

The Theory-Practice Gap in the Initial Assessment Phase of the Nursing Process: A Survey of Clinical Practices in a Hospital in the North-West Region of Cameroon

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Abstract

Initial nursing assessment is the first and most critical step of the nursing process, providing essential data for planning patient care. It is typically conducted at admission within 8 hours for stable patients and within 24 hours for unstable patients. Despite its importance, gaps between theory and practice persist, potentially affecting patient outcomes. This study aimed to examine nurses' conceptual understanding, practices, and challenges related to the initial assessment phase of the nursing process in a hospital in the North-West Region of Cameroon. A descriptive cross-sectional design was used among 119 nurses selected through convenience sampling. Data were collected using a semi-structured questionnaire and checklist and analyzed using SPSS version 25. Statistical significance was set at $p < 0.05$. Findings revealed that 82.4% ($n = 98$) of participants correctly identified assessment as the first phase of the nursing process, and 97.5% ($n = 116$) acknowledged its importance in improving patient outcomes. However, only 61.3% ($n = 73$) defined assessment as data collection, while a concerning minority of 38.7% ($n = 46$) viewed it as a systematic problem-solving process, indicating a gap in comprehensive conceptual depth. Physical assessment (56.3%) was more emphasized than psychosocial (42.9%) and spiritual/cultural (43.7%) dimensions. Major challenges included workload (90.1%), lack of documentation tools (74.3%), and inadequate administrative support (51.5%). It was also noted that there was no statistically significant relationship between demographic variables and activities implemented (all $p > 0.05$). The study concludes that although nurses demonstrate good theoretical awareness of initial assessment, gaps remain in conceptual

depth and holistic practice. Strengthening training, supervision, and resource availability is recommended.

Keywords

Nursing Process, Initial Assessment Phase, Theory-Practice Gap, Clinical Practice, North West Region, Cameroon

1. Introduction

The nursing process (NP) is one of the key tools used as a framework for providing professional, quality nursing care (Potter et al., 2020). It stands out as a care technology that guides the sequence of logical reasoning and improves the quality of care through systematic clinical assessments, diagnoses, interventions, and outcomes of nursing (Hinkle & Cheever, 2021; Seaback, 2019). The phases of the nursing process are assessment, diagnosis, planning, implementation, and evaluation (Dillon, 2007).

During the assessment phase, data is gathered both from the patient and their families on their perceived health problems. This stage is a cornerstone in establishing the patient's problems and needs, and the success of the entire nursing process depends on how this stage is done (Law, 1981). The assessment phase has been defined as a stage that “involves the systematic and continuous collection of data: sorting, analyzing, organizing that data; the documentation and communication of the data collected” (Ead, 2019). Dillon (2007) holds that it is the first and most important step in the nursing process. Any errors or omissions at this stage negatively affect the patients' care process (Semachew, 2018). To optimize these clinical benefits, structured frameworks have been advocated globally; a recent scoping review emphasized that utilizing designated “whole of patient” initial nursing assessment frameworks systematically reduces hospital readmissions and clinical deterioration by formalizing baseline parameters early (Wiseman et al., 2023).

Initial assessment provides preliminary data (Miskir & Emishaw, 2018). In a study to rate the utilization of the nursing process in Ethiopia, it was found that in initial assessment, the patient's demographic information is collected alongside medical-surgical, obstetrical, medication, social, and family histories, vital signs, and physical examination (Hagos et al., 2014). Mwangi et al. (2019) found that 20% of nurses had inadequate knowledge, while 34.5% acknowledged gaps in assessment. It is very common that some of its components are assessed while others are not. An incomplete assessment leaves out meaningful data that will be needed to establish a diagnosis and plan patient care.

In a study on the implementation of the nursing process, it was found that all participants had identification data on the patient's notes, 64 (77.1%) assessed the chief complaint, and 40 (48.2%) of the participants assessed the history of present-

ing illness. Most of the participants did not assess the socioeconomic (57.8%, $n = 48$), family history (61.4%, $n = 51$), and physical examination (61.4%, $n = 51$) factors. None of the participants assessed the current health state, allergies, and treatments. On observation of patient files, only 80.7% had identification data, and 51.8% did not chart vital signs correctly (Ojewole & Samole, 2017). As revealed by Hagos et al. (2014), 58.5% of nurses performed initial assessment before planning and 40.2% used a specific form. Fifty percent of the nurses said the initial assessment is done within 24 hours of admission. Identification and documentation of nursing problems was done by 71.5%, while 55.9% said they consider the patient/relative's opinion when collecting data.

Despite the importance of a complete patient assessment to nursing care, some of its activities are not done. Yuh and Narthzereth (2020) found that the assessment phase was poorly documented. The study also revealed that the psychological and social aspects of assessment were not mentioned at all. Several other studies have shown that nurses do not complete these activities (Hagos et al., 2014; Mwangi et al., 2019; Ojewole & Samole, 2017). A study on the utilization of the Nursing Process in Cameroon found that several nurses had a knowledge gap in patient assessment while some did not even know its position in the nursing process (Kimbi et al., 2025; Yuh & Narthzereth, 2020). These gaps can lead to a wrong or missed nursing diagnosis. Identification of the activities not performed can guide emphasis during workshops or seminars.

2. Objectives

- 1) To determine nurses' conceptual understanding of the initial assessment phase.
- 2) To investigate the nurses' practices during initial assessment.
- 3) To identify challenges faced during the initial assessment process.

3. Materials and Methods

Study Design and Setting

A descriptive cross-sectional study design was adopted. The study was conducted in a hospital in the North-West Region of Cameroon, covering medical, surgical, pediatric, and intensive care units.

Study Population and Selection Criteria

The study population comprised registered nurses providing bedside care in the selected hospital. All nurses with at least a diploma in nursing who consented to participate and were available during data collection were included. Incomplete questionnaires were excluded from analysis.

Sample Size Determination

The sample size was determined using the standard Cochran's formula (16) (Cochran, 1977):

$$n_0 = \frac{Z^2 pq}{d^2}$$

where:

n_0 = minimum sample size required for the study.

Z = standard normal distribution variable ($Z = 1.96$ for a 95% confidence interval).

p = expected population proportion ($p = 0.5$ for maximum variability).

$q = 1 - p = 0.5$.

d = tolerable margin of error ($d = 0.05$).

Calculating the initial sample size:

$$n_0 = 1.96(1.96) (0.5(0.05))/0.05(0.05) = 384$$

After applying finite population correction based on the facility's accessible population ($N = 172$) and accounting for non-response safety factors, the final sample size was established at 119 participants. Since all distributed tools were successfully completed, a 100% response rate was maintained.

Sampling Technique and Instruments

The sampling technique used was convenience sampling based on ward availability across shifts. A semi-structured self-administered questionnaire and an observation checklist were used for data collection. Both instruments had the same activities. The checklist was used by the principal investigator, who was actively involved in the data collection process, to observe the participants. The participants had been informed of the observations during consent, but the specific time for the observation was not mentioned. The checklist had a rubric with "not performed, performed and well performed" which were ticked by the observer (principal investigator).

The proportion of self-reported activities performed was used to determine participants' compliance with the standard initial assessment. Multiple linear regression was used to model the relationship between sociodemographic variables, training exposure and workload and their level of compliance. To ensure scientific rigor, instrument reliability was pre-tested in a separate hospital facility, demonstrating a stable Cronbach's alpha coefficient of $\alpha = 0.79$.

Ethical Considerations

Ethical clearance was sought from The University of Bamenda Institutional Review Board/Ethical Review Committee, referenced 2024/0019H/UBa/IRB. Administrative research authorizations were fully obtained from the Regional Delegation for Health, North West (414/ATT/NWR/RDPH/BRIGAD) alongside internal clearance from the targeted hospital's administration. Prior to data collection, written informed consent was acquired from each participant. Complete anonymity was maintained by using unique identifier numeric codes instead of personal names.

Data Analysis

Descriptive and inferential analysis was done using the SPSS version 25 (Statistical Package for the Social Sciences). Values were expressed as counts, percentages, and frequency configurations. Statistical significance indicators were evaluated using a threshold of $p < 0.05$.

4. Results

Demographic characteristics of the study participants

Table 1 shows that the majority of the 119 participants were young adults, with 99 (83.2%) aged 21 - 30, and female, 88 (73.9%). Academically, most held a BSc. in Nursing, 91 (76.5%), and nearly half had less than two years of professional experience, 59 (49.6%).

Table 1. Distribution of participants according to demographic information.

Variable	Criteria	Frequency (n)	Percent (%)
Age (years)	<21	1	0.8
	21 - 30	99	83.2
	31 - 40	12	10.1
	>40	7	5.9
Gender	Male	31	26.1
	Female	88	73.9
Academic qualification	State Registered Nurse	23	18.3
	BSc. in Nursing	91	76.5
	Masters in Nursing	5	4.2
Years of professional experience (years)	<2	59	49.6
	2 - 5	47	39.5
	6 - 10	6	5.0
	>10	7	5.9
Unit/Department	Medical	59	49.6
	Surgical	26	21.8
	Pediatrics	20	16.8
	ICU	13	10.9
	Other	1	0.8
Average patient load per shift	<5	7	5.9
	5 - 10	57	47.9
	11 - 15	25	21.0
	>15	30	25.2
Time of last training on assessment phase (years)	<1	61	51.3
	1 - 3	36	30.3
	>3	22	18.5
	Total	119	100.0

Participants were primarily from the medical unit, 59 (49.6%), and typically managed a patient load of 5 - 10 individuals per shift, 57 (47.9%). Finally, slightly over half had received training on the assessment phase within the last year, 61 (51.3%) (**Table 1** above).

Conceptual understanding of the initial assessment phase of the nursing process.

Distribution of participants based on their opinion on the position of assessment in the nursing process.

Table 2 shows that an overwhelming majority 98 (82.4%) of participants correctly identified the assessment step as the first phase of the nursing process.

Table 2. Distribution of participants based on their opinion on the position of the assessment phase in the nursing process.

	Frequency (n)	Percent (%)
First	98	82.4
Second	11	9.2
Third	10	8.4
Total	119	100.0

Participants' conceptual understanding of the assessment phase of the nursing process.

Figure 1 indicates a divergence in participants' conceptual understanding of the assessment phase. While a substantial portion, 73 (61.3%), defined it primarily as "gathering patient information," a significant minority of 46 (38.7%) provided an alternate definition, identifying it as a "systematic problem-solving process."

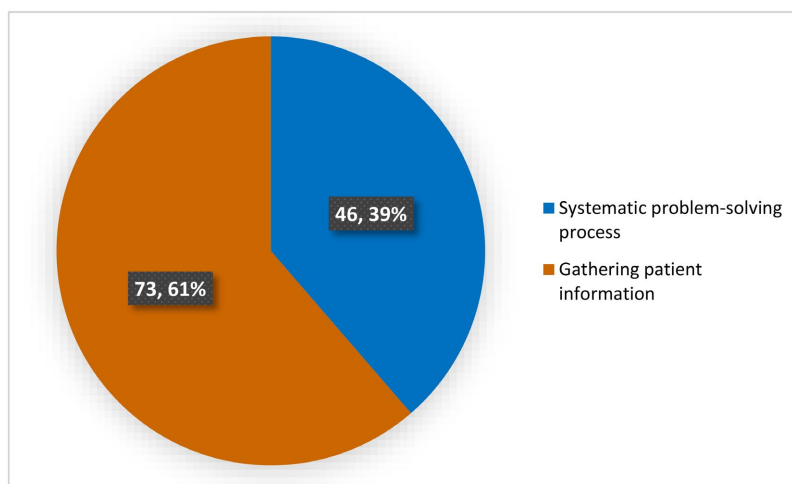


Figure 1. Distribution of participants' opinion on what the assessment phase is (n = 119).

Participants' opinion on when initial assessment should be done.

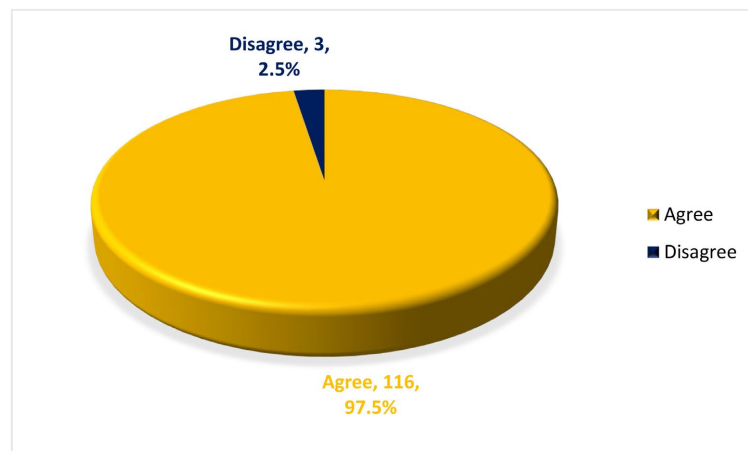
Table 3 reveals that a strong majority of participants, 97 (81.5%), correctly recognize that the initial nursing assessment should be conducted upon a patient's admission. However, a notable proportion held less immediate views, with 16 (13.4%) believing it should be done within the first 12 hours and 6 (5.0%) within the first 24 hours, indicating a potential variance in practice standards regarding the timelines of this critical first step.

Table 3. Distribution of participants' opinion on when initial assessment should be done.

	Frequency (n)	Percent (%)
On admission	97	81.5
First 12 hours	16	13.4
First 24 hours	6	5.0
Total	119	100.0

Initial nursing assessment and its influence on patient outcomes.

Figure 2 demonstrates participants' opinion on the importance of initial nursing assessment, with 116 (97.5%) agreeing that it positively influences patient outcomes. The near-unanimous agreement underscores a strong professional recognition of initial assessment as a foundational and impactful component of nursing care, while the minimal disagreement, represented by 3 (2.5%) of respondents, indicates a negligible dissenting perspective on this established principle.

**Figure 2.** Participant opinion on how initial assessment influences patient outcomes (n = 119).

Activities involved in the initial assessment phase of the nursing process.

Distribution of respondents based on their activities during initial assessment

Figure 3 presents the detailed initial assessment components used during the assessment phase, highlighting variations in emphasis among participants. The most frequently reported components were physical assessment 67 (56.3%), inspection 62 (52.1%), past medical/surgical history 60 (50.4%), and palpation 60 (50.4%). Other commonly noted components included present history 50 (42.0%), spiritual and cultural assessments 52 (43.7%), psychosocial assessment 51 (42.9%), and biographical information 49 (41.2%).

Observations of initial assessment activities among nurses.

Figure 4 presents that on observation, biographical data, vital signs and recording were seen to record 100% performance. However, none of these rated well performed when rated as “not performed”, “performed” and “well performed”. Percussion, organization and validation were not performed at all.

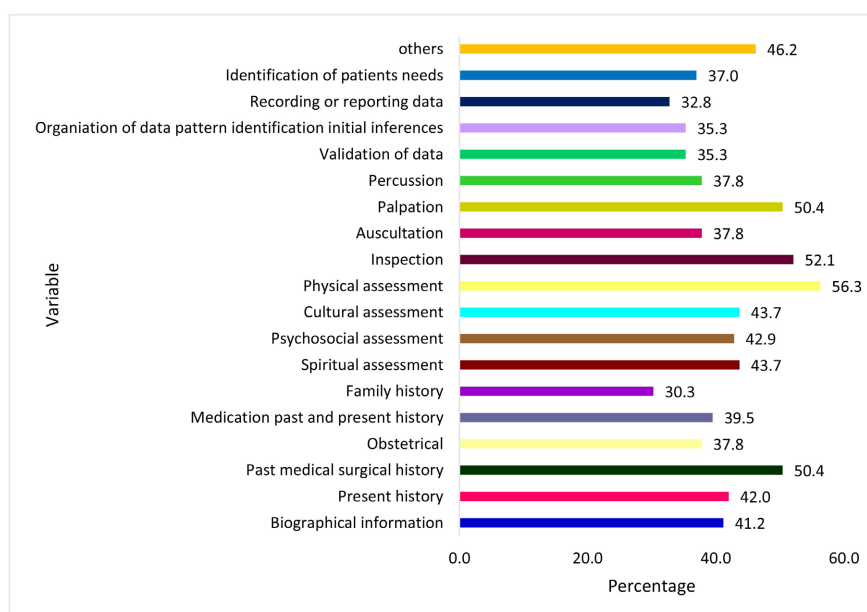


Figure 3. Participants' self-reported rating of activities carried out in the initial assessment.

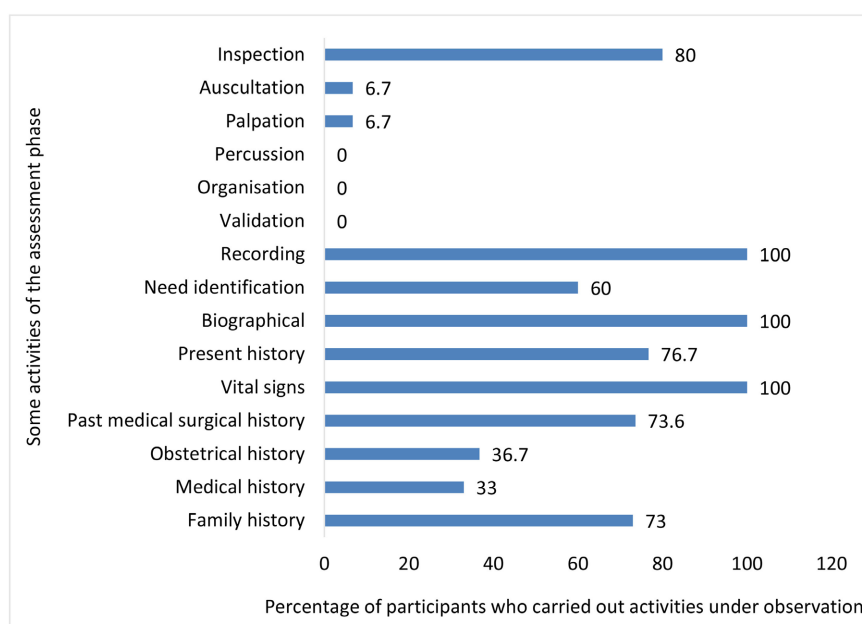


Figure 4. Observation checklist metrics across active nursing actions (n = 119).

Initial assessment activities routinely performed by nurses.

Table 4 shows that a large majority of participants, 83 (69.7%), reported routinely performing 75% - 84% of assessment activities while the smallest portion, 15 (12.6%), performed 50% - 74%.

Association between demographic variables and compliance to initial assessment.

Table 5 below shows that all p values while associating demographic variables and initial assessment activities carried out were not statistically significant ($p > 0.05$).

Table 4. Distribution of approximate proportion of assessment activities routinely performed by nurses.

Proportion of activities performed (%)	Frequency (n)	Percent (%)
<50	21	17.6
50 - 74	15	12.6
75 - 84	83	69.7
85 - 100	0	0
Total	119	100.0

Table 5. Multiple linear regression predicting compliance to the standard nursing assessment.

Predictor Variable	B	SE B	β	t	p
Academic qualification	-0.236	0.153	-0.154	-1.54	0.127
Years of professional experience	-0.13	0.105	-0.138	-1.239	0.218
Average patient load per shift	-0.028	0.082	-0.033	-0.343	0.732
Time of last training on assessment	-0.138	0.117	-0.137	-1.184	0.239
Received formal training (Yes/No)	-0.043	0.26	-0.022	-0.164	0.87
Number of trainings attended	0.077	0.172	0.076	0.447	0.656

R = 0.453, R² = 0.205, Adjusted R² = 0.023, F (22, 96) = 1.126, p = 0.335, Durbin-Watson = 2.017. Note: B = unstandardized coefficient; SE B = standard error; β = standardized coefficient. * $p < 0.05$ = statistically significant at the 5% level.

Challenges faced by nurses in doing a comprehensive initial assessment.

Table 6 based on challenges of initial assessment among participants highlights that most participants (90.1%) said workload was a challenge, 74.3% said the absence of space for documentation, and lack of administrative support at 51.5%. Meanwhile, 0.8% said it was not necessary and 3.4% said it was the physician's responsibility.

Table 6. Distribution of participants according to challenges faced in doing initial assessment.

Challenge category	Disagree n (%)	Agree n (%)
Clients dissatisfaction	87 (73.3)	32 (26.7)
Environment	75 (68.3)	44 (31.7)
Few staff	24 (19.8)	95 (80.2)
Ignorance	81 (68.3)	38 (31.7)
Lack of administrative support	58 (48.5)	61 (51.5)
Lack of incentives	102 (86.1)	17 (13.9)
Lack of policies/procedures	85 (71.3)	34 (28.7)
Absence of space for documentation	31 (25.7)	88 (74.3)
Perceived as not clinically necessary	118 (99.2)	1 (0.8)
Perceived as Physician's responsibility	115 (96.6)	4 (3.4)
Heavy Work load	12 (9.9)	107 (90.1)

5. Discussion

The findings in this study reveal a paradoxical landscape in the current practices of the initial assessment phase of the nursing process. A significant majority of nurses (82.4%) correctly identify assessment as the first phase, and an overwhelming 97.5% acknowledge its critical influence on patient outcomes. This strong theoretical recognition aligns with the foundational principles of the nursing process as a systematic method for delivering care (Seaback, 2019). A minor though surprising percentage misidentify the position of the initial assessment in the nursing process.

However, the positive disposition by the majority is immediately challenged by the nurses' conceptual understanding of the phase itself. Only 61.3% define assessment simply as "gathering patient information," while a concerning minority of 38.7% saw it as "a systematic problem-solving process". This divergence is critical. According to Ida Jean Orlando's theory, the nursing process is interactive and responsive, where assessment, seen as "gathering patient information" is not passive data collection but an active exploration to understand the patient's immediate distress and determine what help is needed (Batra et al., 2016). Qualitative work by Areri et al. (2024) confirms that when clinical nurses reduce this step to checklist-driven information gathering without recognizing the integrated cognitive steps of Orlando's theory, execution remains fragmented and fails to guide subsequent diagnostic phases.

The view of assessment as information gathering risks reducing the nurse to a technician, undermining the deliberative, problem-solving function that is central to professional nursing, but it must be noted that the last step in the assessment phase of the nursing process is identification of the patient's problem. In the context of the nursing profession, "systematic problem-solving process" defines the nursing process, while assessment, which is the first phase of this process is aimed at gathering patient information.

This finding also resonates with the concerns raised in the systematic reviews by Zamanzadeh et al. (2015) and Tadzong-Awasum and Dufashwenayesu (2021) which identified "insufficient conceptual understanding of the nursing process" as a primary barrier to its implementation. The nurses' preference for a simplistic definition suggests that while they know when the process starts (position), about 38.7% of them may not fully grasp the cognitive work that defines it (function), creating a foundational weakness that can compromise all subsequent steps of the nursing process.

The practical application of the assessment phase further illustrates this theory-practice gap. While 81.5% correctly assert that the initial assessment should occur upon admission, a notable 18.4% believe it can be delayed for up to 24 hours. This variance in perceived timing is significant. This delay directly contradicts the purpose of assessment as outlined by Orlando, where immediate engagement with the patient is necessary to identify and address their presenting needs (Sam-poornam, 2015). Furthermore, this finding echoes the work of Bayih et al. (2021)

in their Ethiopian meta-analysis, which identified that implementation of the nursing process is suboptimal and associated with factors like workload and institutional support. A perceived allowance to delay assessment may be a coping mechanism for a heavy workload, or it may stem from a lack of clear, enforced protocols. This delay, regardless of its cause, compromises the very foundation of patient care, as a delayed assessment can lead to missed cues, delayed interventions, and poorer patient outcomes.

The activities nurses prioritize during the initial assessment phase provide the most granular view of their current practices. The most frequently reported components were physical assessment (56.3%), inspection (52.1%), and past medical/surgical history (50.4%). While these are undeniably crucial, their dominance, coupled with the lower reporting of psychosocial (42.9%), spiritual/cultural (43.7%), and biographical (41.2%) data, suggests a practice that remains heavily biomedically focused. This pattern is indirectly supported by the findings of [Melin-Johansson et al. \(2017\)](#), who discussed the role of clinical intuition. While intuition can guide a nurse, it develops from a deep, pattern-based understanding of patients that comes from consistently applying comprehensive, structured assessments.

Based on the observation findings, none of the participants did percussion while only 6.7% did palpation and auscultation. These results contrast the findings of [Melindayanti et al. \(2025\)](#) where 54.4% did physical examination. If the initial assessment is routinely narrow, the foundation for developing nuanced clinical intuition is weakened, potentially forcing nurses to rely on “rapid non-analytic judgements” that may miss critical psychosocial or cultural factors influencing the patient’s health. This narrow focus underscores the utility of target-driven administrative strategies; as shown by [Tolera et al. \(2025\)](#), structured quality improvement projects that integrate mandatory, specialized formatting templates and iterative staff sensitization can effectively drive process adherence up from baseline rates.

The current practices of nurses regarding the initial assessment phase represent a state of transition caught between theoretical knowledge and practical execution. While there is a strong theoretical buy-in regarding the importance and position of assessment, this has not fully translated into a sophisticated conceptual understanding or a consistently comprehensive, timely practice. The nurses appear to be operating with a biomedical model of assessment, rather than the holistic, problem-solving model mandated by Orlando’s theory and operationalized by Gordon’s framework. This implementation gap is consistent with the international literature. The challenges identified by [Kimbi et al. \(2025\)](#), [Zamanzadeh et al. \(2015\)](#), and [Tadzong-Awasum and Dufashwenayesu \(2021\)](#) as conceptual ambiguity, inadequate training, heavy workloads and lack of documents are likely contributing factors.

Similarly, the findings of [Bayih et al. \(2021\)](#) underscore that simply knowing about the nursing process and specifically initial assessment is insufficient; it re-

quires ongoing education, strong institutional support, and adequate resources to become embedded in practice. The gap between self-reported proportion of activities performed (compliance) and observed activities suggests that some participants might have responded based on their knowledge, not practice. This is a known bias in self-reported data.

Qualification, experience, training exposure, and average patient load per shift have no statistical significance with compliance to assessment procedures. This suggests that compliance may not be driven by individual competencies alone but may be more deeply rooted in broader organizational or systemic factors. For example, compliance might be influenced by workflow structure, leadership enforcement, workload magnitude, or the availability of user-friendly assessment tools—factors not fully captured within the work. Practically, this means healthcare managers should not assume that improving training alone will automatically enhance compliance. Instead, more comprehensive interventions such as strengthening supervision, integrating electronic documentation systems, reinforcing accountability mechanisms, and improving working conditions may be needed. The non-significant findings further suggest that compliance may be more behavioral and context-driven rather than skill-driven.

6. Conclusion

The study concludes that nurses possess good theoretical knowledge of the initial assessment phase of the nursing process. However, significant gaps exist in conceptual understanding and comprehensive practice. Institutional and organizational challenges further hinder effective implementation. Strengthening continuous professional training, supervision, and resource availability is essential to improve nursing assessment practice.

Recommendations

- 1) Regular in-service training on initial assessment and the nursing process as a whole should be organized.
- 2) Hospitals should provide standardized assessment tools and documentation templates.
- 3) Staffing levels should be improved to reduce workload.
- 4) Supervisory systems should be strengthened to ensure compliance with assessment standards.
- 5) Continuous professional development programs should emphasize holistic patient assessment.

Limitations

Very limited studies have been done focusing only on the initial assessment phase of the nursing process, hence it has been quite challenging getting empirical literature for the study, and even appropriate works to relate them.

Convenience sampling in a single hospital setting severely limits the generali-

zability and representativeness of these findings, as the sample likely reflects specific local demographics and institutional biases rather than the broader national healthcare landscape. Furthermore, the descriptive cross-sectional design prevents causal interpretation because data were collected at a single point in time, making it impossible to establish a definitive temporal sequence between organizational exposures and nursing compliance outcomes.

Declarations

Authors' Contributions

RBK was involved from the conception, designing, analyzing, interpreting reports; LFN and AMB supervised the work. All have read and approved this manuscript.

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Conflicts of Interest

The authors declare no conflict of interest.

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