

## CHAPTER 1

# Critical Thinking, Clinical Judgment, and the Nursing Process

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## KEY TERMS

**clinical judgment** (KLIN-ih-kull JUDJ-ment)

**collaboration** (koh-LAB-uh-RAY-shun)

**critical thinking** (KRIT-ih-kull THING-king)

**cue** (kyoo)

**evaluation** (e-VAL-yoo-AY-shun)

**intervention** (in-ter-VEN-shun)

**nursing process** (NER-sing PRAH-sess)

**vigilance** (VIJ-eh-lents)

## CHAPTER CONCEPTS

Clinical judgment

Collaboration

Communication

Safety

## LEARNING OUTCOMES

1. Explain the difference between critical thinking and clinical judgment.
2. Discuss why critical thinking and clinical judgment are essential in nursing.
3. Compare the nursing process to the clinical judgment process.
4. Describe attitudes of good critical thinkers.
5. Define vigilance.
6. Prioritize patient care activities based on the Maslow hierarchy of human needs.
7. Discuss the importance of collaboration in nursing practice.
8. Use the SBAR mnemonic to communicate a patient problem.

What do nurses do? What will you do as a nurse? Certainly, you will give injections and baths and change dressings. But your most important role will be to **THINK** like a nurse and make good decisions. What if a nurse gives an injection perfectly according to the book, but then the patient's blood pressure drops to an unsafe level because the medication was inappropriate for the patient? Even though the provider ordered it, the nurse must collect data and make a judgment about whether each dose is safe to give. What if the nurse provides expert tracheostomy care, but the patient hemorrhages during the procedure? Would a better chart review and careful thinking have uncovered this risk? Would better thinking have prevented these problems from occurring? Likely so.

Why is good thinking so important in the nursing profession? A study by Kavanaugh and Szweda (2017) found that only 23% of new nurses are ready to practice safely. Many new nurses are "unable to recognize a change in a patient's condition or identify the urgency of a situation" (Kavanaugh & Szweda, 2017). If a nurse is unable to recognize a change in condition and its urgency, a failure to rescue (FTR) can result. If a change is missed, then communication with the health-care team and subsequent **intervention** will be delayed or omitted. This places patients at serious risk of poor outcomes, including death. Many factors contribute to FTR events. Poor staffing, inadequate resources, and other systems limitations can play a role in addition to poor clinical judgment. Your job is to learn to think and make good decisions so you can recognize changes early and manage other limitations in order to have the best patient outcomes possible.

Let's look at an example. A new nurse notes a patient's blood pressure is 116/74 and thinks, "Great. That's perfect." But because two nurses called in sick, and the pharmacy missed sending some medications,



the new nurse doesn't have time to review the chart before administering a routine dose of blood pressure medication. Otherwise, they would have found that the patient's blood pressure was 188/100 earlier in the day, and the patient received an extra dose of blood pressure medication. The patient's blood pressure continues to drop, but the nurse fails to recheck the blood pressure. The patient has a stroke as a result. This is an FTR. The system put the patient at risk by not having adequate staffing resources and by having disorganized pharmacy delivery. The nurse put the patient at risk by neglecting to review the chart, recheck the blood pressure, and recognize a change. These factors created the perfect storm to endanger the patient's life.

In this chapter, we talk about ways to critically think and make good clinical judgments. Then we provide opportunities to practice these skills throughout the book. You will learn why factors such as choosing priorities; using the **nursing process**; and establishing good communication, active listening, and **collaboration** go hand in hand with thinking skills when providing safe patient care.

Another important reason to learn good thinking skills is that you will need them to pass the NCLEX-PN®. The National Council of State Boards of Nursing (www.NCSBN.org) is the body that creates the NCLEX-PN®. They continuously study what nurses are doing in practice, to be sure the licensure examination focuses on the right topics. As patients become more complex, nurses must learn to think about the complexities at a whole new level. Soon, the NCLEX-PN® will focus more on clinical judgment to help ensure that new nurses are able to think and make good decisions that keep patients safer.

## WHAT ARE CRITICAL THINKING AND CLINICAL JUDGMENT?

### Critical Thinking

Halpern (2013) says that “critical thinking is the use of those cognitive [knowledge] skills or strategies that increase the probability of a desirable outcome” (p. 4). Critical thinking can help you understand the “what and why” of patient data and care needs.

### SAMPLE CRITICAL THINKING EXERCISE

Your neighbor shows you her child's rash and asks your opinion. As a nursing student, you have learned how to collect data about alterations in skin integrity. What do you need to **THINK** about as you respond to your neighbor?

### SUGGESTED ANSWERS

You can start by asking questions such as the following:  
Where is the rash? How widespread is it? Is it getting worse?  
How does it feel? Is it itchy or painful? Is it bothering the child?  
What does it look like? How would you describe it?

Does anything make it better or worse? Was the child exposed to something? Or has the child started on a new medication?

How long has it been present?

Should you avoid touching it because it might be contagious?

Does it look infected?

*You will find Critical Thinking Exercises throughout the text. Suggested answers are provided at the end of each chapter.*

As you can see from the exercise, one part of thinking critically is asking good questions. When collecting data, you can use the What's Up mnemonic to help you remember what to ask (Box 1.1).

Critical thinking also requires a good knowledge base so that your thinking and decisions are based on facts. You must collect appropriate data to have a solid base for decision making. Our goal is to provide you with this foundation of evidence-based, solid medical-surgical knowledge.

### Clinical Judgment

Nursing **clinical judgment** can be defined as “the observed outcome of critical thinking and decision making” (Betts et al, 2019). This process uses nursing knowledge to collect appropriate data, identify a patient problem, and determine the best plan of action. Clinical judgment is based on good critical thinking. It determines what the nurse **DOES** after thinking about a problem.

### LEARNING TIP

An easy way to remember the difference between critical thinking and clinical judgment is that critical thinking asks **why** (Why is this happening? Why is it important?) and clinical judgment is the **do**. What should you *do* after thinking through a problem?

### Box 1.1

#### WHAT'S UP? Guide to Symptom Data Collection

- W—Where is it?
- H—How does it feel? Describe the quality (e.g., is it dull, sharp, stabbing?).
- A—Aggravating and alleviating factors. What makes it worse? What makes it better?
- T—Timing. When did it start? How long does it last?
- S—Severity. How bad is it? This can often be rated on a scale of 0 to 10.
- U—Useful other data. What other symptoms are present that might be related?
- P—Patient's perception of the problem. The patient often has an idea about what the problem is or what the cause is but may not believe that their thoughts are important to share unless specifically asked.



## SAMPLE CLINICAL JUDGMENT EXERCISE

Let's return to your neighbor's child. You have asked good questions and examined the rash. Now, what should you **DO**?

## SUGGESTED ANSWERS

Because licensed practical nurses (LPNs) and licensed vocational nurses (LVNs) do not diagnose, you might encourage the mom to wash the area, to call a provider, or to check it again later. You will use your judgment to determine the best action.

*You will find Clinical Judgment Exercises throughout the text. Suggested answers are provided at the end of each chapter.*

## CRITICAL THINKING ATTITUDES

It is important for nurses to possess attitudes that promote good thinking. The Foundation for Critical Thinking (2019) identifies eight attitudes associated with good critical thinking: (1) intellectual humility, (2) intellectual courage, (3) intellectual empathy, (4) intellectual autonomy, (5) intellectual integrity, (6) intellectual perseverance, (7) faith in reason, and (8) fair-mindedness. We explore three of these attitudes. For more information, go to [www.criticalthinking.org](http://www.criticalthinking.org).

### Intellectual Humility

Have you ever known people who think they know it all? They do not have intellectual humility. People with intellectual humility have the ability to say, "I'm not sure about that. I need more information." Certainly, we want our patients to think we are smart and that we know what we are doing. However, patients and health providers also respect nurses who can say, "I don't know, but I'll find out." It is unsafe to care for patients when you are unsure of what you need to do.

### Intellectual Autonomy

Did your parents ever say, "Just because everyone is doing it doesn't make it okay"? You may see some nurses cutting corners or doing things that you do not think are safe. If you have intellectual autonomy, you will think about what you observe and determine for yourself what is safe. And if you see unsafe practices, you will speak up appropriately.

### Intellectual Integrity

A person with intellectual integrity values the truth. Consider the health-care team member who gossips about a patient over lunch. You know talking about patients in a negative way and in a public setting is wrong, but you don't want to rock the boat. If you have intellectual integrity, you will speak up—but you need to think carefully how to do so! Instead of saying, "You shouldn't do that," you could say, "I am not comfortable talking about a patient."

## BE SAFE!

**Avoid Failure to Communicate!** Use the acronym CUS to speak up when you know something is not right.

**C**—I am Concerned!

**U**—I am Uncomfortable!

**S**—This is a Safety issue!

*From Agency for Healthcare Research and Quality, TeamSTEPPS, [www.AHRQ.gov/teamstepps](http://www.AHRQ.gov/teamstepps)*

## THE NURSING PROCESS AND CLINICAL JUDGMENT

You studied the nursing process in your nursing fundamentals course. Now let's look at how the nursing process fits in with good thinking (Fig. 1.1).

Take a minute to study Figure 1.1. The clinical judgment model simply expands on the nursing process to better explain the type of thinking that is required for good decision making. Let's look at the steps in Table 1.1.

Cue recognition is so essential to providing safe care that you will find practice cue recognition opportunities (Cue Recognition) throughout the book to help you develop this skill.

## SAMPLE CUE RECOGNITION

Let's go back to your neighbor with the child who has a rash. What if she calls you over to her house in a panic, and you see that her child is having severe difficulty breathing?

**Answer:** Sit her up and call 911!

*You will find Cue Recognition Exercises throughout the text. Suggested answers are provided at the end of each chapter.*

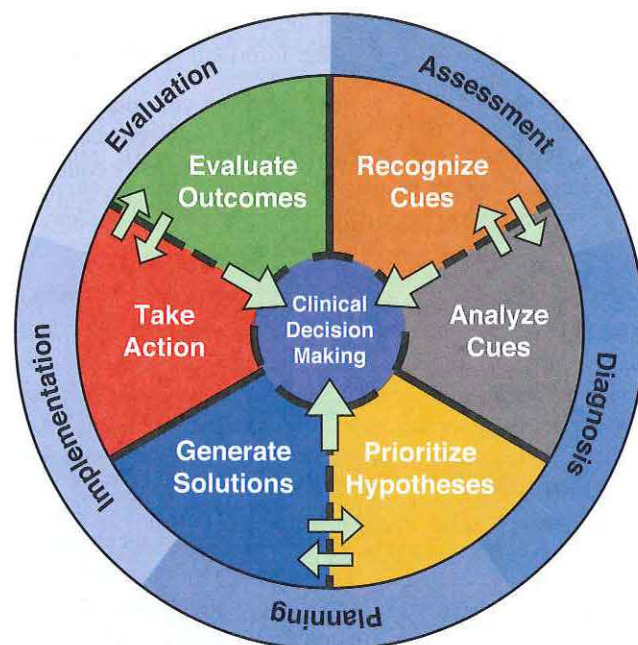


FIGURE 1.1 The nursing process and clinical judgment model.



Table 1.1

## Clinical Judgment Process

<i>Clinical Judgment</i>	<i>Explanation</i>	<i>Example</i>
Identify and analyze cues	<b>Cues</b> are simply relevant bits of data that you have collected. They might include normal or abnormal findings in your patient, the setting you are working in, resource availability, and/or how much time you have. Once you have all the information you need, you must decide which data bits are the most relevant. Are there abnormal findings? Do you have to hurry? Do you have the equipment you need? If you go back to giving a perfect injection, how does the situation change if the medication is unavailable? Or if your patient is emaciated with little muscle mass? All this information must be analyzed before giving the injection.	Mr. Frank is in pain and asks for pain medication. His analgesic is not due for another 40 minutes. As a good critical thinker, you can use intellectual empathy as well as your knowledge base about pain to decide what data you need. You decide to use a pain-rating scale on which the patient rates pain from 0 (no pain) to 10 (the greatest pain possible). You find these cues: <ul style="list-style-type: none"> <li>• Pain is in back, rates it at an 8 on scale</li> <li>• Pain worse since he's been confined to the hospital bed</li> <li>• History of spinal compression fractures</li> </ul> Your empathetic attitude tells you that waiting for 40 minutes for pain relief is not acceptable.
Prioritize hypotheses	Once you have all your information and have decided which cues are relevant, you develop hypotheses. These may be in the form of nursing diagnoses, or you may simply have a list of possible problems. Now you must determine which problems are most urgent. (See later in the chapter for prioritization guidelines.)	<ul style="list-style-type: none"> <li>• Mr. Frank is in pain.</li> <li>• Current analgesics are not sufficient to control pain.</li> </ul>
Generate solutions	What is your goal? Once you determine an appropriate outcome, you can think about what to do for each priority problem. You pull together your knowledge base (yay nursing school!), your best thinking skills, and your resources to determine next steps. You might collaborate with a colleague or gather information before you proceed.	The goal? Pain relief! Possible solutions: <ul style="list-style-type: none"> <li>• Wait 40 minutes and administer analgesic (does not help meet goal).</li> <li>• Give the analgesic early (against policy).</li> <li>• Use nondrug pain-relieving interventions, such as music and distraction.</li> <li>• Consult with RN or provider.</li> </ul>
Take action	Next, carry out your plan. But as you know, things don't always go according to a plan. You will be continually collecting data and may need to think fast if you encounter a surprise.	You decide a 40-minute wait is not appropriate and giving the analgesic early does not follow orders. So, you help Mr. Frank reposition, turn on a television show he likes for distraction, and find the RN for a consultation. The RN contacts the provider for a new analgesic. You administer the first dose, being sure to evaluate his vital signs first and explain the drug's effects and side effects to Mr. Frank. The RN also informs Mr. Frank that the provider has ordered a consultation with the pain clinic.
Evaluate outcomes	Finally, you evaluate the outcome. <b>Evaluation</b> of the effectiveness of an intervention is an important part of clinical judgment. What results were you looking for? Did things go according to plan? Did you get results you expected? How do you know?	As you recheck Mr. Frank 30 minutes later, he rates his pain level at 2 on the 10-point scale. He smiles and thanks you for your attentiveness to his needs. You think back to the desired outcome, compare it with the current data collected, and determine that your interventions were successful.



**Table 1.1**  
**Clinical Judgment Process—cont'd**

<i>Clinical Judgment</i>	<i>Explanation</i>	<i>Example</i>
Repeat	At any point in the cycle, if you encounter a problem or change, you can go back a step or two and try again. It would be great to go through the steps of the nursing process and say “Done!” but we are never truly finished with the nursing process or with clinical judgment. We need to continually refine our thinking and our plans in order to provide the best, safest nursing care.	Be sure to check back with Mr. Frank routinely—make sure his pain remains controlled. Discuss with him how often the medication can be given, and ask him to let you know if the pain returns. And teach him the value of distraction, relaxation, and other nondrug measures. (See Chapter 10.)

### LEARNING TIP

Each time you exit a patient’s room, do a mini-thinking assessment. Ask yourself, “Did I ask the right questions? Was my thinking clear and logical? Is there anything I could have done better?” This 1-minute metacognition exercise will help you develop as a great thinker.

### A WORD ABOUT VIGILANCE

You can also use effective thinking in patient care by anticipating what might go wrong, watching carefully for signs that the problem might be occurring, and preventing it or notifying the registered nurse (RN) or health-care provider (HCP) in time to intervene. Nurses save many lives each year by anticipating and preventing problems. The state of awareness that enables you to anticipate problems is called **vigilance**. An example would be knowing the signs and symptoms of low blood glucose (because of your excellent knowledge base) and watching for them carefully (being vigilant) in a patient taking medication for diabetes. If early symptoms occur, you can intervene before the problem becomes severe. You could also teach the patient and family about low blood glucose and how to prevent it, further reducing the risk.

### NURSING CARE TIP

As you review your patient care assignment at the start of each shift, ask yourself, “What is the worst thing that could happen to each patient today? What cues will tell me this is happening?” Then plan ahead to be vigilant for these cues and do all you can to prevent these occurrences. It’s also a good idea to alert the nursing assistant what to watch for and inform you if cues occur.

### COMMUNICATION WITH THE HEALTH-CARE TEAM

So far, we have established that you need a good knowledge base, good thinking skills, and effective clinical judgment to

be a nurse. You also need to be a good communicator. You must be able to communicate patient data and care needs to the health-care team. One way to communicate effectively is to use the Situation-Background-Assessment/Analysis-Recommendation (SBAR) acronym. You learned this in your nursing fundamentals course. Let’s review doing an SBAR with the RN, whom you need to communicate with about Mr. Frank’s pain. If you collect good data and communicate it well, you will get the best recommendations for your patient.

Without SBAR, it might sound like, “Mr. Frank’s pain is at an 8 out of 10, and his analgesic isn’t due for another 40 minutes.” Sounds pretty good, right? Now let’s look at SBAR.

**S**—“Mr. Frank is in a lot of pain. He says it’s an 8 out of 10.”

**B**—“He has a history of spinal compression fractures.

He looks very uncomfortable. I repositioned him in bed, and he is trying distraction, but it isn’t helping much.”

**A**—“I am concerned that 40 minutes is too long for him to wait and that his analgesic isn’t adequate for him.”

**R**—“I’d like to get an order for additional pain medication. What else do you recommend?”

Using SBAR, you helped focus the RN’s attention on the situation, gave some good relevant data, and shared your thoughts. It was concise and is more likely than the first example to result in a good outcome for your patient.

### Active Listening

Half of good communication involves being a good listener. No doubt you have had someone pretend to listen to you and then find that they didn’t hear a word you said! We need to really listen to our patients. Active listening is much more than simply hearing words. You need to block out all distractions and really focus on what your patient is saying. You learned in your nursing fundamentals course to verify what you hear with responses such as “Let me clarify what I hear you saying,” or “I hear you saying that your pain makes you feel sad.” Clarification helps ensure that you and the patient don’t have different perspectives on what has been said. You can also use follow-up questions such as “Can you tell me



more?” or “What else are you concerned about?” to gather more information.

Using active listening with colleagues and providers can also help improve patient care. If you don't understand what a physician is explaining, never hesitate to say “I don't understand” or “Can you please explain that another way?” or even “Can you spell that please?” Carrying out orders that you don't fully understand can add to the nursing error statistics and harm your patients. Even when you do understand, *always* repeat orders back to the provider to verify that you heard correctly.

## PRIORITIZING CARE

Once you know what problems need to be addressed, you must decide which problem or intervention should be taken care of first. Because care should always be *patient-centered*, with the patient at the center of the health-care team, such decisions should involve the patient as well as the RN and LPN/LVN. The Maslow hierarchy of human needs can be used as a basis for determining priorities (Fig. 1.2). According to Maslow, humans must meet their most basic needs, at the bottom of the triangle, first. They then move up the hierarchy to higher-level needs.

Physiological needs are the most basic. For example, a person who is having difficulty breathing is not worried about love or self-esteem; they just want to be able to breathe. Once physiological needs are met, the patient can concentrate on meeting safety and security needs. Love, belonging, and self-esteem needs are next; self-actualization needs are generally the last priority when planning care. Needs can occur simultaneously on different levels and must be addressed in a holistic manner, with prioritization guiding the care provided.

If several physiological needs are present, life-threatening needs are ranked first, health-threatening needs are second, and health-promoting needs, although important, are last.

You studied additional ways to prioritize care in your nursing fundamentals course. This is a good time to review them.

### LEARNING TIP

If you are stuck wondering which physiological need should take priority, ask yourself, “Which problem is most threatening to my patient's life?”

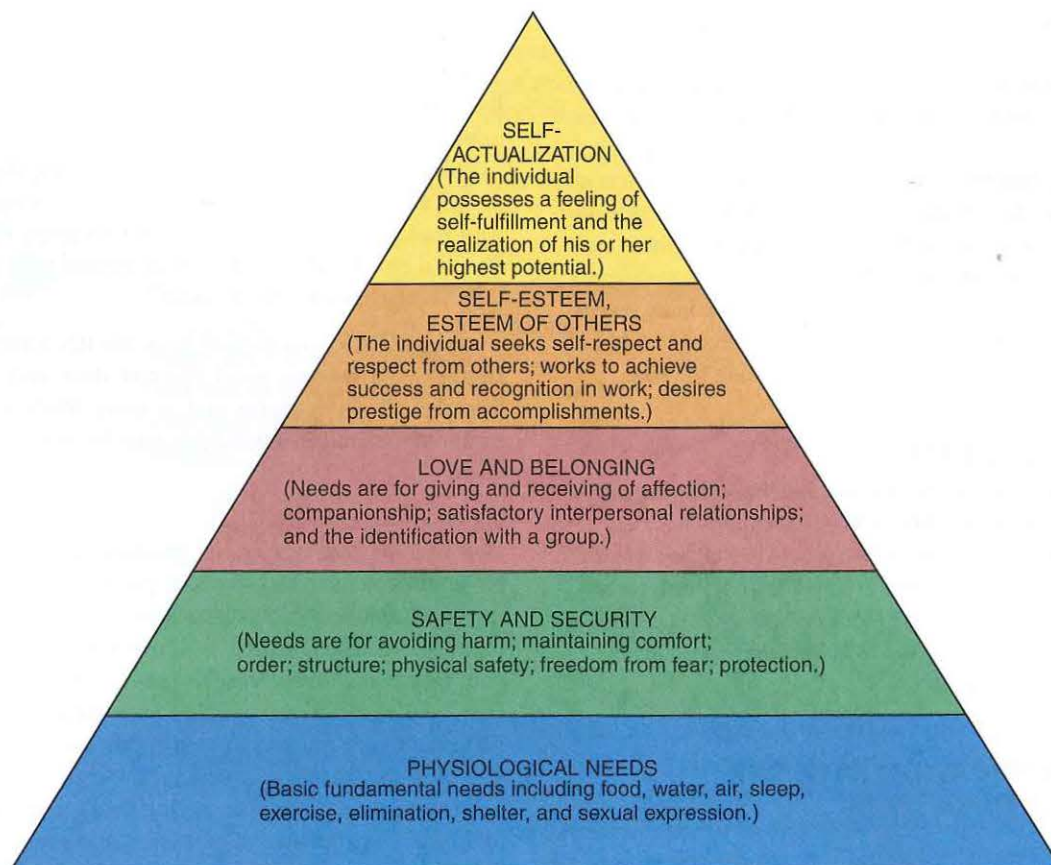


FIGURE 1.2 The Maslow hierarchy of human needs.



## CRITICAL THINKING

**The Maslow Hierarchy of Human Needs:** Based on the Maslow hierarchy of human needs, list the following nursing diagnoses in order from highest (1) to lowest (5) priority. Give rationales for your decisions.

- \_\_\_ Deficient Knowledge
- \_\_\_ Constipation
- \_\_\_ Disabled Family Coping
- \_\_\_ Readiness for Enhanced Self-Concept
- \_\_\_ Ineffective Airway Clearance

*Suggested answers are at the end of the chapter.*

## COLLABORATION

Have you ever heard that two heads are better than one? It's almost always helpful to have another opinion, especially in complex situations. Fortunately, in most clinical settings, you can always find a partner for collaboration. It might be another nurse, a physician, a physical therapist, a dietary aide, or any of the multiple workers in your setting. ALWAYS include your patient in your collaboration efforts. Remember, the patient is the most important member of the health-care team. Sometimes, you might be part of a care team meeting, where various team members meet to discuss patient care. Because you, as the nurse, often have the most direct relationship with the patient, it will be your responsibility to think about who can be most helpful and to consult with others or request a team meeting. This approach results in improved patient outcomes.

## NURSING KNOWLEDGE BASE

In addition to good thinking skills, nurses must have a solid knowledge base to safely care for patients. You would not drive a car without first learning the basics of how a car works and the rules of the road. In the same way, you must understand the human body in health and illness before you can understand how to take care of an ill patient. This is the reason you are going to school and studying this book.

Information is found in many places; some information is reliable, and some is questionable. For example, health

information found on a Web site may have been put there by a major university or other reputable source, or it may have been put there by a patient or by someone who wants to sell you a product. The latter sources may be biased, or the information may simply be untrue. Therefore, you must select your information sources carefully.

The best knowledge on which to base your practice comes from research. When nursing care is based on good, well-designed research studies, it is called *evidence-based practice*. You will learn more about evidence-based practice in Chapter 2.

## WHAT IS ON THE NCLEX-PN®?

That's the million-dollar question, right? But guess what! The NCSBN tells us what's on it! Every 3 years, NCSBN conducts a Practice Analysis (PA) for LPN/LVNs that tells them (1) what new LPN/LVNs do, and therefore, (2) what they should be tested on. They survey thousands of LPN/LVNs and educators and employers of LPN/LVNs. Access this information on the NCBSN Web site. Keep a copy of the Practice Analysis Average Frequency and Importance Ratings in your study area, and make sure you are studying the items to know what you will be expected to do as an LPN/LVN. You will also find PA tips throughout this book to remind you what is on the Practice Analysis. Following are some sample tips. You can see the importance of studying the information in this chapter!

### PRACTICE ANALYSIS TIP

#### Linking NCLEX-PN® to Practice

- Organize and prioritize client care based on client needs.
- Participate in client data collection.
- Use data from various credible sources in making clinical decisions.
- Involve client in care decision making.
- Recognize and report change in client condition.

Read each Practice Analysis Tip carefully and be sure to study the content—because it WILL be on NCLEX—and you will be prepared to safely care for your patients!

## Key Points

- Only 23% of new nurses are ready to practice safely. Many new nurses are “unable to recognize a change in a patient’s condition or identify the urgency of a situation” (Kavanaugh & Szveda, 2017). If a nurse is unable to recognize a change in condition and its urgency, an FTR can result.
- Critical thinking in nursing uses good thinking skills to improve patient care outcomes. Critical thinking can help you understand the “what and why” of patient data and care needs.
- Clinical judgment is the decision making nurses engage in every day. It must be based on good critical thinking. It determines what the nurse DOES after thinking about a problem.
- Good thinking requires attitudes such as intellectual humility, intellectual autonomy, and intellectual integrity.
- The clinical judgment process works well with the nursing process. Identifying and analyzing cues is part of good data collection. Prioritizing hypotheses might include problem statements in the form of nursing



diagnoses. Generating solutions is part of the planning process. Taking action and evaluating outcomes are analogous to intervention and evaluation.

- Nurses must be vigilant in anticipating and recognizing potential problems and then intervening before it's too late. Think ahead with each patient: "Based on my patient's diagnosis and current data collection, what could go wrong today?" Monitor closely for signs that a problem could be developing, and intervene to prevent the occurrence.
- Use the SBAR acronym to communicate effectively with the health-care team. S = What is the situation? B = What background is essential so the listener understands the situation? A = What is my assessment or analysis of the situation? R = What are my recommendations?
- Be an active listener with patients and the health-care team. Pay close attention to what is being said, and ask clarifying questions.
- Use Maslow's hierarchy to prioritize patient care. Physiological needs come first, then safety and security; love and belonging; self-esteem; and finally, self-actualization. If several physiological needs are present, manage life-threatening needs first, then health-threatening, and finally, health-promoting.
- Collaboration with others will lead to better outcomes. Remember, the patient is also on the health-care team. Patient-centered care means you always include the patient in planning and decision making.
- Become familiar with the NCSBN Practice Analysis for LPN/LVNs in order to be prepared for practice and also for the NCLEX-PN®.

## SUGGESTED ANSWERS TO CHAPTER EXERCISES

### Critical Thinking & Clinical Judgment

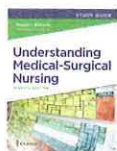
#### The Maslow Hierarchy of Human Needs

1. *Ineffective Airway Clearance*: physiological need that can be life-threatening
2. *Constipation*: physiological need that can be health-threatening
3. *Deficient Knowledge*: safety and security need
4. *Disabled Family Coping*: love and belonging need
5. *Readiness for Enhanced Self-Concept*: self-esteem need

## Additional Resources



Go to Davis Advantage to complete your learning: strengthen understanding, apply your knowledge, and prepare for the Next Gen NCLEX®.



A Study Guide is also available.