View metadata, citation and similar papers at core.ac.uk

brought to you by CORE

provided by SJSU ScholarWorks

San Jose State University
SJSU ScholarWorks

Master's Projects | Master's Theses and Graduate Research

12-1-2004

Fostering Clinical Judgment During Preceptorship

Susan McNiesh
San Jose State University

Follow this and additional works at: https://scholarworks.sjsu.edu/etd_projects

Part of the Other Nursing Commons

Recommended Citation
McNiesh, Susan, "Fostering Clinical Judgment During Preceptorship" (2004). *Master's Projects*. 790.
DOI: https://doi.org/10.31979/etd.hfj4-t85z
https://scholarworks.sjsu.edu/etd_projects/790

This Master's Project is brought to you for free and open access by the Master's Theses and Graduate Research at SJSU ScholarWorks. It has been accepted for inclusion in Master's Projects by an authorized administrator of SJSU ScholarWorks. For more information, please contact scholarworks@sjsu.edu.

SAN JOSE STATE UNIVERSITY
SCHOOL OF NURSING

MASTER'S PROGRAM PROJECT OPTION (PLAN B)
PROJECT SIGNATURE FORM

STUDENT NAME Susan McNiesh

SEMESTER ENROLLED Fall 2004

TITLE OF PROJECT Preceptors' Perceptions of Evidence of Clinical Judgment in New Nurse Orientees

NAME OF JOURNAL Journal of Nursing Education

The project and manuscript have been successfully completed and meet the standards of the School of Nursing at San Jose State University. The project demonstrates the application of professional knowledge, clinical expertise, and scholarly thinking. An abstract of the project and two copies of the manuscript are attached.

[signature] — 12-6-04
ADVISOR'S SIGNATURE — DATE

[signature] — 12-10-04
ADVISOR'S SIGNATURE — DATE

Please submit this form to the Graduate Coordinator. Attach abstract, two copies of the manuscript, and documentation of submission to the journal (i.e., postal receipt).

JHC: Spring, 2000

Mcniesh

From:
To:
Sent: Monday, December 13, 2004 3:32 PM
Subject: Manuscript Submission

You have successfully submitted your manuscript, Fostering Clinical Judgment During Preceptorship. Your Manuscript Number is: .

Take note of this number for future reference. You can log on at any time to see the current status of your manuscript(s). The web address is www.rapidreview.com and your username is .
If you wish to contact the journal office, here's how:

Journal of Nursing Education
Journal of Nursing Education
SLACK Incorporated
6900 Grove Road
Thorofare, NJ 08086
USA
Phone:
Fax:

Thank you for your submission.

Karen Stanwood, ELS
Managing Editor
Journal of Nursing Education

Phyllis Connolly

From: Mcniesh [redacted]
Sent: Monday, December 13, 2004 3:46 PM
To: [redacted]; Phyllis Connolly; Christine Hooper
Subject: Fw: Manuscript Submission

Yay! Here it is...put too bed! Thanks to all. I will bring a hard copy to submit to Phyllis on Wednesday. I have copies of the copyright transmittal form that I will put in Susan and Chris' box that same day. It sounds as though they want those sent out right away. They can be snail mailed or faxed.
Susan McNiesh
----- Original Message -----
From: [redacted]
To: [redacted]
Sent: Monday, December 13, 2004 3:32 PM
Subject: Manuscript Submission

You have successfully submitted your manuscript, Fostering Clinical Judgment During Preceptorship. Your Manuscript Number is: [redacted].

Take note of this number for future reference. You can log on at any time to see the current status of your manuscript(s). The web address is www.rapidreview.com and your username is [redacted].
If you wish to contact the journal office, here's how:

Journal of Nursing Education
Journal of Nursing Education
SLACK Incorporated
6900 Grove Road
Thorofare, NJ 08086
USA
Phone: [redacted]
Fax: [redacted]

Thank you for your submission.

Karen Stanwood, ELS
Managing Editor
Journal of Nursing Education

Fostering Clinical Judgment During Preceptorship

Susan McNiesh, Susan O. Murphy, and Christine Hooper

San Jose State University

School of Nursing

December 1, 2004

Fostering Clinical Judgment During Preceptorship

The role transition from student nurse to new graduate nurse commonly includes a preceptor relationship. Preceptorships are often the culminating nursing education experience for senior baccalaureate nurses and are used as well for orienting new graduates as they begin their staff nurse role in the hospital setting. The preceptee is paired with an experienced nurse who is charged with supporting, teaching, and exemplifying safe and competent patient care. In many cases preceptors are ascribed the task of independently validating the preceptee's ability to exercise clinical judgment.

Today's health care environment requires nurses to be proficient critical thinkers. Patients need more complex care delivered in a shortened time frame in a technology-laden environment and with a frequently changing knowledge base. In addition, nursing practice continues to become increasingly autonomous. How do nursing students safely transition from task orientation to safe, competent, and independent practice?

Literature Review

Preceptorship Utilization in Orientation

The use of preceptorships in facilitating nurses' transition into practice first appeared in classification in 1975 (Shamian & Inhaber as cited in Letizia & Jennrich, 1998). Our recent literature review revealed a peak in the number of articles on preceptorships in nursing, written between 1984 and 1994. However, in the last five years there has been a renewed interest in the preceptorship model, perhaps fueled by the nursing shortage and the desire by hospitals to recruit and retain more nurses.

Recurrent themes can be seen in the recent literature on preceptorship. Measurement tools and the documentation of competencies are seen as an important

element of successful orientation programs utilizing the preceptorship model (Greene & Puetzer, 2002). The preceptee/preceptor relationship can be facilitated, reinforced, and evaluated by the use of a manager, nurse educator, or clinical nurse educator as a mentor (Beecroft, Kunzman, & Krozek, 2001; Greene & Puetzer; Hom; LaVoie, et al., 2002; Rashotte & Thomas, 2002). Both informal and formal ongoing and summative evaluation of preceptored orientation programs increases their effectiveness (Greene & Puetzer; LaVoie, et al.). Critical thinking exercises and evaluation of critical thinking competencies are seen as an integral part of recent programs incorporating the preceptorship model (Greene & Puetzer; Hom; LaVoie, et al.; Rashotte & Thomas).

Critical Thinking and Clinical Judgment

The concepts of critical thinking and clinical judgment are frequently used in the literature of nursing education literature; yet there is a lack of consensus as to the relationship between the two terms. Some authors consider critical thinking necessary for clinical decision making (Kataoka-Yahiro & Saylor, 1994; Facione & Facione, 1996; Conger & Mezza, 1996; Oermann, 1997). According to Case (1994) critical thinking and clinical decision making share the same characteristics. On the other hand, O'Neil and Dhulý (1997) propose a clear distinction between critical thinking and diagnostic reasoning as thought processes. The authors view diagnostic reasoning as a "cognitive streamlining process" to sift through data and weed out the insignificant elements. Diagnostic reasoning is used when an immediate and precise response is necessary. When a broader time frame and perspective is available to evaluate a problem, critical thinking is used.

Clinical Experience and Clinical Judgment

Clinical experience is cited as a foundational component of clinical decision making and critical thinking. In studies of nursing students, graduate nurses, and expert nurses, critical thinking and decision making increased with the level of clinical experience (King & Clark, 2002; Martin, 2002; Burman, Stepans, Jansa, & Steiner, 2002; Watkins, 1998). However, a study of critical thinking in senior baccalaureate nursing students found no statistically significant correlation between critical thinking and clinical competence (May, Edell, Butell, Doughty, & Langford, 1999). The authors hypothesized that critical thinking may require more clinical experience before it becomes an apparent skill.

Benner's theory of nurse role transition (1984) posits that nurses gain skills by moving through transitional roles from novice to advanced beginner to competent to proficient, and finally, to expert. The theory is based on the Dreyfus Model of Skill Acquisition (original research was to study the response of pilots in emergency situations), and states that each role builds on prior experiences. Benner states that expert nurses use a certain "discretionary judgment" in the clinical setting that is a departure from rule based practice, and that expert clinical judgments are context-based. Benner views new grads as "advanced beginners", defined as "ones who can demonstrate marginally acceptable performance, ones who have coped with enough real situations to note (or to have pointed out to them by a mentor) the recurring meaningful situational components that are termed *aspects of the situation* in the Dreyfus Model" (Benner, 1984, p. 291).

Preceptorship & Critical Thinking

There has been little research on the experience of acquiring clinical judgment in the beginning practice of new nurses, and even less exploration of the effect of preceptorship on this process, however, one study is especially salient to this research. Myrick questioned (2002) whether critical thinking skills are promoted by nurse preceptors, and if so, what is the process? Her research revealed an interactive and dynamic process which she named *enabling*. Two variables in the enabling process are the *climate* and *bringing about*.

The second variable, *bringing about,* includes both incidental and purposive methods of encouraging critical thinking in the preceptee. The incidental category is divided into categories of role model, facilitates, guides, and prioritizes. Myrick identified a preponderance of incidental as opposed to purposive facilitation of critical thinking by preceptors. Although Myrick's research supports the theoretical importance of preceptorships, the preceptors in Myrick's study encouraged critical thinking primarily through unintentional processes.

Research Question

This research was an exploratory study that aimed to more clearly identify the preceptorship process and how preceptors recognize evidence of clinical judgment in new graduate nurse orientees. The research queries that guided this qualitative interview study were: What intentional processes do preceptors use to facilitate clinical judgment in new graduate nurses during the orientation process? How do preceptors recognize evidence of clinical judgment in new graduate nurse orientees in labor and delivery?

Methodology

Research Design

Following human subjects approval, five registered nurses currently orienting new graduate nurses to labor and delivery were purposively recruited, because they had been assigned to orient new graduates during the timing of this study. The sample size was intentionally small since the purpose of the research was exploratory. Data were gathered in the form of semi-structured, audiotaped, one-on-one interviews. For the convenience of the informants, interviews, conducted by the first author, occurred at the preceptors' hospitals immediately before or after the preceptor's scheduled shift. The informants were given information about the research in both verbal and written form, and signed a letter of consent.

Each informant was asked about her experiences as a preceptor for new graduate nurses in the labor and delivery setting. Interviews were limited to one specialty area since the literature review suggests that specific knowledge base is a significant element in the development of clinical judgment. In addition, the first author's expertise is in inpatient obstetrics. A semi-structured, open-ended interview guide was used to focus the interviews. Informants were encouraged to be expansive and descriptive, utilizing their own words. Throughout the interview process the interviewer attempted to clarify informant responses "in the moment" if a line of thought seemed ambiguous or tenuous. Additional interview questions were added based on concepts uncovered during the earlier interviews.

Twelve interviews, lasting 30-50 minutes were conducted during a nine-week period coinciding with new graduate orientations. Preceptors were female, ranging in age from

33 to 58. Experience in labor and delivery ranged from 5 to 21 years and experience as a preceptor ranged from 3 ½ to 10 years. Three preceptors had associate degrees in nursing and two held baccalaureate degrees in nursing. Three informants were interviewed three times, one informant was interviewed twice, and one informant was interviewed one time due to illness and an inability to arrange alternate dates. Consideration was then given whether to include a sixth informant. After review of existing transcripts the authors agreed that the data were sufficiently complete so as not to require further recruitment. As categories were identified in the data, questions in the third interview focused on the "fit", whether the themes made sense to the informants and whether the informants could give further description to the themes (Strauss & Corbin, 2001).

Data analysis

Data collection and analysis were concurrent and ongoing. As initial interviews were conducted a professional transcriber transcribed the data. The primary researcher did line by line coding, reading each interview once through, and then doing a second reading highlighting significant statements and common themes. As concepts emerged from subsequent interviews they were compared with existing categories for "fit" or a new category was created. As categories were compared, some categories coalesced to form subcategories within another, more inclusive category (Strauss & Corbin, 2001). Finally, the data were reviewed as a whole to determine relationships among categories.

Research findings

A narrative theme was obtained across informants' responses and was named as *fostering clinical judgment*, a process that included two major constructs. This article focuses on the first, the *processes utilized by preceptors* to promote the acquisition of

clinical judgment in new graduate nurses as well as the *characteristics of new orientees* which they perceived to be assets. A subsequent article will detail the second construct, *evidence of clinical judgment* in new graduate nurse orientees as perceived by the preceptors.

Findings revealed that preceptors provided a *guided progression of experiences* for the new graduates and clinical practice served as the core activity. During orientation, preceptors often pointed out *meaningful characterisitics* of each patient care situation, thus accumulating concrete examples that illustrate theoretical concepts in real world clinical practice. Preceptors guided the new nurse orientees by means of a *progression* of *role modeling, asking questions, nurturing, pushing*, and finally, *letting go.*

Preceptors also identified qualities that the new graduates brought to the orientation setting that they believed enhanced the process. These qualities included *prior experience, learning style, and personal attributes (inquisitive, common sense, caring, flexibility,* and *thinking on one's feet*). These are not meant to be an exhaustive list of personal facilitating qualities, but were based on these informants' descriptions.

Prior experience could include medical experience or diverse life experiences. For example, preceptors commented:

> This woman I think has a fair amount of life experience and I also think she already worked in a hospital as a unit secretary. This is beneficial for just seeing how things run and the stress and the pace it can be. And so I think she already comes in with some understanding.
>
> She's got an advantage because she worked in a doctor's office so she's not afraid to talk to doctors. Some people are hesitant to talk to doctors and it causes a lot of anxiety.
>
> I mean even women who have had kids have had the experience of seeing how they handle stress and how they handle all that stuff. So I think life experience is a really big piece.

Certain *personal attributes* can affect the new graduates capacity for learning. According to preceptors, these included *thinking on one's feet, compassion, common sense,* and *inquisitiveness*. One informant explained:

> Someone who has the ability to think on their feet..because it's about changing and listening not just to the intellectual feedback that we get from the monitor but listening to the feedback of the mother and what's really working and not working for her.

Another preceptor described *inquisitiveness* as follows:

> The most successful ones are really people who do ask the questions. Because then it gives me the opportunity to teach. They just get what they want.

While preceptors did not identify one particular *learning style* that facilitated the journey through orientation, they believed it was helpful if the orientee knew how she learned and shared this information with the preceptor. One informant acknowledged, "It's part of the preceptors role to try and figure it out." But another preceptor noted:

> Some people learn better by observing. Some people learn better if you take them a little more to the edge and kind of—you don't want them to completely fall, but sometimes they have to stand on that brink before they learn. And other people, you tell then and they do it. And they're totally right there with that.

Conflicting learning/teaching styles created dissonance between preceptor and preceptee as evidenced in the following comment:

> I recommended that she work with another person as well as myself because I don't think we're really doing that good a job together, of her getting what she needs. I feel like I have this sense of, oh I'm not enjoying this. And I can tell she's not enjoying this. I have a lot of respect for her intelligence and her capacity and I don't feel like we're doing it that well together. I think her process of knowing is very different than mine.

The context that preceptor-informants considered essential for new graduate nurses to acquire clinical judgment was *providing varied and multiple clinical experiences*. A preceptorship is an ideal time to develop clinical judgment in which experiential learning

takes place with expert guidance. Clinical judgment is learned through exposure to many different kinds of experiences. Preceptors remarked:

> It's an ongoing process just because the more experiences that you have and the more times you do it the better you become and the more likely you get to know that if A and B happen then C is going to follow.
>
> I really think that's the only way you can learn it here. I think you have to pretty much see it, or see something similar, or be around it and see it with someone else. I think that's the best way of learning it.
>
> Then we'll start looking for situations. I'll ask the charge nurse for situations that we haven't had yet.

Clinical judgment is context-based and dependent on what is happening at a particular time with a particular patient. And as one preceptor commented, "In labor and delivery nothing is out of a textbook...hardly." A preceptor pointed to situational components in the following excerpt:

> What's important, what to emphasize to her, it's going to vary from situation to situation. I think a lot of it is just showing them, having them observe, and then they've got to start making their own decisions. I really think at this point that's the only way that they would know. How would they know otherwise? They weren't in that situation. Until they get to that situation they wouldn't know what is important and what isn't important.

Within the labor and delivery context the preceptors shared their collective experiences with the orientees to describe clinical situations that are not apparent in textbooks. For example, experienced nurses notice how a change in a patient's demeanor can signal a change from early to active labor or the transition phase. Expert nurses can also *share exemplars* comparing the rate of labor for a multipara with that of a primipara as noted in the following preceptor's statement:

> Knowing when she's going to deliver- knowing that if it's her second baby and she's 8cm you'd better be waking them up [the doctor] and telling them to get here.

Preceptors share with the orientees their concerns about *meaningful characteristics* of the situation that might signal a departure from the norm and may resemble an exemplar from their past experiences such as this example of a potential shoulder dystocia:

> I share a lot of that..what I'm thinking about. Like it's taking the person a really long time to push, kind of what my concerns are, going on in the back of my mind that we should be paying attention to. So I'm really thinking about the shoulders here..things like that, the different things to be thinking about.

All preceptors acknowledged that *gaining the big picture* takes longer than the orientation period and that the preceptees will continue to gain from their clinical experiences well into their solo practice. The expectation of preceptors was that by the end of the orientation period, the orientees would be cognizant of the limits of their knowledge base and would rely on the expertise of other nurses within the practice setting to act as safety nets. Preceptors acknowledged this in the following excerpts:

> The big picture- it doesn't come until a year out. Until your comfort level gets to the point where you can start anticipating your needs or anticipating what the doctor is going to order. I think that is when you've gotten the big picture is when you can kick into anticipation mode.

> Oh like critical thinking…I think that's a learning that takes years…long after she's oriented that's all going to come together. I mean I hope they get from here is that they can see when things are going well and they can see when things aren't going well. And that's what I want them to be able to do.

> As a new nurse I never felt like I was completely alone. I never hesitated to hit the emergency button. I want her to know that that's completely okay to do when you need another hand in there…when you need that safety net. Fortunately, I think on our shift we all are very much a team effort. And so nobody is left without a safety net.

> I think that's the main thing about a person, when she can go on her own, is when she knows when she doesn't know and she knows how to call for help.

Preceptors in the labor and delivery setting preferred that preceptees follow a certain step-wise progression of experiences. Often they used a variant of the "see one, do one" model, with the third step of verbal feedback from the orientee. Preceptors commented:

> Usually what I would do is show her how I would do something and then give her other ways, show her different ways and then the next time it's her turn to do it and I watch and I just continually do that.
>
> So there is a beginning stage when I'm talking—talking at them. Then there's the stage when I pull back a little and see what they have to say back to me.

Patient care situations offered for the orientee typically followed a progression from simple and/or normal to more complex or high risk as noted in this preceptor's statement:

> I think you have to have the right assignment as well. I know the other day we had an insulin dependent diabetic who was also a preclamptic. No, no we don't do that. Maybe one or the other. You don't need to have both of those and try to figure all that out. Let's go a little slower since we have the option of taking a regular labor, take the regular labor.

Preceptors acted as *role models*, acting in ways appropriate for the preceptee to emulate. Preceptors commented: "Otherwise my role is by example", "Listen to what I'm saying and watch what I'm doing", "I can just talk out loud as I do my assessment, sort of talk it out loud." Preceptors explained:

> And I want you to listen to the questions I'm asking her and see kind of how I organize everything and how I can get them assessed without- and kind of even by the time you have them on the monitor they're halfway assessed.

Preceptors acted as *guides* for the new graduates as they gradually accumulated more clinical experience. Through *reflecting outloud* preceptors pointed out how all the puzzle pieces fit into a meaningful whole. Preceptors understood that new graduates don't start out with the same wholistic clinical picture as a seasoned nurse might have obtained. In the words of informants:

> I think as a new nurse the difficulty is that you have the book learning and you know all these pieces, but one doesn't always connect to another until you start in the actual on-the-floor scene, where you start being able to put the pieces together.
>
> I'll just walk into the room with them and I'll say okay let's stop and notice what we see right here. She has an IV pole and she has an IV—just all this stuff that experienced labor nurses don't even think twice about; we're already in that space. We don't even-it's like walking-we do it naturally. But as a new nurse you don't know that stuff.
>
> Before we go into the room I tell her the things I'm going to look for that you can assess without asking a question. You can see the general color of your patient, you can see her facial expression, you can tell if the IV is dripping, you can see if you have oxygen on the wall, you can see if you have emergency suction, and you can eyeball your strip and look at reactivity without having to sit there and be concentrated.

Preceptors developed *questioning strategies* to help the new graduates differentiate the relevant from the relevant and the normal from the abnormal in clinical situations. They also used questions to determine the progress of the preceptee. Informants stated:

> Usually further along in her orientation, I'll walk into the room and visually do my entire assessment. I really can see the whole thing. Then I'll walk out leaving the orientee to do her thing. And then when she comes out I'll ask her to tell me what's going on, and what her plan of care is. What is she planning? That really gives me some clue about the big picture.
>
> I'm going to question, so I'm going to say things like, What's the baseline on the baby? Is this a reassuring or a nonreassuring strip? What are you going to do next? And mostly that's the way I notice. If they answer appropriately then I'm going to start giving them more and more autonomy and of course just continuing to follow up to see if my assessment matches their assessment. And the more those come together, then the more autonomy I'm going to be able to give them.

Preceptors believed *nurturing* the preceptee was important to enhance and encourage learning clinical judgment. The process of gaining experiential knowledge is slow and discomfiting. Preceptors concluded:

> I just reassure them through the whole process. I tell them that it is really hard to be constantly in a learning state for all this time because it makes you feel like you're nonstop stupid. That you don't know anything because there's always something

> more I'm going to be telling them that they didn't know or that they could have done better or differently or whatever.
>
> This is a slow process and it will happen for them. So I always send them off with that because I think it's really important. I think it's really hard. So that's the way I nurture them.

Preceptors stated that at least for some preceptees, an important part of the learning process is to be *pushed towards independence*. In fact, it allows both the preceptor and the orientee to discover how the new nurse functions under stressful situations. Informants commented:

> I hate pushing but I do it. The way I like to push is I want to make sure it doesn't feel like a trick. I want to make sure it doesn't feel like I'm letting them go off the deep end and then if they fall, they didn't know that they were being led off the road. So I usually say to them, today I'm going to push you some. And this is going to be a challenge and I know that. So what I'm going to do is I'm not going to go in the room with you. I'm going to let you completely assess the patient and the strip (of course I'm looking at it out at the desk anyway). Then I'm going to have you come and tell me exactly what you think is going on. I think it is important for them to get that I'm challenging them.
>
> It's important to let them know that I'm pushing them. And it's not because I want to see how much they know or don't know—it's because I want THEM to see how much they DO know.

At a certain point preceptors needed to let go and give the preceptees more autonomy. Informants stated:

> That's a part of the letting go when you have to put your hands in your pockets and shut your mouth and just let them work through it on their own, as long as it's not unsafe.
>
> Letting go is when I can sit back in the delivery room and have my hands taped to my sides- and watch them do all that they can do.

Discussion

Preceptors fostered the acquisition of clinical judgment by *providing clinical experiences* while *guiding* the new graduate *through these experiences*. See Figure 1 for a

conceptual diagram of *fostering clinical judgment*. The preceptors used a progression of strategies including *role modeling, asking questions, nurturing, pushing*, and finally, *letting go*. Though *role modeling* behaviors continued throughout orientation, the preceptors relied on this strategy much more during the initial phases of orientation. *Asking questions* and *nurturing* occurred throughout orientation, though initial questioning was of a lower order and required less critical thinking. *Pushing* and *letting go* were strategies reserved for the latter part of the orientation process. Preceptors provided *clinical experiences* throughout the orientation period. Furthermore, all preceptors agreed that the cycle of *gaining experiences*, *identifying meaningful characteristics*, and retaining eventual *exemplars* continued well past the official end of orientation.

When asked specifically, none of the preceptors were familiar with Benner's adaptation (1984) of the Dreyfus model of skill acquisition. However, the findings in this study demonstrate that the process used by the preceptors appears to support Benner. The preceptors modeled the praxis of personal knowledge and clinical experience central to Benner's theory. The skills acquisition model emphasizes the importance of real situations in learning to recognize and collect the recurring "aspects of the situation" (Dreyfus, as cited in Benner, p.22). In a comparable way the preceptor-informants acknowledged the importance of accumulating clinical experiences in which the preceptors could point out the salient recurrent patterns.

Limitations

As in most qualitative research, the voices of the informants were key to this study's significance. However, there are limitations. We relied on actions and verbal statements

made by the orientees as perceived by the preceptors, that is, the orientees themselves were not interviewed. In addition, some subjectivity is inevitable but the intent was to allow meanings to emerge from the informants' voices and all efforts were made to avoid leading the participants to a particular directive response.

Implications

The results of this study add to our understanding of the acquisition of clinical judgment and the role preceptors play in the development of clinical judgment in new nurses. These individual preceptors identified an intentional progression of guided experiences, although this progression was sometimes only seen retrospectively. Given these findings, we feel that preceptors may benefit by reflecting on this process even prior to serving as preceptors. These authors also believe that making this progression conscious and naming the strategies could also benefit preceptors of nursing students. Such reflection would include:

- Enhancing the learning of the preceptee, using role modeling, higher level questioning, nurturing, pushing, and letting go
- Pointing out salient characteristics in each clinical situation, comparing normal to abnormal and noting how particular clinical situations are similar or dissimilar and thereby facilitating the preceptee in accumulating clinical knowledge base

Based on the preceptors' widely held view that orientation is only the beginning step in gaining clinical judgment, agencies might want to consider assignment of mentors after formal orientations are complete to act as safety nets as new graduates continue to gain clinical experiences and add to their understanding of the *big picture* in clinical situations.

Nursing education faculty could also use these findings. Although students are just beginning to accumulate clinical experiences, they can be assigned journaling activities to write narratives of their clinical encounters. In a post-conference seminar clinical instructors can then help students reflect on their experiences. Over time students can review their narratives to help draw comparisons and exceptions and begin to form exemplars of how textbook cases might look in real clinical practice.

References

Beecroft, P., Kunzman, L., & Krozek, C. (2001). RN internship: Outcomes of a one year pilot study. *Journal of Nursing Administration, 31*, 575-582. Retrieved 2/23/04 from http://libaccess.sjsu.edu:2086/ovidweb.cgi

Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. Menlo Park, CA: Addison-Wesley.

Burman, M., Stepans, M., Jansa, N., & Steiner, S. (2002). How do NPs make clinical decisions. *The Nurse Practitioner, 27(5),* 57-64. Retrieved 2/26/04 from http://libaccess.sjsu.edu:2234/ovidweb.cgi

Case, B. (1994). Walking around the elephant. *Journal of Continuing Education in Nursing, 25,* 101-109.

Conger, M., & Mezza, I. (1996). Fostering critical thinking in nursing students in the clinical setting. *Nurse Educator*, *21(3),* 11-15. Retrieved 12/2/03 from http://libaccess.sjsu.edu:2409/ovidweb.cgi

Facione, N., & Facione, P. (1996) Externalizing the critical thinking in knowledge development and clinical judgment. *Nursing Outlook*, *44*, 129-136.

Greene, M., & Puetzer, M. (2002). The value of mentoring: A strategic approach to retention and recruitment. *Journal of Nursing Care Quality*, *17(1)*, 63-70. Retrieved 11/18/03 from: http://libaccess.sjsu.edu:2409/ovidweb.cgi

Hom, E. (2003). Coaching and mentoring new graduates entering perinatal nursing practice. *Journal of Perinatal and Neonatal Nursing, 17(1)*, 35-49. retrieved 10/18/03 from: http://www.libaccess.sjsu.edu:2059/ovidweb.cgi

Kataoka-Yahiro, M., & Saylor, C. (1994). A critical thinking model for nursing judgment. *Journal of Nursing Education, 33*, 351-356.

King, L., & Clark, J. (2002). Intuition and the development of expertise in surgical ward and intensive care nurses. *Journal of Advanced Nursing, 37*, 322-329. Retrieved 3/29/04 from http://libaccess.sjsu.edu:2054/ovidweb.cgi

Lavoie-Tremblay, M., Viens, C., Forcier, M., Labrosse, N., Lafrance, M., Laliberte, D., & Lebeuf, M. (2002). How to facilitate the orientation of new nurses in the workplace. *Journal of Nurses in Staff Development, 18*, 80-85. Retrieved 11/18/03 from http://libaccess.sjsu.edu:2409/ovidweb.cgi

Letizia, M., & Jennrich, J. (1998). A review of preceptorship in undergraduate nursing education: Implications for staff development. *Journal of Continuing Education in Nursing, 29*, 211-216.

Martin, C. (2002). Theory of critical thinking in nursing. *NLN Nursing Education Perspectives, 23*, 243-247.

May, B., Edell, V., Butell, S., Doughty, J., & Langford, C. (1999). *Journal of Nursing* Education, 38, 100-110.

Myrick, F. (2002). Preceptorship and critical thinking in nursing education. *Journal of Nursing Education, 41*, 154-164.

Oermann, M. (1997). Evaluating critical thinking in clinical practice. *Nurse Educator, 22(5),* 25-28. Retrieved 2/8/04 from http://libaccess.sjsu.edu:2086/ovidweb.cgi

O'Neill, E., & Dluhy, N. (1997). A longitudinal framework for fostering critical thinking and diagnostic reasoning. *Journal of Advanced Nursing, 26,* 825-832.

Retrieved 2/15/04 from http://libaccess.sjsu.edu:2141/ovidweb.cgi

Rashotte, J., & Thomas, M. (2002). Incorporating educational theory into critical care orientation. *Journal of Continuing Education in Nursing, 33,* 131-137. Retrieved 3/28/04 from http://libaccess.sjsu.edu:2054/hww/emailorintsave/emailprintsave

Strauss, A., & Corbin, J. (1991). *Basics of qualitative research: Grounded theory procedures and techniques.* Newbury Park, CA: Sage.

Watkins, M. (1998). Decision-making phenomena described by expert nurses working in urban community health settings. *Journal of Professional Nursing, 14(1),* 22-33.