	3.71	3.98	52

Specific Findings for Four Diagnoses

The findings and discussion of 4 specific diagnoses will be presented in the text. Whenever data regarding the diagnoses have been summarized, the complete data are in Appendix L. The tabulated findings for each of the 14 diagnoses are to be found in Appendix L as well and

may be studied in the same manner as the 4 presented in the text. The 4 diagnoses chosen are (a) one which received both high validation and a high score of importance to the profession: Mobility, impairment of, (b) one receiving fairly high validation and a fairly high mean importance score: Functional performance, variations in self care, (c) the one receiving the lowest validation and a low mean importance score: Functional performance, variations in home maintenance management, and (d) one receiving a low validation but fairly high score of perceived importance: Parenting, alterations in.

Mobility, impairment of. Of the subjects, 100% validated the diagnosis. Mean scores of agreement for the characteristics show the greatest range of any diagnosis in the study--from 5.83 to 3.94. The list of characteristics with mean agreement scores are shown in Table 6. Of the sample, 15% preferred an alternative label for the diagnosis and its cluster of symptoms. Of the 8 labels given, 4 added a phrase that either further defined the condition ("2° to" or "related to") or indicated the extent of impairment, 3 rephrased the diagnostic label still using forms of the word mobility, and 1 recommended the use of a precise statement of observations. Measures of perceived utility/importance were close to 4 ("quite") as shown in Figure 4. The comments included two which would prefer more specificity. Two others requested differentiation between psychological and physiological factors. Five comments were favorable and spoke to the perceived importance or utility of the diagnosis. Two comments were directed toward the characteristics associated with perception: one subject suggested that "focusing on immobility when altered perception is involved may be a case of missed

Table 6

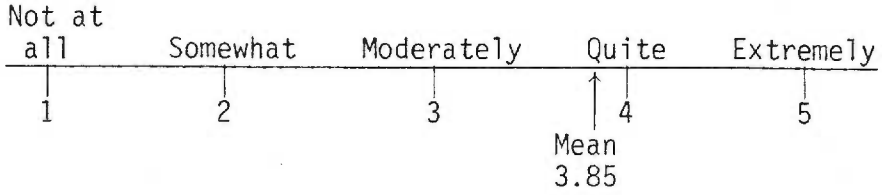
Agreement with Defining Characteristics:

Mobility, Impairment of

Defining characteristics	Mean Agreement Score	n
Altered perception of presence of body part(s)	5.83	53
Reluctance to attempt movement	5.73	53
Limited active range of motion	5.47	53
Goals incongruent with abilities	5.41	53
Altered perception of position of body part(s)	5.40	52
Inability to move	4.98	53
Alteration in coordination of movement	4.83	53
Perceived inability to move	4.77	53
Decreased muscle strength and/or control	4.62	53
Imposed restrictions of movement	3.94	53

priorities"; while another subject pointed out the overlap into areas of "neurological and/or psychological problems."

How useful do you think this diagnosis is in terms of your own practice?



How useful/important is this diagnosis for the profession of nursing?

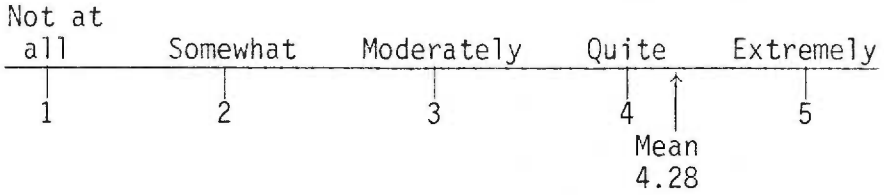


Figure 4. Mean perceived utility/importance scores: Mobility, impairment of.

Functional performance, variations in self care. The diagnosis and characteristics were validated by 92% of the subjects. The "no" and "don't know" choices each received 4% of the responses. The defining characteristics all received fairly high mean agreement scores, with the lowest being 5.40. (Table 7.) Of the subjects, 40% indicated the choice of an alternative label. Of these labels, 12 used the term ADL (activities of daily living), and 1 included a "related to _____" clause. Various phrasing to describe limitations in self care were used in 4 other labels, while another 2 referred to "daily living activities." The mean scores of perceived utility/importance are shown in Figure 5.

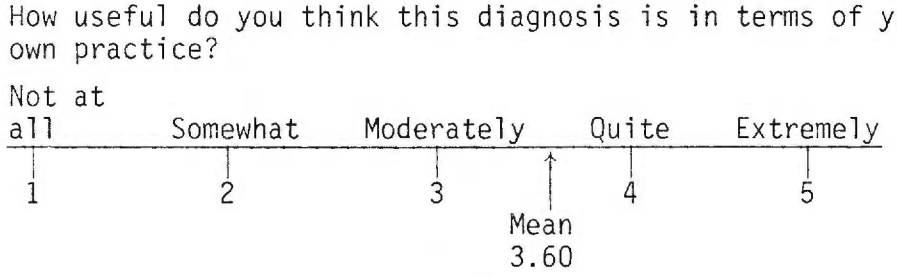
Comments regarding this diagnosis include recommendations about various characteristics, comments regarding areas of overlap with other diagnoses, and a criticism of the area as too broad. Two comments were made about the conceptualization of the diagnosis; one subject wondered

Table 7

Agreement with Defining Characteristics, Functional Performance, Variations in Self Care

(n = 53)

Defining characteristics	Mean Agreement Score
Inability to participate in any self care activity	5.77
Alteration in ability to feed self	5.58
Alteration in ability to bathe self	5.60
Alteration in ability to perform personal hygiene & grooming	5.60
Alteration in ability to dress self	5.53
Alteration in ability to use toilet	5.53
Alteration in ability to move in bed	5.40



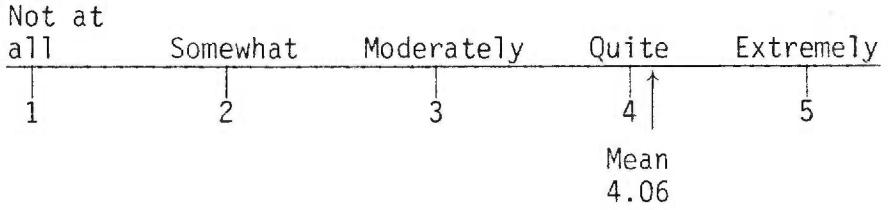


Figure 5. Mean utility/importance scores: Functional performance, variations in self care.

why the diagnosis only deals with "ability" in relation to variations in self care performance. Another recommended adding data to clarify the difference between physical handicaps/limitations and refusal on the part of the patient.

Functional performance, variations in home maintenance management. This diagnosis received 83% validation, the lowest of the group of diagnoses studied. Mean scores of agreement with the characteristics ranged from 5.65 to 4.96. (Table 8.) Of the fifty-two responses to question two, 21% indicated a preference for another label. Of the 21%, 3 preferences included "home management" but dropped "functional performance," 3 referred to difficulty in "home environment," 1 simply stated "social problems," and another chose to refer to "inability to maintain adequate health standards." The mean scores of perceived utility/importance (see Figure 6) were 3.35 and 3.65 respectively.

Seven comments indicate criticisms of the label as "too broad" or too "wordy," although one subject finds it "erudite, but correct." Six comments were directed toward the characteristics and four comments reflected how the subjects handle this problem in their own practice setting. Two comments address the question of whether or not this diagnosis is in the domain of nursing (giving some explanation for either the negative or "don't know" validation choice, as well as for the relatively low scores of utility/importance).

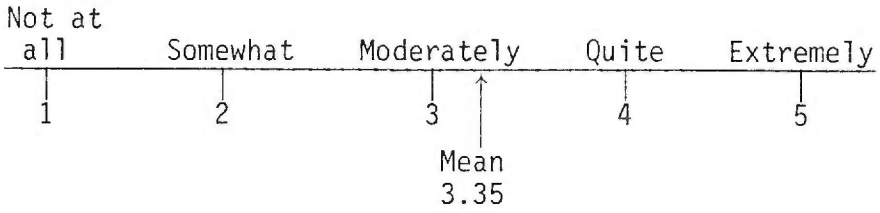
Table 8

Agreement with Defining Characteristics: Functional Performance, Variations in Home Maintenance Management

(n = 52)

Defining characteristics	Mean Agreement Score
Household members express difficulty in maintaining their home in a comfortable fashion	5.65
Accumulation of dirt, food wastes or hygienic wastes	5.60
Repeated hygienic disorders, infestations or infections	5.50
Unwashed or unavailable cooking equipment, clothes or linen	5.44
Lack of necessary equipment or aids	5.35
Overtaxed family members, e.g., exhausted, anxious	5.27
Reports from health workers	5.19
Household requests assistance with home maintenance	5.10
Household temperature overly warm or cool	5.04
Household members describe outstanding debts or financial crises	4.96

How useful do you think this diagnosis is in terms of your own practice?



How useful/important is this diagnosis for the profession of nursing?

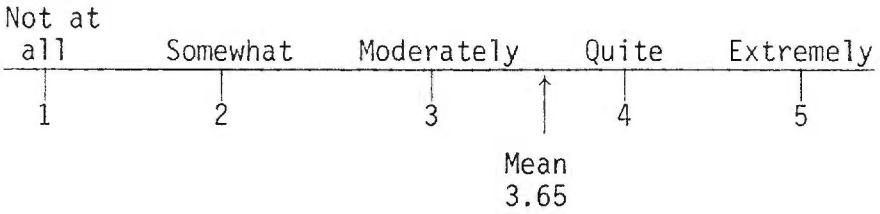


Figure 6. Mean utility/importance scores: Functional performance variations in home maintenance management.

Parenting, alterations in. This diagnosis had the second lowest validation of 86% with 8% choosing "no" and 6%, "don't know." The highest agreement score in validating the characteristics was 5.57 with the lowest, 4.24. (Table 9.) Alternative labels were recommended by 24% with four of the choices given being in the child abuse/neglect area and nine alternative labels dealing with parenting patterns or parenting skills. Two recommended citing the specific problem. The perceived utility score for subjects' own practice is the lowest in the study. However, subjects identify the diagnosis as quite important to the profession (see Figure 7).

The comments are not easily summarized. The label is criticized as "too general" by two subjects. Another is pleased because it is non-judgmental. Five comments related to the need to consider cultural

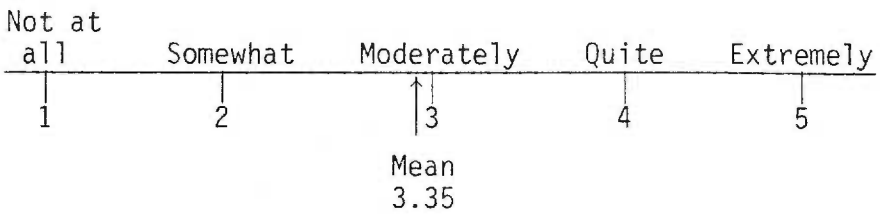
Table 9

Agreement with Defining Characteristics:

Parenting, Alterations in

Defining characteristics	Mean Agreement Score	n
Lack of parental attachment behaviors:		
negative attachment of meanings to infant/child's characteristics	5.48	52
negative identification of infant/child's characteristics	5.47	53
inappropriate visual, tactile, auditory stimulation	5.45	53
Verbalization of resentment towards the infant/child	5.66	53
History of child abuse or abandonment by primary caretaker	5.66	53
Abandonment	5.58	53
Constant verbalization of disappointment in gender or physical characteristics of the infant/child	5.57	53
Inappropriate caretaking behaviors	5.47	53
Evidence of physical and psychosocial trauma	5.41	53
Verbal disgust at body functions of infant/child	5.40	53
Inappropriate or inconsistent discipline practices	5.34	53
Verbalization of role inadequacy	5.26	53
Growth and development lag in the child	5.21	52
Child receives care from multiple caretakers without consideration for the needs of the infant/child	5.21	52
Frequent accidents	5.17	53
Runaway	5.15	53
Verbalization cannot control child	5.11	53
Non-compliance with health appointments for self and/or infant/child	5.02	53
Frequent illness	4.93	53
Compulsively seeking role approval from others	4.79	53
Verbalizes desire to have child call him/herself by first name versus traditional cultural tendencies	4.24	53

How useful do you think this diagnosis is in terms of your own practice?



How useful/important is this diagnosis for the profession of nursing?

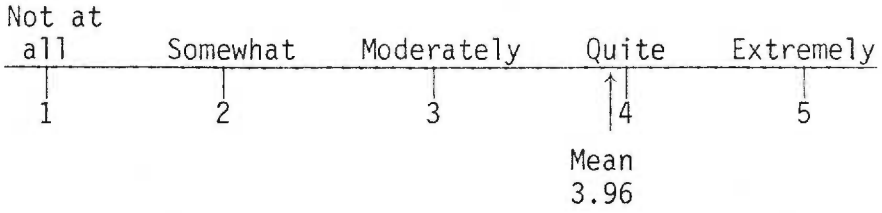


Figure 7. Mean utility/importance scores: Parenting, alterations in.

variations and to the concern that some of the characteristics are judgmental. Two subjects recommend separation of the two related concepts that seem to be involved.

CHAPTER 4

DISCUSSION

Sample

The research design is based on a sample that has sufficient clinical experience to retroactively validate the diagnoses--to recognize a nursing diagnosis when presented with one. The characteristics surveyed indicate that most of the subjects were not naive to the concept of nursing diagnosis and, while new in the present position, were experienced in the specialty area and in nursing.

Instruments

The pretesting of the nursing diagnosis questionnaire indicated that the procedure was quite time-consuming. It is not possible to evaluate whether the length of the task interfered with the subjects' attention or critical judgment. All questionnaires were completed, however.

The first questionnaire returned caused some concern regarding the validity of the data obtained by the questionnaire. The response pattern was extremely consistent: all diagnoses were validated and all defining characteristics given the highest rating. However, the lowest possible utility and importance scores were given for each item. The pattern might have passed unnoticed except the respondent included a "critique" on the instruction page indicating disagreement with the "idea of nursing diagnosis" and questioning a separate body of nursing knowledge.

It was decided not to discard this questionnaire since it was noticed originally only because of the respondent's comments, but to be aware of this particular halo effect in interpreting the data as well as the possibility that other respondents' feelings about nursing diagnosis could produce unexpected results. No other questionnaires had a single consistent response pattern throughout, however.

The more usual pattern of halo effect might be expected in this study so that if a subject values the diagnosis highly, he/she would rate all the defining characteristics positively without considering each individually. This is especially problematic with the checklist rating format used in the questionnaire (Oppenheimer, 1966). A pattern of uniform high agreement was not found consistently in the rating of the characteristics; however, halo effect cannot be ruled out as a threat to the validity of that portion of the results. Oppenheimer (1966) recommends having rating scales on separate pages to help offset halo effects. Such separation does occur frequently in the questionnaire, although by chance, not design. It seems that the time factor could also produce a halo effect as subjects become fatigued and give less attention to individual characteristics.

The halo phenomenon may also affect the validation scores themselves, causing subjects to choose to agree with an expert opinion rather than disagree. This is of particular concern where the validation is >75%, yet 40% would prefer another label or the diagnosis is not perceived as very useful in practice. This is compensated for, to some extent, by the open-ended questions that generate information about disagreement with the diagnoses.

One reason for pretesting a questionnaire is to reveal questions that are worded in a misleading fashion. One such problem was not revealed in pretesting but emerged later. In the second item in Section K of the Inventory of Professional Characteristics (Appendix K), the third and fifth sections refer to use of a list of diagnostic labels without the qualifier "nursing." Subjects who work in some county community mental health centers are required to use the Diagnostic and Statistical Manual, 2nd Edition, for diagnostic labels. Their positive answers in these items produce somewhat misleading data regarding the sample.

In the Inventory of Professional Characteristics, subjects were asked to give the county in which they were employed. This data did not prove helpful. Subjects were also asked if they had "advanced preparation in a clinical specialty (i.e., were a clinical specialist). Subjects apparently misunderstood and responded regarding operating room and intensive care unit preparation as well as the expected responses.

The data on the highest degree or certificate held may be misleading if used to assume the level of academic preparation in nursing. Some subjects solicited through the Nurse Practitioner special interest group and psychiatric advanced practice group lack the master's degree only by virtue of not having completed a thesis despite being certified as Nurse Practitioners. Thus they are part of the group claiming a baccalaureate as the highest degree held.

Discussion of Four Diagnoses

Mobility, impairment of. The diagnosis was validated by 100% of

the sample. However, the other findings indicate that the subjects see room for improvement. The characteristic "goals incongruent with abilities" received the lowest mean agreement score of the study and its association with that diagnosis becomes suspect. Of the sample, 85% were content with the label and all the suggestions used a variation of the word mobility, so the label is probably satisfactory. The comments add further input to evaluate regarding the conceptualization of individual characteristics. Further refinement of the diagnosis using the data is possible.

Functional performance, variations in self care. This diagnosis also has a high validation. However, 8% of the sample chose "no" or "don't know." The comments do not give any indication of the subjects' reasons. The defining characteristics all have fairly high mean agreement scores. However, 40% of the subjects chose to attach another label to the diagnosis. Although most of the alternative labels deal with the Activities of Daily Living (ADL) term, some also use the self care terminology. The label is not very acceptable to the subjects. However, the diagnosis is perceived as important to nursing and more than moderately useful, and so it clearly warrants a place in the list of accepted diagnoses. The comments identify and overlap the diagnosis of impairment of mobility. Another comment is made about the conceptualization: "Why the emphasis on ability here? People vary self-care performance for other reasons . . . " It may be that the lower validation of this diagnosis results primarily from some of the subjects' distaste for the lengthy label. A group reviewing this diagnosis would need to evaluate the comments and incorporate/integrate the new input in view of the high

percentage of subjects preferring another label.

Functional performance, variations in home maintenance management. The validation of this diagnosis is the lowest in the group; only one diagnosis has a lower score of perceived importance to the profession. The comments address two major problems with the diagnosis as a whole: nine comments are critical of the label as "too general" or "too wordy"; two identify this problem as out of the domain of nursing. Nurses do not always agree on the domain of nursing or the scope of nursing. This diagnosis exposes one of the many "gray areas" where the professional boundary lines are less certain and clinicians disagree. Other comments address the problem of the defining characteristics seeming judgmental. Further development of the diagnoses could respond to the problem of the seemingly unwieldy label and the defining characteristics. However, the diagnosis will probably still be hotly contested in some settings/ circles regarding the scope of nursing dilemma.

Parenting, alterations in. The results for this diagnosis are mixed. The validation score is low and the perceived importance in the subjects' own practice is the lowest in the study. This probably reflects the low number of subjects who deal with children and families (see Appendix K). However, the perceived importance to the profession is somewhat higher. Both the comments and the alternative labels give a strong indication of the direction for further development: the conceptual separation into two diagnoses, one in the area of parenting and parenting skills, the other involving the issues of child abuse and/or neglect.

The data regarding the remaining ten diagnoses can be similarly interpreted to suggest direction for the further development of the

diagnoses. One diagnosis that received a high validation had few suggestions regarding alternative labels and all but defining characteristic has a mean score of more than 5.00; the comments dealt primarily with the characteristics, suggesting possibilities to consider/reconsider regarding this diagnosis. In two cases, more than 40% of the sample indicated a desire for a different label and more than 25 alternative labels were suggested for each, indicating a need for evaluation of the diagnoses. In some of the diagnoses, alternative labels fall into distinct groups that, with the comments, suggest the need for attention to the conceptualization of the diagnoses, which seem to encompass more than one issue. For example, sexuality, alterations in seems to contain issues of both sexuality and sexual function. Subjects also question which aspects of grieving are "normal" and which require intervention by nurses.

Looking at the mean agreement scores of the defining characteristics identifies items that were questioned and in several of the diagnoses the comments reveal the subjects' concern. For example, regarding Alteration in nutrition: more than body requirements, the characteristic "weight gain of five pounds or more in a month" received a mean agreement score of 4.75 and four comments were addressed to the idea that altered nutrition is not the only factor influencing weight gain.

The findings regarding Alterations in patterns of sexuality may serve to identify another "gray area," with 12% of the sample choosing "no" or "don't know" in question 1a and comments that "intervention requires special preparation" and "relationship to nursing care depends

on precipitating factors."

Data from the questionnaires were made available to the small groups working on perfecting diagnoses at the Fourth National Conference for Classification of Nursing Diagnoses in April 1980. If the small group work reveals decisions to delete or to change diagnoses in the directions that seem indicated by this study's results, that would serve to validate the results of this study.

Limitations

The study is limited by the small size of the sample. Other limitations regarding the sample are that subjects were self-selected and not representative of all areas of nursing practice. The study did not address all the diagnoses accepted at the Third National Conference. The tendency of subjects to agree rather than disagree when no alternative is offered and to agree with what is perceived as an "expert opinion" can be viewed as a limitation of the design of the study, possibly producing scores that are inflated.

CHAPTER 5

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

There have now been four National Conferences for the Classification of Nursing Diagnoses. A list of "accepted" diagnoses has appeared after each such conference. It was the purpose of this study to establish consensual validation of a group of the diagnoses with their defining characteristics which were developed and accepted at the Third National Conference.

A sample of 53 Oregon nurse clinicians completed a Nursing Diagnosis Questionnaire developed for the study in which the same series of five questions was applied to each of 14 nursing diagnoses. Validation of a diagnosis was determined by a positive response indicating that the diagnosis and its defining characteristics fit the definition of a nursing diagnosis used for the study: a client/patient condition which is actually or potentially unhealthful and which nursing intervention can help to change in the direction of health.

The diagnoses are developed and initially validated by a national group of about 100 nurses and are based on the nurses' experiences in and perceptions of nursing and nursing practice. Before developing more elaborate research models and/or field trials, it is important to demonstrate that the diagnoses represent a clinical entity/phenomenon of nursing to nurses beyond that small circle. It is possible to further

establish the consensual validation of the diagnoses by presenting the labels and characteristics to a different sample of nurses for approval (Gordon & Sweeney, 1979).

All 14 of the diagnoses were validated as indicated by >51% of the sample agreeing that the label and defining characteristics described a nursing diagnosis as defined in the study. Additional questions addressed (a) the extent of agreement that each of the characteristics represented a defining characteristic of that diagnosis, (b) possible alternative labels the subjects attach to the same cluster of characteristics, (c) the usefulness of that diagnosis in the subjects' own practice, and (d) the perceived importance of the diagnosis for the profession of nursing. An opportunity for comments was included. A mean agreement score was determined for each defining characteristic, allowing determination of which characteristics were seen as most strongly associated with the diagnosis. Mean scores of perceived usefulness in practice and importance for the profession were determined and alternative labels used/preferred by subjects were identified. The subjects' comments clarified their responses, addressed the conceptual development of the diagnoses, and/or recommended changes in the list of characteristics for a particular diagnosis. The results thus establish consensual validation of the diagnoses and suggest a direction or directions for further development for each diagnosis as well as possible directions for research.

The results of this study were part of the information given to the small groups working on development of individual diagnoses at the Fourth National Conference in April 1980.

Conclusions

Each label with its defining characteristics was validated as representing a nursing diagnosis as defined in the study. Because of the tendency of these percentage scores to be high, those with validation of less than 90% are somewhat questionable and indicate a need to reevaluate or further develop the diagnosis. Mean agreement scores determined for each defining characteristic allowed identification of those characteristics that subjects perceived as most strongly or weakly associated with the diagnosis. Alternative labels were identified and, in some cases, indicate the nature of the subjects' disagreement with the diagnosis and/or directions for change. The perceived importance of the diagnoses in the subjects' own practice and for the profession was determined and assists more realistic interpretation of the high validation. Evaluation of the findings for each diagnosis reveals a suggestion of the possible direction for further development of the concept.

Because the study did not address all the diagnoses accepted at the Third Conference, in the strictest sense, it cannot then be assumed that all the remaining diagnoses would also be validated. Nonetheless, in a circular fashion the process of the National Conferences in developing the diagnoses is validated when the products of the process are validated. This enhances the confidence that other diagnoses that have been developed by that process would also prove to be meaningful to nurses in practice.

The Nursing Diagnosis Questionnaire permits both documentation of validation and the gathering of information that can suggest directions for the further development of the diagnosis. Such a mechanism is needed

if consensual validation is sought beyond the group processes used by the National Conferences. This methodology allows input into the process from a larger number of nurses.

The development of the diagnosis has been considered an inductive approach to defining the domain of nursing (Roy, 1975a). Validation of the diagnoses gives confidence that this work is meaningful in helping define concepts, the preliminary work of theory building (Kritek, 1978). Similarly, identifying "gray areas," as with Functional performance, variations in home maintenance management, helps focus attention on those areas where nurses disagree on what is nursing's domain.

Recommendations

For this investigator, primarily a clinician, the study allows use of the nursing diagnosis labels in practice with increased certainty that the terms represent nursing diagnoses and using them allows individual practice to be focused on nursing care and nursing process.

Where the results indicate the need to differentiate between two concepts seeming to be included within the same diagnosis, it is recommended that a clarifying statement/phrase be added. For example, the findings seem to indicate the need to separate out issues of parenting skills versus child abuse or neglect in the diagnosis Parenting, alterations in (see Appendix L). One might choose to record the diagnosis as "Alterations in parenting, poor parenting skills" or "Alteration in parenting, current physical abuse of child."

Use of the diagnostic labels in communication about nursing problems and nursing care with other nurses, nursing students, and agencies

delivering nursing care will also provide increasing opportunity for nurses in practice to begin to use nursing diagnoses as a language with which to communicate about nursing practice.

Further research of many kinds is important for the area of nursing diagnosis. Research regarding these diagnoses might include a study of what "symptoms" are most often present when nurses make a certain diagnosis to validate the defining characteristics and define others from a current clinical focus rather than a retrospective one.

It may be assumed that those who did not volunteer to participate in the study are different from the sample in some manner. A survey might be made using the Nurse Practitioner Interest Group to evaluate the characteristics and attitudes of non-volunteers. Replication of this study should attempt to compensate for the limitations of the relatively small number of diagnoses presented to a small sample. Yet, acknowledging that the questionnaire may have been too long, the researcher might reduce its length by decreasing the number of diagnoses presented to each subject. Within a larger and more representative sample, different groups of subjects would receive different groups of diagnoses.

Some changes are recommended in the instruments before future use.

1. In the inventory of professional characteristics
    a. Item F: Insert "current" before "practice setting."
    b. Item B: Omit "County in which employed."
    c. Item E: Evaluate terminology "advanced preparation in a clinical specialty" to discover a way to exclude continuing education for inservice and advanced on-the-job training.
    d. Item K: Insert "nursing" before "diagnosis" in the second and

fifth statements. Substitute "make" for "use" in the fourth statement.

e. Item D: Develop a category that will identify those clinicians who lack the master's degree only by virtue of not having completed the thesis requirement.

2. In the Nursing Diagnosis Questionnaire, Format

a. Consider changing the order of the questions so that the agreement with defining characteristics is the last item and using both forms in a more extensive pretest to see if the results are significantly different.

b. Question 1b: Change to read "To what extent do you agree that each . . . " to correspond with the terminology of the rating scale.

c. Question 2: Change to read "Do you attach . . . " to more precisely correspond with the intent of identifying alternative labels used by nurses.

A change in the procedure of the Fourth National Conference has omitted the process of voting on the diagnoses at the conclusion of the conference. This process had provided the initial consensual validation of the diagnoses. Therefore, methods for establishing concensual validation become increasingly important in the development of the diagnoses. At the same time, diagnoses are now more often being initially developed by individuals or groups and at regional conferences and then submitted to the National Group for further development and acceptance.

It is recommended that this study's methodology be evaluated for use in validating diagnoses that have been generated by individuals or

groups before the diagnoses are submitted to the National Conference Group. This would insure obtaining measurable consensual validation from the outset. Then, after the diagnoses are accepted at the National Conference level, more complex research could be planned to further test their validity. Such a procedure would provide the "grass roots" participation of more nurses in the development of nursing diagnosis, as well as increase their interest in and, hopefully, use of nursing diagnosis labels.

REFERENCES

ANA Convention '76. American Journal of Nursing, 1976, 76, 1126.

Angell, R. C. Consensus. In J. Gould & W. L. Kolb (Eds.), A dictionary of the social sciences. New York: The Free Press, 1964.

Aspinall, M. J. Nursing diagnosis: The weak link. Nursing Outlook, 1976, 24, 433-436.

Avant, K. Nursing diagnosis: Maternal attachment. Advances in Nursing Science, 1979, 2, 45-55.

Babbie, E. R. Survey research methods. Belmont, California: Wadsworth Publishing Co., Inc., 1973.

Bircher, A. U. On the development and classification of diagnoses. Nursing Forum, 1975, 14, 10-29.

Bloch, D. Some crucial terms in nursing: What do they really mean? Nursing Outlook, 1974, 22, 689-694.

Bloom, B. S. (Ed.) Taxonomy of educational objectives: The classification of educational goals handbook I: Cognitive domain. New York: David McKay Co., 1956.

Bowers, R. V. Validity. In J. Gould & W. L. Kolb (Eds.), A dictionary of the social sciences. New York: The Free Press, 1964.

Brown, M. The epidemiological approach to the study of nursing diagnoses. Nursing Forum, 1974, 13, 346-359.

Bruce, J. A. Implementation of nursing diagnosis: An administrator's perspective. Nursing Clinics of North America, 1979, 14, 509-515.

Bullough, B. Law and the expanding nurse role. In N. Chaska (Ed.), The nursing profession: Views through the mist. New York: McGraw-Hill, 1978.

Campbell, A. A., & Katona, G. The sample survey: A technique for social science research. In L. Festinger & D. Katz (Eds.), Research methods in the behavioral sciences. New York: The Dryden Press, 1953.

Campbell, C. Nursing diagnosis and nursing intervention in nursing practice. New York: John Wiley & Sons, 1978.

Carnevali, D., & Little, D. The diagnostic statement: The problem defined. In J. Walter, G. Pardee, & D. Molbo (Eds.), Dynamics of problem-oriented approaches: Patient care and documentation. New York: J. B. Lippincott, 1976.

Castles, M. R. Research plan. Unpublished research proposal, 1976.

Chambers, W. Nursing diagnosis. American Journal of Nursing, 1962, 62, 102-104.

Conference names four priorities in evaluation plan. American Nurse, August 20, 1979.

Dalton, J. M. Nursing diagnosis in a community health setting. Nursing Clinics of North America, 1979, 14, 525-531.

Dickoff, J., James, P., & Weidenbach, E. Theory in a practice discipline. Part I: Practice-oriented theory. Nursing Research, 1968, 17, 415-435.

Durand, M., & Prince, R. Nursing diagnosis: Process and decision. Nursing Forum, 1966, 4, 50-64.

Field, L. The implementation of nursing diagnosis in clinical practice. Nursing Clinics of North America, 1979, 14, 497-508.

Fredette, S., & O'Connor, L. Nursing diagnosis in teaching and curriculum planning. Nursing Clinics of North America, 1979, 14, 541-552.

Fry, V. The creative approach to nursing. American Journal of Nursing, 1953, 53, 301-302.

Gebbie, K. M. Development of a taxonomy of nursing diagnosis. In J. Walter, G. Pardee, & D. Molbo (Eds.), Dynamics of problem-oriented approaches: Patient care and documentation. New York: J. B. Lippincott, 1976a.

Gebbie, K. M. (Ed.). Summary of the second national conference, classification of nursing diagnoses. St. Louis: Clearinghouse, National Group for Classification of Nursing Diagnoses, 1976b.

Gebbie, K. M. ANS open forum. Advances in Nursing Science, 1978, 2, 96-98.

Gebbie, K. M. (Ed.). Proceedings of the third national conference on the classification of nursing diagnoses. In press.

Gebbie, K. M., & Lavin, M. A. Classifying nursing diagnoses. American Journal of Nursing, 1974, 74, 250-253.

Gebbie, K. M., & Lavin, M. A. (Eds.). Proceedings of the first national conference on classification of nursing diagnoses. St. Louis: Mosby, 1975.

Gordon, M. Nursing diagnosis and the diagnostic process. American Journal of Nursing, 1976, 76, 1298-3000.

Gordon, M. The concept of nursing diagnosis. Nursing Clinics of North America, 1979, 14, 487-496.

Gordon, M., & Sweeney, M. A. Methodological problems and issues in identifying and standardizing nursing diagnoses. Advances in Nursing Science, 1979, 2, 1-15.

Gordon, M., Sweeney, M. A., & McKeehan, K. Nursing diagnoses: Looking at its use in the clinical area. American Journal of Nursing, 1980, 80, 672-678.

Guzzetta, C. E., & Forsyth, G. L. Nursing diagnosis pilot study: Psychophysiologic stress. Advances in Nursing Science, 1979, 2, 27-44.

Haines, V. M., & Rossi, L. P. Nursing diagnoses related to myocardial infarction. Cardiovascular Nursing, 1979, 15, 11-15.

Henderson, B. Nursing diagnosis: Theory and practice. Advances in Nursing Science, 1978, 1, 75-83.

Hornung, G. The nursing diagnosis: An exercise in judgement. Nursing Outlook, 1956, 4, 29-30.

Jacox, A. Theory construction in nursing: An overview. Nursing Research, 1974, 23, 4-13.

Jones, P. A terminology for nursing diagnosis. Advances in Nursing Science, 1979, 2, 65-71.

Komorita, N. Nursing diagnosis. American Journal of Nursing, 1963, 63, 83-86.

Kritek, P. B. The generation and classification of nursing diagnoses: Toward a theory of nursing. Image, 1978, 10, 33-40.

Kritek, P. B. Commentary: The development of nursing diagnosis and theory. Advances in Nursing Science, 1978, 2, 73-79.

Levine, M. Trophicognosis: An alternative to nursing diagnosis. Exploring progress in medical-surgical nursing practice: ANA Regional Clinical Conferences, 1965, 2, 55-70.

McKay, R. P. What is the relationship between the development and utilization of a taxonomy and nursing theory? Nursing Research, 1977, 26, 222-224.

McKeehan, K. M. Nursing diagnosis in a discharge planning program. Nursing Clinics of North America, 1978, 14, 517-524.

Mundinger, M. O., & Jauron, D. F. Developing a nursing diagnosis. Nursing Outlook, 1975, 23, 94-98.

Oppenheim, A. N. Questionnaire design and attitude measurement. New York: Basic Books, 1966.

Parten, M. Surveys, polls, and samples: Practical procedures. New York: Harper & Brothers, 1950.

Puder, B. What you should know about nursing diagnosis. Medical Record News, 1975, 46, 87-90.

Rothberg, J. S. Why nursing diagnosis? American Journal of Nursing, 1967, 67, 1040-1042.

Roy, Sr. C. The impact of nursing diagnosis. AORN Journal, 1975a, 21, 1023-1028.

Roy, Sr. C. A diagnostic classification system for nursing. Nursing Outlook, 1975b, 23, 90-93.

Soares, C. A. Nursing and medical diagnoses: A comparison of variant and essential features. In N. Chaska (Ed.), The nursing profession: Views through the mist. New York: McGraw-Hill, 1978.

Sokal, R. R. Classification: Purposes, principles, progress, prospects. Science, 1974, 185, 1115-1123.

Standards of Nursing Practice. New York: American Nursing Association Inc., 1973.

The Task Force on Nomenclature and Statistics of the American Psychiatric Association. Diagnostic and statistical manual of mental disorders, 3rd ed. (draft). Washington, D.C.: American Psychiatric Association, 1978.

Weber, S. Nursing diagnosis in private practice. Nursing Clinics of North America, 1979, 14, 533-539.

Working papers and advance mailings. Third National Conference on Classification of Nursing Diagnoses, 1978. Unpublished.

Working papers. Fourth National Conference on Classification of Nursing Diagnoses, 1980. Unpublished.

APPENDIX A

NURSING DIAGNOSES ACCEPTED BY THE NATIONAL CONFERENCE GROUP

Those marked with an asterisk (*) were developed or altered at the Third National Conference.

ANXIETY, MILD
ANXIETY, MODERATE
ANXIETY, SEVERE
ANXIETY, PANIC
BODY FLUIDS, EXCESS
BOWEL ELIMINATION, ALTERATION IN: CONSTIPATION
BOWEL ELIMINATION, ALTERATION IN: DIARRHEA
BOWEL ELIMINATION, ALTERATION IN: IMPACTION
BOWEL ELIMINATION, ALTERATION IN: INCONTINENCE
CARDIAC OUTPUT, ALTERATION IN: DECREASED
CIRCULATION, INTERRUPTION OF
*COMFORT, ALTERATION IN: PAIN
*CONSCIOUSNESS, ALTERED LEVELS OF
*COPING PATTERNS, FAMILY, INEFFECTIVE
*COPING PATTERNS, INDIVIDUAL, MALADAPTIVE
*FLUID VOLUME DEFICIT, ACTIVE LOSS
*FLUID VOLUME DEFICIT, FAILURE OF REGULATORY MECHANISMS
*FLUID VOLUME DEFICIT, POTENTIAL
*FUNCTIONAL PERFORMANCE, VARIATIONS IN
*FUNCTIONAL PERFORMANCE, VARIATIONS IN: HOME MAINTENANCE MANAGEMENT
*GRIEVING
IMPAIRMENT OF SIGNIFICANT OTHERS ADJUSTMENT TO ILLNESS
*INJURY, POTENTIAL FOR
*INJURY, SUSCEPTIBILITY TO HAZARD
*KNOWLEDGE, LACK OF (SPECIFIED AS TO AREA)
*MOBILITY, IMPAIRMENT OF
*NON-COMPLIANCE
*NUTRITION, ALTERATIONS IN: LESS THAN BODY REQUIREMENTS
*NUTRITION, ALTERATIONS IN: MORE THAN BODY REQUIREMENTS
*NUTRITION, ALTERATIONS IN: CHANGES RELATED TO BODY REQUIREMENTS
*PARENTING, ALTERATIONS IN: ACTUAL OR POTENTIAL
RESPIRATORY DYSFUNCTION
*SELF-CONCEPT, ALTERATION IN: BODY IMAGE, SELF-ESTEEM, ROLE PERFORMANCE, PERSONAL IDENTITY
*SENSORY/PERCEPTUAL ALTERATIONS
*SEXUALITY, ALTERATION IN PATTERNS OF
*SKIN INTEGRITY, IMPAIRMENT OF: ACTUAL
*SKIN INTEGRITY, IMPAIRMENT OF: POTENTIAL
SLEEP/REST ACTIVITY, DYSRHYTHM OF
*SPIRITUALITY: SPIRITUAL CONCERNS
*SPIRITUALITY: SPIRITUAL DISTRESS
*SPIRITUALITY: SPIRITUAL DESPAIR
*TISSUE PERFUSION, ABNORMAL, CHRONIC
URINARY ELIMINATION, IMPAIRMENT OF: ALTERATION IN PATTERNS
URINARY ELIMINATION, IMPAIRMENT OF: INCONTINENCE
URINARY ELIMINATION, IMPAIREMENT OF: RETENTION

APPENDIX B

INFORMED CONSENT FORM

I _____, herewith agree to serve as a
First name Middle name Last name
subject in the investigation entitled "Validation Study of Nursing Diagnoses" by Margaret D. McComb, RN, MA, under the supervision of Florence Hardesty, RN, PhD.

The investigation aims at the evaluation of professional consensus for 14 nursing diagnoses and identifying characteristics for each, as developed by the Third National Conference on Classification of Nursing Diagnoses. My participation will require spending about thirty minutes completing a questionnaire. There are no risks involved with this procedure. I understand that I will not directly benefit as a result of my participation, but that the resulting data may assist in the development of the profession of nursing.

I understand that the information obtained will be confidential and that my anonymity will be protected by the use of code numbers to identify individual questionnaires. A master list of participants' names and assigned code numbers will be kept in a locked drawer.

Margaret D. McComb has offered to answer any questions I might have about my participation in this study. I understand that I am free to refuse to participate or to withdraw from participation at any time without effect on my employment at _____ or professional affiliation.

It is not the policy of the Department of Health, Education and Welfare, or any other agency funding the research project in which you are participating, to compensate or provide medical treatment for human subjects in the event the research results in physical injury. The University of Oregon Health Sciences Center, as an agency of the state, is covered by the State Liability Fund. If you suffer injury from the research project, compensation would be available to you only if you establish that the injury occurred through the fault of the Center, its officers or employees.

I have read the above and agree to participate in this investigation.

_____ _____
Date Participant's signature

_____
Witness's signature

APPENDIX C

INVENTORY OF RELEVANT PROFESSIONAL CHARACTERISTICS

Code # _____

INVENTORY OF RELEVANT PROFESSIONAL CHARACTERISTICS

A. Age _____ B. County in which employed _____

Please check (✓) appropriate answers:

C. Basic preparation in nursing
- __ 1. diploma from hospital school of nursing
- __ 2. associate arts degree in nursing
- __ 3. baccalaureate degree in nursing
- __ 4. master's degree in nursing
- __ 5. doctoral degree in nursing

D. Highest certificate or degree held
- __ 1. diploma from hospital school of nursing
- __ 2. associate arts degree in nursing
- __ 3. baccalaureate degree in nursing
- __ 4. master's degree in nursing
- __ 5. doctoral degree in nursing
- __ 6. associate arts degree, non-nursing
- __ 7. baccalaureate degree, non-nursing
- __ 8. master's degree, non-nursing
- __ 9. doctoral degree, non-nursing
- __10. non-degree nurse practitioner program

E. Do you have advanced preparation in a clinical specialty?
__ No __ Yes (please specify) _____

F. Practice setting
- __ 1. hospital
- __ 2. nursing home or long-term care
- __ 3. ambulatory care
- __ 4. home health care
- __ 5. private practice
- __ 6. other (please specify) _____

G. How long have you worked in this practice setting? _____

H. Specialty area in nursing
- __ 1. maternity
- __ 2. children
- __ 3. mental health
- __ 4. medical nursing
- __ 5. surgical nursing
- __ 6. community nursing
- __ 7. geriatric nursing
- __ 8. oncology nursing
- __ 9. other (please specify) _____

Code # _____

Relevant Professional Characteristics

I. How many years in practice (NOT number since graduation)? ____ Years
How many years in specialty area? ____ Years

J. Previous exposure to material regarding nursing diagnosis:

__ 1. none
__ 2. familiar with the term, but have no specific information
__ 3. continuing education program
__ 4. inservice program
__ 5. basic nursing program
__ 6. graduate nursing program
__ 7. participation in a nursing diagnosis workshop to generate and/or refine diagnostic terms

K. Use of nursing diagnosis in own practice.

1. Do you:

	never	occasionally	frequently	always
use term "nursing diagnosis"				
make own nursing diagnoses but don't chart them				
use diagnostic labels from a list but don't chart them				
use & chart own nursing diagnoses				
use & chart from a list of diagnostic labels				

2. Does the agency where you work:

__ 1. require use & charting of nursing diagnoses
__ 2. require use & charting of nursing diagnoses from an accepted list of labels
__ 3. have forms with a space for a nursing diagnosis
__ 4. have no official acknowledgment of nursing diagnoses

APPENDIX D

NURSING DIAGNOSIS QUESTIONNAIRE, FORMAT

1. Please consider the following diagnosis with its list of defining characteristics ("symptoms").

   Diagnosis _____

   Defining characteristics

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

1a. Do you recognize this diagnosis and the characteristics as fitting the definition of a nursing diagnosis as defined in this study? (For definition, see "Directions," pg. 1)

___ 1. yes

___ 2. no

___ 3. don't know

1b. Please consider each of the characteristics ("symptoms") listed. To what extent do you think each represents a defining characteristic of the diagnosis?

(Please check ( ) one answer in each row)

		Strongly agree	Moderately agree	Somewhat agree	Somewhat disagree	Moderately disagree	Strongly disagree
1	_____						
2	_____						
3	_____						
4	_____						
5	_____						
6	_____						
7	_____						
8	_____						

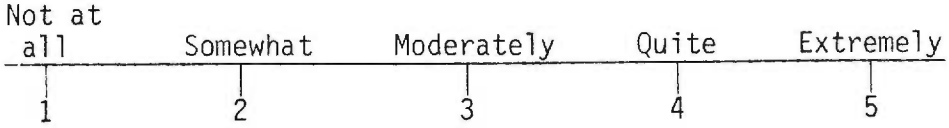
2. Would you attach another (different) label to this same cluster of characteristics?

___ no

___ yes

3. How useful do you think this diagnosis is in terms of your own practice?

(Please circle appropriate number)



4. How useful/important is this diagnosis for the profession of nursing?

(Please circle appropriate number)

Not at all	Somewhat	Moderately	Quite	Extremely
1	2	3	4	5

5. Do you have any comments regarding this diagnosis?

_____

_____

_____

APPENDIX E

SAMPLE: NURSING DIAGNOSIS QUESTIONNAIRE

NURSING DIAGNOSIS QUESTIONNAIRE Code # _____

Please consider the following diagnosis with its list of defining characteristics ("symptoms").

Diagnosis: FUNCTIONAL PERFORMANCE, VARIATIONS IN SELF CARE

Defining characteristics:

Inability to participate in any self care activity

Alteration in ability to feed self

Alteration in ability to bathe self

Alteration in ability to perform personal hygiene & grooming activities

Alteration in ability to dress self

Alteration in ability to use toilet

Alteration in ability to move in bed

1a. Do you recognize this diagnosis and the characteristics as fitting the definition of a nursing diagnosis as defined in this study? (For definition, see "Instructions")

(1) ___ yes (2) ___ no (3) ___ don't know

1b. Please consider each of the characteristics ("symptoms") listed. To what extent do you think each represents a defining characteristic of the diagnosis?

(Please check (✓) one answer in each row)

FUNCTIONAL PERFORMANCE, VARIATIONS IN SELF CARE	Strongly agree	Moderately agree	Somewhat agree	Somewhat disagree	Moderately disagree	Strongly disagree
Inability to participate in any self care activity						
Alteration in ability to feed self						
Alteration in ability to bathe self						
Alteration in ability to perform personal hygiene & grooming						
Alteration in ability to dress self						
Alteration in ability to use toilet						
Alteration in ability to move in bed						

NURSING DIAGNOSIS QUESTIONNAIRE Code # _____

2. Would you attach another (different) label to this same cluster of characteristics?

___ no ___ yes (specify) _____

3. How useful do you think this diagnosis is in terms of your own practice?
(Please circle appropriate number)

Not at all	Somewhat	Moderately	Quite	Extremely
1	2	3	4	5

4. How useful/important is this diagnosis for the profession of nursing?
(Please circle appropriate number)

Not at all	Somewhat	Moderately	Quite	Exremely
1	2	3	4	5

5. Do you have any comments regarding this diagnosis?

_____

_____

_____

APPENDIX F

NURSING DIAGNOSIS QUESTIONNAIRE
INSTRUCTIONS

Thank you for agreeing to participate in this study of nursing diagnoses.

The first part of the following questionnaire is a survey of your professional background and previous use of nursing diagnoses.

In the second part, you will be asked to validate 15 different nursing diagnoses which were developed by the Third National Conference on Classification of Nursing Diagnoses in 1978.

In each case you will be asked to consider a single diagnostic label with its defining characteristics or symptoms. The first question requires that you reflect on your nursing experience and evaluate if the patient or client condition described by the label (diagnosis) and its defining characteristics fits this study's definition of a nursing diagnosis:

> "a client/patient condition which is actually or potentially unhealthful, and which nursing intervention can help to change in the direction of health."

Following that you will be asked to consider each defining characteristic or symptom individually and to indicate the extent to which you agree or disagree that each is a characteristic of the particular patient or client condition.

Question 1b regarding the characteristics asks "To what extent do you think the following represent....? You are asked to respond "strongly agree", "moderately agree", "somewhat agree", "somewhat disagree", etc. in a series of boxes to the right of each defining characteristic. This requires one check mark (✓) representing the degree of your agreement next to each defining characteristic.

Next, because you may be very familiar with the condition being described but use a different name for it in your practice, question 2 asks you to give an alternative label you use.

Last, you are asked to consider the usefulness and importance of this diagnosis in questions 3 and 4. You are asked to respond by circling a number on a rating scale. For example, if you think a given diagnosis is only somewhat useful in your practice of nursing but considerably more important to the profession of nursing, your questionnaire might look like this:

3. How useful do you think this diagnosis is in terms of your practice?
   (Please circle appropriate number)

Not at all	Somewhat	Moderately	Quite	Extremely
1	(2)	3	4	5

4. How useful/important is this diagnosis for the profession of nursing?
   (Please circle appropriate number)

Not at all	Somewhat	Moderately	Quite	Extremely
1	2	3	(4)	5

Directions also accompany each question.

Do not put your name on the questionnaire. The questionnaires are identified by code number only.

When it is completed, please mail the questionnaire to me in the enclosed envelope. If you have any questions about completing the questionnaire or any other aspect of the project, please contact me:

Margaret (Peggy) McComb
8022 SW 19th Avenue
Portland, OR 97219
(503) 244-1570

APPENDIX G

INSTRUCTIONS FOR PRETESTERS

Thank you for volunteering to pretest the questionnaire for my research project.

The purpose of the project is to obtain information from a group of nurses regarding 15 nursing diagnoses from the Third National Conference on the Classification of Nursing Diagnoses. The reason for pretesting the questionnaire is to make sure that both the questions and directions will be clar and to estimate the time needed to complete the task.

Therefore, I am asking you to complete the questions on the 15 nursing diagnoses and then to complete the "Questions for Pretest Participants" which is the last sheet. Please call me if you have any questions about this (244-1570). Please return the questionnaire and pretest questions to me in the enclosed envelope as soon as possible.

Thank you for your assistance,

Margaret D. McComb

APPENDIX H

QUESTIONS FOR PRETEST PARTICIPANTS

1. Please specifically describe any problem(s) you had in understanding the general directions of the questionnaire.

2. Please specifically describe any problem(s) you had in understanding the questions themselves.

3. How long did it take you to complete the questions on all 15 diagnoses (not counting any interruptions, of course)?

4. What other comments do you have about the questionnaire?

APPENDIX I

RECRUITMENT LETTER

I am a graduate student in the School of Nursing at the University of Oregon Health Sciences Center. I obtained your name from the Oregon Nurses' Association's list of the nurse practitioner special interest group.

My master's thesis is a validation study of 14 of the nursing diagnoses developed at the Third National Conference for the Classification of Nursing Diagnoses. I am looking for nurses who are at least 50% in direct patient care to complete a questionnaire as part of that study. This will replicate the process that takes place at the National Conference where the diagnoses which are the product of small task groups are validated or rejected by all the participants. I plan to report on this project at the Fourth National Conference this year, as well as send the results to the Clearinghouse for the National Group for Classification of Nursing Diagnoses. That means that if you decide to participate, your contribution will have more impact than simply "helping a poor student through school."

If you are willing to participate and you meet the 50% direct patient care requirement, will you so indicate on the enclosed post card and send it back to me? I will then mail you a consent form and the questionnaire.

If you have any questions, please contact me or so indicate and send back the post card.

Margaret (Peggy) McComb

8022 SW 19th Avenue
Portland, OR 97219
(503) 244-1570

APPENDIX J

RESPONSE POST CARD

____ I would like to participate in your study; please send the materials.

____ I am interested in participating, but I need more information <u>first</u> regarding

____ I would like to receive the results of the study.

Name: _____ Phone: _____
(Please print)

Address: _____

_____

_____

APPENDIX K

TABULATED DATA FROM QUESTIONNAIRE: INVENTORY OF PROFESSIONAL CHARACTERISTICS

1. Age

Range: 24-56

Median: 35

Mean: 34.5

Distribution:

Age	n	%
20-25	2	4
25-29	10	19
30-34	14	26
35-39	12	23
40-44	5	9
45-49	7	13
50-54	1	2
55-60	2	4
Total	53	100

2. County in which employed	n
Multnomah	25
Lane	8
Washington	6
Clackamas	4
Lincoln	3
Douglas	2
Union	1
Park	1
Malheur	1
Yamhill	1
Marion	1
Total	53

3. Basic Preparation in Nursing

Degree/diploma	Number	%
Associate arts degree in nursing	6	11
Diploma from hospital school of nursing	13	24
Baccalaureate degree in nursing	29	56
Master's degree in nursing	5	9
Doctoral degree in nursing	0	0
Total	53	100

4. Highest certificate or degree held

Certificate/degree	n	%
Baccalaureate degree in nursing*	32	60
Non-degree nurse practitioner program*	8	15
Diploma from hospital school of nursing	5	9
Associate arts degree in nursing	3	6
Master's degree in nursing	2	4
Baccalaureate degree, non-nursing	3	4
Master's degree, non-nursing	1	2
Doctoral degree in nursing	0	0
Associate arts degree, non-nursing	0	0
Doctoral degree, non-nursing	0	0

*Some artificiality as those with NP certification after completing clinical work for MN, but not completed academic requirements, as well as those who have graduated with certification (non-degree program) may have responded to either of the first choices.

5. Advanced preparation in a clinical specialty

Yes - 25 (47%)

Specialty areas	n
Psychiatry/mental health	6
Family practice/family health	4
Gerontology	4
OB/GYN - maternal-child	3
Pediatrics	2
Coronary care	2
Family planning	1
School health	1
Diabetes	1
Adult medicine	1

6. Practice setting

		n*	%
1. Hospital		4	7
2. Long-term care facility		5	9
3. Ambulatory care**		11	20
4. Home health care		19	35
5. Private practice		6	11
6. Other:	schools	2	4
	corrections	4	7
	mental health emergency unit	3	5
	ER	1	2
	Total	55*	100

*Some subjects indicated more than one response.

**The following practice settings listed as "other" were included as ambulatory care: community mental health center, college health service, clinic, health maintenance organization.

7. How long in practice setting?

Range: .12 years to 13 years

Median: 2.0 years

Mean: 2.76 years

Distribution:

Years	n	%
Less than 1	16	30
1-3	15	28
3-5	9	17
5-7	8	15
7-9	4	8
More than 9	1	2

8. Specialty area in nursing

		n	%
1. Maternity		2	3
2. Children		3	5
3. Mental health		9	14
4. Medical nursing		6	10
5. Surgical nursing		3	5
6. Community nursing		22	35
7. Geriatric nursing		6	10
8. Oncology nursing		1	2
9. Other:	rehabilitation	2	3
	pain unit	1	2
	adult health	2	3
	family practice	3	5
	OB/GYN	1	2
	college health	1	2
	Total	62*	101

*Subjects indicated more than one response.

9a. Years in practice

Range: 1.0 to 32

Median: 8

Mean: 9.77

Distribution:

Years	n	%	
0-5	10	19	
5-10	19	36	} 59%
10-15	12	23	
15-20	5	9	
20-25	2	4	
25-30	2	4	
30-35	2	4	

9b. Years in specialty area

Range: 0 to 17

Median: 4

Mean: 4.49

Distribution:

Years	n	%
Less than 1	6	11
1-3	11	21
3-5	12	23
5-7	14	26
7-9	4	7
9-11	3	6
11-13	1	2
13-15	1	2
15-17	1	2

10. Previous exposure to material regarding nursing diagnosis

	n*
1. None	2
2. Familiar with the term, but have not specific information	14
3. Continuing education program	5
4. Inservice program	10
5. Basic nursing program	17
6. Graduate nursing program	15
7. Participation in a nursing diagnosis workshop to generate and/or refine diagnostic terms	5

*Subjects indicated more than one response.

11. Use of nursing diagnosis in own practice

a. Do you:

	Never	Occas	Freq	Always	n
1. Use term "nursing diagnosis"	35% (18)	38% (20)	19% (10)	8% (4)	52
2. Make own nursing diagnoses but don't chart them	33% (16)	46% (22)	21% (10)	0% (0)	48
3. Use diagnostic labels from a list but don't chart them	81% (38)	19% (9)	0% (0)	0% (0)	47
4. Use & chart own nursing diagnoses	4% (2)	23% (12)	51% (26)	21% (11)	51
5. Use & chart from a list of diagnostic labels	56% (27)	14% (7)	25% (12)	4% (2)	48

11. Use of nursing diagnosis in own practice (con't.)

b. Does the agency where you work:

	n	%
__ 1. Require use & charting of nursing diagnoses	14	26
__ 2. Require use & charting of nursing diagnoses from an accepted list of labels	3	6
__ 3. Have forms with a space for a nursing diagnosis	12	23
__ 4. Have no official acknowledgment of nursing diagnosis	24	45

APPENDIX L

TABULATED DATA FROM QUESTIONNAIRES

1. Diagnosis: Mobility, impairment of

   a. Validation: 1) yes 100% 2) no 0% 3) don't know 0%

   b.

Defining characteristics	Mean Agreement	n
Altered perception of presence of body part(s)	5.83	53
Reluctance to attempt movement	5.73	53
Limited active range of motion	5.47	53
Goals incongruent with abilities	5.41	53
Altered perception of position of body part(s)	5.40	52
Inability to move	4.98	53
Alteration in coordination of movement	4.83	53
Perceived inability to move	4.77	53
Decreased muscle strength and/or control	4.62	53
Imposed restrictions of movement	3.94	53

   c. Different label? 1) no 85% 2) yes 15%

   d. Utility in own practice: mean score 3.85

   e. Importance to profession: mean score 4.28

   f. Alternative labels given:

   - immobility
   - use of precise subjective/objective observations
   - physical impairment of mobility
   - lack of mobility
   - inability to move related to _____
   - decreased mobility 2° to _____
   - impaired mobility 2° to _____
   - mobility, followed by qualification, e.g., limited impairment, complete impairment

g. Comments:

- characteristics associated with perception cross over - areas involving neurological and/or psychological difficulties
- use it frequently (2)
- make it more specific
- focusing on the immobility when altered perception is involved may be a case of missed priorities
- regarding #4: add "for mobility" after "goals": label perception or omit
- most important diagnoses nurses make
- group characteristics under: 1) psychogenic
  2) somatogenic
- good in terms of standardization
- needs objective clarification
- differentiate between psychosomatic/psychological and physical
- what about external variables, i.e., ramps - may be part of "imposed restrictions" - clarify as internal/external
- the nursing diagnosis needs to reflect that intervention will be different in differing etiologies, e.g., catatonia vs. cast
- would use the diagnosis, but would record a term more specific to individual patient's problem
- in a mental health practice, especially useful relative to tardive dyskinesia

2. Diagnosis: Body image, alteration of

a. Validation: 1) yes 100% 2) no 0% 3) don't know 0%

b. Defining characteristics	Mean Agreement Score	n
Non-verbal response to actual or perceived change in structure and/or function	5.64	53
Verbal response to actual or perceived change in structure and/or function	5.62	53
Clinically validated by:		
actual change in structure and/or function	5.68	53
preoccupation with change or loss	5.60	53
missing body part	5.56	53
verbalization of negative feelings about body	5.51	52

b. Defining characteristics (con't.)	Mean Agreement Score	n
verbalization of fear of rejection by others	5.48	52
focuses on past strength, function or appearance	5.46	52
verbalization of fear of reaction of others	5.44	52
change in ability to estimate spatial relationship of body to environment	5.34	53
hiding or overexposing body part	5.32	53
not looking at body part	5.30	53
verbalization of feelings of helplessness	5.27	52
not touching body part	5.24	53
(intentional or unintentional) trauma to non-functioning part	5.19	52
verbalization of feelings of hopelessness	5.17	52
verbalization of change in life style	5.17	52
change in social involvement	5.15	53
verbalization of feelings of powerlessness	5.13	52
emphasis on remaining strengths - heightened achievement	4.96	53

c. Different label: 1) no 92% 2)yes 8%

d. Utility in own practice: mean score 3.57

e. Importance to profession: mean score 4.15

f. Alternative labels given:

- alteration in body image as evidenced by _____ (giving physical, social, verbal, nonverbal indicator)
- altered body image

g. Comments:

- regarding group of characteristics beginning with "verbalizes":
  - the "fear of" is the characteristic, verbalization would be the first step in a related goal
  - verbalization of fears, negative feelings, may not be a problem
- hopelessness, helplessness can have other components than the obvious disability
- use body image diagnosis when there is a physical change, label helplessness, hopelessness as low self-esteem
- wonder about need to conceptually separate neglect demonstrated by an amputee 2° to denial and grief from neglect demonstrated by a patient with a Rt CVA (organic etiology)
- need to be aware of potential for this when even routine surgery is done
- overlaps altered self-concept, low self-esteem
- very broad, need more specificity (2)
- probably more useful in hospital setting
- looks good

3. Diagnosis: Grieving

a. Validation: 1) yes 98% 2) no 0% 3) don't know 2%

b.

Defining characteristics	Mean Agreement Score	n
Verbal expression of distress at loss	5.71	53
Sadness	5.69	53
Crying	5.67	53
Expression of unresolved issues	5.66	53
Anger	5.64	53
Interference with life functioning	5.63	52
Expression of guilt	5.58	53
Alterations of sleep patterns	5.55	53
Reliving of past experiences	5.53	52
Denial of loss	5.52	52
Difficulty in expressing loss	5.51	53

b. Defining characteristics (con't.)	Mean Agreement Score	n
Alterations in eating habits	5.51	53
Alterations in activity level	5.50	53
Alterations in concentration and/or pursuit of tasks	5.49	53
Idealization of lost object	5.43	53
Developmental regression	5.28	53
Labile affect	5.28	53
Altered libido	5.19	53
Alterations in dream patterns	5.17	53

c. Different label? 1) no 87% 2) yes 13%

d. Utility in own practice: mean score 3.87

e. Importance to profession: mean score 4.25

f. Alternative labels given:

- depression
- reaction to loss of significant other
- unresolved guilt
- grief process/pathological grief

g. Comments:

- some characteristics overlap with depression - need to differentiate (3)
- concern about differentiating between the normal process of grieving and grief process which is potentially unhealthful or problematic (4)
- isn't "unresolved grieving" a medical diagnosis?
- how does one identify "difficulty in expressing loss"?
- would prefer another label but cannot identify one
- label "too broad"
- great - all components pertinent
- clear description of characteristics

4. Diagnosis: Alteration in nutrition, more than body requirements

a. Validation: 1) yes 90% 2) no 4% 3) don't know 6%

b.

Defining characteristics	Mean Agreement Score	n
Obesity reflected by weight of 20% or more over ideal body weight	5.57	53
Reported intake indicates more than body requirements	5.26	53
Weight gain of 5# or more in a month	4.75	53
Skinfold thickness at triceps greater than 15 mm for men and 25 mm for women	4.75	52
Denial of excessive food intake	4.45	53
Perceives weight gain as related to glandular factors	4.43	53

c. Different label? 1) no 53% 2) yes 47%

d. Utility in own practice: mean score 3.26

e. Importance to profession: mean score 3.68

f. Alternative labels given:

- obesity (10)
- excessive weight gain (3)
- excessive weight 2° to _____ (2)
- overweight (5)
- unwanted/undesired weight gain
- obesity plus a comment regarding the effect of the condition on the person
- excessive food intake
- weight gain → obesity
- weight gain related to _____
- sudden weight gain
- difficulty in maintaining optimal dietary intake
- nutritional concerns
- addictive process in relation to food

g. Comments:

- too wordy, needs simplification, contrived-sounding (5)
- nutrition not the only factor affecting weight gain, e.g., 5 lb weight gain/month could be due to edema (4)
- 5 lb weight gain has different implication in thin and fat persons
- football players are all >20% over ideal weight
- may not be an alteration, may be a lifetime pattern
- need to be concerned with effect of obesity or weight gain (2)
- add: a psychological factor
- add: profound inactivity for age; perception of body image
- label should suggest approach

5. Diagnosis: Alteration in nutrition, less than body requirements

a. Validation: 1) yes 94% 2) no 4% 3) don't know 2%

b. Defining characteristics	Mean Agreement Score	n
20% or more under ideal body weight	5.53	53
Aversion to eating	5.49	53
Reported inadequate food intake	5.43	53
Loss of weight with adequate food intake	5.32	53
Reported or evidence of lack of food	5.28	53
Perceived inability to ingest food	5.28	53
Lack of interest in food	5.27	52
Weakness of muscles required for swallowing or mastication	5.17	53
Reported altered taste sensation	5.00	53
Sore, inflamed bucal cavity	4.98	53
Diarrhea and/or steatorrhea	4.98	53
Satiety immediately after ingesting food	4.75	53
Abdominal pain with or without pathology	4.75	53

b. Defining characteristics (con't.)	Mean Agreement Score	n
Abdominal cramping	4.68	53
Hyperactive bowel sounds	4.62	53
Poor muscle tone	4.57	53
Pale conjunctiva and mucus membranes	4.53	53
Excessive loss of hair	4.43	53
Capillary fragility	4.41	53
Lack of or mis- information	4.36	52
Misconceptions	4.36	52

c. Different label? 1) no 56% 2) yes 46%

d. Utility in own practice: mean score 3.55

e. Importance to profession: mean score 2.85

f. Alternative labels given:

- underweight (3)
- under nutrition
- malnutrition/malnourishment (7)
- inadequate intake/inadequate nutritional intake (2)
- inadequate nutrition (3)
- weight loss
- weight loss, undesired or unhealthful (2)
- sudden weight loss
- inadequate body weight
- loss of appetite/anorexia (2)
- difficulty in maintaining adequate dietary intake to maintain wt/nutrition
- specify, e.g., 20% <normal weight for height and frame
- weight for height <___%
- inability to eat due to _____

g. Comments:

- too wordy, please simplify, too broad
- word salad - nutrition & digestion mixed
- too many characteristics
- several characteristics do not serve to further define diagnosis
- concern is that client weight's too little for good health; characteristics listed to not sum up to the diagnosis; each indicates a different problem that could be a diagnosis alone; each requiring different sorts of intervention
- need to separate emotional and physical etiologies
- some characteristics seem to be etiologies
- several characteristics are not specific to the diagnosis - examples given: lack of information, misconceptions (4)
- how about having the body image of being fat?
- don't see problem often
- 20% of my patients have this problem
- like label - "takes the sting out of skinny (or fat)" - more descriptive than malnutrition

6. Diagnosis: Alteration in comfort, pain

a. Validation: 1) yes 98% 2) no 0% 3) don't know 2%

b. Defining characteristics	Mean Agreement Score	n
Communication (verbal or coded) of pain descriptors	5.79	53
Guarding behavior - protective	5.62	53
Self focusing	5.04	52
Narrowed focus:		
altered time perception	5.07	53
withdrawal from social contact	5.07	53
impaired thought process	5.00	53
Distraction behavior:		
moaning	5.55	53
crying	5.45	53
pacing	5.28	53

b. Defining characteristics (con't.)	Mean Agreement Score	n
seeks out other people and/or activities	4.41	53
restless	5.33	53
Facial mask of pain:		
eyes - lack luster, "beaten look", fixed or scattered movement	5.47	53
grimace	5.58	52
Alteration in muscle tone - may span from listless to rigid	5.32	53
Autonomic responses (seen in acute or episodic pain):		
diaphoresis	5.62	53
Bp and P increases or decreases	5.64	53
dilated pupils	5.32	53
increased or decreased respiratory rate	5.43	53

c. Different labels? 1) no 81% 2) yes 19%

d. Utility in own practice: mean score 3.98

e. Importance to profession: mean score 4.57

f. Alternative labels given:

- pain (5)
- pain with descriptors (2)
- discomfort, uncomfortable
- inability to control pain/inadequate pain control (2)

g. Comments:

- well defined; to-the-point
- covert symptoms listed - only clues to pain, not always indicative
- "beaten look" more suggestive of depression than pain
- would like to explore other possibilities for label
- see problem related to control of pain, not pain itself
- not complete, add: regression; increased hostility; cultural orientation to expression of pain
- distraction behaviors depend on depth of pain
- autonomic responses suggest shock
- little seen in one practice

7. Diagnosis: Functional performance, variations in self care

a. Validation: 1) yes 92% 2) no 4% 3) don't know 4%

b. Defining characteristics	Mean Agreement Score	n
Inability to participate in any self care activity	5.77	53
Alteration in ability to feed self	5.58	53
Alteration in ability to bathe self	5.60	53
Alteration in ability to perform personal hygiene and grooming	5.60	53
Alteration in ability to dress self	5.53	53
Alteration in ability to use toilet	5.53	53
Alteration in ability to move in bed	5.40	53

c. Different label? 1) no 60% 2) yes 40%

d. Utility in own practice: mean score 3.60

e. Importance to profession: mean score 4.06

f. Alternative labels given:

- ADL, functional performance
- ADL (2)
- difficulty managing ADL's
- altered ability to perform ADL's
- inability to independently perform ADL's
- inability to perform ADL's related to _____
- dependency in ADL
- impairment of ADL
- altered performance in ADL
- decreased ADL
- alterations in ADL
- inability to meet daily living activities
- altered ability to care for self
- disability in self care
- deterioration in self care behavior with note on evidence and effect
- limitations in self care
- aids to daily living alteration

g. Comments:

- why the emphasis on "ability" here? People vary self care performance for other reasons than changes in their ability
- add: inability to communicate needs
- related to impairment of mobility
- "alteration in ability to move in bed" belongs with mobility diagnosis
- want to add information when using in terms of physical limitations or refusal on the part of the patient
- "variation" or "alteration" are preferable to "inability"
- too broad

8. Diagnosis: Functional performance, variations in home maintenance management

a. Validation: 1) yes 83% 2) no 8% 3) don't know 9%

b. Defining characteristics	Mean Agreement Score	n
Household members express difficulty in maintaining their home in a comfortable fashion	5.65	52
Accumulation of dirt, food wastes or hygienic wastes	5.60	52
Repeated hygienic disorders, infestations or infections	5.50	52
Unwashed or unavailable cooking equipment, clothes or linen	5.44	52
Lack of necessary equipment or aids	5.35	52
Overtaxed family members, e.g., exhausted, anxious	5.27	52
Reports from health workers	5.19	52
Household requests assistance with home maintenance	5.10	52
Household temperature overly warm or cool	5.04	52
Household members describe outstanding debts or financial crises	4.96	52

c. Different label? 1) no 77% 2) yes 21%

d. Utility in own practice: mean score 3.35

e. Importance to profession: mean score 3.65

f. Alternative labels given:

- home maintenance management, impaired
- difficult home environment
- inability/disability in home management
- inability to manage home environment
- deterioration of home management
- inability to maintain adequate health standards
- loss of control over maintenance of safe, comfortable home
- social problems

g. Comments:

- regarding label
  - big and awkward; couldn't think of another
  - not specific enough (2)
  - too broad (3)
  - too long and wordy (2)
  - "variation" not descriptive here
  - erudite but correct
- not particular to nursing for intervention; dominion of social worker
- "report of health worker" not a characteristic; what is reported may be a characteristic
- "reports from" is too vague
- difficult to judge "acceptable standards"
- "presence of vermin" a neighborhood problem (2)
- a "variation" for one family may be normal for another family, environment, culture
- need something to indicate logical direction of action
- significance exists for patients expected to go home
- can't be known without home visit
- I deal with characteristics, don't use diagnosis at all
- I put financial problems as a separate diagnosis
- agency combines ADL and home management

9. Diagnosis: Alterations in patterns of sexuality

a. Validation: 1) yes 88% 2) no 6% 3) don't know 6%

b. Defining characteristics	Mean Agreement Score	n
Actual or perceived limitation imposed by disease &/or therapy	5.66	53
Verbalization of problem	5.64	53
Inability to achieve desired sexual satisfaction	5.46	53
Misconceptions about sexuality	5.41	53
Knowledge deficit of sexuality	5.36	53
Alteration in achieving sexual satisfaction	5.31	53
Alteration in relationship with significant other	5.26	53
Alterations in achieving perceived sex role	5.24	53
Conflicts involving values	5.17	53
Misinformation of sexuality	5.13	53
Seeking confirmation of desirability	5.09	53
Change of interest in self and others	4.98	53

c. Different label? 1) no 79% 2) yes 21%

d. Utility in own practice: mean score 3.09

e. Importance to profession: mean score 3.58

f. Alternative labels given:

- sexual dysfunction (2)
- dysfunctional or conflictual patterns of sexuality
- perceived problems in sexuality
- sexual problems
- changes in sexuality
- "sexuality" is too general
- list specific problem

g. Comments:

- too broad/general (2)
- "alteration" not satisfactory
- whose patterns? Diagnosis tangential to the issue of unsatisfactory sex life
- characteristics seem to refer to other psychological problems - make subjective judgments of patient
- intervention requires special preparation
- relationship to nursing care depends on precipitating factors
- many characteristics are not discussed with RN
- "lack of knowledge/"misconceptions" are normal for some - i.e., children
- confusing wording - does it deal with sex or sexuality?

10. Diagnosis: Non-compliance

a. Validation: 1) yes 92% 2) no 4% 3) don't know 4%

b. Defining characteristics	Mean Agreement Score	n
Behavior indicative of failure to adhere:		
direct observation	5.79	53
statements by patient or significant others	5.57	53
Unexpected response to prescribed therapeutic regimen or suggested self-care regimen which has been:		
mutually agreed upon by patient and nurse	5.45	53
prescribed by another health care provider	5.17	53
Patient's personal statement of non-compliance	5.62	53
Direct observation of patient not following therapeutic plan	5.60	53
Failure to keep appointments	5.47	53
Family statement regarding patient's behavior	5.26	53
Expressed or observed confusion regarding therapy	5.21	53

b. Defining characteristics (con't.)	Mean Agreement Score	n
Objective tests:		
physiological measures	5.20	53
detection of markers	5.02	51
Evidence of the development of complications	5.15	53
Evidence of the exacerbation of symptoms	5.13	53
Passive resistance	5.11	53
Hostility	4.94	53
Failure to progress	4.62	53

c. Different label: 1) no 83% 2) yes 17%

d. Utility in own practice: mean score 3.88

e. Importance to profession: mean score 4.08

f. Alternative labels given:

- non-compliance, then: "agreed upon by RN and patient" or "Rx'd by health professional"
- non-compliance with treatment plan
- impaired motivation to comply with therapeutic regimen
- lack of motivation
- discharge plan

g. Comments:

- need a term which is more interactional
- dissatisfied with term/label but haven't an alternative (3)
- has "bad" connotation
- can be a diagnosis for either patient or provider
- non-descript
- specify
- good diagnosis, but wouldn't use it unless treatment plan has been fully explained
- may be detrimental vs. useful to profession
- threw this diagnosis out 4 yrs ago - too many non-therapist-related factors - ignores non-detrimental effects of "uncooperative behavior" - a parent-child game perpetuated by therapists
- "mutually agreed upon" should be further defined as "by patient and nurse:
- "failure to progress" has other possible causes
- regarding the use of term "unexpected" in first characteristic:
  - non-compliance is frequent enough to suggest that it is an inappropriate term - almost anything can be expected when dealing with people
  - need to validate failure to adhere
- deal with it under diagnosis such as "inadequate nutritional intake"

11. Diagnosis: Fluid volume deficit, potential

a. Validation: 1) yes 96% 2) no 4% 3) don't know 0%

b. Defining characteristics	Mean Agreement Score	n
High risk factors:		
excessive loss through normal routes (e.g., diarrhea)	5.92	53
extremes of age	5.54	52
extremes of weight	5.40	52
Medications (diuretics)	5.79	53
Deviations affecting access to, intake of, of absorption of fluids (e.g., immobility)	5.76	51
Loss of fluid through abnormal routes (e.g., indwelling tubes)	5.67	49
Factors influencing fluid needs	5.40	53
Knowledge deficiency	5.15	53

c. Different label? 1) no 81% 2) yes 19%

d. Utility in own practice: mean score 3.45

e. Importance to profession: mean score 3.92

f. Alternative labels given:

- potential dehydration (4)
- dehydration (5)
- altered fluid balance
- altered fluid needs
- potential fluid/electrolyte imbalance
- compromised body systems 2° to _____

g. Comments:

- symptoms too general
- "potential" is ridiculous
- add: febrile conditions
- add physical symptoms: cracked lips, decreased elasticity, color of urine, thirst
- "factors influencing fluid needs" is too vague

g. Comments (con't.):

- because of nature of practice, includes body fluids and associated problems with major causative factor
- don't see often
- do not consider this a diagnosis until the actual problem exists - do teach to prevent and so record, but don't list it as a problem

12. Diagnosis: Parenting, alterations in

a. Validation: 1) yes 86% 2) no 8% 3) don't know 6%

b. Defining characteristics	Mean Agreement Score	n
Lack of parental attachment behaviors:		
negative attachment of meanings to infant/child's characteristics	5.48	52
negative identification of infant/child's characteristics	5.47	53
inappropriate visual, tactile, auditory stimulation	5.45	53
Verbalization of resentment towards the infant/child	5.66	53
History of child abuse or abandonment by primary caretaker	5.66	53
Abandonment	5.58	53
Constant verbalization at disappointment in gender or physical characteristics of the infant/child	5.57	53
Inappropriate caretaking behaviors	5.47	53
Evidence of physical and psychosocial trauma	5.41	53
Verbal disgust at body functions of infant/child	5.40	53
Inappropriate or inconsistent discipline practices	5.34	53
Verbalization of role inadequacy	5.26	53

b. Defining characteristics (con't.)	Mean Agreement Score	n
Growth and development lag in the child	5.21	52
Child receives care from multiple caretakers without consideration for the needs of the infant/child	5.21	52
Frequent accidents	5.17	53
Runaway	5.15	53
Verbalization cannot control child	5.11	53
Non-compliance with health appointments for self and/or infant/child	5.02	53
Frequent illness	4.93	53
Compulsively seeking role approval from others	4.79	53
Verbalizes desire to have child call him/herself by first name versus traditional cultural tendencies	4.24	53

c. Different label? 1) no 73% 2) yes 24%

d. Utility in own practice: mean score 2.89

e. Importance to profession: mean score 3.96

f. Alternative labels given:

- suspected child abuse
- child abuse (2)
- negligence
- dysfunctional parenting (2)
- maladaptive parenting
- parenting difficulty (2)
- problems with parent/child interaction
- ineffective parenting
- parenting skill level
- parenting
- name specific problem (2)

g. Comments:

- too general (2)
- "alterations" - is there only 1 way to parent?
  don't like the word in this sense
  - too neutral
  - can't be positive
  - not necessarily a problem
- addresses 2 problems: parenting and child abuse/neglect
- should address parenting skill levels instead of "alterations"
- label non-judgemental
- some characteristics seem to be judgemental (3)
- must be aware of cultural/social variations (2)
- "frequent illness" not necessarily associated with parenting
- add "history of parental abuse"
- need more related to older child

13. Diagnosis: Altered levels of consciousness

a. Validation: 1) yes 100% 2) no 0% 3) don't know 0%

b. Defining characteristics	Mean Agreement Score	n
Changes in response to sensory stimuli	5.73	53
Changes in pupillary response	5.66	53
Alteration in voluntary &/or involuntary motor response	5.60	53
Lethargy	5.52	52
Disoriented in time, place, person &/or situation	5.48	52
Alteration in verbal &/or non-verbal communication	5.44	52
Restlessness	5.41	53
Alteration in coordination	5.38	52
Changes in mobility	5.36	52
Alteration in vital signs	5.35	53
Alteration in abstraction ability	5.31	52

b. Defining characterstics (con't.)	Mean Agreement Score	n
Alteration in conceptualization ability	5.31	52
Alteration in memory	5.31	52
Alteration in body chemistry	5.30	53
Personality change	5.19	52
Inability to problem-solve	5.17	52
Change in behavior	5.13	52
Decreased ability to follow commands	5.13	52
Anxiety	5.04	52
Change in personal appearance and hygiene	5.02	52

c. Different label? 1) no 85% 2) yes 15%

d. Utility in own practice: mean score 3.68

e. Importance to profession: mean score 4.21

f. Alternative labels given:

- altered state of consciousness
- consciousness, altered levels of

g. Comments:

- too broad, too vague
- finally, an understandable use of "alteration"
- characteristics not specific to diagnosis - some related to emotional disorder; ability to abstract not related
- ought to be able to define very objectively - characteristics too subjective

14. Diagnosis: Sensory/perceptual alterations

a. Validation: 1) yes 100% 2) no 0% 3) don't know 0%

b. Defining characteristics	Mean Agreement Score	n
Disoriented to place	5.73	52
Disoriented in time	5.70	53
Measured change in sensory acuity	5.68	53
Hallucinations	5.62	53
Disoriented to persons	5.61	52
Altered abstraction	5.61	52
Altered conceptualization	5.61	52
Change in usual response to stimuli	5.58	53
Change in problem-solving ability	5.56	52
Report of change in sensory acuity	5.51	53
Indication of body image alteration	5.51	53
Change in behavior pattern	5.40	53
Altered communication patterns	5.40	53
Inappropriate responses	5.40	53
Apathy	5.25	52
Irritability	5.24	53
Anxiety	5.23	53
Restlessness	5.15	53
Change in muscular tension	5.07	53
Alteration in posture	5.03	53
Complaints of fatigue	4.90	53

c. Different label? 1) no 89% 2) yes 11%

d. Utility in own practice: mean score 3.71

e. Importance to profession: mean score 3.98

f. Alternative labels given:

- mental illness
- disorientation
- altered thought pattern
- thought disorder
- distorted reality testing
- perceptual alterations
- state specific client problem

g. Comments:

- too general, non-descriptive
- includes both sensory perceptual problem and reality testing problems
- overlaps level of consciousness diagnosis - neither is specific enough - characteristics all pertinent, diagnosis is too broad
- overlaps body image and L.O.C.
- prefer to list observations as mental status exam
- some characteristics should address physical malfunctions associated with, others mental malfunctions
- nice to use instead of "schizophrenia"
- complete and useful
- with all these alterations, I feel like nursing is a branch of tailoring!

AN ABSTRACT OF THE THESIS OF

MARGARET DEETER McCOMB

For the MASTER OF NURSING

Date of Receiving this Degree: June 8, 1980

Title: VALIDATION STUDY OF NURSING DIAGNOSES

Approved: [redacted]
Florence Hardesty, Ph.D., Thesis Advisor

Developing a standard diagnostic nomenclature and a classification of nursing diagnosis has importance for nursing practice, education, and research. The first step is to develop standardized labels for those clinical phenomena nurses identify and treat from nursing knowledge. The purpose of this study was to establish further consensual validation of 14 diagnostic labels with their defining characteristics that were developed and initially validated at the Third National Conference on the Classification of Nursing Diagnoses in 1977. A questionnaire was developed and a sample of nurses in clinical practice was surveyed to:

1. establish validation of each label with its cluster of defining characteristics as representing a nursing diagnosis as defined in the study;

2. establish validation for each of the defining characteristics of each diagnosis;

3. identify alternative labels that nurses may currently attach to that cluster of "symptoms";

4. identify the perceived importance of that label in the nurses' own clinical practice and for the profession. The results produced validation for all the diagnoses used as well as data that provide direction for further development of the diagnoses. The results were part of the data given to the groups engaged in the further development of diagnoses at the Fourth National Conference in April 1980. Validation of these diagnoses, which are the work of the National Conferences, also validates the process of the Conferences. The identification of nursing diagnoses represents the defining of basic concepts of nursing theory. Thus this study contributes to nursing knowledge by adding evidence of the validity of those concepts.