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Helping Novice Nurses Make Effective Clinical Decisions: *The Situated Clinical Decision-Making Framework*

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There is well-documented concern in the nursing literature that decision-making among novice nurses tends to be linear, based on limited knowledge and experience in the profession, and focused on single tasks or problems. Novice nurses, new graduates or nurses with limited experience in the care settings in which they work, tend to view decision-making as responding to patient complaints and following protocols or documented care plans (Chase, 1995; Itano, 1989; Radwin, 1998). As they make decisions, their focus leans toward doing, rather than on thinking and reflecting (Benner, 1984; Benner, Tanner, & Chesla, 1992). Novice nurses often do not recognize or appreciate the relevance of deviations from the textbook picture of a clinical situation (Benner, Tanner, & Chesla, 1996; Haffner & Raingruber, 1998; Tabak, Bar-Tal, & Cohen-Mansfield, 1996).

When confronted with complex or unfamiliar clinical situations, novice nurses frequently respond by drawing on theoretical knowledge and psychomotor skills, rather than enacting decision-making that addresses the complex and multidimensional nature of the situation. Further, when novices lack confidence in the clinical setting, they may rely excessively on more experienced nurses and avoid situations that require them to make decisions. Experiencing role dissatisfaction, some novice nurses will leave the profession (Messmer, Gracia Jones, & Taylor, 2005).

The full significance of this phenomenon becomes evident when placed at the intersection of two current trends in health care. First, a significant percentage of the nursing workforce is expected to retire within the next decade (Yancey, 2005). Second, complexity and acuity of patients is increasing in every sector of health care (Ebright, Patterson, Chalko, & Render, 2003). It is anticipated that the inexperienced nurse will carry increasing responsibility for clinical decision-making about the care of increasingly complex patient situations.

It has been suggested that nurses become expert in their practice when they have sufficient experience in the clinical setting to move from reliance on abstract principles to the application of concrete experience, viewing clinical situations within context and as a whole (Benner et al., 1996; Decker, 2006). However, in practice settings today, nurses function with few supports and mentors. It is clearly not feasible to simply wait for nurses to develop sufficient experiential knowledge to ensure that their decisions will be accurate and safe.

This article presents the Situated Clinical Decision-Making Framework as a means to help novice nurses reflect on the decisions they make in their clinical practice and develop features of expert clinicians. This tool assists the nurse in making decisions based on more than a basic understanding of nursing, patients' reported needs, and documented care plans. It can be used to guide retrospective reflection on the efficacy of decision-making processes and outcomes and to socialize nurses to an understanding of decision-making as complex and interactional, incorporating a broad knowledge and experiential base and influenced by the context of practice. Primarily, it fosters the development of their knowledge, skill, and confidence as nurses.

The framework has been used in various clinical settings, including critical care, high acuity care, and acute medicine and surgery. In addition, it is a curricular component in selected British Columbia Institute of Technology specialty nursing programs. A brief overview of the framework is provided, including its

ABSTRACT The nature of novice nurses' clinical decision-making has been well documented as linear, based on limited knowledge and experience in the profession, and frequently focused on single tasks or problems. Theorists suggest that, with sufficient experience in the clinical setting, novice nurses will move from reliance on abstract principles to the application of concrete experience and to view a clinical situation within its context and as a whole. In the current health care environment, novice nurses frequently work with few clinical supports and mentors while facing complex patient situations that demand skilled decision-making. The Situated Clinical Decision-Making Framework is presented for use by educators and novice nurses to support development of clinical decision-making. It provides novice nurses with a tool that a) assists them in making decisions; b) can be used to guide retrospective reflection on decision-making processes and outcomes; c) socializes them to an understanding of the nature of decision-making in nursing; and d) fosters the development of their knowledge, skill, and confidence as nurses. This article provides an overview of the framework, including its theoretical foundations and a schematic representation of its components. A case exemplar illustrates one application of the framework in assisting novice nurses in developing their decision-making skills. Future directions regarding the use and study of this framework in nursing education are considered.

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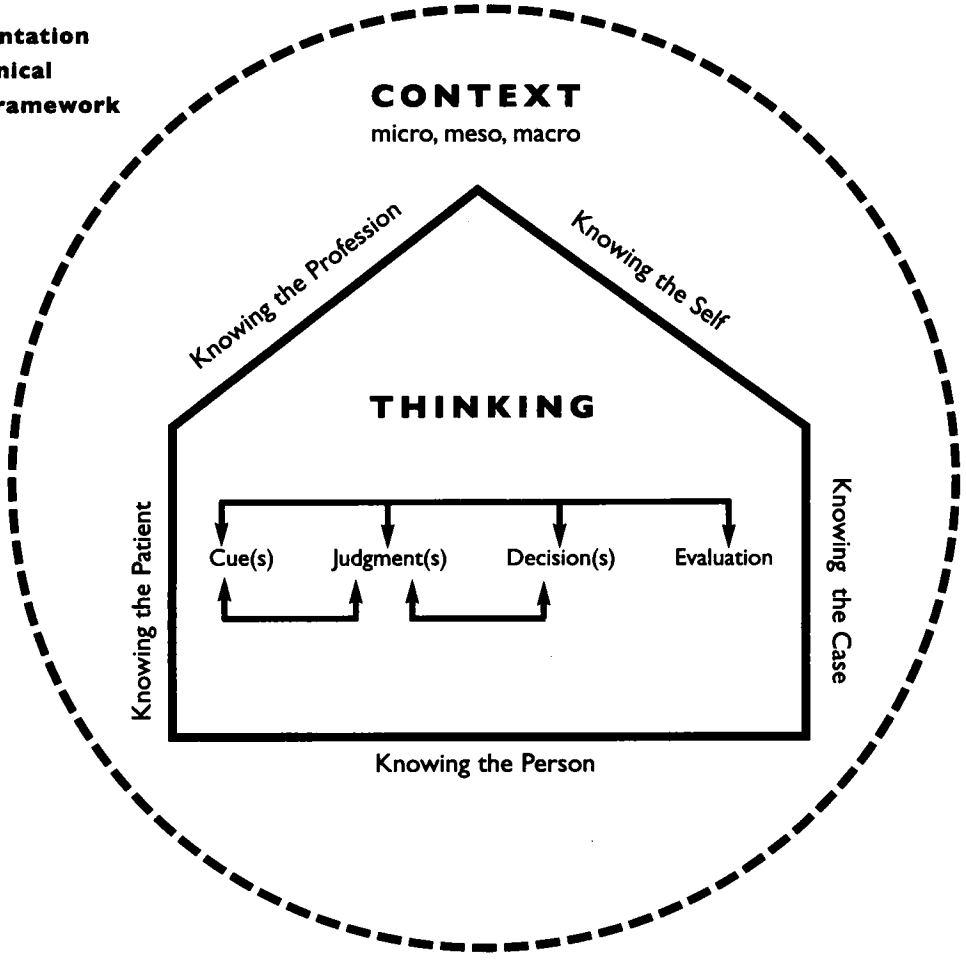
Figure 1.
Schematic Representation of the Situated Clinical Decision-Making Framework



theoretical foundations and a schematic representation of its components. A case exemplar is offered to illustrate how the framework can be used to assist novice nurses to develop their decision-making capacity.

Theoretical Foundations of the Framework Various researchers have attempted to identify models of decision-making in nursing that could be helpful in supporting skill development. In a recent review of approximately 200 studies, many of which are informed by psychological or heuristic theories of information processing, Tanner (2006) identified the limitations of such theories. The predominant limitation is that nursing decision-making has been reduced to linear problem-solving that belies the complex and contextual nature of what nurses do in their everyday practice. For example, Chartier (2001) proposed that the application of cognitive psychology theories of metacognition was appropriate to assist novice nurses in developing their decision-making skills. However, the instrument she proposed focused narrowly on diagnostic decisions pertaining specifically to a patient and his/her situation; the influence of the context is not considered. In addition, some aspects of the instrument are ambiguous, making it difficult to determine their relevance.

The theoretical foundations of the Situated Clinical Decision-Making Framework include those inherent in a model of nursing clinical judgment developed by Tanner (2006). Tanner's model conveys the process of clinical judgment within four aspects: a) In *noticing*, the nurse develops a perceptual grasp of the situation. This initial understanding is a function of expectations, influenced in turn by the nurse's background, relationship with the patient, and the clinical context. b) In *interpreting*, nurses make meaning of available data. c) Interpreting facilitates *responding*, or determining an appropriate course of action. d) In *reflection*, nurses consider the patient's response to interventions (reflection-in-action) and review the whole situation (reflection-on-action).

Situated learning theory (Lave & Wenger, 2003), with its central premises of learning as social and situated within a greater context, also provides theoretical grounding for the Situated Clinical Decision-Making Framework. In the framework, the clinical decision-making process is situated within the immediate and broader context of nursing practice, the nurse as an individual (knowing self), and the scope of the profession (knowing the profession). It is indivisible from multidimensional, patient-related knowledge (knowing the case, patient, and person). Situated learning theory emphasizes the role of a community of practice in supporting an

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individual's learning. The framework recognizes the possibility of collaboration at each phase of the decision-making process, highlighting the contribution of the community of practice to the growing competence of novice nurses' decision-making.

Within a community of practice, novice nurses are *junior partners* or *limited partners* (Paterson, 1998) who are supported in moving from legitimate peripheral participation (Lave & Wenger, 2003) toward increased competence and responsibility in clinical decision-making by *senior partners*, such as experienced nurses and educators. For example, novice nurses gain understanding of clinical decision-making when experienced nurses make explicit their own expert and often obscured decision-making processes, and/or draw attention to the influence of context on nursing decisions made in clinical practice.

These theoretical foundations are reflected in six assumptions that underlie the framework. The first five assumptions also undergird Tanner's (2006) model of clinical nursing judgment. The assumptions are:

1. What novice nurses bring to a clinical situation exerts a greater influence on their decision-making than objective clinical data.
2. Efficacious decision-making relies on what nurses know about a patient, nurses' ability to engage a patient in discussion about his/her needs, and nurses' ability to engage others (e.g., family, heath care practitioners) in both the identification and the evaluation of decisions.
3. Nurses' decision-making is influenced by the social, cultural, political, ideological, economic, historical, and physical context of the clinical situation and the clinical setting.
4. Nurses may use different decision-making approaches, alone or in combination.
5. Reflection-in-practice is critical to the development of decision-making skills in nursing. It most often occurs when errors are made or when novice nurses experience uncertainty or frustration in making decisions. Reflection-in-practice recognizes that the practice of nursing is more than visible actions; it also occurs in silence and without observable action.
6. The development of decision-making skills in nursing is situated within the social learning that occurs as novices work with others as junior partners in the clinical context.

The Framework The Situated Clinical Decision-Making Framework incorporates context, foundational knowledge, decision-making processes, and thinking processes. A schematic representation of the framework is provided in Figure 1. Discussion of the components follows.

CONTEXT The vast array of contextual factors that influence clinical decision-making come into focus when context is viewed as including *micro* (e.g., nurse and patient in relationship), *meso* (e.g., nursing unit or department, health care agency or institution), and *macro* (e.g., society, government, and profession) levels. Each level potentially includes social, cultural, political, ideological, economic, historical, temporal, and physical factors.

Situating clinical decision-making within this layered context has three implications. First, it highlights the relational matrix within which nurses make their decisions and, in turn, emphasizes the importance of effective communication and the possibility of collaboration within clinical decision-making. Second, it draws attention to the relational nature of nursing practice and, correspondingly, the ethical dimension inherent in all clinical decisions. Third, it recognizes the unique and contextual nature of clinical decision-making in nursing practice.

FOUNDATIONAL KNOWLEDGE The "house" in the conceptual schematic represents the foundational knowledge that informs nurses' clinical decision-making processes. This knowledge arises from various dimensions: the nursing profession, self, and general and specific aspects of the patient situation. These dimensions of knowledge are defined in Figure 2.

Effective clinical decision-making requires the nurse to do more than simply have knowledge. Rather, it entails active acquisition of new knowledge pertinent to the specific patient and situation, along with thoughtful selection and use of existing knowledge. In this framework, the active engagement of the nurse in knowledge acquisition and utilization is reflected in the use of *knowing* rather than *knowledge.*

Knowing the profession reflects incorporation of knowledge of the scope and standards of nursing practice, including competencies, skills, and roles of nurses, into clinical decision-making. Determined by provincial (state) legislation and national and provincial (state) nursing regulatory bodies, this knowledge defines the scope of nurses' clinical decision-making.

Knowing the self highlights the importance of nurses' knowing their strengths, limitations, skills, experiences, beliefs, values and assumptions, preconceptions, learning, and other needs in making clinical decisions. Knowing the self, therefore, offers a critical contribution to provision of safe patient care. Direction is taken from Liaschenko (1997) in considering patient-related knowledge in clinical decision-making.

Knowing the case reflects nurses' use of knowledge of general patient populations in making clinical decisions. More specifically, nurses utilize knowledge of relevant pathophysiology, patterns that exist in typical cases, patient responses, and the predicted trajectory of progress.

Knowing the client or patient occurs when nurses focus on understanding the individual's clinical state. In this way, nurses come to know a patient's baseline data, patterns that exist in an individual's laboratory and other diagnostic data, and patterns within his/her physiological responses to pathology and treatment.

Finally, knowing the person recognizes the importance of understanding the individual's past experience in relation to health and illness, patterns within a personal response to pathology and treatment, and preferences, supports, and resources in making appropriate clinical decisions.

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Figure 2. The Situated Clinical Decision-Making Framework: Foundational Knowledge and Clinical Decision-Making Process

FOUNDATIONAL KNOWLEDGE	CLINICAL DECISION-MAKING PROCESS
Knowing the profession Knowledge of standards of practice, competencies, skills, and roles of nurses	**Cues** • Observations • Statements from patients or others • Laboratory and assessment data • Atypical responses/behavior/data • Intuition
Knowing the self Knowledge of individual strengths, limitations, skills, experience, assumptions, preconceptions, learning, and other needs	**Judgments** • What could be happening? • What data/evidence supports this? • Do I need more information? From whom? • Whom should I involve/consult? • What priority does this have?
Knowing the case Knowledge of pathophysiology, patterns that exist in typical cases, predicted trajectory, and patient responses	
Knowing the patient or client Knowledge of a patient or client's baseline data, patterns that exist in laboratory and other data, or patterns in physiological responses to pathology and treatment	**Decision(s)** • Should I wait and watch? • Should I try something? • Should I inform someone? • Should I involve or consult someone else? • How will I know if I made the best decision?
Knowing the person Knowledge of a patient or client's past experience in relation to health and illness, patterns in their personal response to pathology and treatment, preferences, supports, and resources	**Evaluation of outcomes** • Did the decisions achieve what I wanted to happen? • Should I make another decision? • Should I collect more information? • Whom should I involve or consult?

THE CLINICAL DECISION-MAKING PROCESS The various phases that comprise the clinical decision-making process are not linear, but inform and may be informed by one another. Key questions that guide nurses in various phases of clinical decision-making (i.e., cues, judgments, decisions, and evaluations of outcomes) are provided in Figure 2.

Cues Clinical decision-making processes are triggered by recognition of a cue from the patient. Cues may be a patient response or the absence of something expected. From this point of attention, the nurse collects additional cues in order to build an understanding of the situation. Cues are collected from multiple sources and in a variety of ways, including observations of patients; conversations with patients, families and significant others, and other health care professionals; through assessment; from review of documentation on the patient (e.g., nursing and medical history, diagnostic data, documentation from other health care professionals); and from the nurse's intuition. In this framework, intuition refers to experience-based knowledge arising from recognition of particular patterns of patient cues or discrepancies within anticipated patterns (Benner et al., 1996). This perspective is made evident in the inclusion of patterns within the definitions of knowing the case, patient, and person.

Judgment Judgment is defined as the best conclusion a nurse can reach at a point in time, given the information available. The flexibility inherent in this vision of judgment reflects clinical reality and sets it apart from the more finite implications of identifying a problem or nursing diagnosis. Forming a judgment is a dynamic process. The nurse begins with the question, "What can be happening here?" and explores possible judgments. Further cue collection informs, and is informed by, the nurse's evolving understanding and continues toward a *best conclusion.* In understanding a judgment as a best conclusion, the nurse is prompted to remain open to revising that judgment as new information emerges. In this phase, safe practice is supported by nurses' awareness of their progress (knowing the self). When unable to progress to forming a best conclusion, the framework prompts the nurse to consider, "Whom should I involve or consult?"

The final question in this phase directs the nurse to consider the priority of the judgment. In assigning priority, the nurse ranks the judgment within concerns about the individual patient as well as within an assigned group of patients. Prioritization will be influenced by factors arising from all levels of context, including resource availability, predominant patient-care philosophy, and time-related factors (Bowers, Lauring, & Jacobson, 2001; Bucknall, 2003; Chase, 1995; Hendry & Walker, 2004).

Decision(s) Forming a judgment propels the nurse toward determining a course of action, a phase that requires consideration of both *what* should be done and *how* that should occur (Boblin-Cummings, Baumann, & Deber, 1999). The guiding questions highlight an invisible, but important, step in which the nurse considers a need for action: Should I do something or wait and watch? Although most nurses would confirm including this option in their clinical decision-making process, it has received scant attention in the literature. Waiting and watching is highlighted here as a decision in its own right, making it much more than an outcome of uncertainty or passive delay. Patient safety is influenced by the nurse's ability to differentiate from these two outwardly similar states and to seek assistance when inaction arises from uncertainty. Other questions offer direction for this situation, recognizing the important role of sharing information and the possibility of collaboration in choosing an appropriate course of action.

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The question "Should I try something?" highlights the possibility of generating several possible decisions and then acting on one. Thus, a decision to act may often include a component of testing and confirmation through information gathered from the outcome of an action. When the desired outcome is not reached, the nurse may implement an alternate decision.

Finally, the question, "Is this the best decision?" acknowledges a potential stalling point for novice nurses: their concern regarding making a *right* decision. Framing the goal as a best decision draws attention to two key points: First, in some instances, there may be several courses of action that constitute safe, appropriate, and ethical care. Second, the most appropriate decision will be influenced by the unique circumstances of the situation, that is, it is contextually determined.

Evaluation of Outcomes In evaluating outcomes nurses consider the effectiveness of the decision. Has the initial situation been resolved? The framework recognizes the clinical reality in which nurses may return from evaluation to any point in the decision-making process, or may recognize the need for assistance and choose to involve another health care professional.

Thinking The inclusion of thinking in this framework makes explicit the critical contribution of critical, systematic, creative, and anticipatory thinking to clinical decision-making. It also differentiates thinking processes from foundational knowledge. Critical thinking within clinical decision-making supports nurses in identifying and challenging their assumptions, values, and beliefs in a given situation; considering context; imagining possibilities; and maintaining reflective skepticism (Brookfield, 1987). Systematic thinking highlights the importance of nurses' ability to collect and organize information in a systematic manner that supports formation of a sound judgment and evaluation. The inclusion of creative thinking acknowledges the reality of present-day nursing: The individuality of patients, their increasing acuity and complexity, and the growing scarcity of resources challenge nurses to find creative solutions to patient situations, many of which will be non-textbook in nature.

In anticipatory thinking, nurses use foundational knowledge of the patient and person to extend their vision of patient care beyond the now. Integral to the process of planning ahead, anticipatory thinking is essential to prevention and early detection of potential patient problems; timely intervention when problems occur; alignment of specific decisions with broader patient care goals; and consequently, favorable outcomes for patients (Benner, Hooper-Kyriakidis, & Stannard, 1999; Minick & Harvey, 2003).

Exemplar This exemplar illustrates the utility of the Situated Clinical Decision-Making Framework. It reflects a clinical educator's discussion with a novice nurse about her decision-making in a particular clinical situation. Although this case is a retrospective analysis, the framework can also be used as a tool by novice nurses to guide their decision-making.

Iva, a nurse with three months of experience, had recently completed her orientation to an acute medical ward in a tertiary hospital. Eric, one of the four patients assigned to Iva, was 32 years old. He was morbidly obese and had had Type 1 diabetes for 22 years. He had been admitted the evening before with a diagnosis of community-acquired pneumonia. At 10 AM, when Iva answered his call bell, Eric told her, "My chest feels so tight. I am having trouble breathing." Iva auscultated his chest and noted the crackles in his right-lower-lung field were increased compared to her morning assessment. His arterial oxygen saturation was 93 percent by pulse oximeter, placing it just within acceptable limits defined by the ward protocol.

Concluding that his discomfort was related to his pneumonia, Iva reassured Eric, encouraging him to relax and focus on breathing slowly. She told him that she would return in an hour to check on him and that she needed to bathe her other patients. At 10:40 AM, Eric rang his call bell again. Another nurse answered it and discovered that he was ashen, perspiring profusely, rubbing his chest, and in obvious discomfort. She instigated the ward's chest pain protocol, including notifying the physician. A subsequent electrocardiogram revealed myocardial ischemia.

The clinical educator, Norm, met with Iva to review the situation. Iva offered her insights into her decision-making, acknowledging that she had failed to build an understanding of the situation. Instead of collecting additional cues to support the formation of a best conclusion, she had jumped to the conclusion that Eric's responses were related to his pneumonia. Further, Iva acknowledged that her decision to leave Eric and bathe her other patients reflected poor prioritization, citing her anxiety about getting behind with her work as an explanation. From this beginning, Norm used the Situated Clinical Decision-Making Framework to guide further exploration of the situation.

In order to understand the contribution of Iva's foundational knowledge to her decision-making process, Norm asked her how well she felt she understood Eric's presentation in this situation. After reiterating that her focus on his diagnosis of pneumonia sidetracked her from other information she knew about him, Iva readily identified Eric's risk factors for cardiovascular disease (knowing the case and patient) and outlined additional cues that would have enhanced her assessment. She added that she had been too busy to "get to know Eric very well." In response to Norm's invitation to "walk me through your thinking in this situation," Iva stated that she had not taken time to think about other possible causes (critical thinking, forming a judgment) and recognized she had made lots of assumptions (knowing the self). She also shared that she had considered the protocol for starting oxygen therapy in making her decision to not start Eric on supplemental oxygen (knowing the profession/scope of nursing practice, knowing the case). Finally, with the intention of understanding relevant contextual influences, Norm asked what else was happening on the ward at that time. This inquiry confirmed the influence of time-related aspects of meso context, embodied in Iva's anxiety about being behind in her work, and social aspects as she revealed that the

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ward was short staffed. Knowing the staffing situation, Iva had been reluctant to consult a more senior nurse as "they were all too busy."

The direction provided by the Situated Clinical Decision-Making Framework facilitated comprehensive review of the situation and identification of key concerns. Significantly, it supported Norm and Iva in discovering that Iva had adequate case knowledge of Eric's health challenges; however, her lack of critical inquiry had resulted in her failing to use this knowledge to consider a variety of causes for his clinical presentation. Differentiating thinking processes from knowledge as an issue is important to the selection of appropriate strategies to support development of Iva's clinical decision-making.

When inadequate judgments and prioritization are attributed to a lack of knowledge, educators are prompted to recommend that nurses review relevant theory. In this situation, the development of Iva's clinical decision-making would be supported by strategies that promote the use of her adequate case knowledge to build an understanding of patients as individuals, to generate and explore alternative judgments, and to establish appropriate priorities.

The multidimensional nature of the framework also drew attention to the influence of various contextual factors on Iva's decision-making. At the micro-context level, Iva's limited clinical experience constrained the practical knowledge that she brought to the situation. Further, time constraints arising from her workload (meso context) influenced her decision to leave Eric and bathe her patients. Finally, inadequate staffing (meso context) decreased her opportunity for collaboration and consultation in the decision-making process. Iva's future decision-making would be supported by strategies that minimize these contextual influences; for example, formalizing the availability of a more experienced nurse for collaboration and consultation, rather than leaving this process to chance.

Discussion Although the Situated Clinical Decision-Making Framework has been used and modified by use in clinical nursing education, it is presented here as a work-in-progress. Its further development would be enhanced by use in nursing educational processes in a wider range of clinical settings. It is anticipated that others will critique the framework and contribute to its refinement. In addition, the utility of the framework in achieving the intended goals requires empirical testing.

IMPLICATIONS FOR EDUCATORS To date, the framework has emerged as a positive tool for supporting development of clinical decision-making. Experience suggests that it can be utilized effectively by individuals and groups of learners in classroom, distance education, and clinical practice environments. The framework can be used to facilitate nursing students' and novice nurses' understanding of the complexity of everyday clinical decision-making, guide their decision-making in clinical and theoretical contexts, and focus their critical reflection on their clinical decisions and associated learning needs.

While it represents the reality of clinical nursing practice, the inherent complexity of this framework may be construed as a barrier to its use as a learning tool. In actuality, the framework accommodates flexibility with respect to implementation. Its application can be leveled to the student, and the situation can examined as a whole or in pieces. For example, when working with a beginning student, an educator may choose to focus on knowing the case (and exploration of knowledge related to general patient populations). Similarly, discussion with a more advanced student may focus on the influence of context on a clinical decision. When using this framework within clinical education practice, the educator can intentionally reserve time to engage in discussion about aspects of clinical decision-making with individual students or student groups, just as clinical teachers currently schedule time for post-conference or patient discussions.

Use by students encompasses the same potential for leveling and graduated use. Students have commented that the framework provides a checklist to ensure that their decisions in clinical practice are appropriate: "I go through it to make sure I haven't missed anything. It helps me to see what I do know, as well as the things I need to find out, before I make a decision." As a retrospective review tool, students have observed that the framework helps them recognize their strengths as well as areas for development.

As an analysis tool, the framework provides comprehensive direction for educators in identifying learners' difficulties and needs related to clinical decision-making. Subsequently, it guides their choice of relevant strategies to support learning. In particular, educators are prompted to differentiate between issues that arise from the learner per se and issues that impact the learner's decision-making but actually arise from the context. Further, use of this framework in post-basic nursing education indicates that registered nurses readily recognize and understand the structural components of the Situated Clinical Decision-Making Framework, suggesting that preceptors and mentors could easily be familiarized with the framework.

IMPLICATIONS FOR ADMINISTRATION The centrality of clinical decision-making to nursing practice means that key aspects of nursing practice are embodied in the Situated Clinical Decision-Making Framework. In completing performance appraisal processes, managers could ask novice nurses to use the framework to guide self-evaluation of their clinical decision-making capacity within their nursing practice. Emerging areas of concern could be addressed in plans for future professional development.

IMPLICATIONS FOR PRACTICE The influence of the clinical practice environment on nurses' decision-making processes has been well established (Bowers et al., 2001; Bucknall, 2003; Chase, 1995). This framework promotes differentiation of issues of content from issues related to the nurse as an individual. Critically, it also highlights the importance of creating structures and processes that promote consultative and collaborative practice for supporting novice nurses, for example, formal clinical mentorship programs.

IMPLICATIONS FOR RESEARCH The utility of the Situated Clinical Decision-Making Framework has been informally demon-

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strated in education for undergraduate nursing students and registered nurses in classroom, distance education, and clinical learning environments. Nurses confirm the inclusive nature of the framework as it guides their reflection on their existing clinical decision-making processes, assists them in anticipating similarities and differences for clinical decision-making in various contexts of practice, and offers direction for clinical decision-making. While this is encouraging, the framework needs to be empirically tested with regard to learning and clinical outcomes. In addition, efficacy of approaches to implementation requires exploration.

Conclusion The current health care environment of increased patient acuity and complexity, greater workloads, changes in delivery of nursing care, and diminishing resources constitutes an increased challenge for decision-making by all nurses. For novices, this challenge is even greater. The Situated Clinical Decision-Making Framework can serve as a tool for guiding their clinical decisions, helping them reflect on the efficacy of their decision-making processes and build an understanding of the many components that ultimately influence how decisions are made. In this framework, the complex nature of clinical decision-making is made evident. Clinical decision-making processes are situated within the immediate and larger context of nursing practice. They are informed by the nurse's multidimensional knowledge base and supported by various thinking processes.

The Situated Clinical Decision-Making Framework also provides direction for nurse educators in analyzing learners' clinical decision-making. Its comprehensive perspective facilitates locating the learner's relevant strengths and challenges within the many components necessary for effective decision-making. The framework can be used to guide the selection of appropriate strategies to support the evolution of novice nurses' decision-making processes. NLN

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