New Graduate Nurse Experiences in Clinical Judgment: What Academic and Practice Educators Need to Know

Janet Lusk Monagle, Kathie Lasater, Sydnee Stoyles, and Nathan Dieckmann

Abstract

AIM The aim of the study was to determine if use of a structured reflection exercise using a clinical judgment framework would result in more practice-ready new graduate nurses (NGNs).

BACKGROUND Clinical judgment is a critical skill for all nurses, yet it is identified as a deficit in NGNs.

METHOD Seventy-four NGNs in two groups participated in this mixed-methods study in their first year in practice. Scores from two quantitative measures were collected for all participants. The Lasater Clinical Judgment Rubric framed the structured intervention.

RESULTS Although the quantitative data showed no significant differences between the groups, use of the reflection exercise indicated a positive impact on NGNs. Qualitative data revealed four themes that present challenges for preparation of NGNs: enhancing communication, finding interprofessional support, responding to complexity of care, and appreciating the role of the nurse.

CONCLUSION Implications provide guidance for academic and practice educators to smooth the transition into practice.

KEY WORDS Clinical Judgment – New Graduate Nurses – Reflection – Workplace Culture

Nurse leaders have indicated that most new graduate nurses (NGNs) are not practice-ready (Parker, Giles, Lantry, & McMillan, 2014), particularly in their ability to make clinical judgments (Bashford, Shaffer, & Young, 2012; Kavanaugh & Szweda, 2017; Theisen & Sandau, 2013). This lack of preparedness may be partially ascribed to how NGNs were supported during their academic programs (Newton, 2011). The growing demands of the acute care setting, including complex patients and staffing challenges, only complicate the issue. Hospital patient care units may be challenged to support NGNs' needs for clinical judgment development. These factors indicate that the need for effective strategies to help the NGN make the transition from academia to practice is more crucial than ever (Edwards et al., 2015).

Reflection has been touted as an important strategy to promote professional development. Although most students write many reflections during their nursing programs and participate in oral reflections during postconferences, the literature supports that structured or guided strategies may be required to shape their thinking (Asselin & Fain, 2013; Lasater & Nielsen, 2009). The purpose of this study was to test the use of a structured reflection intervention as one way to promote the development of clinical judgment. In addition, the study sought to evaluate the impact of the clinical environment on the development of clinical judgment.

REVIEW OF THE LITERATURE
Transition to Practice

Several authors have cited that the transition for NGNs into practice is stressful and difficult (Andrews, 2013; Chandler, 2012; Duclos-Miller, 2011; Dwyer & Hunter Revell, 2016; Ebrahimi, Hassankhani, Negarandeh, Azizi, & Gillepsie, 2016). Recently, transitional issues with NGNs were documented in Iran, Canada, and Australia, indicating that this is a global issue (Ebrahimi et al., 2016; Gardiner & Sheen, 2016; Laschinger et al., 2016). Much of the stress may be related to gaps between academic programs and the realities of clinical practice, that is, not having enough realistic practice experiences in academic programs (Dwyer & Hunter Revell, 2016; Ebrahimi et al., 2016; Gardiner & Sheen, 2016; Steen, Gould, Raingruber, & Hill, 2011). Even though nurse educators strive to foster the knowledge, skills, and attitudes necessary to practice in the complex environment of patient care, there still seems to be a gap that causes frustration and may impede safe, quality patient care. In their review of the literature, Missen, McKenna, and Beauchamp (2014) identified that a supportive workplace culture is one way to combat the disparity and narrow the gap.

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Laschinger et al. (2016) identified a link between positive workplace culture and improved retention and job satisfaction of NGNs in Canada. They also found that negative workplace culture factors created feelings of uncertainty. Others have noted that NGNs perceive their workloads to be unmanageable (Ebrahimi et al., 2016; Purling & King, 2012). Some studies have posited that NGNs may be unable to interpret and respond to difficult situations (Lasater, Nielsen, Stock, & Ostrogorsky, 2015; Purling & King, 2012), suggesting a need for longer orientation. Pedagogies that support clinical judgment formation and stress management of NGNs who enter health care today remain a gap in the literature (Dwyer & Hunter Revell, 2016).

Reflection

Starting with Dewey (1933) and later Schon (1987), there has been support for the relationship between reflection and learning. Reflective journaling is a tool that develops self-awareness and fosters positive practice implications (Kim, 1999). Some have asserted that reflection may foster clinical judgment development (Lavoie, Pepin, & Boyer, 2013; Tanner, 2006) or provide an avenue to link coursework to clinical thinking (Asselin, 2011).

Lasater and Nielsen (2009) reported reflective journaling allowed faculty to evaluate how students reason and provide feedback during clinical situations. Others have described the benefits of reflection during the first year of practice to improve retention and ease the transition (Bolden, Cuevas, Raia, Meredith, & Prince, 2011). These studies often used a framework or structure to guide the learners. Structured group reflection derives from one of Mezirow's phases of transformative learning dialogue, that is, exploring options with others following a disorienting dilemma (https://sites.google.com/site/transformativelearning/elements-of-the-theory). However, there is little empirical evidence using valid and reliable tools to document the effectiveness of structured reflection with NGNs. For the purposes of this article, structured reflection is a reflective experience in which participants used prompts to individually and collectively reflect on patient care experiences to describe their clinical judgment.

Theoretical Model of Clinical Judgment

Clinical judgment is defined 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 improvise new ones as deemed appropriate by the patient's response" (Tanner, 2006, p. 204). Critical thinking and clinical judgment, both forms of clinical decision-making, are often used interchangeably but are not the same (Tanner, 2006). According to Tanner's model of clinical judgment, the theoretical model for this study, complex reasoning processes that nurses use to make clinical judgments involve four aspects: a) noticing, or a perceptual grasp of the situation; b) interpreting, or using evidence to understand the situation; c) responding, or choosing a course of action; and d) reflecting, which includes evaluating the action or outcomes. Tanner identified the context of the environment as important to the development of one's clinical judgment.

Using the Tanner model as part of a framework for reflection, learners may begin to recognize patterns. Consistent recognition and use of patterns may enhance the NGN's ability to use theoretical information in nursing practice, cope with the stress of transition, and uncover other relevant practice issues. Accordingly, one may hypothesize that structured reflection could promote the development of clinical judgment. In addition, information regarding the impact of the workplace culture on the development of clinical judgment may support new graduates in these complex environments.

Based on this review, three research questions were proposed: a) Is there a significant difference on mean scores of critical thinking (a stand-in for clinical reasoning) and workplace culture between participants in experimental and control groups, indicating an effect of a structured reflection intervention? b) Does the culture of the workplace support learning and the development of clinical judgment? c) What are the lived experiences of NGNs in the first year of practice relative to clinical judgment? The major aim of the study was to determine if structured reflection, using a clinical judgment framework, had potential to diminish the gap between academic programs and practice, resulting in more practice-ready NGNs. Another aim was to determine what factors supported or impeded learning in NGNs' first year of practice.

METHOD
Study Design

This bicoastal study took place at four acute care hospitals — three community hospitals on the east coast and one medical research center on the west coast. A triangulation, mixed-methods, experimental, pretest/posttest design was used. Qualitative data were collected at two points in time between the pre- and posttesting. Participants were employed for less than three months, and the researchers described the study and obtained consent during their orientation sessions. Participants were then randomized using an online computer program to either an experimental or control group at each hospital.

Participants completed two quantitative measures, both at the beginning and end of their first year of practice. The qualitative data consisted of experimental group participants' self-assessments of their clinical judgment as well as facilitator notes from two structured reflection sessions — one at 5 to 7 months and the other at 10 to 12 months. The institutional review boards at all locations approved the study; all participants used a unique identifier to maintain confidentiality.

Sample

A priori power analyses suggested that a total of 70 participants (35 from each coast) would allow the detection of small- to medium-sized effects between groups across time (Cohen's d = .35), assuming power = .80, alpha = .05, and correlation between an outcome across time = .50. A convenience sample of 74 NGNs with less than three months of nursing experience was enrolled. The age range was 21 to 48 years old, with a mean of 29. The sample consisted of 56 women, 13 men, and 5 who chose not to answer. Areas of practice included 47 in medical-surgical areas (encompassing both pediatric and adult units), 19 in critical care (including pediatric and adult patients and intensive care, emergency, and operating rooms), and 4 others (including maternal-child health); 4 participants chose not to identify an area of practice.

Instruments

HEALTH SCIENCE REASONING TEST (HSRT) To answer the research questions, it would be most accurate to use a measure to examine clinical judgment; however, no such measure was found. The HSRT is a normed, copyrighted 33-item multiple-choice-format test designed to measure the ability to reason in health science curricula

and professions (Huhn & Deutsch, 2011; Insight Assessment, 2014). The instrument has five subscales: Analysis, Inference, Evaluation, Induction, and Deduction. Overall internal consistency of the instrument is .80 (Insight Assessment, 2014).

CLINICAL WORKPLACE LEARNING CULTURE SURVEY (CWLC) The CWLC was initially designed to determine perceptions of students and faculty about the learning culture in clinical experience contexts (Newton, Henderson, & Jolly, 2014). The scale development involved a rigorous qualitative process of interviews and fieldwork observations ($n = 95$) in multiple contexts of care, followed by an extensive factor analysis ($n = 753$) (Newton, Henderson, Jolly, & Greaves, 2015). The factor analysis revealed seven subscales: Collegiality, Workplace Inertia, Being Valued, Work Satisfaction, Consideration for Others, Flexibility, and Workload Balance.

The CWLC scale has 31 items, scored on a 5-point Likert scale. The Cronbach's alpha was .92. As this survey has recently been developed, the validity of the tool is still to be determined.

LASATER CLINICAL JUDGMENT RUBRIC (LCJR) The LCJR describes a research-derived subset of 11 dimensions (see Table 1) for the four aspects of Tanner's (2006) model of clinical judgment (Lasater, 2007). Lasater (2011) contended that the leveled descriptors provide a trajectory of clinical judgment development for prelicensure students. Two recent papers posited the use of the LCJR as a structure to enhance the value of self-reflection in practice (Miraglia & Asselin, 2015; Nielsen, Lasater, & Stock, 2016). In the current study, experimental group participants used the LCJR, rather than a measurement scale, as a structured framework to reflect on and report anecdotes from practice.

Table 1: LCJR Dimensions

Aspects of Clinical Judgment (Tanner, 2006)	Dimensions (Lasater, 2007)
Noticing	Focused observation
	Recognizing deviations from expected patterns
	Information seeking
Interpreting	Prioritizing data
	Making sense of data
Responding	Calm, confident manner
	Clear communication
	Well-planned intervention/flexibility
	Being skillful
Reflecting	Evaluation/self-analysis
	Commitment to Improvement
Reproduced with permission of author (Lasater, 2007).	

Procedure for Intervention

The experimental groups attended three sessions facilitated by the researchers: a) one in-service session early in the study (months 1 to 3) aimed at teaching the NGN's clinical judgment development and use of the LCJR as a structure for clinical anecdote reflection and b) two structured reflection sessions at 5 to 7 and 10 to 12 months after starting employment to formulate clinical anecdotes and analyze and discuss them (see Table 2).

ANALYSIS AND FINDINGS
Quantitative

The researchers did not examine the relationship between demographic factors and outcome scores due to the small sample sizes in some groups (e.g., very few men) that would have limited the interpretability of these results. Mixed analysis of variance was used to compare overall HSRT scores, HSRT subscores, CWLC scores, and CWLC subscores between control and experimental groups. There were no significant differences between the control and experimental groups for overall HSRT scores or any of the subscores. HSRT overall scores showed no significant change over time in either group.

Pearson's correlation was used to evaluate the association between HSRT and CWLC overall scores at both pre- and post-assessment as well as to evaluate association of overall CWLC and LCJR scores. There was no correlation between high scores in CWLC and high scores in LCJR. Even those NGNs who reported their environment to be good and self-scored higher on the LCJR did not have an increase in HSRT scores.

There were no significant differences across the one-year study time frame in CWLC total scores between the groups. However, there were significant findings for two CWLC subscales (CWLC rating scale ranges from 1 = *strongly disagree* to 5 = *strongly agree*). There was a significant time main effect for the Being Valued subscale, such that ratings increased from $M = 3.79$ (pre) to $M = 3.96$ (post) for both groups, $F(1,46) = 5.64$, $p = .02$. Four items loaded on the factor of Being Valued, and together, they are indicative of individuals seeking to being recognized for their contribution to the work of the team (Newton et al., 2014).

There was also a significant Group × Time interaction for the Work Satisfaction subscale, $F(1,46) = 4.57$, $p = .04$. For the control group, there was a steeper decrease in Work Satisfaction across time ($M = 4.21$, pre; $M = 3.76$, post) as compared to the treatment group ($M = 3.97$, pre; $M = 3.93$, post). Measurement of Work Satisfaction was described as three items that demonstrate the importance individuals place on valuing their work and, in doing so, gaining a sense of satisfaction, leading to a motivation to want to come to work (Newton et al., 2014).

Qualitative

The qualitative data analysis method was a manual coding process, described by Miles, Huberman, and Saldana (2014), designed to foster trustworthiness of the data. For the first cycle, two of the researchers, one from each coast, independently used the rationales from the experimental groups' written self-evaluations to identify a code for each datum; they did the same with the facilitators' written notes. This method is *process coding*, which uses gerunds (verbs with "-ing" endings) to code the actions and outcomes from the data.

Table 2: Study Sequence for Experimental Group

Session Timing	Content	Length of Session
Months 1-3	Didactic re: clinical judgment, LCJR, example anecdote	1 hour
Months 5-7	Discussion re: participants' clinical anecdotes, self-assessment, both using the LCJR	2 hours
Months 10-12	Discussion re: participants' clinical anecdotes, self-assessment, both using the LCJR	2 hours

Note. LCJR = Lasater Clinical Judgment Rubric.

For the second cycle, both researchers collated the codes by frequency of occurrence, compared their notes and findings, and refined the codes. As they discussed their own observations from the respective sessions, they returned frequently to the data to rethink the codes, then independently read through the data again to verify the codes. In addition, data from months 5 to 7 were grouped to compare data from months 10 to 12 to look for patterns over time. Finally, the researchers reached consensus on the four themes that emerged from the coded data: a) enhancing communication, b) finding interprofessional support, c) responding to complexity of care, and d) appreciating the role of the nurse (see Figure 1).

ENHANCING COMMUNICATION This theme focused on communication between NGNs and patients, family members, other nurses, and the larger team. At 5 to 7 months, several NGNs spoke of the value of listening to their patients and providing them explanations. For example, one mentioned, "I [wish I] could do a better job, a smoother job at explaining and how to comfort [the patient] better." One participant at 5 to 7 months noted that (s)he was "now asking the 'why' questions" to amplify her knowledge to connect it to patient care.

Even at the end of the first year, another participant identified that "communication was not always effective and did not convey the urgency the situation required." Similarly, a participant noted with some frustration: "I was skillful in knowing that another intervention was needed; however, I didn't know what specifically to ask for," implying that the NGN did not have enough knowledge to think through a specific next step.

INTERPROFESSIONAL SUPPORT Most of the NGNs were able to look beyond themselves to recognize the value of "working to be approachable to team members [new medical students]." At 5 to 7 months, many expressed frustration in trying to get the medical teams' attention on behalf of deteriorating patients. But even at this early stage, one NGN noted, "Approaching team members face-to-face seems to get the most action." Another had enough insight to state, "I'm learning which issues to *take* to the team and which problems to *give* to the team" (emphasis is researcher's), implying a sense of trust in the team that the NGN could leave some issues with them.

At 10 to 12 months, one NGN stated, "I was able to effectively communicate with the team but lacked the confidence to push for a more reasonable intervention," indicating progress in interprofessional communication and support but lacking knowledge or experience to advocate effectively on behalf of patients.

COMPLEXITY OF PATIENTS At the 5- to 7-month sessions, NGNs noted their gaps in considering the complex needs of patients, such as, "I focused on the big issue [septic shock] and missed some possible important issues," and "I didn't have enough knowledge to map out why [the deterioration] occurred." They were able to reflect on their decisions and learn from them, indicating, "I wish I had checked [the patient] earlier; maybe I could have intervened earlier." Another NGN learned the value of knowing the patients, saying, "I like to take the same patients on 2nd and 3rd nights because I really learn more that way." Based on their experiences, as well as conversations with more experienced nurses, most developed an understanding for anticipating issues before they happened.

APPRECIATING THE ROLE OF THE NURSE This theme only emerged at 10 to 12 months. Many described surprise about the role of the nurse beyond what they had experienced or even noticed as students. One NGN stated, "I think that sometimes my lack of overall confidence in my practice might hinder my ability to respond." Another NGN saw a lack of confidence as an opportunity for growth: "Being outside of my comfort zone further instilled the necessity of continued learning — for myself to grow as a professional nurse." Several mentioned that "I have an important role; I have to be the one to report things and follow up," yet another summed up others' observations more broadly: "My greatest takeaway is how much of an impression we as nurses can make in the lives of families and to trust our intuition as well as past experiences and the experience of our peers."

DISCUSSION

The researchers believe there are three potential reasons for the lack of differences in clinical reasoning between the experimental and control groups. First, despite construct description of the HSRT as a measurement of clinical reasoning, critical thinking may have been inappropriate for measuring aspects of clinical judgment. Second, although conceptually sound, the dose and intensity of the structured reflection intervention may have been ineffective for developing a clinical judgment framework for a novice practitioner. Last, the participants in the small groups changed each time because of scheduling challenges; maintaining a consistent group and building trust over the year may have contributed to change over time.

The structure of the LCJR appeared to provide a safe way for participants to think about their thinking, share with a small group of peers and the facilitator, and analyze all aspects of the situation. The participants became adept at using the LCJR (Lasater, 2007), based on the Tanner (2006) model, to identify key areas of clinical judgment development, such as being able to interpret and prioritize what they had noticed. They grew in their appreciation recognizing what clinical judgments were appropriate and how to make sense of their experiences. Still, the ongoing uncertainty persisted throughout their first year.

Seesawing between frustration and a growing confidence without warning can be emotionally draining (Chesser-Smyth & Long, 2013), particularly when patients' lives are in the balance and can ultimately lead to leaving their first positions prematurely or even the

profession (Chandler, 2012; Theisen & Sandau, 2013). Yet, at the 10 to 12 month sessions, most participants were reporting their confidence was growing, congruent with the findings of Ortiz' (2016) study of NGNs.

This study illustrates that overall work satisfaction was affected by a structured reflection intervention. Positive responses on the CWLC regarding Work Satisfaction did not decrease over time as in the control group, suggesting that the structured reflection intervention may have had a beneficial effect. The Being Valued subscale showed improvement in both groups over time. Improvement in this area suggests that there was a positive working environment for the participants and, over time, they realized their own value as part of the team. This has not always been the case for NGNs; several authors have identified high NGN turnover rates related to negative work environments (Chandler, 2012; Moore & Cagle, 2012; Young, Stuenkel, & Bawel-Brinkley, 2008).

The CWLC also identified some key areas of needed attention. Despite different geographic areas and orientation programs, the overall group scored high in "we work as a team here," but both coasts were low in "I am able to negotiate my workload." NGNs' perceptions of workload management correlate with previous findings of Purling and King (2012) and Ebrahini et al. (2016), which indicated that NGNs are not prepared academically for patient workloads and are often overwhelmed in clinical settings.

The participants of this study were sometimes close to tears or angry while sharing their clinical judgment anecdotes and, at other times, jubilant in their successes. An overarching impression of the researchers from the yearlong study was that the NGNs moved forward in their clinical judgment development in an ongoing context of uncertainty that ranged from frustration to growing confidence, sometimes during the same shift (see Figure 1).

Implications

These findings have implications for both academic and practice educators. Evidence from the CWLC and qualitative data suggests that the focus of the first year of practice should be workload management and prioritization skills. In addition, the CWLC results support regular use of structured reflection in consistent, small peer groups to prevent erosion of workplace satisfaction in the early years of practice. The researchers found focused attention on situations affecting clinical judgment, including debriefing difficult situations, illustrates a way of assisting NGNs toward growing confidence to ease their frustration.
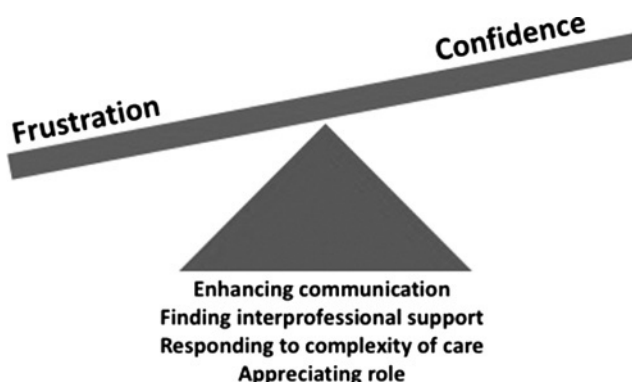
Figure 1. Promoting a positive transition into practice.

The data also suggest that NGNs' orientation time should be longer than 12 months. Further research is needed to understand the structure of such an orientation, but consistent, periodic debriefing may be one component. The National League for Nursing (NLN, 2015) Vision Statement, Debriefing Across the Curriculum, which states that the skills of debriefing from simulation hold a critical key to assist students to fully use their knowledge as they transition into practice sessions. Two elements of debriefing predominate: deep questioning and feedback. Utilizing these strategies throughout academic programs is designed to "to fully assist students to reveal the knowledge behind the action and attach meaning to information, bridging past learning within the context of a new situation" (NLN, 2015, p. 6). The same strategies could be useful for preceptors who work with NGNs to more quickly develop their clinical judgment.

The qualitative comments about not knowing what the next steps might be or how to best communicate with the team should be addressed when NGNs are students. Findings show that providing opportunities for students to practice clinical reasoning and interprofessional communication is imperative. For the participants of the current study, the recommendation for action was a challenge, even late in the first year of practice.

There is strong unity among health care leaders for the use of SBAR (situation, background, assessment, and recommendation) as a template for interprofessional communication (Institute for Healthcare Improvement, n.d.). In considering this finding, the researchers posit that more attention is focused on the SBA components and much less on the R; this is likely because academic faculty recognize students' lack of experience for making recommendations. However, it is essential to help students connect their learning with practice. Lastly, qualitative data suggest students and NGNs may benefit from simulation training with multiple patients (Franklin, Gubrud-Howe, Sideras, & Lee, 2015) in order to address the clinical judgment gap (Kavanaugh & Szweda, 2017).

Limitations

Quantitative findings were limited because 24 of the 74 participants did not complete the posttesting, giving an overall attrition rate of 32 percent, which impacts the generalizability of the study. The attrition rate was likely related to two explanations: a) several mentioned the level of their anxiety right after orientation precluded them from participating in "anything extra" and b) leadership changes at one hospital resulted in a change in employment for several of the NGNs.

CONCLUSION

Many previous studies regarding preparation for and transition into practice have not adequately described today's environment as context for the transition. Although NGNs are feeling more valued, they continue to struggle with communication, complex patient situations, interprofessional care, and their role, regardless of their setting or on which coast of the United States they work. Practice-ready graduates require focus on bridging the gap between academia and practice in these key areas and a supportive work environment. Helping to ease NGNs' frustration and assist toward confidence should be the goal of academic and orientation programs. Frequent structured reflection with experienced preceptors among groups of peers is useful to assist NGNs to frame the discussion of difficult experiences and learn from them in meaningful ways.

Finally, it is only prudent that academic and practice educators collaborate to ensure a smooth transition. Academic educators must

be aware of practice needs to best prepare students for practice as NGNs, and practice educators need to know what students have learned in their academic programs.

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