Introduction

Nurses’ clinical decision-making is a complex process that holds potential to influence the quality of care provided and patient outcomes. The evolution of nurses’ decision-making that occurs with experience has been well documented. In addition, literature includes numerous strategies and approaches purported to support development of nurses’ clinical decision-making. There has been, however, significantly less attention given to the process of assessing nurses’ clinical decision-making and novice clinical educators are often challenged with knowing how to best support nurses and nursing students in developing their clinical decision-making capacity. The Situated Clinical Decision-Making framework is presented for use by clinical educators: it provides a structured approach to analyzing nursing students’ and novice nurses’ decision-making in clinical nursing practice, assists educators in identifying specific issues within nurses’ clinical decision-making, and guides selection of relevant strategies to support development of clinical decision-making. A series of questions is offered as a guide for clinical educators when assessing nurses’ clinical decision-making. The discussion presents key considerations related to analysis of various decision-making components, including common sources of challenge and errors that may occur within nurses’ clinical decision-making. An exemplar illustrates use of the framework and guiding questions. Implications of this approach for selection of strategies that support development of clinical decision-making are highlighted.

© 2010 Elsevier Ltd. All rights reserved.

Article history:
Accepted 7 February 2010

Keywords:
Clinical decision-making
Clinical judgment
Clinical nursing education
Assessment

Nurses’ clinical decision-making is a complex process that holds potential to influence the quality of care provided and, subsequently, patient outcomes (Benner et al., 1999; Minick and Harvey, 2003; Tanner, 2006). Effective clinical decision-making processes develop over time as nurses acquire necessary knowledge, thinking processes and clinical experience (Benner et al., 1996). While theorists’ descriptions of nurses’ clinical decision-making at various level of skill performance provide vision for professional growth (Benner, 1984; Benner et al., 1996), the process of supporting novice nurses and nursing students in building decision-making skills toward expertise often challenges novice clinical educators.

There has been a longstanding interest in assisting nurses and nursing students to develop clinical judgment and decision-making processes. Research and descriptive literature presents programs, pedagogical approaches and specific strategies intended to develop nurses’ clinical decision-making and reasoning. There has been, however, significantly less attention given to the process of assessing nurses’ clinical decision-making processes. Literature includes descriptions of a specifically designed Clinical Decision-Making Assessment tool (CDMA) (Grossman et al., 1996) and the Objective Structured Clinical Assessment tool (Boney and Baker, 1997). More recently, rubrics that incorporate dimensions of clinical judgment have been used to assess nurses’ clinical judgment during simulated clinical experiences (Dillard et al., 2009; Lasater, 2007). In addition, research studies examining the relationship between critical thinking and clinical decision-making or judgment have used the Watson—Glaser Critical Thinking Appraisal tool (Tanner, 2006).

Novice clinical educators often struggle with knowing how to effectively support nursing students and novice nurses in developing their clinical decision-making capacity. This challenge is reflected in observations related to new graduate nurses in the United States: Del Bueno notes that “only 35% of new registered nurse graduates, regardless of educational preparation and credentials, meet entry expectations for clinical judgment” (2005, p. 278). In considering this phenomenon against existing literature,
two points of interest emerge. First, nurses’ clinical decision-making is well recognized as a complex, multidimensional process (Benner, 1984; Benner et al., 1996; Tanner, 2006). Nurses’ clinical decisions occur within the dynamic context of clinical practice, are informed by multiple sources of knowledge, influenced by all that the nurse brings to the situation, and supported by a range of thinking processes (Gillespie and Paterson, 2009; Tanner, 2006). As such, the effectiveness of clinical decision-making can be influenced by any of its component parts. In contrast, the majority of strategies described in literature focus on improving clinical decision-making as a whole, with limited consideration of specific components of the larger process. This blanket approach to intervention offers little direction for educators in determining which strategies will best support the development of specific clinical decision-making components. Second, the discussion of strategies assumes that educators are able to effectively analyze a situation and identify the components of a nurse’s clinical decision-making process that require development. This assumption obscures a critical challenge for educators: Typically, when nurses or nursing students lack capacity in some aspect(s) of clinical decision-making, issues tend to present as general concerns about their practice e.g., ‘poor clinical judgment’, ‘ineffective patient care’, or ‘inappropriate decisions’. Identification of the specific source(s) of issues underlying the broader concern regarding a nurse’s clinical decision-making capacity is an essential prerequisite to selecting strategies that offer relevant and meaningful support for development.

In this article, the Situated Clinical Decision-Making framework is presented as a tool that provides clinical educators with a structured approach to analyzing nursing students’ and novice nurses’ decision-making in clinical nursing practice, and assists them in identifying specific issues within nurses’ clinical decision-making. By supporting identification of specific issues, the framework also guides educators in selecting relevant strategies to support development of clinical decision-making. Following the structure of the framework, the discussion highlights key considerations related to analysis, including common issues and errors that may occur within nurses’ clinical decision-making. An exemplar illustrates use of the framework. Finally, implications of this approach for selection of strategies that support development of clinical decision-making are highlighted.

The Situated Clinical Decision-Making framework

The Situated Clinical Decision-Making framework incorporates context, foundational knowledge, decision-making processes, and thinking processes (Fig. 1). The framework and its theoretical foundations have been described in detail in a previous publication (Gillespie and Paterson, 2009). This article introduces a series of questions that will prompt for educators in the process of analyzing nurses’ clinical decision-making (Fig. 2).

Context

Nurses make clinical decisions within a multi-layered context that includes micro-level (nurse and patient in relationship), meso-level (nursing unit and health care agency) and macro-levels (profession, society and government). Each level potentially includes social, cultural, political, ideological, economic, historical, temporal, and physical factors that may influence clinical decision-making. There are aspects of each contextual level that require educators’ consideration when analyzing nurses’ clinical decision-making (see Fig. 2).

At the macro-level, the scope of nurses’ clinical decision-making is defined by the boundaries of professional nursing practice and influenced by the characteristics of the health care system. The meso-level of context incorporates the relational matrix within which nurses make their decisions and, in turn, emphasizes the importance of effective communication and the possibility of collaboration within clinical decision-making. Collaborative possibilities are strongly influenced by social aspects of the nursing unit such as unit culture, organizational structure, nursing workload, and the availability of appropriate persons with which to collaborate (Bucknall, 2003; Chase, 1995). Although often a source of support for clinical decision-making, the relational matrix may also embody challenges for nurses. The influence of interruptions and the need for nurses to refocus their thinking, have been noted to influence the quality of clinical decisions (Ebright et al., 2003; Hedberg and Larsson, 2004; McCarthy, 2003; Potter et al., 2005). Other meso-contextual factors reported as influencing decision-making include physical layout of the unit, time of day, and fiscal restraint (Bucknall, 2003).

The inclusion of the nurse and patient within the micro-level context highlights the relational nature of nursing practice and the ethical dimension inherent in all clinical decisions. In this regard, educators are prompted to consider moral issues as a source of difficulty within nurses’ clinical decision-making (Doane, 2002; Hartrick, 1997). In particular, as junior staff within the health care hierarchy, novice nurses may be uniquely challenged in maintaining moral agency within their decisions (Beckett et al., 2007). Theorists’ descriptions of the influence of

<table>
<thead>
<tr>
<th>Foundational knowledge: Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowing the profession</td>
</tr>
<tr>
<td>Knowing the self</td>
</tr>
<tr>
<td>Knowing the case</td>
</tr>
<tr>
<td>Knowing the patient/client</td>
</tr>
<tr>
<td>Knowing the person</td>
</tr>
</tbody>
</table>

Fig. 1. The Situated Clinical Decision-Making framework (Gillespie and Paterson, 2009). Reproduced with the permission of the National League for Nursing.
nurses’ experience on their clinical decision-making (Benner, 1984; Benner et al., 1996; Tanner, 2006) provide a benchmark for educators’ expectations regarding nurses’ clinical decision-making at various levels of practice. For example, novice nurses’ decision-making characteristically tends toward rule-based thinking, with a focus on task completion or responding to discrete patient issues while, in contrast, more experienced nurses are more likely to view patient situations as a whole and within context (Benner et al., 1996; Decker, 2006). Educators can also use these ‘benchmarks’ to consider the implications of the ‘fit’ between a nurse’s level of experience and patients’ acuity and complexity for nurses’ decision-making. Finally, the limiting influence of a lack of confidence on novice nurses’ clinical reasoning and decision-making should be considered (Etheridge, 2007; Haffer and Raingruber, 1998).

Overall, acknowledging that nurses’ clinical decision-making occurs within the larger context emphasizes the need for educators to differentiate contextual factors from nurse-related factors as a source of challenge for nurses’ clinical decision-making. When issues reside in the context (e.g., limited opportunities to

Context
Is there evidence that clinical decision-making is being influenced by

**Micro level**
- moral or ethical issues?
- the nurse’s experience level relative to the patient assignment?
- the nurse’s personal capacity for communication?
- the nurse’s confidence?
- patient complexity and acuity?

**Meso level**
- unit culture (e.g. nursing care priorities, collaborative practice)
- nursing workload and staffing patterns?
- availability of appropriate resources?
- lines of communication with the unit?
- physical layout of the unit?

**Foundational knowledge**

**Knowing the profession**
- Is the nurse’s decision-making within the scope of nursing practice?
- Does decision-making reflect expected competencies, skills and abilities for nurses in this practice setting?

**Knowing the self**
- Is the nurse aware of their strengths, limitations, skills, experience and learning needs as they relate to the situation?
- Is the nurse aware of the influence of personal beliefs, values, assumptions and preconceptions?

**Knowing the case**
- Does the nurse have adequate knowledge related to relevant patient populations, including pathophysiology, patterns in patient responses, and typical trajectories of progress?

**Knowing the patient**
- Does the nurse use case knowledge to build an understanding of the individual patient, including their baseline data, patterns in their responses, and physiological responses to pathology and treatment?

**Knowing the person**
- Does the nurse consider the patient’s experience of health and illness, as well as their preferences, supports and resources?

**Clinical decision-making processes**

**Cues**
- Are cues and their associated significance recognised? (e.g. abnormal patient responses, absence of expected responses).
- Are cues collected from multiple sources (e.g. observations, conversations, physical assessment, documentation, intuition)?

---

Fig. 2. Analyzing nurses’ clinical decision-making: guiding questions for educators.
collaborate) then effective support will entail altering the context, rather than focusing remedial action with the nurse.

**Foundational knowledge**

Nurses’ clinical decision-making is informed by foundational knowledge that arises from multiple dimensions: the nursing profession, self, and general and specific aspects of the patient situation (Fig. 1). The use of *knowing* rather than *knowledge* in naming the various dimensions reflects the need for nurses to move beyond ‘having’ knowledge: Effective decision-making entails active acquisition of new knowledge pertinent to the specific patient and situation, along with thoughtful use of existing knowledge. The defining attributes of each knowledge dimension provide direction for educators when analyzing nurses’ use of knowledge within their clinical decision-making (Fig. 2).

Nurses’ capacity for *knowing the profession* is made evident in clinical decision-making that reflects the scope and standards of nursing practice, and specific nursing unit roles, competencies and skills. *Knowing the self* highlights the importance of nurses’ awareness of all that they bring to a decision-making situation and, as such, offers a critical contribution to patient safety. Nurses’ capacity to reflect on their clinical judgment and their self-awareness are essential components in developing clinical decision-making capacity (Etheridge, 2007; Tanner, 2006). When considering this dimension of foundational knowledge, educators may explore nurses’ awareness of their strengths, limitations, skills, experience, and learning needs as they relate to the situation and their willingness to seek or offer help as appropriate. In addition, effective and ethically sound clinical decision-making will be grounded in nurses’ awareness of the potential for their beliefs, values, assumptions and preconceptions to influence their clinical decisions.
Case, patient or client and person dimensions (Liaschenko, 1997) encompass patient-related knowledge used in clinical decision-making (Fig. 1). In assessing knowing the case, educators will focus on nurses' understanding of the theoretical concepts related to general patient populations and, critically, their capacity to apply this knowledge in making clinical decisions. For novice practitioners, case knowledge will be drawn primarily from text books; with experience this base is expanded through the acquisition of experiential knowledge (Benner et al., 1996). Knowing the client or patient occurs when nurses use case knowledge to build an understanding of an individual’s clinical state, focusing on baseline information, patterns and trends in physiologic and diagnostic data. Knowing the person incorporates a patient’s past and current experience of health and illness, as well as their preferences, supports and resources. Knowing the patient and person are foundational to the provision of individualized nursing care and supports nurses’ anticipatory thinking (Ebright et al., 2003).

There are several issues that may influence nurses’ capacity to build knowledge that supports individualized clinical decision-making and nursing care. First, because case knowledge provides direction for knowing the patient and person, deficits in case knowledge will limit the nurses’ ability to build individualized knowledge. Second, nurses’ may have adequate case knowledge but, due to underdeveloped thinking processes, have difficulty using this knowledge to build patient and person knowledge, guide accurate problem identification, and to inform decision-making (del Bueno, 2005). Third, nurses’ experience will influence their capacity to build individualized knowledge. For example, novice nurses may experience difficulty building an understanding of patients as individuals when clinical situations are complex. With increasing experience, nurses begin to view situations more holistically and attend to patients as individuals (Benner et al., 1996).

The clinical decision-making process

In this framework, the phases that comprise the clinical decision-making process (i.e., cues, judgments, decisions, and evaluations of outcomes) are non-linear, inform and may be informed by one another. Questions provided in Fig. 2 guide analysis of each of these phases.

Cues

Nurses’ clinical decision-making processes are initiated when they recognize a cue from the patient; this may be either a particular patient response or the absence of something expected. From this beginning point, nurses collect additional cues from multiple sources in order to understand the situation.

There are several aspects of nurses’ cue collection that warrant consideration by educators. First, because assessment and communication are central to the process of cue collection, nurses’ competence in these areas will influence the quality of cue collection. Secondly, novice nurses’ reliance on rule bound thinking and lack of experiential knowledge challenges them completing appropriate cue collection (Benner et al., 1996). With limited ability to recognize salient aspects of a patient situation, novice nurses may collect a wide range of cues in a relatively non-discriminating manner, and then struggle with making sense of the accumulated information. Alternatively, either because of lack of knowledge, or in response to a real or perceived sense of urgency to ‘solve the problem,’ novice nurses may fail to collect adequate cues and subsequently form a judgment that is based in limited information (Taylor, 2002). Nurses’ lack of ‘a total picture’ of a patient situation emerged as a theme surrounding novice nurses’ near-miss and adverse-event situations (Ebright et al., 2004). Accordingly, analysis of this phase of nurses’ clinical decision-making process should consider the sources, scope and relevancy of cues collected as well as nurses’ recognition of patterns within cues and their capacity to assign meaning to cues.

Judgment

Judgment is defined as the best conclusion a nurse can reach at a point in time, given the information available (Gillespie and Paterson, 2009). This definition reflects the clinical reality in which nurses engage in a dynamic process, moving between possible judgments and cue collection. Ongoing cue collection informs, and is informed by, a nurse’s evolving understanding of the situation and continues toward a best conclusion. Analysis of this phase is guided by questions in Fig. 2.

There are several potential sources of error in the process of moving between cues and possible judgments to form a best conclusion. First, novice nurses’ limited knowledge base may result in them failing to consider and explore a full range of explanations for patients’ presenting cues, resulting in formation of an incorrect judgment (Chase, 1995; Taylor, 2002). Second, errors can occur when nurses fail to consider cues that do not fit their favored judgment: this may arise from a nurse’s sense of urgency to ‘make a decision,’ or from bias arising from misplaced confidence or lack of understanding. When a judgment is favored, nurses may collect cues to ‘rule in’ that judgment, and consequently narrow their scope of consideration. In contrast, when cue collection is structured to build evidence related to a variety of possible judgments and ultimately ‘rule out’ less likely explanations, the probability of an accurate judgment is increased (Evans, 2005). Similarly, errors may occur if, after forming an initial judgment, nurses fail to remain open to revising the judgment as new information emerges (Chase, 1995; Harbison, 1991). Finally, the time spent in collecting cues to confirm judgments must always be weighed against the patient’s clinical state. In more acutely ill patients, delay in forming a judgment may result in deterioration in patient condition. Safe practice is supported by nurses’ awareness of their progress toward forming a judgment (knowing self) and their willingness to seek assistance from other health care professionals.

Once a judgment is formed, the nurse assigns priority by ranking the judgment within concerns related to the individual patient as well as within an assigned group of patients. Appropriate priorities are congruent with patient care goals and reflect patient safety. Nurses’ ability to assign appropriate priority to judgments is influenced by their knowledge base and thinking processes. As well, nurses’ experience influences their vision of priorities in care, with novice nurses often placing emphasis on completion of assigned tasks, while more experienced nurses focus on care of patients and families more broadly (Benner et al., 1996). Finally, prioritization is influenced by various contextual factors including the nurse—patient relationship, resource availability, predominant patient-care philosophy, unit culture, and time-related factors (Bowers et al., 2001; Bucknall, 2003; Chase, 1995; Hendry and Walker, 2004).

Decision(s)

Having reached a ‘best conclusion’, the nurse must determine a course of action, a phase that requires consideration of both what should be done and how that should occur (Boblin-Cummings et al., 1999). The Situated Clinical Decision-Making framework acknowledges that nurses may enact decisions in various ways including ‘waiting and watching’ and ‘trying something’ (Gillespie and Paterson, 2009). When assessing this phase of nurses’ clinical decision-making, educators must differentiate between the outwardly similar states of choosing to ‘wait and watch’ and a delay in decision-making that arises from uncertainty. Inaction arising from uncertainty holds significant implications for patient safety, and highlights
the importance of nurses recognizing when they need to seek assistance. The decision option of ‘trying something’ recognizes a quality of testing that is inherent in many nursing decisions. In this decision variant, nurses choose to proceed with a tentative course of action but remain open to revising the actions as new information becomes available to them. Patient safety, and a focus for educator assessment, rests on the nurses’ ability to differentiate between consciously choosing to test a course of action versus trying something because they lack other alternatives, as well as the nurses’ capacity to revise actions based on patient responses. Finally, novice nurses’ concern about making a right decision can be a stalling point in this phase of their clinical decision-making process. The Situated Clinical Decision-Making framework frames the goal of the decision phase as a best decision, highlighting two relevant points for educators to consider. First, there may be more than one course of action that constitutes safe, appropriate, and ethical care. Second, the best decision will consider the uniqueness of the patient and the surrounding context.

**Evaluation of outcomes**

In the final phase of clinical decision-making, nurses consider the effectiveness of the decision, a process that requires effective assessment processes and adequate cue collection. In response to their conclusion regarding outcomes, nurses may return from evaluation to any point in the decision-making process, or may recognize the need for assistance and choose to involve another health care professional. These various possibilities guide educators in considering the effectiveness of the evaluative phase of nurses’ decision-making.

**Thinking**

The Situated Clinical Decision-Making framework makes explicit the critical contribution of critical, systematic, creative, and anticipatory thinking to clinical decision-making. This multidimensional perspective of thinking mirrors Tanner’s (2006) assertion that nurses use a variety of reasoning processes in making clinical decisions and offers guidance for educators in assessing nurses’ decision-making (see Fig. 2 for guiding questions).

Critical thinking underpins nurses’ inquiry and generative thinking and has been linked to effective clinical decision-making (Boney and Baker, 1997; Cruz et al., 2009; del Bueno, 2005). Critical thinking becomes evident in nurses’ ability to identify and challenge assumptions, values, and beliefs that they bring to a situation; consider the influence of context; generate possible explanations, judgments and decisions; and maintain reflective skepticism (Brookfield, 1987). Critical thinking ability may be inhibited by a variety of contextual factors including workload, time pressures, and a narrow focus on a patient issue (Ebright et al., 2004; Potter et al., 2005). Systematic thinking is reflected in nurses’ ability to collect, analyze and organize information in a methodical manner that supports pattern recognition, formation of sound judgments, selection of actions, and evaluation. Creative thinking is integral to and made evident in nurses’ responses to everyday challenges in the clinical environment that arise from patients’ individuality, increasing acuity and complexity of patients, and limitations in resources. Finally, anticipatory thinking or ‘thinking ahead’ is essential to prevention and early detection of potential patient problems, timely intervention when problems occur, alignment of specific decisions with broader patient care goals and, consequently, favorable outcomes for patients (Benner et al., 1999; Minick and Harvey, 2003). Anticipatory thinking also supports prioritization and workload planning (Ebright et al., 2003). Novice nurses’ predominant orientation toward present time and task completion, often limits their ability to think ahead. With experience, capacity for anticipatory thinking evolves, becoming evident at competent level of practice (Benner et al., 1996).

The inclusion of thinking in the framework is highly relevant to analysis of nurses’ clinical decision-making. First, by differentiating thinking from foundational knowledge, educators are prompted to consider both areas as possible sources of challenge: that is, to determine if nurses’ clinical decision-making issues arise from inadequate knowledge or from an inability to use various thinking processes to utilize existing knowledge to a specific patient situation. This differentiation is critical as many novice nurses experience challenges related to thinking within clinical decision-making. In a recent study, new graduates reported feeling unprepared and overwhelmed by the thinking required in the provision of patient care (Etheridge, 2007), while surveys of new graduates’ critical thinking and clinical judgment reveal poor performance in thinking processes (del Bueno, 2005).

**Using the framework**

Clinical nurse educator roles are enacted in various ways across the global nurse education community and, accordingly, afford different opportunities for assessment of nurses’ clinical decision-making. While the inherent complexity of the framework may be perceived as a constraint, its structure offers flexibility in its application. The framework can be used to guide an in-depth examination of a nurse’s clinical decision-making or a focused exploration of specific components of the larger decision-making process. The order of assessment is contextually dependent, with exploration potentially beginning at any component of decision-making and expanding to other aspects as appropriate. In all situations, the guiding questions (Fig. 2) streamline the assessment process by drawing an educator’s attention to relevant points for consideration. The questions are intended to guide inquiry: information related to these questions may be obtained through observation of clinical practice and through conversation with learners. Educators are cautioned against rigidly using the guiding questions as an ‘interview tool’. Instead, inviting the nurse to ‘talk through’ a clinical decision-making situation will provide insight not only into various phases of nurses’ clinical decision-making, but also their thinking processes and knowledge. The following example illustrates the use of Situated Clinical Decision-Making framework and questions as an analysis tool.

**Exemplar**

A clinical nurse educator (Jill) was working with a group of senior undergraduate nursing students. She was concerned about one student’s (Sue) ability to set appropriate priorities in providing care for acutely ill medical patients. To understand the influence of context on Sue’s clinical decision-making, Jill began by reviewing the meso-context of the situation. From the question “what opportunities exist for Sue to collaborate and consult?” Jill investigated the adequacy of unit staffing, influence of physical layout and unit culture on consultation, and workload (for Sue and her ‘buddy RN’). She looked for evidence of correlation between Sue’s capacity to prioritise and her workload and patient assignments. At the micro-context level, Jill considered Sue’s level of confidence, her communication ability, and the fit between her level of experience and the acuity of assigned patients.

Next, aware that adequate cue collection and judgment formation necessarily precede appropriate prioritization, Jill explored these phases of Sue’s decision-making process. To augment her previous observations of Sue’s decision-making, Jill arranged a time and location to talk with Sue. After outlining the purpose of their conversation, Jill focused Sue on a recent patient care situation. She
asked Sue to describe her actions, and to articulate her thinking related to those actions, including considerations about the patient's condition. As Sue shared her 'story', Jill listened for information relevant to the cues and judgments questions, as well as evidence of Sue's thinking processes and use of relevant knowledge. As the conversation continued, Jill's evolving understanding directed her ongoing exploration. For example, Jill noted that Sue's 'story' reflected limited cue collection and was unsure if this was a result of inadequate knowledge, thinking or contextual influences. Consequently, Jill explored Sue's case knowledge relevant to the situation, as well as her capacity to generate and use patient and person knowledge in decision-making processes. Jill concluded that workload and staffing patterns were significantly impacting Sue's opportunity to consult with her buddy RN. Further, it was evident that while Sue's knowledge in this situation was reasonable, her capacity to 'think ahead,' and consider the implications of planned actions, was not well developed. Ultimately, Jill identified two focal areas to support Sue in developing her clinical decision-making: First, to strengthen opportunities for consultation and collaboration and second, to build her capacity for anticipatory thinking. Her next step would be to select and implement relevant strategies.

Selection of strategies

Clear identification of the origin of issues within a nurse’s clinical decision-making sets the stage for selection of strategies that are aligned with developing the capacities needed for effective clinical decision-making. With a clear focus for development, educators may make meaningful selections from the numerous strategies and approaches for developing clinical decision-making that have been described in literature. Additionally, the Situated Clinical Decision-Making framework is designed to guide novice nurses in making clinical decisions in simulated and clinical practice. Previous publication includes questions that guide nurses in the phases of clinical decision-making, while the multidimensional knowledge base prompts nurses' use of various kinds of knowledge (Gillespie and Paterson, 2009). Educators can also use the framework as the basis for a rubric that describes levels of performance in clinical decision-making that in turn, can guide development (Lasater, 2007). Finally, the framework provides educators and nurses with a shared language for feedback regarding nurses' clinical decision-making (Gillespie and Paterson, 2009; Tanner, 2006).

Implications for education and research

The Situated Clinical Decision-Making framework has been used within specialty nursing education to support development of registered nurses’ clinical decision-making in classroom, distance and clinical learning environments (Gillespie and Paterson, 2009). The ready comprehension of this framework by registered nurses further suggests that clinical educators could easily be familiarized with the framework and the guiding questions, supporting its use within clinical nursing education. Anecdotal reports from clinical educators within specialty nursing programs indicate that the framework alone provides useful direction in assessing nurses' clinical decision-making. More recently, the guiding questions have been added to enhance its utilization by novice clinical educators. Finally, while this anecdotal evidence is encouraging, the use of the Situated Clinical Decision-Making framework as a tool to assess nurses’ clinical decision-making requires empirical testing.

Conclusion

The multidimensional nature of the Situated Clinical Decision-Making framework assists educators in 'unpacking' the complexity of nurses' clinical decision-making and identifying the source of issues than impair decision-making processes. By drawing attention to the many contextual factors that influence clinical decision-making, it prompts educators to make critical distinctions between issues arising from the context and nurse-related factors that influence nurses' decision-making. The various dimensions of foundational knowledge prompts consideration of nurses' self knowledge within their decision-making process, and highlights critical differences between understanding general theoretical concepts and using that information to build knowledge of individual patients. There are many variables that can disrupt the effectiveness of the process: By identifying the various phases of the clinical decision-making process, the framework guides educators in exploring a nurse's effectiveness in each of the phases. Finally, the inclusion of various thinking processes prompts educators to differentiate between clinical decision-making issues that arise from inadequate knowledge and concerns that have their origins in poorly developed thinking processes. By assisting educators to clearly identify sources of issues that contribute to a nurse's ineffective clinical decision-making, the possibility of effective support is enhanced. With a clearly identified issue, the educator is then able to work with the nurse to select meaningful and relevant strategies that will help develop clinical decision-making capacity.

Acknowledgment

The author acknowledges Dr. Barbara Paterson for her work in developing the original version of the Situated Clinical Decision-Making Framework.

References

Dillard, N., Sideras, S., Ryan, M., Carlton, M.H., Lasater, K., 2009. A collaborative project to apply and evaluate the clinical judgment model through simulation. Nursing Education Perspectives 30 (2), 99–104.


