So, we really do have to figure out how to create a scaffolding in order to help support and facilitate safe and effective care. And one of the ways that we are looking at creating that scaffolding is in clinical judgment, how they make decisions. Because primarily, the problem is, entry-level nurses, they make ineffective clinical judgment, not right, not wrong, that's just what it is, because they're really in that place where they haven't gotten a chance where they have enough of those hours under their scaffolding.

So, some data that you see here, all of those variables that I just mentioned kind of result here that novice nurses are more likely to commit a practice error, and that's just inevitable. It's certainly not an environment where you want to be punitive, but you wanna create an environment to help them, you know, kind of decrease that practice error.

And a part of it is really helping them to make clinical decisions. We know that many employers are dissatisfied with how entry-level nurses are showing up in terms of work. And what that really means is, there's just a disconnect between the expectations and who shows up on the first day. I think traditionally as a profession, there are some schools of thought that as soon as you get your license, your NCLEX, okay, yeah, let's go, you're ready.

Well, that's absolutely not congruent. When we think about in a medical model, a physician has a required residency, and part of that period is to support that new physician as they're gaining those additional skill and practice hours.

In our profession, that's not required, nor is it always embedded in practice. So, we do have a dynamic where we have new nurses that need the support, but we're struggling to try to figure out how to create that environment. So, I think ultimately, you know, just kind of that last point was that clinical decision making is very important in the entry level period.

Because once again, when you think about, you know, sometimes there are thoughts that, "Oh, well, this is a new nurse, and we don't give new nurses those kind of patients." Well, you may not in hospital A, but in hospital B, they do. So, there's always this thought around whoever the entry-level nurse is, we do have to create that environment to help them practice safely.

So, the council, as we were developing our work arn-USS3-6(w)6(ght)(a)(ound w)7(hoe)(ve)(t)(h)20(e)(nt)(y)T

Qian and I, we looked at a lot of our practice analysis data, and we were able to essentially describe today's entry-level nurse. And the rest of the presentation, the information will be presented in both ways. We know that we're interested in entry-level nursing, not only at RN, but as PN as well. So, according to the practice analysis data analyzed over several years, this is kind of a snapshot of who a new nurse is as an RN.

One of the things that we'll highlight here is at the end is that there is an increase in formal orientation internships, which is actually very promising in terms of creating that support. The other thing that we do see is that entry-level RNs, they are beginning to increase a presence in more critical care areas, emergency departments, etc.

Now, what that means is, once again, the care for a client in an ED and an ICU is very different from the care of a client on a med-surg floor. Now, granted, med-surg clients, now, they certainly have a very high acuity, and that's important as well. But when you think about an entry-level nurse that's working in an ED or an ICU, those are really high-stake clients.

And so, once again, there's no way to prohibit them from working in those areas. Yes, we should encourage it, but then we also have to figure out how do we make them safe in those high-risk areas. And this is kind of the snapshot of the PN. Now, the interesting two points on here, as you can see, a lot of the characteristics are the same, but the two things that really jump out for me for the PN population is, A, they're now beginning to...we probably didn't capture it here, but PNs are now beginning to work more regularly in acute care settings.

I know you guys probably have seen years ago when there was kind of a mass exodus of PNs in acute care, they went to long-term care facilities. On average, they're still there, that that's the largest center. But we do see that there is an increased trend that they're moving into acute care settings. So, the care that a PN nurse would traditionally give kind of our framework around that, we really do have to rethink that because if we're considering that, oh, well, a PN nurse would be responsible for, you know, 15, 20 patients on a ward, she's passing medications, you know, he or she, they're doing wound care.

Well, now you take that same person who does have a license to work in an ICU. Now, what do you do? You have to really think about how do you make that person safe in that area as well. But the other thing about PNs, unlike RNs, PNs are more likely to than RNs not have any orientation at all.

And that's very interesting. So, this graph is just a depiction of, we looked at entry-level RN orientation over the years. And as you can see, the orange line is the model of the preceptor model. So, overall, that is pretty much the predominant model. But the one thing that you probably see around 2017 is that model...well, actually, before then, around 2011, that model started to dip and there's an increase in the propensity of entry-level nurses engaging in nurse res-7(e) to(-)20(7)(d3.00000be7(fore)ntrye d3.00000beforeipo78.88 T

because sometimes we realize that, you know, there's some school of thought that a new nurse may not know what she doesn't know.

So, we wanted to be sure to ask experienced nurses what is their thoughts and their experience as the relevancy of clinical judgment. Standard deviation was relatively low. So, a lot of consistency in the ratings. The other thing that comes out on this survey, there was one portion of the survey that we allowed a question that they could respond to that they just didn't know.

So, let's say one of the surveys had 147 activity statements, but along that Likert scale, one of the responses was that you just don't know. The one thing that we did find is that of the 73 or however many entry-level nurses that we had, and times that in terms of those activity statements, there were only approximately 1% of ratings of don't know.

So, which means that the experienced nurses felt pretty strongly about their ratings, because they certainly had the opportunity to say, "Well, yeah, I just don't know." But they did not. And we just wanted to point this out just as a highlight. Looking at the PN results, once again, very comparable to the RNs, average rating of 3.42. So, certainly between important and essential, relatively low standard deviation.

A lot of consistency in the ratings. So, once again, felt like they felt very strongly about that. And comparably to RNs, once again, a relatively low 1% rating of those statements that were associated with them just not knowing. So, they felt pretty comfortable in the ratings that they provided.

So, the second survey really focused on our measurement model. So, not just the definition but our measurement model. And our measurement model is NCSBN Clinical Judgment Measurement Model. Oh, my good, I can't see that, Jen. Oh, oh, okay. That's a hurry-up sign.

And the thing about the measurement model is if you can see on layer three, we focus on those six steps that starts with recognized cues all the way through evaluate outcomes. And our interest here is we wanted to understand what was experienced nurses thoughts about how relevant those steps are in carrying out those activity statements using that same Likert scale.

So, once again, that's just kind of a snapshot of it. And here we got relatively similar data. So, on average, 3.34 lower standard deviation using that same Likert scale for the RN. Now, this one, I'm just over the moon excited about because what this tells me is if you can look at the comparative ratings for all of those six steps in the Clinical Judgment Model, what it says is all of them are important.

So, not just one, not two, not this one is more important than the other, all of them are essentially relatively important. So, the same thing from PN, those results, you kind of see how a lot of that is aggregated, at least over the 3 lower standard deviation. And PN did the same thing. Now, the interesting thing about is not all 73 nurses were in the same room at the same time. As I mentioned, we did this over a two-year period, eight different sessions.

So, many of the nurses did not know each other at all. So, there was no similarities in that way other than what they really think about clinical judgment in terms of entry-level nurses. So, some of the study limitations is that the session discussion format, sometimes that was a bit difficult to keep that consistent because once we got talking, some nurses really wanted to talk about some other things.

So, it was hard to kind of keep them on track. A convenient sample. You know, certainly, this is not