AN EXAMINATION OF NURSE EDUCATORS' EXPERIENCES WITH CLINICALLY FAILING STUDENTS

BY

JEANMARIE MALONEY MSN, RN, CNE

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This dissertation proposal is approved by the following members of the Final Oral Review Committee:
Dr. Richard Phillips, Committee Chairperson, Department of Education, Delaware State University
Dr. Patricia Carlson, Committee Co-Chair Department of Education, Delaware State University
Dr. Nirmaljit Rathee, Committee Member & Director of Graduate Education, Department of Education, Delaware State University
Dr. Nicole Bell Rogers, Committee Member, Department of Nursing, Delaware State University
Dr. Jacqueline Henaghan, External Committee Member, Department of Nursing, Delaware Technical Community College

DEDICATON

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An Examination of Nurse Educators' Experiences
with Clinically Failing Students

Jeanmarie Maloney MSN, RN, CNE

Faculty Advisor: Dr. Richard Phillips

ABSTRACT

This research describes the experience of nursing educators who have assigned an earned falling clinical grade to nursing students. The fundamental activity of the nursing educator in the clinical setting is clinical teaching or clinical instruction. The nursing educator guides, encourages, facilitates learning, and ultimately evaluates a nursing student's clinical performance. Clinical evaluations are one of the most challenging aspects of being a clinical nursing educator. Using a case study construct guided by the Self Determination Theory, seven nursing educators were interviewed to examine their personal experiences that surrounded the process. Three questions drove the research: 1. What is the lived experience of nursing educators who have administered an earned clinical failing grade to a nursing student(s) in an associate degree nursing program? 2. What motivated these nurse educators to assign a deserved failing clinical grade? 3. What is the personal impact on the nursing faculty when they experience a clinically failing student? The data was entered into the Atlas Ti8 software and three major themes were identified: the role of nursing educators, criteria used in clinical grading and challenges faced in grading students. One anticipated theme that did not emerge was that of assigning blame on previous educators. This research did reinforce and identify the need for support and guidance when assigning an earned failing clinical grade.

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CHAPTER I

INTRODUCTION

1.1 Introduction

It is a professional obligation of nursing educators to evaluate which students can critically think and behave professionally in the clinical setting and which students are not able to do so (Tanicala, Scheffer & Roberts, 2011). Patients and their significant others should feel assured that a graduate nurse has obtained an effective, reliable education and that they will be safe under that nurse's care. Nurse educators have a dual role of not only protecting the community but also of facilitating successful careers of their nursing students (Dobbs, 2017). Fulfillment of these dual roles will support students' professional development and prevent failing students from becoming registered nurses, thus safeguarding the public from incompetent practitioners" (Brown, Douglas, Garrity & Shepard, 2012).

This chapter will outline the background of the problem as it relates to the clinical component evaluation that must be diligently performed by clinical nursing educators. The statement of the problem is introduced; there is a minimal availability of research in the United States that explores the lived experiences of clinical nursing educators. The overall research questions will be noted. Terminology that is commonly associated with the clinical experience will be explained, as well as any concepts that will be discussed throughout this research. The Self-Determination Theory is the framework on which this research is built. Factors that motivate an individual and commitments that drive an individual's choices will be described within the context of this theory.

1.2 Background of the Problem

The word clinical is an adjective meaning involvement in direct observation of a patient. In the world of nursing education, this adjective modifies the nouns teaching, practice, instruction or evaluation (Gaberson, Oermann, & Shellenbarger, 2015). The fundamental activity of the nursing educator in the clinical setting is clinical teaching or clinical instruction. The nursing educator guides, encourages, facilitates learning, and ultimately evaluates a nursing student's clinical performance. Clinical evaluations are one of the most challenging aspects of being a clinical nursing educator.

The clinical practice portion of nursing education should provide numerous opportunities for students to develop critical thinking skills and to learn to function as competent and prudent nursing professionals. Nurse educators move clinical nursing students beyond academic practice sessions and assist the student in seeing how the learning activity will contribute to their development as nurses (Adelman-Mullally, T., Mulder, C.K., McCarter-Spalding, D., Haler, D.A., . . .Young, P.K., 2013). According to the National League for Nursing [NLN] (2012), it is vital for nursing students to evolve into effective and worthy members of society with respect for the ideals of the nursing profession. In the various clinical settings, nursing educators are responsible to create a climate that inspires students to use sound clinical judgment, to practice utilizing ethical standards, and to support and respect their peers (NLN, 2012).

Nurse educators are legally, ethically, and professionally obligated to identify safety issues for patients and to prevent students from causing injury in the clinical settings (Tanicala, Scheffer, & Roberts, 2011). Patients and their families should feel assured that a graduate nurse has obtained an effective, reliable education and that they will be safe under that nurse's care (Dobbs, 2017). If a nursing educator chooses to avoid the difficult decision of applying an

earned failing clinical grade, they have breached the nurse educator's moral imperative to prepare competent and knowledgeable graduate nurses (McGregor, 2007).

Nurse educators have a dual role of not only protecting the community, but also of facilitating the successful careers of their nursing students (Dobbs, 2017). It is a disservice to the student and ultimately to the patient population, to minimize the significance of incompetent clinical performance. Thus, it is a professional obligation of nursing educators to evaluate which students can critically think and behave professionally in the clinical setting and which students are not able to do so (Tanicala et al., 2011).

Nursing educators share the responsibility of providing safe and effective nursing care while providing learning opportunities for students and yet many experience angst in the management of the student who does not present with satisfactory performance (Chunta, 2016). One study that highlights the meaning of being a nurse educator and their attraction to academia noted that maintenance of the standards of safe patient care is crucial and makes a direct contribution to the profession (Laurencelle, Scanlan, & Brett, 2016). Nurse educators recognize that, regardless of the emotional challenges faculty and students must face, their professional obligation is protecting the public (Laurencelle, et al., 2016).

1.3 Statement of the Problem

Nursing students are advancing through their education unable to demonstrate safe nursing practice and/or consistent achievement of clinical objectives. There is no official guide to the process of dealing with a clinically failing student and little recognition in the literature of the impact the experience has on the nurse educator. Based on the scarcity of available research generated from within the United States, the experience of dealing with a clinically failing

nursing student is not often officially addressed as a learning opportunity or shared directly with other nurse educators.

Faculty are respectful of student privacy issues and are often reluctant to discuss potentially negative information related to the clinically failing student (Lewallen & DeBrew, 2012). Interviews documenting those exchanges and correlating the results with previous research of the lived experience of faculty who have been in a situation with clinically failing nursing students may be beneficial to those who have not had the experience. A goal for this case study is to describe empowered nurse educators who strive to evaluate each student with confidence and objectivity to determine if the student meets the clinical learning objectives and evaluates if they have or have not been met, resulting in a deserved failure (Chunta, 2016; Elliott, 2016; Luhanga, Larocque, MacEwan, Gwekwerer, & Danyluk, 2014; Suplee, Gardner, & Jerome-D'Emilia, 2014; Jervis & Tilki, 2011; McGregor, 2007). As Baxter and Jack (2008) identify when reporting a case study:

> The goal of the report is to describe the study in such a comprehensive manner as to enable the reader to feel as if they had been an active participant in the research and can determine whether or not the study findings could be applied to their own situation (p. 555).

1.4 Purpose of the Study

The purpose of this research is two-fold. One is to document the lived experiences of nursing educators and to identify if there are common themes associated with the experiences of, nursing faculty who have determined that a nursing student did not meet the clinical performance criteria for their specific course and who have applied the earned failing clinical grade. "Reflecting on one's own experiences with clinical evaluation and hearing about the experiences

of other faculty can make that process more deliberate" (DeBrew & Lewallen, 2014, p. 632). The other purpose is that this research will attempt to identify what factors served to motivate and support the nursing educators in their experience of assigning an earned clinical failing grade.

1.5 Research Questions

The following three questions will guide the study:

1. What is the lived experience of nursing educators who have administered an earned clinical failing grade to a nursing student(s) in an associate degree nursing program?
2. What motivated these nurse educators to assign a deserved failing clinical grade?
3. What is the personal impact on the nursing faculty when they experience a clinically failing student?

1.6 Importance of the Study

Clinical evaluation can be trying for nurse educators and the processes that they experience as they make the decision to assign a passing or failing grade to a nursing student is not well understood (DeBrew & Lewallen, 2014). The process and impact that clinically failing students have on nursing educators has not been extensively researched. By sharing the lived experiences of nurse educators who have experienced dealing with a student who has clinically failed, those nurse educators who have not had the experience and who are wary of what it entails, will be exposed to the processes the participants went through. Nurse educators who have had the experience may learn that their practical knowledge and experience, whether positive or negative, might not be an isolated situation. Existing research reviewed has many useful observations and plans for addressing the primary themes regarding social promotion of

borderline or below standard nursing students, but few address the lived experiences of nursing educators who have dealt with nursing students who have failed in the clinical component of their course evaluation, regardless of their didactic grade.

The National League for Nursing [NLN], whose mission is to promote excellence in nursing education, has identified core values that foster the academic progression of nursing students. These seven values include "caring, diversity, ethics, excellence, holism, integrity, patient-centeredness" (NLN, Board of Governors, 2011). In addition, the Accreditation Commission for Education in Nursing [ACEN] identified a need for safety in the education of nurses, noting that a curriculum should provide clinical opportunities that are not only evidence based, but that also mirror existing nursing practice and nationally identified patient health care safety guidelines (Chunta, 2016).

Even with these two major nursing education organizations stressing the need for safe, efficient, and knowledgeable graduates, educators continue to allow borderline and poorly performing students to clinically pass. Common themes are reported throughout research on this phenomenon; these themes may help identify why instructors may pass a student who was borderline or had less than satisfactory performance in the clinical arena (Jervis & Tilki, 2011). Research has shown that nurse educators are drawn to academia because they enjoy educating nurses but other aspects, such as giving students bad news, were identified as less enjoyable and a cause of difficulty and disconcertion (Laurencelle et al., 2016). Included in the description of the unattractive aspects of education, is the dilemma nursing educators face when maintaining the balance between fostering excellence in practice, patient safety, and the challenges of confronting the failing student (Laurencelle et al., 2016).

Common themes identified in the literature were reflected in the question designs. Participants did reveal some similarities, in their practice, to some, but not all, of the commonly reported themes related to failing to fail a student. These included but were not limited to:

1. Patient safety is the major principle in the clinical evaluation of nursing students at all levels (Luhanga et al., 2014).
2. Clinical faculty may have trouble defining their role (Elliott, 2016).
3. Instructors are keenly aware of the significant increase in workload when proving that a clinical failure is warranted (Dobbs, 2017).
4. Instructors are leery of the processes associated with a student challenging the failure (Elliott, 2016).
5. There is a reluctance to fail students early in their career as they may need time for improvement (Jervis & Tilki, 2011). This relates to the "benefit of a doubt" mentality (Elliott, 2016, p. 252). Nurse educators report a sense of being unfair if they fail a student early in the curriculum; that maybe the student needs time to adjust and learn (Lewallen & DeBrew, 2012).
6. A lack of experience or confidence in clinical evaluation skills inhibited administering a failing grade (Jervis & Tilki, 2011).
7. Nurse educators may feel that a student with a clinical failure reflects poorly on their ability to teach (Dobbs, 2017).
8. Nurse educators may feel they do not possess the proper communication techniques for early identification of and intervention for the failing student (Elliott, 2016).

If clinical nursing educators felt comfortable with sharing information from their personal experiences, the literature supports there may be opportunity for growth and personal development (DeBrew & Lewallen, 2014).

1.7 Scope of the Study

This study will contribute to the existing body of research as it relates to the process of assigning an earned clinical failing grade to students and the impact that the experience(s) had on the nurse educators. Much literature exists on the impact upon the student and on why social promotion of clinically failing students is widespread. There is sparse research existing from the United States on the lived-experiences of nurse educators who adhere to the result requirements of an earned failing clinical grade.

1.8 Definition of Terms

Assessment – evaluation of clinical performance in relation to clinical evaluation criteria which are created from measurable performance outcomes (MPOs) for each course. (Osters & Tu, 2005)

Associate Degree Nursing Program – Typically based on a two-year program, realistically, most programs of study last a minimum of three years with prerequisites completion (Cabaniss, 2014).

Atlas tI 8.3 – computer program used in qualitative data interpretation for analysis, enables user to organize text, to code, annotate, and compare fragments of information (Cresswell, 2013).

Clinical – A core component of nursing education is the clinical experience. Students participate in supervised learning sessions in real world health care environments, which provide them with the opportunity to put what they have learned in the classroom into practice.

(University of Pittsburg School of Nursing, n.d.)

Clinical Advisement – form written by clinical instructor and given to nursing student when there is a clinical occurrence that is out of standard for clinical criteria. Each form describes the occurrence in detail, which clinical criteria were violated, and outlines a plan for improvement. The student keeps a copy and signs a copy to be kept with their permanent record while in the nursing program (Delaware Technical Community College Nursing Student Handbook, 2016-2017).

Clinical Failure – when a student consistently fails to meet clinical criteria and is unsuccessful in the completion of a nursing course regardless of academic grade. Students must pass both theory and lab/clinical components to pass the course (Delaware Technical Community College, Syllabus Addendum, 2018).

Clinical Variance – A clinical variance is documentation of practices or behaviors in the patient care environment which could ultimately result in patient injury. This form is an internal form for the department of nursing and not the clinical institution. A student receiving two (2) clinical variances in the same course will receive a failure (F) grade for that clinical experience and consequently a failure (F) grade for the course. A student receiving four (4) clinical variances in the Nursing Program will be dismissed from the Program (Delaware Technical Community College Nursing Student Handbook, 2016-2017).

Codes – in vivo codes are exact words used by the participants in the interview process, used to describe information and develop themes. Codes can represent information expected to be found before the study, information not expected to be found, and information that is interesting or unusual (Creswell, 2014, p. 184).

Critical Incident Theory – a method of data collection that observes the processes used to resolve practical problems, it gathers data from participants that is meaningful to them and is identified as important, special, potentially life changing moments (DeBrew & Lewallen, 2014).

Eudaimonic approach - focuses on meaning and self-realization and defines well-being in terms of the degree to which a person is fully functioning (Ryan & Deci, 2001).

HIPPA - an acronym for The Health Insurance Portability and Accountability Act that enforced in 1996. This Act was created to provide protection for personal health information: provides needed information to health care providers for patient care, but also provides patients certain rights to that personal information. The enforcement activities resulted in an improvement of privacy protection for the health care information of individuals. The Privacy Rule is a federal law which allows certain rights over personal health information. This law sets rules and limitations on who can view and receive your personal information whether it is verbal, electronic, or written. The information that is protected includes any information that is put in your medical record by doctors, nurses, or other health care providers (http://www.onlyhealthy.com/understanding-the-hipaa-law/).

Institute of Medicine (IOM) – A nonprofit organization established in 1970 as a section of the US National Academy of Sciences, works outside the framework of government to provide evidence-based research and recommendations for public health and science policy (MedicineNet, n.d.). The Institute of Medicine has been renamed the National Academy of

Medicine. The name change comes as part of an internal reorganization at the National Academies (Maradiaga, 2015).

Learning Outcome – course outcomes and competencies that are derived from end-of-program and program semester or year that identify what nursing students should know and be able to perform and identify as valuable at the end of a semester or program. Must be written at appropriate level of learning and drive the learning materials, activities, and assessments (Billings & Halstead, 2012).

Measurable Performance Outcomes – The three essential components of a measurable learning outcome include: student learning behaviors, appropriate assessment methods, and specific student performance criteria. Learning outcomes are what students can demonstrate upon completion of a course, a span of courses or a program. (Osters & Tu, 2005)

Mentor – in the United Kingdom clinical nursing educators are referred to as mentors. These individuals have undergone approved training in teaching and assessing students in the clinical settings (Black, Curzio, & Terry, 2014).

Nursing Faculty – Nursing faculty in Registered Nurse (RN) programs (full-time and part-time) are required to have either a master's degree or a doctoral degree in nursing. Their personal education must include graduate preparation in the science of nursing and clinical practice, in addition to graduate preparation in teaching and learning. This must include curriculum development and implementation. A graduate-level foundation in the science of nursing is essential as is graduate coursework in the science of teaching/learning. The faculty member is responsible for directing student learning, he or she must understand the science of education, including an understanding of learning styles. They must understand education theory; be able to

evaluate and assess learners, a curriculum and program outcomes (National Council of State Boards of Nursing, 2008).

Self-determination Theory – Self-Determination Theory (SDT) is a theory that links character, human motivation, and ideal functioning. It postulates that there are two core types of motivation; intrinsic and extrinsic and they are powerful forces in shaping who a person is and how that person behaves. It is a theory that evolved from researchers Edward L. Deci and Richard M. Ryan's work on motivation in the 1970s and 1980s (Deci & Ryan, 2000).

Standard 3 Committee (aka Student Issues and Evaluation Committee) - The purpose of the Standard 3 Committee is to provide a means to support students in meeting the clinical objectives of a course. The Standards 3 Committee is to review, investigate, and suggest action when applicable with regard to the clinical evaluation of students within the Associate Degree Nursing Program. Members will review and recommend action for any issues/policies that affect students in the Associate Degree Nursing Program. The committee also provides a means for student participation in the governance of the Associate Degree Nursing Program. (Standard 3 Committee Bylaws, Delaware Technical Community College, Stanton Campus, 2018).

Social Promotion – the practice of promoting students to the next grade level even when they have not learned the material they were taught or achieved expected learning standards; it is called "social" promotion because non-academic factors and considerations, including societal pressures and expectations, influence promotion decisions (The Glossary of Education Reform, 2014).

Themes – in qualitative research are broad units of information that consist of several codes combined to form a common idea (Cresswell, 2014, p. 186).

1.9 Theoretical Framework

This research will be guided by the theoretical framework of Self-Determination Theory otherwise known as SDT. This theory will drive the research questions and be used to interpret responses. Self-Determination Theory evolved from research conducted by psychologists Edward L. Deci and Richard M. Ryan on motivation (Ryan & Deci, 2000). This theory links personality, human motivation, and optimal functioning based on several types of motivation "each of which has specifiable consequences for learning, performance, personal experience, and well-being" (Ryan & Deci, 2000, p. 69). It addresses basic conditions such as development, self-regulation, life goals, psychological needs, and culture/social impact on human behavior (Deci & Ryan, 2008). Humans are driven to meet three basic needs according to this model which explains the why and what of goal motivation (Gatling, Kim, & Milliman, 2015):

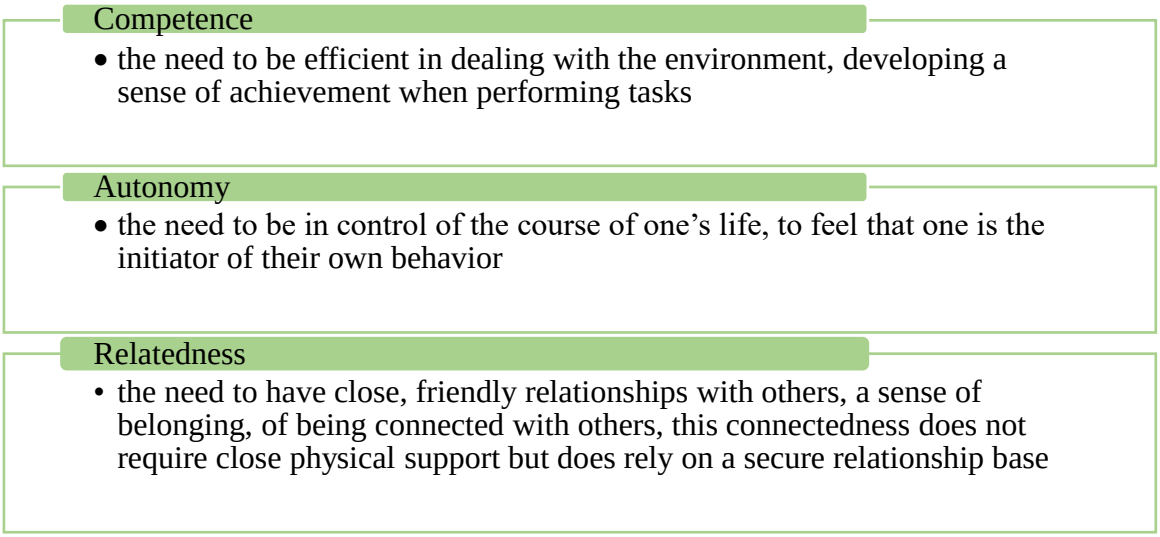

Figure 1. Basic needs for goal motivation Adapted from Sanchez-Olivia, Pulido-Gonzalez, Leo, Gonzalez-Ponce, & Garcia-Calvo, 2017; Ackerman & Tran, 2016; Ryan & Deci, 2000; Ryan & Deci, 2002.

Self-Determination Theory identifies that there are two main kinds of motivation with many layers within and between them. Extrinsic and intrinsic motivational forces shape how individuals conduct themselves (Ackerman & Tran, 2018). External forces result in rewards such as respect, a positive employee evaluation or awards. Intrinsic motivation stems from within; a person's core values, beliefs, and "sense of morality" (Ackerman & Tran, 2018, para 8). Those who are intrinsically motivated are likely to participate in activities that satisfy their three basic needs (Gatling et al., 2015). Individuals are complex and rarely driven by a single type of motivation. SDT holds that motivation is on a continuum that ranges from non-self-determined motivation to self-determined motivation. (See Figure 2)

Self-Determination Theory examines autonomous motivation which can be combination of intrinsic and certain types of extrinsic motivation where an individual has noted an activity's worth and have integrated it to their sense of self. Controlled motivation is a combination of external regulation and introjected regulation. Regulation relates to the locus of control for action (Deci & Ryan, 2008). Introjected motivation occurs when an action has been partially internalized but still recognizes the input of external motivation. Amotivation occurs when an individual has no motivation or intention. Autonomous motivation leads to long-term persistence (Deci & Ryan, 2008).

Self-Determination Continuum						
Motivation	**Amotivation**	**Extrinsic Motivation**				**Intrinsic**
Regulatory Styles	Non-regulation	External Regulation	Introjected Regulation	Identified Regulation	Integrated Regulation	Intrinsic Regulation
What is the source of the motivation?	Impersonal	External	Somewhat External	Somewhat Internal	Internal	Internal
What regulates the motivation?	Nonintentional, Nonvaluing, Incompetence, Lack of Control	Compliance, External Reward & Punishments	Self-control, Ego-invovlemen Internal Reward & Punishments	Personal Importance, Conscious Valuing	Congruence, Awareness, Synthesis With Self	Interest, Enjoyment, Inherent Satisfaction

Figure 2. *Self-Determination Continuum related to regulatory styles, sources of motivation and regulation of motivation. Adapted from Ryan & Deci, 2000; Ackerman &Tran, 2018.*

There are sub-theories within SDT. The first is the Cognitive Evaluation Theory (CET). Its purpose was to identify and explain the variables related to intrinsic motivation. CET is based on the premise that certain social and environmental influences facilitate or thwart intrinsic motivation. Cognitive Evaluation Theory focuses on the identified basic needs of competence and autonomy. "The theory argues, first, that social-contextual events (e.g. feedback, communications, rewards) that conduce towards feelings of competence during action can enhance intrinsic motivation for that action" (Ryan & Deci, 2000, p. 70). Feeling of competence will not affect intrinsic motivation unless the individual also has a sense of autonomy. Individuals must have both a sense of autonomy combined with a belief that their actions are self-determined for intrinsic motivation to be the trigger for behaviors. According to Baard, Deci, and Ryan, intrinsic motivation increases when an individual's "work orientation or environmental context is congruent with his or her needs and desires for growth and self-

actualization at work" (as cited in Gatling et al., 2015, p. 474). Individuals who received extrinsic rewards for performing an activity or action had diminished interest and commitment over time when compared to individuals who engage in the activity or action without receiving a reward. In this case the action(s) becomes controlled by the reward which impacts a sense of autonomy (Ackerman & Tran, 2018; Ryan & Deci, 2000).

Another sub-theory is the Organismic Integration Theory (OIT) designed to identify the various forms of extrinsic motivation and "the contextual factors that either promote or hinder internalization and integration of the regulation for these behaviors" (Ryan & Deci, 2000, p. 72). On the continuum of motivation one end identifies amotivation explained as a state of inaction where individuals are merely going through the motions. On the other end of the spectrum there is intrinsic regulation where actions are internally motivated by interest, satisfaction, and even joy: the actions are self-determined. According to the OIT there are basically four types of external motivation:

- External regulation – behaviors performed to meet an external demand or gain reward (completely external);
- Introjected regulation – behaviors that are partially internalized and completed to avoid shame, protect their feelings of self-worth or to gain approval (partially external);
- Regulation through identification – more autonomous, the behavior is perceived as more personally important (partially internal);
- Integrated regulation – behaviors are motivated by self-awareness and are in congruence with individual core values and needs, still extrinsic because they are

still motivated by outcomes rather than for enjoyment (Ryan & Deci, 2000 p. 72-73).

One more sub-theory is the Basic Psychological Needs Theory. Basic psychological needs, when met, trigger well-being but, when hindered, can lead to adverse consequences. Deci and Ryan (2002) identified a strong link between satisfaction of autonomy, competence, and relatedness needs and eudaimonic well-being. Definitions of eudaimonic well-being are varied. In 2014, Huta and Waterman (as cited in Huta, 2015) conducted a wide-ranging review of the psychological definitions of eudaimonia and identified four contents that appeared most frequently in all the definitions:

> Meaning/value/relevance to a broader context, personal growth/self-realization/maturity, excellence/ethics/quality, and authenticity/autonomy/integration. These variables are associated with certain mindsets, including a balance of focusing on the self and others, a balance of focusing on the present and the future, a tendency to be guided by abstract and big-picture concepts, and a focus on cultivating and building what one values and envisions. A greater degree of eudaimonia exists if all these contents are combined (e.g., if a person ensures that their authentic self-expression is also ethical) (p. 3).

According to Deci and Ryan (2008), research has shown that employees report that satisfaction of basic needs in the work environment are related to self-esteem, overall health, and vitality. Vitality is energy that is available to self, allowing the individual to feel empowered and behave more autonomously and persistently in important activities (Deci & Ryan, 2008). The concept of basic psychological needs provides insight on how different social forces and interpersonal settings affect controlled versus autonomous motivation.

Within the context of SDT Basic Psychological Needs theory there are two general individual difference concepts: causality orientations and aspirations or life goals. Causality orientations speak to the orientation of a person environmentally in relation to behavior and the degree to which they are self-determined in general. Three orientations have been identified.

Autonomous orientation results from enduring satisfaction of all three basic needs. Controlled orientation results when there is some satisfaction in the needs of competence and relatedness but frustration in meeting the need for autonomy. Impersonal orientation is the result of ongoing thwarting of all three basic needs (Deci & Ryan, 2008). Aspirations or life goals have been labeled either intrinsic or extrinsic. Intrinsic aspirations are comprised of goals of affiliation, personal development, and generativity. Extrinsic aspirations relate to fame, wealth or external appearance. Focus on intrinsic aspirations is resultant of consistency in having basic needs met; focus on extrinsic aspirations often stems from consistent insult to the needs of competence, relatedness, and autonomy. Pursuit of such extrinsic aspirations serves as a substitute in the absence of true need satisfaction but these aspirations lack contribution to well-being that intrinsic aspirations provide (Deci & Ryan, 2002; Deci & Ryan, 2008).

Self-Determination Theory addresses the issues of activity or passivity, responsibility or idleness. This theory postulates that humans are inclined towards activity and responsibility but are vulnerable to passivity. Contexts that support the three basic needs of autonomy, competence, and relatedness tend to develop greater internalization and integration than situations or conditions that thwart need satisfaction. Internalization refers to a person "taking in" a value or regulation and integration describes additional transformation of that regulation into their own being so that this value or commitment will "emanate from the sense of self" (Ryan & Deci, 2000, p. 71). In every setting certain behaviors and values are expected and warranted; values and behaviors that are not personally pertinent or interesting will not be assimilated. Some behaviors are inherent to an individual and intrinsically motivated; they are self-determined actions. Some are not and SDT attempts to understand the process by which these initially extrinsically motivated behaviors can become truly self-determined and the

influences of the social environment upon that process. Summed up by Ryan, "One of the things that we see in high-quality motivation, no matter the domain, is that people are passionate about what they are doing, and they really value it" (Knispel, 2017, para. 10).

1.10 Educational Leadership Theories

As a nurse educator, it is essential to assume a leadership role and work collaboratively with other faculty to create a "dynamic educational climate that demonstrates significant student learning outcomes and is responsive to the ever-changing regulatory higher education environment" (Patterson & Krouse, 2015, p. 76). The NLN identifies leadership as a relevant aspect of the educator role (Adelman-Mullally et al., 2013). Two leadership approaches will combine to establish a framework from which the researcher can obtain information efficiently and disperse the findings with beneficial efficacy. Using the Situational Leadership framework, which was developed by Dr. Paul Hersey and Dr. Ken Hartley Blanchard in 1969, will be pertinent to this research. The researcher will need to adapt to the demands of different situations (as cited in Northouse, 2016). The Situational Leadership framework has both directive and supportive dimensions. Supportive behaviors facilitate a level of comfort in the participants regarding how they view themselves, their peers, and situations (as cited in Northouse, 2016). The supportive aspect involves open communication and verbal exchanges that show both social and emotional support to others (as cited in Northouse, 2016). Within this leadership framework there are varying levels of development. The participants in this research could be categorized as those with the highest development "having both a high degree of commitment to getting the job done. They have the skills to do the job and the motivation to get it done," (Northouse, 2016, p. 96). In this context the researcher would be referencing the dual role a nursing educator must fulfill.

It is necessary to acknowledge that individuals will vary in terms of relative competence and commitment to undertake such an imposing action as assigning a deserved failing clinical grade. This framework acknowledges that members act differently during different stages of goal attainment. There are four distinct categories in situational leadership that address varying degrees of either directive or supportive behaviors: directing, coaching, supporting, or delegating (Northouse, 2016). It will be important to acknowledge these categories to effectively address the various nurse educators who may review this research. This framework is applicable to this research as the recipients of its findings may experience fluctuations in competency and commitment over time and require varying types of leadership interventions:

- High-task/low-relationship leader behavior (S1) is referred to as "telling" because this style is characterized by one-way communication in which the leader defines the roles of followers and tells them what, how, when, and where to do various tasks.
- High-task/high-relationship behavior (S2) is referred to as "selling" because with this style most of the direction is still provided by the leader. The leader also attempts through two-way communication and socioemotional support to get the followers psychologically to "buy into" decisions that must be made.
- High-relationship/low-task behavior (S3) is called "participating" because with this style the leader and followers now share in decision making through two-way communication and much facilitating behavior from the leader, since the followers have the ability and knowledge to do the task.

- Low-relationship/low-task behavior (S4) is labeled "delegating" because the style involves letting followers "run their own show." The leader delegates since the followers are high in readiness, have the ability, and are both willing and able to take responsibility for directing their own behavior. (Hersey & Blanchard, n.d., para. 5)

Using an Adaptive Leadership approach will be valuable to this research. Real life experiences of nursing educators who have assigned a failing grade to clinical nursing students will be recorded and analyzed for themes. Learning of the experiences and the impacts they had on nurse educators who have dealt with the processes associated with a student who failed clinically may offer insights and provide knowledge for nurse educators who do not have those experiences. An adaptive leadership style will help regulate distress, provide direction, keep focus on key issues, empower nurse educators and most importantly, give an opportunity to inexperienced nurse educators who feel intimated or marginalized when social promotion of failing students is being analyzed (Northouse, 2016).

"Adaptive leaders understand that people need a supportive environment and adapt more successfully when they face difficult problems directly…. resolve internal conflicts, and learn new attitudes and behaviors" (Northouse, 2016, p. 260). Adaptive leadership focuses on the theory that leaders and followers affect each other. It is interactive without a formal designated leader. This leadership style focuses on the follower; it stresses follower involvement and follower growth (Northouse, 2016).

This theory will be beneficial when the lived experience research is shared with all faculty. It will allow for an environment where other faculty can learn and grow from the shared experiences of those who have dealt with the situations associated with a student who is failing

or has failed clinically. Through adaptive leadership, faculty who may have been hesitant to fail a nursing student clinically may be empowered to confront their personal hindrances and obtain an awareness of the experience of failing a nursing student based on their clinical performance. Adaptive leadership centers on creating a safe environment for addressing challenging issues.

1.11 Limitations and Delimitations

Using a case study methodology is not without its limitations. The volume of data coupled with time restrictions can impact the depth of analysis. It is important to avoid collecting as much data as is available; adequate time must be set aside for its analysis and explanation of what are frequently "highly complex data sets" (Crow et al., 2011, p. 7). In research, there are certain population characteristics that are the basis for either inclusion criteria also known as eligibility or exclusion criteria also known as delimitations (Haber, 2014). As Haber (2014) reports: "Remember that inclusion and exclusion criteria are established to control for extraneous variability or bias that would limit the strength of evidence contributed by the sampling plan in relation to the study's design" (p. 233). Planned sample exclusion/delimitations will increase the research's accuracy, its strength of evidence, thus contributing to the meticulousness and generalizability of the results.

Limitations

- Small scale.
- The results may not be applicable to faculty in different types of nursing programs or different sized programs.
- As information is disseminated it must be acknowledged that recipients of the findings will vary in terms of relative competence and commitment to undertaking the tasks associated with the failing clinical nursing student.

- Participants will be volunteers and may have other motives for describing the experiences.
- Only active, fulltime nursing educators will participate.

Delimitations

- Faculty must be actively employed at the institution.
- Faculty must be fulltime and teach both clinically and didactically.
- Faculty must have had experience of dealing with a nursing student who has clinically failed their nursing course.

1.12 Summary

This chapter highlighted the background of the problems associated with the experience of dealing with the nursing student who is clinically failing, or has clinically failed, a nursing course. It identified that clinical evaluations are among the most challenging aspects of being a clinical nursing educator. The goal of this study is to add to the body of literature through discussion of the lived experiences of clinical instructors who have issued a failing grade. It reviewed that the experience of assigning a failing clinical grade is limited in availability of research from the United States and the experience of dealing with clinically failing a nursing student is not often openly discussed and presented as a learning opportunity. The importance and scope of the study were shared as they relate to the factors that prohibit the assignment of an earned failing clinical grade and the obligations that a nursing educator has in relation not only to the student population but to the public as well. The theoretical framework that drives this research, the Self-Determination Theory, was also discussed. Terms that will be used throughout the research were specified. Next, a comprehensive review of current literature will be examined.

CHAPTER II

LITERATURE REVIEW

2.1 Introduction

In this chapter the role of nursing educator will be defined in terms of the available empirical research and data accepted explanations. The clinical experience and expectations will be reviewed. The criteria of clinical competence will be presented. Obstacles to safe clinical behavior will be examined. Pertinent research on the social promotion of such students will be presented. The current research on the experiences of nursing educators who have worked with clinically failing nursing students will also be discussed.

2.2 Nursing Educators

A nurse educator is a registered nurse who has advanced education which often includes advanced clinical training in a healthcare field. In the United States, a nurse educator is prepared with a master's or doctoral level degree and serves as faculty in universities, colleges, hospital-based schools of nursing or technical schools. Their roles include assisting individuals to obtain either diploma, associates or Bachelor of Science degrees in nursing. Often, nurse educators teach clinical courses that parallel with their area(s) of clinical expertise, which may include adult medical-surgical care, family health, pediatrics, obstetrics, public health, and psychiatric/mental health. In an associate degree program, such as the one used in this research, nurse educators are expected to have an 18 or above number of contact hours with the nursing students. Nursing educators are responsible not only for classroom teaching, but also creating and conducting lab experiences. They are personally responsible for class and clinical preparation, student advisement and holding open office hours, in addition to participating in

interdepartmental and college-wide committees and monthly faculty meetings (Cabaniss, 2014; McDonald, 2010).

Nurse educators play a crucial role in establishing a strong, safe nursing workforce; they serve as role models and provide student nurses with the leadership needed to engage in evidence-based practice. They are critical in assuring excellence in educational experiences that prepare future nurses for a varied, ever-changing health care environment (Nurses for a Healthier Tomorrow, n.d.). To be proficient, nurse educators should demonstrate a commitment to lifelong learning, exercise leadership, and be concerned with the scholarly advancement of nursing practice (National League of Nursing, n.d.). They should have a solid knowledge base in theories of teaching, learning, and evaluation.

Nurse educators are role models for their clinical students whether that role is deliberate or incidental. They could be identified as transformational leaders. Because of their clinical expertise they are familiar with the complexities associated with patient care. Thus, they are competent not only in technical skills, but also in the areas of patient teaching, counseling, assessing and monitoring, clinical judgment, and teamwork. Nurse educators set the example by skills performance and, more importantly, role model clinical decision making. Sharing the decision-making process with nursing students allows the students to discuss possible options and understand how decisions for determining the best approach to patient care are made (Adelman-Mullally et al., 2012).

Nursing education is an intricate endeavor that combines the art and science of nursing and clinical training into teaching, learning activities. Teaching nursing encompasses a skill set that is essential to promote student learning outcomes (Billings & Halstead, 2012). As

transformational leaders, nurse educators inspire students to see the broader scope of the profession of nursing not just the completion of tasks. They support nursing students to achieve their professional goals. As Adelman-Mullally and her fellow researchers (2012) noted:

> …professional nursing is more than theory and technical skills. Experienced nurses need to help students see nursing in its complexity, merging theory, and knowledge with the relationship with a patient. Clinical educators are well positioned to demonstrate the complexities of nursing practice because they often bridge the clinical and educational worlds (p. 31).

The National League of Nursing identifies competencies that are expected of a nursing educator. Such competencies promote excellence in the role of nurse educator. They include:

1. Facilitate Learning;
2. Facilitate Learner Development and Socialization;
3. Use Assessment and Evaluation Strategies;
4. Participate in Curriculum Design and Evaluation of Program Outcomes;
5. Function as a Change Agent and Leader;
6. Pursue Continuous Quality Improvements in the Nurse Educator Role;
7. Engage in Scholarship;
8. Function Within the Educational Environment (NLN, n.d.).

The competencies assist in the identification of nursing education as a specific area of practice. They also provide nurse educators with a guide that outlines the complexity and value their role encompasses. Nursing educators must identify their responsibility for assisting the student nurses to mature into professional nurses. The graduates of a nursing program must assimilate the standards and actions essential to fulfilling the obligations of the role of nurse. Nurse educators are professionals who work in both classroom and the practice settings; they are responsible for preparing and mentoring nurses (Nurses for a Healthier Tomorrow, n.d.).

A nurse educator is responsible for designing classroom, clinical, and laboratory settings that promote student learning and facilitate intellectual, emotional, and psychomotor skills. The nurse educator must be competent in utilizing a variety of approaches to evaluate and assess the student nurse's efficiency in the classroom, laboratory, and clinical settings (National League for Nursing, n.d.). Nurse educators are tasked with designing, implementing, and evaluating their teaching formats; they are also responsible for revising academic programs for student nurses (Nurses for a Healthier Tomorrow, n.d.). Nurse educators have a responsibility to identify program outcomes to identify curriculum that is reflective of current health care trends, and to prepare graduates of their programs to effectively function in a multitude of health care environments.

It is essential that nurse educators have an awareness that their role is multidimensional. A nurse educator must have a commitment to continuously developing and maintaining competence in this role; this is crucial (National League for Nursing, n.d.). The forte of a nurse educator is his or her proficiency in teaching/learning, outcomes assessment, course development, and advisement/guidance of the student nurses. Nurse educators must have substantive knowledge in the areas they teach and must possess the skills to accurately share that knowledge in a variety of approaches to the students they educate. They must utilize a variety of teaching techniques that recognize the various learning styles and increases student motivation and achievements (Billings & Hallstead, 2012).

Past learning and personal life experiences influence how each individual nursing student views the world. Nursing educators bridge theory to practice, support learning opportunities in the clinical setting, and they must do so as they consider the uniqueness of each nursing student.

As discussed by Adelman-Mullally et al. (2013), the nurse educator is responsible for creating trusting relationships that inspire and stimulate clinical nursing students to learn and to think. A trusting relationship between the clinical nurse educator and the clinical nursing student is significant; it allows the clinical nursing student to feel autonomous, which, in turn, fosters a desire to seek learning experiences. The student develops a sense of empowerment that promotes critical thinking and the opportunity to grow personally and professionally. Clinical educators must create a learning environment in the clinical setting that supports experimentation, nurtures learning, and promotes critical thinking skills. Nursing educators exhibit their leadership skills as they manage and assess students in a setting that is highly stimulating. These skills are not only a balancing act; they have significant impact on the learning experiences of the clinical nursing student (Adelman-Mullally et al., 2013).

2.3 The Clinical Experience

The clinical experience: learning is an active, individual process. The nursing student is the person who experiences the learning. Nursing educators cannot deliver the experiences; they can only provide opportunities for the experiences. It is considered that designing and providing appropriate activities that will promote learning is one of the nursing educator's roles (Gaberson et al., 2015). As each student is different and each opportunity may have a difference, each student will experience an activity in a different way. Aptly described by Adelman-Mullally et al. (2013), "transformational clinical nursing opportunities are crafted not created; are genuine, not contrived; and are ways in which faculty members share with students what is unique to the domain of nursing" (p. 34).

Like other practice professions, postsecondary education of nursing students is viewed as preparation of practitioners. As a practice discipline, nursing requires the development of an elevated level of cognitive skills, psychomotor, and technical skills, in addition to values (Oermann & Gaberson, 2013). Nursing educators diligently attempt to provide nursing students with realistic clinical experiences where students are expected to function in the health care setting, including hands-on care (Matt, Maheady, & Fleming, 2015). Clinical practicums are essential and a very important part of nursing education. They provide occasions for students to apply what they are being educated upon in theory courses, to practice skills, and improve their clinical judgment skills. Clinical practicum experiences for nursing students provides them with opportunities to use concepts learned in class, practice skills learned in lab, and to interact with patients, families, and other nurses (Rowbotham & Owen, 2015).

As noted by authors Dr. Marylyn Oermann and Dr. Kathleen Gaberson (2013), nursing care is driven by evidence-based practice. In the clinical setting, nursing students acquire knowledge of evidence-based practices; they can search for, critique, and use evidence-based practices in their patient care. Sigma Theta Tau International Honor Society of Nursing (n.d.), defines evidence-based nursing as:

> an integration of the best evidence available, nursing expertise, and the values and preferences of the individuals, families and communities who are served. This assumes that optimal nursing care is provided when nurses and health care decision-makers have access to a synthesis of the latest research, a consensus of expert opinion, and are thus able to exercise their judgment as they plan and provide care that takes into account cultural and personal values and preferences. This approach to nursing care bridges the gap between the best evidence available and the most appropriate nursing care of individuals, groups and populations with varied needs (para 5).

In addition, clinical experiences offer opportunity for nursing students to development their personal and team communication skills and to collaborate with the health care team. In a culturally diverse live clinical setting, students can develop cultural competence and refine the knowledge and attitudes needed to provide multicultural health care. Clinical experiences enhance student competencies in a patient-centered setting, "recognizing patients as partners in care; providing compassionate care; continuously coordinating care; and advocating for patients" (Oermann & Gaberson, 2013, p. 235).

Clinical evaluation assesses clinical competence. Decisions regarding passing or failing the clinical portion of a course stem from these assessments. Formative evaluations are an ongoing process. Students are informed of their strengths and of areas that need to be improved with strategies to address those areas being provided. By using an ongoing approach, both the clinical nursing student and the clinical nursing educator can monitor progression towards meeting the required clinical criteria (Oermann, Yarbrough, Saeww, Ard & Charasika, 2009). Summative evaluation is done at the course's completion. It provides the final judgment of the nursing student's success or failure in the clinical portion of a course. This evaluation reflects whether or not a nursing student successfully met the required student learning outcomes for competence and safe nursing care. Traditionally, formative evaluation represents guiding and summative evaluations represent grading. In an ideal clinical setting, both approaches should be employed (Oermann et al., 2009).

Examination of student performances can also be used to assist faculty in gaining awareness of their own teaching behaviors, so they can help clinical nursing students be successful. Clinical nursing educators should develop the skills necessary to be effective

evaluators of student learning and understand how to provide constructive feedback. These skills enable faculty to be more effective in the clinical setting. Constructive feedback has many essential components including:

- given with the goal of improvement;
- timely;
- honest;
- respectful;
- clear;
- issue-specific;
- objective;
- supportive;
- motivating;
- action-oriented;
- solution-oriented (Wilhelm, n.d., para. 6).

2.4 Defining Clinical Competence

Nursing student practice in clinical settings exposes them to the realities of professional practice that cannot be portrayed by simulation or experienced through a textbook (Gaberson et al., 2015). "Critical thinking has been defined as the process of purposeful thinking and reflective clinical reasoning through which nurses examine ideas, assumptions, principles, beliefs, and actions in the context of practice" (Billings & Halstead, 2012, p. 27). Clinical practice places students in ambiguous and unique patient situations that may not fit the textbook

descriptions, requiring the student to critically think about what actions to take. It helps them develop a higher level of cognitive skill (Oermann & Gaberson, 2013).

"Clinical reasoning is the method by which nurses make their decisions, and includes the careful process of creating changes, evaluating them against the evidence, and then applying the most suitable one" (Billings & Halstead, 2012, p. 28). It is also defined as reasoning that can change over the course of care with relation to certain situations, changes in the patient's state or concerns and/or changes in the caregiver's perceptions of the patient's clinical condition or concerns. Clinical judgement is the result of critical thinking in nursing practice. It utilizes information regarding a patient's needs and health problems to dictate the choice of whether to act or not, to employ or to modify current approaches or to design new approaches based upon patient response to interventions (Billings & Halstead, 2012).

Students who are unable to appropriately think critically might not question their practice which could result in weak decision making and substandard clinical judgments (Killam, Luhanga, & Bakker, 2011). Students are not expected to be nurses (Oermann & Gaberson, 2013). Acquisition of skills is a multifaceted process involving committing errors, identifying how to correct them, and ultimately avoiding repetition of those mistakes. The clinical setting is where students can evaluate theory and employ it in practice. Some applications will be more successful than others.

Nursing educators should anticipate that students will make mistakes and should not expect perfection. In fact, nurse educators should "allow plentiful learning time with ample opportunity for feedback before evaluating student performance summatively" (Gaberson et al., 2015, p. 11). While in the clinical setting, students should be comfortable voicing questions and

seeking the guidance of the nursing educator as opposed to avoiding them (Oermann & Gaberson, 2013; NLN, 2012). Creating a supportive atmosphere is essential for effective assessments so the nursing student has the opportunity for feedback that will enhance their performance (Oermann & Gaberson, 2013). A single incidence of borderline or below standard performance by a nursing student in clinical may cause concern. The clinical nursing educator should absolutely be very concerned if a nursing student consistently demonstrates inconsistent and incorrect skill performance, errors in judgement or poor communication skills, as these types of consistencies are reflective of dangerous practice (Killam et al., 2011).

Nurse educators teaching clinical nursing are accountable for guiding their students towards developing professional skills and values. Clinical experiences should have opportunities that promote the ability to become safe, competent care givers. Patient safety is recognized as a "transglobal mandate central to nursing care across all sectors and settings" (Killam, Montgomery, Raymond, Mossey, Timmermans, and Binette, 2012, p. 1). Since nursing is a professional practice discipline, it is plausible that the clinical experiences of nursing students are more important than what they may demonstrate in the classroom setting (Gaberson et al., 2015). Billings and Halstead (2012) attest to the following:

> Applying a theoretical knowledge base, developing psychomotor skills, using appropriate communication technique with patients and staff, exhibiting decision-making and organizational skills, and behaving in a professional manner are examples of the types of competencies that nursing students are expected to achieve through their clinical experiences (p. 44).

Ideally, should a student exhibit behavior that poses a risk to patient well-being, they should be subject to a failing grade in the clinical portion of their nursing education. However, students are more frequently unsuccessful in a nursing course if they fail academically than they are for a clinical performance that does not fulfill clinical criteria (Jervis & Tilki, 2011). In fact,

nursing students are five times more likely to fail academically than clinically (Hunt, McGee, Gutteridge & Hughes, 2012). When nursing educators identify a nursing student who is not satisfactorily meeting the course objectives, it is their legal and ethical responsibility to deny the student's progression. The social promotion of unsafe students causes difficulties for employers and staff education specialists when the hired graduate student cannot perform at the expected entry level of competency and safety (Chunta, 2016).

2.5 Safe or Unsafe Clinical Care

Quality of care and patient safety are two of the key foundations of nursing practice. Safety and quality are the universal values on which all healthcare is based (Sherwood, 2011). The Robert Wood Johnson Foundation, in 2005, sponsored a national study to educate nurses about quality of care and patient safety. This was done in recognition of the significant role that nursing care plays in patient outcomes. The project was planned to address the gap that existed between nursing education and practice. The overall goal was to improve patient outcomes through the provision of a solid foundation of the skills, knowledge, and attitudes necessary for student nurses, who would ultimately be practicing nurses, to provide safe and effective quality care.

The Quality and Safety Education for Nurses (QSEN) competencies, which would be included in both undergraduate and graduate curriculums, were developed during phase two of the project (Hunt, 2012). Six competencies were identified as essential to safe patient care; in addition, the knowledge, skills, and attitudes that were identified for each competency were highlighted. To determine the competencies, ten faculty experts, an advisory panel representative of groups that influenced educational policy, nursing practice, and resident

medical education were identified as integral to the project's genesis. The project included hospital-based diploma programs, two-year community college associate degree programs (ADN), and four-year university-based baccalaureate programs (BSN). All three of the pre-licensure programs were included as all graduates must successfully pass the same licensing exam and possess the required skills to become safe registered nurses (Sherwood, 2011).

Focus groups were used to identify and evaluate the identified competencies and the ability of these to be intertwined with nursing education. These competencies should be woven throughout a nursing curriculum and injected into both didactic and clinical experiences. In fact, as noted by Cronenwett, Sherwood, Barnsteiner, Disch, Johnson and Mitchell (as cited in Cabaniss, 2014), QSEN competencies cannot be mastered only through a didactic setting or in one course. The competencies include:

- Patient-centered care – inclusion of patient in all decisions, compassion, consideration of patient's cultural background and beliefs;
- Teamwork and collaboration – interdisciplinary collaboration, shared decision making among the members of the health care team;
- Evidence-based practice – providing care that is grounded in research-based evidence;
- Quality improvement – data collection, evaluation, and enhancement of patient outcomes;
- Safety – prevention of harm to patients;
- Informatics – the use of technology to enhance patient safety and quality of care (Killam et al., 2012; Hunt, 2012).

According to QSEN guidelines, at the time of graduation from a nursing program, a nursing student should have been exposed to and have a basic grasp of the function and use of each of the six competencies. They should possess the ability to implement these competencies, the knowledge or understanding of these competencies, and hold the attitudes or values that should be carried over into their professional practice settings. Nursing educators should model these behaviors in their practice with nursing students, provide examples of these competencies, and offer clinical opportunities to hone these competencies (Hunt, 2012).

These competencies are aimed at patient safety and quality of care; as a nursing student progresses through a curriculum their abilities to perform these competencies should increase with each level of learning. Lack of knowledge and skill ineptitude out of proportion to the student's level of study places patients at risk for clinical mistakes (Killam et al., 2011). Clinical practice is where students can learn to take responsibility for their decisions and actions with regards to patient care. They should be learning to accept errors in judgement and grow from them (Oermann & Gaberson, 2013). Ineffective interpersonal interactions, knowledge, and skill incompetence characterize the unsafe nursing student. One of the core competencies identified by the Institute of Medicine for all health care professionals was the capability to use informatics to manage information, prevent health care errors, to communicate, and to support decision making (Oermann & Gaberson, 2013).

In an integrative literature review, Killam, Luhanga, and Bakker (2011) reported on eleven relevant articles, including both theoretical and research studies that related to unsafe baccalaureate nursing student behaviors in clinical practice. Students who are borderline achievers in clinical nursing practice may be permitted to progress in a program, graduate, and

become unsafe nurses. Early identification of unsafe behaviors opens the way for remediation to take place, so the student can eventually be successful. These researchers identified that one of the difficulties in identifying unsafe behaviors was that there is no formalized description of them. They conducted their review to describe the unsafe nursing students' characteristics. From their analysis they identified three themes: ineffective interpersonal interactions, knowledge and skill ineptitudes, and unprofessionalism. A combination of all the data compiled from the eleven articles revealed the following characteristics:

Synthesis of Unsafe Nursing Student Characteristics

Theme	Category	Findings
Ineffective Interpersonal Interactions	Poor communication	Weak verbal and written communication skills
		Failure to articulate learning needs (ask questions and for help)
		Inappropriate nonverbal communication
	Difficulty developing	Inappropriate interaction with patients
	Relationships	Ineffective relations with educators and health care professionals
Knowledge and skill incompetence	Limited cognitive ability	Knowledge deficit, Poor insight
		Lack of critical reasoning, Repetitive errors
	Weak skill demonstration	Inconsistent assessment skills
		Failure to perform basic care/skills
	----------	Lack of organization skills
Unprofessional Image	Inappropriate attitudes	Disrespect, anger, Defensiveness, apathy
	Inappropriate behaviors	Overconfidence, low confidence
		Uncontrolled anxiety/nervousness
		Lack of preparation, Violating procedures,

	Lack of accountability	Lateness, avoidance, Not reporting important data, Crossing boundaries, Dishonestly, carelessness/risk-taking behavior Illegal behavior

Figure 3. Synthesis of unsafe clinical behavior. Killam, Luhanga, & Baker, 2011, p. 443.

Students demonstrating such actions, behaviors or attitudes are challenged to meet the practice competencies set forth by the nursing regulatory organizations. They will not meet the minimum requirements for new graduate nurses. Ineffective interactions interrupt the safe patient care continuum. Physical and psychological harm may come to the patient when pertinent information is missed, unreported or misinterpreted. Students who are unable to critically think may not be concerned about their practice, have poor clinical judgement skills, and lack appropriate decision-making skills. Single or rare instances of incompetence can be remedied but consistent demonstration of the identified findings related to the three major themes would be considered dangerous (Killam et al., 2011).

Determining the significance of unsafe behavior along with the appropriate response can be difficult for a nursing educator. "Clinical educators may have a difficult time weighing some of the nuances within the varying degrees of unsafe student behavior" (Killam et al., 2011, p. 444). When evaluating behaviors, the clinical educator must consider the type of occurrence, the frequency of the behavior, the degree of risk associated with the behavior, the student's level within the curriculum and within the term. Evaluation must be completed in terms of growth, determining if the student is learning from errors or if the student is not modifying their pattern of identified unsafe behaviors.

Regardless of the type of degree program, clinical education focuses on the advancement of knowledge, technical performance, self-evaluation, and critical thinking skills. As the nursing student progresses through a curriculum, expectation of performance should increase in relation to the course competencies. Clear objectives that are geared to the level in curriculum may help nurse educators more readily identify unsafe clinical behaviors, document these findings, and initiate remediation. The findings of this integrative review identify actions, attitudes, and behaviors that are related to the three major themes of ineffective interpersonal interactions, knowledge and skill ineptitude, and unprofessional behavior. Many reasons contribute to the social promotion of clinically unsafe nursing students: fear of litigation, lack of confidence, limited familiarity with remediation or evaluation techniques or lack of support (perceived or actual).

Decisive policies regarding identification and management of unsafe behaviors would support the clinical evaluation efforts of nursing educators. Policies that reflect clear expectations and ramifications of unsafe behavior would be beneficial not only to the clinical nurse educator completing the evaluation, but also for the clinical students as well. These observations are echoed throughout literature focusing on safe behaviors. As noted by Killam and associates (2012):

> Although characteristics of unsafe students identified within the literature help potentially problematic situations, clarity of clinical expectations and an understanding of what constitutes unsafe practice is needed. These guidelines would facilitate consistent identification of potential threats to patient safety and remediation. (p. 2)

In most clinical settings, nursing educators use a clinical evaluation tool. Generally, each curriculum utilizes the same tool applying modifications that are course specific (Oermann et al., 2009). Clarity of clinical criteria was also acknowledged by Drs. Oermann and Gaberson (2013), "criterion-referenced clinical evaluation involves comparing the student's clinical performance with predetermined criteria and not to the performance of other students in the group" (p. 238). This approach is transparent in the criteria expectations and is available to both nursing educator and clinical nursing student in advance. Dr. Grant Wiggins (as cited in Jonsson, 2014), who was a nationally recognized assessment expert, educator, and author, argued that in order to improve performance and educate students, all tasks, standards and criteria must be transparent to students and teachers. Not knowing what is expected can have a negative impact on an already stressful experience for student (Oermann & Gaberson, 2013; Jonsson, 2013).

Tanicala, Scheffer, and Roberts (2011) conducted qualitative research that addressed the culture of safety. It was the first portion of a multiphase research designed to assist nurse educators to create an evidence base for defining what constitutes passing or failing clinical behaviors so that safety requirements would be met. The goal was to identify behaviors that earned a failing clinical grade among students in baccalaureate nursing programs throughout the United States and Canada. Phase I of the five phased projects used four focus groups. Based on Tanicala, Scheffer, and Roberts' literature review, six questions were asked in this phase of the study:

1. What is your definition of failure in a clinical nursing course?
2. What specific student behaviors result in failure in a clinical nursing course?

3. How often do student behaviors need to occur to result in a failing grade?
4. Is there a specific order during a semester that the behaviors need to occur before failure is the result?
5. What is the demarcation between pass and fail in the clinical course?
6. When does pass become fail? (p. 156)

Tanicala et al. (2011) used an inductive qualitative approach following Krueger's six-step approach which includes:

1) sequencing of questions to capitalize on data;

2) data collection through note taking and electronic sources;

3) coding patterns of data;

4) verifying data collected with participants;

5) debriefing after each session with focus groups;

6) preparation for distribution of results. (p. 156)

The purposive sample of participants included part-time and full-time nursing educators, from public and private nursing curriculums, from varied clinical sites, and with various degrees in nursing. Each of the groups was interviewed using the same procedure/format with one researcher as moderator and another as the recorder. Each recording was transcribed, and data were analyzed using NVivo version 7 to identify links between identified concepts and responses collected (Tanicala et al., 2011).

Data analysis yielded one primary theme with five additional subthemes. The primary theme identified related to patterns and context. Participants identified context by reporting there is a need for recognition that the time within the curriculum, the location of the clinical setting,

and the type of behaviors displayed are assessed with regards to passing or failing the clinical portion of a course. The higher the level, the higher the performance expectation. Patterns emerged as consistency and repetition of behaviors or lack of improvement.

One subtheme that was at the forefront was safety. This priority was identified in other research and confirmed that safety is a key issue in healthcare. This subtheme was woven throughout the other noted subthemes. Standards for the course and the profession were also noted as a subtheme. Within this subtheme four areas were identified as essential. Math competency, an awareness of agency policy and course objectives were revealed as important to clinical success. Without the minimal level of competency within these four skill sets, the participants reported that patient safety will be compromised.

Another subtheme included communication which encompassed quality of written, unsuitable interactions with and uncaring behaviors towards patients. The inability to communicate with sensitivity or inappropriately with diverse populations was identified as unsafe behavior. It was also identified as having a direct impact on purposeful clinical behaviors. Thinking was another subtheme that emerged from the data collected. It was identified as an important indicator of a student's ability to apply theory to practice: to think critically. Ethics was also reported upon. Dishonesty related to skills or documentation or arriving to the clinical site under the influence, and even not seeking help when required were seen as unethical behaviors and deserving of a failing clinical grade. This study was conducted to design a tool that would better understand the items that nurse educators assess when determining if students' clinical behaviors warrant a passing or failing clinical grade.

Tanicala, Scheffer, and Roberts (2011) predicted that further studies will be of benefit not only for nurse educators, but for students and the patients they serve in the healthcare settings. They call for the promotion of a culture of safety rather than one of blame. "How students learn to keep patients safe and what role the educational processes play in patient safety need to be determined by nurse educators" (Tanicala et al., 2011, p. 160). The nursing student should understand their roles in the creation of a safe health care system and a culture of safety in each clinical arena, they should learn about health care errors, how to prevent errors, and the importance of reporting errors if they should occur; these are essential competencies that are fostered in clinical practice (Oermann & Gaberson, 2013).

The description of a culture of safety also emerged from a study conducted by Killam and associates (2012), which focused on student perspectives of unsafe clinical practices. Using a Q methodology, incorporating both qualitative and quantitative techniques, the researchers administered 43 Q-sample statements regarding unsafe student clinical practices to 59 final-year baccalaureate nursing students. The participant responses reflected their understanding of safety as a shared responsibility. Their viewpoint suggested "the responsibility to uphold a culture of safety is not only the purview of students, but also educators and the nursing program as a whole" (Killam et al., 2012, p. 11). The students saw the culture of safety as a resultant of the partnership between them and the nursing educators. Nursing educators are expected to guide and evaluate nursing students' development of competencies that uphold safety. In this study, nursing students reported that they are responsible for their individual development in accordance with program and professional standards.

As a leader, the nursing educator has the opportunity to role model professional responsibility if a safety issue or error occurs. When a clinical nursing student makes, or nearly makes, an error, it is important that the nursing educator respond in a reflective manner rather than a punitive one. This type of response, while acknowledging the error and addressing it, provides opportunity to role model ethical behavior on how a nurse should respond when an error is committed. Responding responsibly and professionally in a real time setting has more impact that what could be explained in the didactic setting (Adelman-Mullally et al., 2012).

Dr. Kristy Chunta (2016) also addressed faculty role in the management of students exhibiting unsafe clinical behavior. In her study, she cited both QSEN and ACEN protocols which have been previously identified within this document as they relate to patient safety. She also cites the complexities faced by nursing educators when dealing with unsafe clinical behavior. These include limited personal experience, sundry approaches to addressing unsafe behaviors, vague policies, lack of administrative support, and fear of litigation which are echoed throughout all the literature. Literature review for this article reflected similar themes identifying unsafe clinical behavior. These themes included knowledge and skill ineptitude, ineffective social interactions, and unprofessionalism. Other identified categories included inability to relay knowledge or perform skills, attitude dysfunction, and poor communication skills. It falls onto faculty to communicate clear expectations, to document unsafe behavior, to provide for remediation and to develop a positive relationship with the student.

Preferably, nursing educators should identify what constitutes unsafe behaviors. Exhibition of these identified behaviors would result in an assigned clinical failing grade. This information can be distributed via the syllabus, included in a handbook as policy, or in a handout

(Chunta, 2016). Expectations of acceptable clinical behavior must be conveyed. Unsafe performance guidelines also help prevent bias by ensuring consistency among expectations of all the nursing students in the group. Examples of unacceptable behaviors, such as not correctly following precaution guidelines, administering medications without review by instructor, verbal and nonverbal unprofessional behavior towards others and unexcused absences or being late, should be conveyed by the instructor. The lists will be clinical area specific and may not cover every possible area but will provide the nursing student with guidelines for safe clinical behavior (Chunta, 2016).

Faculty should examine the variables of unsafe clinical behavior. Identified behaviors include: "type of incident, frequency of event and patterns of repetitive behavior, risk level associated with the incident, level of the student in the nursing program and timing in the semester" (Chunta, 2016, p. 87). Evaluation becomes subjective when faculty use their own judgment to determine unsafe behavior or situations. Other researchers had noted this phenomenon as well; nursing educators' values do influence the evaluation process. It is imperative that nursing educators are aware of their personal values and the potential for them to cause bias in their evaluations of students. The nursing educator must keep such values in check to avoid an unfair critique of the clinical nursing students' performance (Oermann & Gaberson, 2013). As Dr. Chunta reports, they must also provide the students with opportunity to correct; this can be nursing educator facilitated through questioning that prompts the student to rethink their plans or self-corrected by the student. Unsafe behaviors should be identified and addressed as soon as identified to allow the students time to remediate. When possible, simulation can be employed to identify potential unsafe behavior in a controlled setting and address it before entering the clinical setting.

According to Chunta (2016), once at-risk students are identified, it is important that the nursing educator record the unsafe behavior and provide developmental feedback. Of note, Oermann and Gaberson (2013) identify five principles for providing constructive feedback including:

- Feedback should be precise and specific – what areas are lacking and how to improve them.
- Feedback should be visual and verbal when identifying procedural, technological or psychomotor skills. Skills should be demonstrated and then performed by the student with guidance.
- Feedback should be supplied in real time or immediately following it.
- Feedback should be given in private and in relation to the student's specific needs; some students will require more guidance and feedback than others and this may be relative to their placement in the curriculum.
- Feedback should be analytic and offer guidance for improvement (p. 242-244).

Chunta (2016) reports that documentation will allow for accurate student evaluation, identification of repetitive errors, and provides a paper trail should the student challenge the failing clinical grade either within the institution or in the courts. However the nursing educator chooses to identify and record the unsafe behavior, it should be done in real time whenever possible with as much detail as possible. When deficits are noted, remediation should quickly ensue. Remediation has been shown to improve the nursing student's chance of clinical success and in meeting the clinical course objectives. This coincides with the promotion of a culture of safety rather than one of blame as identified by Tanicala and peers (2011). The first stage should

include a verbal exchange identifying the concerning behavior and provide opportunity for the student to understand why the behavior was unsafe.

Remediation may take the form of practicing in a simulation lab or writing a paper if the unsafe behavior was intangible, such as is seen with verbal or nonverbal disrespect. Chunta (2016) suggests a learning contract be initiated and signed by both the student and the instructor. The remediation should include regularly scheduled meetings between the nursing educator and the student nurse. Building a positive rapport with the student will help them see the benefit of remediation. Remediation should not be punitive; all students should know that they are receiving due process and that there is equality among student performance expectations. The student should understand that unsuccessful remediation will result in a clinically failing grade. Applying an earned failing clinical grade will be necessary to sustain patient safety and standards of practice (Chunta, 2016).

2.6 Social Promotion of Clinical Nursing Students

Clinical evaluations can be one of the most difficult and dreaded aspects of being a nursing educator. The clinical evaluations that nursing educators complete on students are considered a legal document. The task of the faculty member is to evaluate whether that student has met the minimum objectives to progress in the program (Hall, Daly, & Madigan, 2010). The clinical portion of nursing education should provide opportunities for students to develop critical thinking skills and to learn to function as a competent professional. The nurse educator agrees to take on the responsibilities of balancing learning and growth with preventing patient harm.

Several key themes have emerged from previous studies as to why students who do not meet expected requirements are permitted to progress through a nursing program. A common

theme identifies educator confidence, or lack of confidence, as a primary factor in the social promotion of the borderline or below standard clinical student. Clinical evaluations of student performance do have a certain degree of subjectivity and the responsibility of completing them usually falls upon one nursing educator per clinical rotation (Hall et al., 2010). In one study, nursing educator participants identified that they felt unprepared to assess students clinically. Participants with less than two years' experience as an educator wanted student approval of their teaching techniques and felt that student failure was a reflection on their inadequate instruction (Dobbs, 2017). Educators may internalize a student failure and perceive it as their own personal failure as educators (Luhanga et al., 2014). When a nursing educator applies an earned failing grade to a nursing student it makes them feel like a failure; a sensation of self-doubt is felt (DeBrew & Lewallen, 2014).

This sentiment was echoed in other research where lack of self-confidence inhibited the clinical nurse educator's documentation of student ineptitude and a blurred identification of their own role allowed them to be influenced by a student's personal situations (Casey & Clark, 2011). Some students have come to expect that educators view their clinical performance while considering the student's personal situations when grading them (shifts worked, family situation, and finances). This, too, causes stress for the nurse educator trying to remain objective in their evaluation (McGregor, 2007). In a study on the processes and support that affect a nurse mentor/clinical nurse evaluator's (educator's) assessment of borderline or failing students, the researchers found that the first step when considering failing a student is the student's performance. The rest of the process centered on if the mentor/clinical nurse evaluator felt they could personally tolerate the challenges of their assessment (Hunt, McGee, Gutteridge, & Hughes, 2016).

Some students may contest a negative evaluation and nurse educators are challenged by this action. The ability to separate personal feelings from assessment evaluation is a challenging one for the nurse educator who questions their own skill level as an evaluator. It has been hypothesized that it is difficult to clinically fail students who are aggressive/assertive, as well as those that are popular/amiable as they become significantly upset or disappointed; this difficulty is compounded if the educator lacks the confidence in their evaluation skills (Elliott, 2016). Expert clinical nurses who have transitioned into faculty are in the position to guide clinical nursing students to learn in a new way that is frequently much more memorable than what can be achieved in the classroom setting (Adelman-Mullally et al., 2013). Clinical nurse educators may be experts in their clinical area but may not be sufficiently prepared to manage clinical teaching encounters and possess appropriate evaluation skills or tools (Suplee, Gardner, & Jerome-D'Emilia, 2014). In an article reported in the British Journal of Community Nursing (Carr et al., 2010), researchers identified that mentors and educational representatives who work with nursing students in the clinical setting experienced "dread that skills would not be good enough to manage a situation where a student was angry, upset, or disagreed with their assessment" (Carr et al., 2010 p. 595).

Another theme identifies the clinical nurse educator's perception of their role. Regardless of outlined clinical objectives, there is still a degree of subjectivity associated with a clinical evaluation. Lane and Corcoran (2016), explored the struggle nursing educators face as they balance between the role of educator and counselor. The clinical setting poses situations that can be emotionally charged, and students must develop strategies to cope. The nurse educator may be required to provide counsel to the struggling student. Diving too deeply into the role of counselor may affect the nurse educator's ability to exercise sound judgement when

determining if a nursing student should pass or fail the clinical portion of a course. The researchers note a key concept that addresses the conflict: "Nurse educators are still nurses, but their students are not patients" (Lane & Corcoran, 2016, p. 192). The lack of a clearly defined professional relationship can lead to a confusion of the clinical nurse educator as a friend rather than an evaluator who must be both supportive and objective to render unbiased assessment decisions (Casey & Clark, 2011). There may a deficiency of clarity regarding when clinical teaching ends and assessment begins. It can be difficult to identify when the time for learning transitions to a time for evaluation (DeBrew & Lewallen, 2014).

Educators may be hesitant to fail a student early in their career, believing the student really needs more time to improve. They may be disinclined to fail a student in the early portion of their student career with the thought the problems with performance will resolve over time (Lewallen & DeBrew, 2012; Casey & Clark, 2011). There is hesitancy to fail students in later portion of their training because they had made it thus far (Jervis & Tilki, 2011). In fact, participants in one study shared that failure in the terminal year of a program seems more distressing than other courses because of the investment students had already made towards their career (Luhanga et al., 2014).

It is imperative that clinical nurse educators recognize that formerly demonstrated safety in one clinical area does not guarantee future clinical safety; each experience should be evaluated on its own merit (Mossey, Montgomery, Raymond, & Killam, 2012). Heaslip and Scammell (2012) noted:

> Giving good news is less stressful perhaps than helping students to face areas of difficulty. However, the avoidance or 'down-playing' of developmental issues may give students a distorted perception of their abilities within practice. Further opportunities for improvement based on honest feedback may be lost. (p. 99)

The ‘benefit of a doubt’ has also been identified as a contributing factor to passing the borderline student who is also likeable or assertive/aggressive (Elliott, 2016). This ‘benefit of a doubt’ mindset can lead to detriment to the student, as noted in one study: an educator who passed a borderline student expressed relief upon hearing that student failed their licensure exam (Luhanga et al., 2014). It must be questioned morally if it is fair to give failing students the ‘benefit of a doubt’ and pass them early on in a program only to have them fail later (Heaslip & Scammell, 2012). Dobbs (2017), in her qualitative research on why educators do not fail students clinically, also reported on an educator who passed a borderline student with the hopes that someone would fail the student later.

Another contributing factor that emerges from the research on clinical social promotion despite being borderline or not meeting clinical criteria, is the physical and emotional intensity associated with failing a student clinically. It can be very difficult to fail a student who is pleasant and tries diligently (Carr et al., 2010). It is difficult for nursing professionals whose careers include caring for others to assign an earned failing clinical grade to a student who is motivated to be successful (Jervis & Tilki, 2011). Educators are keenly aware of the significant increase in workload when proving that a clinical failure is warranted (Dobbs, 2017). Failing a student is time-consuming, as the educator must justify the failure with significant amounts of paperwork (Luhanga et al., 2014). Clearly, failing a student is an intricate process, but it is the clinical nurse educator’s responsibility to do so to ultimately ensure the safety of the patient population.

The process of failing a student is agitating, in part due to the excessive amount of time it takes, and the discomfort associated with discussing the failure with the student (Luhanga et al., 2014). Failing a student clinically is emotionally taxing, traumatic, and may be threatening for

the clinical educator; perceptions and previous experiences may cause a student who is not meeting the clinical criteria to be passed nonetheless (Jervis & Tilki, 2011). In previous research, two of the experienced participants noted it was not worth the energy it took to fail students, especially if the student is successful in the appeal: the process took so much effort and left them feeling as though their professional integrity was being challenged (Dobbs, 2017).

Finch and Taylor (2013) corroborate these findings in their exploration of the emotional experiences of practice assessors when dealing with failing social work students in practice learning settings. In England, a practice assessor is an individual who mentors and evaluates students in the practice or clinical settings. Between 2003 and 2009, the social work educational structure in England underwent major changes that were designed to improve standards in both education and practice and to improve social work practice quality with the goal of improving public faith and confidence in the social work profession. One of the approaches that was identified as important was an increased focus on practice learning, internationally known as the clinical setting. Further changes took place between 2009 and 2012 with the endorsement of a competence framework known as the Standards of Proficiency (Finch & Taylor, 2013). This framework is the support for regulation and provides the root for social work responsibility.

The researchers identified that this field is also challenged by the social promotion of clinically failing students. Stakeholders, such as employers and governments, throughout England, expressed concern about the profession, the quality and quantity of practice placements, and the rarity of reported practice failures. Finch and Taylor (2013) found a scarcity of data related to the area of failing social work students. They were compelled to branch out into other areas of assessment practice such as nursing, occupational therapy, and counseling psychology. The researchers then identified five key themes in reported experiences of the

challenges of dealing with failing clinical/practice students. They were:

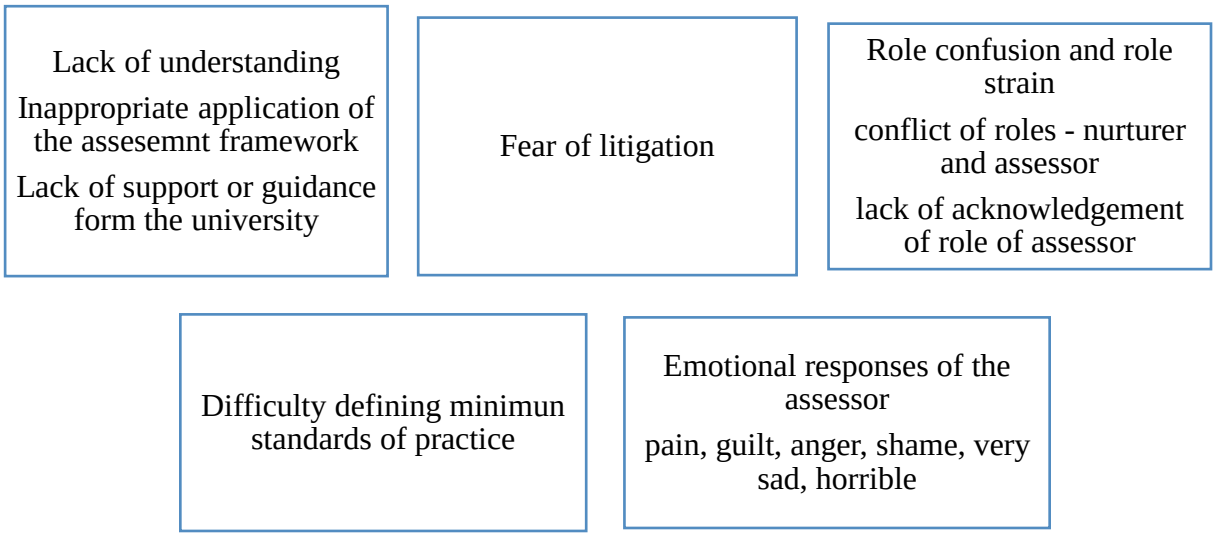

Figure 4. Five key themes related to the challenges of dealing with failing students. Adapted from Finch & Taylor, 2013.

This research was qualitative following ethnographic, narrative, and lived experience stories. Finch and Taylor initially focused on the failure to fail phenomenon, then transitioned to a theory building approach. Twenty participants were gleaned from a purposeful sampling. The requirement to being part of the research was that the practice assessors had worked with struggling or failing students. They came from ten universities and an array of practice settings. Participants were informed that one of the researchers was also a practice assessor. Finch & Taylor (2013) faced challenges including:

> …emotionally charged tone of the interviews…. raising ethical dilemmas and tensions as the research progressed. Strongly expressed views emerged as potentially at odds with social work values and acceptable standards of professional discourse although it was felt to be important to explore the emotionality rather than be distracted by the surface content. Some interviews also revealed poor assessment practice, raising further ethical dilemmas for the researcher-practitioner. (p. 248)

The researchers analyzed the data from the interviews and stories each participant relayed during the interviews; the researchers divided their findings into five stories. These groupings reflect the categorization of the emotional content gleaned from the interviews.

Guilty Story	Angry Story	What is my role story?	Idealized Learner Story	Internalizing Failure Story
∞ "the guilt was unbearable… could have been end of her career" (p. 249) ∞ related to students they should have failed but did not	∞ With students: "unprofessional, rude" (p. 250) working harder than them ∞ With university: - intimated by - do not fail student- quota vs quality	∞ nurturer-enabler verses assessor roles ∞ struggle between the two caused distress ∞ adapt roles: "protect the service users" (p. 251)	∞ gap between fantasy about and actuality of student commitment, performance ∞ Passive learners versus engaged	∞ student's failure became the assessor's ∞ assessors' "fault" (p. 252) ∞ managed situation wrong and student failing so passed them

Figure 5. *The five interview stories of clinical failures. Adapted from Finch & Taylor, 2013.*

In their findings, the researchers noted that the crucial finding was that engaging with a struggling student has the potential to elicit intense, uncomfortable feelings. This can lead to a blurring of the assessment process to the point that students who deserve a failing grade are not receiving a failing grade. That, however, can having lasting ramifications. One participant

noted, after passing a student who did not meet the criteria, that "it was the worst career decision I ever made" (Finch & Taylor, 2013, p. 253). Finch and Taylor concluded that emotional factors have significant impact on decisions to fail or pass social work students.

The researchers identified four key issues from their study. First, there is value in assessment frameworks, although these will not necessarily spare the assessors from uncomfortable feelings or make it less difficult to assign a failing grade. Second, practice assessors need support and training to clearly understand their role; the potential for role conflict, how to reconcile the roles, and how to manage these issues when engaged with students. Third, the need for support from agencies and universities towards practice assessors, especially those working with borderline or failing students. They consider the fourth issue to be the most significant as it identified new information regarding the intense, angry feelings that were identified through the interviews. While some of the participants' responses may have seemed unprofessional, the researchers felt that "it reveals the need for reflective practitioners who can be supported to make sense of the complex processes they are engaged in and respond more appropriately to the intense feelings that are likely to emerge" (Fitch & Taylor, 2013, p. 255). The emotional issues experienced by those practice assessors studied echoes the emotional experiences reported by nursing educators when dealing with underperforming students including disappointment, dismay, confusion, and misery (Hunt et al., 2016).

Educators are leery of the processes associated with a student challenging the failure (Elliott, 2016). In a research project regarding what influences a clinical mentor to pass or fail a student, 144 of the 277 respondents admitted passing a student they assessed to be failing. They did so based on the belief that their decision to fail the student would be overturned anyway (Brown et al., 2012). Support is considered a key component of caring and of nurse educators'

work satisfaction (Brett, Branstetter, & Wagner, 2014). Significantly, Dr. Mary Beth Kuehn's research identified that dealing with challenging students was cited among the reasons that nurse educators chose to leave the role and return to practice (as cited in Brett et al., 2014, p. 360).

There is also a worry that students will bring litigation against the clinical nurse educator who assigns a failing clinical grade to them (Jervis & Tilki, 2011). Fear of litigation is a legitimate one. Some students who have been unsuccessful in the appeal process with faculty, department chairperson and the institution's administration are taking their cases to the judicial system (Wren & Wren, 1999). The judicial system has maintained a policy of noninterference with deference to academics in the issues of academic concern when prior notification of policy and informal hearings have taken place. The judicial system will usually only intercede when situations are deemed illogical or impulsive (Wren & Wren, 1999). To avoid the institution's appeal process or challenging students, faculty may give the benefit of a doubt and pass unsafe or borderline students (Luhanga et al., 2014).

2.7 Nursing Educator Experiences with Failing Clinical Students

Researchers Patterson and Krouse (2015) conducted a qualitative description study to identify and describe competencies considered to be essential for educators to fill the roles of leaders in nursing education. Several competencies emerged as important. The participants were in, or had been in, leadership roles in either nursing education or in a professional nursing organization. A leader in nursing education was identified as one who possesses vision to align with the times and a willingness to change as the health care setting changes. A leader in nursing education sees that education and quality patient care are tightly linked; therefore, nursing education must simultaneously address the needs of the students and the public.

Additionally, a leader in nursing education must function as an agent for the profession and nursing education; including making challenging and difficult decisions. Participants noted that educational nursing leaders "must embrace the professional values of uncompromising ethics, morality, honesty, accountability, and credibility" (Patterson & Krouse, 2015, p. 79). Ethics was described as treating others fairly and doing what is necessary even when it is not considered the most popular action to take. Professional values included both personal and institutional integrity involving a strong sense of right verses wrong.

Researchers Skúladóttir and Svavarsdóttir (2016) conducted a study to create a valid assessment tool to guide clinical education and assist in the evaluation of nursing students' clinical performance. Qualitative and quantitative data were collected through a mixed-methods approach which included self-administered questionnaires, formal discussion groups, informal discussion, and individual structured interviewing. Participants included supervisory teachers, a pedagogical consultant, clinical teachers, clinical expert teachers, and nursing students from the University of Akureyri in Iceland. The instrument's construction was generated through a four-step process: "planning, construction, quantitative evaluation, and validation" (Skúladóttir & Svavarsdóttir, 2016, p. 33).

During the validation phase (Skúladóttir and Svavarsdóttir, 2016), after the tool had been pilot tested, clinical teachers were asked to describe the skills and competencies required to pass a clinical course. The piloted format was then honed to meet the suggestions of the participants related to its efficacy. When asked to identify which skills were most important when determining if a student met the requirements one participant shared:

> Yes, it is insecurity and lack of knowledge and not being precise enough, those factors interact. […] For example, I perceive medical safety as extremely important, […] with

> repeated medical errors one should not pass, even if everything else is satisfactory. (Skúladóttir & Svavarsdóttir, 2016, p. 34)

This and other descriptions were then used to assemble a detailed compilation of competencies (Skúladóttir and Svavarsdóttir, 2016). Obtaining an unsatisfactory performance rating resulted in a failing clinical grade. The sensitivity of the tool, when identifying students who fail to meet the required level of competency, was further enhanced by these detailed descriptions, and consultations with ward nurses, clinical expert teachers, and clinical teachers during the formative interim and final assessments. The personal assessment items that identified were: caring, enthusiasm, initiative, and realistic self-confidence, competence in cooperation with staff and competence in cooperation with clients. The professional factors that were assessed included:

- theoretical knowledge,
- critical thinking,
- self-control,
- patient assessment and patient care,
- clinical competence,
- documentation,
- informing and educating patients (Skúladóttir and Svavarsdóttir, 2016).

These assessment criteria were scored on a scale from excellent, very good, good, satisfactory, to unsatisfactory with detailed descriptions attributed to each. Students were provided the assessment tool and, therefore, had guidance on where to focus to work towards meeting their course criteria. The nursing educators also had specific descriptions of the levels of performance and could therefore assist their students in meeting the criteria more efficiently.

The criteria they identified for unsatisfactory clinical performance are echoed throughout other studies and included:

Demonstrates a lack of care and respect. Disregards the code of silence. Has limited enthusiasm and does not utilize learning activities. Demonstrates limited independence and needs constant guidance. Lacks initiative. Does not know his/her limitations and is unreliable at times. Has difficulty working with others. Has difficulty communicating with clients. Lacks responsibility.	Has difficulty connecting theory to practice. Lacks organization and discipline and has problems prioritizing. Has difficulty following orders and instructions. Is insecure and lacks clinical competence. Is imprecise. Patient documentations do not reflect knowledge, understanding, or skills. Does not meet his/her client's needs. Makes repeated mistakes. Has shown no or little progress during the clinical period.

Figure 6. Criteria for unsatisfactory clinical behaviors. Adapted from Skúladóttir & Svavarsdóttir, 2016.

Many similar criteria were examined in DeBrew and Lewallen's (2014) research titled "To pass or to fail? Understanding the factors considered by faculty in the clinical evaluation of nursing students," to identify factors that were acknowledged as important by nurse educators when grappling with the decision to pass or fail a nursing student in the clinical setting. Using the Critical Incident Technique of data collection to gather information for their qualitative descriptive study (which was part of a larger qualitative descriptive study) the researchers interviewed 24 nurse educators. Through semi-structured interviews of these participants, the authors attempted to describe the nurse educators' decision-making processes on student clinical

evaluations. The participants were nursing educators in associate or bachelor's degree programs. Respondents were also solicited to provide a representation of the types of nursing programs in the specific area of the study and these included public, private and historically black and American Indian institutions. Eighty-eight percent of the participants' course clinicals were in the hospital medical surgical setting.

There were no predetermined categories or codes; these were identified based upon the participants' responses (DeBrew and Lewallen, 2014). Each critical incident was coded individually; then codes from each interview were combined into categories. These categories were then broken down into two areas: faculty factors and student factors for failing a nursing student in the clinical setting. The described incidents did not focus on failure to achieve a specific learning outcome but did focus on behaviors that made the evaluation process challenging.

In this research (DeBrew and Lewallen, 2014), several factors were identified for assigning a failing grade to a nursing student's clinical performance. The most common factor in assigning a failing clinical grade was poor student communication skills. Written and verbal skills with patients, staff, and faculty were included in the evaluation process. The next common factor listed by participants was the lack of progress by the student despite faculty interventions of a learning contract or extra time being spent with the student. Medication errors or unsafe medication administrations were also cited as deciding factors. Single medication errors did not warrant a failure, but such errors were a cause for concern regarding student competence. Another critical incident that was identified by some participants was the inability of the nursing student to critically think or to prioritize care. Evidence of not being prepared was the fifth most

commonly identified cause for student clinical failure. Students who were disorganized, sloppy or slow did poorly in the clinical setting.

Faculty factors were also identified in relation to assigning a failing grade (DeBrew and Lewallen, 2014). These included faculty beliefs, influences, and feelings. Faculty emotion was listed most frequently among the participants. The decision to pass or fail a nursing student was identified as complicated and influenced by faculty security or insecurities. Another common theme was that the student's behavior gave indication that they did not want to be a nurse. This was surmised to explain the student's inabilities to improve or be prepared. Lack of administration's support was an issue for some of the participants.

Results of the study indicated that the decision to fail a student can be described as "ambiguous and inconsistent, based on student characteristics and behaviors, and influenced by faculty factors" (DeBrew & Lewallen, 2014 p. 634). Nursing educators struggle when a student technically meets an objective but exhibits problematic behaviors. Communication difficulties, unprofessionalism, and being identified as weak in the clinical setting are difficult to measure and difficult to teach. Yet these behaviors were noted to be essential for the clinical nursing student to be successful in the clinical setting.

Hunt et al. (2016) conducted research in England to identify what had helped mentors assign a failing grade to underperforming students. The researchers pursued this aim since reluctance to fail has reported internationally from Canada, Ireland, Malaysia, Singapore, and the United States. They too identified the minimal availability of articles or research that identify mentors who have applied an earned failing clinical grade and the situations that influenced them to do so despite the consistently reported reluctance of their counterparts to do the same. Hunt et al. (2016) sought mentors who had experience with failing clinical nursing students to find what

helped them to overcome the prevailing hesitancy to assign an earned failing clinical grade (Hunt et al., 2016). The aim of the study was to investigate what enabled some mentors to apply a failing grade to underperforming students.

In England, practicing nurses with a minimum of one-year experience who have received additional training are called mentors. These nurses then become responsible for the learning and assessment of student nurses in clinical settings. Historically, these mentors have been reluctant to fail clinical nursing students and have reported that they require support to fulfill their obligations. In response, the "Nursing and Midwifery Council published Standards to Support Learning and Assessment in Practice" (Hunt et al., 2016, p. 80) to bolster the mentor role. One inclusion was for mentors to take a preparation program which provided instruction regarding the process of failing students clinically. An updated revision included detailed descriptions regarding how the mentors should measure student competence.

Roles were developed to support mentors and students in the clinical settings. These are usually filled by university lecturers, identified by the term link lecturers, or designated staff specifically employed by the hosts of the clinical setting. In this research, the term Practice Education Facilitator (PEF) identified the numerous titles applied to the practice support staff. Their responsibilities covered:

- provision of a link between academic and practice settings
- enhancing the equality of practice learning environments
- offering support to both mentors and students (Hunt et al., 2016)

Mentors continue to report that their roles and activities are expanding in complexity disproportionate to their available time. Literature relating to University perception of the

purpose of clinical have documented as more "serving an encouraging and affirming purpose; rather than a professional gatekeeping function" (Hunt et al., 2016 p. 80). Hunt and constituents (2016) note that there is suggestion from other research that senior University managers in the United Kingdom assign a smaller percentage of academic resources on the clinical portion in the curriculum; that there is a lower status assigned to clinical success than there is to academic success. Mentors stress their need for more support, but the terminology is ambiguous and thus identifying what support worked for mentors who had assigned a failing grade was identified as an area requiring further exploration.

The Hunt et al. (2016) study employed an interpretivist grounded theory, as this approach is beneficial in the exploration of shared meaning and actions in situations where there is little understood or known. The research was nationally publicized, and participants volunteered to contribute. During 2011 and 2012, 31participants from the nursing fields of adult, child, mental health, and learning disabilities were recruited from across England. Each of the participants had the experience of administering a failing clinical grade to a nursing student within the prior two years. The evaluation of recorded responses yielded five categories of commonality.

The first category (Category 1) identified was "braving the assessment vortex" (Hunt et al., 2016, p. 81). Participants spoke to the difficulties of workload, expectations, and responsibilities that they were burdened with which caused conflict and stress. Reported negative emotions were abundant when dealing with a borderline student including frustration, confusion, dismay, indignation, and disappointment. Failing someone was inconsistent with their nursing values and there was a feeling that it would reflect poorly on their personal practice. Mentors expressed worry that the time consumption and stress of managing an underperforming

student would impact their organization's willingness to assign them future placements. These emotions and worries contributed to a loss of confidence, stress, and anxiety. Assigning a failing grade was described as "bracing oneself to grasp that nettle" (Hunt et al., 2016, p. 82). The mentor had to rely on integrity, tenacity, and courage which set them apart from those who engaged in social promotion.

The Hunt et al. (2016) study then identified three additional categories as stages that the participants went through as they decided if they would assign the failing grade. Progression through these stages served to strengthen their beliefs that their decision was appropriate and to increase the odds that they would commit to assigning the failing grade. Category 2 (stage 1) was identifying the impression that the student was underperforming and garnishing tangible evidence to substantiate that impression. The question of whether this student would be allowed to care for the mentor's personal loved ones became a focal point for recognition of concerning behavior. Putting this impression into valid articulation of the underperformance to the student was reportedly challenging. Participants relayed that they put off a request for assistance until they could aptly describe the behaviors, so they were not perceived as unwise. They identified a need for an approachable expert, to help them organize their approach. They needed someone who would be supportive and not belittle them, and that was usually a link lecturer or a practice education facilitator.

Category 3 (stage 2) was that of tempering approach. The mentors review their own practice to ensure they are not at fault (Hunt et al., 2016, p. 82). The mentor needed verification that they were not the cause of the student's failure; that the student was responsible for their own failure. Mentors evaluated if they had done everything they could have to foster the student's success. The increased time spent with or on the underperforming student often

interfered with their other obligations to their healthcare setting. Mentors reported coming in early and staying late to get their own work completed. This in turn placed personal strain on the mentor's relationships "The personal cost? I nearly had a divorce" (Hunt et al., 2016, p. 82).

There was a constant tension resulting from the balance of patient needs and student learning outcomes (Hunt et al., 2016). Often, students responded negatively to feedback and displayed behaviors that were intimidating, manipulative or belligerent. The mentors, link lecturers, and practice education facilitators all reported increased levels of stress resultant of the fear, frustration, and guilt that was triggered by the student's unreceptive behaviors. Emotional support was critical for mentors to allow them to express their frustration, review their personal motives, and seek confirmation. This support came from family or friends, which again placed pressure on these informal supporters or from the link lecturers, and practice education facilitators, who would then need support themselves.

Category 4 (phase 3) identified the mentors' perception of university support in their decision (Hunt et al., 2016). When they felt that support, they then felt secure enough to apply the failing grade. If there was a perceived lack of support or a notion that the university would overturn their decision, then the mentors were hesitant to apply the earned failing grade. Students could appeal whenever there was any indication that the mentor did not follow the intricate policy guidelines for failing a student. Appeals were usually granted. Mentors spoke to a need for a guide, a support person to help them navigate the intricate and infrequently used steps to applying a failing grade. Mentors received training and updates on how to apply a failing grade, but often their grade was overturned. They questioned that administration was more focused on placating the students, protecting the financial status and the reputation of the university. When a mentor's applied failing grade was overturned it made them more hesitant to

assign an earned failing clinical grade to subsequent underperforming students. Mentors who felt valued and an equal partner with the academic staff were more willing to apply a failing grade to underperforming students.

Category 5 (Hunt et al., 2016) identified by all participants, was the identification of the mechanisms that helped them to cope with the stress and provided the much-needed support to enable them to commit to applying a failing clinical grade. Support came from formal and informal sources. Mentors used these resources to bolster them emotional status, to review their actions, and to gain assurance. Mentors were especially appreciative of the support of the lecture link lecturers and practice education facilitators.

When identifying and dealing with an underperforming student, the participants in this study (Hunt et al., 2016) identified the need for support and validation of their efforts. The first step in the process was triggered by the student's substandard performance and the rest of the process focused on the mentor's ability to survive and meet the challenges the process would present. The researchers noted that this is concerning; the challenges of applying a failing grade are superseded by the more relevant fact that a student is not performing up to the required standard. The gatekeeping of the nursing profession was dependent upon the mentor's willingness to use their own personal time and the willingness of their informal support systems to provide both domestic and emotional support. The formal support of the link lecturers and the practice education facilitators was critical in the process of applying a failing grade to underperforming students. As face to face support has been identified as the most efficient, the researchers suggest that formal support be visible in the placement areas.

The aim of this study (Hunt et al., 2016) was to identify what enabled some mentors to apply an earned failing clinical grade to underperforming students. The researchers share that

the central theme identified in this research is that mentors need to feel secure in their roles. Informal support was the main factor in mentor commitment and the researchers suggested that more formal support processes are needed to bolster mentor confidence. Patients should be placed at the center of all healthcare actions and decisions. Stakeholders must be committed to the future nursing workforce in fostering competent and capable nursing students through accurate and confident assessment of their clinical performance skills. Mentors should be recognized for their critical role in the profession and be supported in the endeavors. Findings of this study were also identified in Weins, Babenko-Mould, & Iwasiw's (2014) research on clinical instructors' perceptions of empowerment. That study also identified that most essential structural empowerment was reliant on support from other faculty members.

Black, Curzio, and Terry (2014) conducted a qualitative study of nineteen mentors from seven healthcare locations located in southeast England that addressed their experiences assigning a failing final semester student nurses. In the study the last semester is identified as the final placement or final period of practice before the students graduate. The researchers identified a new prospect of understanding "moral courage in mentorship" (Black et al., 2014, p. 227). Three key themes were gleaned from the reflective interviews and included moral stress, moral integrity, and moral residue.

Moral distress was explained as the personal price a mentor must pay when following through with the assignment of a failing clinical grade. Mentors shared that guilt, and true concern about their own competence, practice, and quality of their mentorship became pronounced when assigning an earned failing clinical grade in the final clinical experience. Personal feelings of failure; of failing the student and not being able to help them pass led to moral distress. Psychological and physical symptoms of stress, worry, insomnia, and fatigue

were commonly identified by the participants because of their moral distress. They felt genuine concern for the students and the impact this grade would have on their lives. Failing a student in the final placement also reportedly created feelings of anger and disappointment at being left to handle the student's failure. The researchers noted:

> Ultimately, their stress was caused by dissonance between what they expected and their actual experience, a challenge to their values about mentorship as a moral activity and not allowing an incompetent student to progress their own guilt, an expectation that the student should pass and their disappointment in the assessment decisions made by previous mentors. (Black et al., 2014, p. 230)

The second theme identified was a commitment to moral integrity: professional responsibility and accountability with regards to fitness to practice nursing. It was described as an obligation to public protection and this was considered the ultimate impetus to assign a failing clinical grade. The participants felt that a student's previous mentors were remiss in their beliefs regarding professional responsibility or that they were more concerned with personal rather than public ramifications when making the decision to socially promote an incompetent student. For the participants, assigning a failing clinical grade was based on an objective professional standpoint rather than a subjective decision based on sympathy towards the final semester student. The researchers determined that the participants demonstrated moral integrity by "doing the right thing, trying to develop the student, ultimately failing the student, gatekeeping the profession and safeguarding patients" (Black et al., 2014, p. 231).

The final theme that emerged from this research was that of moral residue. Moral residue stems from having what was described as possessing the strength and courage to assign a failing

grade despite a sense of powerlessness to change the mindset of failing to fail by others. These participants faced their moral stress and bravely stayed true to their assessment findings regardless of the negative consequences this fortitude generated. The participants expressed a sense of feeling powerless to truly change the culture of social promotion other than by example. The moral residue was also identified in the reports of concern for the efficacy of mentors and of mentor training. Moral residue can be troublesome as one's personal values become challenged leading to a loss of integrity. However, the researchers identify that it can also have a positive effect. "This is the case for these mentors who continue to believe in the values of good mentorship and correct assessment decisions regardless of the consequences to themselves" (Black et al., 2014, p. 234).

This research described the turmoil that surrounds assigning a failing grade to a nursing student, particularly in the final clinical rotation. Such a grade can lead to a requirement to repeat a course instead of graduating or, in the worst-case scenario, dismissal from the program without obtaining a degree. Terms like courage, fear, stress, and self-doubt are internationally associated with the experience that nursing educators have when assigning a failing clinical grade. This research added a new dimension to consider in terms of moral decisions. The results support the need to upgrade and commit to coaching, support, preparation and the creation of an environment that endorses a sense of courage to make the right assessment evaluations for all students (Black et al., 2014).

Creation of such an environment may lead to a sense of empowerment. Dr. Gretchen Spreitzer (1995) noted empowerment is a psychological understanding perceived by individuals that governs the success of their participation in "empowering initiatives" (as cited in Weins et al., 2014, p. 266). Psychological empowerment is a motivational concept and consists of the

components of "meaning, confidence, autonomy, and impact" (Wiens et al., 2014, p. 266). Combined, these components facilitate active involvement in the work role. Meaning represents the individual's belief in congruency between the role expectations and personal values. Confidence arises from the individual's belief in their ability to fulfill the requirements of the role and to meet organizational expectations. Autonomy denotes the choices to initiate and sustain work processes. Impact is the individual's concept of influence on work outcomes (Wiens et al., 2014). Within the precepts of these descriptors one can understand that motivations for nursing educators to pass or fail a clinical student are individualized.

Failing a student in the clinical portion of a nursing course is consistently challenging. The question becomes what motivates a clinical nursing educator to be willing to assign an earned failing clinical grade despite the clear and present discomfort it will generate (Dysvik & Kuvaas, 2013; Ackerman & Tran, 2018). Motivation can be directed through either internal or external triggers, or a combination of both. The concept of motivation can be utilized to explain influences on a person's actions or beliefs (Deci & Ryan, 2000). Yet, it is a difficult phenomenon to understand because it is so personalized and essentially intangible (Zulkosky & Huse, 2013). According to Dysvik and Kuvaas (2013), intrinsically and extrinsically motivated individuals are stimulated to complete work based on different factors.

"Intrinsic motivation comes from within. There are internal drives that motivate us to behave in certain ways, including our core values, our interests, and our personal sense of morality" (Ackerman & Tran, 2018, para 9). Intrinsically motivated people work on assignments because they either bring joy, are interesting or because participation is its own recompense. Historically, intrinsic motivation stems from "doing something for its own sake" (Reiss, 2012 p. 152). Intrinsic motivation exists within an individual but also between individuals and certain

activities (Zulkosky & Huse, 2013). An example would be motivation not only existing within the nursing educator but also between the nursing educator, their students, and their peers within the profession. Intrinsic motivation effects performance and perseverance.

Externally motivated individuals perform activities to avoid discord, to receive accolades or to avoid feeling guilty if the activity is not done correctly (Dysvik & Kuvaas, 2013). This aspect of external motivation is what Reiss (2012) described as the pursuit of a goal. Within the concept of extrinsic motivation, authors Zulkosky and Huse (2013) identify there are two types. The first type is when an individual partakes in an activity because it is expected of them by others. The second type of extrinsic motivation involves both an external trigger along with a sense of self-determination as an individual recognizes the benefit of being compliant with the expected activity. This second type is also known as autonomous motivation which is generated from both the internal loci and extrinsic sources if the person has aligned their beliefs with an activity's value and it aligns with their sense of self (Ackerman & Tran, 2018).

Many theorists acknowledge that motivation is fluid, on a continuum with blurred lines between the notion of merely intrinsic or extrinsic motivation. Dr. Steven Reiss (2012) contends that human motives are too varied to be divided into just two categories. In previous research he identified a total of sixteen motivators that were neither specifically intrinsic nor extrinsic and were identified as "16 universal reinforcements (also called 16 human needs)" (Reiss, 2012, p. 154). His research conclusion was that everyone is motivated by these 16 factors but to varying degrees. Among this list were the following:

- Acceptance - the desire for positive self-regard
- Honor - the desire for upright character
- Curiosity - the desire for understanding

- Eating - the desire for food
- Idealism - the desire for social justice
- Family - the desire to have and be with family
- Independence – the desire for self-reliance
- Honor - the desire for upright character
- Order - the desire to be organized and clean
- Power – the desire for influence or leadership
- Physical activity - the desire for muscle exercise
- Social contact – the desire for peer companionship
- Romance - the desire for beauty and sex
- Saving, the desire to collect
- Status – the desire for respect based on social standing
- Tranquility – the desire to be free of anxiety and pain (Reiss, 2012, p. 154)

This concept of these sixteen universal reinforcements could potentially explain why a nursing educator may sometimes chose social promotion over assigning a failing grade and why others will assign the deserved failing grade despite the controversy it may generate. There are many factors that must be assessed in the clinical arena. While the grade should be based on defined criteria, there can be mitigating factors that prohibit the assignment of a deserved clinical grade. Acceptance by their peers as an idealistic, independent, powerful educator who has honor to the profession, the students, and the patient population may be the series of motivating factors that empower educators to address the issue with a sub-standard performing clinical student (Brown et al., 2012; Black et al., 2014; Cabaniss, 2014). Anxiety and a sense of powerlessness may motivate others to assign a passing clinical grade to one who does not adequately meet the

criteria (Finch & Taylor, 2013). This current research attempts to identify how nursing educators have been motivated to address and overcome the barriers associated with assigning a failing clinical grade and what the life experiences were with that choice.

2.8 Summary

This chapter identified nursing educator qualifications and responsibilities. It offered definitions of the role and noted obligations and expected competencies. There was discussion regarding the clinical experience and the expectations surrounding nursing educators and the clinical nursing student. Competence in the clinical setting was identified as essential to successfully provide safe patient care and to complete the clinical portion of a nursing course. Safe and unsafe clinical practices were reported through the available research regarding social promotion and applying an earned failing clinical grade. Research related to reported hindrances in applying a failing clinical grade were discussed and similarities were identified. Research that reviewed nursing educators who had experiences with failing clinical students was reported. Parallels to the theories of motivation as those noted in Self-Determination Theory were presented. The next chapter is the methodology section.

CHAPTER III

METHODOLOGY

3.1 Introduction

This collective, instrumental case study will describe the experiences of nursing instructors who have had the lived experience of assigning an earned failing clinical grade to a nursing student in the clinical setting. A collective case study is the study of several cases so as to inquire into a certain phenomenon (Zucker, 2009). The intent of this study is to understand this concerning problem and, as such, it will also be an instrumental case study (Creswell, 2013; Zucker, 2009).

3.2 Research Design

The case study is a sound approach for this qualitative research on the issue of the dealing with assigning the deserved failing clinical grade and the experiences of nursing educators will be recorded to illustrate similar or different perspectives on the situation. In this respect, it will be a real-life multiple case of a small group of nursing instructors who have all experienced the process of assigning a clinically failing grade to a below standards nursing student (Baxter & Jack, 2008). Unlike other types of qualitative research, the case study method necessitates that a literature review of relevant research is needed before data collection (Yazan, 2015).

This case study focused on the participants' perspectives. It focused on the experience and impact that assigning an earned failing clinical grade to a student had on the nursing educators involved: what they experienced and how they experienced it. Case study research is different from case study teaching. In case study research, all evidence is reported accurately as it exists. Case study teaching allows the evidence to be manipulated to teach a point; outcomes are dependent upon user choices (Yin, 2003).

The qualitative case study methodology permits the exploration of individuals or groups; the exploration of basic to intricate relationships, actions, cohorts or programs (Baxter & Jack, 2008). According to Yin (2003), "case studies are the preferred strategy when 'how' or 'why' questions are being posed, when the investigator has little control over events, and the focus is on a contemporary phenomenon within some real-life context" (p. 1). The case study is the most appropriate approach as the contemporary event of the lived experience of nursing educators who have had experience with students who have failed clinically will be explored and the researcher cannot manipulate the nursing educators' description of their behaviors that were associated with the experience. The case will be the experience of the nursing educators within the context of dealing with a clinically failing nursing student. This approach differs from historical research as the participants will be interviewed. In addition, there will be a review of documents and artifacts (Yin, 2003).

Yin (2003) encourages the use of multiple sources of evidence to ensure construct validity. This study used interviews and two types of documents. One-to-one interviews were conducted and recorded. Anecdotal notes were used to clarify terms and document body language observed during the interviews. Clinical evaluation tools respective to each participant's course were reviewed. Clinical advisement forms utilized by the nursing instructors was reviewed for commonalities. Student specific documents will not be used as the students involved were not provided opportunity to permit or deny their use. These documents can provide evidence that may corroborate information received in the interview process (Yin, 2003). The rationale for utilizing multiple sources of data is to facilitate the triangulation of the information. Triangulation increases the reliability of the data and the process of collecting them (Tellis, 1997).

These case study research results will be shared with faculty at the institution being studied. It is the researcher's goal to report the study clearly, with accuracy and reliability that allows the readers to reflect on and analyze the findings for use in their own practice. According to Dr. Ruth Taylor (2013), in her article "Case-study Research in Context" she argues that case-study research should contain the following components:

- Allows for the exploration of complexity using multiple data sources.
- Is situated in the real-life setting.
- Is suited to nursing research where phenomena are complex and based in realities.
- Is contextual with thick description enabling others to make judgements about the relevance of findings to their own situation (p. 4).

3.3 Research Participants

Data survey population for this study included a convenience sample of nursing educators in an associate degree nursing program in a small Mid-Atlantic state community college. Each instructor selected was full-time, teaching both didactically and clinically. Data was obtained qualitatively through personal interviews, which were recorded with permission of the participants. Each semi-structured open-ended formal interview averaged between fifteen and twenty minutes. Interviews are one of the most important sources of case study information (Yin, 2003; Tellis, 1997). "The interviews will appear to be guided conversation rather than structured queries" (Yin, 2003, p. 89). Demographic data will include years as a nurse, years as a didactic instructor, years as a clinical instructor, degree held, and certifications. There is a total of four semesters in the site's nursing curriculum with seven courses taught within those

semesters. Courses include adult medical surgical nursing, psychiatric nursing, pediatric and obstetrical nursing, community and professional concepts in nursing.

3.4 Data Collection Procedure

Institutional Review Board (IRB) approval from Delaware State University and acceptance of the research proposal from the institution where the participants are nurse educators was acquired prior to collecting data. The criteria for inclusion was that the nursing educator will have had the experience of applying an earned failing clinical grade to a nursing student within the past five years. A hand-delivered description of the study with an invitation to participate was given to full-time members of the faculty with known experience in assigning an earned failing clinical grade. The choice of hand-delivery was made as electronic communication could have been be overlooked by the potential participants.

All participants had the right to withdraw at any time. Each participant was assigned a participant letter to protect their identity. All unique qualifiers were removed. Interviews were conducted in a private setting and responses were stored securely on a private thumb drive. Interview data was not evaluated while on the campus grounds. All data review took place on a personal computer system with passcode access in a private setting.

3.5 Ethical Issues

- Interviews were conducted in private.
- Interviews were uploaded in private.
- The associated course was not overtly identified.
- The nursing educator was not identified.
- Data was stored on the researcher's USB flash drive which is being stored in a locked area/office that only the researcher can access.

- A password is required to access data on the researcher's personal computer.
- No data is stored on a public computer.
- All references to gender specificity were removed from the transcribed interviews with the participants' verbal approval to protect the identities of the students involved when specifics were presented.

3.6 Interview Questions

Questions, in the form of a guided interview, will be constructed as follows:

1. How do you describe the criteria that triggered your decision to assign an earned failing clinical grade?
2. Describe the student behaviors that determine a student is failing a clinical course.
3. What concerns were there regarding the student's ability to meet the criteria?
4. Please describe how you view your clinical role. Is there a point in your practice when clinical teaching ends and assessment begin, if so when does this occur?
5. How did the confidence to assign a failing clinical grade evolve?
6. How do you describe the process?
7. What is the format for failing a student? Please describe the steps you took.
8. How would you describe the personal impact the experience had on you during and after the grade was given?
9. Do you feel it is a difficult process to justify/document a clinically failing student? Please explain.
10. Has the process of failing a student ever caused you distress? Please explain.
11. Have you ever passed a borderline or below-clinical-standard student and been troubled? If so, why?

12. Have you ever felt pressured into passing a borderline student?
13. What support did you have during your experience: were those supports formal or informal? Guidance? (Creswell, 2014)

3.7 Data Analysis

Credibility was addressed through member checking so that interpretation of the data could be shared with each specific respondent which provided an opportunity to discuss and offer clarity on their statements (Baxter & Jack, 2008). Responses were analyzed for common codable themes. Responses were analyzed for differences and the impact those differences had on the experience of failing a nursing student clinically. These commonalities and differences were then cross- referenced with the current literature on the experience of assigning an earned clinical failing grade to a nursing student, "…the researcher must ensure that the data are converged in an attempt to understand the overall case, not the various parts of the case, or the contributing factors that influence the case" (Baxter & Jack, 2008, p. 555). Due to the volume of transcribed data obtained, the data was entered an ATLAS.ti 8.3 program for coding. Demographic data was also analyzed to assess for commonalities or differences that may have affected the experience.

3.8 Summary

In summary, case study research and physical artifacts will be utilized to assist in the compilation of data. Clinical evaluation tools were reviewed for student learning outcomes clinical criteria expectations of the course. The manner in which the instructor utilizes the clinical tool was reviewed and evaluated for similarities and differences from other instructors interviewed during the study. Clinical advisement forms were also reviewed.

Chapter IV

Research Findings

4.1 Summary of Study Participants

Seven instructors were selected to participate in this study. An individual in-depth interview was used to gather responses from each of the selected participants. To protect the identities of the participants letters A to G were used to refer to participants when transcribing and analyzing the interviews. The demographic characteristics of participants are shown on Table 1.

Table 1: Demographic characteristics of participants

Participant	Years as an RN	Years of Clinical Instruction	Years of Didactic & Clinical Instruction	Degree Obtained & Certifications
A	41	30	29	MA, CNE
B	18	8	6	Ed. D
C	21	5	4	Ed. D
D	32	10	10	MSN, CERT
E	22	12	7	MSN, Ed. D candidate
F	38.5	18	16.5	MSN, CNE
G	14	10	7	MSN, CNS child & adolescent psychology

4.2 Validation Strategies

In triangulation of data the researcher uses multiple and different sources, methods, and theories to provide corroborating evidence (Cresswell, 2013). Triangulation of the data involved review of the transcribed interviews and the referenced clinical evaluation tool (Appendix C), the clinical advisement tool (Appendix D), and the lab referral tool (Appendix E) used by the participants in their description of the processes instituted to promote student success. Member checking was used to establish credibility. This step involved taking "data, analyses, interpretations, and conclusions back to the participants so that they can judge the accuracy and credibility of the account" (Cresswell, 2013, p. 252). After each recorded interview was transcribed verbatim, the written transcription was taken to each participant for confirmation of accuracy. Each participant was encouraged to verify their statements and given opportunity to change documentation of the interview to reflect their original intent.

4.3 Data Analysis Process

The seven interviews were imported into ATLAS.ti version 8.3 for coding. ATLAS.ti version 8.3 is a computer program that enables the organization of text which then identifies themes and the codes related to those themes (Cresswell, 2013). The coding process is aimed at examining each line of text in the interviews for relevance. All pieces of text found relevant were coded using a short descriptive text. This process was repeated until all the text in the interviews was examined for relevance and assigned a descriptive code. The codes developed were carefully examined to identify similar codes. As in DeBrew and Lewallen's study (2014) there were no predetermined themes or codes. All similar codes were placed into one group that formed a theme. The codes and themes that emerged from the interviews are listed on Table 2.

Table 2: Themes that Emerged from the Data

Theme	Codes
Roles of nursing educators	Teaching and evaluation Guiding students to improve clinical practice Ensuring students are competent
Criteria used in clinical grading	Clinical objectives Consultation with other faculty members Academic grading Documentation Student appeals
Challenges faced in grading students	Student aggression Uncertainty in the evaluation process Poor attitude among students

4.4 Theme I: Role of nursing educators

This theme offers insights to nursing educator responses as they pertained to the research question "what motivated these nurse educators to assign a deserved failing clinical grade?" The participants in this case study were highly motivated to ensure that the graduates of this particular nursing program were prepared to fulfill the roles of novice expert registered nurses. This included reported formative evaluations and the design of interventions that would assist in the students' success. When students were unable to successfully demonstrate the clinical objectives which are the course competencies, despite clinical nurse educator guidance, then those nursing students did receive an earned failing clinical grade. These nursing educators were

motivated by a dedication to foster safe, competent, and professional graduates of their program, thus ensuring the safety of the patient population and the integrity of the profession of nursing educator and registered nurse.

Interviews with participants revealed their perceived roles of nursing instructors. These roles are discussed in detail in the next sections.

4.4.1 Code 1.1: Teaching and Evaluation.

Patient safety is the major principle in the clinical evaluation of nursing students at all levels (Luhanga et al., 2014). Clinical evaluation assesses clinical competence; decisions regarding passing or failing the clinical portion of a course stem from these assessments. Formative evaluations are an ongoing process. Killam et al. (2011) reported that evaluation must be completed in terms of growth, determining if the student is learning from errors or if the student is not modifying their pattern of identified unsafe behaviors.

By using an ongoing approach, both the clinical nursing student and the clinical nursing educator can monitor progression towards meeting the required clinical criteria (Oermann et al., 2009). Summative evaluation is done at the course's completion. It provides the final judgment of the nursing student's success or failure in the clinical portion of a course. This evaluation reflects whether or not a nursing student successfully met the required student learning outcomes for competence and safe nursing care. Formative evaluation represents guiding and summative evaluations represent grading. In an ideal clinical setting, both approaches should be employed (Oermann et al., 2009).

Interviews from this current research revealed that teaching and evaluation were seen as an important responsibility of nursing instructors. These nursing educators engage in both

formative and summative assessments. Their clinical teaching approaches are described as more focused in the beginning of the clinical rotation with a transition to demonstrated student autonomy, as the rotation progresses. Participant A noted at the beginning of a clinical experience they will do more teaching but towards the end of the clinical rotation they would reduce the teaching role and engage more in evaluation. During the first few weeks of the rotation the nursing educator would answer student questions but towards the middle and end of clinical rotation, the nursing educator would expect to see what students think as they would be soon be going out to provide care. The nursing educator had to make a determination if the student could provide safe care to patients.

Participant B noted their responsibility was coaching and facilitation, but they also had to do evaluation. During the early weeks of the rotation the nursing educator acted as a guide but in later weeks the nursing educator would shift to evaluation. Though there were non-negotiable issues, such as safety, learned in previous courses that students were expected to demonstrate without cuing, in this higher level. This educator shared that students were initially given some leeway to 'settle down' in the very beginning of the rotation and given a short amount of time to readjust to the learning environment.

Participant F noted they had worked as a nursing manager for fifteen years and the process of evaluating employees was similar to evaluating students. This particular nursing educator described her role as coach and facilitator with a shift to evaluator as the weeks progressed. Participant F gives the student nurse feedback, helps them develop an improvement plan, and when there is no improvement moves to the next step. Participant G reported that in week two they did a thorough assessment of the student to establish a baseline of performance. Assessment continued throughout the rotation using clinical paperwork and observation when

handling patients. "In the beginning I'm teaching more, but every week I see that I pull back from my teaching role and I'm evaluating more" (Participant A).

> So, the criteria I go by is our clinical objectives which are our program graduate competencies, so I look for students to be able to meet those. If they, you know, if they can't initially I look for progression to meeting them. Then if ultimately, they don't, then they don't pass clinical. I guess the focus is more safety issues, things that could harm a patient like medication administration. Safety issues like leaving beds high, putting the patient in an unsafe position. More unsafe care, I guess. I realize they are beginning practitioners so even though you would like them to be able to connect every dot with theory to clinical but it's probably not gonna happen. You look for them to progress but probably the safety issues are my big criteria issues." (Participant F)

4.4.2 Code 1.2: Guiding Students to Improve Clinical Practice.

> My clinical role? A guide-at-the-side. I guess trying to observe their care and then have my 'Stop- ready' every time they contaminate something. What is stop ready? There's a word that you have to say when they're about to hurt the patient it's called 'STOP!' So, I have to get my 'Stop' ready, so it's actually it was like 'Stop!' I tell them – 'I say "stop" you have to stop moving, like do not proceed further'. I've had students that were a bull in a china shop, and they go so quickly, and they are contaminating along the way and it's like "no, no, no, stop... Stop!" I have my 'stop!' ready (Participant D).

Clarity of clinical criteria was also acknowledged by Drs. Oermann and Gaberson (2013), "criterion-referenced clinical evaluation involves comparing the student's clinical performance with predetermined criteria and not to the performance of other students in the group" (p. 238). This approach is transparent in the criteria expectations and is available to both nursing educator and clinical nursing student in advance. Dr. Grant Wiggins (as cited in Jonsson, 2014), argued that in order to improve performance and educate students, all tasks, standards and criteria must be transparent to students and teachers. Not knowing what is expected can have a negative impact on an already stressful experience for the student (Oermann & Gaberson, 2013; Jonsson, 2013).

Interviews with participants revealed that nursing educators felt a responsibility to help students to meet clinical performance competencies. Participant A noted they had an obligation to provide correct information to the student, provide continuous feedback, encourage them when they were doing well, and support them when they were not doing well and to provide suggestions. That same participant observed it was important to let the student know their level of performance during the process. The nursing educators used clinical advisements which explain the area of growth identified as a student need and provides suggestions or a plan for improvement.

These nursing educators noted they met with the student(s) to discuss the advisement(s) instead of just sending it to them so that the student could understand the instructor concerns. Participant B noted they routinely informed the students there was no expectation of perfection. The instructor was there to help and support students, but students were expected to ask questions. Participant C reported use of advisements, one-on-one counseling, and Student Evaluation Review Committee meetings to guide the student. This particular nursing educator also used written objectives that the student was required to meet. A quote from Participant B is shown below:

> So, for me the steps that I took ...so students are evaluated clinically weekly, I meet with my students every week to discuss their progress. What areas they need to improve, strengths and weaknesses basically. If there are more weaknesses, we need to discuss those. What's going on? What are the student's perspectives? And I develop a plan for them… what they need to do so that they can be successful and meet those clinical objectives in the future. The students that earned the clinical failure, they were not able to meet those objectives. We were meeting weekly and going over it. I definitely passed someone that I knew they were going to struggle, and when that happens I do talk to the student and let them know where their strengths and weaknesses lie and what they need to do to be successful when they move onto the next course (Participant B).

4.4.3 Code 1.3: Ensuring Students are Competent

> .... the number one question I have to ask is 'are they safe?' and if I hesitate on 'are they safe' .... I've answered my question... they're not ready to go they're not ready to pass the course clinically (Participant A).

As Chunta (2016) noted, when nursing educators identify a nursing student who is not satisfactorily meeting the course objectives, it is their legal and ethical responsibility to deny the student's progression. The social promotion of unsafe students causes difficulties for employers and staff education specialists when the hired graduate student cannot perform at the expected entry level of competency and safety (Chunta, 2016). From the majority of the interviews, it was found that these nursing educators had personally taken the responsibility of ensuring that only competent student nurses were allowed to progress through the curriculum and to graduate. Participant A noted they had an obligation to the community to send out competent nurses who can provide care to critically ill or unstable patients. That participant also felt they had an obligation to the nursing profession to send out nurses that are professional, ethical, and competent. These participants were committed to working with the students to achieve success although that was not always the end result:

> This student was continuously guided and given opportunities to advance the student's knowledge such as time in the lab one-on-one with me, as the clinical instructor, as well as time with other students that could help guide the student. Each attempt to make this student stronger and have them learn from their experiences were met with failure. The student just continuously could not apply knowledge in the clinical setting as well as not perform skills in a safe manner (Participant B).

Participant F noted no one was intent on failing a student who wanted to become a nurse. However, a nursing educator has the responsibility of seeing students graduate as safe novice practitioners. Participant A noted early in their career they had passed borderline students.

However, the instructor later realized they were not doing the student, the community or the profession by “giving students a break”. That participant further noted it was easier to sleep at night knowing that a potentially incompetent nurse would not be providing care to a seriously ill patient. Participant B observed their role was also to protect the patient and to ensure patient safety. A student who would not practice in a safe manner placed, patient’s health at risk. Participant F observed by not being honest with students, they were being set up for failure. It was better for students to fail during training instead of during clinical practice and harm a patient.

> Again, this came down to trusting the student had the skill and knowledge base to be able to perform basic nursing care. If I didn’t trust them to take proper care of my family member, I do not feel they should be able to take care of the general public. Since lives could be at risk, I feel it is better to have my personal emotional battels with failing a student vs a student providing unsafe care that could result in permanent disability or death (Participant C).

> I need to ask these questions....." would I want this student caring for my family member?" "Are they safe?" If the answer is No, they need to fail. I understand that they still have clinicals to take after my course, but were they safe at my level? (Participant D)

> Again, I think it's a safety issue. And I think if you aren't honest with students you put them out there to set them up for failure and I think it's better for them, even as terrible as it is for them, to fail here rather than in clinical practice and actually harm somebody: so, I'd rather have that occur here. (Participant F)

4.5 Theme II: Criteria Used in Clinical Grading

Regardless of the type of degree program, clinical education focuses on the advancement of knowledge, technical performance, self-evaluation, and critical thinking skills. As the nursing student progresses through a curriculum, expectation of performance should increase in relation to the course competencies. Clear objectives that are geared to the specific level in the

curriculum may help nurse educators more readily identify unsafe clinical behaviors, document these findings, and initiate remediation. The findings of an integrative review identify actions, attitudes, and behaviors that are related to the three major themes of ineffective interpersonal interactions, knowledge and skill ineptitude, and unprofessional behaviors (Killam, et al, 2011).

This theme and its subsequent codes address the research question what is the lived experience of nursing educators who have administered an earned clinical failing grade to a nursing student(s) in an associate degree nursing program? Interviews with participants revealed the criteria used in grading students were clinical objectives, course competencies, and consultations with other faculty, academic grading, documentation, and student appeals. Even when a nursing student clearly did not meet the expected clinical competencies, the participants described the meticulous details that were required to validate their evaluation of student performance. They discussed the increase in their personal time expenditure meeting with students one-on-one, prescribing actions and activities that were designed to improve the student's performance and to understand the required concepts. The participants utilized resources for themselves as well. They sought the input of fellow nurse educators, of a committee designed to augment efforts to promote the students' clinical success and of their department chairperson. Their efforts were time consuming but their dedication to their professional obligations were the driving force behind those efforts and therefore worth every minute spent.

4.5.1 Code 2.1: Clinical Objectives

"The clinical grading tool that we use at the college where I work has specific objectives each student must meet in order to pass the clinical block" (Participant C). A set of course specific clinical objectives was one of the main criteria used in grading students. Each level in

this particular curriculum had an evaluation tool that built upon the level preceding it. The clinical objectives are descriptors that identify if a student can apply theory to practice. Participant A noted the nursing educator required a strong understanding of clinical objectives and how to operationalize them. Students exhibiting difficulties at the beginning of the semester were required to demonstrate growth and if at the end of the semester the student did not meet clinical objectives the instructor had an obligation of assigning a failing grade. Participant C did note it was difficult to assign a failing grade when the student was passing the theory portion of the course. However, nursing is a practice profession and a student's safe practice has to be directly observed when providing care to the patients.

As previously noted, ineffective interactions interrupt the safe patient care continuum. Physical and psychological harm may come to the patient when pertinent information is missed, unreported or misinterpreted. Students who are unable to critically think or who do not possess clinical reasoning, may not be concerned about their practice, have poor clinical judgement skills, and lack appropriate decision-making skills. Single or rare instances of incompetence can be remedied but consistent demonstration of the identified findings related to the three major themes of ineffective interpersonal interactions, knowledge and skill incompetence, and unprofessional image could be considered treacherous (Killam et al., 2011). Participant D reported most of the students who failed did not show any progression and they did not take suggestions for improvement. This became an issue with that nursing educator when the students did not use suggestions or change their actions to improve their clinical performance. This led to a determination that the student was unsuccessful and when a student could not meet clinical objectives, they had to receive a failing grade. The participant noted with concern, that

after the instructors in that terminal level, there would not be anybody following them to help students meet clinical objectives.

Participant A noted that although it would be easy to assume the student would learn while in practice, any faculty member who observed unsafe practice had the obligation of assigning an earned failing clinical grade. This observation identifies the quandary that nursing educators face in the clinical setting. The 'benefit of a doubt' has been identified as a contributing factor to passing the borderline student who is also likeable or assertive/aggressive (Elliott, 2016). This 'benefit of a doubt' mindset can lead to detriment to the student, as noted in one study: an educator who passed a borderline student expressed relief upon hearing that student failed their licensure exam (Luhanga et al., 2014). It must be questioned morally if it is fair to give failing students the 'benefit of a doubt' and pass them early on in a program only to have them fail later (Heaslip & Scammell, 2012). Dobbs (2017), in her qualitative research on why educators do not fail students clinically, also reported on an educator who passed a borderline student with the hopes that someone would fail the student later.

Participant B noted that the clinical objectives were clearly outlined:

> They were clearly, I felt pretty clearly outlined, for what the student needed to do or not do and if a student did not meet that… I mean some of it was really cut and dry like professionalism, about arriving on time arriving prepared, you know just even coming to clinical; so, some of that is easier. The ones about their clinical ability, related to clinical competence - a lot of that you can find in their paperwork or when I was talking to the student if they didn't understand the patients' diagnosis or appropriate nursing interventions, couldn't identify complications - that's when I would become concerned about their ability to meet clinical objectives (Participant B).

With participant D a specific student failed to meet multiple objectives because the student was not carrying out correct procedures. The student kept contaminating the patient's

dressing. The old dressing fell on the floor and the student picked it with their gloves but attempted to proceed to work on the surgical wound with dirty gloves. This generated a major concern about the ability of student to meet clinical objectives. Participant E reported the case of a student who had multiple incidences of being late and disorganized. The student could not differentiate two patients and attempted to administer the wrong medication at the wrong time. There were many issues with the student, and they could not complete care to the two patients within the required time. Participant G reported a case of a student who shared patient information. This was a HIPAA violation which had major consequences.

4.5.2 Code 2.2: Consultation with Fellow Nurse Educators

> I do feel it was because of the support that I had, I felt more confident to do what I had to do. If other faculty members don't have the support of their course mates, they will potentially second guess themselves alone. If you are not strong enough or confident enough, not having support…. could they really do it? (Participant E)

Support was identified as an important issue for each of the participants which echoes the findings of previous research. In a study on the processes and supports that affect a nurse mentor/clinical nurse evaluator's (educator's) assessment of borderline or failing students, the researchers found that the first step when considering failing a student is the student's performance. The rest of the process centered on if the mentor/clinical nurse evaluator felt they could personally tolerate the challenges of their assessment (Hunt, McGee, Gutteridge, & Hughes, 2016). When they felt that support, the clinical nurse evaluators then felt secure enough to apply the failing grade.

When identifying and dealing with an underperforming student, the participants in the study conducted by Hunt et al. (2016) identified the need for support and validation of the evaluator's efforts. The aim of that study (Hunt et al., 2016) was to identify what enabled some

mentors to apply an earned failing clinical grade to underperforming students. The researchers shared that the central theme identified in that research was that mentors need to feel secure in their roles. The nursing educators in this current research team teach course content and each sought the counsel of other faculty members before assigning an earned failing clinical grade.

Participants A, B, C, D, E and F reported they had a close relationship with other nurse educators and that was important as they examined their evaluations. The nursing educators reported sharing the advisements and discussions that they had with the students with their course mates and the department chair. They then received pertinent feedback from their team and the department chair that determined if there were enough details to justify assigning an earned failing clinical grade. Most of the participants noted inclusion of the department chair's input before the grade was ultimately assigned. All participants observed that one of the steps in assigning an earned failing clinical grade was that it basically required the backing of the department chair and that their department chair was known to be both honest and supportive.

Participant B advised before assigning an earned failing clinical grade, it is important to consult a more experienced colleague and seek their advice on handling a failure. Other educators should be involved in looking at clinical objectives and advisements. Participant C reported the educators supported each other formally through the student evaluation review committee which offers support to both the students and the faculty. A quote from participant B: "I also talked with other faculty to make sure I was on the right track. Getting their perspective, especially clinical faculty that had more clinical experience than myself" (Participant B).

4.5.3 Code 2.3: Documentation

> You look for them to demonstrate improvement. If they don't they would get another advisement. How many advisements does it take to fail clinical? It's different I think

> based on the topic that you're looking at. If its med errors and they maybe make 2 or 3 med errors consistently in a row, I think that's a failing. If it's an inability to totally comprehend lab work, you know, may not fail them because they are still in a developmental point in that" (Participant F).

This research corroborates the findings of Chunta (2016) where it was reported that documentation will allow for accurate student evaluation, identification of repetitive errors, and provides a paper trail should the student challenge the failing clinical grade either within the institution or in the courts. However, the nursing educator chooses to identify and record the unsafe behavior, it should be done in real time whenever possible with as much detail as possible. When deficits are noted, remediation should quickly ensue. Remediation has been shown to improve the nursing student's chance of clinical success and in meeting the clinical course objectives. This coincides with the promotion of a culture of safety rather than one of blame as identified by Tanicala and her peers (2011).

As identified by Chunta ((2016) the first stage of remediation should include a verbal exchange identifying the concerning behavior and provide opportunity for the student to understand why the behavior was unsafe. Remediation may take the form of practicing in a simulation lab or writing a paper if the unsafe behavior was intangible, such as is seen with verbal or nonverbal disrespect. The remediation should include regularly scheduled meetings between the nursing educator and the student nurse. Building a positive rapport with the student will help them see the benefit of remediation. Remediation should not be punitive; all students should know that they are receiving due process and that there is equality among student performance expectations. The student should understand that unsuccessful remediation will result in a clinically failing grade. Applying an earned failing clinical grade will be necessary to sustain patient safety and standards of practice (Chunta, 2016).

> The clinical lab referrals - if someone really bombs a skill in clinical setting and you send them for remediation supposedly if they fail that remediation, they fail the course. Which is high stakes, so sometimes it's tough to send a student for a lab remediation. You may pair it down a little because maybe they haven't done that skill for over a year and you encourage them to look up the clinical practice guideline before they do the skill or to practice in the lab (Participant D).

Interviews with participants revealed documentation was an important part in assigning a grade. Participant B reported the actual assignment of an earned failing clinical grade was made less difficult due to their detailed documentation. While the other aspects of assigning that earned failing clinical grade were very challenging, the documentation related to the case of clinical failure was justifiable to the department chair, the dean of instruction, and the college's legal counsel. No one questioned the nurse educator's judgment because of documentation. Participant G noted other faculty helped with their documentation to ensure everything was detailed.

Participant D recalled that assigning an earned failing grade that was validated because of the documentation provided. The student in that situation consistently failed to meet objectives. Therefore, through the detailed advisements and planning that was not used by the student, the nurse educator could document that the student had not shown progression and was dangerous in a clinical setting. That participant also noted it was important to ensure all clinical advisement forms were clearly documented. A paper trail was important in identifying an unsafe student or a student not meeting objectives. Many shared the importance of documentation for student success or to show the attempts that were made to promote it: "You've gotta be able to stand behind it and you need to show the documentation - that due process was followed, and the student received all the benefits of your instruction that are possible....." (Participant A). "I feel like it was not that difficult to justify the failing grade because of the documentation that I had continuously provided" (Participant C).

4.5.4 Code 2.4: Student Appeals

> There is a formal process for the student to grieve their grade if they feel like their grade is unfair and I've gone through that process a number of times and I feel I've always felt supported by my colleagues and also my supervisor, the chair of the department, and I've never had an experience where my decision was overturned on one of these grievance procedures (Participant A)

Existing research indicates that educators are leery of the processes associated with a student challenging the failure (Elliott, 2016). To reiterate, in a research study regarding what influences a clinical mentor to pass or fail a student, 144 of the 277 respondents admitted passing a student they assessed to be failing. They did so based on the belief that their decision to fail the student would be overturned anyway (Brown et al., 2012). Support is considered a key component of caring and of nurse educators' work satisfaction (Brett, Branstetter, & Wagner, 2014). Significantly, Dr. Mary Beth Kuehn's research identified that dealing with challenging students was cited among the reasons that nurse educators chose to leave the role and return to practice (as cited in Brett et al., 2014, p. 360). The participants in this current case study did not report this type of incidence; they consistently identified they had support.

As discussed previously there is worry that students will bring litigation against the clinical nurse educator who assigns a failing clinical grade to them (Jervis & Tilki, 2011). Fear of litigation is a legitimate one. Some students who have been unsuccessful in the appeal process with faculty, department chairperson and the institution's administration are taking their cases to the judicial system (Wren & Wren, 1999). One participant in this current research did experience an incidence that they felt would result in legal proceedings:

> But the decision was made to tell the student before the third (exam) and the final. Then the student was… the student lashed out saying that I had deliberately tried to like to take their knees out by telling them that they were failing clinically before the third and fourth exams. Then the student passed that third and final exam and then fought me every,

> every bit of the way! That's the one I was fearing a lawsuit. That's the student that went all the way up to the president of the college, the lawyer, the dean. I didn't park… that's when I didn't park my car where I normally park (Participant D).

In fact, these nursing educators were aware of the appeal process and actually identified it for students in effort to promote due process. Interviews revealed students had the opportunity to appeal a failed grade. Participant E reported there was a formal process for students to grieve their grade if they felt it was unfair. The participant revealed none of their decisions was ever overturned by the process. That participant reported having the experience of a student who appealed even though the student felt they needed to repeat the course. The faculty member felt supported because the appeal was not honored:

> I was reviewing the policy of in our Handbook of how to clinically fail a student: what is our policy and what are the student's rights behind it too? I had a student who, even though they appealed the grade, the student at the end of the day, the student felt that they needed to repeat the course, too. So, that made me feel better but there are different students that do fight it until the end and deny and they were picked on and so that does leave a…almost like ...God, almost like a trauma for the faculty members. Because faculty don't…it's hard to deal with that on top of everything else you know? They don't want to …. they don't want to go through this and not have it end the way that they feel that it should end. If the student ends up going forward into the next class instead of repeating this class because it got appealed, then faculty don't feel supported. Where I felt like I was supported with my decision because the appeal wasn't honored (Participant E).

4.5.5 Code 2.5: Academic Grading

"Sometimes there is people that you are not sure about and you look at their theory grade to see how they have done with that knowledge to ease your conscious" (Participant F). This code relates to previous data that identifies should a student exhibit behavior that poses a risk to patient well-being, they should be subject to a failing grade in the clinical portion of their nursing education. However, students are more frequently unsuccessful in a nursing course if they fail academically than they are for a clinical performance that does not fulfill clinical criteria (Jervis

& Tilki, 2011). In fact, nursing students are five times more likely to fail academically than clinically (Hunt, McGee, Gutteridge & Hughes, 2012). Nursing students are required to achieve a passing grade both academically and clinically to successfully complete a course. Participant D, who has had experience with assigning earned failing clinical grades to three nursing students reported that making a decision for one student who had earned a clinical failing grade was more difficult that the two students who had also earned failing clinical grades. Those two students were also failing academically so their clinical failure was not the only reason for them to fail the course.

Participant C reported on the case of a student who did not consistently meet objectives but showed weekly improvement. This student should have failed clinically yet did not receive an earned failing clinical grade instead, the student failed academically and did not proceed with the program. The student was below standard in a clinical environment and passed clinically but failed academically:

> According to our prior clinical tool, as long as a student does not fail one objective repeatedly, he or she would be able to pass in the clinical setting. So, this student would basically put a band aid on whatever issue they had that week and the following week would come up with a new issue. Unfortunately, each time the student was able to fix that small problem however when looking at the big picture, the student really should have failed clinically luckily for me, the student failed academically so the student did not progress in the program. So, it was a direct not being able to apply knowledge to skills and get the critical thinking; so, yes the student was below-standard in the clinical setting and passed clinically however failed academically. So, the student did not move on (Participant C).

4.6 Theme III: Challenges Faced in Grading Students

The codes that emerged from this theme offer an overall description of the answers to the research question what is the personal impact on the nursing educators when they experience a

clinically failing student? The nurse educators in this research describe feelings of anxiety, doubt, sadness, worry, and in some cases, outright fear. They analyzed their roles in the students' ultimate failure. Even those with years of experience expressed self-doubt; they questioned if *they* had done enough for the student. They shared that they understood that each student earned that failing grade, yet, each noted a sense of sorrow on behalf of the student. While they felt empathy for the students' plight they also identified a sense of moral obligation to the safety of the patient population. These participants were invested in the profession of nursing and in the development of safe practitioners.

Their reflections corroborated research that noted nursing educators share the responsibility of providing safe and effective nursing care while providing learning opportunities for students and yet many experience angst in the management of the student who does not present with satisfactory performance (Chunta, 2016). Nurse educators recognize that, regardless of the emotional challenges faculty and students must face, their professional obligation is protecting the public (Laurencelle, et al., 2016). However, one of the unattractive aspects of education is the dilemma nursing educators face when maintaining the balance between fostering excellence in practice, patient safety, and the challenges of confronting the failing student (Laurencelle et al., 2016). Interviews revealed instructors faced some challenges when grading students. These challenges are discussed in following sections.

4.6.1 Code 3.1: Student Aggression

> The final one student did not handle the clinical failure as well and was also out of the program…. personal impact? It was a big personal impact! He became irate and he made a lot of allegations through Title IX and it lasted a year? Year and a half? It finally ended with the Office of Civil Rights. The student slandered my reputation, made egregious, ridiculous allegations towards me so I wasn't sure what the student was capable of. Yes, there was distress! (Participant B)

Student aggression when receiving an earned failing clinical grade has been documented and addressed in previous research. It has been hypothesized that it is difficult to clinically fail students who are aggressive/assertive, as well as those that are popular/amiable as they become significantly upset or disappointed; this difficulty is compounded if the educator lacks the confidence in their evaluation skills (Elliott, 2016). In an article reported in the British Journal of Community Nursing (Carr et al., 2010), researchers identified that mentors and educational representatives who work with nursing students in the clinical setting experienced "dread that skills would not be good enough to manage a situation where a student was angry, upset, or disagreed with their assessment" (Carr et al., 2010 p. 595). Hunt, et al. (2016) noted there was a constant tension resulting from the balance of patient needs and student learning outcomes. Often, students responded negatively to feedback and displayed behaviors that were intimidating, manipulative or belligerent. The mentors, link lecturers, and practice education facilitators in the Hunt et al. research all reported increased levels of stress resultant of the fear, frustration, and guilt that was triggered by the student's unreceptive behaviors.

Student aggression was one of the major challenges faced by the nursing educators in this current case study. Participant B had concerns on personal safety because of student aggression. This nursing educator was distressed on their personal safety even at home because anybody could use Google to find their house. Participant D reported they feared a lawsuit and never parked at nursing parking because of the difficulty with failing one student. The nurse educator shared her experience:

> … I knew it was going to be a difficult failure, because the student she was going to fight it every bit of the way….the student kind of trained me how to treat her….as when I was telling her that PPD needed to be done and she responded with "all I want to do is get an F-ing job" and I was like "Oh, ho…OK!" So then when the student was making mistakes in clinical, then they had an emotional breakdown. It was 'this is par for the course, this

> is kinda what she…. she can't control her emotions'. Then the student would make a mistake and repeat the mistake the very next day and wasn't able to kind of gather their thoughts, so I knew that that was gonna have to be a failure. The student was not following directions, the student was not doing the 5 or 12 rights (now) of med administration. It was just mistake after mistake so that one was an easy one but because of their personality …the paperwork part, the not meeting the objectives was easy but the telling the student and waiting for the fall out as they went to the president of the college, the lawyer, the dean of instruction; so, she went and just drug my name through….that was a difficult failure. I parked far away - I was worried about damage and the student lashing out. So, it is very difficult, I definitely think twice before failing a student but if it's got to be done; if they're unsafe you got to fail them (Participant D).

Research conducted by Black, Curzio, and Terry (21014) described the turmoil that surrounds assigning a failing grade to a nursing student, particularly in the final clinical rotation. Terms like courage, fear, stress, and self-doubt are internationally associated with the experience that nursing educators have when assigning a failing clinical grade. That research added a new dimension to consider in terms of moral decisions. Their results support the need to upgrade and commit to coaching, support, preparation and the creation of an environment that endorses a sense of courage to make the right assessment evaluations for all students (Black et al., 2014). Sharing the news that the student will be receiving their earned clinical grade requires preparation. Even when the faculty has been transparent all along with student, having one-on-one meetings, discussing clinical requirements, and giving clinical advisements the process can still become volatile as it did with Participant G:

> We set up a time, sat with the student and made sure the student understood we were not coming at them as a group, the student had their advisor there as their point person. It proceeded much differently than we expected. The student became hysterical when we spoke with her and she realized the consequence. Eventually the student was escorted out of the building as we had campus security there just in case something was to happen. With the history of the student, there were some concerns and the student needed to be escorted out. The student proceeded to come back in the second entrance, the main entrance, to our school. The student began threatening other peers… Yes, absolutely, it was definitely nerve-racking for several days until we were notified from campus security that if the student were to return to campus everybody would be notified. And the

student would not be able to come further into the building. That night I absolutely feared for my physical safety (Participant G).

4.6.2 Code 3.2: Uncertainty in the Evaluation Process

> But you know assigning a failing clinical grade is never an easy process it's something that you usually second guess yourself and you want to make sure "did I give the student the benefit of the doubt like I would with any other student? Did I give them every opportunity to be successful? … but if you're seeing unsafe behavior um I think, I think that the faculty member has an obligation to assign that failing grade and it never feels good and I never feel 100% certain that that's the right thing. I usually feel at least 90% certain but I'd never feel 100% about it because whatever you can say… that clinical evaluation you can never remove the subjective component from it that (Participant A).

In previously identified research it was reported that faculty factors were identified in relation to assigning a failing grade (DeBrew and Lewallen, 2014). These included faculty beliefs, influences, and feelings. Faculty emotion was listed most frequently among the participants. As participant D from this current case study shared: "…on the other hand you have the students that you really like and they are working the hardest that they can work but they are not where they need to be in order to deliver safe care. Those are the ones that just break my heart. And question my decision...should I stay in this line of work?" The decision to pass or fail a nursing student was identified as complicated and influenced by faculty security or insecurities. In the Hunt et al. study (2016), each of the participants had the experience of administering a failing clinical grade to a nursing student within the prior two years. The evaluation of recorded responses yielded five categories of commonality; category 3 (stage 2) was that of tempering blame. The mentors reviewed their own practice to ensure they were not at fault (Hunt et al., 2016, p. 82). The mentor needed verification that they were not the cause of the student's failure, that the student was responsible for their own failure.

These mentors evaluated if they had done everything they could have to foster the student's success. Moral distress was explained as the personal price a mentor must pay when

following through with the assignment of a failing clinical grade. Mentors shared that guilt, and true concern about their own competence, practice, and quality of their mentorship became pronounced when assigning an earned failing clinical grade in the final clinical experience. Personal feelings of failure; of failing the student and not being able to help them pass led to moral distress. Psychological and physical symptoms of stress, worry, insomnia, and fatigue were commonly identified by the participants because of their moral distress. They felt genuine concern for the students and the impact this grade would have on their lives (Hunt et al., 2016).

Interviews with participants revealed that the nursing instructors in this current research faced some level of uncertainty in the evaluation process. Participant D noted assigning a failing grade is not an easy process and there were doubts if the student had been given every opportunity to be successful. Participant E noted in clinical evaluation it was not possible to remove the subjective component. Participant A observed there was no total confidence in assigning a failing grade. This was because the student was not just getting a failing grade, they were also failing out of the program. This reserve must be tempered with resolve: "They need to have confidence in their decision. Sometimes it helps to do a pro and con list or a list of weekly progress to see if student has progressed or not to sort out their decision. They can also discuss with other faculty or the Student Committee to see how other students have been evaluated" (Participant F).

4.6.3 Code 3.3: Poor Attitude among Students

> What I find it's particularly difficult is that there's something about student that I don't care for: one problem I have with students is when they don't accept any responsibility for their errors. I have a real problem with that but I need to step back from that and then view them like I would view any other student and evaluate them according to the criteria and give them the same amount of feedback, give them the same amount of opportunities to be successful. I feel I've always felt pressured by the student because the student will argue with my perception of how things have been." (Participant A)

Clinical practice is where students can learn to take responsibility for their decisions and actions with regards to patient care. They should be learning to accept errors in judgement and grow from them (Oermann & Gaberson, 2013). Participant A reported having a problem with a student who could not accept responsibility for their errors. In an integrative literature review, Killam, Luhanga, and Bakker (2011) reported on eleven relevant articles, including both theoretical and research studies that related to unsafe baccalaureate nursing student behaviors in clinical practice. From their analysis they identified three themes: ineffective interpersonal interactions, knowledge and skill ineptitudes, and unprofessionalism. Unprofessional image was related to inappropriate attitudes, inappropriate behaviors, and lack of accountability. Such behaviors were exhibited by disrespect, anger, defensiveness, apathy, overconfidence, low confidence, uncontrolled anxiety/nervousness, lack of preparation, and violating procedures (Killam, Luhanga, & Baker, 2011, p. 443).

> Finally, don't meet with the student alone to inform them of their earned failing clinical grade. Even though you have been transparent with the student about their progress throughout the clinical rotation, a clinical failure may still come as a shock to them. If a student begins to yell, call you names, or engage in any behavior that appears to be threatening immediately notify security and follow your institutions harassment/violence policy. This behavior is not okay and should not be tolerated. I wish I would have filed a harassment report when I felt threatened by a student that earned a failing clinical grade, it's the only regret I have (Participant B).

> Since lives could be at risk, I feel it is better to have my personal emotional battels with failing a student vs a student providing unsafe care that could result in permanent disability or death. For safety, and sometimes you do worry about your personal safety, when students are clinically failing, it would be helpful if there were guidelines to keep everybody safe and not have to worry about repercussions from the earned grades that you assign." (Participant C)

4.7 Summary

This chapter identified the themes that emerged from these specific interviews. Many of the shared observations and actions correlated with present research data. These nursing educators firmly believed that their priority was to ensure safe practitioners and patient safety. They each identified ongoing interactions with students to promote success. They identified the need to use resources for both the student and for themselves. While some of the participants identified troubling situations surrounding student clinical failure, all of them believed that they had done the right thing for the student, the profession, and the public.

Chapter V

Discussion, Implications, Recommendations, Strengths, Limitations, Recommendations and Conclusions

5.1 Introduction

The driving force behind this study was to examine the participant nursing educators' experiences with clinically failing students. Using the qualitative approach of case study research, seven participants were queried on their professional and personal experiences when a nursing student earns a failing clinical grade. This chapter will discuss the findings and implications for nursing educators. The limitations and thoughts for future research will be presented.

5.2 Discussion

Nursing educators are blessed with the opportunity to nurture and foster the development of the next generation of healthcare providers. They are also sometimes cursed with the obligation to identify nursing students who are not meeting the clinical course competencies. This case study was guided by the theoretical framework of Self-Determination Theory. Self-Determination Theory proposes that motivation is on a continuum. After reflection on the interviewees' comments, it became evident that they function in the Integrated Regulation regulatory style. They are in the final step of extrinsic motivation where they are internally motivated in congruence with the expectations of a nursing educator role and where they have an awareness of self and purpose.

As described by Ryan and Deci (2000), they are not in the full Intrinsic Phase on the continuum of motivation. They do not have a sense of enjoyment nor do they report inherent

satisfaction when assigning an earned failing clinical grade despite their obvious dedication to patient safety. These individuals' actions could be identified in the sub-theory Organismic Integration Theory (OIT) designed to identify the various forms of extrinsic motivation and "the contextual factors that either promote or hinder internalization and integration of the regulation for these behaviors" (Ryan & Deci, 2000, p. 72). Using the OIT it can be confirmed they would be in the Integrated Regulation of externally motivated behaviors as they are motivated by self-awareness and their actions are in congruence with individual core values and needs, yet their motivation is extrinsic because they are still motivated by outcomes rather than for enjoyment (Ryan & Deci, 2000 p. 73). Their outcomes and goals were consistently identified as preparing nursing students to either successfully progress to the next level of learning within the curriculum or to graduate and become novice nurses who are safe to practice but attainment of these goals was not without conflict:

> I do feel seriously that my role as nursing instructor is to see that the students that are graduating are safe practitioners. I think that educators who have made a decision not to fail a student clinically who deserves to, who earned that grade, shirk their responsibility to the student, our program and the profession. It's not an easy thing to fail a student clinically. But, I feel like it's my responsibility and it's the hard part of my job. So, if I have to do it I will. (Participant A)

> Yeah, I did feel horrible; this student was trying to make a better life for themselves and I worried that because of my grade that I gave them, it would cause additional distress and less money. You know…. I actually worried because the student was not a U.S. citizen. I was worried about them being deported back to their country where they would be put in harm's way, the particular country that the student is from. So yeah, it did affect me personally, but professionally I needed to…. I realized that I needed protect the patients. In the end this student's particular actions failed them, I didn't fail the student: the student failed themselves. (Participant C)

> It's stressful. You don't ever want to see anybody fail and you hope that you can give them the opportunity to improve. But it is their choice if they do that or not and if they don't then it's really their issue. So sure, you're sad when people don't make it through, but you want to put out a safe nurse too. So, I just think of our responsibility to do that. (Participant F)

The interviews teased out a glance of how these nurse educators described their development, self-regulation, professional life goals, psychological needs, and culture/social impact on human behavior (Deci & Ryan, 2008). Each identified that they had to mature and develop to the role of nursing educator and this growth gave them the strength to engage in a process that was clearly challenging, if not on somatic or psychological levels, then certainly in terms of workload generated.

> I think I wonder that when I was a new clinical instructor if I passed people that I maybe shouldn't have just because I wasn't really clear on what the expectation was as a new clinical instructor. I wasn't taught how to fail a student. Now? A lot of paperwork/documentation making sure everything is perfect. I'm asking my colleagues to read my advisements. Consulting the nursing chair and letting her know that this was my plan and seeing if there's anything else that I should do prior to failing the student. Was it something that I didn't do? Did I not provide enough paperwork along the way to let the student know, that they were failing? The paperwork is overwhelming and then the follow through to make sure that it points to the failure. So, paperwork needs to be backed by advisements. (Participant D)

> I think that's experience as a clinical instructor. I don't know like if I would have passed those three students my very first semester as a clinical instructor. It's quite possible they would have passed. Because I didn't have anything to compare it to, I was a bedside nurse and I was doing the best I could as a clinical instructor. I enjoyed it and I was learning everything I could. But you didn't have anything to compare it to. I didn't know what a student should really know at that level. I had to learn that over time. So now it's a lot easier I have been doing clinical almost 8 years. I know what a student should know and what they may not know. (Participant B)

> Earlier in my career, my teaching career, I have passed borderline students and I still remember their names because it's 20 some odd years later I realize ..well, I've come to realize, that I'm not doing either the student or certainly the community or the profession a favor when I quote/unquote 'give the student a break'. (Participant A)

In their honesty, they shared how they had to recognize their potential bias and through self-regulation, accept that the process had to be fair and comprehensive. They battled feelings

that so many nurse educators identify because nurses are grounded in a caring profession yet by giving an earned failing clinical grade as nurse educators they are preventing or at least slowing a person from achieving their dream.

> Personal stress, Oh my God yes! You know you do worry about the students…these students - this is what they planned for their life, before they got to me there like in school for 2 to 3 years doing all their pre-recs. Getting, you know, there so when they get to me and I have to fail them it's like that you are the bad guy, even though they earned that failure! You are seen as the barrier to them passing and having a life for themselves. Yes, that's a lot of distress! Failing a student is not taken lightly absolutely not TAKEN LIGHTLY. (Participant D)

> It was a lot of 'am I doing this right? Am I singling out this person? Should I be paying attention more to the other students?' It's a lot of second guessing to like 'OK do I feel comfortable doing this? Am I seeing this the way that I'm seeing it?' (Participant E)

> Probably you would like it to all be objective but there is some subjective in there too. I know I try to level my clinical group in if I know I gave somebody an advisement for a med error, I know, even if you kind of feel for another student, you have to do the same for that student too. I know in our course we try to do that too. (Participant F)

When referring to professional life goals, the participants validated the study presented by Killam, Luhanga, and Baker (2011) that identified patient safety not only as a directive but also a "moral and ethical imperative when nurses provide care" (Killam, Luhanga, & Bakker, 2011, p. 437). These participants described the plans they devised and the oral and written feedback that they continuously provided. Unfortunately, despite all of the teaching and learning strategies aimed at guiding success, some students just cannot meet the expectations to provide safe patient care that corresponds with their level of learning whether it is first semester or fourth semester. Self-Determination Theory addresses the issues of activity or passivity, responsibility or idleness. This theory postulates that humans are inclined towards activity and responsibility but are vulnerable to passivity. Contexts that support the three basic needs of

autonomy, competence, and relatedness tend to develop greater internalization and integration than situations or conditions that thwart need satisfaction. Internalization refers to a person "taking in" a value or regulation and integration describes additional transformation of that regulation into their own being so that this value or commitment will "emanate from the sense of self" (Ryan & Deci, 2000, p. 71). This sentiment was eloquently echoed by participant A:

> I look at it three ways: first I look that I have an obligation to the student to provide correct information, to give them continual feedback, ah, to encourage them when they are doing well, to give them support when they're not and to give them specific suggestions. So, I definitely have an obligation to the student, but I also have two other obligations. . . I have an obligation to the community to send out nurses that are competent and that can provide care to people who may be critically ill or at least very unstable. Then third I really feel I have an obligation to the profession of nursing. To send out nurses that are professional, that are ethical and that can provide competent care at a beginning level.

The Basic Psychological Needs sub-theory of SDT was also evidenced in their responses. As previously discussed, Deci and Ryan (2002) identified a strong link between satisfaction of autonomy, competence, and relatedness needs and eudaimonic well-being. Eudaimonic well-being has been linked with four variables including a balance of focusing on the self and others, a balance of focusing on the present and the future, a tendency to be guided by abstract and big-picture concepts, and a focus on cultivating and building what one values and envisions (Huta, 2015, p. 3).

> I feel it meets no one's need to pass a student clinically who has not met the clinical objectives. The student is ill prepared to provide safe, competent nursing care. The patient is at risk with this person being their nurse. The community is ill served to have the institution graduating nurses who are not competent. Plus, it's easier for me to sleep at night knowing that an incompetent nurse is not out there providing care to a seriously ill patient. (Participant A)

> I pursue it because I want to only pass safe practitioners. (Participant F)

> I spoke to my course mates and I spoke to my chair person too, just say this is where I'm standing, this is what I see: I don't feel comfortable. That student is going to be

> graduating and practicing right alongside of me and this is not OK! And just… morally, I knew that if the student repeated, it was gonna be for their benefit as a future practitioner. (Participant E)

The participants identified challenges and the difficulties that occur when identifying and then coping with these students which is a common situation identified by previous research (Chunta, 2016; Killam, Luhanga, & Bakker, 2011, Luhanga, 2014, Killam, Montgomery, Raymond, Mossey, Timmermans and Binette, 2012). Certainly not all students exhibit unsafe behavior or continue with unsafe behavior once it's identified but nurse educators cannot become complacent in their evaluation practice. The nurse educators in this research identified the extra work that such a grade generated not only to try to prevent it but to validate it when it does. They identified the complexities of assigning the earned failing grade from the perspective of not only an evaluator but also as one person telling another person that they have not met the criteria, they have not made the cut, and that all the work the student has completed before this period in time cannot prevent the inevitable, explained by participant C:

> The personal impact I felt was… it was hard because I… you know you're human, and you see how hard a lot of these students work. This student, in particular, as I said, was working 2 jobs. The student was leaving one job at one point and coming into the clinical setting and then going back to another job after. I can tell you, I worried about their personal health. I worried about the student driving back and forth with zero sleep; if the student was going to injure themselves or someone else. But when it all comes down to is that I… my job… is to protect the patient and the patient's safety. This student continuously did not perform in a safe manner and put patients' health in jeopardy. Yeah I did feel horrible; this student was trying to make a better life for themselves and I worried that because of my grade that I gave them it would cause additional distress and less money. So yeah, it did affect me personally, but professionally I needed to…. I realized that I needed protect the patients. (Participant C)

Every participant discussed the importance of and essential need to have support of peers not only to correctly and fairly assign the earned failing clinical grade, but also to have strength and confidence to complete the process. This sense of relatedness is identified as a need to have

close friendly relationships to have a secure relationship base. Relatedness is one of the three basic needs that describes goal motivation. Intrinsic motivation stems from within; a person's core values, beliefs, and "sense of morality" (Ackerman & Tran, 2018, para 8). Those who are intrinsically motivated are likely to participate in activities that satisfy their three basic needs (Gatling et al., 2015). The support of other nurse educators and the department chair was identified as critical to their commitment to the student, the profession, and the public.

> Because again, it's especially difficult if the student is passing the course, passing the theory tests but nursing is a practice profession so I can't just say, well, they're passing theory….. they must be safe. I have to visually see it and when they are providing direct patient care, I look at myself - I second guess, and third guess and fourth guess myself again. And to me the most effective way that I have dealt with it is by having really close relationships with the teachers that I teach with so that we can all sit down, and I can present what I've done and show them advisements that I have done, that I've given. I summarize the discussions I've had with the students and get feedback from those faculty members as to whether this is in fact is a justified grade or not. (Participant A)

Even though one of the nurse educators described the process of assigning an earned failing clinical grade as harrowing, professionally horrific, potentially career ending, in addition to being the source of physical and psychological presentations (fear, paranoia, and presence of an instance-related eye twitch), that individual remained true to her assessments based on the clinical criteria. She relied heavily on the support that was offered throughout the process.

> Our courses are team taught so we have a faculty to talk to and then informal supports you know just even from some of the faculty particularly the last clinical failure. You know faculty would come up to me and be like "hey I heard stuff's going on I'm really sorry" so like I had that kind of support. My Department Chair was incredibly supportive of every single one of the clinical failures particularly again the last one that probably caused her just as much stress as it caused me with that student. I never felt alone in the process with that last clinical failure. (Participant B)

5.3 Implications

As researchers Ramsburg and Childress noted, the role of nursing educator is intricate and success in this role requires dedication to committing to an ongoing continuum of skill attainment (Ramsburg & Childress, 2012)). These researchers reported that "designing and validating a method to assess the total level of skill acquisition among nurse educators is necessary to determine current levels of expertise, as well as to guide nurse educator curricula and professional development activities" (Ramsburg & Childress, 2012 p.312). The skills and capabilities of the future nursing workforce are intricately linked to the nurse educator degree of competence.

The researchers used the NLN set of core competencies to evaluate perceived nurse educator skill attainment among three hundred and thirty-nine nurse educators and these included:

1. Facilitate learning;
2. Facilitate learner development and socialization;
3. Develop assessment and evaluation strategies;
4. Participate in curriculum design and program evaluation;
5. Function as a change agent and leader;
6. Pursue continuous quality improvement in the nurse educator role;
7. Engage in scholarship;
8. Function within the educational environment; (Ramsburg & Childress, 2012 p. 313)

The participants in that study reported moderate, moderately high or high levels of confidence in the completion of activities that corresponded with the nurse educator role. The majority of those participants (57.1 percent) had obtained a master's degree in nursing and 26.2 percent had a doctoral degree. Similarly, the 71% of the participants in this current research had a master's degree and 28% had a doctoral degree. Ramsburg and Childress (2012) reported that "specific experiences increase skill acquisition because experience most effectively leads to knowledge acquisition" (p. 316). This is demonstrated by the current participants who knew what needed to be done upon the identification of the clinical nursing student who could not meet the objectives as summarized by participant A:

> You have to have a good understanding of what the clinical objectives are and how to operationalize them. And then you need to evaluate the student over time so ... and typically a student has difficulty in the beginning part of the semester and what you are looking for is growth and that they take your advice and move forward …..at the end of the semester you have to make a final determination did the student meet those clinical objectives and if not you are obligated to assign a failing clinical grade. (Participant A)

Ramsburg and Childress' (2012) conclusion advised that professional development programs and taking part in experiences in the nurse educator role would be of great benefit in ensuring nurse educator skill acquisition. This current research on the examination of experiences with clinically failing students reinforces that conclusion; each participant had a mentor to guide them and personal exposure to the process and each identified the struggles they experienced. Offering the opportunities to enhance skill acquisition in this particular aspect of the nurse educator role would be beneficial not only to the experienced nurse educator but to the novice nurse educator as well and would contribute to the skill directly related to the NLN core competencies of developing assessment and evaluation strategies and the pursuit of continuous quality improvement in the nurse educator role (Ramsburg & Childress, 2012, NLN, n.d,).

Each interviewed individual had devised a personal plan that was beneficial to promote safe student behavior and the opportunity to have success in that particular clinical experience. In this curriculum the nursing educators have resources called the clinical advisement (see Appendix C), the Lab Referral form (see Appendix D) along with a dedicated nursing lab faculty to assist struggling students with skill acquisition, and a committee that is designed to assist students who may be struggling (Standard 3 Committee/Student Evaluation and Review Committee). The participants in this research described reliance on these resources. Yet they also described a lack of knowledge regarding these resources as they related to the clinically failing student when they were neophyte nursing educators.

One has to wonder if the stress and angst that accompanies the process of assigning an earned failing clinical grade could be diminished if nursing educators were exposed to these tools at the onset of their career, instead of when the need to utilize them becomes imminent. Since the skills to meet the ever-expanding roles of a nursing educator are also life-long learning requirements so should the opportunity to obtain continuing education that relates to the process of assigning an earned failing clinical grade.

At the very minimum, the experiences of nursing educators in assigning earned failing clinical grades should be shared within the profession. As Participant C noted: "So, I do feel like there is support but yes, there could always be more support maybe support throughout all of the courses and not just the ones you work with individually". These implications are applicable to any field in the practice professions. Although the protocols or criteria may be different among the various programs of study, the personal experiences of the educators transcend those and can be very similar in impact. The experience of assigning an earned failing clinical grade should not be insulated, it should be a dirty little secret. Not every student will successfully complete a

clinical rotation, and this is true for students in nursing, education, social work, respiratory therapy, physical and occupational therapies.

Clearly, among the participants in this research, even under the best circumstances the process is a harsh situation. It is an experience that all educators should be sharing openly. This will not only lessen the burden that the educator carries, even though the student technically fails themselves, but it will also strengthen the commitment to foster the growth of students who have chosen to enter a practice profession. Educators are expected to be transparent with their students, the same should hold true among educators who have had the lived-experience of assigning an earned failing clinical grade with each other and with those who have yet to have had the experience.

5.4 Recommendations

Based on the data reviewed through the review of literature for this study, the data collected through participant interviews and personal experience with assigning an earned failing clinical grade this researcher would make the following recommendations:

1. Transparency should be of the utmost importance for students. With students, nurse educators need to invest time upfront to be very clear with what each specific clinical expectation is and provide examples for clarity. For consistency, this should be part of course and clinical orientations, provided in writing, and be posted on the course site with the clinical forms. A course within the examined curriculum has used a portion of the weekly post-conferences as a platform to address each clinical competence and this has been student driven. Nursing students must be presented with clear information regarding failure to meet the clinical requirements; they must understand the ramifications of failing to meet those competencies. Students must be

aware that their nurse educator will assign an accurate grade that reflects the student performance. The role of the nurse educator should also be defined for the student to understand teaching and evaluation techniques. These statements, with examples should also be available to the students in verbal and written forms. Finally, evaluations should be formative not merely summative.

2. Transparency should be of the utmost importance for faculty. For nurse educators, initial and ongoing information should be consistently available with regards to the process of assigning an earned failing clinical grade. This experience, in all probability, will occur at least once in a nurse educator's professional experience. Knowledge of the process should be proactive not reactive. In monthly faculty meetings the topic of challenging clinical situations should be a regular portion in the agenda. Management of those situations can be discussed, evaluated for efficacy, and perhaps improved upon. Clinical failure experiences should not be isolated but should be shared among all nurse educators faculty for knowledge acquisition and continuity. Open communication with experiences related to effective and ineffective clinical evaluations should be discussed to strengthen commitment to student success.
3. Clinical nurse educators consistently identify support as an essential component to surviving the processes associated with assigning an earned failing clinical grade. This support should be offered from faculty across a curriculum not just within a course or within a level. Open dialog will accentuate the knowledge base regarding the assignment of an earned failing clinical grade: what was the student behavior(s), how did the nurse educator address the situation(s) with the student, what was the plan(s) of action for student success, what supports were used, and finally, how did

the nurse educator experience the process? Sharing the process strengthens the process and will generate consistency among clinical nurse educators.

4. Written communication such as hard copy or electronic handbooks are reliable sources of information. Clinical failures are inherent in any curriculum. Providing an objective outline of expectations and requirements will not only promote nurse educator compliance when a below-standard student is identified but will also ensure the student receives due process. The students' privacy could be maintained but the protocol and potentials could be openly addressed and documented. The opportunity to attend workshops that are either faculty driven or professionally constructed should be strongly recommended for nurse educators.

5.5 Strengths

This research was designed to answer three main questions; what was the lived experience of nursing educators who have administered an earned clinical failing grade to a nursing student(s) in an associate degree nursing program, what motivated these nurse educators to assign a deserved failing clinical grade, and what is the personal impact on the nursing faculty when they experience a clinically failing student? The strength of the research was that those questions were answered for the seven participants. The participants' responses mirrored the information that has been reported by other researchers, in terms of commitment, motivation, support and yes, stress. This research will contribute to the current body of knowledge as it relates to nurse educator impact on the experience of assigning an earned failing clinical grade. The information can be disseminated to educators in other practice professions as they too face this situation with their student populations.

One facet of the experience that none of the participants noted was that of blame. Other research related to assigning a failing clinical grade and on social promotion frequently report educator frustration with peers who have passed along a below-standard or borderline student. Failing a student in the final placement also reportedly created feelings of anger and disappointment at being left to handle the student's failure (Black, et al, 2014). This phenomena generates frustration and anger in those who are now faced with assigning an earned failing clinical grade. Each of the participants in this current research took ownership of the situation and designed a plan of action that would benefit that student at that moment in time. This is important data, it emphasizes the focus on the student at the current level in their career, not where they have come from but where they are and what can be done to honestly and realistically aid them towards the future.

The nurse educators noted an awareness of what the students should bring to their level but recognized that formerly demonstrated safety in one clinical area does not guarantee future clinical safety; each experience should be evaluated on its own merit (Mossey, Montgomery, Raymond, & Killam, 2012). This was impressive as more than one report identified the compounded feelings of frustration because the participants felt that a student's previous mentors were negligent in their beliefs regarding professional responsibility or that they were more concerned with personal rather than public ramifications when making the decision to socially promote an incompetent student (Dobbs, 2017; Black, et al, 2014; Fitch & Taylor, 2013).

Each one of this research's participants identified their personal role, their personal obligation to patient safety and how they experienced the situation; they did not assign blame. The focus for them was assisting the student by creating a plan of action and to validate their assessment of the students' performance, to follow protocol, and to use all the resources

available from meetings, forms, committees, and peers to first prevent and then complete the assignment of an earned failing clinical grade. Interestingly, their approach, their sense of ownership of the current student situation echoes the shift from the culture of blame that is normally assigned to student performance to a culture of safety. The participants' statements reflected "the responsibility to uphold a culture of safety is not only the purview of students, but also educators and the nursing program as a whole" (Killam et al., 2012, p. 11). Time was not wasted asking *how* the student got to their level, it was spend constructively attempting to promote student success and recognizing when success would not be the outcome.

5.6 Limitations and Recommendations for Further Research

The questionnaire utilized in this study was too broad. Some of the questions were not initially clear to the participants until clarified by the interviewer. Dependent upon participant responses, some interviews generated additional queries. Although all levels of this associate degree nursing program were represented, all course types were not represented. Further research that addresses the nature of a course's curriculum in terms of clinical evaluation criteria would also expand the knowledge base for the lived experiences of nursing educators who have assigned an earned failing clinical grade. All seven participants were Caucasian females in a community college setting. It would be beneficial to engage a more varied nurse educator population. The results may not be applicable to faculty in different types of nursing programs or different sized programs. Replication of this study in Bachelor of Science or graduate nursing curriculums would be of interest in terms of nursing educator experiences in those settings.

It would have been beneficial to interview adjunct clinical instructors, as well; their perspective would be encouraged to include in future research. Only two participants had less

than eight years' experience as a clinical instructor; it would be beneficial to interview other novice nurse educators for their perspectives on assigning an earned failing clinical grade.

5.7 Conclusion

It is doubtful that one could find a nursing educator who thought assigning an earned failing clinical grade was a seamless process. Even at its best, the situation is saturated with physical and emotional components. If clinical nursing educators felt comfortable with sharing information from their personal experiences, the literature supports there may be opportunity for growth and personal development (DeBrew & Lewallen, 2014). Clinical nurse educators may be experts in their clinical area but may not be sufficiently prepared to manage clinical teaching encounters and possess appropriate evaluation skills or tools (Suplee, Gardner, & Jerome-D'Emilia, 2014).

Clinical nursing educators are dedicated to their profession, but that does not make the requirements easy to fulfill. If a student does not meet the outlined clinical objectives despite ongoing and active intervention from the nursing educator, then that student cannot meet the course competencies and should receive a failing clinical grade. The process should be one that promotes eventual student success and not one that fills the hearts of nursing educators with dread. "Reflecting on one's own experiences with clinical evaluation and hearing about the experiences of other faculty can make that process more deliberate" (DeBrew & Lewallen, 2014, p. 632). As a certified nursing educator with fifteen years' experience, I am proud to be in a profession where commitment to all facets of the role is not only expected, it saves lives.

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Appendix A

Consent to Participate in Research

Principle Investigator: Jeanmarie Maloney, Ed. D. student, DSU

Title of Project: An Examination of Nurse Educators' Experiences with Clinically Failing Students

Purpose of Study: To explore the lived-experiences of nursing educators who have had to assign an earned failing clinical grade to nursing student, despite their didactic score. to be able to report upon nurse educators' perspectives on an experience(s) and the impact(s) that assigning an earned failing clinical grade to a student had on them as a nursing educator. To report upon nurse educators' perspectives on an experience(s) and the impact(s) that assigning an earned failing clinical grade to a student had on them as a nursing educator.

Participants: Fulltime nursing educators in a nursing program who teach in the clinical setting and have had the experience of assigning an earned failing clinical grade. Nursing educators with this personal experience who are willing to discuss it are essential to this research.

Procedure: Private interviews will take place on the Delaware Tech Stanton Campus. These will be conducted by the primary researcher and will take approximately thirty minutes to complete. With permission, interviews will be recorded. Participants may be contacted post-interview to verify and clarify statements.

Confidentiality: Identities will remain confidential. All interviews will be transcribed in private and stored on a secured, personal computer. This consent will be privately stored.

Risks: There are no risks associated with this study.

Description of benefits: Participation is voluntary and there is no direct benefit to participants other than to contribute to the body of research associated with this experience.

You may withdraw from this research at any time.

Questions:

If you have any questions regarding your rights as a participant, contact the Office of Sponsored Programs

Please address any other questions to the following:

Jeanmarie Maloney MSN, RN, CNE

Dr. Richard Phillips, Chair

I acknowledge that I have received a personal copy of this consent form and am willing to participate in this research.

_____ _____

Signature Date

Appendix B

Interview Questions

1. How do you describe the criteria that triggered your decision to assign an earned failing clinical grade?
2. Describe the student behaviors that determine a student is failing a clinical course.
3. What concerns were there regarding the student's ability to meet the criteria?
4. Please describe how you view your clinical role. Is there a point in your practice when clinical teaching ends and assessment begin, if so when does this occur?
5. How did the confidence to assign a failing clinical grade evolve?
6. How do you describe the process?
7. What is the format for failing a student? Please describe the steps you took.
8. How would you describe the personal impact the experience had on you during and after the grade was given?
9. Do you feel it is a difficult process to justify/document a clinically failing student? Please explain.
10. Has the process of failing a student ever caused you distress? Please explain.
11. Have you ever passed a borderline or below-clinical-standard student and been troubled?
12. If so, why?
13. Have you ever felt pressured into passing a borderline student?
14. What support did you have during your experience: were those supports formal or informal? Guidance? (Creswell, 2014)

Appendix C

CLINICAL PERFORMANCE OBJECTIVES
NUR XXX – Nursing Concepts IV

Student: _____ **Semester:** _____

Clinical grade (Please Circle): **Pass** **Fail**

Theory grade: _____ -1%_____ -2% _____

Final course grade: _____ **A**=92-100 **B**=83-91 **C**=75-82 **F**=74 or below

Advisor: _____ **Final absences:** _____ **Instructor:** _____

_____

Late: _____

The student nurse, by demonstrating principles of sound nursing judgment, communication, caring, leadership, and civic professionalism exemplifies those characteristics that support the philosophy of the Nursing Program.

1. Nursing Judgment: Integrate sound nursing judgment, incorporating theoretical knowledge and clinical

1.1 Theoretical Knowledge: Relate theoretical knowledge necessary for safe nursing care.

1. Integrate knowledge of anatomy and physiology, pathophysiology, growth and development, nutrition, safety and pharmacology into a nursing plan of care.
    a. Use the nursing process to construct a plan of care supported by principles of evidence-based practice.
    b. Modify the plan of care as needed.
2. Analyze data to develop a patient specific plan of care.
3. Practice nursing interventions that achieve health promotion and disease prevention.
4. Integrate scientific principles underlying nursing procedures.

1.2 Clinical Reasoning: Appraise clinical reasoning skills to prioritize a plan of nursing care for patients in a variety of health care settings.

1. Identify measureable outcomes that promote, restore or maintain an optimal level of comfort and health.
2. Analyze the outcomes of care through critical examination of patient data.
3. Adapt quality improvement strategies to meet established outcomes through a developed plan of care.
4. Value a spirit of inquiry to improve the quality and safety of patient centered care.
    a. Practice appropriate problem-solving strategies.
    b. Interpret patient data prior to performing care.
    c. Model safe performance of nursing skills in order to prevent patient/ nurse injury.
    d. Outline quality improvement initiatives related to the improvement of patient centered care.
    e. Exhibit self-direction by seeking appropriate learning experiences.

	Satisfactory Progress	**Unsatisfactory Progress**	**Supplemental Documentation Provided**
Week 1			
Week 2			
Week 3			
Week 4			
Week 5			
Week 6			
Week 7			

End of Course Evaluation:

o The student has **MET** the learning objectives related to Nursing Judgment.

o The student has **NOT MET** the learning objectives related to Nursing Judgment.

1.3 Clinical Competency: Illustrate clinical competence through evidence-based practice in the care of patients in a variety of health care settings. 1. Support principles of safety to minimize risks of harm to patients, providers, and members of the health care team. a. Select interventions that support National Patient Safety Goals to improve patient outcomes. b. Articulate drug action, use, side effects, dosage ranges, contraindications, and interactions as it relates to the individual patient. c. Relate treatment regimen with medication administration and laboratory testing. d. Employ physical assessment techniques to evaluate the patient on an ongoing basis. e. Perform nursing skills based on principles of evidence-based practice. 2. Implement patient-centered care that is reflective of patient preferences, values, and needs. 3. Integrate informatics to communicate, manage knowledge, mitigate error, and support decision-making. a. Administer medications safely and accurately adhering to the Rights of Medication administration. b. Use specific institutional computerized resources to provide safe and effective patient care. c. Document accurately according to facility protocol and instructor directions.	

reasoning skills, to provide clinically competent nursing care for individuals, families, and communities.

2. Caring: Integrate the diversity of the individual, family, and community to maintain caring relationships.

2.1 Display caring behaviors that respect unique cultural, ethnic, socioeconomic, and lifestyle diversity. 1. Incorporate patient and family diversity into the plan of care. **2.2 Practice interventions that maintain patient dignity and demonstrate respect.** **2.3 Illustrate the values of caring that advocate for optimal patient comfort, function, and wellness.** 1. Support patients, families, and significant others in a non-judgmental manner. 2. Establish and maintains therapeutic relationships with patients and families. 3. Incorporate Advanced Directives in the plan of care. 4. Advocate for interventions that optimize comfort, function, and wellness across the lifespan.		**Satisfactory Progress**	**Unsatisfactory Progress**	**Supplemental Documentation Provided**
	Week 1			
	Week 2			
	Week 3			
	Week 4			
	Week 5			
	Week 6			
	Week 7			
	End of Course Evaluation: ○ The student has **MET** the learning objectives related to Caring. ○ The student has **NOT MET** the learning objectives related to Caring.			

3Communication: Employ appropriate communication techniques while functioning as a member of the healthcare team.

3.1 Refine verbal and nonverbal communication techniques that promote optimal health outcomes. 1. Select correct medical terminology, grammar, spelling, and legible writing in all communication and documentation. 2. Outline a teaching plan to assist the patient to overcome knowledge deficits. 3. Analyze the effect of own verbal and nonverbal behaviors on others. **3.2 Examine the impact of therapeutic communication on the health care team in promoting optimal health outcomes.** 1. Provide thorough "hands-off" communication to appropriate members of the healthcare team. 2. Exhibit tact and respect when communicating with faculty, peers, and facility staff. 3. Maintain confidential information regarding patients and families in accordance with the Health Insurance Portability and Accountability Act (HIPAA). 4. Identify the significance of unusual findings and promptly report, using the SBAR tool, to the instructor and appropriate members of the health care team.		**Satisfactory Progress**	**Unsatisfactory Progress**	**Supplemental Documentation Provided**
	Week 1			
	Week 2			
	Week 3			
	Week 4			
	Week 5			
	Week 6			
	Week 7			
	End of Course Evaluation: ○ The student has **MET** the learning objectives related to Communication. ○ The student has **NOT MET** the learning objectives related to Communication.			

4. Leadership : Manage care for a group of patients using organization, collaboration, and delegation.

4.1 Incorporate collaboration principles to assure optimal health outcomes. 1. Display cooperation and collaboration when working with others as part of the multidisciplinary team. 2. Involve the patient in planning and implementation of care. 3. Employ appropriate conflict resolution techniques. **4.2 Integrate management principles used by the interdisciplinary team to achieve optimal patient outcomes.** 1. Articulate the significance of referrals on patient outcomes.		**Satisfactory Progress**	**Unsatisfactory Progress**	**Supplemental Documentation Provided**
	Week 1			
	Week 2			
	Week 3			
	Week 4			
	Week 5			
	Week 6			
	Week 7			

4.3 Identify opportunities in which nurses can act as change agents in the health care environment **4.4 Delegate appropriate care based on established program and institutional policies, protocols, and procedures.** 1. Practice within the role of a nursing student. **4.5 Practice effective time management, prioritization, and organizational skills.** 1. Complete care within prescribed time in the clinical setting. 2. If caring for more than one patient, articulate priorities of care for each patient to the instructor.	End of Course Evaluation: o The student has **MET** the learning objectives o related to Leadership. o o The student has **NOT MET** the learning objectives o related to Leadership.

5 **Civic Professionalism: Integrate civic professionalism, ethical, and legal standards into nursing practice.**

5.1 Analyze behaviors that adhere to professional standards of nursing practice. 1. Model professionalism and maintain personal composure. 2. Prepare appropriately for clinical (i.e. have necessary equipment, research patient related information etc.) 3. Accept constructive feedback with a positive attitude. 4. Integrate suggestions to improve clinical performance. 5. Identify own strengths and weaknesses in the clinical setting. 6. Develop strategies to improve nursing practice. **5.2 Evaluate legal and ethical accountability in nursing practice.** **5.3 Value integrity through adherence to established policies, protocols, and procedures.** 1. Accept responsibility and accountability for own actions. 2. Integrate professional, ethical, and legal standards of nursing practice. 3. Request appropriate assistance from instructor and inform instructor of all changes in patient condition or any abnormal findings. 4. Adhere to guidelines regarding student behavior and appearance as found in the Delaware Tech Associate Degree Student Nursing Handbook and course materials. 5. Submit assignments on time and per directions. 6. Arrive on the clinical site on time as specified by the instructor and be prepared to deliver care. 7. Participate at the assigned clinical site for the alloted time period.		**Satisfactory Progress**	**Unsatisfactory Progress**	**Supplemental Documentation Provided**
	Week 1			
	Week 2			
	Week 3			
	Week 4			
	Week 5			
	Week 6			
	Week 7			
	End of Course Evaluation: o The student has **MET** the learning objectives o related to Civic Professionalism. o The student has **NOT MET** the learning objectives o related to Civic Professionalism.			

Weekly Evaluative Summary

Week 1 Date:	Student Signature_____ Instructor Signature_____
Week 2 Date:	Student Signature_____ Instructor Signature_____
Week 3 Date:	Student Signature_____ Instructor Signature_____
Week 4 Date:	Student Signature_____ Instructor Signature_____
Week 5 Date:	Student Signature_____ Instructor Signature_____
Week 6 Date:	Student Signature_____ Instructor Signature_____
Week 7 Date:	Student Signature_____ Instructor Signature_____

	Satisfactory Progress	**Unsatisfactory Progress**	**Student Signature**
Mid-Point Evaluation			
Final Evaluation			

End of Course Evaluation:

- **The student has MET the learning objectives related to Nursing Judgment, Caring, Communication, Leadership, and Civic Professionalism.**
- **The student has NOT MET the learning objectives related to Nursing Judgment, Caring, Communication, Leadership, and Civic Professionalism.**

Instructor _____ Date: _____

Weekly Satisfactory: Demonstrates progress towards meeting the clinical objectives. The student will provide safe patient care at all times. **Weekly Unsatisfactory:** Fails to demonstrate progress towards meeting the clinical objectives. The clinical instructor will complete supplemental documentation for each unsatisfactory objective. The instructor will review the plan for expected improvement with the student and document a due date for any mandated remediation or assignments. Continued failure to meet clinical objectives will result in failure of the course. **Course Objectives Met**: Demonstrated safe nursing practice and consistent achievement of the clinical objectives. **Course Objectives Not Met**: Failed to demonstrate safe nursing practice and/or consistent achievement of clinical objectives.

Consistent: predominant student behavior that reflects satisfactory achievement of clinical objectives.

Appendix D

ADVISEMENT FORM

STUDENT: _____ **COURSE:** _____

DATE OF ABSENCE/ADVISEMENT: _____ **# Absences: 1st 2nd 3rd**

DAY OF ADVISEMENT: M_____ T _____

INSTRUCTOR: _____ **SEMESTER:** ___ **WEEK:**
MATH COMPETENCY FAILURE: Score 1ST Attempt:_____ Score 2ND Attempt: _____

VARIANCE: Yes:_____ No:_____

CLINICAL UNSATISFACTORY: Yes:_____ **No:** _____ **OBJECTIVE(s):** _____

OCCURRENCE:
PLAN:

ATTEND SERC: Yes: _____ No: _____

Continued failure to meet these objectives may result in an unsuccessful completion of the NUR _____clinical objectives.

Any student with two absences, variance, or difficulty meeting clinical objectives must attend SERC.

Instructor: _____ **Date:**_____

Student signature: _____ **Date:** _____

FACULTY USE:
SERC DROPBOX:_____ **ADVISOR:** ___ **COURSE COORDINATOR:** ____ **GRADE BOOK:**_

Appendix E

DEPARTMENT OF ASSOCIATE DEGREE NURSING

Campus Lab Referral

Student: Date:

Referring Instructor: Course:

_____

Reason for Referral:

Brief description:

.

Plan:

Date Referral must be completed:
Student signature: _____
Date: _____

_____

Date Referral completed:
Instructor:
Campus lab instructor comments:

Student signature: _____
Date: _____

Appendix F

DELAWARE STATE UNIVERSITY

Institutional Review Board – Human Subjects Protection Committee

February 28, 2019

Ms. Jeanmarie Maloney
Department of Education
Delaware State University
1200 N. DuPont Highway
Dover, DE 19901

Ms. Maloney,

Delaware State University's Institutional Review Board (IRB)-Human Subjects Protection Committee has reviewed your application for the research project titled **"An Examination of Nurse Educators' Experiences with Clinically Failing Students"**.

The Committee has **approved** the application and requires that a Final Study Report form be submitted on or before February 28, 2020. Please send this report to:

Institutional Review Board
Office of Sponsored Programs
Attention: Chanel Haman
Delaware State University
1200 N. DuPont Highway
Dover, DE 19901

Sincerely,

Dr. Brian Friel
Chair—Human Subjects Protection Committee

ekh

1200 N. DUPONT HWY. • DOVER, DE • 19901-2277 • (302) 857-6818 • Fax: (302) 857-6804

Appendix G

DELAWARE TECHNICAL COMMUNITY

COLLEGE

Check box that applies:

✓Doctoral Dissertation ☐Master's Thesis ☐Course Project/Research Paper ☐Other-Specify:_____

RESEARCH APPROVAL REQUEST

Delaware Tech employees seeking to use College time, data, and/or staff/student participation in research projects related to graduate course work, degree attainment, or grant research are required to complete this form describing the purpose of the study, the benefit to the College, the resources needed to complete the project, and the protocol that will be used to ensure the ethical and fair treatment of study participants.

To be considered for approval, the research request must be comprised of one of the following (check all that apply for your proposal):

✓Research including surveys, interviews, or observation of each participant's behavior

_____Research conducted in established educational settings involving normal educational practice such as comparison among curricula, instructional strategies, or classroom management techniques.

_____ Research involving the use of educational tests.

____Research involving the collection or study of existing data, documents, and records.

In addition, the research must meet all of the following conditions:

l) No treatment is associated with participants in the investigation;

II) Appropriate procedures are established to ensure anonymity in the research;

III) Confidentiality is clearly explained in an informed consent form for participants; and

IV) Participants are exposed to no more than the minimum risk.

Moreover, applicants must attach copies of the Institutional Review Board approval and/or exemption

from the degree granting institution to this Research Approval Request Form in order for such research requests to be considered for approval by the Associate Vice President for Academic Affairs.

Updated February 27, 2018

The employee's dean/director and the Campus Director must approve the request before it is forwarded to the Associate Vice President for Academic Affairs in the Office of the President for final approval.

EMPLOYEE NAME: Jeanmarie Maloney

EMPLOYEE EMAIL & PHONE NUMBER: XXXXXXXXX

TITLE OF STUDY: AN EXAMINATION OF NURSE EDUCATORS' EXPERIENCES

WITH CLINICALLY FAILING STUDENTS

INSTITUTION ATTENDING: DELAWARE STATE UNIVERSITY

FACULTY SPONSOR NAME, DEPARTMENT, & CONTACT INFO: _DR. RICHARD PHILLIPS DSU EDUCATION DEPARTMENT _

By signing this application, you (the researcher) are attesting that the project will be conducted as described on this application and that you agree to fulfill your responsibilities for the project. If it becomes necessary to change the study protocol or otherwise revise any response to this application, you agree to submit, in writing, a letter specifying the reasons for the change and detailing how the change will impact the study to the Associate Vice President for Academic Affairs, for his or her approval, prior to conducting research.
SIGNATURE OF EMPLOYEE/RESEARCHER:
XXXXXXXXXXXXXXXXXXXXXXXXXX
DATE: 12/17/19

APPROVAL PAGE

Delaware Technical Community College supports thoughtful, valid research designed to benefit the College and its students. However, the College is in no way obligated to approve research requests. Approval will be determined by 1) the study's potential benefit to the College and 2) the human and financial resources available for the level of support requested. Therefore, the decision of the Associate Vice President for Academic Affairs is final and non-appealable. In no instance shall research approval be granted to an individual who is not an employee of Delaware Tech.

It is the employee's responsibility to move the application through the signature process. Once you obtain the signatures of your Director/Dean and Campus Director, please allow two weeks for the application to be reviewed by Academic Affairs. Once approved, the employee will be notified via email and a signed PD o the application will be attached. Hard copies of approved applications will be filed stored in Academic Affairs, Office of the President.

DEAN/DIRECTOR DATE

VICE PRESIDENT/CAMPUS DIRECTOR DATE/

VICE PRESIDENT FOR ACADEMIC AFFAIRS