4.2: Basic Concepts

Before learning how to use the nursing process, it is important to understand some basic concepts related to critical thinking and nursing practice. Let’s take a deeper look at how nurses think.

Critical Thinking and Clinical Reasoning

Nurses make decisions while providing patient care by using critical thinking and clinical reasoning. Critical thinking is a broad term used in nursing that includes “reasoning about clinical issues such as teamwork, collaboration, and streamlining workflow.”

Using critical thinking means that nurses take extra steps to maintain patient safety and don’t just “follow orders.” It also means the accuracy of patient information is validated and plans for caring for patients are based on their needs, current clinical practice, and research.

“Critical thinkers” possess certain attitudes that foster rational thinking. These attitudes are as follows:

- **Independence of thought**: Thinking on your own
- **Fair-mindedness**: Treating every viewpoint in an unbiased, unprejudiced way
- **Insight into egocentricity and sociocentricity**: Thinking of the greater good and not just thinking of yourself. Knowing when you are thinking of yourself (egocentricity) and when you are thinking or acting for the greater good (sociocentricity)
- **Intellectual humility**: Recognizing your intellectual limitations and abilities
- **Nonjudgmental**: Using professional ethical standards and not basing your judgments on your own personal or moral standards
- **Integrity**: Being honest and demonstrating strong moral principles
- **Perseverance**: Persisting in doing something despite it being difficult
• **Confidence**: Believing in yourself to complete a task or activity
• **Interest in exploring thoughts and feelings**: Wanting to explore different ways of knowing
• **Curiosity**: Asking “why” and wanting to know more

**Clinical reasoning** is defined as, “A complex cognitive process that uses formal and informal thinking strategies to gather and analyze patient information, evaluate the significance of this information, and weigh alternative actions.”[^2] To make sound judgments about patient care, nurses must generate alternatives, weigh them against the evidence, and choose the best course of action. The ability to clinically reason develops over time and is based on knowledge and experience.[^3]

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**Inductive and Deductive Reasoning and Clinical Judgment**

Inductive and deductive reasoning are important critical thinking skills. They help the nurse use clinical judgment when implementing the nursing process.

**Inductive reasoning** involves noticing cues, making generalizations, and creating hypotheses. Cues are data that fall outside of expected findings that give the nurse a hint or indication of a patient’s potential problem or condition. The nurse organizes these cues into patterns and creates a generalization. A **generalization** is a judgment formed from a set of facts, cues, and observations and is similar to gathering pieces of a jigsaw puzzle into patterns until the whole picture becomes more clear. Based on generalizations created from patterns of data, the nurse creates a hypothesis regarding a patient problem. A **hypothesis** is a proposed explanation for a situation. It attempts to explain the “why” behind the problem that is occurring. If a “why” is identified, then a solution can begin to be explored.

No one can draw conclusions without first noticing cues. Paying close attention to a patient, the environment, and interactions with family members is critical for inductive reasoning. As you work to improve your inductive reasoning, begin by first noticing details about the things around you. A nurse is similar to the detective looking for cues in Figure 4.1.[^4] Be mindful of your five primary senses: the things that you hear, feel, smell, taste, and see. Nurses need strong inductive reasoning patterns and be able to take action quickly, especially in emergency situations. They can see how certain objects or events form a pattern (i.e., generalization) that indicates a common problem (i.e., hypothesis).

**Example**: A nurse assesses a patient and finds the surgical incision site is red, warm, and tender to the touch. The nurse recognizes these cues form a pattern of signs of infection and creates a hypothesis that the incision has become infected. The provider is notified of the patient’s change in condition, and a new prescription is received for an antibiotic. This is an example of the use of inductive reasoning in nursing practice.
Deductive reasoning is another type of critical thinking that is referred to as “top-down thinking.” Deductive reasoning relies on using a general standard or rule to create a strategy. Nurses use standards set by their state’s Nurse Practice Act, federal regulations, the American Nursing Association, professional organizations, and their employer to make decisions about patient care and solve problems.

**Example:** Based on research findings, hospital leaders determine patients recover more quickly if they receive adequate rest. The hospital creates a policy for quiet zones at night by initiating no overhead paging, promoting low-speaking voices by staff, and reducing lighting in the hallways. (See Figure 4.2). The nurse further implements this policy by organizing care for patients that promotes periods of uninterrupted rest at night. This is an example of deductive thinking because the intervention is applied to all patients regardless if they have difficulty sleeping or not.
Clinical judgment is the result of critical thinking and clinical reasoning using inductive and deductive reasoning. Clinical judgment is defined by the National Council of State Boards of Nursing (NCSBN) as, “The observed outcome of critical thinking and decision-making. It uses nursing knowledge to observe and assess presenting situations, identify a prioritized patient concern, and generate the best possible evidence-based solutions in order to deliver safe patient care.” The NCSBN administers the national licensure exam (NCLEX) that measures nursing clinical judgment and decision-making ability of prospective entry-level nurses to assure safe and competent nursing care by licensed nurses.

Evidence-based practice (EBP) is defined by the American Nurses Association (ANA) as, “A lifelong problem-solving approach that integrates the best evidence from well-designed research studies and evidence-based theories; clinical expertise and evidence from assessment of the health care consumer’s history and condition, as well as health care resources; and patient, family, group, community, and population preferences and values.”

Nursing Process

The nursing process is a critical thinking model based on a systematic approach to patient-centered care. Nurses use the nursing process to perform clinical reasoning and make clinical judgments when providing patient care. The nursing process is based on the Standards of Professional Nursing Practice established by the American Nurses Association (ANA). These standards are authoritative statements of the actions and behaviors that all registered nurses, regardless
of role, population, specialty, and setting, are expected to perform competently. The mnemonic **ADOPIE** is an easy way to remember the ANA Standards and the nursing process. Each letter refers to the six components of the nursing process: **Assessment**, **Diagnosis**, **Outcomes Identification**, **Planning**, **Implementation**, and **Evaluation**.

The nursing process is a continuous, cyclic process that is constantly adapting to the patient's current health status. See Figure 4.3 for an illustration of the nursing process.

![Figure 4.3 The Nursing Process](https://med.libretexts.org/Bookshelves/Nursing/Nursing_Fundamentals_(OpenRN)/04%3A_Nursing_Process/4.02%3A_Basic...

Review Scenario A in the following box for an example of a nurse using the nursing process while providing patient care.

**Patient Scenario A: Using the Nursing Process**

A hospitalized patient has a prescription to receive Lasix 80mg IV every morning for a medical diagnosis of heart failure. During the morning assessment, the nurse notes that the patient has a blood pressure of 98/60, heart rate of 100, respirations of 18, and a temperature of 98.7F. The nurse reviews the medical record for the patient's vital signs baseline and observes the blood pressure trend is around 110/70 and the heart rate in the 80s. The nurse recognizes
these cues form a pattern related to fluid imbalance and hypothesizes that the patient may be dehydrated. The nurse gathers additional information and notes the patient’s weight has decreased 4 pounds since yesterday. The nurse talks with the patient and validates the hypothesis when the patient reports that their mouth feels like cotton and they feel light-headed. By using critical thinking and clinical judgment, the nurse diagnoses the patient with the nursing diagnosis Fluid Volume Deficit and establishes outcomes for reestablishing fluid balance. The nurse withholds the administration of IV Lasix and contacts the health care provider to discuss the patient’s current fluid status. After contacting the provider, the nurse initiates additional nursing interventions to promote oral intake and closely monitor hydration status. By the end of the shift, the nurse evaluates the patient status and determines that fluid balance has been restored.

In Scenario A, the nurse is using clinical judgment and not just “following orders” to administer the Lasix as scheduled. The nurse assesses the patient, recognizes cues, creates a generalization and hypothesis regarding the fluid status, plans and implements nursing interventions, and evaluates the outcome. Additionally, the nurse promotes patient safety by contacting the provider before administering a medication that could cause harm to the patient at this time.

The ANA’s Standards of Professional Nursing Practice associated with each component of the nursing process are described below.

Assessment

The “Assessment” Standard of Practice is defined as, “The registered nurse collects pertinent data and information relative to the health care consumer’s health or the situation.” A registered nurse uses a systematic method to collect and analyze patient data. Assessment includes physiological data, as well as psychological, sociocultural, spiritual, economic, and lifestyle data. For example, a nurse’s assessment of a hospitalized patient in pain includes the patient’s response to pain, such as the inability to get out of bed, refusal to eat, withdrawal from family members, or anger directed at hospital staff.

The “Assessment” component of the nursing process is further described in the “Assessment” section of this chapter.

Diagnosis

The “Diagnosis” Standard of Practice is defined as, “The registered nurse analyzes the assessment data to determine actual or potential diagnoses, problems, and issues.” A nursing diagnosis is the nurse’s clinical judgment about the client’s response to actual or potential health conditions or needs. Nursing diagnoses are the bases for the nurse’s care plan and are different than medical diagnoses.

The “Diagnosis” component of the nursing process is further described in the “Diagnosis” section of this chapter.

Outcomes Identification

The “Outcomes Identification” Standard of Practice is defined as, “The registered nurse identifies expected outcomes for a plan individualized to the health care consumer or the situation.” The nurse sets measurable and achievable short- and long-term goals and specific outcomes in collaboration with the patient based on their assessment data and nursing...
diagnoses.

The “Outcomes Identification” component of the nursing process is further described in the “Outcomes Identification” section of this chapter.

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### Planning

The “Planning” Standard of Practice is defined as, “The registered nurse develops a collaborative plan encompassing strategies to achieve expected outcomes.” \[16\] Assessment data, diagnoses, and goals are used to select evidence-based nursing interventions customized to each patient’s needs and concerns. Goals, expected outcomes, and nursing interventions are documented in the patient’s nursing care plan so that nurses, as well as other health professionals, have access to it for continuity of care.\[17\]

The “Planning” component of the nursing process is further described in the “Planning” section of this chapter.

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### Nursing Care Plans

Creating nursing care plans is a part of the “Planning” step of the nursing process. A nursing care plan is a type of documentation that demonstrates the individualized planning and delivery of nursing care for each specific patient using the nursing process. Registered nurses (RNs) create nursing care plans so that the care provided to the patient across shifts is consistent among health care personnel. Some interventions can be delegated to Licensed Practical Nurses (LPNs) or trained Unlicensed Assistive Personnel (UAPs) with the RN’s supervision. Developing nursing care plans and implementing appropriate delegation are further discussed under the “Planning” and “Implementing” sections of this chapter.

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### Implementation

The “Implementation” Standard of Practice is defined as, “The nurse implements the identified plan.” \[18\] Nursing interventions are implemented or delegated with supervision according to the care plan to assure continuity of care across multiple nurses and health professionals caring for the patient. Interventions are also documented in the patient’s electronic medical record as they are completed.\[19\]

The “Implementation” Standard of Professional Practice also includes the subcategories “Coordination of Care” and “Health Teaching and Health Promotion” to promote health and a safe environment.\[20\]

The “Implementation” component of the nursing process is further described in the “Implementation” section of this chapter.

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### Evaluation

The “Evaluation” Standard of Practice is defined as, “The registered nurse evaluates progress toward attainment of goals and outcomes.” \[21\] During evaluation, nurses assess the patient and compare the findings against the initial assessment to determine the effectiveness of the interventions and overall nursing care plan. Both the patient’s status
and the effectiveness of the nursing care must be continuously evaluated and modified as needed. \[22\]

The “Evaluation” component of the nursing process is further described in the “Evaluation” section of this chapter.

**Benefits of Using the Nursing Process**

Using the nursing process has many benefits for nurses, patients, and other members of the health care team. The benefits of using the nursing process include the following:

- Promotes quality patient care
- Decreases omissions and duplications
- Provides a guide for all staff involved to provide consistent and responsive care
- Encourages collaborative management of a patient’s health care problems
- Improves patient safety
- Improves patient satisfaction
- Identifies a patient’s goals and strategies to attain them
- Increases the likelihood of achieving positive patient outcomes
- Saves time, energy, and frustration by creating a care plan or path to follow

By using these components of the nursing process as a critical thinking model, nurses plan interventions customized to the patient’s needs, plan outcomes and interventions, and determine whether those actions are effective in meeting the patient’s needs. In the remaining sections of this chapter, we will take an in-depth look at each of these components of the nursing process. Using the nursing process and implementing evidence-based practices are referred to as the “science of nursing.” Let’s review concepts related to the “art of nursing” while providing holistic care in a caring manner using the nursing process.

**Holistic Nursing Care**

The American Nurses Association (ANA) recently updated the definition of nursing as, “Nursing integrates the art and science of caring and focuses on the protection, promotion, and optimization of health and human functioning; prevention of illness and injury; facilitation of healing; and alleviation of suffering through compassionate presence. Nursing is the diagnosis and treatment of human responses and advocacy in the care of individuals, families, groups, communities, and populations in the recognition of the connection of all humanity.” \[23\]

The ANA further describes nursing is a learned profession built on a core body of knowledge that integrates both the art and science of nursing. The art of nursing is defined as, “Unconditionally accepting the humanity of others, respecting their need for dignity and worth, while providing compassionate, comforting care.” \[24\]

Nurses care for individuals holistically, including their emotional, spiritual, psychosocial, cultural, and physical needs. They consider problems, issues, and needs that the person experiences as a part of a family and a community as they use the nursing process. Review a scenario illustrating holistic nursing care provided to a patient and their family in the following box.
**Holistic Nursing Care Scenario**

A single mother brings her child to the emergency room for ear pain and a fever. The physician diagnoses the child with an ear infection and prescribes an antibiotic. The mother is advised to make a follow-up appointment with their primary provider in two weeks. While providing discharge teaching, the nurse discovers that the family is unable to afford the expensive antibiotic prescribed and cannot find a primary care provider in their community they can reach by a bus route. The nurse asks a social worker to speak with the mother about affordable health insurance options and available providers in her community and follows up with the prescribing physician to obtain a prescription for a less expensive generic antibiotic. In this manner, the nurse provides holistic care and advocates for improved health for the child and their family.

**Note**

Review how to provide culturally responsive care and reduce health disparities in the "Diverse Patients" chapter.

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**Caring and the Nursing Process**

The American Nurses Association (ANA) states, “The act of caring is foundational to the practice of nursing.”[25] Successful use of the nursing process requires the development of a care relationship with the patient. A care relationship is a mutual relationship that requires the development of trust between both parties. This trust is often referred to as the development of rapport and underlies the art of nursing. While establishing a caring relationship, the whole person is assessed, including the individual’s beliefs, values, and attitudes, while also acknowledging the vulnerability and dignity of the patient and family. Assessing and caring for the whole person takes into account the physical, mental, emotional, and spiritual aspects of being a human being.[26] Caring interventions can be demonstrated in simple gestures such as active listening, making eye contact, touching, and verbal reassurances while also respecting and being sensitive to the care recipient’s cultural beliefs and meanings associated with caring behaviors.[27] See Figure 4.4[28] for an image of a nurse using touch as a therapeutic communication technique to communicate caring.

**Note**

Review how to communicate with patients using therapeutic communication techniques like active listening in the “Communication” chapter.

Dr. Jean Watson is a nurse theorist who has published many works on the art and science of caring in the nursing profession. Her theory of human caring sought to balance the cure orientation of medicine, giving nursing its unique disciplinary, scientific, and professional standing with itself and the public. Dr. Watson’s caring philosophy encourages nurses to be authentically present with their patients while creating a healing environment.[29]

**Note**

Read more about Dr. Watson’s theory of caring at the Watson Caring Science Institute.
Figure 4.4 Touch as a Therapeutic Communication Technique

Now that we have discussed basic concepts related to the nursing process, let's look more deeply at each component of the nursing process in the following sections.


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