

ORIGINAL RESEARCH

Incorporation of the Lasater Clinical Judgment Rubric in evaluating the performance of nursing students in experiential settings

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ABSTRACT

Background: Evaluating nursing students' performance, in particular, clinical judgment development in experiential settings is challenging. Clinical judgment is a complex concept to define and measure. However, clinical judgment is considered a core skill and is therefore crucial to evaluate. No clinical judgment development measurement tools have been developed for use in experiential (non-simulation) settings. The purpose of this project was to incorporate an evidence-based rubric into extant tools to better evaluate student clinical judgment in experiential settings.

Methods: Literature was analyzed to support curriculum and evaluation tool development. The revised Lasater Clinical Judgment Rubric was incorporated into formative and summative evaluations that were administered by undergraduate nursing faculty on a cohort of first-year nursing students (upper division admission).

Results: Faculty feedback suggests that the tool is feasible for use in an experiential setting. Scores revealed growth across the academic year in all areas of clinical judgment.

Conclusions: The revised Lasater Clinical Judgment Rubric is feasible and provided easily accessible documentation of clinical judgment growth across the first year of nursing school. Incorporation of the rubric may help address the practice-readiness gap and contribute to positive patient outcomes.

Key Words: Clinical judgment, Experiential, Evaluation, Nurse, Rubric, Student, Tool

1. INTRODUCTION

Standardized evaluation tools intended to provide feedback to nursing students in clinical environments have not been widely adopted in the United States.^[1-3] Formative and summative evaluation in experiential settings is challenging because numerous components of clinical performance must be assessed. Clinical judgment (CJ) is one such component and is foundational to safe, effective nursing practice.^[1,4-6]

Recent national initiatives underscore the profession's shared

emphasis on CJ. The National Council of State Boards of Nursing (NCSBN) introduced the Clinical Judgment Measurement Model (CJMM) in 2019.^[7] The American Association of Colleges of Nursing (AACN) highlighted clinical judgment in The Essentials^[8,9] as a core competency within Domain One: Knowledge for Nursing Practice. A recent scoping review found limited research measuring CJ in nursing students and new graduates.^[11] These drivers served as an impetus for our School of Nursing (SoN) to revise our curriculum and evaluation tools. This article describes 1)

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our process in refining existing evaluation tools to more fully capture the concept of CJ of nursing students in the clinical environment, and 2) results from our first year in utilizing the revised tools with students.

2. BACKGROUND

2.1 Clinical Judgment: Definition and Measurement

The concept of CJ has been discussed in nursing literature for decades,^[10] though its definition continues to evolve.^[11–13] While a widely agreed upon definition remains elusive, nursing authors generally agree that CJ is a reflective cognitive process that uses a variety of data about a patient or clinical situation and results in a clinical decision. Tanner's Clinical Judgment Model (2006) defines CJ as an interpretation or conclusion about patient needs or decisions to act or not act, including modification of standard approaches based on patient responses.^[6] Tanner identifies four phases: Noticing, Interpreting, Responding, and Reflecting. Strengths of this model are that it focuses on not only the cognitive process of the nurse, but also metacognition (reflection), psychomotor process of actions and affective processes^[14] and it recognizes the importance of contextual factors (environment, what the nurse brings to the clinical situation, etc.). We chose to base our work on Tanner's model because it was the most used framework when studying CJ, it aligns with the CJMM,^[4] and it has documented psychometrics among nursing students.^[15]

Although no single evaluation tool is likely to fully capture student nurse CJ development in experiential settings, the Lasater Clinical Judgment Rubric (LCJR), based on Tanner's model, provides a potential approach. The LCJR, primarily used in simulation, evaluates Tanner's four phases of CJ, i.e., noticing, which includes the domains of focused observation, recognizing deviations from expected patterns, and information seeking. Interpreting includes the domains of prioritizing data and making sense of data. Responding includes the domains of calm, confident manner, clear communication, well-planned interventions/flexibility, and being skillful. Finally, reflecting includes the domains of evaluation/self-analysis and commitment to improvement. The four phases are rated across 11 domains scored from 1 (Beginning) to 4 (Exemplary).

Only two studies have used the LCJR with nursing students in clinical settings.^[16,17] Both used the tool as a summative evaluation and found that the tool distinguishes students by level, students rate themselves higher than faculty, and Interpreting scores are rated lowest while Reflecting scores are rated highest. Lasater & Nielsen (2024) note a potential gap in our knowledge; the LCJR can also support formative evaluation when used with reciprocal communication, knowl-

edge of the student's background, transparent expectations, and safe spaces for self-assessment.^[18] Besides further research being needed to evaluate the tool as both a formative and summative assessment, other noted gaps in our knowledge of assessment using the LCJR include the feasibility of longitudinal assessments that can document student growth (or lack thereof). Therefore, the purpose of this project is to describe the process of tailoring an existing evaluation tool to capture CJ in the clinical environment and to present results from its initial implementation as a formative and summative assessment tool in undergraduate clinical courses.

2.2 Development and Testing of the LCJR

Dr. Kathie Lasater developed the LCJR in 2007, based upon Tanner's model to describe levels of CJ performance in the simulation environment.^[19] Junior level nursing students enrolled in an adult medical-surgical clinical course were observed in a simulation lab over seven weeks. Fifty-three observations were completed via a description-observation-revision-review cycle in which a simulation facilitator and the researcher wrote best and worst descriptors of Tanner's four model phases and created distinct dimensions to each phase. Noticing includes focused observation, recognizing deviations from expected patterns, and information seeking. Interpreting includes prioritizing data and making sense of data. Responding includes calm, confident manner, clear communication, well-planned interventions/flexibility, and being skillful. Finally, reflecting includes evaluation/self-analysis and commitment to improvement. These 11 domains were rated on a rating scale of Beginning (1), Developing (2), Accomplished (3), Exemplary (4), with a total score of 11-44 points possible. The LCJR has been translated into over 20 languages.^[18] Psychometric data for the simulation environment reveals interrater reliability of 0.89, intrarater reliability of 0.91, and an internal consistency of 0.97.^[15,16] Validity was documented as acceptable in that faculty could discern between junior and senior level students.

Overall, authors who have used the tool in their published work describe several benefits specifically related to the development of CJ. Straightforward verbiage provides a common language for instructors (or RN preceptors) and students to discuss specific and actionable ways to improve their clinical performance. This occurs through the promotion of constructive feedback, higher-level questioning, and goal setting.^[20] Critiques of the LCJR included that wide range of domains and multiple users necessitate extensive training to all using the LCJR in practice.^[2]

While it is unlikely that a 'one-size-fits-all' tool will ever be available to evaluate clinical judgment in the experiential setting, a reasonable approximation may be the LCJR –

though it was originally developed and tested in a simulation setting. We chose to utilize the LCJR because it is the most frequently used tool to evaluate the development of clinical judgment in nursing^[1,21] and is aligned with the most used model for clinical judgment.^[1,18] Further, nurse researchers emphasize the importance of building upon prior evidence in utilizing instruments that are valid and reliable such as the LCJR.^[1,5,18,20,21]

3. METHODS

3.1 Development of the Experiential LCJR (E-LCJR)

We aimed to build upon Tanner and Lasater's work and closely model the LCJR to fit a clinical or experiential environment (i.e., non-simulation). Our interest was in incorporating the LCJR into formative and summative evaluations throughout our junior level curriculum at a Midwest university offering a traditional, upper division admission baccalaureate degree in nursing.

In preparation for revising our curriculum, a Clinical Judgment Fellowship program was offered to our SoN experiential faculty. Our school partnered with the campus Center for Teaching, Learning and Mentoring to develop a semester long program to support faculty in learning about CJ, including Tanner's CJ model. Faculty gathered weekly to meet program outcomes which included content acquisition, skills development, and application of clinical judgment. The fellowship fostered the identification, practice, and implementation of teaching approaches that helped students learn clinical judgment skills in ways that prepare them for their future careers. After the fellowship concluded, these authors were spurred to conduct a critical appraisal of our clinical evaluation instruments. An initial scoping review of the literature was undertaken to analyze what is known on the topic of extant instruments used to evaluate nursing student performance in the clinical environment. Our question was: "Within published literature, what is known about the assessment of nursing students' clinical judgment within the clinical environment?" Of the identified articles, there was no tool identified to measure CJ in clinical settings.

With a paucity of literature to guide our work, we decided to focus on recent national drivers (AACN BSN New Essentials, competency-based education, and the NCSBN CJMM) and our own expertise. Ultimately, we determined that the LCJR was a reasonable choice to incorporate into our new vision for evaluation tools. It was rooted in an established CJ framework,^[6] utilized common language for all partners (instructors, RN preceptors that students would interact with during their final year clinicals, and students), and had acceptable

published psychometric properties in similar populations of students.

The authors reviewed course objectives and student learning outcomes and then cross-referenced these items with the New Essentials and the LCJR. Our summative evaluation tool was revised to include the categories of 1) Clinical Judgment, 2) Professionalism, 3) Communication, and 4) Safe & Therapeutic Nursing Care. We then incorporated a version of the LCJR into section 1 (Clinical Judgment). To adapt the LCJR for the clinical environment, we made three revisions with permission of Kathie Lasater (email communication 6/29/24). First, in the domain of Responding, we reversed the order and listed "Being Skillful" first followed by "Well-Planned Intervention/Flexibility". Our reasoning was that nurses generally perform a skill (e.g., administer a medication, provide patient education) and then monitor progress to ascertain if a change is needed (e.g., medication did/not have intended effect, patient education was/not effective). Second, we added Tanner's terms "Reflection-IN-Action" (i.e., patient evaluation, post-intervention) in the Responding domain of "Well-Planned Intervention/Flexibility) and "Reflection-ON-Action" (i.e., self-evaluation of performance) in the Reflecting domain. Third, in the domain of reflecting, we emphasized the word "Self" (by bolding/underlining) in both areas: "Evaluation/Self-Analysis" and Commitment to Self-Improvement". We felt these final two changes were important to clarify, as the domains of Responding and Reflecting both include the word 'reflection', but the focus of the reflection is quite different between the two domains. As our goal was to update both formative and summative evaluation tools, we incorporated the revised E-LCJR (see Figure 1) into weekly clinical journal assignments (see Figure 2) and midterm/final evaluations (as described above).

3.2 Setting

The SoN is in a midwestern urban setting. The BSN program is an upper division admission program, with 2 years in pre-nursing courses and 2 years in nursing courses. A recent shift from concept-based to competency-based occurred based on the development and introduction of the 2021 AACN Essentials and subsequent 2026 AACN Essentials.

Our 3rd-year (junior) level students engage in an assessment course and basic clinical skills course (7 weeks) and then attend clinical at assisted living and skilled nursing (long-term care) facilities over the second 8 weeks of the fall semester. Both courses include CJ concepts. Second semester (spring) students spend 15 weeks in an acute care setting. All experiential learning is supervised by clinical instructors and is taken as credit/no credit.

Effective NOTICING involves:				
	Exemplary	Accomplished	Developing	Beginning
Focused Observation	Focuses observation appropriately; regularly observes and monitors a wide variety of objective and subjective data to uncover any useful information	Regularly observes/monitors a variety of data, including both subjective and objective; most useful information is noticed, may miss the most subtle signs	Attempts to monitor a variety of subjective and objective data, but is overwhelmed by the array of data; focuses on the most obvious data, missing some important information	Confused by the clinical situation and the amount/type of data; observation is not organized and important data is missed, and/or assessment errors are made
Recognizing Deviations from Expected Patterns	Recognizes subtle patterns and deviations from expected patterns in data and uses these to guide the assessment	Recognizes most obvious patterns and deviations in data and uses these to continually assess	Identifies obvious patterns and deviations, missing some important information; unsure how to continue the assessment	Focuses on one thing at a time and misses most patterns/deviations from expectations; misses opportunities to refine the assessment
Information Seeking	Assertively seeks information to plan intervention; carefully collects useful subjective data from observing the client and from interacting with the client and family	Actively seeks subjective information about the client's situation from the client and family to support planning interventions; occasionally does not pursue important leads	Makes limited efforts to seek additional information from the client/family; often seems not to know what information to seek and/or pursues unrelated information	Is ineffective in seeking information; relies mostly on objective data; has difficulty interacting with the client and family and fails to collect important subjective data
Effective INTERPRETING involves:				
Prioritizing Data	Focuses on the most relevant and important data useful for explaining the client's condition	Generally focuses on the most important data and seeks further relevant information, but also may try to attend to less pertinent data	Makes an effort to prioritize data and focus on the most important, but also attends to less relevant/useful data	Has difficulty focusing and appears not to know which data are most important to the diagnosis; attempts to attend to all available data
Making Sense of Data	Even when facing complex, conflicting or confusing data, is able to (1) note and make sense of patterns in the client's data, (2) compare these with known patterns (from the nursing knowledge base, research, personal experience, and intuition), and (3) develop plans for interventions that can be justified in terms of their likelihood of success	In most situations, interprets the client's data patterns and compares with known patterns to develop an intervention plan and accompanying rationale; the exceptions are rare or complicated cases where it is appropriate to seek the guidance of a specialist or more experienced nurse	In simple or common/familiar situations, is able to compare the client's data patterns with those known and to develop/explain intervention plans; has difficulty, however, with even moderately difficult data /situations that are within the expectations for students, inappropriately requires advice or assistance	Even in simple of familiar/common situations has difficulty interpreting or making sense of data; has trouble distinguishing among competing explanations and appropriate interventions, requiring assistance both in diagnosing the problem and in developing an intervention
Effective RESPONDING involves:				
Calm, Confident Manner	Assumes responsibility; delegates team assignments, assess the client and reassures them and their families	Generally, displays leadership and confidence, and is able to control/calm most situations; may show stress in particularly difficult or complex situations	Is tentative in the leader's role; reassures clients/families in routine and relatively simple situations, but becomes stressed and disorganized easily	Except in simple and routine situations, is stressed and disorganized, lacks control, making clients and families anxious/less able to cooperate
Clear Communication	Communicates effectively; explains interventions; calms/reassures clients and families; directs and involves team members, explaining and giving directions; checks for understanding	Generally, communicates well; explains carefully to clients, gives clear directions to team; could be more effective in establishing rapport	Shows some communication ability (e.g., giving directions); communication with clients/families/team members is only partly successful; displays caring but not competence	Has difficulty communicating; explanations are confusing, directions are unclear or contradictory, and clients/families are made confused/ anxious, not reassured
Being Skillful	Shows mastery of necessary nursing skills	Displays proficiency in the use of most nursing skills; could improve speed or accuracy	Is hesitant or ineffective in utilizing nursing skills	Is unable to select and/or perform the nursing skills
Well-Planned Intervention/Flexibility	Interventions are tailored for the individual client; monitors client progress closely and is able to adjust treatment as indicated by the client response	Develops interventions based on relevant patient data; monitors progress regularly but does not expect to have to change treatments	Develops interventions based on the most obvious data; monitors progress, but is unable to make adjustments based on the patient response	Focuses on developing a single intervention addressing a likely solution, but it may be vague, confusing, and/or incomplete; some monitoring may occur
Reflection-IN-Action [Evaluation of Patient Response] Reflection-ON-Action [Self-Evaluation of Performance]	Effective REFLECTING involves:			
	Independently evaluates/ analyzes personal clinical performance, noting decision points, elaborating alternatives and accurately evaluating choices against alternatives	Evaluates/analyzes personal clinical performance with minimal prompting, primarily major events/ decisions; key decision points are identified, and alternatives are considered	Even when prompted, briefly verbalizes the most obvious evaluations; has difficulty imagining alternative choices; is self-protective in evaluating personal choices	Even prompted evaluations are brief, cursory, and not used to improve performance; justifies personal decisions/choices without evaluating them
	Demonstrates commitment to ongoing improvement: reflects on and critically evaluates nursing experiences; accurately identifies strengths/ weaknesses and develops specific plans to eliminate weaknesses	Demonstrates a desire to improve nursing performance: reflects on and evaluates experiences; identifies strengths/ weaknesses; could be more systematic in evaluating weaknesses	Demonstrates awareness of the need for ongoing improvement and makes some effort to learn from experience and improve performance but tends to state the obvious, and needs external evaluation	Appears uninterested in improving performance or unable to do so; rarely reflects; is uncritical of him/herself, or overly critical (given level of development); is unable to see flaws or need for improvement

Figure 1. Experiential-Lasater Clinical Judgment Rubric, adapted with permission from Dr. Kathie Lasater, email communication June 29, 2024^[19]

3.3 Participants

Students (161) were predominantly female identifying (88%), with an average age of 21.6 (range 19-54). Per admission

statistics, 71% were white and 35% stated they had completed certified nursing assistant training.

N316 Weekly Clinical Judgment Journal and Self-Evaluation

Clinical Judgment Journal				
Noticing: Briefly describe something from your clinical day with your resident/patient that you initially noticed as abnormal or significant or concerning.				
Interpreting: Describe your interpretation of what you noticed. Name your patient priority (ex. pain, nausea, skin integrity, nutritional issues, fluid imbalance, etc.). List subjective and objective data that provide evidence for why this was the most important priority today. Significance: Why did you think this was clinically significant? Create a SMART patient goal.	Patient Priority #1			
	Assessments:			
	Significance:			
	S-M-A-R-T Patient Goal:			
Responding: How did you (and/or your nurse) respond to this issue (what intervention or nursing action occurred)? What goal do you hope your patient will achieve because of your intervention/action? How did you know if your intervention/nursing action was effective? If it was not, what would you do differently next time?				
Reflecting: Describe one thing you felt good about in clinical this week and why. Aim to use the language of the E-LCJR				
Describe one thing you would have changed about your performance in clinical this week and why.				
Self-Evaluation				
Select one for each area of the E-CJR: Beginning, Developing, Accomplished, or Exemplary [rare]	Noticing =	Interpreting =	Responding =	Reflecting =
Professionalism (MET/ UNMET):				
S-M-A-R-T Goal - Create a SMART goal r/t your clinical performance. Please do not write a goal based on completing a specific psychomotor nursing skill. - Did you meet last week's SMART goal? Explain.	Next week, From last week,			

Figure 2. Weekly clinical judgment journal and self-evaluation template

Clinical instructors (15 and 14 in the fall and spring, respectively) were predominantly female identifying (> 90%) and white (83%), with an average age of 51. The instructors were all masters or doctoral prepared and all were employed full-time by the SoN. Each clinical group had a maximum of eight students.

3.4 Procedure

Training

Training regarding the evaluative process was provided to instructors and students each semester. In the fall (week 7

of the semester, before clinical rotations began), students received instruction on the weekly (formative) CJ journal expectations and accompanying rubric and the summative evaluation tool. This included an overview of Tanner's model, the E-LCJR and examples of student responses/actions in the different areas (Noticing, Interpreting, etc.) and at what level of CJ they were evaluated (Beginning, Developing, etc.). In the spring, students were reoriented to the evaluation tools (formative and summative) with a review of the E-LCJR and by actively participating in 'grading' distinct examples, such as 'patient with chest pain, student did not obtain or

assess VS' as 'Beginning' in 'Recognizing Deviations from Expected Patterns'.

Before each semester, clinical instructors were oriented to the formative and summative evaluation tools by the author (CV). The objectives of this training were (1) define CJ, (2) describe Tanner's CJ model and the Lasater CJ rubric, (3) analyze three short written vignettes of student clinical performance, and reach consensus on vignettes of subscale (i.e., 'Interpreting', etc.) and level (i.e., 'Beginning', etc.), and (4) identify categories of evaluation (e.g., CJ, professionalism, communication, and safe and therapeutic nursing care). During orientation to the E-LCJR, an emphasis was placed on use of the formative tool in evaluation of the nursing student's overall clinical performance that week (i.e., entire clinical shift, post-conference debriefing, etc.) and not just the student's weekly journal.

Though four levels (Beginning through Exemplary) of the CJ tool are included in the rubric, instructors and students were instructed that a total score of Exemplary was not expected during first year of clinical rotations. An emphasis was placed upon CJ as a process and development over time, not CJ as an endpoint for any given semester. Further, it was not reasonable to expect 'exemplary' or a score of '44' as a junior-level student. Rather, progress each week (formative) and each semester (summative) was the expectation.

3.5 Data Collection

3.5.1 Formative Evaluations

Students submitted journals most weeks of both semesters. Orientation, evaluation, and heavy clinical assignment (care plans) weeks were exempt. A Word document template was created with focused CJ prompts (see Figure 2). Students completed the document (including a self-evaluation of CJ development) and uploaded the document to our online learning platform (Canvas) within 48 hours of their clinical day. Instructors utilized the E-LCJR as part of their evaluation of the weekly journal, clinical performance and post-conference participation. Instructor feedback was given before the following clinical week.

3.5.2 Summative Evaluations

Only a final evaluation was done in the first semester due to the short timeframe of eight weeks. Second-semester summative evaluation data included midterm and final scores. The same tool was used each semester and included strengths and areas for improvement. The evaluation included the E-LCJR under the main heading of Clinical Judgment (scored as Beginning, Developing, Accomplished, or Exemplary), as well as the main headings of Professionalism, Communication, and Safe and Therapeutic Nursing Care. The final three areas

were evaluated as "meets expectations/does not meet expectations/exceeds expectations". Students completed the form first in our online system (Exxat), followed by instructors. Students and instructors met in person for 20-30 minutes at each point to discuss clinical performance. E-LCJR scores were extracted from the online system and analyzed (e.g., standard deviation) via Excel software.

4. RESULTS

Formative evaluations were done most weeks over the academic year and based upon the student's clinical performance, written journal, and post-conference participation. Journals were submitted by students and evaluated by instructors in a timely manner. Overall, instructor feedback was positive in that the rubric served as a tool to develop student CJ skills (see Discussion).

The first semester (final only) and second semester (midterm and final) total E-LCJR averages revealed clinical instructor scores of 26.71, 25.93, and 33.81, respectively. Student total E-LCJR averages were 22.52, 24.13, and 29.19, respectively. All instructor average scores were consistently higher than student average scores. Instructor average scores (total and sub scores) revealed a slight decrease at midterm of the second semester, except for Reflecting which increased each time. All student average total and sub scores increased each semester. Both instructors and students consistently scored the overall category Interpreting as the lowest and Reflection as the highest. Average instructor scores for the year increased from 26.71 (61%) to 33.81 (77%), revealing growth from 'Developing/Accomplished' to 'Accomplished'. Average student scores increased from 22.52 (51%) to 29.19 (66%), demonstrating growth from 'Developing' to 'Developing/Accomplished'.

Summative results (total scores, sub scores, standard deviations and percentages) are summarized in Table 1.

5. DISCUSSION

This article describes 1) a process for refining an existing evaluation tool to more fully capture the concept of clinical judgment among nursing students in the clinical environment, and 2) aggregate results from our first year in utilizing the revised tools with students. To our knowledge, two prior reports investigated the utility of using the LCJR in the clinical environment with nursing students.

Our process and subsequent finding differed from prior reports^[16,17] in four critical ways that add to the current literature. First, we first revised the LCJR to more closely align with clinical practice (i.e., perform a skill, then assess patient response to that intervention). Second, we included

the E-LCJR in both formative and summative evaluations. Third, we included instructor evaluations and all student self-evaluations over the course of two semesters to demonstrate sensitivity to change for the tool. This contrasts with utilizing only instructor evaluations,^[16] using a subset of students, and utilizing the LCJR over the course of one semester.^[16,17] Finally, we elicited clinical instructor feedback on this new process. Instructor insights at the end of the academic year suggest the incorporation of the E-LCJR into our evaluation tools was helpful at guiding students in their learning about CJ:

“I found the weekly journal question on setting priorities extremely helpful in starting and maintaining a dialogue with students. They would often approach me to ask for help with their critical thinking on what should be their first priority out of the 2-3 they had come up with based on their patient assessment, chart review and report. Then I could ask questions as to which would be most clinically significant, how the priorities are depending on one another and possibly the root cause. Then we could establish a goal along with pharm and non-pharm interventions.”

Table 1. Experiential-lasater clinical judgment rubric aggregate scores

Instructor	Possible Range	1st Semester Final Score		2nd Semester Midterm Score		2nd Semester Final Score	
		Final Score (SD)	Percentage (%)	Final Score (SD)	Percentage (%)	Final Score (SD)	Percentage (%)
E-LCJR Total	11-44	26.71 (5.49)	61	25.93 (3.49)	59	33.81 (5.61)	77
Noticing	3-12	6.96 (1.56)	58	6.62 (1.09)	56	9.13 (1.73)	77
Interpreting	2-8	4.43 (1.01)	55*	4.25 (0.63)	54*	5.9 (1.1)	74*
Responding	4-16	10.2 (2.48)	64**	9.65 (1.57)	61	12.14 (2.1)	76
Reflecting	2-8	5.12 (1.1)	64**	5.25 (0.92)	66**	6.42 (1.09)	81**
Student	Possible Range	Final Score (SD)		Percentage (%)		Final Score (SD)	
		Final Score (SD)	Percentage (%)	Final Score (SD)	Percentage (%)	Final Score (SD)	Percentage (%)
E-LCJR Total	11-44	22.52 (5.28)	51	24.13 (4.4)	55	29.19 (4.64)	66
Noticing	3-12	5.9 (1.5)	49	6.25 (1.19)	52	7.65 (1.33)	64
Interpreting	2-8	3.78 (1.08)	47*	3.94 (0.86)	50*	4.83 (0.98)	61*
Responding	4-16	8.29 (2.16)	52	8.95 (1.98)	56	10.82 (1.92)	68
Reflecting	2-8	4.55 (1.16)	57**	4.83 (1.11)	61**	5.7 (1.16)	72**

*Lowest percentage; **Highest percentage.

“The tool also helped the teaching process. After reviewing responses, instructors could give feedback to students directing or molding their critical thinking and clinical judgment. It also gave instructors a tool with which they could evaluate student progress throughout the semester and to see the student’s growth in clinical judgment.”

“Weekly journals helped me for midterm and final evaluations; I reflected on students’ growth.”

Aggregate results from our first year of incorporating the LCJR align with prior studies in clinical and simulation settings with nursing students. This includes the end-of-year average E-LCJR aggregate scores (student: 29.19, Developing/Accomplished and instructor: 33.81, Accomplished) and sub scores. Manetti (2018) reported junior-level student total LCJR average scores of 30 (instructor only).^[16] Vreugdenhil & Spek (2018) reported scores of 30.32 (nurse educators), 30.93 (nurse coaches) and 32.34 (students), though junior-level results were not specifically reported as all student data

was combined.^[17]

Similar to prior reports, the overall category of Reflecting was consistently the highest rated by instructors and students. In Reflecting, the subscale of “Commitment to Self-Improvement” was rated highest 5 of 6 times over the course of the year. Throughout the year, the weekly journals included multiple questions on reflection (see Figure 2), so this requirement may partially explain the high scores of the subscale. Another reasonable explanation is that self-reflection in clinical practice may be a more transferable skill than the categories of Noticing, Interpreting, and Responding. Continuing to foster meaningful reflection in nursing students remains a fundamental and foundational competency in nursing students as they develop CJ skills.

Consistent with prior studies,^[16,17] the category of Interpreting was scored the lowest at each time point over the year by both instructors and students and was noted as a deficit in a recent report of New Graduate Nurses (NGNs).^[22] Of

the two criteria in Interpreting, “Making Sense of Data” was consistently (5 of 6 times) scored the lowest by both students and instructors, over “Prioritizing Data”, similar to Vreugdenhil & Speck coach/educator results. This may be explained by the ability of students to write in their journals and speak about what happened during the clinical day in post-conference. Although students can voice **what** occurred, they may still struggle in explaining **why** events/situations happened. This finding presents an opportunity for clinical instructors to focus on real-time questions during the clinical day (including post-conference) that help students make meaning of why the clinical scenario unfolded in a certain way. Gonzalez et al., encourages the specific question (Prioritizing Data): “What was the number one priority for this patient and why?” In Making Sense of Data, a recommended question is: “What did you know (or need to know) that helped you to determine what this patient needed?”^[23](p. 490).

As anticipated, E-LCJR scores generally increased over the course of two semesters. Interpretation should be tempered by the exploratory nature of our project design and descriptive analysis. In other words, the increase in scores may be a function of time, with students’ scores naturally progressing via the nursing curriculum. There was a slight decrease for instructors’ scores at midterm second semester. This may be explained by the fact that students were at a new clinical site (acute care), with a new instructor. A difference from prior reports is that students rated themselves lower than instructors. Our orientation and reiteration over the course of the year that first-year nursing students would be unlikely to demonstrate clinical judgment at an Exemplary level may explain this result. A surprising finding was no use of our usual Student Success Plans (SSPs) for struggling students related to CJ. This may be explained by utilizing a common language around CJ development if struggling in the clinical environment: verbally (during the clinical day and in post-conference) as well as in written student journals and instructor feedback on the journal and weekly performance. To our knowledge, this is the first report of a large cohort (161 students) incorporating the revised LCJR (E-LCJR) into formative and summative evaluations over one year for nursing students in clinical practice. We plan to utilize a version of the E-LCJR with our senior students and RN preceptors next year.

Though we did not study or document specific psychometrics, the fact that 1) students and instructors aligned 2) scores increased over time, and 3) our scores were consistent with two previous studies of nursing students in the experiential setting, may provide further evidence for construct validity,

internal consistency, interrater reliability and intra-rater reliability. Rigorous and well-designed studies are needed to document the reliability and validity of the E-LCJR.

Our results were similar to scores in a recently published study focused on simulation with 53 students over 2 years,^[20] suggesting extrapolation from simulation to clinical (and vice versa) may be warranted to tease out any differences in development of CJ across these two ‘clinical’ learning environments.

Implications for nursing education, practice and research

The results of this project have several implications. This project focused on the process of incorporating the E-LCJR into extant formative and summative evaluation tools and found that it is feasible and positively received by both students and faculty. As CJ is a foundational concept around which professional nursing has coalesced, it should be evaluated in most, if not all SoN clinical courses. Incorporating specific elements of the E-LCJR or the entire rubric may be a straightforward endeavor. Benefits of using the rubric as we did include alignment of CJ common language in both formative and summative evaluation tools, contributing to meaningful and impactful dialogue between instructors (or preceptors) and students, and the opportunity for learning to reflect upon their growth and recognize that learning is life-long in the profession. The potential long-term benefit of increasing readiness-to-practice to positively impact patient outcomes remains to be seen and requires further follow-up and longitudinal data.

Another implication is that this work contributes to a growing body of knowledge around the struggle that students face with the Interpreting domain, specifically in Making Sense of Data. Posing more focused, higher-level questions to students can help them begin to ‘think like a nurse’. Specific dialogue around the Interpreting domain can clarify gaps in knowledge that provide feedback for actionable change and clinical performance improvement. The weekly journal prompts (easily posed during the clinical day and in post-conference discussion) for this area are listed in Figure 2. The Tanner/Lasater domain of Interpreting aligns with the CJMM areas (Layer 3): Analyze Cues, Generate Hypotheses, and Generate Solutions. Questions such as: “What findings did you expect based on the client’s diagnosis/concern? What other information can you gather to help you determine the significance of the cues? What sets of cues are most concerning?” all reveal student thinking around Analyzing Cues. The prompts: “What is most likely occurring? What makes you say that? What will happen if this is not treated? What

else could be going on?” help instructors discuss thinking around Generating Hypotheses. Finally, questions: “What are the desired outcomes related to your hypothesis? (Give at least 2). What interventions are indicated? What interventions should be avoided?” elucidate student thoughts around Generating Solutions^[24](p. 130).

Future research with studies designed to provide correlational and/or causal evidence for the E-LCJR is needed. Further, these studies could document psychometrics for the E-LCJR in experiential settings, including intra-rater reliability. We did not vigorously test intra- and inter-rater reliability, and so another area of study could focus on scoring or rubric drift to ensure instructors and preceptors score consistently over time and context. Another potential area of research is to utilize the E-LCJR in Nurse Residency programs to assess CJ development longitudinally and has previously been suggested.^[5,25] The profession cannot hope to improve what it cannot measure, and though concepts as complex as CJ are not fully measurable, the endeavor itself is important to ensure well-prepared New-to-Practice nurses and positive patient outcomes.

6. CONCLUSION

The process of incorporating valid and reliable tools to evaluate CJ in experiential settings is feasible and beneficial. Including the E-LCJR can ensure that students are developing skills to provide safe and effective care to patients^[26] and has the potential to increase readiness to practice in new graduate nurses.^[27] The use of an evaluation tool in formative and summative assessments can foster a deeper understanding of clinical judgment development and reduce bias by establishing objective criteria and leveling. Formative evaluations are effective when they involve 1) reciprocal communication (individually during the clinical day or in reading feedback on a journal, or in group settings like post-conference), 2) knowing the student’s background (as educators typically do in an 8-15 week long clinical experience), 3) transparent expectations (via a well-written rubric utilizing a common language), and 4) providing safe spaces for self-assessment (via repetition with written weekly journals).^[18] Disentangling the four distinct domains of CJ helps instructors and preceptors with individual students to elucidate specific components of the CJ development process by posing more focused, high-level questions during the clinical day, in weekly/formative written journals and in post-conference debriefing sessions. Finally, aggregate data from summative evaluations, may help guide schools to more strategic curricular adjustments.

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AUTHORS CONTRIBUTIONS

Ms. Voge was responsible for the initial project idea and led development of the E-LCJR. Dr. Bratzke provided mentoring and collaboration for the project design, data collection, and analysis. Ms. Voge provided the initial draft of the manuscript and Dr. Bratzke revised the manuscript. Both authors approved the final draft of the manuscript. Both authors contributed to the manuscript in substantive and meaningful ways.

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The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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No additional data are available.

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