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NURSING PROCESS: A TOOL FOR PROFICIENCY IN NURSING PRACTICE AND QUALITY NURSING CARE

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ABSTRACT

The topic of the seminar is Nursing Process: A tool for proficiency in nursing practice and quality nursing care. The nursing process is a systematic, patient-centered approach that serves a foundational framework for nursing practice. This seminar aims to explore the significance of the nursing process in enhancing nursing proficiency and ensuring high-quality patient care. By examining the five key stages of the nursing process-Assessment, diagnosis, planning, implementation and evaluation. We will highlight how each phase con tribute to the overall effectiveness of nursing interventions and patient outcomes. Through combination of theoretical insight and practical case studies, participants will gain a deeper understanding of how the nursing process fosters critical thinking, promotes evidence-based practice and encourage collaborative care among healthcare teams. Additionally. we will discuss the challenges nurses face in implementing the nursing process in diverse clinical settings and explore strategies to overcome these barriers. By the end of the seminar, the attendees will be equipped with the knowledge and skills to apply the Nursing process more effectively in their practice, ultimately leading to improved patient satisfaction and safety. This session is designed for nursing professionals at all levels who are committed to advancing their practice and enhancing the quality of care they provide.

***KEYWORDS**: Nursing Process, Clinical Proficiency, Quality Care, Patient-Centered Practice, Evidence-Based Nursing.*

INTRODUCTION

In the past nursing practice was based on common sense, and experiences from older nurses (example Florence Nightingale). Today nurses are held responsible for safe effective care that reflects the standard for nursing practice. Nursing as a profession became concerned with the clients' total need and made concerted effort to develop a more systematic and rational pattern for the practice of nursing. Nursing process is the fruit of all these efforts and it has been adopted as the frame of reference for nursing practice. (American Nurses Association, 2021). The nursing process is a systematic method used by nurses to provide patient care. It involves a series of steps that guide nurses in assessing, diagnosing, planning, implementing and evaluating patient care. Different authors and nursing theorists have defined the nursing process in varies ways, emphasize its importance in delivery effective nursing care. Here are some definitions from notable authors (Marrier 2020) According to Henderson (1966) as cited in Merrier (2020) defined the nursing process as a method that helps nurses to identify the needs of the patients and to assist them in achieving independence in meeting those needs. She emphasized the importance of understanding the patient as a whole and the role of the nurse in facilitating health and well-being.

Abdellah (2023) described the nursing process as a problem-solving approach that focuses on patients' needs. She emphasized the importance of assessing the patient's problem and planning care that is tailored to those needs, which aligns with her 21 nursing problems theory. Orem (2024) In her self-care deficit theory highlights the nursing process as a means to help patients meet their self-care needs. She defined the NP as a framework for assessing the patient's ability to perform self-care and for planning, interventions that promote self-sufficiency. Watson (2023). Watson 's theory of Human caring emphasizes the relational aspect of the NP. She defined it as a holistic approach that considers the emotional, spiritual and physical needs of the patient, focusing on the caring relationship between the nurse and the patient. Benne (2024) In her work, described the NP as way to develop clinical judgment and expertise. She emphasized the importance of experiential learning and the role of the nursing process in guiding nurses

from novice to expert levels of practice. Parker (2022) defined the nursing process as a systematic, rational method of planning and providing individualized nursing care. She highlighted the importance of critical thinking and evidence-based practice in each step of the nursing process.

Nursing and Midwifery Council [NMC] (2024) in United Kingdom defines the nursing process as a framework that guides nurses in assessing patients, planning care, implementing interventions and evaluating outcomes. This definition emphasizes the importance of a structured approach to ensure safe and effective care. Various nursing textbooks and educational materials began to standardize the NP into the five steps: Assessment, Diagnosis, Planning, Implementation, and Evaluation. These authors and their contributions have played significant roles in shaping the nursing process as a fundamental framework for nursing practice. These definitions reflect the evolution of the nursing process and its significance in providing patient-centered care. Each author brings a unique perspective, but all emphasis the importance of systematic assessment, individualized care and the nurse's role in promoting health and well-(NMC 2024).

Importance of Nursing Practice

Nursing process is a critical component of the healthcare system, playing a vital role in promoting health, preventing illness and providing care to individuals across the lifespan. Wilkinson (2020). In his work highlighted the following important points which include;

Patient care and Advocacy: Nurses are often the primary caregivers for patient, providing direct care, emotional support and education. They advocate for patients needs and preferences, ensuring that voices are heard in the healthcare process.

Holistic Approach: Nursing process emphasizes a holistic approach to patient care, addressing not only physical health but also emotional, social and spiritual well-being. This comprehensive perspective helps in delivery more effective and personalized care (NMC, 2024).

Health promotion and disease prevention: Nurses play a crucial role in health education and promotion, helping patients understand their health conditions and encouraging health lifestyle choices. They are instrumental in disease prevention through vaccinations, screenings, and health education initiatives.

Collaboration and Teamwork: Nurses work collaboratively with other healthcare professionals, including physicians' therapists and social workers to provide co-ordinate care. This teamwork in essential for improving patient outcomes and ensuring comprehensive care. (Alfaro-Lefevre2025).

Critical Thinking and Decision-Making: Nursing process requires strong critical thinking and clinical judgment skills. Nurses assess patient conditions, into practice data and make informed decisions about care plans, often in high-pressure situations (Wilkinson 2020).

Research and evidence-based practices: Nurses contribute to the advancement of healthcare through research and the applications of evidence-based practices. This commitment to ongoing learning and improvement helps to enhance the quality of care provided to patients.

Cultural competence: Nurses often work with diverse populations and must be culturally competent to provide effective care understanding and respecting cultures difference can improve patient trust and satisfaction.

Emotional support and counseling: Nurses provide essential emotional support to patients and their families during difficult times such as illness, injury or end-of-life care. Then presence can significantly impact patients' emotional well-being.

Leadership and Management: Many nurses take on leadership roles within healthcare settings, influencing, policy improving practice and monitoring new nurses. Their leadership is vital for fostering a positive, work environment and improving patient care.

Adaptability and Residence: The healthcare landscape in constantly changing and nurses must be adaptable and resilient. They are often at the forefront of responding to public health crises, such as pandemics and play a lay role in emergency preparedness and response.

Finally, nursing process is essential for delivery high-quality healthcare, improving patient outcomes, and enhancing the overall health of communities. The multifaceted role of nurses underscores their importance in the healthcare system and society as a whole.

Link between Nursing Process, Proficiency and Quality care.

The nursing process, proficiency and quality care are inter-connected concepts that play a crucial role in delivery effective healthcare. (Benner 2023) She explained how they are linked:

Nursing process. The nursing process is a systematic patient-centered approach used by nurses to ensure comprehensive care. It consists of five key steps:

- Assessment: Gathering comprehensive data about the patient's health status.
- Diagnosis: Analyzing the assessment data to identify patient problems.
- Planning: Developing a plan of care that outlines strategies to address the identified problem.

- Implementation: Executing the plan of care through interventions
- Evaluation: Assessing the effectiveness of the intervention and modifying the plan as necessary.

Proficiency: Proficiency in nursing refers to the skills, knowledge and competencies that nurses develop through education, training and experience. Proficient nurses are able to:

- Apply critical thinking and clinical judgment in various situations.
- Utilize evidence-based practices to inform their care
- Communicate effectively with patients and other healthcare professionals
- Adapt to changing patient needs and healthcare environments.

Quality care: Quality care is defined as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes. It encompasses several dimensions include:

- Safety: Avoiding harm to patients.
- Effectiveness: Providing services based on scientific knowledge to all who could benefit.
- Patient-centeredness: Respecting responding to individual patient preferences needs a value.
- Timeliness: Reducing waits and harmful delays for both those who receive and those who give care.
- Efficiency: Avoiding waste, including waste of equipment, supplies ideas and energy Wilkinson further explained the links between the concepts as thus;
- Systematic Approach; The NP provides a structured framework that guides nurses in delivery care. This systematic approach is essential for ensuring that care is thorough, organized and focused on patient needs, which directly contributed to quality care

HISTORICAL BACKGROUND REGARDING NURSING PROCESS

The nursing process is a systematic method used by nurses to provide patient care. It is a critical thinking framework that guides nurses in assessing diagnosing, planning, implementation and evaluating patient care. The historical background of the nursing process can be tracked through several key developments in nursing education and practice. Early foundations, Florence Nightingale (1820-1910) often considered the founder of modern nursing, Nightingale emphasizes the importance of a systematic approach to patient care. Her work during the Crimean war lighted the need for sanitation, proper nutrition, and the environment's role in patient recovery. While she did not formalize the nursing process, her principles laid the groundwork for future nursing practice. (Ackley *et al.*, 2020). Nightingale, Notes on Nursing (1895), in this seminal work, Nightingale outlined the importance of observation and assessment in nursing. She advocated for a holistic approach to patient care which includes understanding the patient's environment and needs (Carpenito, Moyet, Lynda, 2020). In 1940s – 1950s Nursing process begin to develops. The nursing process began to take shape as a formalized method. During this time, nursing educators and practitioners started to recognize the need for a structured approach to nursing care. The American Nurses Association (ANA) began to promote the idea of a systematic method for nursing practice.

In 1960s, the nursing process was further refined and defined by various nursing theorists and educators. The ANA published the first official definitions of the nursing process, which included five steps assessment, diagnosis, planning, implementation and evaluation. This frame work became widely adopted in nursing education and practice (Carpenito, 2020). In 1970s-1980s, the NP gained recognition as a standard practice in nursing. Nursing schools began to incorporate the NP into their curricula, and it became a fundamental component of nursing practice. The process was also integrated into nursing documentation and care planning. In 1980s to the present, the nursing process has continued to evolve, with an increasing emphasis on evidence-based practice, patient-centered care and interdisciplinary collaboration. The NP is now recognized as a critical component of nursing practice worldwide (Manson and Attress 2022). And it is used to ensure high-quality, individualized patient care.

The nursing process has a rich historical background that reflects the evaluation of nursing as a profession from its early foundation in the work of Florence Nightingale to its current status as a standardized framework for nursing practice. The nursing process has become an essential tool for nurses in delivery effective and compassionate care. It emphasizes critical thinking, systematic assessment, and the importance of evaluating outcomes, ensuring that nursing care in both effective and responsive to patient needs. By integrating those theoretical frameworks, nurses can enhance their critical thinking decision-making and overall effectiveness in patient care (Wilkinson, 2020).

STEPS IN NURSING PROCESS

McClain (2022) stated that Yara and Walsh in (1967) was the first to identify the steps of Nursing process as: Assessment, planning, implementation, and evaluation. Since then, nursing has undergone many changes. Advances in standard of care, quality assurance programming, nursing audit and revision of the Nursing Practice Acts have impacted on the nursing process, And because of the importance of nursing diagnosis to the planning and implementation of care. nursing diagnosis, was formerly an aspect of assessment, was carved out to become a step on its own. (Wilkinson, 2020). The steps or components of nursing process are now assessment, nursing diagnosis, planning, implementation and evaluation.

Nursing Assessment: According to McClain (2022) defined Nursing Assessment as a logical and systematic

and ordered collection of data used to evaluate the health status of the client in order to identify problem of body-mind-spirit Wayne (2023) affirmed nursing assessment is the orderly collection of information concerning the patient's health status and that it is aimed at identifying patient's current health status, actual and potential health problems and areas for health promotion. From the above definition, assessment provides the baseline data for formulating nursing diagnoses and planning the care, it is a continuous process. A comprehensive holistic assessment provides information that enables the nurse to deliver quality patient care. Assessment establishes the foundation for comparison and the basis for interpreting future observation plan and evaluation. The purpose of nursing assessment is to get a total picture of the patient and how the patient can be helped.

The Basic Phases of Nursing Process

In assessment phase, the nurse will collect, organize, validate, and record data about the patients present health status. The nurse obtains data by examining the patient and talking to the patient and their families. The nurse also reads charts and records. The findings from the initial ongoing assessment assist nurses in making decisions about whether to alter, expand or discontinue the current treatment plan (Wayne, 2023). Assessment demands that nurses have an insight into human behavior relationships, developmental processes and reaction to stressors and be sensitive and open to human interactions, learn new techniques approaches and procedures that would make assessment accurate and beneficial (Bellack and Moshel, 2020) After carrying out the components of the assessment; it is necessary to document all the findings. It is only when assessment is comprehensive and relevant that appropriate diagnosis are made and effective care plan is drawn.

Overview of assessment phase

1. Collect data

Interview
Observation
Physical Examination

2. Validate data with client and significant others

Compare subjective with objective data
Validate conflicting data

3. Organize and record Data

Initial assessment: use printed form (admission database) ongoing or nursing progress note Special purpose assessment perform as needed.

Even though the steps of nursing process are discussed separately to help to understand them, they are actually interrelated and over lapping. This is especially true of the assessment phase. Assessment data must be accurate and complete because they form the basis for decisions making in the remaining steps of the nursing process.

The usefulness and validity of the nursing diagnoses depend greatly on thorough accurate data collection. In planning, the nurse uses patient data to decide which goals are realistic and which nursing orders will be most effective. In effect, assessment is a continuous process carried out during all phases of the nursing process. For instance, one may begin to formulate a tentative problem in the mind (diagnosis phase) while still collecting data. Assessment overlaps with implementing and evaluation in that one will continue to collect patient data while carrying out these steps. Again, Assessment is not merely writing information on the assessment form. It needs critical thinking skills and a good knowledge based on which assessment to make, how much information is needed and where and how to get that information. (Wilkinson 2020). When performing assessment, one has to apply the principles and theories about basic human needs, anatomy and physiology, disease process, human growth and development, human behavior, socioeconomic patterns and trends and various cultures and religion.

The nurse must make reliable observations, distinguish relevant and important data from irrelevant and unimportant data and recognize when information is missing. All of this requires critical thinking as does organizing and categorize data in a useful manner (Wilkinson, 2023).

In clinical practice, critical thinking requires reflection and the core questions for reflection more deeply, asking questions as:

- Who is this person?
- What is this person's story?(example what health event caused the person to seek care)
- How has the person's life been changed by this illness/events?
- Who and what are this person's support? How is this person feeling?

Collecting Data

Is the process of gathering information about clients, family or community health status. For these to be effective, one should develop data collecting skills. (Bellack and Meschel 2020) The data should also have the following qualities such as:

1. **Clarity**; A statement must be clear in order to know whether it is accurate, relevant.
2. **Accuracy**: statement can be clear, but not accurate for instance if blood pressure is difficult to hear, ask for another nurse to check it.
3. **Precision**: a statement can be clear, accurate, and precise, but not relevant to the issue. For instance, appearance of is relevant and data about patient mobility and nutrition. It is irrelevant that's the patient is coughing.

4 Depth: statements can be clear, accurate, precise, un relevant superficial. Data that would shed some light On the problems.

5 Breath: A line of reasoning can meet all other standards but one-sided.
6 Logic: Reasoning brings various thoughts together and some kind of o order. When they thoughts, make sense in combination, thinking is logical.

7 Significance: related to relevance. What is most important?

Data can be subjective and objective
Table 1.

	subjective	**objective**
Description	covert data: symptoms. What's the patient says. Can be perceived and verified only by the patient.	**Overt data:** can be observed by others or measured against a standard.
Examples	- itching - pain - anxiety - afraid - weak all over.	- pulse rate 100 bpm - Blood pressure 120|80mmHg - skin pale and cool to touch - x-ray results - skin turgors - postures.

Example of subjective and objective Data
When used in process, the terms subjective and objective have the special meanings. Subjective does not suggest bias information or personal interpretation of meaning as it does in common use and objective does not necessary carry the meaning of impartial.

At times, it is difficult to obtain subjective data. Kozier et a(2019) in Wilkinson (2023) suggested that Nursing action to use when it is difficult to obtain subjective data include.

Table 2.

Contributing factors	**Symptoms**	**Nursing activities**
Language barrier (example not fluent in English)	unable to communicate information clearly	use simple, clear, language, obtain, an interprets.
Severe illness or pain	short response, patient's main concern is to obtain relief, impatient with questioning	.provide needed interventions (e.g. gives pain medication) before interviewing ask closed questions obtain only essential data. Ask family or friends.
Anxiety	rapid in coherent, speech, distorted or inaccurate information.	Speak slowly and quietly to the person. Emphasize that you need accurate information to give appropriate help.
Fears of incapacitating effect of illness	denying setting symptoms or deliberately given misleading facts.	explore discrepancies between client statements and physical finance or data from other source
Limited mental capacity	may give inaccurate unreliable information	encourage client to provide as much information as possible, then use secondary sources to fill in gaps and validate data.
Previous negative experience with healthcare professionals, lack of trust	reluctant to provide data. Believes it won't help me anyway. It didn't do any good before.	Acknowledge previous experience and the imperfection of health professionals. Request another chance to help. Demonstrates competence convey respect for client's thoughts and feelings

Nursing action to use when it is difficult to obtain subjective data

Primary and secondary data source
Data source falls into two broad categories: primary and secondary. The nurse should use the most reliable source of data whether it is the patient or is significant others and the nose should indicate the source on the patient's record.

Table 3.

	primary	secondary
Description	Subjective ore objective data obtained directly from the patient.	Information about the patient obtained from family and friends. verbal report from health care professional, information from patients record.
Examples	- patient statement of pain -patient statement of anxiety - pulse rate - Skin color - posture	Statement from records (e.g. x-ray result, nurse's note that 'client refused dinner') Verbal report from care givers (e.g. "needed pain medication at 8am") Family statement "he has been in pain all day"

PRIMARY AND SECONDARY DATA SOURCES

In fact, the initial (admission) assessment is also called database assessment. The complete database consists of the nursing history and physical examination and data from the patient record, consultation and also review of the literature.

Ongoing assessment: this consists of data gathered after the data is completed. Ideally during every nurse-patient interaction. These data are used to identify new problems and evaluate the status of the problems that have already been identified.

Focus assessment: the gather data about an actual, potential or possible problem that has been identified. The assessment focuses on a specific topic or particular area of the body instead of the client's overall health status. The data from assessments are used to evaluate the status of existing problem and identify new problems. (Wilkinson, 2023).

Use of Computer In Assessment

Many healthcare institutions use computerized information systems to facilitate data collection. In some automated assessment systems, patients respond directly to interview questions on the computer screen. In other system, the nurse interviews the patient and enters the data into a bedside terminal. Nurses may also use bedside terminals to prompt them through a systematic and complete physical examination of a patient (Nadia *et al*, 2025).

In addition, these are also a variety of monitors that can be programmed to make continuous or periodic patient assessment. Examples are digital thermometers, digital scales, pulse oximeters, electrocardiogram, telemetry, hemodynamic monitors, apnea monitors, fetal health monitors, and blood glucose analyses. Most of these instruments keep a record of the most recent value. Some can transmit the data to a more sophisticated computer or print out a paper record. some computers have digital display that's" talk" to the users, given them instructions or results. most have alarms to indicate either that the instruments is malfunctioning or that the assessed value is outside predetermined parameters. These devices, with their tiny but powerful computers clips, make it possible to extend the nurse's observation and provide valid and reliable data (Kozier *et al*, 2020).

Validating the data; Broughton (2020) defined validation as an act of "double-clicking" or verifying data. Critical thinkers, validate data in order to:

- Ensure that assessment information is complete, accurate and factual
- Eliminate their biases, arrows and misperception of the data.
- avoid jumping to faulty conclusions about the data

After data about client have been collected through history taken, physical examination, review of relevant record and report and diagnosis and laboratory investigation the north and analyses them and inferences based on them. Inferences that are related are clustered and grouped, and given a name, which is termed the nursing diagnosis. All information is recorded and sorted (Broughton 2020) Excellent record keeping us fundamental so that all the data gathered is documented and explained in a way that is accessible to the whole health team and can be referenced during evaluation.

Nursing Diagnosis: NANDA (2019**)** as cited in Ighani (2023) defined nursing process as a clinical judgment concerning a human response to health condition/life processes or a vulnerability for that response, by an individual, family, group or community**.** This is the second phase of nursing process. Nurses use diagnostic reasoning to analyze data and conclusion about the client's health status. They verify this conclusion with the client, select standardized, labels, and record them on the care plan. This step of nursing process is interdependent and overlapping. Diagnosis is a pivoted step, all activities preceding the steps are directed towards formulating the nursing diagnosis.

All care planning activities following this step are based on the nursing diagnosis. Diagnosis depends on the assessment phase because the quality of the data acquired during assessment affect the accuracy of the nursing diagnosis, the two stages overlap. Diagnoses also affect the planning, implementation, and evaluation steps. When specifically, and accurately stated, the problem and strength identified during diagnosis guide the nurse in developing appropriate groups and nursing orders for the care plan (planning). The diagnosis is an implementation phase sometimes or call almost simultaneously (Ighani, 2023). For example, in an emergency situation, a nurse may take actions (implementation), as soon as the urgent problem is

recognized, before consciously planning or identifying the rest of the problem or even before completely assessing the patient. Diagnosis also overlaps with evaluation phase. During evaluation, the nurse determines whether the patient's health status has changed. If not, Nursing diagnosis are examining to be sure, they were diagnosed correctly and completely. (Ighani, 2023.)

Historical perspective of nursing diagnosis

The term diagnosis first appeared in the nursing literature in the early 1950s to describe the functions of a professional nurse, but was not wildly recognized until the 1970s. Carpenito (2020) stated that Fry in 1953 introduced the term nursing diagnosis to describe a step necessary in developing nursing care plan and that for over 20 years, references to nursing diagnosis appeared only sporadically in literature. In 1973 the first conference on nursing diagnosis was held to utilize nursing knowledge and establish a classification system suitable for computerization Subsequently, national conferences involving practitioners; educators, researchers and theorists were held biannually (Carpenito, 2020). The goal of the conferences has been to develop a standard nomenclature for describing health problems, amenable to treatment by nurses and also to develop a theoretical framework for classifying and organizing nursing diagnosis according to category set. A National task force group form to carry on the work between the biannual conferences adopted the name North American Nursing Diagnosis Association (NANDA) in 1982. The group took the responsibility for formulation, classification and accepting nursing diagnosis and testing them clinically (Carpenito, 2020).

During the clinical test, nursing diagnosis are used in actual clinical practice to refine them, they are related factors and their defining characteristics. Ideally, this should lead to the prescription of nursing intervention and projected outcome for each nursing diagnosis. It is important in using the accepted List of nursing diagnosis, the nurse must be careful not to lose sight of the individual needs and the uniqueness of each patient. To be useful, the nurse and diagnosis and its implied intervention and outcomes must be modified and adopted to fit each patient and family. (Carpenito 2020).

Definition of Nursing Diagnosis

Since 1973, when the first meeting of the national group for classification of noting that diagnosis was held, nursing diagnosis has gained a lot of attention in literature and various definitions of nursing diagnosis have emerged. Carpenito (2020) noted that at the 12th conference of NANDA in 2010 the general assembly approved, an official definition of nursing diagnosis as: clinical judgment about an individual, family or community responses to actual or potential health problems / life process. Nursing diagnosis provides the basis for selection of nursing interventions to achieve outcome for which the nurse is accountable (Carpenito, 2020).

From the above definition, the nursing diagnosis can simply be said to be ' a conclusive statement based on the analysis, and interpretation of systematically, collected data, describing the Actual potential health problem, or the patient's respond to these for which professional nurses is qualified and licensed to intervene(Carpenito 2020). Nursing diagnosis is not the same as medical diagnosis. Their differences derive from difference in the model that guides their practice. Medicine traditionally is involved with the pathology, diagnoses and cure of diseases. That is, most medical specialties have been involved primarily with the physical or biological aspect of patient care. As a result, medical diagnosis is involved with identifying the etiology of disease and treatment is directed towards this etiology. In contrast, practice is guided by a holistic model that reflects the inter-relationship of body – mind-spirit and focuses on maintaining, regaining and promoting health (Wilkinson, 2023).

Process of making accurate nursing diagnosis

Diagnosis is formulated after the assessment data analysis, and these, according to Wilkinson (2020) and Kozier et al (2000) Nursing diagnosis consist of four activities, which include;

- Collecting data
- Interpreting data
- Clustering information
- Naming the cluster

These activities do occur in a continuous, overlapping and ongoing fashion. The nurse may be interpreting and clustering information while additional data is being gathered.

From the above activities**, data collections** have been done in assessment phase. These data have to be analyzed and meaning derived from them. Interpretation takes place through a memory search for previous knowledge that helped to define a problem. It involves a analytical reasoning after which references are drawn. An inference is based on all available data, and in addition, clinical judgment that the nurse makes after carefully studying the meaning of the data collected. Thus **interpretation** is a reasoning process based on theoretical knowledge of the nurse and clinical judgment t(Wilkinson and Kozier *et al*,2020).

Cluster of information: during the interpretation process, each clinical data that was collected during assessment is seen as a cue. Similar cues are grouped (clustered) to make the inference. When many cues are considered before making an inference, it is more likely that (accurate inference will be made (Korzier *et al*, 2020). Name the cluster: after the cues have been clustered, the name that unites all of them (that is the inference) is given to the cluster, for example, if a patient reports with

a history of a vomiting for two days, following ingestion of vegetable salad, and rice at a party, physical examination, the nurse find that the eyes are sunken, the lips and skin are dry, and there is loss of skin tugor. [collecting data) and the nurse is to manage the patient. Considering the data, the nurse find that vomiting, sunken eyes, dry lips and skin, loss of skin tugor are identified as cues (interpretation of data) (Wilkinson 2020). These cues are related because each of them can either lead to or be a result of loss of fluid from the body, and therefore can be grouped together (clustering of information). A nurse that unifies all these cues, that is "fluid volume deficit" is giving to the cluster (naming the cluster). The NANDA diagnostic label should be used. (NANDA2024)**.** The thought process that the nurse uses in making inferences may be based on inductive and deductive reasoning. With deductive inference, the thought process moves from specific in general, that is, generation is developed from a set of observations or facts. With deductive reasoning, the thought process moves in the opposite direction that is, from general to specific by anticipating what will likely happen knowledge of general pattern (Wilkinson, 2020).

Validation of inference

After inference have been formulated, the nurse should try to validate them so as to establish your correct us. The outcome of the validation may be confirmation of the accuracy of the inference as recognition of error. Whenever possible, patient should serve as a primary source of validation. For example, from the behavior of the patient and what, he had said, the nurse can infer anxiety (Kozier *et al*, 2020). To validate these, the nurse can voice this inference to the patient by saying that the patient is anxious about thing. The will either confirm or refute the inference. Occasionally an inference may need to be confirmed using some diagnostic tools. For example, an inference of pyrexia can be validated by measuring the patient's temperature. Validation can also be achieved with the help of colleagues and other health professionals. Examples, a nurse may infer that a post-partum patient is depressed basing the inference on some observed cues If other nurses and physicians agree on the inference, their consensus will add credence to the inference (Carpenito 2020).

Another means of validating an inference is through reference to an authoritative source, that is reading up about the particular thing in literature or by discussing it with somebody who is well known authority in that particular subject. Validation of inference is important so as to avoid using invalid inference to plan the care of a patient. Any of the above-mentioned validation modes could be alone or combined to confirm inference. Therefore, diagnosis involves analyzing the cues and searching for relationships, clustering these cues that seems to be related and making an inference that is hypothesizing nursing diagnosis.

Types of nursing diagnosis

Carpenito in Wilkinson (2023) identified five types of nursing diagnosis with the difference being in their structure, which implies the components. Actual nursing diagnosis: an actual nursing diagnosis is a problem that is actually present at the time of making assessment. It is recognized by the present of the associated signs and symptoms (defining characteristics). Nursing care is directed toward relieving, resolving or coping with actual problems.

1 The actual nursing diagnosis has four components which include: label, definition, characteristics and related factors. According to Wilkinson (2023) stated that,

- Label or descriptor is an adjective that describes human response. Examples of

NANDA approved labels are altered, impaired, ineffective, deficit, increased, decreased, potential for or risk for.

The definition is the human response and is the actual or potential health problem or wellness factor that the nurse has synthesized from the clustered data. This forms the basis for the complete nursing diagnosis. Examples of the human responses pain, anxiety, hyperthermia incontinence. The human responses are amenable to nursing intervention. The defining characteristics: these are signs, symptoms or statement made by the patient that validate the existence of the problem. The defining characteristics also relate to the signed and symptoms of the pathology. For example, for a case of diarrhea with nursing diagnosis "fluid volume deficit related to diarrhea" such signs and symptoms as dry lips, loss of skin rigor, sunken eyes will be the defining characteristics (major and minor characteristics).

Related factors: these are etiology or conditions/ circumstances that contribute to the development/ maintenance of health status of the health status changes to the diagnosis. They are the origin of the patient's health problems and can be changed with nursing intervention. Such factors can be grouped into four categories: (Lukey and Wagner, 2025).

Patho-physiological factors (biological and physiological) example here includes: abnormal fluid loss, loss of body part or body function, disfigurement from trauma or birth defects, compromised immune system, inadequate peripheral circulation.

Situational factors (environmental or personal) example for a nursing diagnosis "fluid volume deficit related to insufficient intake the contributing factor is personal. Again "altered sleep pattern, insomnia related to noisy environment, the contributing factor is environmental.

Maturational factors: examples are failure to achieve grade level objective, loss of autonomy and independence, disruption in body image, signs of ageing, menopause.

Treatment related; these include diagnostic investigation surgery etc.

2 Potential (risk) nursing diagnosis; Potential (risk) nursing diagnosis is one that is likely to develop if the nurse does not intervene. This is usually diagnosed by the presence of the risk factor that predisposes a patient to develop a problem. A potential (risk) nursing diagnosis should be used only for patient who has a higher than normal risk for developing a problem. Those who have more risk factor than the general group to which they belong (NANDA 2020).

At the 19th conference NANDA in 2010 stated that those who have the same risk as general population, a collaborative problem (potential complication) can be used. Furthermore, Carpenito (2020) states that collaborative problems are certain physiological complication that nurses monitor to detect their onset or changes in status. Nurses manage collaborative problems by utilizing physician -prescribed and nursing-prescribed interventions to minimize the complication.

3) Possible nursing diagnosis: a possible nursing diagnosis is one the nurse believe that it exists, having enough data to solve a problem but not enough to be sure. A possible problem direct nursing care towards gathering focus data to confirm or eliminate the diagnosis. Using possible problem can help to avoid omitting an important nursing diagnosis and making an incorrect diagnosis because of insufficient data

4) Wellness diagnosis: wellness diagnosis describes areas in which a healthy client is functioning normally, there is no problem, but wishes to achieve a high level of wellness. NANDA defines a wellness diagnosis as describing human response to level of wellness in an individual, family, or community that have a potential for enhancement to higher status (NANDA 2020).

5) Computer - assisted diagnosis: in some health care institutions, nurses use computer to classify and interpret assessment data. Application program called expert system (or knowledge-based system). They are a kind of artificial intelligence that uses reasoning to infer conclusion from stored fact, after the nurse enters the data, the software compares the cues to those that are associated with each nursing diagnosis in its data base. It then generates a list of abnormal or a list of possible diagnosis and the nurse chooses which diagnosis to accept or reject or add to the list.

When the nurse chooses a diagnostic label, the next screen shows that the label will all be associated to the signs and symptoms so that the nurse can compare them to the actual patient data If the nurse accepts the diagnostic labels, she completes the problem statement by choosing the appropriate etiologies (causes) of the problem from the next screen (Lukey and Wagner, 2025).

The advantages of Computer - assisted diagnosis are that computers are consistent, systematic and organized. They do not experience fatigue, distraction or other human weaknesses; therefore, they are able to identify patterns the nurse might overlook. The nurse must use professional judgment in evaluating the Computer - assisted diagnosis. The computer will assume that the patient data is true, correct and current. The nurse must be sure this is so, patient responds to health problems in infinite ways, so it's impossible to predict all combination of cues and all possible diagnosis. Finally, some NANDA nursing diagnoses have very small difficult databases making accurate diagnosis difficult. (Lukey and Wagner, 2025)

PLANNING: This is third phase of NP. Planning is the act of determining the things to do to ensure that the client is assisted to achieving restoration, maintenance and promotion of health. It is a pre-perquisite for the successful operation of nursing care. without planning, it will be difficult to meet the requirements and standard of nursing care. Planning eliminates the delay in nursing care and waste of professional skills and materials. It ensures an efficient and effective use of personnel and facilities in patient care (Wayne, 2024). At the 21st century, with increasing knowledge and practice, nurses are increasing assuming responsibility and accountability for the care they give to patients. The plan nurses develop for the care of the patient is based on the nursing diagnosis, which are formulated based on the comprehensive assessment of the patient by the nurse. Also because of the patient increase knowledge of health and illness, patient are increasingly being involved in drawing of this plan, in this way making the plan more relevant and satisfying to the patient. The main reason for recording plan so specific is to:

a. Promote communication between caregivers
b. Direct care and documentation
c. Create a record that can later be used for evaluation, research and legal reasons.
d. Provide documentation of health care needs.

Alfaro-levre (2023) and Kozier and Erb(2022) and Wilkinson(2023) identified the following as the steps in planning nursing care :

1. Setting priority
2. Setting objectives
3. Setting appropriate nursing intervention
4. Writing a care plan

Setting Priority

The planning stage starts with priority setting. Setting is the process of establishing a preferential order in the delivery of nursing care. After nursing diagnosis have been formulated for the patient, the nurse needs to determine which problem are the most vital to the patient's wellbeing at that particular time.(Kozier and Erb, 2022) The decision to choose one diagnosis as the most important should be based on:

- Actual or imminent life- threatening concerns

- Actual or potential health- threatening concerns
- Client, perception of the health concern.

Other things that aid the settings of priority include theories, concept, model and principles.

Maslow's theory of hierarchy of needs is one of such theories that can guide the nurse in setting priority. Maslow maintains that physiologic needs; safety and security, love and belongings, self-esteem and self-actualization are the five basic human needs. That are related and are in a hierarchy beginning with the physiologic needs and progressing upward to self – actualization. The most basic needs are life- threatening needs and will need to be attended to first before the higher needs. As one needs becomes satisfied, there is gradual emergency of the next on the hierarchy (Kozier and Erb, 2022). In some cases, the patient's needs may not fellow Maslow's hierarchy or may change overtime. Example is an emergency, where safety and security needs will need to be met before physiologic needs. Physiologic principles are also helpful in judging the concerns of the patient. Consideration of the principle guide the nurse is giving immediate attention to life-threatening concerns e.g. respiratory distress and circulatory failures. Other information such as result of diagnostic examinations and changes in patient behavior or conditions may guide the nurse's prioritization. (Wagner, 2023) Again, how helpful the patient is in setting priority and planning care depends on the patient's physical and mental state of health, his understand of the current situation and his past abilities for problem solving. The nurse must assume responsibilities for planning and setting priority for actual ill patient until his Physiologic and safety needs have been satisfied. An increase in patient's need for love and self-esteem indicate he is in a good state to participate in the planning of his care.

Setting Objectives

After the nurse diagnoses have been prioritized, each diagnosis is picked and an objective set for it. The objective is statement of the expected change in a patient's behavior denoting progress towards resolution of the altered human response over a specific period of time. The objectives can be short-term or long –term (Wagner, 2023) The short-term objectives are the outcomes can be met quickly and will probably have a high priority. Example patient's temperature will reduce to 37^{o}C within one hour of therapy Wagner (20250) stated that a long-term objective is an outcome that requires a longer time before it is achieved and usually a lower priority. Example patient will lose 5kg within two weeks of therapy. Each objective should identify the terminal behavior that will be accepted as evidence that the patient has met it. Wagner further explained the four components of objective, which include; the subject, verb, criteria of performing and condition.

a) Subject is usually the patient or any part of the patient. Example, the patient's blood pressure or patient's temperature etc.
b) Verb is the action of the patient or the desired performance of the patient. The verb should be measurable example; identify, verbalize etc.
c) The criterion of performance (standard) is level at which the patient should perform. this must include a time frame that designate the time by which the objective should be met
d) The condition is added to indicate the circumstances under which the behaviors are to be performed. Example "the patient will be able to give himself insulin injection one the thigh with one week after watching four demonstration".

- The object should be patient centered and in behavior term.
- It should be appropriate for the nursing diagnosis and limitations of the patient.
- It should be observable and measurable.
- It should be derived from only one diagnosis
- It should be achievable
- Words that are not open to several interpretations should be used.

Selecting Appropriate Nursing. Interventions

Nursing interventions are planned strategies based on scientific rationale which the nurse plan to carry out to achieve the set objectives. Several alternation nursing measures can be used to meet the objectives and should be realistic. Again, information on the strengths and weakness of the patient is often very useful in making a final choice (Monleiro, 2025). When choices are made, it is essential to involve the patient since many a time a patient has his own ideas of how to achieve an objective. Nursing and other health team members is recommended when selecting care for a particular patient. This practice often serves to reinforce each other's efforts and knowledge. Again, the knowledge of the patient's culture and religious background is useful in selecting care. The nurse should always bear in mind that her culture and religious customs may be inappropriate as the norms when selecting care for a patient holding different beliefs from hers (Monleiro, 2025). The interventions that are selected can be independent and collaborative nursing actions. Independent nursing interventions are those that the nurse is legally capable of implementing based on education and experience while collaborative interventions are physician prescribed and nurse implemented.

Tammy and Jennikes (2023). In their work stated that the number of interventions per patient, the objectives varies. What is essential is that the plan of care is comprehensive enough to ensure that the patient can meet the objectives. Sometimes one alternative that is selected may meet several objectives simultaneously and other times several nursing actions may be necessary to meet one objective. When one action is dependent on another action, they should be arranged the way they

should occur. There is no absolute certainty a particular action will result in successful achievement of nursing care objective. What may be successful for one person may not be for another. (Monleiro, 2025). Thomas (2024) in his write-up stated the criteria for choosing nursing strategies, which include; The planned strategy must be:

- Safe for the patient
- Achievable with the available resources
- Congruent with other therapies
- Congruent with patient's beliefs and values.
- Based on nursing knowledge
- Within the stated policy of institution
- Appropriate for the patient's age and health.

Nursing Care Plan

Nadia et al (2025) affirmed \that most current format for nursing care plans is typically the electronic or digital format. Many heath care facilities use electronic health records (HER) or electronic medical records (EMR) to document and communicate patient care information, including nursing care plan. These electronic systems allow for real-time updates, easy sharing among health care providers and improved healthcare providers and improved accessibility to the care plan information. Additionally, electronic platforms often include standardized templates and formats for nursing care plans, ensuring consistency and efficiency in care planning. A nursing care plan is a crucial tool for providing quality nursing care because it helps nurse to effectively plan, communicate, and evaluate patient care. Wilkinson (2020) stated that nursing care plan serves as a tool for quality nursing care in many ways; which include,

Individualized care, it is designed to be individualized for each patient, considering their unique needs, preferences and goals, ensuring that care is personalized and addresses all aspects of the patient's health and well-being.

Coordination of care, nursing care plans provide a structured framework for coordinating care among multiple health care providers. By clearly outlining the patient's needs, interventions, and goals, nurses can communicate effectively with other team members and ensure that care is delivered in a coordinated and consistent manner.

Monitoring and evaluation, nursing care plan include measurable goals and objectives that allow nurses to track the patient's progress overtime. By regularly evaluating the effectiveness of intervention and adjusting the care plan as needed, nurses ensure that the patient is receiving optimal care and achieving the desired outcomes.

Communication. It serves as a communication tool among healthcare providers, ensuring that all team members are informed about the patient's care needs and goals. By documenting care plans in a clear and standardized format, nurse can facilitate effective communication and collaboration among the care team.

Evidence -Based Practice, nursing care plans are based on evidence-based practice guidelines, which are grounded in the best available research and clinical expertise. By following evidence-based guidelines when developing care plans, nurses can ensure that care is based on the latest evidence and best practices, leading to improved patient outcomes. Overall nursing care as they provide a comprehensive framework for planning and delivering individualized, coordinated and evidence-based care to patients. By using nursing care plans effectively, nurses can promote patient safety, improve outcomes and enhance the overall quality of care provided (Wilkinson, 2020).

Implementation

This is the fourth step of the nursing process. It is the process of stepping into a human system to resolve the needs of that malfunctioning system as stated in the nursing care plan. Implementation of intervention requires the nurse to use critical thinking and clinical judgment. After the initial plan of care is developed, continual reassessment of the client is necessary to detect any changes in the client's conditions requiring modification of the plan. the need for continual client reassessment underscores the dynamic nature of the NP and is crucial to providing safe care. (Potter *et al*, 2024) During implementation phase of the NP, the nurse prioritizes planned interventions, assesses client safety while implementing interventions, delegates interventions as appropriate, and documents interventions performed.

Prioritizing implementation of intervention; Potter *et al*, (2024) pointed out that the implementation follows a similar method as to prioritizing nursing diagnoses. Maslow's hierarchy of needs and the ABC of airway breathing and circulation are used to establish top priority interventions. When possible, least invasive actions are usually preferred due to risk of injury from invasive options. Potential impact on future events, especially if a task is not completed at a certain time, is also included when prioritizing nursing interventions.

For example, if patient is scheduled to undergo a surgical procedure later in the day, the nurse priorities initiating a NIL by mouth (NPO) prescription prior to completing pre-operation client education about the procedure. (Potter *et al*, 2024). The rationale for this decision is that if the client eats food or drinks water, surgery time will be delayed. Knowing and understanding the client's purpose for care current situation and expected outcomes are necessary to accurately priorities interventions.

Client Safety: Is essential to consider client safety when implementing interventions. At times, clients may experience change in conditions that makes a planned

nursing interventions or provider prescription no longer safe to implement. For example, an established nursing care plan for a client states that the nurse will ambulate the client 100 feet, three times daily, however, during assessment this morning, the client reports feeling dizzy and the blood pressure is 90/60 mmHg. Using critical thinking and clinical judgment, the nurse decides to not implement the planned intervention of ambulating the client. This decision and supporting assessment findings should be documented in the client's chart and also communicated during the shift handoff report, along with appropriate notification of the provider of the client's change in condition. Implementing interventions goes far beyond implementing. Provider prescription and completing tasks identified on the nursing care plan, must focus on client safety Nurses are in position to stop errors before they reach the clien(ANA 2021).

Delegation of interventions

Delegation is defined by the ANA, (2021) as the assignment of the performance of activities or tasks related to client care to unlicensed assistive to personnel or licensed practical nurse (LPN), while retaining accountability for the outcome. Implementing interventions, nurses may elect to delegate nursing tasks. They are accountable for determining the appropriateness of the delegated tasks according to the condition of the client and circumstance, the communication provide to an appropriately trained nurse, the level of supervision provided, and the evaluation and documentation of the task completed. The nurse must also be aware of the State Nurse Practice Act and Federal regulations before delegating. The nurse cannot delegate responsibilities requiring clinical judgment (ANA, 2021).

Documentation As interventions are performed, they must be documented in the client's record in a timely manner. Lack of documentation is considered a failure to communicate and a basis for legal action. A basis rule of thumb is if an intervention is not documented. It is considered not done in a court of law. It is also important to document administration of medication and other interventions in a timely manner to prevent errors that can occur due to delayed documentation time (ANA, 2021).

Coordination of care and Health Teaching/ Health Promotion; coordination of care includes competencies such as organizing the components of plan engaging the client in self-care to achieve goals, and advocating for the delivery of dignified and holistic care by the inter - professional team. Health Teaching and Health Promotion is employing strategies to teach and promote health and wellness (Taylor *et al*, 2020). Health education is an important component of nursing care and should be included during every client encounter. Example, client education may include teaching about the side effects while administrating medications or teaching clients how to self-image their conditions at home (Taylor *et al*, 2020).

Evaluation

During evaluation, nurses assess the patient and compare the findings against the initial assessment to the effectiveness of the interventions nd overall nursing care plan. patient evaluations gather comprehensive data to aid in, accurate diagnoses, treatment planning, and ongoing patient care. For patients, evaluation lead to accurate diagnosis, personalized treatment, preventive care and improved communication with healthcare providers.

Evaluation is important in Healthcare because it supports an evidence-based approach to practice delivery. It is used to assess in judging how well something is working. It can inform decisions about the effectiveness of a service and what changes could be considered in improve service delivery. (Moule et al 2020).

The evaluation stage in the nursing process involves assessing the effectiveness of the nursing care plan and determining whether the desired outcomes have been achieved for the for the patient. Moule et al (2020), stated the key details of evaluation in the nursing process which include:

1) Reassessment; the nurse reassesses the patient's condition and compares it to the initial assessment data to determine any change or improvements in the patient's health status.
2) Comparison: The nurse compares the actual outcomes achieved with the expected out comes set forth in the care plan. Any discrepancies are noted and analyzed.
3) Documentation: The nurse documents the findings of the evaluation process in the patient's medical records, including any changes in the patient's condition, progress made, and any modifications to the care plan
4) Communication: the nurse communicates the evaluation finding to the healthcare team, including other nurses, doctors and other healthcare professionals involved in the patients care. This ensures continuity of care and collaboration among team members.
5) Modification of the care plan. Based on the evaluation findings, the nurse may need to modify the care plan to address any issues or changes in the patient's condition. This may involve adjusting goals, interventions, strategies to better meet the patient's needs.
6) Patient education: the nurse educates the patient and their family on the progress made, any changes to the care plan, and ways to continue managing the patient's health at home
7) Fellow-up: The nurse schedules fellow-up appointments or contacts with the patient to monitor progress, address any concerns and determine if further interventions are needed.

Overall, the evaluation stage in the nursing process is crucial for ensuring the effectiveness of the care

provided to the patient and promoting positive health outcomes. It allows nurses to continuously assess reassess and modify the care plan to meet the changeling needs of the patient and provide quality care.

Theories that underpin nursing process

Several theories and models underpin the nursing process providing a frame work for nurses to deliver effective care. All nursing theories and models are applicable to the NP and some key theories that influence the nursing process(sOpenAI, 2025). These. include:

Orem's self-care theory: Dorothea Orem's theory emphasizes the importance of self-care in maintaining health. It suggests that individuals can take responsibility for their own health and that nursing should focus on supporting patients in their self-care efforts. This theory informs the assessment and planning phases of the nursing process.

Roy's Adaptation Model: Sister Callista Roy's model views individuals as adaptive systems. It emphasizes the importance of helping patients adapt to changes in their health status. This model guides nurses in assessing patient's adaptive responses and planning interventions to promote adaptation.

Peplau's Interpersonal Relations Theory: Hildegard Peplaus theory focuses on the nurse-patient relationship and the importance of communication in nursing care. It highlights the phases of nurse-patient relationship (orientation, working and termination) and informs the implementation and evaluation phases of the nursing process.

Leininger's Transcultural Nursing theory: Medelaine Leininger's theory emphasizes the importance of cultural competence in nursing care. It encourages nurses to consider patients cultural backgrounds when assessing needs and planning acre, ensuring that interventions are culturally appropriate.

Waston's Theory of Human Caring: Jean Waston's theory emphasizes the importance of caring in nursing process. It focuses on the holistic nature of care and the nurses role in fostering a caring relationship with patients. This theory influences all phases of the nursing process, particularly in the implementation of care.

Benner's Novice to Expert Model: Patricia Benner's and model describes the stages of skill acquisition in nursing from novice to expert. It emphasizes the importance of experience and institution in nursing process, which can influence how nurses assess situations and make clinical decisions throughout the nursing practice.

Maslow's Hierarchy of Needs: This is not a nursing theory persa. Abraham Maslow's hierarchy provides a framework for understanding human motivation and needs. It can guide nurses in prioritizing patient needs during the assessment and planning phases of the nursing process.

The Health Promotion Model: Developed by Nola Pender this model focuses on promoting health and preventing illness. It emphasizes the role of individual characteristics and experiences in influencing health behaviors, which can inform the assessment and planning phases of the nursing process.

These theories and models provide a foundation for the nursing process, guiding nurses in their practice and helping them deliver holistic patient-centered care by integrating these theoretical frameworks, nurses can enhance their critical thinking decision-making and overall effectiveness in patient care (OpenAI, 2025).

NURSING PROCESS AND PROFICIENCY IN NURSING PRACTICE

The nursing process is a systematic patient-centered approach used by nurses to provide care and improve patient outcomes. It consists of five key steps. ADPIE. Each step is interrelated and cyclical allowing for continuous improvement in patient care. According to Wayne (2023), the initial step, assessment, nurses gather comprehensive data about the patient's health status this includes: Subjective data: Information reported by the patient, such as symptoms feelings and concerns. Objective Data: observable and measurable data obtained through physical examinations, laboratory tests and diagnostic imaging.

Diagnosis: After collecting data, nurses analyze the information to identify actual and potential health problems this involves:

- Using standardized language (such as NANDA-1) to describe the patient's condition.
- Prioritizing diagnoses based on the severity and urgency of the tissues identified (Monkiro, 2025).

Planning: In this phase, nurses develop a plan of care that outlines strategies to address the identified diagnoses: This includes:

- Setting measurable and achievable goals for the patient
- Identifying nursing intervention that will help achieve these goals.
- Collaborating with other health care professionals to ensure a comprehensive approach to care.
- Collaborating with other health care professionals to ensure a comprehensive approach to care.

Implementation: During implementation, nurses carryout the planned interventions. This treatment may involve administering medication.

- Educating the patient and their family about health management.
- Coordinating care with other healthcare team members. Documentation of the care provided is also a critical component of this step.

Evaluation: The final step involves assessing the effectiveness of the interventions and the patient's progress toward the established goals. This includes:

- Determining whether the goals were met partially met or not met.
- Modifying the care as necessary based on the evaluation findings.
- Continuing the cycle of the nursing process to ensure ongoing patient and improvement.

Benner (2023) defined proficiency in nursing process as the ability of nurses to effectively apply their knowledge, skills and judgment in providing high-quality care. She further explained the key components of proficiency which include:

- **Clinical competence**: Mastery of clinical skills and knowledge relevant to nursing process, including, technical skills, critical thinking and decision making.
- **Communication skills**: The ability to communicate effectively with patients, families and inter-disciplinary terms to ensure clear understanding and collaboration.
- **Cultural competence**: Understanding and respecting diverse cultural backgrounds and tailoring care to meet the unique needs of each patient.
- **Ethical practices**: Adhering to ethical principles and standards in nursing, including patient advocacy, confidentiality and informed consent.
- **Lifelong learning**: Commitment ot ongoing education and professional development to stay current with advancements in healthcare and nursing process.

Proficiency in nursing practice is essential for delivery safe, effective and compassionate care, ultimately leading to improved patient outcomes and satisfaction.

How Nursing Process and Proficiency in Nursing Practice Enhance Critical Thinking and Decision-Making.

The nursing process and proficiency in nursing practice are integral to enhancing critical thinking and decision-making skills among nurses. Mielke (2023) explained how NP enhance critical thinking and decision making through these essential competencies:

Structured Framework: The nursing process provides a systematic approach to patient care consisting of five key steps. ADPIE. This structured framework encourages nurses to think critically at each stage, ensuring that they gather relevant information, analyze it and make informed decisions.

Comprehensive Assessment: During the assessment phase, nurses collect data from various sources including patient history, physical examinations and diagnostic tests. This thorough data collection fosters critical thinking as nurses must evaluate the information, identify patterns and recognize potential health tissues.

Critical judgment: The diagnosis phase requires nurses to synthesize assessment data to identify patient problems. This process enhances clinical judgment, as nurses must differentiate between actual and potential health issues, prioritize them, and consider the implications of their decisions.

Good setting and planning: In the planning phase nurses set measurable and achievable goals for patient care. This requires critical thinking to anticipate patient needs, consider available resources and develop interventions that are evidence-based and tailored to individual patients.

Implementation of Care: During implementation, nurses must adapt their plans based on real-time patient response. Their flexibility enhances decision-making skills as nurses must evaluate the effectiveness of interventions and adjust as necessary.

Evidence Based Practices: Proficiency nursing process, often involves staying current with evidence-based guidelines and research. This knowledge base supports critical thinking by providing nurses with the latest information to inform their decisions, ensuring that care is grounded in the best available evidence.

Inter-professional Collaboration: Nurses frequently collaborate with other healthcare professionals which enhances critical thinking and decision-making. Engaging in discussions with colleagues allows nurses to consider multiple perspectives, share insights and arrive at more comprehensive care plans.

Ethical considerations: Nurses often face ethical dilemmas in practice. The nursing process encourages critical thinking by prompting nurses to consider ethical principles, patient autonomy, and the implications of their decisions on patient care.

Continuous Learning: Proficiency in nursing process involves ongoing education and skill development. This commitment to lifelong learning fosters a mindset of inquiry and critical analysis, and improve their decision-making capabilities (Mieslke, 2023).

In summary, the nursing process and proficiency in nursing practice are vital for enhancing critical thinking and decision making. by providing a structured approach to patient care, encouraging reflective practice and promoting evidence-based decision making, these elements empower nurses to deliver high-quality care and improve patient outcomes.

Nursing Process and Proficiency Contribute to Clinical Judgment and Problem Solving in Nursing Practice.

The Nursing process and Proficiency in nursing practice are fundamental components that significantly contribute to clinical judgment and problem solving in healthcare settings. They interrelated as fellow, each step-in nursing process plays a crucial role in enhancing clinical judgment and problem-solving abilities (OpenAI, 2025). During assessment phase, proficient nurses utilize critical thinking to gather relevant information through patient interviews physical examinations and diagnostics tests. This thorough assessment lays the groundwork for accurate clinical judgment After assessment, which is diagnosis, nurses analyst the data to identify actual or potential health problems. Proficiency in nursing process allows nurses to recognize patterns and make informed diagnoses, which is essential for effective problem-solving accurate nursing diagnosis guide the development of appropriate care plans. Planning phase, nurses set measurable and achievable goals for patient care based on the diagnoses proficient nurses prioritize interventions and collaborate with other healthcare professionals to create a comprehensive care plan. This collaborative approach enhances clinical judgment by integrating diverse perspectives and expertise. During implementation phase, nurses carryout the planned interventions. Proficiency in nursing process ensures that these interventions are evidence-based and tailored to the individual patient's needs effective implementation requires ongoing assessment and adaptability, which are critical for problem solving in dynamic clinical environments. The final step, evaluation, involves assessing the effectiveness of the interventions and determining whether the goals have been met. Proficient nurses use evaluation data to refine care plans, make necessary adjustments. This reflective practice fosters continuous improvement in clinical judgment and enhances problem solving skills for future patient care. Proficiency in Nursing process encompasses a nurse's knowledge, skills, experience and ability to apply evidence-based practices. It contributes to clinical judgment and problem-solving in several ways (OpenAI, 2025) Such as.

- Knowledge Base: A strong foundation in nursing theory, clinical guidelines and Evidence-based practices enable nurses to make informed decisions proficient nurses Can quickly identify relevant information and apply it to patient care scenarios.
- Critical thinking: Proficient nurses possess advanced critical thinking skills, allowing them to analyze complex situations, recognize patterns and anticipate potential complications (OpenAI, 2025) as cited in Benner, (2023). This ability is essential for effective clinical judgment and timely problem-solving.
- Experience: With experience, nurses develop intuition and the ability to recognize subtle changes in a patient's condition. This experiential knowledge enhances their clinical judgment, enabling them to respond effectively to emerging problems. (Benner, 20223).
- Collaboration and Communication: Proficient nurses excel in teamwork and communication, which are vital for problem-solving in healthcare. They can effectively collaborate with interdisciplinary terms share insights and advocate for patients, leading to better outcomes.
- Adaptability: The healthcare environment is often unpredictable. Proficient nurses are adaptable and can modify their approach based on changing patient needs or new information, which is crucial for effective problem-solving.

The Role of Nursing Process in Professional Development and Lifelong Learning

The nursing process plays a significant role in professional development and lifelong learning for nurses in several ways (Wayner, 2024).

Structured Framework for learning: The nursing process provide a structured framework that helps nurses systematically approach patient care. This structure encourages critical thinking and problem-solving, which are essential skills for professional development.

Continuous improvement: By engaging in the nursing process, nurses can continuously assess and improve their practice. The evaluation step allows nurses to reflect on outcomes, identify areas for improvement and implement changes, fostering a culture of lifelong learning.

Evidence-Based Practice: Nursing process emphasizes the importance of using evidence-based practice. Nurses are encouraged to seek out the latest research and integrate it into their care plans, promoting ongoing education and professional growth.

Adaptability and Flexibility: The nursing process is adaptable to various clinical situations and patient needs. This flexibility encourages nurses to learn new skills and approaches enhance their ability to provide individualized care and promoting lifelong learning.

Inter professional collaboration: The nursing process often involves collaboration with other healthcare professionals. This team work foster communication skills and encourages nurses to learn from colleagues in different disciplines, broadening their knowledge base and professional development.

Patient-centered care: By focusing on the individual needs of patients, the nursing process encourages nurses to develop empathy and cultural competence. This patient-centered approach enhances their ability to provide holistic care and promotes personal and professional.

Goal setting and Accountability: The planning and evaluation phase of the nursing process involves setting specific measure goals for patient care. This practice encourages nurses to take responsibility for their learning

and development following a sense of accountability in their professional journey.

Reflective Practice: The nursing process encourages reflective practice. Where nurses assess their experiences and outcomes. This reflection is crucial for personal and professional growth, as it helps identify strength and areas for improvement.

Lifelong learning mindset: Engaging in the nursing process instills a mindset of lifelong learning, nurses are encouraged to seek out new knowledge, skills and experiences throughout their careers, ensuring they remain competent and confident in their practice.

Career Advancement: Mastery of nursing process care lead to opportunities for career advancement, such as leadership roles, specialized practice or advanced education. This progression often requires ongoing learning and professional development.

Real Life Case Scenarios on Nursing Process Role in Professional Development and Lifelong Learning
Implementing Evidence-Based Practice in Nursing Unit: A nursing unit in a busy hospital is facing challenges with patient outcomes related to post-operative care. The nursing staff has noticed an increase in complication such as infection and longer recovery times. To address these issues, the nurse manager decides to implement a quality improvement project focused on evidence-based practice (EBP) in post-operative care.

Nursing Process Role
Assessment: The nurse manager conducts a thorough assessment of the current post-operative care practice. This include reviewing patient charts, interviewing nursing staff and gathering data on infection rates and recovery times. The manager identifies gaps in knowledge and practice among the nursing staff regarding evidence-based practice (EBP) guidelines for post-operative care.

Diagnosis: Based on the assessment, the nurse manager diagnoses the problem as a lack of adherence to evidence- based protocols and insufficient knowledge about current best practices among the nursing staff, this diagnosis highlights the need for professional development and ongoing education.

Planning: The nurse manager develops a comprehensive plan to address the identified issues. This plan includes organizing workshops and training sessions on EBP, inviting guest speakers who are experts in post-operative care, and creating a recourses library with the research articles and guidelines. The plan also includes setting measurable goals such as reducing infection rates by 20% within x six (6) months.

Implementation: The nurse manager implements the plan by scheduling the training sessions and encouraging all nursing staff to participate. During the workshops, nurses engage in hands-on activities, case studies and discussions about the importance of EBP in improving patient outcomes. The manager also promotes a culture of lifelong learning by encouraging nurse to pursue further education and certifications related to post-operative care.

Evaluation: After six (6)months, the nurse manager evaluates the outcomes of the implemented changes. This includes analyzing infection rates, recovery times and staff feedback on the training sessions. The evaluation shows a significant decrease in infection rates and improved patient satisfaction scores. Additionally, nursing staff report feeling more confident in their ability to apply EBP in their practice.

NURSING PROCESS AND QUALITY NURSING CARE
Quality of nursing care is essential for improving patient outcomes, enhancing patient satisfaction and promoting overall health well-being. It requires ongoing education adherence to standards and in commitment to continuous improvement in practice. For effective nursing practice, nursing process is the framework for the practice. (NMC, 2024)

Improving patient outcomes through individualized care, this involves tailoring healthcare approaches to meet the unique needs, preferences and circumstances of each patient. Here are several strategies to achieve this (OpenAI, 2025).

1. Comprehensive Assessment: Conduct through assessments that consider not only medical history but also social, psychological and environmental factors. Understanding a patient's lifestyle, beliefs and support systems can inform more personalized care plans.
2. Share Decision-Making: Engage patients to their own case by involving them in decision-making processes. Discuss treatment options, potential outcomes and risks, allowing patients to express their preferences and values.
3. Personalized Treatment Plans: Develop treatment plans that are specifically designed for the individuals. This may include customized medication; regimen tailored therapy approaches or lifestyle modifications that align with the patient's goals.
4. Continuous Monitoring and Feedback: Implement systems for ongoing monitoring of patient progress and outcomes. Regular follow-ups can help adjust care plans as needed and ensure that patients feel supported throughout their treatment journey.
5. Interdisciplinary Collaboration: Foster collaboration among healthcare providers from various disciplines to address the multifaceted needs of the patients. This team approach can lead to more comprehension and coordinated care.

6. Technology Utilization: Leverage technology such as tele health, mobile health apps and electronic health records to enhance communication, streamline care, add prove patients with easy access to their health information.
7. Behavioral and Mental Health Support: Recognize the importance of mental health in overall well-being integrate behavioral health support into care plans addressing issues such as anxiety, depression, or stress that may impact physical health.

Empowerment and Self-Management: Encourage patients to take an active role in managing their health. Provide tools and resources that promote self-management such as goal setting, tracking process and accessing community resources

8. Feedback Mechanisms: Establish channels for patients to provide feedback on their care experience. This can help identify areas for improvement and see that care remains patient-centered.
9. Addressing Social Determinants of Health: Recognize and address social determinants that may affect health outcomes, such as socio-economic status, access to care and education. Connecting patients with community resources can help mitigate these barriers.
10. Cultural Competence: Recognize and respect cultural differences that may influence a patient's health beliefs and behaviors. providing culturally sensitive care can enhance trust and improve adherence to treatment.

By implementing these strategies healthcare providers can create a more individualized care experience that not only improves patient satisfaction but also leads to better health outcomes.

Evidence Based Practice Integration In Nursing Process

Evidence-based practice (EBP) integration in the nursing process refers to the systematic approach that nurses use to incorporate the best available research evidence, clinical expertise and patient preferences into their decision making and care delivery. The nursing process itself is a framework that consists of five steps; Assessment, diagnosis, planning, implementation and evaluation. (Eineaout, Overholt, Carol and Greenberg, 2023)

How EBP can be integrated into each steps

1 Assessment, in this initiate step, nurses gather comprehensive data about the patient's health status. EBP integration involves using validated assessment tools and evidenced-based guidelines to ensure that the data collected is relevant and reliable. This may include using standardized screening tools or evidence-based questionnaires to assess the symptoms or risk factors.

2 Diagnosis: After assessment, nurses analyze the data to identify patient problems or nursing diagnoses. EBP integration means using current clinical guidelines and research findings to inform the diagnostics process, ensuring that the diagnoses are based on the most recent evidence and best practice.

3 Planning: In this phase, nurses develop a case plan that outlines the goals and interventions for the patient. EBP integration involves selecting interventions that are supported by research evidence, considering the effectiveness of various treatment options and tailoring the plan to align with the patient's preference and values.

4 During implementation, nurses carry out the interventions outlined in the care plan. EBP integration means using evidence-based protocols and guidelines to ensure that the interventions are performed correctly and effectively. This may also involve educating patients about their care based on the latest evidence

5 Evaluation: Finally, nurses assess the outcomes of the interventions to determine their effectiveness. EBP integration in this step involves using evidence to evaluate whether the goals were met and to identify areas for improvement. If outcomes are not as expected nurses may refer to current research to modify the care plan accordingly.

Overall integrating evidence-based practice into nursing process enhances the quality of care, improves patient outcomes and promotes a culture of continuous learning and improvement within the nursing profession. It encourages nurses to stay updated with the latest research and to apply this knowledge in their daily practice, ultimately leading to more informed and effective patient care.

Patient Safety and Reduced Medical Errors in Nursing Process.

Patient safety and the reduction of medical errors are critical components of the nursing process. The nursing process is a systematic method used by nurses to ensure quality care and improve patient outcomes. And using each step can contribute to patient safety and minimize medical errors. The comprehensive data collection, nurses gather detailed information about the patient's medical history, current health status, medications, allergies and other relevant factors. This thorough assessment helps identify potential risks and areas of concern (Castle, 2020). Also, the use of standardized tools can help to ensure that critical information is not overlooked, reducing the likelihood of errors. Accurate Nursing Diagnoses, based on the assessment data, nurses formulate accurate nursing diagnoses. Clear and precise diagnoses help in developing appropriate care plans and intervention including the risk of miscommunication and errors. Again, engaging with other healthcare professionals to validate diagnoses can enhance accuracy

and ensure a comprehensive understanding of the patient's need.

Setting Clear Goals: Establishing specific, measurable, achievable, relevant, and time-bound (SMART) goals for patient care helps in focusing efforts and reducing ambiguity, which can lead to errors. Prioritize interventions based on the severity of the patient's condition, ensuring that critical needs are addressed first which enhances safety. In implementation, adherence to established clinical guidelines and protocols during care delivery minimizes variability and reduces the risk of errors. Monitoring Outcomes: In evaluation, regularly evaluating patient outcomes against the established goals allows nurses to identify any deviations from the expected results, enabling timely intervention to correct issues. Again, implementing feedback loops where nurses can report errors or near misses without fear of retribution fosters a culture of safety and continuous improvement. Additional strategies for enhancing patient safety could be the use of technology that is implementing electronic health records (EHRs) beaconing systems for medication administration and decision support systems can help reduce errors related to documentation and medication management (Nadia *et al*, 2023) Inter Professional Collaboration: Working collaboratively with other healthcare professionals enhances communications and ensure a comprehensive approach to patient care.

Continuous Education and Training: Ongoing education and training for nurses on best practices, new technologies and safety protocols are essential for maintaining high standards of care.

Holistic and Patient-Centered Approach

A holistic and patient-centered approach in healthcare emphasizes treating the whole person rates than just addressing specific symptoms of diseases. This approach recognizes that a patient's physical, emotional and spiritual needs can help providers provide optimal care and improve outcome. Holistic and patient-centered care approaches in health care that prioritize the individual needs preferences and overall well-being of patients. Erbs, (2021) explained the breakdown of each concept.

Holistic Care: Holistic care considers the whole person, including their physical, emotional, social, spiritual and environmental factors. It recognizes that these aspects are interconnected and can influence a person's health and well-being.

- The physical health, this addresses medical condition and physical well-being.
- Emotional health, supporting the mental health and emotional well-being.
- Social wellbeing, considering relationships, community support and social interactions.
- Spiritual health, acknowledging beliefs, values, and spiritual practices that may impact health.
- Environmental factors, recognizing how a person's environment (home, work, community) affects their health.

Holistic care often involves a multidisciplinary team of health care providers who collaborate to create in comprehensive care plan tailored to the individuals needs.

Patient-centered care focuses on the patient as an individual and emphasizes their active participation in their own healthcare. Erbs further explained the need to prioritize the patient's preferences, needs and values in the decision-making process. Hence the main components are:

- Respect for patient preferences: Acknowledge and in cooperating the patient's values and choices into their care.
- Information sharing: Providing patients with clear, comprehensive information about their conditions and treatment options.
- Emotional support: Recognizing and addressing the emotional and psychological needs of patients.
- Co-ordination of care: Ensuring that care is well coordinated among different providers and settings
- Involvement of family and friends: Encouraging the participation of family members and caregivers in the care process.

Patient centered care fosters a partnership between patients and healthcare providers, promoting open communication and shared decision-making. When combined holistic and patient-centered care creates a comprehensive approach that not only addresses the medical needs of patients but also considers their emotional, social and spiritual well-being. This integrated approach can lead to improved patient satisfaction, better health outcomes and a more positive health care experience overall.

- In practice, healthcare providers who adopt these approaches often take the time to listen to their patients, understand their unique circumstances and tailors' interventions that align with their individual goals and valu Involvement of family and friends: Encouraging the participation of family members and caregivers in the care process.
  Importance of Nursing Process in Patients Outcomes

The nursing process is a systematic patient-centered approach that is essential for delivery high-quality care and improving patient outcomes. It consists of five steps: assessment, diagnosis, planning, implementation and evaluation. Wilkinson (2023) affirmed the importance aspects of the nursing process and how they contribute to positive patient outcomes.

Comprehensive Assessment: The nursing process begins with a thorough assessment of the patient's physical, emotional, social and spiritual needs. This comprehensive understanding allows nurses to identify

health issues, accurately and clear interventions accordingly.

Accurate Diagnosis: Based on the assessment data, nurses formulate nursing diagnoses that reflect the patient's actual or potential health problems. Accurate diagnoses guide the development of effective care plans and interventions.

Individualized care planning: The planning phase involves setting realistic and measurable goals for the patient's care individualized care plans ensure that interventions are tailored to the specific needs and preferences of the patient, which can enhance engagement and adherence to the treatment plan.

Evidence-Based Interventions: During the implementation phase, nurses utilize evidence-based practices to carryout interventions. This approach not only improves the likelihood of achieving desired health outcomes.

Ongoing Evaluation: The evaluation step allows nurses to assess the effectiveness of the care provided and make necessary adjustments to the care plan. Continuous evaluation ensures that the care remains relevant and responsive to the patient's changing conditions.

Collaboration and communication: The nursing process encourage collaboration among healthcare team members, including physicians, therapists and social workers. Effective communication fosters a holistic approach to patient care which can lead to better outcomes.

Patient education and empowerment: Nurses play a critical role in educating patients about their health conditions and treatment options. Empowering patients with knowledge enhance their ability to participate in their own care, leading to improved adherence and self-management.

Patient Education and Empowerment: Nurses play a critical role in educating patients about their health conditions and treatment options. empowering patients with knowledge enhance their ability to participate in their own care, leading to improved adherence and self-management.

Holistic Approach: The nursing process considers the whole person, not just the illness. By addressing physical, emotional and social factors, nurses can help improve overall well-being and quality of life for patient.

Quality improvement: The nursing process is integrated to quality improvement initiatives in healthcare settings. By systematically evaluating outcomes and processes, nurses can identify areas for improvement and implement changes that enhance patient care.

Patient safety: A structured approach to care helps minimize errors and enhances patient safety. By following the nursing process, nurses can ensure that all aspects of patient care are considered and addressed.

In summary, the nursing process is vital for achieving positive patient outcomes. It provides a framework for delivering individualize evidence-based care, promotes collaboration among healthcare providers and safety. By following this systematic approach, nurses can significantly enhance the quality of care aid improve the overall health and well-being of their patients.

Challenges in Implementation of Nursing Process

The nursing process is a systematic method used by nurses to provide patient care, consisting of five key steps: assessment, diagnosis, planning, implementation and evaluation. It is a fundamental aspect of nursing process. Marriener (2020) pointed several challenges that can arise during its implementation, some common challenges along with recommendation to address them.

Challenges in Implementation of the Nursing process

- Inadequate training and education: Many nurses may not receive sufficient training in the nursing process during their education, leading to inconsistent application in practice.
- Time constraints: High patient to nurse rating and heavy workloads can limit the time available for thorough assessments and planning.
- Lack of standardization: Variability in how the nursing process is taught and implemented can lead to inconsistencies in patient care.
- Inter disciplinary communication: Poor communication among healthcare team members can hinder the effective implementation of the nursing process.
- Resistance to change: Some nurses may be resistant to adopting the nursing process due to familiarity with other methods or skepticism absent its effectiveness.
- Documentation challenges: inadequate or inefficient documentation systems can make it difficult to track the nursing process and patient outcomes.
- Cultural and Ethical considerations: Diverse patient populations may present unique challenges that require culturally competent care, which may not always align with standardized nursing processes.
- Unlimited Resources: Insufficient access to resources, such as staffing, technology and support services, can impede the effective implementation of the nursing process.

Strategies for Overcoming Challenges in Implementation of Nursing Process

Kozier *et al*, (2019 as cited in Wilkinson (2023) suggested that implementing the NP can present various challenges but there are several strategies that can help overcome these obstacles, these strategies are:

Education and Training: provide comprehensive training for nursing staff on the NP including assessment, diagnosis, planning, implementation and evaluation. Use simulation and role-playing to enhance understanding and application of the nursing process in real-life scenarios.

Standardization of Protocols: Develop standardized protocols and guideline that outline the steps of the NP, making it easier for nurses to follow. Ensure that these protocols are easily accessible and regular updated based on best practice and evidence- based research.

Interdisciplinary Collaboration: Foster a collaborative environment where nurses work closely with other healthcare professionals such as physicians, pharmacists and social workers, to ensure comprehensive patient care. Encourage regular interdisciplinary meetings to discuss patient care plans and share insights.

Utilization of Technology: Implement electronic health records (EHR) and other technological tools that facilitate documentation of the nursing process. Use decision support systems to assists nurses in making evidence-based decisions during the nursing process.

Time Management: Train nurses in effective time management techniques to ensure they can allocate sufficient time for each step of the nursing process. Prioritize tasks and delegate appropriately to ensure that patient care is not compromised.

Supportive leadership: Encourage nursing leadership to support staff in the implementation of nursing process by providing resources, mentorship and encouragement. Create a culture that values continuous improvement and open communication regarding challenges faced in the nursing process.

Patient and Family Involvement: Involve patients and their families in nursing process to ensure that care plan is tailored to their needs and preferences. Educate patients about their care plans to enhance their understanding and compliance.

Regular evaluation and feedback: Establish a system for regular evaluation of nursing process, implementation including feedback from nursing staff and patients. Use this feedback to identify areas for improvement and to make necessary adjustments to protocols and training.

Addressing Burnout and Stress: Implement strategies to reduce nurse burnout such as providing mental health resources promoting work-life balance and ensuring adequate staffing levels. Encourage staff-care practices among nursing staff to maintain their well-being and effectiveness in implementing the nursing process.

Continuous Professional Development: Encourage ongoing education and professional development opportunities for nurses to stay updated on best practices and advancements in the nursing field. Support participation in workshops, conferences and certification programs related to the nursing process. By employing these strategies, healthcare organizations can enhance the implementation of the nursing process, leading to improved patient outcomes and greater job satisfaction among nursing staff.

CONCLUSION

A knowledge gap in relation to the utilization of NP and a negative attitude were noted to be associated significantly with the utilization of NP among nurses and midwives. It is recommended on job training, supportive supervision, and value clarification and attitude transformation (VCAT) are best interventions to address the knowledge gap and negative attitude respectively. The nursing process is fundamental to nursing practice, influencing not only the quality of care provided to patients but also the professional development of nurses and the overall effectiveness of health care systems. By adhering to their practice, improve patient outcomes and contribute to a more efficient and effective healthcare environment.

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