Chapter 1

The NANDA International Taxonomy II
2012–2014

T. Heather Herdman, Gunn von Krogh

History of the Development of Taxonomy II

The history of the development of Taxonomy I and II can be found in detail on the NANDA-I website (www.nanda.org). A brief summary of the history of Taxonomy II, the current structure for NANDA-I, is provided here. In 1994, the NANDA Taxonomy Committee submitted a Q-sort methodology using four different potential taxonomic frameworks to the NANDA Board of Directors. None of these frameworks was entirely satisfactory, although Gordon’s (1998) Functional Health Pattern framework was felt to be the best fit. With Gordon’s permission, the Taxonomy Committee modified this framework to create a fifth framework.

One domain of the Functional Health Pattern framework was divided into two to reduce the number of classes and diagnoses falling within it. A separate domain was added for growth and development because the original framework did not contain that domain. Several other domains were renamed to better reflect the content of the diagnoses within them. The final taxonomic structure is much less like Gordon’s original, but the changes have reduced misclassification errors and redundancies to nearly zero, which is a much-desired state in a taxonomic structure. This new structure was presented to, and accepted by, the NANDA membership in April 1998, at the 13th biennial conference in St. Louis, Missouri (USA).

Definitions were developed for all the domains and classes within the structure. The definition of each diagnosis was then compared with that of the class and the domain in which it was placed. Revisions and modifications in the diagnosis placements were made to ensure maximum match among domain, class, and diagnosis.

In January 2003, the Taxonomy Committee made further refinements to the terminology in Taxonomy II. Additionally, to foster its international focus, the axes in Taxonomy II were reviewed and compared with the International Standards Organization (ISO) Reference Terminology Model for a Nursing Diagnosis.

As with any expanding taxonomy, work continues as NANDA-I develops more terms to represent nursing knowledge. In 2007, the Taxonomy Committee again began a review of the current taxonomic structure, under the leadership of its chairperson, Gunn von Krogh. Concerns regarding the current taxonomic structure were presented at the NANDA-I conference in Miami (2008) and published in the NANDA-I journal (von Krogh, 2008). A draft of a new knowledge- and ontology-based taxonomy was presented at the 2010 Asociación Española de Nomenclatura,
Taxonomía y Diagnósticos de Enfermería (AENTDE)/NANDA-I International Congress in Madrid, Spain, in 2010. A taxonomy workgroup was formed to develop this draft further and to establish rules for ontological review of nursing diagnoses. A revised draft of this work was presented at the 2011 NANDA-I Latin American Symposium (São Paulo, Brazil). Development of these proposed changes is still ongoing at the date of publication of this text, so Taxonomy II will be maintained throughout the life cycle of this edition.

For the 2012–2014 edition of the taxonomy, the nursing diagnoses and supporting materials that were approved by the Diagnosis Development Committee (DDC) were made available for voting to members on the NANDA-I website. This marks the second release of this text in which this method of approval was used for the ongoing expansion and revision of Taxonomy II. The Taxonomy Committee placed diagnoses within both the NANDA-I Taxonomy II and the NANDA-I, Nursing Interventions Classification (NIC), and Nursing Outcomes Classification (NOC) combined NNN Taxonomy of Nursing Practice, following approval of the nursing diagnoses by the DDC, NANDA-I membership and Board of Directors.

Structure of Taxonomy II

Clinicians are primarily concerned with the diagnoses within the taxonomy and may believe that they do not need to use the taxonomic structure itself. Familiarity with how a diagnosis is structured will, however, aid the clinician who needs to find information quickly, as well as those who wish to submit new diagnoses. A brief explanation of how the taxonomy is designed is therefore included here.

A taxonomy is defined as a “Classification: especially orderly classification of plants and animals according to their presumed natural relationships”; the word is derived from the root word, taxon – “the name applied to a taxonomic group in a formal system of nomenclature” (Merriam-Webster, 2009). We can adapt the definition for a nursing diagnosis taxonomy; specifically, we are concerned with the orderly classification of diagnostic foci of concern to nursing, according to their presumed natural relationships. Taxonomy II has three levels: domains, classes, and nursing diagnoses. Figure 1.1 depicts the organization of domains and classes in Taxonomy II; Table I.1 in the Introduction shows Taxonomy II with 13 domains, 47 classes, and numbers of diagnoses. A domain is “a sphere of knowledge, influence, or inquiry”; a class is “a group, set, or kind sharing common attributes” (Merriam-Webster, 2009).

The Taxonomy II code structure is a 32-bit integer (or if the user’s database uses another notation, the code structure is a five-digit code). This structure provides for the stability, or growth and development, of the classification structure by avoiding the need to change codes when new diagnoses, refinements, and revisions are added. The Informatics Committee assigns new codes to newly submitted diagnoses that have been approved by the DDC and successfully voted upon by the NANDA-I membership and Board of Directors.

Taxonomy II has a code structure that is compliant with recommendations from the National Library of Medicine (NLM) concerning healthcare terminology codes. The NLM recommends that codes do not contain information about the classified concept, as did the Taxonomy I code structure, which included information about the location and the level of the diagnosis.

50 Nursing Diagnoses 2012–2014
Figure 1.1  Taxonomy II domains and classes
Figure 1.1  Continued
The NANDA-I Taxonomy II is a recognized nursing language that meets the criteria established by the Committee for Nursing Practice Information Infrastructure of the American Nurses Association (ANA) (Lundberg, Warren, Brokel, Bulechek, Butcher, Dochtermann, Johnson, et al., 2008). The benefit of a recognized nursing language is the indication that the classification system is accepted as supporting nursing practice by providing clinically useful terminology. The ANA recognition facilitates the inclusion of NANDA-I in the ANA Nursing Information and Data Set Evaluation Center criteria for clinical information systems (nursingworld.org/nidsec/index.htm) and the NLM’s Unified Medical Language System (www.nlm.nih.gov/research/umls/umlsmain.html). NANDA-I diagnoses have been modeled into the Systematized Nomenclature of Medicine-Clinical Terms (SNOMED CT), which has been accepted as a terminology standard for the US Department of Health and Human Services, the US Consolidated Health Information Initiative, and the United Kingdom’s National Health Service. A map of this modeling effort is available from SNOMED International (www.snomed.org). SNOMED CT “provides a consistent way of indexing, storing, retrieving and aggregating clinical data across specialties and sites of care” (Lundberg et al., 2008). NANDA-I nursing diagnoses are located within SNOMED CT under the top-level hierarchy of “clinical findings,” which includes diagnoses, disorders, diseases that are necessarily abnormal, clinical observations, and signs and symptoms. The NANDA-I nursing diagnoses also comply with the ISO terminology model for a nursing diagnosis (Figure 1.2).

**Figure 1.2**  The ISO reference terminology model for a nursing diagnosis

Finally, the taxonomy is registered with Health Level Seven International (www.HL7.org), a healthcare informatics standard, as a terminology to be used in identifying nursing diagnoses in electronic messages among clinical information systems.

**A Multiaxial System for Constructing Diagnostic Concepts**

The NANDA-I diagnoses are concepts constructed by means of a multiaxial system. This system consists of axes out of which components are combined to make the diagnoses substantially equal in form, and in coherence with the ISO model.
NANDA-I does not support the *random construction* of diagnostic concepts that would occur by simply matching terms from one axis to another to create a diagnosis label to represent judgments based on a patient assessment. Clinical problems/areas of nursing foci that are identified and that do not have a NANDA-I label should be carefully described in documentation to ensure accuracy of other nurses’/healthcare professionals’ interpretation of the clinical judgment. Creating a diagnosis to be used in clinical documentation by matching terms from different axes, without development of the definition and other component parts of a diagnosis (defining characteristics, related factors, or risk factors) in an evidence-based manner, negates the purpose of a standardized language as a method to truly represent, inform, and direct clinical judgment and practice. This is a serious concern with regard to patient safety, because the lack of the knowledge inherent within the component diagnostic parts makes it impossible to ensure diagnostic accuracy. Nursing terms arbitrarily created at the point of care could result in misinterpretation of the clinical problem/area of focus, and subsequently lead to inappropriate outcome setting and intervention choice. It also makes it impossible to accurately research the incidence of nursing diagnoses, or to conduct outcome or intervention studies related to diagnoses since, without clear component diagnostic parts (definitions, defining characteristics, and related or risk factors), it is impossible to know if the concept being studied truly represents the same phenomena. Therefore, when discussing construction of diagnostic concepts in this chapter, the intent is to inform clinicians how diagnostic concepts are developed, and to provide clarity for individuals who are developing diagnoses for submission into the NANDA-I Taxonomy. It *should not* be interpreted to suggest that NANDA-I supports the creation of diagnosis labels by clinicians at the point of patient care.

An axis, for the purpose of the NANDA-I Taxonomy II, is operationally defined as a dimension of the human response that is considered in the diagnostic process. There are seven axes. The *NANDA-I Model of a Nursing Diagnosis* displays the seven axes and their relationship to each other (Figure 1.3). The ordering and some of the labels and definitions were changed after the 2005–2006 edition of this book in order to parallel the International Standards Reference Model for a Nursing Diagnosis:

- **Axis 1:** the diagnostic focus;
- **Axis 2:** subject of the diagnosis (individual, family, group, community);
- **Axis 3:** judgment (impaired, ineffective, etc.);
- **Axis 4:** location (bladder, auditory, cerebral, etc.);
- **Axis 5:** age (infant, child, adult, etc.);
- **Axis 6:** time (chronic, acute, intermittent);
- **Axis 7:** status of the diagnosis (actual, risk, health promotion).

The axes are represented in the labels of the nursing diagnoses through their values. In some cases, they are named explicitly, such as with the diagnoses *Ineffective Community Coping* and *Compromised Family Coping*, in which the subject of the diagnosis (in the first instance “community” and in the second instance “family”) is named using the two values “community” and “family” taken from Axis 2 (subject of the diagnosis). “Ineffective” and “compromised” are two of the values contained in Axis 3 (judgment).

In some cases, the axis is implicit, as is the case with the diagnosis *Activity Intolerance*, in which the subject of the diagnosis (Axis 2) is always the patient. In
some instances, an axis may not be pertinent to a particular diagnosis and therefore is not part of the nursing diagnostic label. For example, the time axis may not be relevant to every diagnosis. In the case of diagnoses without explicit identification of the subject of the diagnosis, it may be helpful to remember that NANDA-I defines “patient” as “an individual, family, group or community.”

Axis 1 (the diagnostic focus) and Axis 3 (judgment) are essential components of a nursing diagnosis. In some cases, however, the diagnostic focus contains the judgment (e.g., Nausea); in these cases, the judgment is not explicitly separated out in the diagnostic label. Axis 2 (subject of the diagnosis) is also essential, although, as described above, it may be implied and therefore not included in the label. The DDC requires these axes for submission; the other axes may be used where relevant for clarity.

Definitions of the Axes

Axis 1: The Diagnostic Focus

The diagnostic focus is the principal element or the fundamental and essential part, the root, of the diagnostic concept. It describes the “human response” or experience that is the core of the diagnosis.

The diagnostic focus may consist of one or more nouns. When more than one noun is used (e.g., Activity Intolerance), each one contributes a unique meaning to the diagnostic focus, as if the two were a single noun; the meaning of the combined term, however, is different from when the nouns are stated separately. Frequently, an adjective (Spiritual) may be used with a noun (Distress) to denote the diagnostic focus Spiritual Distress.

In some cases, the diagnostic focus and the diagnostic concept are one and the same, as is seen with the diagnosis of Nausea. This occurs when the nursing diagnosis is stated at its most clinically useful level and the separation of the diagnostic focus adds no meaningful level of abstraction. It can be very difficult to determine exactly what should be considered the diagnostic focus. For example, using the
diagnoses of Bowel Incontinence and Stress Urinary Incontinence, the question becomes: Is the diagnostic focus incontinence alone, or are there two foci – bowel incontinence and urinary incontinence? In this instance, incontinence is the focus, and the location terms (Axis 4) of bowel and urinary provide more clarification about the focus. However, incontinence in and of itself is a judgment term that can stand alone, and so it becomes the diagnostic focus regardless of location.

In some cases, however, removing the location (Axis 4) from the diagnostic focus would prevent it from providing meaning to nursing practice. For example, if we look at the focus of the diagnosis Risk for Imbalanced Body Temperature, is the diagnostic focus body temperature or simply temperature? Or if you look at the diagnosis Disturbed Personal Identity, is the focus identity or personal identity?

Decisions about what constitutes the essence of the diagnostic focus, then, are made on the basis of what helps to identify the nursing practice implication, and whether or not the term indicates a human response. Temperature could mean environmental temperature, which is not a human response – so it is important to identify body temperature as the diagnostic concept. Similarly, identity can mean nothing more than one’s gender, eye color, height, or age – again, these are characteristics but not human responses; personal identity, however indicates one’s self-perception and is a human response. In some cases, the focus may seem similar, but is in fact quite distinct: violence and self-directed violence are two different human responses, and therefore must be identified separately in terms of diagnostic foci within Taxonomy II.

The diagnostic foci of the NANDA-I nursing diagnoses are:

- Activity intolerance
- Activity planning
- Adverse reaction to iodinated contrast media
- Airway clearance
- Allergy response
- Anxiety
- Aspiration
- Attachment
- Autonomic dysreflexia
- Behavior
- Bleeding
- Blood glucose level
- Body image
- Body temperature
- Breast milk
- Breastfeeding
- Breathing pattern
- Cardiac output
- Caregiver role strain
- Childbearing process
- Comfort
- Communication
- Confusion
- Constipation
- Contamination
- Coping
- Death anxiety
- Decisional conflict
- Decision-making
- Denial
- Dentition
- Development
- Diarrhea
- Disuse syndrome
- Diversional activity
- Dry eye
- Electrolyte imbalance
- Energy field
- Environmental interpretation syndrome
- Failure to thrive
- Falls
- Family processes
- Fatigue
- Fear
- Feeding pattern
- Fluid balance
- Fluid volume
- Gas exchange
- Gastrointestinal motility
- Gastrointestinal perfusion
- Grieving
- Growth
- Growth and development
- Health
- Health behavior
- Health maintenance
- Home maintenance
- Hope
- Hopelessness
- Human dignity
- Hyperthermia
- Hypothermia
- Immunization status
- Impulse control
- Incontinence
- Infection
- Injury
- Insomnia
- Intracranial adaptive capacity
- Jaundice
- Knowledge
- Lifestyle
- Liver function
- Loneliness
- Maternal–fetal dyad
- Memory
- Mobility
- Moral distress
- Nausea
- Noncompliance
- Nutrition
- Oral mucous membrane
- Other-directed violence
- Pain
- Parenting
- Perioperative positioning injury
- Peripheral neurovascular dysfunction
- Personal identity
- Poisoning
- Post-trauma syndrome
- Power
- Powerlessness
- Protection
- Rape-trauma syndrome
- Relationship
- Religiosity
- Relocation stress syndrome
- Renal perfusion
- Resilience
- Role conflict
- Role performance
- Self-care
- Self-concept
- Self-directed violence
- Self-esteem
- Self-health management
- Self-mutilation
- Self-neglect
- Sexual dysfunction
- Sexuality pattern
- Shock
- Skin integrity
- Sleep
- Sleep pattern
- Social interaction
- Social isolation
- Sorrow
- Spiritual distress
- Spiritual well-being
- Spontaneous ventilation
- Stress
- Sudden infant death syndrome
- Suffocation
Axis 2: Subject of the Diagnosis

The subject of the diagnosis is defined as the person(s) for whom a nursing diagnosis is determined. The values in Axis 2 are individual, family, group, and community, representing the NANDA-I definition of “patient”:

- **Individual**: a single human being distinct from others, a person.
- **Family**: two or more people having continuous or sustained relationships, perceiving reciprocal obligations, sensing common meaning, and sharing certain obligations toward others; related by blood and/or choice.
- **Group**: a number of people with shared characteristics.
- **Community**: a group of people living in the same locale under the same governance. Examples include neighborhoods and cities.

When the subject of the diagnosis is not explicitly stated, it becomes the individual by default. However, it is perfectly appropriate to consider such diagnoses for the other subjects of the diagnosis as well. The diagnosis Grieving could be applied to an individual or family who has lost a loved one. It could also be appropriate for a community that has experienced a mass casualty or suffered the loss of an important community leader, devastation due to natural disasters, or even the loss of a symbolic structure within the community (a school, religious structure, historic building, etc.).

Axis 3: Judgment

A judgment is a descriptor or modifier that limits or specifies the meaning of the diagnostic focus. The diagnostic focus together with the nurse’s judgment about it forms the diagnosis. The values in Axis 3 are:
<table>
<thead>
<tr>
<th>Value</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complicated</td>
<td>Intricately involved, complex</td>
</tr>
<tr>
<td>Compromised</td>
<td>Damaged, made vulnerable</td>
</tr>
<tr>
<td>Decreased</td>
<td>Lessened (in size, amount, or degree)</td>
</tr>
<tr>
<td>Defensive</td>
<td>Used or intended to defend or protect</td>
</tr>
<tr>
<td>Deficient/deficit</td>
<td>Insufficient, inadequate</td>
</tr>
<tr>
<td>Delayed</td>
<td>Late, slow, or postponed</td>
</tr>
<tr>
<td>Disabled</td>
<td>Limited, handicapped</td>
</tr>
<tr>
<td>Disorganized</td>
<td>Not properly arranged or controlled</td>
</tr>
<tr>
<td>Disproportionate</td>
<td>Too large or too small in comparison with the norm</td>
</tr>
<tr>
<td>Disturbed</td>
<td>Agitated, interrupted, interfered with</td>
</tr>
<tr>
<td>Dysfunctional</td>
<td>Not operating normally</td>
</tr>
<tr>
<td>Effective</td>
<td>Producing the intended or desired effect</td>
</tr>
<tr>
<td>Enhanced</td>
<td>Improved in quality, value, or extent</td>
</tr>
<tr>
<td>Excess</td>
<td>Greater than necessary or desirable</td>
</tr>
<tr>
<td>Failure</td>
<td>Cessation of proper functioning or performance</td>
</tr>
<tr>
<td>Imbalanced</td>
<td>Out of proportion or balance</td>
</tr>
<tr>
<td>Impaired</td>
<td>Damaged, weakened</td>
</tr>
<tr>
<td>Ineffective</td>
<td>Not producing the intended or desired effect</td>
</tr>
<tr>
<td>Insufficient</td>
<td>Quantity or quality that is not able to fulfill a need or requirement</td>
</tr>
<tr>
<td>Interrupted</td>
<td>Having its continuity broken</td>
</tr>
<tr>
<td>Low</td>
<td>Below the norm</td>
</tr>
<tr>
<td>Organized</td>
<td>Properly arranged or controlled</td>
</tr>
<tr>
<td>Perceived</td>
<td>Observed through the senses</td>
</tr>
<tr>
<td>Readiness for</td>
<td>In a suitable state for an activity or situation</td>
</tr>
<tr>
<td>Risk for</td>
<td>Increased danger, probability, or vulnerability</td>
</tr>
<tr>
<td>Situational</td>
<td>Related to a particular circumstance.</td>
</tr>
</tbody>
</table>

**Axis 4: Location**

Location describes the parts/regions of the body and/or their related functions— all tissues, organs, anatomical sites, or structures. The values in Axis 4 are:

- Auditory
- Bladder
- Body
- Bowel
- Breast
- Cardiac
- Cardiopulmonary
- Cerebral
- Dentition
- Gastrointestinal
- Gustatory
- Intracranial
- Kinesthetic
Liver
Mucous membranes
Neurovascular
Olfactory
Oral
Peripheral
Peripheral vascular
Renal
Skin
Tactile
Tissue
Vascular
Verbal
Visual
Urinary.

Axis 5: Age

Age refers to the age of the person who is the subject of the diagnosis (Axis 2). The values in Axis 5 are:

- Fetus
- Neonate
- Infant
- Toddler
- Preschool child
- School-age child
- Adolescent
- Adult
- Older adult.

Axis 6: Time

Time describes the duration of the diagnostic concept (Axis 1). The values in Axis 6 are:

- **acute**: lasting less than 6 months;
- **chronic**: lasting more than 6 months;
- **intermittent**: stopping or starting again at intervals, periodic, cyclic;
- **continuous**: uninterrupted, going on without stopping.

Axis 7: Status of the Diagnosis

The status of the diagnosis refers to the actuality or potentiality of the problem/syndrome or to the categorization of the diagnosis as a health promotion diagnosis. The values in Axis 7 are as follows:
- **Actual**: existing in fact or reality, existing at the present time.
- **Health promotion**: behavior motivated by the desire to increase well-being and actualize human health potential (Pender, Murdaugh & Parsons, 2006).
- **Risk**: vulnerability, especially as a result of exposure to factors that increase the chance of injury or loss.
- ** Syndrome**: clinical judgment describing a specific cluster of nursing diagnoses that occur together, and are best addressed together and through similar interventions.
- **Wellness**: NANDA International no longer defines a category of nursing diagnosis as a “wellness diagnosis.” It was determined at the NANDA-I Think Tank meeting (2009) that this area of concern was already encompassed within the health-promotion nursing diagnosis category. This diagnosis type and definition were eliminated from the NANDA International taxonomy, and any wellness diagnoses were converted to health-promotion diagnoses.

### Construction of a Nursing Diagnostic Concept

A nursing diagnosis is constructed by combining the values from Axis 1 (the diagnostic focus), Axis 2 (subject of the diagnosis), and Axis 3 (judgment) where needed, and adding values from the other axes for relevant clarity. Thus, you start with the diagnostic focus (Axis 1) and add the judgment (Axis 3) about it. Remember that these two axes are sometimes combined into a single diagnostic concept, as can be seen with the nursing diagnosis Fatigue. Next, you specify the subject of the diagnosis (Axis 2). If the subject is an “individual,” you need not make it explicit (Figure 1.4). You can then use the remaining axes, if they are appropriate, to add more detail. Figures 1.5 and 1.6 illustrate other examples, using the “risk” diagnoses (Figure 1.5) and “readiness for enhanced” diagnoses (Figure 1.6).

Please see Chapter 8, *The Process for Development of an Approved NANDA-I Nursing Diagnosis*, for a detailed explanation on the diagnosis submission process for new

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**Figure 1.4** A NANDA-I nursing diagnosis model: (Individual) Ineffective Coping

![Diagram of NANDA-I nursing diagnosis model: Ineffective Coping](image-url)
and revised diagnoses. It is also recommended that you review the submission guidelines posted on the NANDA-I website (www.nanda.org), as any updates that might be made to these guidelines after the publication of this text will be available at that location.

The NNN Taxonomy of Nursing Practice

The NANDA-I Taxonomy II appeared for the first time in NANDA Nursing Diagnoses: Definitions and Classification, 2001–2002. During this period, NANDA began to negotiate an alliance with the Classification Center at the College of Nursing, University of Iowa, Iowa City, Iowa (USA). As a part of that alliance, the possibility of developing a common taxonomic structure was explored. The purposes of a common structure are to make relationships among the three classifications – nursing
diagnoses, nursing interventions, and nursing outcomes – visible, and to facilitate the linkage of the three systems. The possibilities were discussed among members of the NANDA Board of Directors and the leadership of the Classification Center.

Dr. Dorothy Jones, representing NANDA, and Dr. Joanne McCloskey, representing the Classification Center, developed a proposal to convene an invitational conference. The proposal was funded by the NLM, and a 3-day meeting was held in August 2001 at the Starved Rock Conference Center in Utica, Illinois. It was attended by 24 experts in standardized nursing language development, testing, and refinement. The goal was to develop a common taxonomic structure for nursing practice, including NANDA (nursing diagnoses), NIC (nursing interventions), and NOC (nursing outcomes), with the possibility of including other languages. A detailed account of the conference, as well as the history and development, can be found in Unifying Nursing Languages: The Harmonization of NANDA, NIC, and NOC (Dochterman and Jones, 2003).

The NANDA-I Taxonomy Committee met in January 2003 to place the nursing diagnoses from the NANDA-I Nursing Diagnoses: Definitions and Classifications 2003–2004 into the NNN Taxonomy of Nursing Practice. The committee established rules governing the placement of the nursing diagnoses:

1. The nursing diagnosis definition, defining characteristics, or risk factors guide the placement of the nursing diagnosis.
2. When a nursing diagnosis bridges two or more domains, the Taxonomy Committee reviews the nursing diagnosis definition, defining characteristics, related factors or risk factors, and places it in the domain most clinically consistent with that information.
3. Upon review of the definition, defining characteristics or risk factors of a nursing diagnosis, if it is clinically consistent with two or more domains, the nursing diagnosis is placed where the practicing nurse would most expect to find it.
4. “Risk for” or “readiness for enhanced” nursing diagnoses are placed in the same domain and class as the actual nursing diagnosis, when one exists.

Table I.2 in the Introduction shows the placement of the 217 current nursing diagnosis approved by NANDA-I in the NNN Taxonomy of Nursing Practice.

Further Development of the NANDA-I Taxonomy

A taxonomy and a multiaxial framework for developing nursing diagnoses allows clinicians to see where gaps exist in the taxonomy, and provides the opportunity to develop clinically useful new diagnoses. If you construct a new diagnosis that is useful to your practice, please submit it to NANDA-I so that others can share in the discovery. Submission guidelines are found in Chapter 8, The Process for Development of an Approved NANDA-I Nursing Diagnosis. Submission forms and information can also be found on the NANDA-I website (www.nanda.org). The DDC will be glad to help you prepare the submission. For assistance and/or questions, contact the DDC committee chair through the NANDA-I website.
References


