A framework to support preceptors’ evaluation and development of new nurses’ clinical judgment

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Abstract

In today’s complex, fast-paced world of hospital nursing, new graduate nurses do not have well-developed clinical judgment skills. Nurse preceptors are charged with bridging the gap between new graduates’ learning in school and their autonomous practice as RNs. In one large, urban medical center in the U.S., a clinical judgment model and rubric were used as a framework for a new evaluation and orientation process. Preceptors of new graduate nurses who had used the former and new processes described their experiences using the framework. The findings indicated that having a structured framework provided objective ways to evaluate and help develop new graduate nurses’ clinical judgment. It is hypothesized that academic clinical supervisors may find such a framework useful to prepare students for transition to practice.

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1. Introduction

In today’s complex, fast-paced world of hospital nursing, new graduate nurses (NGNs) face significant challenges to providing care and are often unprepared to deal with the realities of practice (Berkow et al., 2009; Hickey, 2009; Whitehead et al., 2013). Furthermore, NGNs must integrate knowledge into practice, think critically, and make judgments about how theoretical knowledge applies to direct patient care (Baldwin et al., 2014; Benner et al., 2010; Hartigan et al., 2010; Myrick and Yonge, 2004; Tanner, 2006). Health care organizations have a responsibility to determine that all newly hired nurses, experienced or not, are practicing at levels for safe independent practice by the end of the orientation period (Joint Commission n.d.).

In the U.S., the model for nurse orientation often includes a general hospital orientation, inundating newly hired nurses with policies and procedures as well as information about organizational structure, roles and responsibilities, patient safety mandates, and quality improvement initiatives (Culley et al., 2012). From there, the NGN is assigned a staff nurse preceptor who is the liaison between hire and launch of the NGN into autonomous practice. This part of the orientation varies in length and may become focused on checking off a myriad of psychomotor skills, designed to ensure a level of competency.

While safe execution of psychomotor tasks is certainly critical, the need for NGNs to develop the ability to clinically reason to make appropriate and safe clinical judgments for best patient outcomes has been identified in the literature (Baldwin et al., 2014; Hartigan et al., 2010; Hooper, 2014; Maneval et al., 2012; Miraglia and Asselin, 2015; Rush et al., 2013; Theisen and Sandau, 2013; Whitehead et al., 2013). A recent study that evaluated a new competency evaluation and orientation process in a large, urban U.S. medical center revealed that an evidence-based model and rubric for orientation may provide a useful framework for developing precepting strategies that support clinical judgment development of NGNs (Lasater et al., 2015). The quantitative study examined orientation for all newly hired nurses; however, in the focus groups that constituted the qualitative part of the study, preceptors’ descriptions focused on their experiences with NGNs. The purpose of this paper is to report the data from the preceptor focus groups.

The NGN may be known in other areas of the world as the graduate nurse or the newly qualified nurse. These designations refer...
to nurses who have completed their academic requirements and are at the point immediately following registration or entering their graduate year. In U.S. practice settings, the nurse assigned to orient and support the NGN is most often called a preceptor. In other places, this person may be known as a tutor or mentor. New graduate nurse (NGN) and preceptor are the terms that will be used in this paper.

2. Background literature

2.1. New graduate nurses

Development of clinical judgment skill is central to safe patient care (Hartigan et al., 2010; Hooper, 2014; Maneval et al., 2012; Theisen and Sandau, 2013). Specific NGN learning needs related to clinical judgment have been identified, including development of critical thinking, clinical reasoning, holistic assessment skills, recognition of acute deterioration, communication (Hartigan et al., 2010; Rush et al., 2013; Theisen and Sandau, 2013). Despite identifying concerns about development of these skills, no clear path addressing the needs exists.

NGNs use clinical situations as a way to connect their theoretical learning with practice and to develop and deepen their thinking about patient situations (Benner, 2001). They rely on individual knowledge, standards of care, and unit procedures to guide their decisions; they depend on the clinical judgment of others, especially in ambiguous or unfamiliar situations (Benner et al., 2009). Experienced nurses must support safe clinical decision-making through discussion and feedback. As they gain clinical experience, NGNs incorporate their experiential knowledge into the reasoning process (Benner et al., 2010). But experience is only one aspect of clinical judgment development.

2.2. Preceptors

Institutions generally identify preceptors as staff nurses who support the orientation of NGNs and other newly hired nurses. The evidence is clear: skilled and caring preceptors are crucial to successful orientation and effective role transition in NGNs (Baxter, 2010; Billay and Myrick, 2008; Gallonardo et al., 2010; Kaddoura, 2013; Myrick and Yonge, 2004; Schumacher, 2007; Sorensen and Yankech, 2008; Whitehead et al., 2013). Their primary roles include teaching, evaluating, and providing feedback (Omansky, 2010; Whitehead et al., 2013). To develop NGNs’ skills in patient care, preceptors must learn to observe performance carefully, then provide effective feedback that supports growth in thinking and performance (Baxter, 2010; Winfield and Myrick, 2009). While ongoing evaluation of and feedback on practice are integral parts of development of clinical competence, preceptors often feel unprepared to provide it (McClure and Black, 2013).

Much of the literature about preceptors focuses on their training (Anderson, 2008; Foy et al., 2013; Kaddoura, 2013; Luhanga et al., 2010; Smedley et al., 2010; McClure and Black, 2013; Sorensen and Yankech, 2008) and general effectiveness of their work with NGNs (Baxter, 2010; Mårtensson et al., 2013; Schumacher, 2007). Preceptors often do not ask deeper level questions that foster clinical judgment (Profetto-McGrath et al., 2004). Prioritizing, critical thinking, and giving feedback were ranked among the top five topics identified by preceptors when asked about their education needs (Foy et al., 2013). Preceptors identified needing support to help NGNs integrate theoretical knowledge and practice application as well as to teach critical thinking and reflection (Kaddoura, 2013; Luhanga et al., 2010; Mårtensson et al., 2013; Sorensen and Yankech, 2008). Improved support for preceptors in facilitation of learning and making sense of clinical experiences is needed, as is communication about NGN skills and learning needs among those involved in orientation (Henderson and Eaton, 2013).

Effective precepting influences preceptee outcomes. Preceptors support development of thinking about nursing care through discussion of cases, encouragement, bridging the gap between theory and practice (Kaddoura, 2013), and skilled questioning (Myrick and Yonge, 2002; Sorensen and Yankech, 2008). Reflection and critical thinking have been associated with improved confidence in NGNs, an important outcome of preceptorship (Whitehead et al., 2013). In one small study, use of an evidence-based framework, focused on reflection, coaching, and discussion, was shown to support development of NGNs’ critical thinking (Forneris and Peden-McAlpine, 2007). One finding of a recent critical review of studies that identified crucial competencies needed for NGNs to be successful concluded that more research that focuses on clinical thinking is needed (Theisen and Sandau, 2013).

2.3. Framework for clinical judgment

NGNs benefit from a process model that reflects the evolving, non-linear, patient care situation (McNish, 2007). Tanner defined clinical judgment as “an interpretation or conclusion about a patient’s needs, concerns, or health problems, and/or the decision to take action (or not), use or modify standard approaches, or improve new ones as deemed appropriate by the patient’s response” (2006, p. 204). The Tanner Model of Clinical Judgment describes four aspects of how nurses think, Noticing, Interpreting, Responding, and two types of Reflecting (Reflection-in-Action and Reflection-on-Action) that all interact in a non-linear fashion as nurses make decisions about patient care. A key feature of the model is the acknowledgment that all care occurs in and is influenced by the context of care, the nurse’s background, and the relationship with the patient (Tanner, 2006). A recent systematic review of the literature further suggested that clinical judgment can be taught (Cappelletti et al., 2014). Using a model for clinical judgment can guide the NGN through situated thinking with consideration for the context of care (Lasater and Nielsen, 2009).

The model has been used as a framework to support NGNs in clinical judgment development during orientation (Modic, 2013a, 2013b). A rubric based on the model may be used in clinical agency settings as a tool to enhance and assess learning activities, as a framework for reflection, to enhance communication and feedback, and to evaluate competence (Miraglia and Asselin, 2015). The Lasater (2007) Clinical Judgment Rubric (LCJR) describes development of the various aspects of clinical judgment in the Tanner (2006) model and has been used to evaluate clinical judgment in simulation (Adamson and Kardong-Edgren, 2012; Cato et al., 2009; Lasater, 2007, 2011), to guide communication about development of clinical judgment with prelicensure students in response to reflective writing (Lasater and Nielsen, 2009), and to develop effective questions focused on clinical judgment (Lasater, 2011). Having a common language about clinical judgment allows preceptors to provide meaningful feedback to NGNs. Together, the Tanner model and the LCJR form a framework for clinical judgment development. The framework became a starting point for a partnership between practice and academic educators in developing the new hire evaluation process.

3. Study overview

This paper describes the qualitative findings from a large study that incorporated a modified version of the Lasater Clinical Judgment Rubric (LCJR) for initial evaluation of the clinical judgment of all newly hired nurses at a large medical center hospital. The quantitative sub-study described levels of development of clinical
judgment in a sample of newly hired nurses over a year’s time and is published elsewhere (Lasater et al., 2015). The hospital educators had been dissatisfied with their process of competency evaluation and orientation planning, which involved skill and task focus and use of checklists to confirm competence. The educators recognized that tracking and monitoring psychomotor skills of newly hired nurses, especially NGNs, was not enough to ensure their competency at the bedside and wanted to look more closely at clinical thinking evaluation and development. To do so, a group of educators created case studies for nine different contexts of care. NGNs as well as other newly hired nurses wrote answers to three of these paper and pencil cases from the context of care to which they were hired. To score the case studies, they modified an existing instrument that assesses clinical judgment.

The LCJR was initially created to form a trajectory of development for students (Lasater, 2007). It expands the four aspects of the Tanner Model into 11 dimensions and four levels to describe what effective Noticing, Interpreting, Responding, and Reflecting look like. The LCJR was modified, with permission of the author, to reflect expectations of practicing nurses. The written responses to case studies from over 200 newly hired nurses were scored, using the modified LCJR and then shared with the newly hired nurse and his/her preceptor to identify the priority foci for clinical judgment development during orientation and beyond.

4. Research methodology

The primary aim of this qualitative descriptive sub-study was to gain insight about the new assessment process of clinical judgment from the lived experiences of preceptors, thus answering the question, what was the experience of preceptors who participated in both the former and new assessment processes of newly hired nurses, both NGNs and more experienced nurses? The theoretical basis for the inquiry was the Tanner Model of Clinical Judgment (2006), developed through review and synthesis of studies of clinical judgment in expert nurses and other healthcare professions over a 30-year period. Aspects of the model have already been described and are further elucidated in the Findings section.

4.1. Participants and recruitment

Inclusion criteria for the current study were that participants must have used both the former and new assessment processes in their role as preceptors and have been exposed to the Tanner Model (2006). To recruit participants, the researchers asked nurse managers for names of experienced preceptors who met these criteria, then sent invitations to those identified; this strategy reflects the recommendation that participants in a focus group share characteristics relevant to the research question (Marshall and Rossman, 1999). Seven volunteered to participate, and managers supported their participation with paid time.

4.2. Data collection and ethical procedures

According to Morgan (1997), focus groups not only offer an ability to collect data centered on the topic of interest but also involve group interaction to produce the data. Two focus groups met for 90 min each; the groups were audio-recorded and later transcribed for analysis. The moderator of the focus groups was not a hospital employee and used a semi-structured interview guide that gave the moderator the opportunity to review the Tanner Model of Clinical Judgment (2006) before asking specific questions about the model (See Table 1). The guide was comprised of open-ended questions, allowing participants to respond from their perspectives as well as to each other’s. The Institutional Review Board (IRB) at the university approved the study; pseudonyms are used to protect participants’ identities in the Findings section.

4.3. Data analysis procedures

From the data, a rigorous thematic analysis was undertaken. Two of the three researchers were present during the focus groups; one was not. Their different roles (one hospital and two academic educators with different clinical expertise, all with decades of education experience) provided another form of triangulation. No prefigured codes were used; rather, each used her own interpretive strategy after listening several times to the recordings to note patterns from the data and gain emergent intuitive perspectives, as described by Marshall and Rossman (1999), [adapted from Crabtree and Miller (1992)]. Each developed written categories based on her own interpretations before meeting together to sort the aggregated categories and reach consensus of the themes that emerged.

5. Findings that support a clinical judgment framework

The data, which specifically focused on the aspects of clinical judgment as defined by Tanner (2006), converged primarily on the needs of and precepting strategies for NGNs. One unexpected but clear finding from the data was the preceptors’ strong support for the use of the Tanner (2006) Model and adapted LCJR (Lasater, 2007) as a framework for their orientation of NGNs. The analysis of the qualitative data resulted in the following themes: (1) the need for a framework; (2) the framework’s support of Tanner’s aspects of clinical judgment; and (3) the value of the framework for performance evaluation. To foster clarity, each of these subsections includes participant data as well as related discussion.

5.1. Need for a framework

Over and over again, participants identified that a framework of clinical judgment provided an objective means for evaluation of NGN’s clinical judgment. For example, Charissa acknowledged that NGNs require a different approach to orientation than experienced nurses. She suggested that, “the rubric was helpful because of the descriptions, which give me things to clue in on; it gives me a frame of reference so I know where (the new nurse’s) baseline is.” Robin added, “I like (the rubric); it is something to work from, more objective. I can compare my ideas with the new grad’s experience on paper.” Alida called it “springboard for conversation.” Sally described her perspective:

The new grads I’ve worked with tend to rate themselves a lot higher than I would. (The framework) opens discussion, like, “well, why do you score yourself at that level?” Like as far as exemplary, new graduates are rarely at that level by the time they are even done with orientation, but some of them will think that they are. So I think it makes them think more about the whole picture.

Using a framework to contextualize NGNs’ knowledge and experiences may be useful; as well, NGNs may be able to place themselves on the rubric to set goals for future learning.

5.2. Using the framework to foster clinical judgment

During the focus groups, the preceptors spoke about multiple teaching strategies they used to apply the framework in their work with NGNs. None of these is new to experienced clinical educators or most preceptors; however, Table 2 is a useful summary of a variety of strategies that can be used for clinical judgment
Noticing. In the Tanner Model, nurses interpret the patient situation in various ways. Limited or no experience with a given situation triggers a hypothetico-deductive, analytic reasoning process of interpretation. Experienced nurses may immediately recognize a pattern based on previous experiences and make sense of the situation, intuitively or tacitly (Tanner, 2006).

Most of the questions the preceptors ask are straightforward and focused on patient care, such as the one Dana poses to her orientees: “I tell them, here’s what we’re going to do first—why do you think?” In this way, Dana linked her own direction and questioning to set the stage for prioritization. Given the complexity of nursing in the 21st century (Ebright et al., 2003), Dana recognized that NGNs may lack a sense of salience, meaning what’s critical to know or do (Benner et al., 2010) and gives them a way to think about it.

Brigit agreed that NGNs often struggle to prioritize, describing the approach she uses to help them, “I … use the anticipated patient outcomes to help them prioritize.” In so doing, Brigit helps the new nurse link the outcomes with nursing care planning, including interpreting the patient’s situation and preparing to choose an appropriate response. Alida wants the NGN to gain a sense of the bigger picture. She asks them to identify their plan for the day, that is, what needs to be done. She said, “Sometimes they don’t notice what is said in report and prioritize those items.”

By asking NGNs to identify their care priorities, Alida and Brigit are not making assumptions about their priorities but helping them to discuss the priorities. Benner et al. (2010) described the use of narrative as an important means for learners to develop their thinking. The preceptor’s availability and talking aloud together offers the potential for role modeling of care planning (Lasater et al., 2014; Schumacher, 2007; Whitehead et al., 2013). Alida described how she helps NGNs interpret their patients’ situations: “I think they learn by example through us—it takes time. We can help interpret what they are doing for the patient so it helps the learning process.”

Table 1
Focus Group Approach and Semi-structured Interview Questions.

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<thead>
<tr>
<th>Initial questions</th>
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<tr>
<td>What has been your experience in using the new individualized evaluation and orientation process with new graduate nurses?</td>
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<tr>
<td>What are your suggestions for improving the new individualized evaluation and orientation process with new graduate nurses hire?</td>
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Table 2
Preceptor coaching strategies for clinical judgment (by frequency of mentions in focus groups).

<table>
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<tr>
<th>Strategy</th>
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<tr>
<td>Questioning</td>
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<tr>
<td>Providing direction</td>
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<tr>
<td>Thinking out loud</td>
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<tr>
<td>Reflection/co-reflection</td>
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<tr>
<td>Advising</td>
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<tr>
<td>Being available</td>
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<tr>
<td>Building on past learning</td>
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<tr>
<td>Role modeling</td>
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<tr>
<td>Explicit observation/assessment</td>
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<tr>
<td>Discussing/open dialogue</td>
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<tr>
<td>Prompting</td>
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<tr>
<td>Providing examples</td>
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<tr>
<td>Feedback</td>
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<tr>
<td>Patient care goal identification</td>
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<tr>
<td>Prioritizing</td>
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<tr>
<td>Giving more independence</td>
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<td>Encouraging</td>
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Noticing is critical because it starts the entire clinical judgment process. Robin described her strategy of getting at the nurse’s background and how that impacts noticing: “I like to ask them, have you had this kind of patient before? Did you see this in school? What did you do for them? Based on that experience, what would you do for this patient?” This line of questioning recognizes the value of the nurses’ past experiences (Tanner, 2006). By calling it out, Robin respects the nurse’s background but also helps the NGN build on that experience to transfer knowledge.

Charissa observed that NGNs often focus on one or two aspects rather than the whole patient so she uses questions to probe more deeply, thereby helping the NGN to go further in thinking: “what did you notice about the patient?” Followed by multiple, repeated questions, “what else did you notice?” In this way, Charissa implied that there is more to notice, pushing the limits of the NGN’s observation skills.

Interpreting. In the Tanner Model, nurses interpret the patient situation in various ways. Limited or no experience with a given situation triggers a hypothetico-deductive, analytic reasoning process of interpretation. Experienced nurses may immediately
Responding. In the Tanner Model, the nurse responds to a patient situation based on its interpretation. Less experienced nurses tend to focus on nursing tasks as responses whereas experienced nurses focus on patient-centered responses and thinking about the larger picture of patient care (Benner, 2001; Benner et al., 2009).

The participants gave strong impressions about how easy it is for NGNs to focus on the tasks of nursing rather than the thinking behind the tasks or seeing the whole picture of the patient. For example, both Fiona and Brigit emphasized the challenge of balancing psychomotor skills yet maintaining the bigger picture to integrate the uniqueness of the patient’s situation.

Sometimes new nurses get caught up in the skills and ask to do the skills on the patients of others. And we say, ‘Yeah, you know, how often do you get this skill?’ But on the other hand, you don’t want them to get so caught up in the skills that they aren’t paying attention to what’s going on with the patient (Fiona).

You know, you put in a Foley once, twice, three times … they know how to do it. What we want them to do is the critical thinking involved in placing a Foley … They need to learn how to think (Brigit).

Fiona and Brigit have validated Tanner’s (2006) assertion that tied the context of care to the reasoning that nurses use to make clinical judgments.

Robin used specific questioning to build on what Benner et al. (2010) referred to as clinical imagination to help an NGN. She described the situation:

We were awaiting a change of code status, but it wasn’t quite there—a very complex situation. So I asked my mentee: what should we do? If you were writing the orders, what would you want to be written? I like to ask them this question before we call the doctors.

By asking the NGN to imagine herself in the place of the doctor, Robin is promoting critical thinking and setting up the NGN to respond by calling the physician for additional orders and give a reasoned recommendation, part of the SBAR strategy (Haig et al., 2006).

Whitehead et al. (2013) described how critical the role of the preceptor is to help new nurses develop their confidence. Dana relayed a story about NGNs’ lack of confidence related to questioning standards or provider orders:

I think it’s the lack of confidence gets in the way of their learning sometimes.

I tell them to make sure that if their guts tell them something, they need to stop and listen to that … If the blood pressure is low, don’t send the patient off the unit. Call the doctor, get an order … Don’t just follow orders without thinking.

Dana concluded her observation about NGNs’ lack of confidence by implying that they are often focused on the tasks rather than the bigger picture of the patient. She said, “They don’t realize that part of patient care is when you question.”

Robin described how she supports a NGN through a patient procedure to facilitate their confidence through verbalization: “I think they do better with more ownership, but I walk them through it verbally, then ask, what do you need from me?” Robin is balancing an NGN’s lack of confidence and the potential safety hazards with their need for development and autonomy. In the process, she invites the NGN to reflect on what they know and feel comfortable doing and what they don’t know. NGNs identified gradual promotion of autonomy as supporting development of critical thinking (Kaddoura, 2013).

Alternatively, Fiona described the challenges with those who have too much confidence: “New graduate nurses are more over-confident and tend to rate themselves higher than I would. They don’t always recognize what they don’t know.”

These data suggest that it is critical for preceptors to evaluate the appropriateness of NGNs’ confidence to help them learn to accurately self-evaluate.

Reflecting. Reflection is a key element in the development of clinical judgment. Reflection-on-action occurs after the fact, often in response to a situation that did not go well. It results in learning from a situation (Tanner, 2006). Nurse preceptors can guide reflection through questioning and discussion.

The nature of Reflecting is a response to guiding questions, such as “how did that go?” “what went well?” “what didn’t go well?” and “why?” Using role modeling as a strategy, Charissa described her approach: “I role model reflection by sharing with the NGN what I would do differently. (I do this) so they don’t come out feeling ashamed at the end of a difficult shift. Reflection brings out the greatness of our work and allows us to make changes.” In this way, Charissa guided the NGN to consider alternative responses to patient needs (Lasater and Nielsen, 2009). Charissa described what educators from Dewey’s time to the present have known: reflection is a valuable key to learning (Dewey, 1933; Tanner, 2006). By taking it a step further to role model reflection, Charissa exposes herself as a lifelong learner and encourages the new graduate nurse to be the same.

Sally found that the framework allowed her to co-reflect with NGNs. She said, “at the end of the day, especially a hectic one, I’ll ask, how did the day go?” She continued, saying that the NGN will often reflect on what they were uncomfortable with so that the issues can be addressed and learning can occur. Brigit concurred, “I try to get them to reflect on their own practice; often, they’re more worried about charting rather than patient changes or intervening. They need to refocus on patient issues.” Given this invitation to co-reflect, the preceptor can help NGNs to put the events of the day, both positive and negative, into perspective and guide them to think about the learning and apply it to a different situation.

This kind of reflection results in learning from the day’s events rather than encouraging the circular thinking that Benner (2001) described of NGNs. NGNs growth and development depends upon reflection and kind, but honest, feedback from their preceptors throughout the orientation period (Schumacher, 2007; Whitehead et al., 2013). Alida summarized several of the group’s thoughts: “(The framework) provides an objective means for reflecting on situations; you can talk about the outcomes you were looking for, making it more of a teaching moment.” Alida’s experience is convergent with studies that identified a link between self-evaluation (a form of reflection) and improved self-directedness (Nicol and Macfarlane-Dick, 2006) and enhanced personal and professional judgment (Fitzpatrick, 2006; Maclellan and Soden, 2006).

5.3. Evaluating competence

The orientation period is designed to help NGNs develop competence for safe, autonomous practice. Given the new process that these preceptors were using, it was critical to ask them about its adequacy to support NGNs’ development, particularly of clinical judgment. The preceptor participants identified the importance for NGNs to see their progress throughout orientation. Many of them described how the rubric allowed the NGNs to track their progress
as well as set goals for future learning. This ties to Lasater’s (2011) assertion that the LCJR offers a trajectory to assist learners to see their next steps; in addition, the LCJR provides a common language for questioning, offering feedback, and setting goals.

Fiona described an example, saying: (The framework) helped me to compare what I know as a preceptor to what (the new nurse) knew.” Sally reinforced the value of frequent feedback: “I think they can see their growth, week by week. They can see they are doing better and that makes them a little bit more confident to see that they are improving.” Fiona concurred:

Yeah, and you know it’s measurable. I was precepted under the old system. I had a big binder of check-offs and it was absolutely overwhelming and I didn’t get it all done in the 6 weeks. I had a very supportive unit and a great preceptor, but it was overwhelming. There was no measurement of where I was and then it was, ‘you’re on your own.’ I think it helps to have someone watching you, giving you proof that you are improving in your care.

6. Study limitations

Limitations of this study include the nature of sampling. While the 7 participants provided significant data about their experiences with the new model, it should be noted that this is a small sample from various units in one hospital setting, which could limit generalizability of findings. Furthermore, it must be acknowledged that these participants were volunteers and might represent particular viewpoints.

7. Implications and recommendations

Preceptors and clinical educators of all types can learn about facilitation of transition into practice from these preceptor study participants. Preceptors have the benefit of a one-to-one relationship with the NGN, perhaps allowing them flexibility to focus on clinical judgment development; however, many carry a full patient load in the midst of orienting NGNs, and they report having difficulty with providing good feedback, supporting prioritization, and fostering development of critical thinking and clinical judgment (McClure and Black, 2013; Foy et al., 2013). The clinical judgment framework served to effectively and efficiently support registered nurses, as preceptors in this study.

Although the participants were speaking about their experiences with NGNs, many of them also precept pre-licensure students. The authors posit that the same clinical judgment framework may well be useful for clinical faculty and preceptors while students are still in their academic programs of study, thus serving to better bridge the gap between academic and practice (MacPhee et al., 2009). If there were a better bridge, might new nurses be ready to practice autonomously sooner? A longitudinal study using the clinical judgment framework and focused on students moving into their first year of practice might provide evidence to answer the question.

8. Conclusion

Staff nurse preceptors in focus groups reflected on their use of a framework, consisting of an evidence-based model and rubric, for developing and evaluating NGNs’ clinical judgment. Themes from the data supported the effectiveness of the new process to evaluate clinical judgment: (1) the need for a framework; (2) the framework’s support of Tanner’s aspects of clinical judgment; and (3) the value of the framework for performance evaluation. As they described their experiences, the participants offered a wide variety of strategies for using the framework to support development as well as a more objective means to evaluate performance.

The findings can be used to inform teaching practices in the academic as well as the clinical environment. Use of the framework of clinical judgment can provide a foundation for objective evaluation and a frame of reference to track progress. It can support questioning and discussion strategies that foster development in all elements of clinical judgment and ultimately assist in assessment of readiness for autonomous practice in a given unit setting.

References


