Review Article

A review of nursing diagnoses prevalence in different populations and healthcare settings

Revisão da prevalência de diagnósticos de enfermagem em diferentes populações e cenários de cuidado à saúde

Revisión de prevalencia de diagnósticos de enfermería en diferentes poblaciones y contextos de asistencia sanitaria

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Descriptores
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Abstract

Objective: To provide an overview of the prevalence of nursing diagnoses in different patient populations and healthcare settings, and on the methods identifying nursing diagnoses.

Methods: A descriptive review with a systematic method was applied according to Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines. All studies, in Medline and CINAHL databases from January 2007 to January 2020, reporting nursing diagnoses prevalence were included regardless of population and setting retrieving 1839 articles.

Results: After the screening, 328 articles were included for the analysis. Twenty different patient populations with their respective nursing diagnoses prevalence were identified. Most studies were conducted in inpatient settings (e.g., intensive, and surgical units). NANDA International was a widespread standard nursing language used, and risk for infection was the most frequently identified nursing diagnosis. Several gaps were identified regarding the methods used in the articles analyzed.

Conclusion: The most prevalent nursing diagnoses in different patient populations were identified. Moreover, the nursing diagnoses in the five standard nursing languages recognized by the American Nurses Association were summarized. Advances, gaps, and a call to action were identified.

Resumo

Objetivo: Fornecer uma visão geral da prevalência de diagnósticos de enfermagem em diferentes populações de pacientes e cenários de cuidado à saúde, e sobre os métodos de identificação dos diagnósticos de enfermagem.

Métodos: Revisão descritiva com aplicação de método sistemático de acordo com as diretrizes do *Preferred Reporting Items for Systematic Reviews and Meta-Analyses*. Foram incluídos estudos das bases de dados Medline e CINAHL publicados entre janeiro de 2007 e janeiro de 2020, que relataram a prevalência de diagnósticos de enfermagem, independentemente da população e do cenário (n=1839).

Resultados: Após a triagem, foram incluídos 328 artigos para análise. Foram identificadas 20 populações diferentes de pacientes com suas respectivas prevalências de diagnósticos de enfermagem. A maioria dos estudos foi realizada em ambientes hospitalares (por exemplo, unidades de terapia intensiva e cirúrgicas). A Classificação da NANDA International foi uma linguagem padronizada de enfermagem amplamente utilizada

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e o Risco de infecção foi o diagnóstico mais frequentemente identificado. Foram identificadas diversas lacunas quanto aos métodos utilizados nos artigos.

Conclusão: Foram identificados os diagnósticos de enfermagem mais prevalentes nas diferentes populações de pacientes. Além disso, foram sumarizados os diagnósticos de enfermagem das cinco linguagens padronizadas de enfermagem reconhecidas pela *American Nurses Association* e identificados avanços, lacunas e uma chamada para ação.

Resumen

Objetivo: Proporcionar una visión general de la prevalencia de diagnósticos de enfermería en diferentes poblaciones de pacientes y diferentes contextos de asistencia sanitaria y de los métodos para identificar los diagnósticos de enfermería.

Métodos: Se aplicó una revisión descriptiva con método sistemático de acuerdo con las orientaciones de la *Preferred Reporting Items for Systematic Reviews and Meta-Analyses*. Se incluyeron todos los estudios de las bases de datos Medline y CINAHL, de enero de 2007 a enero de 2020, que reportaron la prevalencia de diagnósticos de enfermería, sin distinción de población ni contexto. Se obtuvieron 1839 artículos.

Resultados: Después de la revisión, se incluyeron 328 artículos para el análisis. Se identificaron 20 poblaciones de pacientes con sus respectivas prevalencias de diagnósticos de enfermería. La mayoría de los estudios fueron desarrollados en el contexto de pacientes hospitalizados (unidades intensivas y quirúrgicas). La clasificación internacional NANDA fue el lenguaje estándar más utilizado, y el riesgo de infección fue el diagnóstico de enfermería identificado con más frecuencia. Se identificaron varios vacíos respecto a los métodos utilizados en los artículos analizados.

Conclusión: Se identificaron los diagnósticos de enfermería más prevalentes en diferentes poblaciones de pacientes. Además, los diagnósticos de enfermería se resumieron en los cinco lenguajes de enfermería estándar reconocidos por la Asociación Americana de Enfermería. Se identificaron avances, vacíos y un llamado a la acción.

Introduction

Nursing diagnosis (ND) communicated through standard nursing languages (SNLs) has been promoted by nursing associations since the 1970s.[1,2] ND represents the nurse's clinical judgment about the client's human response to an actual or potential condition related to health from a holistic perspective, and it is the basis to elaborate a nursing care plan to enhance the patient's health status.[3]

Through the decades, different SNLs have been developed to comprise not only NDs, but also nursing interventions and patient-sensitive outcomes. However, NDs have always been an element present in all SNLs. Currently, seven SNLs are recognized by the American Nurses Association (ANA) as standard terminologies that support nursing practice, out of which five communicate NDs - the Clinical Care Classification System (CCC), the International Classification of Nursing Practice (ICNP), the NANDA-International Classification of Nursing Diagnoses (NANDA-I), the Omaha System and the Perioperative Nursing Data Set (PNDS). The literature shows how these SNLs are not uniformly widespread, implemented, or validated.[2,4]

Prevalence studies about NDs are instrumental to identify trends in health status from a nursing perspective, to characterize patients' profiles, to support best practices and satisfy patients' needs,[5] and to understand their use in clinical settings after almost 50 years of implementation. Some studies about the prevalence of NDs have been conducted in different patient populations (e.g., pediatric and adult patients) and settings such as hospital units, primary health care and ambulatory settings.[6-8] However, no article has yet provided a general description and a synthesis of these studies, also identifying potential gaps. There is a lack of knowledge about the prevalence of NDs of the five ANA-recognized SNLs in different patient populations and especially how these studies have considered NDs (e.g., the timepoint in the healthcare continuum when the NDs were identified, criteria used to identify NDs). To our knowledge, a few literature reviews about ND prevalence in specific patient populations have been conducted.[9,10]

To provide an overview of the prevalence of NDs in different patient populations and healthcare settings, with a focus on 1) the study methods (e.g., sampling technique, sample size); 2) the SNL used to communicate NDs; 3) the criteria used to identify NDs; 4) the timepoint in the healthcare continuum when the NDs were formulated. The main research questions were: 1) What was the prevalence of NDs in different patient populations? 2) What was the prevalence of NDs in the different SNLs? The research questions were developed according to our PICO where Population was represented by any type of population, Intervention was the use of one of the five ANA-recognized SNLs, Comparator (we

did not have any Comparator), and the Outcome was the prevalence of the NDs.

Methods

A descriptive literature review[11] with a systematic method was conducted in accordance with the PRISMA guidelines[12] to ensure quality and transparency of the process. A descriptive review aims to find patterns and trends in a specific research field's body of knowledge and follows a structured process that involves searching, categorizing, and analyzing studies. This method uses structured searches to create a representative sample from published works and extracts key variables helping to identify trends and draw overall conclusions about existing concepts, methods, or findings. In essence, a descriptive review provides a state of knowledge in a particular domain (in our review, the prevalence of NDs in different patient populations and healthcare settings). The review was not registered, as it is not a formal requirement for descriptive reviews.

The search strategy was developed with the assistance of a librarian at the University of Groningen, the Netherlands. The search strategy was conducted in Medline and CINAHL databases, where most nursing literature on SNLs is indexed. We used a combination of terms, including Medical Subject Headings (MeSH), text words, and word variants concerning SNLs, nursing diagnosis, and prevalence (Supplementary Table 1). The search was limited from January 2007 to 2020, because there has been a significant rise in the use of ND and electronic health records since 2007.[13]

Studies were included if they were quantitative primary studies on the prevalence of ND from an ANA-recognized SNL. To improve the sensitivity of our search strategy, we did not exclude a priori any study design: for example, ND validation studies or cross-mapping studies (e.g., narrative problems mapped into a SNL) were included if these studies reported the ND prevalence. The ND prevalence had to be expressed as a fraction or as a percentage of the total number of participants found to have that ND (e.g., Acute pain 5/10 or Risk for infection 54%). Only studies that used one of the five SNLs communicating NDs recognized by the ANA were included. Studies published in Dutch, English, French, German, Italian, Portuguese, or Spanish were considered.

Studies were excluded if they were published on non-indexed conference proceedings, or if they were dissertations, journal editorials, case studies and literature reviews. However, if we found literature reviews about ND prevalence, we analyzed their primary studies, and if these studies met our inclusion criteria, we included them. Studies in which NDs were identified by nursing students and not by clinical nurses or nurse researchers were also excluded: when NDs were identified by nursing students this was clearly reported in the method section of the studies.

The process of study selection was performed in two rounds, using Rayyan®.[14] The first round included the selection of the relevant documents by reading their title and abstract by groups of two or three researchers. Initially, each researcher performed an independent evaluation that was subsequently compared and discussed with the group member(s) for consensus. Members from other groups were consulted when consensus was not reached. In the second round, the same groups included or excluded the full texts of the documents selected in the first round, following the same independent evaluation and consensus technique.

Data extraction was performed by each group using a Microsoft Excel spreadsheet form specially developed for this purpose. The following data were extracted from each document: the first author, country and year of publication, title, study design, sample size, type of sampling, study setting, population, age category, SNL used, timepoint in the healthcare continuum when NDs were formulated, descriptive statistics of NDs per patient, the prevalence of NDs (%), the number of NDs considered in the study, and criteria used by nurses to identify the NDs. The template for data collection forms and data extracted from included studies can be made available upon request to the authors.

Descriptive statistics were used to synthesize the data extracted. Due to the heterogeneity of the

studies, the first research question was addressed by categorizing studies with the same characteristics (i.e., same patient population, SNL, age category, setting, and timepoint in the healthcare continuum). The data considered to create a group of studies with similar and consistent characteristics are described in Supplementary Table 2. To create a group of studies, a minimum of two studies had to be present. We reported the maximum and minimum prevalence for each high-frequency ND in each group of studies – those NDs in the fifth quintile (20%).[5]

To address the second research question, we categorized all the studies according to the SNL regardless of the patient population or other criteria considered for the first research question. The data were tidied and analyzed using the R software package v. 4.1.1.[15]

Mostly NDs were not reported using their unique identification code and often we found typos or flawed translations in English (e.g., disfunction vs dysfunction or sleep pattern disturbed vs disturbed sleep pattern). In the case of NANDA-I and the ICNP, we found potentially duplicated NDs labels, since NANDA-I updates their NDs quite frequently over the years, modifying ND label terms, and the ICNP does not determine pre-set labels, thereby favoring a potential lack of uniformity in diagnostic labels.

To deal with this issue, we established some rules to map inconsistent NDs labels into their original ones: 1) NDs reported with labels that did not belong to any original diagnosis label in a SNL were defined as 'non-standardized' and were not considered; 2) NDs reported with typos or flawed translations were mapped into their respective label if there was an agreement between two researchers otherwise were considered as 'non-standardized'; 3) specific methods were applied for NANDA-I and ICNP NDs due to the considerations above: a) for NANDA-I NDs labels that have been updated over the years, we considered the NDs published on the 2018-2020 NANDA-I Classification edition, which was the last version at the time of our search;[16] when NANDA-I NDs had been replaced by new diagnoses, we mapped the old/retired diagnoses to the new ones; when NANDA-I NDs had been revised, we considered the new label (e.g., the old diagnosis label *readiness for enhanced therapeutic regimen management*, code = 00162, was mapped to the new one, *readiness for enhanced health management*, code = 00162); b) for ICNP NDs labels that were built using the axis system, if possible and if there was agreement between researchers, we mapped these to the ICNP subset using the latest version available, published in the ICNP browser,[17] to reduce heterogeneity of labels.

Results

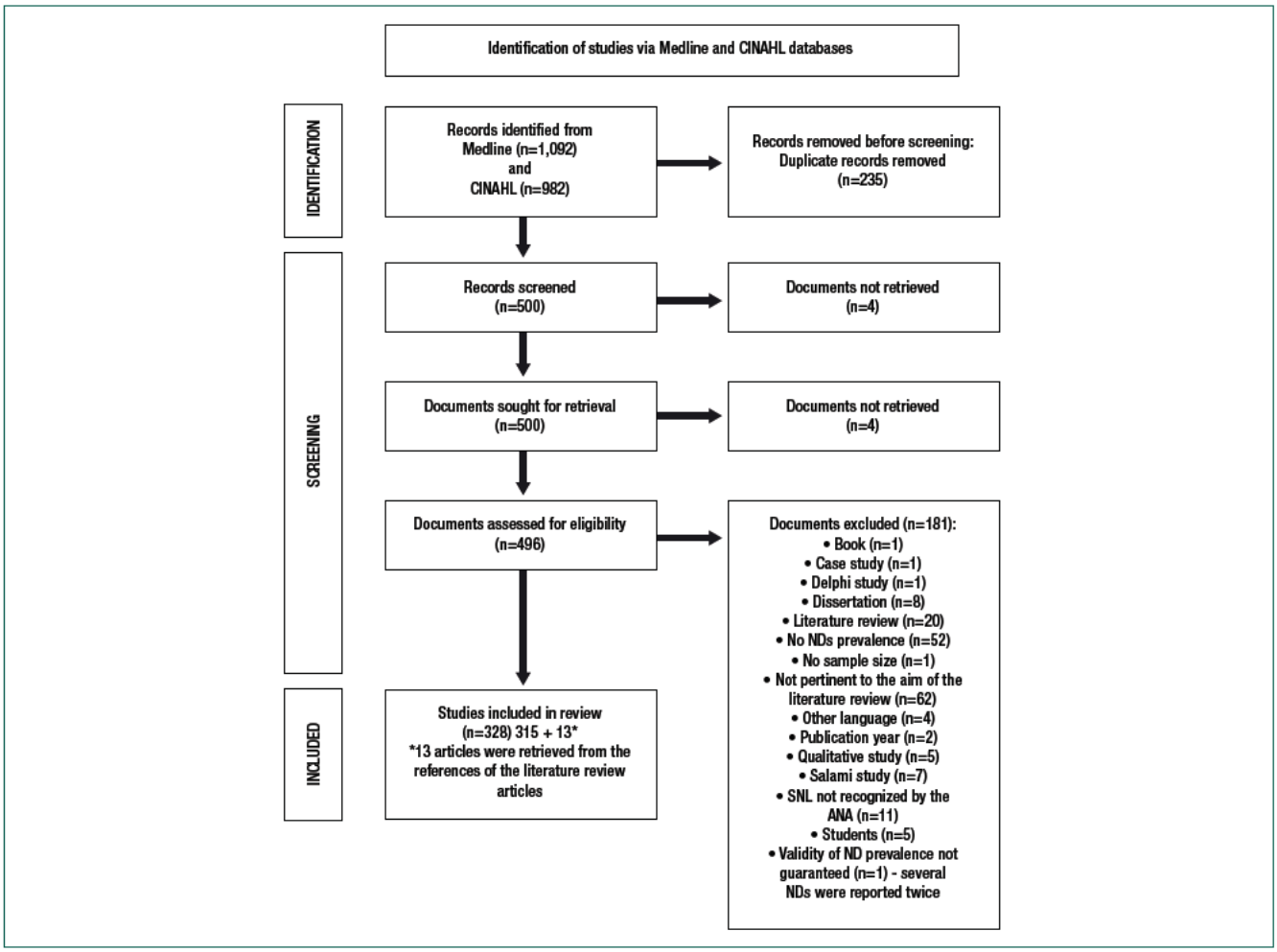
Following duplicate exclusion, a total of 1839 articles were found in the two databases. After full-text reading, 328 articles (supplementary tables 1, 2, 3, 4 and 5) were included (Figure 1). Table 1 shows the descriptive results of the studies.

NDs in different patient populations

In the 328 studies, 371 different samples were detected because some studies identified the ND prevalence in more than one sample with different characteristics (e.g., pre-operatively vs. postoperatively). We identified 51 different patient populations (Table 1) but only 20 were considered for the analysis of NDs in patient populations according to the criteria described in Methods, i.e., a group with similar and consistent characteristics. These 20 patient populations were further categorized into 30 groups by considering the SNL, the age category, the study setting and the timepoint in the healthcare continuum (Supplementary Tables 3 and 4).

NDs prevalence in different SNLs

Three SNLs, the Omaha System, the PNDS, and the NANDA-I had high-frequency NDs that fell in the fifth quintile (Table 2), while CCC and ICNP had no high-frequency ND. The Omaha System had 11 high-frequency NDs. Seven NDs were high-frequency NDs in the PNDS although only two studies were conducted with this SNL. The NANDA-I had 68 high-frequency NDs and five NDs were identified in more than 100 samples.



ANA – American Nurses Association; ND – Nursing Diagnosis; SNL – Standardized Nursing Languages

Figure 1. PRISMA flow diagram of the literature review process

Discussion

This literature review focused on identifying the prevalence of NDs in different patient populations and SNLs. This is the most comprehensive literature review about NDs prevalence in the five ANA-recognized SNLs.

Overall, a total of 19 countries showed data on ND prevalence. There was a big gap between Brazil and other countries. Most studies were conducted in Brazil (76.8%), others in Spain, the USA, Turkey, Italy, and Portugal, and just two or one were conducted in other countries. In Brazil, as early as the 60s, NDs started being promoted as part of a scientific nursing approach to care.[18] The Federal Nursing Council (COFEN) determines not only that nursing care should be performed according to the nursing process elements in every healthcare institution[19] but also that it is the nurse's right to do so.[20] In this context, NDs are one of the elements in the nursing process that are most frequently documented.[21]

Non-probability sampling (convenience or consecutive sampling) was used in most studies (90.9%), and the sample size calculation was performed only in one-quarter of the studies, thereby determining limitations on the representativeness of the populations.

Almost three-quarters of the studies focused on inpatients, especially in the different inpatient units of a hospital, while nearly a quarter included outpatients, especially in the ambulatory care clinics. This result could still reflect a major appeal for nursing in the hospital compared to outpatient or community

Table 1. Characteristics of the included studies (n = 328)

Variables	n(%)
Country	
Brazil	252(76.8)
Spain	22(6.7)
USA	12(3.7)
Turkey	11(3.4)
Italy	9(2.7)
Portugal	6(1.8)
Finland	2(0.6)
Korea	2(0.6)
Switzerland	2(0.6)
Colombia	1(0.3)
Denmark	1(0.3)
Iceland	1(0.3)
Iran	1(0.3)
Netherlands	1(0.3)
Nigeria	1(0.3)
Norway	1(0.3)
South Korea	1(0.3)
Sweden	1(0.3)
Taiwan	1(0.3)
Year of publication	
2007	15(4.6)
2008	14(4.3)
2009	19(5.8)
2010	30(9.1)
2011	32(9.8)
2012	19(5.8)
2013	30(9.1)
2014	18(5.5)
2015	34(10.4)
2016	34(10.4)
2017	31(9.4)
2018	21(6.4)
2019	28(8.5)
2020	3(0.9)
Design	
Observational/cross-sectional	310(94.5)
Observational/longitudinal	9(2.7)
Retrospective	6(1.8)
Quasi-experimental	3(0.9)
Standardized nursing language	
NANDA-I Classification of Nursing Diagnoses	298(90.8)
International Classification for Nursing Practice	16(4.9)
OMAHA System	11(3.3)
Clinical Care Classification System	2(0.6)
Perioperative Nursing Data Set	1(0.3)
Age groups	
Adult	123(37.5)
Adult and elderly	99(30.2)
Elderly	54(16.5)
Children	22(6.7)
Not available	10(3.0)
Adolescent	8(2.4)
Newborn	6(1.8)
Child and adolescent	3(0.9)
Child and adult and elderly	3(0.9)
Macro setting	
Inpatient	230(70.1)
Outpatient	73(22.2)

Continue...

Continuation.

Variables	n(%)
Home care	15(4.6)
School	7(2.1)
Prison	3(0.9)
Micro setting	
Ambulatory care clinics	36(11.0)
Intensive care unit	36(11.0)
Surgical unit	29(8.8)
District health unit	28(8.6)
Medical unit	27(8.2)
Home	20(6.1)
Hemodialysis unit	15(4.6)
Emergency department	14(4.3)
Pediatric unit	13(4.0)
Oncology unit	11(3.4)
Cardiology unit	10(3.1)
Medical and surgical unit	10(3.1)
Long-term care institution	9(2.7)
Obstetric unit	9(2.7)
Psychiatric unit	9(2.7)
Rehabilitation unit	9(2.7)
Infectious disease unit	8(2.4)
Neurological unit	7(2.1)
School	7(2.1)
Different inpatient units (at least three different inpatient units)	4(1.2)
Post-anesthetic recovery room	4(1.2)
Operating room	3(0.9)
Prison	3(0.9)
Not available	2(0.6)
Human milk bank	1(0.3)
Nurse-managed wellness center	1(0.3)
Nursing home and rehabilitation unit	1(0.3)
Nursing-led unit	1(0.3)
Palliative care unit	1(0.3)
Patient population	
Cardiovascular disease	35(10.7)
Critical care	24(7.3)
Chronicity	19(5.8)
Kidney disease	18(5.5)
Medical (non-specific)	16(4.9)
Obstetric	16(4.9)
Surgical	15(4.6)
Cancer	13(4.0)
Psychiatric disorders	13(4.0)
Respiratory disorders	13(4.0)
Diabetes	12(3.7)
HIV/AIDS	11(3.4)
Medical/surgical	10(3.1)
Healthy	9(2.7)
Cerebrovascular disease	8(2.4)
Neurological problems	8(2.4)
Caregiver	7(2.1)
Transplant	7(2.1)
Orthopedic disorders	5(1.5)
Pressure injury risk	5(1.5)
Wounds	5(1.5)
Hypertension and diabetes	4(1.2)
Infectious diseases	4(1.2)
Not available	4(1.2)
Obesity	4(1.2)

Continue...

Continuation.

Variables	n(%)
Palliative	4(1.2)
Ostomy	3(0.9)
Prisoner	3(0.9)
Prostatectomy	3(0.9)
Vulnerability	3(0.9)
Alcoholism	2(0.6)
Homeless	2(0.6)
Malnutrition	2(0.6)
Prematurity	2(0.6)
Social isolation	2(0.6)
Alveolar bone graft	1(0.3)
Appendectomy	1(0.3)
Bed falls	1(0.3)
Bedridden	1(0.3)
Cochlear implantation	1(0.3)
Cognitive impairment (rehabilitation problems)	1(0.3)
Esophageal surgery	1(0.3)
Insufficient physical activity	1(0.3)
Mastectomy	1(0.3)
Nasoenteral tube placement	1(0.3)
Nosocomial infection	1(0.3)
Postural instability	1(0.3)
Psychological distress	1(0.3)
Radiological interventions	1(0.3)
Special health care needs	1(0.3)
Thoracic surgery	1(0.3)
Urological surgery	1(0.3)
Sample size calculation	
Yes	84(25.6)
No	243(74.1)
Not needed	1(0.3)
Sampling	
Convenience	162(49.4)
Consecutive	136(41.5)
Random	23(7.0)
Systematic	4(1.2)
Census (complete enumeration)	1(0.3)
Cluster and systematic	1(0.3)
Multistage	1(0.3)
Criteria used to identify nursing diagnoses	
Not available	65(19.8)
Instrument	57(17.4)
Instrument and interview and physical examination	31(9.4)
Instrument and agreement	25(7.6)
Mapping	24(7.3)
Instrument and interview	23(7.1)
Instrument and physical examination	18(5.5)
Instrument and interview and physical examination and agreement	17(5.2)
Instrument and physical examination and agreement	11(3.4)
Interview and physical examination	11(3.4)
Interview and physical examination and agreement	10(3.1)
Interview	9(2.7)
Physical examination	6(1.8)
Instrument and interview and agreement	5(1.5)
Interview and agreement	4(1.2)
Agreement	2(0.6)
Instrument and interview and physical examination and clinical decision-making support	2(0.6)

Continue...

Continuation.

Variables	n(%)	
Instrument and mapping	2(0.6)	
Physical examination and agreement	2(0.6)	
Clinical decision-making support	1(0.3)	
Instrument and interview and accuracy	1(0.3)	
Instrument and physical examination and mapping	1(0.3)	
Physical examination and mapping	1(0.3)	
Time of identification of ND		
During the length of stay	120(36.6)	
During outpatient visit	82(25)	
On admission	66(20.1)	
After surgical intervention	33(10.1)	
Post-partum	6(1.8)	
During hemodialysis treatment	5(1.5)	
On discharge	5(1.5)	
Before surgical intervention	4(1.2)	
During breast-feeding	3(0.9)	
After procedure	1(0.3)	
Before labour	1(0.3)	
During radiation treatment	1(0.3)	
During surgical treatment	1(0.3)	
Studies that considered all the NDs available in that SNL		
yes	173(52.7)	
Variables	**Min**	**Max**
Median sample size		
73	8	582,171
Mean/median of the NDs identified per patient		
8.5/6.6	1.3	44.3

care, which can also result in the larger use of SNLs in the hospital setting.[22] Interestingly, we found 51 different patient populations in which NDs prevalence was reported; mainly, the medical conditions were used by authors as a major characteristic of the population whose NDs were identified but also health or social status or medical procedures were used as a way to describe NDs in a specific population. According to the medical condition, NDs prevalence was mostly described in individuals with cardiovascular diseases, which is not surprising, because heart diseases are the most prevalent in the world.[23]

Eighty-four percent of the studies included adult and or elderly patients, while fewer studies included children, adolescents or newborns. This finding could be partly linked to a greater burden of diseases in these populations and partly to the ageing of the population due to increased life expectancy and decreased fertility rates. However, these findings also represent gap in studies with the youngest population and those economically disadvantaged. The sample size of the studies was not large, consid-

Table 2. Nursing diagnosis prevalence according to Standardized Nursing Language

Nursing diagnosis	Number of studies having the diagnosis	Prevalence range	
		Max	Min
NANDA-I Classification of Nursing Diagnoses			
Risk for infection	160	100.0	0.4
Acute pain	131	100.0	1.1
Anxiety	112	100.0	0.9
Impaired skin integrity	111	100.0	0.2
Impaired physical mobility	102	100.0	0.1
Imbalanced nutrition: less than body requirements	92	93.9	0.1
Risk for falls	91	100.0	1.2
Bathing self-care deficit	85	100.0	0.04
Ineffective breathing pattern	78	100.0	0.5
Risk for impaired skin integrity	78	100.0	0.1
Deficient knowledge	71	100.0	1.8
Disturbed sleep pattern	66	100.0	0.6
Constipation	62	96.1	0.1
Activity intolerance	59	100.0	0.0001
Ineffective health management	58	100.0	0.5
Impaired tissue integrity	56	100.0	1.0
Ineffective airway clearance	54	100.0	0.2
Ineffective peripheral tissue perfusion	54	100.0	0.01
Impaired urinary elimination	53	100.0	0.01
Decreased cardiac output	51	100.0	3.4
Impaired verbal communication	51	100.0	0.2
Excess fluid volume	50	100.0	0.7
Impaired gas exchange	50	100.0	0.5
Fatigue	49	91.1	0.2
Ineffective protection	49	100.0	0.9
Chronic pain	48	80.0	0.2
Fear	48	100.0	1.3
Impaired walking	48	100.0	2.8
Risk for constipation	48	100.0	1.0
Risk for aspiration	45	100.0	0.1
Risk for unstable blood glucose level	44	100.0	2.0
Imbalanced Nutrition: More Than Body Requirements	43	77.8	0.5
Dressing self-care deficit	42	100.0	0.1
Feeding self-care deficit	41	100.0	0.4
Impaired dentition	40	100.0	1.9
Acute confusion	39	80.0	0.3
Impaired memory	39	100.0	0.1
Nausea	38	94.7	0.04
Sedentary lifestyle	33	88.9	4.0
Situational low self-esteem	33	100.0	0.1
Deficient fluid volume	32	65.1	0.03
Hyperthermia	32	61.9	0.2
Impaired social interaction	32	100.0	0.2
Insomnia	32	83.3	0.04
Impaired bed mobility	31	100.0	0.04
Toileting self-care deficit	31	100.0	0.1
Sexual dysfunction	30	66.6	1.0
Impaired comfort	29	100.0	5.4
Impaired swallowing	29	100.0	0.7
Diarrhea	28	33.8	0.1
Risk for bleeding	28	100.0	1.0
Impaired spontaneous ventilation	27	100.0	1.6
Ineffective health maintenance	27	100.0	0.8
Functional urinary incontinence	26	53.2	0.004

Continue...

Continuation.

Nursing diagnosis	Number of studies having the diagnosis	Prevalence range	
		Max	Min
Hopelessness	26	100.0	1.0
Impaired oral mucous membrane integrity	26	84.2	0.02
Risk for injury	26	100.0	1.7
Readiness for enhanced health management	25	100.0	3.1
Risk for imbalanced fluid volume	25	100.0	0.9
Self-care deficit	25	100.0	1.0
Ineffective coping	24	79.0	0.6
Interrupted family processes	24	93.0	0.9
Risk for deficient fluid volume	24	100.0	0.1
Risk for loneliness	22	98.03	2.0
Disturbed body image	21	75.0	0.9
Noncompliance	21	69.0	0.3
Chronic confusion	20	90.0	0.1
Risk-prone health behavior	20	94.4	5.0
Risk for activity intolerance	19	100.0	0.2
Risk for ineffective thermoregulation	19	100.0	3.0
Social isolation	19	96.1	1.3
Disturbed thought processes	18	85.0	1.1
Ineffective sexuality pattern	18	100	3.0
Impaired transfer ability	17	94.0	0.6
Hypothermia	16	70.0	0.002
Risk for electrolyte imbalance	16	100	0.1
Bowel incontinence	15	55.7	0.004
Dysfunctional family processes	15	96.7	0.04
Risk for peripheral neurovascular dysfunction	14	100.0	0.7
Sleep deprivation	14	100.0	0.4
Caregiver role strain	13	100.0	0.1
Chronic sorrow	13	44.0	0.8
Impaired home maintenance	13	77.0	0.1
Risk for ineffective renal perfusion	13	100.0	5.6
International Classification for Nursing Practice			
Impaired walking	6	82.1	0.7
Risk for infection	6	72.3	1.2
Alcohol abuse	5	46.9	2.4
Impaired sleep	5	47.5	10.8
Tobacco abuse	5	63.3	5.4
Anxiety	4	61.2	5.3
Impaired ability to bath	4	86.1	8.0
Risk for fall	4	84.9	5.5
Constipation	3	28.0	13.6
Depressed mood	3	46.9	1.2
Hypertension	3	40.6	25.0
Non adherence to therapeutic regime	3	69.4	2.4
Bowel incontinence	2	43.5	5.3
Drug abuse	2	31.6	24.5
Dyspnea	2	32.3	23.8
Edema	2	33.3	20.8
Impaired ability to dress	2	77.2	7.6
Impaired family process	2	22.6	8.1
Impaired food intake	2	52.4	10.5
Impaired self-toileting	2	68.3	8.5
Impaired skin integrity	2	15.9	5.3
Impaired vision	2	49.1	26.5
Insomnia	2	31.6	28.3
Lack of knowledge of medication regime	2	10.8	5.3
Musculoskeletal pain	2	20.8	1.2
Nonadherence to exercise regime	2	10.0	8.3

Continue...

Continuation.

Nursing diagnosis	Number of studies having the diagnosis	Prevalence range	
		Max	Min
Overweight	2	28.8	21.0
Risk for pressure ulcer	2	28.0	24.4
Self-care deficit	2	69.6	1.2
Sleep deprivation	2	60.7	22.6
Urinary incontinence	2	72.2	1.2
Omaha System			
Circulation	11	89.0	1.6
Nutrition	10	88.0	0.7
Health care supervision	8	100.0	0.8
Income	8	44.0	7.7
Neuromusculoskeletal function	8	89.0	2.0
Pain	8	67.0	2.0
Residence	8	67.5	2.8
Caretaking/Parenting	7	65.0	6.8
Medication regimen	7	78.0	2.9
Mental health	6	100.0	0.3
Respiration	6	78.0	0.3
Communication with community resources	5	44.9	4.4
Growth and development	5	64.3	4.6
Skin	5	33.0	3.0
Cognition	4	71.1	0.2
Digestion-hydration	4	78.0	1.0
Urinary function	4	33.0	2.8
Clinical Care Classification System			
Activity intolerance	2	6.2	1.7
Bathing/hygiene deficit	2	68.7	0.7
Diversional activity deficit	2	2.1	2.3
Sleep pattern disturbance	2	10.4	3.0
Perioperative Nursing Data Set			
Dryness of mouth	1	28.0	10.0
Hemorrhage	1	37.0	36.0
Impaired physical mobility	1	14.0	12.0
Impaired urinary elimination	1	23.0	21.0
Ineffective breathing patterns	1	26.0	18.0
Pain	1	69.0	50.0
Risk for fluid volume imbalance	1	48.0	27.0

ering a median of 73 patients, although one study enrolled 582,171 patients.

The prevalence of NDs in all the five ANA-recognized SNLs was reported mainly in NANDA-I (90.8%), whereas the CCC or the PNDS had just two and one study, respectively. This finding corroborates other literature reviews.[2,24] Overall, we found 13 different timepoints in the healthcare continuum when NDs were identified, mostly during the length of stay for inpatients or during the visit for outpatients, although this was not specifically reported in a precise time of the length of stay (e.g., the X day of the length of stay) or the visit (e.g., the X visit) but just generically mentioned. Fewer studies reported a more precise time when NDs were identified, such as on admission or on discharge, after or before surgical intervention; however even in this case the time could be described differently from study to study (e.g., after surgical intervention could mean within 24 or 48 or 72 hours). A clear description of the timepoint in the healthcare continuum when NDs are formulated is a key point to draw conclusions about NDs (e.g., their prevalence or trajectories).[24] Our review found a major gap in this area.

Descriptive metrics of the NDs, such as their mean or median prevalence, were reported in 73 studies (29.7% of the studies in which these metrics were relevant). More than two-thirds of the studies did not report any descriptive metrics about ND. The mean/median number of NDs per patient can be a proxy of the nursing complexity,[5,25] therefore its reporting should always be present to provide more information about the patient care condition.

About half of the studies used all the possible NDs in a SNL; however, only the prevalence of the most frequent NDs was often reported and not always the prevalence of all diagnoses. The lack of data on all NDs identified could be due to journal restrictions or an authors' choice, but we recognize this as a gap since this hinders a valid comparison and aggregation data analysis of the NDs prevalence results among the studies. Therefore, we suggest providing the full list of NDs in the appendix sections of the article.

One-fifth of the studies did not report any criteria on how NDs were identified by nurses while the rest of the studies reported different methods, with the most common being the use of specific assessment instruments. Another common method was the use of a specific instrument along with the patient's anamnesis and their physical examination. We found this last method as the most comprehensive to correctly identifying NDs. Accurate NDs are fundamental for clinical aspects and for the internal and external validity of the studies; NDs must be identified after an accurate clinical reasoning.[26] Studies about the prevalence of NDs should accurately report the methods used to identify NDs.[5]

Twenty different patient populations were identified, totaling 30 groups. All the studies used the

NANDA-I NDs. Overall, NDs identified on admission were more acute diagnoses compared to NDs identified during the length of stay. Due to synthesis issues, it is not possible to discuss all the results of the different populations, so we have provided some considerations only for the groups of patients that had a considerable number of studies (i.e., ≥ 3 studies) and where we found other reviews conducted in the same or similar population to make a possible comparison with them.

The cardiovascular group was the most homogeneous with the higher number of studies (n=21). These studies were categorized into five groups according to different settings, age categories, and timepoint in the healthcare continuum when NDs were identified. Interestingly NDs were different in the groups, such as inpatients and outpatients or NDs identified during the length of stay or on admission. We found four integrative reviews aiming to identify the most common NDs in patients with heart failure[27,28] or in patients following cardiovascular surgery.[29,30] Although any comparison between our results and these integrative reviews could be inappropriate due to different methods and specific populations (i.e., heart failure vs. cardiovascular patients) used in the integrative reviews, we compared the most similar groups of patients we found with those of the integrative reviews.

The group of adult and elderly inpatients with cardiovascular diseases with NDs identified during the length of stay were compared with the two integrative reviews about patients with heart failure. In one of these reviews, the population was adult hospitalized patients, but there was no information about the time when NDs were identified (e.g., on admission or during the length of stay).[27] In the second review, no clear information was provided about the age of the patients, setting and timepoint in the healthcare continuum of ND identification.[28] Some NDs were common between our group and those found in the two integrative reviews, such as activity intolerance, acute pain, decreased cardiac output, deficient knowledge, and risk for infection.

The other two integrative reviews[29,30] focused on NDs in cardiovascular patients after surgery, although no information was provided about patient age. Comparing the results of these two integrative reviews with our group of studies (adults and elderly patients after cardiovascular surgical intervention), we found that the most common NDs in both reviews, i.e., risk for infection and acute pain, were also among the most common in our group of studies. Decreased cardiac output, risk for falls, and risk for bleeding were among the most common NDs found in our group and in one of these integrative reviews,[30] while different most common NDs were found in the second review.[29]

Critical adult and elderly inpatients were another homogeneous group with a total of 18 studies categorized into two groups: patients in the ICU and in the emergency department, with NDs detected during the length of stay and on admission, respectively. The most common NDs in patients admitted to the emergency department were related to acute conditions (e.g., acute pain or hypothermia) compared to those in the ICU. An integrative review was conducted to identify the most common NDs in the ICU,[31] although no information was provided about patient age and timepoint in the healthcare continuum when NDs were identified. Comparing these results with our group of critical patients in ICU we found several similarities among the most common NDs. The most common NDs were those in the NANDA-I domain of safety/protection (risk for infection, risk for aspiration, impaired skin integrity), and activity/rest (impaired bed mobility, impaired physical mobility).

Adult and elderly patients undergoing hemodialysis comprised a group of ten studies categorized into two groups (before hemodialysis vs. during the hemodialysis procedure). It is interesting to note that even in a quite homogeneous group of patients with the same medical condition and at the time of the same procedure, a different timepoint in the healthcare continuum of NDs identification determined different pattern of NDs. A literature review about the nursing care plans for patients with chronic kidney disease undergoing hemodialysis aimed to identify the most common NDs in this population although it did not provide any information about patient age and the timepoint in the healthcare continuum when NDs were identified.

[32] The most common diagnosis found in this review, i.e., excess fluid volume, was also among the most common NDs in our group of patients when NDs were identified before hemodialysis.

Adult and elderly psychiatric inpatients with NDs identified during the length of stay were a group of nine studies. NDs belonging to the domains of activity/rest (self-care class), health promotion (health management class), perception/cognition (communication class), and role relationship (role performance class) were the most common NDs for this group of patients. As expected, these NDs were quite different from other populations and related to the self-care, social and psychological spheres. A scoping review and an integrative review were aimed to identify the most frequent NDs in the psychiatric population.[33,34] The scoping review was focused on inpatient and outpatient populations with no information about patient age; disturbed thought processes and impaired social interaction were the most frequent NDs.[33] The integrative review was focused on adult and elderly institutionalized patients and the most frequent NDs were anxiety and ineffective health management.[34] Although the two reviews found different NDs as the most frequent, all four NDs identified were among the most common NDs that were also found in the group of nine studies of our review.

Adults and elderly inpatients with cancer, with NDs identified during the hospital stay comprised a group of four studies. Acute pain was the only ND identified in all studies. An integrative review aiming at identifying the most common NDs considered the same population of our group except for the fact that they did not specify when NDs were identified.[10] Comparisons between our review and the integrative review showed that acute pain and risk for infection were among the NDs most common in both literature reviews while other common NDs in our review such as nausea and imbalanced nutrition: less than body requirement were not found in the integrative review.

Only three SNLs had high-frequency NDs and only the NANDA-I Classification also had a considerable number of studies, this result is supported by a literature review.[2] No high-frequency NDs were found from the CCC or the ICNP. This could be attributed to a potential deficiency in implementation and validation studies concerning these SNLs compared to the NANDA-I Classification;[2,4,35] in particular, for the CCC, a low number of studies could be the reason for this finding, whereas for the ICNP, the reason could be a more difficult standardization of the ND labels.[36]

Some limitations of this literature review should be considered. Firstly, even if there is no specific guideline about the adequate number of databases to be searched, other databases could be useful to retrieve more documents about this topic. However, a strength of this review is the inclusion of seven different languages, which enabled us to retrieve more studies. Secondly, we did not perform any qualitative assessment of the studies but given that our intent was to provide an overview of the ND prevalence in the SNLs and the methods used to assess this, a qualitative assessment was beyond our scope.

Conclusion

Our review provided an overview of the most prevalent NDs in different patient populations and the most frequently identified NDs in the five ANA-recognized SNLs. We also identified advances, gaps and call to action in SNLs.

It is important to note that apart from the NANDA-I Classification, the other SNLs either lack validation studies on the NDs or do not contain defining characteristics or signs and symptoms essential for accurately identifying an ND. Although all the five ANA-recognized SNLs are organized around domains/components or a framework of health, their structure is not the same for all the five. The NANDA-I Classification, and the Omaha system provide a diagnosis definition and the main defining characteristics or signs and symptoms but only the NANDA-I also provides etiological factors, a diagnosis definition is also provided by the CCC. This aspect should be considered by SNLs to improve the number of studies about the prevalence of NDs in the population.

Further reviews should be conducted to investigate and update the epidemiology of NDs. Literature reviews like this one should be replicated every two-five year to provide feedback on the epidemiology of patient needs from a nursing perspective and on the use of the NDs to the nursing community; studies like these should be promoted within the SNL associations.

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Supplementary Table 1. Search strategy in Medline and CINAHL databases

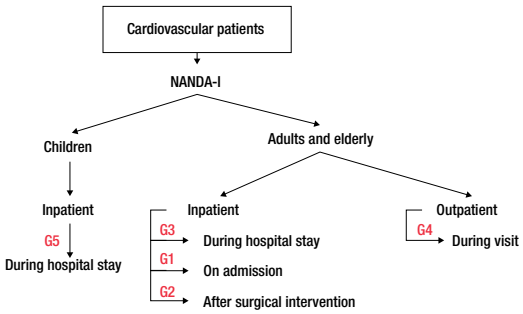
Medline **Nursing diagnosis or standardized nursing language related terms**		**Medline** **Prevalence terms**
"Standardized Nursing Terminology"[Mesh] OR nursing language*[tiab] OR nursing terminolog*[tiab] OR nursing classification*[tiab] OR nursing taxonom*[tiab] OR "Nursing Diagnosis"[Mesh] OR nursing diagnos*[tiab] OR NANDA International [tiab] OR Clinical Care Classification System [tiab] OR International Classification for Nursing Practice [tiab] OR Omaha System [tiab] OR Perioperative Nursing Data Set [tiab]	AND	"Prevalence"[Mesh] OR prevalen*[tiab] OR frequen*[tiab] OR distribution*[tiab] OR identif*[tiab] OR descri*[tiab]
CINAHL **Nursing diagnosis or standardized nursing language related terms**		**CINAHL** **Prevalence terms**
(MH "Nursing Classification+") OR (MH "NANDA International") OR (MH "Nursing Diagnosis") OR (MH "NANDA Nursing Diagnoses") OR (MH "Saba Clinical Care Nursing Diagnoses") OR (MH "International Classification for Nursing Practice") OR (MH "Omaha System+") OR AB nursing language* OR AB nursing terminolog* OR AB nursing classification* OR AB nursing taxonom* OR AB Perioperative Nursing Data Set OR TI nursing language* OR TI nursing terminolog* OR TI nursing classification* OR TI nursing taxonom* OR TI Perioperative Nursing Data Set	AND	(MH "Prevalence") OR AB prevalen* OR AB frequen* OR AB distribution* OR AB identif* OR AB descri* OR TI prevalen* OR TI frequen* OR TI distribution* OR TI identif* OR TI descri*

Supplementary Table 2. Sample data considered for the creation of study categories and their grouping criteria

Sample data	**Description of grouping criteria**
Number of nursing diagnoses considered in the study	Studies including all the nursing diagnoses or a large group of nursing diagnoses from a standardized nursing language were grouped. Studies that considered only one nursing diagnosis or nursing diagnoses belonging only to particular domains/areas of a standardized nursing language (e.g., nutrition) were not considered.
Patient population	Studies on the same patient population were grouped based on disease or medical specialty (e.g., cardiovascular, cancer), health status (e.g., chronicity, pressure injury risk), social status (e.g., vulnerability, homeless, caregiver) or procedure (e.g., appendectomy, nasoenteral tube placement)
Standardized nursing language	Studies that used the same standardized nursing language were grouped.
Age category	Studies on the same age category were grouped (e.g., children).
Study setting	Studies that were conducted in the same setting were grouped (e.g., inpatient and intensive care unit). We first considered the macro setting (e.g., inpatient vs outpatient). Whenever there was information on the micro setting (e.g., intensive care unit vs medical unit), we also considered it.
Timepoint in the healthcare continuum when nursing diagnoses were formulated	Studies that considered the same timepoint in the healthcare continuum were grouped (e.g., nursing diagnoses identified on admission).

Supplementary Table 3. Prevalence of nursing diagnoses in each group of patient population, determined according to the standardized nursing language, age, setting, and timepoint in the healthcare continuum

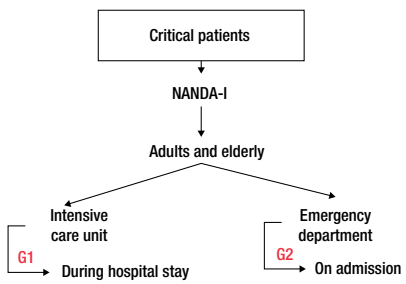
Section 1: Cardiovascular patients



Nursing diagnosis	Number of samples with the diagnosis	Prevalence range (%)	
		Max	Min
Group 3 (G3) – 10 samples/8 studies			
Activity intolerance	9	100.0	9.4
Acute pain	7	100.0	7.7
Decreased cardiac output	7	100.0	56.7
Deficient knowledge	7	100.0	6.7
Risk for infection	7	100.0	3.3
Excess fluid volume	6	78.8	1.3
Anxiety	5	76.7	0.3
Risk for falls	5	100.0	16.7
Impaired gas exchange	4	80.3	0.5
Ineffective breathing pattern	4	45.0	0.9
Risk for constipation	4	99.0	20.0
Risk for impaired skin integrity	4	100.0	0.1
Bathing self-care deficit	3	77.5	0.1
Disturbed body image	3	40.0	1.3
Imbalanced nutrition: less than body requirements	3	16.7	0.1
Imbalanced nutrition: more than body requirements	3	38.1	3.3
Impaired physical mobility	3	66.9	0.3
Impaired skin integrity	3	98.7	0.6
Impaired walking	3	53.0	3.3
Ineffective health maintenance	3	50.0	0.8
Nausea	3	94.7	20.0
Risk for deficient fluid volume	3	53.6	0.1
Group 1 (G1) – 5 samples/4 studies			
Risk for impaired skin integrity	5	64.5	6.1
Bathing self-care deficit	4	100.0	42.0
Acute pain	4	48.9	3.3
Impaired physical mobility	4	100.0	12.4
Risk for infection	4	100.0	84.5
Ineffective protection	3	39.3	25.5
Risk for constipation	3	98.5	69.6
Risk for decreased cardiac output	3	97.0	75.8
Risk for falls	3	96.8	61.0
Risk for unstable blood glucose level	3	58.1	34.1
Group 5 (G5) – 2 samples/ 2 studies			
Activity intolerance	2	83.3	73.3

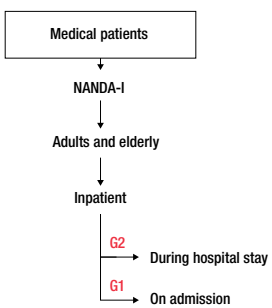
Continue...

Continuation.

Decreased cardiac output	2	64.4	62.2
Deficient fluid volume	2	22.2	21.5
Delayed growth and development	2	77.8	77.8
Impaired gas exchange	2	91.5	88.9
Ineffective airway clearance	2	55.6	31.1
Ineffective breathing pattern	2	86.7	73.3
Ineffective tissue perfusion	2	73.0	71.1
Risk for aspiration	2	37.4	33.3
Risk for impaired skin integrity	2	44.4	43.7
Risk for infection	2	82.2	82.2
Group 2 (G2) – 2 samples/ 2 studies			
Acute pain	2	53.8	30.0
Anxiety	2	19.2	18.0
Constipation	2	96.1	11.5
Decrease cardiac output	2	50.0	7.7
Imbalanced nutrition: less than body requirements	2	4.0	3.9
Impaired physical mobility	2	100.0	10.0
Impaired skin integrity	2	100.0	20.0
Ineffective breathing pattern	2	34.6	12.0
Risk for bleeding	2	100.0	34.0
Risk for decreased cardiac tissue perfusion	2	100.0	60.0
Risk for falls	2	100.0	16.0
Risk for infection	2	100.0	92.0
Risk for shock	2	36.0	23.0
Risk for unstable blood glucose level	2	76.9	22.0
Group 4 (G4) – 2 samples/ 2 studies			
Activity intolerance	2	32.3	2.2
Anxiety	2	50.8	16.7
Imbalanced nutrition: more than body requirements	2	33.8	16.7
Impaired sleep pattern	2	46.4	3.3
Noncompliance	2	15.6	15.4
Risk for unstable blood glucose level	2	14.4	13.8
Sedentary lifestyle	2	47.7	34.4
Section 2. Critical patients			
			
Group 1 (G1) – 10 samples/ 10 studies			
Risk for infection	9	100.0	3.6
Impaired bed mobility	7	98.7	1.0
Impaired physical mobility	7	100.0	0.5
Impaired skin integrity	7	95.3	7.7
Ineffective breathing pattern	7	92.2	1.0
Risk for aspiration	7	98.7	16.0
Anxiety	6	100.0	11.0

Continue...

Continuation.

Decreased cardiac output	6	88.2	6.7
Impaired tissue integrity	6	87.0	22.1
Ineffective airway clearance	6	86.3	0.5
Risk for falls	6	100.0	2.0
Risk for impaired skin integrity	6	100.0	75.4
Acute pain	5	70.1	2.6
Excess fluid volume	5	76.6	2.0
Impaired gas exchange	5	100.0	5.0
Acute confusion	4	26.1	1.0
Bathing self-care deficit	4	100.0	100.0
Risk for unstable blood glucose level	4	80.0	55.1
Group 2 (G2) – 8 samples/ 7 studies			
Acute pain	8	100.0	18.2
Deficient fluid volume	6	43.5	1.3
Impaired gas exchange	6	52.3	0.9
Ineffective airway clearance	6	31.8	1.3
Acute confusion	5	23.0	2.4
Impaired skin integrity	5	77.9	10.0
Ineffective breathing pattern	5	82.8	20.6
Chronic pain	4	31.7	1.3
Decreased cardiac output	4	59.1	5.4
Hypothermia	4	47.8	1.9
Impaired physical mobility	4	80.4	13.6
Impaired spontaneous ventilation	4	77.3	2.7
Impaired tissue integrity	4	68.2	54.1
Ineffective peripheral tissue perfusion	4	43.9	12.3
Nausea	4	15.1	4.4
Risk for aspiration	4	86.4	2.8
Risk for electrolyte imbalance	4	18.2	0.4
Risk for imbalanced fluid volume	4	47.8	0.9
Risk for infection	4	95.4	0.4
Section 3. Medical patients			
			
Group 2 (G2) – 8 samples/7 studies			
Imbalanced nutrition: less than body requirements	6	32.0	7.0
Risk for impaired skin integrity	6	54.1	16.0
Anxiety	4	48.0	9.2
Impaired physical mobility	4	68.0	19.4
Disturbed sleep pattern	4	40.0	1.4
Impaired tissue integrity	4	68.0	2.0
Risk for infection	4	100.0	11.7
Acute pain	3	68.0	12.0

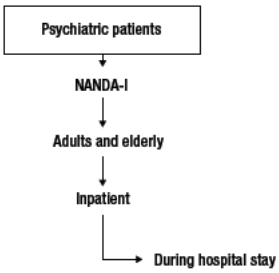
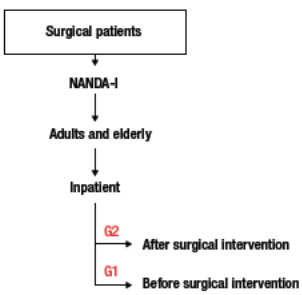
Continue...

Continuation.

Constipation	3	44.0	11.0
Deficient fluid volume	3	7.1	4.0
Disturbed thought processes	3	14.7	7.1
Excess fluid volume	3	42.0	5.6
Impaired skin integrity	3	88.0	6.0
Risk for constipation	3	35.3	5.0
Risk for falls	3	72.0	20.0
Activity intolerance	2	56.0	1.0
Acute confusion	2	12.0	5.6
Chronic confusion	2	8.0	2.5
Chronic pain	2	18.4	8.0
Decreased cardiac output	2	12.0	3.6
Diarrhea	2	16.0	2.0
Fear	2	68.0	12.0
Hopelessness	2	24.0	1.0
Impaired environmental interpretation syndrome	2	8.0	2.5
Impaired memory	2	46.4	12.0
Impaired social interaction	2	40.0	5.6
Impaired verbal communication	2	40.0	6.1
Impaired walking	2	76.0	28.6
Ineffective breathing pattern	2	42.0	0.5
Ineffective health maintenance	2	14.8	13.0
Nausea	2	8.0	2.0
Risk for deficient fluid volume	2	16.8	8.0
Risk for loneliness	2	40.0	5.6
Sexual dysfunction	2	8.0	2.0
Group 1 (G1) – 4 samples/ 4 studies			
Hyperthermia	4	58.8	2.0
Impaired skin integrity	4	41.2	14.2
Risk for falls	4	57.1	17.6
Acute confusion	3	22.4	7.1
Acute pain	3	88.2	32.7
Anxiety	3	30.6	13.3
Decreased cardiac output	3	35.3	6.7
Impaired oral mucous membrane	3	17.6	13.3
Impaired physical mobility	3	69.4	20.0
Impaired tissue integrity	3	63.3	11.8
Ineffective breathing pattern	3	35.3	8.2
Ineffective peripheral tissue perfusion	3	41.2	6.7
Risk for impaired skin integrity	3	59.2	23.5
Risk for infection	3	100.0	29.4
Deficient knowledge	2	82.1	20.4
Disturbed sleep pattern	2	82.4	12.2
Fatigue	2	82.2	3.3
Imbalanced nutrition	2	57.1	3.3
Impaired gas exchange	2	8.2	3.3
Ineffective airway clearance	2	43.3	4.1
Nausea	2	52.9	6.7
Risk for aspiration	2	22.4	6.7
Risk for ineffective thermoregulation	2	29.4	6.1
Situational low self-esteem	2	35.3	3.5

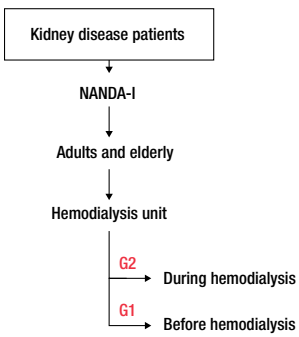
Continue...

Continuation.

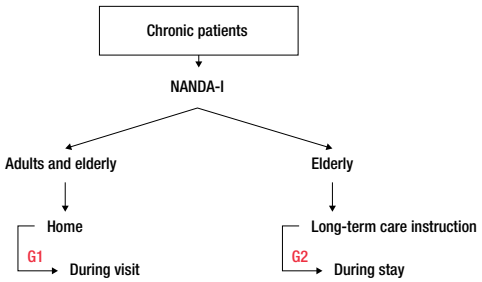
Urinary retention	2	14.3	3.3
Section 4. Psychiatric patients			
			
9 samples/ 6 studies			
Bathing self-care deficit	7	80.0	8.0
Impaired social interaction	5	41.3	4.0
Impaired verbal communication	5	36.7	0.3
Ineffective health management	5	90.0	4.7
Anxiety	4	37.0	6.0
Disturbed thought processes	4	48.1	8.0
Imbalanced nutrition: less than body requirements	4	6.8	2.0
Constipation	3	39.4	0.2
Deficient diversional activity	3	33.3	5.0
Impaired skin integrity	3	7.0	0.2
Ineffective coping	3	42.0	7.4
Risk for other-directed violence	3	21.0	2.0
Section 5. Surgical patients			
			
Group 2 (G2) – 8 samples/ 8 studies			
Acute pain	8	100.0	10.5
Risk for infection	8	100.0	8.1
Anxiety	7	100.0	2.6
Impaired skin integrity	5	100.0	2.6
Impaired bed mobility	4	100.0	14.2
Ineffective airway clearance	4	15.0	2.6
Ineffective breathing pattern	4	60.0	3.5
Nausea	4	76.7	4.6
Risk for falls	4	100.0	4.0
Risk for imbalanced fluid volume	4	100.0	2.0
Risk for unstable blood glucose level	4	100.0	10.8
Fear	3	75.0	4.0
Hypothermia	3	70.0	15.4
Imbalanced nutrition: less than the body requirements	3	14.2	2.6
Impaired physical mobility	3	66.7	2.9
Impaired tissue integrity	3	100.0	92.8

Continue...

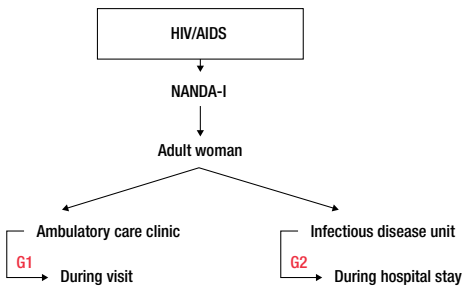
Continuation.

Impaired verbal communication	3	100.0	1.5
Ineffective peripheral tissue perfusion	3	30.0	2.6
Risk for aspiration	3	100.0	26.7
Risk for impaired skin integrity	3	100.0	5.0
Group 1 (G1) – 3 samples/ 2 studies			
Acute pain	3	28.1	26.3
Anxiety	3	81.3	10.5
Disturbed sleep pattern	3	37.5	15.8
Impaired dentition	3	36.8	6.3
Impaired skin integrity	3	31.6	7.9
Risk for infection	3	63.2	13.2
Fear	2	50.0	36.8
Impaired comfort	2	57.9	34.4
Obesity	2	25.0	10.5
Overweight	2	21.1	21.1
Relocation stress syndrome	2	37.5	21.1
Risk for allergic reaction	2	25.0	15.8
Risk for delayed surgical recovery	2	52.6	37.5
Risk for perioperative position injury	2	25.0	10.5
Stress overload	2	25.0	5.3
Section 6. Patients with kidney diseases			
			
Group 2 (G2) – 6 samples / 6 studies			
Risk for infection	6	100.0	25.5
Deficient knowledge	4	75.0	16.7
Excess fluid volume	4	99.4	25.5
Ineffective protection	4	100.0	12.9
Chronic pain	3	54.3	4.6
Impaired physical mobility	3	100.0	3.3
Impaired skin integrity	3	100.0	6.7
Acute pain	2	75.0	11.2
Constipation	2	9.7	5.6
Fatigue	2	47.2	31.2
Fear	2	68.7	13.3
Insomnia	2	83.3	25.3
Risk for electrolyte imbalance	2	100.0	23.7
Risk for falls	2	50.3	37.1
Risk for vascular trauma	2	100.0	100.0
Sedentary lifestyle	2	57.0	53.3
Group 1 (G1) – 4 samples / 4 studies			
Acute pain	4	38.0	11.2

Continue...

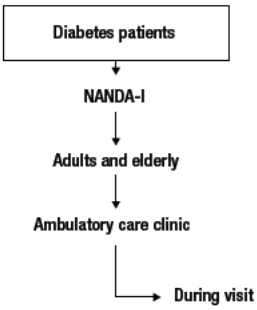
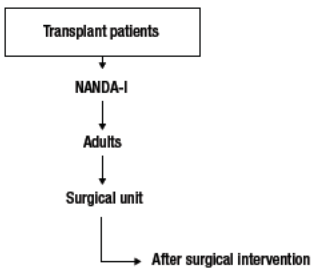
Risk for infection	4	100.0	100.0
Constipation	3	28.0	5.0
Disturbed sensory perception: visual	3	64.0	10.0
Excess fluid volume	3	99.4	51.6
Ineffective protection	3	100.0	12.9
Activity intolerance	2	46.0	22.6
Anxiety	2	10.0	9.6
Disturbed sleep pattern	2	40.0	10.0
Dressing self-care deficit	2	11.2	5.0
Fatigue	2	48.0	47.2
Imbalanced nutrition: less than body requirements	2	32.2	1.1
Impaired dentition	2	64.0	38.2
Impaired physical mobility	2	100.0	35.4
Impaired skin integrity	2	100.0	6.7
Impaired urinary elimination	2	100.0	19.4
Nausea	2	16.1	5.0
Risk for falls	2	37.1	14.0
Section 7. Chronic patients			
			
Group 1 (G1) – 3 samples/ 3 studies			
Impaired physical mobility	3	47.8	4.3
Bathing self-care deficit	2	39.1	10.3
Constipation	2	17.4	6.9
Impaired walking	2	8.0	4.3
Ineffective management of therapeutic regimen	2	6.9	4.3
Risk for deficient fluid volume	2	21.7	4.3
Risk for falls	2	39.1	4.3
Risk for impaired skin integrity	2	26.0	9.2
Group 2 (G2) – 2 samples / 2 studies			
Anxiety	2	27.1	13.8
Bathing self-care deficit	2	82.8	30.5
Chronic confusion	2	38.0	25.4
Constipation	2	6.9	3.4
Dressing self-care deficit	2	62.1	30.5
Feeding self-care deficit	2	20.3	10.3
Impaired dentition	2	100.0	67.7
Impaired memory	2	51.7	38.9
Impaired physical mobility	2	86.2	15.2
Impaired skin integrity	2	17.2	6.7
Impaired transfer ability	2	44.8	16.9
Impaired urinary elimination	2	31.0	25.4
Impaired verbal communication	2	86.2	47.5
Impaired walking	2	62.1	28.8

Continuation.

Impaired wheelchair mobility	2	34.5	1.7
Ineffective peripheral tissue perfusion	2	8.5	3.4
Insomnia	2	34.5	3.4
Risk for falls	2	100.0	52.5
Risk for impaired skin integrity	2	72.4	13.5
Risk for infection	2	44.8	1.7
Risk for unstable blood glucose level	2	23.7	10.3
Sexual dysfunction	2	48.3	3.4
Social isolation	2	27.1	10.3
Toileting self-care deficit	2	69.0	30.5
Wandering	2	15.2	6.9
Section 8. Patients living with HIV/AIDS			
			
Group 1 (G1) – 3 samples/ 3 studies			
Anxiety	2	73.3	1.9
Deficient knowledge	2	80.0	19.6
Diarrhea	2	7.8	6.6
Imbalanced nutrition: less than body requirements	2	33.0	7.8
Impaired skin integrity	2	46.6	11.7
Insomnia	2	46.6	25.4
Risk for infection	2	100.0	100.0
Sexual dysfunction	2	66.6	54.0
Situational low self-esteem	2	20.0	1.9
Social isolation	2	73.3	9.8
Group 2 (G2) – 3 samples/ 3 studies			
Anxiety	3	90.0	6.7
Ineffective protection	3	100.0	100.0
Acute confusion	2	80.0	3.3
Acute pain	2	53.3	27.4
Constipation	2	23.3	10.6
Deficient knowledge	2	88.3	80.5
Disturbed sleep pattern	2	100.0	31.9
Feeding self-care deficit	2	91.6	26.7
Imbalanced nutrition: less than body requirements	2	76.7	22.1
Impaired verbal communication	2	80.0	13.3
Ineffective denial	2	10.0	5.3
Insomnia	2	40.0	12.4
Risk for impaired skin integrity	2	86.6	40.0
Sexual dysfunction	2	54.0	13.3

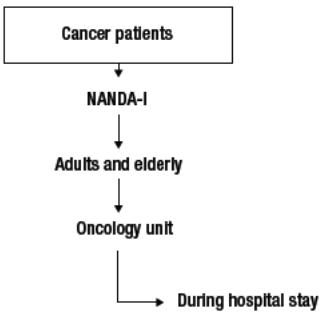
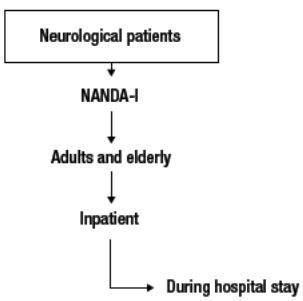
Continue...

Continuation.

Section 9. Diabetic patients			
			
6 samples/ 6 studies			
Deficient knowledge	6	51.0	1.8
Imbalanced nutrition: more than body requirements	6	71.4	3.7
Acute pain	4	42.9	4.2
Impaired skin integrity	4	100.0	3.0
Risk for infection	4	100.0	3.0
Chronic pain	3	57.2	3.6
Effective therapeutic regimen management	3	33.9	9.0
Ineffective therapeutic regimen management	3	67.7	22.4
Risk for peripheral neurovascular dysfunction	3	57.2	12.9
Risk for unstable blood glucose level	3	28.6	2.4
Sedentary lifestyle	3	65.7	9.6
Readiness for enhanced therapeutic regimen management	3	28.6	3.2
Section 10. Transplanted patients			
			
6 samples/ 6 studies			
Acute pain	6	83.7	11.8
Risk for infection	6	100.0	25.1
Bathing self-care deficit	4	100.0	8.5
Ineffective protection	4	100.0	93.0
Impaired bed mobility	3	100.0	100.0
Impaired gas exchange	3	79.6	43.0
Anxiety	2	21.0	9.1
Decreased cardiac output	2	87.7	71.0
Deficient knowledge	2	100.0	10.3
Hyperthermia	2	10.0	5.7
Hypothermia	2	57.0	7.0
Impaired skin integrity	2	100.0	100.0
Impaired tissue integrity	2	100.0	69.0
Impaired urinary elimination	2	97.0	73.0
Impaired verbal communication	2	100.0	24.0
Ineffective breathing pattern	2	79.6	43.0
Nausea	2	36.0	21.0

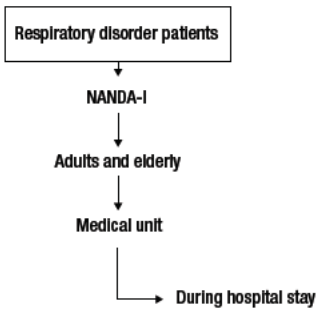
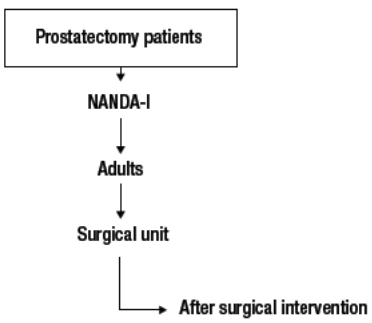
Continue...

Continuation.

Risk for aspiration	2	100.0	100.0
Risk for falls	2	100.0	16.0
Section 11. Patients with cancer			
			
4 samples / 4 studies			
Acute pain	4	90.0	11.0
Imbalanced nutrition: less than body requirements	3	70.0	1.6
Nausea	3	60.0	1.0
Risk for infection	3	100.0	91.0
Anxiety	2	70.0	48.6
Fatigue	2	80.3	58.0
Fear	2	73.0	41.6
Impaired comfort	2	70.0	6.4
Impaired skin integrity	2	8.5	8.1
Risk for injury	2	94	5.9
Section 12. Neurological patients			
			
4 samples / 4 studies			
Bathing self-care deficit	3	40.0	7.5
Constipation	3	81.0	2.1
Impaired physical mobility	3	100.0	10.6
Acute confusion	2	1.5	1.1
Anxiety	2	48.0	4.5
Chronic pain	2	75.0	11.9
Chronic sorrow	2	44.0	6.0
Disturbed sleep pattern	2	83.0	11.9
Dressing self-care deficit	2	8.5	3.0
Fear	2	44.0	1.5
Feeding self-care deficit	2	69.0	10.6
Impaired bed mobility	2	11.7	1.5
Impaired memory	2	84.0	11.9
Impaired skin integrity	2	9.6	4.5
Impaired urinary elimination	2	89.0	59.7
Impaired verbal communication	2	14.9	1.1

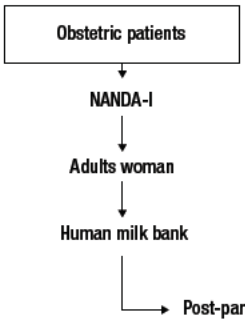
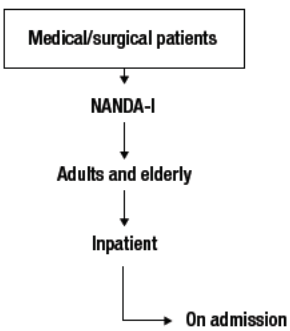
Continue...

Continuation.

Ineffective coping	2	79.0	3.0
Ineffective peripheral tissue perfusion	2	38.0	1.5
Sexual dysfunction	2	51.0	1.5
Section 13. Patients with respiratory disorder			
			
3 samples/ 1 study			
Deficient knowledge	3	100.0	98.4
Imbalanced nutrition: less than body requirements	3	80.6	19.0
Ineffective breathing pattern	3	86.6	22.2
Risk for falls	3	100.0	50.8
Section 14. Prostatectomy patients			
			
3 samples / 3 studies			
Risk for infection	3	100.0	100.0
Acute pain	2	48.0	36.0
Anxiety	2	12.5	6.0
Constipation	2	24.0	16.0
Deficient knowledge	2	100.0	20.0
Impaired comfort	2	40.0	10.0
Impaired dentition	2	94.0	18.0
Impaired skin integrity	2	100.0	6.0
Impaired walking	2	100.0	30.0
Risk for deficient fluid volume	2	100.0	94.0
Imbalanced nutrition: less than body requirements	2	18.0	2.0
Toileting self-care deficit	2	100.0	6.0

Continue...

Continuation.

Section 15. Obstetric patients			
			
2 samples / 1 study			
Acute pain	2	38.0	11.1
Anxiety	2	55.5	52.3
Impaired sleep pattern	2	77.7	76.1
Interrupted breastfeeding	2	33.3	33.3
Overweight	2	44.4	19.0
Risk for disturbed maternal-fetal dyad	2	33.3	33.3
Risk for impaired parenting	2	33.3	33.3
Section 16. Medical/surgical patients			
			
2 samples / 2 studies			
Activity intolerance	2	35.0	13.4
Acute confusion	2	2.8	1.6
Acute pain	2	50.0	24.3
Anxiety	2	23.3	20.9
Bathing self-care deficit	2	12.6	6.6
Bowel incontinence	2	3.0	1.6
Constipation	2	41.6	8.7
Deficient fluid volume	2	8.3	1.6
Fatigue	2	25.5	4.6
Fear	2	9.9	5.0
Imbalanced nutrition: less than body requirements	2	25.2	10.0
Imbalanced nutrition: more than body requirements	2	11.6	11.5
Impaired physical mobility	2	26.6	20.8
Impaired skin integrity	2	26.6	3.9
Impaired swallowing	2	3.7	1.6
Impaired urinary elimination	2	10.6	5.0
Ineffective airway clearance	2	5.0	2.4
Ineffective breathing pattern	2	10.4	3.3
Ineffective coping	2	18.3	0.6

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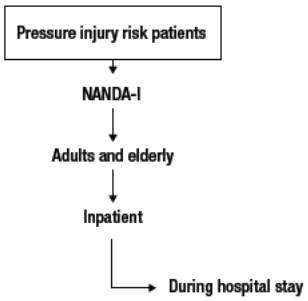
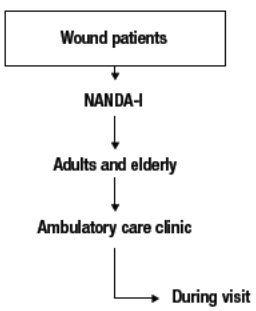
Risk for aspiration	2	6.6	5.1
Risk for constipation	2	23.8	1.6
Risk for impaired skin integrity	2	25.5	18.3
Risk for infection	2	64.6	58.3
Section 17. Patients with pressure injury risk			
			
2 samples / 2 studies			
Bathing self-care deficit	2	58.0	43.0
Imbalanced nutrition: less than body requirements	2	37.0	24.0
Impaired physical mobility	2	47.0	32.0
Impaired skin integrity	2	31.5	13.0
Impaired tissue integrity	2	21.0	20.5
Impaired urinary elimination	2	21.0	14.0
Ineffective breathing pattern	2	53.0	26.0
Risk for impaired skin integrity	2	16.0	13.0
Risk for infection	2	63.0	55.0
Section 18. Patients with wounds			
			
2 samples / 2 studies			
Anxiety	2	65.0	1.6
Bathing self-care deficit	2	5.0	0.3
Chronic pain	2	80.0	1.0
Excess fluid volume	2	95.0	4.9
Imbalanced nutrition: less than body requirements	2	5.0	0.3
Impaired physical mobility	2	100.0	2.3
Impaired sleep pattern	2	30.0	0.6
Impaired tissue integrity	2	100.0	3.9
Ineffective peripheral tissue perfusion	2	100.0	6.1
Risk for infection	2	100.0	2.6
Risk for unstable blood glucose	2	30.0	3.9

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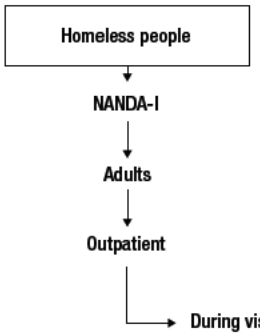
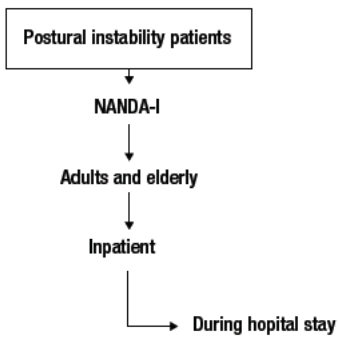
Section 19. Homeless people			
			
2 samples / 2 studies			
Anxiety	2	43.8	10.0
Bathing self-care deficit	2	30.0	16.8
Impaired skin integrity	2	13.0	11.7
Impaired dentition	2	83.6	78.0
Ineffective health maintenance	2	67.1	60.0
Section 20. Patients with postural instability			
			
2 samples / 2 studies			
Activity intolerance	2	33.3	4.0
Bathing self-care deficit	2	96.8	10.0
Feeding self-care deficit	2	74.6	10.0
Impaired physical mobility	2	100.0	12.0
Impaired walking	2	100.0	14.0
Risk for falls	2	100.0	29.0
Sedentary lifestyle	2	57.1	4.0
Toileting self-care deficit	2	94.0	10.0

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317.	Villarejo Aguilar, L., & Pancorbo-Hidalgo, P. L. (2011). Diagnósticos de enfermería, resultados e intervenciones identificadas en pacientes ancianos pluripatológicos tras el alta hospitalaria. Gerokomos, 22(4), 152-161. doi:10.4321/S1134-928X2011000400002
318.	Vitor, A. F., Moura, L. A., de Medeiros Araújo, J. N., Moisés, L. J. A., Costa, R. A., & da Costa, R. G. (2015). Nursing diagnoses of disposal area and exchange in patients identified in postoperative. Revista de Pesquisa Cuidado é Fundamental Online, 7(2), 2453-2463. doi: 10.9789/2175-5361.2015.v7i2.2453-2463
319.	Volpato, M. P., & Cruz, D. d. A. L. M. d. (2007). Nursing diagnoses in patients admitted to a medical-surgical unit. Acta Paulista de Enfermagem, 20, 119-124.
320.	Vorpagel, M., & Bonelli, W. (2011). Systematization of nursing care in the Family Health Program (FHP): construction of a healthcare plan from the community diagnosis. Saúde Coletiva, 8(52), 174-179.
321.	Waterkemper, R., de Aguiar Cicolella, D., dos Santos Sanches, K., Campo, L. L., & Goldberg Rabin, E. (2017). Nursing consultation for patients with continuous cancer: description of the diagnosis, interventions and results. Journal of Nursing UFPE/Revista de Enfermagem UFPE, 11(12). doi:10.5205/1981-8963-v11i12a15214p4838-4844-2017
322.	Yalcinturk, A. A., Melike Dissiz, R., & Kurt, N. (2018). Nursing diagnoses of the patients who have been treated in acute psychiatry clinics in the recent year. International Journal of Caring Sciences, 11(3), 1736-1742.
323.	Yang, M. J., Kim, H. Y., Ko, E., & Kim, H. K. (2019). Identification of Nursing Diagnosis-Outcome-Intervention Linkages for Inpatients in the Obstetrics Department Nursing Unit in South Korea. Int J Nurs Knowl, 30(1), 12-20. doi:10.1111/2047-3095.12187
324.	Yu, F., & Lang, N. M. (2008). Using the Omaha System to examine outpatient rehabilitation problems, interventions, and outcomes between clients with and without cognitive impairment. Rehabil Nurs, 33(3), 124-131. doi:10.1002/j.2048-7940.2008.tb00216.x
325.	Yücel, Ş., Eşer, I., Güler, E. K., & Khorshid, L. (2011). Nursing diagnoses in patients having mechanical ventilation support in a respiratory intensive care unit in Turkey. Int J Nurs Pract, 17(5), 502-508. doi:10.1111/j.1440-172X.2011.01959.x
326.	Zamora-Sánchez, J. J., Martínez Luque, R., Puig Girbao, N., Lladó Blanch, M., & Quilez Castillo, F. (2009). Programa de continuidad de cuidados al alta en una unidad de hospitalización a domicilio. Metas de Enfermería, 2009, vol. 12, num. 3, p. 23-30.
327.	Zampieron, A., Aldo, S., & Corso, M. (2011). A retrospective study of nursing diagnoses, outcomes, and interventions for patients admitted to a cardiology rehabilitation unit. Int J Nurs Terminol Classif, 22(4), 148-156. doi:10.1111/j.1744-618X.2011.01184.x
328.	Zeffiro, V., Sanson, G., Carboni, L., Malatesta, A., Vellone, E., Alvaro, R., & D'Agostino, F. (2018). The nursing-led in-patient unit: a descriptive study of nursing care delivered. Igiene e Sanità Pubblica, 74(4), 359-376.

Supplementary Table 5. Patient populations and respective references

Group	Patient population	Country
	CARDIOVASCULAR	
G1	Oliveira, M. F., & da Silva, L. d. F. (2010). Enfermagem em laboratório de hemodinâmica: diagnóstico e intervenção fundamentados na Teoria da Adaptação de Roy. Revista Eletrônica de Enfermagem, 12(4), 678-685.	Brazil
	Moizés, A. S., Shiotsu, C. H., & Takashi, M. H. (2016). Profile of Patients Admitted in a Cardiovascular Hospital. Rev. enferm. UFPE on line, 2595-2603. doi:10.5205/1981-8963-v10i7a11319p2595-2603-2016	Brazil
	#da Silva Alves Souza, L. M., Cotait Ayoub, A., & Ruiz Zimmer Cavalcante, A. M. (2017). Nursing Diagnosis for People With Heart Failure Based on the Hemodynamic Profiles. Int J Nurs Knowl, 28(4), 199-203. doi:10.1111/2047-3095.12151	Brazil
	Moon, M. (2019). Identifying Nursing Diagnosis Patterns in Three Intensive Care Units Using Network Analysis. Int J Nurs Knowl, 30(3), 137-146. doi:10.1111/2047-3095.12226	USA
G2	Portolan, C.R. (2015). Nursing diagnoses for patients in the postoperative period of cardiac surgery. Rev Rene, 16(2). Retrieved from http://periodicos.ufc.br/rene/article/view/2698	Brazil
	de Andrade, A. Y. T., de Lima Tanaka, P. S., de Brito Poveda, V., & Turrini, R. N. T. (2019). Immediate postoperative complications of myocardio revascularization. Revista SOBECC, 24(4), 224-230. doi:10.5327/Z1414-4425201900040008	Brazil
G3	Pereira, J. d. M. V., Cavalcanti, A. C. D., Santana, R. F., Cassiano, K. M., Queluci, G. d. C., & Guimarães, T. C. F. (2011). Nursing diagnoses for inpatients with cardiovascular diseases. Escola Anna Nery, 15, 737-745. doi:10.1590/S1414-81452011000400012	Brazil
	Reppetto, M. A., & Souza, M. F. d. (2008). Diagnósticos de enfermagem frequentemente identificados sem unidades de internação em um hospital universitário. Rev. paul. enferm, 27(1), 38-43.	Brazil
	*Scherb, C. A., Head, B. J., Maas, M. L., Swanson, E. A., Moorhead, S., Reed, D., . . . Kozel, M. (2011). Most frequent nursing diagnoses, nursing interventions, and nursing-sensitive patient outcomes of hospitalized older adults with heart failure: part 1. Int J Nurs Terminol Classif, 22(1), 13-22. doi:10.1111/j.1744-618X.2010.01164.x	USA
	Sartori, A. A., Gaedke, M., Moreira, A. C., & Graeff, M. D. S. (2018). Nursing diagnoses in the hemodynamics sector: an adaptive perspective. Rev Esc Enferm USP, 52, e03381. doi:10.1590/s1980-220x2017006703381	Brazil
	Park, H., & Tucker, D. A. (2017). Capturing Key NANDA-I Nursing Diagnoses From Actual Clinical Data for Patients With Heart Failure. Int J Nurs Knowl, 28(1), 30-36. doi:10.1111/2047-3095.12097	USA
	Zampieron, A., Aldo, S., & Corso, M. (2011). A retrospective study of nursing diagnoses, outcomes, and interventions for patients admitted to a cardiology rehabilitation unit. Int J Nurs Terminol Classif, 22(4), 148-156. doi:10.1111/j.1744-618X.2011.01184.x	Italy
	Nunciaroni, A. T., Gallani, M. C., Agondi Rde, F., Rodrigues, R. C., & Castro, L. T. (2012). Caracterização dos diagnósticos de enfermagem de pacientes internados em uma unidade de cardiologia. Rev Gaucha Enferm, 33(1), 32-41. doi:10.1590/s1983-14472012000100005	Brazil
	Reiners, A., Dióz, M., Teixeira, N., & Gonçalves, P. d. S. (2009). Nursing diagnoses among pregnant patients with hypertension. Revista Mineira de Enfermagem, 13(2), 232-237.	Brazil
G4	Lima, C., Balbino, P., & Salgado, P. (2017). Nursing diagnoses identified in subjects with hypertension. Enfermagem Brasil, 16(5), 267-275.	Brazil
	Calegari, D., Goldmeier, S., Moraes, M., & Souza, E. d. (2012). Nursing diagnosis in hypertensive patients followed in multidisciplinary ambulatory. Rev Enferm UFSM, 2(3), 610-618. Retrieved from http://biblioteca.cofen.gov.br/wp-content/uploads/2015/04/Diagnosticos-de-enfermagem-em-pacientes-hipertensos-acompanhados-em-ambulatorio-multiprofissional.pdf	Brazil
G5	Martins da Silva, V., de Oliveira Lopes, M. V., & Leite de Araujo, T. (2010). Odds ratio for nursing diagnoses in children with congenital heart disease. Investigación Y Educación En Enfermería, 25(1). https://doi.org/10.17533/udea.iee.5416	Brazil
	Martins da Silva, V., Lopes, M. V., & Leite de Araujo, T. (2007). Nursing diagnoses in children with congenital heart disease: a survival analysis. Int J Nurs Terminol Classif, 18(4), 131-141. doi:10.1111/j.1744-618X.2007.00068.x	Brazil
	CRITICAL PATIENTS	
G1	Cabral, V. d. H., Andrade, Í. R. C., Melo, E. M., & Cavalcante, T. d. M. (2017). Prevalence of nursing diagnoses in an intensive care unit. Rev Rene, 18(1). doi:https://doi.org/10.15253/2175-6783.2017000100012	Brazil
	Melo, E. M., Albuquerque, M. P., & Aragão, R. M. (2012). Nursing diagnosis prevalence in patients at an intensive care unit of a public hospital. Journal of Nursing UFPE/Revista de Enfermagem UFPE, 6(6). doi:10.5205/reuol.2365-18138-1-LE.0606201213	Brazil
	Magela, G.S. (2011). Diagnóstico de enfermagem dos pacientes internados em uma Unidade de Terapia Intensiva. Revista Saúde Coletiva, 8(47). Retrieved from http://www.redalyc.org/articulo.oa?id=84217101006	Brazil
	Castellan, C., Sluga, S., Spina, E., & Sanson, G. (2016). Nursing diagnoses, outcomes and interventions as measures of patient complexity and nursing care requirement in Intensive Care Unit. J Adv Nurs, 72(6), 1273-1286. doi:10.1111/jan.12913	Italy
	Paganin, A., Menegat, P., Klafke, T., Lazzarotto, A., Fachinelli Tde, S., Chaves, I. C., & de Souza, E. N. (2010). [Implementation of nursing diagnosis in intensive care units: a periodic review]. Rev Gaucha Enferm, 31(2), 307-313. doi:10.1590/s1983-14472010000200015	Brazil
	Ramos, G., Santana, L., Ferreira, P., Chianca, T., & Guedes, H. (2013). Nursing diagnosis documented in patients' records in the intensive care unit. R. Enferm. Cent. O. Min., 3, 679-686	Brazil
	Salgado Pde, O., & Chianca, T. C. (2011). Identification and mapping of the nursing diagnoses and actions in an Intensive Care Unit. Rev Lat Am Enfermagem, 19(4), 928-935. doi:10.1590/s0104-11692011000400011	Brazil
	Chianca, T. C., Lima, A. P., & Salgado Pde, O. (2012). [Nursing diagnoses identified in inpatients of an adult intensive care unit]. Rev Esc Enferm USP, 46(5), 1102-1108. doi:10.1590/s0080-62342012000500010	Brazil
	de Medeiros Dantas, A. L., Pinheiro, R. L., de Almeida Medeiros, A. B., Andriola, I. C., de Sa Tinoco, J. D., & de Carvalho Lira, A. L. B. (2016). Association of the diagnosis of physical injury class with its components: a cross-sectional study. Online Brazilian Journal of Nursing, 15(3), 361-371.	Brazil
	Oliveira, M. F., & Freitas, M. C. (2009). [Frequent nursing diagnoses and interventions for women under critical care]. Rev Bras Enferm, 62(3), 343-348. doi:10.1590/s0034-71672009000300002	Brazil

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G2	Bertoncello, K. C. G., Cavalcanti, C. D. A. K., Ilha, P., & do Nascimento, E. R. P. (2013). Diagnósticos de risco e propostas de intervenções de Enfermagem aos pacientes vítimas de múltiplos traumas. Revista Brasileira de Pesquisa em Saúde/Brazilian Journal of Health Research, 15(2).	Brazil
	Cyrillo, R. M. Z., Dalri, M. C. B., da Silva Canini, S. R. M., de Carvalho, E. C., & Lourencini, R. R. (2009). Diagnósticos de enfermagem em vítimas de trauma atendidas em um serviço pré-hospitalar avançado móvel. Revista Eletrônica de Enfermagem, 11(4), 811-819.	Brazil
	Sallum, A. M. C., & Sousa, R. M. C. d. (2012). Nursing diagnoses in trauma victims in the first six hours after the event. Acta Paulista de Enfermagem, 25, 256-262. doi:10.1590/S0103-21002012000200016	Brazil
	Sallum, A. M., Santos, J. L., & Lima, F. D. (2012). Nursing diagnoses in trauma victims with fatal outcomes in the emergency scenario. Rev Lat Am Enfermagem, 20(1), 3-10. doi:10.1590/s0104-11692012000100002	Brazil
	Franco, B., Busin, L., Chianca, T. C. M., Moraes, V. M., Pires, A. U. B., & Lucena, A. F. (2018). Association between Manchester Triage System discriminators and nursing diagnoses. Rev Gaucha Enferm, 39, e20170131. doi:10.1590/1983-1447.2018.2017-0131	Brazil
	López Alonso, S. R., Martínez García, A. I., Arroyo Rodríguez, A., Linares Rodríguez, C., Romero Serrano, R., & Martín Caravante, S. (2017). Diferencias por sexo en la casuística de urgencias domiciliarias atendidas por una enfermera. Index de Enfermería, 26(4), 260-264. Retrieved from https://scielo.isciii.es/scielo.php?script=sci_arttext&pid=S1132-12962017000300005	Spain
	[#]de Souza, C. C., da Mata, L. R., de Carvalho, E. C., & Chianca, T. C. (2013). Nursing diagnoses in patients classified as priority level I and II according to the Manchester protocol. Rev Esc Enferm USP, 47(6), 1318-1324. doi:10.1590/s0080-623420130000600010	Brazil
	MEDICAL PATIENTS	
G1	Guedes, H. M., Santos, W. L. d., Nakatani, A. Y. K., & Chianca, T. C. M. (2011). Diagnósticos de enfermagem na admissão e alta hospitalar de idosos. Rev. enferm. UERJ, 564-570.	Brazil
	Da Silva, G. R., Xavier, A. T., & Silva, P. C. V. (2012). Nursing diagnoses identified in a medical clinic unit: proposal of results and interventions. Revista de Enfermagem UFPE on line, 6(5), 986-993. doi:10.5205/1981-8963-v6i5a7161p986-993-2012	Brazil
	Dias de Araújo, D., Rodrigues de Carvalho, R. L., & Machado Chianca, T. C. (2014). Nursing diagnoses identified in records of hospitalized elderly. Investigación y educación en enfermería, 32(2), 225-235. doi:10.17533/udea.iee.v32n2a05	Brazil
	Fontes, C. M., & da Cruz, D. A. (2007). [Documented nursing diagnoses for medical clinic patients]. Rev Esc Enferm USP, 41(3), 395-402. doi:10.1590/s0080-62342007000300008	Brazil
G2	Güler, E. K., Eşer, I., Khorshid, L., & Yücel, S. (2012). Nursing diagnoses in elderly residents of a nursing home: a case in Turkey. Nurs Outlook, 60(1), 21-28. doi:10.1016/j.outlook.2011.03.007	Turkey
	Martínez Martín, M. L., Canalejas Pérez, M., Martín Salinas, C., Cid Galán, M. L., & Vera Cortés, M. L. (2009). Requisitos de autocuidadode pacientes mayores de 75 añosal alta hospitalaria. Metas enferm, 12(8), 68-75.	Spain
	Santos, A. d. S. R. d., Souza, P. A. d., Valle, A. M. D. d., Cavalcanti, A. C. D., Sá, S. P. C., & Santana, R. F. (2008). Characterization of nursing diagnoses identified in records of the elderly: a retrospective study. Texto & Contexto-Enfermagem, 17, 141-149.	Brazil
	Lira, L. N., Santos, S. S. C., Vidal, D. A. S., Gautério, D. P., Tomaschewski-Barlem, J. G., & Piexak, D. R. (2015). Diagnósticos y prescripciones de enfermería para ancianos en situación de hospitalización. Avances en Enfermería, 33(2), 251-260. doi:10.15446/av.enferm.v33n2.30762	Brazil
	Sousa, R. M. d., Santana, R. F., Santo, F. H. d. E., Almeida, J. G. d., & Alves, L. d. A. F. (2010). Diagnósticos de enfermagem identificados em idosos hospitalizados: associação com as síndromes geriátricas. Escola Anna Nery, 14, 732-741. doi:10.1590/S1414-81452010000400012	Brazil
	[#]Thoroddsen, A., Ehnfors, M., & Ehrenberg, A. (2010). Nursing specialty knowledge as expressed by standardized nursing languages. Int J Nurs Terminol Classif, 21(2), 69-79. doi:10.1111/j.1744-618X.2010.01148.x	Iceland
	Lopes, E. B., Pupulim, J. S. L., & Oliva, A. P. V. (2016). Profile of nursing diagnoses of patients hospitalized at a medical clinic unit. Ciência, Cuidado e Saúde, 15(2), 358-365. doi:10.4025/cienccuidsaude.v15i2.29356	Brazil
	PSYCHIATRIC PATIENTS	
	Yalcinturk, A. A., Melike Dissiz, R., & Kurt, N. (2018). Nursing diagnoses of the patients who have been treated in acute psychiatry clinics in the recent year. International Journal of Caring Sciences, 11(3), 1736-1742.	Turkey
	Frauenfelder, F., van Achterberg, T., & Müller Staub, M. (2018). Nursing diagnoses related to psychiatric adult inpatient care. J Clin Nurs, 27(3-4), e463-e475. doi:10.1111/jocn.13959	Switzerland
	Abderhalden, C., Needham, I., Faust, A. M., Grywa, D., Quiblier, U., Stefan, H., & Willard, W. (2007). [Nursing diagnoses in acute psychiatric wards in Switzerland and Austria: commonalities and differences]. Pflege, 20(3), 149-156. doi:10.1024/1012-5302.20.3.149	Switzerland
	[¥]Escalada-Hernández, P., Muñoz-Hermoso, P., González-Fraile, E., Santos, B., González-Vargas, J. A., Feria-Raposo, I., . . . García-Manso, M. (2015). A retrospective study of nursing diagnoses, outcomes, and interventions for patients with mental disorders. Appl Nurs Res, 28(2), 92-98. doi:10.1016/j.apnr.2014.05.006	Spain
	Silva, T. G. d., Souza, P. A. d., & Santana, R. F. (2015). Adequacy of nursing language to the practice with elderly residents in a long term psychiatric institution: cross mapping. Revista de Pesquisa: Cuidado é Fundamental Online, 7(4), 3467-3478. doi:10.9789/2175-5361.2015.v7i4.3467-3478	Brazil
	Thoroddsen, A., Ehnfors, M., & Ehrenberg, A. (2010). Nursing specialty knowledge as expressed by standardized nursing languages. Int J Nurs Terminol Classif, 21(2), 69-79. doi:10.1111/j.1744-618X.2010.01148.x	Iceland
	SURGICAL PATIENTS	
G1	#Monteiro, L., Souza, P. A., Almeida, P. F., Bitencourt, G. R., & Fassarella, C. S. (2019). Nursing diagnoses in adults and elderlies in the preoperative period: a comparative study. Rev Bras Enferm, 72(suppl 2), 56-63. doi:10.1590/0034-7167-2017-0959	Brazil
	Fernandes Martins, N. F., Tarouco da Silva, B., Gautério Abreu, D. P., Moura da Rosa, B., Piveta de Lima, J., & de Oliveira Bandeira, E. (2019). Nursing diagnoses in elderly people admitted in surgical unit. Revista de Pesquisa: Cuidado e Fundamental, 11(1). doi:10.9789/2175-5361.2019.v11i1.11-19	Brazil

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G2	Araújo, E. A. G. d., Oliveira, L. A. F. d., Paula, W. K. A. d., & Arruda, A. C. d. V. (2011). Sistematização da assistência de enfermagem na sala de recuperação pós-anestésica. Rev. SOBECC, 43-51.	Brazil
	Silva, H., Souza, V., & Silva, P. (2016). Systematization of perioperative nursing care in a postanesthetic recovery unit. Rev Enferm UFPE, 10(10), 3760-3767. doi:10.5205/reuol.9667-87805-1-ED1010201606	Brazil
	Souza, T., Carvalho, R., & Paldino, C. (2012). Nursing diagnoses, prognostics and interventions in the post-anesthesia care unit. Rev Sobec, 17(4), 33-47.	Brazil
	Novaes, E. S., Torres, M. M., & Oliva, A. P. V. (2015). Nursing diagnoses in surgical clinic. Acta Paulista de Enfermagem, 28, 26-31. doi:10.1590/1982-0194201500006	Brazil
	Moon, M. (2019). Identifying Nursing Diagnosis Patterns in Three Intensive Care Units Using Network Analysis. Int J Nurs Knowl, 30(3), 137-146. doi:10.1111/2047-3095.12226	USA
	Vasconcelos, A. C., de Castro, C. G. A., da Silva, D. F., & de Sousa, V. J. (2015). Frequency of nursing diagnoses in a surgical clinic. Rev Rene, 16(6), 826-832. doi:10.15253/2175-6783.2015000600008	Brazil
	Cruz, A. P. O., & Lopes, R. (2010). Diagnóstico de enfermagem no pós-operatório de cirurgias cardíacas. Salusvita, 29(3), 293-312. Retrieved from https://www.semanticscholar.org/paper/DIAGN%C3%93STICO-DE-ENFERMAGEM-NO-P%C3%93S-OPERAT%C3%93RIO-DE-in-Cruz-Lopes/1dbb04c1a9ebc896711023215b85600982ae92dc	Brazil
	Fernandes Martins, N. F., Tarouco da Silva, B., Gautério Abreu, D. P., Moura da Rosa, B., Piveta de Lima, J., & de Oliveira Bandeira, E. (2019). Nursing diagnoses in elderly people admitted in surgical unit. Revista de Pesquisa: Cuidado e Fundamental, 11(1). doi:10.9789/2175-5361.2019.v11i1.11-19	Brazil
	KIDNEY DISEASE PATIENTS	
G1	Poveda, V., Alves, J., Santos, E., & Garcia, E. (2014). Nursing diagnoses in patients undergoing hemodialysis. Enferm Glob, 13(2), 58-69. Retrieved from https://scielo.isciii.es/pdf/eg/v13n34/en_clinica3.pdf	Brazil
	de Souza, E. F., De Martino, M. M., & Lopes, M. H. (2007). Nursing diagnoses in chronic renal patients using Imogene King's conceptual system as reference. Rev Esc Enferm USP, 41(4), 629-635. doi:10.1590/s0080-62342007000400013	Brazil
	Bisca, M. M., & Marques, I. R. (2010). Perfil de diagnósticos de enfermagem antes de iniciar o tratamento hemodialítico. Rev Bras Enferm, 63(3), 435-439.	Brazil
	Farias de Queiroz Frazão, C. M., de Almeida Medeiros, A. B., Mariano Nunes de Paiva, M., Cruz Enders, B., de Oliveira Lopes, M. V., & Brandão de Carvalho Lira, A. L. (2015). Nursing diagnoses and adaptation problems among chronic renal patients. Invest Educ Enferm, 33(1), 119-127. doi:10.17533/udea.iee.v33n1a14	Brazil
G2	Frazão, C. M. F. d. Q., Medeiros, A. B. d. A., Lima e Silva, F. B. B., Sá, J. D. d., & Lira, A. L. B. d. C. (2014). Nursing diagnoses in chronic renal failure patients on hemodialysis. Acta Paulista de Enfermagem, 27, 40-43. doi:10.1590/1982-0194201400009	Brazil
	Costa, A. G. d. S., Santos, R. M. B. d., Vitor, A. F., & Araujo, T. L. d. (2010). Nursing diagnosis of patients in treatment of hemodialysis in teaching hospital. Journal of Nursing UFPE on line [JNUOL/DOI: 10.5205/01012007], 4(3), 1477-1483.	Brazil
	Holanda, R.-H., & Martins da Silva, V. (2009). Nursing diagnosis of patients in treatment of hemodialysis. Rev Rene, 10(2). 10.5205/reuol.1047-8515-1-LE.0403201019	Brazil
	Mendonça, N., Dutra, M., Funghetto, S., Stival, M., & Lima, L. (2013). Nursing diagnoses of patients on hemodialysis in use of double-lumen catheter. Rev Enferm Cent O Min [Internet], 3(2), 632-644. Retrieved from https://pesquisa.bvsalud.org/portal/resource/pt/lil-734090	Brazil
	Spigolon, D. N., Teston, E. F., Souza, F. O., Santos, B. D., Souza, R. R., & Moreira Neto, A. (2018). Nursing diagnoses of patients with kidney disease undergoing hemodialysis: a cross-sectional study. Rev Bras Enferm, 71(4), 2014-2020. doi:10.1590/0034-7167-2017-0225	Brazil
	Debone, M. C., Pedruncci, E., Candido, M., Marques, S., & Kusumota, L. (2017). Nursing diagnosis in older adults with chronic kidney disease on hemodialysis. Rev Bras Enferm, 70(4), 800-805. doi:10.1590/0034-7167-2017-0117	Brazil
	CHRONIC PATIENTS	
G1	Popim, R., DellAcqua, M., Antonio, C., & Braz, A. (2010). Prevalent nursing diagnoses in geriatrics according to disability level. Ciênc Cuid Saúde, 9(1), 21-27.	Brazil
	Villarejo Aguilar, L., & Pancorbo-Hidalgo, P. L. (2011). Diagnósticos de enfermería, resultados e intervenciones identificadas en pacientes ancianos pluripatológicos tras el alta hospitalaria. Gerokomos, 22(4), 152-161. doi:10.4321/S1134-928X2011000400002	Spain
	Ribeiro, I. A., Lima, L. R., Volpe, C. R. G., Funghetto, S. S., Rehem, T., & Stival, M. M. (2019). Frailty syndrome in the elderly with chronic diseases in Primary Care. Rev Esc Enferm USP, 53, e03449. doi:10.1590/s1980-220x2018002603449	Brazil
G2	de Freitas, M. C., Pereira, R. F., & Guedes, M. V. C. (2010). Diagnósticos de enfermagem em idosos dependentes residentes em uma instituição de longa permanência em Fortaleza-CE. Ciência, Cuidado e Saúde, 9(3), 518-526. doi:10.4025/cienccuidsaude.v9i3.9544	Brazil
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#Study generating two samples; *Study generating three samples; ¥Study generating four samples