Critical Thinking, the Nursing Process, and Clinical Judgment

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LEARNING OUTCOMES

After studying this chapter, students will be able to:
• Define critical thinking
• Describe the importance of critical thinking in nursing
• Contrast the characteristics of “novice thinking” with those of “expert thinking”
• Explain the purpose and phases of the nursing process
• Differentiate between nursing orders and medical orders
• Explain the differences between independent, interdependent, and dependent nursing actions
• Describe evaluation and its importance in the nursing process
• Define clinical judgment in nursing practice and explain how it is developed
• Devise a personal plan to use in developing sound clinical judgment

Almost every encounter a nurse has with a patient is an opportunity for the nurse to assist the patient to a higher level of wellness or comfort. Whether or not this actually happens depends in large measure on the nurse’s ability to think critically about the patient’s particular needs and how best to meet them. It also depends on the nurse’s ability to use a reliable cognitive approach that leads to sound clinical decisions about what the patient’s priority nursing needs are. This chapter explores several important and interdependent aspects of thinking and decision making in nursing: critical thinking, the nursing process, and clinical judgment.

DEFINING CRITICAL THINKING

Defining critical thinking is a complex task that requires an understanding of how people think through problems. Educators and philosophers struggled with definitions of critical thinking for several decades. In 1990 the American Philosophical Association’s Committee on Pre-College Philosophy published an expert consensus statement (Box 8-1) describing critical thinking and the ideal critical thinker. This expert statement was the culmination of 3 years of work by Facione and others who synthesized the work of numerous persons who had defined critical thinking. In his essay “Critical Thinking: What It Is and Why It Counts,” Facione (2006) suggested that giving a definition of critical thinking that can be memorized by the learner is actually antithetical to critical thinking! This means that the very definition of critical thinking does not lend itself to simplistic thinking and memorization. Paul and Elder’s (2005) definition of critical thinking is similar: “Critical thinking is a process by which the thinker improves the quality of his or her thinking by skillfully taking charge of the structures inherent in thinking and imposing intellectual standards upon them.” They go on to describe a “well-cultivated critical thinker” as one who does the following:
• Raises questions and problems and formulates them clearly and precisely
• Gathers and assesses relevant information, using abstract ideas for interpretation
• Arrives at conclusions and solutions that are well-reasoned and tests them against relevant standards
• Is open-minded and recognizes alternative ways of seeing problems, and has the ability to
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assess the assumptions, implications, and consequences of alternative views of problems
- Communicates effectively with others as solutions to complex problems are formulated

The similarities are evident between Facione’s and Paul and Elder’s definitions: critical thinking is a process that requires disciplined engagement of the intellect to solve problems most effectively.

You may be asking, “What does this have to do with nursing?” The answer is very simple. Making good clinical judgments requires excellent critical thinking skills. For you as a practitioner of professional nursing responsible and accountable for your own decisions, the development of critical thinking skills is crucial as you provide nursing care for patients with increasingly complex conditions. Critical thinking skills provide the nurse with a powerful means of determining patient needs, interpreting physician orders, and intervening appropriately. Box 8-2 presents an example of the importance of critical thinking in the provision of safe care.

CRITICAL THINKING IN NURSING

You may be wondering at this point, “How am I ever going to learn how to make connections among all of the data I have about a patient?” This is a common response for a nursing student who is just learning some of the most basic psychomotor skills in preparation for practice. You need to understand that, just like learning to give injections safely and maintaining a sterile field properly, you can learn to think critically. This involves paying attention to how you think and making thinking itself a focus of concern. A nurse who is exercising critical thinking asks the following questions: “What assumptions have I made about this patient?” “How do I know my assumptions are accurate?” “Do I need any additional information?” and “How might I look at this situation differently?”

Nurses just beginning to pay attention to their thinking processes may ask these questions after nurse-patient interactions have ended. This is known as reflective thinking. This is the same process described in Chapter 5 about reflecting on ethical dilemmas that you encounter in practice. Reflective thinking is an active process valuable in learning and changing behaviors, perspectives, or practices. Nurses can also learn to examine their thinking processes during an interaction as they learn to “think on their feet.” This is a characteristic of expert nurses. As you move from novice to expert, your ability to think critically will improve with practice. In Chapter 6 you read about Dr. Patricia Benner (1984, 1996), who studied the differences in expertise of nurses at different stages in their careers, from novice to expert. So it is with critical thinking; novices think differently than experts. Box 8-3 summarizes the differences in novice and expert thinking.

Mr. Smith is a 77-year-old man admitted to your general medicine unit with several problems, including dehydration secondary to severe nausea and vomiting and a urinary tract infection. His medication orders include hydrochlorothiazide 50 mg q am for mild hypertension, ampicillin 2 g q6 hours. His IV order is D 5LR at 125 mL/hour. His laboratory values show a serum potassium level of 2.6 mEq/L. You recognize that this is low. Mr. Smith seems weak and lethargic; his urine output has been 35 mL/hour for the past 2 hours. You are concerned about him and his condition.

A nurse using good critical thinking skills will note the following: the source of his dehydration, his antibiotic order for his UTI, his low potassium level, his IV rate, his low urinary output, and his daily use of a diuretic known to be associated with potassium loss. His lethargy and weakness could be a product of his age and general condition, but you also know that they are signs of hypokalemia. Critical thinking does not stop at noting these issues, however. Critical thinking requires making a judgment about what to do with your concerns. A nurse not using critical thinking may simply follow physician orders with the expectation that Mr. Smith will feel better once his dehydration is reversed and his UTI is adequately treated. Using your good critical thinking skills, however, you come to the conclusion that Mr. Smith may be better supported with a different approach to his care. You call his physician to discuss your concerns, describing in detail the “big picture.” The specific, detailed information that you communicate clearly allows the physician to reconsider Mr. Smith's medical regimen and proceed from a more informed position. The next day you are pleased to see Mr. Smith walking in the hall when you come onto the unit at the beginning of your shift. He says that he feels “like a new person.”

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**Box 8-2  Using Critical Thinking Skills to Improve a Patient’s Care**

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**Box 8-3  Novice Thinking Compared With Expert Thinking**

**NOVICE NURSES**
- Tend to organize knowledge as separate facts.
- Must rely heavily on resources (e.g., texts, notes, preceptors). Lack knowledge gained from actually doing (e.g., listening to breath sounds).
- Focus so much on actions that they tend to forget to assess before acting
- Need clear-cut rules
- Are often hampered by unawareness of resources
- Are often hindered by anxiety and lack of self-confidence
- Must be able to rely on step-by-step procedures. Tend to focus more on procedures than on the patient response to the procedure.
- Become uncomfortable if patient needs preclude performing procedures exactly as they were learned
- Have limited knowledge of suspected problems; therefore they question and collect data more superficially

**EXPERT NURSES**
- Tend to follow standards and policies by rote
- Learn more readily when matched with a supportive, knowledgeable preceptor or mentor
- Tend to store knowledge in a highly organized and structured manner, making recall of information easier. Have a large storehouse of experiential knowledge (e.g., what abnormal breath sounds sound like, what subtle changes look like).
- Assess and think things through before acting
- Know when to bend the rules
- Are aware of resources and how to use them
- Are usually more self-confident, less anxious, and therefore more focused
- Know when it is safe to skip steps or do two steps together. Are able to focus on both the parts (the procedures) and the whole (the patient response).
- Are comfortable with rethinking a procedure if patient needs require modification of the procedure

(Continued)
Critical thinking in nursing, however, involves more than good problem-solving strategies. It is a complex, purposeful, disciplined process that has specific characteristics that make it different from run-of-the-mill problem solving. Consciously developed to improve patient outcomes, critical thinking by the nurse is driven by the needs of the patient and family. Critical thinking in nursing is undergirded by the standards and ethics of the profession. Nurses who think critically seek to build on patients’ strengths while honoring patients’ values and beliefs (Alfaro-LeFevre, 1999). They are engaged in a process of constant evaluation, redirection, improvement, and increased efficiency. Be aware that critical thinking involves far more than stating your opinion. You must be able to describe how you came to a conclusion and support your conclusions with explicit data and rationales. This is a different way of thinking for most people and requires practice. Dimensions of critical thinking include both cognitive skills and “habits of the mind” (Scheffer and Rubenfeld, 2000).

Box 8-4 summarizes these characteristics and offers an opportunity for you to evaluate your progress as a critical thinker.

Directions: Listed below are 15 characteristics of critical thinkers. Mark a plus sign (+) next to those you now possess, mark IP (in progress) next to those you have partially mastered, and mark a zero (0) next to those you have not yet mastered. When you are finished, make a plan for developing the areas that need improvement. Share it with at least one person, and report on progress weekly.

**CHARACTERISTICS OF CRITICAL THINKERS: HOW DO YOU MEASURE UP?**

- Inquisitive/curious/seeks truth
- Self-informed/finds own answers
- Analytic/confident in own reasoning skills
- Open-minded
- Flexible
- Fair-minded
- Honest about personal biases/self-aware
- Prudent/exercises sound judgment
- Willing to revise judgment when new evidence warrants
- Clear about issues
- Orderly in complex matters/organized approach to problems
- Diligent in seeking information
- Persistent
- Reasonable
- Focused on inquiry

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An excellent continuing education self-study module designed to improve your ability to think critically can be found online (http://www.nurse.com/ce/CE168-60/Improving-Your-Ability-to-Think-Critically/). Continuing one’s education through lifelong learning is an excellent way to maintain and enhance your critical thinking skills. The website http://www.nurse.com has more than 500 continuing education opportunities available online and may be helpful to you as you seek to increase your knowledge base and
improve your clinical judgment. In addition, you can also begin to learn about the many facets of critical thinking by participating with classmates in the Critical Thinking Challenge, Six Caps, below. This exercise will allow you to practice thinking through the various questions that need to be asked in response to very complex patient and family issues.

### CRITICAL THINKING Challenge 8-1

**Six Caps**

This is an hour-long group activity designed to clarify the various types of thinking that constitute critical thinking. For every six participants, you will need six pieces of colored paper (one white, one red, one black, one yellow, one green, and one blue). You will also need six straight pins. Divide the group into smaller groups of six and give each group member a pin and piece of colored paper. Each person draws a cap on the paper and pins it to his or her shirt in plain view. These represent the six “thinking caps,” that is, the various types of thinking to be explored:

- **White cap**—Information. Asks the questions, “What information do we have, what is needed, and how can we get it?”

- **Red cap**—Feelings, intuition, and emotion. Asks the questions, “What are we, the patient, and the family feeling, and how do we know?”

- **Black cap**—Policies, codes, standards, protocols, laws. Asks the questions, “What are the standards we should consider, and what are the risks?”

- **Yellow cap**—Optimism. Asks the questions, “What are the benefits, who benefits, and what are the values being expressed?”

- **Green cap**—Growth. Asks the questions, “What don’t we try it this way?” and “What are some different alternatives?”

- **Blue cap**—Focuses on thinking. Asks the questions, “How are we going to proceed in thinking through this situation?” and “What have we achieved and what do we want to achieve?”

Read the case study below (or one prepared by your teacher), and discuss it from the viewpoint of each “cap.” Identify issues for reflection. Then switch “thinking caps.” Discuss the case study again. How easy or difficult was it to change your type of thinking? Do some types of thinking come more naturally to you than others? Which ones will you have to work to develop? Do you see value in each type of thinking? When the group reconvenes, summarize what you have learned on a flip chart.

### CASE STUDY FOR SIX CAPS

Marianne is a 79-year-old woman who was admitted to the emergency department yesterday with a severe headache. Shortly after admission, she became unresponsive; a brain scan revealed she had experienced a hemorrhagic stroke. Marianne’s pupils are dilated and do not respond to light; she is breathing with the assistance of a respirator. Her elderly husband and three adult children are all assembled. The physician has recommended surgery to remove the blood clot but cannot offer much assurance that she will recover function. She has no advance directives, but her husband wants to “try everything.” The children believe that she would not want to undergo this surgery only to be kept alive with poor quality of life, which they agree is the likely outcome. The ethics committee is assembled to assist the family in making the decision. Before meeting with the family, the committee meets to discuss the situation.

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**THE NURSING PROCESS: AN INTELLECTUAL STANDARD**

Critical thinking requires systematic and disciplined use of universal intellectual standards (Paul and Elder, 2005). In the practice of nursing, the *nursing process* represents a universal intellectual standard by which problems are addressed...
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and solved. The nursing process is a method of critical thinking focused on solving patient problems in professional practice. The nursing process is “a designated series of actions intended to fulfill the purposes of nursing” (Yura and Walsh, 1983).

A simple example of using a process approach to problem solving is illustrated by examining a daily decision that you and most other people face: how to dress for the day. Before putting on your clothes, there are several factors you need to consider. What is the expected temperature? Will it be clear, raining, or snowing? How much time will be spent outdoors? Are there any activities planned that require special dress? Next, you probably look at the possible clothing choices. Some clothes may be out of season, and others need repairs, are too dressy or casual, or do not fit quite right. After considering the environmental factors, the day’s activities, and your mood, you select the day’s clothing. After dressing, you may look in a mirror to evaluate how you look. You may then modify your outfit on the basis of your image in the mirror. At this point, you have solved the problem of clothing yourself. You have identified a problem, considered various factors related to the problem, identified possible actions, selected the best alternative, evaluated the success of the alternative selected, and made adjustments to the solution based on the evaluation. This is the same general process nurses use in solving patient problems through the nursing process.

For individuals outside the profession, nursing is commonly and simplistically defined in terms of tasks nurses perform (e.g., give injections). Many students get frustrated with activities and courses in nursing school that are not focused on these tasks, believing themselves that the tasks of nursing are nursing. Even within the profession, the intellectual basis of nursing practice was not articulated until the 1960s, when nursing educators and leaders began to identify and name the components of nursing’s intellectual processes. This marked the beginning of the nursing process.

In the 1970s and 1980s, debate about the use of the term diagnosis began. Until then, diagnosis was considered to be within the scope of practice of physicians only. Although nurses were not equipped to diagnose medical conditions in patients, nurses recognized that there were human responses amenable to independent nursing intervention. These responses could be identified (diagnosed) through the careful application of specific defining characteristics. In 1973, the National Group for the Classification of Nursing Diagnosis published its first list of nursing diagnoses. This organization is now known as NANDA International (NANDA-I; NANDA is the acronym for North American Nursing Diagnosis Association). Its mission is to “facilitate the development, refinement, dissemination and use of standardized nursing diagnostic terminology” with the goal to “improve the health care of all people” (http://www.nanda.org). In December 2008, NANDA-I published its 2009-2011 edition of Nursing Diagnoses: Definitions and Classifications. Currently, NANDA-I has 206 diagnoses approved for clinical testing and has recently added 21 new diagnoses and 9 revised diagnoses. Some of the new diagnoses include “impaired comfort,” “dysfunctional gastrointestinal motility,” and “ineffective peripheral tissue perfusion.” Diagnoses are also retired if it becomes evident that their usefulness is limited or outdated, such as the newly retired diagnosis “disturbed thought processes.”

Here is a simple example of how one of the newly approved nursing diagnoses may be used:

Two days after a surgery for a large but benign abdominal mass, Mr. Pierce has not yet been able to tolerate solid food and has diminished bowel sounds. His abdomen is somewhat distended. Your diagnosis is that Mr. Pierce has dysfunctional gastrointestinal motility. This diagnosis is based on NANDA-I’s (2008) taxonomy because you have determined that the risk factors and physical signs and symptoms associated with this diagnosis apply to him.

A more detailed discussion of nursing diagnosis is located in the next section of this chapter.

The nursing process as a method of clinical problem solving is taught in schools of nursing
across the United States, and many states refer to
it in their nurse practice acts. The nursing pro-
cess has sometimes been the subject of criticism
among nurses. In recent years some nursing lead-
ers have questioned the use of the nursing pro-
cess, describing it as linear, rigid, and mechanistic.
They believe that the nursing process contributes
to linear thinking and stymies critical thinking.
They are concerned that the nursing process for-
at, and rigid faculty adherence to it, encourages
students to copy from published sources when
writing care plans, thus inhibiting the develop-
ment of a holistic, creative approach to patient
care (Mueller, Johnston, and Bligh, 2002). Cer-
tainly the nursing process can be taught, learned,
and used in a rigid, mechanistic, and linear man-
ner. Ideally, the nursing process is used as a cre-
ative approach to thinking and decision making
in nursing. Because the nursing process is an inte-
gral aspect of nursing education, practice, stan-
dards, and practice acts nationwide, learning to
use it as a mechanism for critical thinking and as
a dynamic and creative approach to patient care
is a worthwhile endeavor. Despite reservations
among some nurses about its use, the nursing
process remains the cornerstone of nursing stan-
dards, legal definitions, and practice and, as such,
should be well understood by every nurse.

PHASES OF THE NURSING PROCESS

Like many frameworks for thinking through
problems, the nursing process is a series of organ-
ized steps, the purpose of which is to impose
some discipline and critical thinking on the pro-
vision of excellent care. Identifying specific steps
makes the process clear and concrete but can
cause nurses to use them rigidly. Keep in mind
that this is a process, that progression through the
process may not be linear, and that it is a tool to
use, not a road map to follow rigidly. More cre-
ative use of the nursing process may occur by
expert nurses who have a greater repertoire of
interventions from which to select. For example,
if a newly hospitalized patient is experiencing a
great deal of pain, a novice nurse might proceed
by asking family members to leave so that he or
she can provide a quiet environment in which
the patient may rest. An expert nurse would real-
ize that the family may be a source of distraction
from the pain or may be a source of comfort in
ways that the nurse may not be able to provide.
The expert nurse, in addition to assessing the
patient, is willing to consider alternative explana-
tions and interventions, enhancing the possibility
that the patient's pain will be relieved.

Phase 1: Assessment

Assessment is the initial phase or operation in the
nursing process. During this phase, information
or data about the individual patient, family, or
community are gathered. Data may include physi-
ologic, psychological, sociocultural, developmen-
tal, spiritual, and environmental information. The
patient's available financial or material resources
also need to be assessed and recorded in a stan-
dard format; each institution usually has a slightly
different method of recording assessment data.

Types of data

Nurses obtain two types of data about and from
patients: subjective and objective. Subjective data
are obtained from patients as they describe their
needs, feelings, strengths, and perceptions of the
problem. Subjective data are frequently referred
to as symptoms. Examples of subjective data are
statements such as, “I am in pain” and “I don't
have much energy.” The only source for these
data is the patient. Subjective data should include
physical, psychosocial, and spiritual information.
Subjective data can be very private. Nurses must
be sensitive to the patient's need for confidence in
the nurse's trustworthiness.

Objective data are the other types of data
that the nurse will collect through observation,
examination, or consultation with other health
care providers. These data are measurable, such
as pulse rate and blood pressure, and include
observable patient behaviors. Objective data are
frequently called signs. An example of objec-
tive data that a nurse might gather includes the
observation that the patient, who is lying in bed,
is diaphoretic, pale, and tachypneic, clutching his
hands to his chest.
Objective data and subjective data usually are congruent; that is, they usually are in agreement. In the situation just mentioned, if the patient told the nurse, “I feel like a rock is crushing my chest,” the subjective data would substantiate the nurse’s observations (objective data) that the patient is having chest pain. Occasionally subjective and objective data are in conflict. A stark example of incongruent subjective and objective data well-known to labor and delivery nurses is when a pregnant woman in labor describes ongoing fetal activity (subjective data); however, there are no fetal heart tones (objective data), and the infant is stillborn. Incongruent objective and subjective data require further careful assessment to ascertain the patient’s situation more completely and accurately. Sometimes incongruent data reveal something about the patient’s concerns and fears. To get a clearer picture of the patient’s situation, the nurse should use the best communication skills he or she possesses to increase the patient’s trust, which will result in more openness.

Sources of patient data
Patient data can be obtained from many sources (Figure 8-1). The patient is considered the only primary source. Sources of data such as the nurse’s own observations or reports of family and friends of the patient are considered secondary sources. Tertiary sources of data include medical records and information gathered from other health care providers such as physical therapists, physicians, or dietitians.

Methods of collecting patient data
A number of methods are used when collecting patient data. The patient interview is a primary means of obtaining both subjective and objective data. The interview typically involves a face-to-face interaction with the patient that requires the nurse to use the skills of interviewing, observation, and listening (Figure 8-2). Many factors influence the quality of the interview, including the physical environment in which the interaction occurs. If the patient is not in a private room,
the open exchange of information may not occur easily. Sometimes the presence of family members constrains the flow of information from a patient, especially when dealing with sensitive or private issues. Similarly, if an interview takes place in a cold, noisy, or public place, the type of data obtained may be affected by environmental distractions. Internal factors related to the patient's condition may influence the amount and the type of data obtained. For example, when interviewing a patient who is having difficulty breathing, the verbal data obtained by the interview may be limited, but careful observation and attentive listening can yield much information about the patient's condition.

Physical examination is the second method for obtaining data. Nurses use physical assessment techniques of inspection, auscultation, percussion, and palpation to obtain these data. A third method of obtaining data is through consultation. Consultation is discussing patient needs with health care workers and others who are directly involved in the care of the patient. Nurses also consult with patients' families to obtain background information and their perceptions about the patients' needs.

Organizing patient data
Once patient data have been collected, they must be sorted or organized. A number of methods have been developed to assist nurses in organizing patient data. Abdellah's 21 nursing problems, Henderson's 14 nursing problems, Yura and Walsh's human needs approach, and Gordon's 11 functional health patterns are commonly used frameworks for collecting and organizing patient data. Contemporary nursing theorists continue to develop other organizing frameworks, including those of Madeleine Leininger, Sister Callista Roy, Dorothy Orem, and others you will read about in Chapter 13. Nurses choose different methods of organizing patient data depending on personal preference and the method used in the agencies where they are employed.

Confidentiality of patient data
A word of caution is needed in regard to patient data. Earlier, it was mentioned that patients confide personal information to nurses only if they believe the nurse is trustworthy. Patients need to know and trust that nurses share such information only with the other treatment team members. Nurses must respect patients' privacy rights and should never discuss patient information with anyone who does not have a work-related need to know. This is not only an ethical issue but also a legal issue. Patients' privacy is now protected by Federal law (see Health Insurance Portability and Accountability Act [HIPAA] on page 89).

Ensuring patients' privacy is complicated in that vast amounts of patient data may be stored digitally and retrieved relatively easily. Although the issues of confidentiality and access to electronically stored data have yet to be fully resolved, each nurse should be entrusted never to violate a patient's privacy by revealing patient information except to other members of that patient's treatment team.

Phase 2: Analysis and Identification of the Problem
During the data-gathering phase of the nursing process, nurses obtain a great deal of information about their patients. These data must first be validated and then compared with norms to sort out data that might indicate a problem or identify a pattern. Next, the data must be clustered or grouped so that problems can be identified.
and their cause discerned. Knowledge from the science of nursing, biologic sciences, and social sciences enables nurses to observe relationships among various pieces of patient data. This process is known as data analysis and results in the identification of one or more problems that are amenable to nursing intervention. The problems are often characterized as nursing diagnoses. In 1976, Gordon defined nursing diagnosis as “actual or potential health problems which nurses, by virtue of their education and experience, are capable and licensed to treat” (p. 1299). In 1990, NANDA defined nursing diagnosis as making “a clinical judgment about individual, family, or community responses to actual or potential health problems/life processes (which) provide the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable.”

**Distinctions between medical and nursing diagnosis**

Nursing diagnosis is different from medical diagnosis and was never intended to be a substitute for it. Rather than focusing on what is wrong with the patient in terms of a disease process, a nursing diagnosis identifies the problems the patient is experiencing as a result of the disease process, that is, the human responses to the illness, injury, or threat.

An important difference between nursing diagnosis and medical diagnosis is that nursing diagnoses address patient problems that nurses can treat within their scope of practice. Proponents of nursing diagnosis argue that it does little good for nursing diagnoses to include “appendicitis” because appendicitis is a medical diagnosis requiring surgery, and nurses may not perform surgery. A nursing diagnosis for a patient after an appendectomy might be “ineffective airway clearance related to incisional pain.” Because it is within the scope of practice in all states for nurses to provide comfort measures and to assist patients to cough and deep breathe, this would be an appropriate nursing diagnosis that is remedied by nursing interventions. The medical diagnosis becomes a platform from which nursing diagnoses are developed: a patient with a new medical diagnosis of diabetes will have some very specific nursing diagnoses and interventions based on the requirements of the medical condition (diabetes) that caused the patient to seek care.

Although nursing diagnosis is still used in nursing, it does not have universal support among various constituencies of the discipline and profession. Critics believe that the language of nursing diagnosis obscures rather than clarifies patient problems. This causes confusion between disciplines involved in care of patients. For instance, Mr. Pierce, in the earlier example, may have a simple postoperative ileus. This is a medical diagnosis, but its management has important implications for nursing. The nursing diagnosis “dysfunctional gastrointestinal motility related to decreased motor activity status post abdominal surgery,” with its accompanying “impaired comfort related to intolerance of medications” is a very long way of saying that Mr. Pierce has an ileus, has not been moving around, is in pain and not tolerating his medications. This more streamlined description of Mr. Pierce’s clinical condition is recognizable across disciplines, and the implications for nursing management remain the same. In 2008, the American Association of Colleges of Nursing (AACN) issued an executive summary, “The Essentials of Baccalaureate Education for Professional Nursing Practice,” which is described in Chapter 7. This summary emphasizes patient-centered care in interprofessional teams, which requires excellent communication across disciplines. Particular emphasis is placed on the translation of evidence into practice. Nursing diagnosis is not mentioned among the nine essentials. The complete summary can be found on the AACN website (http://www.aacn.nche.edu/Publications/positions/index.htm).

Despite a new focus on evidence-based practice, the need for interdisciplinary collaboration, and interprofessional teamwork, many schools of nursing still teach NANDA-I nursing diagnoses, and many advanced practice nurses use them in their own practices. NANDA-approved nursing diagnoses consist of five components (NANDA, 2003, pp. 263-264):

1. **Label:** Concise term or phrase that names the diagnosis
2. **Definition:** Term or phrase that clearly delineates meaning and helps differentiate from similar diagnoses

3. **Defining characteristics:** Clusters of observable cues or inferences

4. **Risk factors:** Factors that increase vulnerability to an unhealthful event

5. **Related factors:** Factors that precede, are associated with, or relate to the diagnosis

All nursing diagnoses must be supported by data, which NANDA-I refers to as defining characteristics, also known as signs and symptoms. Remember that a sign is observable and is objective, whereas a symptom is reported by the patient and is subjective. An easy way to understand the difference is to remember the difference between the words in the commonly used phrase “nausea and vomiting.” Nausea is a subjective report of a specific feeling by a patient but is not directly observable by the nurse. Vomiting, on the other hand, is objective, verifiable, and quantifiable. It is a clear sign that the patient’s report of nausea (a symptom) was correct.

Accurate diagnosis of human responses is very important. All nursing actions flow from the diagnosis, and inaccurate diagnoses can lead to lost time and wasted resources and may endanger the patient. Accuracy of diagnosis is a professional behavior, one of nursing’s accountabilities (Lunney, 2001). Lunney (2008) wrote an appeal to nurses in practice and education to address this issue of diagnostic accuracy based on research findings that there is a need for more diagnostic consistency among nurses, that the issue of accuracy will always be present because of the complexities of nursing, and that electronic health records make the issue of accuracy of diagnosis even more broad-based.

**Writing NANDA-I nursing diagnoses.** A format used to write the diagnostic statement, called the PES format (Box 8-5), was developed by Gordon (1987). In this format, the **P** stands for the concise description of the problem, using the NANDA-I diagnostic label, for example, “ineffective breathing pattern.”

<table>
<thead>
<tr>
<th><strong>Box 8-5</strong> Writing Nursing Diagnoses</th>
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<tbody>
<tr>
<td><strong>P</strong> = Problem (NANDA-I diagnostic label)</td>
</tr>
<tr>
<td><strong>E</strong> = Etiology (causal factors)</td>
</tr>
<tr>
<td><strong>S</strong> = Signs and symptoms (defining characteristics)</td>
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</table>

The **E** part of the statement stands for etiology, cause, and begins with the words “related to.” These related factors are conditions or circumstances that can cause or contribute to the development of the problem. To extend the previous example, “ineffective breathing pattern related to anxiety,” explains the cause of the ineffective breathing pattern as the patient’s high anxiety level. The etiology part of the statement is important, because if the cause were decreased energy or fatigue rather than anxiety, the nurse would need to select different nursing actions to solve the problem. A diagnosis may be technically correct, but, if the etiology is incorrect, interventions are likely to be ineffective. In early 2009, NANDA-I issued a position statement that the “related to” field in nursing diagnosis is an effective teaching strategy but may be too complex to be practical in clinical practice. Hence its new position is that just the diagnostic label may be acceptable. NANDA-I also notes in this statement that some electronic care plan systems may not be amenable to the inclusion of “related to” factors (http://www.nanda.org).

The last part of the diagnostic statement is **S**, which stands for signs and symptoms, or as NANDA-I refers to them, “defining characteristics.” Thus the complete diagnostic statement for our sample diagnosis might be “ineffective breathing patterns related to anxiety as manifested by dyspnea, nasal flaring, use of accessory muscles to breathe, and respiratory rate of 24/minute.” Some nurses use the phrase “as evidenced by” or “AEB” to preface to the list of defining characteristics.

**Prioritizing nursing diagnoses**

After diagnoses are identified, the nurse must put them in order of priority. Two common frameworks are used to establish priorities. One of these considers the relative danger to the patient.
With use of this framework, diagnoses that are life threatening are the nurse's first priority. Next are those that have the potential to cause harm or injury. Last in priority are those diagnoses that are related to the overall general health of the patient. Thus a diagnosis of “ineffective airway clearance” would be dealt with before “sleep pattern disturbance,” and “sleep pattern disturbance” could have priority over “knowledge deficit.”

Another framework used to prioritize diagnoses is Maslow’s (1970) hierarchy of needs (refer to Chapter 12, Figure 12-2). When this framework is used, there is an inverse relationship between high-priority nursing diagnoses and high-level needs. In other words, highest priority is given to diagnoses related to basic physiologic needs. Diagnoses related to higher-level needs such as love and belonging or self-esteem, although important, have priority only after basic physiologic needs are met.

Except in life-threatening situations, nurses should take care to involve patients in identifying priority diagnoses. Because varied sociocultural factors have a great impact on the manner in which patients prioritize problems, nurses must be aware of these factors and take them into consideration when planning patient care. The nurse's own cultural perspective must not take priority over that of the patient in determining priorities. For example, many maternity nurses are very strong proponents of breast-feeding and consider it one of their priorities in assisting new mothers to establish effective breast-feeding patterns. However, for some women, breast-feeding is not a cultural norm or a desirable outcome of new motherhood. Although it may be difficult to understand for the maternity nurse who has expertise in the benefits of breast-feeding, imposing the nurse's cultural and professional perspective on the patient is unacceptable and can lead to diminished effectiveness of nursing care in other domains in which the new mother needs assistance.

### Phase 3: Planning

Planning is the third phase in the nursing process. Planning begins with identification of patient goals and determination of ways to reach those goals. Goals are used by the patient and the nurse to guide the selection of interventions and to evaluate patient progress. Bloom's taxonomy (as described by Clark, 2001) (Box 8-6) provides a simple description of domains of learning that drive the development of patient goals: psychomotor, cognitive, and affective.

<table>
<thead>
<tr>
<th>Box 8-6  Bloom’s Taxonomy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Psychomotor domain:</strong> Involves physical movement and increasingly complex activities in the motor-skill arena. Learning in this domain can be assessed by measures such as distance, time, and speed.</td>
</tr>
<tr>
<td><strong>Nursing goal:</strong> Patient will move from bed to chair 3 times today without assistance.</td>
</tr>
<tr>
<td><strong>Cognitive domain:</strong> Involves knowledge and intellectual skills. Cognitive skills range from simple recall to complex tasks such as synthesis and evaluation.</td>
</tr>
<tr>
<td><strong>Nursing goal:</strong> Patient will list five signs of illness in her newborn infant by the date of hospital discharge.</td>
</tr>
<tr>
<td><strong>Affective domain:</strong> Involves the emotions, such as feelings, values, and attitudes.</td>
</tr>
<tr>
<td><strong>Nursing goal:</strong> Patient will describe feeling more accepting of new colostomy within 1 week of providing ostomy self-care.</td>
</tr>
</tbody>
</table>

Setting nursing goals using Bloom's taxonomy is a simple way to address three important domains of the patient's needs. A single patient is likely to have goals in each of these domains.
is incapacitated in some way. In that event, family members or significant others can collaborate with the nurse. Goals give the patient, family, significant others, and nurse direction and make them active partners.

**Writing patient goals and outcomes**

The terms *goal* and *objective* are frequently used interchangeably. Note that the word *objective* is used differently here than its earlier use, when it was used as an adjective describing observable and measurable data. In terms of outcomes, the word *objective* is a noun and means a goal or specific aim of intervention. Goals or objectives are statements of what is to be accomplished and are derived from the diagnoses. Because the problem or diagnosis is written as a patient problem, the goal should also be stated in terms of what the patient will do rather than what the nurse will do. The goal begins with the words “the patient will” or “the patient will be able to.” The goal sets a general direction, includes an action verb, and should be both attainable and realistic for the patient.

**Outcome criteria** are specific and make the goal measurable. Outcome criteria define the terms under which the goal is said to be met, partially met, or unmet. Each diagnosis has at least one patient goal, and each patient goal may have several outcome criteria. Effective outcome criteria state under what conditions, to what extent, and in what time frame the patient is to act. For the postoperative patient who had an abdominal procedure, a sample patient goal with outcome criteria might be, “The patient will have effective bowel elimination as evidenced by having one soft, formed stool every other day without the use of laxatives or enemas within 2 weeks.” It is easy to see that this goal is written in terms of what the patient will do (have a bowel movement at least every other day), is measurable (one soft, formed stool), gives conditions (without the use of laxatives or enemas), and has a specified time frame for accomplishment (2 weeks).

Establishing a time frame for patient goals to be met is important. **Short-term goals** may be attainable within hours or days. They are usually specific and are small steps leading to the achievement of broader, long-term goals. For example, “The patient will lose 2 pounds” is a short-term goal, and the time limit for accomplishment can be brief, perhaps a week or 10 days. **Long-term goals**, however, usually represent major changes or rehabilitation. A goal such as “The patient will lose 75 pounds” may take months or perhaps even years to accomplish, and the time frame should be set accordingly. Setting realistic goals in terms of both outcomes and time is extremely important. Frustration and discouragement can occur when goals are unrealistic in outcomes or time.

The nurse can be a good resource for helping patients in determining accessible goals. For example, assume that your patient is a young man with a severely injured thigh and knee from a single-car automobile accident. The injury will require several orthopedic surgeries. To complicate matters, he has a nosocomial (hospital-acquired) infection in his surgical site. One day, he mentions to you that his goal is to run a marathon within a year. Running a marathon is a worthy goal and is reachable eventually for this young man. However, as his nurse, you recognize the importance of setting some short-term goals right now that will improve his health and better the chances of achieving some short-term goals right now that will improve his health and better the chances of achieving his goal of running a marathon. Your care plan should reflect the short-term, attainable goals (such as walking with a walker the length of the hallway twice a day) that he needs to reach in the meantime that will move him toward his long-term, personal goal.

Cultural congruency is an important consideration in setting patient goals and selecting interventions. A culturally congruent intervention is one that is developed within the broad social, cultural, and demographic context of the patient’s life. The patient is more likely to benefit from an intervention that is tailored to his or her specific sociocultural needs and interests. Although cultural congruency is an important element to effective intervention, the nurse must take care not to stereotype patients or assume that “all ________” (fill in the blank) like the same things, will react the same way, or respond to the same intervention. The Cultural Considerations Challenge on p. 184
Cultural Considerations Challenge
Impact of Culture on Nursing Interventions

From the Association of Black Nursing Faculty website (http://www.abnf.net):

“The purpose of the Association of Black Nursing Faculty, Inc. (ABNF) is to form and maintain a group whereby Black professional nurses with similar credentials, interests and concerns may work to promote certain health-related issues and educational interests for the benefit of themselves and the Black community.”

An example of the interests and work that have developed from the ABNF is found in The ABNF Journal, published six times each year. Volume 17 (1) in 2006 was dedicated to the issue of breast cancer in African-American women. The research article “Getting Ready: Developing an Educational Intervention to Prepare African American Women for Breast Biopsy” describes the efforts to produce intervention materials for African-American women preparing to undergo breast biopsies. African-American women are more likely to die of breast cancer than are white American women, although fewer black women than white women have a diagnosis of breast cancer. This is a source of great concern in the African-American community and among researchers, who are trying to determine why this is the case. Theresa Swift-Scanlan, PhD, RN, whose research is highlighted in Chapter 11, is examining the epigenetics of breast cancer. It is her hope that this health disparity can be eliminated completely through research to determine why African-American women have a worse prognosis in breast cancer.

In the Implications section at the end of the article, the authors refer to the cultural appropriateness of study materials to be used in an intervention. As you read this article, consider these questions:
1. In addition to ethnicity, can you think of other ways that interventions should be made culturally appropriate?
2. What might happen if an intervention is not culturally appropriate?
3. Who determines what is and is not culturally appropriate?

You can find the article here:

Describes a research report explaining the importance of having culturally appropriate educational materials to prepare African American women for their breast biopsies.

Selecting interventions and writing nursing orders
After short-term and long-term goals are identified through collaboration between nurse and patient, the nurse writes nursing orders. Nursing orders are actions designed to assist the patient in achieving a stated goal. Every goal has specific nursing orders, which may be carried out by a registered nurse (RN) or delegated to other members of the nursing staff.

Nursing orders and medical orders differ. Nursing orders refer to interventions that are designed to treat the patient’s response to an illness or medical treatment, whereas medical orders are designed to treat the actual illness or disease. An example of a nursing order is “Teach turning, coughing, and deep-breathing exercises prior to surgery.” These activities are designed to prevent postoperative respiratory problems caused by immobility. They are appropriate nursing orders because prevention of complications due to immobility is a nursing responsibility. Nursing orders may include instructions about consultation with other health care providers, such as the dietitian, physical therapist, or pharmacist.

Types of nursing interventions. Nursing interventions are of three basic types: independent, dependent, or interdependent. Independent interventions are those for which the nurse’s...
intervention requires no supervision or direction by others. Nurses are expected to possess the knowledge and skills to carry out independent actions safely. An example of an independent nursing intervention is teaching a patient how to examine her breasts for lumps. The nurse practice act of each state usually specifies general types of independent nursing actions.

**Dependent interventions** do require instructions, written orders, or supervision of another health professional with prescriptive authority. These actions require knowledge and skills on the part of the nurse but may not be done without explicit directions. An example of a dependent nursing intervention is the administration of medications. Although a physician or advanced practice nurse must order medications in inpatient settings, it is the responsibility of the nurse to know how to administer them safely and to monitor their effectiveness. The nurse also must question orders that he or she feels are incongruent with safe care or are not within accepted standards of care.

The third type, **interdependent interventions**, includes actions in which the nurse must collaborate or consult with another health professional before carrying out the action. One example of this type of action is the nurse implementing orders that have been written by a physician in a protocol. **Protocols** define under what conditions and circumstances a nurse is allowed to treat the patient, as well as what treatments are permissible. They are used in situations in which nurses need to take immediate action without consulting with a physician, such as in an emergency department, a critical care unit, or a home setting.

**Writing the plan of care**

Once interventions are selected, a written plan of care is devised. Some health care agencies use individually developed plans of care for their patients. The nurse creates and develops a plan for each patient. Others use standardized plans of care that are based on common and recurring problems. The nurse then individualizes these standard plans of care. An advantage of using standardized plans is that they can decrease the time spent in generating a completely new plan each time a patient is seen. These plans are easily computer generated, with the nurse making selections from menus to individualize the plan to the particular patient. The amount of time needed to update and document these plans is then vastly decreased. Computer use also facilitates data collection for research.

Because of the decreasing average length of stay for patients in health care facilities, the increasing focus on achieving timely patient outcomes in the specific time frame permitted by reimbursement systems, and the emphasis by accrediting bodies on multidisciplinary care, many agencies adopted the use of multidisciplinary plans of care known as **critical paths**, care tracks, or care maps. Critical paths have been replaced with other types of multidisciplinary care plans in some settings. Multidisciplinary care plans are written in collaboration with physicians and other health care providers and establish a sequence of short-term daily outcomes that are easily measured. This type of care planning facilitates communication and collaboration among all members of the health care team. It also permits comparisons of outcomes between treatment plans, as well as among health care facilities. As with the nursing process, unyielding adherence to the critical path without taking a patient’s idiosyncratic responses into consideration can negatively affect patient outcomes and is a detriment to successful nursing care.

The development of appropriate plans of care depends on the nurse’s ability to employ critical thinking. Nurses must be able to analyze information and arguments, make reasoned decisions, recognize many viewpoints, and question and seek answers continuously. At the same time, nurses must be logical, flexible, and creative and take initiative while considering the holistic nature of each patient.

**Phase 4: Implementation of Planned Interventions**

Implementation, the fourth phase or operation of the nursing process, occurs when nursing orders are actually carried out. Most people think of
nursing as “doing something” for or to a patient. Notice, however, that in using the nursing process, nurses do a great deal of thinking, analyzing, and planning before the first actual nursing action takes place.

Professional nurses understand the crucial nature of the first three phases of the nursing process in ensuring that safe and appropriate care occurs. Nurses who forgo these essential phases and move immediately into action are not providing care in a responsible, professional manner. Patients feel a greater sense of trust in nurses who are providing care when dependent, independent, and interdependent orders are planned and carried out in an orderly, competent manner. Common nursing interventions include such actions as managing pain, preventing postoperative complications, educating patients, and performing procedures (such as wound care and catheter insertion) that are ordered by other health care providers. As the nurse carries out planned interventions, he or she is continually assessing the patient, noting responses to nursing interventions, and modifying the care plan or adding nursing diagnoses as needed. Documentation of nursing actions is an integral part of the implementation phase.

**Phase 5: Evaluation**

Evaluation is the final phase of the nursing process. In this phase, the nurse examines the patient’s progress in relation to the goals and outcome criteria to determine whether a problem is resolved, is in the process of being resolved, or is unresolved. In other words, the outcome criteria are the basis for evaluation of the goal. Evaluation may reveal that data, diagnosis, goals, and nursing interventions were all on target and that the problem is resolved.

Evaluation may also indicate a need for a change in the plan of care. Perhaps inadequate patient data were the basis for the plan, and further assessment has uncovered additional needs. The nursing diagnoses may have been incorrect or placed in the wrong order of priority. Patient goals may have been inappropriate or unattainable within the designated time frame. It is possible that nursing actions were incorrectly implemented.

Evaluation is a critical phase in the nursing process and one that is often slighted. The best nursing care plan is one that is evaluated frequently and changed in response to the patient’s condition. Sometimes a care plan will reflect all of the most common nursing interventions used to treat specific diagnoses; it is not enough, however, to continue to do the “right things” if the patient is not improving in the expected manner. If, on evaluation, the problem is not resolving in a timely way or will not resolve at all, the nursing care plan must be revised to reflect the necessary changes.

**DYNAMIC NATURE OF THE NURSING PROCESS**

Although the phases in the nursing process are discussed separately here, in practice they are not so clearly delineated nor do they always proceed from one to another in a linear fashion. The nursing process (Figure 8-3) is dynamic, meaning that nurses are continuously moving from one phase to another and then beginning the process again. Often a nurse performs two or more phases at the same time, for instance, observing a wound for signs of infection (assessment) while changing the dressing on the wound (intervention) and asking the patient the extent of care plan identification.

![Figure 8-3](image)

*Figure 8-3*  The nursing process is a dynamic, nonlinear tool for critical thinking about human responses.
to which pain has been relieved by comfort measures (evaluation).

Now that you have read about the phases of the nursing process, we will look back at the opening scenario. The problem that was identified was the necessity to wear appropriate clothing. Data, both objective (the temperature outdoors) and subjective (the mood one is in), were gathered. Selection was made and implemented, and an evaluation of the implementation was carried out by looking in the mirror. This comparison reveals that problem solving is something each person does every day. The use of the nursing process simply provides professional nurses with a patient-oriented framework with which to solve clinical problems.

An example of using the nursing process in a high-priority clinical situation is described in Box 8-7. This case study demonstrates how using the nursing process becomes so natural

### Box 8-7 Nursing Process Case Study of a High-Priority Diagnosis

You have just received a report from the day shift about Mr. Burkes. You were told that he had been admitted with a diagnosis of cancer of the tongue and that he had a radical neck dissection yesterday. He has a tracheostomy and requires frequent suctioning of his secretions. He is alert and responds by nodding his head or writing short notes.

When you enter his room, you note that he is apprehensive and tachypneic and is gesturing for you to come into the room. You auscultate his lungs and note coarse crackles and expiratory wheezes. You can see thick secretions bubbling out of his tracheostomy. He has poor cough effort.

On the basis of these data, you realize that a priority nursing diagnosis is ineffective airway clearance. You immediately prepare to perform tracheal suctioning. As you are suctioning, you watch the patient’s nonverbal responses and note that he is less apprehensive when the suctioning is completed. You also auscultate the lungs and note that there are decreased crackles and that the expiratory wheezes are no longer present. Mr. Burkes writes “I can breathe now” on his note pad.

I. Assessment
   A. Subjective data
      1. None because of inability to speak
   B. Objective data
      1. Tracheostomy with copious, thick secretions
      2. Tachypnea
      3. Gesturing for help
      4. Coarse crackles and expiratory wheezes
      5. Poor cough effort

II. Analysis
   A. Ineffective airway clearance related to copious, thick secretions

III. Plan
   A. Short-term goal: Patient will maintain patent airway as evidenced by absence of expiratory wheezes and crackles, decreased signs of anxiety and air hunger.
   B. Long-term goal: Patient will have patent airway as evidenced by his ability to clear the airway without the use of suctioning by the time of discharge.

IV. Implementation
   A. Assess lung sounds every hour for crackles and wheezes.
   B. Suction airway as needed.
   C. Elevate head of bed to 45 degrees.
   D. Teach patient abdominal breathing techniques.
   E. Encourage patient to cough out secretions.

V. Evaluation
   A. Short-term goal: Achieved as evidenced by decreased crackles and absent wheezes when auscultating the lungs; patient appears less anxious, indicated by writing that he “can breathe now”
   B. Long-term goal: Will be evaluated before discharge
that experienced nurses go through the phases fluidly and automatically. Although no responsible nurse would take the time to write out this care plan in advance of acting on a diagnosis of “ineffective airway clearance,” you should understand that the nursing process is exactly the same for those high-priority nursing situations that require immediate action and those that will evolve over time.

**DEVELOPING CLINICAL JUDGMENT IN NURSING**

Becoming an effective nurse involves more than critical thinking and the ability to use the nursing process. It depends heavily on developing excellent clinical judgment. Clinical judgment consists of informed opinions and decisions based on empirical knowledge and experience. Nurses develop clinical judgment gradually as they gain a broader, deeper knowledge base and clinical experience. Extensive direct patient contact is the best means of developing clinical judgment.

Critical thinking and clinical reasoning used in the nursing process are both important aspects of clinical judgment. A nurse who has developed sound clinical judgment knows what to look for (e.g., elevation of temperature in a surgical patient), draws valid conclusions about possible alternative meanings of signs and symptoms (e.g., postoperative infection, atelectasis, dehydration), and knows what to do about it (e.g., listen to breath sounds, assess for dehydration, check incision for redness and drainage, seek another opinion, notify the physician). Developing sound clinical judgment requires recalling facts, recognizing patterns in patient behaviors, putting facts and observations together to form a meaningful whole, and acting on the resulting information in an appropriate way.

Knowing the limitations of your expertise is an important aspect of clinical judgment. Most nurses have an instinctive awareness of when they are approaching the limits of their expertise and will seek consultation with other professionals as needed. Your state’s nurse practice act, health agency policies, school policies, and the professions’ standards of practice all provide guidance in making the decision about nursing actions within your scope of practice. Nursing students, whether new to nursing or RNs in baccalaureate programs, must consider policies and standards in determining their scope of practice in any given nursing situation.

**Box 8-8  Clinical Judgment: Nine Key Questions**

1. **What major outcomes (observable beneficial results) do we expect to see in this particular person, family, or group when the plan of care is terminated?** Example: The person will be discharged without complications, able to care for himself, 3 days after surgery. Outcomes may be addressed on a standard plan, or you may have to develop these outcomes yourself. Make sure any predetermined outcomes in standard plans are appropriate to your patient’s specific situation.

2. **What problems or issues must be addressed to achieve the major outcomes?** Answering this question will help you prioritize. You may have a long list of actual or potential health problems needing to be structured to set your priorities.

3. **What are the circumstances?** Who is involved (e.g., child, adult, group)? How urgent are the problems (e.g., life threatening, chronic)? What are the factors influencing their presentation (e.g., when, where, and how did the problems develop)? What are the patient’s values, beliefs, and cultural influences?

4. **What knowledge is required?** You must know problem-specific facts (e.g., how problems usually present, how they are diagnosed, what their common causes and risk factors
Alfaro-LeFevre (1999) developed a list of nine key questions (Box 8-8) to consider as you seek to improve your clinical judgment. Because the goal of nursing is to provide the best care to patients based on research and clinical evidence, the development of excellent clinical judgment is a professional responsibility. As you work to gain clinical experience and improve your own clinical judgment, these questions will help focus your thinking.

Nurses are responsible for developing sound clinical judgment and are accountable for their decisions and nursing practice that arises from those decisions. Your current level of clinical judgment can always be improved. It would be wise for you to devise a personal plan for improving your own clinical decision making. Working thoughtfully through the self-assessment in Box 8-9 will help you begin.
Chapter 8  Critical Thinking, the Nursing Process, and Clinical Judgment

Box 8-9  Self-Assessment: Developing Sound Clinical Judgment

Answer the following questions honestly. When finished, make a list of the items you need to work on in your quest to develop sound clinical judgment. Keep the list with you and review it frequently. Seek opportunities to practice needed activities.

1. Use references.
   • Do I look up new terms when I encounter them to make them part of my vocabulary?
   • Do I familiarize myself with normal findings so that I can recognize those outside the norm?
   • Do I use research findings and base my practice on scientific evidence?
   • Do I learn the signs and symptoms of various conditions, what causes them, and how they are managed?

2. Use the nursing process.
   • Do I always assess before acting, stay focused on outcomes, and make changes as needed?
   • Do I always base my judgments on fact, not emotion or hearsay?

3. Assess systematically.
   • Do I have a systematic approach to assessing patients to decrease the likelihood that I will overlook important data?

4. Set priorities systematically.
   • Do I evaluate both the problem and the probable cause before acting?
   • Am I willing to obtain assistance from a more knowledgeable source when indicated?

5. Refuse to act without knowledge.
   • Do I refuse to perform an action when I do not know the indication, why it works, and what risks there are for harm to this particular patient?

6. Use resources wisely.
   • Do I look for opportunities to learn from others, such as teachers, other experts, or even my peers?
   • Do I seek help when needed, being mindful of patient privacy issues?

   • Do I read facility policies, professional standards, school policies, and state board of nursing rules and regulations to determine my scope of practice?
   • Do I know the clinical agency’s policies and procedures affecting my particular patients?
   • Do I attempt to understand the rationales behind policies and procedures?
   • Do I follow policies and procedures carefully, recognizing that they are designed to help me use good judgment?

8. Know technology and equipment.
   • Do I routinely learn how to use patient technology such as intravenous pumps, patient monitors, computers?
   • Do I learn how to check equipment for proper functioning and safety?

   • Do I always remember the needs and feelings of the patient, family, and significant others?
   • Do I value knowing my patients’ health beliefs and values within their own cultural contexts?
   • Do I “go the extra mile” for patients?
   • Do I demonstrate the belief that every patient deserves my very best efforts?

Summary of Key Points

• Critical thinking is a skill that can be learned. In nursing, critical thinking is a purposeful, disciplined, active process that improves clinical judgment and thereby improves patient care.

• Thinking by novice nurses is different from that of expert nurses in identifiable ways.

• The nursing process is a systematic problem-solving framework that ensures that care is developed in an organized, analytic way.

• The phases of the nursing process are assessment, analysis and diagnosis, planning, implementation, and evaluation.

• Properly used, the nursing process is cyclic and dynamic rather than rigid and linear.

• Nurses may initially find that using the nursing process feels awkward or slow. With experience, however, most find it becomes a natural, organized approach to patient care.

• Consistent, comprehensive, and coordinated patient care results when all nurses use the nursing process effectively.

• Through the use of the nursing process, nurses are able to work toward resolving patient problems in a systematic and thorough manner, thus advancing both the scientific basis of nursing and professionalism.

• Sound clinical judgment is created by using critical thinking, applying the nursing process, staying current with developments in practice and research, understanding your scope of practice, and acquiring substantial clinical experience.

Critical Thinking Questions

1. Describe the characteristics of critical thinkers and explain why critical thinking is important in nursing.

2. List at least four ways in which novice thinking and expert thinking differ and give an example that illustrates each.

3. Describe the phases in the nursing process and explain the activities of each phase.

4. List a short-term career goal for yourself and a long-term career goal using all the essential elements of effective goals. Evaluate your progress toward these goals.

5. Explain the difference between independent, dependent, and interdependent nursing interventions and give an example of each.

6. List the pros and cons related to the use of nursing diagnosis.

7. Explain the difference between medical and nursing diagnoses.

8. Describe what is meant by the statement, “The nursing process is a cyclic process.”

9. Using what you learned about yourself from Self-Assessment: Developing Sound Clinical Judgment (Box 8-9), set short-term goals for improvement in each of the nine areas. Make a checklist to take to your next clinical experience and consciously work on improving your clinical judgment.

Evolve To enhance your understanding of this chapter, try the Student Exercises on the Evolve site at http://evolve.elsevier.com/Chitty/professional.

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