**N** is for the nursing process. The nursing process is at the heart of any allegation of nursing negligence. *Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations.* (American Nurses Association, 2010, p. 3)

The Standards of Practice describe a competent level of nursing care as demonstrated by the critical thinking model known as the nursing process. The nursing process includes the components of assessment, diagnosis, outcomes identification, planning, implementation, and evaluation. The nursing process is the common thread uniting different types of nurses who work in varied areas of practice, from intensive care, newborn nursery, and nursing informatics to legal nurse consulting.

The nursing process in practice is not linear, but is a fluid process which relies heavily on the bi-directional feedback loops from each component. The process consists of six standards or components.

1. Assessment. The RN uses a systematic, dynamic way to collect and analyze data about a patient. This includes physiological, psychological, sociocultural, spiritual, economic and life-style factors. A nurse's assessment of pain includes the physical cause of pain, how the pain is manifested, the patient's response (i.e., inability to get out of bed or request for pain medication).

2. Diagnosis. Nurses do diagnose. However, this is not a clinical diagnosis but is the nurse's clinical judgement about the patient's response to actual or potential health conditions or needs. Examples of nursing diagnoses include pain, impaired gas exchange, altered tissue perfusion, altered urinary elimination, etc. The diagnosis is the basis for the nurse's plan of care.

3. Outcomes identification. Based on the assessment and diagnoses, the nurse sets measurable and achievable goals for the patient. A goal for a patient with inadequate nutrition might be to increase intake from 25% to 75% at each meal.

4. Planning. The RN develops a plan that prescribes strategies and alternatives to attain the expected outcomes. The nursing plan of care for a patient with a stated diagnosis of malnutrition or poor intake might include offering smaller, more frequent meals or offering meal substitutes such as Ensure at bedtime.

5. Implementation. Nursing care is implemented according to the care plan, so continuity of care for the patient is assured by all members of the nursing team. Care provided to the patient is documented in the patient's medical record.

6. Evaluation. Both the patient's status and the effectiveness of the nursing care must be continuously evaluated and the care plan modified as needed.

**Failure to follow the nursing process will be found in all cases involving nursing negligence**.