

**CLINICAL NURSING INSTRUCTORS' EXPERIENCES TEACHING STUDENTS
DEEMED AT RISK OF FAILURE**

by

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Abstract

The experience of the clinical nursing instructor (CNI) in teaching nursing students deemed at risk of failure has not been well explored in nursing literature. It may be difficult for the CNI to support as well as evaluate a student when that student's performance is judged to be unsatisfactory or unsuccessful. The purpose of this study was to explore CNIs' experiences in teaching undergraduate nursing students deemed at risk of failure, to discover how CNIs identify potentially unsuccessful students and to describe what supports and resources CNIs utilize to help them manage such students. A pilot study using a qualitative phenomenological approach was used to interview CNIs who had at least one experience teaching an undergraduate nursing student deemed at risk of failure at the University of British Columbia (UBC) and the British Columbia Institute of Technology (BCIT) schools of nursing. The study found that CNIs identified students at risk of failure using "red flags" that included a range of actions, behaviours, and attitudes. These red flags included deficits in the demonstrated thinking, knowledge, and skills; deficits in the social and cultural aspects of nursing practice; disorganization and tardiness; and lack of integrity. CNIs felt that early and clear communication of their concerns with faculty and students deemed at risk of failure was beneficial for both the student and CNI. CNIs made decisions to fail students by considering patient safety and objective evidence while at the same time supporting and nurturing these students by providing opportunities for success.

Preface

S. MacLeod conducted the research interviews and S. MacLeod wrote the majority of this thesis with guidance and supervision from B. Garrett, L. Currie and M. Gillespie.

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List of Acronyms

BC	British Columbia
BCIT	British Columbia Institute of Technology
CNI	Clinical Nursing Instructor
CRNBC	College of Registered Nurses of British Columbia
MSN	Master of Science in Nursing
UBC	University of British Columbia

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Chapter 1: Introduction

Teaching undergraduate nursing students as a clinical nursing instructor (CNI) can be a very rewarding experience. However, teaching a student deemed at risk of failure may be distressing because the CNI supports as well as evaluates the student. This distress may be caused by many factors, including conflicting values and beliefs, a lack of resources to support these students, or barriers to evaluating these students. Clinical nursing instructors' experiences of teaching nursing students deemed at risk of failure have not been adequately explored in nursing literature.

The purpose of this study was to explore clinical nursing instructors' experiences of teaching undergraduate nursing students deemed at risk of failure at the University of British Columbia (UBC) and the British Columbia Institute of Technology (BCIT) schools of nursing and to discover what CNIs learn from teaching students at risk of failure. A pilot study using a qualitative phenomenological approach was undertaken with clinical nursing instructors, a specific type of CNI, who had at least one experience teaching an undergraduate student deemed at risk of failure at UBC and BCIT.

1.1 Background to problem

Patient safety is a moral and ethical responsibility for all health care professionals (Earle-Foley, Myrick, Luhanga, & Yonge, 2012). The clinical setting is a venue through which the CNI ensures that students are socialized into the profession of nursing and provide safe patient care (Earle-Foley et al.). Part of the CNI's role is to ensure that students achieve competency in the clinical setting so that they are safe to practice. This gatekeeping role also maintains the integrity of the profession as well as the credibility of the educational institution (Earle-Foley et al.).

1.1.1 Role of the clinical nursing instructor

Historically, clinical nursing instructors have a traditional role in models of nursing education (DeYoung, 2009). Clinical nursing instructors are employed by the educational institution and supervise between eight and twelve nursing students within a clinical agency. The instructor identifies patient assignments and works closely with the students and agency staff to provide learning opportunities for students that reflect the theoretical content learned in the classroom (DeYoung). The clinical nursing instructor is responsible for providing learning opportunities as well as assessing and evaluating student behaviours and learning outcomes (Lewallen & DeBrew, 2012).

Most of the research done on the reluctance to fail undergraduate nursing students is based in the UK where models of nursing education differ from Canada (L. Brown, Douglas, Garrity, & Shepherd, 2012; Duffy, 2003). At present, most of the research has been from the perspective of mentors or nurse preceptors (Woodcock, 2009). Preceptors are experienced nurses in formal one-to-one relationship with a student or novice nurse (Canadian Nurses Association, 2004). These are registered nurses employed by the health agency supervising and teaching a student, while a clinical nursing instructor oversees and indirectly supervises the student (Billay & Yonge, 2004). The preceptor is someone who can fail the student for the clinical episode however the CNI is considered faculty and is responsible to fail the student within the program, which may mean that the student needs to leave the program or may need to repeat the clinical rotation. For consistency, the term “clinical nursing instructor” or CNI is used as an umbrella term to mean clinical instructors, mentors and preceptors in the clinical setting when referring to the literature and the clinical nursing instructors who participated in this study. Finally, the term “faculty” is an umbrella term to mean course leaders, faculty advisors, supervisors and program

heads who support CNIs and have direct ties to the schools of nursing.

1.1.2 Student-teacher relationships

CNIs have a moral imperative to adopt fair and respectful evaluation practices when determining the success and failure of nursing students (McGregor, 2007). An instructor who is knowledgeable, approachable, and respectful forms relationships with their students that can enhance the students' learning experiences (Killam, Luhanga, & Bakker, 2011). This is even more important for a student at risk of failure. CNIs are obligated to be fully present to foster professional and personal growth of students who are struggling (McGregor). The interaction between student and teacher is of utmost importance when tensions about clinical performance arise (Gillespie, 2005; McGregor). Vulnerable students require a CNI who will support them when they are struggling in their clinical performance. CNIs who form relationships with students based on mutual knowing, transparency, trust, and respect create the greatest opportunity for success and at the same time maintain students' sense of worth and dignity when they are not successful in the clinical setting (Gillespie).

It may be difficult for the CNI to support as well as evaluate a student when that student's performance is judged to be unsatisfactory or unsuccessful. Symanski (1991) states that nursing students deemed at risk of failure require more time, more resources, more energy and place an emotional strain on the CNI, which may lead to higher rates of dissatisfaction and burnout.

There is some evidence to suggest that CNIs exhibit a reluctance to fail students in the clinical setting due to conflicting values and barriers associated with doing so (Dudek, Marks, & Regehr, 2005; Duffy, 2003). For example, Dudek, Marks, & Regehr (2005) found that physician clinical supervisors would not fail students unless there was gross professional misconduct. This

was because the perceived impediments of failing a student outweighed the professional obligation in doing so. They found that the reluctance to fail was due to barriers like improper or lack of knowledge in documentation of inadequate performance, fear of the appeal process, and the absence of remedial options for these students.

Very little evidence exists within the literature regarding the CNI's experience of supporting and evaluating students who may not be successful in the clinical setting. The purpose of this study was to uncover the experiences of clinical nursing instructors, to examine if they feel prepared to teach and evaluate nursing students at risk of failure, and to examine their feelings towards failing students who are unsuccessful.

1.2 Research questions

The primary question answered by this study is:

What are CNIs' experiences of teaching undergraduate nursing students deemed at risk of failure at the University of British Columbia and the British Columbia Institute of Technology schools of nursing?

The following interrelated sub-questions also explored are:

- What are CNIs' feelings about failing students who demonstrate poor clinical performance?
- How do CNIs make their assessment decision?
- What resources were available to support CNIs teaching undergraduate nursing students deemed at risk of failing?

1.3 Research purpose

The purpose of this study was to uncover the CNIs' experiences teaching undergraduate nursing students deemed at risk of failure at the University of British Columbia (UBC) and the British Columbia Institute of Technology (BCIT).

1.4 Theoretical perspective: traditional versus caring based education

CNIs may find it difficult to operate within contradictory paradigms of traditional competency-based education and caring education (Schreiber & Banister, 2002). Traditional competency-based nursing education is based on standards, objectives, and behaviours that emphasize training and evaluation (Cohen, 1993). Competency-based models of nursing education are prompted by initiatives that equate safe patient care with outcome based nursing curriculum (Lenburg, Klein, Abdur-Rahman, Spencer, & Boyer, 2009). Despite these initiatives, CNIs lack a comprehensive guide to identify and evaluate students' performance in the clinical setting (Lewallen & DeBrew, 2012; Scanlan, Care, & Gessler, 2001).

Caring education is based on Friere's definition of education as created through the student-teacher relationship based on transformation, emancipation and liberation (Cohen, 1993). CNIs place a high emphasis on caring for their students because caring is a basic tenet of nursing practice (Scanlan et al., 2001). CNIs who value caring and empowering strength-based approaches to nursing education must balance contradictory postpositivist expectations of traditional competency-based nursing programs in which students are expected to achieve academic performance and meet evaluation criteria (Schreiber & Banister). It is possible that this conflict may have a role in the challenges associated with teaching students who demonstrating inadequate clinical performance.

In the clinical setting, CNIs are in the position of being gatekeepers for the profession by evaluating students and failing those who are deemed not suitable for the profession (Bogo, Regehr, Power, & Regehr, 2007; Hunt, McGee, Gutteridge, & Hughes, 2012; Larocque & Luhanga, 2013). Brammer (2008) defines “gatekeeping” as monitoring and guiding students to ensure safe practice. Gazza (2009) and Paterson (1994) found that CNIs valued their role as gatekeeper in ensuring the safe practice and quality of students progressing through a nursing education program and eventually into the profession. However, Bogo, et al. (2007) found that social work field instructors were conflicted in their role as gatekeeper because the role differed from the role of supporting students in a strengths-based approach. Bogo, et al. found that these field instructors were conflicted between their responsibilities to uphold professional standards of competence and also foster the students’ ability to develop and build their capacities. Jervis and Tilki (2011) discussed the paradox for nurses who professionally care for vulnerable people and therefore may find it difficult to fail students and cause emotional upset in the student who the CNI sees as being vulnerable. Hbrowsky & Kersbergen (2002) found that the fear, anxiety and self-doubt of reporting a student’s unsatisfactory performance outweighed the fear for patient safety.

Luhanga, Yonge and Myrick (2008a) studied CNIs’ reluctance to fail undergraduate nursing students and found that, although CNIs acknowledged their role as gatekeeper to the profession and the importance of maintaining the public image of nursing, they had several reasons explaining why students were passed despite demonstrating inadequate or unsafe performance. These reasons included: lack of experience as an educator, reluctance to cause personal cost for the student, their own feelings of guilt or shame for their perception of being a

poor teacher, complacency and reluctance to take on the extra work of failing a student, lack of evaluative support and tools and pressure to create graduates (Luhanga et al., 2008a).

1.5 Conclusion

The role of the CNI may appear to be contradictory when looked at from both competency-based and caring-based education frameworks. This may complicate the relationship between the CNI and the undergraduate nursing student who is at risk of failure. This relationship requires more time, energy, and support on behalf of the CNI in order to overcome many of the barriers of upholding standards of nursing education. The next chapter reviews the current literature of CNI experiences of having students at risk of failure.

Chapter 2: Literature Review

The nursing competency framework used by provincial nursing regulatory bodies in Canada provides a guide for CNIs to ensure specific outcome are met by nursing students. However, the “nursing student deemed at risk of failure” is described in many ways in the literature and how CNIs determine student safety and fitness to practice of these particular students can be challenging. In this chapter, the phenomenon of reluctance to fail is explored as well as reasons CNIs may be hesitant to fail students deemed at risk of failure specifically because of a lack of evidence. Finally, the support that CNIs perceive to have in their role is discussed.

2.1 Competency framework

In Canada, the provincial nursing regulatory bodies determine the competencies required for all registered nurse practice (J. Black et al., 2008). These core competencies include the essential knowledge, skills, abilities and judgments necessary to practice safely, competently and ethically as an entry-level registered nurse (J. Black et al.; Canadian Nurses Association, 2004). Nursing education programs use these competencies as a framework to describe expectations of entry-level students and to guide CNIs in clinical practice (J. Black et al.). Use of a competency-based framework for the practical assessment of undergraduate nursing students protects patient safety as part of a self-regulatory process that ensures minimal standards of practice (Heaslip & Scammell, 2012; Hunt et al., 2012).

In British Columbia, nursing education programs follow the College of Registered Nurses of British Columbia (CRNBC) entry-level competency framework for assessment and evaluation of their undergraduate nursing students (CRNBC, 2013). These competencies are organized

within four categories: (1) professional responsibility and accountability; self-regulation, (2) knowledge-based practice, (3) client-focused provision of service and (4) ethical practice (CRNBC). CNIs for undergraduate nursing programs use these competencies as student clinical performance indicators to clearly identify safe levels of practice.

2.2 The student at risk of failure

The CNI is responsible for identifying a student at risk of failure and for making the decision to fail a student when the student demonstrates incompetent or unsafe practice (Bogo et al., 2007; Larocque & Luhanga, 2013). A student at risk of failure may be defined in many ways. Hrobsky & Kersbergen (2002) found that students at risk of failure presented with certain hallmark traits and characteristics that were apparent very early on in the clinical rotation. These students did not ask appropriate questions in the context of their clinical setting, they were unable to perform the necessary skills for nursing and they displayed an unenthusiastic attitude towards nursing (Hrobsky & Kersbergen, 2002). Duffy & Hardicre (2007b) present a list of “red flags” that may indicate a student at risk of failure. These are presented in the following table.

Table 2.1: Red flags that indicate student at risk of failure

Inconsistently met the required level of competence for their expected level
Inconsistently performed in clinical practice
Lacked insight into weaknesses and did not change following constructive feedback
Demonstrated unsafe practice
Responded inappropriately to feedback
Lacked interest or motivation
Possessed limited practical, interpersonal and communication skills
Lacked professional boundaries and/or displayed poor professional behaviour
Experienced continual poor health, depressed, uncommitted, withdrawn, sad, tired or listless
Were unreliable, persistently late/absence
Were preoccupied with personal issues
Lacked theoretical knowledge

Note. Adapted from “Supporting failing students in practice 1: Assessment” by Duffy and Hardicre (2007b), Nursing Times, p. 29

2.2.1 Safety and fitness for practice

A student at risk of failure may also be defined as an “unsafe student” (Luhanga, Yonge, & Myrick, 2008b). Many CNIs define an unsafe student in relation to patient safety being compromised (Duffy, 2003). Defining an unsafe student is rarely straightforward because of the many indirect ways that a student could potentially compromise patient safety. Furthermore, how CNIs define what constitutes safe practice may change over time since “best practice” changes

over time (Skingley, Arnott, Greaves, & Nabb, 2007).

Killam, Luhanga & Bakker (2011) performed a literature review to determine the characteristics of an unsafe student. They found that the ambiguity in the literature to define unsafe practice contributes to the challenges CNIs have when identifying a student at risk of failure. Killam, et al. found three characteristics of unsafe nursing students, including: ineffective interpersonal interactions, lack of knowledge and skills, and portraying an unprofessional image. Ineffective interpersonal interaction involved both communication and relational problems between the unsafe student and the educator, patients, and staff (Killam et al.). An unsafe student's lack of knowledge and skills was assessed in comparison to their peers or year of study, and was especially evident when a student demonstrated a lack of insight or critical thinking ability (Killam et al.). Finally, the unsafe student may portray an unprofessional image either by an inappropriate attitude or behaviour, or an absence of accountability to their practice (Killam et al.).

Scanlan, Care & Gessler (2001) define unsafe clinical practice of undergraduate students as behaviour that places others at risk for physical harm or emotional jeopardy. The patient or family is put in emotional jeopardy when the student creates an environment of anxiety or distress that causes harm (Scanlan et al.) This presents as an unacceptable degree of risk that may be a pattern of behaviour or a single occurrence (Scanlan et al.).

Nursing regulatory bodies designate specific standards or competencies that can be used by CNIs to determine a nursing student's fitness for nursing practice (Jervis & Tilki, 2011). A school of nursing may define what constitutes "unsafe" practice but it is still up to the CNI to determine whether the student is meeting the minimum standards of safe practice (Duffy, 2003; Killam et al., 2011; Scanlan et al., 2001). CNIs must also consider the type of event, pattern,

timing, and frequency of the behaviour and the level of risk posed by the nursing student (Killam et al.). Assessing students based on nursing standards and competencies is rarely straightforward and it is difficult to assess students who meet these standards and competencies yet displayed other traits of a student at risk of failure such as poor attitude, a lack of interest, or motivation (Jervis & Tilki, 2011; Luhanga et al., 2008b). CNIs feel less confident evaluating students based on traits, like attitudes and values, which cannot easily be objectified (Duke, 1996).

Norman, Watson, Murrells, Calman & Redfern (2002) tested various undergraduate clinical nursing competency tools for reliability and validity for the National Board for Scotland. They found that most tools used by the CNI were difficult to understand and apply to students in practice. They were unable to test the tools' ability to determine clinical competence because too few students failed, raising doubts about the CNIs' ability to discriminate between competent and incompetent students when using these tools (Norman et al.). This may suggest that CNIs base their decisions on subjective criteria rather than standards or clinical competencies (Duffy, 2003). Killam, Luhanga & Bakker (2011) stressed that there is a need for CNIs to use clear objectives that are appropriate to the students' level or year of study in order to determine competent from incompetent students. Many schools of nursing may not have clear enough policies or guidelines available for CNIs when determining if a student is failing (Killam et al.; Scanlan et al., 2001).

2.3 Reluctance to fail

Very little research has been conducted regarding the reluctance to fail poorly performing nursing students in clinical practice. Some research into the reluctance to fail phenomenon has been done within the medical and social work professions (Bogo et al., 2007; Dudek et al., 2005;

Jervis & Tilki, 2011). Dudek, et al. (2005) interviewed 21 clinical supervisors at a Canadian University to explore what factors affected their reluctance to report medical students' poor clinical performance. They found four main barriers that clinical supervisors perceived when considering failing a student (Dudek et al.). The barriers included a lack of documentation of the failing student, lack of knowledge in regards to what to specifically document, anticipating an appeal of the failing, and a lack of remediation options for the student (Dudek et al.).

Duffy (2003) studied CNIs in Scotland using a grounded theory approach to uncover their experiences of reluctance to fail nursing students. She found that students who demonstrated poor clinical performance were often still successful due to a lack of documentation despite comments that they were unsatisfactory (Duffy, 2003). She found that CNIs reluctance to fail poorly performing students might have been attributable to a lack of reliable or valid practice assessment tools (Duffy). Finally, she found a differing agenda between the institution and the CNI, such that the institution valued retention of students over gatekeeping of the profession (Duffy).

Heasli and Scammell (2012) found that even after providing CNIs with grading tools, awarding a failing grade to students who were unsatisfactory remained problematic. This could be explained, at least in part by Jervis and Tilki's (2011) qualitative study exploring CNIs' reluctance to fail. They found that CNIs' reluctance to fail students was related to the complexity and contextual factors of assessing students and the difficulty of assessing attitudes and the CNIs' confidence about their own assessment decisions (Jervis & Tilki).

Rationale for allowing students with unsatisfactory performance to pass clinical may also be associated with the emotions associated with students at risk of failing. Hbrowsky & Kersbergen (2002) conducted a qualitative study that explored CNIs' views of teaching students

with unsatisfactory clinical performance. They found that CNIs' experienced feelings of fear, anxiety, and self-doubt knowing their student would fail if they reported them. Unfortunately, these feelings outweighed the fear of maintaining patient safety through gatekeeping of the profession, resulting in students with unsatisfactory clinical performance being successful in the clinical (Hrobsky & Kersbergen). Assessing students' clinical performance when the student is unsuccessful is a particularly challenging process that requires self-confidence and support. Novice CNIs may be more reluctant to fail students due to their own inexperience and lack of preparation in evaluating their students' performance and abilities (Luhanga et al., 2008a; Scanlan et al., 2001).

Some CNIs reported that failing a student reflects negatively on their abilities to teach students and looked at as a personal failing (Duffy & Scott, 1998; Paterson, 1994). Siler & Kliener (2001) found that novice CNIs judged their teaching ability according to whether their students were successful or not. The CNIs reported that failing a student meant that they had failed as well (Duffy & Scott, 1998). Luhange, Yonge & Myrick (2008a) and Brown, et al. (2012) found CNIs viewed failing a student as their own failure or feared being labeled by others (i.e., the student) as a 'bad person'.

2.3.1 Lack of evidence to substantiate failing a student

A large survey of CNIs by a large Scottish university (n=1790) found that eighteen percent of those who responded to the survey reported passing a student with poor clinical performance (L. Brown et al., 2012). They provided many examples of why CNIs passed students who demonstrated unsatisfactory performance. These included being unable to validate their concerns with proof, giving students the benefit of the doubt, believing the decision would

be overturned by the university, avoiding conflict between themselves and the student, as well as lacking confidence in dealing with the situation of a student with poor performance (L. Brown et al.). This is similar to an internet survey of almost 2000 CNIs conducted by nursingtimes.net, based in the UK, that found that some CNIs did not fail an unsatisfactory student because they lacked solid documentation and evidence to do so or they felt that it would be over turned by more senior decision makers in their school (Gainsbury, 2010). Luhanga, Yonge, & Myrick (2008a) also found that students were given the benefit of the doubt because CNIs lacked evidence or documentation to prove it.

A CNI may be reluctant to fail an incompetent or unsafe student when they perceive a lack of support from faculty members (Larocque & Luhanga, 2013). CNIs become frustrated and disrespected when their assessments and evaluations are devalued or overturned by faculty (Gainsbury, 2010; Larocque & Luhanga). In addition, CNIs may feel their concerns regarding a student's clinical incompetence are not validated because of pressure to pass a failing student (L. Brown et al., 2012). The pressure perceived by CNIs to pass students is also echoed in Duffy's (2003) and Diekelmann & McGregor's (2003) findings in which universities valued the retention of nursing students for fiscal reasons.

2.4 Perceived support for CNIs

CNIs may report feeling unprepared for their roles and responsibilities when faced with a student deemed at risk for failing. Siler & Kleiner (2001) found that novice CNIs were surprised at the expectations and independence they had when compared to when they were novice clinical nurses during which time they were mentored and coached closely in the clinical setting. Often, CNIs did not have qualifications or teaching experience beyond their initial registration (Duke,

1996). Furthermore, McClure & Black (2013) found that CNIs receive inadequate training and preparation in their role as evaluator of student performance.

Brown, Douglas, Garrity, & Shepherd (2012) found that most CNIs would initiate contact with the university if they needed help to support a student. One quarter of CNIs stated they would contact the university as soon as a problem arose (L. Brown et al.), and less than ten per cent of the sample rated the support they received from the university to be “poor”. The authors, however, found a significant positive relationship between CNIs passing a student at risk of failing and the CNIs’ perceiving poor support from the university.

CNIs looked to other faculty members for support when they encounter a student who they perceive is not doing well. The CNIs in Hrobsky & Kersbergen’s (2002) study identified three qualities of faculty who were effective in supporting an unsuccessful student. These were listening (allowing verbalization of their story), being supportive (validating their concerns and being available), and following up after the experience (meeting with the student and checking in later). Luanga, Yonge, & Myrick (2008b) found that the difficulties of the process of failing a student were eased with the support of faculty members, especially when these faculty members were freely available. Laroque and Luhanga (2013) recommended discussing failing or underperforming students within team meetings between CNIs and faculty as a way of supporting them.

2.5 Conclusion

CNIs are responsible for identifying a student at risk of failure and making decisions to fail these students when the student demonstrates incompetent or unsafe practice, however the student at risk of failure may be defined in many ways. Although there are frameworks and

guidelines to define competency in the clinical setting, the literature shows that assessing a student based on nursing standards and competencies is rarely straightforward. CNIs must consider context, as well as undefined or subjective traits of a student at risk of failure.

Furthermore, CNIs may be reluctant to fail a student deemed at risk of failure for a variety of reasons. Specifically, CNIs may not have enough evidence to demonstrate incompetency, they may lack preparation in failing a student and they may not feel supported in failing a student.

The next chapter outlines the methodology of the study and the plan to discover if CNIs in this study have similar experiences to those described in the literature.

Chapter 3: Methodology

In this chapter the phenomenological study design and methods are discussed. This includes a description of the sampling plan, data collection, data analysis, and methods to ensure study rigor. The various ethical considerations and any study limitations of this thesis are also conveyed.

3.1 Phenomenology

A phenomenological approach was used for this study to explore CNIs' experiences of teaching students deemed at risk of failure. This qualitative approach was considered the best way to gain insight into the experiences, perceptions and meanings of CNIs. Phenomenology in nursing research focuses on the meaning of the person's lived experiences (Beck, 1994; Chamberlain, 2009). Phenomenology aims to understand the person's cognitive subjective perspective and the effect of that perspective on their lived experience through a process of induction and description (Flood, 2010). The study consisted of ten individual (one-to-one) semi-structured interviews with current and former undergraduate clinical nursing instructors and one faculty advisor. During interviews, the researcher guided participants to uncover the meaning of their experiences with students at risk of failure. Meaning was created through the interaction between the researcher and participant, constructing the intersubjective phenomena (Beck; Flood, 2010). The intersubjective phenomena are shared meanings that comprise of a blend of both the participant and researcher (Flood). The intersubjective phenomena were synthesized as shared themes that emerged from the recounts of the CNIs' experiences.

3.2 Sample plan

Participants were recruited using a non-probability purposeful convenience sampling method. The sample consisted of clinical nursing instructors and one faculty advisor who have had experience teaching undergraduate nursing students at two schools of nursing in western Canadian post-secondary institutions (The University of British Columbia and The British Columbia Institute of Technology). These participants could not be randomly selected because they had to be willing to discuss the phenomenon in question and have some experience with students at risk of failing. The number of participants in the study was not fixed and could have been changed as the study progressed to achieve data saturation. Data saturation happens when any new information obtained in the interviews becomes redundant and no new insights are achieved (Polit & Beck, 2012). Interviews were conducted after informed consent was obtained (Appendix A). Two study sites were chosen for this study so that the findings could not be attributed to the phenomenon or culture of a specific institution but instead be more generalizable as phenomenon that are applicable to a wider population of CNIs.

3.2.1 Inclusion criteria

CNIs were qualified according to the post secondary institution's standards and prerequisites for being employed as an undergraduate clinical nursing instructor. These included: current registration or practicing license with a professional accreditation body (College of Registered Nurses of British Columbia), a minimum Bachelor's degree in nursing, and a minimum of two years of experience as a Registered Nurse. Roughly half the participants were from UBC and the other half were from BCIT so that there was equal representation from both study sites.

Participants in the study had at least one experience teaching undergraduate nursing students who was identified as being at risk of failing the clinical rotation but not necessarily deemed unsuccessful. Participants who had not failed students but nonetheless had students identified at risk of failure were included because it was important to uncover why participants made the decision to deem a student at risk of failure successful and discover the circumstances under which these events occurred.

3.2.2 Recruitment

Participants for the study were recruited using several different methods. All undergraduate CNIs were sent an e-mail through the internal server of the post secondary institution inviting them to participate in a 30-60 minute interview (Appendix C). A description and explanation of the study including the study aims, research question, background and consent form was sent as an attachment in the e-mail. Contact information of the researcher was provided to the participants to contact the researcher. Snowball sampling was also used to recruit others to participate in the study by asking initial participants to refer other potential study participants from their institution. A gift card of ten dollars for a coffee shop was offered to CNIs who participated in the study to compensate them for their time.

3.3 Data collection

Semi-structured individual interviews were chosen due to the sensitive nature of the issue of teaching students at risk of failure and to facilitate deeper exploration of the issues on an individual level (i.e., focus groups may have presented a problem related to willingness for participants to be candid about issues or concerns they would not want to share with other CNIs

associated with their school). The researcher prepared a written topic guide listing questions that were asked during each interview (Appendix B). Participants were encouraged to speak freely about the topics within the guide.

The interviews took place at various locations and times convenient for the participant in a private setting where the participant felt comfortable discussing the subject matter. The researcher conducted the interviews after obtaining informed consent. The interviews were approximately thirty to sixty minutes in duration and were recorded using a digital recording device. Demographic information was obtained from participants and included: gender, highest education, specialty courses related to clinical nursing education, years as a registered nurse, and years of experience as a CNI.

3.4 Data analysis

Data analysis occurred simultaneously with data collection and recurrent themes were identified once the interviews were completed. Recorded data were transcribed by a professional transcriptionist and verified by the researcher for consistency and accidental alterations of the data. The researcher coded the entire data set to ensure the highest consistency across all interviews (Polit & Beck, 2012). A naïve reading was done first where data was read and re-read by the researcher to get a sense of the whole and grasp its meanings (Flood, 2010). The researcher developed a structural analysis using a preliminary category system after reading and re-reading the data. Transcripts were read in their entirety and loosely coded using the “comments” section of Word and then arranged into category schemes using NVivo qualitative analysis software version 10.0.3.

Various words were highlighted to indicate specific themes and essences (Chamberlain, 2009). Essences are themes that are common to persons who have a lived experience, in this case, CNIs that have worked with students deemed at risk of failure (Flood, 2010). Content analysis conveys the essential meanings of the data, which can be condensed into themes and subthemes (Flood). The researchers subdivided each major category into smaller descriptive subthemes that were consistently conveyed by CNIs. The subthemes were analyzed for content by looking for natural variations and relationships between them. These were coded and named according to the content they represent and then rearranged based on similarities to facilitate comparison across cases (Polit & Beck).

Finally, all themes were summarized and reflected on in relation to the context of the study and the original research question (Flood, 2010). Relevant excerpts from the interviewee's narratives were used to illustrate themes and subthemes as well as to further describe the phenomenon (Chamberlain, 2009). Finally, the transcripts were read again to confirm consistencies and contradictions in the literature to help revise or enhance the understanding of the interviews (Flood, 2010).

3.5 Rigor

Field notes were also taken during and immediately after the interview documenting the environment and context of the interview, any feelings or prevailing moods of the researcher and immediate reflections of the interview. A brief overview or summary of the interview was also recorded. These field notes ensure reliability of data and also help prevent total accidental loss of recorded information loss (Polit & Beck, 2012).

When using phenomenological methods, the presuppositions and expert knowledge of the researcher are considered valuable, and even necessary for the study (Flood, 2010). However, this makes the study susceptible to bias because the principal researcher collects the data and performs the actual data analysis. The researcher's preconceptions of teaching undergraduate students at risk of failure were documented prior to commencing the data collection in order to limit potential bias. These were reviewed, reflected on and bracketed throughout the data collection and data analysis process. Bracketing is a process whereby the researcher identifies and sets aside their opinions or preconceived beliefs about the phenomenon being studied in an effort to confront the data in its purest form (Chamberlain, 2009; Polit & Beck, 2012). This promotes scientific rigor within a phenomenological inquiry (Chamberlain; Flood, 2010). Bracketing was continued throughout the analysis and themes that emerge from the data were scrutinized for bias.

An e-mail was sent to the CNIs who participated in the individual interviews after the interviews were completed and themes emerge from the data. Responses to this e-mail were used as a "member check" to validate and confirm the themes that emerged from the data and allowed participants to comment on what the researcher synthesized.

3.6 Ethical considerations

Ethical approval was obtained from the University of British Columbia and the British Columbia Institute of Technology schools of nursing and their Research Ethics Boards. Consent forms and a written explanation of the study were provided to participants before they were enrolled in the study. The consent form provided the following information: background information, purpose of study, and approximate time commitment for study, responsibilities of

instructors, and rights of participants. Participants were able to withdraw from the study at any time.

All personal information obtained from the study was stripped of any identifiers (de-identified) (e.g. names, student ID, hospital, specific demographical information) as to maintain confidentiality. Confidentiality was maintained by using codes instead of names. In addition, all information obtained from the study will be stored in an encrypted and secured database belonging to the researcher's supervisor for 5 years at the University of British Columbia.

Participant did not gain financially from taking part in the study. Participation in the study did not affect position or employment status of participants. The researcher involved in this study is not employed or affiliated with the nursing programs used in the study (i.e., there are no dual relationships). There were no known benefits to participating in this study.

3.7 Study limitations

Due to the limited resources and scope of the master's thesis, the study could not confirm a saturation of data due to lower enrollment of participants. The researcher was unable to randomly sample the population of CNIs and the sample interviewed may not have been representational of the general population. It is possible that enrollment of CNIs may also differ between study sites (UBC and BCIT), biasing the results of the study. The researchers inexperience with phenomenological research methods and conducting interviews may have also affect the results of the study.

3.8 Conclusion

The phenomenological approach chosen in order to answer the following question: What

are CNIs' experiences of teaching undergraduate nursing students deemed at risk of failure at UBC and BCIT schools of nursing? A phenomenological approach was appropriate in order to gain insight into the experiences, perceptions and meanings of CNIs. The following chapter describes the findings related to CNIs' experiences identifying a student deemed at risk of failure, how they determine if a student will be unsuccessful and the various insights, contextual factors, and perceived supported related to this.

Chapter 4: Results

In this chapter, the major findings from the eleven participant interviews are presented. During these interviews, insightful and meaningful experiences of teaching students deemed at risk of failure were disclosed with the interviewer. Four major themes arose from the interview data: the “competency framework”, the “student at risk of failure”, “weighing the risks of failing a student”, and “supports and resources” with subthemes explored within each.

4.1 Participant demographics

Eleven CNIs participated in the study. All participants were female and were 30 to 60 years old ($M = 41.5$; $SD = 7.7$; Median = 40). Six of the participants had a master’s degree, most in nursing and one in education. Four of the participants were currently in a Master of Nursing program. Very few participants had any specialty training in clinical nursing education, with the exception of one participant who took the Canadian Association of Schools of Nursing Clinical Educator course on-line and another who took the British Columbia Provincial Instructors Program through Vancouver Community College. Two others mentioned the orientation provided by their employer as formal preparation for their role. All participants have been registered nurses for 7-40 years ($M=19$; $SD=8$) and CNIs for 2 – 22 years ($M= 7.5$; $SD=4.9$). Each participant is identified numerically from #1 through #11.

4.2 Summary of findings

Below is a table summarizing the key themes and subthemes found with the number of times they occur in the data and the specific participant interviews in which the themes or subthemes were discussed.

Table 4.1: Summary of findings

Theme / Subtheme	Frequency	Participant
Competency framework	21	#1, #2, #3, #4, #6, #7, #9, #11
The student at risk of failure <i>Red Flags</i>	16	#1, #4, #5, #6, #8, #9, #11
The student at risk of failure <i>Integrity</i>	16	#1, #3, #9, #10, #11
The student at risk of failure <i>Early identification</i>	11	#1, #2, #3, #4, #6, #8, #9, #11
The student at risk of failure <i>Addressing concerns early/clearly</i>	15	#1, #2, #3, #4, #5, #6, #7, #8, #9, #11
The student at risk of failure <i>Safety: the absolute criterion</i>	19	#1, #2, #3, #4, #5, #6, #9, #10, #11
Weighing risks of failing student <i>Benefit of the doubt</i>	9	#1, #2, #4, #5, #6, #7, #10, #11
Weighing risks of failing student <i>Taking personal responsibility</i>	13	#1, #2, #5, #6, #9, #10, #11
Weighing risks of failing student <i>Creating “thereness”</i>	12	#2, #3, #4, #9, #11
Supports and resources	21	ALL

4.3 Competency framework

All participants stated that they used a competency framework to evaluate students. Most stated that they used the College of Registered Nurses of British Columbia (CRNBC) Professional Standards for Registered Nurses (November 2012) or a modification thereof within the syllabus provide by the institution. Participant #4 and Participant #6 stated that they used a competency framework daily with students to enhance learning and set clear expectations. Participant #6 stated, “I also give examples of what I have found the average student in their, you know ‘a student at your level should be able to recognize that...’” She felt that the competency framework was useful in preparing students to be successful. Participant #4 liked how she could relate practice in the clinical setting to the competencies, connecting the learning outcomes to real life situations. “We’ll talk about what the specific learning deficits are and those I take directly from analysis from the competencies that are set forth in our school of nursing competencies” (Participant #4).

For Participant #3, a competency framework was the best tool to minimize subjectivity in the evaluation of a student at risk of failure. It was evident, however, that this process was still challenging for her. She stated, “It’s very difficult [you know, like I said] we have these standards and indicators that they must meet in order to pass but it never feels like its black and white. It never feels like it’s an easy decision.”

Similarly, Participant #2 discussed the difficulty in using competency frameworks to evaluate students. She felt that the standards or competencies did not truly fit or help to identify why she felt the student was at risk of failure. She states,

There’s 21 competencies with reams, I can’t even tell you how many... It’s an inch thick if you print it. At least it feels like it. And it really doesn’t say anything at all either. So I

mean you have to make it kind of fit everybody but when you have a student that, that first instructor needs to be mentored on how to evaluate (Participant #2).

Participants accepted the use of the competency framework as a learning guide to use with students yet many found that it was a problematic tool in determining a student's success or failure. These CNIs found applying the competency framework to fail a student stressful because they had to make the student "fit" within a "grey" or under defined area. For example, Participant #4 talked about the difficulty in evaluating aspects of a student's performance that went beyond their concrete skills like "inside judgment". She identified these performance aspects as important in nursing but too intangible to fit within the competency framework.

Both Participant #4 and Participant #11 stated that this "grey" area in a student's evaluation was especially true in mental health or psychiatry. They felt that the usual fundamental principles and skills of medical and surgical nursing did not apply in these specialty areas. Interviews with Participants #4 and Participant #11 highlighted the complexity of evaluating clinical nursing competency and decision-making, which will be discussed in the next chapter.

4.4 The student at risk of failure

Participants were asked to discuss how they determined if a student was at risk of failure in the clinical setting. They described the importance of using "red flags" as a way to identify students at risk of failure. They felt that providing clear feedback as soon as problems arose was beneficial for both the student and CNI. Ultimately, CNIs failed students if they felt that patient safety was compromised by the nursing students' practice.

4.4.1 Determining risk of failure

Nursing students at risk of failure demonstrated behaviours, actions or attitudes in the clinical setting that concerned participants. Often students at risk of failure were identified by recognizing patterns of behaviour that they identified as different from the norm or typical student. Participants became concerned for a variety of reasons and often used the term “red flag” when discussing how they identified students at risk of failure.

Participants described specific attributes or “red flags” that were different from other students. Through experience, participants learned to look for these “red flags,” which would identify a wide variety of attitudes, behaviours and actions that concerned them. Participants discussed many examples of “red flags.” These ranged from deficits in demonstrated thinking, knowledge, and skills; deficits in the social and cultural aspects of nursing practice; tardiness and disorganization; and lack of integrity. Participants prioritized these red flags in terms of perceived harm or threat to patient safety, which will be discussed later.

Although some participants did not use the term “red flag” to describe these students, they used strategies to quickly identify students at risk of failure as being an outlier from the normal patterns of behaviour that were exhibited or expected of other students. For example, Participant # 1 stated:

And so in this third group I had a student who on the very first day of class seemed to ask, or on the very first day of clinical seemed to ask questions that didn't fit whatever the content was, so but it's early, its day one. And by day 6 or 7 we should be cleared up and what happened was, which made me very concerned right at the onset, were not only were the questions not quite lining up with the level of conversation that everyone else seemed to be operating at.

Participant # 4 had a similar experience with a student who exhibited a different way of thinking on the first day of clinical. She used an activity to identify a student very early in the clinical rotation as a way of ensuring that the student received extra help and attention.

So she was very concrete. She did not follow...everyone else in the whole room, got the fact that this was a story and we had just talked about narratives. So I can flag them that way because I could tell. They're sort of outlier thinking. And then I try to craft my teaching to try and help them (Participant #4).

Participant #4 used these strategies to elicit students' patterns of thought and decision-making before observing them in the clinical setting.

Some participants identified these patterns or "red flags" as a way to help identify students at risk of failure early in the clinical rotation. Participant #5 talked about "obvious" signs that a student was at risk of failure, for example the student demonstrating a consistent lack of knowledge of pathophysiology. Participant #9 talked about how the student's inability to grasp the social and cultural aspects of nursing was a real "red flag" for her. For instance, the student never understood the "routine" of a typical nursing shift, like charting or emptying urinary catheter bags at the end of shift.

Participant #8 identified a student at risk of failure through patterns of tardiness and disorganization. Interestingly, when she confronted the student, the student confided to her that she had a learning disability and required accommodations for it. The participant and the student worked together to form a modified learning plan but the student's behaviour escalated and she began lying and covering her errors in clinical, which further concerned the CNI. After this experience, Participant #8 felt that in the future she would be better able to identify students at risk of failure.

Many participants cited 'lack of integrity' as a "red flag". These students attempted to hide their lack of knowledge or preparation through patterns of lying, aversion or making excuses. Participant #1 recalled a situation where a student lied about being unable to find information about a commonly used medication. Participant #1 stated, "...Which right away alarmed me as a lie, which concerned me right away because one of the foundation principles to

becoming a good nurse is solid integrity so I was very concerned right away that the integrity was shaking...”

Students who lacked integrity were very challenging for participants because without receiving the student’s full disclosure, the participants were unable to meet the student’s learning needs. Furthermore, participants felt that students who lacked integrity had increased potential for unsafe behaviours and practices to continue in the future. For example, Participant #10 stated,

She was just not safe. If she was lying like this as a student to cover-up I just don’t think that’s safe at all. If she is doing this right now, what is she going to do when she has actually graduated? I think that she would be potentially hurting a patient.

Participants felt that students who lied showed that they were practicing in an unsafe manner and that they had no insight or motivation to change their practice. These concerns of student integrity will be discussed further in the next chapter.

4.4.2 Early identification

Participants stressed the importance of using these “red flags” to identify students at risk of failure early, even if the concern for the student ended up being unwarranted. The participants stated that there was more benefit in identifying a student who may be at risk of failure and addressing the concerns early, rather than finding out too late into the clinical term. Finding out too late meant that participants had insufficient time or opportunity for the student to be successful and that failing the student was more difficult process for those involved.

...as soon as you identify that there’s a problem, even a potential problem, gather up your information and documentation and then you contact your course leader. It’s not a good idea to not have everybody on board quite early. So sometimes it can be like, “I’m just a little bit concerned about this person and this is what I’m doing right now and I will let you know if... which way things go”. So it could be as simple as that and nothing happens. But if you wait too long...it’s not, you know. (Participant #2).

This participant felt that the risk of sharing concerns about a student before being certain of the student’s performance outweighed the risk of informing other faculty too late.

Participant #8 talked about a student who was given a “conditional pass” of the clinical rotation, meaning the student started the next clinical rotation with a corrective learning plan already in place. She felt that the student should not have passed, but her time with the student was too short to properly identify and evaluate the student in a fair manner. She said, “...because our rotations are so quick, 6 weeks, 3 days a week. They go by kind of in a blink and so sometimes you are kind of identifying these things and you are almost finished.” Participant #8 felt that the structure of the clinical rotations hindered her ability to evaluate students fairly. These time constraints illustrate the importance of identifying students at risk of failure as soon as possible.

Students also benefitted from being identified early as at risk of failure because participants felt that they had more control over influencing the student to be successful in the clinical rotation. Many participants stated that if they were able to identify these students early enough, they could often intervene in the student’s behaviour and create change. As one stated,

...they benefit from being sort of identified early. So I talk to them like right away these little side chats right away. If something to my inner, sort of my spidey-senses is “ I don’t think they know what they are saying...” I will investigate further, ask more questions. So I try to get on top of them, identify that they are weak and in what way are they weak early, early, early (Participant #6).

In fact, Participant #11 believed that identifying the student too late in the clinical rotation did them a disservice. She felt that CNIs had the potential to intervene early enough in the student’s practice so that they would do well in the next level instead of setting them up for failure. These CNIs conceptualized identifying a student at risk of failure in a positive way so that more support and resources could be given to these students.

4.4.3 Addressing concerns early and clearly

Once participants identified a student at risk of failure, they stressed the importance of communicating their concerns with the student in a clear and timely manner. Participant #3 stated that she needed to be, “clear and honest with the student” and “talk about issues immediately...” Participant #1 talked about how she learned that her language with the student at risk of failure was different from conversations she had with other students. She found that she needed to be more concrete, clear and specific when she discussed the student’s expectations as compared to her other students. This is the example she provided, “So instead of saying, ‘I expect you to come prepared for clinical practice’ I said ‘you need to come prepared with some sort of support resource, be it writing, be it memory. You have to have some evidence of preparation that you actually had gone through and prepared all these medications.’”

Participant #4 similarly said “...I’m going to make sure my boundaries are clear and my expectations are clear and if she can follow through with that and you know render safe care in a timely manner.” She acknowledged that although these conversations would be different for every student, they have the same basic standard or minimum criteria that need to be made clear to a student at risk of failure.

Participant #8 talked about how important it was for everyone to have a clear understanding of how she evaluates her students and what they need to do to be successful in the clinical rotation. She stated,

So that is a big part I think, being proactive and I think mentally for me just to verbalize it and then for them to hear it. It’s all out there then and that I feel is helpful. But it doesn’t mitigate, it doesn’t say that [being failed] is not going to happen.

Participant #11 also talked about the importance of how she needed to establish a clear understanding of student expectations from the beginning. She said, “What I started to do with

students from the orientation was how to succeed in this – a very clear checklist for them like ‘How. You. Will. Succeed.’ in this rotation and so it aligned with the clinical indicators.”

Participants felt that being straightforward and frank with students helped to ensure success.

Participants indicated that it was important for the student at risk of failure to clearly understand the gravity or seriousness of their concerns right away. This way the student was more likely to internalize the feedback and have ample time to demonstrate change necessary for success. Additionally, participants felt that early and consistent communication made the process of failing the student less stressful for both parties. Participant #5 described how regular and timely meetings with the student made failing the student much easier because they were not surprised by the outcome. She referred to failing a student as not being “as painful” for them because they had been talking about on a regular basis. Similarly, Participant #11 stated,

So I just kind of lay it out in plain language for them, and really being able, like for myself I need to say ‘it’s not personal’. Like, if you are not meeting those clinical indicators then we have to have this conversation really early because when it gets to the end its too late and I have done you a disservice because you won’t do well in the next level. Having those conversations really early with students.

The participants stressed the importance of communicating clear and explicit expectations in a timely manner so that students deemed at risk of failure remained safe to care for patients, had opportunity to improve their clinical performance and were prepared in the event that they were unsuccessful.

4.4.4 Safety: the absolute criterion

Competency frameworks guided participants’ student evaluations, but most felt confident to fail a student based on the perceived “safety” that the student deemed at risk of failure exhibited. Students were more likely to be unsuccessful if their behaviour or practice

compromised patient safety. This minimum standard of “patient safety” was difficult for participants to define because, like the “red flags”, it involved multiple examples of the nursing student’s practice, attitudes and behaviours. These included both real and implicit observations of compromised patient safety.

For example, Participant #1 ended up passing a student deemed at risk of failure stating that although the student never achieved the same level of competence as their counterparts, she felt that the student achieved a basic level of patient safety through transparency.

I understood that the expectation was going to be for me to do to get to the student, whatever way I could, to bring her up to a very bare minimum standard in which she would actually pass. And that would be at the very minimal, a safe nursing practice, which would be characterized by transparency and very minimum telling people what she didn’t know and recognizing her own lack of knowledge (Participant #1).

As reflected in this example, integrity and transparency were strong determinants of student success for the participants in this study.

Interestingly, participants passed students at risk of failure if they felt comfortable having the student deemed at risk of failure one day caring for herself or a loved one. Participant #6 put it like this, “But I also think about the safety of patients in the future. I always think to myself if I woke up from surgery and they were standing over me would I smile or scream?” Similarly, Participant #4 stated,

You want everyone to pass and you...but you also realize like, and I know other clinical instructors have said this: Would I let this person look after my child or my parent or myself? Would I want this person to be in the nursing profession at his or her current ability level? That’s always that question to ask, right?

These common criteria for measuring student competence were useful for participants to reflect upon when making their decision to fail a student and will be discussed in the next chapter.

Participant #5 was a very experienced CNI who stated that through her experience she became more assured and as a result more “tolerant” with students at risk of failure. She believes that she fails fewer students now than when she was a novice CNI. She stated,

So I’ve learned that even if they don’t hear it by week sixteen, certain things, I just kind of expect that. As long as it doesn’t impact the safety too much. So I’ve become more tolerant of it. So, I think what I was trying to say...get at, was like, I think when I look at all the failures that I’ve done, I think some of the students that I failed earlier in my inexperienced novice instructing days, I probably wouldn’t have failed today.

Participant #5 is interesting because she suggested that her implicit understanding of “patient safety” and clinical nurse competence has changed through her experience. She felt that her experience helped her to make better assessments of students deemed at risk of failure and perhaps more easily determine how their behaviour and practice impacted patient safety.

Participants in this study used a number of indicators or red flags to help identify students at risk of failure. They felt that identifying students at risk of failure as early as possible derived the most benefit for both the student and CNI, even if it ended up being unwarranted. Early identification helped them to establish clear and explicit expectations with students deemed at risk of failure so that students would understand the gravity of these concerns, have opportunity to be successful, and accept the outcome of being unsuccessful more easily. Patient safety was a priority for participants in this study and there was an implicit understanding that students at risk of failure would not be successful if they compromised patient safety. Participants’ mandate was to balance the learning needs of students deemed at risk of failure while maintaining standards of patient safety.

4.5 Weighing the risks of failing a student

Participants in this study discussed many examples of how they considered many factors in their decision to fail a student. These instances involved being fair to multiple parties including students, patients, other CNIs, and themselves. Participants took personal responsibility for ensuring patient safety through student competence and often used it as a benchmark to determine if a student was unsuccessful. Participant #3 stated,

...it's hard because you want your students to learn and if you keep sending them home, they're not going to. But we have a responsibility to these patients and the unit isn't going to ask us to come back if we, you know, don't keep patients safe."

Participant #3 acknowledged that CNIs must maintain balance between conflicting priorities. These priorities included giving students at risk of failure opportunities to learn and improve practice and simultaneously maintain patient safety and relations with unit staff.

Participant #9 also talked about how students who came unprepared for clinical created unsafe situations, not just through their own practice, but by requiring too much of the CNIs' attention. This potentially hindered her ability to supervise other students in the clinical group and provide safe care for their patients. She explains it like this, "So then we have to step in and say, 'OK. Is the student safe to be here? They need to go home.' They have to go home. You have got seven other students you need to focus on." In this example, Participant #9 considered not only what was fair for the student at risk of failure, but also what was fair for the patients being caring for, the other students and herself.

4.5.1 Giving the benefit of the doubt

When participants were faced with the decision to fail a student, they did not take this lightly. They continually acknowledged the difficulty to deem the student unsuccessful and made

sure to consider the circumstances particular to the student. Participants talked about how they would try to get to know their students and understand the student's personal context, as well as their previous experience.

When the student's context was considered, participants often tried to give the student the benefit of the doubt in case they were either wrong about the student or did not provide the student with enough opportunities to be successful. In these cases, they obtained another opinion of the student's performance to ensure that their evaluation was indeed impartial. For example, Participant # 7 said, "I am the second instructor, maybe we need a third one. Probably there are some strengths that I haven't seen from the student, and probably this third instructor can identify some strategy, different strategy for the student." This participant's point of view highlighted her role as supporting the student to be successful. Her use of strategies is interesting as it is implied that the student's success is highly dependent on the CNI's support.

Participant # 9 however spoke of an incident where the student ended up being successful when given the benefit of the doubt, despite having demonstrated a borderline clinical performance.

He was sort of overwhelmed with his personal life and just having troubles coping with the volume [of the program], it's really heavy, it's a compressed time frame. It's really hard. He had a family and girlfriend and had separated from his wife and there were a lot of dynamics going on from the home and he was under-performing and I gave him more of a harsh, he did sort of pass barely, so it was a bare pass but he didn't take it well.

This CNI used the student's context to justify her decision for him to be successful. At the same time she acknowledged that she was justified in being more "harsh" with him due to his poor clinical performance.

Although other participants tried to give students the benefit of the doubt, they stated that they would still fail students if their behaviours and practices in clinical were unsafe or had the potential to be unsafe. Participant #10 put it like this,

...even though I tried to put my feelings behind me and just give this student the benefit of the doubt. And I worked with her and I supported her throughout each of the labs, I really worked closely with her. Just the way things were happening in clinical out of the lab, overall, I'm glad it happened the way that it did.

Participant #10 felt "glad" that she failed this student because she could still justify the decision despite giving the student the "benefit of the doubt" and supporting them adequately.

4.5.2 Taking personal responsibility

Participants felt that they needed to consider the context in which they made their decision to fail a student. They often considered their own responsibility for the students' clinical performance and wondered if they had supported the student enough to help them succeed. When making the case to fail a student, participants were challenged to maintain their supportive relationship with a student at risk of failure and at the same time evaluate the student's clinical performance.

Many participants discussed feeling personally responsible for students at risk of failure. They saw themselves as also being culpable for the student's clinical performance and partially responsible for the student having failed instead of the student being responsible for their own clinical performance. Participant #1 stated,

But when it came to nursing students I really, I really took personal responsibility for why they weren't following I guess the direction that were laid out by nursing school and by me in order to learn nursing. And I should have perhaps considered that this individual student, I'll call her Annie in her case, would have been an individual functioning in the context of her life and making these decisions, hearing the advice and the directions but not...just choosing to opt out of it. But I never thought of it that way. I always thought of it as my shortfall. What am I not doing, not saying? What is the relationship looking like

that's not allowing me to have this student to be successful? So probably too much responsibility I placed on myself for students who do well and do poor. ...I am uncomfortable with my own self when others are not successful at nursing. Which is an interesting thing...ya. So I guess I must have been taking on some responsibility for her practice, which was insightful.

The powerful self-reflection of Participant #1 highlights the supportive relationship between CNIs and their students and their perceived relationship to the student's success.

Participant #11 found that she questioned herself when teaching students deemed at risk of failure, "And then oftentimes I will think, well, is it me? Are my personal expectations coming into this and what I think the student ought to be versus is?" She found it difficult to balance what she called her "due diligence" to ensure that she had done everything possible to ensure the student's success with allowing them to "independently be successful". She questioned whether she had done too much for the student at risk of failure and whether she had determined the best course of action for this particular student, who ended up being successful in the clinical rotation.

Similarly, Participant #7 saw her student failing as a result of her own shortcomings and lack of resources:

I really want to help her. I feel that she has potential to improve. She does require a lot of attention, like one-one attention, that's why I think she needs the support of the school. I also feel so sorry to my other students because I think that they are right. They are doing very good at this stage, but they also want to improve their practice. They want to prepare them well for when they will really work as a registered nurse, independently. So I feel kind of like a Catch 22 right now. I want to help her, but I don't have enough resource, I don't have much time, I don't have energy.

Participant #7 had a strong belief to do everything possible to help her students to be successful, as opposed to the student's success as independent of herself. This is similar to Participant #5 who stated,

...I'm always questioning, "am I doing the right thing? Was I fair? Did I give the student every...all the help that I could have given them?" I feel bad ... Did I do everything that I can to help this particular student?

These CNIs struggled internally with balancing their role of nurturing students at risk of failure and at the same time making the decision to fail these students.

Participant #9 went further to explain that in her experience CNIs are chosen as educators because of their vast clinical experience and knowledge, not necessarily because of their teaching skills. This often means that they have little teaching and evaluation experience and are given limited training prior to teaching students. As a result, she found that CNIs often have a difficult time evaluating students deemed at risk of failure. She stated it like this, "...we have so many teachers that have come from practice and are moving into education. They often come with their nursing hat on, they are the nurse, they are not the teacher so I have to get them through that transition" (Participant #9). This balance is discussed further in the next chapter.

4.5.3 Creating "thereness": collecting evidence while supporting the student

Many participants discussed the challenge of collecting evidence and examples to justify failing a student. Participant #11, for example, talked about how she had to use a lot of self-reflection to determine whether or not a student at risk of failure would be successful. She talked about how she had to make sure that she remained as objective as possible when she collected evidence and that she had considered the context in which she was making her case. She had to ensure the evidence she observed was what led her to conclude the student was at risk of failure, as opposed to actively look for evidence to build a case against the student. This is how she put it,

...looking at just sort of evidence around can really help open up "ok, maybe I'm thinking a bit too narrow about what the student needs to do to succeed" Maybe it is

some of me using a different approach, me sort of checking in with myself or asking “are you actually starting to pick on this person? Or seek them out? Because you are potentially are now at this point looking for points of failure so you are trying to substantiate your case?” Sort of checking in (Participant #11).

This self-reflection was evident with many participants as they considered the context of their decision and their responsibility to the student deemed at risk of failure.

Participant #2 was a CNI and was also faculty advisor for clinical instructors and preceptors in the nursing program. She talked about how uncomfortable CNIs were with collecting evidence to make a case for a student to fail a clinical rotation. She stated,

So if you start the nurses are going to get really upset or concerned that they’re going to be failing students and, ‘is it my responsibility to fail a student that I met three day ago’, you know. ‘No it’s not your responsibility to do that’. And it’s, you have to keep reiterating that and say ‘you know your collecting data’ so that the school can make the decision based on the data that is presented (Participant #2).

Participant #2 also discussed how difficult it was to balance teaching and at the same time collect evidence to make a case for failing a student. As such, the CNI struggled with providing learning opportunities for these students and keeping the patients they are caring for safe. For example, participant #2 stated,

Well, you have to look at the evidence. So, what is this medication? Well we can’t give it because you don’t know what it is. So you have to be on your toes to see that they’re...not to catch them, you’re not trying to catch them but you have to give them patients that they can care for that are going to be challenging but the patient’s not in danger. Right? But there’s enough of a challenge there for them to go “oh, ok. I need to get organized to work on these.” So that they can see it for themselves. If they can see it, if they have insight.

In this instance, Participant #2 reframed her relationship with the student at risk of failure to one of facilitator. She was there to help the student “see it for themselves” instead of “catching them” when they made mistakes.

Similarly, Participant #3 talked about how difficult it was for her to collect evidence when she closely observed a student at risk of failure and at the same time maintain a nurturing

student-teacher relationship. She found that her close observation of the student caused added anxiety and stress for them. Participants talked about how challenging the two roles of the CNI were. Participant #4 called it an:

...art in doing that is to have students not feel like they're under surveillance but rather that you are there with them. So there's sort of that 'thereness' that you want to kind of have for them without that sense of 'I'm watching for every mistake you make'.

The "thereness" referred to in this example implied that the CNI ensured the student at risk of failure was providing safe, competent care while maintaining a supportive, non-punitive relationship.

Participants suggested that their supportive relationship was also independent of their evaluation of a student at risk of failure. Participants explained how they strived to make their evaluation remain objective for the student at risk of failure. They thought of themselves as presenting objective facts to the student at risk of failure, as opposed to providing a subjective judgment. Participants felt that the examples they collected for their evaluation could be looked at objectively instead of as their opinion of the student's performance.

So we have done a lot of work with how to collect the evidence and not in a punitive way just in those anecdotal notes I said. I suggest that the teachers use that, that it is totally transparent, they give the feedback on the spot to the student...The student is going to leave things out, or the student is going to be weeping or wailing, but all we care about is what you did. So I want the student to see the good stuff they did as well as the errors that they needed to fix (Participant #9).

Participants had to balance many seemingly conflicting needs associated with a student deemed at risk of failure. They had to maintain patient safety while at the same time provide students opportunities to be successful. They felt personally responsible for the student's success while at the same time understanding the student's responsibility of learning. They had to evaluate and collect evidence for a student at risk of failure while at the same time support and nurture them.

Balancing and maintaining these needs was challenging and time consuming for participants. As such, they utilized the various supports and resources available to themselves and these students.

4.6 Supports and resources

Participants acknowledged that they needed both formal and informal supports and resources to teach a student deemed at risk of failure. This included faculty such as advisors or leaders, colleagues, student counseling services, remedial intervention, staff nurses and student nurses.

Similar to the earlier finding of identifying a student at risk of failure early on, Participant #3, Participant #4 and Participant #6 discussed how important it was for faculty to be informed of students deemed at risk of failure as soon as possible and frequently. Participant #3 called it keeping them “in the loop” and it was as simple as making sure they were copied on e-mails between the CNI and student.

Participant #3 identified monthly meetings with all the CNIs and faculty as extremely supportive as a venue to discuss students at risk of failure. She found these meetings beneficial because it was a formal meeting in which faculty could remain informed about any students at risk of failure but also a way to share experiences and advice and garner help from colleagues.

Informal support from colleagues was also very helpful for participants. Participant #5 and Participant #11 discussed how their office space was helpful to talk with other colleagues who had various levels of experience and perspectives. Participant #5 found it helpful to change her methods of teaching and supporting students. Participant #6 and Participant #7 discussed the importance of mentors because they offered different perspectives and strategies of their own.

Participant #6 discussed the relationship she had with another educator as a mentor. This mentor helped her for a number of years and she used the relationship to help inform her decisions.

In general, most participants were aware of the extra support available to a student deemed at risk of failure. These included remedial interventions such as “skill labs” or “extra practice labs” where students learned patient care in simulated environments under supervision from nursing faculty. Participant #9 talked about how she used resources available to her students to help support them and ensure their success:

So right now we would be sending that student to our student support faculty, we have an actual full-time role, or a 60% role for student support. And it's a confidential faculty member who is there for all students for any kind of issues: coping, anxiety, anything. [I]...might send the student to counseling, would send the student to peer tutoring and all the resources within the library. We have peer tutoring there and we have fourth and fifth level nursing students that are the peer tutors and it's a paid role. There's 3 evenings a week, 4 hours a week or 12 hours a week that these students are available for drop-in tutoring.

Participant #7 had also discussed the importance of utilizing informal resources when she taught a student at risk of failure. Specifically, she conceptualized the student nurses as part of a “team” or unit that all had a shared responsibility or stake to ensure her students’ success. She saw the hospital unit as welcoming of students. This strategy helped increase her capacity to support a student at risk of failure in addition to the other students she had on the unit.

Furthermore, Participant #7 encouraged her students to help each other through informal peer partnerships as a way to alleviate her workload. However, Participant #9 cautioned against using student peer relationships since they sometimes put too much pressure on stronger students or resulted in “...two poor students [working] together and that doesn't really help either of them.”

Many of the CNIs perceived the resources and supports around them as opportunities to foster the success of students deemed at risk of failure. They also valued others’ experience and advice to help them support a student at risk of failure. Regardless of the amount of support and

resources provided to participants, they still acknowledged how difficult and stressful it was to fail a student because of the various contextual factors and their own beliefs and values that conflicted with their role when they evaluated these students.

4.7 Conclusion

The CNIs who participated in this study identified a wide variety of attitudes, behaviours and actions that caused them to become concerned with a nursing student and deem the student at risk of failure. Although these “red flags” varied, the premise of maintaining patient safety through nursing student competence was a strong theme. Participants identified the importance of early identification and interventions for students deemed at risk of failure and have clear expectations with all of their students. When they decided to fail a student, participants made sure to consider the situational context of their decision, often by reflecting on their practice, as well as making a case or justification for their decision. Regardless, participants acknowledged the importance of their formal and informal resources to help them make their decision to pass or fail a student at risk.

Chapter 5: Discussion

The experiences of teaching a student deemed at risk of failure can be a very difficult for CNIs. These students may exhibit certain patterns of behaviour that need to be identified early by the CNI to be beneficial for them and the student and help to ensure success in the clinical setting. Although CNIs may find it difficult to support and at the same time evaluate these students, they must find a balance in doing so by providing learning opportunities for the student while simultaneously ensuring patient safety. With the use of various formal and informal supports, CNIs can attempt to navigate through these challenging situations to preserve the student-teacher relationship and uphold competency standards.

5.1 Competency framework

This study was done at two different post secondary institutions. The participants from UBC used a very detailed competency framework that included a specific set of 21 competencies outlining safe practice and clinical expectations detailed to the level of the program (University of British Columbia School of Nursing, 2010). The participants at BCIT used the CRNBC competency framework for entry-level registered nurses in BC as their framework (CRNBC, 2013), which is more generalized when compared to UBC's lengthy set of competencies. Some participants stated that they used the CRNBC professional standards interchangeably with the CRNBC competency framework. The competency framework is derived from the four professional standards set forth by CRNBC and is used to determine if a nursing student is eligible to proceed to registration (CRNBC, 2013). CNIs in this study found the competency framework useful to guide their teaching practice and set clear expectations with students.

One might expect that the more detailed competency framework from UBC would benefit CNIs in assessment and evaluation of students deemed at risk of failure because it has numerous clear and objective indicators that could be applied to these students. However, this did not appear to be the case according to several participants who discussed difficulty in navigating and using the more detailed competency framework. One participant felt that CNIs needed to be mentored to use the framework for assessment and evaluation. She recommended that CNIs receive more guidance to help “fit” students deemed at risk of failure into the framework. For example, CNIs found that the UBC framework was not useful to evaluate ‘grey’ areas, like “inside judgment”, that were expected of nursing students.

The use of one competency framework to evaluate nursing students within varying clinical settings was especially problematic for some participants. They found this “grey” area of nursing practice difficult because the area of nursing they taught, like psychiatric nursing, was so different from the typical expectations of most medical or surgical areas of nursing. Tanner (2004) discussed the challenge of creating clear objectives to rate performance without creating lengthy, unwieldy guidelines. Tanner states, “the closer we come to requiring real-world performance on an assessment task (authenticity), the more difficult it is to objectively rate the performance” (p. 435). On the other hand, Emerson (2007b) suggests that course objectives are often too open to variability and not specific enough to be applied to students in a meaningful way. This was evident in participants from BCIT that used the more general competency framework. Participants from BCIT discussed difficulty in making their assessment and evaluation of students deemed at risk of failure objective. They felt that they had to be vigilant in collecting evidence and specific examples of students deemed at risk of failure to objectify the student’s inability to meet standards and indicators.

As previously found in the literature, CNIs identified many areas of assessment and evaluation that were inadequately or inappropriately defined in nursing standards and competencies but instead occupied a ‘grey’ area of evaluation (Deegan, Rebeiro, & Burton, 2012; Duke, 1996; Jervis & Tilki, 2011; Luhanga et al., 2008b; Scanlan et al., 2001). Participants shared how difficult it was to teach, assess, and evaluate ‘grey’ areas of nursing practice, such as critical thinking, decision-making and judgment. Participants regarded these areas as important to entry-level nursing but much harder to teach, assess and evaluate in students at risk of failure. For example, issues with a student’s clinical decision-making may stem from more than inadequate knowledge but instead from an inability to use various thinking processes (Gillespie, 2010).

Pijl-Zieber, Barton, Konkin, Awosoga, & Caine (2014) and Norman, et al. (2002) also highlight the problematic use of competency frameworks in determining clinical competence since most have not or cannot be tested for reliability or validity. They argue that competencies have become too generalized as nursing education programs have moved away from concrete, skills-based competencies. In this study, however, it appeared that some CNIs found the more general competency framework easier to apply to students deemed at risk of failure. For example, “accountability” as a nursing standard could be applied to various forms of dishonesty and participants could then use specific examples from the student’s practice to describe why they did not meet this standard.

Complex and detailed competency frameworks were not necessarily useful for CNIs when applying to the ‘grey’ areas of evaluating students at risk of failure because they did not apply to their clinical setting. Faculty must be mindful of the usability of their competency framework by considering both the navigability of the document as well as its application to

student performance within specific clinical settings. Faculty mentorship and guidance of CNIs can help facilitate that process. The operationalization of competence with the use of competency frameworks appears to be an ongoing issue for nursing education (Pijl-Zieber et al.), specifically, how CNI's use of competency frameworks to teach, assess and evaluate students at risk of failure in the clinical setting.

Alternatively, Gregory, Guse, Dick & Russell (2007) suggest we change our perspective of the failing student so that we look at student errors from an "education systems perspective" (pp. 80). They encourage consideration of how current clinical education models and curricula may be contributing to individual error. The expectations of patient safety in relation to student performance may not be the same as what the student is expected to learn in the program. For example, Participant #2 discussed how she went through each of the competencies one by one but none of them answered or addressed what she felt was really going on. This was an example of what participants called the "grey" area of evaluating nursing students. DeBrew & Lewallen (2014) suggest that this "grey" or subjective area comes from CNIs' expectations of what Allen, et al. (2011) call a *hidden curriculum*.

It is suggested that there may be disconnect between what students deemed at risk of failure are taught and what they are expected to know in the clinical setting. This theory-practice gap is illustrated in the practice setting where CNIs have expressed expectations of student performance in areas such as "critical thinking" or "inside judgment". These traits were identified by CNIs as essential for success in the clinical setting, however, it was not clear that CNIs have the capacity to teach these skills to students (DeBrew & Lewallen). Participant #4, for example, felt that she could teach the "concrete" skills but that teaching things like "inside judgment" was her "biggest challenge". Participant #6 was also challenged in teaching clinical

decision-making to a student deemed at risk of failure. She stated that the student had adequate knowledge of pathophysiology but was unable to apply the knowledge to various clinical situations. She felt that if the student did not come with an innate ability to use various thinking processes, she could not teach them. Gillespie (2010) recommended the use of a situated clinical decision-making framework to guide student thinking and elicit their judgment and clinical decision-making abilities. CNIs could use clinical decision-making frameworks to aid in teaching, assessing, and evaluating “grey” areas of nursing practice, such as clinical decision-making.

In this study, it was difficult to determine how CNIs were assessing clinical decision-making and judgment abilities of student nursing practice. They often described it as feelings, intuition, or “spidey-senses” when describing why a student may be deemed at risk of failure. This is similar to DeBrew & Lewallen (2014) who showed that CNIs found it difficult to quantify problematic behaviours based on clinical objectives and outcomes. Carr, et al. (2012) and Duffy & Hardacre (2007a) recommend that CNIs trust their judgment or intuition to identify students at risk of failure, as there was usually a foundation for concern. As identified by previous studies, nursing education would benefit from further exploration of how the clinical decision-making and judgment abilities of students at risk of failure are identified and evaluated by CNIs (Killam, Montgomery, Luhanga, Adamic, & Carter, 2010). It would also be beneficial to know if CNIs have explicit and hidden curricular expectations of students deemed at risk of failure.

5.2 The student deemed at risk of failure

Participants in the study were asked how they identified a student at risk of failure. Similar to this study, many other authors have found that CNIs use “red flags” to identify students deemed at risk of failure (Duffy & Hardicre, 2007b; Hrobsky & Kersbergen, 2002; Jervis & Tilki, 2011). These red flags are similar to other studies and highlight the diverse behaviours, attitudes and skills that are assessed in the clinical setting. Integrity was a surprisingly strong indicator of nursing student success, which will be discussed in more detail later. Emerson (2007b) highlights the complexity of determining “unsatisfactory clinical performance” due to the variety of reasons students may be deemed unsuccessful. The findings of this study confirm the broad ways students deemed at risk of failure exhibit difference in being, knowing and doing from what was typically considered the standard for these CNIs.

Participants were asked how they determine if a student deemed at risk of failure would be successful or not. They stated that they failed nursing students who were unsafe. The problem with using safety as criteria is that there are a myriad of situations in which CNIs may perceive a nursing student as potentially unsafe (Killam et al., 2010; Scanlan et al., 2001; Skingley et al., 2007). This is because the nature of unsafe clinical practice depends on many factors and contexts (Tanicala, Scheffer, & Roberts, 2011) and changes over time (Skingley et al.). For example, two participants found it difficult to evaluate students using the competency framework, which is aimed more toward medical-surgical skills than relational skills. The competencies do not reflect the diversity of clinical settings within nursing (Brennan & Hutt, 2001). The timing in the course and level of student must also be considered when deciding unsafe clinical practice (Tanicala et al., 2011). Specifically, participants in the study discussed that they failed students with borderline performance when they felt that their clinical

performance would be inadequate or unsafe for the next level. When they considered the timing of the course, participants identified students at risk of failure early on but would wait to deem the student unsuccessful until at least mid-term.

Brown, Neudorf, Poitras & Rodger (2007) emphasized the importance of having consistent, clear and impartial processes when evaluating a student deemed at risk of failure. They too found that among faculty members, the definition of “unsafe clinical practice” was diverse and there were myriad opinions on how to address and intervene with students who demonstrated unsafe clinical practice. In this study, one participant discussed how the criterion she used to determine student success changed as she gained experience such that she would not have failed students that she did in the past. The findings of this study corroborate Tanicala, Scheffer, & Roberts (2011) and Killam, et al.’s (2010) that we have only begun to uncover how CNIs make decisions about what constitutes unsafe clinical practice and how they determine if a nursing student is competent or not.

5.2.1 Clinical integrity

Honesty is fundamental to patient safety because nurses are professionals who work independently in practice (Killam et al., 2010; Krueger, 2014; Langone, 2007; Tanicala et al., 2011). The concern raised by these authors is that nursing students who are dishonest in the clinical setting may continue to be dishonest when they are professionals. Unfortunately, there has been little to no research conducted that correlates the behaviours of nursing students to that of regulated nurses (DeBrew & Lewallen, 2014). One participant, for example, did not fail a student at risk of failure because she felt that the student had learned to become transparent and

accountable for her clinical practice. This is similar to DeBrew & Lewallen's (2014) finding that CNIs did not fail a student if the student indicated remorsefulness for their mistake.

Interestingly, Krueger (2014) found incongruence between CNIs' and nursing students' perception of what behaviours were morally and ethically acceptable in the clinical setting. She stressed the need for CNIs to be clear in the behavioural expectations of nursing students. For example, CNIs need to make clear from the onset that lying or covering up mistakes will result in the student being unsuccessful. This shared understanding ought to support accountability and professionalism in the clinical setting (Krueger).

Langone (2007) suggested the use of "honour codes" in the clinical setting to dissuade students from clinical dishonesty. The example included a two-page document that students signed each semester. The code document made explicit the expected behaviour of students and possible consequences for infractions. She also discussed the importance of establishing a system for reporting infractions and to encourage other students to report violations as a way to protect "the integrity of the nursing profession" (p. 46). In this study, lack of integrity was a common characteristic of a student at risk of failure. The use of honour codes in undergraduate nursing programs would foster a culture of integrity and patient safety and therefore discourage clinical dishonest.

5.2.2 Addressing concerns early and clearly

Participants in this study consistently discussed the importance of addressing concerns with students early and clearly. Previous studies found that students at risk of failure responded positively when concerns or issues were discussed with them early in the clinical rotation (Carr et al., 2012; Duffy & Hardicre, 2007a; Scanlan et al., 2001). Students at risk of failure saw these

concerns and issues as opportunities to develop because they knew they had sufficient time to be successful. This is similar to the findings of this study where CNIs highlighted the importance of identifying students at risk of failure quickly in order to give them the feedback they needed to change.

Duffy (2003) also found that CNIs were unable to fail students who did not meet clinical expectations because they had not addressed issues with them early enough in the clinical rotation. Duffy refers to CNIs “leaving it too late” and subsequently unable to fail an incompetent student because there was no opportunity for the student to change. Although the participants in this study did not explicitly state this, it can be inferred. For example, when a participant discussed the importance of identifying problems early by saying, “but if you wait too long...it’s not, you know.” She suggested that waiting too long to address concerns resulted in increased challenges of difficulties to fail the student.

The participants in Duffy’s study explained that the decision to fail a student after leaving it too late could easily be overturned through the appeal process. In this study, only one participant talked about a situation where a student used the appeal process to overturn her decision. She too states that faculty could have overturned her decision for these same reasons Duffy found. In this study, fear of appeal or legal implications surrounding failing a student did not appear to be a prominent issue. This may be because the decision to fail a student is made jointly with other faculty in the program (Luhanga et al., 2008a). The participants in this study felt that addressing concerns clearly and as early as possible with students at risk of failure made failing them easier and less stressful for both the student and the CNI.

5.3 Weighing the risks of failing a student

The decisions to fail students were taken quite seriously by CNIs. Their decisions required careful deliberation of the benefits and consequences of failing students. This was especially apparent for the borderline student, whose clinical performance could be perceived somewhere between competent and incompetent or as a reflection of the CNIs ability to teach these students.

5.3.1 The borderline student

Participants thoroughly considered the implications and consequences of failing a student at risk (Emerson, 2007a). Deciding to fail a student was an important decision that required careful deliberation. They tried to give students deemed at risk of failure the benefit of the doubt when making the decision for the student to be successful or not. This was similar to Duffy (2003) who found that CNIs passed “borderline” students by ensuring all efforts were made for the student to be successful. Several participants discussed examples of students deemed at risk of failure who were successful yet considered borderline in terms of their evaluation. The borderline student appeared to be the most challenging student at risk of failure because CNIs are uncertain of their competence and subsequently give them benefit of the doubt (Deegan et al., 2012). The participants of this study gave students deemed at risk of failure the benefit of the doubt because of the complexity of the clinical setting and the complexity of evaluating these students (Deegan et al.). The consequences of failing a student were so great for the participants that they felt they had to be sure they were making the right decision.

Larocque & Luhanga (2013) suggest that CNIs give students the benefit of the doubt to avoid a false or unwarranted failure. The results of this study therefore confirm previous findings

that there was reluctance to fail students at risk of failure. Specifically, when the student's evaluation was perceived as borderline by the CNI (Jervis & Tilki, 2011). CNIs could not be confident in their decision to fail a borderline student because the decision involved many factors and had serious consequences for those involved.

5.3.2 Taking personal responsibility

CNIs taking personal responsibility for their students' clinical performance is well documented in other studies (Diekelmann & McGregor, 2003; Duke, 1996; Larocque & Luhanga, 2013; Poorman & Mastorovich, 2014). The participants in this study were always reflecting back on how they affected the outcome of unsuccessful students. They asked themselves if they could have done more, if they could have done something differently, or if they had missed something that resulted in a student being unsuccessful.

As in this study, Poorman & Mastorovich found that CNIs took great responsibility for facilitating the success of their students. Diekelmann & McGregor called this "personalizing student failure". They state that nurse educator perspectives come from an "outcome-based" education that view teaching and learning as a personal deficit. From this perspective, the educator fails to adequately facilitate learning for the unsuccessful student. Instead, they challenge us to rethink the perspective of failing a student from a personal standpoint to a broader one. For example, they suggest CNIs view their teaching as a "practice" where they learn and improve through their experiences with students at risk of failure. These experiences can be interpreted as opportunities to develop instead of personal failures.

Black, Curzio & Terry (2014) attempt to dissect the CNIs' "moral journey" when making a decision to fail a nursing student in a clinical setting. They stated that the moral distress caused

by taking personal responsibility for their students' success or failure must be measured against the sense of duty to protect the public. Most importantly, they stated that the moral courage needed to fail a student out of professional and public responsibility must outweigh the moral stress and fear of doing so. Black, Curzio & Terry suggested that faculty support CNIs through orientation, coaching, and by developing a culture of responsibility and accountability of CNIs so that they may maintain their values and moral integrity in the clinical setting.

5.3.3 Creating “thereness: collecting evidence while supporting the student

Duffy & Hardicre (2007a) discussed the importance of collecting evidence to establish a “pattern of failing performance” (p. 3). The participants in this study struggled with documenting evidence of a student at risk of failure because they perceived it as unsupportive and time consuming. They regarded making a case to fail a student as perhaps contradictory to the student-teacher relationship. Participants were sensitive to how students deemed at risk of failure reacted to them “watching” them and adding undue anxiety to an already stressful situation. This sensitivity to increased evidence collection and surveillance of students deemed at risk of failure has validity (O'Mara, McDonald, Gillespie, Brown, & Miles, 2014). Students deemed at risk of failure are less likely to accurately learn, make the suggested changes and improve when they are anxious (Emerson, 2007b).

Participant #4 talked about using a “thereness” where she could still support and reassure the student deemed at risk of failure while simultaneously make a case for a final decision. Duke (1996) refers to this role conflict as “moral caring” in which the CNI encounters a dilemma in collecting evidence to fail while maintaining a nurturing relationship with the student deemed at risk of failure. CNIs may see deeming students unsuccessful as incongruent with their goal to

encourage nursing students and create environments conducive to learning. CNIs must be mentored and coached on how to balance these seemingly contradictory roles. For example, Duke suggests the use of small group discussions with CNIs to share experiences, debrief and devise teaching strategies specifically for students deemed at risk of failure.

5.3.4 Gatekeeping the profession

The participants in this study maintained patient safety through the gatekeeping of the profession. This was not a surprising finding as it is a commonly described in nursing literature (Killam et al., 2010; Luhanga, Yonge, & Myrick, 2008c; Penn, Wilson, & Rosseter, 2008; Tanicala et al., 2011). Emerson (2007a) also discussed the “nursing education conundrum” of maintaining patient safety as a professional obligation and at the same time providing opportunities for student to improve deficiencies, learn and pass the course as a faculty obligation.

Tanicala, Scheffer, and Roberts (2011), Hall (2013) and Emerson (2007a) discussed the need for nursing education culture to shift from blaming and penalizing errors to analyzing errors as part of a learning process. This is similar to Killam, et al.’s (2010) discussion of a *humanistic curriculum* that encourages nursing students to purposefully discuss clinical errors so that they can learn and influence future practice. This would reflect health care’s current goal to create a culture of safety, which promotes a culture of reporting errors and addressing them from a systems perspective. Brennan & Hutt (2001) stated that students are hesitant to discuss difficulties or errors they experience with their CNI because they believe they may fail as a result. Creating a culture of safety requires CNIs to foster nursing student learning by setting clear expectations of integrity and reflection into practice. From a student’s perspective,

establishing clear expectations also creates positive clinical learning environments and opportunities to develop as a nurse (O'Mara et al., 2014).

Similar to the findings in this study, Luhanga, Yonge, & Myrick (2008b) also found what they call “the old test” which involved the CNI creating a hypothetical situation by asking themselves if they were comfortable with the student at risk of failure taking care of a relative or work as a colleague. In addition to using the competency framework, CNIs frequently made the decision to deem a student unsuccessful using “the old test” to reflect on if the student at risk of failure was safe to care for others. Black, Curzio, & Terry (2014) also discussed this common finding as an example of “demonstrating moral integrity” (p. 230). They stated that CNIs use this common criterion as a way of morally justifying their decision to fail a student. Imagining the student in these hypothetical situations helped the CNI see the student at risk of failure outside the context of their relationship. The participants in this study regarded maintaining the moral integrity of the profession as imperative in their role as gatekeeper to the profession while simultaneously supporting and providing learning opportunities for students deemed at risk of failure.

5.4 Supports and resources

Seeking support from colleagues helped CNIs confirm their assessment of a student deemed at risk of failure. This is a common finding in other studies where CNI's feeling were confirmed when they spoke to faculty (Duffy & Hardicre, 2007a). Seeking support from other CNIs builds personal reliance, which is necessary to help mitigate the stress associated with deciding to deem a student unsuccessful (Carr et al., 2012). Duke (1996) discussed the importance of using small groups of CNIs to discuss students at risk of failure and share

experiences and teaching strategies. Participants from one of the schools stated that they used regularly scheduled CNI meetings throughout the term. They found these meetings invaluable when they taught a student deemed at risk of failure. These meetings offered validation and encouragement to CNIs when they assessed and evaluated students at risk of failure. This was most apparent for participants who took personal responsibility for the student at risk of failure. They used other CNIs to corroborate or refute their doubts and uncertainties in order to support their decisions.

The majority of CNIs in this study discussed resources and supports as student-centered instead of teacher-centered. They saw themselves as part of a network that supported the student deemed at risk of failure and facilitated remedial opportunities for these students. This was a positive finding because, although some CNIs took personal responsibility, they also saw themselves as part of a team of people who shared responsibility for the student's success. Similarly, CNIs also viewed the decision to fail a student as a decision made in concert with faculty. This eased the burden of stress of failing a student and again fostered their personal reliance and confidence.

5.5 Limitations

Limitations of this study included a lack of diversity regarding participant gender, level of education, and experience as a registered nurse. All participants were female and most of the participants in the study had a master's degree or were in the process of obtaining one. As a result, this sample may have a higher level of education than the general population of CNIs in western Canada. The participants also had an average of 19 years as a registered nurse and 7.5 years of experience as a CNI, suggesting that the results of the study may be more applicable to

intermediate or experienced CNIs. Information on the current composition of the population of CNIs in BC would have been useful to compare to the CNIs who participated in this study.

Another limitation of this study was the inclusion of only two schools of nursing and the small sample size (N=11) of this qualitative pilot study / master's thesis. This is similar in size and power to other studies of this topic (Killam et al., 2010). Nonetheless, the results of this study support the findings from other similar studies.

The major findings of this study have been discussed within the context of the current literature regarding clinical nursing instructors' experiences teaching students deemed at risk of failure. The following chapter provides a brief overview of these findings, the implications for practice in the field of clinical nursing education and directions for future research.

Chapter 6: Conclusion

The original research question of this study was: what are CNIs' experiences of teaching undergraduate nursing students deemed at risk of failure at the University of British Columbia and the British Columbia Institute of Technology schools of nursing? The results of this study uncovered four major themes:

1. CNIs' used competency frameworks to enhance learning and set clear expectations but found it difficult to apply competency frameworks to the evaluation of students deemed at risk of failure. CNIs found it difficult to "fit" a student at risk of failure into "grey" areas of evaluation like clinical decision-making or judgment.
2. CNIs identified students at risk of failure using various "red flags" or early signs that CNIs looked for to identify students who could be at risk of failure. Lack of integrity and lack of patient safety were identified as the most important factors used to identify and determine students at risk of failure. It was essential for CNIs to identify these students early and communicate their concerns to all involved. This was viewed as ultimately beneficial for the student and CNI.
3. CNIs weighed the risk of teaching, assessing, and evaluating students deemed at risk of failure with supporting them and maintaining the student-teacher relationship. These risks included giving the student the benefit of the doubt, especially to borderline students, taking personal responsibility for the student's performance, and creating "thereness" where the CNI collect evidence to fail the student while supporting their learning.
4. CNIs utilized various supports and resources when teaching students deemed at risk of failure. These included various remedial options for students, other students and

hospital staff, faculty members, and structured meetings where students at risk of failure were discussed.

The results of this study corroborate the findings from other studies that have explored CNIs' experiences teaching students deemed at risk of failure. The use of competency frameworks to evaluate students at risk of failure was compared between two schools of nursing. CNIs argued for and against using detailed and general frameworks. While appearing more objective, the detailed framework did not meet the needs of the CNIs, especially when used in a specialty clinical setting like psychiatry or mental health. The reasons for this were because many of the competencies of nursing practice taught, assessed and evaluated in students at risk of failure were rarely straightforward but nonetheless essential for entry-level practice. This was evident in the study as it was difficult to elicit how CNIs were teaching, assessing and evaluating “grey” or under defined competencies. These competencies included skills such as clinical-decision making and judgment, especially in specialty areas of nursing like mental health. The additional use of tools like clinical-decision making frameworks to established competency frameworks may be beneficial for CNIs who feel unequipped to teach, assess, and evaluate clinical-decision making and judgment in the clinical setting.

The students deemed at risk of failure were identified as early as possible using “red flags” that caused concern for the CNI and these included many ways of knowing, being and doing. Patient safety was a priority for these CNIs, however this was problematic because how we define and operationalize patient safety differs in opinion, depends on multiple factors and contexts, and changes over time. Clinical integrity, or lack thereof, however was a strong cause of concern because it made CNIs unsure of the student's capabilities and they feared that

dishonesty would continue to impact patient safety, especially if the dishonestly continued into the student's independent practice or licensure.

Once students at risk of failure were identified, it was imperative for CNIs to communicate their concerns with the student and other faculty as early as possible. Students deemed at risk of failure had opportunities to grow and improve if issues were identified and communicated early and therefore had the opportunity to change. In addition, early and clear communication ensured that the process involved in deeming the student unsuccessful was much easier for both the CNI and student.

CNIs made the decision to fail a student by considering the circumstances and significance of the decision and weighed conflicting values when making decisions to fail students. These conflicting values included giving the student the benefit of the doubt, taking personal responsibility for the student outcome and making a case to fail the student while simultaneously supporting them to succeed. Giving students the benefit of the doubt was a strategy used for borderline students where the CNI had to carefully consider the complexity of the clinical setting and the complexity of teaching, assessing and evaluating the borderline student, specifically the consequences of failing a student. CNIs also took a lot of personal responsibility for the student's clinical performance and had to measure this against their sense of duty to protect the nursing profession. CNIs also struggled with creating a "thereness" that involved the collection of evidence to establish the student at risk of failure as unsuccessful, while simultaneously support the student and maintain the student-teacher relationship.

Finally, CNIs used the supports and resources available to them to help ensure a student at risk of failure would have every opportunity to be successful. They also used faculty and other CNIs to validate their concerns and build their personal reliance when teaching a student deemed

at risk of failure. Regular meetings of CNIs and faculty appeared to provide the most support for CNIs teaching students deemed at risk of failure because they were able to confirm their evaluation and judgment and learn from other CNIs' experiences. Most participants felt well supported to teach students at risk of failure but acknowledged how difficult the experience is regardless of support or experience.

6.1 Implications for practice

The implications of this study pertinent to clinical nursing education are divided into the implications for CNIs in the clinical setting and implications for faculty responsible for program development and CNI support.

6.1.1 Clinical nursing instructors

This study found that CNIs felt better prepared to teach students at risk of failure when they developed strategies to identify them early. CNIs could use activities like case studies or group discussions to get a sense of a student's competence in the clinical setting. These activities would be especially important for assessing clinical decision-making skills, critical thinking, and professionalism, which CNIs identified as the most challenging competencies to assess.

Participants in this study identified the importance of setting clear expectations with students as early as possible so that students have a shared understanding of what is required of them within the clinical setting. CNIs can be assured that the evaluation of the student at risk of failure is justified when clear expectations have been established from the beginning.

Furthermore, CNI concerns of a student at risk of failure need to be communicated to the student and faculty as clearly and early as possible, even if the concerns end up being

unwarranted. This was beneficial in a number of ways: 1) the student at risk of failure receives feedback immediate and has the opportunity and time to improve, 2) the student at risk of failure understands the seriousness and potential consequences of the CNI's concerns and is therefore more likely to change, 3) the student and CNI are more likely to utilize remedial supports and resources available to them, and 4) in the event that the student is deemed unsuccessful, they are better prepared and more likely to accept the result.

Finally, CNIs should develop a clear understanding of their role in teaching students deemed at risk of failure. The role may carry conflicting values such as gatekeeping the nursing profession while ensuring students at risk of failure succeed. These conflicts are especially important when making decisions to fail the borderline student and are ethically challenging for the CNI. Specifically, CNIs must reflect and learn from the experiences of teaching students at risk of failure, view teaching in the clinical setting as a practice to improve, and develop their moral courage to fail students who demonstrate incompetency.

6.1.2 Faculty

This study uncovered the challenge of developing competency frameworks that adequately capture what CNIs teach, assess and evaluate in the clinical setting, specifically for the student deemed at risk of failure. Including additional tools like clinical-decision making frameworks may help to specifically address some of these issues. Faculty must ensure CNIs have a shared understanding of what competence means and how to apply competency frameworks to the clinical setting. Faculty could do this through the use of examples and case studies of borderline students and students at risk of failure. Providing specific mentoring and coaching to novice CNIs to teach, assess and evaluate students at risk of failure would also be

meaningful and help to mitigate some of the challenges and stress related to teaching a student deemed at risk of failure.

Although CNIs valued various formal and informal supports available to them, schools should use regular formal meetings of CNIs and faculty to discuss students deemed at risk of failure. These meetings are beneficial for a number of reasons: 1) CNIs confirm their assessment and evaluation of students deemed at risk of failure with multiple people, reinforcing their confidence and personal reliance, 2) faculty stay informed of students deemed at risk of failure, 3) CNIs learn from the experiences of other CNIs teaching students deemed at risk of failure, and 4) they develop a shared understanding of student competence and clinical expectations.

6.2 Directions for future research

The CNIs in this study were enthusiastic to share their experiences of teaching students deemed at risk of failure, indicating interest in the topic. A study of this kind is timely as patient acuity is increasing and there is increased pressure on schools of nursing to produce competent graduate nurses in tandem with hiring and maintaining competent clinical nursing instructors. The CNIs' experiences of teaching students deemed at risk of failure have real consequences for CNIs, students, schools of nursing, the nursing profession, and patient safety and therefore need to be addressed in the nursing literature. CNIs and students find the experience of failing students stressful and schools may have a vested interest in maintaining student enrolment. On the other hand, CNIs are also expected to be gatekeepers to the profession and maintain established standards and more importantly, ensure patient safety.

The findings of this study provide a deepening understanding of CNIs' experiences of teaching students deemed at risk of failure from a phenomenological perspective. It also creates a

foundation for more specific questions to be investigated from the perspective of clinical nursing instructors with the use of quantitative, qualitative or mixed methods research.

Important questions for future inquiry to explore should include:

- How do CNIs use competency frameworks to evaluate students at risk of failure in specific clinical situations?
- Do CNIs have explicit and hidden curricular expectations of students deemed at risk of failure?
- Do CNIs prefer general or specific competency frameworks to evaluate students deemed at risk of failure?
- Are CNIs reluctant to fail unsatisfactory or unsafe undergraduate nursing students?
- How do novice CNIs' experiences of teaching students deemed at risk of failure differ from expert or experienced CNIs'?
- Do CNIs value gatekeeping of the profession more than supporting students at risk of failure or vice versa?
- Do students attempt to hide their incompetence so that they cannot be deemed unsuccessful at the expense of learning and improving their clinical performance?

Finally, larger replication of studies exploring clinical nursing instructors' experiences of teaching students deemed at risk of failure would be beneficial since similar studies to this one are limited by small sample sizes. Replication and larger sample size would aid in confirming and reinforcing similar study findings.

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Appendices

Appendix A Consent Form: In-person Focus Group Participants



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British Columbia Institute of Technology
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You are invited to participate in a study entitled **Clinical Nurse Instructors Experiences of Teaching Students Deemed at Risk of Failure** that is being conducted through the University of British Columbia School of Nursing and the British Columbia Institute of Technology School of Nursing. The study is being conducted by Stefanie MacLeod, MSN(c), UBC Master's Student in Nursing, Bernie Garrett, PhD, RN, Leanne Currie, PhD, RN and Mary Gillespie, MN, RN.

Should you have questions about this study, you may contact Stefanie MacLeod at (XXX) XXX-XXXX, e-mail: XXXX@XXXX.ca or XXXX@XXXX.ca.

This research study is funded by the Elizabeth Kenny McCann Education Grant.

Purpose and Objective

The purpose of this study is to explore clinical instructors experiences of teaching undergraduate nursing students deemed at risk of failure at the University of British Columbia (UBC) and the British Columbia Institute of Technology (BCIT) schools of nursing and to discover if clinical instructors feelings about failing students.

Importance of this Research

You are being invited to participate in this research study because clinical instructors' experiences of teaching nursing students deemed at risk of failure have not been adequately addressed in nursing. We want to learn more about how the instructor supports as well as evaluates a student when that student's performance is judged to be unsatisfactory or unsuccessful.

Participant Selection

You are being asked to participate in this study because you are clinical nursing instructor in the undergraduate program at the School of Nursing at either the UBC or the BCIT.

What is Involved

If you consent to voluntarily participate in this research, your participation will include an individual meeting with the researcher that will take about ½ to 1 hour that will take place in a private location agreed upon between you and the researcher. We will ask you about any experiences you have had in the past with students who were deemed at risk of failing their clinical practicum. The interview will be audio taped and transcribed. Notes will also be taken during the discussion.

After the individual meetings are completed and the researcher has compiled the results, you will be asked to participate in a focus group with the other participants and the researcher that will take about ½ to 1 hour. This focus group is to confirm the results of the individual interviews.

The recordings and transcriptions will be stored on a secure, password-protected hard drive. The research team members will have access to the transcriptions of the interviews only and will read and analyze the data obtained for themes, ideas and opinions expressed by the participants.

Transcripts and audio recordings of data will be kept for five years after the close out of the project and will be destroyed after that time period. Electronic data stored on a secured, password protected and encrypted hard drive that will be erased at the end of the project.

Study results will be reported as an aggregate only; there will be no way for comments or opinions to be attributed to any individual participant.

The results of this study will be reported in a graduate thesis and may also be published in journal articles and books.

Inconvenience

Participation in this study may cause some inconvenience to you, including travelling to the meeting site for in-person interviews and focus group participation.

Potential Risks and Benefits of the Study

There are no known or anticipated risks or benefits to you by participating in this research.

Compensation

As a way to compensate you for any inconvenience related to your participation, you will be given a \$10 gift card for a coffee shop.

Voluntary Participation

Your participation in this research must be completely voluntary. If you decide to participate, you may withdraw at any time without any consequences or explanation. If you withdraw from the study it will be impossible to remove your data from the database. You will be able to keep your compensation for participation.

Anonymity

In terms of protecting your anonymity, your name and other identifying information will not be shared with anyone other than the researcher. In the data set you will be referred to by your assigned code or pseudonym. No names or identifying places will be written down in notes taken at the in-person interview. Participants will not be introduced to each other and you will be asked to refrain from using other people's name and identifying places.

Focus group participants must be willing to agree to hold in confidence the identity of others in the group and the conversations/discussions that emerge within the group.

Confidentiality

If you consent to participate in this project your responses will be confidential and all data will be kept strictly confidential. All data will be stored on a secure, external hard drive and on password-protected computers. Printed information will be kept in a locked filing cabinet in an office at the UBC School of Nursing. Following transcription, pseudonyms or codes will be applied to all data, and only members of the research study will have access to the actual participant names. Your name or any other identifying information will not appear in any reports on the completed project.

Contact for information about the study:

If you have any questions or think you may wish to participate in this study, please contact Stefanie MacLeod at (XXX) XXX-XXXX, e-mail: XXXX@XXXX.ca or XXXX@XXXX.ca or Bernie Garrett at (XXX) XXX-XXXX e-mail: XXXX@XXXX.ca

Contact for Concerns about the Rights of Research Subjects:

If you have any concerns about your treatment or rights as a research subject, you may contact the UBC Office of Research Services at (XXX) XXX-XXXX or e-mail: XXXX@XXXX.ca or the Chair of the BCIT Research Ethics Board at (XXX) XXX-XXXX or email: XXXX@XXXX.ca

Taking part in this study is entirely up to you. You have the right to refuse to participate in this study. If you decide to take part, you may choose to pull out of the study at any time without giving a reason and without any negative impact on your employment.

Your signature below indicates that you understand the above conditions of participation in this study, that you have had the opportunity to have your questions answered by the researchers, that you consent to participate in this research project, and that you have received a copy of this consent form.

Name of Participant

Signature

Date

Appendix B

Topic Guide

I'd like you to think about an example or a time you had a student who wasn't doing well in their clinical rotation and you thought that they might not pass clinical.

1. Can you describe the student and what made you think they weren't doing well?
2. What was the experience of teaching this student like for you? What were you feeling?
3. Did someone help you through passing / failing this student? Who was it?
4. In the end, how did you feel about passing / failing this student?
5. What did you learn about the whole experience?
6. Is there anything else you'd like to tell me, or something you think I should have asked?

Appendix C

Internal E-mail

Subject Line: **Invitation to Participate – Clinical Nursing Instructors Interviews**

Body of E-mail:

Invitation to participate - Interview: Clinical Nursing Instructors Experiences with Students Deemed at Risk of Failure

If you are a clinical nursing instructor working for either UBC or BCIT **you are invited to participate in a study** entitled **Clinical Nurse Instructors Experiences of Teaching Students Deemed at Risk of Failure**. This study is being conducted through the University of British Columbia School of Nursing and the British Columbia Institute of Technology School of Nursing. The study is being conducted by Stefanie MacLeod, MSN(c), UBC Master's Student in Nursing, Bernie Garrett, PhD, RN, Leanne Currie, PhD, RN and Mary Gillespie, MN, RN.

We are interested in exploring clinical instructors experiences of teaching undergraduate nursing students deemed at risk of failure at the University of British Columbia (UBC) and the British Columbia Institute of Technology (BCIT) schools of nursing and to discover if clinical instructors are reluctant to fail students. You are being invited to participate in this research study because clinical instructors' experiences of teaching nursing students deemed at risk of failure have not been adequately addressed in nursing. We want to learn more about how the instructor supports as well as evaluates a student when that student's performance is judged to be unsatisfactory or unsuccessful.

Participation will be outside of your regular work hours. If you consent, your participation will include an in-person interview at a mutually agreed upon place with the research that will take between ½ - 1 hour.

To thank you for your involvement in this important project, you will be given a \$10 gift card for a coffee shop.

Interested in participating?

Please contact Stefanie MacLeod at (XXX) XXX-XXXX (call or text) or email: XXXX@XXXXX.ca or XXXX@XXXX.ca

Please share this with a colleague.