

ORIGINAL RESEARCH

The experience and understanding of clinical judgment of internationally educated nurses

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ABSTRACT

Clinical judgment is critical to the development of professional knowledge, as it supports the reasoning necessary for nursing practice. However, the literature indicates that a significant number of novice practitioners in health care do not meet entry-to-practice expectations for clinical judgment and have difficulty transferring knowledge and theory into practice, regardless of educational preparation and credentials. In the Ontario health-care environment, Internationally Educated Nurses (IENs) are considered novice practitioners. This study explores IENs' experience and understanding of clinical judgment when engaged in a simulated clinical environment and in stimulated recall and reflective practice. The research employs qualitative descriptive open-ended exploratory and interpretive methods, informed by constructivism and transformative-learning theories. The participants (four IENs, aged 27-37, who were attending a university academic bridging program) participated in three interactive simulated clinical activities using high-fidelity SimMan™ manikins; each simulated activity was followed by a stimulated recall session and a focus group. The simulated activities were videotaped and stimulated recall and focus groups were audiotaped. Tanner's Model of Clinical Judgment was used to guide this process. Thematic analysis uncovered six themes pertaining to IEN's experience and understanding of clinical judgment: the shift from expert to novice, the need to rethink cultural competence and culturally competent care, the acknowledgement that culture and diversity are integral to understanding clinical judgment, the role of communication as a means to understanding clinical judgment, the recognition of unlearning as a way to understanding clinical judgment, and the phenomenon of unknowing as a dimension of understanding clinical judgment.

Key Words: Clinical judgment, Internationally educated nurses, Reflection, Stimulated recall, High-fidelity patient simulation, Novice practitioners

1. INTRODUCTION

Clinical judgment is a critical component of nursing practice, as it assumes a great importance within a changing and dynamic health-care system. The application of clinical judgment is essential, as the provision of safe and effective care requires nurses to be able to make accurate decisions about what is happening, what needs to be done, how soon, and why. When a nurse is unable to effectively respond, the patient's condition is unlikely to be safely managed. Various

studies have identified that a significant number of novice nurses and new graduates do not meet expectations for entry-level clinical judgment, primarily as a result of consistent limitations related to accurate problem recognition. This finding is consistent amongst nurses who graduated from a range of post-secondary programs, including diploma, associate degree, and baccalaureate.^[1-3]

Internationally Educated Nurses (IENs) are also considered novices, specifically when introduced to the practice and

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culture of nursing within the Ontario health-care environment. The literature acknowledges that IENs have experienced barriers in meeting entry-to-practice requirements and in obtaining full licensure to practice in Ontario.^[4,5] This finding emphasizes the significance of investigating IENs' experience and understanding of clinical judgment, as clinical judgment is based on one's values and beliefs and may differ from one culture to another. Further, the language of clinical judgment is culturally determined and, thus, the understanding of its meaning may differ amongst practitioners.

In Ontario, IENs who do not meet entry-to-practice competencies must enter bridging programs in order to meet the College of Nurses of Ontario (CNO) practice standards. My research is predicated on the position that the transition to practice of newly arrived international nurses is an issue both from an education and a regulatory position. To support IENs' ability to meet current CNO standards and competencies, additional pedagogical modes of education are to be considered. Research indicates that those IENs who do obtain registration experience integration difficulties in the workplace, mainly due to cultural barriers.^[5,6]

Clinical judgment is essential for nursing practice, as performance is based on judgment. Although clinical judgment is a requisite skill for every nurse, teaching it has been a challenge. While teaching methods exist to promote the application of clinical judgment within undergraduate nursing education, conflicting results have limited the application of these methods in the educational front.^[7] Research studies that evaluated the effectiveness of interventions to enhance clinical judgment have yielded results that "do not inform pedagogical practice"^[7] (p. 214).

Given that health care is an ever-evolving field and that nursing content is continually changing, it is impossible to teach nurses or nursing students "everything"; Therefore, it is imperative to explore novice practitioners' experience and understanding of clinical judgment in order to apply appropriate pedagogical approaches that support and enhance clinical judgment in both the classroom and the clinical arena. Exploring how clinical judgment is understood and experienced will provide an opportunity to better recognize the challenges related to its application within practice.

2. METHODS

This study investigated IENs' understanding and experience of clinical judgment by employing a simulated clinical environment, as well as reflection and stimulated recall. This investigation was performed using a qualitative, open-ended, exploratory, descriptive, and interpretive framework. Exploring IENs' experience and understanding of clinical judgment

will, potentially, provide educators with implications in terms of the best pedagogical approaches to use to support IENs' acquisition of clinical judgment and decision-making skills.

2.1 Conceptual framework

Tanner's Clinical Judgment Model^[8] was used as the conceptual framework in this research, as it describes the components of clinical judgment in patient-care situations. The model guided methodology and data collection in order to further explore the understanding and experience of clinical judgment among IENs when engaged in high-fidelity simulation. The four stages of Tanner's model—*noticing, interpreting, responding, and reflecting*—describe "the major components of clinical judgment in complex patient-care situations that involve changes in status and uncertainty about the appropriate course of action"^[9] (p. 497). Nurses' employment of these components to refine their patient-management skills and to transfer knowledge when facing complex situations suggests a link between reflection and clinical judgment. Clinical judgment within the context of reflective practice allows nurses to think about their actions while they carry them out and to change their actions should their assessment of the situation change.

2.2 Participants and setting

A purposive sample of four students enrolled in the IEN program at a local university in Toronto, Ontario was employed in this study. The literature suggests that a group of four students is ideal for simulation experience.^[10]

After consent was obtained, participants engaged in a) a preliminary interview to collect data regarding their demographics and their educational, clinical, and professional background; and b) three interactive clinical-simulation group activities, using SimManTM high-fidelity manikins. The rationale for using the group format in this study stems from a theoretical perspective rooted in and aligned with sociocultural learning; working and learning in groups will prepare students for their future, as working in this manner is part of nursing practice.^[11] From a teaching-learning perspective, the use of stimulated recall is an effective tool for investigating cognitive processes, which are ameliorated when there is "indirect means of introspection in complex interactive contexts, such as the classroom"^[11] (p. 861).

2.3 Participant demographics

The participants, who were all in the same cohort and in their fifth term when engaged in the study, are identified by pseudonyms: Molly, Beatrice, Peter, and Lillian. The participants (three women and one man) ranged in age from 27 to 38 years old. All had immigrated to Canada (one from Belarus, one from Ukraine, and two from Nigeria). None

of the participants had practiced nursing in Ontario, but all had practiced outside Canada (three had three years nursing experience; the fourth had 15 years experience).

2.4 Setting

The study took place in a simulated clinical environment in local university in Toronto, Canada. The IEN program is a 20-month, 6-term program. The pedagogical activities used in this study include the application of an unfolding case (involving three successive scenarios) using high-fidelity patient simulation, reflection, and stimulated recall. In this study, the clinical-simulation environment is used as a both a tool and a pedagogical activity.

2.5 Simulation environment setup

The three simulated-case scenarios were video recorded for observation and stimulated-recall purposes. The participants had not engaged in a high-fidelity patient simulation activity during the course of their program and had no other experience using the technology prior to the recording. Three days prior to the initial video recording of the simulation activity, a 30-minute introduction session was provided to the participants, in order to familiarize them with the simulation environment. The participants were provided with instructions on how to use a human patient simulator (HPS), such as how to take and monitor blood pressure, respiration and oxygen saturation, and pulse.

I performed the function of simulation facilitator (*i.e.*, I programmed and controlled the technology to facilitate the activities and to respond to the actions of the participants). The participants were provided with a description of the functions of the simulation facilitator, which included playing the roles of various interdisciplinary team members (doctor, pharmacist, respiratory therapist, charge nurse, nursing instructor, occupational therapist, and speech therapist). One day prior to each simulation activity, the participants were provided with a brief overview of the HPS's condition. Finally, five minutes prior to engaging with the HPS, participants were given a nurse's shift report.

2.6 Video recording setup

The video recording in this study was an imperative factor in stimulated recall. A video camera mounted in the simulation room provided a view of the HPS lying in the bed and activities that occurred directly at the bedside. While the camera captured video of only those participants in the room who were at the bedside and providing direct care, it recorded the voices of all participants in the room. For each of the three simulated-case activities, recording began once the participants had entered the room; when the simulation was completed, the recording was saved for viewing during

the stimulated-recall sessions. For all three simulated-case activities, the video recording and observations of the participants' responses, as a group, were described and interpreted against the framework of Tanner's model.

2.7 Unfolding-Case scenarios and associated expectations

The research was conducted in a simulated environment during a three-phased unfolding-case scenario, which revolved around a 58-year-old male patient who had undergone a thoracic (mitral valve) surgery and had been transferred to the cardiovascular surgery ward for monitoring. For each of the three case scenarios, participants engaged in a 25-minute simulation activity, followed by an audiotaped 90-minute group stimulated-recall and focus-group session.

The simulated patient's demographics and clinical history were provided to the participants prior to the first activity. Further information related to the patient's condition was emailed to participants the night before each activity, and a brief report updating the patient's condition was given five minutes before each simulation. Finally, participants received additional information during the simulation activity, including a) a medication administration record (MAR), b) a report of the patient's latest blood work, c) updated medical orders, and d) nursing notes or the patient report. The patient report provided an overview of the expectations and goals for each scenario. These scenarios were presented between five and seven days apart, and each subsequent scenario was related to the care provided in the previous one. Due to the nature of this study, the participants were not told what to do; rather, working as a team, they were to demonstrate the application of clinical judgment through their interactions with the HFPS.

The roles of the participants were different in each of the three case scenarios. The participants chose their roles (primary nurse, assessment nurse, medication nurse, or documentation nurse) prior to initiating each simulation activity and discussed how they were going to divide their roles five minutes before entering the simulated environment. Once they had decided on their individual roles, they were given a shift report, which allowed them an opportunity to ask questions of the nurse reporting off.

3. RESULTS

The study uncovered six essential themes in relation to IENs' understanding and experience of clinical judgment: the shift from expert to novice, the need to rethink cultural competence and culturally competent care, the acknowledgement that culture and diversity are integral to understanding clinical judgment, the role of communication as a means to

understanding clinical judgment, the recognition of unlearning as a way to understanding clinical judgment, and the phenomenon of unknowing as a dimension to understanding clinical judgment. This section will provide a description of the themes that emerged during observation of the simulation and stimulated-recall activities and focus groups, and will discuss the implications of these findings for the teaching and learning of IENs.

3.1 IENs' experience of clinical judgment: A shift from expert to novice

In analyzing the video recordings, observations, and field notes, I observed that although IENs were experts in their previous clinical settings, they were novices in their approach to the culture of care in the Ontario context. I identify this theme as a shift from expert to novice.^[12] The participants' experience during the simulations led them to an enhanced understanding of their shift back to novice in the context of this different environment.

To illustrate, consider this example: One of the expectations for the second scenario was that the participants would provide discharge teaching to the patient. Yet the participants neither provided nor planned to provide discharge teaching for the patient. When asked to share their rationale, one participant indicated that discharge planning and teaching begins only when there is an order from a physician. In the Ontario context, however, while it is the physician who writes an order for discharge, it is the nurse who conducts appropriate assessments at the time of care and determines if the patient is actually ready for discharge. This discrepancy between the participants' perceived role and their actual role within the Ontario context both emphasizes a difference in cultures of care and illustrates potential implications for practice.

Further, in the Ontario context, the nurse is to consider the patient when creating a plan of care; this acknowledges the need for individualized care, as two patients may have the same diagnosis, yet require different plans. The experience of IENs in the study illustrates that they were unaware of the nurse's role as teacher in the scenario. This lack of awareness of the teaching function may influence the decision-making process and may have negative implications for patient safety.

Through their experiences and reflections on their responses in the simulation activities, participants arrived at the understanding that, in Ontario, nurses are considered independent and autonomous practitioners who play an important role both in communicating potential recommendations to members of the health-care team and advocating on behalf of patients under their care. The participants' actions during the

simulations exemplify IENs' shift from expert to novice and emphasize their need for guidance in order to develop communicative, interactive, and leadership skills and to frame their learning in and from practice.

3.2 The need to rethink cultural competence and culturally competent care in understanding clinical judgment

Rethinking cultural competence in the context of this study is vital, as culture is not a homogenous concept, nor are IENs a homogenous group. The following example illustrates this: During the second scenario, the patient's chest incision had dehisced and was at risk for infection, and a dressing needed to be applied. Although participants were competent in terms of knowing how to care for the patient's incision and perform related interventions, they became aware that their nursing approach was not necessarily congruent with the standards of nursing practice in Ontario. The approach the participants took in this case was related to their own cultural norms and cultural expectations. A statement by Beatrice highlights the need to rethink cultural competence from this context:

Previously, from my experience, we were trained mostly on "what I do" not on "how or why I do it." So basically here if it was back home, my intervention is to change the dressing, to assess the site, to check the fever, and patient goes last. . . Back home we don't usually talk that much to patients. We don't explain procedure itself and we just do it and patient expects that as normal. It's normal for them.

The other participants corroborated that their cultural background influenced their approach; this was particularly true of their experience during the third scenario, in which they cared for the patient who had undergone a stroke. Beatrice related her experience of caring for the simulated patient by reflecting on a time when she had cared for an unconscious patient. She stated that speaking to an unconscious patient was a "strange" practice: "In my country we were not supposed to speak to patient with neurological deficits or if they are unconscious." She added, "If I would see [a nurse] talking to an unconscious patient I would think 'oh my gosh.'"

Throughout the course of the study, participants tended to focus mainly on the pathological processes of the patient's disease as opposed to their psychological experience of illness. This was reflected in their lack of communication and interaction with the patient and lack of attention to either the patient's emotional wellbeing or his affective side.

My understanding of the participants' experiences allows me to further understand that cultural differences can influence patient-care outcomes. Further, it indicates that rethinking cultural competence is both relevant in the context of understanding clinical judgment and paramount in the context of this study.

3.3 Acknowledging that culture and diversity are integral to understanding clinical judgment

Throughout the course of the study, participants acknowledged that their behaviours toward illness and health were influenced by culture. Peter commented that one's culture—which includes the fundamental aspects of values and beliefs, such as background, faith, and sexuality—influences the way one provides and receives care. The participants recognized that culture and cultural background play an important role in how one perceives patient care and interprets clinical findings (*e.g.*, whether within normal limits or pathological) and interventions. They indicated that, in order to establish a relationship with a patient, it is important to understand his culture. Peter reflected on an incident that occurred at his clinical placement that exemplified how culture impacts patient care and outcomes:

Canada is a multicultural place... like it happened in my placement. A woman did not want me to care for her. I called my preceptor to the bedside and told her that the patient does not want me to [provide care]... I was going to apply topical cream to her perineum area and she did not want me to and that she needed a female nurse or wait for her daughter. I am bringing that to this scenario... that for instance [if] in this man's [the simulated patient] culture a woman is not supposed to see him naked and then the nurse could just leave and go to the chart and write that he refused catheterization.

There was an understanding among all participants that culture was a phenomenon that impacted both the caregiver and the recipient of care. The participants repeatedly raised the notion of the impact of their cultural experiences on patient-care outcomes in the Ontario context. Throughout the study they demonstrated an understanding that clinical judgment is associated with the need to collaborate with the interdisciplinary team members and communicate clearly with and listen to the patient; they also demonstrated an understanding that these behaviours greatly impact overall patient care-outcomes. All these elements indicate an understanding of patient-centered care.

Although there is a great emphasis on the idea that the transition challenges of IENs are related to gaps in knowledge and clinical skill,^[13] my study illustrates that the challenges are often due to the sociocultural differences that IENs encounter in their adoptive country, including a differently structured health-care system and unfamiliar new surroundings. In the context of this study, culture is recognized as a concept that relates not only to the attitudes and behaviours of a particular group, but also to the participants' interpretation of the manner in which nursing care is provided to and perceived by the patient. Over the course of the study, participants began to develop an understanding that both the care provided to the simulated patient and the patient's response to this care were very much influenced by culture, particularly their culture of care; they also came to understand that culture is more than a set of beliefs and that practices can be identified as a paradigm or a set of learned and shared knowledge and meanings within a given context. In this respect, the nature of culture becomes integral to the way one interacts with others and to the concept of social learning or cumulative cultural adaptation.^[14]

3.4 The role of communication in clinical judgment

The term communication was repeatedly mentioned during the course of the study, as participants became increasingly aware that communication is vital to nursing practice in Ontario. Participants' experiences led them to an understanding that communication was not only an interchange of words but also a life-long attitude and approach to nursing practice. After observing their behaviour on the video recordings, participants were able to identify the impact of communication on the care they provided; they identified a need to communicate with a patient in order to collect subjective findings, which provide a better understanding of what is actually happening with a patient. They agreed that there was a relationship between appreciating one's subjectivity and overall nursing practice. Peter illustrated:

I learned that, in Canada, patient is best that can relate to what is going on. It's the first-hand best presence. So we don't have that over there. The patients are the last and what we have learned in the book is the first. Just from my book knowledge I am trying to figure out how to help him and not what he is saying. But here [in the scenario] what he is saying lead up to and can help me and that is the actual practice.

Although the participants' experiences in this study illustrate that communication is an important element in understanding clinical judgment, in the third focus group participants

noted that they needed more practice in this area. Although their academic program included a communication course that highlighted the relevance of communication to nursing practice, participants stated that they were unaware of how to transfer this concept into practice. Molly noted, “We are talking in our courses about communication and nurse-patient relationships and here the obvious case was we could not even establish a yes and no answer for the patient from this case.”

Molly’s statement acknowledges the need to expose participants to realities of practice through simulation or other means. Moreover, an understanding of how to transfer this concept into practice is a critical component of clinical judgment. The how indicates not only the ability to make connections, interpret ideas, and develop ways of understanding the concept of communication, but also the understanding that communication is about the ability to adapt, change, and generate new knowledge in order to improve nursing care and practice.

By making this connection, participants developed an appreciation and understanding of how a lack of communication can cause misinterpretations and assumptions and adversely affect patient care. Participants also acknowledged that misunderstandings can arise when people operate from differing core beliefs. Through this lens, communication can be perceived as a creation of meaning and understanding and a means by which “culture is transmitted and preserved”^[15] (p. 4).

3.5 Recognizing the need to unlearn as a way to understanding clinical judgment

Hedberg^[16] defines unlearning as the process of eliminating or reducing old knowledge in order to make room for new learning. The term unlearning was used several times during the course of the study. Participants noted that the way nursing practice is perceived across cultures is very different and requires a level of unlearning. The following conversation between Peter and me provides an example of how this can impact the nurse-patient relationship.

Peter: When you tell a patient in my country that [you know what they are going through] that is the best medicine you are giving that patient that day. They will believe that you’re putting yourself in their position. . . if you say, “tell me more about [the pain]” then [the patient] would abuse you. They will tell “Don’t you know, can’t you see I’m in distress.” Here [in Canada] it’s opposite. In my country if you tell them [the patient], you know what they’re going through it’s like them feeling or thinking this is a very

good nurse and he’s seeing everything from my perspective.

Principal Investigator: That is very interesting. So is that something you learned from your clinical practice or is that something which was reinforced in school?

Peter: Definitely society. . . whether in hospital or home. That is the best response you can give [patients] that you know what they are going through. . . When I came to Canada I had to unlearn a lot of things. . . my education is based on medical knowledge. No psychosocial. . . it’s all empirical.

This statement exemplifies that, for the participants, clinical judgment is experienced and exercised as empirical and, potentially, technical. This perspective does not encompass the psychosocial, emotional, and affective dimensions of care, which may suggest a type of knowledge, or knowing, that needs to be acknowledged. Peter’s statement about unlearning indicates that past experiences and ways of learning impact the delivery of health care in Ontario, which again involves the concepts of culture and communication. The statement was corroborated by other participants, which led to further exploration of its meaning in the context of the study.

The need to unlearn was repeatedly raised by the participants, particularly in relation to making assumptions. Consider, for example, the scenario in which the patient was moaning as a way of expressing himself. In response to this, the participants assumed the patient was in pain and administered a painkiller. Upon reflecting on the consequence of this assumption, the participants indicated that their assumption that a painkiller was required might have negatively affected the patient in this case. The participants learned that making an assessment of the patient’s condition, as opposed to making an assumption, was critical.

After carefully analyzing their performance, the participants recognized making assumptions without conducting a full assessment of the patient’s condition was unsafe. The participants learned both that assumptions have an impact on the care they deliver and that a proper assessment of the patient includes assessing not only the state of his physical being but also his capacity to communicate and interact.

Unlearning, within the context of safety, became relevant during the course of the study, as the participants developed an understanding that replacing or unlearning prior knowledge was necessary in order to provide safe care. Peter elaborated:

Yes, it comes down to safety and replacing or un-

learning what I have before. Because I worked in different environment, it's totally different and we don't approach seniors like this. So everything is different, psychosocial and safety and everything. So I need to unlearn that and replace it with what I learn now. For example, in this very scenario [participants] did not pay so much attention [to the simulated patient]. Where I'm coming from, we won't pay so much attention to what the patient is saying. It's more or less book knowledge. I will just look at the patient and whatever it's [patient] saying is rubbish. I try to figure out what I have to do and it's [patient] talking is disturbing me. It's disturbing what I've learned. I want to practice what I've read.

Unlearning, in this context, was vital to the way the participants experienced and understood clinical judgment. By the end of the study, participants were able to provide examples on how, by unlearning, they came to understand the significance of patient-centered care in the context of patient-care outcomes. Beatrice commented:

Here [Canada] is more like treating the person as an individual. The way we think here is very different. It changed my perception of people and life. . . and this scenario has already changed me. I have been in nursing for 15 years. . . but here I think I will see person more or a patient more as a person and not as one just getting care.

Participants identified that the way patient care is provided varies across cultures and, in the context of the study, required a degree of unlearning. Their experience led them to recognize that the need to unlearn is important in cultivating clinical judgment. The participants acknowledged that their understanding of clinical judgment in relation to patient care changed based on their experiences in this study and recognized that their past experiences were very different from what is standard to the Ontario context.

Through an explication of the findings, the notion of unlearning emerged as a means of changing and enhancing views, both of the importance of the affective and emotional component and of human interactions and their implications regarding how one perceives and is perceived by others. From this perspective, living systems can also be considered as learning systems. The findings show that the process of unlearning is not merely a deconstruction of knowledge, but also a creation and evolution towards new knowledge.

3.6 The phenomenon of unknowing as a dimension to understanding clinical judgment

Nursing is a profession that requires the development of multiple ways of knowing: empirical, moral, personal, and aesthetic.^[17] Munhall^[18] proposes that this concept of knowing may lead one to close oneself to alternative ideas, based on confidence in one's own interpretation of knowledge; this idea led Munhall to identify a fifth pattern of knowing, which he termed unknowing.

Unknowing stems from the idea that "we don't know what we don't know" and can be considered a prerequisite for knowing. For example, in the study, when the simulated patient tried to express himself by moaning, the participants continued to provide direct care but did not communicate with the patient. Molly explained her rationale for this response: "You stop communicating with a patient who cannot respond." While reflecting on these actions and responses, participants came to perceive that their confidence in their own knowledge led to a lack of interaction and influenced the patient-care outcomes. This perception led to the understanding that the outcome might have been different if they had responded differently.

Although the patient was not able to express himself with words, he was verbal and was clearly able to respond. The lack of interaction during the scenario was due to the participants' inability to understand the patient's way of communicating. The incident led participants see the patient as an important constituent to the care they provide. The underlying conviction that emerged through reflection was that perhaps it was the participants' who lacked understanding and who were unable to communicate in a manner that the patient could understand. This experience highlights unknowing as an integral component in the acquisition of clinical judgment.

Unknowing, from this view, can be further perceived as being underexposed or unexposed to certain circumstances. Participants agreed that "not knowing" affects the "whole system." Molly noted:

I don't know that I have to talk to [the patient] and it affects the whole idea of health care. For example, how I should establish my communication style with this kind of patient because I never did this and I did not see this in my practice. We had patients who were confused, but I did not have good examples how to establish communication, which we did here.

Molly made reference to the need for exposure to realistic circumstances and the need to be taught how to cope with

realities of practice that often do not match the textbook portrayal. There was a general agreement among the participants that there was a direct relationship between unknowing and providing safe care.

The themes in this study illustrate that the participants' clinical judgment was influenced by the transition from one culture to another. Their understanding of clinical judgment was evident in both their shift in thinking and their construction of knowledge. The analysis of the study's findings identified that the process of engaging in reflective practice contributes to knowledge attainment, clinical reasoning, and the development of clinical judgment, all of which are critical to nursing practice^[9,19] and are "desired outcomes in nursing education"^[20] (p. 99).

4. DISCUSSION

The findings and themes identified illustrate that IENs' experience and understanding of clinical judgment involve a paradigm shift to their way of thinking. This shift facilitates both their developing expertise and their transition to nursing practice in the Ontario context. All participants corroborated that their worldview changed due to their experience in this study; further, participants illustrated this point as, through their participation, they gained a broader and more inclusive understanding of the influence of cultural differences on professional competence and clinical judgment. This understanding stemmed from the participants' reflection-in-action and reflection-on-action, which ultimately led participants to self-awareness and critical consciousness of the meaning of patient care and overall nursing practice.

The findings suggest that the understanding of clinical judgment develops from the application of cultural experiences, which include cultural background and clinical experience. The integration of these prior experiences allowed the participants to create meaning for their future practice in Ontario. The themes that emerged from the data illustrate that the participants understood clinical judgment in a narrow and technical way. Yet, through reflection-in-action and reflection-on-action, the participants came to understand that clinical judgment encompasses not only technical judgment, but also the ability to interpret and view practice as a holistic approach to care.^[12]

The experience of providing care to the simulated patient allowed participants to see that nursing practice in Ontario requires them to communicate clearly, collaborate with a team, and integrate the patient as part of the health-care team. They illustrated an understanding that effective nursing care is dependent on interactions and is very much associated with the emotional and affective domain of care. Further,

they understood that this approach has a great impact on the overall practice and culture of care as well as patient-safety and -care outcomes.

The participants' experiences in this study led them to realize that nursing care is centred on the patient, and that patient-centred care involves accurate data collection, effective communication, and avoidance of assumptions; this, in turn, led them to an understanding that clinical judgment requires a holistic approach. Peter's description of his experience in the study highlights how the experience contributed to his understanding of clinical judgment:

Absolutely when I come across something like this in practice this is going to come to my mind. The discussion we are having will come back to my mind. It is very important, especially if we have not started practicing here. If I come across a patient like this, I will know based on this discussion what to do at every point, and I know whom to consult and everything would be the way we just discussed. Even the previous [activities] we did they are so important to me especially when we have never practiced here. I know whom to consult and I know how I should consult and how things should be. I can now understand how the [nursing theory] becomes important.

The major goal of nursing educators is to develop programs and institute practices that will allow nurses to develop a deep sense of professional identity and commitment to professional values and to act with ethical comportment. Research in the area of nursing education indicates that nurse educators tend to overload the curriculum with content that focuses more on skills and knowledge and less on a deeper understanding of the material.^[21,22]

Although the current IEN curriculum includes courses that were created to meet the entry-to-practice competencies, participants in my study did not demonstrate these competencies when they engaged with the simulated patient. This observation supports the need for guidance in developing expertise.^[12] While simulated scenarios expose learners to the realities and complexities of practice in the Ontario context, it is the application of guidance that highlights why, how, and when to apply the competencies in practice circumstances. Approaching curriculum from this perspective recognizes the knowledge that IENs bring to nursing practice in Ontario and allows for development of both professional expertise and competence.

This suggests the need for approaches that engage IENs in their learning by allowing them to participate in realistic

circumstances in the classroom. Additionally, this study indicates that a form of experiential method may benefit non-clinical courses, as the knowledge provided in these courses (e.g., nursing ethics, nursing theory, and nursing leadership) was neither reflected in the participants' responses nor effectively transferred when providing patient care.

The participants noted that, despite being introduced to concepts in class, they were not able to apply and transfer the concepts to practice, particularly in their care to the simulated patient. These comments are of paramount importance to the teaching and learning of IENs and have implications for the education of novice practitioners. This finding also indicates the need for additional research in order to identify how experiential pedagogy can be incorporated in nonclinical courses.

Another finding from the study highlights the need for reflection as a constituent to the development of expertise. Reflection is vital to the process of understanding and growth, specifically in the education of professionals.^[23] Yet, the research on "the effectiveness of strategies to foster reflection and reflective practice is still early in development"^[24] (p. 609). Further, the literature on reflection and reflective practice is "dispersed across several fields and [it] is unclear which approach may have efficiency or impact"^[24] (p. 595). The nursing literature suggests a need to explore how the use of reflection in the curriculum impacts the development of clinical judgment and reasoning.^[20]

In the study, stimulated recall, as a form of reflection, was a beneficial tool for understanding clinical judgment and developing expertise. The participants reported that viewing themselves on the video recording allowed them both to consider themselves from a different perspective and to acknowledge what they had "missed", what they needed to learn, and, potentially, how they needed to learn.

Although a range of studies have suggested that reflective practice is a means to improving and enhancing professional development,^[23] educators need to be prepared for the possibility that students may not know how to reflect. To promote meaningful reflective practice, it is vital that nurse educators recognize the value of reflection and that they model this behaviour for their students. My observation of the participants' responses both enhanced my understanding of teaching and transformed me as an educator, by affording me an opportunity to be more consciously aware of my pedagogical approach and my way of interacting with students.

4.1 Limitations

A number of limitations to this study have been identified. These include a) sample size and composition, b) role of the

researcher and position in relation to the study, and c) setting where the research took place.

Although the sample size was small, it was appropriate for preliminary research and appropriate in the context of this study.^[10] The small number of students participating in this study, and their enrolment in the IEN program, limit the researcher's ability to generalize the findings to other populations. It should also be noted that research was conducted with the sample performing as a group, as opposed to individually, which could challenge the validity of the findings. Although the findings contribute to the literature on clinical judgment, a larger sample size may have generated more data. In future studies with similar focus, a larger sample size may lead to diverse perceptions and more extensive findings.

Another limitation is that the sample was not broken down by gender or culture, nor was it large enough to do so; nonetheless, these differences may have influenced the findings. This indicates the need to research IENs by gender and culture, as one's gender may influence one's culture, and one's culture may influence one's culture of care and nursing practice.

My role within the study, both as an educator in the program and as an "insider", may have influenced the findings. Although I was not teaching the participants at the time of the study, they knew me as an educator in the program. Participants' perception of me may have influenced their responses and actions during the simulation activities, group stimulated recall, and focus-group sessions.

Moreover, being an insider provided me with insider knowledge of the institution and its social systems and, thus, may have influenced the research outcomes. This type of knowledge can, potentially, impact the researcher's degree of objectivity and expose the research to concerns regarding both the validity of the research process and the possibility of researcher bias in the process of data collection and analysis.

However, I would argue that, in most cases, it is impossible to access practice without involving the practitioner, as action or practice is informed by value systems and beliefs that may not be fully accessible from the outside. Oftentimes, researchers are not fully aware of the meaning of their values until they try to embody them in their actions.

Other limitations to the study are that it was conducted in one university and that the participants were all in the same cohort of IENs and in the same stage (their 5th semester) of the program. The IENs were selected from an academic university-level program, rather than from other bridging programs available in Canada. The knowledge the participants had already gained through their enrolment in the program may have influenced the thinking that occurred during data

collection and the findings. This indicates the need to conduct similar research in non-academic settings.

The roles participants assumed in each case scenario of the simulation experience may present another limitation of the study. Variations in clinical skills demonstrated by students may have been a result of their previous clinical or work experience and may have influenced their selection of roles to play during the case scenarios.

Although this study answers a number of questions about IENs' experience and understanding of clinical judgment, many questions still remain, such as, how does this experience or understanding of clinical judgment transfer to the clinical arena and associated patient-care outcomes? These remaining questions may be better addressed by other researchers from different cultural or professional backgrounds, such as practice leaders, academic and policy makers, and those from different conceptual frameworks, as they may bring a different perspective to the meaning of clinical judgment and its integration in the transition to practice.

4.2 A summary of further recommendations for research

Further research is needed to augment my preliminary research. Other scholars might consider the following research activities:

- (1) Explore how reflective learning practices (such as stimulated recall) influence patient-care outcomes.
- (2) Investigate the application of simulated learning environments in combination with reflective practice; in particular, conduct research within other courses in the IEN curriculum.
- (3) Explore the relationship between reflective practice and level of clinical experience, particularly prior health-care experience, and identify how the length of clinical experience influences reflection.
- (4) Research how clinical judgment developed through the use of simulation transfers to clinical judgment in practice.
- (5) Explore the development of clinical judgment of IENs from different geographical, educational, and practice backgrounds.

5. CONCLUSION

Through the course of the research study, it became clear that there is no such thing as one type of learner or one way of learning, nor is there one type of setting in which learning takes place. It also emerged that knowledge is both culturally

situated and individually constructed. The act of learning, in this study, refers to an evolution of knowledge or knowing that is constructed by the individual.^[25]

It is important to support IENs in their transition to practice in Ontario and to ensure that they are equipped to practice safely. The process of integration and transition into practice in a new setting can be overwhelming, given the unfamiliar roles that nurses may be expected to play in this new context, not to mention the often significant differences in health-care systems and the specialized language of nursing. These factors make the process of integration and adjustment difficult.

Although IENs can be considered novices within the Ontario health-care context, this study found that IENs come with great amounts of knowledge and are experts in their countries of origin. The findings suggest a need for further discussion in the academic literature regarding how we view clinical judgment and the expert. That being said, it is important to guide and facilitate education through new and innovative ways that illustrate the complexity of nursing care and consider different cultures of care. Acknowledging and recognizing these differences within the IEN program will both enhance clinical judgment and support transition to practice.

This study has advanced the understanding of both how participants learn within the context of reflection and how reflective practice influences developing expertise and clinical judgment.

Knowledge gained in this study represents merely the tip of the iceberg in understanding how IENs learn, experience, and understand clinical judgment in a simulated setting and through stimulated recall and reflection. Further research—including similar studies that incorporate samples that are larger or that include participants from a wider range of cultural backgrounds—is needed in this area.

The ideas raised in this article will better equip faculty members to implement pedagogical implications and develop educational resources for IENs. Further, these ideas represent a means to facilitate the development of expertise and the transition to practice in Ontario. The findings provide insight into the culture of care and culture of practice of IENs and, thus, contribute to the overall development of nursing knowledge and pedagogy.

CONFLICTS OF INTEREST DISCLOSURE

The author declares that she has no competing interests.

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