全国高等学校创新教材

供本科护理学类专业用

护理专业英语

第2版

主编 高燕 郭宏

人民卫生出版社

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人民卫生出版社

图书在版编目(CIP)数据

护理专业英语 / 高燕，郭宏主编. —2 版. —北京：人民卫生出版社，2015

ISBN 978-7-117-20013-4

Ⅰ. ①护… Ⅱ. ①高… ②郭… Ⅲ. ①护理学－英语－医学院校－教材 Ⅳ. ①H31

中国版本图书馆 CIP 数据核字(2015)第 033116 号

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主　　编：高　燕　郭　宏
出版发行：人民卫生出版社（中继线 010-59780011）
地　　址：北京市朝阳区潘家园南里 19 号
邮　　编：100021
E - mail：pmph @ pmph.com
购书热线：010-59787592　010-59787584　010-65264830
印　　刷：北京汇林印务有限公司
经　　销：新华书店
开　　本：787 × 1092　1/16　　**印张：**17
字　　数：424 千字
版　　次：2009 年 2 月第 1 版　　2015 年 3 月第 2 版
2015 年 3 月第 2 版第 1 次印刷（总第 2 次印刷）
标准书号：ISBN 978-7-117-20013-4/R · 20014
定　　价：35.00 元
打击盗版举报电话：010-59787491　E-mail：WQ @ pmph.com
（凡属印装质量问题请与本社市场营销中心联系退换）

前　言

护理专业英语是全国高等学校护理专业本科创新教材体系中的一门专业教科书。本教材可供护理专业普通本科和涉外护理方向本科生使用，也可作为临床护理人员自学专业英语的参考书。本教材的特点如下：

1. 紧贴护理专业，突出护理特色，内容有机而完整。

本教材将英语教学和专业教学有机结合，内容紧贴护理专业。每个单元都有一个明确的护理专科主题，从文章、习题到情景会话都紧密围绕着单元主题而编写。十二个单元涵盖了护理专业最常见的专科护理和护理项目，包括了临床上最常见的疾病名称、症状，常用的治疗方法和护理措施等。这样使学生在学习专业英语的同时强化专业知识，也增加了学习的趣味性，增强了教材的实用性。

2. 教材难度由浅入深，循序渐进，以满足不同程度学习者的需求。

本教材以培养学生专业英语阅读能力为主，含口语会话练习。每个单元含三篇阅读文章和一段情景会话。三篇阅读文章由浅入深，相互照应，难度和长度上逐篇加大，以供不同英语程度学习者使用。Warm up 的阅读文章可供学生课前自测练习，也可作为课堂的热身练习。Passage one 阅读文章适合护理专业普通本科生学习，内容涉及各专科的基本知识或经典病例，并配有各种形式的课后练习以帮助学生掌握。Passage two 供涉外护理专业本科生、护理研究生或有能力的学生自学。文章涉及专科知识更广且深，多选自原版专业教材。教师可根据学生英语水平和学时数决定是全部选用，还是选用某一部分。

3. 实用性强，融合多种护理英语考试题型。

本书增加了与医护英语水平考试三级难度相当的文章和习题，同时按专科选取国际护士执业考题供学生学习，还分类列出常见的医学术语，为学生在校和日后面临的各种护理英语考试以及阅读医学专业文献打下良好的基础。

本教材的编写团队是由一批高学历、高素质、充满创新精神的教师组成。她们大都具有海外学习、进修的经历，且均来自护理教学一线，各单元主题也是由具有相应护理专科工作经验的教师执笔。为保证教材严谨性，我们还邀请国外护理专家参与教材的编写与审核，在此一并致谢。由于护理专业英语教材编写难度大、编写时间紧迫和编者水平有限，书中疏忽、缺漏及不足之处在所难免，望同行和读者发现后不吝赐教。

编　者

2015 年 2 月

CONTENT

Chapter 1 Fundamentals of Nursing

Section A Readings

Warm-up

Vital Signs

Vital signs—temperature (T), Pulse (P), respirations (R), and blood pressure (BP) —are indicators of a person's health status. Many factors such as the temperature of the environment, physical activity and the effects of illness cause vital signs to change, sometimes beyond a normal range. An alteration from normal range may signal the need for medical or nursing intervention. Checking the vital signs is a quick and efficient way of monitoring a condition or identifying the presence of problems. Hospitalized patients have vital signs measured several times a day. The purpose of this assessment is to establish baseline data in order to judge the significance of deviations from what appear to be the "characteristic" or "normal" vital signs for an individual. They must be measured and recorded accurately. Any vital sign that is changed from a previous measurement must be reported immediately.

● Body Temperature

Body temperature is a measurement of the amount of heat in the body. Body temperature reflects the balance between the heat produced and the heat lost. The Fahrenheit (F) and Centigrade or Celsius (C) scales are used to measure temperature. The common sites for measuring body temperature are the mouth, rectum and axilla. The normal adult body temperature is about 37℃. There is a normal range 36-37℃in which a person's body temperature may vary and still be considered normal.

● Pulse

The pulse is the rhythmical throbbing of arteries produced by the regular contraction of the heart. When the heart beats, it pumps a certain amount of blood into the arteries which causes the arteries to expand and return to their normal size. Pulse rate is usually assessed at the wrist and neck. It is measured to show how fast the heart is beating. Normal adult pulse rate is from 60 to 100 beats per minute. Measuring the pulse is a simple method of observing how the circulatory system is functioning.

● Respiration

Respiration is a general process the human body uses to exchange gases between itself and the atmosphere. It refers to the intake of air into the lungs and the transport of oxygen to the body cells through the blood. Several factors can affect respiration such as age, sex, exercise, emotion

and etc. Normal respiration rate is from 16 to 20 times per minute.

● **Blood pressure**

Blood pressure is the force of the blood pushing against the walls of the arteries. It indicates arterial pressure. The highest pressure is called systolic pressure. The diastolic pressure is the pressure when the ventricles are at rest, which is the lowest pressure. The difference between systolic and diastolic pressure is the pulse pressure. The normal range of the systolic pressure for healthy adults is 90 to 140mmHg; the diastolic pressure is 60 to 90mmHg, and the pulse pressure is 30 to 40 mmHg. Hypotension and hypertension are common blood pressure abnormalities that refer to blood pressure values above 90/140mmHg and below 60/90mmHg.

New Words and Phrases

vital ['vaitl] adj. 至关重要的，维持生命所必需的
respirations [respə'reiʃnz] n. 呼吸（作用）
hospitalized ['hɔspɪtl,aɪzd] v. 送…住院，使留医
celsius ['selsiəs] adj. 摄氏的 n. 摄氏度
temperature ['temprətʃə(r)] n. 温度
throbbing [θrɔbiŋ] adj. 跳的 v. 跳动，悸动
contraction [kən'trækʃ(ə)n] n. 收缩，紧缩

Exercises

A. Select the best answer from the choices given according to the passage

1. Which of the following statements is not true according to the first paragraph?
   a. The change of vital signs could be caused by many factors.
   b. Hospitalized patients have vital signs measured several times a day.
   c. Sometimes an alteration from normal may not need for medical or nursing intervention.
   d. We can monitor a condition or identify the presence of problems by checking vital signs.
2. The reason why the hospitalized patients have vital signs measured several times a day is that.
   a. It is a rule carried out by the hospital.
   b. The patients ask the nurses to do such work.
   c. To identify what illness they have.
   d. To establish baseline data in order to judge if they are normal or need to be reported immediately.
3. Which of the following statements is true about body temperature?
   a. Body temperature is a measurement of the amount of heat produced in the body.
   b. Only the Fahrenheit (F) scale is used to measure temperature.
   c. The common sites for measuring body temperature are the mouth, rectum and axilla.
   d. It is not normal if a person's body temperature is not 37℃.
4. From the passage, we know pulse
   a. is the rhythmical throbbing of arteries produced by the regular contraction of the heart.

b. is only assessed at the wrist.

c. is measured to show how fast the veins are beating.

d. is an accurate sign of how the circulatory system is functioning.

B. Chart and documentation: Respiratory Rates

1. Mr. Wilmott, an 86-year-old man who lives alone, has been admitted to the hospital for treatment. In pairs, look at his record and discuss the following questions.

a. What is Mr. Wilmott's diagnosis?

b. What did happen in the morning?

c. What is the treatment?

Patient Record

Surname: Wilmot Given name: Ronald DOB:15.9.1933 ADM: 28.3.2008 Sex :Male	
DATE&TIME	
11:00 28/03/08	New admission to the ward with a diagnosis of poorly managed asthma. Recent URTI treated with antibiotics. Pt still c/o SOB. RR elevated. For CXR and review by Respiratory Team in am. Started on p/f readings and Pt ed. regarding asthma.

2. Abbreviations are often used in both Patient Records and verbal handovers. Some are only found in written documents. It is important to check which abbreviations are approved at the hospital where you are working, as there may be some variance. Match the abbreviations from the Patient Records to their meanings.

(1). DOB	a. respiratory rate
(2). c/o	b. admission date
(3). ADM	c. shortness of breath
(4). URTI	d. date of birth
(5). SOB	e. complain of
(6). RR	f. chest X-ray
(7). CXR	b. peak flow; the most air expired
(8). p/f	c. patient education
(9). Pt ed	d. under respiratory tract infection

C. Match the pictures with the following fever patterns.

a. **Sustained Fever**: the body temperature sustains above 39℃, but has little fluctuation of less than 1℃in 24h.

b. **Irregular Fever**: The body temperature irregularity alternates between a period of fever and a period of normal temperature values.

c. **Remittent Fever**: the body temperature has great fluctuation above the normal with more than 1℃in 24h.

d. **Relapsing Fever**: the body temperature suddenly rises above 39℃and sustains for several days then suddenly falls to normal or below normal.

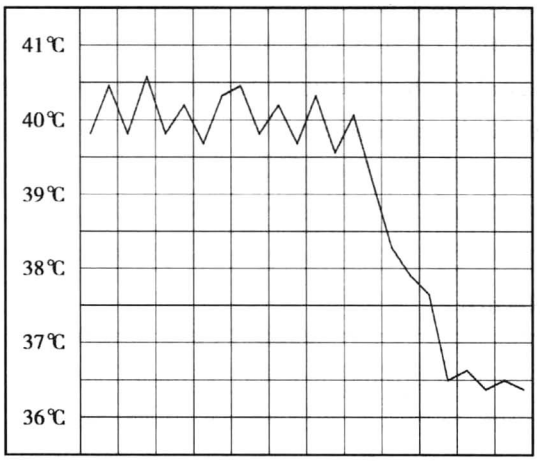

Fig. 1-1

(1) _____

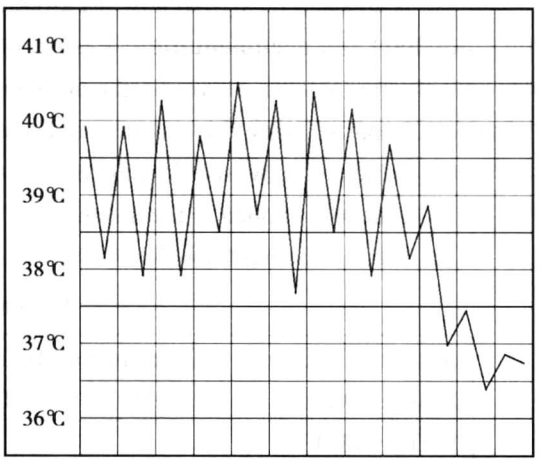

Fig. 1-2

(2) _____

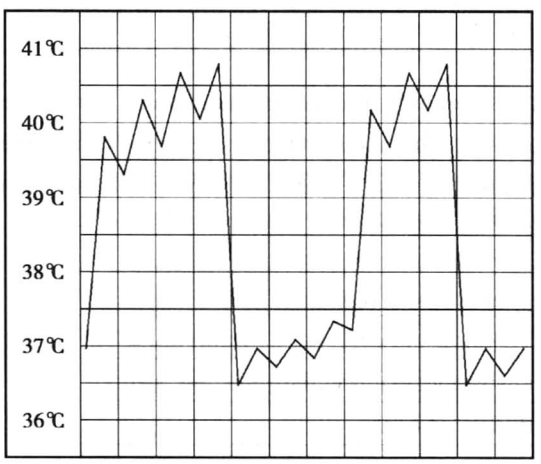

Fig. 1-3

(3) _____

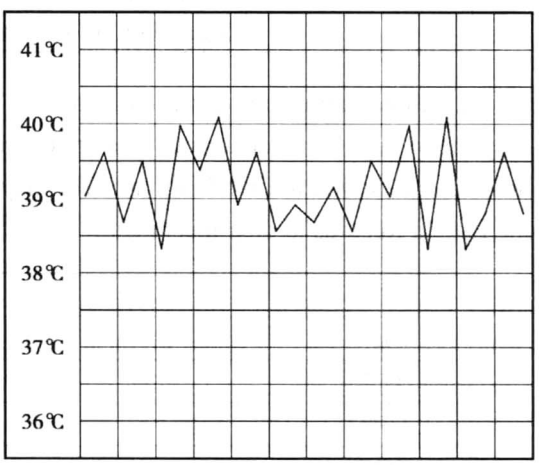

Fig. 1-4

(4) _____

Passage one

Nursing Process

● **Introduction**

The nursing process is an orderly, systematic and scientific method of identifying and treating client's response to actual or potential health problems. It is an integrated, dynamic, strategic and feedback thinking and practice process. The nursing process is used for the purpose of promoting and regaining health and to carry out a series of nursing activities. It bases on several theories, such as system theory, cybernetics and etc. Four basic core concepts involved

in the nursing process include client, environment, health and nursing. The nursing process was proposed by Dr. Hall in 1955. She theorized that the nursing process is a scientific working procedure concerning observation, measurement, data collection and analysis of the result. After Hall, some theorists tried to enrich the nursing process until Yura and Walsh ascertained the four steps of the nursing process: assessment, diagnosis, implementation and evaluation in 1967. Gebbie and Lavin added the nursing diagnosis in the nursing process in 1973. On the same year, American Nurses Association (ANA) stipulated the process which included the five major steps: assessment, diagnosis, planning, implementation and evaluation.

● **Assessment**

Assessment is the deliberate and systematic collection of information about a patient to determine his/her current and past health history, functional status and his/her past and present coping patterns. Nursing assessment includes five steps: data collecting, data validation, organizing data, data analysis and data documentation. Data collecting has two primary sources of data: subjective data and objective data. Subjective data are the patients'verbal descriptions of their health problems. Only patients provide subjective data. Subjective data usually include feelings, perceptions, and self-report of symptoms. Objective data are observations or measurements of a patient's health status. Inspecting the condition of a surgical incision or wound, describing an observed behavior, and measuring blood pressure are examples of objective data. The nurses collect the data according to two methods: interviewing patient and checking objective clinical documents. The data content involves patient's common information, present illness and patient's expectation. The nurses could analyze the data by three methods: (a) Maslow's hierarchy of needs. (b) Gordon's functional health patterns. (c) NANDA taxonomy. The successful interpretation and validation of assessment data ensure a collection of a complete database of the patient. Ultimately this leads to the second step of the nursing process, in which clinical decisions are made in the patient's care. Data documentation is the last part of a complete assessment. The timely, thorough, and accurate documentation of facts is required in recording patient data.

● **Diagnosis**

During the nursing assessment process, a nurse gathers the information needed to make diagnostic conclusions about patient care. A diagnosis is a clinical judgment based on information. The nurse reviews information collected about a patient, sees cues and patterns in the data, and identifies the patient's specific health care problems. Some of the conclusions lead to identifying nursing diagnoses, whereas others do not. Diagnostic conclusions include problems treated primarily by nurses (nursing diagnoses) and those requiring treatment by several disciplines (collaborative problems). Nursing diagnoses and collaborative problems represent the range of patient conditions that require nursing care. There are four types of nursing diagnosis: actual nursing diagnosis, risk nursing diagnosis, wellness nursing diagnosis and syndrome nursing diagnosis. An actual nursing diagnosis describes human responses to health conditions or life processes that exist in an individual, family, or community, such as impaired social interaction. A risk nursing diagnosis describes human responses to health conditions or life processes that may

develop in a vulnerable individual, family, or community, such as risk for loneliness. A wellness nursing diagnosis is a clinical judgment of a person's, family's, or community's motivation, desire, and readiness to increase well-being and actualize human health potential as expressed in their readiness to enhance specific health behaviors, for example, nutrition and exercise. A syndrome nursing diagnosis is a series current or potential nursing diagnoses caused by a special situation or incident. A nursing diagnosis comprises four parts: label, definition, defining characteristic and related factors. The PES format is a common nursing diagnosis statement including problem (P), etiology (E) and symptoms or signs (S) such as impaired physical mobility(P) related to incisional pain (E), evidenced by restricted turning and positioning(S).

● **Planning**

After you identify a patient's nursing diagnoses and collaborative problems, you begin planning, the third step of the nursing process. Planning involves setting priorities, identifying patient-centered goals and expected outcomes, and prescribing individualized nursing interventions. Ultimately during implementation, interventions resolve the patient's problems and achieve the expected goals and outcomes. A plan of care is dynamic and changes as the patient's needs change. Priority setting is classifying nursing diagnoses or patient problems according to urgency and/or importance to establish a preferential order for nursing actions. In other words, as the nurse cares for a patient or a group of patients, he/she must deal with certain aspects of care before others. By ranking a patient's nursing diagnoses in order of importance, you attend to each patient's most important needs and organize ongoing care activities better. The elements of planning include setting the priorities, establishing goals and expected outcome, selecting the intervention and writing the plan. First, the nurse needs to classify a patient's priorities as high, intermediate, or low importance. Nursing diagnoses that, if untreated, result in harm to a patient or others (e.g., those related to airway status, circulation, safety, and pain) have the highest priorities. Intermediate priority nursing diagnoses involve none emergency, nonlife-threatening needs of patients. Low-priority nursing diagnoses are not always directly related to a specific illness or prognosis but affect the patient's future wellbeing.

● **Implementation**

Implementation, the fourth step of the nursing process, formally begins after the nurse develops a plan of care. With a care plan based on clear and relevant nursing diagnoses, the nurse initiates interventions that are designed to achieve the goals and expected outcomes needed to support or improve the patient's health status. A nursing intervention is any treatment based on clinical judgment and knowledge that a nurse performs to enhance patient outcomes. Interventions include direct and indirect care measures aimed at individuals, families, and/or the community. Direct care interventions are treatments performed through interactions with patients. Indirect care interventions are treatments performed away from the patient but on behalf of the patient or group of patients. Preparation for implementation ensures efficient, safe, and effective nursing care. Five preparatory activities include reassessing the patient, reviewing and revising the existing nursing care plan, organizing resources and care delivery, anticipating and preventing complications, and implementing nursing interventions.

● **Evaluation**

Evaluation, the final step of the nursing process, is crucial to determine whether, after application of the nursing process, the patient's condition or well-being improves. You apply all that you know about a patient and his or her condition and your experiences with previous patients to evaluate whether nursing care was effective. You conduct evaluative measures to determine if your patients met expected outcomes, not if nursing interventions were completed. The expected outcomes established during planning are the standards against which the nurse judges whether goals have been met and if care is successful. During evaluation you make clinical decisions and continually redirect nursing care. To determine if the goals have been achieved involves two components: observation of client's changes about behaviors and response; judgment about how well these changes meet the expected outcomes by the changes and the expected outcomes. Revision of care plan is based on the reassessment of the client. The plan will be stopped, continued, cancelled or modified after reassessment.

New Words and Phrases

orderly ['ɔ:dəli] adj. 有秩序的，整齐的
integrate ['intigreit] vt. 使…完整，使…成整体 adj. 整体的
dynamic [dai'næmik] adj. 动态的，动力的，动力学的 n. 动态，动力
strategic [strə'ti:dʒik] adj. 战略上的，战略的
feedback ['fi:dbæk] n. 反馈
cybernetics [ˌsaibə'netiks] n. 控制论
stipulate ['stipjuleit] vi. 规定，保证 vt. 规定，保证
deliberate [di'libərət] adj. 故意的，深思熟虑的，从容的
perception [pə'sepʃn] n. 知觉，感觉，看法
symptom ['simptəm] n. 症状，征兆
surgical ['sɜ:dʒikʒl] adj. 外科的，手术上的 n. 外科手术，外科病房
incision [in'siʒən] n. 切口，切割，切开
interpretation [in,tɜ:pri'teiʃn] n. 解释，翻译，演出
syndrome ['sindrəum] n. 综合征，并发症状
vulnerable ['vʌlnərəbl] adj. 易受攻击的，易受…的攻击
readiness ['redinəs] n. 准备就绪，愿意
etiology [ˌi:ti'ɔlədʒi] n.[病理] 病因学，病原学，致病源
positioning [pə'ziʃniŋ] n. 定位，配置 v. 定位
collaborative [kə'læbərətiv] adj. 合作的，协作的
prescribe [pri'skraib] vi. 开药方 vt. 规定，开处方
preferential [ˌprefə'renʃl] adj. 优先的，选择的，特惠的，先取的
revise [ri'vaiz] v. 修正，复习，校订 n. 修订，校订
assessment [ə'sesmənt] n. 评定，估价
diagnosis [ˌdaiəg'nəusis] n. 诊断
evaluation [iˌvælju'eiʃn] n. 评价，评估，估价，求值

taxonomy [tæk'sɔnəmi] n. 分类学，分类法
validation [ˌvæli'deiʃn] n. 确认，批准，生效
cue [kju:] n. 提示，暗示，线索 vt. 给…暗示
outcome ['autkʌm] n. 结果，结局，成果
intervention [intə'venʃ(ə)n] n. 介入，调停，妨碍
urgency ['ɜ:dʒənsi] n. 紧急，催促，紧急的事
interaction [ˌintər'ækʃn] n. 相互作用，互动
reassessment [ri:ə'sesmənt] n. 重新评估，重新考虑

Exercises:

A. Answer the following questions

1. The information obtained in a review of systems is:
   a. Objective
   b. Subjective
   c. Based on the nurse's perspective
   d. Based on physical examination findings
2. Which of the following is the correctly stated nursing diagnosis?
   a. Needs to be fed related to broken right arm
   b. Impaired skin integrity related to fecal incontinence
   c. Abnormal breath sounds caused by weak cough reflex
   d. Impaired physical mobility related to rheumatoid arthritis
3. The planning step of the nursing process includes which of the following activities?
   a. Assessing and diagnosing
   b. Evaluating goal achievement
   c. Setting goals and selecting interventions
   d. Performing nursing actions and documenting them
4. Measuring the patient's response to nursing interventions and his or her progress toward achieving goals occurs during which phase of the nursing process?
   a. Planning
   b. Evaluation
   c. Assessment
   d. Nursing diagnosis
5. Evaluation is:
   a. Only necessary if the health care provider orders it
   b. An integrated, ongoing nursing care activity
   c. Begun immediately before the patient's discharge
   d. Performed primarily by nurses in the quality assurance department

B. Match the following terms that relate to diagnostic conclusions

1. Medical diagnosis____
2. Collaborative problem____
3. Defining characteristics____
4. Actual nursing diagnosis____

a. The clinical criteria or assessment findings that support the nursing diagnosis
b.. Describes human responses to health conditions or life processes that exist in an individual, family, or community
c. Identification of a disease condition
d.. Actual or potential physiological complication that is monitored in collaboration with others

5. Risk nursing diagnosis____ e. Human responses to health conditions that may possibly develop in a vulnerable individual, family, or community

6. Nursing process____ f. Fundamental blueprint for how to care for a patient

C. Translate the following into English

1. 护理程序_____ 2. 护理评估_____
3. 护理诊断_____ 4. 实施_____
5. 主观资料_____ 6. 数据收集_____
7. 马斯洛需要层次论_____ 8. 健康状态_____
9. 临床决策_____ 10. 护理措施_____
11. 中优问题_____ 12. 预期目标_____
13. 合作性问题_____ 14. 护理计划_____

D. Translate the following sentences into Chinese

1. Objective data are observations or measurements of a patient's health status. Inspecting the condition of a surgical incision or wound, describing an observed behavior, and measuring blood pressure are examples of objective data.

2. The timely, thorough, and accurate documentation of facts is required in recording patient data.

3. Diagnostic conclusions include problems treated primarily by nurses (nursing diagnoses) and those requiring treatment by several disciplines (collaborative problems).

4. A risk nursing diagnosis describes human responses to health conditions or life processes that may develop in a vulnerable individual, family, or community.

5. A wellness nursing diagnosis is a clinical judgment of a person's, family's, or community's motivation, desire, and readiness to increase well-being and actualize human health potential as expressed in their readiness to enhance specific health behaviors.

E. Charting and documentation: in pairs, discuss your own opinions about nursing process based on the following chart.

Nursing Process Focus: Patients Receiving Regular Insulin

Assessment	**Potential Nursing Diagnoses**
• Assess vital signs. • Assess blood glucose level. • Assess appetite and presence of any symptoms that indicate the patient will not be able to consume or retain next meal. • Assess patient's knowledge of insulin and insulin administration.	• Risk for Injury (hypoglycemia), related to adverse effects of drug therapy • Deficient Knowledge, related to need for self injection • Risk for Imbalanced Nutrition, related to adverse effects of drug therapy

Planning: Patient Goals and Expected Outcomes	
The patient will: • Demonstrate knowledge of symptoms of complication of drug therapy including irritability, dizziness, diaphoresis, hunger, behavior changes and changes in level of consciousness. • Demonstrate ability to self-administer insulin. • Demonstrate understanding of lifestyle modifications necessary for successful maintenance of drug therapy.	
Implementation	
Interventions and Rationales	**Patient Education/Discharge Planning**
Increase blood glucose monitoring if patient is experiencing fever, nausea, vomiting, or diarrhea. (Illness may increase insulin need.)	*Instruct patient to increase blood glucose monitoring when experiencing fever, nausea, vomiting or diarrhea, as illness usually requires adjustments in insulin doses.
*Monitor blood pressure and pulse. (Increased pulse and blood pressure are early signs of hypoglycemia or renal dysfunction.)	Teach patient and caregivers: • to take the patient's blood pressure and pulse. • to report significant changes to the healthcare provider.
Evaluation of Outcome Criteria	
Evaluate the effectiveness of drug therapy by confirming that patient goals and expected outcomes have been met.	

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Passage Two

Common Knowledge in Fundamentals of Nursing

Introduction

The nursing profession is always responding to dynamic change and continual challenges. Today nurses need a broad knowledge to provide care. More importantly, nurses require the ability to know how to apply best evidence in practice to assure the best outcomes for their patients. Fundamentals of nursing aim at the foundation knowledge and practice skills of nursing profession.

Health and illness

Nurse's primary role, as caregiver, is to promote health, prevent illness, restore health and facilitate coping so as to maximize wellness of all people at each stage of life span, in any setting, and in both health and illness. Health is central to nursing. It is one of the four essential concepts-person, environment, health, and nursing, in nursing science. Wellness is more than just good health. It is an active process in which individual's progress toward the maximum potential