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What Do I Do Now?

Clinical Decision Making by New Graduates

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Newly graduated nurses (NGNs) are thrust into roles that some purport they are inadequately prepared to handle. This study investigated the experience of NGNs as they made clinical judgments in the critical care setting. Three themes emerged: developing confidence in practice, seeking assistance, and decision making. Nursing professional development educators can use the results to coordinate an education plan that extends beyond formal orientation and provides support for NGNs throughout the first year of practice.

There is a growing concern about newly graduated nurses' (NGNs) readiness to practice including claims that NGNs are inadequately prepared to care for the high acuity patients found in the acute care setting (Carlisle, Luker, Davies, Stilwell, & Wilson, 1999; Morolong & Chabeli, 2005). Casey, Fink, Krugman, and Propst (2004) found that only 4% of NGNs were comfortable with their skills and that it took up to 1 year for them to feel competent and confident with their abilities. Cantrell, Browne, and Lupinacci (2005) reported that NGNs feel shocked, unprepared, and overwhelmed with the responsibility of the professional role. del Bueno (1994) reported that only 38% of new graduates met expectations for recognizing acute changes in patient health status; initiating and understanding the relevance of independent and collaborative interventions; and differentiating between emergent, urgent, and nonurgent situations. Alarmingly, although 57% of chief nurse executives deemed NGNs were unsafe for practice, 38% of those nurses were assigned to care for six to seven patients, 11% cared for more than seven patients per shift (Casey et al., 2004), and 80% of critical care units reported hiring NGNs (Duvall, 2009).

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REVIEW OF LITERATURE

Clinical decision making or judgment is a deliberate problem-solving activity or process where conclusions are developed based on an actual or perceived patient need or response. Conclusions influence care plans about which actions, if any, are required, developed, and implemented. These care plans can be developed based on didactic knowledge, previous clinical encounters, collaboration with the healthcare team, intuition, weighing options, or other reasoning processes (Tanner, 2006). The ability to make effective clinical decisions relies on accurately assessing the patient and properly interpreting that information before initiating action. NGNs' lack of contextual knowledge and clinical experiences affects the way they are able to make decisions and act independently.

Few studies targeting NGNs' decision making are found in the literature. Ferguson and Day (2004) explored the process by which clinical judgment (CJ) skills were developed by 25 baccalaureate (BSN)-prepared NGNs. The researchers identified five stages that must be accomplished by new nurses: orienting to the practice environment, learning practice norms, developing confidence, consolidating relationships, and seeking challenges. NGNs need a supportive environment as they pass through these distinct stages and develop decision-making skills.

Using the performance-based development system, del Bueno (2005) measured critical thinking and CJ in experienced nurses and NGNs. Nurses with 1 or more years of experience answer correctly for 66.2% of the time, but NGNs respond correctly for only 31.8% of the time. It is concerning that, nearly 70% of the times, NGNs were unable to recognize and synthesize patient and needs and provide safe care.

Etheridge (2007) studied NGNs' perceptions of their decisions to ascertain what experiences were most helpful in learning to make judgments. Six BSN-prepared NGNs identified nursing judgment as learning to think like a nurse and believed that, to think like nurses, they had to develop confidence, learn responsibility, form relationships with the healthcare team, and think critically. NGNs found clinical experiences and discussion with peers to be the most beneficial learning strategies. Furthermore, NGNs wished to be challenged to discover their knowledge by working through problems rather than being told the solutions by faculty and preceptors.

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Tanner (2006) presented a CJ model based on conclusions drawn from a review of 191 articles. First, nursing CJs are affected by the nurse's prior experience and knowledge base more than by the objective data gained in any particular situation. Experienced nurses rely on practical knowledge gained over time, assess the situation quickly, recognize patterns in patient presentations, and respond based on prior successful experiences. Conversely, NGNs who lack experience must reason analytically, learn to recognize similarities in patient conditions, and apply theoretical knowledge to develop practical knowledge and sound judgments. Second, CJs are linked with knowing the patients, their patterns of response, and their concerns. This tacit knowing allows nurses to make CJs and provide individualized care. Third, CJs are influenced by contextual aspects such as knowledge of the unit, workflow, healthcare team relationships, social and moral beliefs, and hospital politics. Fourth, nurses use a combination of reasoning patterns when making CJs including intuition; analytical processes when the nurse lacks prior experience, when there is incongruence in what is expected and what occurs, and when making a conscious choice between multiple options; and narrative thinking to make sense of a situation and consider the meaning of the situation to the patient and others involved. Fifth, nurses act on their conclusions by responding to the patient's problem and observing the patient's response to the intervention. As the patient responds, the nurse confirms or disconfirms the conclusions and either proceeds with care or re-evaluates after gathering more information to construct a better understanding of the situation. Finally, reflection-in-action is used to evaluate CJs and is required to improve a nurse's clinical reasoning. Tanner purported that use of the nursing process, which is the basis of most nursing programs, does not adequately describe the decision-making processes of nurses and that relying solely on that framework for teaching students may be a disservice to them.

PURPOSE OF THE STUDY

The purpose of this study was to interpret the experience of NGNs as they made CJs in the critical care setting and to see if those experiences differed based on the NGN's length of critical care experience. NGNs were defined as licensed registered nurses who had been working for fewer than 18 months, and critical care nurses were defined as those registered nurses who worked in intensive care units (ICUs) and did not include step-down units or the emergency department.

THEORETICAL FRAMEWORK

The "From Novice to Competent Nurse: A Process Model" (Schoessler & Waldo, 2006) blends Kolb's Experiential Learning Theory (1984) and Bridges Transition Theory (1980) with the Novice-to-Expert Nursing Theory of Benner (2001) to provide an interdisciplinary framework, which forms the underpinnings for this study. Each new graduate makes a transition from school to employment. The Novice-to-Competent Nurse Process Model intertwines relevant concepts faced by new graduates— transition, learning, and competence—and asserts that this process takes up to 18 months, requiring that the new graduate be supported throughout that entire period.

RESEARCH METHODS

Data were obtained using a hermeneutic phenomenological approach by conducting one-on-one interviews with NGNs to elicit their lived experiences as they made CJs. Human subject protection was obtained before the study, and informed consent was gained from the participants. The sample included NGN volunteers from adult ICUs in seven hospitals. Four BSN-prepared nurses and one ADN-prepared nurse participated (see Table 1).

The nurse researcher constructed open-ended questions that were validated by the dissertation committee members. During individual audiotaped interviews conducted by the researcher, the NGN was asked to reflect on patient situations in which the NGN was challenged to make CJs or decisions and then to share that experience with the researcher. Follow-up questions were used to complete the NGN's stories as needed.

Data analysis occurred using an approach outlined by Creswell (2003) including transcribing data, reading and coding data, rendering descriptions, and interpreting the data. To clarify the meaning of some statements made by the NGNs, follow-up telephone conversations were made with three participants.

RESULTS

The following three themes were identified in the data analysis: developing confidence in practice, seeking assistance, and decision making (see Table 2).

TABLE 1 Demographics of Nurses Interviewed

NGN Pseudonym	Degree	Experience at BKAT	Experience at Interview
Shelby	BSN	14 months[a]	17 months[a]
Chloe	BSN	4 months	6 months
Addie	BSN	3 months	8 months
Hailey	BSN	12 months	17 months
Mel	ADN	2 weeks	4 months

[a]Includes 3-month maternity leave.

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TABLE 2 Qualitative Themes

Theme	Described	Example
Developing confidence in practice	Situational paralysis	"I felt like I didn't know what I was doing anymore…and questioned myself am I fit to do this—to be an ICU nurse?
	Self-confidence	"It was easy enough. I'm not cocky. I am good—I know that"
	Defining moment	"Dr. S., like honestly I don't feel comfortable extubating him. He doesn't look…. he just doesn't look OK at all."
Seeking assistance	Importance of support	"Honestly, I think that the key to like being comfortable when you're a new grad is having strong people you work with and people who are willing to help you."
	Lack of support	"My preceptor is the last person I will go to. I just don't feel that I can talk to her."
	Calling the physician	"The most difficult part is when to call the doctor [sic]."
		"I always check with another nurse before I call the physician"
Decision making	Self-doubt	"I just couldn't even think of what to do…. I was shaking so bad."
	Lack of experience	The NGN walked out of the room frustrated because she could not explain the patient condition to the family.
	Decision framework	"You know, I thought airway–breathing–circulation and everything comes together…it's all going to work out…. I just have to bag him."
	Reflection	"I should have planned better." "Now I know who to call."

Developing Confidence in Practice

Confidence, or lack thereof, was a theme identified by all of the NGNs. Examples ranged from situational paralysis, self-doubt, and second-guessing decisions to defining moments. Four of the NGNs mentioned concerns about making an error or described errors that shattered their confidence.

Two of the NGNs described situations where they became paralyzed and were unable to provide care for the patients. In each case, the charge nurse intervened and managed patient care until the crisis was over. Chloe shared a crisis situation when she had 3 months of experience and a patient's fresh tracheostomy became dislodged. Chloe described "freaking out" to the point of being unable to follow directions to bag the patient or pull medications from the dispenser: "I just didn't know what to do." As she reflects on this experience months later, Chloe stated that, based on her experience now, "I definitely wouldn't freak out like I did—I didn't know anything…now I know who to call…. I'd be a lot calmer and not so flustered and out of control."

Shelby described a patient 6 months after graduation. While Shelby was charting, the patient self-extubated and pulled out her only intravenous access. Shelby stated: "…she was restrained, so I thought…I thought everything was alright…. The physician was really mad at me—I got yelled at, SCREAMED at." That experience caused Shelby to question her abilities: "I felt like I didn't know what I was doing anymore…and questioned myself…am I fit to do this—be an ICU nurse."

When recounting a first patient code about 3 months after graduation, Hailey described a patient who had been recently extubated, was permitted to eat, and subsequently coded. Hailey second guessed herself stating, "So maybe he aspirated. That one was hard because then you start thinking maybe I shouldn't have fed him. We try to intubate and you know tons of stuff came out…. he didn't make it."

Three of the five NGNs provided evidence of a defining moment when they displayed confidence and truly felt like nurses. Addie described a code situation where an initial "what did I do to cause this" moment was followed by a fleeting feeling of being "helpless," but rather than becoming paralyzed, Addie took charge of the situation and directed team members. She spoke of the importance of thinking on her feet: "You have to think about it right now… you know I thought airway, breathing, circulation…. That's how I made decisions—starting from airway and moving down…. you delegate because you have the help that you need…and everything comes together." She prided herself in the ability to give a comprehensive patient report to the code physician who was not familiar with the patient: "You know, so I was proud of myself and actually, I wasn't happy that he coded, but I was still focused on what happened."

Seeking Assistance

Each of the NGNs sought the help of co-workers to provide patient care. Staff nurses and other team members provided valuable resources to back up the NGNs, validate their knowledge, solve a problem, or intervene when the NGN lacked knowledge about or confidence in the situation.

Frequently, the NGNs opted to delegate to more experienced nurses who had the necessary knowledge to provide

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safe care. Within the concept of seeking help, NGNs identified those to whom they were most and least likely to turn and described times when they chose not to seek assistance. On the basis of their interpersonal experiences, some relied more heavily on the preceptor as a mentor or information source after orientation than did others. The level of preceptor support ranged from little support and interaction to great support and continued mentorship. All of the NGNs used the charge nurses as resources.

The NGNs consistently acknowledged conferring with an experienced nurse before calling a physician. Mel admitted, "The most difficult part is when to call the physician." Twice, Shelby mentioned fear of communication with physicians stating, "As a brand new grad, I was scared to death to talk to a physician" and "I always call physicians last.... I used to be afraid of them." The NGNs feared being laughed at for asking questions, not being able to express themselves, not knowing answers to questions, and angering the physician by calling needlessly. NGNs combated this fear by seeking validation from other nurses before making the call. As the NGNs gained experience and confidence, four of the five NGNs found telephone calls to physicians less intimidating.

These NGNs appeared to be finding balance between independent action, interdependence, and seeking assistance. Although overconfidence can result in risky behaviors, NGNs are expected to push beyond their comfort zone in developing their skills and decision-making ability. Two of the NGNs described how they built their confidence and skill. Chloe described safety as the denominator as whether to work through problems or seek help stating, "I've been doing a lot of stuff by myself and trying not to ask for help unless I feel like it's going to be a safety issue to the patient because I feel that it's going to make me better as far as organizing stuff." Addie preferred to look things up in references or on the computer rather than asking for help, keeping a critical care text and drug book nearby for easy access, and validating with an experienced nurse if needed. These practices helped the NGNs build their knowledge, skill, and independence.

In a contrary case, Mel prided independence stating that she "felt like doggy paddling for a while" when trying to settle a newly admitted patient to the ICU. When Mel finally elicited help from the charge nurse, that nurse questioned why Mel had not sought help sooner signaling a concern that Mel was not yet prepared for that level of independence. In a separate incident, Mel described choosing not to call a physician for orders or requesting help with a patient who became hypotensive, but instead, she proceeded to start fluid boluses without orders and documented her admission assessment, thus raising questions about her level of decision making and prioritization and her understanding of the scope of practice, the patient's condition, and patient safety.

Decision Making

Theoretical knowledge, practical knowledge, and personal knowing all influence the nurses' ability to make decisions. The NGNs displayed a variety of decision-making experiences that ranged from Addie's using an airway–breathing–circulation approach to plan her care during a crisis situation to Shelby and Hailey becoming paralyzed and unable to make decisions or provide care.

Self-doubt, tunnel vision, and a lack of experience often limited the ability to make decisions requiring reliance on charge nurses and preceptors. For example, Chloe's superficial knowledge of the drugs required for rapid sequence intubation, and the resulting flood of adrenaline rendered her unable to make a decision when trying to gather meds: "I just couldn't even think. When I was at the Pyxis, I couldn't.... I was just so scared.... I was shaking so bad." Addie and Chloe talked about their initial lack of experience and the need for better planning and prioritization but also stated that, with increased experience, they can now anticipate what the patient may need and plan accordingly.

The NGNs provided examples of reflection on action, which allowed them to dissect situations after the fact and work through how decisions could be made differently in similar experiences. Regardless of when it occurs, reflection is an integral part of learning and deepening superficial knowledge. Hailey recounted her decision to call a physician because she believed that the patient was experiencing disseminated intravascular coagulation. Stemming from her theoretical knowledge about dissemwas able to assess changes in the patient's condition, interpret what they meant, and deduce that the changes warranted physician notification. Hailey expressed frustration that she was ignored by the physician, but she followed the chain of command to elicit the help of the charge nurse to make her case. Appropriate laboratory tests were ordered "after a couple of hours," and the physician eventually acknowledged Hailey's conclusion; however, treatment was not initiated before the patient was coded.

DISCUSSION

Decision making is a fluid process that combines both looking inward and knowledge and outward at the situation at hand and combining the elements to make a judgment. The themes identified by these NGNs are consistent with Benner's novice and advanced beginner levels and Tanner's Model of Clinical Judgment. The NGNs shared their struggles making decisions—struggles that stemmed from a lack of experience-based knowledge, lack of confidence, lack of support, and a lack of knowing the team resources available for use. Applying the Novice-to-Competent Nurse framework, the researchers identified that the NGNs were at different points in their transition experience, accounting for the differences in their accounts of practice.

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These results are similar to those of Etheridge (2007) who found that, to think like nurses, NGNs needed to develop confidence, learn responsibility, form relationships with the healthcare team, and think critically. Although the difficulties of making decisions can be concerning from a safety standpoint, these challenges are expected and well documented in the literature. Research by McKenna and Green (2004) found that, during the first 6 months of practice, NGNs focused primarily on tasks while they struggled to survive. In addition McKenna and Newton (2008) found that NGNs had difficulty responding to unexpected situations during their entire first year of practice.

Benner (2001) discussed clinical knowledge, a combination of theoretical knowledge and practical knowledge, which is gained over time based on repeated experiences. The nurse is often unaware that this database of knowledge is being built but calls upon it to recognize patterns, predict outcomes, and make decisions. Because of their lack of experience, NGNs do not have this resource from which to pull and, therefore, often have difficulty deciding how to proceed. Likewise, these NGNs are at different points of knowing the patient, an integral part of decision making (Tanner, Benner, Chelsea, & Gordon, 1993). Repeated patient exposures provide NGNs with an understanding of the patient's needs and desires. Knowing the patient enables nurses to make better care decisions. In most examples provided by the NGNs in this study, that level of interaction and knowing the patient had not been achieved and could not be transferred to decision making. Until the time occurs when nurses make judgments based on tacit knowledge, they generally use analytical thinking to make sense of the situation and decide upon a course of action (Tanner, 2006).

Knowledge can be described as both horizontal, bits of knowledge about a broad range of topics, and vertical, in-depth knowledge about topics. Both types of knowledge are necessary for effective clinical practice; however, it takes more than knowledge to make good decisions. The NGNs interviewed seemed to have the horizontal knowledge necessary to make decisions and judgments during expected typical patient scenarios. However, they often lacked the vertical and contextual knowledge necessary to make decisions when met with unexpected or unfamiliar events. They followed a set of known rules and became stuck when they met a challenge. The NGNs focused on tasks, for example, beginning CPR or pushing drugs and demonstrating basic levels of task-oriented decision making but not portraying understanding of the overall patient situation.

Conversely, experienced nurses make decisions based on intuition, clinical reasoning, and personal knowing of the patient. In addition, experienced nurses have increased familiarity with the standards of practice, resources available to them, and increased comfort communicating with various members of the healthcare team. This socially embedded knowledge is gained over time, often without the nurses' knowledge.

CONCLUSION

Etheridge (2007) found that NGNs learned by discussing clinical experiences with peers and preferred to work through problems rather than being given solutions. Similarly, del Bueno (2005) asserted and NGNs concurred that group participation in questioning activities such as case studies (Benner, Sutphen, & Day, 2009) where NGNs face challenges and must apply knowledge are more effective learning strategies than didactic content alone.

In the clinical setting, these strategies could be used to promote decision making by providing NGNs with scenarios where they make safe decisions. These scenarios could be examples of actual patients or developed cases. In addition, when available, the use of simulation could be added to these case discussions. Working as a team, the NGNs can share knowledge, roles, and responsibilities and role play various crisis situations. These repeated experiences with patient problems, whether real or simulated, provide NGNs with additional exposure to scenarios with which they are likely to be faced. Mastery of complex clinical situations and the ability to think critically "on the fly" are traits needed by the NGNs caring for patients in high-acuity settings.

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