Nursing Diagnosis in the 21st Century

How many of you are scratching your heads right now and thinking, “Nursing diagnosis! Didn’t that die out a long time ago?” Well, no. Not only did it not die, but thanks to a small but concerted group of nurses, nursing diagnosis and its sister classifications for nursing interventions and outcomes also have been growing steadily and gaining a presence worldwide and in the computerized databases that monitor biomedical activity. I recently attended a conference sponsored jointly by the three U.S.-based organizations that promote these efforts. I left the meeting surprised and excited by all that is going on and the potential role that specialty organizations can play in what I believe are vital efforts to ensure that nursing is visible and accounted for.

NANDA International (formerly known as the North American Nursing Diagnosis Association) is doing this work on many levels. The organization continues to develop and promote the use of nursing diagnosis worldwide, but its leadership also is involved in developing the use of all nursing terminologies in the global and cross-professional efforts to monitor and document healthcare activities. These terminologies include NANDA and other taxonomies of diagnostic language as well as the Nursing Interventions Classification (NIC) and the Nursing Outcomes Classification (NOC) developed by groups of nurses based at the University of Iowa. The NANDA/NIC/NOC Alliance joins international nursing groups in Europe, South America, Spain, and Japan in working to define what nurses do and standardize the language so that it becomes relevant in a variety of cultures and meaningful to practicing nurses everywhere. This is no small task but rather one that is vital to nursing’s continued presence at some very important tables.

These efforts are relevant to specialty practice from a couple of standpoints. First, many levels of content need to be “filled in.” A great deal of room exists between labeling an entity (e.g., diagnosis, intervention, outcome) and developing the research base for and conceptual understanding of that label. Many diagnostic labels cross specialties, but each specialty can develop its own perspective on the label, thereby resulting in a richer, more detailed view. Each specialty develops many of its own particular interventions to achieve its desired outcomes. These outcomes, which are so very necessary in validating our professional existence, are being documented on many fronts, and the efforts of the specialty nursing organizations need to be viewed in the larger picture that is nursing worldwide. We need to find ways to tie these efforts together into a more cohesive network. Currently, this work is being done only by individuals. Unless the collaboration begins to occur on an organizational level, the work will not move forward as quickly as it can.

This brings me to my second point—what’s in it for us as a specialty organization? The Oncology Nursing Society can be rightfully proud of its pioneering efforts regarding some seminal nursing diagnoses (e.g., fatigue, risk for infection, caregiver role strain, decisional conflict, ineffective coping). In addition, as an organization, we have identified the importance of outcomes research and can look forward to the results of our funded and ongoing research projects. The potential exists for us to disseminate our efforts to a larger audience, share our work with a wider group of nurses, and strengthen our own efforts by collaborating with those working in basic and advanced ways to ensure that nursing’s contribution to health care is recognized, documented, and tracked. I firmly believe that formal collaboration with NANDA/NIC/NOC could be as advantageous to them as it would be to us. From what I experienced at the meeting, I think that the NANDA leadership is ready to reach out to specialty organizations. We must be ready to meet those contacts and say yes to participating in the effort. I do not think that we will be disappointed, and I believe that we will receive a great deal in return.

Clearly, many of these efforts seem to be far removed from the bedside, where we strive so hard for clinical excellence for our patients. That bedside focus, of course, must continue to be our priority. In the larger picture, however, our goal to transform cancer care cannot be achieved solely at the individual bedside. We must consider our role in the large arena that is cancer care and the even greater arena that is health care worldwide. The steps to take are small and the resources needed are modest, but the potential benefits are substantial. I would hate to see us miss our chance to participate.

Rose Mary Carroll-Johnson, MN, RN
Editor