

NURSING DIAGNOSES COMMONLY DOCUMENTED  
FOR EMERGENCY PATIENTS

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I am submitting herewith a dissertation written by

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entitled Nursing Diagnoses Commonly Documented for  
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## DEDICATION

This dissertation is dedicated to my family--to my husband, Steve, for the hours of support and caring--to my children, Kristin and Ryan, for tackling some of the household duties, for constantly reorienting me to reality, and for never letting me forget that I still was someone's mom.

## ACKNOWLEDGEMENTS

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Nancy Kathleen Miller Baldwin

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ABSTRACT

The problem of study was the validation, by emergency nurses, of investigator generated nursing diagnoses occurring in ill or injured emergency patients. Research questions were:

What is the frequency of occurrence, as estimated by emergency nurses, of selected investigator generated (actual or potential) unhealthful responses and selected investigator generated nursing diagnoses in ill or injured emergency patients?

What additional etiologies are associated with the selected investigator generated (actual or potential) unhealthful responses in ill or injured emergency patients as identified by emergency nurses?

To what extent are those additional etiologies associated with the independent or interdependent role?

The study used the descriptive design. The setting was 59 local chapter meetings of the Emergency Nurses'

Association. The population consisted of emergency nurses who were members of the chapters. Subject were selected by means of a convenience technique, however, cluster sampling was also evident. Ten questionnaires were mailed to each selected chapter (590 questionnaires) and 245 questionnaires were returned (42%).

Four investigator generated instruments were used to collect the data: the Demographic Data Sheet, the Response Component Questionnaire, the Etiology Component Survey, and the Etiology Evaluation Questionnaire. The first three instruments were completed by the sample; the last, by a panel of experts in nursing diagnosis. A degree of content validity was established for the nursing diagnoses through pilot studies, but reliability is unknown. Some degree of reliability for the Etiology Evaluation Questionnaire was established through interrater agreement procedures.

The following findings are discussed. Forty percent of the sample stated they had never been taught to write nursing diagnoses. Forty-seven percent stated they were taught to write nursing diagnoses in their basic nursing programs. None of the response components or nursing diagnoses were observed in greater than 50% of patients

by the majority of subjects. Responses were recognized as occurring in patients by more subjects than were actual diagnoses. A total of 887 different etiologies were generated under the Additional Etiologies section, and 311 (35%) were found to represent independent role. Four of the six most frequently seen response components in greater than 50% of patients were part of the six most frequently seen nursing diagnoses. The least frequently seen response component was part of the least frequently seen nursing diagnosis. One of the most frequently seen response components in greater than 50% of patients was included in one of the least frequently seen nursing diagnoses.



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## CHAPTER I

### INTRODUCTION

In order to be useful a theory must be broad enough to be relevant to members of the profession who will use it. Nursing diagnosis can be viewed as the beginning step in theory development and could be the focus for nursing theory development. Nursing diagnosis represents an attempt by professional nursing to name and classify the phenomena of nursing (Gordon, 1982).

Emergency nursing represents a small part of professional nursing and can be classified as occurring in a critical care setting. Nurses in the emergency setting, as in most critical care settings, function primarily in an interdependent role. The literature reflects that some nurses in other areas of critical care have begun to address the independent role of nursing and the subsequent use of nursing diagnosis in their areas. Emergency nurses have also begun to address the issue of the independent role. To date, three articles and one editorial on nursing diagnosis and independent role have appeared in the Journal of Emergency Nursing.

In the 1980 Social Policy Statement the American Nurses' Association defined nursing as "the diagnosis and treatment of human responses to actual or potential health problems" (p. 9). In order to be able to describe their independent role in a particular area of nursing, nurses in that area must be able to identify the particular human responses which they diagnose and treat. Some human responses are seen more frequently than others. Some occur so frequently that they are seen in the majority of patients and can be considered commonly occurring responses. Identification of the commonly occurring responses with which nurses deal in a particular area of nursing can be viewed as an initial step in delineation of the independent role for nursing in that area. Documentation of the responses can be accomplished by the use of nursing diagnosis.

#### Problem of the Study

The problem of the study is the validation, by emergency nurses, of investigator generated nursing diagnoses occurring secondary to illness/injury in emergency patients.

#### Justification of the Problem

Nurses whose speciality area is emergency nursing

are currently fighting to preserve their professional autonomy both individually and through their professional organizations. Because of escalating costs and changes in insurance reimbursement, cost-containment has become a major priority to hospitals. Every avenue is being explored in order to cut expenses. One of those avenues involves replacing professional nurses in the emergency department with emergency medical technicians and paramedics, who are viewed as more cost-effective. According to the Emergency Nurses' Association "over 26% of the emergency departments in the United States currently use or plan to use emergency medical technicians of all levels within their departments" (in a position statement on the use of prehospital care providers (EMT's) in emergency departments, 1985, p. 4).

Efforts to combat the takeover of emergency nursing positions by emergency medical technicians have been made. These efforts include a position paper by the Emergency Nurses' Association that states the position against the use of paramedics in emergency departments, certification of all emergency nurses, marketing principles designed to increase public awareness, and political activism to increase input into legislative action (Westra, 1983).

Another useful approach would be to delineate the independent role of emergency nursing. While emergency nurses function in an interdependent role much of the time, there is a significant part of their care that involves independent functions. Ziegler, Vaughan-Wrobel, and Erlen (1986) defined independent nursing functions as "those activities which nurses initiate and perform under their own professional license" (p. 17). These functions are unique to nursing and would be lost if an emergency department replaced professional nurses with paramedics.

Since emergency nurses have not yet described their independent role, they are unable to accurately state what aspects of care will be lost if an emergency department abandons professional nurses and hires paramedics. Wake, McLane, and Gotch (1985) voiced their concerns by stating:

The numerous grey areas of medical/surgical nursing practice in critical care settings make the delineation of nursing's unique area of concern a priority for the 1980's. Given the current trends in reimbursement, the development of a diagnostic classification system will surely impact on the type of staffing and quality of care available to patients in the critical care units of the future. (pp. 447-448)

Research into this area of independent role function could greatly benefit emergency nursing. Such research would give emergency nurses the ability to delineate those aspects of emergency care that are uniquely nursing's and the ability to justify the necessity of keeping professional nurses in emergency departments. Nursing diagnosis provides the means to delineate an independent role for emergency nurses.

#### Conceptual Framework

The Nursing Process Model of Ziegler et al. (1986) represented a means by which nurses can function independently, enhance professional status, and improve the quality of nursing care. The model identifies five steps which are necessary for systematic nursing care delivery: assessing, diagnosing, planning, implementing, and evaluating (Ziegler et al., 1986).

Diagnosis is viewed as the "pivotal step of the nursing process" (Ziegler et al., 1986, p. 73). The product of diagnosing consists of two components: an unhealthful or potentially unhealthful response and the hypothesized etiology of that response. The process of diagnosing is "the cognitive act of analyzing the client data, comparing the data to standards and norms, and



making a judgment whether or not a need for nursing exists" (Ziegler et al., 1986, p. 74).

In order to diagnose an unhealthful or potentially unhealthful response, a nurse must be able to identify significant cues that cluster together and form a pattern. The pattern is analyzed and, if it is unhealthful or potentially unhealthful, it is given the appropriate label. The etiology of the response is hypothesized, and nursing care is planned, implemented, and evaluated.

Identification of unhealthful or potentially unhealthful responses common to a particular area of nursing assists the nurses employed in that area in care planning. Additionally, commonly identified responses provide a base upon which speciality nurses can begin to generate a body of knowledge specific to their particular area of nursing. The generation of nursing diagnoses from those common responses provides a means of determining independent role function in a specific area of nursing.

#### Assumptions

The following assumptions were identified for the study:

1. Nursing diagnoses are applicable to individuals or groups.

2. Nursing diagnosis is the pivotal point of the nursing process.

3. Nursing diagnosis reflects the independent role of the nurse.

4. The etiology component of the diagnosis statement determines whether the statement is a nursing diagnosis or not.

5. The etiology component of the nursing diagnosis statement must be amenable to nursing's independent intervention.

6. The response component of the nursing diagnosis statement represents a human response to an actual or potential health problem.

#### Research Questions

The following were the research questions for this study:

1. What is the frequency of occurrence, as estimated by emergency nurses, of the investigator generated (actual or potential) unhealthful responses of ill or injured emergency patients?

2. What is the frequency of occurrence, as estimated by emergency nurses, of the selected investigator generated nursing diagnoses (selected investigator generated

responses plus selected investigator generated etiologies) which reflect the independent nursing role in ill or injured emergency patients?

3. What additional etiologies are associated with the selected investigator generated (potential or actual) unhealthful responses in ill or injured emergency patients as identified by emergency nurses?

4. To what extent are additional nursing etiologies (for the selected investigator generated responses) identified by the emergency nurses associated with the independent or interdependent nursing role?

#### Definition of Terms

There were five key terms which are defined for this study. They were:

1. Investigator generated potential or actual unhealthful responses - a list of 24 actual or potential responses which were identified by the researcher and validated by experts in the field of nursing diagnosis as meeting the appropriate format. Measurement was accomplished by use of the Response Component Questionnaire (see Appendix A).

2. Ill or injured emergency patients - patients who have come to a hospital emergency department because of

the sudden onset of illness or injury.

3. Emergency nurses - registered nurses who were currently employed in a hospital emergency department. Those nurses will be identified by membership in local chapters of the Emergency Nurses' Association.

4. Selected investigator generated diagnoses - a list of 25 nursing diagnoses (response components and etiology components) which were identified by the researcher and validated by experts in the field of nursing diagnosis as representing diagnoses amenable to intervention by nurses in the independent role. Measurement was accomplished using the Etiology Component Survey (see Appendix B).

5. Additional etiologies - other etiologies identified by the emergency nurses participating in the study that may or may not be amenable to intervention within the independent role of emergency nurses. Identification was accomplished using the Etiology Component Survey (see Appendix B). Whether or not the identified etiologies are within the independent or interdependent role was measured by the Etiology Evaluation Questionnaire (see Appendix C). Agreement, by at least three of four experts in a panel of experts, that the diagnosis met the criteria for independent nursing diagnoses determined whether the

diagnosis was to be included in the list of the new diagnoses.

#### Limitations

The study had the following limitations:

1. Because a nonprobability sampling technique was used, the sample was not a true random sample. Thus, the generalizability of the findings may be affected.
2. The instruments utilized in the study were generated by the researcher and have unknown reliability.
3. Subjects may have interpreted the terminology used in the diagnosis statements differently.
4. Nurse subjects may not have recalled accurately the frequency of prior observations of clients.
5. Nurse subjects may have various levels of understanding of the concept of nursing diagnosis.

#### Summary

The identification of an independent role in emergency nursing is a necessity if professional nurses are to survive in that area of nursing. Nursing diagnosis presents one method for delineating an independent role in emergency nursing. Research in this area is limited, but extremely necessary. The Nursing Process Model of

Ziegler et al. (1986) represents a structured framework for the generation of nursing diagnoses and is applicable to an area of nursing where the concept of nursing diagnosis is just beginning to be explored.

## CHAPTER II

### REVIEW OF LITERATURE

Evidence of an increasing interest in the phenomenon of nursing diagnosis can be seen in the rapidly increasing number of articles published in the past three years. Many different speciality areas of nursing have begun to discuss the use of diagnostic labels specific to their areas. Problems with implementation abound, as the concept of nursing diagnosis is defined differently by different theorists. The review of the literature is comprised of articles and studies concerning diagnostic activities of nurses in clinical areas. Subheadings are: competing views of nursing diagnosis, diagnosis by nurses in critical care, diagnosis by nurses in emergency nursing, and diagnosis by nurses in other areas of nursing.

#### Competing Views of Nursing Diagnosis

The concept of diagnosis in nursing is still in the formative stages of evolution. Within the profession there currently exist two major views of nursing diagnosis. The proponents of one view believe that nursing diagnosis should be used to describe the independent role of the

nurse. They contend that certain patient problems can and should be treated by nurses acting independently under their own professional licenses. Proponents of this view of nursing diagnosis include: Gordon (1982), Ziegler et al. (1986), Carnevali (1985), Gebbie (1984), and Munding (1980).

The proponents of the other view believe that nursing diagnosis should be used to describe both the independent and the interdependent role of the nurse. They consider nursing diagnostic activities to be applicable to both independent and interdependent role activities. Proponents of this view of nursing diagnosis include: Kim (1980), and Guzzetta and Dossey (1983).

The interdependent role of nursing consists of all of the other activities performed by professional nurses under the direction of another health care professional. Examples of activities in the interdependent role include: following written and verbal orders of others, secretarial chores, and meeting hospital organizational demands.

The independent nursing role consists of those autonomous activities performed by professional nurses utilizing the nursing process when they are functioning in a collegial role with other health care professionals. Ziegler et al. (1986) defined independent nursing role as



those activities which nurses initiate and perform under their own professional license. Professional nurses do not require direction from another health care professional or health care agency to diagnose the need for or to implement these nursing interventions. Such activities as activities of daily living, guidance and counseling, nurturing, motivating, modifying the environment, teaching, patient advocacy, socializing, and encouraging are included within the independent role. Independent nursing functions are accomplished by the use of the nursing process and nursing diagnosis.

Gordon (1982) addressed the independent role with nursing diagnosis. She defined nursing diagnosis as a clinical diagnosis made by nurses which describes actual or potential health patterns which nurses, by virtue of their education and experience, are capable and licensed to treat. She listed 11 functional health patterns from which nurses assess health problems or potential health problems, diagnose them, and then plan, implement, and evaluate interventions.

Allen (1984) discussed independent interventions in perioperative nursing. She defined them as those activities which nurses perform independently.

Carnevali (1984) believed that independent nursing functions involved a co-professional role relationship. Nurses assume primary responsibility for diagnosis and treatment management within the nursing domain.

Clark (1984) stated that nursing plays a major role in assessing patients at risk and implementing appropriate lifestyle alterations to enhance their state of health. She defined nursing diagnosis as a statement of actual or potential problems that require nursing interventions for effective management. She believed nursing diagnosis would aid in further delineating the independent and collegial role of nursing in health problems.

Gebbie (1984) defined nursing diagnosis as a label for a client or patient condition (response to health or illness) that nurses are able, and legally responsible, to treat. Because nurses are the first to identify the conditions or to label them, or because nurses have been the ones to research and develop the appropriate treatment, nurses assume responsibility for the care.

Guzzetta and Dossey (1983) viewed nursing diagnosis from a critical care focus. They defined the role of the critical care nurse as totally interdependent, thus disagreeing with the concept of independent nursing diagnosis. They stressed the importance of utilizing

psychologic nursing diagnoses within the interdependent role.

Kim (1982) believed nurses would be held accountable for nursing actions based on nursing diagnosis. Kim felt pertinent issues in nursing diagnosis would include the collaborative and progressively changing nature of nursing. She stated that the nature of nursing is determined by the dynamic equilibrium between its independent and interdependent activities.

Mundinger (1980) defined independent nursing functions as autonomous nursing functions within the nursing process used to plan professional care. She believed it involved diagnosis.

#### Diagnosis by Nurses in Critical Care

Since the major controversy over nursing diagnosis concerns whether or not the diagnosis should represent only the independent role of the nurse or whether it should reflect both the independent and interdependent role of the nurse, literature in critical care contains advocates of both points of view. Much of the critical care nursing literature, however, omits the discussion of nursing diagnosis altogether.

Broome (1985) described the crisis response of families of children in an intensive care unit and

divided her discussion into three phases: admission, family's ability to cope, and maintenance and care. Assessment strategies and nursing interventions were discussed for each phase. Although Broome mentioned the nursing process, nursing diagnosis was not addressed in the article.

Carnevali (1985) advocated the delineation of an independent role in critical care nursing, although she agreed that much of the nursing care in that area centered around interdependent functions. Carnevali proposed that the balance model of daily living and functional health status be used to determine areas of independent nursing role in critical care nursing.

Kaplow and Fromme (1985) discussed the use of high-frequency jet ventilation on intubated critical care patients. A standardized care plan was presented utilizing nursing diagnoses. Most of the diagnoses addressed interdependent functions and most etiologies were medically orientated. An example was: "Potential for alteration in body image related to subcutaneous emphysema when administering high levels of positive end expiratory pressure with high flow jet ventilation therapy" (Kaplow & Fromme, 1985, p. 27). Little can be done independently by nurses to correct the etiology in this

diagnostic statement because a physician's order is required to alter the ventilation pressures. Thus, this diagnosis addresses interdependent nursing functions.

Steele and Whalen (1985) developed two new nursing diagnoses which they called physiological diagnoses related to critical care nursing: potential for organ failure and potential for tissue destruction. Defining characteristics were presented for each diagnosis and a case study utilizing both diagnoses was given. The case study and the use of the diagnoses largely reflected the interdependent role of critical care nursing, as greater than half of the nursing actions for both diagnoses involved physician consultation and administration of medication.

Tanner (1985) presented an overview of the use of nursing diagnosis in critical care nursing. A discussion about the current debate over whether nursing diagnoses should reflect the independent role or both the independent and interdependent roles of the nurse was presented. Tanner (1985) believed that the debate might be partially created by the unclear meaning of the term, accepted diagnosis. Gordon (1982) was identified as the major proponent of the use of nursing diagnosis to define only independent role. Kim (1982) and Guzzetta and Dossey

(1983) were identified as the major proponents of the use of nursing diagnosis to define the interdependent roles of nursing. The need to better understand diagnostic reasoning was also discussed.

Wake, McLane, and Gotch (1985) reported on the meeting of the speciality interest section for critical care held at the Fifth National Conference on the Classification of Nursing Diagnosis. Nine areas of concern to critical care nurses that were not currently on the accepted list of nursing diagnoses were delineated: "energy deficit, altered hemodynamics, compromised immunologic defenses, endocrine-metabolic alterations, electrolyte-acid-base imbalances, psychophysiologic stress, altered temperature regulation, altered comfort states, and developmental delays" (p. 446). Several issues related to the use of nursing diagnoses in critical care areas were discussed and included: the need for a clear definition of the concept of nursing diagnosis, validation of defining characteristics of nursing diagnoses, and issues of implementation. Many suggestions for needed research in this area were given.

Hubalik and Kim (1984) studied nursing diagnoses related to congestive heart failure by surveying critical care nurses. Six nursing diagnostic labels, "heart

failure, fluid overload, decreased activity tolerance, anxiety, lack of knowledge, and potential skin breakdown" (p. 145), were identified and were supported by their panel of experts and staff nurses. The authors concluded that interdependent nursing functions were within the realm of nursing practice and that clinical specialists should be used as subjects in the primary testing of diagnostic labels. Recommendations for replication of the study, in addition to clinical testing and validation of labels were made.

Hoppe (1983) discussed nutritional management of the trauma patient. Following an indepth discussion, a table identifying the concept, the nursing diagnosis, the expected outcome, and the nursing interventions was presented. The nursing diagnoses consisted of a problem list identified from the North American Nursing Diagnosis Association (NANDA) nationally accepted list. The etiology components were not identified.

Guzzetta and Dossey (1983) discussed the adaptation of nursing diagnosis to critical care nursing. Questioning whether or not critical care nursing contained any dependent or independent functions, the authors viewed the role of the critical care nurse as totally interdependent. A case study and care plan were presented. The necessity of

utilizing physiologic nursing diagnoses within the interdependent role of critical care nursing was emphasized.

Johnson (1983) addressed post-operative low cardiac output in young children following cardiac surgery. An indepth discussion of the causes, the clinical picture, and the treatment of the patient were presented. Although she did suggest that various nursing interventions could be utilized to decrease oxygen consumption, none were identified. The article was medically oriented and contained no mention of nursing diagnostic activities.

Rossi (1984) advocated the use of Gordon's (1982) functional health patterns in intensive care units, because she believed this was one way of implementing nursing diagnoses in critical care settings. A list of potential benefits from instituting nursing diagnosis included: improved collaboration of nurses and physicians, high quality of patient care, and the ability to develop more goal-directed nursing interventions.

Yoder (1984) discussed the use of nursing diagnoses in the operating room. Nursing diagnosis was seen as one means of making the public aware of the role of perioperative (operating room and recovery room) nurses. Several diagnoses consisting of diagnostic response components from the NANDA nationally accepted taxonomy which might



be seen in each area were identified. Preoperative diagnostic response components included: anxiety or fear, impaired verbal communication, knowledge deficit, and sensory perceptual alterations. Intraoperative diagnostic response components were identified as largely potential responses and included: potential for injury, potential fluid volume deficit, potential or actual alterations in cardiac output, potential or actual alterations in tissue perfusion, and potential or actual impairment of skin integrity. A case study and a care plan utilizing these nursing diagnoses were also presented.

Cardona (1982) discussed post-operative care of the patient with multiple trauma. The article stated that these patients were true nursing challenges. However, the article was focused on the interdependent role of the trauma nurse. Nursing diagnosis was not mentioned.

Giubilata (1982) utilized a case study to outline nursing diagnoses applicable to high-level quadriplegic patients. Four areas of concern were identified: respiratory system alterations, cardiovascular reflexes, changes in temperature control, and problems with elimination. Nursing diagnosis examples were presented for each area, however, most of the etiologies were medical and required interdependent nursing functions. An

example of the diagnosis for respiratory system alteration was "at risk for hypoventilation due to paresis/paralysis of diaphragm, intercostal musculature, fatigue" (p. 129). An example of the diagnosis listed for cardiovascular reflexes was "alterations in cardiovascular status secondary to loss of sympathetic innervation" (p. 129). Temperature control changes had one diagnosis listed "alterations in temperature regulation due to loss of sympathetic innervation" (p. 129). Several diagnoses were listed for elimination problems including: "potential for paralytic ileus due to loss of sympathetic innervation, and alterations in bladder function secondary to spinal shock or damage to reflex arc (atonic bladder)" (p. 129).

Current literature in critical care nursing reflects proponents of both the independent and independent/interdependent role for nursing diagnosis. However, many of the authors believe nursing diagnosis should be used to describe the independent role of the nurse. Development of an independent role in critical care nursing, regardless of how small that role may be, will increase nurses' visibility as independent practitioners and not just extensions of the physician. Knowledge that critical care nurses contribute something unique to the care of the critically ill patient may increase job

satisfaction, thus increasing retention of nurses in a area where an acute nursing shortage exists.

#### Diagnosis by Nurses in Emergency Nursing

Emergency nursing literature has recently begun to include the concept of nursing diagnosis. Earlier literature in emergency care reflects emphasis on the medical model and pathophysiology.

Thompson (1986) presented an overview of nursing diagnosis and discussed its application to emergency department nursing. An example of a detailed care plan for a trauma patient, which dealt with the diagnostic response component of ineffective breathing patterns, was given. Potential etiologies for the response were identified as: "airway obstruction, anxiety, decreased lung expansion because of chest trauma, drugs, fatigue or decreased energy, musculoskeletal impairment (ruptured diaphragm), neurological impairment (cervical spine or head injury), pain (splinting), perception or cognitive impairment, and tracheobronchial disruption or esophageal perforation" (p. 222). The majority of etiologies required medical interventions to correct and thus, reflected interdependent nursing functions. The necessity for further research on nursing diagnoses in emergency

nursing was emphasized.

Corrigan (1986) recommended the use of Gordon's (1982) functional health pattern assessment guide as a way of determining autonomous and collaborative areas of practice. Implementation of the framework in a large city emergency department was described. Emergency nursing diagnosis within a SOAP format was discussed, but no examples of emergency nursing diagnoses were contained in the article.

Larson (1986) discussed nursing diagnosis in her monthly editorial in the Journal of Emergency Nursing and stressed that nursing diagnoses involve only independent functions of registered nurses. A challenge to emergency nurses to develop nursing diagnoses that can be utilized in their settings was issued.

Blansfield, Fackler, and Bergeron (1985) discussed implementation of standardized care plans in their emergency department. A standardized care plan for a patient with head trauma was presented which contained two medical diagnoses (head trauma and possible brain trauma) and one response component from the standardized list of nursing diagnoses (knowledge deficit).

Burgess (1985) presented a brief description of the crisis response to rape. In the article's abstract she

stated that the foci of the article were the etiology, the defining characteristics, and the signs and symptoms of the nursing diagnosis labeled rape-trauma syndrome. However, the term nursing diagnosis was not mentioned in the article and no nursing diagnoses were generated utilizing the information in the article. No link was made between the information in the article and the nursing process.

Novotny-Dinsdale (1985) published the first article on nursing diagnosis utilization in emergency nursing. In the article Gordon's (1982) framework and the list of NANDA approved nursing diagnoses were utilized by the author. A description of Novotny-Dinsdale's (1985) experiences in implementing the use of nursing diagnosis in a suburban emergency department was given. Some of the etiologies, like bleeding, injury, diarrhea, and congestive heart failure, reflected medical diagnoses and required interdependent nursing functions.

Toth, Cost, Keyes, Deli, and Berkowich (1984) described the implementation of nursing diagnosis in a major trauma center. Mundinger's (1975) criteria were utilized for evaluation of the nursing diagnoses at that facility. Research was said to be continuing in order to revise and improve the diagnoses; however, the authors

listed several commonly identified responses in the trauma setting. Included in the list were: "altered level of consciousness, potential for impaired wound healing and/or infection, potential for hypoxia and/or atelectasis, potential for skin breakdown, contractures, constipation, potential for prolonged anxiety and anger, fear of being left alone, potential for life-threatening cardiac dysrhythmias, alteration in vital organ perfusion, and impaired motor and sensory function of an extremity" (p. 295). Etiologies reflected independent and interdependent nursing roles, but focused on the independent role. Two examples of nursing diagnoses including the common responses were given: restlessness and disorientation related to sensory overload and unfamiliar surroundings and potential for hypoxia and/or atelectasis related to retained secretions secondary to lung contusion. A care plan was formulated and nursing interventions were given for the diagnoses.

Visser and Volkman (1984) compiled patient data from 1982 in order to determine the reliability of medical diagnoses made by ambulance nurses of trauma patients in Belgium. The article was medically oriented and contained no mention of nursing diagnosis.

Hill and Fink (1983) discussed hypertensive emergencies in their article. The article was medically focused and dealt with assessment of the patient, identification of medical problems, and drug therapy. Nursing diagnosis was not mentioned.

Hoyt (1983) described blunt and penetrating chest trauma including the related medical and nursing care and listed numerous nursing diagnoses. Two examples of her nursing diagnoses were: acute severe respiratory distress related to increased intrapleural pressure and acute severe interruption of circulation related to great vessel injury. All of the diagnoses presented contained a medical diagnosis in the etiology component and reflected treatment plans using interdependent nursing functions.

Sigmon (1983) presented an excellent description of the interdependent role of the trauma nurse by presenting a case study of the trauma patient. The major focus of the article was the importance of team effort in the care of the trauma patient. Assessment skills were stressed, but nursing diagnoses and the nursing process were not addressed.

Thompson (1983) presented an extensive discussion of the assessment of blunt and penetrating abdominal trauma. Although the title of the article mentioned a care plan

for the patient, none was presented. Nursing diagnoses were not included.

Podgorny and Stanley (1982) discussed the care of victims of gunshot wounds. The first sentence stated that "a gunshot-wound victim often gets his first qualified care from an R.N." (p. 47). The rest of the article dealt with the assessment and the concurrent pathophysiology of various wounds. The interdependent role of nursing was represented, but no evidence of an independent role or of nursing diagnosis could be found.

Saclarides, Parrish, and Saclarides (1982) presented a sequential approach to patients with ocular emergencies. Several types of ocular emergencies were outlined. The article was medically focused and contained no evidence of nursing diagnoses.

Estrada (1981) described the system of triage and the role of nursing within the system. Basic triage was defined as assessing the patient, determining the priority of needs, and assigning the patient to a treatment area. Advanced triage was defined as initially assessing the patient, performing an appropriate physical exam, initiating diagnostic procedures, documenting findings, and referring the patient. Thus, the nursing process was reflected in the description of the process of triage,



however, nursing diagnosis was not mentioned.

Miller (1981) focused on emergency management of the unconscious patient and stressed the importance of a collaborative approach to the care. Nursing assessment and nursing interventions within the independent and interdependent roles were presented. However, nursing diagnosis was not mentioned.

Moynihan and Duncan (1981) detailed the role of the nurse in the care of victims of sexual assault. The nurse was viewed as the primary provider of crisis counseling for the victim and significant others. Although assessment of the victim was discussed, nursing diagnosis was not mentioned.

Emergency nurses are starting to address the role of nursing diagnosis in their practice. However, the concept does not appear to be clearly understood. Thus, the literature reflects proponents of both the independent and the independent/interdependent role for nursing diagnosis.

#### Diagnosis by Nurses in Other Areas of Nursing

There are other areas of nursing in which nurses have recognized the concept of nursing diagnosis and have attempted to adapt it to their area. The articles

published by them reflect the infancy of the nursing diagnosis movement and necessity for further research.

Coffman (1986) described the signs and symptoms of the nursing diagnosis, alteration of bowel elimination related to neurogenic bowel. The subjects were children with myelomeningocele. The most frequent problems cited by study participants were incontinence, diarrhea, and constipation. A discussion of causes of the problems, attitudes of the parents of the subjects toward problems, and various management techniques was presented. Further testing to provide validation for the findings was recommended.

Hoskins, McFarland, Rubenfeld, Walsh, and Schreier (1986) conducted a large, descriptive study to identify nursing diagnoses in the chronically ill. Fifty-one nursing diagnostic response components were identified utilizing an inductive approach. Many of these reflected the diagnostic categories in the NANDA list. Others, however, were generated from the research and included: impaired circulation, uncontrolled hypertension, health management deficit in respiratory self-care, potential for nutritional deficiency, nonadherence to diet, diarrhea, perceived constipation, inadequate physical activity, inadequate dental care, potential health

management deficit from financial insecurity, potential for loneliness, lack of spiritual support, threat to sexual integrity, illness-imposed changes in sexual activity, and lack of purpose in life (p. 88). Maslow's (1954) framework of needs was used to provide guidelines for patient assessment and diagnosis formulation. The purposes of the study were: to identify nursing diagnoses in a sample of chronically ill medical outpatients, to validate the diagnoses in a second comparison sample, and to distinguish defining characteristics of the diagnoses.

Cleary (1985) related the process of implementation of nursing process utilizing nursing diagnosis in the critical care units where she was a nurse educator. Midproject evaluation revealed a lingering medical focus in the nurses' charting. Several adjustments resulted in a final project evaluation which showed marked improvement and reflected nursing diagnostic processes.

Edel (1985) defined compliance and noncompliance and related these terms to nursing and stated why she was opposed to utilizing the term noncompliance as a nursing diagnosis. In her argument Edel stated that this diagnosis did not focus on nursing therapies, but focused instead on perceived power and powerlessness.

Forsyth (1985) adapted nursing diagnosis to occupational health patients utilizing the NANDA list of nursing diagnoses. A worksheet was developed which could be used in an occupational health setting to determine nursing diagnoses. The author encouraged occupational health nurses to develop nursing diagnoses specifically describing situations occurring in their field.

Halloran (1985) attempted to predict nursing care time utilizing diagnosis related groups (DRG's), nursing conditions using 37 nursing diagnoses identified at the First National Conference on the Classification of Nursing Diagnosis, and demographic data of the adult patients in an acute-care, community hospital. Using multiple regression analysis, Halloran found that nursing conditions predicted variations in nursing care time better than DRG's or demographics. A combined nursing diagnosis-DRG model improved prediction of variation in nursing care time. However, approximately 40% of the variation remained unexplained.

Allen (1984) related the concept of nursing diagnosis to perioperative nursing. The history of nursing diagnosis, the problems existing in definition, and the process of implementation of nursing diagnosis were described. Nursing diagnosis was considered to be a

large part of the future of nursing.

Clark (1984) combined the concepts of nursing diagnosis and health promotion in an article on nursing diagnosis in an ambulatory care setting. An assessment format was developed and then used with an example of an ambulatory care patient, emphasizing health promotion and disease prevention. Recommendations were made for the incorporation of nursing diagnosis and the nursing process in ambulatory care nursing.

Davidson (1984) discussed the present and future roles of nursing diagnosis in the acute care setting. Three factors were identified that influence nurses' ability to diagnose in acute care settings: patient acuity, hospital traditions of nursing care, and economic issues. Research was believed to be essential to the continuation and growth of nursing diagnosis use in these settings.

Gaines and McFarland (1984) surveyed 74 baccalaureate schools of nursing to determine whether or not nursing diagnoses were included in their curricula. The use of nursing diagnosis was present in 70 of the schools. From this study the authors concluded that nursing diagnosis was being taught to the next generation of nurses and that nursing diagnosis should become more and more

evident in clinical practice settings.

Johnson (1984) utilized adaptation as the theoretical framework for describing nursing assessment and nursing diagnosis in mental health nursing. Four clients of care were discussed: the individual, the family, the group, and the community. An assessment guide was presented and a diagnostic and intervention matrix that was to be applicable to all four groups was formulated.

Kim, Amoroso-Seritella, Gulanick, Moyer, Parsons, Scherbel, Stafford, Suhayda, and Yocum (1984) conducted a study to determine content and face validity of ten cardiovascular nursing diagnoses and their defining characteristics and to document their clinical relevance. Clinical specialists were found to identify more nursing diagnoses than staff nurses. A high rating of relevance for the physiologic nursing diagnoses led to the conclusion that physiologic nursing diagnoses were part of nursing's domain of practice. Recommendations for further clinical validation of the defining characteristics and diagnoses were made.

Tanner and Hughes (1984) outlined the process for clinical testing of nursing diagnoses. Identification of current and past problems and solutions for them were

presented. The importance of conducting research in the practice setting and of including the nurse clinician in the research process was stressed.

Westfall (1984) combined the concepts of nursing diagnosis and quality assurance by delineating a model for quality assurance in nursing and using nursing diagnosis as a means of exploring outcomes from a nursing perspective. Nursing diagnosis offered a much needed means of defining nursing-specific outcomes in quality assurance according to the article.

Young and Lucas (1984) detailed common problems in the implementation of nursing diagnosis. Using Lewin's change theory, they presented a means for implementation of nursing diagnosis and discussed reasons for failure or difficulty in implementation. The normative-reeducative strategy for change coupled with continuous reinforcement for expected behaviors was recommended for changing the behavior of nurses.

Hamilton (1983) presented an overview of nursing diagnosis at a community level. Nursing diagnosis was described as one way in which community health nurses could describe the focus of their practice. Identification of current problems in generating nursing diagnoses at a

community level and suggestions for further research were given.

Sjoberg (1983) detailed commonly seen nursing diagnoses in patients with chronic obstructive pulmonary disease (COPD). Four of the diagnoses from the approved list, activity intolerance, sleep pattern disturbance, noncompliance, and potential for ineffective family coping, and several etiology components for each response component were presented. Most of the etiologies reflected the independent role of nursing and could be resolved by independent nursing intervention. A case study and care plan were outlined for the patient with COPD.

Deback (1981) hypothesized that nursing curricula based on systems models would predict greater ability to formulate nursing diagnoses by senior nursing students than other curriculum models. After surveying 10 students from each of 20 baccalaureate nursing programs, the conclusion that senior nursing students could not competently formulate nursing diagnoses, regardless of the type of conceptual model used in the curriculum, was reached.

Avant (1979) studied the nursing diagnosis, maternal attachment, and described maternal attachment behaviors between new mothers and their infants. Five provisional



criteria of maternal attachment were defined and tested in the study. The provisional criteria included: visual contact between mother and child, touching of the child by the mother, a positive affect associated with the child, reciprocal interaction, and vocalization by at least one of the two. All five of the criteria were supported. A small sample size was cited as a detriment to generalizability of results. Suggestions were made for further studies.

Guzzetta and Forsyth (1979) conducted a pilot study on the nursing diagnosis, psychophysiologic stress. Using the Holland-Sgroi-Solkoff Anxiety-Depression Scale to measure psychophysiologic stress in five newly admitted patients with myocardial infarctions, the authors found that the scale measured psychological stress, but not physiological stress. The anticipated cluster of signs and symptoms was not observed.

The use of nursing diagnosis by nurses in other areas of nursing besides critical care and emergency nursing also reflects confusion concerning a true definition of the concept. However, in areas where a large independent role for nursing exists, nursing diagnoses tend to address independent role concepts. In areas of nursing where independent role is limited, the focus of

nursing diagnosis tends to be both within the independent and interdependent realm.

#### Summary

Literature was reviewed which dealt with diagnostic activities by nurses in critical care nursing, emergency nursing, and other areas of nursing. Literature which focused on both medical and nursing diagnoses, as well as nursing diagnosis activities in the independent and interdependent roles, was presented. As can be seen by the previous literature review, much work needs to be done in terms of clinical validation of nursing diagnoses. The concept is relatively new and many practicing nurses are unfamiliar with it. Problems abound in implementation and acceptance of nursing diagnosis in clinical settings. There are differing opinions as to how the concept should be defined and whether independent and/or interdependent functions should be included in the definition. Although the research base for nursing diagnosis is increasing rapidly, no clear answers for the problems are being identified.

Before the concept of nursing diagnosis will be adopted by the practicing nurse in any area of nursing, it must be useful and easily understood. This study

attempted to link frequently seen responses with common etiologies in emergency patients. Thus, the study increases the research base of nursing diagnosis within the independent role in emergency nursing. By increasing the research base, a better understanding of the concept should result.

A major deficit that was identified in the emergency nursing literature was lack of specific nursing diagnoses that reflected primarily the independent role of the nurses. This study addressed that deficit by identifying and validating selected nursing diagnoses for ill or injured emergency patients.

### CHAPTER III

#### PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

The study used a quantitative research method, the descriptive survey design. Shelley (1984) stated that quantitative research is "concerned with the measurement of phenomena, characteristics, concepts, or things" (p. 7). Quantitative research can be divided into two types: descriptive and experimental. The difference between the two types is that experimental research tests causal relationships and descriptive research does not.

The purpose of descriptive research is "to construct a picture or account of events as they naturally occur" (Waltz & Bausell, 1981, p. 125). Waltz and Bausell divide descriptive studies into two types: case studies and surveys. Surveys are subdivided into: simple descriptive surveys, comparative surveys, correlational surveys, and developmental surveys. The simple descriptive survey approach was utilized in the study. A simple descriptive survey can be defined as one where "the aim is to describe an intact situation or area of interest factually and accurately" (Waltz & Bausell, 1981, p. 128).

In this chapter the setting, population, and sample for the research are discussed. The instruments generated by the researcher are introduced. Previous pilot studies are described. Finally, the planned statistical treatment of the data collected in this research is discussed.

### Setting

The setting for the research was chapter meetings of the Emergency Nurses' Association in selected cities in the United States. The sites of the meetings varied from city to city, but meetings were usually held in the evening in a designated room of a local hospital. Members who consented to be subjects completed the questionnaires in a setting of their choosing.

### Population and Sample

The population of the study consisted of emergency nurses who are members of the local, state, and national Emergency Nurses' Association chapters. A list of local chapters was obtained from the national office of the Emergency Nurses' Association. The chapters were divided into six geographical areas.

Systematic sampling and cluster sampling, both probability sampling techniques, were to be utilized to select a representative group of chapters from the

national list of Emergency Nurses' Association chapters. Although Shelley (1984) stated that systematic sampling was a nonprobability sampling technique, Polit and Hungler (1978) stated that it "can be classified as either a probability or nonprobability sampling approach, depending upon the exact procedure used" (p. 463). In systematic sampling "the first element chosen here is selected arbitrarily rather than randomly" (Shelley, 1984, p. 247). According to Polit and Hungler (1978)

if the researcher has a list, or sampling frame, the following procedure can be adopted. The desired sample size is established at some number (n). The size of the population must be known or estimated (N). By dividing N by n, the sampling interval width (k) is established. The sampling interval is the standard distance between the elements chosen for the sample . . . . The first element should be selected randomly, using a table or random numbers . . . . In actual practice, systematic sampling conducted in this manner is essentially identical to simple random sampling. (p. 464)

The probability sampling technique described above was to be utilized in the study. The number 9 was chosen from a table of random numbers. An attempt to contact every ninth chapter was made. However, because of changes that had occurred in the local chapters, many of the selected chapters could not or would not participate. In order to obtain the sample of 59 chapters, 135 chapters were contacted.

The actual sampling technique became convenience sampling rather than systematic sampling. From each geographical area 25% of the chapters were selected for inclusion in the study using the convenience sampling method. This method resulted in 59 chapters being selected. The presidents of each chapter were contacted by phone. Permission to survey the chapter and the assistance of each president was requested during the phone call. A conversation guide utilized during the phone calls is included in Appendix D.

Ten questionnaires and an audio cassette tape describing the study were mailed to each of the 59 selected chapters whose presidents agreed to participate in the study. Thus, 590 questionnaires were distributed. The audio cassette tape was played and the questionnaires were distributed by the chapter presidents at the following chapter meeting. Those members wishing to participate completed the questionnaires at a time and place of their choosing. The message from the audio cassette tape is contained in Appendix E.

The sample for this study can be classified as one of convenience. Shelley (1985) defined a convenience sample as "the simplest and most commonly used sample. It is obtained by including in the sample whatever elements

happen to be available or are convenient to use" (p. 246). The individual subjects from the chapters were selected by means of a convenience technique.

Cluster sampling, a type of random sampling, can also be referred to as multistage sampling and involves successive random sampling units (Polit & Hungler, 1978, p. 463). Because 59 local chapter meetings of the Emergency Nurses' Association were asked to participate in the study, the use of cluster sampling is evident in the study. Of the 590 questionnaires mailed to the local chapters, 245 (42%) were returned.

#### Protection of Human Subjects

The study was exempt from review by the Texas Woman's University Human Research Review Committee because it qualified as Category I research according to the federal guidelines and the policies of the Texas Woman's University Human Subjects Review Committee. The study was exempt because it was a survey research in which anonymous questionnaires were used.

In order to ensure protection of human subjects, a letter of explanation was mailed with each questionnaire to each chapter included in the study (see Appendix F). Although the chapters were coded for identification of



geographic area, individual participants were guaranteed anonymity by omission of any names on the questionnaires. The participating chapters were guaranteed confidentiality. An addressed, stamped envelope was included with each questionnaire for returning the questionnaires once they were completed or for returning unanswered questionnaires if the chapter and/or subject chose not to participate. Permission to conduct the study was obtained from Texas Woman's University before data collection began.

#### Instrumentation

Four instruments were utilized to collect the data needed to answer the research questions: the Demographic Data Sheet (see Appendix G), the Response Component Questionnaire (see Appendix A), the Etiology Component Survey (see Appendix B), and the Etiology Evaluation Questionnaire (see Appendix C). The first three instruments were completed by the study's sample. The last instrument was completed by a panel of experts in nursing diagnosis.

#### Demographic Data Sheet

The researcher-generated demographic data sheet (see Appendix G) was utilized to ascertain the type of institution in which the nurse was employed and some

general information about the participant. Questions included the type of institution in which the nurse was employed, the monthly census, the current position of the nurse, hours worked per week by the nurse, the education of the nurse, and whether or not the nurse was ever taught to write nursing diagnoses. The information generated was used to describe the sample.

#### Response Component Questionnaire

Because of the lack of published nursing diagnoses in emergency nursing which reflect independent role, a list of 24 commonly seen response components was developed by the researcher. The list was comprised of responses from the NANDA approved list and frequently observed patient responses to emergency treatment seen by the researcher over her 15 years of emergency nursing practice (see Appendix A).

Subjects were asked to read each response and to decide whether or not they have observed patients who had exhibited the response. If they had not, they were asked to place a check mark in the zero column. If they had, they were asked to estimate what percentage (of the total number of patients they had seen) had had the response. They were then asked to place a check mark in the

appropriate percentage column that best described the frequency of their observations. Percentages were broken down into four ranges: 1-25%, 26-50%, 51-75%, and 76-100%.

#### Etiology Component Survey

Because of the lack of published nursing diagnoses in emergency nursing, a list of 25 commonly seen nursing diagnoses (combining the 24 response components with commonly observed etiology components) were generated by the researcher. The response component, potential for loss of consciousness, was paired with two separate etiology components to make two different diagnoses. Each diagnosis was presented as an example of a response and etiology component which can be treated within the independent role of emergency nurses (see Appendix B).

The subjects were asked to read each nursing diagnosis and asked in what proportion of patients the listed etiology is the cause of the response. Possible proportions were: zero, 1-25%, 26-50%, 51-75%, and 76-100%. After completing the 25 items, they were asked to return to the first item and to decide whether they had seen patients with the response component, but with a different etiology component. If they had not, they were

asked to proceed down the list. If they had, they were asked to write the additional etiology component(s) in the space provided below each item.

#### Etiology Evaluation Questionnaire

The study's subjects were asked to generate additional etiologies for the response components. In order to ascertain whether or not the potential etiologies actually reflected the independent role of nursing, a panel of experts was asked to evaluate them. The Etiology Evaluation Questionnaire (see Appendix C), developed by the researcher, contained a list of those responses and etiologies (diagnoses) thought to reflect independent role and was mailed to the panel of experts on nursing diagnosis and the Ziegler et al. (1986) model. The panel of experts consisted of four nurses who had published or lectured in the field of nursing diagnosis using the Ziegler et al. (1986) Nursing Process Model. The experts were asked to place each diagnosis under the independent or interdependent role of the nurse. Agreement of three of the four experts constituted acceptance of a diagnosis as representing the independent role.

#### Validity

Validity refers to whether or not an instrument measures what it is suppose to measure. Content validity

refers to whether or not an instrument adequately samples a content domain. Waltz et al. (1984) stated that content validity can be assessed by content specialists, whose role is to interpret the instrument in terms of how well it satisfies the specifications of the domain or objective.

The list of 25 commonly seen nursing diagnoses in emergency department patients which comprised the examples in the Etiology Component Survey (see Appendix B) was assessed for content validity in the second pilot study. There was at least 75% agreement that the diagnoses met the criteria for nursing diagnoses of Ziegler et al. (1986) in all but one criterion of one diagnosis. The researchers felt that the etiology in diagnosis 16 was not concrete enough to generate nursing actions. Minor changes in the etiology component were made, incorporating the suggestions of the experts, to make the etiology more concrete. Thus, a degree of content validity has been established for the list of diagnoses prior to data collection.

### Reliability

Reliability refers to "the consistency with which an instrument assesses the content domain . . . the extent to which measurements are free from measurement error and the degree to which observed scores reflect true scores"

(Waltz, Strickland, & Lenz, 1984, p. 187). Reliability is a prerequisite for validity.

Reliability of the questionnaires is unknown; however, some degree of reliability can be ascertained for the Etiology Evaluation Questionnaire through the use of interrater agreement procedures. Waltz et al. (1984) stated that "the focus of interrater agreement in the criterion-referenced case is on the consistency of classification of two (or more) different raters who classify a specified group of objects or persons using the same measurement tool on the same measurement occasion" (p. 193). Interrater agreement was assessed utilizing Cohen's K.

Cohen's K is a statistical test which measures the proportion of objects consistently classified in the same category, by two or more raters, beyond that expected by chance. The formula for Cohen's K is:

$$K = \frac{P_o - P_c}{1 - P_c}$$

where:

$P_o$  = observed agreements and

$P_c$  = chance agreements (Waltz et al., 1984, p. 190).

Cohen's K has a range of -1.00 to +1.00 with scores approaching +1.00 representing a high degree of interrater

agreement. The Cohen's K for the Etiology Evaluation Questionnaire was +.70 indicating relatively high inter-rater agreement.

#### Data Collection

The United States was divided into six geographical areas: northeast, southeast, north central, south central, northwest, and southwest. Vertical lines were drawn using the time zone lines. If greater than 50% of a state lay within a specific time zone, it was considered to be part of that zone. East consisted of the eastern and atlantic time zones. Central consisted of the central time zone. West consisted of the mountain and pacific time zones. The dividing line between north and south was the 40th parallel, the line which most closely reflected the Mason-Dixon line that separated the north and south in the Civil War.

A list of local Emergency Nurses' Association chapters was divided into the six geographical areas. Twenty-five percent of the chapters were surveyed from each geographical area. Ten questionnaires were mailed to each selected chapter.

The subjects for the study were those nurses who attended the first meeting of the selected chapter after

receipt of the instruments and who agreed to participate in the study. The presidents of the selected chapters were contacted by phone and asked to assist with the study (see Appendix D). If they agreed, ten questionnaires were mailed to them for distribution at the next chapter meeting. Chapter members were asked by the chapter president to participate in the study at the beginning of the meeting and to return the questionnaire to the researcher in the enclosed addressed-stamped envelope within one week. The chapter presidents were asked to return any unanswered questionnaires to the researcher within one week, if there were not 10 members willing to participate present at the meeting.

If the chapter president of a selected chapter could not be contacted or refused to assist with the study, the next chapter president on the list was contacted by phone and assistance was requested. An attempt was made to include one chapter from every state in the geographical area. Twenty-five percent of the 230 chapters of the Emergency Nurses' Association were sampled (59 chapters). Ten questionnaires were mailed to each chapter (590 questionnaires). Return of at least 200 questionnaires was anticipated which would equal a 34% response rate.



The 25 nursing diagnoses utilized in this study were submitted to a panel of experts in the Nursing Process Model of Ziegler et al. (1986) in the first pilot study. In the second pilot study a revised list of 25 nursing diagnoses commonly seen in emergency patients was submitted to a panel of experts in nursing diagnosis. In the third pilot study the complete questionnaire was given to a group of practicing emergency nurses in order to test the instrument before it was mailed to a large number of subjects. The results of the pilot studies are discussed below.

### Pilot Study One

#### Problem of Study

The problem of the study was to evaluate the structure, form, and acceptability of 25 nursing diagnoses commonly seen in emergency department patients.

#### Procedure for Data Collection and Treatment

Four experts in the construction of nursing diagnoses utilizing the Ziegler et al. (1986) criteria were mailed a list of 25 diagnoses, a list of the criteria for diagnosing, directions for evaluation, and an answer sheet (see Appendix I). After the evaluation was completed the answer sheets were returned to the researcher by mail.

### Summary of Findings

Responses were returned by three of the four expert panel members. The answers were collated and the following information was obtained. All of the diagnoses met some of the criteria. None of the diagnoses met all of the criteria. The panel of experts suggested some rewording to make them more acceptable. A revised list of diagnoses, which was submitted to a new panel of experts in the second pilot study, was drafted utilizing the suggestions of the respondents (see Appendix J).

### Pilot Study Two

#### Problem of Study

The problem of the study was to evaluate the content validity of 25 nursing diagnoses commonly seen in emergency department nursing.

#### Procedure for Data Collection and Treatment

Fifteen experts who had published and/or lectured about the concept of nursing diagnosis were mailed the list of 25 diagnoses, a list of the criteria for diagnosing, directions for evaluation, and an answer sheet (see Appendix J). A letter of introduction and request to participate in the study were mailed to each expert also (see Appendix J).

### Summary of Findings

Responses were returned by four of the 15 experts on nursing diagnosis. Three additional experts returned letters explaining why they declined to participate. The eight other experts chose not to participate. The answers were collated and the following information was obtained. All but one criterion on one diagnosis met with at least 75% agreement from the panel. Minor changes were made in the one diagnosis to conform to the suggestions of the two dissenting experts. Minor changes were also made in three other diagnoses to make them more understandable to the average staff nurse, as requested by two of the experts. A second revision to the list was drafted and was used as part of the Etiology Component Survey for distribution to the sample of emergency nurses chosen for the study (see Appendix K).

### Pilot Study Three

#### Problem of Study

The problem of the study was to test the complete questionnaire for readability and understandability by a group of practicing emergency nurses.

#### Procedure for Data Collection and Treatment

Ten practicing emergency nurses who work in a

metropolitan emergency department were given the questionnaire to complete (see Appendix H). They were asked to complete and return the questionnaire within one week with any suggestions they might have for improvement.

### Summary of Findings

Six of the ten questionnaires were returned. A few suggestions for minor alterations were made. Recent graduates had little difficulty grasping the content of the questionnaires. Those nurses who had been to school prior to the advent of nursing process had difficulty understanding the content of the questionnaire because of limited exposure to the concept of nursing diagnosis. Minor changes in the arrangement of the demographic data sheet were made as a result of this pilot study.

### Treatment of Data

#### Research Question One

The first research question asked the frequency of occurrence, as estimated by emergency nurses, of the investigator generated (actual or potential) unhealthful responses of emergency patients that are secondary to illness/injury. The results were tabulated and the descriptive statistics are presented in table form. The number and percentage of subjects choosing each of the

four response categories are presented in table form.

#### Research Question Two

The second research question asked the frequency of occurrence, as estimated by emergency nurses, of the selected investigator generated nursing diagnoses (selected investigator generated responses plus selected investigation generated etiologies) which reflect the independent role in emergency patients secondary to illness/injury. The Etiology Component Survey was given to the members of 59 chapters of the Emergency Nurses' Association. The frequency of occurrence of the nursing diagnoses was assessed and the results are presented in table form. The number and percentage of subjects choosing each of the nursing diagnoses are presented in table form.

#### Research Question Three

The third research question asked what additional etiologies were associated with the selected investigator generated (potential or actual) unhealthful responses in emergency patients secondary to injury/illness as identified by emergency nurses. A list of the additional etiologies was formulated. Because of the magnitude of the list the etiologies were sorted into six categories: etiologies which contain attributes which are not

changeable; etiologies which contain events which are not changeable; etiologies which contain medical diagnoses or which require a physician's order for treatment; etiologies which refer to the ED staff and not the patient; etiologies which are unclear, ambiguous, circular, or incomplete; and etiologies which when combined with the response component form additional nursing diagnoses representing the independent role (see Appendix L).

#### Research Question Four

The fourth research question asked to what extent the additional nursing etiologies (for the selected investigator generated responses) identified by the emergency nurses were associated with the independent or interdependent nursing role. The potential additional nursing diagnoses representing the independent role were mailed to a panel of experts on the Ziegler et al. (1986) model and in nursing diagnosis as part of the Etiology Evaluation Questionnaire (see Appendix C). The nursing diagnoses which were felt to reflect the independent role by at least three of the four researchers are contained in Appendix L.

## CHAPTER IV

### ANALYSIS OF DATA

In this chapter the sample which provided the data for the study is described in detail. The findings are summarized for each of the research questions. Tables are used to assist with the presentation of the findings. A summary of the findings is included.

#### Description of Sample

The population for the study consisted of practicing emergency nurses. Nurses were accessed through local chapter meetings of the Emergency Nurses' Association. A list of local chapters was obtained from the national office. The chapters were divided into six geographical areas, and 25% of the chapters were selected for inclusion in the study. A cluster random sampling method was used to obtain the chapters.

Because a national survey was conducted, participants came from all parts of the United States. An attempt was made to survey at least one local chapter of the 50 states and the District of Columbia which have Emergency Nurses' Association chapters. Nine chapters were inactive. One

chapter was not meeting until after the close of data collection. Sixty-six chapter presidents chose not to participate. However, chapter presidents from 59 chapters and 38 states agreed to participate in the survey.

Once a chapter president agreed to participate, 10 questionnaires were mailed to the president for distribution at the next chapter meeting (n=590). The sample consisted of the 245 questionnaires that were returned. The questionnaire return rate ranged from 16% to 79% across the geographical areas. The overall questionnaire return rate was 42% (see Table 1). Information is not available concerning the total number of the 590 questionnaires actually passed out at local chapter meetings.

The ages of the sample ranged from 20-59. Fifty-one percent of the sample were between the ages of 30 and 39 (see Table 2). Employment positions ranged from staff nurse through clinical specialist (see Table 3). Sixty-three percent of the subjects were staff nurses. Hours worked per week were divided into 20 hours or less or greater than 20 hours per week. Ninety-six percent of the sample worked greater than 20 hours per week. The sample was closely divided between being employed by a public (45%) or a private (47%) institution. Census of emergency departments ranged from those seeing less than 500 patients per month to those



Table 1

Questionnaire Return Rate by Geographical Area and Number of  
Chapters and States in Each Geographical Area

Area	Percent of Chapters	Percent of States	Percent of Surveys Sent	Percent of Surveys Returned	Percent of Total Returned
Northeast	19	11	190	79	42%
Southeast	10	6	100	50	50%
North Central	8	6	80	35	44%
South Central	11	7	110	36	33%
Northwest	5	4	50	8	16%
Southwest	6	4	60	37	62%
Total	59	38	590	245	42%

seeing greater than 2,000 patients per month (see Table 4). However, 57% of the sample worked in emergency departments which saw greater than 2,000 patients per month.

Table 2

Age Ranges and Percentage and Number of Sample in Each Range

<u>Age Range</u>	<u>% and # of Subjects</u>
20-29	16% (39)
30-39	51% (126)
40-49	23% (57)
50-59	10% (23)

Table 3

Current Employment Positions and Percentage and Number of Sample in Each Position

<u>Current Employment Position</u>	<u>% and # of Subjects</u>
Staff nurse	63% (154)
Assistant head nurse	5% (12)
Head nurse	12% (29)
Supervisor	8% (20)
Clinical specialist	3% (7)
Other	9% (23)

Table 4

Monthly Emergency Department Census and Percentage and  
Number of Sample Employed There

<u>Monthly Census</u>	<u>% and # of Subjects</u>
Less than 500	3% (8)
501-1000	6% (13)
1001-1500	13% (31)
1501-2000	20% (48)
Greater than 2000	58% (145)

The basic nursing educational preparation of the nurses was varied. Forty-four percent of the sample were from diploma programs; 29% from associate degree programs; and 27% from bachelors programs. Fifty-one percent of the sample stated that the highest level of education they had achieved was an associate degree or a diploma in nursing; 39% had obtained a bachelors degree (with 29% being in nursing); and 10% had achieved a masters degree (with 7% being in nursing).

The level of knowledge and familiarity with nursing diagnosis were diverse. Sixty percent of the sample stated that they had been taught at some time during their

nursing careers to write nursing diagnoses. However, 40% stated that they had never been taught to write nursing diagnoses. Seventy-seven percent of those nurses who were taught to write nursing diagnoses were taught to write them in nursing schools (this percentage reflects only 47% of the total sample). The remainder of the nurses learned about nursing diagnoses through inservice programs, continuing education programs, seminars, or other unspecified means.

### Findings

The findings are reported for each of the research questions. Tables are utilized to present the data.

#### Research Question One

The first research question asked the frequency of occurrence, as estimated by emergency nurses, of the investigator generated (actual or potential) unhealthful responses of emergency patients that are secondary to illness/injury. The results were tabulated and the responses were rank-ordered according to the percent of subjects that observed the response in greater than 50% of their patients.

The ranking of response components was done by combining the 51-75% and the 76-100% columns of the

questionnaire. There were no patient response components seen greater than 50% of the time by greater than 50% of the sample. The potential for infection response component was the only response seen greater than 50% of time by over 40% of the subjects. The response components, increased pain and potential for noncompliance with after-care instructions, were seen by over 30% of the subjects. Four responses (potential for complications, potential noncompliance with medical regimen, potential for incorrect medication useage, and inability to follow directions) were observed by over 20% of the subjects. The remaining response components were seen by less than 20% of the sample. Table 5 contains a rank ordering of the response components according to the percentage of the sample that observed them greater than 50% of the time.

Table 5

Rank Ordering of Response Components According to the  
Percentage of Subjects that Observed the Responses  
Greater than 50% of the Time

Response	% of Sample Observing
1. Potential for infection	42
2. Increased pain	35

Table 5 (continued)

Response	% of Sample Observing
3. Potential for noncompliance with aftercare instructions	32
4. Potential for complications	27
5. Potential noncompliance with medical regimen	24
6. Potential for incorrect medication usage	24
7. Inability to follow instructions	21
8. Severe anxiety	18
9. Inability to problem solve	11
10. Ineffective intrafamily support	10
11. Unrealistic fear for impending treatment	9
12. Denial	9
13. Child's failure to cooperate with treatment	8
14. Potential for self-care deficit	8
15. Potential for violence	7
16. Fear of inadequate treatment	7
17. Potential for loss of consciousness	7
18. Impaired verbal communication	7
19. Potential for rape-trauma syndrome	6
20. Potential for disturbance in self-concept	6

Table 5 (continued)

Response	% of Sample Observing
21. Uncontrolled anger	5
22. Uncontrolled crying	4
23. Potential for injury to a child	4
24. Child abuse	2

The six most frequently seen response components from Table 5 were then classified with the six most frequently seen components in the following categories: 76-100%, 51-75%, 26-50%, and 1-25% and 0%. The results showed that four of the response components (potential for infection, potential for noncompliance with verbal aftercare instructions, increased pain, and potential for noncompliance with medical regimen) were present within the six most frequently seen responses across the first four categories. Thus, they were the most frequently seen response components.

Three response components appeared most frequently in both the 1-25% and 0% categories: child abuse, potential for rape trauma syndrome, and potential for injury to a

child. Thus, they were the least frequently seen response components. The results are presented in Table 6.

Table 6 presents the six most frequently seen response components in each category of the questionnaire. These responses are compared with the six most frequently seen response components from Table 5, represented by the 50%+ category.

Table 6

Rank Order of Response Components According to the  
Percentage of Subjects That Observed the Response in  
Each of the Frequency Categories

Response	<u>Observed Frequency Category</u>					
	100-76%	75-51%	50%+	50-26%	25-1%	0%
Potential for infection	1.5	1	1	4		
Increased pain	5	2	2	5		
Potential for noncompliance with aftercare instructions	3	3	3	2		
Potential for complications	1.5		4	1		
Potential non-compliance with medical regimen	4	6	5	3		



Table 6 (continued)

Response	<u>Observed Frequency Category</u>					
	100-76%	75-51%	50%+	50-26%	25-1%	0%
Potential for incorrect medication usage	6	4	6			
Inability to follow directions		5				
Potential for self-care deficit				6		
Child abuse					1	4
Potential for rape-trauma syndrome					2	1
Uncontrolled crying					3	
Potential for injury to a child					4	2
Uncontrolled anger					5	
Potential for violence					6	
Child's failure to cooperate with treatment						3
Fear of inadequate treatment						5.5

Table 6 (continued)

Response	<u>Observed Frequency Category</u>					
	100-76%	75-51%	50%+	50-26%	25-1%	0%
Potential disturbance in self-concept						5.5

#### Research Question Two

The second research question asked the frequency of occurrence, as estimated by emergency nurses, of the selected investigator generated nursing diagnoses (selected investigator generated responses plus selected investigation generated etiologies) which reflect the independent role in emergency patients secondary to illness/injury. The frequency of occurrence of the nursing diagnoses was tabulated. The nursing diagnoses were rank ordered according to the percentage of subjects that observed the nursing diagnoses in greater than 50% of the patients. Table 7 contains the results.

The ranking of the nursing diagnoses was done combining the 51-75% and the 76-100% categories of the questionnaire. One diagnosis, potential for incorrect medication usage

related to inadequate knowledge regarding prescribed medication protocols, was seen in greater than 50% of patients by 16% of the subjects. Two diagnoses (potential for infection related to inadequate knowledge of post treatment wound care and potential for noncompliance with verbal aftercare instructions related to anxiety induced narrowing of perceptions) were seen by 13% of the subjects. Eleven percent of the subjects stated that they observed the diagnoses, potential for complications related to lack of knowledge about aftercare treatments for injury/illness and ineffective intrafamily support related to family's inadequate knowledge of how to communicate concern in injury/illness situation, in greater than 50% of their patients. Table 7 contains a rank ordering of the nursing diagnoses according to the percentage of the sample that observed them greater than 50% of the time.

Table 7

Rank Ordering of Nursing Diagnoses According to the  
Percentage of Subjects That Observed the Diagnoses in  
Greater Than 50% of the Patients

Nursing Diagnosis	% of Sample Observing the Diagnosis in 50%+ of Patients
1. Potential for incorrect medication usage related to inadequate knowledge regarding prescribed medication protocols.	16
2. Potential for infection related to inadequate knowledge of post treatment wound care.	13
3. Potential for noncompliance with verbal aftercare instructions related to anxiety induced narrowing of perceptions.	13
4. Potential for complications related to lack of knowledge about aftercare treatments for injury/illness	11
5. Ineffective intrafamily support related to family's inadequate knowledge of how to communicate concern in injury/illness situation.	11

Table 7 (continued)

Nursing Diagnosis	% of Sample Observing the Diagnosis in 50%+ of Patients
6. Potential for self-care deficit related to impaired mobility resulting from injury/illness.	10
7. Potential noncompliance with medical regimen related to uncertainty of where to obtain needed information.	10
8. Severe anxiety related to inability to cope with impending treatment without additional information.	10
9. Inability to follow directions related to anxiety induced narrowing of perceptions.	9
10. Child's failure to cooperate with treatment related to parents' inability to provide emotional support.	9
11. Potential disturbance in self-concept related to inability to cope with changes in lifestyle required by injury/illness.	9
12. Increased pain related to lack of knowledge of pain reducing positioning techniques.	9

Table 7 (continued)

Nursing Diagnosis	% of Sample Observing the Diagnosis in 50%+ of Patients
13. Inability to problem solve related to anxiety induced narrowing of perceptions.	8
14. Potential for rape-trauma syndrome related to failure to resolve the crisis of rape.	7
15. Unrealistic fear of impending treatment related to inadequate resolution of previous emergency department experience.	7
16. Child abuse related to inappropriate parental coping strategies.	7
17. Potential for injury to a child related to parents' inadequate knowledge of appropriate safety precautionary measures.	5
18. Potential for violence related to perceptions of powerlessness in emergency situation.	5
19. Uncontrolled anger related to perceived powerlessness over the treatment situation.	5
20. Impaired verbal communication related to anxiety induced disorganization of thought processes.	4

Table 7 (continued)

Nursing Diagnosis	% of Sample Observing the Diagnosis in 50%+ of Patients
21. Fear of inadequate treatment related to uncertainty regarding competencies of emergency department staff.	4
22. Denial related to perceived powerlessness over the treatment situation.	4
23. Uncontrolled crying related to perceived powerlessness over the treatment situation.	3
24. Potential for loss of consciousness related to anxiety induced hypotension (vasovagal).	2
25. Potential for loss of consciousness related to anxiety induced hyperventilation.	1

The top six nursing diagnoses from Table 4 were then compared and contrasted with the top nursing diagnoses in the following categories: 76-100%, 51-75%, 26-50%, 1-25%, and 0%. The results are displayed in Table 8.

Four of the diagnoses appeared within the top six diagnoses in the 50%+, 76-100%, 51-75%, and 26-50%

categories. They were: potential for incorrect medication usage related to inadequate knowledge regarding prescribed medication protocols, potential for infection related to inadequate knowledge of post treatment wound care, potential for noncompliance with verbal aftercare instructions related to anxiety induced narrowing of perceptions, and potential for complications related to lack of knowledge about aftercare treatments for injury/illness.

Four diagnoses also appeared in the top six diagnoses of the 1-25% and 0% categories which made them the least frequently seen diagnoses. The diagnoses were: potential for rape-trauma syndrome related to failure to resolve the crisis of rape, potential for loss of consciousness related to anxiety induced hypotension (vasovagal), potential for loss of consciousness related to anxiety induced hyperventilation, and uncontrolled crying related to perceived powerlessness over the treatment situation. One diagnosis, potential for rape-trauma syndrome related to failure to resolve the crisis of rape, was never seen by 54% of the subjects.

The percentage of subjects who observed any diagnosis greater than 75% of the time was extremely small. The most frequently seen diagnosis, potential for noncompliance with verbal aftercare instructions related to anxiety



induced narrowing of perceptions, was seen 76-100% of the time by only 4% of the sample. The other diagnoses ranged from 0% to 3%.

Table 8 presents the six most frequently seen nursing diagnoses in each category of the questionnaire. These diagnoses are compared with the six most frequently seen nursing diagnoses from Table 7, represented by the 50%+ category.

Table 8

Rank Ordering of Nursing Diagnoses According to the  
Percentage of Subjects That Observed the Response in  
Each of the Observation Frequency Categories

Nursing Diagnosis	<u>Observed Frequency Category</u>					
	100-76%	75-51%	50%+	50-26%	25-1%	0%
Potential for incorrect medication usage related to knowledge regarding perscribed medication protocols.	2	1	1	3		
Potential for infection related to inadequate knowledge of post treatment wound care.	3.25	2	2	6.5		

Table 8 (continued)

Nursing Diagnosis	<u>Observed Frequency Category</u>					
	100-76%	75-51%	50%+	50-26%	25-1%	0%
Potential for non-compliance with verbal aftercare instructions related to anxiety induced narrowing of perceptions.	1	6.5	3	2		
Potential for complications related to lack of knowledge about aftercare treatments for injury/illness.	3.25	5	4	1		
Ineffective intra-family support related to family's inadequate knowledge of how to communicate concern in injury/illness situation.		3	5	5		
Potential for self-care deficit related to impaired mobility resulting from injury/illness.		4	6			
Potential disturbance in self-concept related to inability to cope with changes in lifestyle required by injury/illness.				4		

Table 8 (continued)

Nursing Diagnosis	<u>Observed Frequency Category</u>					
	100-76%	75-51%	50%+	50-26%	25-1%	0%
Inability to follow directions related to anxiety induced narrowing of perceptions.	3.25			6.5		
Potential for rape-trauma syndrome related to failure to resolve the crisis of rape.	3.25				5.5	1
Potential noncompliance with medical regimen related to uncertainty of where to obtain needed information.		6.5				5
Potential for loss of consciousness related to anxiety induced hypotension (vasovagal).					1	2
Potential for loss of consciousness related to anxiety induced hyperventilation.					2	3
Uncontrolled crying related to perceived powerlessness over the treatment situation.					3	4

Table 8 (continued)

Nursing Diagnosis	<u>Observed Frequency Category</u>				
	100-76%	75-51%	50%+	50-26%	25-1% 0%
Fear of inadequate treatment related to uncertainty regarding competencies of emergency department staff.					4
Denial related to perceived powerlessness over the treatment situation.					5.5
Increased pain related to lack of knowledge of pain reducing positioning techniques.					6

### Research Question Three

The third research question asked what additional etiologies were associated with the selected investigator generated (potential or actual) unhealthful responses in emergency patients secondary to injury/illness as identified by emergency nurses.

A list of 887 different etiologies was collated from the responses of the sample. Because of the magnitude of the list the etiologies were sorted into six

investigator generated categories: etiologies which contain attributes which are not changeable; etiologies which contain events which are not changeable; etiologies which contain medical diagnoses or which require a physician's order for treatment; etiologies which refer to the ED staff and not the patient; etiologies which are unclear, ambiguous, circular, or incomplete; and etiologies which when combined with the response component form additional nursing diagnoses representing the independent role.

The six categories were defined using the list of etiologies from the subjects and a list of the common errors in diagnosing from Ziegler et al. (1986). Ziegler et al. stated that the following problems resulted in errors in the etiology components: a statement which is not amenable to nursing's independent functions; a statement which fails to identify a changeable etiology; a statement which is vague or abstract; and a statement which includes multiple etiologies (pp. 92-94). Four of the six categories (etiologies which contain attributes which are not changeable; etiologies which contain events which are not changeable; etiologies which contain medical diagnoses or which require a physician's order for treatment; and etiologies which are unclear, ambiguous,

circular, or incomplete) represented the Ziegler et al. (1986) problems. The fifth category contained etiologies which refer to the staff and not the patient. The sixth category represented those etiologies which were possibly amenable to nursing's independent role. Table 9 describes the number and percent of the 887 subject generated etiology components obtained in each category.

Table 9

Classification of Subject Generated Etiologies - Frequency and Percentage

Category	Etiologies	
	Number	Percent
Etiologies which when combined with response component form additional nursing diagnoses representing independent role.	347	39%
Etiologies which contain attributes which are not changeable.	193	22%
Etiologies which contain medical diagnoses or which require a physician's order for treatment.	134	15%
Etiologies which contain events which are not changeable.	107	12%

Table 9 (continued)

Classification of Subject Generated Etiologies - Frequency  
and Percentage

Category	Etiologies	
	Number	Percent
Etiologies which are unclear, ambiguous, circular, or incomplete.	86	10%
Etiologies which refer to the ED staff and not the patient.	20	2%

Twenty etiology components generated by the sample were classified in category of refers to staff, not to patient. This represented 2% of the subject generated etiologies. Examples of these etiologies included: potential for infection related to contact with staff dealing with a variety of unclean situations; uncontrolled anger related to emergency providers response; fear of inadequate treatment related to age of emergency department staff; increased pain related to manipulation by medical personnel; and potential for noncompliance with verbal aftercare instructions related to inadequate teaching techniques.

Unclear, ambiguous, circular, and incomplete etiologies accounted for 10% of the generated etiologies (n=86). Examples of these etiologies included: severe anxiety related to abnormal Q profile; potential for incorrect medication usage related to traveling through town; and child abuse related to neighbor or grandparents.

In the category of events which are not changeable, 107 etiologies were classified which represented 12% of the generated etiologies. Examples of these etiologies included: severe anxiety related to stat surgery; potential for loss of consciousness related to trauma; uncontrolled crying related to death of a relative; increased pain related to injury itself; and potential for violence related to criminal activity.

Fifteen percent of the etiologies generated by the sample (n=134) were classified in the category of medical diagnoses or physician's order required for treatment. Examples of these etiologies included: severe anxiety related to agoraphobia; potential for infection related to diabetes; inability to follow directions related to head injury; denial related to myocardial infarction; and increased pain related to fracture.

A total of 193 etiologies were classified in the category of attributes which are not changeable. This



represented 22% of the etiologies formulated by the sample. Examples of these etiologies include: severe anxiety related to psychiatric history; potential for infection related to debilitated state; potential for incorrect medication usage related to inability to read; inability to follow directions related to low intelligence level; and potential for self-care deficit related to age.

The remainder of the etiologies generated by the sample, 347 etiologies (39%), when paired with the response components, were believed to possibly represent the independent role. A list was compiled of the diagnoses and they were submitted to a panel of experts for further classification.

#### Research Question Four

The fourth research question asked to what extent the additional nursing etiologies (for the selected investigator generated responses) identified by the emergency nurses were associated with the independent or interdependent nursing role. A total of 347 potential additional nursing diagnoses representing the independent role were mailed to a panel of four experts on the Ziegler et al. (1986) model and in nursing diagnosis. Acceptance of a diagnosis by three of the four panel members constituted acceptance

of the diagnosis as one representing the independent role of nursing.

From the list of 347 potential diagnoses, 311 were believed to reflect the independent role by three of the four members of the panel of experts. Interrater reliability was assessed using Cohens K. The resulting  $+0.70$  indicated a relatively high interrater agreement. In 203 of the potential diagnoses all four members of the panel of experts believed the potential diagnosis reflected independent role activities. The 311 nursing diagnoses which were believed to reflect the independent role by at least three of the four researchers are contained in Appendix L.

#### Summary of Findings

A summary of the findings from this national survey of emergency nurses follows:

1. Forty percent of the sample stated they had never been taught to write nursing diagnoses.
2. Forty-seven percent of the total sample stated they were taught to write nursing diagnoses in their basic nursing programs. This represented 77% of the subjects who stated that they had been taught to write nursing diagnoses.

3. None of the response components were observed in greater than 50% of patients by greater than 50% of the subjects (Research question 1).

4. None of the investigator generated nursing diagnoses reflecting independent role were seen in greater than 50% of patients by greater than 20% of the subjects (Research question 2).

5. The etiologies generated under the Additional Etiologies section of the questionnaire were quite numerous. A total of 887 different etiologies was compiled (Research question 3).

6. Many new etiology components for each response component were generated by the sample and, when critiqued by a panel of experts, 311 (35% of the total) were found to represent nursing diagnoses reflecting the independent role (Research question 4).

7. There was a tendency for the subjects to generate etiologies which did not meet the criteria (65% of the total).

8. Responses were recognized as occurring in patients by more subjects than were complete diagnoses.

9. Four of the six response components most frequently seen in greater than 50% of patients were part of the six

nursing diagnoses most frequently seen in greater than 50% of patients by the subjects.

10. The least frequently seen response component (rape-trauma syndrome) was part of the nursing diagnosis least frequently seen in patients by the subjects.

11. One of the six response components most frequently seen in greater than 50% of the patients by the sample was included in one of the six nursing diagnoses least frequently seen in patients by the sample (potential noncompliance with medical regimen related to uncertainty of where to obtain needed information).

## CHAPTER V

### SUMMARY OF THE STUDY

In this chapter a summary of the study is presented. Findings are discussed and conclusions and implications are drawn. A few recommendations for further studies are suggested.

#### Summary

The problem of the study was the validation, by emergency nurses, of investigator generated nursing diagnoses occurring secondary to illness/injury in emergency patients. Four research questions were investigated during the study. They were:

1. What is the frequency of occurrence, as estimated by emergency nurses, of the investigator generated (actual or potential) unhealthful responses of ill or injured emergency patients?

2. What is the frequency of occurrence, as estimated by emergency nurses, of the selected investigator generated nursing diagnoses (selected investigator generated responses plus selected investigator generated

etiologies) which reflect the independent nursing role in ill or injured emergency patients?

3. What additional etiologies are associated with the selected investigator generated (potential or actual) unhealthful responses in ill or injured emergency patients as identified by emergency nurses?

4. To what extent are additional nursing etiologies (for the selected investigator generated responses) identified by the emergency nurses associated with the independent or interdependent nursing role?

The study used a quantitative research method, the descriptive design. The setting for the research was chapter meetings of the Emergency Nurses' Association throughout the United States. The population of the study consisted of emergency nurses who were members of the local, state, and national Emergency Nurses' Association chapters. The individual subjects from the chapters were selected by means of a convenience technique; however, cluster sampling was used to select chapters from which the volunteer subjects came. Individual participants were guaranteed anonymity, and participating chapters were guaranteed confidentiality.

The United States was divided into six geographical areas: northeast, southeast, north central, south central,

northwest, and southwest. A list of local Emergency Nurses' Association chapters was divided into the six geographical areas. Twenty-five percent of the chapters were surveyed from each geographical area (59 total chapters). Ten questionnaires were mailed to each selected chapter (590 questionnaires). A total of 245 questionnaires were returned (42%).

Four instruments were utilized to collect the data needed to answer the research questions: the Demographic Data Sheet (see Appendix G), the Response Component Questionnaire (see Appendix A), the Etiology Component Survey (see Appendix B), and the Etiology Evaluation Questionnaire (see Appendix C). The first three instruments were completed by the study's sample. The last instrument was completed by a panel of experts in nursing diagnosis.

A degree of content validity had been established for the list of diagnoses prior to data collection through pilot studies. However, the reliability of the questionnaire is unknown. Some degree of reliability was ascertained for the Etiology Evaluation Questionnaire through the use of interrater agreement procedures.

A summary of the findings from this national survey of emergency nurses follows:

1. Forty percent of the sample stated they had never been taught to write nursing diagnoses.

2. Forty-seven percent of the sample stated they were taught to write nursing diagnoses in their basic nursing programs. This represented 77% of the subjects who stated they had been taught to write nursing diagnoses.

3. None of the response components were observed in greater than 50% of patients by greater than 50% of the subjects.

4. None of the investigator generated nursing diagnoses reflecting independent role were seen in greater than 50% of patients by greater than 20% of the subjects.

5. The etiologies generated under the Additional Etiologies section were quite numerous. A total of 887 different etiologies was compiled.

6. Many new etiology components for each response component were generated by the sample and, when critiqued by a panel of experts, 311 (35% of the total) were found to represent nursing diagnoses reflecting the independent role.

7. There was a tendency for the subjects to generate etiologies which did not meet the criteria (65% of the total).



8. Responses were recognized as occurring in patients by more subjects than were actual diagnoses.

9. Four of the six response components seen most frequently in greater than 50% of patients were part of the six nursing diagnoses seen most frequently in greater than 50% of patients by the subjects.

10. The least frequently seen response component was part of the nursing diagnosis least frequently seen in patients by the subjects.

11. One of the six response components seen most frequently in greater than 50% of the patients by the subjects was included in one of the six nursing diagnoses least frequently seen in patients by the sample (potential noncompliance with medical regimen related to uncertainty of where to obtain needed information).

#### Discussion of Findings

The findings of this study reflect some of the current problems existing in implementation of nursing diagnosis within a practice setting. Until the concept is adequately defined by the experts, implementation will be sporadic and confusing, if not impossible.

Forty percent of the subjects in the study stated they had never been taught to write nursing diagnosis. Only

47% of the subjects reported that they were taught to write them within their basic education programs. The majority of the sample received their education in associate degree or diploma programs.

Gaines and McFarland (1984) surveyed 74 baccalaureate schools of nursing and found that the use of nursing diagnosis was present in 70 of the schools. Deback (1981) surveyed 20 baccalaureate nursing programs and found that senior nursing students could not competently formulate nursing diagnoses. Thus, although the concept is being presented within most baccalaureate programs, it is not being understood by the students. Perhaps this is because the concept is poorly understood by the faculties of baccalaureate schools of nursing as suggested by Deback (1981).

Seventy-three percent of the subjects for the study attended associate degree or diploma schools of nursing; 27%, baccalaureate schools. Only 60% of the subjects stated they had been taught to write nursing diagnoses. These findings may account for the large number of subject generated etiologies which failed to meet the criteria for independent role.

The 40% of the subjects who related that they were never taught to formulate nursing diagnoses could have been

exposed to the concept through inservice programs, seminars, or continuing education programs. However, only 50% of the sample who were taught to write nursing diagnoses received that education through inservices, seminars, or continuing education programs. For nurses who have little knowledge of nursing process or nursing diagnosis, perhaps opportunities to obtain that knowledge have not been presented as frequently as necessary. Increased emphasis on inservice and continuing education programs within the practice setting might prove beneficial.

Although the intent of this study was to identify nursing diagnoses commonly observed in emergency patients, none of the response components presented to the subjects were observed in greater than 50% of patients by greater than 50% of the sample. Many of the response components came from the NANDA approved list of responses frequently observed in patients within all areas of nursing. However, none of the responses tested in this investigation are being seen frequently in emergency nursing according to the findings of this study.

Although the subjects stated that the responses were not frequently seen, 887 different etiologies were generated by the subjects for the 24 responses. Additional etiologies of this magnitude are incongruous with the findings from

the Response Component Questionnaire which showed that the response components were infrequently seen in emergency patients. However, the large number of subject generated etiologies may suggest interest within emergency nursing in the development of nursing diagnoses specific to this area.

Another possible explanation for the numerous subject generated etiologies might be the instrumentation used in the study. The instruments were designed to assist the subjects to understand the concept of nursing diagnosis so that they would be able to generate additional etiologies. The 25 listed diagnoses served as examples for the subjects in addition to being part of the data collection. This strategy appears to have worked well for the generation of additional etiologies by the subjects.

None of the investigator generated nursing diagnoses reflecting independent role were seen in greater than 50% of patients by greater than 20% of the subjects. This finding suggests that none of the diagnoses defined commonly seen problems with emergency patients. Perhaps the field of emergency nursing encompasses such a broad range of responses that there are no common nursing diagnoses among emergency patients. This finding may account for the numerous subject generated additional etiologies.

A total of 887 different etiologies were generated by the subjects. Of these, 311 were found to reflect independent role by a panel of experts. This finding seems to suggest that each response component is being seen within emergency patients, but not at the hypothesized frequency of occurrence.

There was a tendency for subjects to generate etiologies which did not meet the criteria. This may have been caused by a poor understanding of the concept of nursing diagnosis, by confusion in the literature over defining the concept, or by infrequent exposure to the concept. Many of the diagnoses reflected errors common to those who are novices at nursing diagnosis. Many diagnoses reflected interdependent role functions. Some experts in nursing diagnoses believe that interdependent role functions should be represented in nursing diagnoses (Hubalik & Kim, 1984; Guzzetta & Dossey, 1983). Current literature reflects both the independent and interdependent roles within nursing diagnoses. The Ziegler et al. (1986) Nursing Process Model reflects only the independent role. Thus, many additional etiology components did not meet the Ziegler criteria. In 1986 Larson challenged emergency nurses to develop nursing diagnoses that reflected independent role and that could be utilized in practice

(p. 127). To date no one has answered that challenge, possibly indicating that the concept of nursing diagnosis is poorly understood by emergency nurses and difficult to relate to practice.

Response components were recognized as occurring in patients by more subjects than were actual nursing diagnoses. Adding the etiology component seemed to have increased the complexity and specificity of the diagnosis, thereby limiting the scope.

Four of the top six response components seen in greater than 50% of the patients were part of the top six nursing diagnoses seen in greater than 50% of the patients by the subjects. Thus, the response components, potential for infection, potential for incorrect medication usage, potential for noncompliance with verbal aftercare instructions, and potential for complications became part of the most frequently seen nursing diagnoses. However, adding the etiology component seemed to limit the scope and applicability of the response components, accounting for the decreased percentage of subjects who encountered the nursing diagnoses.

The top response component which was never seen in patients was part of the top nursing diagnosis which was never seen in patients. Thus, the response component,

potential for rape-trauma syndrome, was the least frequently seen response component and comprised part of the least frequently seen nursing diagnosis. Burgess (1985) described the crisis response to rape in an article which included the etiology, the defining characteristics, and the signs and symptoms of the nursing diagnosis labeled rape-trauma syndrome. Of all of nursing practice, emergency nurses should be seeing this response component and diagnosis. One reason for the discrepancy may be that the treatment of rape victims in very specialized and usually only one or two hospitals in any metropolitan area deal with evidence collection and treatment of the victims of rape. The opinion of the subjects for this study may not have reflected the true occurrence of the nursing diagnosis.

One of the top six response components (potential noncompliance with medical regimen) seen in greater than 50% of patients by the subjects was included in one of the top six nursing diagnoses never seen in patients by the subjects. This finding would suggest that the etiology component makes the difference in the nursing diagnosis. The etiology component individualizes the nursing diagnosis to a specific patient response. The listed etiology component apparently did not reflect the

reason why the response component was seen in emergency patients, or perhaps indeed there are a large number of potential etiologies.

### Conclusions and Implications

Several conclusions can be drawn from the results of the study. First, a variety of nursing diagnoses that address nursing's independent functions are observed in emergency patients by emergency nurses. This suggests that there is an independent role for nurses within this critical care setting. Further research into the independent role of the emergency nurse will enhance understanding of that role by the emergency nursing community.

Second, combining patient responses with an etiology component increases the specificity of the diagnosis and limits the scope. Patient responses were seen more frequently than specific diagnoses by the sample. Many additional etiologies were developed by the subjects to explain each patient response component. This suggests that each response seen in patients has multiple etiological possibilities and implies that there may be no commonly seen nursing diagnoses in emergency patients.

Third, emergency nurses had difficulty separating their independent functions from their interdependent



functions. Thus, they had difficulty writing nursing diagnoses that reflected nursing's independent role. Clarification of the role functions in nursing literature coupled with a consensus among nursing experts on the definition of nursing diagnosis would decrease confusion within the profession.

Fourth, although many of the subjects who responded had little experience with or exposure to nursing diagnosis, the magnitude of the additional etiologies received showed interest within the emergency nursing community in the concept of nursing diagnosis. An increased emphasis on teaching the concept in schools of nursing, as well as through continuing education programs, would increase understanding within the profession. Research within the emergency nursing community into nursing diagnosis may increase use in this area by enhancing understanding of the applicability of the concept to the emergency patient.

#### Recommendations for Further Study

Descriptive studies are the beginning step in researching a specific concept. From the results of this study, research into nursing diagnosis and independent role in emergency nursing can evolve. Each of the 331 subject generated nursing diagnoses could be tested in

clinical settings. Each of the response components could be tested using the subject generated etiologies for each response to determine if common nursing diagnoses occur frequently in emergency patients.

Other potential studies might stem from this study. A two-component nursing diagnosis format for emergency nursing based on the Ziegler et al. (1986) Nursing Process Model could be developed, since this study showed that the model was useful in emergency nursing diagnosis formulation. A quality assurance program based on nursing diagnoses and outcome criteria specific to those diagnoses could be formulated for use in emergency nursing. Further delineation and clarification of the independent role of the emergency nurse could also be researched.

## REFERENCES

- Allen, J. R. (1984). Why nursing diagnoses are important in perioperative nursing. AORN Journal, 40(2), 268-272.
- Avant, K. (1979). Nursing diagnosis: Maternal attachment. Advances in Nursing Science, 2, 45-55.
- Blansfield, J., Fackler, C., & Bergeron, B. (1985). Developing standardized care plans: One emergency department's experience. Journal of Emergency Nursing, 11(6), 304-309.
- Broome, M. E. (1985). Working with the family of a critically ill child. Heart & Lung, 14(2), 368-372.
- Burgess, A. W. (1985). Rape trauma syndrome: A nursing diagnosis. Occupational Health Nursing, 33(8), 405-406.
- Cardona, V. D. (1982). Trauma post op the real nursing challenge. RN, 45(3), 23-29.
- Carnevali, D. L. (1985). A daily living functional health status perspective for nursing diagnosis and treatment in critical care nursing. Heart & Lung, 14(5), 437-443.
- Clark, S. R. (1984). Nursing diagnosis its application in an ambulatory care setting. Topics in Clinical Nursing, 5(4), 57-67.
- Cleary, M. J. (1985). Integration of the nursing diagnostic process within the clinical setting. Critical Care Nurse, 5(1), 28-29.
- Coffman, S. (1986). Description of a nursing diagnosis: Alteration in bowel elimination related to neurogenic bowel in children with myelomeningocele. Issues in Comprehensive Pediatric Nursing, 9, 179-191.

- Corrigan, J. O. (1986). Functional health pattern assessment in the emergency department. Journal of Emergency Nursing, 12(3), 163-167.
- Davidson, S. B. (1984). Nursing diagnosis its application in the acute care setting. Topics in Clinical Nursing, 5(4), 50-56.
- Deback, V. (1981). The relationship between senior nursing students' ability to formulate nursing diagnoses and the curriculum model. Advances in Nursing Science, 3, 51-66.
- Edel, M. K. (1985). Noncompliance: An appropriate nursing diagnosis? Nursing Outlook, 33(4), 183-185.
- ENA position statement on the use of prehospital care providers (EMT's) in emergency departments. (1985, January). Etcetera, p. 4
- Estrada, E. G. (1981). Triage systems. Nursing Clinics of North America, 16(1), 13-23.
- Forsyth, M. C. (1985). Nursing diagnosis in occupational health. Occupational Health Nursing, 33(8), 390-392.
- Gaines, B. C., & McFarland, M. B. (1984). Nursing diagnosis its relationship and use in nursing education. Topics in Clinical Nursing, 5(4), 349.
- Gebbie, K. M. (1984). Nursing diagnosis: What is it and why does it exist? Topics in Clinical Nursing, 5(4), 1-9.
- Giubilato, R. T. (1982). Acute care of the high-level quadriplegic patient. Journal of Neurosurgical Nursing, 14(3), 128-132.
- Gordon, M. (1982). Nursing diagnosis process and application. New York: McGraw Hill.
- Guzzetta, C. E., & Dossey, B. M. (1983). Nursing diagnosis: Framework, process, and problems. Heart & Lung, 12(3), 281-291.

- Guzzetta, C. E., & Forsyth, G. L. (1979). Nursing diagnosis pilot study: Psychophysiologic stress. Advances in Nursing Science, 2, 27-43.
- Halloran, E. J. (1985). Nursing workload, medical diagnosis related groups, and nursing diagnoses. Research in Nursing and Health, 8, 421-433.
- Hamilton, P. (1983). Community nursing diagnosis. Advances in Nursing Science, 5, 21-36.
- Hill, M., & Fink, J. W. (1983). In hypertensive emergencies, act quickly but also act cautiously. Nursing 83, 13(2), 34-41.
- Hoskins, L. M., McFarlane, E. A., Rubenfeld, M. G., Walsh, M. B., & Schreier, A. M. (1986). Nursing diagnosis in the chronically ill. Advances in Nursing Science, 8(3), 80-89.
- Hoppe, M. C. (1983). Nutritional management of the trauma patient. Critical Care Quarterly, 6(1), 1-16.
- Hoyt, K. S. (1983). Chest trauma. Nursing 83, 13(5), 34-41.
- Hubalik, K., & Kim, M. J. (1984). Nursing diagnoses associated with heart failure in critical care. In M. J. Kim, G. K. McFarlane, & A. M. McLane (Eds.), Classification of Nursing Diagnoses Proceedings of the Fifth National Conference (pp. 139-149). St. Louis: C. V. Mosby Company.
- Johnson, D. L. (1983). Postoperative low cardiac output in infancy. Heart & Lung, 12(6), 603-609.
- Johnson, M. N. (1984). Theoretical basis for nursing diagnosis in mental health nursing. Issues in Mental Health Nursing, 6, 53-71.
- Kaplow, R., & Fromme, L. R. (1985). Nursing care plan for the patient receiving high-frequency jet ventilation. Critical Care Nursing, 5(1), 25-27.

- Kim, M. J. (1980). Issues related to research on the classification of nursing diagnosis. In M. J. Kim, G. K. McFarlane, & A. M. McLane (Eds.), Classification of Nursing Diagnoses Proceedings of the Fourth National Conference (pp. 124-133). St. Louis: C. V. Mosby Company.
- Kim, M. J., Amoroso-Seritella, R., Gulanick, M., Moyer, K., Parsons, E., Scherbel, J., Stafford, M. J., Suhayda, R., & Yocum, C. (1984). Clinical validation of cardiovascular nursing diagnoses. In M. J. Kim, G. K. McFarlane, & A. M. McLane (Eds.), Classification of Nursing Diagnoses Proceedings of the Fifth National Conference (pp. 128-138). St. Louis: C. V. Mosby Company.
- Larson, L. (1986). Nursing diagnosis: Defining it and fitting it into the nursing process. Journal of Emergency Nursing, 12(3), 127-128.
- Miller, M. (1981). Emergency management of the unconscious patient. Nursing Clinics of North America, 16(1), 59-73.
- Moynihan, B. A., & Duncan, J. W. (1981). The role of the nurse in the care of sexual assault victims. Nursing Clinics of North America, 16(1), 95-100.
- Mundinger, M. O. (1980). Autonomy of Nursing. Germantown, MD: Aspen Systems.
- Novotny-Dinsdale, V. (1985). Implementation of nursing diagnosis in one emergency department. Journal of Emergency Nursing, 11(3), 140-144.
- Polit, D. F., & Hungler, B. P. (1978). Nursing research: Principles and methods. Philadelphia: J. B. Lippincott Co.
- Podgorny, G., & Stanley, L. (1982). Gunshot victims. RN, 45(4), 47-51.
- Rossi, L. (1984, March). [Letter to the editor]. Heart & Lung, 210-211.
- Saclarides, E. E., Parrish, R. K., & Saclarides, T. J. (1982). Ocular emergencies. Journal of Ophthalmic Nursing and Technology, 1(2), 43-49.

- Shelley, S. I. (1984). Research methods in nursing and health. Boston: Little, Brown, & Co.
- Sigmon, H. D. (1983). Trauma this patient needs your expert help. Nursing 83, 13(1), 33-39.
- Sjoberg, E. L. (1983). Nursing diagnosis in the COPD patient. American Journal of Nursing, 83, 245-248.
- Steele, D., & Whalen, J. (1985). A proposal for two new nursing diagnoses: Potential for organ failure and potential for tissue destruction. Heart & Lung, 14(5), 426-430.
- Tanner, C. A. (1985). Symposium on nursing diagnosis in critical care overview. Heart & Lung, 14(5), 423-425.
- Tanner, C. A., & Hughes, A. G. (1984). Nursing diagnosis issues in clinical practice research. Topics in Clinical Nursing, 5(4), 30-37.
- Thompson, J. D. (1986). Nursing diagnosis: An overview and application to emergency nursing. Journal of Emergency Nursing, 12(4), 218-224.
- Thompson, N. A. (1983). Convert your assessment into a lifesaving care plan for the patient with abdominal trauma. Nursing 83, 13(7), 26-33.
- Toth, L., Cost, D., Keyes, B., Deli, S., & Berkowich, B. (1984). Implementation of nursing diagnosis in the trauma setting. In M. J. Kim, G. K. McFarland, & A. L. McLane (Eds.), Classification of Nursing Diagnosis Proceedings of the Fifth National Conference (pp. 291-298). St. Louis: C. V. Mosby Company.
- Visser, G., & Volckmann, C. (1984). How reliable is the diagnosis by the ambulance nurse in case of accidental injuries? Acta Aneesthesiologica Belgica, 35, 93-95.
- Yoder, M. E. (1984). Nursing diagnosis application in perioperative practice. AORN Journal, 40, 183-188.
- Wake, M. M., McLane, A. M., & Gotch, P. M. (1985). Nursing diagnosis in critical care: Reflections and future directions. Heart & Lung, 14(5), 444-448.

- Waltz, C., & Bausell, R. B. (1981). Nursing research: Design, statistics, and computer analysis. Philadelphia: F. A. Davis Co.
- Waltz, C., Strickland, O. L., & Lenz, E. R. (1984). Measurement in nursing research. Philadelphia: F. A. Davis Co.
- Westfall, U. E. (1984). Nursing diagnosis its use in quality assurance. Topics in Clinical Nursing, 5(4), 78-87.
- Westra, B. (1983). Prehospital care providers in the emergency department. Journal of Emergency Nursing, 9, 241-244.
- Young, M. S., & Lucas, C. V. (1984). Nursing diagnosis common problems in implementation. Topics in Clinical Nursing, 5(4), 68-77.
- Ziegler, S. M., Vaughan-Wrobel, B., & Erlen, J. (1986). Nursing process, nursing diagnosis, and nursing knowledge: Avenues to autonomy. Englewood Cliffs, NJ: Prentice-Hall.



## APPENDICES

APPENDIX A

Response Component Questionnaire

RESPONSE COMPONENT QUESTIONNAIRE

<u>RESPONSES</u>	<u>PERCENT OF PATIENTS WITH RESPONSE</u>				
	<u>Zero</u>	<u>1-25</u>	<u>26-50</u>	<u>51-75</u>	<u>76-100</u>
1. Severe anxiety_____	:	:	:	:	:
2. Potential for infection_____	:	:	:	:	:
3. Potential for incorrect medication usage_____	:	:	:	:	:
4. Potential for loss of consciousness_____	:	:	:	:	:
5. Inability to follow directions_____	:	:	:	:	:
6. Uncontrolled anger_____	:	:	:	:	:
7. Uncontrolled crying_____	:	:	:	:	:
8. Denial_____	:	:	:	:	:
9. Fear of inadequate treatment_____	:	:	:	:	:
10. Increased pain_____	:	:	:	:	:
11. Ineffective intrafamily support_____	:	:	:	:	:
12. Potential for noncompliance with verbal aftercare instructions_____	:	:	:	:	:
13. Potential for rape-trauma syndrome_____	:	:	:	:	:
14. Potential for self-care deficit_____	:	:	:	:	:
15. Potential disturbance in self-concept_____	:	:	:	:	:
16. Inability to problem solve_____	:	:	:	:	:
17. Potential for violence_____	:	:	:	:	:
18. Child's failure to cooperate with treatment_____	:	:	:	:	:
19. Unrealistic fear of impending treatment_____	:	:	:	:	:
20. Potential for injury to a child_____	:	:	:	:	:
21. Impaired verbal communication_____	:	:	:	:	:
22. Potential for complications_____	:	:	:	:	:
23. Child abuse_____	:	:	:	:	:
24. Potential noncompliance with medical regimen:_____	:	:	:	:	:

APPENDIX B  
Etiology Component Survey

## ETIOLOGY COMPONENT SURVEY

RESPONSES & etiologies	PERCENT OF PATIENTS WITH etiologies				
	Zero	1-25	26-50	51-75	76-100
1. SEVERE ANXIETY related to <u>inability to cope</u> with <u>impending treatment</u> without <u>additional information.</u>	:	:	:	:	:
Additional etiologies _____	:	:	:	:	:
2. POTENTIAL FOR INFECTION related to <u>inadequate knowledge of post treatment</u> <u>wound care.</u>	:	:	:	:	:
Additional etiologies _____	:	:	:	:	:
3. POTENTIAL FOR INCORRECT MEDICATION USAGE related to <u>inadequate knowledge regarding</u> <u>prescribed medication protocols.</u>	:	:	:	:	:
Additional etiologies _____	:	:	:	:	:
4. POTENTIAL FOR LOSS OF CONSCIOUSNESS related to <u>anxiety induced hyperventilation.</u>	:	:	:	:	:
Additional etiologies _____	:	:	:	:	:
5. POTENTIAL FOR LOSS OF CONSCIOUSNESS related to <u>anxiety induced hypotension (vasovagal)</u>	:	:	:	:	:
Additional etiologies _____	:	:	:	:	:
6. INABILITY TO FOLLOW DIRECTIONS related to <u>anxiety induced narrowing of perceptions.</u>	:	:	:	:	:
Additional etiologies _____	:	:	:	:	:
7. UNCONTROLLED ANGER related to <u>perceived</u> <u>powerless over the treatment situation.</u>	:	:	:	:	:
Additional etiologies _____	:	:	:	:	:
8. UNCONTROLLED CRYING related to <u>perceived</u> <u>powerlessness over the treatment situation.</u>	:	:	:	:	:
Additional etiologies _____	:	:	:	:	:
9. DENIAL related to <u>perceived powerlessness</u> <u>over the treatment situation.</u>	:	:	:	:	:
Additional etiologies _____	:	:	:	:	:

RESPONSES & etiologies	Percentage of patients with etiology				
	Zero	1-25	26-50	51-75	76-100
10. FEAR OF INADEQUATE TREATMENT related to <u>uncertainty regarding competencies of emergency department staff.</u>	:	:	:	:	:
Additional etiologies _____	:	:	:	:	:
11. INCREASED PAIN related to <u>lack of knowledge of pain reducing positioning techniques.</u>	:	:	:	:	:
Additional etiologies _____	:	:	:	:	:
12. INEFFECTIVE INTRAFAMILY SUPPORT related to <u>family's inadequate knowledge of how to communicate concern in injury/illness situation.</u>	:	:	:	:	:
Additional etiologies _____	:	:	:	:	:
13. POTENTIAL FOR NONCOMPLIANCE WITH VERBAL AFTERCARE INSTRUCTIONS related to <u>anxiety induced narrowing of perceptions.</u>	:	:	:	:	:
Additional etiologies _____	:	:	:	:	:
14. POTENTIAL FOR RAPE-TRAUMA SYNDROME related to <u>failure to resolve the crisis of rape.</u>	:	:	:	:	:
Additional etiologies _____	:	:	:	:	:
15. POTENTIAL FOR SELF-CARE DEFICIT related to <u>impaired mobility resulting from injury/illness.</u>	:	:	:	:	:
Additional etiologies _____	:	:	:	:	:
16. POTENTIAL DISTURBANCE IN SELF-CONCEPT related to <u>inability to cope with changes in lifestyle required by injury/illness.</u>	:	:	:	:	:
Additional etiologies _____	:	:	:	:	:
17. INABILITY TO PROBLEM SOLVE related to <u>anxiety induced narrowing of preceptions.</u>	:	:	:	:	:
Additional etiologies _____	:	:	:	:	:

RESPONSES & etiologies	Percentage of patients with <u>etiology</u>				
	Zero	1-25	26-50	51-75	76-100
18. POTENTIAL FOR VIOLENCE related to <u>perceptions of powerlessness in emergency situation.</u>	:	:	:	:	:
Additional etiologies _____					
19. CHILD'S FAILURE TO COOPERATE WITH TREATMENT : related to <u>parents' inability to provide emotional support.</u>	:	:	:	:	:
Additional etiologies _____					
20. UNREALISTIC FEAR OF IMPENDING TREATMENT : related to <u>inadequate resolution of previous: emergency department experience.</u>	:	:	:	:	:
Additional etiologies _____					
21. POTENTIAL FOR INJURY TO A CHILD related to <u>parents' inadequate knowledge of appropriate safety precautionary measures.</u>	:	:	:	:	:
Additional etiologies _____					
22. IMPAIRED VERBAL COMMUNICATION related to <u>anxiety induced disorganization of thought processes.</u>	:	:	:	:	:
Additional etiologies _____					
23. POTENTIAL FOR COMPLICATIONS related to <u>lack of knowledge about aftercare treatments for injury/illness.</u>	:	:	:	:	:
Additional etiologies _____					
24. CHILD ABUSE related to <u>inappropriate parental coping strategies.</u>	:	:	:	:	:
Additional etiologies _____					
25. POTENTIAL NONCOMPLIANCE WITH MEDICAL REGIMEN: related to <u>uncertainty of where to obtain needed information.</u>	:	:	:	:	:
Additional etiologies _____					

APPENDIX C  
Emergency Department (ED)  
Etiology Evaluation Questionnaire



## EMERGENCY DEPARTMENT (ED) ETIOLOGY EVALUATION QUESTIONNAIRE

## INDEPENDENT?

YES

NO

## 1. SEVERE ANXIETY related to:

\_\_\_\_\_ fear of permanent injury.  
 \_\_\_\_\_ inability to cope with family/personal affairs.  
 \_\_\_\_\_ inability to cope with life events.  
 \_\_\_\_\_ fear of the unknown.  
 \_\_\_\_\_ perceived threat to health status.  
 \_\_\_\_\_ unable to understand directions.  
 \_\_\_\_\_ inability to cope with life.  
 \_\_\_\_\_ inability to process additional information.  
 \_\_\_\_\_ decreased communication skills.  
 \_\_\_\_\_ inability to cope with traumatic injury.  
 \_\_\_\_\_ altered coping mechanisms.  
 \_\_\_\_\_ fear of death.  
 \_\_\_\_\_ fear of pain.  
 \_\_\_\_\_ inadequate knowledge of health problems.  
 \_\_\_\_\_ powerlessness.  
 \_\_\_\_\_ poor support system.  
 \_\_\_\_\_ unrealistic concept of illness and expectation of treatment.  
 \_\_\_\_\_ knowledge deficit of treatment.  
 \_\_\_\_\_ fear of death.  
 \_\_\_\_\_ lack of adequate explanation by staff.  
 \_\_\_\_\_ embarrassment.

## 2. POTENTIAL FOR INFECTION related to:

\_\_\_\_\_ patient knowingly not taking care of wound.  
 \_\_\_\_\_ noncompliance in taking antibiotics.  
 \_\_\_\_\_ noncompliance with instructions.  
 \_\_\_\_\_ inadequate knowledge of basic wound care and cleanliness.  
 \_\_\_\_\_ inadequate motivation.  
 \_\_\_\_\_ denial of severity of wound.  
 \_\_\_\_\_ willful noncompliance with wound care instructions.  
 \_\_\_\_\_ inadequate access to necessities for post trauma care.  
 \_\_\_\_\_ lack of help at home.  
 \_\_\_\_\_ lack of supplies.  
 \_\_\_\_\_ poor hygiene habits.  
 \_\_\_\_\_ inadequate knowledge base.  
 \_\_\_\_\_ impaired skin integrity.  
 \_\_\_\_\_ inability to procure necessary supplies.  
 \_\_\_\_\_ anxiety induced inability to recall information given.  
 \_\_\_\_\_ inadequate knowledge regarding transmission of disease.  
 \_\_\_\_\_ unrealistic expectations of medical staff to provide care.  
 \_\_\_\_\_ inexperience with new or difficult problems.  
 \_\_\_\_\_ language barrier.  
 \_\_\_\_\_ self care deficit in good hygiene.

INDEPENDANT?  
YES NO

3. POTENTIAL FOR INCORRECT MEDICATION USEAGE related to:

\_\_\_\_\_ denial of medical condition necessitating medication.  
\_\_\_\_\_ increased anxiety which decreased learning.  
\_\_\_\_\_ personal changing of dosages.  
\_\_\_\_\_ stop taking after feel better.  
\_\_\_\_\_ anxiety.  
\_\_\_\_\_ inadequate knowledge base.  
\_\_\_\_\_ noncompliance.  
\_\_\_\_\_ incorrect advise from lay people.  
\_\_\_\_\_ language barrier.  
\_\_\_\_\_ inadequate knowledge of therapy goals.  
\_\_\_\_\_ inaccurate measuring devices.  
\_\_\_\_\_ self care deficits.  
\_\_\_\_\_ mixing and measuring at home.  
\_\_\_\_\_ inability to retain information given.  
\_\_\_\_\_ failure to take responsibility for self.  
\_\_\_\_\_ decreased range of motion.  
\_\_\_\_\_ ineffective coping mechanisms.  
\_\_\_\_\_ disbelief that meds will help.  
\_\_\_\_\_ anxiety induced narrowing of perceptions.  
\_\_\_\_\_ patient not understanding or questioning orders.  
\_\_\_\_\_ stress at the time of instruction.  
\_\_\_\_\_ inability to comprehend.

4. POTENTIAL FOR LOSS OF CONSCIOUSNESS related to:

\_\_\_\_\_ inadequate knowledge of injury complications.  
\_\_\_\_\_ severe anxiety.  
\_\_\_\_\_ attention seeking behavior.  
\_\_\_\_\_ decreased coping mechanisms.  
\_\_\_\_\_ decreased self esteem.

5. INABILITY TO FOLLOW DIRECTIONS related to:

\_\_\_\_\_ anger.  
\_\_\_\_\_ lack of understanding of directions.  
\_\_\_\_\_ knowledge deficit.  
\_\_\_\_\_ language barrier.  
\_\_\_\_\_ lack of support at home.  
\_\_\_\_\_ preconceived ideas.  
\_\_\_\_\_ altered coping mechanisms.  
\_\_\_\_\_ lack of self esteem.  
\_\_\_\_\_ impaired perception of benefit/reward.  
\_\_\_\_\_ inability to understand disease process.  
\_\_\_\_\_ noncompliant behavior.  
\_\_\_\_\_ lack of understanding of medical terminology.  
\_\_\_\_\_ limited resources.  
\_\_\_\_\_ poor attention span.  
\_\_\_\_\_ inconvenience.  
\_\_\_\_\_ impracticality.

## INDEPENDANT?

YES NO

## 6. UNCONTROLLED ANGER related to:

\_\_\_\_\_ grief.  
 \_\_\_\_\_ real or imagined injury to body and/or soul.  
 \_\_\_\_\_ fear or anxiety regarding treatment.  
 \_\_\_\_\_ being restrained.  
 \_\_\_\_\_ acting out.  
 \_\_\_\_\_ decreased coping mechanisms.  
 \_\_\_\_\_ denial.  
 \_\_\_\_\_ perceived discrimination.  
 \_\_\_\_\_ lack of adequate support mechanisms.  
 \_\_\_\_\_ powerlessness over environment control.  
 \_\_\_\_\_ inability to cope with impending treatment without additional information.

## 7. UNCONTROLLED CRYING related to

\_\_\_\_\_ perceived powerlessness over life events.  
 \_\_\_\_\_ uncontrolled anxiety.  
 \_\_\_\_\_ grief.  
 \_\_\_\_\_ fear without previous trauma.  
 \_\_\_\_\_ lack of coping mechanisms.  
 \_\_\_\_\_ fear of the unknown.  
 \_\_\_\_\_ anxiety.  
 \_\_\_\_\_ fear of family reprisals.  
 \_\_\_\_\_ hysteria.  
 \_\_\_\_\_ anger.  
 \_\_\_\_\_ fear of pain.  
 \_\_\_\_\_ invasion of child's space.  
 \_\_\_\_\_ guilt feelings.  
 \_\_\_\_\_ panic.  
 \_\_\_\_\_ worry over family's reaction to illness.  
 \_\_\_\_\_ attention seeking.

## 8. DENIAL related to:

\_\_\_\_\_ grieving.  
 \_\_\_\_\_ inability to understand or lack of knowledge of disease process.  
 \_\_\_\_\_ lack of understanding of discharge diagnosis.  
 \_\_\_\_\_ lack of knowledge of bodily functions.  
 \_\_\_\_\_ fear of death.  
 \_\_\_\_\_ fear of outcome.  
 \_\_\_\_\_ powerlessness over diagnosis.  
 \_\_\_\_\_ threat of altered body image.  
 \_\_\_\_\_ fear of perceived or real loss of function or control.  
 \_\_\_\_\_ knowledge deficit of treatment.  
 \_\_\_\_\_ perceived stigma of diagnosis.  
 \_\_\_\_\_ inability to comprehend true situation.  
 \_\_\_\_\_ lack of available information sources.  
 \_\_\_\_\_ inability to cope with implications of symptoms.

## INDEPENDANT?

YES NO

## 9. FEAR OF INADEQUATE TREATMENT related to:

\_\_\_\_\_ lack of patient education.  
 \_\_\_\_\_ lack of knowledge.  
 \_\_\_\_\_ misinformation provided by laypersons.  
 \_\_\_\_\_ fear of socioeconomic loss resulting from injuries.  
 \_\_\_\_\_ knowledge deficit of expected treatment.  
 \_\_\_\_\_ fear of waiting long periods of time before treatment begins.  
 \_\_\_\_\_ lack of understanding of procedures.  
 \_\_\_\_\_ perceived seriousness of illness or injury.  
 \_\_\_\_\_ inadequate medical knowledge.  
 \_\_\_\_\_ perceived powerlessness over situation.  
 \_\_\_\_\_ sense of loss of control.  
 \_\_\_\_\_ ignorance of health practices.  
 \_\_\_\_\_ knowledge of being in a small hospital.  
 \_\_\_\_\_ lack of understanding of needed ED tests.  
 \_\_\_\_\_ anxiety of being a victim.  
 \_\_\_\_\_ being unfamiliar with the medical setting.

## 10. INCREASED PAIN related to:

\_\_\_\_\_ anxiety.  
 \_\_\_\_\_ hysteria.  
 \_\_\_\_\_ denial.  
 \_\_\_\_\_ lack of knowledge of treatment regime which increases anxiety.  
 \_\_\_\_\_ fear.  
 \_\_\_\_\_ position.  
 \_\_\_\_\_ ineffective coping.  
 \_\_\_\_\_ restlessness.  
 \_\_\_\_\_ noncommunication of symptoms.  
 \_\_\_\_\_ failure to comply with treatment regime.  
 \_\_\_\_\_ not allowing oneself to relax.  
 \_\_\_\_\_ lack of knowledge as to cause of pain.  
 \_\_\_\_\_ failure to follow directions.  
 \_\_\_\_\_ inability or unwillingness to employ relaxation techniques.  
 \_\_\_\_\_ impaired mobility resulting from illness/injury.

## 11. INEFFECTIVE INTRAFAMILY SUPPORT related to:

\_\_\_\_\_ noncompliant family member.  
 \_\_\_\_\_ fear of not being treated.  
 \_\_\_\_\_ abusive parents.  
 \_\_\_\_\_ fear of not understanding information.  
 \_\_\_\_\_ poor interpersonal relations.  
 \_\_\_\_\_ inadequate support system.  
 \_\_\_\_\_ inadequate coping strategies.  
 \_\_\_\_\_ inability to communicate with each other.  
 \_\_\_\_\_ overwhelming anxiety of family members.  
 \_\_\_\_\_ family's basic lack of knowledge.  
 \_\_\_\_\_ family's state of denial.  
 \_\_\_\_\_ uncontrolled anger.  
 \_\_\_\_\_ breakdown in family unit.  
 \_\_\_\_\_ inability to follow directions.  
 \_\_\_\_\_ inability to cope with changes in lifestyle required by injury/illness.

INDEPENDANT?  
YES NO

12. POTENTIAL FOR NONCOMPLIANCE WITH VERBAL AFTERCARE INSTRUCTIONS related to:

\_\_\_\_\_ low priority given to consistent health maintenance.  
\_\_\_\_\_ lack if understanding.  
\_\_\_\_\_ inability to understand verbal instructions.  
\_\_\_\_\_ lack of general knowledge.  
\_\_\_\_\_ patient's lack of willingness to participate in own care.  
\_\_\_\_\_ sensory overload.  
\_\_\_\_\_ denial.  
\_\_\_\_\_ hard of hearing.  
\_\_\_\_\_ no family support in ED.  
\_\_\_\_\_ limited perception.  
\_\_\_\_\_ language barrier.  
\_\_\_\_\_ inadequate knowledge of medical protocols.  
\_\_\_\_\_ did not listen to instructions.  
\_\_\_\_\_ unavailability of resources.  
\_\_\_\_\_ anger about long waits in ED.  
\_\_\_\_\_ self care deficit.  
\_\_\_\_\_ low self esteem.  
\_\_\_\_\_ inability to problem solve long term.  
\_\_\_\_\_ lack of comprehension.  
\_\_\_\_\_ resolution of immediate problem and lack of perception of any further needed care.  
\_\_\_\_\_ lack of understanding of treatment regimen.  
\_\_\_\_\_ apathy.  
\_\_\_\_\_ hostility toward caregivers.  
\_\_\_\_\_ anger.

13. POTENTIAL FOR RAPE-TRAUMA SYNDROME related to:

\_\_\_\_\_ no follow-up care.  
\_\_\_\_\_ ineffective intrafamily support.  
\_\_\_\_\_ lack of communication.  
\_\_\_\_\_ denial.  
\_\_\_\_\_ crying.  
\_\_\_\_\_ nervousness.  
\_\_\_\_\_ altered self concept.  
\_\_\_\_\_ low self esteem.  
\_\_\_\_\_ immature attitudes towards sexuality.  
\_\_\_\_\_ lack of available counseling.  
\_\_\_\_\_ children returned to the same environment without psychological support.  
\_\_\_\_\_ family/significant others failure to resolve crisis.  
\_\_\_\_\_ fear of disease.  
\_\_\_\_\_ pregnancy.  
\_\_\_\_\_ inadequate follow-up.

14. POTENTIAL FOR SELF-CARE DEFICIT related to:

\_\_\_\_\_ lack of knowledge regarding disease process.  
\_\_\_\_\_ need to care for others at home.  
\_\_\_\_\_ lack of family support.  
\_\_\_\_\_ ineffective coping and dependency needs.  
\_\_\_\_\_ lack of knowledge of area's out-patient resources.  
\_\_\_\_\_ fear.

## INDEPENDANT?

YES NO

\_\_\_\_\_ noncompliance.  
 \_\_\_\_\_ inability to understand aftercare instructions.  
 \_\_\_\_\_ impaired mobility.  
 \_\_\_\_\_ poor self esteem.  
 \_\_\_\_\_ increased weakness from injury/illness.  
 \_\_\_\_\_ anxiety induced narrowing of perceptions.  
 \_\_\_\_\_ fear of reinjury.  
 \_\_\_\_\_ knowledge of folk methods.

## 15. POTENTIAL DISTURBANCE IN SELF-CONCEPT related to:

\_\_\_\_\_ lack of available resources.  
 \_\_\_\_\_ lack of responsibility of own health care.  
 \_\_\_\_\_ lack of knowledge about illness/injury.  
 \_\_\_\_\_ rape trauma syndrome.  
 \_\_\_\_\_ denial.  
 \_\_\_\_\_ low self esteem.  
 \_\_\_\_\_ inability to accept diagnosis.  
 \_\_\_\_\_ perceived social stigma associated with condition.  
 \_\_\_\_\_ inability to cope with role changes within family structure.  
 \_\_\_\_\_ changes in self image due to injury/illness.

## 16. INABILITY TO PROBLEM SOLVE related to:

\_\_\_\_\_ anxiety, depression.  
 \_\_\_\_\_ lack of education.  
 \_\_\_\_\_ low self-esteem.  
 \_\_\_\_\_ inadequate problem solving skills.  
 \_\_\_\_\_ grieving.  
 \_\_\_\_\_ fear.  
 \_\_\_\_\_ feelings of powerlessness.  
 \_\_\_\_\_ patient's loss of independence.  
 \_\_\_\_\_ general inability to problem solve.  
 \_\_\_\_\_ knowledge deficit.  
 \_\_\_\_\_ inability to care for oneself.  
 \_\_\_\_\_ diminished cognitive skills.  
 \_\_\_\_\_ lack of support systems.  
 \_\_\_\_\_ lack of experience.  
 \_\_\_\_\_ not wanting to participate in actual problem solving process.  
 \_\_\_\_\_ poor coping mechanisms.

## 17. POTENTIAL FOR VIOLENCE related to:

\_\_\_\_\_ perception of powerlessness.  
 \_\_\_\_\_ anxiety.  
 \_\_\_\_\_ attention getting behavior.  
 \_\_\_\_\_ self anger.  
 \_\_\_\_\_ altered self concept.  
 \_\_\_\_\_ decreased coping skills.  
 \_\_\_\_\_ negative role models.  
 \_\_\_\_\_ denial.

## INDEPENDANT?

YES NO

\_\_\_\_\_ lack of knowledge of routine.  
 \_\_\_\_\_ lack of control over situations.  
 \_\_\_\_\_ grief.  
 \_\_\_\_\_ inability to cope with impending treatment without additional information.

## 18. CHILD'S FAILURE TO COOPERATE WITH TREATMENT related to:

\_\_\_\_\_ fear of the unknown.  
 \_\_\_\_\_ fear of pain.  
 \_\_\_\_\_ anxiety.  
 \_\_\_\_\_ hysteria.  
 \_\_\_\_\_ perceptions of powerlessness.  
 \_\_\_\_\_ parents refusal to control child.  
 \_\_\_\_\_ child abuse.  
 \_\_\_\_\_ parents inability to process instructions.  
 \_\_\_\_\_ lack of understanding of the treatment by the child.  
 \_\_\_\_\_ parents fear and hysteria.  
 \_\_\_\_\_ parents misperception of child's actual pain or discomfort.  
 \_\_\_\_\_ parents lack of understanding and knowledge.  
 \_\_\_\_\_ poor parenting skills.  
 \_\_\_\_\_ prehospital learned fear.  
 \_\_\_\_\_ parents making treatment seen as a punishment.  
 \_\_\_\_\_ parents failure to prepare and explain.  
 \_\_\_\_\_ fear of medical personnel.  
 \_\_\_\_\_ immature coping skills.  
 \_\_\_\_\_ families inadequate knowledge of how to communicate concerns in  
 injury/illness situation.

## 19. UNREALISTIC FEAR OF IMPENDING TREATMENT related to:

\_\_\_\_\_ lack of explanation.  
 \_\_\_\_\_ lack of knowledge of disease process and relationship of treatment.  
 \_\_\_\_\_ inappropriate information either perceived or actual.  
 \_\_\_\_\_ anxiety about outcome.  
 \_\_\_\_\_ lack of family support.  
 \_\_\_\_\_ failure to listen to explanation.  
 \_\_\_\_\_ no previous ED experience.  
 \_\_\_\_\_ misconception of EDS.  
 \_\_\_\_\_ inaccurate knowledge of ED procedures.

## 20. POTENTIAL INJURY TO A CHILD related to:

\_\_\_\_\_ neglect.  
 \_\_\_\_\_ lack of supervision.  
 \_\_\_\_\_ inadequate support system in family.  
 \_\_\_\_\_ inadequate parental attention.  
 \_\_\_\_\_ inability of parent to cope with family stress.  
 \_\_\_\_\_ parental apathy.  
 \_\_\_\_\_ child abuse.  
 \_\_\_\_\_ parents inability to effectively prioritize.

INDEPENDANT?  
YES NO

\_\_\_\_\_ lack of education of parents.  
\_\_\_\_\_ parental immaturity.  
\_\_\_\_\_ inadequate instruction to parents by staff about dangers in ED.  
\_\_\_\_\_ child's lack of understanding.  
\_\_\_\_\_ untreated severe anxiety/stress with no outlet for release.  
\_\_\_\_\_ failure of parents to change behavior or environment.

21. IMPAIRED VERBAL COMMUNICATION related to:

\_\_\_\_\_ language barrier.  
\_\_\_\_\_ fear.  
\_\_\_\_\_ use of jargon, slang, or medical terms.

22. POTENTIAL FOR COMPLICATIONS related to:

\_\_\_\_\_ low priority given health maintenance.  
\_\_\_\_\_ noncompliance, disregard for self.  
\_\_\_\_\_ inability to understand aftercare instructions.  
\_\_\_\_\_ patient's lack of willingness to participate in own care.  
\_\_\_\_\_ apathy.  
\_\_\_\_\_ poor nutritional status.  
\_\_\_\_\_ language barrier.  
\_\_\_\_\_ patient not taking aftercare instructions seriously enough.  
\_\_\_\_\_ inadequate means of follow up.  
\_\_\_\_\_ anxiety induced narrowing of perceptions.  
\_\_\_\_\_ belief in folk medicine.

23. CHILD ABUSE related to:

\_\_\_\_\_ lack of societal and family support systems.  
\_\_\_\_\_ parents inability to provide safe environment.  
\_\_\_\_\_ lack of basic parenting skills.  
\_\_\_\_\_ inadequate supervision of child by others.  
\_\_\_\_\_ unreleased stress.

24. POTENTIAL NONCOMPLIANCE WITH MEDICAL REGIMEN related to:

\_\_\_\_\_ inability to prioritize information and assimilate it's usefulness.  
\_\_\_\_\_ poor self image.  
\_\_\_\_\_ lack of adequate information given out in the first place.  
\_\_\_\_\_ lack of understanding of initial instructions.  
\_\_\_\_\_ denial of severity of illness/injury.  
\_\_\_\_\_ inability to understand medical regimen.  
\_\_\_\_\_ lack of obtaining information (self-motivation).  
\_\_\_\_\_ patient's lack of willingness to participate in own care.  
\_\_\_\_\_ apathy due to prolonged debilitating illness/injuries  
\_\_\_\_\_ requiring major life style changes.  
\_\_\_\_\_ uncertainty of where to get information.  
\_\_\_\_\_ mistrust of care providers.  
\_\_\_\_\_ lack of clarity of information.  
\_\_\_\_\_ language barrier.  
\_\_\_\_\_ lack of support systems.  
\_\_\_\_\_ lack of education.



## INDEPENDANT?

YES NO

_____	lack of knowledge of long-term consequences.
_____	apathy.
_____	unrealistic expectations.
_____	inability to change from previously established use of health care practices--
_____	(inappropriate use of ED as primary care setting).
_____	resolution of immediate problem and lack of perceptions of importance of medical
_____	regimen.
_____	uncertain as to purpose of medicine and what side effects might be expected.
_____	patients disagreement with regime as prescribed.
_____	hostility toward authority figures.
_____	anxiety induced narrowing of perceptions.
_____	distrust of medicine.
_____	inability to concentrate on instructions given in ED.

## APPENDIX D

### Phone Conversation Guide

## PHONE CONVERSATION

Hello, may I speak with \_\_\_\_\_. Are you still the president of the \_\_\_\_\_ chapter of E.N.A.

IF NO

My name is Kathy Baldwin. I am an emergency nurse and a member of the Dallas County Chapter of E.N.A. in Dallas, Texas. I am conducting a research project utilizing emergency nurses. I would like to discuss the possibility of surveying the \_\_\_\_\_ Chapter of E.N.A. with the current president. Could you please give me the name and phone number of the current president? Thank you, goodbye.

IF YES

My name is Kathy Baldwin. I am an emergency nurse and a member of the Dallas County Chapter of E.N.A. in Dallas, Texas. I am conducting a research project which is part of the requirements for completing a PhD in nursing at Texas Woman's University. I'd like to tell you about the study and to discuss the possibility of surveying your local chapter. Have you got a few minutes to talk with me?

IF NO

Can I return this call at a more convenient time? When would that be?

IF YES

I am trying to delineate the independent role of emergency nurses through the use of nursing diagnoses. I believe that by documenting what emergency nurses do independently of physicians will be the key to preserving our branch of nursing from take over by physicians assistants or emergency medical technicians. The study is exploratory and descriptive in nature. I have generated 25 nursing diagnoses that I believe are exhibited by emergency patients. The study asks emergency nurses to relate the diagnoses according to how often they have observed emergency patients who could have had the diagnosis. So, practicing emergency nurses are a vital part of the study. I am attempting to access this group through local E.N.A. chapters. Your local chapter was one of the chapters I selected for inclusion in the study. Do you think your members might be willing to participate in the study?

IF NO

Thank you for your time, goodbye.

IF YES

The questionnaire that I developed has three parts and takes around 30 minutes to complete. There are no right or wrong answers. I only want your members opinions based on their years of emergency nursing practice. I am phoning you to ask if you would be willing to distribute the questionnaires and to play a five minute cassette tape of me briefly explaining the study at your next chapter meeting. Your members can then complete the questionnaire at their convenience. I will provide return envelopes with postage for them to return their questionnaires to me. I will also provide an envelope with postage for the return of any extra questionnaires. Will you please return them to me? I really appreciate your help with this study. Are there any questions you would like to ask me? Could you give me an address where I can mail the questionnaires to you. The address given to me by national E.N.A. is \_\_\_\_\_. I will include my address and phone number in the packet. If you have any further questions please call me collect. Thank you again, goodbye.

APPENDIX E

Audio Cassette Message

## AUDIO CASSETTE MESSAGE

Hello, my name is Kathy Baldwin. I am an emergency nurse and a member of the Dallas Emergency Nurses Association. I'm also a doctoral candidate at Texas Woman's University in Denton, Texas and am currently conducting a study on the identification of common nursing diagnoses in emergency patients. The study is going to be used as part of my dissertation on emergency nursing diagnosis.

There's been very little work done in this area, so you will be helping with some new and some necessary research if you agree to participate in this study. The population that I'm studying consists of practicing emergency nurses in emergency departments, and I am using local chapters of the Emergency Nurses Association to access those nurses. Your chapter was selected from a list sent to me by the national headquarters, and I have contacted your president and ask that they help me by passing out the questionnaires, that I've mailed to them, this evening.

I would like at this time to thank your president for giving me a few minutes of your meeting time. I know how precious meeting time can be, and so I will be as brief as possible with this. I sincerely hope that you will agree to complete the questionnaire. It will take about 30 minutes of your time and contains six tasks, which are listed on the first page of the questionnaire. There is no reason why I would need to know your name for this, so you will have

anonymity. However, the questionnaire will contain a code number that tells me which geographical area of the United States you live in.

I know of no potential risks to this study and again I would greatly appreciate your help. If you agree to participate in the study, please complete the questionnaire within one week of receiving it and return it to me in the self addressed stamped envelope that you will also be receiving. If you choose not to participate in the study, please just fold the unanswered questionnaire, put it in the envelope, and also mail it back to me.

I will only be able to identify the questionnaires by geographical area, so at the end of the study I will be mailing each participating chapter a copy of the results. I will again mail those to your chapter president, so that she can share them with you--she or he can share them with you. Again, I would like to thank you for your help with this. I want you to know that there's no way I can do this study without you. And, I have been on the end--receiving end--of a lot of questionnaires, know that it does take some time to fill them out, and I also know that sometimes people don't say thank you. So, I do want you to know that I really do appreciate what you're doing for me. I will close now and let you get back with your meeting.

APPENDIX F  
Letter of Explanation



KATHLEEN M. BALDWIN  
742 QUAIL CIRCLE  
LEWISVILLE, TEXAS 75067  
214-221-3353

Dear fellow E.N.A. members,

I am currently conducting a study concerning the identification of common nursing diagnoses in emergency patients. The study will be used as part of my dissertation on nursing diagnosis use in emergency departments. Very little work has been done in this area, so you will be helping with new and necessary research.

The population that I am studying consists of practicing registered nurses who are employed in emergency departments. I am using local chapters of the Emergency Nurses Association to access those nurses. Your chapter has been selected from a list of all national chapters of the Emergency Nurses Association for participation in the study. I sincerely hope some of you will agree to complete the enclosed questionnaire. The questionnaire contains a code number which identifies the geographical area of the United States in which you live. However, I do not need to know your names.

Six tasks are required to complete the questionnaire. They include:

1. Checking the appropriate responses on the DEMOGRAPHIC DATA SHEET--which takes about 5 minutes.
2. Reading the directions for the RESPONSE COMPONENT QUESTIONNAIRE--which takes about 5 minutes.
3. Checking the appropriate percentages on the RESPONSE COMPONENT QUESTIONNAIRE--which takes 5-10 minutes.
4. Reading the directions for the ETIOLOGY COMPONENT SURVEY--which takes about 5 minutes.
5. Checking the appropriate percentages on the ETIOLOGY COMPONENT SURVEY--which takes about 10 minutes.
6. Writing additional etiology components--which takes about 10 minutes.

I know of no potential risks associated with the study, and I would greatly appreciate your help. If you agree to participate in the study, please complete the questionnaire at, or within one week of, your chapter meeting and seal it in the attached envelope. Please return the completed questionnaire to me within one week of the meeting. If you choose not to participate, please return the uncompleted questionnaire to me.

Since I will not be able to identify your chapter, only your geographical location, I wish to thank you in advance

for your help with this study. My study could not be completed without your help. I will always be extremely grateful to each of you for your participation. I will be mailing a summary of findings from the study to each participating chapter, once the results are collated.

Sincerely yours,

Kathy Baldwin RN, CEN  
Doctoral Candidate  
College of Nursing  
Texas Woman's University  
Denton, Texas

APPENDIX G  
Demographic Data Sheet

COMPLETION OF THIS QUESTIONNAIRE SIGNIFIES INFORMED CONSENT

## DEMOGRAPHIC DATA SHEET

PLEASE CHECK THE APPROPRIATE RESPONSE

## TYPE OF HOSPITAL WHERE YOU WORK:

Public\_\_\_\_  
 Private\_\_\_\_  
 City\_\_\_\_  
 Suburban\_\_\_\_

300 or more beds\_\_\_\_  
 Less than 300 beds\_\_\_\_

## WHAT IS YOUR MONTHLY EMERGENCY DEPARTMENT CENSUS?

Less than 500\_\_\_\_  
 501-1000\_\_\_\_  
 1001-1500\_\_\_\_  
 1501-2000\_\_\_\_  
 Greater than 2000\_\_\_\_

## WERE YOU EVER TAUGHT TO WRITE NURSING DIAGNOSES?

Yes\_\_\_\_  
 No\_\_\_\_

## IF YOUR ANSWER IS YES, WHERE?

(you may check more than one response)

A.D. program\_\_\_\_  
 Diploma program\_\_\_\_  
 B.S.N. program\_\_\_\_  
 Inservice program\_\_\_\_  
 Seminar\_\_\_\_  
 Continuing education program\_\_\_\_  
 Other\_\_\_\_

## DO YOU WORK:

20 hour or less per week\_\_\_\_  
 More than 20 hours per week\_\_\_\_

## WHAT IS YOUR BASIC EDUCATIONAL PREPARATION?

A.D.\_\_\_\_  
 Diploma\_\_\_\_  
 B.S.N.\_\_\_\_

## WHAT IS YOUR HIGHEST LEVEL OF EDUCATION?

A.D.\_\_\_\_  
 Diploma\_\_\_\_  
 B.S.N.\_\_\_\_  
 B.A.\_\_\_\_  
 B.S.(other)\_\_\_\_  
 M.S.N.\_\_\_\_  
 M.N.\_\_\_\_  
 M.S.(other)\_\_\_\_  
 PhD (nursing)\_\_\_\_  
 PhD (other)\_\_\_\_  
 DNSc.\_\_\_\_  
 EdD\_\_\_\_

## WHAT IS YOUR CURRENT EMPLOYMENT POSITION?

Staff nurse\_\_\_\_  
 Head nurse\_\_\_\_  
 Clinical specialist\_\_\_\_  
 Assistant head nurse\_\_\_\_  
 Supervisor\_\_\_\_  
 Other (specify)\_\_\_\_

## WHAT IS YOUR AGE?

20-29\_\_\_\_  
 30-39\_\_\_\_  
 40-49\_\_\_\_  
 50-59\_\_\_\_  
 Over 60\_\_\_\_

## APPENDIX H

### Complete Questionnaire

KATHLEEN M. BALDWIN  
742 QUAIL CIRCLE  
LEWISVILLE, TEXAS 75067  
214-221-3353

Dear fellow E.N.A. members,

I am currently conducting a study concerning the identification of common nursing diagnoses in emergency patients. The study will be used as part of my dissertation on nursing diagnosis use in emergency departments. Very little work has been done in this area, so you will be helping with new and necessary research.

The population that I am studying consists of practicing registered nurses who are employed in emergency departments. I am using local chapters of the Emergency Nurses Association to access those nurses. Your chapter has been selected from a list of all national chapters of the Emergency Nurses Association for participation in the study. I sincerely hope some of you will agree to complete the enclosed questionnaire. The questionnaire contains a code number which identifies the geographical area of the United States in which you live. However, I do not need to know your names.

Six tasks are required to complete the questionnaire. They include:

1. Checking the appropriate responses on the DEMOGRAPHIC DATA SHEET--which takes about 5 minutes.
2. Reading the directions for the RESPONSE COMPONENT QUESTIONNAIRE--which takes about 5 minutes.
3. Checking the appropriate percentages on the RESPONSE COMPONENT QUESTIONNAIRE--which takes 5-10 minutes.
4. Reading the directions for the ETIOLOGY COMPONENT SURVEY--which takes about 5 minutes.
5. Checking the appropriate percentabes on the ETIOLOGY COMPONENT SURVEY--which takes about 10 minutes.
6. Writing additional etiology components--which takes about 10 minutes.

I know of no potential risks associated with the study, and I would greatly appreciate your help. If you agree to participate in the study, please complete the questionnaire at, or within one week of, your chapter meeting and seal it in the attached envelope. Please return the completed questionnaire to me within one week of the meeting. If you choose not to participate, please return the uncompleted questionnaire to me.

Since I will not be able to identify your chapter, only your geographical location, I wish to thank you in advance

for your help with this study. My study could not be completed without your help. I will always be extremely grateful to each of you for your participation. I will be mailing a summary of findings from the study to each participating chapter, once the results are collated.

Sincerely yours,

Kathy Baldwin RN, CEN  
Doctoral Candidate  
College of Nursing  
Texas Woman's University  
Denton, Texas

COMPLETION OF THIS QUESTIONNAIRE SIGNIFIES INFORMED CONSENT

## DEMOGRAPHIC DATA SHEET

PLEASE CHECK THE APPROPRIATE RESPONSE

## TYPE OF HOSPITAL WHERE YOU WORK:

Public\_\_\_\_\_

Private\_\_\_\_\_

City\_\_\_\_\_

Suburban\_\_\_\_\_

300 or more beds\_\_\_\_\_

Less than 300 beds\_\_\_\_\_

## WHAT IS YOUR MONTHLY EMERGENCY DEPARTMENT CENSUS?

Less than 500\_\_\_\_\_

501-1000\_\_\_\_\_

1001-1500\_\_\_\_\_

1501-2000\_\_\_\_\_

Greater than 2000\_\_\_\_\_

## WERE YOU EVER TAUGHT TO WRITE NURSING DIAGNOSES?

Yes\_\_\_\_\_

No\_\_\_\_\_

## IF YOUR ANSWER IS YES, WHERE?

(you may check more than one response)

A.D. program\_\_\_\_\_

Diploma program\_\_\_\_\_

B.S.N. program\_\_\_\_\_

Inservice program\_\_\_\_\_

Seminar\_\_\_\_\_

Continuing education program\_\_\_\_\_

Other\_\_\_\_\_

## DO YOU WORK:

20 hour or less per week\_\_\_\_\_

More than 20 hours per week\_\_\_\_\_

## WHAT IS YOUR BASIC EDUCATIONAL PREPARATION?

A.D.\_\_\_\_\_

Diploma\_\_\_\_\_

B.S.N.\_\_\_\_\_

## WHAT IS YOUR HIGHEST LEVEL OF EDUCATION?

A.D.\_\_\_\_\_

Diploma\_\_\_\_\_

B.S.N.\_\_\_\_\_

B.A.\_\_\_\_\_

B.S.(other)\_\_\_\_\_

M.S.N.\_\_\_\_\_

M.N.\_\_\_\_\_

M.S.(other)\_\_\_\_\_

PhD (nursing)\_\_\_\_\_

PhD (other)\_\_\_\_\_

DMSc.\_\_\_\_\_

EdD\_\_\_\_\_

## WHAT IS YOUR CURRENT EMPLOYMENT POSITION?

Staff nurse\_\_\_\_\_

Head nurse\_\_\_\_\_

Clinical specialist\_\_\_\_\_

Assistant head nurse\_\_\_\_\_

Supervisor\_\_\_\_\_

Other (specify)\_\_\_\_\_

## WHAT IS YOUR AGE?

20-29\_\_\_\_\_

30-39\_\_\_\_\_

40-49\_\_\_\_\_

50-59\_\_\_\_\_

Over 60\_\_\_\_\_



DIRECTIONS FOR EVALUATING THE RESPONSE  
COMPONENT QUESTIONNAIRE

The next page contains a list of actual or potential human responses secondary to injury/illness. These responses are thought to be frequently seen in emergency patients. I wish to determine how frequently these responses are observed by practicing emergency department nurses. Thus, your experience is extremely valuable to me. In order to complete the questionnaire:

1. Read each response
2. Decide whether or not you have observed patients who have exhibited the response.
3. If you HAVE NOT SEEN patients with the response, place a check mark in the zero column.
4. If you HAVE SEEN patients with the response, estimate what percentage (of the total number of emergency patients you have seen) have had the response and place a check mark in the appropriate percentage column to the right of the response.
5. I thank you for completing this questionnaire.

RESPONSE COMPONENT QUESTIONNAIRE

<u>RESPONSES</u>	<u>PERCENT OF PATIENTS WITH RESPONSE</u>				
	<u>Zero</u>	<u>1-25</u>	<u>26-50</u>	<u>51-75</u>	<u>76-100</u>
1. Severe anxiety_____	:	:	:	:	:
2. Potential for infection_____	:	:	:	:	:
3. Potential for incorrect medication usage_____	:	:	:	:	:
4. Potential for loss of consciousness_____	:	:	:	:	:
5. Inability to follow directions_____	:	:	:	:	:
6. Uncontrolled anger_____	:	:	:	:	:
7. Uncontrolled crying_____	:	:	:	:	:
8. Denial_____	:	:	:	:	:
9. Fear of inadequate treatment_____	:	:	:	:	:
10. Increased pain_____	:	:	:	:	:
11. Ineffective intrafamily support_____	:	:	:	:	:
12. Potential for noncompliance with verbal aftercare instructions_____	:	:	:	:	:
13. Potential for rape-trauma syndrome_____	:	:	:	:	:
14. Potential for self-care deficit_____	:	:	:	:	:
15. Potential disturbance in self-concept_____	:	:	:	:	:
16. Inability to problem solve_____	:	:	:	:	:
17. Potential for violence_____	:	:	:	:	:
18. Child's failure to cooperate with treatment_____	:	:	:	:	:
19. Unrealistic fear of impending treatment_____	:	:	:	:	:
20. Potential for injury to a child_____	:	:	:	:	:
21. Impaired verbal communication_____	:	:	:	:	:
22. Potential for complications_____	:	:	:	:	:
23. Child abuse_____	:	:	:	:	:
24. Potential noncompliance with medical regimen_____	:	:	:	:	:

## DIRECTIONS FOR EVALUATING THE ETIOLOGY

## COMPONENT SURVEY

The next pages contain a list of actual or potential human responses secondary to illness/injury and selected etiologies for those responses which reflect the independent role of nurses. I wish to determine how frequently these responses and etiologies are observed by practicing emergency department nurses. Thus, your experience in extremely valuable to me. In order to complete the survey:

- A.
  1. Read each response component and the selected etiology.
  2. Decide whether or not you have observed patients who have exhibited the response and etiology.
  3. If you HAVE NOT SEEN patients with the response and etiology, place a check mark in the zero column
  4. If you HAVE SEEN patients with the response and etiology, estimate what percentage (of the total number of emergency patients you have seen) have had the response and etiology.
  5. Place a check mark in the appropriate percentage column to the right of the response and etiology that best describes your observations.
- B.
  1. AFTER COMPLETING THE ABOVE SECTION, go back to the first response and etiology .
  2. Read the first example of a response and etiology again.
  3. Decide whether you have seen patients with the response component, but with a different etiology component.
  4. If you HAVE, write the additional etiology component or components on the line below the example.
  5. If you HAVE NOT, go to the next example of a response and etiology and continue this process for the entire 25 statements.
  6. I thank you for completing this survey.

ETIOLOGY COMPONENT SURVEY

RESPONSES & etiologies	PERCENT OF PATIENTS WITH etiologies				
	Zero	1-25	26-50	51-75	76-100
1. SEVERE ANXIETY related to <u>inability to cope with impending treatment without additional information.</u>	:	:	:	:	:
Additional etiologies _____	:	:	:	:	:
2. POTENTIAL FOR INFECTION related to <u>inadequate knowledge of post treatment wound care.</u>	:	:	:	:	:
Additional etiologies _____	:	:	:	:	:
3. POTENTIAL FOR INCORRECT MEDICATION USAGE related to <u>inadequate knowledge regarding prescribed medication protocols.</u>	:	:	:	:	:
Additional etiologies _____	:	:	:	:	:
4. POTENTIAL FOR LOSS OF CONSCIOUSNESS related to <u>anxiety induced hyperventilation.</u>	:	:	:	:	:
Additional etiologies _____	:	:	:	:	:
5. POTENTIAL FOR LOSS OF CONSCIOUSNESS related to <u>anxiety induced hypotension (vasovagal)</u>	:	:	:	:	:
Additional etiologies _____	:	:	:	:	:
6. INABILITY TO FOLLOW DIRECTIONS related to <u>anxiety induced narrowing of perceptions.</u>	:	:	:	:	:
Additional etiologies _____	:	:	:	:	:
7. UNCONTROLLED ANGER related to <u>perceived powerless over the treatment situation.</u>	:	:	:	:	:
Additional etiologies _____	:	:	:	:	:
8. UNCONTROLLED CRYING related to <u>perceived powerlessness over the treatment situation.</u>	:	:	:	:	:
Additional etiologies _____	:	:	:	:	:
9. DENIAL related to <u>perceived powerlessness over the treatment situation.</u>	:	:	:	:	:
Additional etiologies _____	:	:	:	:	:

RESPONSES & etiologies	Percentage of patients with <u>etiology</u>				
	Zero	1-25	26-50	51-75	76-100
10. FEAR OF INADEQUATE TREATMENT related to <u>uncertainty regarding competencies of emergency department staff.</u>	:	:	:	:	:
Additional etiologies _____	:	:	:	:	:
11. INCREASED PAIN related to <u>lack of knowledge of pain reducing positioning techniques.</u>	:	:	:	:	:
Additional etiologies _____	:	:	:	:	:
12. INEFFECTIVE INTRAFAMILY SUPPORT related to <u>family's inadequate knowledge of how to communicate concern in injury/illness situation.</u>	:	:	:	:	:
Additional etiologies _____	:	:	:	:	:
13. POTENTIAL FOR NONCOMPLIANCE WITH VERBAL AFTERCARE INSTRUCTIONS related to <u>anxiety induced narrowing of perceptions.</u>	:	:	:	:	:
Additional etiologies _____	:	:	:	:	:
14. POTENTIAL FOR RAPE-TRAUMA SYNDROME related to <u>failure to resolve the crisis of rape.</u>	:	:	:	:	:
Additional etiologies _____	:	:	:	:	:
15. POTENTIAL FOR SELF-CARE DEFICIT related to <u>impaired mobility resulting from injury/illness.</u>	:	:	:	:	:
Additional etiologies _____	:	:	:	:	:
16. POTENTIAL DISTURBANCE IN SELF-CONCEPT related to <u>inability to cope with changes in lifestyle required by injury/illness.</u>	:	:	:	:	:
Additional etiologies _____	:	:	:	:	:
17. INABILITY TO PROBLEM SOLVE related to <u>anxiety induced narrowing of perceptions.</u>	:	:	:	:	:
Additional etiologies _____	:	:	:	:	:

RESPONSES & etiologies	Percentage of patients with <u>etiology</u>				
	Zero	1-25	26-50	51-75	76-100
18. POTENTIAL FOR VIOLENCE related to <u>perceptions of powerlessness in emergency situation.</u>	:	:	:	:	:
Additional etiologies _____					
19. CHILD'S FAILURE TO COOPERATE WITH TREATMENT : related to <u>parents' inability to provide emotional support.</u>	:	:	:	:	:
Additional etiologies _____					
20. UNREALISTIC FEAR OF IMPENDING TREATMENT : related to <u>inadequate resolution of previous: emergency department experience.</u>	:	:	:	:	:
Additional etiologies _____					
21. POTENTIAL FOR INJURY TO A CHILD related to <u>parents' inadequate knowledge of appropriate safety precautionary measures.</u>	:	:	:	:	:
Additional etiologies _____					
22. IMPAIRED VERBAL COMMUNICATION related to <u>anxiety induced disorganization of thought processes.</u>	:	:	:	:	:
Additional etiologies _____					
23. POTENTIAL FOR COMPLICATIONS related to <u>lack of knowledge about aftercare treatments for injury/illness.</u>	:	:	:	:	:
Additional etiologies _____					
24. CHILD ABUSE related to <u>inappropriate parental coping strategies.</u>	:	:	:	:	:
Additional etiologies _____					
25. POTENTIAL NONCOMPLIANCE WITH MEDICAL REGIMEN: related to <u>uncertainty of where to obtain needed information.</u>	:	:	:	:	:
Additional etiologies _____					

## APPENDIX I

### Pilot Study #1 Questionnaire

## DIRECTIONS FOR THE EVALUATION

Enclosed is an answer sheet, a list of 25 nursing diagnoses, and a list of characteristics of the nursing diagnosis statement from the Ziegler, Vaughan-Wrobel, and Erlen book. Please evaluate each of the nursing diagnoses and circle the appropriate Y or N which indicates whether or not the statement meets the particular criterion. For those statements which fail to meet all of the criteria, please feel free to revise the statement to more clearly reflect the criteria. Space is provided at the bottom of the answer sheet for revisions.

I want to sincerely thank you for your assistance in this endeavor. I will appreciate any feedback that you can give me, and I will be glad to furnish you with the end results of the study if you so desire. Please write your address at the top of the first answer sheet if you wish the results.

Sincerely,

Kathy Baldwin



## COMMON EMERGENCY NURSING DIAGNOSES

1. Anxiety related to uncertainty about impending treatment.
2. Potential for infection related to knowledge deficit of aftercare.
3. Potential for incorrect medication related to knowledge deficit regarding prescribed meds.
4. Hyperventilation related to generalized anxiety.
5. Loss of control related to anxiety about illness (or injury).
6. Crying related to fear of impending treatment.
7. Anger related to inability to cope with illness (or injury).
8. Hypotention (vasovagal) response related to anxiety about illness (or injury).
9. Denial related to inability to cope with illness (or injury).
10. Fear of impending treatment related to uncertainty about qualifications of emergency department staff.
11. Pain related to improper positioning.
12. Ineffective family (or individual) coping related to lack of understanding of loved one's illness or injury.
13. Potential for noncompliance with aftercare instructions related to inability to totally assimilate verbal instructions.
14. Rape trauma syndrome related to inability to cope with the crisis of rape.
15. Self-care deficit related to illness (or injury).
16. Disturbance in self concept related to inability to cope with injury.
17. Alteration in thought processes related to crisis response to acute illness or injury (individual or family).

18. Potential for violence related to inability to cope with injury (individual or family).

19. Alterations in parenting related to inability to cope with child's injury (or illness).

20. Fear of impending treatment related to bad memories of previous emergency department experiences.

21. Knowledge deficit of aftercare related to inexperience in dealing with injury (or illness).

22. Impaired verbal communication related to a crisis response to illness (or injury).

23. Potential of childhood injury related to parent's inadequate knowledge of dangers.

24. Child abuse related to inappropriate parental coping strategies.

25. Knowledge deficit of illness (or injury) related to uncertainty of where to obtain information.

## ZIEGLER, VAUGHAN-WROBEL, ERLÉN CRITERIA FOR DIAGNOSING

## GENERAL

1. Both the response and the etiology component are present.
2. The components are joined with a "related to" phrase.
3. The response component is written first and the etiology component is written second.
4. The statement is asymmetrical, not circular.

## RESPONSE COMPONENT

5. The response is clearly unhealthful or written as a potentially unhealthful response.
6. Only one response is identified for each diagnosis statement.
7. The response is potentially modifiable.
8. The response is concrete enough to generate specific client goals.

## ETIOLOGY COMPONENT

9. Only one etiology is identified for each diagnosis statement.
10. The etiology is potentially changeable.
11. The activity required to modify is within the boundaries of nursing's independent functions; nurse is capable, and is legally and ethically expected to treat.
12. Etiology is concrete enough to generate specific nursing actions.

## ANSWER SHEET

CHARACTERISTICS	CRITERION	DX# 1	:	DX# 2	:	DX# 3	:	DX# 4	:	DX# 5
GENERAL	1	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	2	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	3	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	4	Y N	:	Y N	:	Y N	:	Y N	:	Y N
RESPONSE	5	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	6	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	7	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	8	Y N	:	Y N	:	Y N	:	Y N	:	Y N
ETIOLOGY	9	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	10	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	11	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	12	Y N	:	Y N	:	Y N	:	Y N	:	Y N

## SUGGESTIONS FOR REVISION

DX# 1 \_\_\_\_\_

DX# 2 \_\_\_\_\_

DX# 3 \_\_\_\_\_

DX# 4 \_\_\_\_\_

DX# 5 \_\_\_\_\_

## ANSWER SHEET

CHARACTERISTICS	CRITERION	DX# 6	:	DX# 7	:	DX# 8	:	DX# 9	:	DX#10
		:		:		:		:		:
GENERAL	1	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	2	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	3	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	4	Y N	:	Y N	:	Y N	:	Y N	:	Y N
RESPONSE	5	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	6	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	7	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	8	Y N	:	Y N	:	Y N	:	Y N	:	Y N
ETIOLOGY	9	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	10	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	11	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	12	Y N	:	Y N	:	Y N	:	Y N	:	Y N

## SUGGESTIONS FOR REVISION

DX# 6 \_\_\_\_\_

DX# 7 \_\_\_\_\_

DX# 8 \_\_\_\_\_

DX# 9 \_\_\_\_\_

DX# 10 \_\_\_\_\_

## ANSWER SHEET

CHARACTERISTICS	CRITERION	DX#11	:	DX#12	:	DX#13	:	DX#14	:	DX#15	
GENERAL	1	Y	N	Y	N	Y	N	Y	N	Y	N
	2	Y	N	Y	N	Y	N	Y	N	Y	N
	3	Y	N	Y	N	Y	N	Y	N	Y	N
	4	Y	N	Y	N	Y	N	Y	N	Y	N
	5	Y	N	Y	N	Y	N	Y	N	Y	N
RESPONSE	6	Y	N	Y	N	Y	N	Y	N	Y	N
	7	Y	N	Y	N	Y	N	Y	N	Y	N
	8	Y	N	Y	N	Y	N	Y	N	Y	N
	9	Y	N	Y	N	Y	N	Y	N	Y	N
ETIOLOGY	10	Y	N	Y	N	Y	N	Y	N	Y	N
	11	Y	N	Y	N	Y	N	Y	N	Y	N
	12	Y	N	Y	N	Y	N	Y	N	Y	N

## SUGGESTIONS FOR REVISION

DX#11 \_\_\_\_\_

DX#12 \_\_\_\_\_

DX#13 \_\_\_\_\_

DX#14 \_\_\_\_\_

DX#15 \_\_\_\_\_

## ANSWER SHEET

CHARACTERISTICS	CRITERION	DX#16	DX#17	DX#18	DX#19	DX#20
GENERAL	1	Y N	Y N	Y N	Y N	Y N
	2	Y N	Y N	Y N	Y N	Y N
	3	Y N	Y N	Y N	Y N	Y N
	4	Y N	Y N	Y N	Y N	Y N
RESPONSE	5	Y N	Y N	Y N	Y N	Y N
	6	Y N	Y N	Y N	Y N	Y N
	7	Y N	Y N	Y N	Y N	Y N
	8	Y N	Y N	Y N	Y N	Y N
ETIOLOGY	9	Y N	Y N	Y N	Y N	Y N
	10	Y N	Y N	Y N	Y N	Y N
	11	Y N	Y N	Y N	Y N	Y N
	12	Y N	Y N	Y N	Y N	Y N

## SUGGESTIONS FOR REVISION

DX# 16 \_\_\_\_\_

DX# 17 \_\_\_\_\_

DX# 18 \_\_\_\_\_

DX# 19 \_\_\_\_\_

DX# 20 \_\_\_\_\_

## ANSWER SHEET

CHARACTERISTICS	CRITERION	DX#21	:	DX#22	:	DX#23	:	DX#24	:	DX#25
GENERAL	1	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	2	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	3	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	4	Y N	:	Y N	:	Y N	:	Y N	:	Y N
RESPONSE	5	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	6	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	7	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	8	Y N	:	Y N	:	Y N	:	Y N	:	Y N
ETIOLOGY	9	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	10	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	11	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	12	Y N	:	Y N	:	Y N	:	Y N	:	Y N

## SUGGESTIONS FOR REVISION

DX#21 \_\_\_\_\_

DX#22 \_\_\_\_\_

DX#23 \_\_\_\_\_

DX#24 \_\_\_\_\_

DX#25 \_\_\_\_\_



APPENDIX J

APPENDIX J

Pilot Study #2 Questionnaire

APPENDIX J

## DIRECTIONS FOR THE EVALUATION

Enclosed is an answer sheet, a list of 25 nursing diagnoses, and a list of characteristics of the nursing diagnosis statement from the Ziegler, Vaughan-Wrobel, and Erlen book. Please evaluate each of the nursing diagnoses and circle the appropriate Y or N which indicates whether or not the statement meets the particular criterion. For those statements which fail to meet all of the criteria, please feel free to revise the statement to more clearly reflect the criteria. Space is provided at the bottom of the answer sheet for revisions.

I want to sincerely thank you for your assistance in this endeavor. I will appreciate any feedback that you can give me, and I will be glad to furnish you with the end results of the study if you so desire. Please write your address at the top of the first answer sheet if you wish the results.

Sincerely,

Kathy Baldwin

## REVISED DIAGNOSIS LIST

1. Severe anxiety related to inability to cope with impending treatment without additional explanation.
2. Potential for infection related to inadequate knowledge of post treatment wound care.
3. Potential for incorrect medication usage related to inadequate knowledge regarding prescribed medication protocols.
4. Potential for loss of consciousness related to anxiety induced hyperventilation.
5. Inability to follow directions related to anxiety induced narrowing of perceptions.
6. Uncontrolled crying related to perceived powerlessness over treatment situation.
7. Uncontrolled anger related to perceived powerlessness over treatment situation.
8. Potential for loss of consciousness related to anxiety induced hypotension (vasovagal).
9. Denial related to perceived powerlessness over treatment situation.
10. Fear of inadequate treatment related to uncertainty regarding competencies of emergency department staff.
11. Increased pain related to lack of knowledge of pain reducing positioning techniques.
12. Ineffective intrafamily support related to family's inadequate knowledge of how to communicate concern in injury/illness situation.
13. Potential for noncompliance with verbal aftercare instructions related to anxiety induced narrowing of perceptions.
14. Potential rape-trauma syndrome related to failure to resolve the crisis of rape.
15. Potential for self-care deficit related to impaired mobility resulting from illness/injury.

16. Potential disturbance in self concept related to failure to make necessary changes in lifestyle required by injury/illness.

17. Inability to problem solve related to anxiety induced narrowing of perceptions.

18. Potential for violence related to anxiety induced perceptions of powerlessness in emergency situations.

19. Child's failure to cooperate with treatment related to parents' anxiety induced inability to provide emotional support.

20. Unrealistic fear of impending treatment related to inadequate resolution of previous emergency department experience.

21. Potential for complications related to inexperience in performing aftercare treatments for illness/injury.

22. Impaired verbal communication related to anxiety induced disorganization of thought processes.

23. Potential for injury to child related to parents' inadequate knowledge of appropriate safety precautionary measures.

24. Child abuse related to inappropriate parental coping strategies.

25. Potential noncompliance with medical regimen related to uncertainty of where to obtain needed information.

## ZIEGLER, VAUGHAN-WROBEL, ERLÉN CRITERIA FOR DIAGNOSING

## GENERAL

1. Both the response and the etiology component are present.
2. The components are joined with a "related to" phrase.
3. The response component is written first and the etiology component is written second.
4. The statement is asymmetrical, not circular.

## RESPONSE COMPONENT

5. The response is clearly unhealthful or written as a potentially unhealthful response.
6. Only one response is identified for each diagnosis statement.
7. The response is potentially modifiable.
8. The response is concrete enough to generate specific client goals.

## ETIOLOGY COMPONENT

9. Only one etiology is identified for each diagnosis statement.
10. The etiology is potentially changeable.
11. The activity required to modify is within the boundaries of nursing's independent functions; nurse is capable, and is legally and ethically expected to treat.
12. Etiology is concrete enough to generate specific nursing actions.

## ANSWER SHEET

CHARACTERISTICS	CRITERION	DX# 1	:	DX# 2	:	DX# 3	:	DX# 4	:	DX# 5
GENERAL	1	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	2	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	3	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	4	Y N	:	Y N	:	Y N	:	Y N	:	Y N
RESPONSE	5	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	6	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	7	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	8	Y N	:	Y N	:	Y N	:	Y N	:	Y N
ETIOLOGY	9	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	10	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	11	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	12	Y N	:	Y N	:	Y N	:	Y N	:	Y N

## SUGGESTIONS FOR REVISION

DX# 1 \_\_\_\_\_

DX# 2 \_\_\_\_\_

DX# 3 \_\_\_\_\_

DX# 4 \_\_\_\_\_

DX# 5 \_\_\_\_\_

## ANSWER SHEET

CHARACTERISTICS	CRITERION	DX#11	:	DX#12	:	DX#13	:	DX#14	:	DX#15
		:	:	:	:	:	:	:	:	:
GENERAL	1	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	2	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	3	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	4	Y N	:	Y N	:	Y N	:	Y N	:	Y N
RESPONSE	5	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	6	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	7	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	8	Y N	:	Y N	:	Y N	:	Y N	:	Y N
ETIOLOGY	9	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	10	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	11	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	12	Y N	:	Y N	:	Y N	:	Y N	:	Y N

## SUGGESTIONS FOR REVISION

DX#11 \_\_\_\_\_

DX#12 \_\_\_\_\_

DX#13 \_\_\_\_\_

DX#14 \_\_\_\_\_

DX#15 \_\_\_\_\_

## ANSWER SHEET

CHARACTERISTICS	CRITERION	DX#16	:	DX#17	:	DX#18	:	DX#19	:	DX#20
GENERAL	1	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	2	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	3	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	4	Y N	:	Y N	:	Y N	:	Y N	:	Y N
RESPONSE	5	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	6	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	7	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	8	Y N	:	Y N	:	Y N	:	Y N	:	Y N
ETIOLOGY	9	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	10	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	11	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	12	Y N	:	Y N	:	Y N	:	Y N	:	Y N

## SUGGESTIONS FOR REVISION

DX# 16 \_\_\_\_\_

DX# 17 \_\_\_\_\_

DX# 18 \_\_\_\_\_

DX# 19 \_\_\_\_\_

DX# 20 \_\_\_\_\_



## ANSWER SHEET

CHARACTERISTICS	CRITERION	DX#21	:	DX#22	:	DX#23	:	DX#24	:	DX#25
GENERAL	1	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	2	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	3	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	4	Y N	:	Y N	:	Y N	:	Y N	:	Y N
RESPONSE	5	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	6	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	7	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	8	Y N	:	Y N	:	Y N	:	Y N	:	Y N
ETIOLOGY	9	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	10	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	11	Y N	:	Y N	:	Y N	:	Y N	:	Y N
	12	Y N	:	Y N	:	Y N	:	Y N	:	Y N

## SUGGESTIONS FOR REVISION

DX#21 \_\_\_\_\_

DX#22 \_\_\_\_\_

DX#23 \_\_\_\_\_

DX#24 \_\_\_\_\_

DX#25 \_\_\_\_\_

APPENDIX K

Diagnosis List

1. [illegible]  
2. [illegible]  
3. [illegible]  
4. [illegible]  
5. [illegible]  
6. [illegible]  
7. [illegible]  
8. [illegible]  
9. [illegible]  
10. [illegible]  
11. [illegible]  
12. [illegible]  
13. [illegible]  
14. [illegible]  
15. [illegible]  
16. [illegible]  
17. [illegible]  
18. [illegible]  
19. [illegible]  
20. [illegible]  
21. [illegible]  
22. [illegible]  
23. [illegible]  
24. [illegible]  
25. [illegible]  
26. [illegible]  
27. [illegible]  
28. [illegible]  
29. [illegible]  
30. [illegible]  
31. [illegible]  
32. [illegible]  
33. [illegible]  
34. [illegible]  
35. [illegible]  
36. [illegible]  
37. [illegible]  
38. [illegible]  
39. [illegible]  
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41. [illegible]  
42. [illegible]  
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46. [illegible]  
47. [illegible]  
48. [illegible]  
49. [illegible]  
50. [illegible]  
51. [illegible]  
52. [illegible]  
53. [illegible]  
54. [illegible]  
55. [illegible]  
56. [illegible]  
57. [illegible]  
58. [illegible]  
59. [illegible]  
60. [illegible]  
61. [illegible]  
62. [illegible]  
63. [illegible]  
64. [illegible]  
65. [illegible]  
66. [illegible]  
67. [illegible]  
68. [illegible]  
69. [illegible]  
70. [illegible]  
71. [illegible]  
72. [illegible]  
73. [illegible]  
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76. [illegible]  
77. [illegible]  
78. [illegible]  
79. [illegible]  
80. [illegible]  
81. [illegible]  
82. [illegible]  
83. [illegible]  
84. [illegible]  
85. [illegible]  
86. [illegible]  
87. [illegible]  
88. [illegible]  
89. [illegible]  
90. [illegible]  
91. [illegible]  
92. [illegible]  
93. [illegible]  
94. [illegible]  
95. [illegible]  
96. [illegible]  
97. [illegible]  
98. [illegible]  
99. [illegible]  
100. [illegible]

## DIAGNOSIS LIST

1. Severe anxiety related to inability to cope with impending treatment without additional explanation.
2. Potential for infection related to inadequate knowledge of post treatment wound care.
3. Potential for incorrect medication usage related to inadequate knowledge regarding prescribed medication protocols.
4. Potential for loss of consciousness related to anxiety induced hyperventilation.
5. Inability to follow directions related to anxiety induced narrowing of perceptions.
6. Uncontrolled crying related to perceived powerlessness over treatment situation.
7. Uncontrolled anger related to perceived powerlessness over treatment situation.
8. Potential for loss of consciousness related to anxiety induced hypotension (vasovagal).
9. Denial related to perceived powerlessness over treatment situation.
10. Fear of inadequate treatment related to uncertainty regarding competencies of emergency department staff.
11. Increased pain related to lack of knowledge of pain reducing positioning techniques.
12. Ineffective intrafamily support related to family's inadequate knowledge of how to communicate concern in injury/illness situation.
13. Potential for noncompliance with verbal aftercare instructions related to anxiety induced narrowing of perceptions.
14. Potential rape-trauma syndrome related to failure to resolve the crisis of rape.
15. Potential for self-care deficit related to impaired mobility resulting from illness/injury.
16. Potential disturbance in self concept related inability

to cope with changes in lifestyle required by injury/illness.

17. Inability to problem solve related to anxiety induced narrowing of perceptions.

18. Potential for violence related to perceptions of powerlessness in emergency situations.

19. Child's failure to cooperate with treatment related to parents' inability to provide emotional support.

20. Unrealistic fear of impending treatment related to inadequate resolution of previous emergency department experience.

21. Potential for complications related to lack of knowledge about aftercare treatments for illness/injury.

22. Impaired verbal communication related to anxiety induced disorganization of thought processes.

23. Potential for injury to child related to parents' inadequate knowledge of appropriate safety precautionary measures.

24. Child abuse related to inappropriate parental coping strategies.

25. Potential noncompliance with medical regimen related to uncertainty of where to obtain needed information.

· APPENDIX L

Etiologies Reflecting Independent Role

## ETIOLOGIES REFLECTING INDEPENDENT ROLE

## 1. SEVERE ANXIETY related to:

\_\_\_\_\_ fear of permanent injury.  
 \_\_\_\_\_ inability to cope with family/personal affairs.  
 \_\_\_\_\_ inability to cope with life events.  
 \_\_\_\_\_ fear of the unknown.  
 \_\_\_\_\_ perceived threat to health status.  
 \_\_\_\_\_ unable to understand directions.  
 \_\_\_\_\_ inability to cope with life.  
 \_\_\_\_\_ inability to process additional information.  
 \_\_\_\_\_ decreased communication skills.  
 \_\_\_\_\_ inability to cope with traumatic injury.  
 \_\_\_\_\_ altered coping mechanisms.  
 \_\_\_\_\_ fear of death.  
 \_\_\_\_\_ fear of pain.  
 \_\_\_\_\_ inadequate knowledge of health problems.  
 \_\_\_\_\_ powerlessness.  
 \_\_\_\_\_ poor support system.  
 \_\_\_\_\_ unrealistic concept of illness and expectation of treatment.  
 \_\_\_\_\_ knowledge deficit of treatment.  
 \_\_\_\_\_ fear of death.  
 \_\_\_\_\_ lack of adequate explanation by staff.  
 \_\_\_\_\_ embarrassment.

## 2. POTENTIAL FOR INFECTION related to:

\_\_\_\_\_ patient knowingly not taking care of wound.  
 \_\_\_\_\_ noncompliance in taking antibiotics.  
 \_\_\_\_\_ noncompliance with instructions.  
 \_\_\_\_\_ inadequate knowledge of basic wound care and cleanliness.  
 \_\_\_\_\_ inadequate motivation.  
 \_\_\_\_\_ denial of severity of wound.  
 \_\_\_\_\_ willful noncompliance with wound care instructions.  
 \_\_\_\_\_ inadequate access to necessities for post trauma care.  
 \_\_\_\_\_ lack of help at home.  
 \_\_\_\_\_ lack of supplies.  
 \_\_\_\_\_ poor hygiene habits.  
 \_\_\_\_\_ inadequate knowledge base.  
 \_\_\_\_\_ impaired skin integrity.  
 \_\_\_\_\_ inability to procure necessary supplies.  
 \_\_\_\_\_ anxiety induced inability to recall information given.  
 \_\_\_\_\_ inadequate knowledge regarding transmission of disease.  
 \_\_\_\_\_ unrealistic expectations of medical staff to provide care.  
 \_\_\_\_\_ inexperience with new or difficult problems.  
 \_\_\_\_\_ language barrier.  
 \_\_\_\_\_ self care deficit in good hygiene.

## 3. POTENTIAL FOR INCORRECT MEDICATION USAGE related to:

\_\_\_\_\_ denial of medical condition necessitating medication.  
 \_\_\_\_\_ increased anxiety which decreased learning.  
 \_\_\_\_\_ personal changing of dosages.  
 \_\_\_\_\_ stop taking after feel better.  
 \_\_\_\_\_ anxiety.  
 \_\_\_\_\_ inadequate knowledge base.  
 \_\_\_\_\_ noncompliance.  
 \_\_\_\_\_ incorrect advise from lay people.  
 \_\_\_\_\_ language barrier.  
 \_\_\_\_\_ inadequate knowledge of therapy goals.  
 \_\_\_\_\_ inaccurate measuring devices.  
 \_\_\_\_\_ self care deficits.  
 \_\_\_\_\_ mixing and measuring at home.  
 \_\_\_\_\_ inability to retain information given.  
 \_\_\_\_\_ failure to take responsibility for self.  
 \_\_\_\_\_ decreased range of motion.  
 \_\_\_\_\_ ineffective coping mechanisms.  
 \_\_\_\_\_ disbelief that meds will help.  
 \_\_\_\_\_ anxiety induced narrowing of perceptions.  
 \_\_\_\_\_ patient not understanding or questioning orders.  
 \_\_\_\_\_ stress at the time of instruction.  
 \_\_\_\_\_ inability to comprehend.

## 4. POTENTIAL FOR LOSS OF CONSCIOUSNESS related to:

\_\_\_\_\_ inadequate knowledge of injury complications.  
 \_\_\_\_\_ severe anxiety.  
 \_\_\_\_\_ attention seeking behavior.  
 \_\_\_\_\_ decreased coping mechanisms.  
 \_\_\_\_\_ decreased self esteem.

## 5. INABILITY TO FOLLOW DIRECTIONS related to:

\_\_\_\_\_ anger.  
 \_\_\_\_\_ lack of understanding of directions.  
 \_\_\_\_\_ knowledge deficit.  
 \_\_\_\_\_ language barrier.  
 \_\_\_\_\_ lack of support at home.  
 \_\_\_\_\_ preconceived ideas.  
 \_\_\_\_\_ altered coping mechanisms.  
 \_\_\_\_\_ lack of self esteem.  
 \_\_\_\_\_ impaired perception of benefit/reward.  
 \_\_\_\_\_ inability to understand disease process.  
 \_\_\_\_\_ noncompliant behavior.  
 \_\_\_\_\_ lack of understanding of medical terminology.  
 \_\_\_\_\_ limited resources.  
 \_\_\_\_\_ poor attention span.  
 \_\_\_\_\_ inconvenience.  
 \_\_\_\_\_ impracticality.

## 6. UNCONTROLLED ANGER related to:

\_\_\_\_\_ grief.  
 \_\_\_\_\_ real or imagined injury to body and/or soul.  
 \_\_\_\_\_ fear or anxiety regarding treatment.  
 \_\_\_\_\_ being restrained.  
 \_\_\_\_\_ acting out.  
 \_\_\_\_\_ decreased coping mechanisms.  
 \_\_\_\_\_ denial.  
 \_\_\_\_\_ perceived discrimination.  
 \_\_\_\_\_ lack of adequate support mechanisms.  
 \_\_\_\_\_ powerlessness over environment control.  
 \_\_\_\_\_ inability to cope with impending treatment without additional information.

## 7. UNCONTROLLED CRYING related to

\_\_\_\_\_ perceived powerlessness over life events.  
 \_\_\_\_\_ uncontrolled anxiety.  
 \_\_\_\_\_ grief.  
 \_\_\_\_\_ fear without previous trauma.  
 \_\_\_\_\_ lack of coping mechanisms.  
 \_\_\_\_\_ fear of the unknown.  
 \_\_\_\_\_ anxiety.  
 \_\_\_\_\_ fear of family reprisals.  
 \_\_\_\_\_ hysteria.  
 \_\_\_\_\_ anger.  
 \_\_\_\_\_ fear of pain.  
 \_\_\_\_\_ invasion of child's space.  
 \_\_\_\_\_ guilt feelings.  
 \_\_\_\_\_ panic.  
 \_\_\_\_\_ worry over family's reaction to illness.  
 \_\_\_\_\_ attention seeking.

## 8. DENIAL related to:

\_\_\_\_\_ grieving.  
 \_\_\_\_\_ inability to understand or lack of knowledge of disease process.  
 \_\_\_\_\_ lack of understanding of discharge diagnosis.  
 \_\_\_\_\_ lack of knowledge of bodily functions.  
 \_\_\_\_\_ fear of death.  
 \_\_\_\_\_ fear of outcome.  
 \_\_\_\_\_ powerlessness over diagnosis.  
 \_\_\_\_\_ threat of altered body image.  
 \_\_\_\_\_ fear of perceived or real loss of function or control.  
 \_\_\_\_\_ knowledge deficit of treatment.  
 \_\_\_\_\_ perceived stigma of diagnosis.  
 \_\_\_\_\_ inability to comprehend true situation.  
 \_\_\_\_\_ lack of available information sources.  
 \_\_\_\_\_ inability to cope with implications of symptoms.



## 9. FEAR OF INADEQUATE TREATMENT related to:

\_\_\_\_\_ lack of patient education.  
 \_\_\_\_\_ lack of knowledge.  
 \_\_\_\_\_ misinformation provided by laypersons.  
 \_\_\_\_\_ fear of socioeconomic loss resulting from injuries.  
 \_\_\_\_\_ knowledge deficit of expected treatment.  
 \_\_\_\_\_ fear of waiting long periods of time before treatment begins.  
 \_\_\_\_\_ lack of understanding of procedures.  
 \_\_\_\_\_ perceived seriousness of illness or injury.  
 \_\_\_\_\_ inadequate medical knowledge.  
 \_\_\_\_\_ perceived powerlessness over situation.  
 \_\_\_\_\_ sense of loss of control.  
 \_\_\_\_\_ ignorance of health practices.  
 \_\_\_\_\_ knowledge of being in a small hospital.  
 \_\_\_\_\_ lack of understanding of needed ED tests.  
 \_\_\_\_\_ anxiety of being a victim.  
 \_\_\_\_\_ being unfamiliar with the medical setting.

## 10. INCREASED PAIN related to:

\_\_\_\_\_ anxiety.  
 \_\_\_\_\_ hysteria.  
 \_\_\_\_\_ denial.  
 \_\_\_\_\_ lack of knowledge of treatment regime which increases anxiety.  
 \_\_\_\_\_ fear.  
 \_\_\_\_\_ position.  
 \_\_\_\_\_ ineffective coping.  
 \_\_\_\_\_ restlessness.  
 \_\_\_\_\_ noncommunication of symptoms.  
 \_\_\_\_\_ failure to comply with treatment regime.  
 \_\_\_\_\_ not allowing oneself to relax.  
 \_\_\_\_\_ lack of knowledge as to cause of pain.  
 \_\_\_\_\_ failure to follow directions.  
 \_\_\_\_\_ inability or unwillingness to employ relaxation techniques.  
 \_\_\_\_\_ impaired mobility resulting from illness/injury.

## 11. INEFFECTIVE INTRAFAMILY SUPPORT related to:

\_\_\_\_\_ noncompliant family member.  
 \_\_\_\_\_ fear of not being treated.  
 \_\_\_\_\_ abusive parents.  
 \_\_\_\_\_ fear of not understanding information.  
 \_\_\_\_\_ poor interpersonal relations.  
 \_\_\_\_\_ inadequate support system.  
 \_\_\_\_\_ inadequate coping strategies.  
 \_\_\_\_\_ inability to communicate with each other.  
 \_\_\_\_\_ overwhelming anxiety of family members.  
 \_\_\_\_\_ family's basic lack of knowledge.  
 \_\_\_\_\_ family's state of denial.  
 \_\_\_\_\_ uncontrolled anger.  
 \_\_\_\_\_ breakdown in family unit.  
 \_\_\_\_\_ inability to follow directions.  
 \_\_\_\_\_ inability to cope with changes in lifestyle required by injury/illness.

## 12. POTENTIAL FOR NONCOMPLIANCE WITH VERBAL AFTERCARE INSTRUCTIONS related to:

\_\_\_\_\_ low priority given to consistent health maintenance.  
 \_\_\_\_\_ lack of understanding.  
 \_\_\_\_\_ inability to understand verbal instructions.  
 \_\_\_\_\_ lack of general knowledge.  
 \_\_\_\_\_ patient's lack of willingness to participate in own care.  
 \_\_\_\_\_ sensory overload.  
 \_\_\_\_\_ denial.  
 \_\_\_\_\_ hard of hearing.  
 \_\_\_\_\_ no family support in ED.  
 \_\_\_\_\_ limited perception.  
 \_\_\_\_\_ language barrier.  
 \_\_\_\_\_ inadequate knowledge of medical protocols.  
 \_\_\_\_\_ did not listen to instructions.  
 \_\_\_\_\_ unavailability of resources.  
 \_\_\_\_\_ anger about long waits in ED.  
 \_\_\_\_\_ self care deficit.  
 \_\_\_\_\_ low self esteem.  
 \_\_\_\_\_ inability to problem solve long term.  
 \_\_\_\_\_ lack of comprehension.  
 \_\_\_\_\_ resolution of immediate problem and lack of perception of any further needed care.  
 \_\_\_\_\_ lack of understanding of treatment regimen.  
 \_\_\_\_\_ apathy.  
 \_\_\_\_\_ hostility toward caregivers.  
 \_\_\_\_\_ anger.

## 13. POTENTIAL FOR RAPE-TRAUMA SYNDROME related to:

\_\_\_\_\_ no follow-up care.  
 \_\_\_\_\_ ineffective intrafamily support.  
 \_\_\_\_\_ lack of communication.  
 \_\_\_\_\_ denial.  
 \_\_\_\_\_ crying.  
 \_\_\_\_\_ nervousness.  
 \_\_\_\_\_ altered self concept.  
 \_\_\_\_\_ low self esteem.  
 \_\_\_\_\_ immature attitudes towards sexuality.  
 \_\_\_\_\_ lack of available counseling.  
 \_\_\_\_\_ children returned to the same environment without psychological support.  
 \_\_\_\_\_ family/significant others failure to resolve crisis.  
 \_\_\_\_\_ fear of disease.  
 \_\_\_\_\_ pregnancy.  
 \_\_\_\_\_ inadequate follow-up.

## 14. POTENTIAL FOR SELF-CARE DEFICIT related to:

\_\_\_\_\_ lack of knowledge regarding disease process.  
 \_\_\_\_\_ need to care for others at home.  
 \_\_\_\_\_ lack of family support.  
 \_\_\_\_\_ ineffective coping and dependency needs.  
 \_\_\_\_\_ lack of knowledge of area's out-patient resources.  
 \_\_\_\_\_ fear.

\_\_\_\_\_ noncompliance.  
 \_\_\_\_\_ inability to understand aftercare instructions.  
 \_\_\_\_\_ impaired mobility.  
 \_\_\_\_\_ poor self esteem.  
 \_\_\_\_\_ increased weakness from injury/illness.  
 \_\_\_\_\_ anxiety induced narrowing of perceptions.  
 \_\_\_\_\_ fear of reinjury.  
 \_\_\_\_\_ knowledge of folk methods.

15. POTENTIAL DISTURBANCE IN SELF-CONCEPT related to:

\_\_\_\_\_ lack of available resources.  
 \_\_\_\_\_ lack of responsibility of own health care.  
 \_\_\_\_\_ lack of knowledge about illness/injury.  
 \_\_\_\_\_ rape trauma syndrome.  
 \_\_\_\_\_ denial.  
 \_\_\_\_\_ low self esteem.  
 \_\_\_\_\_ inability to accept diagnosis.  
 \_\_\_\_\_ perceived social stigma associated with condition.  
 \_\_\_\_\_ inability to cope with role changes within family structure.  
 \_\_\_\_\_ changes in self image due to injury/illness.

16. INABILITY TO PROBLEM SOLVE related to:

\_\_\_\_\_ anxiety, depression.  
 \_\_\_\_\_ lack of education.  
 \_\_\_\_\_ low self-esteem.  
 \_\_\_\_\_ inadequate problem solving skills.  
 \_\_\_\_\_ grieving.  
 \_\_\_\_\_ fear.  
 \_\_\_\_\_ feelings of powerlessness.  
 \_\_\_\_\_ patient's loss of independence.  
 \_\_\_\_\_ general inability to problem solve.  
 \_\_\_\_\_ knowledge deficit.  
 \_\_\_\_\_ inability to care for oneself.  
 \_\_\_\_\_ diminished cognitive skills.  
 \_\_\_\_\_ lack of support systems.  
 \_\_\_\_\_ lack of experience.  
 \_\_\_\_\_ not wanting to participate in actual problem solving process.  
 \_\_\_\_\_ poor coping mechanisms.

17. POTENTIAL FOR VIOLENCE related to:

\_\_\_\_\_ perception of powerlessness.  
 \_\_\_\_\_ anxiety.  
 \_\_\_\_\_ attention getting behavior.  
 \_\_\_\_\_ self anger.  
 \_\_\_\_\_ altered self concept.  
 \_\_\_\_\_ decreased coping skills.  
 \_\_\_\_\_ negative role models.  
 \_\_\_\_\_ denial.

\_\_\_\_\_ lack of knowledge of routine.  
 \_\_\_\_\_ lack of control over situations.  
 \_\_\_\_\_ grief.  
 \_\_\_\_\_ inability to cope with impending treatment without additional information.

18. CHILD'S FAILURE TO COOPERATE WITH TREATMENT related to:

\_\_\_\_\_ fear of the unknown.  
 \_\_\_\_\_ fear of pain.  
 \_\_\_\_\_ anxiety.  
 \_\_\_\_\_ hysteria.  
 \_\_\_\_\_ perceptions of powerlessness.  
 \_\_\_\_\_ parents refusal to control child.  
 \_\_\_\_\_ child abuse.  
 \_\_\_\_\_ parents inability to process instructions.  
 \_\_\_\_\_ lack of understanding of the treatment by the child.  
 \_\_\_\_\_ parents fear and hysteria.  
 \_\_\_\_\_ parents misperception of child's actual pain or discomfort.  
 \_\_\_\_\_ parents lack of understanding and knowledge.  
 \_\_\_\_\_ poor parenting skills.  
 \_\_\_\_\_ prehospital learned fear.  
 \_\_\_\_\_ parents making treatment seem as a punishment.  
 \_\_\_\_\_ parents failure to prepare and explain.  
 \_\_\_\_\_ fear of medical personnel.  
 \_\_\_\_\_ immature coping skills.  
 \_\_\_\_\_ families inadequate knowledge of how to communicate concerns in  
 \_\_\_\_\_ injury/illness situation.

19. UNREALISTIC FEAR OF IMPENDING TREATMENT related to:

\_\_\_\_\_ lack of explanation.  
 \_\_\_\_\_ lack of knowledge of disease process and relationship of treatment.  
 \_\_\_\_\_ inappropriate information either perceived of actual.  
 \_\_\_\_\_ anxiety about outcome.  
 \_\_\_\_\_ lack of family support.  
 \_\_\_\_\_ failure to listen to explanation.  
 \_\_\_\_\_ no previous ED experience.  
 \_\_\_\_\_ misconception of EDS.  
 \_\_\_\_\_ inaccurate knowledge of ED procedures.

20. POTENTIAL INJURY TO A CHILD related to:

\_\_\_\_\_ neglect.  
 \_\_\_\_\_ lack of supervision.  
 \_\_\_\_\_ inadequate support system in family.  
 \_\_\_\_\_ inadequate parental attention.  
 \_\_\_\_\_ inability of parent to cope with family stress.  
 \_\_\_\_\_ parental apathy.  
 \_\_\_\_\_ child abuse.  
 \_\_\_\_\_ parents inability to effectively prioritize.

\_\_\_\_\_ lack of education of parents.  
 \_\_\_\_\_ parental immaturity.  
 \_\_\_\_\_ inadequate instruction to parents by staff about dangers in ED.  
 \_\_\_\_\_ child's lack of understanding.  
 \_\_\_\_\_ untreated severe anxiety/stress with no outlet for release.  
 \_\_\_\_\_ failure of parents to change behavior or environment.

21. IMPAIRED VERBAL COMMUNICATION related to:

\_\_\_\_\_ language barrier.  
 \_\_\_\_\_ fear.  
 \_\_\_\_\_ use of jargon, slang, or medical terms.

22. POTENTIAL FOR COMPLICATIONS related to:

\_\_\_\_\_ low priority given health maintenance.  
 \_\_\_\_\_ noncompliance, disregard for self.  
 \_\_\_\_\_ inability to understand aftercare instructions.  
 \_\_\_\_\_ patient's lack of willingness to participate in own care.  
 \_\_\_\_\_ apathy.  
 \_\_\_\_\_ poor nutritional status.  
 \_\_\_\_\_ language barrier.  
 \_\_\_\_\_ patient not taking aftercare instructions seriously enough.  
 \_\_\_\_\_ inadequate means of follow up.  
 \_\_\_\_\_ anxiety induced narrowing of perceptions.  
 \_\_\_\_\_ belief in folk medicine.

23. CHILD ABUSE related to:

\_\_\_\_\_ lack of societal and family support systems.  
 \_\_\_\_\_ parents inability to provide safe environment.  
 \_\_\_\_\_ lack of basic parenting skills.  
 \_\_\_\_\_ inadequate supervision of child by others.  
 \_\_\_\_\_ unreleased stress.

24. POTENTIAL NONCOMPLIANCE WITH MEDICAL REGIMEN related to:

\_\_\_\_\_ inability to prioritize information and assimilate it's usefulness.  
 \_\_\_\_\_ poor self image.  
 \_\_\_\_\_ lack of adequate information given out in the first place.  
 \_\_\_\_\_ lack of understanding of initial instructions.  
 \_\_\_\_\_ denial of severity of illness/injury.  
 \_\_\_\_\_ inability to understand medical regimen.  
 \_\_\_\_\_ lack of obtaining information (self-motivation).  
 \_\_\_\_\_ patient's lack of willingness to participate in own care.  
 \_\_\_\_\_ apathy due to prolonged debilitating illness/injuries  
     \_\_\_\_\_ requiring major life style changes.  
 \_\_\_\_\_ uncertainty of where to get information.  
 \_\_\_\_\_ mistrust of care providers.  
 \_\_\_\_\_ lack of clarity of information.  
 \_\_\_\_\_ language barrier.  
 \_\_\_\_\_ lack of support systems.  
 \_\_\_\_\_ lack of education.

\_\_\_\_\_ lack of knowledge of long-term consequences.  
\_\_\_\_\_ apathy.  
\_\_\_\_\_ unrealistic expectations.  
\_\_\_\_\_ inability to change from previously established use of health care practices--  
\_\_\_\_\_ (inappropriate use of ED as primary care setting).  
\_\_\_\_\_ resolution of immediate problem and lack of perceptions of importance of medical  
\_\_\_\_\_ regimen.  
\_\_\_\_\_ uncertain as to purpose of medicine and what side effects might be expected.  
\_\_\_\_\_ patients disagreement with regime as prescribed.  
\_\_\_\_\_ hostility toward authority figures.  
\_\_\_\_\_ anxiety induced narrowing of perceptions.  
\_\_\_\_\_ distrust of medicine.  
\_\_\_\_\_ inability to concentrate on instructions given in ED.

APPENDIX M

Additional Nursing Diagnoses Representing  
the Independent Role

## ADDITIONAL NURSING DIAGNOSES REPRESENTING THE INDEPENDENT ROLE

## 1. SEVERE ANXIETY related to:

\_\_\_\_\_ fear of permanent injury.  
 \_\_\_\_\_ inability to cope with family/personal affairs.  
 \_\_\_\_\_ inability to cope with life events.  
 \_\_\_\_\_ fear of the unknown.  
 \_\_\_\_\_ unable to understand directions.  
 \_\_\_\_\_ inability to process additional information.  
 \_\_\_\_\_ decreased communication skills.  
 \_\_\_\_\_ altered coping mechanisms.  
 \_\_\_\_\_ fear of pain.  
 \_\_\_\_\_ inadequate knowledge of health problems.  
 \_\_\_\_\_ powerlessness.  
 \_\_\_\_\_ unrealistic concept of illness and expectation of treatment.  
 \_\_\_\_\_ knowledge deficit of treatment.  
 \_\_\_\_\_ lack of adequate explanation by staff.  
 \_\_\_\_\_ embarrassment.

## 2. POTENTIAL FOR INFECTION related to:

\_\_\_\_\_ patient knowingly not taking care of wound.  
 \_\_\_\_\_ noncompliance in taking antibiotics.  
 \_\_\_\_\_ noncompliance with instructions.  
 \_\_\_\_\_ inadequate knowledge of basic wound care and cleanliness.  
 \_\_\_\_\_ inadequate motivation.  
 \_\_\_\_\_ denial of severity of wound.  
 \_\_\_\_\_ willful noncompliance with wound care instructions.  
 \_\_\_\_\_ inadequate access to necessities for post trauma care.  
 \_\_\_\_\_ lack of help at home.  
 \_\_\_\_\_ lack of supplies.  
 \_\_\_\_\_ poor hygiene habits.  
 \_\_\_\_\_ inadequate knowledge base.  
 \_\_\_\_\_ impaired skin integrity.  
 \_\_\_\_\_ inability to procure necessary supplies.  
 \_\_\_\_\_ anxiety induced inability to recall information given.  
 \_\_\_\_\_ inadequate knowledge regarding transmission of disease.  
 \_\_\_\_\_ unrealistic expectations of medical staff to provide care.  
 \_\_\_\_\_ inexperience with new or difficult problems.  
 \_\_\_\_\_ self care deficit in good hygiene.

## 3. POTENTIAL FOR INCORRECT MEDICATION USAGE related to:

\_\_\_\_\_ denial of medical condition necessitating medication.  
 \_\_\_\_\_ increased anxiety which decreased learning.  
 \_\_\_\_\_ personal changing of dosages.  
 \_\_\_\_\_ stop taking after feel better.  
 \_\_\_\_\_ anxiety.  
 \_\_\_\_\_ inadequate knowledge base.  
 \_\_\_\_\_ noncompliance.



\_\_\_\_\_ incorrect advise from lay people.  
 \_\_\_\_\_ inadequate knowledge of therapy goals.  
 \_\_\_\_\_ inaccurate measuring devices.  
 \_\_\_\_\_ self care deficits.  
 \_\_\_\_\_ mixing and measuring at home.  
 \_\_\_\_\_ inability to retain information given.  
 \_\_\_\_\_ failure to take responsibility for self.  
 \_\_\_\_\_ ineffective coping mechanisms.  
 \_\_\_\_\_ disbelief that meds will help.  
 \_\_\_\_\_ anxiety induced narrowing of perceptions.  
 \_\_\_\_\_ patient not understanding or questioning orders.  
 \_\_\_\_\_ stress at the time of instruction.  
 \_\_\_\_\_ inability to comprehend.

4. POTENTIAL FOR LOSS OF CONSCIOUSNESS related to:

\_\_\_\_\_ inadequate knowledge of injury complications.  
 \_\_\_\_\_ severe anxiety.  
 \_\_\_\_\_ decreased coping mechanisms.  
 \_\_\_\_\_ decreased self esteem.

5. INABILITY TO FOLLOW DIRECTIONS related to:

\_\_\_\_\_ anger.  
 \_\_\_\_\_ lack of understanding of directions.  
 \_\_\_\_\_ knowledge deficit.  
 \_\_\_\_\_ lack of support at home.  
 \_\_\_\_\_ preconceived ideas.  
 \_\_\_\_\_ altered coping mechanisms.  
 \_\_\_\_\_ lack of self esteem.  
 \_\_\_\_\_ impaired perception of benefit/reward.  
 \_\_\_\_\_ inability to understand disease process.  
 \_\_\_\_\_ noncompliant behavior.  
 \_\_\_\_\_ lack of understanding of medical terminology.  
 \_\_\_\_\_ limited resources.  
 \_\_\_\_\_ poor attention span.  
 \_\_\_\_\_ inconvenience.  
 \_\_\_\_\_ impracticality.

6. UNCONTROLLED ANGER related to:

\_\_\_\_\_ grief.  
 \_\_\_\_\_ fear or anxiety regarding treatment.  
 \_\_\_\_\_ being restrained.  
 \_\_\_\_\_ acting out.  
 \_\_\_\_\_ decreased coping mechanisms.  
 \_\_\_\_\_ denial.  
 \_\_\_\_\_ perceived discrimination.  
 \_\_\_\_\_ lack of adequate support mechanisms.  
 \_\_\_\_\_ powerlessness over environment control.  
 \_\_\_\_\_ inability to cope with impending treatment without additional information.

## 7. UNCONTROLLED CRYING related to

\_\_\_\_\_ perceived powerlessness over life events.  
 \_\_\_\_\_ uncontrolled anxiety.  
 \_\_\_\_\_ grief.  
 \_\_\_\_\_ fear without previous trauma.  
 \_\_\_\_\_ lack of coping mechanisms.  
 \_\_\_\_\_ fear of the unknown.  
 \_\_\_\_\_ anxiety.  
 \_\_\_\_\_ fear of family reprisals.  
 \_\_\_\_\_ anger.  
 \_\_\_\_\_ fear of pain.  
 \_\_\_\_\_ invasion of child's space.  
 \_\_\_\_\_ guilt feelings.  
 \_\_\_\_\_ panic.  
 \_\_\_\_\_ worry over family's reaction to illness.  
 \_\_\_\_\_ attention seeking.

## 8. DENIAL related to:

\_\_\_\_\_ grieving.  
 \_\_\_\_\_ inability to understand or lack of knowledge of disease process.  
 \_\_\_\_\_ lack of understanding of discharge diagnosis.  
 \_\_\_\_\_ lack of knowledge of bodily functions.  
 \_\_\_\_\_ powerlessness over diagnosis.  
 \_\_\_\_\_ threat of altered body image.  
 \_\_\_\_\_ fear of perceived or real loss of function or control.  
 \_\_\_\_\_ knowledge deficit of treatment.  
 \_\_\_\_\_ perceived stigma of diagnosis.  
 \_\_\_\_\_ inability to comprehend true situation.  
 \_\_\_\_\_ lack of available information sources.  
 \_\_\_\_\_ inability to cope with implications of symptoms.

## 9. FEAR OF INADEQUATE TREATMENT related to:

\_\_\_\_\_ lack of patient education.  
 \_\_\_\_\_ lack of knowledge.  
 \_\_\_\_\_ misinformation provided by laypersons.  
 \_\_\_\_\_ fear of socioeconomic loss resulting from injuries.  
 \_\_\_\_\_ knowledge deficit of expected treatment.  
 \_\_\_\_\_ fear of waiting long periods of time before treatment begins.  
 \_\_\_\_\_ lack of understanding of procedures.  
 \_\_\_\_\_ perceived seriousness of illness or injury.  
 \_\_\_\_\_ inadequate medical knowledge.  
 \_\_\_\_\_ perceived powerlessness over situation.  
 \_\_\_\_\_ sense of loss of control.  
 \_\_\_\_\_ ignorance of health practices.  
 \_\_\_\_\_ knowledge of being in a small hospital.  
 \_\_\_\_\_ lack of understanding of needed ED tests.  
 \_\_\_\_\_ anxiety of being a victim.  
 \_\_\_\_\_ being unfamiliar with the medical setting.

## 10. INCREASED PAIN related to:

\_\_\_\_\_ anxiety.  
 \_\_\_\_\_ denial.  
 \_\_\_\_\_ lack of knowledge of treatment regime which increases anxiety.  
 \_\_\_\_\_ fear.  
 \_\_\_\_\_ position.  
 \_\_\_\_\_ ineffective coping.  
 \_\_\_\_\_ restlessness.  
 \_\_\_\_\_ noncommunication of symptoms.  
 \_\_\_\_\_ failure to comply with treatment regime.  
 \_\_\_\_\_ not allowing oneself to relax.  
 \_\_\_\_\_ lack of knowledge as to cause of pain.  
 \_\_\_\_\_ failure to follow directions.  
 \_\_\_\_\_ inability or unwillingness to employ relaxation techniques.  
 \_\_\_\_\_ impaired mobility resulting from illness/injury.

## 11. INEFFECTIVE INTRAFAMILY SUPPORT related to:

\_\_\_\_\_ fear of not being treated.  
 \_\_\_\_\_ fear of not understanding information.  
 \_\_\_\_\_ poor interpersonal relations.  
 \_\_\_\_\_ inadequate support system.  
 \_\_\_\_\_ inadequate coping strategies.  
 \_\_\_\_\_ inability to communicate with each other.  
 \_\_\_\_\_ overwhelming anxiety of family members.  
 \_\_\_\_\_ family's basic lack of knowledge.  
 \_\_\_\_\_ family's state of denial  
 \_\_\_\_\_ uncontrolled anger.  
 \_\_\_\_\_ breakdown in family unit.  
 \_\_\_\_\_ inability to follow directions.  
 \_\_\_\_\_ inability to cope with changes in lifestyle required by injury/illness.

## 12. POTENTIAL FOR NONCOMPLIANCE WITH VERBAL AFTERCARE INSTRUCTIONS related to:

\_\_\_\_\_ low priority given to consistent health maintenance.  
 \_\_\_\_\_ lack of understanding.  
 \_\_\_\_\_ inability to understand verbal instructions.  
 \_\_\_\_\_ lack of general knowledge.  
 \_\_\_\_\_ patient's lack of willingness to participate in own care.  
 \_\_\_\_\_ sensory overload.  
 \_\_\_\_\_ denial.  
 \_\_\_\_\_ no family support in ED.  
 \_\_\_\_\_ limited perception.  
 \_\_\_\_\_ inadequate knowledge of medical protocols.  
 \_\_\_\_\_ did not listen to instructions.  
 \_\_\_\_\_ unavailability of resources.  
 \_\_\_\_\_ anger about long waits in ED.  
 \_\_\_\_\_ self care deficit.  
 \_\_\_\_\_ low self esteem.  
 \_\_\_\_\_ inability to problem solve long term.  
 \_\_\_\_\_ lack of comprehension.  
 \_\_\_\_\_ resolution of immediate problem and lack of perception of any further needed care.  
 \_\_\_\_\_ lack of understanding of treatment regimen.  
 \_\_\_\_\_ apathy.  
 \_\_\_\_\_ hostility toward caregivers.

anger.

13. POTENTIAL FOR RAPE-TRAUMA SYNDROME related to:

no follow-up care.  
 ineffective intrafamily support.  
 lack of communication.  
 denial.  
 crying.  
 nervousness.  
 altered self concept.  
 low self esteem.  
 immature attitudes towards sexuality.  
 lack of available counseling.  
 children returned to the same environment without psychological support.  
 fear of disease.  
 inadequate follow-up.

14. POTENTIAL FOR SELF-CARE DEFICIT related to:

lack of knowledge regarding disease process.  
 need to care for others at home.  
 ineffective coping and dependency needs.  
 lack of knowledge of area's out-patient resources.  
 fear.  
 noncompliance.  
 inability to understand aftercare instructions.  
 impaired mobility.  
 poor self esteem.  
 increased weakness from injury/illness.  
 anxiety induced narrowing of perceptions.  
 fear of reinjury.  
 knowledge of folk methods.

15. POTENTIAL DISTURBANCE IN SELF-CONCEPT related to:

lack of available resources.  
 lack of responsibility of own health care.  
 lack of knowledge about illness/injury.  
 denial.  
 low self esteem.  
 inability to accept diagnosis.  
 perceived social stigma associated with condition.  
 inability to cope with role changes within family structure.  
 changes in self image due to injury/illness.

16. INABILITY TO PROBLEM SOLVE related to:

anxiety, depression.  
 low self-esteem.  
 inadequate problem solving skills.  
 grieving.  
 fear.  
 feelings of powerlessness.  
 patient's loss of independence.

\_\_\_\_\_ general inability to problem solve.  
 \_\_\_\_\_ knowledge deficit.  
 \_\_\_\_\_ inability to care for oneself.  
 \_\_\_\_\_ lack of experience.  
 \_\_\_\_\_ not wanting to participate in actual problem solving process.  
 \_\_\_\_\_ poor coping mechanisms.

17. POTENTIAL FOR VIOLENCE related to:

\_\_\_\_\_ perception of powerlessness.  
 \_\_\_\_\_ anxiety.  
 \_\_\_\_\_ attention getting behavior.  
 \_\_\_\_\_ self anger.  
 \_\_\_\_\_ altered self concept.  
 \_\_\_\_\_ decreased coping skills.  
 \_\_\_\_\_ negative role models.  
 \_\_\_\_\_ denial.  
 \_\_\_\_\_ lack of knowledge of routine.  
 \_\_\_\_\_ lack of control over situations.  
 \_\_\_\_\_ grief.  
 \_\_\_\_\_ inability to cope with impending treatment without additional information.

18. CHILD'S FAILURE TO COOPERATE WITH TREATMENT related to:

\_\_\_\_\_ fear of the unknown.  
 \_\_\_\_\_ fear of pain.  
 \_\_\_\_\_ anxiety.  
 \_\_\_\_\_ perceptions of powerlessness.  
 \_\_\_\_\_ parents refusal to control child.  
 \_\_\_\_\_ parents inability to process instructions.  
 \_\_\_\_\_ lack of understanding of the treatment by the child.  
 \_\_\_\_\_ parents fear and hysteria.  
 \_\_\_\_\_ parents misperception of child's actual pain or discomfort.  
 \_\_\_\_\_ parents lack of understanding and knowledge.  
 \_\_\_\_\_ poor parenting skills.  
 \_\_\_\_\_ prehospital learned fear.  
 \_\_\_\_\_ parents making treatment seem as a punishment.  
 \_\_\_\_\_ parents failure to prepare and explain.  
 \_\_\_\_\_ fear of medical personnel.  
 \_\_\_\_\_ immature coping skills.  
 \_\_\_\_\_ families inadequate knowledge of how to communicate concerns in injury/illness situation.

19. UNREALISTIC FEAR OF IMPENDING TREATMENT related to:

\_\_\_\_\_ lack of explanation.  
 \_\_\_\_\_ lack of knowledge of disease process and relationship of treatment.  
 \_\_\_\_\_ inappropriate information either perceived or actual.  
 \_\_\_\_\_ anxiety about outcome.  
 \_\_\_\_\_ failure to listen to explanation.  
 \_\_\_\_\_ no previous ED experience.  
 \_\_\_\_\_ misconception of EDS.  
 \_\_\_\_\_ inaccurate knowledge of ED procedures.

## 20. POTENTIAL INJURY TO A CHILD related to:

\_\_\_\_\_ neglect.  
 \_\_\_\_\_ lack of supervision.  
 \_\_\_\_\_ inadequate support system in family.  
 \_\_\_\_\_ inadequate parental attention.  
 \_\_\_\_\_ inability of parent to cope with family stress.  
 \_\_\_\_\_ parental apathy.  
 \_\_\_\_\_ parents inability to effectively prioritize.  
 \_\_\_\_\_ lack of education of parents.  
 \_\_\_\_\_ parental immaturity.  
 \_\_\_\_\_ inadequate instruction to parents by staff about dangers in ED.  
 \_\_\_\_\_ child's lack of understanding.  
 \_\_\_\_\_ untreated severe anxiety/stress with no outlet for release.  
 \_\_\_\_\_ failure of parents to change behavior or environment.

## 21. IMPAIRED VERBAL COMMUNICATION related to:

\_\_\_\_\_ fear.  
 \_\_\_\_\_ use of jargon, slang, or medical terms.

## 22. POTENTIAL FOR COMPLICATIONS related to:

\_\_\_\_\_ low priority given health maintenance.  
 \_\_\_\_\_ noncompliance, disregard for self.  
 \_\_\_\_\_ inability to understand aftercare instructions.  
 \_\_\_\_\_ patient's lack of willingness to participate in own care.  
 \_\_\_\_\_ apathy.  
 \_\_\_\_\_ poor nutritional status.  
 \_\_\_\_\_ patient not taking aftercare instructions seriously enough.  
 \_\_\_\_\_ inadequate means of follow up.  
 \_\_\_\_\_ anxiety induced narrowing of perceptions.  
 \_\_\_\_\_ belief in folk medicine.

## 23. CHILD ABUSE related to:

\_\_\_\_\_ parents inability to provide safe environment.  
 \_\_\_\_\_ lack of basic parenting skills.  
 \_\_\_\_\_ inadequate supervision of child by others.  
 \_\_\_\_\_ unreleased stress.

## 24. POTENTIAL NONCOMPLIANCE WITH MEDICAL REGIMEN related to:

\_\_\_\_\_ inability to prioritize information and assimilate it's usefulness.  
 \_\_\_\_\_ poor self image.  
 \_\_\_\_\_ lack of adequate information given out in the first place.  
 \_\_\_\_\_ lack of understanding of initial instructions.  
 \_\_\_\_\_ denial of severity of illness/injury.  
 \_\_\_\_\_ inability to understand medical regimen.  
 \_\_\_\_\_ lack of obtaining information (self-motivation).  
 \_\_\_\_\_ patient's lack of willingness to participate in own care.  
 \_\_\_\_\_ apathy due to prolonged debilitating illness/injuries  
     \_\_\_\_\_ requiring major life style changes.  
 \_\_\_\_\_ uncertainty of where to get information.  
 \_\_\_\_\_ mistrust of care providers.  
 \_\_\_\_\_ lack of clarity of information.

\_\_\_\_\_ lack of support systems.  
\_\_\_\_\_ lack of knowledge of long-term consequences.  
\_\_\_\_\_ apathy.  
\_\_\_\_\_ unrealistic expectations.  
\_\_\_\_\_ inability to change from previously established use of health care practices--  
\_\_\_\_\_ (inappropriate use of ED as primary care setting).  
\_\_\_\_\_ uncertain as to purpose of medicine and what side effects might be expected.  
\_\_\_\_\_ patients disagreement with regime as prescribed.  
\_\_\_\_\_ hostility toward authority figures.  
\_\_\_\_\_ anxiety induced narrowing of perceptions.  
\_\_\_\_\_ distrust of medicine.  
\_\_\_\_\_ inability to concentrate on instructions given in ED.