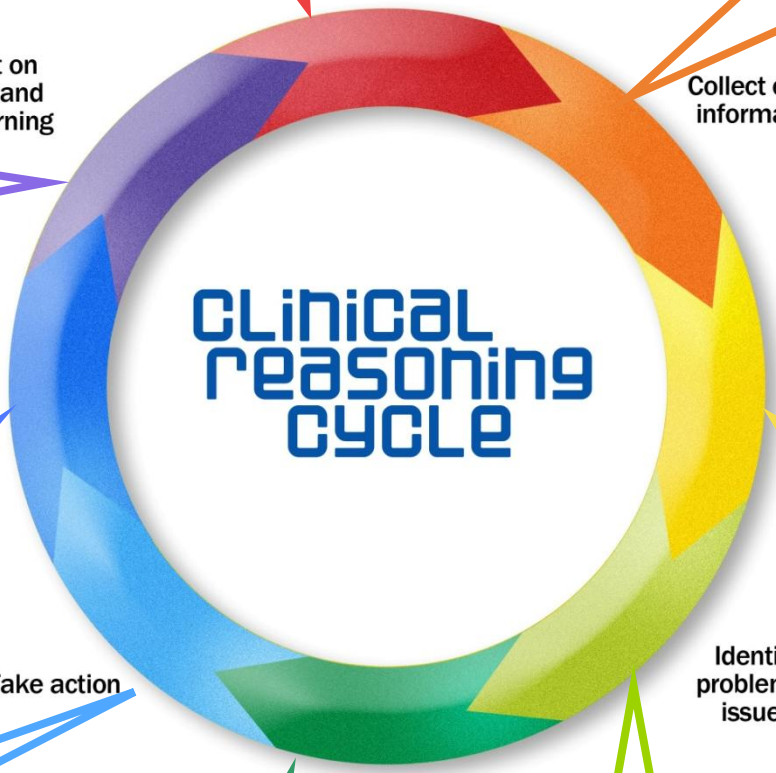
Clinical reasoning cycle



DESCRIBE context, people and situation.

REVIEW current information (e.g. handover reports, patient history, patient charts, results of investigations and nursing/medical assessments previously undertaken).
GATHER new information (e.g. undertake patient assessment)
RECALL knowledge (e.g. physiology, pathophysiology, pharmacology, epidemiology, therapeutics, context of care, ethics, law etc)

INTERPRET: analyse data to come to an understanding of signs or symptoms. Compare normal Vs abnormal.
DISCRIMINATE: distinguish relevant from irrelevant information; recognise inconsistencies, narrow down the information to what is most important and recognise gaps in cues collected.
RELATE: discover new relationships or patterns; cluster cues together to identify relationships between them.
INFER: make deductions or form opinions that follow logically by interpreting subjective and objective cues; consider alternatives and consequences.
MATCH current situation to past situations or current patient to past patients (usually an expert thought process).
PREDICT an outcome (usually an expert thought process).

SYNTHESISE facts and inferences to make a definitive diagnosis of the patient's problem.

DESCRIBE what you want to happen, a desired outcome, a time frame.

SELECT a course of action between different alternatives available.

EVALUATE the effectiveness of actions and outcomes. Ask: "*has the situation improved now?*"

CONTEMPLATE what you have learnt from this process and what you would do differently next time. What else do you need to know?

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