MASTERING PRECEPTING

THIRD EDITION

BETH ULRICH

USD $54.95

PRECEPTORS

are the essential link between what healthcare providers are taught and what they do, and between what they know and what they *need* to know.

Preceptors have the power and opportunity to inspire nurses and other healthcare providers to achieve greatness. Effective precepting programs depend on two critical groups: those who organize and manage the programs and those who support, teach, and coach. Beth Ulrich and her team of expert contributing authors provide the knowledge, tools, skills, and wisdom both groups need for success.

Written for staff nurses and other care providers, managers, and educators, this third edition of *Mastering Precepting* teaches preceptors both the science and art of precepting and empowers them to seek the support they need to be effective. For managers, it emphasizes the importance of providing preceptors with positive and supportive experiences. For educators, it provides the information and knowledge required to develop and improve preceptor programs. This fully revised third edition covers:

- **NEW: Developing a professional identity**
- **NEW: The role and responsibilities of nursing professional development (NPD) practitioners in developing, supporting, recognizing, and retaining preceptors**
- **NEW: Preceptor competencies based on the ANPD national study**
- **Self-care for preceptors**
- **Information on developing, implementing, and evaluating preceptor programs**
- **Precepting advanced practice registered nurse students and new graduates**

Beth Tamplet Ulrich, EdD, RN, FACHE, FAONL, FAAN, is a Professor at the University of Texas Medical Branch School of Nursing in Galveston in the DNP Program, and Editor-in-Chief of the *Nephrology Nursing Journal*. She is a nationally recognized thought leader who is known for her research studying nursing work environments and the experiences of new graduate nurses as they transition from nursing school into the workforce.

"This book is brilliant, relevant, and a must-have resource for all preceptors and those supporting the lifelong learning journey of preceptors. This edition provides updated strategies for all preceptors and the ability to develop meaningful action plans to enhance the learning journeys."

–**Sylvain Trepanier**
DNP, RN, CENP, FAONL, FAAN
SVP, Chief Nursing Officer
Providence, Renton, Washington

"In today's turbulent healthcare environment, preceptors play a crucial role in the successful professional transition of nurses. The nurse tenure in acute care settings has dropped over the past years, and many of today's preceptors are new to their roles. Precepting is both an art and a science. This new edition of Mastering Precepting *provides an evidence-based road map for preceptor development and strategies to avoid preceptor burnout."*

–**Rose O. Sherman**
EdD, RN, NEA-BC, FAAN
Professor Emeritus
Florida Atlantic University
Editor-in-Chief, *Nurse Leader*

Sigma
GLOBAL NURSING EXCELLENCE

www.sigmamarketplace.org/sigmabooks

ISBN 978-1-64648-068-5

Mastering Precepting

Third Edition

Beth Tamplet Ulrich, EdD, RN, FACHE, FAONL, FAAN

The Sigma Theta Tau International Honor Society of Nursing (Sigma) is a nonprofit organization whose mission is developing nurse leaders anywhere to improve healthcare everywhere. Founded in 1922, Sigma has more than 135,000 active members in over 100 countries and territories. Members include practicing nurses, instructors, researchers, policymakers, entrepreneurs, and others. Sigma's more than 540 chapters are located at more than 700 institutions of higher education throughout Armenia, Australia, Botswana, Brazil, Canada, Chile, Colombia, Croatia, England, Eswatini, Finland, Ghana, Hong Kong, Ireland, Israel, Italy, Jamaica, Japan, Jordan, Kenya, Lebanon, Malawi, Mexico, the Netherlands, Nigeria, Pakistan, Philippines, Portugal, Puerto Rico, Scotland, Singapore, South Africa, South Korea, Sweden, Taiwan, Tanzania, Thailand, the United States, and Wales. Learn more at www.sigmanursing.org.

Sigma Theta Tau International
550 West North Street
Indianapolis, IN, USA 46202

To request a review copy for course adoption, order additional books, buy in bulk, or purchase for corporate use, contact Sigma Marketplace at 888.654.4968 (US/Canada toll-free), +1.317.687.2256 (International), or solutions@sigmamarketplace.org.

To request author information, or for speaker or other media requests, contact Sigma Marketing at 888.634.7575 (US/Canada toll-free) or +1.317.634.8171 (International).

ISBN: 9781646480685
EPUB ISBN: 9781646480692
PDF ISBN: 9781646480746
MOBI ISBN: 9781646481118

LCCN: 2023025306

First Printing, 2023

Publisher: Dustin Sullivan
Acquisitions Editor: Emily Hatch
Cover Designer: Michael Tanamachi
Interior Design/Page Layout: Rebecca Batchelor
Indexer: Larry D. Sweazy
Managing Editor: Carla Hall
Project and Development Editor: Rebecca Senninger
Copy Editor: Erin Geile
Proofreader: Todd Lothery

About the Author

Beth Tamplet Ulrich, EdD, RN, FACHE, FAONL, FAAN

Beth Ulrich is a nationally recognized thought leader who is known for her research studying nursing work environments and the experiences of new graduate nurses as they transition from nursing school into the workforce, and for her leadership in developing the roles of nephrology nurses and improving the care of nephrology patients. Ulrich has extensive experience as a healthcare executive, educator, and researcher. She is currently serving as a Professor at the University of Texas Medical Branch School of Nursing in Galveston in the DNP Program, and Editor-in-Chief of the *Nephrology Nursing Journal*, the professional journal of the American Nephrology Nurses Association. Ulrich has been a co-investigator on a series of national nursing workforce and work environment studies and five national studies of critical-care nurse work environments conducted with the American Association of Critical-Care Nurses.

Ulrich received her bachelor's degree from the Medical University of South Carolina, her master's degree from The University of Texas Health Science Center at Houston, and her doctorate in Allied Health Administration and Education from the University of Houston in a collaborative program with Baylor College of Medicine. She is a past president of the American Nephrology Nurses' Association, a fellow in the American Academy of Nursing, a fellow in the American College of Healthcare Executives, and a fellow in the American Organization for Nursing Leadership. She was recognized as the Outstanding Nursing Alumnus of the Medical University of South Carolina in 1989, as a distinguished alumnus of The University of Texas Health Science Center at Houston School of Nursing in 2002, received the Outstanding Contribution to the American Nephrology Nurses Association award in 2008, and received the Marguerite Rodgers Kinney Award for a Distinguished Career from the American Association of Critical-Care Nurses in 2018. Ulrich has numerous publications and presentations to her credit on topics including nephrology nursing, nurses' work environments, and how new graduate nurses transition into professional nurses.

Contributing Authors

Larissa Africa, MBA, BSN, RN, FAAN

Larissa Africa is the President & CEO of Versant Healthcare Competency Solutions and is responsible for its strategic and operational leadership. Africa is instrumental in driving Versant's mission to fundamentally transform healthcare outcomes by developing the workforce's ability to provide safe, efficient, competency-based care. She has spent two decades implementing, managing, and leading strategies to develop nursing organizations. As a pioneer in the transition to practice space, she has led the deployment of a competency-based model that integrates and standardizes nursing workforce development across the healthcare continuum, addressing high-demand areas such as long-term care, home health, and advanced practice nursing. Africa is a Fellow in the American Academy of Nursing. She is actively engaged in several committees within the American Organization for Nursing Leadership and is currently serving as the Foundation's treasurer. She presents at the national and international level, has published on the topic of transition to practice, and is a peer reviewer for several nursing journals.

Lauren A. Arrington, DNP, CNM, FACNM

Lauren Arrington is interested in applying tactics that emerge from social justice movements to achieve equity in perinatal care. She is an Assistant Professor in the Doctor of Nursing Practice Program at Georgetown University School of Nursing, a practicing midwife in Maryland, and has experience as a maternal health advisor for global health projects. She is a lead contributor to the Maryland Maternal Health Innovation Program's maternal health equity toolkit for Maryland hospitals. She serves on the Board of Commissioners for the Accreditation Commission for Midwifery Education and is an Associate Editor for the *Journal of Midwifery and Women's Health*. Her work leading a hospital-based quality improvement initiative to reduce peripartum racial and ethnic disparities was recognized with an award from the Alliance on Innovation and Maternal Health.

Cherilyn Ashlock, DNP, RN, NE-BC

Cherilyn Ashlock is the Director of Professional Practice at Johns Hopkins All Children's Hospital in St. Petersburg, Florida. Prior to coming to this role, Ashlock worked with Versant RN Residencies to support implementation of a clinical transition to practice program for new graduate registered nurses. In her current role as director for professional practice, Ashlock oversees clinical and unit-based onboarding, development, and education, nursing research, and nursing quality outcomes. Under her leadership, Johns Hopkins All Children's continues to develop their transition to practice programs, as well as build upon the preceptor role for nursing and patient care services. Ashlock completed her Doctor of Nursing Practice degree in executive leadership at Old Dominion University in 2017 and focused her capstone work on interventions to prevent missed nursing care in the pediatric acute care environment.

Cindy Bianchini, DNP, RN, NPD-BC

Cindy Bianchini is the Director of the RN Residency Program at Legacy Health in Portland, Oregon. She received her DNP from The University of South Alabama 2019 and her master's degree in nursing in 2016. Her clinical background is in perioperative nursing, spending five years as a system-wide educator for surgical services, helping to onboard new employees and facilitate ongoing professional development. Bianchini assumed responsibility for the Legacy RN Residency program in its fifth year and has led the building and development of the current program including specialty competencies, a mentor program, curriculum design, and guiding subject-matter experts. She also oversees preceptor development and support with a focus on continuous quality improvement.

Carol A. Bradley MSN, RN, FAONL

Carol Bradley is a nationally known speaker and frequent contributor to journals, media, and professional publications on topics important to nursing and workforce development. She is currently the chief nurse executive for Prolucent Health focused on workforce management technology and services. She previously served as system chief nurse executive for Legacy Health, an eight-hospital system in the Pacific Northwest, as well as nursing executive roles in several other prominent health systems on the West Coast.

Bradley holds a master's degree from the University of Arizona and is a 1991 Wharton Fellow and a Fellow in the American Organization for Nursing Leadership, where she served as president in 1999. She has served on numerous boards, including the Association of California Nurse Leaders (President), California Association of Hospitals, the Oregon Association of Hospitals and Health Systems (Chair), and the Commission on Foreign Nursing Schools (President). She has contributed to several books and serves on the editorial board of *Nursing Administrative Quarterly*. In 1999, she received the DAISY Lifetime Achievement Award.

Cathleen M. Deckers, EdD, RN, CNE, CHSE

Cathleen Deckers has over 40 years of nursing education experience in both the service and academic arenas. Her academic areas of expertise include utilization of high-fidelity simulation for education and competency assurance, online learning with active learning strategies, and virtual reality/gaming simulation. She is an active participant on the Accreditation Council for the Society of Simulation in Healthcare, working to improve standardization of simulation practices internationally. She serves as the Director of the ISEP simulation education program for the International Nursing Association for Clinical Simulation and Learning. Deckers currently works as an Associate Professor of Nursing at California State University, Long Beach. Prior to coming to this role, Deckers worked as Vice President, Nursing Professional Practice, Education, and Nursing Operations for Glendale Memorial Hospital and Health Center in Glendale, California. In this role she provided oversight and direction to the precepting of new nurses to the facility.

Amy K. Doepken, MSN, RN

Amy Doepken is the Director of Patient Care Services at Legacy Salmon Creek Medical Center in Vancouver, Washington. Doepken holds a BSN from the University of Portland and a master's degree in health system leadership from Gonzaga University. She has partnered with the University of Portland to adopt their Dedicated Education Unit model and previously served as the program director for the Legacy Health RN Residency Program. She has a passion for promoting a positive preceptor experience and was instrumental in the design and development of Legacy's preceptor program, including debriefing and mentoring. Doepken completed the AONL Nurse Manager Fellowship program and was the AACN 2010 Circle of Excellence Award winner in 2010.

Virginia Downie, MSN, RN-BC, NPD-BC

Virginia Downie previously served as the Nursing Education and Practice Specialist at Legacy Health in Portland, Oregon. She provided program support for the Legacy RN Residency Program in the areas of curriculum, mentorship, and preceptorship. She spearheaded the development of the Preceptor Program, including recruitment, training, support, and recognition for RN and non-RN preceptors throughout the organization. Downie received her master's degree in nursing education from Nebraska Methodist College in 2014 and is board certified as a Nursing Professional Development Specialist.

Denise D. Fall, DNP, RN

Denise Fall recently retired as President, Legacy Good Samaritan Medical Center. She also served for many years as Chief Nursing Officer at both Legacy Good Samaritan and Legacy Salmon Creek Medical Centers. Fall received her DNP from the University of San Francisco. She is known for building strong collaborative teams who drive quality and patient outcomes. Fall also served on the board of the Oregon Center for Nursing.

Nelda Godfrey, PhD, ACNS-BC, RN, FAAN, ANEF

Nelda Godfrey is Professor and Associate Dean for Innovative Partnerships and Practice at the University of Kansas School of Nursing. A thought leader in nursing innovation and nursing education, Godfrey writes often on new care delivery models that can be influenced by a stronger emphasis on the nurse within—researching and developing strategies to create the whole person experience in nursing practice going forward. Her work with the International Society for Professional Identity in Nursing is transforming the way nurses, healthcare professionals, and society understand what it means to "think, act and feel like a nurse." This work offers new language and new knowledge for the journey—helping nurses heal, flourish, and expertly care for others. Godfey also serves and the chair of the American Nurses Association Ethics and Human Rights Advisory Board.

Mary S. Haras, PhD, MBA, APN, NP-C, CNN

Mary Haras is an Associate Professor in the School of Nursing at Georgetown University and teaches in the DNP program. Prior to this role, Haras was the Chair, Department of Advanced Nursing Practice at Georgetown University, and Associate Dean for Graduate Nursing at Saint Xavier University. Haras completed her PhD in nursing at Mennonite College of Nursing–Illinois State University in 2014 with her dissertation focus on measuring nephrology nurse perceptions of advance care planning. Haras is currently a member of the *Nephrology Nursing Journal* Editorial Board.

Mary Harper, PhD, RN, NPDA-BC

Mary Harper is the Director of Research and Inquiry for the Association for Nursing Professional Development (ANPD). She obtained her master's degree in nursing administration from the University of Florida and her PhD in nursing from the University of Central Florida. She is a former Director on the Board of Directors of ANPD and has published widely on topics and research related to nursing professional development and precepting. She is co-editor of the 3rd and 4th editions of *Nursing Professional Development: Scope and Standards of Practice*.

Cindy Lefton, PhD, RN, CPXP

Cindy Lefton has combined her knowledge as an organizational psychologist with her extensive experience as a registered nurse to develop strategies aimed at helping hospitals across the country positively impact their communication and collaboration. As a Consultant for Psychological Associates and a Staff Nurse in both the emergency department and the Women's Infusion Center at Barnes-Jewish Hospital in St. Louis, Missouri, Lefton utilizes a variety of evidence and resources to guide patient care areas in creating and sustaining healthy work environments and positively impacting patient perceptions. Lefton has published articles on communication, collaboration, and meaningful recognition and has presented these topics at various national conferences. Lefton has served as member of the Editorial Board for the *Journal of Trauma Nursing*, an Associate Editor for the *Journal of Emergency Nursing*, and is currently the Director of Patient Experience for The DAISY Foundation.

Robert E. Lefton, PhD

Robert Lefton passed away in 2022 as we were preparing this chapter for the 3rd edtion. He was co-founder, Chairman and CEO of Psychological Associates, Inc., St. Louis, Missouri. As a leading United States consultant in leadership and organization development, he worked with many of Fortune's top 500 companies. Lefton also served on the faculty of Washington University, the Motorola Executive Institute, the ALCOA Executive Institute, and CEO International, Inc. As one of the original developers of Dimensional Training, he conducted seminars for and consulted with several hundred leading corporations in the United States and Europe. Lefton co-authored five books, and a contributed to various business journals as Sales Meetings, Training & Development Journal, National Productivity Review, and Marketing. Lefton served on the Board of Directors for Stifel, Nicolaus & Company, Inc., Barnes-Jewish Hospital of St. Louis, and numerous privately held and family-owned businesses.

Patsy Maloney, EdD, MSN, RN, NPD-BC, CEN, NEA-BC

Patsy Maloney is a Teaching Professor at the University of Washington Tacoma. She earned her master's degree as an Adult Health Clinical Nurse Specialist from Catholic University of America and her EdD in Higher, Adult, and Professional Education from the University of Southern California. She is past president of ANPD (2018–2020). She is co-editor of *Nursing Professional Development: Scope and Standards of Practice*, 3rd and 4th edition, and *NPD Anthology: Making a Difference* and has written numerous articles and book chapters on professional development and leadership.

Kim A. Richards, RN, NC-BC

Kim Richards, an ANCC Board Certified Nurse Coach, inspirational speaker, and author, is passionate about coaching people to create the life they've dreamed. She combines over 30 years of resiliency research into the components of Self-Care Academy. Her extensive research on the science of self-care and burnout prevention has been widely published. A book of her personal journey is in the works. Combining her love for sailing and inspiring others, Richards and her husband are living their dream by crewing a luxury charter sailing catamaran in the Caribbean.

Laura Lynn Rooney, DNP, RN, FNP-BC, BC-ADM, FAANP

Laura Rooney has over 25 years of nursing and advanced nursing practice experience, and more than 10 years in nursing education, focusing on the advanced practice role. Rooney has been a family nurse practitioner in primary care, pain management, occupational health, and rural medicine. As director of a nurse-managed clinic, Rooney was successful in implementing the first certified Diabetes Education Management Program in the system, followed by Level 3 recognition from the National Center for Quality Assurance as a Patient Centered Medical Home—the first nurse-managed clinic with this distinction in the health system. As the director and head administrator for the clinic, Rooney was instrumental in establishing protocols and procedures, recruiting and retaining staff, and facilitating teamwork while demonstrating leadership. She now holds a clinical operations and research position with a focus on development of novel therapeutics to treat acute and chronic disease.

Lori Shank, DNP, RN, CPN

Lori Shank is Director of the Registered Nursing program at Johnson County Community College in Overland Park, Kansas. In her current role as Program Director, Shank leads the registered nursing department in accordance with local, state, and professional education essentials and practice. She is also involved in fostering clinical agency affiliations and relationships, coordinating the RN didactic and clinical curriculum, and facilitating matriculation of students through a selective admission process and transition to professional credentialing and practice. Prior to this role, she was a full-time nursing faculty member at the same institution since 2014, teaching didactic and clinical courses in a concept-based curriculum across the life span.

Shank has been a registered nurse for 28 years, beginning her career at the bedside in medical-surgical acute care nursing and also working in family practice, Phase 1 clinical research, and pediatric acute care nursing. She retains her pediatric nurse certification and completed her DNP degree in nursing organizational leadership at the University of Mary in 2023, focusing her leadership practicum experiences on interprofessional collaboration, innovation, and professional identity in nursing. Her collaboration with Nelda Godfrey on Chapter 5 was an outcome of her doctoral preceptorship with Godfrey during the summer of 2022.

Laurie Shiparski, MS, BSN, RN

Laurie Shiparski has over 30 years' experience in nursing and healthcare leadership positions. She has worked in various roles including critical-care RN, clinical hospital leadership, healthcare consulting business owner, and corporate executive in a healthcare technology and clinical practice company. She is currently a principal at Edgework Institute. As a consultant, Shiparski works in partnership with hospital leadership on leadership development and coaching, communication, physician-driven practice improvement, strategy, and operations improvement. Shiparski has sought to uncover her gifts and bring her authentic self to work and life, which has inspired her to offer programs that focus on taking care of self, navigating change, finding passion and purpose, and creating new possibilities. She is also an international speaker and an author of numerous articles and five books.

Kelly C. Walker, DNP, CNM, FACNM

Kelly C. Walker is an Associate Professor and the Director of Evaluation and Outcomes at Georgetown University's School of Nursing. Prior to that she was an Assistant Professor and program director for the Nurse Midwifery & Women's Health Nurse Practitioner Program at Georgetown University School of Nursing and Health Studies. She was a member of the Regional Perinatal Center at Upstate Medical University as a Certified Nurse Midwife and faculty member and in a community outpatient setting. She holds a bachelor's degree in English from Russell Sage College, a bachelor and master's degree in nursing from New York University and a DNP degree from Stony Brook University. Walker also completed a post-doctorate fellowship in leadership and education at Stony Brook University.

Joan Insalaco Warren, PhD, RN, NPD-BC, NEA-BC, FAAN

Joan Warren is the former Executive Director for the Maryland Organization of Nurse Leaders, Inc./ Maryland Nurse Residency Collaborative and former president (2014–2016) and board member of the ANPD. She earned her master of science as a Trauma/Critical Care Clinical Nurse Specialist and doctor of philosophy in nursing from the University of Maryland Baltimore School of Nursing. She is nationally recognized for her research, publications, book chapters, and presentations addressing workforce advancement of nursing professional development practitioners, preceptors, and entry-to-practice nurses.

Table of Contents

Foreword by Kathleen Sanford

This is the third edition of this wonderful book, and I think it is even better than the preceding versions. That is an especially impressive accomplishment because the first and second editions were both recipients of American Journal of Nursing Book of the Year Awards. The updated information in this version comprises an equally well written and comprehensive compendium about the art and science of precepting, with the addition of two new important and timely chapters.

Beth Ulrich and her contributing colleagues discuss the various roles of a nurse preceptor in depth while also addressing the needs of preceptees, managers, and their organizations. They focus on crucial topics such as resilience, compassion fatigue, mindfulness, Just Culture, critical thinking, and the use of instructional technologies. Their practical guidance covers all these topics to help nurses bridge the gap between theoretical knowledge and the reality of practice. The newest chapters address the importance of professional identity and the role of nursing professional development practitioners in educating, developing, and supporting preceptors.

I know that this book will be of value to readers, regardless of their current and future professional career choices. The year I started my nursing career, Marlene Kramer's book Reality Shock: Why Nurses Leave Nursing was published. Among other things, she spelled out the merits of preceptorship to mitigate the reality shock that new nurses experience. Almost 50 years later, preceptors are needed more than ever. Our profession is experiencing an unprecedented turnover rate among graduate nurses. Some of my nurse executive colleagues report that a number of these graduates indicate they will leave the profession. While we know that there are a variety of strategies we need to implement to reverse this exodus, a major tactic is to provide a better experience for our newest colleagues. That includes pairing them with experienced nurses who have been well prepared as educated preceptors.

It is widely accepted that new nurses need help to successfully navigate the change from academia to their working lives. However, they are not the only ones who will benefit from precepting. While it is essential that new graduates are paired with preceptors who welcome them into our profession, nurses who choose to pursue positions in new and different specialties could have equally enriched experiences when they have preceptors to guide them.

That's why I am so grateful for this book. Nurses are increasingly telling leaders that they want opportunities to grow as professionals and as individuals. Very few of those who are early in their careers indicate that they will want to stay in the same job for more than a few years. I am not worried about that trend. We have always been a profession that encourages lifelong learning, and it makes intuitive sense that our colleagues may want to experience more variety in their careers. I believe that

we should encourage our colleagues to pursue new adventures in nursing. We should help them do that by ensuring that they are supported by preceptors who are proficient in a variety of teaching, coaching, role-modeling, and leadership skills. This complete guide helps ensure that they will be.

–Kathy Sanford, DBA, RN, FACHE, FAAN
Executive Vice President/Chief Nursing Officer
CommonSpirit Health

Foreword by Gwen Sherwood

The familiar adage "It takes a village" fits the process of developing each generation of nurses. Academic educators cannot alone prepare each generation of nurses capable of safe, quality practice. It requires a village of educators, role models, coaches, clinical experts, and managers, all part of the healthcare education and delivery systems working in tandem to educate for the future. The evolution of academic-practice partnerships offers updated models and expectations of preceptors as a core part of academic education, integrating precepted learning as a core educational experience helping learners socialize their identity into practice.

Healthcare delivery settings are dynamic—constantly changing to match societal needs for maintaining the health of the public. Nursing is a critical universal profession existing in some form in every country, situating nurses as the largest healthcare professional group in the world. Assuring nurses are prepared to confront current work world demands largely depends on relevant workplace learning experiences best guided by skilled preceptors.

Nursing educators in both academic and clinical settings have the responsibility for designing, implementing, and evaluating workplace learning experiences to maintain a well-prepared nursing workforce. With advancing technology driving developments in treatment, managing, and documenting healthcare interventions and health promotion models, preceptors are a logical, necessary, and effective choice for guiding learners regardless of level in adapting to new settings and responsibilities.

Finding effective ways to coach, guide, mentor, and role-model learners—all part of the preceptor model—has become increasingly challenging. Preceptors have a vital role in preparing the nursing workforce during academic programs, in the transition to new employment, and anytime a nurse changes roles and responsibilities. Pre-licensure focuses on generalized practice as a nurse, yet the real world operates along population health models and specialty practice. Preceptors are an inherent aspect of helping nurses transition, whether from academia to practice or to a new area of practice.

To appreciate the complexity of the nurse preceptor role, we can turn to Benner et al. (2010), who describe nursing preparation as an apprenticeship comprised of three essential aspects:

- Acquiring and using knowledge and science
- Using clinical reasoning and skilled know-how
- Ethical comportment and formation

Developing as a nurse both at the new graduate and graduate specialty level emphasizes a multifaceted phased approach to expectations for lifelong learning across one's nursing career. Apprenticeship

enables and guides experiential learning that takes place by interacting with a community of practice. Learning in a community of practice—that is, workplace learning—situates learning within the context of a particular setting and population in which learners are coached by teachers or preceptors role-modeling aspects of complex practice that are not readily attained through didactic learning. Preceptors, employees of healthcare delivery settings, are vital in that they have current experience in applying knowledge through evidence-based practice guided by clinical reasoning, applying up-to-date clinical skills working within ethical principles of fairness and justice.

A strength of this third edition of *Mastering Precepting* in its description of the preceptor model is its grounding in the knowledge, skills, and attitudes of precepting consistent with the apprenticeship model set forth by Benner and team. These apprenticeships provide a preceptor framework easy for faculty and clinicians to follow in capturing the essence of workplace learning. The book is a ready access guide to selecting nurses with the mindset, preparation, and skills to coach, guide, and facilitate learners based on accepted standards, assuring quality precepting. Precepting is bidirectional, with responsibilities on the part of the preceptee and their supervisor or educator, in addition to knowing the role and responsibilities of the manager and the organization.

Experience alone does not assure professional identify formation grounded in safety and quality standards of practice. Reflection on experience is an essential part of workforce development in taking the professional identity of professional nursing (Armstrong & Sherwood, 2023). Preceptors and educators work together in emphasizing reflective practice as a workplace learning strategy, guiding learners in reflecting before, in, and on action to consciously integrate social learning of the professional role.

This book is further notable for the expertise of the editor, Dr. Ulrich, an expert recognized across the profession for her research and professional advancements in workforce development. It is easy to assume that any nurse can be a preceptor, but as the chapters in this book unfold, the competencies, theoretical underpinning, and expectations reveal a robust role. Novices look up to their preceptors as key sources of professional identity formation, now emphasized in the essential competencies of the American Association of College of Nursing (2021). This book is a clarion call for investing in preceptors as a critical aspect of nursing workforce development to prepare nurses capable of delivering safe, quality care, fulfilling the workplace needs of the world's largest healthcare workforce.

–Gwen Sherwood, PhD, RN, FAAN, ANEF
Professor Emeritus
University of North Carolina at Chapel Hill

References

American Association of Colleges of Nursing. (2021). *The essentials: Core competencies for professional nursing education.* Author.

Armstrong, G., and Sherwood, G. (2023). Reflective learning: Recalibrating collaboration and evaluation for safety and quality competencies. In S. Horton-Deutsch and G. Sherwood (Eds.), *Reflective practice: Reimaging ourselves, reimaging nursing* (3rd ed.). Sigma Theta Tau International.

Benner, P., Sutphen, M., Leonard, V., & Day, L. (2010). *Educating nurses: A call for radical transformation.* Jossey-Bass.

Introduction

"Live as if you were going to die tomorrow. Learn as if you were going to live forever."

–Mahatma Gandhi

Preceptors live at the intersections of education and practice and of the present and the future. They practice at the point where theoretical learning meets reality and where the gap between current and needed knowledge and expertise gets filled. Preceptors are the essential link between what nurses are taught and what they do, and between what nurses know and what they need to know. Having competent preceptors is critical to educating nursing students, transitioning new graduate nurses to the professional nursing role, and transitioning experienced nurses to new roles and specialties.

Preceptors teach at the point of practice. They create experiences in which the preceptee can engage and learn. Benner and colleagues (2010, p. 42) noted that "only experiential learning can yield the complex, open-ended, skilled knowledge required for learning to recognize the nature of the particular resources and constraints in equally open-ended and undetermined clinical situations," and that "experiential learning depends on an environment where feedback in performance is rich and the opportunities for articulating and reflecting on the experiences are deliberately planned" (p. 43). Preceptors must be knowledgeable and competent in their specific clinical or functional area and in the preceptor roles of role model, teacher/coach, facilitator, protector, socialization agent, leader/influencer, and evaluator.

Myths

Several myths about preceptors and precepting need to be dispelled. The first is that because you are a good clinical nurse, you will be a good preceptor. While preceptors do indeed need to be competent in the area of nursing they will be precepting, becoming a preceptor is like learning a new clinical specialty. Although some previously learned knowledge and skills are useful, there is much more to learn before you become a competent preceptor. The next myth is that you have to be an expert clinician to be a preceptor. In many cases, being much more expert than the person you are precepting can be a hindrance and is frustrating to the preceptor and the preceptee. Yet another myth is that precepting must work around whatever patient assignment is made and whatever is happening on the unit. Such activity is not precepting. It is ineffective at its best and, at its worst, disheartening and anxiety-provoking for the preceptor and the preceptee. Every nurse deserves a competent preceptor and a safe, structured environment in which to learn. That is not to say that every precepting activity will go as planned. It will not. There is much unpredictability in the nursing work environment, but precepting activities must start with a plan based on the needs of the preceptee and the outcomes that must be obtained. Part of the competence of preceptors is making the plan, adjusting when the need arises, and recognizing and using teachable moments.

The Third Edition

When we wrote the first edition of *Mastering Precepting*, there was not a lot of information available on precepting, and most of the information that was available was largely focused on precepting pre-licensure nursing students in the clinical setting. The good news is that since the first edition, there has been an increased awareness of the importance of the use of preceptors and the need to educate and support RNs who transition into the preceptor role.

In preparation for developing the second and third editions, we asked for input and suggestions for improvement from people who had used the previous editions of the book—preceptors and those who developed and implemented preceptor programs. In this third edition, all of the chapters have been updated with the most recent evidence. In addition, two new chapters have been added—one on professional identity (Chapter 5) and one on the role and responsibilities of nursing professional development practitioners in developing, supporting, recognizing, and retaining preceptors (Chapter 15).

Who Should Read This Book

This book is written for individual preceptors and to be a resource for those who are developing or improving preceptor programs. The book is both evidence-based and pragmatic. It provides information on the why and the how and is written in a style that can be easily read by busy registered nurses who are moving into the preceptor role and by current preceptors who want to improve their practice.

Book Content

The chapters in the book build on each other and are designed to be read in order.

- Chapter 1 is an introduction to precepting and discusses the context in which precepting occurs and all the aspects of the preceptor role.
- Chapter 2 provides an overview of learning theories, learning stages, learning styles, and learning preferences.
- Chapter 3 is on core precepting concepts including developing competence and confidence; critical thinking, clinical reasoning, and clinical judgment skills; and situational awareness, expert reasoning, and intuition.
- Chapter 4 offers an overview of precepting strategies, beginning with the preceptor and manager setting role expectations and responsibilities.
- Chapter 5 is a new chapter, written by Nelda Godfrey and Lori Shank, on developing professional identity.
- Chapter 6 is about planning experiences for preceptees and developing and using goals, objectives, and outcomes.

- Chapter 7 discusses communication skills, preceptee handoffs, and managing difficult communication.
- Chapter 8 provides information on coaching—establishing, conducting, and ending a coaching relationship.
- Chapter 9 presents an overview of instructional technologies—from web-based strategies to high fidelity human patient simulation and virtual reality—and details on when and how to use the technologies effectively.
- Chapter 10 offers information and strategies on specific learner populations—pre-licensure nursing students, new graduate registered nurses, post-baccalaureate graduate students, experienced nurses learning new specialties or roles, internationally educated nurses, and nurses from different generations.
- Chapter 11 has details specific to precepting advanced practice registered nurses in student and graduate roles.
- Chapter 12 discusses assessing, addressing, and influencing preceptee behaviors and motivation and providing preceptees with action-oriented feedback as well as using Just Culture as a problem-solving framework.
- Chapter 13 offers pragmatic information on the day-to-day performance of the precepting role including organization and time management, delegation, problem-solving preceptor-preceptee relationships, and addressing challenging behaviors.
- Chapter 14 discusses the need for preceptors to practice self-care behaviors and provides suggestions to prevent burnout and create optimal healing environments.
- Chapter 15, a new chapter, discusses the role and responsibilities of nursing professional development (NPD) practitioners in developing, supporting, recognizing, and retaining preceptors.
- Chapter 16 is designed for managers and discusses how to select, support, and sustain preceptors.
- Chapter 17 includes information on developing preceptors and on developing, implementing, and evaluating preceptor programs.

You will find a Preceptor Development Plan at the end of the first 14 chapters, an NPD Practitioner Plan at the end of Chapter 15, a Manager Plan at the end of Chapter 16, and a plan to do an initial assessment in preparation for developing a preceptor program at the end of Chapter 17. The Preceptor Development Plans are templates for preceptors to use to create their own development plans. The templates are available as modifiable documents (Microsoft Word, but compatible with Google Docs) from SigmaNursing.org/MasteringPrecepting3 and from RNPreceptor.com for use by individuals or

organizations. By putting your own plan in writing, you will be making a commitment to implement the plan. For organizations, the plans can be used to set goals and measure progress for participants in preceptor programs.

More Information Online

The author has an accompanying website (RNPreceptor.com) that provides additional resources for preceptors and preceptor education. Follow @RNPreceptor on Twitter to ask questions or share your own experiences.

Final Thoughts

It has been heartening to see the increased attention paid to developing and supporting preceptors since we published the first edition of *Mastering Precepting*. New graduate registered nurse residencies have become the norm, and fellowships for advance practice nurses are on the rise. Certification programs for residencies and fellowships have been developed, and recognition programs for individual preceptors are increasing. We have made great progress, but to continue that progress, we must ensure that all preceptors are given the knowledge and support they need to succeed.

Precepting is a complex endeavor that requires competence and commitment. By becoming a preceptor, you have accepted the professional responsibility of sharing your knowledge and expertise with others. There is no greater contribution to nursing and to patient care than to ensure the competence of the next generation of nurses.

–Beth Tamplet Ulrich, EdD, RN, FACHE, FAONL, FAAN
BethTUlrich@gmail.com

Reference

Benner, P., Sutphen, M., Leonard, V., & Day, L. (2010). *Educating nurses: A call for radical transformation*. Jossey-Bass.

"The most important practical lesson that can be given to nurses is to teach them what to observe, how to observe, what symptoms indicate improvement, what the reverse, which are of importance, which are of none, which are evidence of neglect and of what kind of neglect."

–Florence Nightingale

3

Core Precepting Concepts

Beth Tamplet Ulrich, EdD, RN, FACHE, FAONL, FAAN

OBJECTIVES

- Understand development of competence
- Understand critical thinking, clinical reasoning, and clinical judgment and how to help preceptees develop each skill
- Understand the development of preceptee confidence
- Understand core concepts of nursing practice

At the heart of any precepting experience is the development of competence, the development of ability and expertise to effectively utilize that competence, and the confidence to take action when needed. Combined with other core precepting concepts, these form the foundation of effective, safe nursing practice.

Competence

Professional competence is required of all RNs. Although we mostly talk about clinical competence for nurses, all nursing roles and positions require competence. The purposes of ensuring the competence of nurses are to protect the public (the primary purpose), advance the profession, and ensure the integrity of the profession.

Competence is included in the *Nursing Scope and Standards of Practice* education standard: "The registered nurse seeks knowledge and competence that reflects current nursing practice and promotes futuristic thinking" (American Nurses Association [ANA], 2021, p. 98) and in the *Code of Ethics*: "The nurse owes the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth" (ANA, 2015, p. 73). In addition, the ANA Position Statement on Professional Role Competence (ANA, 2014) defines competence and competency and identifies principles for addressing competence in the nursing profession (see sidebar).

ANA Position Statement on Professional Role Competence

The public has a right to expect registered nurses to demonstrate professional competence throughout their careers. ANA believes the registered nurse is individually responsible and accountable for maintaining professional competence. The ANA further believes that it is the nursing profession's responsibility to shape and guide any process for assuring nurse competence. Regulatory agencies define minimal standards for regulation of practice to protect the public. The employer is responsible and accountable to provide an environment conducive to competent practice. Assurance of competence is the shared responsibility of the profession, individual nurses, professional organizations, credentialing and certification entities, regulatory agencies, employers, and other stakeholders.

Source: ANA, 2014, p. 1

The ANA (2014) defines a *competency* as "an expected level of performance that integrates knowledge, skills, abilities, and judgment" (p. 3). Knowledge, skills, ability, and judgment are defined as follows (ANA, 2014, p. 4):

- *Knowledge* encompasses thinking; understanding of science and humanities; professional standards of practice; and insights gained from context, practical experiences, personal capabilities, and leadership performance.
- *Skills* include psychomotor, communication, interpersonal, and diagnostic skills.
- *Ability* is the capacity to act effectively. It requires listening, integrity, knowledge of one's strengths and weaknesses, positive self-regard, emotional intelligence, and openness to feedback.
- *Judgment* includes critical thinking, problem-solving, ethical reasoning, and decision-making.

Requirements for competence and competency assessment have been established by national nursing and nursing specialty organizations, state boards of nursing credentialing boards, and statutory and regulatory agencies. The presence (or absence) of competence can also be a legal issue.

The ANA Position Statement on Professional Role Competence states:

> Competence in nursing practice must be evaluated by the individual nurse (self-assessment), nurse peers, and nurses in the roles of supervisor, coach, mentor, or preceptor. In addition, other aspects of nursing performance may be evaluated by professional colleagues and patients/clients. (ANA, 2014, p. 5)

ANA Principles for Competence in the Nursing Profession

- Registered nurses are individually responsible and accountable for maintaining competence.
- The public has a right to expect nurses to demonstrate competence throughout their careers.
- Competence is definable, measurable, and can be evaluated.
- Context determines what competencies are necessary.
- Competence is dynamic, and both an outcome and an ongoing process.
- The nursing profession and professional organizations must shape and guide any process assuring nurse competence.
- The competencies contained in ANA's various scope and standards of practice documents are the competence statements for each standard of nursing practice and of professional performance.
- Regulatory bodies define minimal standards for regulation of practice to protect the public.
- Employers are responsible and accountable to provide an environment conducive to competent practice.
- Assurance of competence is the shared responsibility of the profession, individual nurses, regulatory bodies, employers, and other key stakeholders.

Source: ANA, 2014, pp. 6–7

Competence is not about checking items off a list. In fact, the frequent use of terms such as "competency checklist" and "checking off preceptees" devalues the work required to develop and maintain competence and makes the process of validating competence sound as if it requires little thought—that it is merely an inconsequential nuisance and a documentation chore to be completed as quickly as possible. Nothing could be further from the truth. The validation of competence is one of the most critical elements to ensure safe, high-quality patient care and competent role performance.

As the 2021 American Association of Colleges of Nursing *Essentials* point out:

> Some learners will achieve select competency outcomes more quickly than others. One and done, however, does not demonstrate the progressive and consistent nature of competency attainment and the assessment necessary in nursing professional education. Repetition plays a role in reinforcing previously acquired knowledge, skills, values, and attitudes. Repetition also allows for intentional and unintentional complexities and context nuances to be introduced, thus building on minimum competency thresholds. (p. 22)

Competence Development

Seeking to better understand the development of competence, the National Council of State Boards of Nursing (NCSBN) completed a qualitative longitudinal (five-year) study of a national sample of nurses from 2002 to 2008 (Kearney & Kenward, 2010). By the end of the fifth year, nurses had identified and demonstrated five characteristics of competence:

- Juggling complex patients and assignments efficiently
- Intervening for subtle shifts in patients' conditions or families' responses
- Having interpersonal skills of calm, compassion, generosity, and authority
- Seeing the big picture and knowing how to work the system
- Possessing an attitude of dedicated curiosity and commitment to lifelong learning

Participants described how competence developed and changed over time. Also of interest was how the development of competence affected their career plans and job satisfaction. Kearny and Kenward (2010) note:

> Those who continued to feel insecure in their ability to efficiently identify and respond to important downturns in patients' conditions in a high-acuity environment, who continually felt beaten down in their attempts to get resources and help for patients from fellow nurses, and/or who believed physicians did not listen to them or respect them appeared most likely to change jobs to less complex or less acute settings or to leave nursing. (p. 13)

This study clearly has implications for preceptors. Nurses' career decisions and job satisfaction are both affected by how well they develop competence, especially for less experienced nurses.

Conscious Competence Learning

The concept of *conscious competence learning* is a description of how individuals learn new competencies. The concept serves to remind us that learning a competency happens in stages. The stages of the conscious competence as described by Howell (1982) and expanded on by Cannon et al. (2010) include unconscious incompetence, conscious incompetence, conscious competence, and unconscious competence:

- **Unconscious incompetence:** The individual seeks to solve problems intuitively with little or no insight into the principles driving the solutions. This stage is especially dangerous with novices. When NGRNs first begin professional practice or experienced nurses move into a new role, they often don't know what they don't know. Preceptors have to be especially vigilant with a preceptee at this level.

- **Conscious incompetence:** The individual seeks to solve problems logically, recognizing problems with their intuitive analysis but not yet knowing how to fix them. This awareness—of knowing what you don't know—can affect confidence. Preceptors can help preceptees in this level understand what they are expected to know at this point versus what they will learn in the future.
- **Conscious competence:** As skills are acquired, individuals become more confident but need to realize that the skills have not yet become automatic. They are not yet ready to spontaneously transfer the concepts of the skill to new situations. Preceptors need to help preceptees see how the concepts transfer from one situation to another.
- **Unconscious competence:** At this level, skills become second nature and are performed without conscious effort. Skills can be adapted creatively and spontaneously to new situations. You know it so well, you don't think about it. The challenge in this level is to not become complacent and be closed to new ways of doing things.

A fifth level of conscious competence learning—reflective competence—has been suggested (Attri, 2017). It involves an awareness that you've reached unconscious competence—analyzing and being able to articulate how you got there well enough to teach someone else to reach that level and opening yourself to the need for continuous self-observation and improvement.

This concept supports adult learning theory concerning learner readiness (discussed in Chapter 2) in the assertion that individuals develop competence only after they recognize the relevance of their own incompetence. It also blends easily with the levels in Benner's Novice to Expert model.

Competency Outcomes and Performance Assessment (COPA) Model

Lenburg (1999) developed the Competency Outcomes and Performance Assessment (COPA) model. She describes it as "a holistic but focused model that requires the integration of practice-based outcomes, interactive learning methods, and performance assessment of competencies" (Lenburg, 1999, para. 2).

The basic framework of the model consists of four guiding questions (Lenburg, 1999):

1. What are the essential competencies and outcomes for contemporary practice? Identify the required competencies and word them as practice-based competency outcomes.
2. What are the indicators that define those competencies? Only identify the behaviors, actions, and responses mandatory for the practice of each competency.
3. What are the most effective ways to learn those competencies?
4. What are the most effective ways to document that learners or practitioners have achieved the required competencies? Develop a systematic and comprehensive plan for outcomes assessment.

Eight core practice competency categories define practice in the COPA model (Lenburg, 1999):

1. Assessment and intervention skills
2. Communication skills
3. Critical thinking skills
4. Human caring and relationship skills
5. Management skills
6. Leadership skills
7. Teaching skills
8. Knowledge integration skills

In the COPA model, learner performance is assessed against a predetermined standard after the learning and practice have occurred. Lenburg (1999) notes how important it is to separate these activities—assessing versus learning/practicing—to keep the focus of each clear. The learner is then better able to concentrate on learning, and the preceptor can concentrate on teaching and coaching during the learning and practice periods, rather than both trying to split their attention and their purposes between learning and assessing and, perhaps, one not always knowing the focus of the other.

Lenburg (1999) has found that assessments are most effective when they are designed and implemented based on 10 basic concepts: examination, dimensions of practice, critical elements, objectivity, sampling, acceptability, comparability, consistency, flexibility, and systematized conditions.

Wright Competency Model

The Wright Competency Assessment Model is an outcome-focused, accountability-based approach that is used in many healthcare organizations. The following principles form the foundation of the model (Wright, 2015, p. 5):

- Select competencies that matter to both the people involved and to the organization.
  - Competencies should reflect the current realities of practice, be connected to quality improvement data, be dynamic, and be collaboratively selected.
  - Competency selection itself involves critical thinking.
- Select the right verification methods for each competency identified.
- Clarify the roles and accountability of the manager, educator, and employee in the competency process.

- Employee-centered competency verification creates a culture of engagement and commitment.

The model is grounded in three concepts—ownership, empowerment, and accountability (Wright, 2005):

- In **ownership**, competencies are collaboratively identified and are reflective of the dynamic nature of the work.
- **Empowerment** is achieved through employee-centered verification in which verification method choices are identified and appropriately match the competency categories.
- In **accountability**, leaders create a culture of success with a dual focus—focus on the organizational mission and focus on supporting positive employee behavior.

Entrustable Professional Activities

Competencies are expected levels of performance. Entrustable professional activities (EPAs) are:

> units of professional practice, defined as tasks or responsibilities to be entrusted to the unsupervised execution by a trainee once he or she has attained sufficient specific competence. EPAs are independently executable, observable, and measurable in their process and outcome, and, therefore, suitable for entrustment decisions. (ten Cate, 2013, p. 157)

As noted by Corrigan et al. (2022), EPAs "break down competencies into tasks, provide explicit directions for stakeholders, and act as competency assessment frameworks" (p. 262). Learners reach entrustable status when they can be trusted to complete the EPA task without supervision (Surjadi et al., 2019). ten Cate (2013) has described the continuum of entrustability based on the level of supervision required with a range from (1) observation, but no execution, even with direct supervision; (2) execution with direct, proactive supervision; (3) execution with reactive supervision (i.e., on request and quickly available); (4) supervision at a distance and/or post hoc; and (5) supervision provided by the learner to more junior learners. Whether using EPAs or other assessment measures, preceptors may find this continuum to be useful in considering the supervision needs of their preceptees.

Formative Assessment

Formative assessment is "an iterative process that provides information to learners and educators about how well the learner is progressing through the instruction. It provides evidence as to the degree to which the learner is acquiring the requisite cognitive, psychomotor, and affective aspects of the content domain" (Andreatta & Lori, 2020, p. 30). In formative assessment, learners are provided with feedback throughout the sequential process of becoming competent. This is an important concept for preceptors. Continuous, specific feedback for preceptees is a critical factor in competence acquisition.

Critical Thinking

Critical thinking is an essential competency for nurses to provide safe and effective care (Berkow et al., 2011). Alfaro-LeFevre (2017) says that *critical thinking* is "deliberate, informed thought" (p. 2) and that the difference between thinking and critical thinking is control and purpose. "Thinking refers to any mental activity. It can be 'mindless,' like when you're daydreaming or doing routine tasks like brushing your teeth. Critical thinking is controlled and purposeful, using well-reasoned strategies to get the results you need" (p. 5).

Jackson (2006, p. 4) notes that three themes are found within all definitions of critical thinking: "the importance of a good foundation of knowledge, including formal and informal logic; the willingness to ask questions; and the ability to recognize new answers, even when they are not the norm and not in agreement with pre-existing attitudes." Chan (2013), in a systematic review of critical thinking in nursing education, found that despite there being varying definitions of clinical thinking, there were some consistent components: gathering and seeking information; questioning and investigating; analysis, evaluation, and inference; and problem-solving and the application of theory. The principles of skepticism and objectivity underlie critical thinking (Chatfield, 2018). *Objectivity* includes recognizing and dealing with both conscious and unconscious bias.

Critical Thinking—A Philosophical Perspective

In 1990, the American Philosophical Association conducted a Delphi study of an expert panel to define critical thinking and to identify and describe the core skills and dispositions of critical thinking. The expert panel, led by Peter Facione (1990), defined *critical thinking* to be a pervasive and deliberate human phenomenon that is the "purposeful, self-regulatory judgment which results in interpretation, analysis, evaluation, and inference, as well as explanation of the evidential, conceptual, methodological, criteriological, or contextual considerations upon which that judgment is based" (p. 2). The core skills and sub-skills identified by the expert panel are shown in Table 3.1.

Table 3.1 Core Critical Thinking Skills and Sub-Skills

INTERPRETATION: To comprehend and express the meaning or significance of a wide variety of experiences, situations, data, events, judgments, conventions, beliefs, rules, procedures, or criteria

Sub-skills: Categorization, decoding significance, clarifying meaning

ANALYSIS: To identify the intended and actual inferential relationships among statements, questions, concepts, descriptions, or other forms of representation intended to express beliefs, judgments, experiences, reasons, information, or opinions

Sub-skills: Examining ideas, detecting arguments, analyzing arguments

EVALUATION: To assess the credibility of statements or other representations which are accounts or descriptions of a person's perception, experience, situation, judgment, belief, or opinion; and to assess the logical strength of the actual or intended inferential relationships among statements, descriptions, questions, or other forms of representation

Sub-skills: Assessing claims, assessing arguments

INFERENCE: To identify and secure elements needed to draw reasonable conclusions; to form conjectures and hypotheses; to consider relevant information and to educe the consequences flowing from data, statements, principles, evidence, judgments, beliefs, opinions, concepts, descriptions, questions, or other forms of representation

Sub-skills: Querying evidence, conjecturing alternatives, drawing conclusions

EXPLANATION: To state the results of one's reasoning; to justify that reasoning in terms of the evidential, conceptual, methodological, criteriological, and contextual considerations upon which one's results were based; and to present one's reasoning in the form of cogent arguments

Sub-skills: Stating results, justifying procedures, presenting arguments

SELF-REGULATION: Self-consciously to monitor one's cognitive activities, the elements used in those activities, and the results educed, particularly by applying skills in analysis and evaluation to one's own inferential judgments with a view toward questioning, confirming, validating, or correcting either one's reasoning or one's results

Sub-skills: Self-examination, self-correction

Source: American Philosophical Association, 1990

According to the American Philosophical Association Delphi study, the affective dispositions of critical thinking (approaches to life and living) include (Facione, 2011):

- Inquisitiveness with regard to a wide range of issues
- Concern to become and remain generally well-informed
- Alertness to opportunities to use critical thinking
- Trust in the processes of reasoned inquiry
- Self-confidence in one's own ability to reason
- Open-mindedness regarding divergent worldviews
- Flexibility in considering alternatives and opinions
- Understanding of the opinions of other people
- Fair-mindedness in appraising reasoning
- Honesty in facing one's own biases, prejudices, stereotypes, and egocentric or sociocentric tendencies

- Prudence in suspending, making, or altering judgments
- Willingness to reconsider and revise views where honest reflection suggests that change is warranted

The dispositions to specific issues, questions, or problems include (Facione, 2011):

- Clarity in stating the question or concern
- Orderliness in working with complexity
- Diligence in seeking relevant information
- Reasonableness in selecting and applying criteria
- Care in focusing attention on the concern at hand
- Persistence though difficulties are encountered
- Precision to the degree permitted by the subject and the circumstance

Critical Thinking in Nursing

Facione and Facione (1996) suggest that to observe and evaluate critical thinking in nursing knowledge development or clinical decision-making, you need to have the thinking process externalized by being spoken, written, or demonstrated. For preceptors, this means having preceptees externalize their thinking processes. Preceptors must also be able to externalize their own critical thinking to role-model critical thinking for preceptees.

Paul, the founder of the Foundation for Critical Thinking, and Heaslip noted that:

> Critical thinking presupposes a certain basic level of intellectual humility (i.e., the willingness to acknowledge the extent of one's own ignorance) and a commitment to think clearly, precisely, and accurately and, in so far as is possible, to act on the basis of genuine knowledge. Genuine knowledge is attained through intellectual effort in figuring out and reasoning about problems one finds in practice. (Paul & Heaslip, 1995, p. 41)

Expert nurses, say Paul and Heaslip, "can think through a situation to determine where intuition and ignorance interface with each other" (1995, p. 43).

Building on the work of Facione and the American Philosophical Association Delphi study, Scheffer and Rubenfeld (2000) conducted a Delphi study of international nursing experts (from 27 US states and eight countries) to develop a consensus statement of critical thinking in nursing. The result of the study was a consensus statement and identification of 10 affective components (habits of the mind) and seven cognitive components (skills) of critical thinking in nursing.

> Critical thinking in nursing is an essential component of professional accountability and quality nursing care. Critical thinkers in nursing exhibit these habits of the mind: confidence, contextual perspective, creativity, flexibility, inquisitiveness, intellectual integrity, intuition, open-mindedness, perseverance, and reflection. Critical thinkers in nursing practice the cognitive skills of analyzing, applying standards, discriminating, information seeking, logical reasoning, predicting and transforming knowledge. (Scheffer & Rubenfeld, 2000, p. 357)

Precepting Critical Thinking

Berkow and colleagues (2011) note that identifying and providing feedback on specific strengths and weaknesses is the first step to help nurses meaningfully improve their critical thinking skills. They interviewed more than 100 nurse leaders from academia, service settings, and professional associations and developed a list of core critical-thinking competencies in five broad categories: problem recognition, clinical decision-making, prioritization, clinical implementation, and reflection. Each of the categories has detailed competencies.

Alfaro-LeFevre (1999) developed a list of critical-thinking key questions that can be used by a preceptor to help preceptees learn how to think critically:

- What major outcomes (observable results) do I/we hope to achieve?
- What problems or issues must be addressed to achieve the major outcomes?
- What are the circumstances (what is the context)?
- What knowledge is required?
- How much room is there for error?
- How much time do I/we have?
- What resources can help?
- Whose perspectives must be considered?
- What's influencing my thinking?

In addition, Alfaro-LeFevre (1999) offers suggestions on thinking critically about how to teach others:

- Be clear about the desired outcome.
- Decide what exactly the person must learn to achieve the desired outcome and decide the best way for the person to learn it.
- Reduce anxiety by offering support.

- Minimize distractions and teach at appropriate times.
- Use pictures, diagrams, and illustrations.
- Create mental images by using analogies and metaphors.
- Encourage people to remember by whatever words best trigger their mind.
- Keep it simple.
- Tune into your learners' responses; change the pace, techniques, or content if needed.
- Summarize key points.

Preceptors can also use role-playing, case studies, reflection, and high-fidelity patient simulation to teach clinical thinking.

Clinical Reasoning

Tanner (2006) defines *clinical reasoning* as:

> the processes by which nurses and other clinicians make their judgments, and includes both the deliberate process of generating alternatives, weighing them against the evidence, and choosing the most appropriate, and those patterns that might be characterized as engaged, practical reasoning (e.g., recognition of a pattern, an intuitive clinical grasp, a response without evident forethought). (pp. 204–205)

Facione and Facione (2008) discuss research in human reasoning that has found evidence of the function of two interconnected "systems" of reasoning. System 1 is "reactive, instinctive, quick, and holistic" and often "relies on highly expeditious heuristic maneuvers which can yield useful response to perceived problems without recourse to reflection" (Facione & Facione, 2008, p. 4). System 2, on the other hand, is described as "more deliberative, reflective, analytical, and procedural" and is "generally associated with reflective problem-solving and critical thinking" (p. 4). They note that the two systems never function completely independently and that, in some cases, the two systems actually offer somewhat of a corrective effect on each other. In fact, they say, "Effectively mixing System 1 and System 2 cognitive maneuvers to identify and resolve clinical problems is the normal form of mental processes involved in sound, expert critical thinking" (p. 5).

Simmons and colleagues (2003) investigated clinical reasoning of experienced (two to 10 years) medical-surgical nurses. They found that the nurses used a number of thinking strategies (*heuristics*) that consolidated patient information and their knowledge and experience to speed their reasoning process. The most frequently used heuristics were (Simmons et al., 2003):

- Recognizing a pattern or an inconsistency in the expected pattern
- Judging the value of the information about which they were reasoning

- Providing explanations for why they had reasoned as they had
- Forming relationships between data
- Drawing conclusions

Tanner (2006), in reviewing research on nurses and reasoning, found three interrelated patterns of reasoning that experienced nurses use in decision-making:

- **Analytic processes:** Breaking a situation down into its elements; generating and systematically and rationally weighing alternatives against the data and potential outcomes.
- **Intuition:** Immediately apprehending a situation (often using pattern recognition) as a result of experience with similar situations.
- **Narrative thinking:** Thinking through telling and interpreting stories.

Benner (2022b, 1:11) said that in making the distinction between the nursing process and clinical reasoning:

> The nursing process is a great way to sort out and intellectually manage a situation when you are coming in as a novice and you have no experience or no lived experience of getting through trajectories and trends in patients' recoveries. You go through what is very much like snapshot reasoning…but notice that freeze-frame snapshot reasoning isn't a motion picture, it's a slide show and clinical reasoning is a motion picture—it's across time.

Benner (2022a, para. 20) further notes that:

> Expert clinical reasoning requires a deep background understanding that allows nurses to perceptually grasp and attune to a particular unfolding clinical situation in the context of what is understood about the particular patient's co-morbidities and about population statistics about patients with similar diagnoses, the notions of good internal to nursing practice, and the nurse's responsibility for the best outcomes and well-being of the patient.

Joplin-Gonzales and Rounds (2022) studied the elements of the clinical reasoning process across nursing, medicine, physical therapy, and occupational therapy in pursuit of an interprofessional consensus on the process. For their study, they defined clinical reasoning as "a process of identifying a patient's real or potential problem, collecting and analyzing the data, hypothesizing and determining treatment, and evaluating and reflecting on the process to determine whether the treatment is working" (p. e146).

Using an expert panel and a Delphi study method, Joplin-Gonzales and Rounds (2022) identified essential elements of the clinical reasoning process across healthcare professions. These elements then created definitions of phases of the process (e147–e148):

- **Problem Presentation Phase:** "A cognitive process of identifying and recognizing a patient problem using cues and pattern recognition as well as information interpretation and perception"
- **Problem Assessment Phase:** "A problem assessed through an investigative process consisting of data collection, recognizing similar patterns, drawing on experiences, and identifying contributing factors"
- **Problem Analysis Phase:** "Using critical thinking, the data are organized and analyzed to determine relationships between the data, cues, context, patterns, and the patient situation"
- **Problem Hypothesis Phase:** "The act of organizing, analyzing, and comparing data to determine relationships between clusters of data to establish goals and propose actions, interventions, and hypotheses"
- **Problem Evaluation and Reflection Phase:** "Using reflection, hypotheses are generated, summarized, evaluated, reassessed, and tested to establish goals, predict outcomes, and draw conclusions about the patient's response to treatment"

Joplin-Gonzales and Rounds (2022) noted that, although there are identified phases, the clinical reasoning process is not linear and that elements such as reflection and analysis are needed throughout the process.

Clinical Judgment and Decision-Making

Critical thinking, clinical reasoning, and clinical judgment are interrelated concepts (Victor-Chmil, 2013). Critical thinking and clinical reasoning are processes that lead to the outcome of clinical judgment. Facione and Facione (2008) described the relationship in this way: "Critical thinking is the process we use to make a judgment about what to believe and what to do about the symptoms our patient is presenting for diagnosis and treatment" (p. 2).

Clinical judgment is defined by the NCSBN (2022) as "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 solutions in order to deliver safe client care" (p. 50).

Clinical judgment and clinical decision-making are complex processes that require both knowledge and experience.

Tanner (2006) proposed a model of clinical judgment, based on a synthesis of the clinical judgment literature, that can be used in complex, rapidly changing patient situations. The model includes:

- **Noticing:** "A perceptual grasp of the situation at hand" (p. 208). Noticing, Tanner says, is "a function of nurses' expectations of the situation, whether they are explicit or not" and further

that "these expectations stem from nurses' knowledge of the particular patient and his or her patterns of responses; their clinical or practical knowledge of similar patients, drawn from experience; and their textbook knowledge" (p. 208).

- **Interpreting:** "Developing a sufficient understanding of the situation to respond" (p. 208). Noticing triggers and reasoning patterns that help nurses interpret the data and decide on a course of action.
- **Responding:** "Deciding on a course of action deemed appropriate for the situation, which may include 'no immediate action'" (p. 208).
- **Reflecting:** "Attending to the patients' responses to the nursing action while in the process of acting" (reflection in action) and "reviewing the outcomes of the action, focusing on the appropriateness of all of the preceding aspects (i.e., what was noticed, how it was interpreted, and how the nurse responded" (p. 208; reflection on action).

The use of this model can be helpful to preceptors as a structure for debriefing. It is a model of expert practice; what the new graduate aims for and what the experienced nurse needs to perfect. Based on Tanner's model, Lasater (2007) developed a detailed rubric (Lasater Clinical Judgment Rubric) that could be used in simulation with dimensions for each of the phases of the model:

- **Noticing:** focused observation, recognizing deviations from expected patterns, information seeking
- **Interpreting:** prioritizing data, making sense of data
- **Responding:** calm, confident manner; clear communication; well-planned intervention/flexibility; being skillful
- **Reflecting:** evaluation/self-analysis, commitment to improvement

While the Lasater Clinical Judgment Rubric has been primarily used in academic settings, Miraglia and Asselin (2015) suggest that it can be used as a framework to enhance clinical judgment skills of novice and experienced nurses.

New graduate nurses have been shown to need major improvements in their clinical judgment skills (Nielsen et al., 2023). A recent study found that only 27% of deans and directors surveyed said their pre-licensure nursing program used a model to teach clinical judgment, though a large percentage of the programs that said they did not use a model reported that they intended to start (Jessee et al., 2023). Muntean (2012), in a detailed literature review of factors that contribute to clinical judgment and decision-making of novice nurses, identified both individual factors and environmental factors (see Table 3.2). Individual factors are those factors related to the decision-maker; environmental factors are contextual features in which the decision occurs. These factors should be considered by the preceptor when working with all preceptees but especially with novices.

Table 3.2 Individual and Environmental Factors That Contribute to Clinical Judgment and Decision-Making of Novice Nurses

Individual Factors
Age
Education
Experience
Knowledge
Cue recognition
Hypothesis updating
Communication
Emotions
Perceptions
Confidence
Professional orientation
Consequences
Personal values
Environmental Factors
Task complexity
Time pressure
Interruptions
Area of specialty
Professional autonomy

Source: Muntean, 2012

In 2023, the NCSBN NCLEX exam changed to the Next Generation (NGN) NCLEX exam. According to the NCSBN, the impetus for the NGN "is based on the recognition that entry-level nursing practice relies upon a strong foundation of clinical judgment (CJ) and effective decision making to ensure patient safety" (Betts et al., 2022, p. 1). The NGN will include stand-alone items as it has previously. It will also add evolving case studies/scenarios that specifically measure clinical judgment. According to the NCLEX (2023) test plan information on clinical judgment:

> The nurse engages in this iterative multistep process that uses nursing knowledge to observe and assess presenting situations, identify a prioritized client concern and generate the best possible evidence-based solutions in order to deliver safe client care. Clinical judgment content may be represented as a case study

> or as an individual stand-alone item. A case study contains six items that are associated with the same client presentation, share unfolding client information and address the following steps in clinical judgment. (p. 4)

Developing Situational Awareness, Expert Reasoning, and Intuition

Situational awareness, expert reasoning, and intuition are critical attributes to move from novice to expert nurse. If you've ever walked into a patient room and instantly become alert because you knew that something wasn't right—even if you didn't know what was wrong—you've used your situational awareness, expert reasoning, and intuition.

Situational awareness is the foundation of decision-making and performance. Put simply, *situational awareness* is being aware of what is happening around you, understanding what that information means now, and anticipating what it will mean in the future (Endsley & Jones, 2012). Begun in the aviation industry, the formal definition of situational awareness is "the perception of the elements in the environment in a volume of time and space, the comprehension of their meaning, and the projection of their status in the near future" (Endsley, 1995, p. 36). Endsley's model of situational awareness has three incremental levels: perception of the elements in the environment (gathering data); comprehension of the current situation (interpreting information); and projection of what can happen in the future (anticipation of future states; Endsley, 1995; Orique & Despins, 2018; Stubbings et al., 2012).

The first level (gathering data) includes becoming aware of overt and subtle important cues that can be perceived through any or all of the senses. A nurse's abilities, training, experience, and information-processing, as well as level of stress, workload, noise, and complexity can all positively or negatively affect whether and how well they perceive cues.

The next level (interpreting information) is comprehending the significance of and discerning the relationships between the cues and synthesizing what may appear to less-skilled nurses as disjointed cues into the whole of the situation.

The last level in the model is predicting and anticipating what will happen next. Endsley and Jones (2012) note the importance of time in situational awareness—that is, anticipating how much time is available in which to act. Nurses with expert situational awareness can quickly identify that something is wrong, distill the important cues, put the pieces of information together, anticipate what will happen next and how quickly it will happen, and know what to do to intervene.

Malcolm Gladwell, in his book *Blink* (2005), discusses the *adaptive unconscious* of the mind, which he describes as "a kind of giant computer that quickly and quietly processes a lot of the data we need in order to keep functioning as human beings" (p. 11) and a "decision-making apparatus that's capable of

making very quick judgments based on very little information" (p. 12). The key themes of the research described in *Blink* are:

- Decisions made very quickly can be every bit as good as decisions made cautiously and deliberately.
- We have to learn when we should trust our instincts and when we should be wary of them.
- Our snap judgments and first impressions can be educated and controlled.

Gladwell describes what he calls *thin-slicing,* "the ability of our unconscious to find patterns in situations and behavior based on very narrow slices of experience" (p. 23). In this case, the term "experience" is not being used, for example, to mean the long-term experience of caring for many patients of the same type, but rather "very narrow slices of experience" would refer to when you first walk into a patient's room and within seconds know that something does not fit the pattern you expect to see.

Gary Klein (2017) has studied nurses and other people who make decisions under time pressure when the stakes are high (e.g., firefighters, Navy SEALS, battlefield platoon leaders). Based on his research, he has found that what is generally termed "intuition" comes from experience, that we recognize things without knowing how we do the recognizing, and that what actually occurs is that we are drawn to certain cues because of situational awareness. He also notes, however, that because we often don't understand that we actually have experience behind "intuition," intuition gets discounted as hunches or guesses. His research, indeed, shows just the opposite. His findings indicate that the part of intuition that involves pattern matching and recognition of familiar and typical cases can be trained by expanding people's experience base.

Klein (2017) describes what he has termed the *recognition-primed decision model,* a model that brings together two processes, "the way decision makers size up the situation to recognize which course of action makes sense, and the way they evaluate the course of action by imagining it" (p. 24).

> Decision makers recognize the situation as typical and familiar . . . and proceed to take action. They understand what types of goals make sense (so priorities make sense), which cues are important (so there is not an overload of information), what to expect next (so they can prepare themselves and notice surprises), and the typical way of responding in a given situation. By recognizing a situation as typical, they also recognize a course of action likely to succeed. (Klein, 2017, p. 24)

This is compared to a rational choice strategy, a step-by-step process of considering and eliminating alternatives, which is similar to the nursing process. Though a rational choice strategy is often needed as a first step for novices or for initially working in teams to determine how everyone views the options, it is less useful with experts, who usually look for the first workable option (based on their knowledge and experience) in the current situation and for high-risk situations that require rapid response.

Klein (2017) notes many things that experts can see that are invisible to others (pp. 148–149):

- Patterns that novices do not notice
- Anomalies, events that did not happen, and other violations of expectations
- The big picture (situation awareness)
- The way things work
- Opportunities and improvisations
- Events that either already happened (the past) or are going to happen (the future)
- Differences that are too small for novices to notice
- Their own limitations

In describing expert nursing, Dreyfus and Dreyfus (2009) note that experts use *deliberative rationality*—that is, when time permits, they think before they act, but normally, "they do not think about their rules for choosing goals or their reasons for choosing possible actions" (p. 16). Deliberative rationality (the kind of detached, meditative reflection exhibited by the expert when time permits thought), they say, "stands at the intersection of theory and practice. It is detached, reasoned observation of one's intuitive, practice-based behavior with an eye to challenging, and perhaps improving, intuition without replacing it by the purely theory-based action of the novice, advanced beginner, or competent performer" (pp. 17–18).

Debriefing after an incident in which situational awareness, expert reason, and intuition are used is important to learning. The preceptor needs to walk through the whole process step-by-step with the preceptee—discussing observations, rationale for actions, etc., and answering whatever questions the preceptee has. This may take some practice and reflection for the preceptor in order to be able to break down what was done intuitively so the preceptee can understand the steps and the logic.

Confidence

Self-efficacy (confidence) is the belief of individuals in their capability to exercise some measure of control over their own functioning and over environmental events (Bandura, 1997). According to Bandura, "A capability is only as good as its execution. The self-assurance with which people approach and manage difficult tasks determines whether they make good or poor use of their capabilities. Insidious self-doubts can easily overrule the best of skills" (1997, p. 35), and "unless people believe they can produce desired results and forestall detrimental ones by their actions, they have little incentive to act or to persevere in the face of difficulties. Whatever other factors may operate as guides and motivators, they are rooted in the core belief that one has the power to produce effects by one's actions" (Bandura, 2009, p. 179).

Kanter (2006) notes that confidence consists of positive expectations for favorable outcomes and influences an individual's willingness to invest. "Confidence," she says, "is a sweet spot between arrogance and despair. Arrogance involves the failure to see any flaws or weaknesses, despair the failure to acknowledge any strengths" (p. 8).

Manojlovich (2005), in a study of predictors of professional nursing practice behaviors in hospital settings, found a significant relationship between self-efficacy and professional behaviors. Ulrich et al. (2010) found that self-confidence improved in new graduate nurses across and beyond an 18-week immersion RN residency that used one-to-one preceptors for new graduate nurses.

Competence and confidence are interrelated. Each builds on, reinforces, and promotes the other. The goal is to be both competent and confident. Being confident without being competent is ineffective and potentially dangerous in the clinical setting. Being competent without being confident means that even though you know how to do something, you may not take action. This competence-confidence gap can be addressed by the preceptor, ensuring that the preceptee has both as part of the competence assessment.

Helping preceptees develop confidence in themselves requires the use of many of the preceptor roles described in Chapter 1 and also requires the creation of a positive, enriching, and supportive learning environment.

Conclusion

Competence, critical thinking, clinical reasoning, clinical judgment, and confidence are all necessary components of any preceptorship. Role competence can be attained only by the connection of theory and practice. Critical thinking, clinical reasoning, and clinical judgment are the keys to making that happen. Competence without confidence is opportunity wasted. Preceptors are charged with helping preceptees master critical thinking, clinical reasoning, and clinical judgment skills so preceptees can move from novice to expert competence.

Preceptor Development Plan: Core Precepting Concepts			
Review the information on the core precepting concepts described in this chapter. What are your strengths? In which areas do you need to increase your knowledge and expertise? What is your plan for expanding your knowledge and expertise? What resources are available? Who can help you?			
Name:			
Date:			
Competence Assessment			
Strengths	**Needs**	**Plan**	**Resources**
Competence Development			
Strengths	**Needs**	**Plan**	**Resources**
Critical Thinking			
Strengths	**Needs**	**Plan**	**Resources**
Clinical Reasoning			
Strengths	**Needs**	**Plan**	**Resources**

Clinical Judgment			
Strengths	**Needs**	**Plan**	**Resources**
Situational Awareness, Expert Reasoning, and Intuition			
Strengths	**Needs**	**Plan**	**Resources**
Confidence			
Strengths	**Needs**	**Plan**	**Resources**

For modifiable documents, visit SigmaNursing.org/MasteringPrecepting3 or RNPreceptor.com or use the QR codes below.

Preceptor Development Plan: Preceptee Role Competencies				
Review the competencies that are required for your preceptee. If written descriptions of these competencies are not available, work with other stakeholders to develop them. Assess your own knowledge and expertise on each of the competencies. What are your strengths? In which areas do you need to increase your knowledge and expertise? What is your plan for expanding your knowledge and expertise? What resources are available? Who can help you?				
Preceptee Role:				
Competency	**Preceptor Strengths**	**Preceptor Needs**	**Plan**	**Resources**

For modifiable documents, visit SigmaNursing.org/MasteringPrecepting3 or RNPreceptor.com or use the QR codes below.

References

Alfaro-LeFevre, R. (1999). *Critical thinking in nursing: A practical approach* (2nd ed.). W.B. Saunders Company.

Alfaro-LeFevre, R. (2017). *Critical thinking, clinical reasoning, and clinical judgment: A practical approach* (6th ed.). Elsevier.

American Association of Colleges of Nursing. (2021). *The essentials: Core competencies for professional nursing education.* AACN.

American Nurses Association. (2014). *Professional role competence* (Position Statement). https://www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/

American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements.* ANA.

American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). ANA. https://www.nursingworld.org/continuing-education/redefining-nursing--reaffirming-our-practice-int/

American Philosophical Association. (1990). *Critical thinking: A statement of expert consensus for purposes of educational assessment and instruction*. ERIC Doc No. ED 315 423.

Andreatta, P., & Lori, J. R. (2020). Developing clinical competence and confidence. In J. Palaganas, B. Ulrich, & B. Mancini (Eds.), *Mastering simulation: A handbook for success* (2nd ed., pp. 23–40). Sigma Theta Tau International.

Attri, R. K. (2017). *5 training guidelines: Skill acquisition towards unconscious competence.* https://www.speedtoproficiency.com/blog/skill-acquisition-unconscious-competence/

Bandura, A. (1997). *Self-efficacy: The exercise of control.* W.H. Freeman.

Bandura, A. (2009). Cultivate self-efficacy for personal and organizational effectiveness. In E.A. Locke (Ed.), *Handbook of principles of organization behavior* (2nd ed., pp. 179–200). Wiley.

Benner, P. (2022a). *Clinical reasoning: A science-using a form of practical reasoning that includes a concern for responsible actions towards patients/families.* Educating Nurses, LLC. https://www.educatingnurses.com/clinical-reasoning-a-science-using-a-form-of-practical-reasoning-that-includes-a-concern-for-responsible-actions-towards-patients-families/

Benner, P. (2022b). *Teaching clinical reasoning* [Video]. YouTube. https://www.youtube.com/watch?v=ogrjiUAGHcI

Berkow, S., Virkstis, K., Stewart, J., Aronson, S., & Donohue, M. (2011). Assessing individual frontline nurse critical thinking. *Journal of Nursing Administration*, *41*(4), 168–171. https://doi.org/10.1097/NNA.0b013e3182118528

Betts, J., Muntean, W., Kim, D., & Kao, S. (2022). *Next Generation NCLEX® News*, Winter. https://ncsbn.org/public-files/NGN_Winter22_English_Final.pdf

Cannon, H. M., Feinstein, A. H., & Friesen, D. P. (2010). Managing complexity: Applying the conscious-competence model to experiential learning. *Developments in Business Simulations and Experiential Learning, 37*, 172–182.

Chan, Z. C. Y. (2013). A systematic review of critical thinking in nursing education. *Nursing Education Today, 33*, 236–240. https://doi.org/10.1016/j.nedt.2013.01.007

Chatfield, T. (2018). *Critical thinking Your guide to effective argument, successful analysis, and independent study.* Sage Publications, Inc.

Corrigan, C., Moran, K., Kesten, K., Conrad, D., Manderscheid, A., Beebe, S. L., & Pohl, E. (2022). Entrustable professional activities in clinical education. *Nurse Educator, 47*(5), 261–266. https://doi.org/10.1097/NNE.0000000000001184

Dreyfus, H. L., & Dreyfus, S. E. (2009). The relationship of theory and practice in the acquisition of skill. In P. Benner, C. Tanner, & C. Chesla (Eds.), *Expertise in nursing practice: Caring, clinical judgment, and ethics* (2nd ed., pp. 1–24). Springer Publishing Company.

Endsley, M. R. (1995). Toward a theory of situation awareness in dynamic systems. *Human Factors, 37*(1), 32–64. https://doi.org/10.1518/001872095779049543

Endsley, M. R., & Jones, D. G. (2012). *Designing for situation awareness: An approach to user-centered design.* (2nd ed.). CRC Press.

Facione, N. C., & Facione, P. A. (1996). Externalizing the critical thinking in knowledge development and clinical judgment. *Nursing Outlook*, *44*(3), 129–136. https://doi.org/10.1016/s0029-6554(06)80005-9

Facione, N. C., & Facione, P. A. (2008). Critical thinking and clinical judgment. In N. C. Facione & P. A. Facione (Eds.), *Critical thinking and clinical reasoning in the health sciences: A teaching anthology* (pp. 1–13). The California Academic Press.

Facione, P. A. (1990). *Critical thinking: A statement of expert consensus for purposes of educational assessment and instruction*. The California Academic Press. https://www.researchgate.net/publication/242279575_Critical_Thinking_A_Statement_of_Expert_Consensus_for_Purposes_of_Educational_Assessment_and_Instruction

Facione, P. A. (2011). *Critical thinking: What it is and why it counts*. The California Academic Press. http://www.insightassessment.com/CT-Resources

Gladwell, M. (2005). *Blink: The power of thinking without thinking*. Little, Brown and Company.

Howell, W. S. (1982). *The empathetic communicator.* Wadsworth Publishing Company.

Jackson, M. (2006). Defining the concept of critical thinking. In M. Jackson, D. D. Ignatavicius, & B. Case (Eds.), *Conversations in critical thinking and clinical judgment* (pp. 3–18), Jones and Bartlett Publishers.

Jessee, M.A., Monagle, J., Nielsen, A., Gonzalez, L., Dickison, P., & Lasater, K. A. (2023). A national report on clinical judgment model use in pre-licensure nursing curricula. *Nursing Education Perspectives, 44*(1), 4–10. https://doi.org/10.1097/01.NEP.0000000000001062

Joplin-Gonzales, P., & Rounds, L. (2022). The essential elements of the clinical reasoning process. *Nurse Educator, 47*(6), e145–e149. https://doi.org/10.1097/NNE.0000000000001202

Kanter, R. M. (2006). *Confidence: How winning streaks and losing streaks begin and end*. Three Rivers Press.

Kearney, M. H., & Kenward, K. (2010). Nurses' competence development during the first 5 years of practice. *Journal of Nursing Regulation, 1*(1), 9–15.

Klein, G. (2017). *Sources of power (20th anniversary edition): How people make decisions.* The MIT Press.

Lasater, K. (2007). Clinical judgment development: Using simulation to create an assessment rubric. *Journal of Nursing Education, 46*(11), 496–503. https://doi.org/10.3928/01484834-20071101-04

Lenburg, C. (1999). The framework, concepts and methods of the Competency Outcomes and Performances Assessment (COPA) model. *The Online Journal of Issues in Nursing, 4*(2), Manuscript 2.

Manojlovich, M. (2005). Predictors of professional nursing practice behaviors in hospital settings. *Nursing Research, 54*(1), 41–47. https://doi.org/10.1097/00006199-200501000-00006

Miraglia, R., & Asselin, M. E. (2015). The Lasater Clinical Judgment Rubric as a framework to enhance clinical judgment in novice and experienced nurses. *Journal for Nurses in Professional Development, 31*(5), 284–291. https://doi.org/10.1097/NND.0000000000000209

Muntean, W. J. (2012). *Nursing clinical decision-making: A literature review*. https://ncsbn.org/public-files/Clinical_Judgment_Lit_Review_Executive_Summary.pdf

National Council of State Boards of Nursing. (2022, April). 2021 RN practice analysis: Linking the NCLEX-RN® examination to practice, U.S. and Canada. *NCSBN Research Brief, 81*. https://www.ncsbn.org/public-files/21_NCLEX_RN_PA.pdf

National Council of State Boards of Nursing. (2023). *Next generation NCLEX RN test plan effective April 2023*. https://www.nclex.com/test-plans.page

Nielsen, A., Gonzalez, L., Jessee, M. A., Monagle, J., Dickison, P., & Lasater, K. (2023). Current practices for teaching clinical judgment: Results from a national survey. *Nurse Educator, 48*(1), 7–12. https://doi.org/10.1097/NNE.0000000000001268

Orique, S. B., & Despins, L. (2018). Evaluating situation awareness: An integrative review. *Western Journal of Nursing Research, 40*(3), 388–424. http://doi.org/10.1177/0193945917697230

Paul, R. W., & Heaslip, P. (1995). Critical thinking and intuitive nursing practice. *Journal of Advanced Nursing, 22*(1), 40–47. https://doi.org/10.1046/j.1365-2648.1995.22010040.x

Scheffer, B. K., & Rubenfeld, M. G. (2000). A consensus statement on critical thinking in nursing. *Journal of Nursing Education, 39*(8), 352–359. https://doi.org/10.3928/0148-4834-20001101-06

Simmons, B., Lanuza, D., Fonteyn, M., Hicks, F., & Holm, K. (2003). Clinical reasoning in experienced nurses. *Western Journal of Nursing Research, 25*(6), 701–719. https://doi.org/10.1177/0193945903253092

Stubbings, L., Chaboyer, W., & McMurray, A. (2012). Nurses' use of situation awareness in decision-making: An integrative review. *Journal of Advanced Nursing, 68*(7), 1443–1453. https://doi.org/10.1111/j.1365-2648.2012.05989.x

Surjadi, M., Stringari-Murray, S., & Saxe, J. M. (2019). Entrustable professional activities in nurse practitioner education. *The Journal for Nurse Practitioners, 15*(5), e97–e102. https://doi.org/10.1016/j.nurpra.2018.12.030

Tanner, C. A. (2006). Thinking like a nurse: A research-based model of clinical judgment in nursing. *Journal of Nursing Education, 45*(6), 204–211. https://doi.org/10.3928/01484834-20060601-04

ten Cate, O. (2013). Nuts and bolts of entrustable professional activities. *Journal of Graduate Medical Education, 5*(1), 157–158. https://doi.org/10.4300/JGME-D-12-00380.1

Ulrich, B., Krozek, C., Early, S., Ashlock, C. H., Africa, L. M., & Carman, M. L. (2010). Improving retention, confidence, and competence of new graduate nurses: Results from a 10-year longitudinal database. *Nursing Economic$*, *28*(6), 363–376.

Victor-Chmil, J. (2013). Critical thinking versus clinical reasoning versus clinical judgment: Differential diagnosis. *Nurse Educator, 38*(1), 34–36. https://doi.org/10.1097/NNE.0b013e318276dfbe

Wright, D. (2005). *The ultimate guide to competency assessment in health care* (3rd ed.). Vktech.

Wright, D. (2015). *Competency assessment field guide: A real world guide for implementation and application.* Creative Health Care Management.

Index

NOTE: Page references noted with an *f* are figures; page references noted with a *t* are tables

A

B

C

D

E

F

G

H

I

J

K

L

M

N

O

P

Q

R

S

T

U

V

W–X–Y–Z