To Pass or to Fail? Understanding the Factors Considered by Faculty in the Clinical Evaluation of Nursing Students

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Abstract:

Making the decision to pass or to fail a nursing student is difficult for nurse educators, yet one that all educators face at some point in time. To make this decision, nurse educators draw from their past experiences and personal reflections on the situation. Using the qualitative method of critical incident technique, the authors asked educators to describe a time when they had to make a decision about whether to pass or fail a student in the clinical setting. The findings describe student and faculty factors important in clinical evaluation decisions, demonstrate the benefits of reflective practice to nurse educators, and support the utility of critical incident technique not only as research methodology, but also as a technique for reflective practice.

Article:

Introduction

Clinical evaluation of nursing students is an important role of nurse educators, who are the gatekeepers to the profession of nursing (Tourangeau et al., 2007). However, clinical evaluation is difficult for faculty, and the process educators go through to make the decision to pass or fail a student is not well understood. There are tools that educators can use for clinical evaluation (Alfaro-LeFevre, 2004, Bofinger and Rizk, 2006 and Scanlan et al., 2001), but completing the process is still problematic (Brown et al., 2007). Part of the difficulty of the process comes from

the fact that the established clinical evaluation tools utilized by faculty are derived from course learning outcomes, which tend to be broad and abstract, and may have little connection to actual specific clinical behaviors that lead to success or failure in the clinical setting. Curricular outcomes generally measure concepts that directly relate to theory content, yet faculty are evaluating students on behaviors that they believe make someone a good nurse. Additionally, professional behaviors, such as appropriate dress and punctuality, are important to assess but may not be reflected in the course learning outcomes. The difficulty of the decision is compounded by the fact that students need time to learn, so mistakes are to be expected (Scanlan et al., 2001), and the line between learning time and evaluation time can become blurred.

The clinical evaluation process is multifactorial, where the faculty member must evaluate data from many sources to reach the decision of whether or not the student has successfully passed the clinical course (Oermann et al., 2009). In a survey of 1573 pre-licensure nursing programs in the United States, faculty reported typically using a variety of evaluation strategies as evidence when determining the summative clinical grade, such as nursing care plans, direct observation of patient care, clinical simulations, or reflective journals which may contain student self-evaluation comments. However, most faculty report that the summative clinical evaluation is determined and recorded using a clinical evaluation tool which is tailored to the course student learning outcomes. Most schools reported grading clinical performance on a pass/fail basis, and narrative comments written on the survey reflected concerns about the subjectivity and inconsistency of the process, especially among faculty in the same clinical course (Oermann et al., 2009).

Faculty members find that failing a student is stressful and lonely. Even experienced faculty find the decision challenging, but it is more of an ordeal for newer faculty and those who are part-time or adjunct faculty (McGregor, 2007). Often faculty are reluctant to ask the advice of colleagues when making this difficult decision, for fear of violating the confidentiality of the student (Diekelmann and McGregor, 2003). The Family Educational Rights and Privacy Act (FERPA) protects students from having their educational information shared inappropriately without their permission, therefore, faculty who do not completely understand FERPA may be unsure if they are permitted to discuss a student situation with a colleague (USDOE, n.d.). Educators who go through this process alone, however, could be missing an opportunity for personal development and growth that could come from reflection and discussion with colleagues.

The benefits of reflecting upon difficult situations in nursing practice have been described by O'Connor (2008), who described how reflection on incidents in her practice allowed her to identify knowledge deficits, make corrections, and prevent comparable incidents in the future. Nurse educators can benefit from similar reflective exercises as they grapple with the decision making required in evaluating clinical students. Reflecting on one's own experiences with clinical evaluation and hearing about the experiences of other faculty can make that process more deliberate. In the study reported here, the authors used critical incident technique to gather information from educators about a time when they had to make a decision about whether or not

to pass or fail a student in the clinical setting. This paper discusses the factors that faculty found important in their decision making.

Critical incident technique (CIT) is a method of data collection that examines the processes used to solve practical problems (Flanagan, 1954). The critical incident technique was used to provide insight into behaviors and habits of the respondents (Alastuey et al., 2005 and Norman et al., 1992). CIT gathers data from subjects that is meaningful to them and stands out as an important, special, even life changing moment. Gathering this type of data allows the respondents to reflect and remember meaningful experiences as a whole, and then choose one of particular significance to them.

The usefulness of CIT to nursing was demonstrated through Keating's work with practicing nurses. Keating (2002) utilized the CIT when studying nursing practice in three diverse nursing settings: neonatal intensive care, palliative care, and care of the demented older adult. She found that the reflective nature of the question allowed the nurses participating in the study to think about their own nursing practice and what interventions worked or did not work when providing care for patients.

Methods

As part of a larger qualitative descriptive (Sandelowski, 2010) study about clinical evaluation (Lewallen and DeBrew, 2012), the authors collected critical incidents from 24 nurse educators in order to describe their decision making regarding student evaluation in the clinical setting. Specifically, participants were asked through semi-structured interviews to describe a time when they had to make a decision whether or not to fail a student in clinical. Educators were given the freedom to choose any student story they felt compelled to share with the researchers, without any prompting to recall a certain type of incident. Probes used included: What was the outcome? How did you decide that the student would pass or fail? Did you feel good about how you handled it when it was over? Did you feel supported by your administration?

Participants

Participants for the study were 24 nurse educators in a southeastern US state; all had at least one year of teaching experience in either an associate degree or a baccalaureate nursing program. Care was taken to select schools of nursing that were representative of the various types of nursing programs in the state where data were collected: associate degree, baccalaureate degree, public, private, and historically minority (Black and American Indian). Nurse educators in the study had a mean age of 47 and had worked an average of 11 years as a nurse educator; most (88%) were Caucasian. Slightly more than half of the sample worked in baccalaureate programs (58%), while the remainder worked in associate degree (2-year) programs. The great majority (88%) did clinical in hospital settings, with med‑surg as the most common clinical specialty (63%). Three-quarters of the sample were master's prepared, and the remainder held a doctoral degree.

Interviews were conducted via telephone by both authors, and participants were provided the interview questionnaire prior to the call. The interviews included questions about successful and unsuccessful nursing students (Lewallen and DeBrew, 2012), and then asked about a specific time when the educators had to make a decision whether or not to fail a student in clinical. Receiving this question ahead of time gave the educators a chance to reflect upon their experiences and choose a critical incident to share with the authors. The phone interviews were recorded, and transcribed.

Prior to data collection, Institutional Review Board approval was granted and each participant signed an informed consent form. Participants agreed to have their phone interviews recorded.

Data Analysis

Content analysis was used to examine the critical incidents. The incidents were read, summarized, and then analyzed for differences in program type, years of faculty experience, age of educator, and reasons for failure or passing of students. The approach to content analysis used (Hsieh and Shannon, 2005) did not rely on predetermined categories or codes, but allowed the discovery of codes by the authors based on participants' responses (Sandelowski, 2000).

Data were gathered from participants from different types of nursing programs, as well as from different parts of the state, in order to gather a variety of viewpoints. In order to ensure trustworthiness of the data, both authors participated in the analysis, as suggested by Flanagan (1954). During data analysis, the demographic characteristics of the participants were kept in mind to determine if any differences were found related to these factors; none were.

The two authors discussed each critical incident together in relation to the entire interview to look for contradictions and the context of the incident. The incidents were then first coded separately, then the codes from all interviews were grouped into categories, and the categories were combined into two broad analytic clusters: student factors and faculty factors.

Results

Critical incidents were collected from 24 nurse educators, and a total of 25 incidents were described. Of the students described, 10 passed the course, and 15 failed; however, one of those who failed was reinstated by administrators. Although all the educators interviewed used clinical evaluation tools based on course learning outcomes, the incidents they chose to describe did not focus on clear failure to achieve a specific learning outcome, but instead on general behaviors that made the evaluation decision challenging.

Student Factors

The broad analytic cluster *student factors* (Table 1) included students' traits described by nurse educators as contributions to the faculty member's decision on whether or not to pass the student.

Table 1. Student factors.

Factor and number of times mentioned
Poor communicators (15)
Student did not make progress (7)
Unsafe medication administration (6)
Unable to prioritize (6)
Unprepared (5)
Weak (4)
Level of student (4)
Student made progress (4)
Previous student failures (4)
Unsafe (3)
Anxiety (3)
Student remorsefulness (3)
Unable to seek out learning opportunities (2)
Unprofessional (1)
Student going through personal problems (1)
Academic integrity (1)

The most common reason given by educators for failing students was that the student was a *poor communicator*. Communication encompassed both verbal and written communication with patients, faculty, and staff nurses. One instructor reported that she was threatened by a student, and another reported that the student was argumentative. One instructor described a student who had difficulty initiating conversation:

> … I had a student that was really afraid of patients. She just didn't know how to communicate with them.

The second most common reason for failing a student was that the student *did not make progress*. Faculty described situations in which students failed to progress even after the faculty attempted to help the students by creating a learning contract or spending extra time with the students. Faculty also noted that some students did not meet all the objectives of the course and therefore failed. One faculty member described a student who failed to make progress in spite of her efforts:

> And he had a plan, he had every opportunity to do it and the last week of clinical he still was doing what he was doing virtually the first week of clinical and so I did fail him.

Unsafe medication administration was cited as an important factor in the evaluation decision by faculty as well; however, a medication error did not automatically result in failure, though it raised suspicions about the competence of the student. One faculty cited a one-time error which did not result in failure because the student acknowledged the error. Another cited a medication error which occurred while the student was with a nurse preceptor; the student did not fail because the faculty member was not present during the error. In the quote below, the nurse educator recounts a time when she questioned the student's medication administration abilities, but did not feel the student could be failed:

> But she was… about to give…a PO, something that was supposed to be PO through a PEG tube. And I said, "Are you good with this, do you know, how to give that?" "Oh yeah, yeah," she knew how to do all that, but something just kind of told me to go and check on her. And as I looked into the room, she was wiping off the triple-lumen catheter and getting set to give a syringe full of PO medicine into the triple-lumen catheter. And when I walked in, she dropped it, and⋯ I said, "You're not going to give that through there, are you?" And she said, "Oh no, no, no, I'm just checking this out." And then she went through kind of an effort of…looking through the covers and that kind of thing, and then she did find the PEG tube and gave it through there.

Being unable to prioritize patient care, which included being unable to identify patient needs, plan care, and think critically, was also cited by educators in their descriptions of critical incidents. They noted the inability of some students to perform skills, and their inability to plan and organize their day. One faculty member said:

> The minute I would ask her questions, she would start tearing up and fumble on words that she had to say. …but as we talked, and as I helped her more into…planning and organizing her day, she got more and more comfortable and, ultimately, when she progressed on and went to the next clinical instructor, that particular clinical instructor said [she was the best student]. She had changed and grown to be a good nursing student.

Lack of preparedness, including being slow, disorganized, and sloppy, was cited as a reason for student failures and was described by one faculty member as follows:

Come the first day of clinical, not prepared. She blatantly said, "well I just didn't do this."
No extra, "oh I just didn't do this." So of course she was sent home.

Faculty members described students who failed as *weak* students, but this was an ambiguous
term. A weak student was often described as one in whom the faculty could not identify a
specific deficit or problem, but could only describe as *weak*. The uncertainty felt by the faculty is
illustrated by this comment:

Well I told the people over me that I kind of felt uneasy passing her, but they ···basically
said "Well, you put her on a contract. Did she do what you said in the contract?" Well
yeah, but just barely. And they said "Well, there really isn't a way, university-wise, that
we can fail her if she's met what you have put down on that contract, and what she agreed
to do, if she agreed to do it and you agreed for her to do it, and she did it, then you're
going to have to pass her."

Another ambiguous term used in the study was *level* of the student. Faculty cited the level of the
student as contributing to failure. Students not at the same level as their peers, not at the level for
the year in the program, and not at the level of a graduating student nurse were more likely to
fail. For example, one instructor said:

Assessment skills borderline, I mean he'd get in there and use his stethoscope and did
some vital signs, but not really the level he should have been at. He was more of a first
year level even though he was ready to graduate.

Students who made progress passed the course. Faculty cited several examples of students who
demonstrated progress and ultimately met the course objectives and passed. One faculty member
commented:

And the interesting thing was, when she came and did clinical for me for those couple
weeks, she was right on the money. I couldn't catch her for anything, and that's really
what it is. She never fell below that line to say you're right, she's unsatisfactory. And then
when she went back to her regular clinical instructor, she did fine the rest of the semester.
Her summative evaluation to send her into capstone was this student has met the minimal
competency to practice at the level of a [nursing] student.

Some faculty were aware of past failures by students, and this seemed to contribute to their
decision to fail the student now. For example, they scrutinized students more closely who had
failed previously, either in another course, or another program, or were failing in the classroom
component of the course. One faculty member described two students who had failed in the
classroom, but passed in clinical:

I never saw him provide unsafe care for a patient. … And he is one that failed three other
courses. And so I … passed him in clinical.

Three faculty cited being *unsafe* in their critical incidents. One said, "unsafe students should fail." Another faculty described a student who was unsafe with insulin administration:

> And she was an older lady and she was really nice but she just was not a safe – she just couldn't get it. She just could not understand – and she had multiple remediations. She had to…do a paper, she had to return to the lab, she had to… take another test and she still, she did the same exact thing in clinical when she returned.

Student *anxiety*, or appearance of anxiety, was cited by three faculty in their critical incidents. Anxiety was thought to interfere with interactions with faculty, and also with patients, as described below:

> But it was to the point where she couldn't even get to the performance of it because she was just always so fearful and so shy. And we also sent her to counseling just to kind of deal with anxiety. So I just think it was just kind of one of those well-rounded kind of things that maybe a year will help.

Student remorsefulness, which included student admission of guilt, respectfulness, and being "appropriately remorseful", was mentioned by three faculty members in their critical incidents. Interestingly, those students who were polite and apologetic, yet had committed some error that could result in failure, did not fail.

> And I said, I don't want you to give meds for the rest of your shift this week, and I'm going to come back and see you next week… I'm going to observe your process, and it was a mistake made between her and her preceptor, and she was appropriately remorseful, and seemed to do well after that, so I didn't think that she needed to fail, but if she had made one more medication error, or any other major errors this semester, I would have failed her.

One faculty member stated that, in the case of one student who failed, if the student had admitted guilt, the failure would have been overturned.

Students who were *unable to seek out learning opportunities*, described by one person as *not engaged*, were mentioned in two critical incidents.

> She basically just kind of shut down and stopped trying to learn… she would show up and I'm not even sure why, but…was not engaged,

Final reasons for failure, each cited once, were *unprofessional behavior*, *student going through personal problems*, and *academic integrity issues*.

> …she had lots of different… excuses… but when it came down to it she finally admitted that there were some personal problems that she had. And she really never admitted them to me; she admitted them to the director. So she was allowed I think medical

withdrawal… mental health kind of thing and… I think she came back and finished and had a totally different attitude by the time she came back.

Faculty Factors

The second broad analytic cluster revealed by the critical incidents was *faculty factors*. This cluster included the faculty members' beliefs, feelings, and influences in failing students in clinical (see Table 2).

Table 2. Faculty factors.

Factor and number of times mentioned
Faculty emotions (5)
Faculty believes student not meant to be a nurse (5)
Faculty perceived cultural differences (3)
Presence or absence of administrative support (3)

One of the most commonly cited categories was *faculty emotions*. It was apparent that the decision to pass or to fail a nursing student was difficult, and one that some faculty felt insecure about making. One faculty member said that her co-workers tried to influence her decision, while another felt fearful enough to notify security when she met with the student.

This particular student. I had security on standby because, again, I wasn't sure how he was going to perceive it. How he was going to take it. It was very scary.

A common belief among faculty was that the failing *student did not want to be a nurse*. Faculty came to this conclusion when no other explanation for the student behavior could be given.

One student repeatedly came to clinical unprepared. And they were sent home several times. And they just didn't turn it around. I really don't think they learned from the situation. … they also had come [sic] from another nursing program where they had failed out there and… you know, I just don't think that this person was meant to be a nurse.

Two faculty, in an attempt to explain student behavior, said that the student had *cultural differences* that led to some inappropriate behavior. The faculty member seemed to be speculating about what might be causing certain behaviors in students.

…I don't know if it was culturally, but just not…being able to really communicate with her patient. when I walked into the room, she would always be in a corner.

Finally, *administrative support* was sometimes an issue; one faculty member said that she had administrative support to fail students, while another said she did not. Perhaps when an extreme incident was shared, the decision to fail the student was clear. This may not have been the case in some of the gray situations involving student failure. An example of an unclear case follows:

> And despite the fact that we set her up on a contract, and she just barely met… the points of the contract…, I really felt like I really did not want to pass her. … but felt that those that were above me, would have said, well, look she didn't do anything unsafe, so why not pass her, you know.

Discussion

The findings showed that clinical evaluation decisions can be ambiguous and inconsistent, based on student characteristics and behaviors, and influenced by faculty factors; and are consistent with prior research (Brown et al., 2007, Diekelmann and McGregor, 2003 and Scanlan et al., 2001). Faculty in our study cited problematic behaviors that they found difficult to quantify based on clinical objectives, so were left feeling uneasy even when the student technically met the objective. The literature shows that other faculty have similar concerns. For example, Isaacson and Stacy (2009) describe difficulties with clinical evaluation including translating academic jargon found in course outcomes to actual clinical behaviors, deciding when to transition from time for learning to time for evaluation, subjectivity of the process, and lack of experience and support in clinical evaluation, especially for novice faculty. They recommend the use of rubrics to translate course outcomes into actual clinical behaviors and clearly delineate the adequacy of performance that is expected. Concerns about clinical supervision are not limited to nursing faculty. In a review of literature regarding the supervision of practicing nurses by their supervisors, supervisors were found to have anxiety related to their ability to adequately provide clinical feedback to their employees (Butterworth et al., 2008). Preceptors of newly graduated nurses also expressed concern about their ability to teach and evaluate their preceptees and expressed the need for more education and support in the role (Sorensen and Yankech, 2008).

The evaluation process is difficult, time consuming, and sometimes painful for nurse educators. Perhaps using the term "process" is a misnomer because there seemed to be no standardized proactive procedure in place, but rather a reaction to student behaviors. In spite of the difficulty with the pass/fail decision, nurse educators make this decision with careful thought. Nurse educators view themselves as the gatekeepers to the profession as they make the important decision of which students will graduate and eventually take the licensure exam. This was evident in the respondents' statements. Nurse educators are preparing those who will care for the public's health and well being (Tanicala et al., 2011). While it is important to keep the public safe; it is not clear how much we know about safety among nursing students. For example, we do not know whether unsafe students are also unsafe nurses, or whether they are ultimately better nurses because they have learned from their mistakes. As suggested by Tanicala et al., these

questions should be addressed in nursing education as we move from a culture of blame to a culture of safety.

Many of the student factors that lead to the pass/fail struggle, such as difficulties with communication, being unprofessional, and being labeled as *weak*, are not only difficult to measure, but are also difficult to teach. Behaviors such as effective communication, professionalism, and strong clinical skills were cited by these faculty as critical to being successful in nursing school (Lewallen and DeBrew, 2012); however, it is unclear whether these skills are being taught to students, or whether nurse educators expect students to inherently know these behaviors. This disconnect is similar to what Allan et al. (2011) call the *hidden curriculum*, which refers to the expectations and practices of a certain profession that are learned outside of the formal academic setting, for example, in the clinical setting. Allan et al. found that there is a breakdown in nursing education: there is an expectation by staff nurses that students should be prepared to work while in the clinical setting, rather than observe, participate, and learn. It is possible that nurse educators, particularly newer faculty and those who continue to practice nursing outside of their educator role, fail to recognize the*hidden curriculum* and expect students to possess skills and characteristics they have not been taught.

Faculty factors show that the decision making process of passing or failing clinical is difficult. Diekelmann and McGregor (2003) found that when nurse educators fail a student, the faculty member feels like a failure as well. This negative feeling only makes a difficult situation even more difficult because the educator experiences self-doubt. Educators tend to question their decisions and have sometimes allowed influences, such as colleagues and administration, to become a part of the decision making process. Administrative and colleague support, when utilized in the decision making process, was helpful to educators. However, input from administration and colleagues given after the nurse educator made her decision was not viewed in a supportive way. Diekelmann and McGregor (2003) point out that administrative goals, faculty goals, and student goals can conflict, only adding to the difficult nature of this process. And while collegial support can be helpful, the fear of violating the U.S. Family Educational Rights and Privacy Act (FERPA) must be considered, as well as the possibility of creating a bias against the student with their future faculty members (Scanlan et al., 2001). Preceptors of new graduate nurses also report feeling guilty when the nurses they precepted left the facility soon after orientation, or were not successful. In one study, preceptors reported lack of support from their colleagues, and feeling pressure from administration to complete evaluation forms under intense time pressure (Chen et al., 2011).

Further study is needed to fully understand more about the process used by nurse educators when deciding to pass or fail a student in the clinical setting. However, recommendations can be derived from this study that can make the process more beneficial for both faculty and students. First of all, clinical evaluation needs to be standardized, at least within institutions, so that students are being evaluated on their progress towards program outcomes, and clinical evaluation tools should be better aligned with desired clinical behaviors so as to be relevant to the students.

Second, structured reflection on the clinical experience may benefit both student and teacher. Rogers (2001) states that reflective practice leads to "…enhanced personal and professional effectiveness" (p. 55). Coward (2011) encourages the use of student journals as a tool for self-reflection. Tigelaar et al. (2006) describe the use of portfolios as a way to examine one's beliefs, as well as a way to learn from experience. Portfolios could be used by students throughout the nursing program to reflect upon their clinical experiences and mistakes made, which could lead to greater self-awareness and improved clinical performance. Murphy and Timmons (2009) discuss the usefulness of reflection in improving nurse educator practice, and especially stress improved self-confidence and the awareness that the educator is not alone in his/her feelings as key benefits of structured reflection.

To examine the usefulness of reflection more closely in our study sample, a follow-up question was sent to our participants asking them to describe any changes in their teaching practice that occurred since participating in the study. Three of the 24 participants were unable to be located, so 21 were sent the question by email and 10 responded. Five of the ten respondents reported that the opportunity given to them through participation in the study to reflect upon their clinical evaluation process resulted in a change in their own teaching. Examples of their comments include:

> Yes…as the student begins to veer off course I quickly point them back on track. I do not think it would have changed the outcome of the unsuccessful student because he was having a crisis in his life but I am more likely to give students feedback earlier than later.

Yes, I have made efforts to utilized more objective criteria for making these pass/fail decisions. For example, a revised rubric. Also, my documentation process of unsatisfactory clinic performance and the revised rubric have been linked directly to the student learning outcomes for the course.

Definitely, following my reflection I realized that I need to put other measures in place to ensure I am treating the student fairly. Taking the survey moved the blame off the student to me.

Personal reflective practice, as described by Mezirow (1991), could help educators become more comfortable with their clinical evaluation decisions. Mezirow believes that reflection must include a "…critical assessment" (p. 104) of the situation, which includes the meanings and beliefs that one brings to it. This can be hard for nurse educators, who must then examine their own biases towards students, and their beliefs about what makes a *good* nurse. Diekelmann and McGregor (2003) suggest that clinical evaluation driven only by course outcomes fails to allow educators to see the desirable qualities that a student might possess, because evaluation tools do not allow the instructor to understand the meanings that students ascribe to the clinical experience. Reflection could help nurse educators sort through their own views of the clinical student who is questionable, as well as what it means to the educator as a *good* clinical instructor. Nurse educators who reflect upon their own process of passing and failing students

can learn from the process and make changes to benefit themselves, future students, and their colleagues. One nurse educator in our study said that her experience with failing a student in clinical was presented in a case study format to her colleagues at their annual faculty workshop. From this presentation and discussion, policy changes were made in her school of nursing. Due to a small sample size, our findings do not clearly demonstrate that reflection improves the performance of faculty in clinical evaluation, but provides information that demonstrates that reflection could be helpful in assisting clinical faculty in the difficult role of student assessment.

Conclusions

Nurse educators interviewed for this study described student factors, as well as faculty factors, as important in the decision whether to pass or fail a student in the clinical setting. Making the decision to pass or to fail a nursing student is often difficult for nurse educators. Clinical supervisors of practicing nurses and preceptors of new graduate nurses express similar difficulty in performing their roles. When faced with this decision, nurse educators draw on their past experiences and personal reflections on the situation to make a final decision. Deliberate, intentional reflective practices are helpful to nurse educators to continually assess their own teaching to ensure that students are being evaluated appropriately. A clearer perspective on clinical evaluation could benefit faculty, students, and ultimately the patients who are the recipients of nursing care.

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