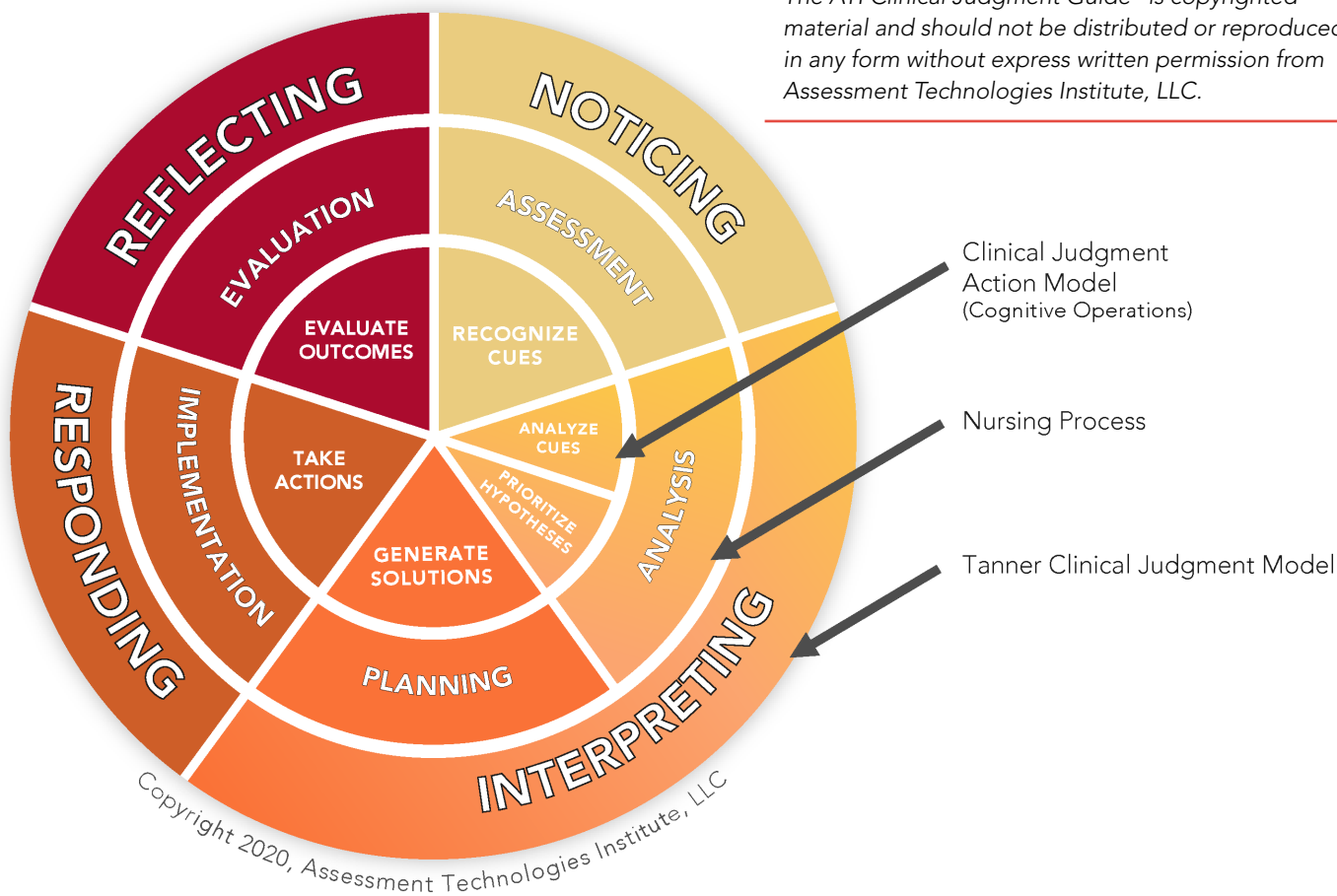


The purpose of the ATI Guide for Clinical Judgment is to assist nurse educators in the development and implementation of learning materials to promote clinical judgment (CJ) skills in nursing students throughout their nursing education experience and transition into nursing practice. For example, the Guide may be used as a framework for creating learning activities such as scenarios for simulation, writing unfolding case studies, and developing test items.

The Guide is based on the National Council of State Boards of Nursing (NCSBN) Clinical Judgment Measurement Model (CJMM) (NCSBN, Winter, 2019, Spring, 2019; Dickison, Haerling, & Lasater, 2019; Dickison, et, al 2016) and contains three major areas of nursing practice including Factors to Consider, Clinical Judgment Functions and Expected Responses and Behaviors (Tables 1 and 2). The NCSBN designed the CJMM to test clinical judgment on the nursing licensure examination. The Clinical Judgment Action Model (CJAM) was subsequently developed to connect what is measured on the licensure exam to what is taught in nursing education. The CJAM is a resource for educators to use as they help students develop clinical judgment skills. The Relationship of Approaches Fostering Clinical Judgment (Figure 1) illustrates the relationship between the CJAM (NCSBN, 2019), Tanner’s Clinical Judgment Model (Tanner, 2006), and the Nursing Process (Smeltzer, 1980).

FIGURE 1 The Relationship of Approaches Fostering Clinical Judgment

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Factors to Consider

Table 1 displays the environmental and individual factors that a nurse must consider and how they relate to expected responses and behaviors (Table 2) for each of the CJ Functions that correspond with the cognitive operations of the CJAM (NCSBN, 2019).

TABLE 1: ENVIRONMENTAL AND INDIVIDUAL FACTORS

| <i>Environmental Factors</i> | <i>Individual Factors</i> |
|--|--|
| Setting, Situation, and Environment (i.e., safety considerations, equipment, surroundings) | Nurse factors: (i.e., knowledge, skills, specialty) |
| Client observation (i.e., age, symptoms of health alteration) | Nurse Characteristics (i.e. attitudes, prior experiences, level of experience) |
| Resources (i.e. staffing, supplies, beds, care partners, etc.) | Cognitive load (i.e. demands on the nurse, stress, problem solving, memory) |
| Health Record (i.e., history, labs, vs, diagnostic tests, I&O, medications, treatments) | |
| Time pressure (i.e., pager, STAT medication, change in client condition) | |
| Cultural Consideration (i.e., language, literacy, religion, diet) | |
| Task complexity (i.e., level of difficulty, complicated versus simple action, number of people involved, sound delegation) | |
| Risk assessment (i.e., identifying and finding ways to remove or minimize harm to promote safety and health) | |

TABLE 2: ATI CLINICAL JUDGMENT GUIDE: CLINICAL JUDGMENT FUNCTIONS AND EXPECTED RESPONSES AND BEHAVIORS

| <i>Clinical Judgment Functions (Nursing Process Steps)</i> | <i>Expected Responses and Behaviors</i> |
|--|--|
| <p>Recognize Cues (Assessment) Filter information from different sources (i.e., signs, symptoms, health history, environment).</p> | <ul style="list-style-type: none"> • Identify relevant information related to the client’s condition. • Use knowledge, experience and evidence to assess clients. • Use verbal, nonverbal, written, and electronic modes of communication. • Recognize relevant subjective/objective client data. • Identify subtle and apparent changes in client condition and related factors |
| <p>Analyze Cues (Analysis) Link recognized cues to a client’s clinical presentation and establishing probable client needs, concerns, or problems.</p> | <ul style="list-style-type: none"> • Compare client findings to evidence-based resources and standards of care. • Analyze expected and unexpected findings in health data. • Anticipate illness/injury and wellness progression. • Identify client problems and related health alterations. • Analyze client needs. • Identify potential complications. • Identify how pathophysiology relates to clinical presentation. • Identify data that is of immediate concern. |
| <p>Prioritize Hypotheses (Analysis) Establish priorities of care based on the client’s health problems (i.e. environmental factors, risk assessment, urgency, signs/symptoms, diagnostic test, lab values, etc.).</p> | <ul style="list-style-type: none"> • Organize client assessment information according to changes, patterns and trends. • Use standards of care and empirical frameworks for priority setting. • Establish and prioritize client problems/needs based on the analysis of information and factors. |
| <p>Generate Solutions (Planning) Identify expected outcomes and related nursing interventions to ensure clients’ needs are met.</p> | <ul style="list-style-type: none"> • Collaborate with members of the interprofessional healthcare team to establish client outcomes and the plan of care. • Collaborate with client and care partners to establish client outcomes and the plan of care. • Identify optimal client outcomes based on information and factors. • Identify evidence-based nursing actions to effectively address the clinical situation of the client’s health problem. • Prioritize plan of care to achieve optimal client outcomes. • Prioritize nursing care when caring for multiple clients. • Re-prioritize nursing actions as the client’s condition changes. • Modify a plan of care to assure achievement of optimal client outcomes when indicated. • Determine the potential impact of selected interventions. |

| <i>Clinical Judgment Functions</i> | <i>Expected Responses and Behaviors</i> |
|--|--|
| <p>Take Actions (Implementation) Implement appropriate interventions based on nursing knowledge, priorities of care, and planned outcomes to promote, maintain, or restore a client's health.</p> | <ul style="list-style-type: none"> • Promptly and accurately perform nursing actions based on prioritized client problems. • Implement a plan of care in collaboration with members of the interprofessional health care team. • Implement a plan of care in collaboration with the client and care partners. • Accurately document client care data and information • Incorporate client preferences and needs when performing nursing actions. • Provide education to the client and/or care partner(s) regarding their health condition and care management. • Participate in coordination of care with the client and healthcare team. • Monitor the client's response to interventions. |
| <p>Evaluate Outcomes (Evaluation) Evaluate a client's response to nursing interventions and reach a nursing judgment regarding the extent to which outcomes have been met.</p> | <ul style="list-style-type: none"> • Reassess client condition to determine achievement of expected outcomes. • Evaluate efficacy of nursing actions determine if client outcomes were met. • Modify client outcomes and/or nursing actions based on the client's response and clinical findings when indicated. • Update and revise the plan of care. |

Assumptions informing ATI Guide for Clinical Judgment

Certain key assumptions were considered when developing the Guide to support nursing actions related to CJ. The assumptions are based on evidence commonly accepted to be true in nursing education and serve as the foundation for the identified actions that nurses must perform when using CJ in the delivery of client care. Client is defined as an individual, family, group, or community. The assumptions that follow must be considered when implementing the ATI Guide for Clinical Judgment.

- Actions and indicators are based on best evidence, science, and empirical works, as well knowledge and reflection on nursing practice.
- Experience often provides an intuitive grasp of a situation, which is influenced by knowledge and reflection on past events and encounters.
- Actions do not happen in isolation as CJ is an iterative, ongoing process.
- Communication such as verbal, nonverbal, written, and electronic are essential to all aspects of CJ related to nursing care.
- Collaboration with members of the interprofessional healthcare team are critical components throughout the CJ process.
- Prioritization of client problems is performed by applying a priority setting framework which may include: Nursing Process, Airway Breathing Circulation, Maslow's Hierarchy, Safety-Risk Reduction, Least Restrictive-Invasive, Acute vs Chronic, Stable vs unstable, Survival potential.
- Nurses are vital members of the interprofessional healthcare team and collaborate with other members to implement actions to achieve desired client outcomes.

- Nurses work with clients and care partners (family members and friends identified by the client, who agree to be included as members of the care team and accept responsibilities for the client's care (Planetree, 2017) to develop and implement an individualized, holistic, inclusive, plan of care.
- Nurses advocate on behalf of clients and care partners to promote optimal health.
- Safety considerations are addressed throughout the iterative CJ process including environmental and individual factors.
- Social Determinants of Health (SDH) and other factors that influence health are considered to achieve optimal client care outcomes.

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