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EXPLORING CLINICAL JUDGMENT IN AN ACCELERATED UNDERGRADUATE  
NURSING CURRICULUM

A Dissertation  
presented in partial fulfillment of requirements  
for the degree of Doctor of Higher Education  
in the Department of Higher Education  
The University of Mississippi

by

MARLIE L. FARRAR

May 2023

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## ABSTRACT

Nurses play a pivotal role in the healthcare world. They play a role in many settings, caring for patients with chronic issues to patients in life threatening situations. These settings call for nurses to be able to analyze patient situations and correctly intervene. This skill is clinical judgment. However, Kavanagh and Swzeda (2018) have shown that new graduate nurses do not demonstrate this skill, potentially causing patient harm. Findings such as this one have led to a reformation of the National Council Licensure Examination for Registered Nurses (NCLEX-RN). The revamped exam called the Next Generation NCLEX (NGN) will focus on exam takers' clinical judgment. However, nurse educators are concerned about students' ability to pass the NGN, particularly since NCLEX-RN pass rates have consistently dropped over the last five years (National Council of State Boards of Nursing, n.d.-c.).

This assessment aims to explore the presence of clinical judgment in an accelerated bachelor of nursing (ABSN) program in a Mississippi school of nursing. Clinical judgment must be built in the nursing school curriculum to better patient outcomes and to assist students in passing the NGN. This project seeks to assess the written curriculum (e.g., syllabi, module outcomes, etc.) for evidence of clinical judgment. After this, program faculty will be interviewed to assess where clinical judgment is incorporated that may or may not be reflected in the written curriculum.

These aspects of assessment will assist in giving a more complete picture of clinical judgment in the curriculum.

Finally, my leadership in my role in this changing, challenging time in nursing education will be discussed. Many opportunities are now available to show strong leadership. Being a scholarly, positive, servant leader is my aim. Servant leadership allows for the encouragement and development of others as I humbly lead the way for opportunities.

## DEDICATION

To my mom and dad, for the years of education you provided and encouraged through.

This work is a culmination of your efforts to invest in my future.

To my husband, your patience and love made this possible. Thank you for everything.

## LIST OF ABBREVIATIONS AND SYMBOLS

AACN American Association of Colleges of Nursing

ABSN Accelerated Bachelor of Science in Nursing

BSN Bachelor of Science in Nursing

CCNE Commission on Collegiate Nursing Education

CITI Collaborative Institutional Training Initiative

CJSR Clinical Judgment Self-Evaluation Rubric

CRC Clinical Reasoning Cycle

DPRT Dual Process Reasoning Theory

HOT Higher Order Thinking

INASCL International Nursing Association for Clinical Simulation and Learning

IRB Institutional Review Board

IPE Interprofessional Education

LCJR Lasater Clinical Judgment Rubric

LMS Learning Management System

NCJMM NCSBN Clinical Judgment Measurement Model

NCLEX-RN National Council Licensure Examination for Registered Nurses

NCSBN National Council of State Boards of Nursing

NED Nurse Educator

NGN Next Generation NCLEX

NGNPS New Graduate Nurses Performance Survey

QSEN Quality and Safety Education for Nurses

RN Registered Nurse

PBL Problem Based Learning

PoP Problem of Practice

SME Subject Matter Experts

SON School of Nursing

UGCC Undergraduate Curriculum Committee

UMMC University of Mississippi Medical Center



## ACKNOWLEDGEMENTS

Many may assume that the pursuit of a doctoral degree is singular: one person's time devoted to finishing one massive scholarly endeavor. Thankfully, the pursuit of scholarly excellence is plural. I have had the greatest honor of having my community of support. Without them, this work would not be possible. To my dear family, I am thankful for all of the times you allowed me to say no so that I could say yes to this and for all the encouragement. To my colleagues at the University of Mississippi Medical Center School of Nursing, I appreciate you nudging me toward this important work and for your constant positivity. To my friends and my church, your prayers and support were lavish and unrelenting. Writing this to you proves that your prayers were answered! Thank you to the National Council of State Boards of Nursing for allowing me to use the image their Clinical Judgment Measurement Model in this work.

To my dissertation committee: Your feedback and commitment to excellence were appreciated more than you will ever understand. To Dr. Whitney Webb, I honestly do not know how I was so blessed to have you as a dissertation chair, but I am forever grateful. Thanks for believing I could do this.

To my husband Joe: Words will never be sufficient to tell you how thankful I am that God gave me you. You made this journey possible in ways you may not even recognize. And last, but most supremely: *Soli Deo gloria*.

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## CHAPTER I: OVERVIEW AND LITERATURE REVIEW

## OVERVIEW AND INTRODUCTION

For 19 years in a row, nursing has been rated the most honest and ethical profession in the United States (Gaines, 2021). This finding illustrates the general public's trust of nurses and their ability to care for the sick in their time of need. However, according to Kavanagh and Szweda (2017), newly graduated nurses are experiencing a competency crisis. The decision-making and critical thinking skills of over 5,000 newly graduated nurses were assessed upon hire at a U.S. midwestern academic health center, and 77% of those nurses either missed patient deterioration cues or were not able to intervene effectively (Kavanagh & Szweda, 2017). Ebright et al. (2004) discovered that nurses with less than one year of experience often used some critical thinking to solve problems; however, they were unable to see the problem through to resolution, resulting in near-miss and adverse events. Adverse events are actions that cause patient harm; near-miss events are actions that are caught before the patient is harmed (Crane et al., 2017; Office of Inspector General, 2012). Additionally, of the nurse leaders surveyed by Berkow et al. (2008), 75% of them are dissatisfied with novice nurse performance. More recently, nurse managers and preceptors ( $n=51$ ) at a rural, 380-bed hospital were asked to rate new graduate nurse performance. Results show these managers and preceptors were not completely satisfied with new graduate nurse performance, with the skills of critical thinking and management of responsibilities scoring the lowest (Gregg, 2020).

Zhang et al. (2018) predicts that there will be a shortage of 510,394 registered nurse (RN) jobs in the United States by 2030. Nursing is further complicated by requirements to be able to manage diverse, aging populations and rapidly changing technology (National Academies of Sciences, Engineering, and Medicine, 2021). A nationwide nursing faculty shortage also affects the overall nursing shortage with 80,407 applicants to schools being denied acceptance “due to an insufficient number of faculty, clinical sites, classroom space, clinical preceptors, and budget constraints” (American Association of Colleges of Nursing, 2020a, p. 1; Perkins, 2021).

Healthcare organizations are in desperate need of competent nursing staff. And, if Kavanagh and Szweda (2017) are correct, these organizations could be hiring nurses that are ill-equipped to produce quality patient outcomes. The COVID-19 pandemic has further exacerbated problems due to a limited amount of clinical experiences for undergraduate students and increased nursing burnout and turnover rates (Blevins, 2021; Boyle, 2021; Office of Inspector General, 2021).

Marked competency deficits caused the National Council of State Boards of Nursing (NCSBN) to cast a critical eye on the U.S. and Canada’s nursing licensure examination, the National Council Licensure Examination for Registered Nurses (NCLEX-RN). NCSBN is responsible for the composition and continual updates of the NCLEX-RN. NCSBN noted missing critical thinking and decision-making skills in newly licensed nurses. Even though these nurses had passed the NCLEX-RN and had been deemed competent for practice, lapses in patient care continue. Nurse educators, new nurses, and subject matter experts agree that clinical judgment is a vital skill for

nurses in any setting to possess (NCSBN, 2018a). *Clinical judgment* is defined as “the observed outcome of two unobserved underlying mental processes, critical thinking and decision-making” (Betts, 2017, slide 6).

Because of growing concern of novice nurses’ clinical judgment deficiency, the NCSBN is revamping the NCLEX-RN. This new exam, or the Next Generation NCLEX-RN (NGN), will use different testing modalities to evaluate examinees’ clinical judgment (NCSBN, n.d.-c) and is expected to be implemented in 2023. With this revision of the exam, nurse educators are left to wonder if students are capable of passing it. If students are unable to pass the NGN, what will become of the nursing shortage and what will become of nursing programs with low pass rates? Most importantly, what will happen to patients in hospitals who lack nurses to care for them? The NGN calls for a radical reformation of nursing education; it calls for educators to 1) teach students to think and 2) teach students to think like a nurse (Caputi, 2019). To do this, educators must incorporate clinical judgment into curricula in schools of nursing. The purpose of this literature review is to explore clinical judgment: its definitions, importance in nursing, and development of it in undergraduate nursing students.

### **Definitions and Frameworks**

Clinical judgment is a complex process that has many definitions. Even within the discipline of nursing, various definitions of clinical judgment exist; several of these are displayed in Table 1.



**Table 1**

*Clinical Judgment Definitions in Nursing Education*

Source	CJ Definition
Benner (as cited by National League for Nursing, 2014)	“Clinical judgment refers to ways nurses come to understand the problems, issues, or concerns of clients/patients, to attend to salient information, and to respond in concerned and involved ways” (p. 1).
Betts et al. (2019)	“Nursing clinical judgment is the observed outcome of critical thinking and decision-making. It is an iterative process that uses nursing knowledge to observe and assess presenting situations, identify a prioritized client concern, and generate the best possible evidence-based solution in order to deliver safe client care” (p. 23).
Manetti (2019)	”. . . sound clinical judgment is a cognitive process in which the nurse forms a holistic assessment of a patient situation” (p. 106).
Tanner (2006)	“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” (p. 204).

Regardless of the different definitions, they have common themes. Clinical judgment: 1) revolves around patient care 2) involves complex cognitive processes such as critical thinking, clinical reasoning and 3) requires the nurse to make a decision based on the information collected.

Leaders in nursing education frequently refer to Tanner's (2006) Clinical Judgment Model and to NCSBN Clinical Judgment Measurement Model (NCJMM) when discussing clinical judgment.

### **Tanner's Clinical Judgment Model**

Tanner's Clinical Judgment Model was developed based on research on how a nurse thinks and makes clinical decisions. This model was built on that idea that clinical judgment is a complex process that is dependent on far more than just textbook knowledge. Nurses process information and make decisions based on their own moral views, past experiences, and familiarity with content and with the patient. Tanner (2006) identifies four phases of clinical judgment: noticing, interpreting, responding, and reflecting. Noticing is essentially born out of a nurse's expectations of a patient situation. That expectation is built from past experiences of the nurse. For example, nurses may view a patient in end-of-life care differently based on their past experiences with similar patient populations or due to their culture. Interpreting and responding are next in the clinical judgment process. Nurses analyze and process the patient situation at hand based on their noticing framework. The nurse may use several methods of reasoning, such as intuition or deductive reasoning, to come to a decision. After making that decision, the nurse intervenes to the patient's situation based on the conclusion of reasoning. Finally,

the nurse has a period of reflection. Reflection-in-action is the active evaluation of how the patient is responding to the nurse's interventions. Reflection-on-action is used after the situation is over to debrief actions performed, particularly if the interventions were not successful (Tanner, 2006).

Tanner's Clinical Judgment Model has been used widely throughout nursing education. Lasater (2007) created an assessment rubric for evaluating clinical judgment development in nursing students using simulation experiences. This rubric is widely cited throughout the literature on clinical judgment in nursing education. Manetti (2019) relies heavily on Tanner's Clinical Judgment Model by defining clinical judgment as "a cognitive process in which the nurse forms a holistic assessment of a patient situation" (p. 106) that integrates noticing, interpreting, responding, and reflection in the process.

### **National Council of State Boards of Nursing Clinical Judgment Measurement Model (NCJMM)**

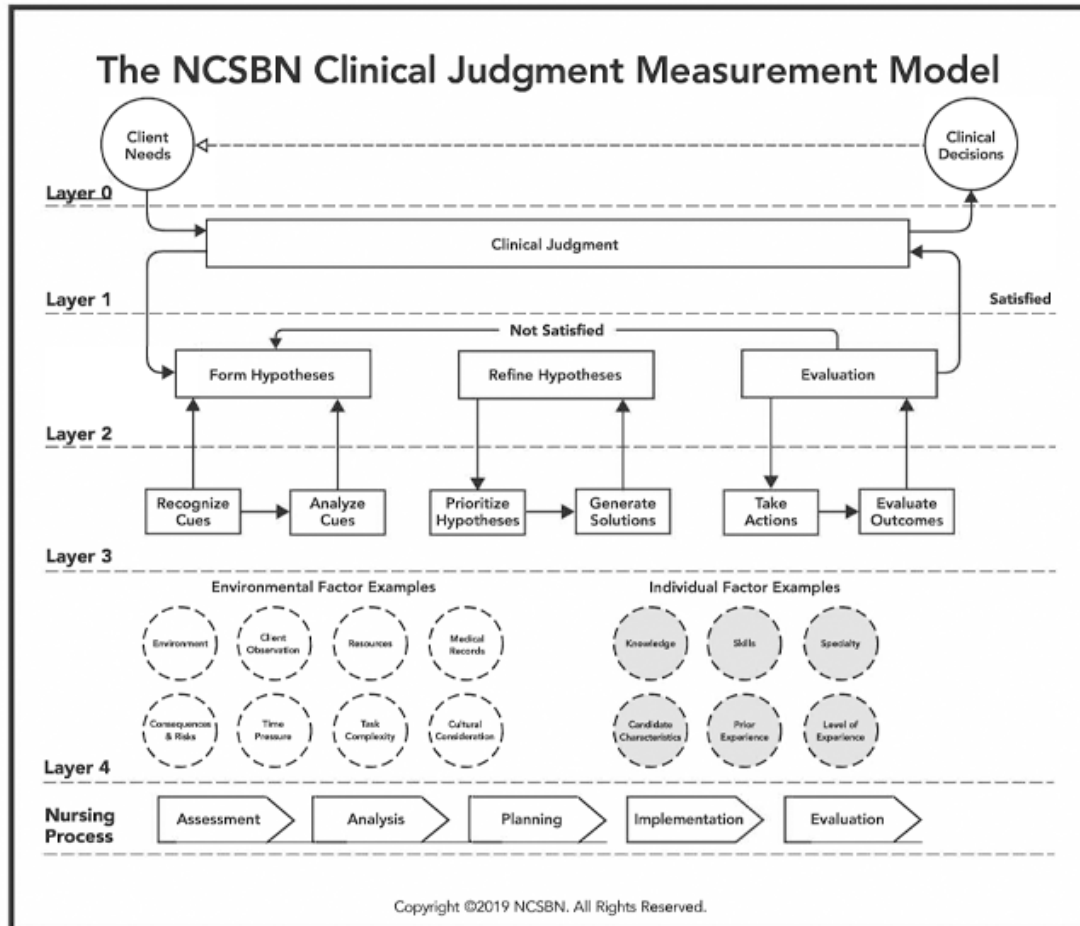
As mentioned earlier, NCSBN (2018a) recognizes the need to transform the NCLEX-RN. This recognition came from NCSBN's practice analyses. Every three years, NCSBN performs these to ensure the NCLEX-RN assesses the correct knowledge and skills expected of and performed by new nurses. New nurses have repeatedly identified clinical judgment as a necessary skill (NCSBN, n.d.-c). NCSBN had to create a way to measure this necessary skill, and thus the NCJMM was created.

NCJMM (NCSBN, n.d.-b) is a model with five layers (Figure 1). Each layer describes components of clinical judgment. The layers progress from broad to specific. Layer 0 describes the context as client needs and clinical decisions. Layer 1 is clinical

judgment. Layer 2 broadly describes nursing decision making as form hypothesis, refine hypothesis, and evaluate. Layer 3 specifies how nurses assess clinical situations and make decisions. This layer includes the categories of recognize cues, analyze cues, prioritize hypotheses, generate solutions, take action, and evaluate outcomes. Layer 4 describes situations that can affect decision making, such as time pressure and level of experience. The final element of the NCJMM is a modified version of the nursing process. The original nursing process includes the steps of assessment, diagnosis, planning, implementation, and evaluation. This process is what allows nurses in various areas to have quality care (American Nurses Association, n.d.-a). NCJMM replaces diagnosis with analysis.

**Figure 1**

*National Council of State Boards of Nursing Clinical Judgment Measurement Model*



*Note.* Used with permission from the NCSBN.

Clinical judgment is a complex process, so including several decision-making models and theories in the creation of NCJMM was important. NCJMM includes three theories and models in its framework: the Intuitive-Humanistic Model from which Tanner's Clinical Judgment Model is heavily based, Dual Process Reasoning Theory, and the Information Processing Model (Dickison et al., 2019).

The use of Tanner's Clinical Judgment Model is seen throughout, as the layers take into account the nurse/nursing student's experiences and environmental pressures. Likewise Dual Process Reasoning Theory is evident. Dual Processing Reasoning Theory (DPRT), originally described as a process for policy makers by Hammond (1980), was transferred to medical literature to discuss clinical decision making. Croskerry (2009) discusses two types of reasoning in decision making: analytical and intuitive. Like Tanner's Model, DPRT also takes the clinician's experiences, environment, and previous training. Intuitive reasoning happens most frequently when a nurse has experienced a similar situation, for example, has seen a patient with the same symptoms or takes care of a patient population consistently. Analytical reasoning occurs when there is no experience upon which to draw or when situations do not align in a textbook fashion (Croskerry, 2009). Additionally, information processing theories were incorporated into the NCJMM. Many information processing theories exist; however, the main ideas throughout them all are similar: "Looking at decision making through the lens of information processing involves questions of how decisions emerge from basic cognitive processing, such as attention, memory, and causal reasoning" (Oppenheimer & Kelso, 2015, p. 290).

## **How Theories Merge**

It may seem as if Tanner (2006) and the NCJMM (NCSBN, n.d.-b) have no correlation. This is far from true. While their languages use different terms, the languages echo similar ideas. Assessment Technologies Institute (ATI, 2020) argues that these two models work in conjunction with the nursing process. The nursing process is the original, revered model of how nurses think and make decisions (American Nurses Association, n.d.-b). The nursing process involve assessment, analysis, planning, implementation, and evaluation. ATI (2020) makes the point that the assessment phase incorporates Tanner's noticing and NCJMM's recognize cues. They all require the nurse to assess the patient and/or situation and notice/recognize cues to recognize there is a problem. Analysis envelopes analyze cues and prioritize hypotheses (NCJMM, n.d.-b). Interpreting (Tanner, 2006) not only encompasses these, but also planning and generate solutions. The reason is because interpreting requires the nurse to analyze the cues found upon assessment, prioritize what he or she believes is wrong, and then start planning solutions for the resolution of the problem. Next in nursing process is implementation. This means the nurse does something; in the content of NCJMM, the nurse takes action, and in the content of Tanner, the nurse responds. Finally, evaluation occurs. According to Tanner, this is a period of reflection in which a nurse evaluates outcomes (NCJMM, n.d.-b). So, while the language may be different, the main themes overlap and correlate.

### ***Next Generation NCLEX-RN (NGN)***

In a world with increasingly complex healthcare needs, nurses have clinical judgment. Gonzalez et al. (2021) suggest that using higher-order thinking (HOT) is a way

to build this important skill. HOTS allow students to bridge the gaps between classroom knowledge and clinical application. NCSBN's (n.d.-a) mission with the NGN is to evaluate a test taker's clinical judgment. The previous NCLEX-RN assessed lower order thinking. Betts et al. (2019) note clinical judgment is a higher order cognitive construct and must be evaluated by higher-order questions. The NGN questions will be case study based. A test taker will read a case study and navigate through a computer chart to learn about the patient. The test taker will be asked six questions about the particular scenario, each question representing a different action in layer 3 of the NCJMM. NCSBN recruited subject matter experts (SMEs) to begin developing test items using the NCJMM. SMEs were asked to build case scenarios that an entry-level nurse would encounter with distractor options that would mimic errors performed in real patient care. Item reviewers then critiqued the questions. After final review of the case study and questions, the questions were converted into a new question format such as drag-and-drop, matrices, grids, and drop-down (Betts et al., 2019).

### ***NCJMM Controversies***

Some nurse educators are skeptical of the new NCJMM. Alfaro-LeFevre (2020) insists that the NCJMM does not align with the American Nurses Association's basic nursing principles, such as the nursing process. While NCJMM does include the nursing process, it does not include the step of diagnosis. Alfaro-LeFevre (2020) also addresses other challenges that the NCJMM's implementation will cause. The transition will be massive and massively expensive. All literature about the NCLEX-RN will have to be



adjusted to the new model. Nursing educators and clinical partners will need extensive training and understanding to be able to assist nursing students.

Alfaro-LeFevre (2020) discusses that enough research has not been done. Perhaps the NCLEX-RN is not the problem, and educators could do different activities in the curriculum to assist with clinical judgment development. The NCSBN was not clear on the process of the model development, so the unknown causes doubt of its development and use. Benner (2019) is also concerned about the development of the model. She argues that NCSBN used outdated information about information processing theories. Additionally, Benner (2019) focuses on the NCSBN's focus on the new questions' reliability and not their validity.

Not all educators are dubious of the NCJMM. Sherrill (2020) expresses enthusiasm over the model. She says the nursing process was developed in 1958 and it should be questioned as the way that nurses are trained. Two of the top reasons newly licensed nurses are placed into disciplinary action is because they have failure to notice and failure to act. NCJMM focuses on noticing; the nursing process does not. Dickison et al. (2019) also did not use the nursing process as an anchor for the development of the NCJMM as it does not include all factors of decision making. Billings (2019) also agrees with the use of the NCJMM, stating that the nursing process and even Tanner's (2006) Model do not adequately capture the complexities of modern-day nursing. Kantar and Alexander (2012) further argue that the nursing process "promotes linear thinking" (p. 450) and should not be emphasized.

Both sides of the argument do agree on several points. Faculty will need a deep knowledge of the topic as they will be creating learning opportunities for students. Students must be introduced to and understand the model. The NCJMM would need to be integrated heavily throughout the curriculum (Alfaro-LeFevre, 2020; Sherrill, 2020).

### **Critical Thinking, Clinical Reasoning, and Clinical Judgment**

Clinical judgment is frequently used interchangeably with *critical thinking* and *clinical reasoning*. While these processes are necessary for clinical judgment, they are not the same. Knowing how these terms are different, yet interrelate, is important in the understanding of clinical judgment.

*Critical thinking* is a term used in many disciplines outside of healthcare. According to Victor-Chmil (2013), critical thinking is a knowledge-based, cognitive process. This process requires the nurse to use logic in clinical situations (NCSBN, 2018b). Basically, critical thinking is the way nurses interpret and analyze a situation (Meijer, 2021). Critical thinking is more than a one time event. It must be a habitual practice and is learned in pieces (Foundation for Critical Thinking, n.d.). Martin (2002) supported this by showing that nurses improve critical thinking and decision-making skills with age and experience.

*Clinical reasoning* is “the application of critical thinking to a clinical situation” (Victor-Chmil, 2013, p. 35). While critical thinking is present in many disciplines and does not strictly relate to patient care, clinical reasoning is specifically patient care focused (Gonzalez et al., 2021). It takes information gleaned through critical thinking and applies it to the patient situation. Clinical reasoning requires the nurse to come to a

conclusion about a patient situation, take action, and evaluate the action. The process is cyclical and steps may be repeated, depending on the outcome of the original action (Banning, 2008).

According to Meijer (2021), clinical reasoning and critical thinking are necessary for clinical judgment. Victor-Chmil (2013) describes clinical judgment as the action resulting from critical thinking and clinical reasoning. Putting into the perspective of the NCJMM, critical thinking is represented in layer 3 by recognize and analyze cues categories; clinical reasoning is found in the prioritize hypotheses and generate solutions categories; clinical judgment is in the take actions and evaluation outcomes categories (Meijer, 2021). While the processes are all separate, they are all equally important.

### **Importance of Clinical Judgment**

Nursing is the largest healthcare profession in the United States at nearly four million workers (American Association of Colleges of Nursing, 2019). Nurses assess and educate patients. They administer medications, requiring deep knowledge of how those medications work and how they could affect the patient. They are coordinators of care and patient advocates (American Nurses Association, n.d.-b). Nursing is a challenging field. Its members are asked to manage the care of complex patients, and the complexity is growing. “Between 2000 and 2030, the number of Americans with one or more chronic conditions will increase 37 percent, an increase of 46 million people” (Anderson, 2010, para. 4). Clinical judgment allows the nurse to notice a problem and react appropriately. Newly licensed nurses report that 46% of their daily job tasks require clinical judgment (NCSBN, 2018b).

In addition to complex chronic conditions, healthcare workers are battling the COVID-19 pandemic. Nurses have shined in their roles as innovators and leaders in healthcare. COVID-19 has forced them to learn to work with limited supplies and staff. Nurses have assisted in making difficult decisions, such as which patients receive ventilator support. They have been champions of organizing and staffing testing and vaccination sites (Tachibana, 2020). The expanding role of the nurse and the challenging healthcare landscape all require nurses to be proficient in clinical judgment.

Graduates of nursing programs must be able to handle the rapidly changing, high acuity nursing environment. However, doubt exists that new graduates are able to do this. Many studies point to a lack of clinical judgment in new nurses. Tang et al. (2007) surveyed nurses ( $n=72$ ), and 37.5% identified new staff as a factor for medication errors. Medication errors are not the only problem new nurses have. They are also involved in patient falls, delay of care, communication deficiencies with other providers, and documentation errors (Saintsing et al., 2011). Additionally, new nurses seem to lack competency in most skills. Berkow et al. (2008) surveyed nurse leaders ( $n=3265$ ) and asked them to rate new nurses on proficiency in 36 competencies. Of those 36 competencies, new nurses were only rated over 50% proficient in two.

### **Clinical Judgment and Competency-Based Education**

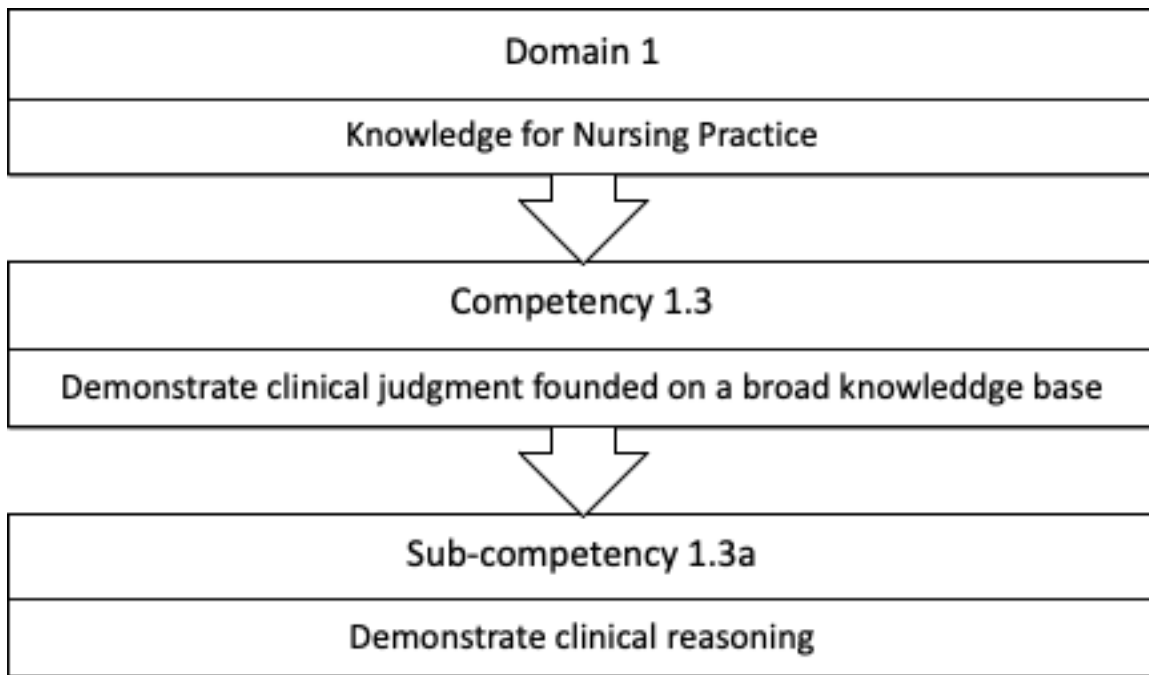
The American Association of Colleges of Nursing (AACN) is one of the leading organizations in nursing education, setting standards for diversity and inclusion, legislation, and curriculum. AACN recognized the need for nurses to demonstrate competency and develop clinical judgment. Recently, AACN (2021) released *The*

*Essentials: Core Competencies for Nursing Education.* The *Essentials* were revised in 2021 to guide nursing education into a new era of transitioning into competency-based education. They set the competencies that nursing program graduates should meet. The purpose of switching to competency-based education is to allow graduates from nursing programs to be consistent in knowledge and performance in the clinical arena. AACN dubbed clinical judgment as an integral concept that must be woven throughout all competencies and nursing curricula. The end goal of the *Essentials* is what nurses should be able to do, not just what nurses should know.

The *Essentials* are divided into different categories: domains, competencies, and sub-competencies. The ten domains are the broadest categories of what skills should be expected of nurses. Competencies are short statements that are narrower than domains, but must be read in the context of a specific domain to be understood. Finally, sub-competencies assist faculty and students in knowing how to fulfill each competency in a measurable way (AACN, 2021). Figure 2 displays how the *Essentials* document structures domains, competencies, and sub-competencies.

**Figure 2**

*Structuring of AACN's Essentials*



Competency 1.3 in the new *Essentials* broadly identifies clinical judgment as an educational target. The sub-competencies supporting this reflect Tanner's (2006) thoughts that clinical judgment is based on the nurse's prior experiences, not just in nursing, but in life. As stated before, this competency is not the sole mention of clinical judgment in the *Essentials*. Clinical judgment is woven throughout the competencies, particularly in domain 2 (person centered care) that focuses on creating, implementing, and evaluating a plan of care for patients and domain 5 (quality and safety) (AACN, 2021).

Along with new competencies, the NCSBN announced the anticipated release of NGN to be 2023. This new examination will focus more on clinical judgment by asking more clinically geared questions. Alternate format questions are included in the NGN. These alternate formats include matrices, grids, multiple response, highlighting, and drop-down items that work in direct relation with a patient case study (NCSBN, n.d.-c).

### **Opportunities and Challenges**

#### **Clinical Judgment in Nursing Education**

The implementation date of the NGN is swiftly approaching in 2023, and as Sherill (2020) continuously reminds educators, preparation needs to start now. The question is how do nurse educators effectively incorporate and evaluate clinical judgment in a nursing program? Gonzalez et al. (2021) recommend selecting a clinical reasoning or clinical judgment framework to create learning experiences. Models such as the NCJMM or Tanner's Model could be used in addition to the Clinical Reasoning Cycle (CRC) (Levitt-Jones et al., 2010). CRC uses the five rights of clinical reasoning to aid nurses in

decision-making: right cue, right patient, right time, right action, and right reason.

Gonzalez et al. (2021) even go as far as to suggest building a program's curriculum on clinical judgment models. However, this subject is poorly studied at this time. Billings (2019) states, "The goal of teaching nurses to make safe clinical judgments is to help them make their judgment behaviors deliberate and visible" (p. 301). Several methods may have proven effective at this.

### ***Clinical Judgment in Simulation***

Simulation is a popular pedagogy in nursing education. Simulation allows students to experience real life scenarios in a safe environment. Students may interact with manikins or with standardized patients (actors) who are simulating a clinical problem. Students are expected to act as if the situation was real. Debriefing usually follows the scenario to discuss performance and improvement points (Venable, 2021). Arthur et al. (2013) proposes that simulations with well-written objectives, trained faculty, and adequate debriefing for students allows for effective learning. Shin et al. (2015) supports this by finding simulations have large effect sizes on learning as compared to traditional learning methods.

However, how does an educator measure clinical judgment in a simulation? Lasater (2007) had the same question. Using Tanner's Clinical Judgment Model as a framework, Lasater developed a rubric to assess clinical judgment during a simulation. The Lasater Clinical Judgment Rubric (LCJR) is the fruit of her labor. To develop LCJR, Lasater and experienced faculty observed participants during simulation learning. Each of them described student negative and positive student behaviors observed using Tanner's



four phases (noticing, interpreting, responding, and reflecting) as a guide. Lasater combined these observations into different behaviors that reflect the four phases. For example, effective noticing involves focused observation, recognizing deviations from expected patterns, and information seeking. Student behavior can be ranked into one of four categories: beginning, developing, accomplished, or exemplary. The behaviors that are expected of each ranking are described in detail on the rubric. Adamson et al. (2012) performed three independent studies on the LCJR to determine validity and reliability. Interrater reliability measured from 57% to 100%; raters all received varying amounts of training prior to using LCJR. Validity was established as raters, independent of each other, could come to the same rating of a student observation.

Bussard (2018) used LCJR to evaluate clinical judgment in students following four simulation learning experiences. Students were evaluated after each simulation experience and were given an opportunity to review LCJR feedback to improve future experiences. Each rank in LCJR was worth one point (beginning = 1 point, exemplary = 4 points). Mean scores from LCJR 1 to LCJR 4 improved from 24.10 to 40.17, respectively. These results suggest that simulation is effective in building clinical judgment.

A crucial part of simulation and clinical judgment building is the use of debriefing. The International Nursing Association for Clinical Simulation and Learning (INASCL) considers debriefing such a pivotal part of simulation learning that it is required in their standards of practice (INASCL, 2016). Debriefing supports the reflection-on-action of Tanner's Clinical Judgment Model by allowing the student to

reflect on performance in simulation. Clinical judgment can be built in debriefing because it “involves moving beyond the simple application of facts and rules to a process of sense making” (Forneris, 2020, p. 367). However, the debriefing facilitator could be a weakness in implementing this tool. If faculty are not properly trained in debriefing or do not use a framework for debriefing, it could be useless (Al Sabei & Lasater, 2016).

### ***Clinical Judgment in Reflective Journaling***

LCJR has been used to evaluate clinical judgment in settings outside of simulation. Lasater and Nielsen (2009) asked students to compose reflective journal entries using a Guide for Reflection. The Guide for Reflection uses Tanner’s Clinical Judgment Model as a framework and assists the students in processing a clinical situation through the lens of clinical judgment (Nielsen et al., 2007). Faculty then reviewed the reflective journals and gave feedback using LCJR; student journals were not graded. This exercise created several benefits. Faculty were able to view how students think and encourage or correct that thinking for the future. Students enjoyed the exercise because it allowed them to evaluate themselves and set goals for future clinical performance. Bussard (2014) echoes these findings, stating that students may even benefit from reflective journaling after simulation experiences.

### ***Clinical Judgment in the Classroom and Assignments***

Incorporating clinical judgment into time with students is vital. Since nursing students spend most of their time in the classroom, it is essential to build clinical judgment opportunities into teaching time. Active learning strategies are the best ways to do this (Sportsman, 2019; Sherrill, 2020). Clinical scenarios are one way to bring clinical

to the classroom (Hensel & Billings, 2020). This technique could be dually beneficial since clinical scenarios are how NGN questions are structured. These scenarios can be inspired by real clinical situations or be from published sources. Completing scenarios in the classroom allows for immediate faculty feedback. Prompts for the scenario should be inspired by the NCJMM Layer 3. Faculty could also give students one sentence prompts to stimulate critical thinking (Sherrill, 2020). An example might include, “The patient with diabetes mellitus and poor eyesight is being discharged and tells you he cannot see the lines on the syringe to administer his insulin.”

Concept mapping may also be a beneficial tool for building clinical judgment (Gerdeman et al., 2013; Kaddoura et al., 2016). Concept maps are tools that help students make connections between concepts in patient care. Gerdeman et al. (2013) created the Clinical Judgment Self-Evaluation Rubric (CJSR) to help students focus on clinical judgment. CJSR focuses on Tanner’s four phases. Unlike LCJR, CSJR allows students to evaluate themselves to evaluate gaps in knowledge. Most students reported that using concept mapping assisted them in knowing how to prioritize nursing interventions in a clinical situation (Kaddoura et al., 2016).

Another pedagogical approach for teaching clinical judgment is the flipped classroom. To use the flipped classroom, the faculty assigns pre-work for class that covers the bases for what will be discussed in class. This frees class time for faculty to engage the students in actively learning about the topic and allow for knowledge application instead of regurgitation. Peisachovich et al. (2016) used this approach and

saw improvement on course grades from the previous cohort where it had not been used. NCLEX-RN pass rates were not studied.

### ***Clinical Judgment in Clinical Experiences***

Surprisingly, little evidence exists in the literature about clinical judgment acquisition in clinical experiences. Nielsen et al. (2016) discuss the importance of preceptors (clinical nurse trainers) using a clinical judgment framework to evaluate and assist new nurses, but this was not studied in students. Nielsen et al. do hypothesize that using a clinical judgment framework in clinical settings, such as LCJR, would be helpful for preceptors training prelicensure students. They even consider that it may assist students in gaining clinical judgment faster. One study by Manetti (2018) did attempt to measure clinical judgment in students in an undergraduate nursing program using LCJR. After receiving training on the rubric, faculty rated junior ( $n=75$ ) and senior nursing students ( $n=61$ ) on LCJR in the clinical setting. Results show that senior level nursing students have increased clinical judgment than their younger counterparts.

Sherrill (2020) does mention some teaching techniques that may be helpful in the clinical setting. Reviewing patients' laboratory trends and asking questions that focus on NCJMM may help students to use clinical judgment. Lasater (2011) suggests using LCJR to create higher-order thinking questions in the clinical setting that focus on clinical judgment. Asking these higher-order, open-ended questions allow students to explore and reflect on their thinking. In addition, LCJR can be used to train precepting nurses on clinical judgment. Nielsen et al. (2016) found that nurses enjoyed having a framework when precepting students. LCJR and Tanner's Clinical Judgment Model provided an

effective way for preceptors and preceptees to speak the same language, spark conversation, and create teachable moments.

Evaluating nursing clinical judgment in the clinical setting needs further consideration and research. Interestingly, students could flounder in using clinical judgment in their undergraduate clinical experiences. Gonzalez et al. (2021) say that clinical experiences can be “random access opportunities” (p. 486) in which the student just learns from patients who are most readily available instead of addressing their actual development needs.

### **Measurement Difficulties**

While clinical judgment is a skill that is considered critical in nursing (AACN, 2021; NCSBN, n.d.-a), measuring it seems elusive due to its complexity (Manetti, 2018). Some measurements do exist, such as LCJR in simulation and reflective journaling. However, little is known about how to measure the amount and to what extent clinical judgment has taken root in students by graduation. Even as subject matter experts began to write new items for the NGN, Betts et al. (2019) admit “there is no easy reference to consult to ensure an item is measuring a specific CJ element” (p. 30).

### **Reflection on Positionality**

As a clinician, I understand the importance of nurses’ ability to notice and correctly respond to patients’ conditions. Sometimes, only seconds stand between an ideal outcome and death. Giving students the opportunity to make clinical judgment calls allows them to start building this skill early in their careers. However, some are dubious that this skill can be cultivated in a 12-month nursing program. Quite frankly, I used to be

one of them. Learning to be a nurse was not possible in just a year. My fellow nurses and I would have this type of accelerated student on our unit and not believe that it was possible that they would be a nurse in three short semesters. However, accelerated nursing students have proven to be motivated and bring a wealth of knowledge into nursing from their previous life experience that a traditional student may not (AACN, 2019a; Christoffersen, 2017).

### **History of the Accelerated BSN Program at the University of Mississippi Medical Center School of Nursing (UMMC SON)**

Traditionally, nursing programs are two years in length. However, institutions around the country began implementing second degree, accelerated nursing programs as early as 1971 (St. Louis University, n.d.) . These programs are typically 11 to 18 months long and accept applicants with bachelor's degrees in other fields (AACN, 2019a). The United States has been experiencing a nursing shortage over the last several years, and the Health Resources and Services Administration (HRSA) began offering grant money to assist with increased enrollment in baccalaureate nursing programs in the early 2000's. Drs. Jean T. Walker and Theresa Doddato knew to receive grant funding, they had to create a unique pitch. With this in mind, they surmised a 15-month, accelerated program that focused on multigenerational nursing and used problem-based learning (PBL) as the main pedagogy. This combination would be the unique idea needed for grant funding.

Multigenerational care was an important foundation for this program, particularly since the program would be in the southeastern United States where families are close and caring for a patient means caring for a family. Walker's dissertation work focused on

PBL. PBL is a form of learning that is heavily self-directed for the learner and uses case studies to move through clinical scenarios. This pedagogy originated in medical education as a way to quickly, yet thoroughly train physicians after World World II as there was a major shortage at that time. PBL helped students build clinical judgment as they sorted through unfolding patient case studies. PBL has been shown to be effective in helping students become self-directed learners, be excellent collaborators, and develop substantial problem-solving skills (Hmelo-Silver, 2004). These factors made it perfect for the small, adult learner program and focused on allowing students to make clinical judgments in class.

The program originally was designed to have 1:1 clinical preceptorships for students. A preceptor is an experienced nurse that mentors and trains nursing students to care for patients. A program with exclusive preceptorship clinical experiences is unique to nursing education as most institutions require faculty to take students to clinical areas for training.

The \$750,000 grant was funded in June 2006 with the first cohort scheduled to begin in July 2006. The first cohort consisted of five students. At the time, Walker was the director of the nurse educator (NED) track, a graduate program at the University of Mississippi Medical Center School of Nursing (UMMC SON). NED students got first-hand experience at curriculum development and evaluation. The graduate students assisted faculty in creating PBL case studies, concept tests, and evaluations for student performance. The cohort graduated the following year, and all five students passed the NCLEX-RN on their first try (J. Walker, personal communication, September 14, 2021).

Over time, the program grew to a cohort of 30 students, and new faculty were charged with leading the program. As this program grew, another undergraduate program in the UMMC SON was struggling. This was a traditional BSN program at the university's satellite campus. The UMMC SON had a flourishing traditional BSN program on the main campus, but the satellite site had challenges. Nearly all lectures were streamed to the Oxford campus from Jackson, but the technology at the time was not sufficient to provide an optimal student experience. Consequently, the satellite campus graduated its last traditional BSN program cohort in May 2014 and began looking at the success of the accelerated program. At the same time, larger, revered schools of nursing began offering second degree accelerated programs in a mere 12 months instead of 15 to 18. This trend challenged faculty at the UMMC SON to consider this option. Faculty began the arduous process of curriculum revision (L. Northington, personal communication, September 8, 2021).

While revising the curriculum for the accelerated BSN program, Dr. Robin Wilkerson received grant funding to implement an accelerated program that had a high emphasis on interprofessional education (IPE), PBL, and concept-based curriculum. Faculty from the main and satellite campuses met to discuss which broad concepts would frame the curriculum, using nursing concept textbooks and baccalaureate nursing standards as a guide (K. Carr, personal communication, September 3, 2021). The 12 month accelerated BSN program began at the satellite campus in August 2014 and at the main campus in January 2016 (T. Martin, personal communication, September 16, 2021).



I joined the accelerated BSN faculty in the fall of 2017. In 2018, UMMC SON administration was encouraged by our main clinical partner to produce more accelerated BSN graduates; therefore, enrollment increased to 60 students per cohort at the main campus for the spring of 2020. PBL was a faculty-intensive pedagogy, requiring no more than ten students per group and each group required a faculty facilitator. Since the program only had four faculty, we had to find an active learning pedagogy that would still allow for collaboration and decision-making like PBL. Team-based learning (TBL) seemed to fit the program's needs. TBL requires student group collaboration, accountability in the form of individual and team readiness assessments, feedback from facilitators, and careful assignment design (Michaelson & Sweet, 2008). Kim and Hong (2016) studied nursing students using traditional teaching methods versus TBL. Study results revealed that students who participated in TBL had increased major satisfaction, critical thinking ability, problem solving ability, communication skills, and self-directed learning ( $p=.000$  in all categories) as compared to the control group. Kim et al. (2016) solidified these results in their study by finding their students who participated in TBL had increased problem solving ability ( $p<.001$ ), knowledge ( $p=.016$ ), and clinical performance ( $p<.001$ ) as compared to the control group.

### **Current Situation**

With all of the methodological changes in the accelerated BSN program, clinical judgment may have gotten lost as a program focus. When the program first changed to 12 months, faculty report that critical thinking and clinical judgment were heavily taken into account when designing courses and classroom activities (T. Martin, personal

communication, September 16, 2021). However, NCLEX-RN pass rates have dropped from 100% on the first take in 2019 to 81.5% on the first take in 2020. With the change to NGN coming in 2023, I am concerned that our students are not prepared to pass this exam. Additionally, the literature suggests that clinical judgment should be part of the framework of the curriculum (Gonzalez et al., 2021). Since clinical judgment will be at the forefront of the NGN and be an underlying concept in the new *Essentials*, it will be of utmost importance to focus on it. Knowing whether or not the elements of clinical judgment exist in our curriculum is a starting point to discovering where we need to go next. However, clinical judgment goes far beyond our academic elements; it can impact patient outcomes in the future.

## **Methodology**

### **Kantar and Alexander (2012)**

Many studies have collected data on different teaching methodologies in connection with higher-order thinking and clinical judgment, but few are done to review a whole curriculum's effect on clinical judgment development. Kantar and Alexander (2012) questioned if the curriculum in three undergraduate nursing programs in Lebanon contributed to clinical judgment development in new graduates. Preceptors ( $n=20$ ) evaluated new graduates using LCJR. Researchers also interviewed preceptors for one hour each. Tanner's Clinical Judgment Model structured the interview questions. Additionally, researchers reviewed the following curriculum documents for elements of clinical judgment: "program philosophy and goals; learning outcomes, assessment approaches, and teaching strategies for all nursing courses; and a curriculum development

plan” (Kantar & Alexander, 2012, p. 446). Kantar and Alexander’s scale of assessing presence of clinical judgment elements in curriculum documents was ordered as follows: high emphasis (>40 frequencies), emphasis (15-40 frequencies), subordinated (6-15 frequencies), and omitted (0-5 frequencies).

Preceptors noted that graduates had problems discerning patient problems from what is expected and heavily relied on the preceptor for their next steps; these skills represent the noticing category. For interpreting, all programs seemed to highly emphasize the nursing process while prioritizing and comparing patient data were either subordinated or omitted. Preceptors saw this as a weakness in graduates. Responding was the theme most frequently identified in curriculum documents for all three programs. However, a responding skill that was omitted was flexibility. Overall, reflection was poorly represented in the curricula.

For the three programs, researchers measured instructional methods used by instructors. The programs heavily used lectures as a means to teach students. Lecture can be an ineffective way to instruct students. Afrasiabifar & Asadolah (2019) found students engaged in active learning are more satisfied with the teaching and scored better on content exams than those students who just receive lectures. Simulation and reflection were the least used methods; this would support each program’s neglect of reflection since debriefing would not have been completed.

### **Current Project**

For this project, Kantar and Alexander (2012) have set its foundation. I want to know to what extent, if any, the current curriculum in the accelerated BSN program at

UMMC SON encompasses clinical judgment. Elements of clinical judgment will be identified using LCJR, Tanner's Clinical Judgment Model, and NCJMM. A program curriculum documents review will be necessary, including course syllabi and course information in the learning management system. Using the frequency scale used in Kantar and Alexander (2012) would be a tool to use as assessing documents.

In addition to document review, I also would like to involve faculty to view a fuller scope of the curriculum. I hypothesize that syllabi will not be helpful in identifying elements of clinical judgment as they are limited in information about teaching methodologies. If this hypothesis is true, clinical judgment elements may seem absent in the curriculum, even if faculty do focus on this in their teaching. Because of this possible issue, faculty interviews would be helpful or an online questionnaire would be helpful. Questions about the curriculum and teaching methodologies that reflect the study framework will be asked.

### **Future Project Opportunities**

Clinical judgment can be viewed from many perspectives to paint a more complete picture of its development. Interviewing new graduates on their perceptions on clinical judgment acquisition could be an interesting angle. Interviewing new graduates instead of current students would remove any idea of coercion and new graduates may have more insight on deficiencies than current students since they are actively involved in the workplace. Williams et al. (2008) used the Student Perception of Clinical Competence (Cronbach's alpha = .98). This scale lists different clinical skills such as "takes learning initiative" and asks the student to rate their confidence in the skill and

their perceived importance of the skill in nursing. This scale could be interesting as previous issues have shown correlation between self-confidence and clinical decision making (Fry & MacGregor, 2014). Also, Williams et al. (2008) used this scale on UMMC SON on traditional students in the past, some of whom had a bachelor's degree prior to entering nursing school.

To gain perspective on the new graduates' performance, the New Graduate Nurse Performance Survey (NGNPS) could also be a valuable tool (Gregg, 2020). This data would be fairly easy to collect as many of the program's graduates remain in the local area. NGNPS assesses 36 competencies that are grouped into six different skill categories: communication, clinical knowledge, critical thinking, management of responsibilities, professionalism, and technical skills. Participants rate new nurse graduate performances on a Likert scale ranging from strongly disagree to strongly agree (Berkow et al., 2008).

Using these multiple angles could yield a better picture of clinical judgment in the UMMC SON accelerated BSN curriculum. Varying assessments and evaluations in this study would help find strengths and gaps in the curriculum. These identifications will allow me to make recommendations for future curriculum changes, particularly as nursing transitions to competency-based education.

### **Conclusion**

Clinical judgment is a complex, iterative process that cannot be learned by practicing once. Nursing students must make frequent and deliberate clinical judgments to become competent nurses. The responsibility of beginning the journey to clinical

judgment falls on nursing faculty. Nursing faculty must use purposeful strategies that are tied to clinical judgment models as a catalyst to critical thinking. Active learning strategies including clinical case scenarios, simulation, reflective journaling, and concept mapping. While one would assume that clinical judgment would be developed in the clinical setting, the literature has limited evidence on this topic. Further research should be done to investigate how much students are practicing clinical judgment in the clinical setting. Overall, an overhaul of nursing education is coming that puts clinical judgment in the center. Nurse faculty must incorporate this critical skill into every aspect of the curriculum for student success, not just on standardized exams, but also in clinical settings after graduation.

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CHAPTER II:  
ASSESSMENT PLAN

## ABSTRACT

Clinical judgment development in nursing students and graduates is being questioned. Clinical judgment development should begin while students are in nursing programs; this statement is backed by the Next Generation NCLEX (NGN) being based on clinical judgment (NCSBN, n.d.-b). Because of this, nursing curriculum should reflect clinical judgment.

This assessment project seeks to find areas of the clinical judgment in the accelerated bachelor of science in nursing (ABSN) program at the University of Mississippi Medical Center. Clinical judgment emphasis in the program is currently unknown. The written curriculum will first be assessed for evidence of Tanner's (2006) clinical judgment elements of noticing, interpreting, responding, and reflecting. The written curriculum is considered written documents available to students such as course syllabi, module objectives, and documents on the learning management system (LMS). However, these documents may not completely depict what actually happens in the curriculum. Program faculty will also be interviewed to assess their knowledge of clinical judgment and how they integrate it in different learning environments. The results of this assessment's findings can be used to modify course documents to reflect clinical judgment. They can also be used identify gaps and strengths in this program so that gaps can be bridges and strengths can be bolstered.

## ASSESSMENT PLAN

Because of growing concern and evidence of novice nurses' clinical judgment deficiency (Berkow et al., 2009; Ebright et al., 2004; Gregg, 2020; Kavanagh & Swzeda, 2017), the National Council of State Boards of Nursing (NCSBN) is revamping the National Council Licensure Examination for Registered Nurses (NCLEX-RN), the licensure exam for RNs in the United States and Canada. The new exam, or the Next Generation NCLEX-RN (NGN), will use different testing modalities to evaluate examinees' clinical judgment (NCSBN, n.d.-a) and is expected to be implemented in April 2023. Simply, *clinical judgment* is defined as “the observed outcome of two unobserved underlying mental processes, critical thinking and decision-making” (Betts, 2017, slide 6).

Beginning to develop clinical judgment in nursing students is critical, particularly with the oncoming of NGN. Extra pressure is put upon schools of nursing since NCLEX-RN first take pass rates can affect program accreditation (Commission on Collegiate Nursing Education, 2018; Mississippi State Institutions of Higher Learning, 2017). The University of Mississippi Medical Center (UMMC) School of Nursing (SON) has an accelerated baccalaureate (ABSN) program that allows students with a bachelor's degree in another field to complete a nursing degree in 12 months. The ABSN program has had a decrease in NCLEX-RN pass rates over the last several years (Table 2), leaving faculty to ponder if students will be able to pass NGN on first take. This project will focus on the ABSN program due to 1) the author's main teaching assignments being in this program

2) small cohort sizes with about 70 students admitted per cohort and 3) small ABSN faculty cohort ( $n=6$ , including ABSN Program Director and myself). The problem of practice is that UMMC SON needs to know if and to what extent clinical judgment currently exists in the ABSN curriculum so NGN preparation can be gauged.

**Table 2**

*Accelerated BSN Demographics for Cohorts Since 2017*

Year	Graduates	Gender	Race/Ethnicity	NCLEX 1 <sup>st</sup> time pass rates
2017	29	Males=6 Females=23	White=25 Black=4	93%
2018	26	Males=3 Females=23	White=23 Black=2 Asian=1	96%
2019	30	Males=6 Females=24	White=24 Black=6	100%
2020	65	Males=7 Females=58	White=54 Black=10 Asian=1	81.5%
2021	66	Males=9 Females=57	White=53 Black=11 Asian=2	81.8%

**Assessment Overview**

The assessment's goals should align with the UMMC SON's vision and mission. The UMMC SON's vision is "Empowering Nurse Leaders, Transforming Healthcare" (J. Sanford, personal communication, January 24, 2022). The UMMC SON's mission is "to develop nurse leaders and improve health within and beyond Mississippi through excellence in education, research, practice and service" (University of Mississippi Medical Center, 2021, p. 135). The overarching aim of this project is that the UMMC



SON will produce empowered nurse graduates by establishing clinical judgment as a pillar in educational endeavors. Other educational pillars in the ABSN program include the Quality and Safety Education for Nurses (QSEN) competences: patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety, and informatics (Cronenwett et al., 2007).

Assessment goals include:

- Identify clinical judgment gaps and presence in the ABSN curriculum.
- Assess faculty knowledge of clinical judgment.
- Assess clinical judgment implementation in student learning encounters.

As a result of my assessment, programs could be created (e.g., a curriculum revision) to ensure clinical judgment is encompassed. The assessment would identify gaps where the UMMC SON lacks and includes clinical judgment in the curriculum. Perhaps clinical judgment is missing in actual course content, course objectives, and/or in program outcomes. This lack would not allow for students to develop this vital skill. How I plan to identify gaps in the curriculum is two-fold: curriculum review and qualitative interviews with faculty.

### **Curriculum Review**

Curriculum mapping is helpful for discovery of “how learning is reinforced and integrated across curricular, co-curricular, and work-based experiences” (National Institute for Learning Outcomes Assessment, 2018, p. 3). Mapping elements of clinical judgment across the curriculum would be ideal. Tanner’s Clinical Judgment Model (Tanner, 2006) defines the elements of clinical judgment to be noticing, interpreting,

responding, and reflecting. NCSBN (n.d.-a) used Tanner's model to build their Clinical Judgment Measurement Model. This model describes clinical judgment through the actions of recognizing cues, analyzing cues, prioritizing hypotheses, generating solutions, taking action, and evaluating outcomes

Kantar and Alexander (2012) have set a foundation for curriculum document review (e.g., course syllabi, learning management system courses, program outcomes). Elements of clinical judgment will be identified using Lasater Clinical Judgment Rubric (LCJR), Tanner's Clinical Judgment Model, and NCSBN Clinical Judgment Measurement Model (NCJMM). LCJR is a valid, reliable tool that is used to measure clinical judgment during simulation experiences, but has also been used to capture elements of clinical judgment in reflective journaling and in new graduate clinical performance (Adamson et al., 2012; Lasater, 2007; Nielsen et al., 2007; Nielsen et al., 2016). Reviewing a program's curriculum documents will be necessary, including course syllabi and course information in the learning management system (LMS). Kantar and Alexander (2012) used a scale to note the frequency of clinical judgment in curriculum documents. This approach will be helpful while assessing documents.

### **Faculty Interviews**

In addition to document review, faculty interviews could be helpful in viewing a wider scope of the curriculum. Since the UMMC SON uses a standardized syllabus template, syllabi may not be helpful in identifying elements of clinical judgment as they are limited in information about teaching methodologies. If this hypothesis is true, clinical judgment elements may seem absent in the curriculum, even if faculty do focus

on this in their teaching. Because of this possible issue, faculty interviews or curriculum mapping with program faculty could be mightily beneficial. Mapping out clinical judgment elements would assist in seeing the elements across the curriculum and gaps that may exist.

### **Assessment Stakeholders**

Clinical judgment is broad and dynamic, requiring assessment over time. Having these stakeholders allows for seeing the whole picture, from the beginning stages of clinical judgment development and its progression as students march through the program and in the beginnings of their nursing careers. The common purpose among these stakeholders is to build quality nursing graduates that produce quality patient care outcomes.

Different stakeholders will be involved in this needs assessment. The Executive Council at the UMMC SON will need to know findings. This Council consists of assistant deans, associate deans, and the Dean. To have faculty support for any project, I will need the support of this administrative body. Clinical partners should also know the results of the needs assessment. If the assessment results show that ABSN graduates may not have ideal clinical judgment skills, these partners should know the plans for projects that are on the rise to fix the problem as well as be involved in their development. Showing the students the results of the needs assessment should be done with caution as they may not be interpreted correctly. UMMC SON faculty will also be intimately involved with this needs assessment, ABSN faculty particularly.

### **School of Nursing Administration**

The SON Dean, Assistant Dean of Undergraduate Programs, and ABSN Program Director will be key administrative stakeholders for this project. Administrative support is necessary for the program to assist with funding and faculty buy-in. The Dean is the only tenured faculty in this list of stakeholders. The Dean and Assistant Dean have the authority to assist with faculty workloads. The Assistant Dean and Program Director will have extra interest in this project. The ABSN program has been struggling with first-time pass rates on the NCLEX-RN before the switch to NGN. This struggle makes this project even more timely and even more important since NGN focuses grossly on clinical judgment.

Each of these administrators have interesting points-of-view for this project. The Dean has the view of seeing the UMMC SON and the ABSN program from different angles. The Dean is an administrator for the American Association of Colleges of Nursing (AACN), which accredits and guides schools of nursing on a national level. She also has the benefit of teaching in different parts of the country and having nationwide contacts to consult for this project. The Assistant Dean has a different perspective. She taught in the ABSN program for several years prior to her promotion to Assistant Dean. She understands the program well and sees opportunities and challenges for faculty, students, preceptors, and employers. The Program Director provides a fresh perspective. She has been an educator in the UMMC SON for several years, but taught in another bachelor's program within the school. I particularly want these stakeholders to review the assessment plan and give their feedback. They have knowledge enough of the ABSN

faculty and of clinical judgment to give solid advice on what should be change and if anything further should and can be assessed.

### **Accelerated BSN Faculty**

The ABSN faculty is a small group of faculty ( $n=6$ ). These faculty have varying levels of experience in nursing and nursing education. None of the faculty are on the tenure track. One of the faculty has experience as a nurse practitioner and has no formal training in education. The other faculty have degrees emphasizing nursing education. Three of the faculty earned doctoral degrees in nursing.

These faculty have a vested interest in the assessment because it analyzes what is currently being done in the curriculum. Faculty need to know if methods are working or not in the development of clinical judgment. Faculty have a mix of adaptability. Depending on the results of the assessment, changes may be needed, and some faculty are more resistant to this than others. Additionally, this assessment could cause anxiety related to what exists versus what could be or what was perceived to be. This assessment could lead to more presentations and publications for faculty, which could simultaneously help faculty with future promotion needs and burden them with work load.

### **Current Students and ABSN Graduates**

#### ***Current Students***

Students ( $n=67$ ) provide an important role in the assessment as they are the ones whose outcomes will be benefited or harmed most by the nursing curriculum. Students value the program because it is their education. They pay tuition and give their time and

effort to learning. Students stand to gain an understanding of their program's ability to train them for passing the new NCLEX and for their future careers in nursing.

### ***ABSN Graduates***

Graduates of the ABSN program provide an important piece of the clinical judgment puzzle. These graduates are products of the ABSN curriculum and their abilities to make clinical judgments as nurses could be a direct result of that curriculum. Equipping them to think and perform as a nurse is the main role of the curriculum, so understanding how they perceive their ability to perform this skill after graduation is key.

While current students and ABSN graduates have valuable insight, using them in the outlined assessment is not feasible. However, it would be ideal to do surveys and/or interviews with these stakeholders in the future to ascertain a better picture of clinical judgment development by the curriculum. This assessment focuses strictly on the written curriculum and faculty perceptions.

### **School of Nursing Clinical Partners**

The ABSN program gives working nurses (preceptors) a chance to educate the next generation of nurses. Preceptors can gain critical knowledge of how they can assist nursing students and new graduates in the development of clinical judgment. Preceptors have strong relationships with students, as they are the ones training them in the clinical setting. Preceptors also have a connection with ABSN faculty, as faculty visit the preceptors when they are working with students several times in a semester. Preceptors may have an interesting dynamic of low interest but high power. They are needed for training students and graduates of the ABSN program, but they are stretched thin with

work obligations. Additionally, the program also adds to the nursing workforce which is critical in the current nursing shortage. Nurse managers often hire graduates from the ABSN program who have done clinical work in their units. Managers frequently reach out to ABSN faculty for references on students when they apply for jobs after graduation.

Again, while these clinical partners are valuable in the development of clinical judgment, their involvement is beyond the purview of this particular assessment of the written curriculum. To gain a better picture of clinical judgment attainment as a whole, it would be interesting to interview and/or survey nurse preceptors and nurse managers who hire ABSN graduates to validate competency in clinical judgment upon graduation.

### **Theoretical Framework**

Tanner's Clinical Judgment Model and the NCJMM serve as a framework for this project. Each of these models frame the key elements of clinical judgment and the definition of each. In turn, these elements will evolve into the tool used reviewing the curriculum.

#### **Tanner's Clinical Judgment Model**

Tanner's Clinical Judgment Model has served as the framework for many clinical judgment tools, including the NCJMM (Lasater, 2007; NCSBN, n.d.-a; Tanner, 2006). Tanner sought to create a framework on how nurses think that would be helpful for nursing instruction. Tanner (2006) defines *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 improvise new ones as

deemed appropriate by the patient's response" (p. 204). After reviewing the literature on the topic, Tanner comes to the following conclusions about clinical judgment:

- A nurse's clinical judgment is influenced greatly by his or her experiences or "what the nurse brings to the situation" (Tanner, 2006, p. 205).
- A nurse's clinical judgment depends, in part, on knowing a patient's normal pattern of behavior.
- Clinical judgment is affected by contextual factors surrounding the situation as well as the nursing culture where the nurse is working.
- Clinical judgment is a result of multiple patterns of reasoning (e.g., analytic processes, intuition, narrative thinking).
- Reflection is crucial in the development of knowledge and clinical reasoning, which both affect clinical judgment.

Out of these observations come Tanner's four aspects of clinical judgment: noticing, interpreting, responding, and reflecting.

### ***Noticing***

Noticing is the first aspect of clinical judgment. Noticing includes the nurse's initial grasp of a clinical situation. However, a nurse's ability to notice a situation is framed by his or her contextual knowledge. This contextual knowledge includes the depth of nurse-patient relationship, the nurse's background, and any expectations that shape the nurse's thinking.

### ***Interpreting and Responding***



The next two aspects of clinical judgment are closely linked. Interpreting requires the nurse to gather data, prioritize the data, and develop a plan for the patient based on the data observed. Responding is when the plan is implemented. These steps are where different analytical processes occur.

### ***Reflecting***

Tanner (2006) notes two different parts of the reflection aspect: reflection-in-action and reflection-on-action. Reflection-in-action allows the nurse to reformulate the plan of care if what was done in the interpreting and responding phase fails to produce desired results. For example, if a patient complains of shortness of breath and his oxygenation status does not improve by sitting the patient upright and starting him on 2 liters of oxygen via nasal cannula, the plan of care and interventions must be reconsidered. Reflection-in-action allows the nurse an opportunity to evaluate if interventions done are successful. Reflection-on-action is retrospective. This aspect allows for nurses to reflect on how they acted and learn from the experience as a whole.

### **National Council of State Boards of Nursing Clinical Judgment Measurement Model (NCJMM)**

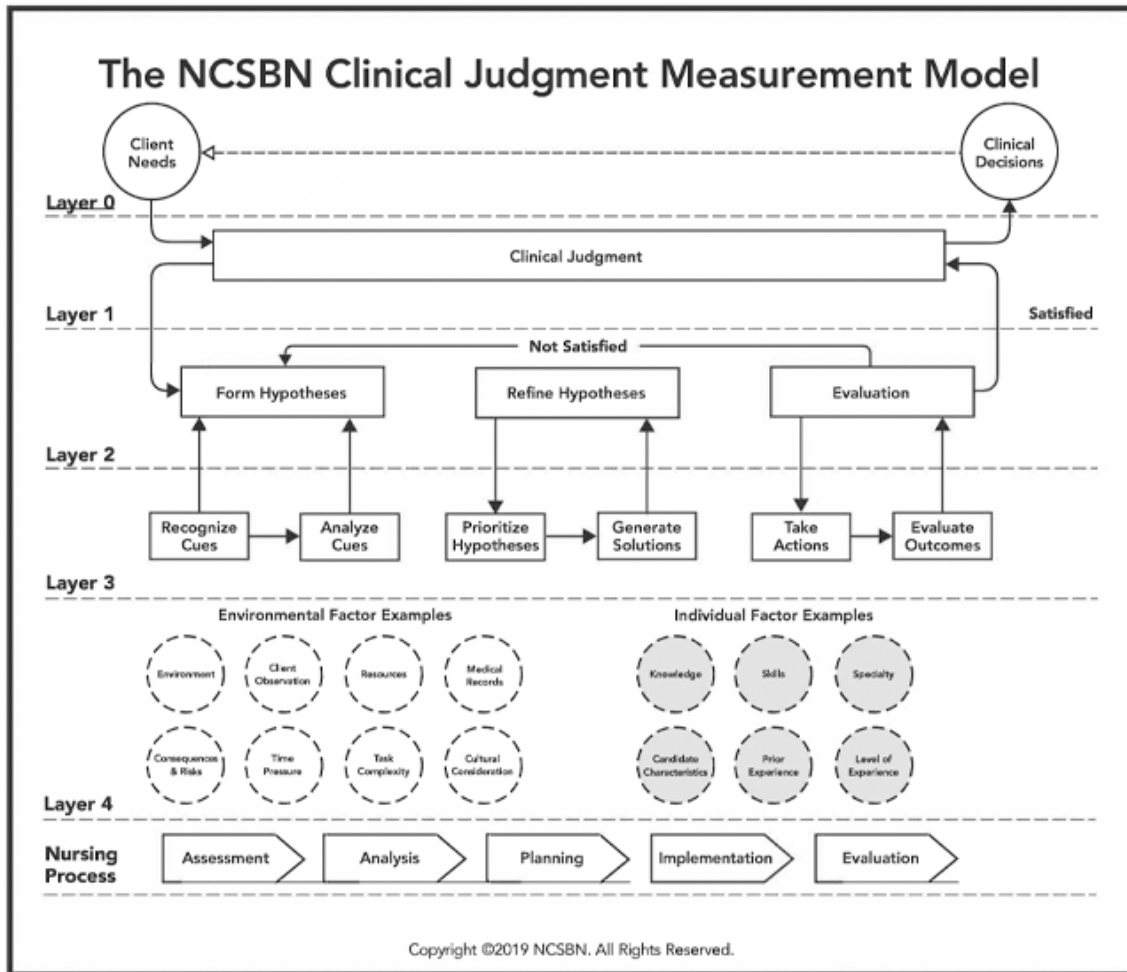
The NCSBN is responsible for the development of the NCLEX-RN. To ensure the exam accurately reflects current nursing practice, the NCSBN conducts a practice analysis every three years. This practice analysis asks new RNs about their current work such as work setting (acute versus chronic), tasks are performed in their work, patient ages, patient health conditions, and educational background (NCSBN, 2022). NCSBN (2018) reports that in their Strategic Practice Analysis release in 2018, “clinical judgment

was linked directly to more than 46 percent of tasks performed by entry-level nurses, while problem solving and critical thinking were linked to more than 30 percent of tasks performed by entry-level nurses” (p. 3). This finding further solidified the need to emphasize clinical judgment on licensure exams, thus the creation of the NCJMM.

NCJMM is a model with five layers (Figure 3). Layer 0 focuses on nurse observation, layers 1-3 focus on “cognitive operations” (Dickison et al., 2019, p. 73), and layer 4 focuses on context. Layer 3 is an iterative process. Layer 4 contains contextual factors that could affect the nurse’s cognitive operations on Layer 3.

**Figure 3**

National Council of State Boards of Nursing Clinical Judgment Measurement Model



*Note.* Used with permission of NCSBN.

Layer 3 contains the breakdown of a nurse’s clinical judgment in six actions: recognize cues, analyze cues, prioritize hypotheses, generate solutions, take actions, and evaluate outcomes (NCSBN, n.d.-a).

***Recognize and Analyze Cues***

Cues are clues that lead the nurse to believe a change from normal has occurred in the patient's condition. First, cues must be recognized. Cues can be obtained from more than just assessing a patient. Cues may be information in the medical record such as laboratory test results or vital signs charted by the nursing assistant. The important question with recognizing cues is did the nurse notice a change from normal and is the nurse able to sort through relevant versus irrelevant information (NCSBN, 2019). Second, cues must be analyzed. Are the cues the nurse first noticed associated with a condition? Which cues are the most concerning (NCSBN, 2019)?

### ***Prioritize Hypotheses and Generate Solutions***

After the nurse finds which cues are most concerning, the nurse will create hypotheses as to what he or she believes could be wrong with the patient. Following this step, the nurse begins to think about the end goal and plan interventions to meet that end goal (NCSBN, 2019).

### ***Take Actions and Evaluate Outcomes***

Next, the nurse acts. After considering which interventions to take, the nurse orders them by priority and begins to execute available interventions. However, interventions are not effective if they are not evaluated. The nurse must implement interventions (take action) and then evaluate the efficacy of the interventions (evaluate outcomes). If interventions were effective, the clinical judgment process comes to an end. If not, the process begins again (NCSBN, 2019).

## **Assessment Implementation**

This assessment will attempt to identify gaps in clinical judgment's incorporation into the curriculum. This will be done by reviewing syllabi and documents in the LMS for verbiage of clinical judgment. Additionally, ABSN faculty will be interviewed to discuss their knowledge of clinical judgment and how they seek to incorporate it into student learning experiences (e.g., clinical, didactic sessions, simulations).

### **Resources for Assessment Implementation**

The UMMC SON does not have any similar projects to this at the present time nor do I know of any like this since I began in 2016. The faculty do sporadically map the curriculum to ensure all areas of the NCLEX-RN are covered in the curriculum, but clinical judgment has never been the focus of these exercises.

The need for this assessment is vital. The American Association of Colleges of Nursing (AACN) has ruled that nursing education will be switching to competency-based education over the next five or so years. With these new competencies, clinical judgment is a threaded concept throughout all competencies (AACN, 2021). Additionally, the Next Generation NCLEX (NGN) will go live for exam takers on April 1, 2023 (NCSBN, n.d.-b). These two factors put extra pressure on schools of nursing to make changes in regard to teaching and reinforcing clinical judgment.

Assessments require funding. Expenses for this project are present. Software is needed for faculty interviews. NVivo is a computer program that assists with organizing and analyzing qualitative data, including coding and transcription. NVivo subscription costs \$2,700 for two users with transcription and collaboration services. The UMMC SON has enough physical space and virtual resources (e.g., web conferencing, cloud

system) to support this project. Another expense would be dissemination of the findings. The National League for Nursing is an organization that supports nursing education. This organization holds an annual conference at which abstracts are accepted for researchers and educators to present their innovations. NLN Summit registration is \$1300, not including travel and lodging. Possible grant sources could be the Sigma Nursing small grant, which awards up to \$5,000 on chosen proposals. The local chapter of Sigma offers a seed grant opportunity in December of every year worth \$500. Additionally, the UMMC SON offers a \$1,000 seed grant for beginner researchers and also offers an intramural grant of \$9,000.

Prior to data collection, Institutional Review Board (IRB) approval needs to be obtained. UMMC requires all researchers to complete Collaborative Institutional Training Initiative (CITI) program courses to maintain ethical standards in the research process. This training is free through the institution. Collaboration between the researcher and participants could be achieved through groups calendars or using software such as Microsoft Teams. The UMMC SON research project managers can assist with any budgeting, grant needs, and IRB management. Data collection programs such as Qualtrics and REDcap are available to UMMC SON faculty free of charge. Both of these programs safely store sensitive information. SPSS is also available free of charge for data analysis. Online communication platforms such as Zoom or WebEx are available for conducting meetings and/or interviews with ease.

### **Identifying Critical Elements of Clinical Judgment**

Nursing education scholars have created a language that revolves around clinical judgment. Tanner's elements of clinical judgment – noticing, interpreting, responding, and reflecting – certainly are critical in the foundation of that language. Additionally, NCJMM's Layer 3 elements (recognize cues, analyze cues, prioritize hypotheses, generate solutions, take action, evaluate outcomes) also has its place in the foundational language of clinical judgment.

My plan is to search the written curriculum for evidence and occurrences of this language. The written curriculum would be course syllabi and information on the LMS available to students (e.g., lesson objectives, test blueprints). However, what if faculty do not use these terms explicitly? Does that mean that clinical judgment is lacking in the curriculum because of that lack of using exact terms? The answer to that is no. However, terms must be identified that could indicate these critical terms. Table 3 shows alternate verbiage from a literature review that may represent parts of Tanner's critical elements.

**Table 3***Alternative Terms Representing Tanner's Clinical Judgment Elements*

Tanner	Alternate Terms	Source
Noticing	Recognizes patterns and pattern deviation	Gerdeman et al., 2013; Kantar & Alexander, 2012; Lasater, 2007
	Observes	Kantar and Alexander, 2012
	Information seeking	Lasater, 2007
	Gathers information/data	Gerdeman et al., 2013; Kantar and Alexander, 2012
	Assessment	Nielsen, 2009
	Recognize cues	ATI, 2020; NCSBN, n.d.
	Identify relevant information	NCSBN, 2019
Interpreting	Prioritizing data	ATI, 2020; Gerdeman et al., 2013; Kantar & Alexander, 2012; NCSBN, 2019
	Analyzing data/cues	Lasater, 2007; NCSBN, n.d.
	Making sense of the patterns in the data	Kantar & Alexander, 2012
	What's happening with the patient	Nielsen, 2009
	Organizing and linking cues to condition	NCSBN, 2019
	Generate solutions	ATI, 2020; NCSBN, n.d.
Responding	Expected outcomes	NCSBN, 2019
	Communication	Kantar & Alexander, 2012; Lasater, 2007
	Individualized intervention/care	Kantar & Alexander, 2012; Lasater, 2007
	Delegation	Lasater, 2007



	Flexibility	Gerdeman et al., 2013; Kantar & Alexander, 2012; Lasater, 2007
	Assumes responsibility	Gerdeman et al., 2013; Kantar & Alexander, 2012; Lasater, 2007
	Take action	NCSBN, n.d.
	Identify outcomes	Nielsen, 2009
	Interventions in correct order	NCSBN, 2019
Reflecting	Evaluate outcomes	ATI, 2020; Lasater, 2007; NCSBN, n.d.
	Identify strengths and weaknesses	Lasater, 2007
	Self-regulation	Kantar & Alexander, 2012

### **Creating and Using a Tool for Curricular Clinical Judgment Assessment**

Each course's written curriculum needs assessment to find evidence and frequency of clinical judgment language. To do this, assessors need access to all course syllabi and all course LMS pages. Each course should be thoroughly explored. For example, I would review all documents in the LMS including documents such as the syllabus, module/unit objectives, clinical/simulation objectives, assignment rubrics, etc. Using the information from Table 3, the documents would be searched for clinical judgment language. The language can be tracked in a spreadsheet. Table 4 is an example of how information can be easily tracked within a course.

**Table 4**

Example of Clinical Judgment Tracking

Course: N434-3 Clinical Practicum III			
Item Reviewed	Element Location	Tanner's Clinical Judgment Element(s)	Element Evidence
LMS	OB Simulation Objectives	Interpreting	Organize safe and effective nursing care for a client
LMS	OB Simulation Instructions	Reflecting	Be involved in an overall debriefing session following completion of simulation
LMS	OB Simulation Post Work Activity	Noticing	Demonstrate accurate and timely assessment of a labouring woman
LMS	OB Simulation Post Work Activity	Noticing	Identify normal findings, abnormal variations and potential complications during labour for the mother and fetus
LMS	OB Simulation Post Work Activity	Noticing	Recognize when additional assistance is required during the labouring process
LMS	Mental Health Simulation Instructions	Noticing	Complete an appropriate focused assessment of the patient with comorbid physical and mental health concerns
LMS	Mental Health Simulation Instructions	Responding	Demonstrate effective, safe therapeutic communication for the patient experiencing a mental health crisis
LMS	Mental Health Simulation Instructions	Interpreting	Plan safe care for a patient experiencing comorbid physical and mental health conditions by identifying three priority nursing actions
LMS	Mental health simulation instructions	Reflecting	Be involved in an overall debriefing session following completion of simulation

The spreadsheet should include the course name and number, item reviewed (i.e., learning management system, course syllabus, etc.), the clinical judgment element using Tanner's Model that was located (noticing, interpreting, responding, or reflecting), the exact location where the element was found, and the evidence of the element. The evidence of the element is the wording the assessor used to identify the clinical judgment element.

What does the frequency of a clinical judgment element really mean? Kantar and Alexander (2012) were clear that their study could not measure the intensity with which each element was covered within the examined courses; only the frequency—a simple tabulation—of each element could be obtained. The researchers decided to give those elements with increased frequency a higher “emphasis” (Kantar & Alexander, 2012, p. 447). The levels of emphasis are as follows: high emphasis (frequency of element > 40), emphasis (frequency of element > 15 and less than or equal to 40), subordinated (frequency of less than or equal to 15 but greater than 5), and omitted (frequency equal to or less than 5). The rationales for these ranges are not discussed. Kantar and Alexander (2012) also studied the curriculum from three different institutions. The details from individual courses are not listed. However, these emphases are irrelevant. Since no studies like this exist for comparison, it is hard to say what frequency of a clinical element equals a higher emphasis in a curriculum. Additionally, just because an element is mentioned somewhere does not represent the rigor or enthusiasm with which the element was emphasized or not. An element may only be mentioned in the written curriculum once or twice but program faculty could have paid close attention to the

element as opposed to simply mentioning it. Therefore, for the purpose of this assessment, it would be helpful to be able to compare various courses throughout one particular program curriculum and also be able to compare frequencies/emphasis between various semesters within the curriculum. Since there are no similar studies to Kantar and Alexander's (2012) work that measures clinical judgment frequencies in a curriculum, I will simply report frequencies of clinical judgment elements for interpretation. By reporting numbers instead of "emphasis", it allows a true comparison between courses and/or semesters instead of labeling.

Frequencies of each clinical judgment element can be easily maintained at the bottom of each course spreadsheet. To compare courses or course semesters, a separate spreadsheet can be made to show frequencies of clinical judgment elements in a curriculum's plan of study. Basic statistical analysis such mean, median, mode, and range could be surmised from the data. However, statistical analysis beyond this would depend on the data. For example, the data on frequencies between two clinical judgment elements in a course could be compared using a *t*-test, but the data would first need to be analyzed to see if the data was normally distributed first.

### ***Interview Program Faculty to Examine Knowledge of Clinical Judgment and Its Incorporation into Student Learning Experiences***

Interviews with faculty will be another way to assess if and how faculty perceive that they incorporate clinical judgment into teaching and learning and how they define clinical judgment. Merriam and Tisdale (2016) suggest that this would be a perfect situation for qualitative interviews. Interviews are ideal for collecting data that cannot be

observed, and developing attitudes and values for or against clinical judgment may not be readily observable. I chose to do interviews instead of a focus group because program participants know each other, and to avoid one or more persons from dominating the conversation. Semi-structured interviews were chosen because they allow for structure and also derailment from the structure to ask clarifying and probing questions and gain better insight into the participant's emotions and thoughts (Merriam & Tisdale, 2016).

It would be ideal to hire a qualitative interviewer to interview all faculty so I could be included in the data. Since we only have six fulltime faculty (myself included) in the ABSN program, any additional data collected makes for stronger evidence and a full picture overall of the program. Also, it allows me to do data analysis without any kind of bias. If all faculty are given pseudonyms to maintain anonymity and confidentiality, this removes bias from the data analysts.

Questions for the interview (Table 5) focus on evaluating participant's knowledge, skills/behaviors, and attitudes toward clinical judgment. The demographic portion of the questions in Table 5 will be placed into Qualtrics, a platform used for collecting data. Participants will be provided a copy of the questions and the NCSBN's Clinical Judgment Measurement Model prior to the interview. Informed consent will be obtained from participants. Participants will have the option to use a pseudonym during the interviews to maintain privacy.

**Table 5***Questions for Semistructured Faculty Interviews Regarding Clinical Judgment*

Themes	Questions
Knowledge	<ol style="list-style-type: none"><li>1. How would you define clinical judgment?</li><li>2. How does the NCSBN's Clinical Judgment Measurement Model apply to clinical nursing practice?</li><li>3. How does the NCSBN's Clinical Judgment Measurement Model apply to nursing education?</li></ol>
Skills/Behaviors	<ol style="list-style-type: none"><li>1. How do you incorporate clinical judgment into your classroom learning?</li><li>2. How do you incorporate clinical judgment into course assignments?</li><li>3. How do you incorporate clinical judgment into simulation (including simulation debriefing)?</li><li>4. How do you incorporate clinical judgment into your test questions?</li></ol>
Attitudes/Values	<ol style="list-style-type: none"><li>1. Clinical judgment has been deemed a vital skill in nursing by several agencies (American Association of Colleges of Nursing, NCSBN). How vital do you think it is to the nursing profession?</li><li>2. How much emphasis do you think should be placed on clinical judgment in the curriculum?</li><li>3. Describe your thoughts on clinical judgment since this intervention started.</li></ol>
Demographics	<ol style="list-style-type: none"><li>1. With which race do you most closely identify?</li><li>2. What is your age?</li><li>3. With which gender do you most closely identify?</li><li>4. How many years of experience do you have as a nurse?</li><li>5. How many years of experience do you have in nursing education?</li></ol>

The UMMC SON has several conference rooms that can be used for these interviews. Interviews can also have back-up recording in these rooms using WebEx. The SON has a subscription to this service that is available to all faculty. Staff are also available to help troubleshoot equipment as needed. The biggest limitation will be scheduling. Faculty time is limited and rooms must be reserved in advance for the interviews. Scheduling can be coordinated using free online scheduling tools to find the best times available for participants.

### **Steps and Timeline**

The best time of year to conduct this study is between May and October. This period allows time for interviews and curriculum review when faculty have breaks from teaching. Ensuring grant money and all research information is prepared before this time is crucial. The first step is to meet with the Associate Dean for Research at the UMMC School of Nursing to let the office know of your plans and any support that is needed. Next, I would need to submit my research proposal to the Institutional Review Board. Several months is necessary for Institutional Review Board review and approval. Funding would also need to be secured. For Sigma Theta Beta seed grants, proposals are typically due in December and funding available in February. Sigma International's small grant proposals are due December 1 and are funded on June 1 the following year. UMC SON intramural grants are due January 15 with funds beginning in February, if selected. Table 6 shows an example timeline for the project.

**Table 6**

*ABSN Curriculum Assessment Timeline*

Time	Task
Months 1 & 2	Consult with SON research office, finalize tools for curriculum assessment, pilot qualitative questions and revise,
Months 3 & 4	Submit plan to the Institutional Review Board, submit for grant funding
Months 5 - 7	Assessment implementation/data collection
Months 8 & 9	Data analysis, stakeholder feedback on results
Month 10+	Data dissemination

**Data Analysis and Interpretation**

Data analysis would be completed after data is collected. Assistance from the School of Nursing’s Office of Research is required. This office has statisticians available for faculty research assistance. This assistance is helpful for any quantitative data. For the qualitative data collected, some SON faculty are experienced in qualitative research. Their assistance will be valuable for analyzing this data.

**Results**

Results could be used in a variety of ways. Results will, most importantly, be used to identify clinical judgment gaps and weaknesses in the curriculum and bolster strengths. For example, I did a curriculum search in one ABSN course using the tool presented in Table 4 to make sure it met the project’s needs. I quickly noticed that the course I was assessing had deficits in reflecting clinical judgment in the syllabus. This discovery is alarming since faculty are expected to frame learning using clinical judgment, but that is not reflected in course objectives. Careful incorporation of clinical judgment into the



curriculum as key. It would be ideal to implement this assessment sooner rather than later, not only because of the NGN go live date, but because of the imminent curriculum revision due to competency-based education.

Stakeholders deserve a say in this assessment and need to be involved with the results. The key stakeholders in this will be undergraduate faculty in the School of Nursing along with SON administration, particularly the Assistant Dean of Undergraduate Programs. ABSN faculty deserve to know the results of the assessment. They are who will be affected most by what is revealed. With such a small sample size for interviews, it is important to mention that I am going to look at overall problems, not to target specific faculty and/or courses. Reporting in a way that is transparent but also is protective of faculty is key. All undergraduate faculty would need to know the results, perhaps not as detailed as the ABSN faculty. They need to process the results and do something to improve all undergraduate programs. For example, in the one course I surveyed using Tanner's clinical judgment elements, the learning tool where clinical judgment was most prevalent in the written curriculum was simulation. This finding was peculiar to me, particularly since I assessed a clinical course where students complete at least 150 hours of clinical practice in a patient care setting. This finding may indicate a need to update course objectives or how clinical judgment is reflected in the course syllabus. Simulation was the sweet spot, with clear objectives that exemplified clinical judgment. Undergraduate faculty also make up the Undergraduate Curriculum Committee (UGCC). This committee will be pivotal in acting on the results of the project. They are faculty stakeholders, but they are stakeholders with a particular emphasis towards

curriculum. They will help in determining the next best steps after the assessment's results are available.

Result dissemination will be tedious. ABSN faculty and the ABSN Program Director most likely need the most detailed information from the results so that changes can be made in teaching-learning areas, if needed. ABSN faculty and our director meet once monthly and as needed. A special meeting can be called to disseminate findings amongst faculty, with a focus on courses as a whole and faculty interview findings as a whole instead of targeting one faculty member or one course. While the SON administration may request a detailed report, they may need a report that hits the high points of the findings with suggestions for an action plan. I also believe giving this information to all SON faculty can be important. All undergraduate faculty use the same syllabi template and may lay information out similarly in the LMS. Additionally, many ideas could be discovered during faculty interviews. What if clinical judgment has dramatically different definitions amongst faculty? What if clinical judgment is not incorporated readily into learning settings? Findings allow for further assessments, perhaps performing this assessment in all undergraduate programs. This is why dissemination amongst all faculty is important; it allows us to all reflect. Assessment findings can be discussed in several meetings such as BSN Council (all undergraduate faculty) and Faculty Organization Meeting (all SON faculty). Additionally, the dissemination amongst all nurse educators is important. Others are not able to assess and improve unless we share ideas. Publications can be made in nursing education journals.

Presentations can be done on this assessment at nursing education conferences; several large conferences are available yearly.

Clinical judgment is a crucial factor in nursing education. I believe this assessment is a necessary step to take in preparing students for the NGN. If our curriculum does not assist students in building clinical judgment, educators cannot expect our students to be successful. All of these changes are fantastic opportunities for leaders to arise. I long to emerge as one of these as nursing education steps into the unknown. The next chapter in this work will discuss my leadership and how I will use it to usher in this new horizon in nursing education.

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CHAPTER III  
LEADERSHIP STATEMENT



## ABSTRACT

Maxwell (1993) says, “Everyone is a leader, because everyone influences someone” (p. 16). This is particularly true for nurse educators because of their role. Nursing education is in a time of change. Leadership opportunities abound. Because of nursing education’s focus going to clinical judgment and competency-based education, taking a positive leadership role is particularly vital. Many leadership types exist, but I contend that servant leadership is one of the better ways to lead because of its development opportunities through humility. This chapter seeks to explain leadership in light of the problem of practice and my leadership competencies.

## LEADERSHIP STATEMENT

My role as a nurse educator is one of leadership by default. In this role, I lead students, educator colleagues via committee service and as a course coordinator, and clinical colleagues via collaboration of clinical experiences for students. Several momentous changes are upcoming in the world of nursing education, but I want to highlight one specifically. In April 2023, the National Council Licensure Exam for Registered Nurses (NCLEX-RN) will be updated. The exam is changing because the National Council of State Boards of Nursing discovered new nurses have poor clinical judgment (Muntean, 2012). The Next Generation NCLEX-RN (NGN) will evaluate a potential new nurse's clinical judgment. *Clinical judgment* is "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). The switch to clinical judgment testing leads to a need for clinical judgment teaching. My project explores the current curriculum for the program in which I teach for evidence of clinical judgment. These changes lend themselves beautifully to leadership opportunities for me. Here, I will discuss my core values, beliefs, and theoretical frameworks for my leadership style.

### **Theoretical Frameworks**

I do not strictly abide by any one leadership theory, but I believe some theories describe where I currently am and aspirations for the future. The theory I see mostly in my practice now is the situational approach. What I aspire to be is a servant leader.

Situational approach is exactly as it sounds. It allows flexibility for the leader to assess the follower's competence and confidence and tailor leadership skills to support the follower in goal attainment (Northouse, 2019). This approach focuses on the follower's needs and the leader's response. Situational leadership defines four types of leadership based on follower competency and confidence: directing, coaching, supporting, and delegating. DalMolin and Shibley (2022) identify four competencies involved in situational leadership: diagnose, adapt, communicate, and advance. Leaders gauge a follower's clarity of the goal at hand. Then, leaders adapt or determine a leadership type based on the diagnosis. Communication involves appreciating the follower's perspective and incorporating them into the finalized work. Advancing represents meeting followers where they are and treating setbacks as "natural, teachable moments [that] create opportunities for increased performance growth and engagement" (DalMolin & Shibley, 2022, p. 36).

Servant leadership was conceptualized in the 1970s by Robert Greenleaf (Northouse, 2019); however, examples of this type of leadership are demonstrated as long ago as Biblical times (Sendjaya et al., 2008). Several key behaviors found in servant leaders are conceptualizing (understanding of the organization), emotional healing (being sensitive to the needs of others), putting others first, helping others succeed, behaving ethically, empowering, and creating value for the community. Servant leaders measure

success by self-actualization of the follower, by organizational performance, and by positive impact on society (Northouse, 2019).

### **Translating Theory into Practice**

Situational leadership applies to what I currently do. As a head of committees and task forces, these teams are assigned certain goals or tasks to accomplish. To meet these goals, the assessment (diagnosis) of each team member is necessary. At times, I work with a wide range of faculty, from novice to expert. The novice faculty may need directing while the expert faculty simply need support to meet the goals of the committee or task force. I enjoy developing others. This approach not only allows me to meet followers where they are, but to develop them into more knowledgeable, well-rounded faculty.

Servant leadership is the approach for which I wish to be known. Why do I identify with servant leadership? First, nursing is defined by caring (Boykin & Schoenhofer, 2013; Watson, n.d.). Caring for others gladly lends itself to the development of others. Northouse (2019) referred to this as helping others succeed and empowering. These behaviors are part of the reason I became a nurse educator. I get the opportunity to develop students daily. I want to change nursing by how I serve my students. I want to challenge their perspectives, help them to always see a patient as a person, and to practice nursing ethically. For these behaviors to be attained, I must first model them. Cohen (2021) says, “What you accept is what you teach” (p. 1). While I agree with this, I want to add to it. What you accept *and model* is what you teach. This task is not an easy one. Modeling nursing is difficult when the students do not seem to

relate to me, when a faculty member and I have vastly differing opinions on a topic, or when the institution puts pressure on faculty to increase NCLEX-RN pass rates.

However, this is when it is helpful for me to try to see situations through the perspectives of others and put them first. To remember that the student that is seemingly difficult may have a poor home situation and little support brings perspective to a situation quickly.

Remembering my purpose quickly aligns my emotions to serve even when it is arduous.

Sendjaya et al. (2008) wrote of different faiths having servant leadership due to serving something higher than themselves out of gratitude. I serve because I believe I was shown the ultimate picture of servant leadership in Jesus.

### **Theory and the Problem of Practice (PoP)**

My problem of practice (PoP) is I am concerned our curriculum does not focus enough on clinical judgment, which could cause students to be unsuccessful on NGN and in nursing practice. My current project is assessing my program's current curriculum for evidence of clinical judgment. Is the institution's faculty teaching in a way that allows the building of clinical judgment in all students? Said another way, is the faculty doing everything to reduce or eliminate learning inequalities in all learning environments (e.g., tests, classroom, simulation, clinical)? Are we assessing clinical judgment in a way that is equitable?

Several theories can help to frame assessments to refocus equity: culture of inquiry and implicit bias (Singer-Freeman et al., 2022). *Implicit bias* is "a form of bias that occurs automatically and unintentionally, that nevertheless affects judgments, decisions, and behaviors" (NIH, 2022, para. 2) Culture of inquiry suggests giving more

attention to institutional deficits in equity than to student deficits on assessments. Singer-Freeman et al. (2022) give recommendations on making equitable assessments that could be helpful in considering clinical judgment. As an institution, we need to hear the student voice and how they feel they are prepared in the realm of clinical judgment. We also need to look at outcomes (e.g., NCLEX-RN pass rates) and reflect on how we can change pedagogical and assessment strategies instead of seeing the student as the problem. Another recommendation is to disaggregate data so we can meet student needs. Students can also be assessed in multiple ways; giving them the choice of how this is done promotes equity. While tests must remain to prepare the students for NCLEX-RN, faculty can create assignments outside of these that allow for students to express their clinical judgment in different ways.

### **Leadership in Action**

Leadership has many different attributes. Institutions require different leadership capabilities in its people to be successful. Being proficient in every area is impossible. However, I can capitalize on my strengths and surround myself with a team who fills in the gaps. Kouzes and Posner (2017) write that leadership is a behavior and can be learned. They have studied organizational leaders in their best leadership moments. They found these leaders have five common practices: modeling the way, enabling others to act, inspiring a shared vision, challenging the process, and encouraging the heart. During the past two years, I have taken an assessment of these qualities, scoring highest in the category of encouraging the heart. This result was not surprising. I truly enjoy encouraging others and helping them to achieve their best. Additionally, I am not always

the strongest visionary. However, I have found that immersion in scholarly activities assists me in catching a vision and adapting because of that.

Being a scholarly leader in nursing academia is vital. During the past year, I have been the chair of task forces and committees at my institution. As these task forces have worked on recommendations and policies that affect all undergraduate programs, it became increasingly clear to me how much research had to be done to make the best possible decisions. This doctoral process has affirmed that. I want what I do in my job to be evidence-based because evidence-based interventions have been thoroughly researched. They are tried and true. What I am learning, too, is that educators have many opportunities for original research. My work team does incredible work. They try different interventions with students to help them in their learning. These interventions may have little or no research, but the ideas are worth investigating. This journey through this program has given me the courage to try to do this. Additionally, it has taught me that asking for help is normal and expected. Mentorship in doing anything new is crucial. One just has to be willing to seek out assistance.

Being scholarly is not limited to simply performing literature reviews or original research; it is also disseminating findings. I firmly believe in the power of sharing ideas. In nursing education, we all have a similar goal: to create competent, caring nurses who have excellent clinical judgment skills. Educators work better together. We need each other to be successful in our goals. Additionally, siloing nursing educators together is not always the best idea. We need the help of practitioners in other fields who also have innovative ideas. For example, nursing education is switching to a competency-based

education model; however, nursing is not the first field in healthcare to do this. We need to glean from other fields who have embarked on this journey first and work in collaboration.

### **Lessons Learned and Applied**

Many life experiences have happened to shape my leadership over the past few years. Not only have I been molded by this doctoral program, but I have also been in a leadership fellowship program. I have also been charged with creating a course to help nurse educators across the state earn their Certified Nurse Educator certification. Frankly, just my role as an educator has changed over the last couple of years. Each cohort of students I teach shapes my leadership in different ways.

Flexibility is one of the most important lessons I have learned. I would have once considered myself to be resistant to change. While sometimes change is not my preference, I have learned that sometimes it is necessary and that I am open to it more than I once was. I enjoy changing methods in the classroom to meet student needs. I am fairly certain I have yet to teach the same content the same way twice because I learn something new I want to try. I have learned that change based off feedback is important. For example, for the 2022 cohort I taught, my team and I realized the students were weak in nursing fundamentals; this is a course I coordinate. So, for the 2023 student cohort, we completed redesigned the course using weak areas from standardized nursing exams as evidence. However, I have to realize that sometimes others are not as readily eager to change. I work with educators who are more hesitant to change than others. I have to



learn to meet them where they are, present them with the evidence for the change, and then take small steps with them to make the change.

My fellowship program allowed me the opportunity to take the CliftonStrengths test, which allows one to discover top strengths in leadership (Rath, 2007). I agreed with this assessment on my top competencies: communication, empathy, woo, responsibility, and developer.

I feel like communication happens in various ways. Communication is not just limited to making sure expectations are clear, though that is a larger part of it. Communication is also giving feedback. Feedback is necessary and should be timely. I struggle with taking criticisms, and I am also shy to give constructive criticism, even when it is needed. I have learned that feedback is vital for improvement. Receiving it and giving it is essential in leadership.

As someone who strives for servant leadership, empathy is a large component of that. Empathy is understanding another's perspectives and feelings. It does not mean I necessarily agree with them, but I can understand how and why another person would feel the way he or she does about a situation. I have found that I have been gifted with the ability of words. This skill will be important as the SON proceeds forth with clinical judgment and competency-based education implementation. Tensions can be high during this change, and being able to listen to others and hear their side will be paramount.

Woo means "winning others over" (Rath, 2007, p. 169). I have an easy time meeting people and making connections. Being a woo-er will be pivotal as nursing

education proceeds. As stated earlier, we need each other, and making connections with others will be one way I can use my strengths to benefit the SON as a whole.

Responsibility means that if I am assigned something or if I commit to something, then I am committed to seeing it through to completion. This aspect of leadership is everything to me. I have been assigned to task forces and committees over the past few years. Additionally, I have committed to be a doctoral student. I find a deep need to complete a task/assignment, but not only to complete it, but to do it well. My weakness in this strength may be that I expect others to do the same, and this may not always be true of them. This is when the wooer and communicator in me is tested. I want to win others over to the task and to communicate the importance of the task.

Finally, I enjoy developing others. I get joy out of seeing others grow, whether that be students or colleagues. I struggle with this strength, though. I feel like I am still developing and still beginning in my career, so figuring out how to mentor when I feel like a beginner is peculiar. It is also difficult for me to truly develop others when I struggle with being a visionary.

As I proceed forward in my career, my hope is to become more engaged in research and publications. I would enjoy learning more about qualitative research as it applies to nursing education. I want to learn how to grow my visionary side. I find myself to be creative, but seeing the vision and big picture of trends in nursing education can be difficult for me. Surrounding myself with people who are strong in this area will be important for me as I grow in leadership. Leaders never stop learning and growing. One way I can do this is by attending seminars and conferences on the hottest topics in

nursing education. This also allows for networking, which helps me grow as I learn from and am mentored by others. Quite simply, my goal for enhancing my skills and knowledge is to never stop learning.

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## VITA

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### **Employment History**

#### **University of Mississippi Medical Center School of Nursing**

*Assistant Professor*

July 1, 2022 - Present

*Instructor*

May 2016 – June 2022

- Coordinate courses for the accelerated BSN program
- Facilitate search to find nurse preceptors for clinical experiences for undergraduate students
- Instruct didactic and laboratory time in several courses to enhance student learning
- Serve on the Undergraduate Curriculum Committee

#### **University of Mississippi Medical Center/Children's of Mississippi**

*Staff Nurse*

September 2012 – May 2016

- Coordinated care for 3 – 5 pediatric patients per shift
- Collaborate with different disciplines to improve patient outcomes
- Precepted undergraduate nursing students from various schools

#### **University of Mississippi Medical Center**

*Staff Nurse*

July 2011 – September 2012

- Coordinated care for 4 – 6 adult patients per shift
- Collaborated with different disciplines to improve patient outcomes

### **Education**

#### **University of Mississippi**

*Doctorate of Higher Education (EdD), Anticipated May 2023*

*Examining Clinical Judgment in a 12 Month Accelerated BSN Program Curriculum*

#### **University of Mississippi Medical Center, School of Nursing, Jackson, MS**

*Master of Science in Nursing, Nurse Educator Track, December 2016*

**Mississippi College**, School of Nursing, Clinton, MS  
*Bachelor of Science in Nursing*, May 2011  
Magna Cum Laude

### **Licensure**

2011 – Present Registered Nurse, Licensed by the Mississippi Board of Nursing

### **Certifications**

2020 – Present Certified Nurse Educator (CNE), National League for Nursing

2015 – 2019 Certified Pediatric Nurse (CPN), Pediatric Nursing Certification Board

### **Professional Memberships**

- Sigma: Theta Beta Chapter
  - Chapter Publicist: June 2021 - Present
- Mississippi Nurses Association

### **Honors/Awards**

2023 UMMC Nelson Order Inductee

2023 DAISY Faculty Award winner

2021 – 2023 Dean’s Emerging Academic Leadership (DEAL) Fellow: Competitive fellowship program; \$5,000 award and two-year leadership development intensive

2012 – 2016 DAISY Award nominations, University of Mississippi Medical Center

2013 Nurse Preceptor of the Year Nomination, University of Mississippi Medical Center

2012 Nurse Rookie of the Year Nominee, University of Mississippi Medical Center

2011 Balfour Award, Mississippi College School of Nursing

### **Publications**

2021 McElwain, S. D., Rhodes, K. A., Carr, K. L., & **Lawrence, M. C.** (2021). Early immersion clinical for an accelerated BSN nursing program. *Nursing Education Perspectives*, 42(6), E107-E108.  
<https://doi.org/10.1097/01.NEP.0000000000000675>

2020 Rhodes, K. A., Walker, J., Wijewardane, J. S., & **Lawrence, M.** (2020). A comparison of internet-based versus clinical sampling in inflammatory bowel disease research. *International Journal of Caring Sciences*, 13(1), 258 – 266.



## **Presentations**

- 2021 **Farrar, M. L.** & Hogg, H. P. *Triple S: The Success Strategy You Didn't Know You Needed*. Podium presentation for the American Association of Colleges of Nursing's Transform 2021 Conference, Dallas, TX.
- 2020 **Farrar, M. L.** *NCSBN NCLEX Review*. Presentation for the UMMC SON Teacher/Scholar Committee.
- 2018 **Lawrence, M.** & McElwain, S. *Innovatively Teaching Fundamentals in a 12-Month Accelerated BSN Program*. Poster presentation for the American Association of Colleges of Nursing's Baccalaureate Education Conference.
- 2015 Lampton, A. & **Lawrence, M.** *MEWS and Staff Resource Utilization*. Presentation for the Code Blue Committee at the University of Mississippi Medical Center, Jackson, MS. July 2015. 0.5 CE hours granted to participants through Mississippi Nurses Foundation.
- 2012 **Lawrence, M.** & Winters, A. *Reducing Anxiety in Actively Dying Oncology Patient Families*. Poster Presentation for the Nurse Residency Program at the University of Mississippi Medical Center, Jackson, MS. July 2012.

## **Teaching Activities**

### **University of Mississippi Medical Center**

July 2021 – Present

- Course Coordinator: N434-1 Clinical Practicum I, N434-2 Clinical Practicum II, N434-4 Clinical Practicum III, N433-1 Interprofessional Education I, N433-2 Interprofessional Education II, N433-3 Interprofessional Education III
- Faculty: N413-1 Health & Illness Across the Lifespan I

October 2017 – July 2021

- Course Coordinator: N434-1 Clinical Practicum I (Co-Coordinator), N434-2 Clinical Practicum II, N434-3 Clinical Practicum III, N433-1 Interprofessional Education I, N433-2 Interprofessional Education III
- Faculty: N413-1 Health & Illness Across the Lifespan I, N412-1 Professional Role Development of the Nurse I, N436 Scholarship for Evidence-Based Practice, N433-3 Interprofessional Education II

October 2017 – December 2019

- Faculty: N413-2 Health and Illness Across the Lifespan II, N413-3 Health and Illness Across the Lifespan III, N405 Basic Health Assessment, N497 Nursing Capstone
- Course Coordinator: N401 Health Promotion in Populations

May 2016 – October 2017

- Simulation faculty for multiple undergraduate programs and courses
- Problem-Based Learning Facilitator for N413
- Guest Lecturer for N427 (Child & Adolescent Health)

### **Professional Service**

2022 Planned and implemented Certified Nurse Educator Exam Review Course as part of the Bower Foundation's grant *Building a Strong Future for Nursing in Mississippi*

### **University Service**

- University of Mississippi Medical Center's Quality Enhancement Plan (QEP) Committee (November 2022 – November 2025)
- Undergraduate Curriculum Committee (August 2020 – Present)
  - Chair: October 2021 – Present
- Faculty Search Committee (December 2019 – Present)
- Strategic Planning Implementation Team for Goal A-3 (September 2018 – May 2019)
- Undergraduate Admissions & Progression Committee (Chair) (August 2018 – July 2020)
- Teacher/Scholar Council (May 2016 – Present)
- BSN Council (May 2016 – Present)

### **Community Service**

2022	Student and Employee Flu Blitz
2021	Health Fair: Rosa Scott School, Madison, MS
2021	Employee COVID Vaccination Blitz
2020 – Present	Mission First Clinic RN
2018	March of Dimes walk volunteer
2017	Great Bear Affair Health Screenings in Mississippi Delta
2016 – 2017	TutorMate Literacy Program with Jackson Public Schools
2014 – 2015	South America medical mission trip with Mississippi College School of Nursing
2015 & 2016	Healthy Hustle 5K by Mississippi College School of Nursing
2013 – 2014	Magnet Champions Committee at UMMC. Committee members assist in educating staff nurses on Magnet Model Practice and attend meetings monthly to aid the hospital in achieving Magnet recognition.
2013	Flu Vaccination Blitz
2011 – 2013	Mission First Low Income Medical Clinic, Jackson, MS: Volunteer RN
2012	UMMC Magnet Champions Car Show: Educated public on sun protection/skin cancer
2011 – 2016	Simulation assistance, Mississippi College School of Nursing
2011 – 2012	Camp nurse: Camp Garaywa, Clinton, MS