

source with the beliefs articulated in the simultaneity paradigm. Therefore, conceptual frameworks and theories within the simultaneity paradigm have their own distinct practice methods.

Nursing Process Practice Method: Totality Paradigm

In 1967, Yura and Walsh write the first comprehensive book describing the components of the nursing process. In 1973, the American Nurses Association adopted and legitimized the nursing process in the *Standards of Nursing Practice*. The manual of the Joint Commission on Accreditation of Healthcare Organizations requires documentation according to the nursing process. Furthermore, since 1973, the state board NCLER exams test knowledge of all five major components of the nursing process.

Nursing education originally developed the nursing process as a teaching guide to assist students to learn critical thinking skills essential for making appropriate clinical judgments concerning patient care. The nursing process consists of five components, each with several phases that are interactive and sequential (Kernzy, 1995). **Assessment** "is a continuous process of collecting relevant data about the patient's human responses, health status, strengths, and concerns" (Kernzy, 1995, p. 10). Gordon's (1994) eclectic multilateral model for guiding nursing assessment based on 11 functional health patterns offers another way of assessing patients, families, groups, or communities from a unique nursing perspective that can also be applied to many of the nursing conceptual frameworks and theories in the totality paradigm. The functional health patterns identified by Gordon (1994) are: (a) health perception-health management; (b) nutritional-metabolic; (c) elimination; (d) activity-exercise; (e) cognitive-perceptual; (f) sleep-rest; (g) self-perception-self-concept; (h) sexuality-reproductive; (i) coping-stress tolerance; and (j) value belief pattern. In her work, Gordon defines each pattern and provides questions and directions to guide assessment and patient examination according to each of the 11 patterns. Assessment data are then interpreted within the selected nursing conceptual framework.

Nursing diagnosis is the analysis and synthesis of data to identify patterns and compare them to norms and conceptual frameworks as a means to recognize abnormal patterns, make inferences, or assign meaning to the problems (Kernzy, 1995). Since 1973, NANDA (North American Nursing Diagnosis Association) has guided the process of identifying and naming the phe-

nomens that nurses diagnose and treat as a means for creating a common language identifying the focus of nursing care, thereby differentiating nursing from medicine. NANDA defines nursing diagnosis as "a clinical judgment about individual, family, or community responses to actual or potential health problems/life processes. Nursing diagnoses provide the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable" (NANDA, 2001, p. 245). NANDA's latest work, *Nursing Diagnosis: Definitions and Classifications, 2001-2002*, features 118 nursing diagnoses, their definitions, defining characteristics, and related-to factors. The new edition also features "Taxonomy II," and new multilateral health pattern framework that organizes the diagnoses into domains according to Gordon's Functional Health Patterns (NANDA, 2001).

Planning, the third step in the nursing process, occurs when the patient and the nurse identify the expected outcomes and actions to correct the nursing diagnosis (Kernzy, 1995). Planning includes prioritizing the patient's concerns, determining desired health outcomes, selecting appropriate nursing interventions, and designing a plan of care based on scientific knowledge both from nursing and theories from other disciplines relevant to nursing care.

Since 1991, a research team at the University of Iowa has been developing a classification of nursing outcomes. In the second edition of *Nursing Outcome Classification (NOC)* published in 2000, 240 "nursing-sensitive" outcomes have been identified and defined. A "nursing-sensitive patient outcome" is defined "as a variable patient or family caregiver state, behavior, or perception that is responsive to nursing interventions" (Johnson, Maas, & Mowbray, 2000, p. 21). Each of the 240 outcomes have a label name, a definition, a list of indicators to evaluate patient status in relation to the outcome, and a five-point scale to measure patient status (Johnson, Maas, & Mowbray, 2000). All NOC outcomes have been linked to NANDA nursing diagnoses, making the NOC classification system a powerful and useful tool for identifying appropriate nursing outcomes when planning nursing care.

Implementation is performing the nursing actions designated in the plan by the patient, nurse, and others. Yura and Walsh (1968) defined implementation, the fourth phase of the nursing process, as "the initiation and completion of actions necessary to accomplish the defined goal of optimal well-being for the patient" (p. 134). The implementation phase for the nursing process relies heavily on intellectual, interpersonal, critical thinking, and technical skills of the nurse. Nursing

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