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The classification systems of nursing practice – the historical and practical perspective

The idea of individualized care draws on the principles of the nursing process whose basic element constitutes the recognition of the biological, mental and social condition of the object of care (an individual person, a family or a group of people other than a family). The result of this recognition, in the form of a specific definition, denotes the nursing diagnosis (7,9). It is defined as "the conclusions based on the data concerning a given patient that point to the bio-psycho-social condition of the person that requires (or does not require) the nursing care with the account of the genesis and prognosis of this condition" (9).

The origin of the interest in nursing diagnosis dates back to the first half of the 1950s. Despite the fact that already in 1953 Frey recognized the nursing diagnosis as an indispensable step in preparing and later developing the nursing care plan (5) the first major steps towards the classification of the diagnosis were not undertaken until 20 years later. In 1973 in the USA the first meeting of the National Group for the Classification of Nursing Diagnosis was held.

The classification of the diagnosis had its basis in the vast scope of data that had been accumulated over the years for the nursing care purposes. The data included documented claims addressing certain kinds of patients' conditions (for example overweight, pain, constipation, with or without the genesis of the condition, lack of knowledge or skills) whose existence was supported by the data available to nurses. The recognized conditions were presented in a descriptive way and only the knowledge, the professional experience and the so called nurses' creative inventiveness limited their scope and character.

Nowadays more and more emphasis is being put on the fact that the contribution in the continuous improvement of nursing care is closely connected with the process of systematic recording of the accumulated data, formulated diagnosis, undertaken actions and achieved results. This in turn constitutes the essence of the 31 Aim of WHO, which stresses the need to continue the rational contribution for the purpose of nursing care improvement as well as to apply all available computer technologies for the purpose of quality increase (6).

The work is of theoretical character and its main aim is to signal the historical conditioning in the process of the development of classification systems and to show their essence and practical values. The paper will briefly outline the process of systematic recording in nursing (with focus on the international experiences – NANDA and the European ones – ICNP). Special attention will be devoted to the theoretical and practical value of ICNP. Hypothetically speaking, it is assumed that the cognitive character of the work may stimulate greater interest of the Polish nursing community in the classification systems that constitute an integral part of individualized nursing.

THE METHOD

To achieve a complex character of the work I have adopted the method of analysis of reference sources mainly including articles that discuss the classification systems developed for the nursing purposes. The directed analysis of their content allows to show the pioneering character of the contribution made by the American Nurses Association (ANA) towards the process of record keeping and coding as well as the actions undertaken by the European nurses for the development of the International Classification of Nursing Practice (ICNP).

THE ESSENCE OF SYSTEMATIC RECORD KEEPING IN NURSING

It has been long the aim of nursing in the world to achieve the level of classification of diagnosis of comparable standard to the one in medicine (2). It was particularly visible in those countries where investing in the very essence of nursing, including the objectification of nurses' professional opinions, is perceived in the categories of measurable values.

SYSTEMATIC RECORDS KEEPING IN NURSING – AMERICAN AND EUROPEAN EXPERIENCES

USA. The first list of nursing diagnosis was complied in the USA already at the beginning of the 1960s and is connected with the theoretical and practical activities of American Nursing Association. It is commonly known that since 1998, based on the previously developed criteria and procedures for the official acceptance of the existing systems, American Nursing Association has acknowledged a few out of the number of available systems of nursing classification, namely: NANDA (North American Nursing Diagnosis Association 1), HHCC (Home Health Care Classification), Omaha system, NIC (Nursing Intervention Classification), NOC (Nursing Outcome Classification), Patient Care Data Set (1).

Europe. The beginnings of the conscious and planned recording of data for the purposes of nursing in Europe fall on the first half of the 1970s and are connected with the initiative of WHO for the broad research scheme (1976-1985) called "The Needs of People for Nursing Care". In 1993 the First European Conference of Nursing Diagnosis was held in Copenhagen, Denmark, whose basic aim was to create the European grounds for professional cooperation among nurses. ICNP was founded in Europe and in order to satisfy the needs of nurses from this part of the world. Its foundation was instigated by the International Council of Nurses (ICN) (13). At present two versions are available: Alfa (first published in 1996) and Beta (published in 1999). Both versions were later developed in traditional and electronic form, although, for obvious reasons, it is the latter Beta version that is now recommended to be used in contemporary nursing (10,11). It does not mean, however, that this version is final.

Poland. The earliest Polish works concerning diagnosis in nursing were published towards the end of the 1960s (4). In 1984 the first Polish conference was organized to discuss the issue of diagnosis in nursing, followed by another conference in 1986[1]. During the first conference the notion of diagnosis in nursing was redefined in a directed way (8). The peak of interest in the issue of diagnosis in nursing falls on the second half of the 1980s. In practical nursing, from the very beginning the traditional approach to diagnosis was accepted, unintentionally so. A practically unlimited freedom of interpretation of the scope of nurses' diagnosis in relation to the object of care (his condition, problems and needs) has remained until today. The lack of experience in applying NANDA hinders (although does not exclude) getting to the ICNP level.

NANDA – THE ESSENCE

The classification (taxonomy) of the NANDA diagnoses until recently was one of the best known and most commonly used in nursing practice. It was officially accepted in 1986 and has

remained in use until today, although it has been novelized a few times. The nursing diagnoses are presented here in the alphabetic order[2] and their number in various works, depending on the source, varies from 90 odd to 100 odd. For the purpose of information processing with the application of available electronic means they were given corresponding numeric codes. Here are the first five types of diagnoses from the quoted list:

Aggression; the proneness towards it, directed onto oneself or others
Aspiration; the proneness to...
Idleness; the potential syndrome
Powerlessness
Diarrhea

All diagnoses have been assigned to one of the nine patterns of human reactions. For the purpose of this article only the first three are given: 1. Exchange: giving and receiving. 2. Communication: sending information (messages). 3. Reference to: establishing relations (12).

Thus, the nurse's diagnosis coded as 1.1.2.2. (Nutrition, the altered way, less than an organism requires) means what was diagnosed "belongs" to the categories: 1 – exchange, refers to the group: 1 – the organism's response to receiving and giving, in relation to 2 – nutrition, and explains that the diagnosed person eats: 2 – less than the organism requires.

Besides what has been recognized, whenever possible, the reason is also stated (e.g. nourishment, less than the organism requires, lack of money). Hence in the NANDA terms one can speak about the binomial nursing diagnoses.

Summing up, the NANDA proposal allows to perform "a clinical diagnosis of a single person, family or community that deals with the actual or potential health problems or vital processes" (12).

NANDA – THE VALUE

The classification makes it possible to use the list of diagnosis arranged in the alphabetic order (together with the corresponding codes) and the taxonomies that cover the nine possible patterns of human reactions. Being a good example to follow for a number of years, not to mention various analyses and evaluations it was subject to, it gave rise to other attempts to reorganize it and create a better developed taxonomy system.

NANDA is used primarily where it was created and in those countries where nursing remains under American influence. It allows to name the problems (conditions, processes) recognized in a patient in a precise way, code them and process for the practical and theoretical purposes. At present it is stressed that the scope of possibilities of NANDA is limited by the possibilities of the very taxonomy.

ICNP – THE ESSENCE

The authors of ICNP went much further because they were able to use the previous experiences and works such as the already mentioned NANDA. It is commonly known that the terms and by analogy the whole ICNP terminology refers to the previously mentioned American classifications and the selected dictionaries of nursing terms (1). When making the ICNP, use was made of the basic assumptions of classification, namely the systematic division used in those areas and fields in which it has basic application (for example in medicine). As a result of those attempts there appeared a systematic, multi-axial structure which extends over more than one criterion (more than one variable). For the purposes of this section of the paper, as an example that illustrates the essence of the nursing diagnosis and its code, I have selected the condition of malnutrition (similarly as was the case with NANDA) (1.A.1.1.1.4.2.5.1).

Having decoded the letter/number sequence one learns of: 1 – phenomenon, which constitutes the object of the nurse's professional interest; A – an axis (among other possible ones that appear in the Classification of Nursing Phenomena ICNP); 1 – a person, 2 – a unit, 3 – a function, 4 – nutrition, 2 – the condition of the organism's nutrition, 5 – malnutrition.

The scope and character of this paper do not leave enough room for the explanation of all the definitions of the terms than constitute the code. Therefore, the illustration has been limited to the last three only: nutrition, the condition of nutrition and malnutrition. Nutrition (1.A.1.1.1.4): The category of functions, the sum of processes and operations connected with the growth and the condition of the nutrition as a whole, the maintenance and repairs of body cells and in particular the processes directly connected with absorbing the nutritious substances and the utilization of food. The condition of nutrition (1.A.1.1.1.4.2.): The category of nutrition; includes overweight and body mass in the ratio to the amount of food and supplements consumed daily, assessment according to the height, body build and age. Malnutrition (1.A.1.1.1.4.2.5): The category of nutrition, malnutrition caused by eating inadequate or insufficient amounts of nutritious substances, connected with inadequate diet, dysfunctional absorption caused by diseases connected with food and nutritious substances intake. Emaciation (1.A.1.1.1.4.2.5.1) The category of bad nutrition, atrophy of the muscles, attenuation and usually in connection with a generally bad health condition and diseases such as cancer or tuberculosis.

ICNP – THE VALUE

ICNP is regarded as one of greater achievements of nursing at the end of the 20th century, inspired by the International Nursing Council (ICN). As of now it has been the only method of classification available to nurses that allows to implement the unified terminology and corresponding numeric codes for the three variables (while NANDA uses only one): 1) the recognized conditions (The International Classification of the Nursing Phenomena); 2) the undertaken actions (The International Classification of the Nursing Actions); 3) the achieved results (The International Classification of Achievements).

Most generally speaking, ICNP creates the possibilities of reaching the state of objectivity and rationalism, or in other words, assuming a sensible approach to data, facts, and states essential in nursing. It also makes it possible to compare the nurses' opinions and at the same time have a direct influence on the quality of nursing.

CONCLUSION

Making one's contribution to local and global data bases as well as using them for the purposes of increasing the quality of individualized nursing must not be understood and analyzed solely in the categories of the nurse's will. The nurse, as any other health service worker, must be professionally interested in the procedure of gathering and processing of the credible data.

The development of world nursing has led to the situation in which it is no longer necessary to convince anyone about the necessity of supporting the practice of nursing on rational basis, including the effective nursing diagnosis. To achieve such a state it is necessary to properly understand the essence and meaning of individualized nursing since both ICNP and NANDA have been developed for the purposes of the nursing care. It is important to notice at this point that because the American Nursing Association has at its disposal the

credible system of nursing classification it can effectively control particular procedures and provide indispensable data in support of the need to follow the American Bill of Responsibility and Health Insurance (from 1997). Various regulations concerning the many health protection areas are used to this effect, including the dictionaries of codes used when filling out forms to claim the health insurance policy damages.

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SUMMARY

The contribution into activities connected with the development of the quality of nursing care is closely combined with the process of systematic recording of accumulated data, of undertaken activities and achieved results. This in turn constitutes the essence of the 31st Aim of WHO which speaks not only about the need to continue the rational contribution towards the increase in the nursing care quality but also the application of adequate computer technologies to improve this quality. The aim of this work is to demonstrate the scope and character of the activities that have been over years undertaken by the nursing community towards the development of the classification systems which are comparable with those used in medicine. The focus has been specifically put on the taxonomy of diagnosis used by the North American Nursing Diagnosis Association (NANDA) and the European International Classification of

Nursing Practice (ICNP). The analysis of the reference sources constitutes the methodological foundation applied in this work. It has allowed to show the pioneering contribution of the American Nursing Association (ANA) into the process of recording and coding of the data that are essential in care delivery as well as their value for the development of ICNP. The latter one is a systematic and multi-axial structure which uses unified terminology and numeric codes for the three categories of variables: the recognized conditions, the undertaken activities and the achieved results.

Systemy klasyfikacyjne praktyki pielęgniarskiej – ujęcie historyczno-merytoryczno-praktyczne

Wkład w kontynuowanie działań związanych z rozwojem jakości opieki pielęgniarskiej łączy się ściśle z nurtem systematycznego dokumentowania gromadzonych danych, podejmowanych działań, uzyskiwanych wyników. To z kolei jest istotą 31 Celu WHO, w którym nie tylko jest mowa o konieczności kontynuowania racjonalnego wkładu na rzecz wzrostu jakości opieki pielęgniarskiej, ale także wykorzystania odpowiednich technologii informatycznych dla potrzeb jakości. Celem pracy jest ukazanie zakresu i charakteru działań podejmowanych przez środowisko pielęgniarskie na przestrzeni lat na rzecz rozwoju systemów klasyfikacyjnych porównywalnych z wykorzystywanymi w medycynie. Szczególna uwaga zwrócona została na taksonomię diagnoz Północnoamerykańskiego Towarzystwa Pielęgniarskiego (NANDA) i europejską Międzynarodową Klasyfikację Praktyki Pielęgniarskiej (ICNP). Analiza materiałów źródłowych stanowi podstawową metodę wykorzystaną w pracy. Pozwoliła ona na ukazanie pionierskiego wkładu Amerykańskiego Towarzystwa Pielęgniarskiego (ANA) w proces dokumentowania i kodowania istotnych dla opieki danych, a także ich wartości dla budowania ICNP. Ta zaś jest strukturą uporządkowaną, wieloosiową, pozwalającą na stosowanie ujednoliconego nazewnictwa i kodów cyfrowych dla trzech kategorii zmiennych: stanów rozpoznanych, podejmowanych działań, uzyskiwanych wyników.