4.11: IV Glossary

Advocacy: The act or process of pleading for, supporting, or recommending a cause or course of action.[1]

Art of nursing: Unconditionally acceptance of the humanity of others, respecting their need for dignity and worth, while providing compassionate, comforting care.[2]

At-risk populations: Groups of people who share a characteristic that causes each member to be susceptible to a particular human response, such as demographics, health/family history, stages of growth/development, or exposure to certain events/experiences.[3]

Associated conditions: Medical diagnoses, injuries, procedures, medical devices, or pharmacological agents. These conditions are not independently modifiable by the nurse, but support accuracy in nursing diagnosis.[4]

Basic nursing care: Care that can be performed following a defined nursing procedure with minimal modification in which the responses of the patient to the nursing care are predictable.[5]

Caring relationship: A relationship described as one in which the whole person is assessed while balancing the vulnerability and dignity of the patient and family.[6]

Client: Individual, family, or group, which includes significant others and populations.[7]

Clinical judgment: The observed outcome of critical thinking and decision-making. It is an iterative process that uses nursing knowledge to observe and access presenting situations, identify a prioritized client concern, and generate the best possible evidence-based solutions in order to deliver safe client care.[8]
Clinical reasoning: 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. [9]

Clustering data: Grouping data into similar domains or patterns.

Collaborative nursing interventions: Nursing interventions that require cooperation among health care professionals and unlicensed assistive personnel (UAP).

Coordination of care: While implementing interventions during the nursing process, includes components such as organizing the components of the plan with input from the health care consumer, engaging the patient in self-care to achieve goals, and advocating for the delivery of dignified and person-centered care by the interprofessional team. [10]

Critical thinking: Reasoning about clinical issues such as teamwork, collaboration, and streamlining workflow. [11]

Cue: Subjective or objective data that gives the nurse a hint or indication of a potential problem, process, or disorder.

Deductive reasoning: “Top-down thinking” or moving from the general to the specific. Deductive reasoning relies on a general statement or hypothesis—sometimes called a premise or standard—that is held to be true. The premise is used to reach a specific, logical conclusion.

Defining characteristics: Observable cues/inferences that cluster as manifestations of a problem-focused, health-promotion diagnosis, or syndrome. This does not only imply those things that the nurse can see, but also things that are seen, heard (e.g., the patient/family tells us), touched, or smelled. [12]

Delegation: The assignment of the performance of activities or tasks related to patient care to unlicensed assistive personnel while retaining accountability for the outcome. [13]

Dependent nursing interventions: Interventions that require a prescription from a physician, advanced practice nurse, or physician’s assistant.

Direct care: Interventions that are carried out by having personal contact with a patient.

Electronic Medical Record (EMR): An electronic version of the patient’s medical record.

Evidence-Based Practice (EBP): 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. [14]

Expected outcomes: Statements of measurable action for the patient within a specific time frame and in response to nursing interventions. “SMART” outcome statements are specific, measurable, action-oriented, realistic, and include a time frame.

during the assessment phase of the nursing process.

**Generalization:** A judgment formed from a set of facts, cues, and observations.

**Goals:** Broad statements of purpose that describe the aim of nursing care.

**Health teaching and health promotion:** Employing strategies to teach and promote health and wellness.

**Independent nursing interventions:** Any intervention that the nurse can provide without obtaining a prescription or consulting anyone else.

**Indirect care:** Interventions performed by the nurse in a setting other than directly with the patient. An example of indirect care is creating a nursing care plan.

**Inductive reasoning:** A type of reasoning that involves forming generalizations based on specific incidents.

**Inference:** Interpretations or conclusions based on cues, personal experiences, preferences, or generalizations.

**Licensed Practical Nurses or Licensed Vocational Nurses (LPNs/LVNs):** Nurses who have had specific training and passed a licensing exam. The training is generally less than that of a Registered Nurse. The scope of practice of an LPN/LVN is determined by the facility and the state’s Nurse Practice Act.

**Medical diagnosis:** A disease or illness diagnosed by a physician or advanced health care provider such as a nurse practitioner or physician’s assistant. Medical diagnoses are a result of clustering signs and symptoms to determine what is medically affecting an individual.

**Nursing:** 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.

**Nursing care plan:** Specific documentation of the planning and delivery of nursing care that is required by The Joint Commission.

**Nursing process:** A systematic approach to patient-centered care with steps including assessment, diagnosis, outcome identification, planning, implementation, and evaluation; otherwise known by the mnemonic “ADOPIE.”

**Objective data:** Data that the nurse can see, touch, smell, or hear or is reproducible such as vital signs. Laboratory and diagnostic results are also considered objective data.

**Outcome:** A measurable behavior demonstrated by the patient that is responsive to nursing interventions.

**PES Statement:** The format of a nursing diagnosis statement that includes:

- Problem (P) – statement of the patient problem (i.e., the nursing diagnosis)
- Etiology (E) – related factors (etiology) contributing to the cause of the nursing diagnosis
• Signs and Symptoms (S) – defining characteristics manifested by the patient of that nursing diagnosis

**Prescription:** Orders, interventions, remedies, or treatments ordered or directed by an authorized primary health care provider.\[18\]

**Primary data:** Information collected from the patient.

**Primary health care provider:** Member of the health care team (usually a medical physician, nurse practitioner, etc.) licensed and authorized to formulate prescriptions on behalf of the client.\[19\]

**Prioritization:** The skillful process of deciding which actions to complete first, second, or third for optimal patient outcomes and to improve patient safety.

**Quality improvement:** The “combined and unceasing efforts of everyone — health care professionals, patients and their families, researchers, payers, planners, and educators — to make the changes that will lead to better patient outcomes (health), better system performance (care), and better professional development (learning).”\[20\]

**Rapport:** Developing a relationship of mutual trust and understanding.

**Registered Nurse (RN):** A nurse who has had a designated amount of education and training in nursing and is licensed by a state Board of Nursing.

**Related factors:** The underlying cause (etiology) of a nursing diagnosis when creating a PES statement.

**Right to self-determination:** Patients have the right to determine what will be done with and to their own person.

**Scientific method:** Principles and procedures in the discovery of knowledge involving the recognition and formulation of a problem, the collection of data, and the formulation and testing of a hypothesis.

**Secondary data:** Information collected from sources other than the patient.

**Subjective data:** Data that the patient or family reports or data that the nurse makes as an inference, conclusion, or assumption, such as “The patient appears anxious.”

**Unlicensed Assistive Personnel (UAP):** Any unlicensed personnel trained to function in a supportive role, regardless of title, to whom a nursing responsibility may be delegated.\[21\]

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8. NCSBN. (n.d.). *NCSBN clinical judgment model.* [https://www.ncsbn.org/14798.htm](https://www.ncsbn.org/14798.htm)


