A. Use a systematic approach to create a list of diagnoses and collaborative problems
   1) Review the admitting diagnosis in textbook or scientific reference
   2) Review the co-morbidities in the history of illness, hospitalizations and surgeries
      a) What is the client’s prior medical and surgical history that requires tertiary prevention?
   3) Research what are the probable nursing diagnoses/collaborative problems in a current med/surg text
      a) These will likely be your highest priorities
         (1) Create diagnoses in PES format for each nursing diagnosis and collaborative problem
   4) Review medication profile prior to hospitalization
      a) Ensure that the client continues to get the medication during hospitalization or there is a reasonable
         explanation for its discontinuation
         (1) Medication that has been discontinued can lead to a collaborative problem for the medical
         problem it is used to manage.
         (a) Create diagnoses in PES format for each nursing diagnosis and collaborative problem.
      b) Ensure that the past medical history reflects the disorders that the client has been prescribed
         medication prior to hospitalization.
         (1) Refer to a current drug guide for collaborative care
         (a) Create diagnoses in PES format for each nursing diagnosis and collaborative problem or
         add to a data cluster for a previously identified diagnosis.
         (i) Carpenito has several example PC statements for commonly used drugs that can be
         used as a template for other PCs
   5) Review each health pattern in the assessment database
      a) Create diagnoses in PES format for each deviation from normal value where a data cluster exists
         that supports its use.
   6) Review lab/diagnostics
      a) Ensure that your daily nursing process plan has the pertinent lab/diagnostics for the medical
         problems.
         (1) Indicate what lab data was not obtained on that sheet
      b) Create diagnoses in PES format for each deviation from normal value where a data cluster exists
         that supports its use or add to a data cluster for a diagnosis already developed.
   7) Review medication profile
      a) Refer to a current drug guide for collaborative care or add to a data cluster for a diagnosis already
         developed.
         (1) Create diagnoses in PES format for each nursing diagnosis and collaborative problem as done
         in medications prior to admission.
   8) Review your nurse’s note
      a) These words shed light onto the context of what your client is experiencing immediately during the
         time that you are providing care.
         (1) Improve your note writing skills by showing it to your clinical instructor before the end of the
         clinical day.
         (a) Begin to list diagnoses and collaborative problems
            (i) Constantly confirm structure, format and appropriate data of labels with Nursing care
            plan book
            (ii) All PC diagnoses are not in nursing care plan book so
                1. Refer to med/surg text for labels under collaborative care
   9) After completing the list, number diagnoses and collaborative problems in order of priority.
Step 1: Look up the client’s diagnosis in the med-surg reference

Can you compile a list of possible potential complications through review of the **pathophysiology section** of the Ignatavicius text?

**NOT SURE?**

**YES?**

Record the potential complications on your priority list as a **one-part statement**.

Can you compile a list of possible nursing diagnoses in the **analysis section** of the Ignatavicius text?

**NOT SURE?**

**YES?**

Look up defining characteristics for each nursing diagnoses in a nursing diagnosis text to identify the **focus assessment**

Can you identify the defining characteristics present in the nursing assessment and daily nursing process plan, lab diagnostics, medication sheets?

**NOT SURE?**

Review the concept of focused assessment page 7

Continue to next page
Can you create a diagnostic statement based on the defining characteristics present using PES format?

**NO?**
- Record the nursing diagnoses as **2-part risk for statements** on your list

**YES?**
- Record the nursing diagnoses as **3-part statements** on your list

**NOT SURE?**
- Review PES format in your fundamentals text and nursing care plan book, page 8

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Repeat these steps and look up the following:
1. The client’s co-morbidities (prior medical history and surgeries) to identify potential exacerbations of chronic illness in the presence of the current stressor.
   - For example:
     - **PC:** hypo/hyperglycemia in the presence of diabetes
     - **PC:** arterial ischemia in the presence of atherosclerosis

Determine what, if any, additional diagnostic statements apply based on the review of the following:
2. medications
3. procedures
4. lab/diagnostics
5. Functional health patterns

Apply a prioritizing framework to the list selecting priorities according to the classification below. Page 10

1. **Is it a life threatening concern or a concern that must be addressed?**
   - Affecting airway, breathing, circulation, bleeding, fluid or electrolytes, nutrition, elimination, integument, pain

2. **Is it a safety concern?**
   - Risk for injury, self-harm, confusional states
   - Page 14

3. **Is it a patient concern?**
   - Causing anxiety, grief, altered role, functional health
   - Page 15
Labeling Potential Complications

Definition of Potential Complications

- Physiologic stressors; otherwise known as diseases and disorders, treatments and procedures that can be diagnosed and primarily managed by a physician are in the domain of medicine.

- Physiologic stressors managed primarily by a physician are assigned medical diagnostic label.

- According to Article 139 of the New York State Nurse Practice Act, "'Diagnosing' in the context of nursing practice means that identification of and discrimination between physical and psychosocial signs and symptoms essential to effective execution and management of the nursing regimen. Such diagnostic privilege is distinct from a medical diagnosis."

- Nursing diagnostic labels should not used to relabel a medical diagnosis because the prescribed nursing interventions can not manage a medical diagnosis independent of physician intervention.

- Alfaro-Lefevre (2004) suggests that addressing the pertinent collaborative problems would be more prudent that focusing on less consequential nursing diagnoses that can not direct nursing actions to correct the medical problem.

- The label, ‘Potential complications’, are diagnostic labels used to classify nursing interventions that are designed to manage complications of physiologic stressors that arise from medical diagnostic labels in collaboration with a physician prescribed regimen.

- Both Carpenito-Moyet (2006) and Alfaro-Lefevre (2004) support the use of the diagnostic label; collaborative problem or ‘PC’ to validate the nursing care that is provided collaboratively with the physician.

- Carpenito-Moyet (2006) defines this practice as the bifocal clinical practice model.

Developing ‘Potential Complications’ Statements

The development of a ‘PC’ statement is a two-step process. The first step involves accurate analysis of the complications that can arise from the pathophysiology of the medical problem. The second step is to succinctly label the grouping of associated complications to effectively direct the plan.

Let’s review the following example describing the pathophysiology and complications of pneumonia excerpted from Nurse’s Disease Quick Check (2005):
Pathophysiology of Pneumonia

- A gel-like substance forms as microorganisms and phagocytic cells break down.
- This substance consolidates within the lower airway structure.
- Inflammation involves the alveoli, alveolar ducts, and interstitial spaces surrounding the alveolar walls.

Complications

- Septic shock
- Hypoxemia
- Respiratory failure
- Pleural effusion
- Empyema
- Bacteremia
- Endocarditis
- Pericarditis
- Meningitis
- Lung abscess

Grouping Potential Complications

Based on the literature, it is apparent that there are numerous complications, some of which can be grouped. Grouping potential complications according to type of complications that are associated reduced the volume of diagnostic statements used.

How would you know how to group the complications? After reviewing the literature on each, you would begin to identify a pattern of similarities. Generally, you begin to note that complications can be associated by their effects on related body systems or types of disorders.

In pneumonia you will learn that pneumonia infections could spread or become systemic, develop into complicated local infections due to the accumulation of the products of fighting the infection, or impede lung function which impedes ventilation and oxygenation. Consider the groupings below:

<table>
<thead>
<tr>
<th>Grouping of complication type</th>
<th>Associated complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related to impaired ventilation and perfusion in the affected lung tissue</td>
<td>Hypoxemia, Respiratory failure</td>
</tr>
<tr>
<td>Related to systemic or spreading infection</td>
<td>Septic shock, Bacteremia, Endocarditis, Pericarditis, Meningitis</td>
</tr>
<tr>
<td>Related to products of infection</td>
<td>Pleural effusion, Empyema, Lung abscess</td>
</tr>
</tbody>
</table>
The nurse analyzes the groupings according to complication type and designs a label that represents the grouping of associated complications. The nurse places the abbreviation, ‘PC:’ in front of the label to create a one-part statement. See the example below:

PC: hypoxia
PC: sepsis
PC: pleural effusion

Instead of eleven PC diagnostic statements (each individual associated complication in column two), the nurse selects 3 representative labels that will include interventions to identify all of the complications of the group and eliminate factors that contribute to their development and integrate actions that will manage their presence.

Summary of Labeling Potential Complications

The label, ‘PC’ is used to identify a condition that the nurse is monitoring or managing to prevent complications in which the physician prescribed the primary interventions to achieve the goal. It is developed through the analysis of the complications that arise from the complications of the pathophysiology of the diseases and disorders, treatments and procedures.

This is derived from the potential complications of the pathophysiology of the client’s stressor or situation. Situations amenable to the label collaborative problem include Diseases, disorders, treatments, procedures, medications.

The use of ‘PC’ permits the nurse to develop plans of care that directly address the medical condition of the client but avoids relabeling the problem with a nursing diagnosis.

Diagnostic Clusters & Tentative Diagnoses

Fundamentals of Diagnostic Clusters and Tentative Diagnoses

• A diagnostic cluster is a list of tentative diagnoses and potential complications related to the stressor.

• A diagnostic cluster may be research based. For example, Carpenito (2004) compiled diagnostic clusters according to physiologic stressor based on the evidence of the frequency in which nurses monitored or observed its use in the care of the client.

• When evidence based practice is lacking to identify diagnostic clusters, the nurse reviews nursing references according to medical diagnosis to base their decisions upon peer reviewed literature.

• Tentative diagnoses are made of nursing diagnostic statements that the nurse suspects that the client may experience based on the analysis of clients experiencing physiologic stressors. Consider the list as a large “rule out” list for developing a plan.

• Every nursing text has a section for analysis or diagnosis for each medical diagnosis for the nurse to review in order to develop a plan of care. For example Ignatavicius (2006) lists the following diagnoses and collaborative problems as a diagnostic cluster for pneumonia:
Potential complications in a diagnostic cluster represent the collaborative care and their inclusion in a problem list is based on the presumption that the client is at risk for or experiencing the problem due to the presence of the stressor.

Tentative diagnoses are neither actual or ‘risk for’ diagnostic statements but rather, are possible diagnoses or “rule out” diagnoses that have been observed in clients experiencing the physiologic stressor.

Potential complications are not classified as possible diagnoses and do not require focused exam to ‘rule in’ the diagnosis.

Possible diagnoses require the completion of a focused exam to elicit the defining characteristics of the diagnostic label.

**Diagnostic Cluster for Pneumonia**

- Impaired gas exchange *
- Ineffective airway clearance
- Potential for Sepsis
- Acute pain
- Deficient fluid volume
- Disturbed Sleep pattern
- Potential for Pleural effusion

* Note the use of impaired gas exchange to describe the potential for hypoxia and acute respiratory failure, a medical diagnosis, is discouraged (see definition of potential complications). A potential complication label is preferred when planning care to manage a medical complication in med-surg nursing care plans.


- Focused assessment (Taylor et al, 2004) refers to the collection of subjective and objective data about a specific problem. The specific problem is a tentative nursing diagnostic statement. The presence of the data confirms or “rules in” the nursing diagnosis.

- Focused assessment may be performed during initial assessment or as routine ongoing data collection.
• If a nurse is attempting to identify a new problem or determine if a problem has been overlooked in an exam, the nurse can select to perform a focused assessment in addition to the comprehensive assessment.

• According to Carpenito (2006) possible diagnoses describe suspected problems and require that the nurse have a suspicion that the diagnosis can occur in the client and require additional focused assessment to ‘rule in’ or exclude.

• Defining characteristics are another term for pertinent subjective and objective data or focused assessment data.

• If the focused exam reveals the presence of the defining characteristics of a suspected problem, the data elicited is referred to as **positive pertinent data**. If the exam reveals that the defining characteristics are absent then the data elicited is referred to as **negative pertinent data**.

• The presence of pertinent positive data confirms the presence of the nursing diagnosis.

**PES format**

**Avoiding Diagnostic error**

• Jumping to conclusions, failing to fully explore alternative explanations and systemically eliminating diagnoses leads to inaccurate diagnoses.

• Diagnostic error can occur when the nurse does not analyze the current stressors to develop a differential diagnosis. The lack of focused assessment data can lead to missed cues and poorly drawn conclusions.

• Diagnostic error can also occur in a setting where the nurse relies on memory or information, they are told instead of analysis of references at point of care. (Alfaro-Lefevre, 2004)

• Diagnostic error can occur when labels are selected without understanding the meaning and defining characteristics. Essentially, the label is applied because it sounds like the problem, but in fact, references do not support its inclusion.

**Review of PES format**

The structure of a nursing diagnostic statement follows the PES format. PES format is the following:
<table>
<thead>
<tr>
<th>Abbrev.</th>
<th>Component</th>
<th>Definition</th>
<th>Hint</th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>Problem</td>
<td>The diagnostic label from the NANDA list</td>
<td>Use the label from the tentative diagnostic list</td>
</tr>
<tr>
<td>E</td>
<td>Etiology</td>
<td>The contributing factor that causes the problem which can be either physiologic, maturational, treatment related, situational</td>
<td>The contributing factors are derived from the reason you suspected the problem. (ie: describe the physiologic dysfunction secondary to the medical diagnosis that led you to select the tentative diagnosis)</td>
</tr>
<tr>
<td>S</td>
<td>Signs &amp; Symptoms</td>
<td>The subjective and objective data from the client’s history and physical exam, review of treatments, procedures, medications and lab/diagnostics that irrefutably support the diagnostic label as defined by its characteristics.</td>
<td>Use the focused assessment and disease, medication treatment that is supportive of the diagnostic label.</td>
</tr>
</tbody>
</table>

**Creating Diagnostic Statements in PES format from Tentative Diagnostic Lists**

- Tentative diagnoses are can be recorded as three-part statements *if the defining characteristics are present* when performing focused exam. This type of nursing diagnosis statement is referred to as an “*actual nursing diagnosis*”.
  - Presume your client with pneumonia has positive rhonchi in bronchovesicular region bilaterally and an ineffective cough. The client is taking a prescribed expectorant, Guaifenesin, every 4 hours.
    - Example:
      - Ineffective airway clearance r/to excessive secretions secondary to pneumonia AEB positive rhonchi in bronchovesicular region bilaterally, ineffective cough, on Guaifenesin Rx, Pneumonia by history
  
- Tentative diagnoses are recorded as two-part statements *if the defining characteristics are absent* when performing focused exam. This type of nursing diagnosis statement is referred to as a “*risk for nursing diagnosis*”. The plan of care will focus on reducing the risk for the development of the problem.
  - Presume your client with pneumonia has clear lung sounds, coughs and deep breathes every two hours, and has not taken any prn Guaifenesin during their admission.
    - Example:
      - Risk for Ineffective airway clearance r/to inflammation of the respiration tract and accumulation of respiratory secretions secondary to Pneumonia.
• Unlike tentative diagnoses, potential complications statements are not ruled in, but are always included and recorded as one-part statements.

  - Presume your client with pneumonia has positive rhonchi in bronchovesicular region bilaterally and an ineffective cough. The client is taking a prescribed expectorant, Guaifenesin, every 4 hours and has a pulse oximetry of 94 % on 2 liter per minute nasal cannula. Alternatively, your client with pneumonia could have clear lung sounds, coughs and deep breathes every two hours, has not taken any prn Guaifenesin during their admission and their pulse oximetry is 95% on room air.

  • Example for both clients:
    • PC:hypoxia
    • Special note:
      • Regardless of their clinical status, you will always be concerned that the client is at risk for respiratory failure and the nursing will be responsible for identifying the presence or the complication and/or managing the complication administering physician prescribed interventions until the client’s diagnosis is resolved.

Prioritizing Framework

*Life-Threatening Concerns or Concerns That Must Be Addressed*

Carpenito (2006) uses “urgent” to describe problems that should top your priority list and separates collaborative problem statements from nursing diagnoses statements. She describes these as things that you can not delay in attending to or the person’s condition could worsen. Alfaro-Lefevre, R. (2006) encourages planners to assign priority to diagnoses that relate to ABC plus V (airway breathing circulation/bleeding plus vital signs). In your initial assessment tool, you learned “A, B, C, In/out, wound, pain, safety. A synthesis of each of these approaches will afford the best prioritization.

To identify what will contribute to a worsening of your client’s situation, you must review the outcomes or goals for the management of the medical problem. For pneumonia, consider the respiratory complications and the impact of overwhelming infection that will most likely contribute to a worsening of the client’s condition.

*Physiologic concerns:*

  - PC: hypoxia
  - PC: Pleural effusion
  - Ineffective airway clearance
  - PC: Sepsis*
  - Deficient fluid volume

*Sepsis is before deficient fluid volume because the complication of sepsis (septic shock) could lead to imminent death.
It becomes more complicated when you do not fully understand the implications of the outcome if the problem is not recognized early. For example, what if your client has an expanding mass in their brain and underwent a craniotomy. You review the postoperative complications of the general surgical client and then review the specific complications of craniotomy. (See charts below)

Table 1.
Diagnostic Cluster for Generic Surgical Client

<table>
<thead>
<tr>
<th>The potential for</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemorrhage</td>
</tr>
<tr>
<td>Hypovolemia/shock</td>
</tr>
<tr>
<td>Evisceration/dehiscence</td>
</tr>
<tr>
<td>Paralytic ileus</td>
</tr>
<tr>
<td>Infection</td>
</tr>
<tr>
<td>Urinary retention</td>
</tr>
<tr>
<td>Thrombophlebitis</td>
</tr>
<tr>
<td>Risk for ineffective respiratory function</td>
</tr>
<tr>
<td>Risk for infection</td>
</tr>
<tr>
<td>Acute Pain</td>
</tr>
<tr>
<td>Risk for imbalanced nutrition</td>
</tr>
<tr>
<td>Risk for constipation</td>
</tr>
<tr>
<td>Activity intolerance</td>
</tr>
<tr>
<td>Risk for ineffective therapeutic regimen management</td>
</tr>
</tbody>
</table>

The craniotomy concerns and post-operative concerns both have to be addressed. Combining the charts and grouping according to type reveals the chart below. (The italicized text in the second column represents the tentative diagnostic list for the generic surgical client."

<table>
<thead>
<tr>
<th>Complications According To Type</th>
<th>Associated Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>PC: increased ICP</td>
<td>Increased intracranial pressure (ICP), Hydrocephalus, Hematomas: subdural, intracerebral, epidural, subarachnoid, Cerebral edema, seizures</td>
</tr>
<tr>
<td>Elevated intracranial pressure arising from surgical procedure</td>
<td></td>
</tr>
<tr>
<td>PC:Hypoxia/Pnu/Atelectasis</td>
<td>Hypoxia, PNU, Atelectasis</td>
</tr>
<tr>
<td>Alterations in respiratory function</td>
<td>Neurogenic pulmonary edema</td>
</tr>
<tr>
<td>Risk for ineffective respiratory function</td>
<td><em>Risk for ineffective respiratory function</em></td>
</tr>
<tr>
<td>PC:pulmonary edema</td>
<td>Neurogenic pulmonary edema</td>
</tr>
<tr>
<td>PC: hypovolemia</td>
<td>Hypovolemic shock, <em>Hemorrhage</em></td>
</tr>
<tr>
<td></td>
<td><em>Hypovolemia/shock</em></td>
</tr>
<tr>
<td>PC:Thrombophlebitis</td>
<td>Thrombophlebitis*</td>
</tr>
<tr>
<td>PC:CSF leak</td>
<td>CSF leak</td>
</tr>
<tr>
<td>PC:infection</td>
<td>Wound infection, Meningitis, <em>Infection</em></td>
</tr>
<tr>
<td></td>
<td>*Evisceration/dehiscence not applicable</td>
</tr>
<tr>
<td>PC:hypo/hyperpituitary function</td>
<td>SIADH, Diabetes insipidus, cerebral salt wasting</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PC: Paralytic ileus</td>
<td>Paralytic ileus,</td>
</tr>
<tr>
<td>PC: Urinary retention</td>
<td>Urinary retention</td>
</tr>
<tr>
<td>Risk for constipation</td>
<td>Risk for constipation</td>
</tr>
<tr>
<td>Acute Pain</td>
<td>Acute Pain</td>
</tr>
<tr>
<td>Risk for imbalanced nutrition</td>
<td>Risk for imbalanced nutrition</td>
</tr>
<tr>
<td>Activity intolerance</td>
<td>Activity intolerance</td>
</tr>
<tr>
<td>Risk for ineffective therapeutic regimen management</td>
<td>Risk for ineffective therapeutic regimen management</td>
</tr>
</tbody>
</table>

The chart above has integrated the two problem lists, post-operative craniotomy and generic surgical client. The left hand column becomes the new problem list. (See revised problem list below)

Tentative Diagnostic List For Post Surgical Craniotomy
- PC: increased ICP
- PC: Hypoxia/Pnu/Atelectasis
- Risk for ineffective respiratory function
- PC: pulmonary edema
- PC: hypovolemia
- PC: Thrombophlebitis
- PC: CSF leak
- PC: infection
- PC: hypo/hyperpituitary function
- PC: Paralytic ileus
- PC: Urinary retention
- Risk for constipation
- Acute Pain
- Risk for imbalanced nutrition
- Activity intolerance
- Risk for ineffective therapeutic regimen management
After review of the literature you would analyze which of the complications would be most urgent and lead to a negative outcome if left unnoticed. If the literature indicates that the goal of care is focused on preserving cerebral perfusion and that a rise in ICP would lead to imminent death, that is the potential complication that becomes your priority. Further analysis would reveal that the interventions to maintain cerebral perfusion include actions to maintain oxygenation and perfusion so that these body systems and prescribed interventions would not be delayed by the unique circumstances of the client that requires aggressive monitoring and management of intracranial pressure.

**Summary of Identifying Life-Threatening Concerns**

- According to Alfaro-Lefevre (2006), life threatening concerns are those which can effect airway, breathing, circulation, bleeding plus vital signs.
- Carpenito (2006) notes that urgent problems are those problems that must be attended to or would otherwise lead to a worsening in the client’s status.
- A synthesis of these two frameworks would require that the nurse analyze the goals of collaborative care for the specific medical diagnosis or procedure and identify the goals of care.
- With complicated patients, multiple problem lists must be integrated to create one tentative list.
- Priority would be assigned to the presence of complications that could lead to an imminent change in client outcomes or that otherwise interfere with airway, breathing, circulation, bleeding plus vital signs.

**Safety Concerns or a Concern that Must be Addressed**

According Alfaro-Lefevre, R. (2006), priorities that follow ABC plus V include physiologic problems that are immediately subsequent to the ABCs plus V such as untreated medical problems, labs, pain, mental status changes while Carpenito-Moyet (2007) refers to them as those diagnoses that must be managed in order for the client to progress. It is presumed that if these problems were not managed it could eventually lead to a decline in the client’s outcome and their condition could worsen. The nurse would probable focus on standards of care for a client type in order to select labels that would enhance progress.

If the nurse has not already integrated fluid, electrolytes, intake, elimination, integument, or pain into the plan, this is where the labels would most likely be placed. Ordering diagnoses as physiologic before safety can be problematic. The unique circumstances or context of the client will always prevail.

For example, you are caring for a client with pneumonia who is unable to cough and deep breathe due to pleuritic chest pain yet you know that deficient fluid volume is a physiologic stressor. What is your priority?

**Acute Pain or Deficient fluid volume**

In view of the context of the client’s unique circumstances, you could make an argument to prioritize pain management over deficient fluid volume. If however, you elicit focused assessment data that indicates that the client is more complicated than deficient fluid volume, but in fact, may be
experiencing the potential complication of hypovolemia, the client would no longer be diagnosed with deficient fluid volume, the label; PC:hypovolemia would be applied and take precedence.

**Summary of Safety Concerns and Concerns That Must Be Addressed**

- Secondary priorities to life-threatening priorities include diagnostic labels that could delay the client’s progress or contribute to harming the client if ignored but can be deferred until the client is stabilized (ABC plus V is within normal limits).
- According to Carpenito, many of these diagnostic labels are labels frequently found in the standard of care for the practice area.
- If the unique context of a client’s circumstance could contribute to harm or decline, the safety diagnosis would have precedence over a physiologic concern that can be deferred.
- Priorities cannot be set in a vacuum and an analysis of focused assessment data facilitates ordering priorities.

**Patient Concerns or Concerns That Effect Long Term Outcomes**

The analysis of the client’s function health patterns may reveal additional diagnostic labels that could impact the client’s outcome. Many nursing assessment tools are organized to collect data in these patterns to identify dysfunction. Dysfunction in any of these patterns could reveal further nursing diagnoses. According to Alfaro-Lefevre, R. (2006), these diagnoses lead to issues in long term outcome. Therapeutic management and health education falls in this category as well as anxiety and coping.

### Gordon’s Functional Health Patterns

- Health perception/health management pattern
- Sleep rest pattern
- Cognitive perceptual pattern
- Self perception and self concept pattern
- Role relationship pattern
- Sexuality-reproductive pattern
- Coping-stress tolerance pattern
- Value-belief pattern
- Nutritional metabolic pattern
- Elimination pattern

**Summary of Patient Concerns**

- According to Carpenito (2006), lower priority problems include those diagnostic labels that can be delayed without harming the client’s outcome while Alfaro-Lefevre suggests that issues in long term outcome can arise.
- Diagnostic labels are elicited through a holistic assessment of functional health patterns.
- Patient concerns are not immediately life-threatening.
References


