**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?

**REFLECT** on process and new learning

**Identify problems/ issues**

**Establish goal/s**

**Process information**

**Collect cues/information**

**RELATE** what you have done with the case.

**CONSIDER** the patient situation

**EVALUATE** outcomes

Support for the development of this resource has been provided by the Australian Learning and Teaching Council Ltd, an initiative of the Australian Government Department of Education, Employment and Workplace Relations. The views expressed in this presentation do not necessarily reflect the views of the Australian Learning and Teaching Council.

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