PROCESSES USED BY NURSING FACULTY WHEN WORKING WITH UNDERPERFORMING STUDENTS IN THE CLINICAL AREA: A THEORETICAL MODEL DERIVED FROM GROUNDED THEORY

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PROCESSES USED BY NURSING FACULTY WHEN WORKING WITH UNDERPERFORMING STUDENTS IN THE CLINICAL AREA: A THEORETICAL MODEL DERIVED FROM GROUNDED THEORY

Clinical nursing faculty members often work with students who underperform in the clinical area. Underperforming students are those who exhibit deficits in nursing knowledge, the application of nursing knowledge, psychomotor skills, motivation, and/or interpersonal skills. The outcomes of faculty work with underperforming students have implications for patient safety and the nursing workforce, yet little is known about how faculty work with underperforming students. The purpose of this project was to develop a theoretical framework that describes how clinical faculty work with underperforming students in the clinical area.

Twenty-eight nursing faculty who had worked with underperforming nursing students during clinical rotations were interviewed and invited to tell stories about working with these students. Their narratives were analyzed using constant comparison analysis, and a theoretical framework was developed. The framework included three stages that unfolded as faculty worked with underperforming students over time. The first stage, *Being Present*, was the process by which faculty came to know students were underperforming. They did this by noticing red flags, taking extra time with students, working side-by-side with students, and connecting with students "where they were at." The second stage, *Setting a New Course*, was the process by which faculty attempted to provide remedial experiences to improve the performance of those students determined to be underperforming. The participants did this by beginning a new course of instruction

for the students, bringing in new people to help the students, and creating new learning experiences for them. This process could result in students turning it [their performance] around, making it through [the clinical rotation], or not making it. The final stage, *Being Objective*, was the process by which participants made negative progression decisions. They did this by relying on objective indices, documenting problematic student behaviors, and obtaining validation for their decisions.

The findings of the study provide foundational information needed to begin the development of evidence-based strategies for faculty who work with underperforming students. Such strategies could have important implications for student success, faculty satisfaction, patient safety, and the nursing workforce.

Claire Burke Draucker, PhD, RN, FAAN, Chair

TABLE OF CONTENTS

CHAPTER I

Introduction

Clinical nursing faculty are responsible for identifying students who are underperforming in the clinical area, making decisions about their progression, and planning remediation strategies if needed (Anastasi et al., 2006; Boley & Whitney, 2003; Katz, Woods, Cameron, & Milam, 2004; Scanlan, Care, & Gessler, 2001). Clinical education provides the best opportunity for nursing students to develop the competences required to succeed in the profession (Anastasi et al., 2006). Identifying best practices for clinical teaching of underperforming students has critical implications for both patient safety and the nursing workforce, yet little is known about how faculty work with underperforming students in the clinical area (Robert Wood Johnson Foundation [RWJF], 2011b; Robshaw & Smith, 2004).

While the majority of nursing students perform adequately in the clinical area, some underperform. Although students can underperform in a variety of ways and can vacillate between adequate performance and substandard performance, underperforming students struggle at some point in their programs to meet minimum standards for providing optimal clinical care (Grealish & Ranse, 2009; Mossey, Montgomery, Raymond, & Killam, 2012; Poorman, Mastorovich, & Webb, 2011; Teeter, 2005). Underperformance is associated with failure to seek faculty support, behaviors that suggest lack of enthusiasm, and disappearance from patient care areas (Hrobsky & Kersbergen, 2002; McGregor, 2007; Robshaw & Smith, 2004). Nursing educators have few guidelines to assist them in identifying and assessing underperforming students,

developing remediation strategies for them, and making decisions about their progression (Killam et al., 2010; McGregor, 2007; Robshaw & Smith, 2004; Teeter, 2005).

Underperforming Students and Patient Safety

Underperforming nursing students can pose risks to patient safety both as students and later as new practitioners. If students who are underperforming are not identified and their performance is not remediated, they are at risk for becoming unsafe practitioners who pose threats to patients, themselves, and the institutions that employ them (Duffy, 2003; Killam et al., 2011; Neary, 2001; RWJF, 2011b).

The Institute of Medicine (IOM) has identified patient safety as a strategic national health issue (IOM, 2000, 2001, 2003, 2004a, 2004b, 2007, 2011). The initial IOM report indicated that up to 98,000 deaths occur each year in hospitals from preventable adverse events. Adverse events are incidents that result in unintended harm to patients by acts of commission or omission by healthcare providers rather than by the underlying disease or condition of the patient (IOM, 2000). Adverse events, including those that resulted in serious but treatable complications, cost the federal Medicare program nearly $7.3 billion and resulted in 79,670 preventable deaths from 2007 through 2009 (Reed & May, 2011).

Patient safety concerns are often associated with the complexity of the healthcare environment (Ebright, Patterson, Chalko, & Render, 2003; Marshall, Jones, & Snyder, 2001; Murphy, Ruch, Pepicello, & Murphy, 1997) and extensive demands on nurses at the point of care (Aiken, 2008; Aiken, Clarke, Sloane, Lake, & Cheney, 2008; Aiken, et al., 2011). Responsibilities of registered nurses (RNs) have become increasingly complex as RNs are called upon to perform a wide variety of tasks, many of which were

not previously considered part of their role (IOM, 2011). In today's healthcare environment, nurses are required to manage multiple distractions, role ambiguity, unpredictable work assignments, and considerable time pressures (Ebright et al., 2003; Ebright, Carter Kooken, Moody, & Latif Hassan Al-Ishaq, 2006; Murphy et al., 1997). According to the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), approximately 24% of unanticipated events in hospitals that result in death, injury, or permanent loss of function are directly linked to nursing at the point of care (Competencies for the 21st Century, 1998; IOM, 2000).

Learning best practices to ensure patient safety at the point of care is an integral part of clinical education in nursing. While most nursing students practice competently and safely under the supervision of nursing faculty, underperforming students may place patients at risk by providing inadequate care (Gregory, Guse, Dick, & Russell, 2009; Neudorf, Dyck, Scott, & Dick, 2008; Shorthall, 2007). Nursing students have clinical experiences in complex healthcare environments and are called upon to respond to urgent patient needs and prioritize nursing actions, yet they have not fully developed the skills required to prioritize patient care and organize their work (Benner, Sutphen, Leonard, & Day, 2010; Casey, Fink, Krugman, & Propst, 2004; del Bueno, 2001; Grealish & Ranse, 2009; Tanicala, Scheffer, & Roberts, 2011). In one school, nursing students were responsible for 154 unsafe events between the years of 1999 and 2005 (Gregory et al., 2009).

Upon graduation, underperforming students who are not identified and remediated are at risk to become underperforming and possibly unsafe practitioners (Brown, Neudorf, Poitras, & Rodger, 2007; Casey et al., 2004; del Bueno, 2001; Duffy, 2003;

Heaslip & Scammell, 2012; Killam et al., 2011; RWJF, 2011b). In one study, approximately only 30% of new graduates were able to meet minimal competency requirements (del Bueno, 2001), creating economic as well as patient safety issues for hiring institutions. Duffy (2003) argues that nursing education programs should enhance the structures, procedures, and processes that underpin clinical assessment in order to provide more competent graduates.

The discipline of nursing has been at the forefront of the patient safety movement (Benner et al., 2010; Clancy, Farquhar, & Collins Sharp, 2005; Ebright et al., 2006; Edmond, 2001; Finkelman & Kenner, 2007; Gregory et al., 2009; Hughes & Clancy, 2005; Neudorf et al., 2008; RWJF, 2011b; Tanicala et al., 2011), and nursing programs are tasked with preparing future nurses with skills necessary to practice safely within complex systems (Ebright et al., 2006). Determining effective educational approaches for working with underperforming students at risk for engaging in unsafe practices contributes to national efforts to enhance patient safety. Information on how nursing faculty work with underperforming students, therefore, can be used as a foundation for determining best practices for teaching students who struggle with performance in their clinical rotations and will ultimately contribute to safer patient environments.

Underperforming Students and the Nursing Workforce

Failure to address the problem of underperforming students could also contribute to the nursing shortage. The Bureau of Labor Statistics (2012) indicates that there are currently 2,737,400 RNs in the United States. By 2020, an additional 711,900 RNs – an increase of 26% – will be needed to meet workforce demands in health care settings. The American Association of Colleges of Nursing (AACN) reports that the numbers of

qualified students rejected from nursing schools have increased from 3,600 in 2002 to 52,115 in 2010 (RWJF, 2011a), and that applications to entry-level Baccalaureate of Nursing (BSN) programs have increased by 70% in the last 5 years (IOM, 2011). In 2006, the National League for Nursing (NLN) reported 147,000 qualified applicants were turned away from accredited nursing programs due to faculty shortages, lack of clinical placement sites, and inadequate classroom spaces (Benner et al., 2010). As seasoned nursing faculty members retire in greater numbers, schools will be unable to keep pace with the demand for competent graduates (Orsolini-Hain & Malone, 2007). Yet, approximately 11% of students admitted to RN programs do not complete their education, and another 14% do not pass the National Council Licensure Examination (NCLEX) on their first try (Kovner & Djukic, 2009). These individuals, many likely to be underperforming students, occupied essential spots in nursing schools that could have been filled by other qualified individuals (Kovner & Djukic, 2009). Educational practices that increase the likelihood for students to successfully complete nursing programs and become effective and dedicated practitioners thus have significant implications for the future nursing workforce.

Identifying, Assessing, and Evaluating Underperforming Students

Clinical nursing faculty need to assess and evaluate student performance in the clinical area and, at times, determine if a student is underperforming. Once faculty members identify characteristics and behaviors of underperformance, they must appropriately assess and evaluate the extent of each student's underperformance. Assessment provides formative information that students can use to determine their clinical progress while evaluation provides summative information and is designed to

measure student competency against benchmarks that provide grading criteria and evidence for progression decisions (Duffy & Hardicre, 2007a).

Optimal student assessment occurs when there is an atmosphere of respect between student and teacher, learning objectives have been clearly delineated, multiple evaluation methods are used, and timely feedback is provided (Duffy, 2003; Gallant, MacDonald, & Smith Higuchi, 2006). Student assessment and evaluation can be inadequate if faculty do not have ample opportunity to observe student practice (Brown et al., 2007; Dolan, 2003; Duffy, 2003, 2004), fail to take into account patterns of behavior, and do not consider the degree of patient care required as a context in which the student is evaluated (Parker, 2009; Tanicala et al., 2011). Most clinical assessment and evaluation approaches focus on technical skills and observable psychomotor behaviors rather than on the cognitive and affective domains of practice – areas that can be the most problematic for underperforming students (Anastasi et al., 2006; Fahy et al., 2011; Miller, 2010; Neary, 2001; Parker, 2009).

Despite the importance of evaluation of clinical performance, most research on evaluation in nursing education has focused on academic competence rather than clinical expertise. Student success is often associated with passing the NCLEX or various forms of high-stakes NCLEX predictor testing (English & Gordon, 2004; Morrison, Free, & Newman, 2002; Reinhardt, Keller, Summers, & Shultz, 2012; Sayles, Shelton, & Powell, 2003; Sifford & McDaniel, 2007; Spurlock, 2006; Stuenkel, 2006). Nursing students fail academic classes five times more frequently than clinical courses (Hunt, McGee, Gutteridge, & Hughes, 2012), suggesting that underperformance in clinical areas may be more difficult to evaluate, and faculty may allow students with clinical performance

deficits to progress without remediation (Duffy, 2003; Luhanga, Yonge, & Myrick, 2008a, 2008b; Rutkowski, 2007). Nonetheless, research regarding evaluation of clinical ability and identification of underperformance is limited (Grealish & Smale, 2011; Katz et al., 2004).

Developing Remediation Strategies for Underperforming Students

Once faculty members determine that students are underperforming, faculty need to provide remediation in performance areas in which students demonstrate deficits (Sifford & McDaniel, 2007). Remediation strategies are based on the belief that additional resources and support will improve students' chances for success (Gallant et al., 2006).

Although much research has focused on remediation for academic underperformance, less is known about successful remediation strategies for nursing students who underperform in clinical. Some research has shown that underperforming students can benefit from focused approaches that include formal meetings between students, clinical faculty, and program administrators as well as the development of student-centered remediation goals and learning contracts (Brown et al., 2007; Duffy, 2003; Gallant et al., 2006; Harding & Connolly, 2012; Jeffreys, 2007; Teeter, 2005; Woodcock, 2009). Underperforming students may also benefit from clinical tutorials or discussion groups where students, preceptors, and faculty discuss and reflect upon actual patient care situations (Haugan, Sorensen, & Hanssen, 2011). Tutorial groups allow students to reflect on the care they provided, while faculty members gain a better understanding of students' knowledge deficits (Haugan et al., 2011). Patient simulators likewise provide remediation opportunities where faculty can determine areas of student

weakness, develop remediation strategies, and provide clinical learning through simulation without increasing student anxiety and patient risk that would most likely occur in the clinical setting (Haskvitz & Koop, 2004; Reising & Deivich, 2004).

Faculty members are often called upon to provide supportive individualized mandatory and/or voluntary interventions for underperforming students but have little to guide them on best remediation practices (Jeffreys, 2007). Research indicates that faculty generally spend more time demonstrating and documenting student failure than developing remediation processes to support student success (Diekelmann & McGregor, 2003; Gallant et al., 2006; Poorman, Webb, & Mastorovich, 2002). Despite the importance of the process of remediation of underperforming students, little is known about how faculty develop and implement remediation strategies in practice.

Making Progression Decisions Regarding Underperforming Students

Clinical nursing faculty members need to make decisions about the progression of students who are underperforming in the clinical area. Decisions about progression can create practical as well as emotional concerns for faculty, in part due to threats of student appeal and repercussions from clinical failure (Duffy, 2003; Boley & Whitney, 2003; Walsh & Seldomridge, 2005; Westrick, 2007). Although these decisions ought to be based on reasoned assessments, application of policies and procedures of the faculty members' institutions, and consideration of student rights (Boley & Whitney, 2003; Killam et al., 2010; Westrick, 2007), clinical faculty members often have little to guide their decisions about whether to progress, retain, or dismiss underperforming students. Current assessment tools fail to provide standardized criteria on which to make these decisions, and such decisions are even more problematic when underperformance is

related to attitude and personality factors rather than skills or knowledge (Duffy, 2003, 2004; Miller, 2010; Parker, 2009). Research also suggests that decisions about student progression may be more associated with faculty concerns than indices of student competence (Brozenec, Marshall, Thomas, & Walsh, 1987; Heaslip & Scammell; 2012; Tiwari et al., 2005). For example, clinical faculty report being reluctant to fail underperforming students for a variety of reasons. Faculty worry about the financial and emotional impact of failure on students, wish to avoid the negative consequences that failing a student might have on their own careers, lack clear guidelines about processes to follow once they find students to be underperforming, lack confidence in their own judgments, believe that students might improve in subsequent clinical placements, consider student failure to be a personal or professional failure for them, feel pressure to produce more graduates, and desire to avoid hassles associated with failing a student due to time and workload pressures (Brown et al., 2007; Duffy, 2003; Heaslip & Scammell, 2012; Jervis &Tilki, 2011; Luhanga et al., 2008a; Miller, 2010; Poorman et al., 2011; Scanlan & Care, 2004; Scanlan et al., 2001; Watson & Harris as cited in Duffy, 2003). In some cases, underperforming students were allowed to progress because decisions about progression were left until faculty considered it to be too late to remediate students' underperformance (Duffy, 2003; Scanlan et al., 2001).

Purpose and Research Questions

The purpose of this project was to develop a theoretical framework that describes how clinical faculty work with underperforming students in the clinical area. The research questions were:

- How do clinical faculty identify, assess, and evaluate nursing students who are underperforming in the clinical area?
- How do clinical faculty remediate underperforming nursing students in the clinical area?
- How do clinical faculty make decisions about the progression of nursing students who are underperforming in the clinical area?

Definition of Terms

The major terms addressed in this study are listed and defined below.

Assessment: Multifaceted methods of judging the effectiveness of students' performance to provide formative feedback about their current status (Duffy, 2003; Duffy & Hardicre, 2007a; Gallant et al., 2006).

Clinical failure: The inability of a nursing student to meet clinical course objectives sufficient to allow progression within the program (Gallant et al., 2006; Haskvitz & Koop, 2004).

Clinical nursing faculty: An individual who is hired by a school of nursing to provide instruction for students in their clinical rotations.

Evaluation: Use of assessment strategies to provide summative feedback for the purpose of grading and making progression decisions (Anastasi et al., 2006; Duffy & Hardicre, 2007a; Fahy et al., 2011; Miller, 2010; Neary, 2001; Parker, 2009).

Identification: Use of observation, faculty-student interaction, and feedback from clinical staff to formulate a preliminary opinion that a student is at risk for underperformance.

Progression: Student succession to the next course or level within a nursing program (Boley & Whitney, 2003; Killam et al., 2010; Westrick, 2007).

Remediation: The provision of supplemental teaching/learning approaches to facilitate performance in areas that students have deficits (Gallant et al., 2006; Sifford & McDaniel, 2007).

Underperforming student: A nursing student who exhibits significant deficits in nursing knowledge, the application of nursing knowledge to clinical practice, psychomotor skills, motivation, and/or interpersonal skills and who may provide unsafe patient care (Duffy, 2003; Hrobsky & Kersbergen, 2002; Luhanga, Yonge, & Myrick, 2008a; Robert Wood Johnson Foundation [RWJF], 2011b; Scanlan et al., 2001).

Qualitative Study of the Problem

Grounded theory methodology (Glaser & Strauss, 1967) was used for this research project. According to Charmaz (2006), grounded theory methods "consist of systematic, yet flexible guidelines for collecting and analyzing qualitative data to construct theories grounded in the data themselves" (p. 2). Consistent with symbolic interactionism (Mead, 1934), grounded theory focuses on individuals' actions and the interactions and meanings that arise from them and is used to identify psychosocial processes of individuals who share a common challenge (Bryant & Charmaz, 2007). Because this researcher believes clinical nursing faculty share the common challenge of working with students who are underperforming and respond to this challenge with shared processes that change over time, grounded theory was the appropriate approach for this study.

The researcher interviewed 28 clinical baccalaureate nursing faculty members who had a minimum of five years' teaching experience, including clinical rotations in adult acute care or medical-surgical settings, and who had worked with underperforming students. Telephone interviews using a semi-structured interview guide were conducted. Participants were invited to describe how they worked with underperforming students. Their narratives were analyzed with standard grounded theory analytic techniques and a theoretical framework describing how faculty work with underperforming students in the clinical area was developed.

Assumptions

The research design for this study was based on the assumption that most faculty who teach clinical in the clinical setting will work with underperforming students at some point and will be able to describe those experiences.

Organization of the Dissertation

This dissertation consists of an introduction to the problem (Chapter 1), a review of current literature on the teaching of underperforming students in clinical nursing courses (Chapter 2), a discussion of the research methods and procedures that were used to conduct this study (Chapter 3), a presentation of the findings and the theoretical framework (Chapter 4), and a discussion of the research (Chapter 5).

CHAPTER II

Review of the Literature

Clinical faculty members are responsible for working with underperforming nursing students in the clinical area. Clinical faculty identify, assess, and evaluate student underperformance; develop remediation strategies aimed at facilitating the success of underperforming students; and make decisions about student progression in nursing programs. Although effective practices for working with underperforming students have implications for improving patient safety and ensuring a robust nursing workforce, little is known about how clinical faculty work with underperforming students in practice. Identifying the processes by which faculty work with underperforming students can provide foundational information for identifying effective educational practices and enhancing the success of this student group. In this chapter, the problem of underperformance by nursing students in the clinical area is discussed and literature concerning the identification, assessment, evaluation, remediation, and progression of underperforming students is reviewed.

Underperforming Nursing Students in the Clinical Area

For the purpose of this research, clinical nursing students who exhibit significant deficits in nursing knowledge, are unable to apply knowledge to clinical practice, are unmotivated, and/or lack technical or interpersonal skills are considered underperforming (Duffy, 2003; Hrobsky & Kersbergen, 2002; Luhanga et al., 2008a; Robert Wood Johnson Foundation [RWJF], 2011b; Scanlan et al., 2001). These students may provide unsafe care and often fail to complete their programs of study (Scanlan et al., 2001).

Several studies have examined what faculty members consider to be good and poor student clinical performance. In one study, nurse educators (n=24) indicated that successful students come to clinical prepared, think critically, communicate well, have positive attitudes, are eager to learn, show progress, accept feedback, and adapt well to the clinical setting. They suggested that unsuccessful students come to clinical unprepared, do not function well, use unsafe practices, have ineffective communication skills, and violate legal-ethical principles (Lewallen & DeBrew, 2012). Similar characteristics were identified in another study in which four preceptors in a school of nursing were asked to discuss their experiences in working with underperforming students (Hrobsky & Kersbergen, 2002). These preceptors indicated that students required closer supervision and were at risk for clinical failure when they neglected to ask questions, had unsatisfactory skill performance, and exhibited unenthusiastic attitudes toward nursing. These characteristics were most concerning when exhibited early in the clinical portion of the students' nursing program (Hrobsky & Kersbergen, 2002). Though few studies use the term "underperforming student," some studies have been conducted with students thought to be providing unsafe patient care. In an integrative literature review, for example, characteristics of these undergraduate nursing students included ineffective interpersonal communication patterns, incompetence in knowledge and skills, and unprofessional demeanors (Killam et al., 2011).

Tanicala et al. (2011) obtained faculty (n=11) descriptions of clinical behaviors exhibited by what the researchers referred to as "borderline" students. The researchers considered borderline students to be those who come to the clinical setting under the influence of alcohol or drugs, come to clinical unprepared, submit poor quality written

work, lie, are unable to think critically, fail to blend theory and practice, lack the ability to look at the whole picture, make errors or "near misses," perform fluid and dosage calculations incorrectly, fail to meet agency expectations, fail to seek assistance, have inappropriate patient interactions, and/or appear uncaring. In this study, focus groups were held with faculty members to ask them what they thought constituted clinical failure, what behaviors should result in clinical failure, and what discriminated a passing versus a failing grade. Participants indicated that determination of failure should include consideration of students' placements in their programs, the type of problematic behaviors they exhibited, and the repetitive nature of these behaviors. The participants suggested that if students did not meet established standards or maintain patient safety, they should fail clinical. The participants, however, were unable to identify a specific point at which failure should occur.

Student perspectives on clinical underperformance have also been studied. Killam et al. (2010) sampled nursing students and clinical educators from four different institutions. Based on a literature search and focus groups with undergraduate nursing students, the researchers identified 39 characteristics of unsafe nursing students in clinical practice environments. They then asked nursing educators (n =14) and students (n = 57) to identify the safety risk of each of the 39 characteristics. Using Q-methodology, the researchers identified three main factors that contributed to students' unsafe practice: compromised professional accountability, incomplete praxis, and clinical disengagement. Compromised professional accountability occurs when students make up assessment data, come unprepared to care for assigned patients, are unable to think through nursing interventions, and avoid the clinical educator. Incomplete praxis occurs when students

document poorly, exhibit discomfort performing basic skills, pretend to know things they do not know, make independent decisions about patient care beyond their current knowledge level, and fail to follow standard procedures. Clinical disengagement occurs when students do not follow the instructions of the clinical educator, display disengaged attitudes toward clinical activities and learning, fail to focus on patient care, and disrespect the needs of the patient. The researchers concluded that when students consistently exhibit these characteristics, further assessments and remediation strategies are essential for patient safety and student success.

In one study of unsafe practice, undergraduate nursing students (n=59) in a final year of a baccalaureate nursing program participated in a Q-sort activity (Mossey et al., 2012). Using 43 cards of behaviors and an empty template, students were asked to place the behaviors in categories from strongly agree to strongly disagree depending on the level of unsafe clinical practice reflected in the behaviors. Five types of unsafe students were identified from this exercise: vulnerable, unprepared, unknowing, distanced, and displaced. Vulnerable students are those who are overwhelmed, demonstrate a lack of confidence, are assigned to clinical placements beyond their abilities, and fail to have regularly documented evaluations. Unprepared students fail to perform consistently in accordance with clinical guidelines, lack knowledge to participate in patient care, and avoid consultation with health team members. Unknowing students do not prioritize their activities according to patient needs, participate in patient-centered care, or work within their scope of practice. Distanced students cut corners and rush through patient care, respond defensively to helpful feedback, and have difficulty communicating with other students and clinical educators. Displaced students are dishonest, demonstrate patterns of

errors, fail to protect patients from injury or abusive situations, lack critical thinking abilities, and perceive the clinical educator as threatening. Displaced students were thought to be the most unsafe, and the researchers recommend that they be removed from the clinical setting immediately (Mossey et al., 2012).

An interpretive phenomenological case study of one student provided insight into the experience of clinical failure from the student's point of view. McGregor (2007) collected data through interviews, field notes, and spontaneous interactions with the student who was underperforming in the clinical area. The student revealed that because her faculty member discussed her underperformance almost constantly, the student became more disconnected from the clinical experience and fearful of making mistakes. She checked her actions multiple times to avert error, but this only increased the faculty member's perception that she was underperforming. The case study demonstrated how interactions between faculty and students during clinical experiences can influence students' ultimate successes or failures.

Identifying, Assessing, and Evaluating Underperforming Students

Clinical faculty must identify, assess, and evaluate students who are underperforming and possibly unsafe in the clinical area (Billings & Halstead, 2012; Hrobsky & Kersbergen, 2002; Killam et al., 2010; McGregor, 2007). Although clinical education provides the best opportunity for nursing students to develop professional competences, the best practices for identifying, assessing, and evaluating underperforming students have not been identified (Anastasi et al., 2006). For the purpose of this research, identification is defined as a preliminary opinion faculty form about student underperformance based on observation, faculty-student interactions, and

feedback from clinical staff rather than from formal assessment. Assessment is defined as the use of systematic multifaceted methods of judging the effectiveness of students' performance to provide formative feedback about their current status (Duffy, 2003; Duffy & Hardicre, 2007a; Gallant et al., 2006). Evaluation is defined as the use of assessment strategies to provide summative feedback for the purpose of grading and making progression decisions (Anastasi et al., 2006; Duffy & Hardicre, 2007a; Fahy et al., 2011; Miller, 2010; Neary, 2001; Parker, 2009).

Identifying underperforming students. Although a variety of procedures have been developed to assess and evaluate student performance in the clinical area, the initial identification of underperforming students is often based on the judgment and insight of faculty members (Billings & Halstead, 2012). Some faculty members have intuitive concerns about underperforming students that they cannot clearly articulate (Duffy & Hardicre, 2007b). In a grounded theory study of assessment of student competence, mentors (i.e. preceptors) and lecturers (i.e. faculty, n=40) were asked how underperforming students are best identified (Duffy, 2003). Both groups acknowledged they often failed to identify such students early in their programs. Based on the results of another grounded theory study exploring how preceptors manage students who are borderline or unsafe in practice, Luhanga et al. (2008b) developed a continuing education module to help preceptors improve their ability to recognize unsafe students. The authors encouraged preceptors who identifed risky student behaviors to plan and implement more focused assessment strategies and to supervise those students more closely throughout clinical rotations.

A survey of clinical nursing faculty (n=1289) demonstrated that those faculty most commonly used the strategy of observation of students to identify and evaluate performance (Oermann, Yarbrough, Saewert, Ard, & Charasika, 2009). Clinical education guidelines encourage faculty to have a sufficient number of faculty-student interactions to make initial or preliminary decisions about students' abilities (Billings & Halstead, 2012; Reilly & Oermann, 1992). When faculty members are able to sufficiently observe and identify underperforming students early, they can better provide direction and thus prevent unsatisfactory evaluations at the end of the clinical rotation (Billings & Halstead, 2012).

Faculty members often rely on other personnel in the clinical setting to observe and identify underperforming students (Billings & Halstead, 2012). Yet, research suggests that faculty do not always respond well to feedback from the clinical staff with whom students are working (Luhanga et al., 2008a, c). A grounded theory study of preceptors' perceptions of faculty revealed that preceptors (n= 22) became frustrated when they tried to give constructive feedback about students, especially when faculty at times would appear unsupportive or uninterested in the preceptors' opinions. The preceptors were also frustrated if they seldom saw faculty or had insufficient time with them to provide feedback about student behaviors, especially when students had problems with their performance (Luhanga et al., 2008a). These findings were confirmed in another qualitative study in which preceptors indicated they wanted more support from faculty when the preceptors identified underperforming students (Hrobsky & Kersbergen, 2002).

Assessing underperforming students. Strategies for assessing and evaluating student performance have been discussed in the nursing education literature. Westrick (2007) argued that multilevel reviews based on objective data are most effective for evaluating student performance. Nurse education scholars encourage frequent and varied assessments that include cognitive, affective, and psychomotor domain components (Benner et al., 2010; Billings & Halstead, 2012; Reilly & Oermann, 1992). In a national survey, Oermann, Yarbrough, et al. (2009) found that nurse educators valued formative assessments throughout all clinical rotations in order to provide feedback on students' learning.

The most commonly used clinical tools for assessment are checklists or scales that faculty complete following observations of student performance (Girdley, Johnsen, & Kwekkeboom, 2009; Karayurt, Mert, & Beser, 2008; Oermann, Yarbrough et al., 2009; Pfeil, 2003; Shanley, 2001). Scales and checklists were developed as early as the 1960's in order to measure learning outcomes. Over time these tools have been revised and modified to be more objective but often still fail to provide accurate measures of clinical performance (Girot, 1993; 2000). Two scales, the Clinical Competencies Criteria Valuing Scale (Ferguson & Calder, 1993) and the Preceptor Evaluation of Student Performance (Freiburger, 2002), were developed to evaluate students in precepted clinical placements. The scales allow both preceptors and faculty to evaluate student performance. Researchers who evaluated the tools, however, reported that assessor leniency, inter-rater inconsistency, and differences in faculty and preceptor expectations limited the validity and reliability of the tools (Seldomridge & Walsh, 2006). Although checklists would be most effective if used to evaluate core competencies, they are often

used to assess students' abilities to complete the steps of a procedure or task rather than to assess their overall clinical performance (Decker, Utteback, Thomas, Mitchell, & Sportsman, 2011).

Self-assessment tools were developed as faculty recognized the advantages of student self-reflection on practice (Clark, Owen, & Tholcken, 2004; Tolley, Ooms, Marks-Maran, Acton, & Rush, 2011a, 2011b; Watson, Calman, Norman, Redfern, & Murrells, 2002). Although faculty members generally view these tools as valid evaluation methods (Oermann, Yarbrough et al., 2009), research demonstrates that self-assessment results do not adequately reflect student ability (Baxter & Norman, 2011; Glover et al. as cited in Scanlan & Care, 2004; Seldomridge & Walsh, 2006). Self-assessment tools can, however, help faculty identify students' perceived weaknesses in order to provide more individualized learning opportunities (Clark et al., 2004).

Continuous clinical assessments gained popularity during the 1980s. With this approach, faculty members evaluate the total care students provide patients instead of limiting assessment to task-oriented skill acquisition (Girot, 1993). One type of continuous assessment, the critical incident technique, allows faculty to describe both positive and negative student behaviors. Research indicates, however, that the unstructured nature of this approach limits its reliability and validity (Shanley, 2001). The Snapshot is a tool that allows faculty to evaluate student performance against a predetermined set of criteria based on course objectives (Tolley, Marks-Maran & Burke, 2010, Tolley et al., 2011a, 2011b). Students and clinical faculty, however, report that continuous clinical assessments based solely on course objectives are too restrictive, create unrealistic expectations, and often result in student failure (Neary, 2001).

The responsive assessment was developed to overcome some of the problems associated with continuous clinical assessments. The responsive assessment focused on student learning and evaluation in response to patient needs and made all evaluations individualized according to the clinical setting (Neary, 2001). Many faculty members reported, however, that tools measuring total patient care lacked robustness (Norman, Watson, Murrells, Calman, & Redfern, 2002).

The Competency Outcomes and Performance Assessment (COPA) model assesses cognitive, affective, and psychomotor domains of performance and addresses core behaviors associated with competence in a simulation laboratory (Lenburg et al., 2011). Within this model, students progress through two days of competency evaluations. Faculty members report, however, that students are often unable to complete basic skills in the simulation setting, leading faculty to reevaluate the differences between perceived and actual competence (Lenburg et al., 2011). Similar to the COPA model, the Structured Observation and Assessment of Practice (SOAP) model is a comprehensive, practice-driven clinical assessment that also assesses cognitive, affective, and psychomotor domains. Instead of being used in a simulation setting, however, the SOAP model is used in the clinical setting (Levett-Jones, Gersbach, Arthur, & Roche, 2011). The SOAP model allows faculty to observe students for two to three hours during their normal patient care delivery and record notes based on patient care situations, nursing actions, and patient outcomes. Following observations, faculty members hold a debriefing session to provide both formative and summative feedback (Levett-Jones et al., 2011).

The Objective Structured Clinical Examination (OSCE) began as an assessment method in medicine and later became popular in nursing (McWilliam & Botwinski, 2012; Rushforth, 2007). The OSCE provides students an opportunity to move through multiple stations in a simulation laboratory where they demonstrate skills and behaviors while working with trained individuals portraying standardized patients (McWilliam & Botwinski, 2010, 2012; Rentschler, Eaton, Cappiello, McNally, & McWilliam, 2007; Robbins & Hoke, 2008; Rouse, 2010; Rushforth, 2007; Shanly, 2001). This approach, although receiving positive reviews from students, is costly, time-consuming, and has been shown to be unreliable (McWilliam & Botwinski, 2012; Rentschler et al., 2007; Reising & Deivich, 2004; Robbins & Hoke, 2008; Rushforth, 2007; Selim, Ramadan, El-Gueneidy, & Gaafer, 2012).

Another form of assessment is the Performance-Based Development System (PBDS) that is currently being used in practice settings (del Bueno, 2001). Performance-based systems use responses to standard video clinical situations to assess decision-making, critical thinking, and prioritization skills. This approach has been modified for use in nursing schools, although its effectiveness has not yet been evaluated (Tong & Henry, 2005), and hospitals currently using PBDS find new nursing graduates lack necessary skills upon initial employment (del Bueno, 2001; Tong & Henry, 2005).

While faculty members thus have a variety of options to assess performance, no strategy has been shown to be highly reliable, valid, and feasible. Furthermore, little research has been conducted to determine if or how these strategies are routinely implemented in practice.

Evaluating underperforming students. The need to evaluate nursing student performance to provide grades or determine progression in a program is challenging for faculty (Benner et al., 2010; Billings & Halstead, 2012; Lewallen & DeBrew, 2012; McGregor, 2007; Reising & Devich, 2004; Scanlan et al., 2001). Research suggests that clinical faculty take their responsibility for making progression decisions seriously and understand consequences associated with their evaluations (Lewallen & DeBrew, 2012; McGregor, 2007; Scanlan et al., 2001). Amicucci (2012) interviewed 11 clinical nurse faculty regarding their concerns about grading and identified five significant concerns: subjectivity of clinical evaluations, difficulty in determining unsafe students, desire to give students another chance to succeed, hope that students would improve with more time, and disappointment in students who were at risk for failure.

Effective evaluation of students requires an atmosphere of respect between student and teacher, positive learning opportunities, clearly defined objectives, multiple evaluation methods, opportunities for faculty to observe students, and timely feedback (Billings & Halstead, 2012; Duffy, 2003; Gallant et al., 2006; Reilly & Oermann, 1992). There are many procedures to evaluate nursing student clinical performance, but none has universal appeal for educators (Billings & Halstead, 2012; Diekelmann & McGregor, 2003; Fitzgerald, Gibson, & Gunn, 2010; Neary, 2001; Norman et al., 2002; Parker, 2009; Robb, Fleming, & Dietert, 2002). Most schools use clinical evaluation forms adapted to assess specific aspects of the course for which they are used (Oermann, Yarbrough et al., 2009).

Despite the importance of evaluation of clinical performance, most research on evaluation in nursing education has focused on academic rather than clinical

achievement. Student achievement is often associated with success on the National Council Licensing Examination (NCLEX) or various forms of high-stakes NCLEX predictor testing (English & Gordon, 2004; Morrison et al., 2002; Reinhardt et al., 2012; Sayles et al., 2003; Sifford & McDaniel, 2007; Spurlock, 2006; Stuenkel, 2006). Rutkowski (2007) suggested that faculty members may not fail students in clinical settings because faculty believe that indices of academic rather than clinical failure are more appropriate for terminating students from programs.

Without appropriate evaluation methods, underperforming clinical students are often allowed to progress without remediation (Duffy, 2003; Luhanga et al., 2008a, 2008b; Rutkowski, 2007). Research conducted in British nursing schools (n=27) revealed nursing students failed academic courses five times more frequently than clinical courses (Hunt et al., 2012). These results suggest that students who underperform academically are identified and evaluated more easily than those who underperform in clinical areas. Yet, research regarding the evaluation of clinical performance is limited (Grealish & Smale, 2011; Katz et al., 2004).

One disadvantage of current assessment and evaluation methods is that they often fail to take into account patterns of behaviors and/or the clinical and patient context in which students are practicing (Parker, 2009; Tanicala, et al., 2011). Furthermore, most evaluation approaches focus on technical skills and observable psychomotor behaviors, whereas faculty also need to evaluate the cognitive and affective domains of practice – areas that can be the most problematic for underperforming students (Anastasi et al., 2006; Fahy et al., 2011; Miller, 2010; Neary, 2001; Parker, 2009). To overcome problems associated with clinical evaluation, most nursing faculty use other forms of

appraisal, such as written assignments and contributions to clinical conferences, to supplement standard assessment tools (Oermann, Yarbrough et al., 2009).

Developing Remediation Strategies for Underperforming Students

Faculty members develop remediation strategies to help students improve in performance areas in which they have deficits (Sifford & McDaniel, 2007). Remediation strategies often involve providing additional resources and support to enhance students' chances for success (Gallant et al., 2006). Remediation strategies have been developed to boost NCLEX pass rates (Carrick, 2011; English & Gordon, 2004; Morrison et al., 2002; Reinhardt et al., 2012), and these strategies have been shown to improve student success in passing the NCLEX on the first attempt (Daley, Kirkpatrick, Frazier, Chung, & Moser, 2003; English & Gordon, 2004; Jeffreys, 2007; Morrison et al., 2002; Reinhardt et al., 2012; Sifford & McDaniel, 2007; Stuenkel, 2006). Students in British nursing schools who received remediation following an unsuccessful evaluation were successful in subsequent academic evaluations 76% of the time and in clinical evaluations 79% of the time (Hunt et al., 2012).

Some literature has described how schools of nursing implement remediation strategies. Nursing faculty at one school, for example, met each week to discuss student underperformance in meeting course objectives and identified students they felt would benefit from a focused remediation strategy (Hutton & Sutherland, 2007). A trained clinical educator took the role of remediator and worked with one or two students on their regularly scheduled clinical days. Students were remediated through role modeling, being questioned about content, opportunities to demonstrate skills, help with decision-making, and help with the development of individualized care plans for assigned patients.

Faculty considered the program a success, and 51 of the 73 students who participated improved and completed their program of study (Hutton & Sutherland, 2007).

Student-centered remediation processes may also be appropriate for clinical remediation. Gallant et al. (2006) described a program incorporating the student-centered learning contract, a traditional remediation process used for academic failure, in the clinical setting. Faculty members met with underperforming students to develop learning goals specific to their remedial needs and to develop individualized learning contracts. The learning contract contained five essential elements: objectives, resources, target dates, evidence of learning, and evaluation criteria. The process included frequent meetings between faculty and students to review progress. Faculty anecdotally reported that the student-centered remediation process bridged a gap in existing evaluation processes, identified areas for remediation, and provided timely support to the students. Faculty noted, however, that the process was time-intensive.

Experts stress that faculty members need to take into consideration how students learn when developing remediation strategies (Carrick, 2011). Carrick (2011) developed a theoretical model that depicts nursing student learning and faculty teaching as two interdependent systems. The two systems are connected by students' abilities to meet learning outcomes and educators' abilities to teach effectively. Educators who are able to adjust teaching methods to better meet students are more likely to improve student learning outcomes. Carrick proposed that students at risk for failure become overwhelmed trying to distinguish what is most important to learn. They often lack experience that would help them discern the most appropriate applications of their knowledge. Carrick suggested that underachievement is not just a student problem but is

also related to educators' teaching approaches; merely expecting students to study more will not necessarily improve student outcomes.

Underperforming students may benefit from clinical tutorial/discussion groups where students, preceptors, and faculty discuss and reflect upon actual patient care situations (Haugan et al., 2011). Haugan et al. (2011) developed tutorial/discussion groups with the goal of helping students reflect upon their experiences in the presence of the nurse or clinician who also participated in those experiences. Group reflection was used to facilitate insight and understanding of complex situations. Group sessions allowed students to analyze weaknesses in the care they provided, while faculty gained a better understanding of the students' knowledge deficits.

Some educators suggest that removing students from clinical settings may benefit students by providing them opportunities to learn in less stressful environments (Haskvitz & Koop, 2004; Yonge, Myrick, & Haase, 2002). Patient simulation provides opportunities for remediation if students are unable to perform skills appropriately, prioritize patient care, and/or integrate didactic knowledge into the clinical setting (Decker et al., 2011; Haskvitz & Koop, 2004; Reising & Deivich, 2004). The use of technology, especially patient simulators, has been recommended by nursing educators but has not been widely or rigorously evaluated (Decker et al., 2011; Haskvitz & Koop, 2004).

Some experts recommend the use of the Objective Structured Clinical Evaluation (OSCE) for remediation purposes (Rentschler et al., 2007; Rouse, 2010). Following a pilot implementation of an OSCE, Rouse (2010) collected student perceptions of their experience. Twelve students in a focus group were asked semi-structured questions to

determine if the OSCE was perceived as a valuable assessment tool and met student learning styles. The students did find the tool to be helpful, suggesting that OSCE could be used for remediation as well as for evaluation.

Based on narrative feedback on their survey, Oermann, Yarbrough, et al. (2009) suggested the OSCE be used to train and improve evaluation skills for faculty and preceptors. The OSCE provides standardized simulations that promote faculty members' ability to observe and evaluate students and identify faculty members' weaknesses in working with underperforming students (Oermann, Yarbrough et al., 2009).

Clinical educators observed that students benefit from focused remediation approaches that include formal meetings between students, clinical faculty, and program administrators with the development of student-centered remediation goals and learning contracts (Brown et al., 2007; Duffy, 2003; Gallant et al., 2006; Harding & Connolly, 2012; Jeffreys, 2007; Teeter, 2005; Woodcock, 2009). Gallant et al. (2006), for example, developed a remediation process based on student-centered learning contracts for nursing students who were at risk for clinical failure. The authors reported that faculty believed these contracts allowed them to specify problem behaviors and develop individualized remediation processes for each student (Gallant et al., 2006). Brown et al. (2007) described how their school of nursing developed a systematic approach to underperformance. They recommended that faculty provide extra support, learning contracts, and remediation opportunities for students who are underperforming. Teeter (2005) proposed the use of the acronym "S-U-C-C-E-S-S" (see, understand, clarify, contract, evaluate, summarize, and sign) to guide faculty in working with students who were underperforming.

To identify factors that affect retention and completion of associate degree nursing students, Jeffreys (2007) reviewed records of students (n=112) admitted during one academic year. Factors that influenced completion were academic grades at a B or higher, no withdrawal or failure from any nursing courses, and an average of at least a B grade in nursing courses. Factors that contributed to failure to complete the program were a C+ grade in the initial medical-surgical course, withdrawal or failure in any nursing course, and an average nursing course grade below a B. Based on these results, Jeffreys encouraged nurse educators to identify strengths and weaknesses of students and initiate appropriate remediation strategies based on that assessment. Jeffreys also indicated that early identification of underperforming students and interventions for them were essential for retention of students and success in passing the licensure exam.

Both preceptors and faculty can be instrumental in developing remediation strategies. In a grounded theory study about how preceptors manage borderline or unsafe students, Luhanga et al. (2008a, b, c) found that preceptors are effective when they design assignments and opportunities that allow students to develop skills and competencies rather than focusing on ways to fail them. Nurse educators Diekelmann and McGregor (2003) encouraged faculty to find multiple and varied remediation strategies to promote student success before determining that the student poses a high risk to patient safety.

Making Progression Decisions about Underperforming Students

Clinical nursing faculty members need to make decisions about progression of students who are underperforming in the clinical area. These decisions ought to be based on reasoned assessments, policies and procedures of the faculty's institution, and consideration of student rights (Boley & Whitney, 2003; Killam et al., 2010; Westrick,

2007). In their discussion of grade disputes and student litigation, Boley and Whitney (2003) presented best practices for faculty in making progression decisions. Faculty should demonstrate leniency when determining grades, allow make-up opportunities, ensure policies are consistently enforced, and fail students only for behaviors that are grievous in nature or would typically result in expulsion from the program (Boley & Whitney, 2003). In response to legal challenges related to academic decisions of student failure, courts generally support faculty in progression decisions as long as appropriate standards have been enacted (Westrick, 2007). Faculty who document repeated warnings of student deficiencies and seek assistance from others in validating their decisions are more likely to have their decisions upheld in cases of student appeal (Westrick, 2007). Killam et al. (2010) argued that when faculty members have clear policies and processes in place, their ability to identify unsafe students and make reasonable progression decisions improves.

Grading policies also impact progression decisions (Heaslip & Scammell, 2012). A survey of nursing schools accredited by the National League for Nursing Accrediting Commission (NLNAC) revealed that about half of nursing schools use a pass/fail system for clinical evaluation, whereas others use a numerical grading structure. Although associate degree programs tended to fail students if they did not pass both the theoretical and clinical portions of their courses, baccalaureate and diploma programs were more likely to progress students if they passed only one component (Oermann, Saewert et al., 2009). The NLNAC survey indicated that there are significant differences in how schools of nursing evaluate clinical performance in order to make progression decisions. A review of the literature revealed that clinical assessments are typically conducted by

clinical staff who have minimal experience in evaluation or who are unfamiliar with the course objectives, while academic assessments are done by experienced nurse educators (Girot, 2000). In a critical overview of issues related to nurses' reluctance to fail underperforming students, Rutkowski (2007) indicated that discrepancies between students' clinical and educational competencies create dilemmas for clinical faculty in determining whether a student should progress.

Decisions about progression can create practical as well as emotional concerns for faculty, in part due to threats of student appeal and repercussions for faculty stemming from their decisions (Boley & Whitney, 2003; Duffy, 2003; Walsh & Seldomridge, 2005; Westrick, 2007). A qualitative study of 30 nurse educators revealed that they spent long and "painful" hours deciding if their judgments helped or hindered students (Poorman et al., 2011). The educators were distressed when they failed students and frequently second-guessed their decisions (Poorman et al., 2011). Based on data analysis from focus group sessions with nursing faculty (n=11), Tanicala et al. (2011) found that faculty take a variety of factors into consideration when making pass-fail decisions. Research suggests that progression decisions are most difficult if they are related to student attitude and personality factors rather than skills (Duffy, 2003, 2004; Miller, 2010; Parker, 2009).

In a grounded theory study using data from forty interviews of nursing mentors and lecturers, Duffy (2003) found mentors (preceptors) and lecturers (faculty) who worked with underperforming students allowed them to progress even when the mentors and/or lecturers had misgivings about their decisions. The mentors reported that when they raised issues about students who were underperforming, lecturers often did not act on the mentors' concerns. The mentors also indicated that they were expected to use

assessment tools that they believed were unreliable or invalid. The mentors experienced conflicts between maintaining professional standards and meeting the retention demands of higher education, were troubled by threats of appeals concerning their decisions to fail students, and were most concerned about unresolved issues of underperformance early in the students' programs (Duffy, 2003).

Some educators believe faculty spend more time demonstrating and documenting student failure than developing remediation processes to support student success (Diekelmann & McGregor, 2003; Gallant et al., 2006; Poorman et al., 2002). In their discussion about looking at new possibilities for dealing with students who may be failing clinical courses, Diekelmann and McGregor (2003) suggested that faculty spend so much time focusing on problems and how to fix them that the students give up on themselves.

Research suggests that decisions about student progression may be more associated with the implications for the faculty than with student competency (Brozenec, Marshall, Thomas, & Walsh, 1987; Heaslip & Scammell, 2012; Tiwari et al., 2005). For example, clinical faculty members are reluctant to fail students for a number of reasons, including concern about the financial and emotional impacts on the students, threats to the faculty members' own careers, lack of clear processes to follow once students are found to be underperforming, lack of confidence in their own judgments, belief that students might be able to improve in subsequent clinical placements, belief that not progressing students is a personal or professional failure, feeling pressure to produce more graduates, desire to avoid hassles associated with failing students, and succumbing to time and workload pressures (Brown et al., 2007; Duffy, 2003; Heaslip & Scammell,

2012; Jervis & Tilki, 2011; Luhanga et al., 2008c; Miller, 2010; Poorman et al., 2011; Scanlan & Care, 2004; Scanlan et al., 2001; Watson & Harris as cited in Duffy, 2003). One study found that faculty did not rank the task of evaluating students in clinical as a high priority (Lee, Cholowski, & Williams, 2002). In some cases, underperforming students were allowed to progress because decisions about progression were left until faculty considered it to be too late to remediate students' underperformance (Duffy, 2003; Scanlan et al., 2001).

Summary

Working with underperforming students is a challenge for clinical nursing faculty. Underperformance can occur in the realms of skills, behaviors, knowledge, and attitudes. Faculty members initially identify underperforming students informally through observations, faculty-student interactions, and discussions with clinical personnel, but few guidelines are available to assist faculty in the systematic and timely identification of underperforming students. More formal processes are often used to assess and evaluate students in order to determine whether students require remediation or should progress in their programs, but faculty members find many of the available tools or procedures to be ineffective or impractical. Making negative progression decisions for underperforming students is particularly stressful for faculty and these decisions are often influenced by faculty discomfort with the process and institutional concerns about grievances and litigation. Few comprehensive and empirically supported practices for working with underperforming students have been developed. In order to identify such best practices, a better understanding is needed of how clinical faculty work with underperforming

students in their “real-life” practices. This grounded theory study therefore identifies the processes by which clinical nursing faculty work with underperforming students.

CHAPTER III

Methodology

Grounded theory methods were used in this study to develop a theoretical framework that describes how clinical nursing faculty members work with underperforming students. This chapter therefore begins with a discussion of the philosophy and history of grounded theory. The procedures used to collect and analyze data in order to meet the study aims will then be presented. Finally, strategies used to protect the rights of the participants will be discussed.

Grounded Theory Methodology

Grounded theory was introduced in the 1960s by sociologists Barney G. Glaser and Anselm L. Strauss with their publication of *Awareness of Dying* (1965) and their seminal work *Discovery of Grounded Theory* (1967). Charmaz (2006) defines grounded theory methods as a set of "systematic, yet flexible guidelines for collecting and analyzing qualitative data to construct theories grounded in the data themselves" (p. 2). The grounded theory approach became well-respected and widely used by social and health scientists during the 1990s (Bryant & Charmaz, 2007). Grounded theory is commonly used to identify common challenges and psychosocial processes that affect health and well-being (Bryant & Charmaz, 2007).

Philosophical foundations. Grounded theory is based on the principles of symbolic interactionism (SI) as outlined by George Herbert Mead (1934) and Herbert Blumer (1969). Mead, who is considered by many to be the founder of symbolic interactionism, was a faculty member at the University of Chicago's Department of Philosophy. He published many articles on symbolic interactionism during the 1920s.

Following his death in 1931, his writings were compiled into several volumes and had a strong impact on educational, sociological, philosophical, and psychological research (Blumer, 2004). According to Mead, each individual's self-concept includes an "I" and a "me." The "I" acts while the "me" defends, evaluates, and interprets the self through internal communication (Blumer, 2004). Objects are items within the individual's environment that may be physical (such as a chair), social (such as a friend or co-worker), or abstract (such as moral principles and ideas). Symbolic interactionism focuses on how the "self" interacts with social objects and develops meanings from those interactions (Blumer, 1969, 2004).

Blumer (1969) was a sociologist at the University of Chicago and a devoted follower and interpreter of Mead's work. Blumer argued that meanings of social objects arise from the way individuals prepare themselves to act toward the object, and that people define objects based on actions. The ability of humans to view themselves as objects enables them to see themselves as others perceive them. These internal interactions between the "I" and "me" influence behavior (Blumer, 2004).

The three basic premises of SI are as follows: a) humans act toward objects, including others, on the basis of the meanings they attribute to the things, b) meanings arise out of social interactions, and c) meanings are modified by individuals through interpretive processes that arise from encounters with others (Blumer, 1969). Consistent with symbolic interactionism, grounded theory focuses on individuals' actions, interactions, and the meanings that arise from them (Charmaz, 2006). Grounded theory is a method used to better understand how humans create and modify meanings through their actions and interactions with others (Glaser & Strauss, 1967). Grounded theorists

often obtain data from in-depth interviews in which participants describe their social experiences and the meanings they attribute to these experiences in their day-to-day lives (Glaser & Strauss, 1967; Milliken & Schreiber, 2001).

History. Glaser and Strauss developed the grounded theory method at the University of California in San Francisco (UCSF) while studying how hospital staff cared for terminally ill patients. Glaser, who came to UCSF from Columbia University, was trained in quantitative methods and midrange theory development, while Strauss, from the University of Chicago, was trained in symbolic interactionism and pragmatism. Dissatisfied with the trends in sociological research at the time, they sought to develop innovative methods to investigate complex social phenomena and provide "a clear basis for systematic qualitative research" (Bryant & Charmaz, 2007, p. 33). Although Glaser argued that grounded theory methods could incorporate both qualitative and quantitative approaches, he and Strauss challenged the dominant quantitative paradigm by focusing on the use of narrative data as the basis for grounded theory methods. Because classic grounded theory emphasized systematic data collection and analysis, it mimicked quantitative orthodoxy and gained legitimacy among scientists (Bryant & Charmaz, 2007). Grounded theory gained prominence as Glaser and Strauss taught the method to a generation of doctoral students in nursing and social work at UCSF, including Juliet Corbin, Kathy Charmaz, Adele Clarke, and Phyllis Stern, among others. These students published texts on the method, and taught and mentored others in grounded theory research (Bryant & Charmaz, 2007).

In later years, the views of Glaser and Strauss diverged on the basic tenets of the grounded theory method. Glaser (1978), who claimed to have stayed closer to the

original intent of the method, continued to emphasize that grounded theory allowed researchers to discover the "6 Cs" (causes, context, contingencies, consequences, covariances, and conditions) of a social phenomenon. According to Glaser, researchers could better understand the data by seeking answers to questions such as:

What are the significant factors (causes) that influence the phenomenon being studied?

Within what realm (context) does the phenomenon exist?

Under what circumstances (conditions) does the phenomenon exist?

What are the variables (contingencies) that are associated with the phenomenon?

How do these variables (covariances) relate to each other and to the phenomenon?

What are the results or outcomes (consequences) of the phenomenon?

Glaser (1978) argued that using the 6 Cs to question findings allowed the researcher to discover processes, and that the research itself remained a creative process. Glaser retained a positivist view as he maintained that researchers should remain neutral in their observations, assure findings are grounded in empirical data, and present data objectively (Charmaz, 2003).

Strauss, along with colleague Corbin, focused on actions and interactions and created a conditional matrix with which to organize data. The matrix, an analytical device, provides a visual representation of interactions and the interrelationships among them that shape the phenomena being studied. The conditional matrix consists of concentric circles; it begins with a small circle in the center that represents the phenomenon of interest and circles of increasing size demonstrate expanding interactions with larger groups. Other methodologists have explained the conditional matrix through

the use of diagrams, concept maps, charts, and figures to construct visual images of relationships within their emerging theories (Charmaz, 2006).

Although Glaser and Strauss eventually diverged in their beliefs about the basic tenets of grounded theory, their early collaboration resulted in the development of a method that has clear epistemological underpinnings and has garnered scientific credibility with researchers who seek to develop a mid-range theory from empirical data. Most agree the differences are concerned more with methodology than philosophy (Bryant & Charmaz, 2007; Charmaz, 2003; Denzin, 2007). Few grounded theory researchers today claim to limit their work to either founders' approach, although many researchers use the work of Strauss and Corbin to guide data analysis (Bryant & Charmaz, 2007). Some contemporary grounded theorists, however, have espoused a constructivist approach to grounded theory.

Constructivist grounded theory. Those who espouse a constructivist worldview believe that reality is a social construction. Researchers who have this worldview believe that findings are co-constructed through interactive processes between researchers and participants. Constructivist grounded theorists seek to clarify rather than challenge meanings of reality. In this approach to grounded theory, researchers situate participant stories within the context of their daily experiences and identify and acknowledge the meanings and values given to those experiences by the participants themselves (Charmaz, 2003).

The constructivist approach described by Charmaz (2003, 2006) has advanced the development of the grounded theory method. Charmaz (2003) encourages researchers to view data repeatedly and to maintain open minds as they develop new ideas. In so doing,

researchers may view, code, and analyze data multiple times and ask new questions about the findings before they ultimately develop the theory. Researchers may also interact with participants multiple times as new questions arise and they recognize a need to further develop ideas found within the data.

Research methods. In grounded theory, data collection and analysis are performed concurrently (Charmaz, 2006). Data are examined through a "general method of comparative analysis" (Glaser & Strauss, 1967, p.1). In comparative analysis, new data are continually compared to existing data as well as to emerging concepts and hypotheses. In this way, data are moved to higher levels of abstraction in order to develop theory (Milliken & Schreiber, 2001). The goal of grounded theory is to construct a model that explains actions and interactions surrounding a phenomenon of interest as they evolve over time. Grounded theorists employ both inductive and deductive reasoning and use multiple data sources to answer their research questions (Milliken & Schreiber, 2001).

Grounded theory methods are used to reveal the psychosocial processes of individuals who share a common challenge. Because this researcher believes that clinical nursing faculty share a common challenge of working with students who are underperforming and respond to this challenge with shared processes that change over time, grounded theory is the appropriate approach for this study. Working with underperforming students entails complex interactions influenced by the sociocultural contexts of the educational institutions of the students and faculty and by the clinical setting.

Study Procedures

Procedures outlined by Chamaz (2006) were used to guide data collection and analysis. Data collection in grounded theory can take the form of direct observations, field notes, written personal accounts, or interviews. Due to the nature of this research, interviews served as the primary source of data. This section provides a basic description of grounded theory procedures and a discussion of how these procedures were completed specifically for this research project.

Sample. In grounded theory studies, participants are selected because they have knowledge of the phenomenon being studied (Charmaz, 2006). The population for this study included clinical faculty in baccalaureate nursing programs who had a minimum of five years' teaching experience in adult acute care or medical-surgical settings. Although it was determined that participants needed to have five years' experience because this would ensure that they had had ample opportunity to have worked with and made decisions about underperforming students, some participants were accepted who had slightly less than five years' experience because they had had significant experiences with underperforming students.

The criterion that participants needed to be teaching in adult acute care or medical-surgical settings was based on the aim of identifying common challenges in working with underperforming students, thus the decision to focus on hospital-based medical care settings. Students who underperform in psychiatric or community health rotations, for example, would likely have different remediation needs than those in adult care or medical-surgical settings. Baccalaureate clinical faculty were selected since literature suggests that faculty interact differently with students in associate degree RN

programs than those in baccalaureate degree RN programs (Benner et al., 2010), thereby introducing a variance that is beyond the scope of this study. In addition, the nursing profession is moving toward making the baccalaureate degree the entry into practice (Benner et al., 2010; Finkelman & Kenner, 2007; Girot, 2000; IOM, 2011), and thus a focus on baccalaureate students provides the most useful information.

Sampling procedure. The researcher recruited participants through the NRSED Listserv, an international listserv for nurse educators with approximately 1700 members, 95% of whom live within the United States (nrsinged@lists.uvic.ca). By using this listserv, the researcher had access to a large group of nurse educators from a wide variety of institutions. Also, by recruiting nurses from across the United States, the researcher was able to obtain information on a broad-base sample not limited by geographic location.

The researcher placed a statement on the listserv alerting members to an upcoming research project and provided a brief explanation of the project, a list of inclusion criteria, and a brief description of study procedures (see Appendix A). Individuals who provided technical support for the NRSED Listserv encouraged an advance notice to alert potential participants to watch for future information on the project (personal communication, June 28, 2012). Approximately two weeks following the initial announcement, the researcher submitted to the Listserv a request for participants. The request included a description of the study, a list of inclusion criteria, a brief description of the study procedures, and researcher contact information (see Appendix B). Interested parties were invited to contact the researcher through her personal email to indicate their interest in participation. The researcher then contacted

these individuals through email, thanked them for their interest in the study, provided a phone number for them to contact the researcher if they had questions, and attached a copy of the informed consent (see Appendix C). If they had no questions about the study and remained interested in participating, the researcher contacted them to obtain a telephone number and set up an interview appointment. All further contact with study participants was done through personal email and telephone. Two further postings to the listserv were done at monthly intervals until a sufficient sample had been obtained.

Sample size. An exact sample size is not identified a priori in grounded theory research but can be estimated based on the nature of the sample and the research aims. Methodologists have suggested that between 30 and 50 participants are adequate to identify key psychosocial processes if the sample is relatively homogeneous and the research aims are focused on a specific topic (Charmaz, 2006). As this project was focused on a circumscribed topic (underperforming students) and a group who share a common challenge (clinical nursing faculty), it was estimated that 30 participants would provide ample data to answer the research questions. Twenty-eight individuals ultimately completed the interview process.

Data collection. The goal of data collection in grounded theory is to gather rich information about the phenomenon of interest from those who share a common experience. Charmaz (2006) encourages researchers to conduct interviews with open-ended questions in order to obtain detailed descriptions of participants' views and actions in their own words. Questions should be chosen carefully and asked slowly in order to encourage reflection. Researchers should avoid framing questions so as to inhibit participants from expressing private thoughts and meanings associated with their

experiences (Charmaz, 2003). An interview guide with well-developed, open-ended questions and follow-up probes can be used. Charmaz (2003) recommends that interviews be ended on a positive note so that participants feel good about their participation.

For this study, data was collected through semi-structured interviews conducted with the use of "Skype" audio-conferencing electronic technology. This technology provided a convenient, low-cost way of interviewing participants across the country and across time zones through a computer-to-telephone interface. The researcher used the computer as the telephone and accessed participants through either a landline or cell phone number to complete the interviews. By using the computer instead of a telephone, the researcher was able to use computer software to record and transcribe the calls while the participants talked on the telephone. Skype technology was used safely and securely by adjusting the privacy settings. The researcher maintained the most secure settings during data collection.

The researcher called the participants at a time agreed to in their email correspondence. Before the interviews began, the researcher reaffirmed that participants met inclusion criteria using the Screening Checklist (Appendix D). The researcher then explained the process of verbal consent and confirmed that the participants had read the informed consent document. The researcher answered any questions the participants had concerning the study or the consent process and then asked them if they were willing to proceed with the interview. Prior to beginning the interview, the participants gave permission for the recording to begin.

Interviews were semi-structured so that participants could freely describe their experiences working with underperforming students according to their own perspectives. Interviews took between 30 and 80 minutes with most taking approximately 40 to 50 minutes. An interview guide (Appendix E) was used to set the parameters of the interview but was used flexibly so that participants' narratives could guide how the interview progressed. Sample questions included:

- Tell me about the nursing education program in which you are a clinical instructor.
- Tell me about your clinical teaching.
- What do you consider the term "underperforming" – as it applies to students in clinical – to mean?
- Pick out one student who stands out for you whom you considered to be underperforming in the clinical area. Tell me about the experience you had working with this student.
- How did you identify that the student was underperforming?
- Once you realized the student was underperforming, how did you work with the student?
- Tell me how you made progression decisions about this student – in other words, whether to pass him/her for the clinical rotation, advance him/her in the program, etc.
- What kinds of things did you do to remediate this student?
- What was the outcome with this student?

- Were there other students that stick out in your mind who were underperforming in a different way? (If the first example was about a student who lacked psychomotor skills, for example, ask about students that were underperforming because they had poor interpersonal skills or a poor attitude toward nursing.) Could you tell me about your work with him/her? (repeat questions above)
- What would you recommend to new faculty who are working with underperforming nursing students?

Data management. All interviews were transcribed and checked for accuracy by the researcher. Data was digitally recorded onto the computer during the interview process. Following the interview, the recordings were transcribed into text by the researcher with the aid of an audio-to-text conversion computer program. The researcher then validated transcriptions with the audio recording and attached a de-identified code to the transcript. Once transcripts had been validated and stored, audio recordings were erased. Transcripts were encrypted and stored according to the participant's study identification on the Research File System (RFS), a centralized storage area designed to support Indiana University researchers. RFS is HIPAA-aligned and all data was encrypted prior to storage. The list of identification codes was maintained in a secured file cabinet by the researcher.

Data analysis. Data was analyzed using grounded theory procedures as outlined by Charmaz (2006). After the first two or three interviews were completed, data was analyzed using constant comparative methods in which data within and between transcripts was constantly compared for similarities and differences. Data was abstracted from the transcripts through coding, which is taking segments of data and attaching labels

that capture the essence of the data. Categories were formed from codes and relationships among categories were determined.

Coding. Grounded theory analysis involves four coding processes: initial, focused, axial, and theoretical (Charmaz, 2006). Coding involves extracting data units (i.e., relevant facts, incidents, or stories) relevant to the research aims, identifying actions and interactions related to the phenomenon of interest, and attaching labels to relevant data units. When possible, *in vivo* codes are used to preserve participants' meanings. *In vivo* codes are words used by participants that have particular significance, innovative phrases that capture meanings and experiences, and "insider shorthand terms" (Charmaz, 2006, p. 55) that reflect the collective perspectives of the group.

Initial coding is a close examination of transcripts through either line-by-line or incident-by-incident review. Gerunds (i.e., words ending in "-ing" that are derived from verbs but function as nouns) serve as codes to identify actions in the data that constitute processes experienced by the participants. Initial coding involves attaching labels to data that capture the essence of all thoughts, actions, and perceptions described by the participants. In this study, the researcher performed initial coding for all transcripts. Selected transcripts were reviewed by the researcher's dissertation chair, a grounded theory methodology expert, for accuracy of transcription and coding.

Focused coding requires closer examination of initial codes for significant or recurrent codes. During focused coding, initial codes are grouped into categories that represent participant experiences. Focused codes are more "directed, selective, and conceptual" (Charmaz, 2006, p. 57) than initial codes. Focused coding allows the researcher to use the most significant and frequently used codes to sort through large

amounts of data. In this study, the researcher developed categories that described how participants identified, assessed, evaluated, remediated, and made progression decisions for underperforming students in the clinical setting by grouping similar codes together and comparing them to other codes. To do focused coding, the researcher held frequent meetings with her committee chair in which they examined and refined the emerging categories with a return to the data.

Axial coding involves defining the attributes, characteristics, and dimensions of emerging categories. Whereas initial coding breaks transcripts apart in order to examine parts of dialogue, axial coding is the beginning process of putting the data back into a comprehensible whole. Axial coding helps the researcher answer the "if, when, how, and why" questions within the data themselves (Charmaz, 2006). Theoretical codes clarify general contexts and specific conditions in which the phenomenon is present while adding precision and clarity. Theoretical codes also assist in making the analysis coherent and comprehensible (Charmaz, 2006). To conduct axial and theoretical coding, the researcher held a two-day meeting with her committee chair during which the preliminary theoretical framework was developed. During this meeting, the researcher presented aspects of the beginning framework to members of her dissertation committee who had expertise in nursing education research. Following this meeting, the researcher continued to refine the theory by returning to the data and holding further meetings with her dissertation chair. The final framework was sent to her committee for additional feedback. The final product of the data analysis was a theoretical framework that described the processes by which clinical faculty work with underperforming students.

Memo-writing. Memo-writing was used to facilitate data analysis. Charmaz (2003) indicates that memos serve multiple purposes including initiating new ideas, refining previous ideas, and generating additional research. Memo-writing is an intermediate step between data collection and writing drafts of papers associated with the research itself. Memo-writing allows the researcher to begin analysis of data early in the process and includes writing down "anything and everything" that comes to mind. Memo-writing allows further development and exploration of ideas while working within the codes and data. As the researcher writes memos, thoughts are saved, ideas are generated, categories are defined, and meanings are discovered (Charmaz, 2006). For this study, the researcher maintained a digital notebook with informal memos that chronicled her thinking about data, codes, and categories as well as questions that entered her mind while working within the data. As relationships within the data began to emerge, the researcher used more formal memo-writing to help define and clarify the relationships. These memos formed the beginning underpinnings of the theoretical framework and were reviewed by the researcher's dissertation chair as the analysis progressed.

Audit trail. An audit trail is a written record that reflects all procedural and analytic decisions and is used to guide theory formation and to enhance the credibility of the study (Charmaz, 2006). The researcher maintained an audit trail throughout the entire study.

Theoretical Sampling. Theoretical sampling is the process of developing and refining categories and determining the relationships among them through further focused data collection (Charmaz, 2006). Data may be obtained by adding focused questions to

subsequent interviews or by interviewing new participants who have had particularly relevant experiences. For example, the researcher may begin to develop a category that captures the experiences of failing students but finds that most participants discuss remediation rather than student failure. In this case, the researcher may theoretically sample by targeting faculty who have had the experience of failing a student or by asking focused questions in subsequent interviews about participants' thoughts/experiences on student failure. As the categories are further refined, they will be integrated into a theoretical framework that explains how clinical faculty work with underperforming students through processes of identification, assessment, evaluation, remediation, and progression. Due to the rich stories that were obtained during the interviews, sufficient data was obtained and theoretical sampling was not needed for this research.

Data validation. The four criteria of credibility, originality, resonance, and usefulness as outlined by Charmaz (2006) were used to validate the methods, data, and final product. Credibility occurs when categories cover the breadth of collected data, supply links between data and the arguments presented, and provide evidence for the emerging theory. Originality occurs when new insights, conceptualizations, and social and theoretical inferences are revealed. Credibility and originality were strengthened in this study through the procedures of memo-writing, maintenance of an audit trail, and peer debriefing with the research team/committee. Resonance occurs when the theory makes sense to those who are experiencing the investigated phenomenon. Usefulness occurs when the theoretical framework can be generalized to practice. Resonance and usefulness of the study findings were assessed by presenting the final framework to three practicing clinicians who work with underperforming nursing students in the clinical

setting. These clinicians were asked to comment on whether the theoretical framework reflects their own experiences and whether it would be useful to them in their clinical teaching. Additionally, six interview transcripts were saved and reviewed following the development of the theoretical model to determine if the theoretical framework resonated with the narratives of those six participants.

Protection of Human Subjects

Participation in this study posed minimal risk to participants as discussing underperforming students is something they likely do in their everyday lives. However, there was a small risk that participation may have been distressing if participants discussed instances in which they worked with underperforming students in ways that they regretted or realized were problematic. In addition, participation may have posed a threat to participants' employment if they worked with underperforming students in a manner that would not have been acceptable to their employers and that information became known.

These risks were addressed in several ways. Once participants indicated intent to participate, they were given a short verbal explanation of the project, including risks and benefits, reminded that participation was voluntary, and told they could withdraw from the study and refrain from answering questions if desired. The researcher obtained the participants' verbal consent prior to beginning the interviews.

Efforts were made to keep information provided by the study participants confidential as indicated in the consent. Participants were each given a study code number that was attached to the transcript in order to maintain confidentiality. No identifying information was placed on the transcripts. Once transcripts were completed

and verified, audio recordings were erased. No information that could identify participants was revealed or will be included in publications or presentations of the study's findings. In addition, the researcher, an experienced nurse educator, was able to provide opportunities for participants to discuss their thoughts or feelings following the interview if they found the experience to be upsetting.

The benefits of the study included the chance to discuss a nursing education challenge with an experienced nurse educator. In addition, the study will contribute knowledge regarding an important issue facing all clinical nursing educators that has implications for patient safety and the nursing workforce.

Summary

Grounded theory is a research method used to identify psychological processes used by individuals who share a common challenge. Based on symbolic interactionism, grounded theory was developed by Barney Glaser and Anselm Straus at UCSF. Although originally based on a positivist worldview, more recently, several methodologists, including Charmaz (2006), have taken a constructivist approach to the method. This research used grounded theory techniques to develop a theory about how clinical faculty identify, assess, evaluate, remediate, and make progression decisions while working with underperforming nursing students. Data collection and analysis techniques outlined by Charmaz (2006) were followed. Twenty-eight faculty members who had a minimum of five years of clinical teaching experience and interacted with baccalaureate nursing students in adult acute or medical-surgical clinical rotations were interviewed about their experiences with underperforming students. Initial, focused, axial, and theoretical coding were used to develop the theoretical framework. Memoing

was used to facilitate the development of the framework. Theoretical sampling, commonly used in grounded theory, was not required due to the rich data obtained from the initial interview process. Procedures to enhance the credibility, originality, resonance, and usefulness of the research were also used.

CHAPTER IV

The purpose of this project was to develop a theoretical framework that describes how clinical faculty work with underperforming students in the clinical area. The research questions were:

- How do clinical faculty identify, assess, and evaluate nursing students who are underperforming in the clinical area?
- How do clinical faculty remediate underperforming nursing students in the clinical area?
- How do clinical faculty make decisions about the progression of nursing students who are underperforming in the clinical area?

In this chapter, a description of the sample and the nature of interviews are provided followed by a brief overview of the theoretical framework. The major portion of the chapter outlines the three-stage framework that describes how the participants worked with underperforming nursing students from the time the participants first suspected something was wrong with a student's performance until they made final progression decisions.

Description of the Sample

Forty-three individuals responded to the request for interviews. Ten of the respondents did not meet inclusion criteria because they had never taught in a Bachelor's Degree in Nursing (BSN) program. Thirty-three potential participants were contacted, and 28 participants completed the interview process. Five individuals could not to be reached by telephone following initial email contact and thus were not included in the study.

The participants ranged in age from 40 to 74 years. They had worked as nurses between 16 to 45 years, with the majority having between 25 and 35 years of nursing experience. Three of the participants had recently retired. The participants' years of teaching experience had ranged from 4½ to 42 years, with the majority having over 15 years' experience. Twenty-one participants were Caucasian, two were African-American, two were Hispanic, and three were of other ethnic backgrounds. Twenty-six were female, and two were male. Due to the study criteria, all participants had some adult medical-surgical clinical teaching experience. Throughout their careers, however, they had worked in numerous clinical areas including mental-health, pediatrics, mother-baby, critical care, gerontology, and community/public health nursing.

Nature of the Interviews

The interviews, which lasted between 30 and 80 minutes with most lasting between 40 and 50 minutes, were conducted during the summer and fall of 2013. The interviews generally began with the participants describing their teaching experiences and the programs in which they currently worked. Many described working in several different nursing programs, and most had extensive experience in dealing with underperforming students. All the participants had definite ideas about what constituted underperformance in the clinical setting and provided much information about how they worked with underperforming students. Most of the participants were able to describe one or two particularly memorable underperforming students, especially when requested to do so by the interviewer. Although the participants described unique experiences with underperforming students, many commonalities were evident in their narratives. Some participants were quite emotional during the interviews as they described the distress they

experienced when working with underperforming students and feelings of guilt for not being able to help them succeed. All the participants were very forthcoming about their experiences with underperforming students, and many expressed gratitude that the topic was being addressed. All the participants were willing to be contacted again to provide further information if needed, and most requested to receive the results when the study was completed.

Faculty Perceptions of Underperforming Students

To provide context for the framework, the participants were asked to describe what they believed constituted underperformance. Generally the participants suggested that students were underperforming if they were unable to meet course objectives, did not keep up with other students, did not take opportunities to learn, or failed to perform even routine nursing care. In addition, the participants provided explanations as to why they thought students may be underperforming.

Perceived Characteristics of Underperforming Students

The participants indicated underperforming students were having problems in one or more of the following areas: attitude, confidence, connecting with others, knowledge, behavior, and skills. The participants stressed that students often had problems in several areas.

Problems with "attitude." Students who had problems with "attitude" were considered underperforming by the participants. The participants described these students as flippant, cocky, hubristic, insolent, arrogant, aggressive, and angry. A 42-year-old female participant with six years' teaching experience described a student who demonstrated problems with attitude. On this particular student's last clinical day, she

drew up 1 milliliter of a medication that was supposed to be 0.1 milliliter. The student "began a verbal argument" with both the participant and the staff nurse about how she was right and they were both wrong. Students who were described as having problems with attitude often treated faculty with disrespect. One 67-year-old female participant with 42 years' teaching experience was taken aback when she asked a student why she was not prepared and the student told her, "You know, I just don't have time to do that." Several participants suggested that students of today had more "attitude" than students of years past. One 37-year-old female participant with six years' teaching experience complained that students wrote glib emails such as "Hey, miss, what's going on?" and others "blew off appointments." Another 55-year-old female participant with 13 years' teaching experience recalled that she had been "bullied" by students as a new instructor. She suggested that if a couple of students had attitude problems, they could affect a whole clinical group. A few participants had been "reported" to deans and university presidents by these students.

Problems with confidence. Students who had problems with confidence were also considered underperforming by participants. These students were described as fearful, overwhelmed, clingy, nervous, and anxious. Some students were so fearful they became "frozen" and completely unable to function in clinical. One 49-year-old female participant with nine years' teaching experience was surprised that although some students were stellar in the classroom, they clung to her in clinical "as though I was a mother bear." Another 48-year-old female participant with eight years' teaching experience indicated that students' lack of confidence could be far-reaching:

> It really depends on the student, but I think confidence is a big, big, big issue, because they are typically struggling in their didactic courses, and

> they're probably struggling in some of their relationships at home, and a lot of times there are underlying feelings that caused these behaviors to happen.

Problems connecting with others. Participants also considered students who had problems connecting with others to be underperforming. These students had difficulty relating to other students, nurses, faculty, and patients. The students underperformed because they could not communicate well beyond casual conversations about matters of importance. While these students could visit with patients and families, they could not engage in therapeutic interactions. A 67-year-old female participant with 42 years' teaching experience assigned a student to a patient with dementia. She states, "The student believed everything the man told him, including that he went out and drove around every day." The participant pointed out that the student's naiveté was dangerous because she did not understanding that the patient had dementia but thought, "Oh, this man is so funny." Another 67-year-old female participant with 14 years' teaching experience gave an example of a student who was unable to connect with his patients. She stated,

> There was a student that had never been in a healthcare facility or that type of job – he had worked at a fast food place – and you know they have to talk to people in the fast food place. He could introduce that type of conversation but could never ask the patients about their health care status…because there's a lot of questions students are embarrassed to ask…and [he was] able to become a little more comfortable asking the questions of a fellow student, but it took him a little longer to ask those questions of a stranger. It was like he had a mental block. [He was] afraid to get too personal.

Some underperforming students would find other students to do their work to avoid interacting with difficult patients, and others would shy away from patients of different cultural backgrounds, gender, or age.

Underperforming students also often had problems connecting with faculty or staff nurses. One 47-year-old female participant with nine years' teaching experience described a male student who did not seem to connect with her, which the participant attributed to the fact that she was a woman. The student had previous healthcare experience, and the participant believed he was intent on proving he knew more than she did. Another 37-year-old female participant with six years' teaching experience described an underperforming student who "opened her mouth and inserted her foot" around staff and patients and required frequent "redirection." Other participants described students who were unable to communicate important patient information to faculty and staff.

Problems with knowledge. A number of participants considered underperforming students to be those who had problems acquiring and applying nursing knowledge. A 48-year-old female participant with eight years' teaching experience described these students: "They did not take their foundational courses seriously enough and remember the content in order to be able to apply it in a clinical setting." Sometimes underperforming students did not "connect the dots" or "see the big picture." Some of these students were good in the classroom setting, but were unable to apply what they had learned at the bedside. A 49-year-old female participant with nine years' teaching experience described how students would "try to prove what they know" but then could not connect what they were learning to their patients. Another 54-year-old male participant with 24 years' teaching experience recognized this problem in one of his students:

> The level of understanding she needed to have must be much deeper. It cannot be at a superficial level. And she was coming at it at kind of your

> typical college student level, where you learn this stuff in order to pass the test and then move on. So she wasn't really integrating it or thinking about the connections.

Problems with behavior. Participants were most likely to consider students who engaged in "unacceptable" behaviors to be underperforming. These unacceptable behaviors included not following directions, leaving the unit without permission, and behaving unprofessionally. One 47-year-old female participant with nine years' teaching experience recalled, "[The student] just couldn't follow the rules.... I told him to take his group and go up to [one] floor to do their scavenger hunt; he decided to go to a different floor because he thought that would be better." A 37-year-old female participant with six years' teaching experience described an underperforming student who inappropriately joked with others even after being warned the joking was inappropriate. She stated,

> She [the student] was walking down to the cafeteria with some classmates, and she made an inappropriate joke. It was a joke laced with ageism, and she made an ageism joke big time. And I told her, "This is the kind of behavior that I don't like to see and that puts you in jeopardy of failing. Other people don't take that as funny, they take it as being serious, and they won't take you seriously as a nurse."

A 55-year-old female participant with 13 years' teaching experience described a student who left a patient in order to attend a family meeting "uninvited." Other participants described students who tried to "override" computer programs and disregarded the recommendations of their supervising nurses. Sometimes the behaviors were so problematic that participants determined the students to be "unsafe."

Problems with skills. Participants identified underperforming students as those who were unable to learn basic skills. The most difficult skills for students were organization, time management, and performing basic psychomotor tasks.

Several participants indicated that underperforming students were unable to care for even one or two patients. These students were disorganized and could not manage their time. One 47-year-old female participant with nine years' teaching experience described a student who came to clinical with information about a patient on multiple slips of paper but was unable to "find the correct slip" to answer questions. Some students were often late doing assessments, providing medications, and performing hygiene care.

In addition to time management and organizational skills, underperforming students were unable to do psychomotor tasks such as sterile procedures and medication administration. One 54-year-old male participant with 24 years' teaching experience described a student who did not understand the need for sterility and did not realize when she contaminated a sterile field. Another 61-year-old female participant with 36 years' teaching experience described a student who "made a few medication errors."

Problems in several areas. Participants frequently described underperforming students who had problems in several, or in some cases all, of these areas. One female participant with 33 years' teaching experience stated that it was "when you put them [the problems] all together you can see they [the students] are underperforming." Another 47-year-old female participant with nine years' teaching experience described a mature, well-liked, bright student who dexterity-wise could complete skills well but was unable to give the rationale or theory behind the skills he performed. A different 47-year-old female participant with seven years' teaching experience recalled a memorable student who struggled in multiple areas, even during her third clinical rotation:

> This student in particular did not have any of those skills [being organized, having time management] at all, sometimes I think students tend to "fly

> under the radar" so to speak, and pass on from semester to semester…. But this student was clearly unsafe in terms of medication preparation, was totally not knowledgeable at all about the medications for the patient that she was assigned to…. You could tell that she didn't know the drugs – the generic name, the brand name – she didn't know when to give the meds or what the dosages were…the medication wasn't prepared correctly, she broke sterile technique, and in addition she had multiple absences.

Perceived Causes of Underperformance by Clinical Nursing Students

The participants not only discussed characteristics of underperforming students but also offered explanations as to why students underperformed. These explanations included language and cultural factors, social disadvantage, mental health problems, and personal life experiences that interfered with school.

Cultural factors. Participants suggested that students' cultural backgrounds might make them more prone to underperformance. Several mentioned that international students with poor English-language skills had a difficult time with medical terminology, understanding assignments, or communicating with patients. Other participants attributed performance problems to cultural beliefs that were at odds with Western values. One female participant with 33 years' teaching experience, for example, described a student who was continually receiving a significant amount of help from other students. When the participant questioned the student about this, the participant learned that the student's culture placed more value on collaborative accomplishments than on individual achievements, and thus enlisting the help of others made sense to the student.

Social disadvantage. Some participants suggested that students from disadvantaged economic, social, and educational backgrounds were prone to

underperformance. A 67-year-old female participant with 42 years' teaching experience explained,

> They [underperforming students] came from poor high schools out in the rural areas. They have poor intellectual backgrounds…. There's just a whole bunch like that, when you teach at a University that opens its doors to these folks that haven't had a lot of education in their families, or they're minorities.

Mental health problems. Participants also indicated that mental health problems were often at the root of students' underperformance. They described students who struggled with anxiety, depression, emotional instability, and Attention Deficit Hyperactivity Disorder (ADHD). The participants suggested that these problems often needed to be addressed before students could be successful. One 63-year-old female participant with 30 years' teaching experience described a student who at first was unable to complete a clinical day due to extreme anxiety but succeeded in clinical following counseling. Another 44-year-old female participant with six years' teaching experience described an especially memorable student with mental health problems:

> [The student] had a history of ADHD and an anxiety disorder. She couldn't stay on task, she couldn't ascertain the most important information, she couldn't get organized – our paperwork is typically 10 pages long at the most – hers was always 30 to 40 pages in length. She would go into the room and she'd have an idea of what she was supposed to do, but if the patient said no, or threw her for a loop, or got her off track in any way, she could never get back to what she was supposed to do. She never had her assessments documented on time; she was late with meds; she couldn't determine what meds to give. Her thought processes were all just a big jumbled mess of mush.

Personal life experiences. Participants also believed that some students underperformed because they were dealing with trying personal life experiences. Financial concerns, heavy work schedules, addictions, family crises, marriage and relationship problems, and abuse all were seen as contributing to underperformance.

These stressors prevented students from devoting the necessary time and attention to nursing school. One 49-year-old female participant with nine years' teaching experience summarized her concerns:

> What I find often times is that when the truth comes out, they [underperforming students] are exhausted. They've been up all night, they've either worked the night before or there's usually other things going on – someone in the family is seriously ill – usually there's other things going on that have led to, "I just can't deal with one more thing," and student is running out of the [patient's] room.

The Theoretical Framework: How Faculty Work with Underperforming Students

The theoretical framework was developed using constant comparison analysis as described in the previous chapter. The framework included three stages that unfolded as faculty worked with underperforming students over time. The first stage, *Being Present*, was the process by which faculty came to know students were underperforming. They did this by noticing "red flags," taking extra time with the students who displayed the red flags, working side-by-side with these students, and connecting with them "where they were at." The second stage, *Setting a New Course*, was the process by which faculty attempted to provide remedial experiences to improve the performance of those students determined to be underperforming. The participants did this by beginning a new course of instruction for the students, bringing in new people to help the students, and creating new learning experiences for them. This process could result in students turning it (their performance) around, making it through (the clinical rotation), or not making it. The final stage, *Being Objective*, was the process by which participants made negative progression decisions. They did this by relying on objective indices, documenting problematic student behaviors, and obtaining validation for their decisions.

Though the framework is described as a progression of sequential steps to provide a theoretical rendering of a common process, there was diversity in how the stages were actually experienced by participants. Some participants described an orderly progression throughout the stages, some focused on one stage and not others, and some moved back and forth between stages. However, the framework outlines a process shared by most of the participants and highlights the most typical experiences described by the sample. The framework is depicted in Figure 1.

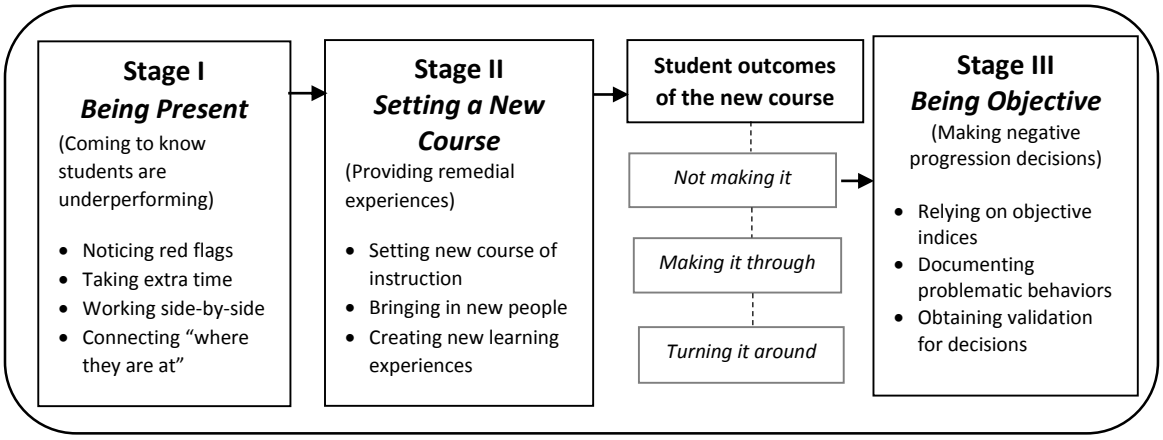

Figure 1. Theoretical Framework: How Faculty Work with Underperforming Students

Stage 1: Coming to Know a Student is Underperforming: *Being Present*

The first stage in working with underperforming students as described by the participants involved coming to know that students were underperforming. This involved a process that is labeled *Being Present*. In order to identify underperforming students, participants stressed that they needed to be fully "present" with students by being particularly attuned to them and by connecting with them in meaningful and mindful ways. Because participants were present with students, the participants could identify students' underperformance by noticing red flags, taking extra time with students who

exhibited red flags, working side-by-side with these students, and connecting with them "where they were at."

Noticing "red flags." Most of the participants became concerned about the performance of some students almost from the outset of their clinical rotations. These students would engage in behaviors that gave participants an early inkling that the students might struggle in clinical. The behaviors were often not egregious but rather served as an indication that there might later be a problem with performance. Some participants described these behaviors as "red flags." Certain red flags suggested to the participants that students were unprepared to care for patients, reluctant to engage in patient care, or particularly anxious.

Red flags could be behaviors that indicated students were unprepared for the clinical day. These behaviors included coming without necessary equipment, failing to do required preclinical paperwork, and not being prepared to discuss assigned patients.

Another red flag presented itself when students showed hesitancy to provide nursing care early in the clinical rotation. Some students observed others providing care but were reluctant to "jump in" and do care themselves. A 65-year-old female participant with 22 years' teaching experience recalled, "I have some students who kind of stand back and let someone else do [the work] for them. I come in and say, 'No, no, no, I need to see YOU do it'." Participants described these students as "tourists" or "wallflowers."

Another red flag appeared when participants could not find students on the unit. The participants noted that these students "wanted to be invisible" and "sought avenues to get away." They would hide to avoid answering questions, doing patient care, or being observed by faculty. For this reason, a 65-year-old female participant with 22 years'

teaching experience indicated that she kept such students within her sight at all times. Another 61-year-old female participant with 36 years' teaching experience remarked, "If at the end of the day, you say, 'Oh my goodness, I didn't see Susie Q at all,' that to me is quite a red flag." These students were described as "hiders."

Students who exhibited extreme anxiety when beginning clinical also sent up red flags. While many students lacked confidence and appeared nervous early on, others seemed "fearful," "overwhelmed," and "lost." Students who were unable to function because they appeared "frozen" were of most concern to faculty. Participants indicated these students "clung" to clinical faculty and spent significant time seeking help, guidance, and support.

One 41-year-old female participant with ten years' teaching experience provided an example of the little things that served as red flags and alerted faculty to potential problems with a student's performance:

> It took [the student] a really long time to get started in the day. She just looked a little lost on the unit.... So that's how I kind of honed in on her. Then as I looked a little further and more closely at her, she just couldn't get herself organized. She mixed things up. Just watching those little things let me know that I needed to pay more attention to her.

Taking extra time. Once participants became alerted by the red flags exhibited by some students, the participants began to take extra time with them in order to determine if they were underperforming. The participants stressed that if faculty do not spend extra time with students who show early signs of struggling, underperforming students might not be identified in a timely fashion. One 67-year-old female participant with 42 years' teaching experience, stated, "You have to be with [the students] and see what they are doing to be able to evaluate and use the instruments that you have."

Participants took extra time throughout the clinical day with students who raised red flags. If participants thought students might not be prepared, they would make a point of spending additional time at the beginning of the day reviewing the students' pre-clinical preparations and determining their readiness to perform nursing care that day. The participants would then continue to spend extra time throughout the shift observing these students. Participants made a point to interact frequently with such students to "see what they are doing" and "understand their thought processes." Most of the participants' time was spent questioning students about their plans of care. A female participant with 33 years' teaching experience, explained:

> And I told her [the student] as she started to talk to me about her patient, my question is always to the student, "Tell me about your person." She started out with his age, and his name, and then she stopped. And I said, "Well, what is this person here for? Why are they here?" And she couldn't tell me. And I said, "Tell me about this person's activity status. What do you have planned for this person today? What are we going to be doing?" "Well I have to give him a bath." "Okay. Does this person have anything going on today that they will be off the unit that we need to take into consideration as we are preparing to do morning care for this person?" And at this point, [the student] stuck her little head up and got a bit angry, and I said, "Well that's not very good preparation. We need to know more to take care of this person."

Participants would also spend extra time at the end of the clinical day to "debrief" students who were showing red flags. While a common practice in working with clinical nursing students is to hold post-conferences that allow them to discuss their clinical experiences as a group, in addition to standard post-conferences, participants met with some students individually if the participants had concerns about how these students fared on that particular day.

Participants also met with students outside of the clinical day if there were emerging concerns about the students' performances. These meetings were described as

consultations, one-on-one counseling meetings, debriefings, and clinical performance reviews. Some participants began to meet regularly with students each week outside of clinical. One 44-year-old female participant with six years' teaching experience stated, "I have personally found that after clinical is not a good time. They [the students] are tired, their brains are overwhelmed by what has happened in the course of the day, and they don't remember 10% of what I tell them."

Working side-by-side. Another way participants were *being present* and coming to know students were underperforming was by working "side-by-side" with them. Participants not only spent extra time with students who showed red flags, but they also often joined them in performing clinical care in order to assess their performance. Participants accompanied students to patient rooms and helped them conduct assessments, perform tasks, and administer medications and treatments. Participants worked side-by-side with students in this way in both clinical and simulation settings. One 52-year-old female participant with 15 years' teaching experience accompanied a student into the patient's room to do an assessment because the student initially could not complete this task without the participant present. Another 41-year-old female participant with ten years' teaching experience assessed a patient with cellulitis because the student could not find the pedal or posterior tibial pulses. A 48-year-old female participant with eight years' teaching experience worked side-by-side with a student who was to assess and "care" for a simulation patient with a tracheostomy. The student applied oxygen by nasal cannula because she did not know the purpose of the tracheostomy. The participant stated, "[The student] did not demonstrate good

knowledge, or clinical judgment, reasoning...she truly did not know that this patient was using a tracheostomy to breathe."

Some participants discussed working side-by-side with students while they performed basic skills in order to detect problems. A 63-year-old female participant with 33 years' teaching experience had clinical in a long-term care facility at which students could regularly change urinary catheters. She helped students change the catheters in order to identify those who could not perform this skill. Another participant, a 61-year-old female participant with 36 years' teaching experience had assisted a student with a wound culture, recalling that the student wanted to use a betadine swab, which "made no sense on any level." A 54-year-old male participant with 24 years' teaching experience assisted a student with a sterile dressing change. The student was able to do the task, but did not recognize the underlying concept of sterility. The participant stated, "When she [the student] touched something that wasn't sterile, it didn't ring true to her that that was an issue." A 47-year-old female participant with seven years' teaching experience also noticed problems with a student's sterile technique. The student was putting in a catheter when her hair came down and contaminated the sterile field. The participant was concerned that the student intended to insert the catheter even after the contamination.

Participants often worked side-by-side with students who showed red flags when administering medications. Although accompanying students as they give medications is common practice, it was an especially important way to assess the performance of these students. A 44-year-old female participant with six years' teaching experience , for example, worked side-by-side with a student preparing meds and observed her drawing 1 milliliter of medication in the syringe although the appropriate dose was 0.1 milliliter. A

62-year-old female participant with 3 ½ years' teaching experience observed a student preparing an intramuscular medication and noted that the student touched the needle, bent it, then tried to re-straighten it with her fingers. A 41-year-old female participant with ten years' teaching experience worked side-by-side with one student who took the patient's pills out of their packages and forgot what they were. The student was also unable to correctly draw up medication for a subcutaneous injection. The participant stated, "Just watching those little things let me know that I needed to pay more attention to her."

One 41-year-old female participant with ten years' teaching experience provided an example of working side-by-side with students while they were doing assessments as well as preparing and administering medications. She stated,

> [The student] had a patient who needed Digoxin. I gave her time to look up the medication. She had a number of medications lined up, so I took the Digoxin medication and I held it [away from the other medications]. We went through the medications and talked about them; I took the Digoxin pill, and said, "Are you ready to go in and give your medications?" And we went into the patient's room and she gave him all of the pills. And I said, "Did you tell me that there was something that you had to do before you gave the medications? Do you think you gave all of your medications?" And she said, "Yeah, I gave them all." And I said, "Are you sure?" And she said, "Yes." And I said, "Look at your MAR [Medication Administration Record] and make sure you gave everything." And she said, "Well I think I may be missing one." And I said, "Well what one do you think you might be missing?" And she said, "The Digoxin." And I said, "Well why do you think I held that away from you?" And she said, "Oh, because I need to check the apical pulse." And I said, "[Let's] go and check your apical pulse." And she proceeded to check the apical pulse in the wrong place, and I showed her how to correctly check the apical pulse. And I asked her what result she received, and she told me. And I asked her if it was safe to give, and she told me it was. And so I said, "Okay, let's go ahead and give it."

Connecting with students "where they are at." A third way the participants came to know that students were underperforming was by *being present* with them "where they were at." Participants indicated that they if they did not build good

relationships with students who showed red flags early in the clinical rotation, students would hide their struggles. The participants therefore tried meeting these students "where they were at" rather than merely evaluating their performance. The participants connected with these students by giving them support, providing opportunities for them to discuss their struggles, and finding out about personal issues that might be affecting their clinical performance.

Some participants connected with students by offering added support when red flags began to appear. Participants would often ask students, "How can I help you?" rather than pointing out and criticizing their mistakes. Participants suggested that by providing support, they created an environment in which students could reveal their performance issues. Many participants spent time talking with these students and, in return, students revealed such things as, "I'm drowning," or "Everyone else gets it, but I don't." Some students communicated these doubts in their journals. A 48-year-old female participant with eight years' teaching experience shared the importance of connecting with students. She stated, "You can't be their friend, and you can't be their mom, but you still need to develop a rapport with the student so they feel they can be honest with you and share things."

Participants also connected with students where they were at by finding out about them as "people" rather than as nursing students and thereby viewing them holistically. One 61-year-old female participant with 36 years' teaching experience described how an Asian-American student showed a red flag when she refused to assess a patient's pain. The participant, upon talking to the student, discovered this was because the student felt it was disrespectful to a physician for a nurse to ask a patient about pain. A 63-year-old

female participant with 30 years' teaching experience told of a student whose anxiety impeded his performance early in his clinical rotation. She was able to recognize his mental health issues and connect him with a mental health professional, thereby helping him improve his performance. Another 56-year-old female participant with 19 years' teaching experience said, "I think it's important to understand students on a personal level and not put them in a box. We can't put our students in a box and think that they can shut out their lives, and come to clinical, and not see them as holistic individuals and people."

Connecting with students where they were at also involved recognizing that those students who suddenly showed red flags might be experiencing life events such as personal or family illnesses that interfered with their clinical experiences. A 49-year-old female participant with 25 years' teaching experience stressed the importance of asking students about "what had changed" if students suddenly demonstrated problems in clinical.

Another way participants connected with students where they were at was to view students in context of their past experiences as healthcare professionals. Many students came into their Bachelor of Science in Nursing (BSN) programs as Licensed Practical Nurses, Certified Nursing Assistants, Paramedics, or Emergency Medical Technicians. The participants indicated that the early red flags of these students might reflect that they were performing as if they were still in their former roles rather than as BSN nursing students.

One 56-year-old female participant with 19 years' teaching experience provided an example of how she connected with a student where she was at and how this allowed

her to come to know the nature of the student's difficulties. She related the following story:

> I can think of a student who was a really bright, bright, straight A student, in an associate degree program, [with a] baccalaureate degree in another field. And [we] went in to perform with a particular patient. Before I go into a room with a student, I try to do a little bit of role-play, and some run-through about, "Okay let's talk about it," and that type of a thing. I picked up some real hesitancy on the part of the student, and I just remember saying to them, "Are you okay with what's going on with you right now?" And the student said, "I'm just really afraid, I'm afraid of hurting [the patient], I'm afraid of doing the wrong thing," and those kinds of things. And [we took] some time to work through that and give them the opportunity to identify that within themselves, and saying it out loud, and making it safe for [her] to be with [her] feelings, and to be with what's going on.... So I think it's important that [we] as faculty, when working with students, honor that place where they are, and to not have them shut that out or push that aside, because that does affect us in our own house.

Stage 2: Remediation with the Underperforming Student: *Setting a New Course*

By *being present* with students who showed red flags, participants could ascertain in a timely manner which students had had a rough start to a clinical rotation and which students would be considered underperforming. Once the participants determined that students were in fact underperforming, the participants initiated a process best described as *Setting a New Course*. The new course involved a series of activities designed to bring the problem of underperformance to the students' attention and to provide opportunities for them to improve their performance. *Setting a new course* included beginning the new course, bringing in new people, and creating new experiences.

Beginning a new course. Typically *setting a new course* began with a strategic meeting to discuss concerns and develop individualized action plans with students whom the participants had determined to be underperforming. Participants described these meetings as a chance to "start afresh." While participants used these meetings to discuss

problems in the students' performance, they also used them to listen to students' concerns and to solicit input to "troubleshoot" the problems. Some participants used the "sandwich" technique in these initial meetings by coupling feedback on poor behaviors with observations of positive ones. One 49-year-old female participant with nine years' teaching experience suggested, "[We should] tell them when they are doing a really good job. They need to hear that too. They don't just need someone pulling them out, and [saying], 'Wow, you really need to work on this....'"

These strategic meetings allowed participants and students to review clinical standards and course expectations and to collaborate on developing action plans. In these meetings, the participants discussed how students must come to clinical well prepared, meet professional standards, and practice safely. Many participants developed action plans based on clinical evaluation forms that delineated "critical behaviors" required to pass the course. The participants stressed that the action plans needed to be specific and individualized. One 61-year-old female participant with 36 years' teaching experience stated,

> Often times students will hear feedback – the instructor will say, "You need to improve in your clinical practice." And they think, "Well everybody could improve," so they don't change anything. Or else they will think, "Oh my word, is everything I'm doing wrong?" And so they try to change everything, and then they become unsuccessful in every area. And so by zeroing in on "these are the areas that need to be improved," it helps the student and also helps the instructor to be more effective.

Action plans were both verbal and written. Many participants began the process by meeting with students and developing informal "verbal" action plans. If verbal plans were unsuccessful, participants then instituted more formal written plans that put underperforming students "on notice." Most written action plans consisted of

descriptions of underperforming behaviors, a delineation of steps required to meet course expectations, identification of benchmarks that would reflect successful completion of the plan, and dates by which the benchmarks were to be reached. Often the plans were signed by both the participants and students. Some action plans were individualized for the student, whereas others were based on official university guidelines. For example, some participants indicated that they needed to complete standardized "clinical counseling" or "clinical warning" forms when behaviors were egregious and students were close to clinical failure. One 49-year-old female participant with nine years' teaching experience indicated she would talk to the students and tell them what they needed to do to meet the objectives of the course. If students did not improve, then she would write up a "counseling form" that drew attention to the issues to help the student improve. Egregious or continued poor behavior required a written "warning" that outlined all the steps required for the student to be successful in the course. She stated "It [the clinical warning] is very prescriptive." Although institution-based contracts clearly delineated expected behaviors and the time frames within which students needed to show improvement, some participants felt standard forms left them with minimal opportunities to individualize the plans. Most participants agreed that meeting with students to formulate individualized action plans was the essential first step in *setting a new course*.

Bringing in new people. Another aspect of *setting a new course* consisted of "bringing in new people" to assist students in becoming more successful. These new people were individuals who had the experience or expertise to help underperforming students in some particular way. New people could be student peers, other faculty, or other professionals.

Several participants enlisted student peers to work with underperforming students. The peers and the underperforming students would "buddy up" on clinical assignments or tasks. Successful or stellar students would therefore serve as role models for underperforming students. Some participants encouraged underperforming students to be involved in study groups to improve their clinical reasoning skills. One 37-year-old female participant with six years' teaching experience found the only way she could "reach" an underperforming student was to encourage peers to provide feedback to that student because she was more receptive to input from her peers than from clinical faculty. In some of the participants' programs, peer tutors were formally employed to work with underperforming students. These tutors could help underperforming students with studying, reading and interpreting difficult textbooks, critical thinking, and note taking.

Participants also frequently enlisted other faculty, professional tutors, and graduate students to assist with underperforming students. Some participants consulted seasoned faculty members when the participants felt unsure about their own perceptions of the students' performance. The participants also solicited help from other faculty colleagues who had particular expertise in areas such as helping with study techniques or training in psychomotor skills. Some of the participants' institutions employed personnel whose main responsibility was to remediate underperforming students.

Sometimes participants referred students to other professionals in order to help the students *set a new course*. In particular, participants frequently referred

students with anxiety, depression, and other mental health concerns to mental health professionals to improve the students' chances for success. Participants acknowledged that they were unable to meet the needs of these students until underlying issues were resolved.

Participants therefore recognized that bringing in new people created opportunities for *setting a new course* that the participants could not provide themselves. A 44-year-old female participant with six years' teaching experience stated, "So between me, her [the underperforming student], the advisor, the counselor, and the nursing resource center – and we also got her a peer teacher – we devoted extra time to help [the student] figure out a better way to prioritize, organize, and make better use of her time."

Creating new experiences. Participants also *set a new course* by creating new experiences for underperforming students. These experiences went beyond those experiences provided for students who were performing adequately. One 56-year-old female participant with 19 years' teaching experience suggested that clinical faculty have "an arsenal of teaching strategies" to rely upon in order to create new experiences for underperforming students. New experiences were provided outside of the clinical setting, usually in a lab, or in the clinical setting itself.

Creating new experiences in a lab setting. Many participants believed that some underperforming students needed additional time to practice the skills that they could not master at the clinical site. The participants therefore often referred underperforming students to a skills lab, which was typically located at the school of nursing.

Underperforming students were advised to work on psychomotor skills such as intramuscular (IM) and intravenous (IV) medication administration and sterile techniques. One 41-year-old female participant with ten years' teaching experience provided underperforming students with opportunities to practice IV set-ups and medication administration in the lab because she recognized these skills were particularly difficult. Other participants encouraged students to practice sterile procedures in the lab because they believed it was critical that students grasp the principles underlying these skills.

Some participants used the lab to help underperforming students improve their time management, organizational skills, and written care plans. Participants determined that some underperforming students needed more time in organizing their thinking before they could become comfortable in providing patient care. A 47-year-old female participant with nine years' teaching experience described how lab personnel at her school helped an underperforming student develop a 15-minute incremental schedule of essential activities to be completed during a clinical shift. Many participants used lab settings to offer case studies that allowed students to practice how to gather and interpret information, develop care plans, and implement appropriate nursing interventions.

Participants also used high-fidelity simulation labs to create new experiences for underperforming students. These labs provided students with clinical experiences using patient simulators that were programmed to respond to student interventions in the same way patients would respond. Participants referred underperforming students to these labs to practice skills without threatening patient safety. One 47-year-old female participant with seven years' teaching experience believed that underperforming students could be

provided new and varied opportunities to apply their knowledge in different contexts through the use of high-fidelity simulation.

Most participants collaborated with laboratory personnel who worked with underperforming students by providing information about the students' specific remediation needs. A female faculty member with 33 years' teaching experience wrote "lab prescriptions" to provide lab personnel with detailed descriptions of students' skill deficits and learning needs along with a timeline for expected progress. The prescriptions facilitated coordination among herself, the student, and the lab personnel and were typically perceived by the student as helpful rather than punitive in nature. Because participants believed that opportunities offered in the lab settings were so critical to underperforming students, they referred to these experiences as "formative learning" and "skilled remediation for success (SRS)."

Creating new experiences in the clinical setting. Participants also provided new experiences for underperforming students throughout the clinical day. Many participants offered students targeted learning opportunities to address their deficits in performance. For example, participants used a variety of teaching strategies to enhance students' cognitive performance if students could not understand the complexity of patients' conditions or identify covert clues to patients' statuses. These strategies included concept mapping, journaling, and reflection papers. Participants often questioned underperforming students (e.g., "Why are you doing this?" "Why is this important?" "Why do we care?") to improve their critical thinking skills. Participants would also "sit down" with underperforming students and go through patient charts, care plans, and

medication administration records to help students learn how to better interpret clinical information.

Another way participants created new experiences for underperforming students was to provide supplemental practice or observational opportunities. For example, many participants helped underperforming students improve medication administration skills by providing multiple opportunities for them to master these skills. One female participant with 33 years' teaching experience "took students down the hall" to observe patient rooms from the doorway and asked students to identify any unsafe conditions. Another 49-year-old female participant with nine years' teaching experience "role-played" situations that underperforming students had handled badly before permitting them to resume patient care.

Another way participants created new experiences for underperforming students was to strategically make patient assignments that addressed particular areas of underperformance. Some participants provided underperforming students with lower acuity patients so the students would have greater chances for success. Other participants assigned underperforming students similar patients on two successive clinical days to help the students apply what they had learned the previous clinical day. Some participants assigned English-learning students to patients who spoke the students' languages. Other participants chose patient assignments based on students' needs to improve on communication or self-confidence. One 63-year-old female participant with 30 years' teaching experience assigned a student who lacked confidence to do a catheter change on a patient who was accustomed to students changing her catheter and was thus "easygoing" with students who had not mastered this skill. One 48-year-old female

participant with eight years' teaching experience articulated how she used individualized clinical assignments to help an underperforming student become successful:

> I knew that he [the student] struggled with confidence. So, the first patient that I gave him was not necessarily the most difficult, challenging patient. But on week two of clinical, I offered him a challenging patient to see whether he would say yes or not. He had heard about this patient during post conference, he knew the challenges that this patient had. He was asked if he could do that [take care of the patient]. It was going to be heavy skills oriented and also communication oriented. And he took that challenge, he said yes, he was interested in taking that patient.

Finally, participants were able to create new experiences for underperforming students by providing them with extra time in the clinical setting. Some participants were able to provide extra clinical days for underperforming students during the clinical rotation in order to work more closely with them in areas in which they were underperforming. One 37-year-old female participant with six years' teaching experience provided an underperforming student an extra two weeks of clinical because the clinical site was available during a school break.

Results of setting a new course. The results of *setting a new course* varied; some students responded well to the new course and others did not. The participants described three student outcomes as the result of a new course: "turning it around," "making it through," or "not making it."

Turning it around. Participants described how some underperforming students were able to "turn it around" and show notable improvement as a result of the new course. Some participants indicated that underperforming students improved their performance in as little as one or two clinical days. Other students had slower responses to the new course but performed quite well by the end of the clinical rotation. Some participants indicated that students were able to turn it

around because the participants had used a stern or serious approach – they showed that they "meant" what they said or put students' "feet to the fire." More often, however, participants indicated that students turned it around due to their own efforts. One 37-year-old female participant with six years' teaching experience stated, "[The student] met the objectives of the course, so eventually I made the decision to pass her. Rather, she was successful enough that she passed. I didn't pass her. She was successful and she passed."

Making it through. Participants also described some underperforming students as merely "making in through" in response to the new course. These students continued to struggle with performance but met minimal requirements to pass the clinical rotation. Although their performance was satisfactory at the end of the rotation, they never performed at the same level as other students in their cohort. A few participants expressed concern that because clinical was graded pass/fail, some students were able to pass even though they continued to have some significant performance deficits. The participants felt conflicted about allowing students to "barely pass" as the participants believed these students would likely continue to struggle in the program and subsequently in nursing practice. Others hoped that these students might do better in other clinical venues. One 49-year-old female participant with nine years' teaching experience reasoned that not all students are "cut out" for hospital nursing but might succeed in other areas:

> We've all had students like that – they sort of self-recognize that they are stressed out in the hospital setting and they cannot manage all of the tasks required on the clinical unit. And they will then sort of proclaim themselves as wanting to go into community health nursing, or they're really interested in psych – which is good, I think they would be great in

> those areas – but they will pull themselves out of the realm of even really wanting to be in the hospital setting.

Not making it. Participants described some students as "not making it" despite the new course set for them. Some were required to repeat the clinical course, and while some students did better the second time, many did not. Some students were considered so unsafe that they were removed from the program. Participants experienced frustration when students did not make it and lamented that some student problems simply could not be overcome. A 47-year-old female participant with seven years' teaching experience described an underperforming student who had experienced many on-going family and relationship stressors, was receiving treatment for anxiety, had failed a previous nursing course, and subsequently dropped out of college. Another 67-year-old female participant with 42 years' teaching experience described her reaction to a student who did not make it:

> There are a lot of people that you can really help but with this one [student] there was no way. If you ever prayed for a student, for help [dealing] with a student, you'll understand. He didn't show up for a 2 o'clock in the afternoon exam one day, and I prayed, "thank you, God," because that's the nail in the coffin.

Stage 3: Making Negative Progression Decisions: *Being Objective*

For the students who did not make it, the participants described the process by which they made and carried out final negative progression decisions that involved failing students in a course or dismissing them from the program. Because the focus of the participants' narratives about this final stage was the need to go "by the book" and be free of any bias, this stage is labeled *Being Objective*. While the participants' narratives about *being present* and *setting a new course* were focused on interactions between

participants and underperforming students, the narratives about negative progression decisions focused more on following policies and procedures.

Some participants discussed the need to *become objective* so they could fully justify failing a student and, in doing so, protect themselves from negative repercussions. Failing students was a stressful experience for the participants. Many participants doubted their own abilities, blamed themselves for student failures, or were fearful they would be sued or viewed as poor instructors by other faculty or administration. Some participants did not feel supported by their institutions when they made negative progression decisions. A few revealed that their institutions did not allow them to make negative progression decisions independently as clinical faculty, which left them feeling that their institutions did not consider them to be professionals. One 54-year-old male participant with 24 years' teaching experience stated, "What we really need is good clinical instructors who are supported by their institutions and who are trained in dealing with underperforming students." The participants employed three main techniques to *be objective* when making negative progression decisions: relying on standard indices as the basis for decisions, meticulously documenting the behaviors of the students that led to the decision, and obtaining validation from others for the decision.

Relying on objective indices to make negative progression decisions. Although some participants acknowledged that progression decisions could be subjective in nature, most focused on their use of objective criteria. The participants stressed that the decisions they made to not progress students were based on the students' failures to meet formal clinical and course objectives and/or display basic competencies published in course syllabi, student handbooks, and clinical evaluation forms. One female

participant with 33 years' teaching experience stressed that it was her obligation to let a student know that she had not met the course outcomes and would need to repeat the course. Another 56-year-old female participant with 19 years' teaching experience developed an individualized plan for an underperforming student that had clear guidelines based on course objectives and expected completion dates for each objective. When the student did not meet these objectives, the participant said, "This day came and you have not completed what you said you would do." One 49-year-old female participant with nine years' teaching experience stressed the importance of being objective:

> What I've learned over time as an educator is that you really have to stick to the black and white policies and the black and white behaviors in the evaluation form. So clearly, if I wrote a warning on them [students] for unsafe medication administration, and they did that again, I would be able to fail them because I wrote it up "that if you do this again, you will fail the course."

Documenting problematic student behaviors. In addition to using objective indices for making negative progression decisions, participants were careful to document any student behaviors that justified negative progression decisions. Participants "documented everything," and "created a paper trail" to detail their students' underperformance. Documentation occurred in anecdotal notes, weekly progress reports, incident write-ups, and clinical warnings. One 55-year-old female participant with 13 years' teaching experience said, "Write it [evidence of student underperformance] up. Write it up at the moment, in your own hand, just for you; then when more instances happen you have not a paper trail but a memory trail 'cause sometimes you don't want to remember."

Participants stressed that it was important not only to document student behaviors but to meticulously document faculty efforts to remediate underperforming students as well. A 37-year-old female participant with six years' teaching experience expressed the importance of documentation:

> You have to document on your end as an educator that yes they [underperforming students] aren't succeeding, but what did you do in return as their teacher? And you better spell out pretty specifically what you do, and the things you told them, and what you expected them to do and see, and whether or not they fulfilled that. You better document it or it may come back and bite you. If you don't show that you gave them an opportunity, if they indeed failed, and you have enough documentation, and they come back and say, "Well, so-and-so just had it in for me." "No I didn't. You didn't succeed. I gave you multiple opportunities. We have a learning contract and you were supposed to do these things, and I showed you the learning contract and you didn't complete these things, and here's what I saw."

Obtaining validation. Another way participants remained objective was to seek validation from others, i.e. seasoned faculty, trusted colleagues, and program directors, for the negative progression decisions they had made or were contemplating. Often participants were hesitant to make these decisions without validation from others. Some sought validation from faculty members who had taught the student previously in order to confirm that a decision to fail a student was well-justified. Some participants sought validation from more seasoned nurses. One 37-year-old female participant with six years' teaching experience related, "I remember talking to [a unit manager], because he'd been a nurse for 30 some odd years as well as the manager, and I just needed someone to talk to about my experience." Participants often sought validation from an authority at the participant's institution, such as the school's program director or dean. A female participant with 33 years' teaching experience summarized this experience as follows:

> I had a student in her last course before graduation, and she was completely unable to document. [She had been] given all kinds of opportunities to remediate, and finally I called the director of the program – this is two weeks before graduation – and I said, "I'm going to send an example of this student's documentation to you along with my anecdotal notes, and I want your permission to not allow this student to graduate." And the director of the program looked at what I had sent and she said, "You cannot allow this student to graduate from our program." And she said to me, "How did this student get to you?" And I said, "That's not for me to answer. You have to go back and review documentation from clinical experiences in all of the previous courses. I can't answer that question; all I can do at this point is tell you that this person is not safe based on all of the bad documentation."

Validation of Data

Validation of data was completed according to the guidelines given by Charmaz (2006). In grounded theory, data is validated through determining the usefulness and resonance of the final theoretical framework. The ways data were validated is presented.

Usefulness of Theoretical Framework

In order to determine usefulness of the theoretical framework, three faculty members who have worked with underperforming students, have greater than 10 years' teaching experience, and are professional colleagues of the researcher but were not participants in the study, were given a diagram of the theoretical framework and a brief discussion of its components. The researcher requested their feedback concerning the relevance and usefulness of the theoretical model in their practice. All three individuals replied with e-mail responses. All indicated they thought the theory was consistent with their experiences with underperforming students and therefore "spoke to them." One faculty member stated, "It was nice to see it [the theory] written down in a process that I do without realizing 'how'." Another stated, "Much of what I read resonated with me. Although I don't see this conundrum as a linear process, I found the stages and their

descriptors as critical and relevant to the role of an educator when working with under-performing students." The concept of *being present* was mentioned as an important aspect of the model. One faculty member indicated that she believed the theory would be useful in her practice: "I can see all sorts of ways I could use the elements of model in practice." Some of the suggestions mentioned by the faculty members, including having the student responses (e.g., not making it, making it through, and turning it around) constitute their own "stage" and describing more about the final stage, were discussed by the researcher and dissertation chair and either incorporated into the document or mentioned as limitations.

Resonance of Theoretical Framework

In order to determine if the theoretical framework resonated with faculty who work with underperforming students, the transcripts of six participants were "withheld" and not included in the development of the theoretical framework. This allowed the researcher to determine if they were congruent with the proposed framework. By reading these transcripts in their entirety, the researcher concluded that they aligned with the framework as a whole. These six participants did in fact describe the stages of the framework in each of their narratives and provided examples that were consistent with the categories that constituted the framework. For example, one 63-year-old female participant described working with an underperforming student in each of the stages. She described *being present* with underperforming students: "There were times when [the student] would make medication errors that I would catch, because I was there, and I always check medications before they administer them. And so I would find that she had made incorrect dosages." She described several aspects of s*etting a new course.* She

stated, "We would develop a plan, talk about how she could plan better. I try to be supportive, [discuss what] the student is doing well, and help with their organization skills if that's the issue." She also described the process of *being objective*. She relied on her school's policy to give the student an "unsatisfactory clinical day" with documentation and feedback about the reason for this decision. She concluded, "Our policies are that if you [the student] receive a third unsatisfactory then you automatically fail the course. So the policy kind of took it out of my hands in terms of giving her the failure." None of the other five transcripts revealed participant experiences that called for moderation or refinement of the framework.

Conclusion

The participants had clear ideas about the characteristics of underperforming students and common causes for underperformance. Participants noted a number of characteristics of underperforming students but were most concerned about students who had problems with behaviors that threatened patient safety and stressed that most underperforming students exhibited a number of problematic characteristics rather than just one. The participants typically attributed underperformance to students' cultural, social, or emotional disadvantages.

The participants worked with underperforming students in three stages: *Being Present*, *Setting a New Course*, and *Being Objective*. The first two stages involved being closely engaged with students in order to enhance their success, whereas the third stage involved a closer focus on following policies and procedures to avoid the negative repercussions that might come from failing a student. Overall, participants described being highly invested in facilitating the success of underperforming students and

experienced frustration when students did not make it. They used a number of different strategies and enlisted a variety of resources in their work with these students. For all the participants, working with underperforming students represented a significant challenge and memories of their experiences with underperforming students remained vivid, in some cases even after many years had passed.

CHAPTER V

Summary

The aim of the study was to develop a theoretical framework that describes how clinical faculty work with underperforming students in the clinical area. Nursing faculty who had worked with underperforming nursing students during clinical rotations were interviewed and invited to tell stories about working with these students. Although the participants told varied stories about their experiences with underperforming students, the participants' narratives included a number of commonalities in regards to how they perceived underperformance and how they worked with students who were underperforming.

Using grounded theory methods, a theoretical framework was developed. Using constant comparison analysis, three stages in working with underperforming students over time were identified and labeled. The first stage, *Being Present*, was the process by which participants came to know students were underperforming. They did this by noticing red flags, taking extra time with the students who displayed the red flags, working side-by-side with these students, and connecting with them "where they are at." The second stage, *Setting a New Course*, was the process participants used to provide remedial experiences. They did this by beginning a new course, bringing in new people, and creating new experiences. As a result of this stage, students experienced one of three outcomes: turning it around, making it through, or not making it. The third stage, *Being Objective*, was the process participants used to make negative progression decisions. They did this by relying on objective indices, documenting problematic interactions with students, and obtaining validation for their decisions.

While the framework is described as a progression of orderly sequential stages, there was variation in how participants progressed through these stages. Some described an orderly progression throughout the stages, some focused on one stage and not others in their stories, and some moved back and forth between stages. However, the framework outlines a common process shared by most participants and highlights the most common experiences described by the sample.

Discussion

Many of the findings of this study are consistent with prior research findings on underperforming students and several of the concepts from the framework link to concepts found in the literature. However, the findings of this study extend the understanding of how faculty work with underperforming students in several ways. This discussion will situate the current findings within extant literature on underperforming students.

Faculty Perceptions of Underperforming Students

The findings of this study are consistent with existing research on how faculty define and characterize students who are "unsafe" in providing care to patients. Although few studies have focused on underperforming students generally, several studies on "unsafe" students revealed that these students do not ask questions, are unenthusiastic, demonstrate unsatisfactory skill performance, come unprepared for the clinical experience, and have difficulty with interpersonal communication (Hrobsky & Kersbergen, 2002; Killam et al., 2010; Lewallen & DeBrew, 2012). Additionally, similar to my findings, problems performing fluid and dosage calculations and medication

administration have been determined to be especially problematic (Hrobsky & Kersbergen, 2002; Luhanga, Yonge, & Myrick, 2008).

The findings of the current study about faculty perceptions of why students underperform also resonated with some prior research studies. Just as my participants pointed to the influence of cultural issues on student clinical performance, Duerksen (2013) discussed how culturally diverse students experience financial stressors, perceived discrimination, language problems, and cultural tensions that contribute to lack of success. Similarly consistent with my findings, other studies have revealed that some faculty perceive that taxing personal life experiences contribute to students' underperformance in the clinical area. Dante, Valoppi, Saiani, and Palese (2011), for example, identified an association between nursing students who had multiple family commitments, such as the care of children and elderly family members, and academic failure. The psychological and mental health issues that were revealed in my study as precursors to underperformance, however, have not been discussed extensively in the literature.

Coming to Know a Student Is Underperforming: *Being Present*

The participants' descriptions of *being present* echoed Byrnes's (2012) discussion of how teachers are "present" with students. Byrnes specified that in order for teachers to "be present," they must be mindful in their practices. *Being present* involves paying attention to the immediate experiences of the students as well as the "big picture" of their educational needs. Byrnes also urges teachers to be mindful of their own responses to students. When teachers are present with students, they work with them to gain new perspectives or solutions. Being compassionate is also an aspect of being present with

students (Byrnes, 2012). My choice of the term *being present* is therefore consistent with Byrnes's concept of the "present" teacher; my participants stressed that identifying underperforming students involved being attuned to early warning signs of struggle, spending time and working closely with students, and showing concern.

The concept of *being present* in the theoretical framework reflects current views in nursing education that active observation of, and close involvement with, students are the most significant strategies for timely identification of underperformance (Oermann et al., 2009). My study extended this work by describing in-depth how this observation takes place – that is, by "noticing red flags," "taking extra time," and "working side-by-side" with students. In addition, my concept of connecting with students *where they are at* is in keeping with recommendations by Duffy (2003), Gallant, MacDonald, & Smith Higuchi (2006), and Gignac-Caille & Oermann (2001). These authors also reported that showing respect for students and having an awareness of their unique situations are critical in addressing underperformance.

Remediation with the Underperforming Student: *Setting a New Course*

The components of the process *setting a new course* identified in the theoretical framework have been discussed in the nursing education literature. The use of verbal and written "action" plans when *setting a new course* are similar to strategies discussed by Clynes and Raftery (2008) and Gallant, MacDonald, and Smith Higuchi (2006). Consistent with my finding that "bringing in new people" was considered an important remediation strategy by the participants, Hutton and Sutherland (2007) recommended using additional faculty to provide one-on-one supervision of underperforming students while the original faculty supervises the rest of the clinical cohort. Several experts have

also suggested that faculty include multiple individuals in providing formative feedback to students to promote their success (Haugan et al., 2011; Poorman, Webb, & Mastorovich, 2002; Skingley, Arnott, Greaves, & Nabb, 2007). Just as the participants in the current study discussed the importance of "creating new experiences" in lab settings, Decker et al. (2011) and Haskvitz and Koop (2004) discussed the value of using high-fidelity patient simulators and other technologies with students who are underperforming.

My findings about *setting a new course* also extended existing research findings in several ways. For example, much of the research on remediation focuses on improving technical skills and psychomotor behaviors, concerns addressed by many of my participants (Anastasi et al., 2006; Fahy et al., 2011; Miller, 2010; Neary, 2001; Parker, 2009). Similarly, my findings that participants continually posed questions to help underperforming students with making clinical decisions and understanding complex clinical problems were consistent with literature on improving critical thinking, reasoning and judgment in nurses and nursing students (Cholowski & Chan, 2004; Gonzol & Newby, 2013; Lee et al., 2013; Marchigiano, Eduljee, & Harvey, 2011). My findings add to our understanding of remediation by also providing a rich description of how faculty tackle other student problems such as "attitude," lack of professional behavior, and psychological distress.

Some researchers report that faculty spend more time demonstrating and documenting student failure than developing remediation processes to support student success (Poorman, Webb, & Mastorovich, 2002). However, my findings suggested that participants were highly engaged with students throughout the *Being Present* and *Setting a New Course* stages of the theory, but became less engaged with students as they entered

the *Being Objective* stage. My findings thus indicated that the process of working with underperforming students is a dynamic process that changes over time – an aspect of working with underperforming students that has not been well explored in the literature.

Making Negative Progression Decisions: *Being Objective*

The final stage of the theoretical framework, *Being Objective,* resembled the findings of Poorman, Mastorovich, and Webb (2011), who discussed how faculty who cared about students sometimes had to "let go" when making progression decisions. My findings suggested that faculty often let go of students for whom they make negative progression decisions by focusing instead on processes and procedures.

Just as the participants in my study suggested that progression decisions were influenced by concerns about their jobs and doubts about their own abilities, Larocque and Luhanga (2013) reported that at times faculty do not fail students due to personal or professional reasons. This report is also consistent with the findings of Sampson, Kelly-Trombley, Zubatsky, and Harris (2013) who suggested that faculty teaching in marriage and family counseling programs experienced reluctance in dismissing underperforming students due to overlapping roles as educators, therapists, and clinical supervisors. My finding that faculty experience distress when making negative progression decisions was supported by a number of studies (Black, Curzio, & Terry, 2014; DeBrew & Lewallen, 2014; Pratt, Martin, Mohide, & Black, 2013).

Many of the constructs in the explanatory model are thus consistent with extant findings in the nursing education literature. My findings added to this body of literature by providing a rich description of faculty experience working with underperforming

students over time – from when they first notice "red flags" until the students are dismissed from their classes or their programs.

Limitations

The findings of my study should be considered in the context of several limitations. Because the inclusion criteria stipulated that all participants must have taught students in an adult medical-surgical setting, the findings of this research may not transfer to student underperformance in other clinical areas that call for different skills. For example, students who underperform in a community setting where they need to function independently might have different characteristics and learning needs than those based in hospital settings where they can be closely supervised. Similarly, students' emotional concerns may be exacerbated in a psychiatric mental health clinical setting and may call for different remediation strategies.

Another limitation is that the framework was developed based only on the perspectives of faculty. Students may likely describe how faculty dealt with their underperformance differently than the participants did. Having both faculty and student narratives would create a more nuanced understanding of faculty-student interactions related to performance issues. Additionally, some participants might have been reluctant to describe actions they took with students that they regretted or that they believed the researcher might have judged to be inadvisable.

Because the interviews were retrospective, a third limitation is potential recall bias. Participants may have forgotten some details of the experiences they described or combined stories of multiple student experiences or encounters to provide coherent accounts. While their accounts might not be entirely historically accurate, however, the

participants had little trouble providing rich stories about their work with underperforming students, most likely because these types of students are particularly challenging and therefore likely to be most memorable.

A fourth limitation is that in-depth data was collected only on how participants worked with and made negative progression decisions about underperforming students. Asking participants about how they worked with students who performed well or whose performance improved over time would allow for more interpretation of what faculty strategies are specific to underperforming students and which are generally considered good faculty practices. This information would also have allowed a more complete model in which the experiences of making negative progression decisions could be compared to strategies used with students who "turned it around."

Implications

Although this research is a beginning step in understanding how faculty work with underperforming students, the findings have implications for nurse educators. The model could be developed further and used in faculty development programs to assist faculty in their work with underperforming students. Implications will be discussed according to the components of the model.

Perceived Characteristics of Underperforming Students and Causes of Underperformance

The finding that a wide range of characteristics constitutes underperformance suggested that faculty development initiatives focused on helping faculty work with underperforming students should address a wide range of student problems rather than focusing only on lack of knowledge or limited skill development. Faculty, especially

those new to clinical teaching, could benefit from discussions about how less overt problems, such as problems with attitude, confidence, and connecting with others, might affect student performance over the course of the clinical rotation. In addition, the identified causes of underperformance might suggest that faculty be especially alert to how students' backgrounds – that is, what they "bring with them" – could influence their clinical experiences. The findings also suggest that faculty need be alert to cultural factors, such as language barriers and customs that vary from patient populations, and personal life stressors that can contribute to underperformance, so they can be addressed early in the clinical rotation.

Stage 1: Coming to Know a Student is Underperforming: *Being Present*

This stage of the model provides information about the early warning signs, or the "red flags," of underperformance. A useful faculty development exercise might be to present a list of these warning signs to faculty and ask them to discuss past or current students who show these warning signs and then to brainstorm other red flags to add to the list. Such a discussion could serve as a springboard for a dialogue of the best ways to respond to these red flags. In addition, faculty might consider that *being present* involves not only spending time observing students but rather actually joining them in providing clinical care. Because the findings also indicate that *being present* with students is an interpersonal process that involves, in many instances, allowing students to discuss their struggles early on without negative repercussions, faculty might need to provide this opportunity early in the clinical rotation.

Stage 2: Remediation with the Underperforming Student: *Setting a New Course*

The findings related to this stage of the model provided information about how faculty remediate underperforming students. A faculty development recommendation related to this stage is to educate clinical faculty, especially new clinical faculty, in ways to implement positive, timely, and strategic faculty-student meetings in order to review course expectations and standards. In so doing, faculty may help students feel support rather than criticism.

Because this stage was time consuming for faculty and often involved other professionals, issues of resource allocations related to remediating student performance may need to be considered by nursing programs. For example, faculty may need additional resources (e.g. peer mentors, staff support from simulation faculty) if they have several underperforming students in one clinical group. Because mental health issues are associated with underperformance, clinical faculty should be aware of mental health resources available for students. In addition, faculty access to consultation services from college or university counseling centers may provide support for faculty working with students with mental health issues.

Stage 3: Making Negative Progression Decisions: *Being Objective*

This stage of the model provides information about how faculty make negative progression decisions. The findings indicate that faculty take an objective stance when failing students because faculty are concerned about negative repercussions, including how student failures reflect on their own professional competence. Faculty development programs might include pairing seasoned clinical faculty mentors with new faculty members to help them through the process of making progression decisions. Such a

mentorship program may help new clinical faculty feel more proficient in their abilities and less distressed when student performance necessitates a negative progression decision. Because dealing with student underperformance is a major challenge for clinical faculty, mentorship regarding this issue may ultimately decrease faculty dissatisfaction and turnover.

Finally, because the study findings suggested that faculty members may pull away emotionally from students during this stage, it is likely that students may experience a sense of loss of faculty engagement during this vulnerable time. Nursing education programs, therefore, may need staff or faculty members other than the clinical faculty who failed the students to follow the students, assess their well-being, and provide support services.

Indications for Future Research

The model from this study could be refined in several ways. Because faculty-student interactions were at the core of the model, research that more clearly explicates the nuances of these interactions is indicated. A prospective study that follows faculty-student dyads over the course of a clinical rotation, obtains data from students as well as from faculty members, uses real-time observation of faculty-student interactions, and obtains data from other individuals who work with clinical nursing students (e.g. hospital staff, remedial tutors) may yield a robust model. More information is also needed to more fully understand the variety of trajectories that constitute student underperformance (e.g., students who "just get by" or students who fail one course but then go on to do well when retaking it). A longitudinal study that follows at-risk students over the course of all

clinical rotations and identifies barriers to and facilitators of success would also add to our knowledge base.

Further research is needed in which the outcomes of strategies faculty now use in their work with underperforming students (e.g., contracts, conferences, use of skill labs) can be measured and best practices determined. Research might also focus on developing and testing innovative strategies for working with particular types of underperforming students. Approaches with students who have "attitude" problems, for example, are likely to differ from approaches with students who have poor skills. Another topic of research that warrants further consideration is the development of evidence-based strategies to work with students who experience underperformance because of family, mental health, or cultural concerns.

The impact on faculty of working with underperforming students, especially when they need to make negative progression decisions, should be further explored. As working with these students can be particularly stressful, the relationship between student performance and faculty role satisfaction is an important area of investigation. In addition, research could address institutional issues that could affect student performance, such as the size of clinical groups, faculty workload, available remedial services, policy and procedures regarding student performance, and supports for students who do not progress.

Conclusion

Student underperformance in the clinical area is one of the most difficult challenges students and faculty experience. This grounded theory research provides a model that if refined, extended, and validated could serve as a valuable tool for nurse

educators and provide foundational information to begin developing evidence-based strategies for working with underperforming students. Such strategies could have important implications for student success and satisfaction, faculty satisfaction, patient safety, and the nursing workforce.

APPENDIX A

Alert for Research Study to Be Placed on Listserv

Processes Used by Nursing Faculty When Working with Underperforming Students in the Clinical Area

Marianne Craven, a doctoral student at Indiana University School of Nursing, will seek clinical faculty members to participate in a research study of how nursing faculty work with underperforming students.

Clinical faculty members who meet the following criteria will be invited to participate in the study:

- Teach in a baccalaureate nursing program
- Have a minimum of five years' experience working with nursing students in adult acute care or medical-surgical clinical rotations

Data will be collected through telephone interviews. Please watch the listserv for further information.

APPENDIX B

Announcement to Be Placed on Listserv

Processes Used by Nursing Faculty When Working with Underperforming Students in the Clinical Area

Marianne Craven, a doctoral student at Indiana University School of Nursing and a faculty member at Utah Valley University, seeks clinical faculty members to participate in a research study of how nursing faculty work with underperforming students. Underperforming students can include those who exhibit significant deficits in nursing knowledge, the application of nursing knowledge to clinical practice, psychomotor skills, motivation, and/or interpersonal skills and who may provide unsafe patient care.

Clinical nursing faculty members who meet the following criteria are invited to participate in the study:

- Teach in a baccalaureate nursing program
- Have a minimum of five years' experience working with nursing students in adult acute care or medical-surgical clinical rotations

Data will be collected through telephone interviews that will last no longer than one hour and be completed at your convenience.

If you are interested in participating, please contact Ms. Craven at cravenma@uvu.edu to receive further information.

APPENDIX C

Indiana University Informed Consent Statement

Processes Used by Nursing Faculty When Working with Underperforming Students in the Clinical Area

You are invited to participate in a research study of how nursing faculty identify, assess, evaluate, remediate, and make progression decisions for underperforming students in the clinical area. You are eligible for the study because you are nursing faculty with a minimum of five years' experience working with students during clinical rotations. You were identified through your response to a request placed on the Nursing Education Listserv (nrsinged@lists.uvic.ca) indicating you meet the criteria and are willing to be interviewed**.** We ask that you read this form and ask any questions you may have before agreeing to be in the study.

The study is being conducted by Marianne Craven, the co-investigator and a doctoral student at the Indiana University School of Nursing, and her advisor, Dr. Claire Draucker, the primary investigator.

STUDY PURPOSE

The purpose of this study is to develop a theoretical framework that describes how clinical faculty work with underperforming students in the clinical area.

NUMBER OF PEOPLE TAKING PART IN THE STUDY:

If you agree to participate, you will be one of 30 to 50 clinical faculty who teach in baccalaureate nursing programs who will be participating in this research.

PROCEDURES FOR THE STUDY:

If you agree to be in the study, you will participate in a telephone interview with Ms. Craven about experiences you have had working with underperforming nursing students in the clinical setting. Ms. Craven will call you on your cell or landline phone using Skype technology. The interview will be recorded and transcribed for analysis. The interview will last no longer than one hour and will be set at a time that is convenient for you. Questions will be asked to encourage conversation and reflection on your experiences.

RISKS OF TAKING PART IN THE STUDY:

Participation in this study poses minimal risk as you will be discussing underperforming students in the same way faculty often do in their everyday practice. However, working with underperforming students in the clinical area may be stressful and discussing past experiences you have had with underperforming students may make you uncomfortable or upset. In addition, some of the information you reveal may indicate that you did not follow your institution's policies and procedures in regards to the students and thus pose some risk to your employment if this information were to become known. In addition, there is an unlikely possibility that information may be accessed (hacked) by individuals

through the use of internet based technology. Therefore, the following procedures will be used to minimize these risks.

You may choose whether or not to answer any or all of the questions as they are posed. You will be given ample time to think about and respond to the questions. You may stop the interview at any time.

No identifying information will associated with your answers. Each interview transcript will be assigned a study code number and any identifying information, such as the name of your school or clinical site, will be removed from the transcripts. Any identifying information regarding students whom you discuss will also be removed from the transcripts.

The researcher will be using Skype technology through a personal, password protected computer that will allow digital recording during the interview. The researcher will use the most private settings on Skype to minimize accidental access from other Skype users. Recordings will be transcribed through voice-to-text software by the researcher and recordings will be kept on the computer in a locked cabinet or room if not being used by the researcher. Once the recordings are transcribed and verified they will be erased. Transcripts will be encrypted and stored according to the participant's study ID number on the Research File System (RFS), a centralized storage area designed to support IU researchers. RFS is HIPAA-aligned and all data will be encrypted prior to storage. The list of ID numbers will be maintained in a secured file cabinet by Ms. Craven.

BENEFITS OF TAKING PART IN THE STUDY:

It is not expected that you will benefit directly from the study although you may find it beneficial to discuss student interactions that were challenging. Nurse educators as a whole may benefit from the study as it may provide a better understanding of how clinical nursing faculty work with underperforming students.

ALTERNATIVES TO TAKING PART IN THE STUDY:

You may choose not to participate in the study.

CONFIDENTIALITY

Efforts will be made to keep your personal information confidential. We cannot guarantee absolute confidentiality. Your personal information may be disclosed if required by law. Your identity will be not be revealed in reports or publications resulting from this study.

Organizations that may inspect and/or copy your research records for quality assurance and data analysis include groups such as the study investigator and his/her research associates, the Indiana University Institutional Review Board or its designees, and (as allowed by law) state or federal agencies, specifically the Office for Human Research Protections (OHRP) who may need to access your research records.

PAYMENT

You will not receive payment for taking part in this study.

CONTACTS FOR QUESTIONS OR PROBLEMS

For questions about the study, you may contact the co-investigator, Marianne Craven, at 801-910-0121, or the primary investigator, Dr. Claire Draucker, 317-274-4139. If you cannot reach the researchers during regular business hours (i.e. 8:00AM-5:00PM), please call the IU Human Subjects Office at (317) 278-3458 or (800) 696-2949.

For questions about your rights as a research participant or to discuss problems, complaints or concerns about a research study, or to obtain information, or offer input, contact the IU Human Subjects Office at (317) 278-3458 or (800) 696-2949.

VOLUNTARY NATURE OF STUDY

Taking part in this study is voluntary. You may choose not to take part or may leave the study at any time. Leaving the study will not result in any penalty.

SUBJECT'S CONSENT (Verbal)

I have had my rights concerning participation in this study discussed with me, I am aware of the risks and benefits, and I agree that I meet the criteria for inclusion in the study.

In consideration of all of the above, through my willingness to participate in the interview, I give my verbal consent to participate in this research study.

APPENDIX D

Screening and Verbal Informed Consent

SCREENING

Thank you, Ms/Mr. _____ for your willingness to participate in the study about how nursing faculty work with underperforming nursing students in the clinical setting. I would first like to make sure you meet study criteria.

1. May I ask you a few questions to make sure you meet the study criteria?
Yes _____ No _____

2. Do you teach baccalaureate students in the clinical area?
Yes _____ No _____

3. Do you teach clinical in an adult acute care or medical-surgical setting?
Yes _____ No _____

4. Have you taught in a clinical setting for at least five years?
Yes _____ No _____

VERBAL CONSENT

(If volunteer meets criteria). Thank you. Now I would like to obtain your verbal consent to participate in the study. Because we are doing the interview on the phone, I have sent you the consent form electronically. After you have read the consent form and I have answered any questions you may have about the study, I will obtain your verbal consent to participate in the study.

1. Have you had the opportunity to read the consent form? Yes _____ No _____

2. (If yes): Do you have any questions about the study or the information on the consent form?

Yes _____ No _____ (answer any questions)

3. (If yes): Now I would like to read you the consent statement: "Having been provided with an informed consent form and having had my questions answered, by participating in the interview process, I give my verbal consent to be interviewed by Ms. Craven for the purpose of learning about how I worked with nursing students during their clinical rotations."

4. May I now begin to record the interview? Yes _____ No _____

(Note: If volunteers had not read the consent form, provide time for them to read while you are on the phone. If they do not have the consent form, email it to them, and if they can readily access it, allow them to read it while on the phone. If they cannot access

email immediately, reschedule a time for the screening after they have been able to access and read the consent form).

APPENDIX E

Interview Guide

Thank you for your willingness to participate in this research project. As I have mentioned, I will ask you several general questions about how you have worked with underperforming students. Feel free to take as much time as you need to respond to the questions. You may answer only those questions you wish to answer. May I now start to record your interview?

- First, could you tell me about the nursing education program in which you are a clinical instructor.
- Tell me about your clinical teaching.
- What do you consider the term "underperforming" – as it applies to students in clinical – to mean?
- Pick out one student who stands out for you whom you considered to be underperforming in the clinical area. Tell me about the experience you had working with this student.
- How did you identify that the student was underperforming?
- Once you realized the student was underperforming, how did you work with the student?
- Tell me how you made progression decisions about this student – in other words, whether to pass him/her for the clinical rotation, advance him/her in the program, etc.
- What kinds of things did you do to remediate this student?
- What was the outcome with this student?
- Were there other students that stick out in your mind who were underperforming in a different way? [If the first example was about a student who lacked psychomotor skills, for example, ask about students that were underperforming because they had poor interpersonal skills or a poor attitude toward nursing]. Could you tell me about your work with him/her? (repeat questions above)
- What would you recommend to new faculty who are working with underperforming nursing students?
- Is there anything else you would like to tell me about your experiences with working with underperforming students that may help me with this research?
- Do you have any questions you would like to ask me?

Thank you again for your participation. I appreciate your willingness to share these experiences with me. Your responses will provide valuable information about underperforming students that can help future faculty members better help this group of students.

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CURRICULUM VITAE

Marianne Craven

Education

Year	Degree	Discipline	Institution
2015	Doctor of Philosophy	Nursing (minor: Informatics)	Indiana University
1995	Master of Nursing	Nursing Administration /Management (minor: Education)	University of Phoenix
1984	Bachelor of Science	Nursing	Brigham Young University
1983	Associate of Science	Nursing	Brigham Young University
1975	Certificate	Practical Nursing	Utah Technical College at Salt Lake

Professional Experience

Year	Title	Institution
Academic Employment		
2012	Associate Chair	Utah Valley University
2011	Interim Director of Nursing Programs	Utah Valley University
2010-2012	Department MSN Program Coordinator	Utah Valley University
Professional Employment		
2000-present	RN consultant	Holladay Home for the Elderly
1997-2003	Staff Nurse	The Orthopedic Specialty Hospital (TOSH)
1990-1996	Team leader	IHC Blood Services
1987-1988	RN, Office Nurse	Gastroenterology Associates
1986-1987	Asst. Director of Nursing	Zion's Care Center
1983-1985	RN, Staff Nurse, Home Health Nurse	Olsten Kimberly Quality Care
1983-1986	RN, Staff Nurse	Holy Cross Hospital

Area of Academic Expertise

Institution	Teaching Expertise
Utah Valley University	Community and public health nursing Medical-surgical nursing Nursing fundamentals Pediatric nursing Health systems and policy Development of roles in nursing education Curriculum development Evaluation of learning outcomes

Caveon Development (independent contractor)	Development of test questions for competency exams in Master of Nursing Education courses -- Including: Curriculum Development, Nursing Assessment, Facilitating Learning, Organizational leadership
Intermountain Health Care Blood Services	Quality Improvement/good manufacturing practices for blood bank employees Developed/revised a self-paced training manual for the health historian in blood banking
Other (private enterprise)	Developed and administered tutoring to individuals who required extensive remediation due to failure on the NCLEX-PN and NCLEX-RN (Approval from Utah State Board of Nursing)
Utah Nurses Association	Developed and Administered a Nursing Skills Update and Refresher Course for RN's who had allowed their license to lapse (Approval from Utah State Board of Nursing)

Area of Clinical Expertise

Institution	**Clinical Expertise**
Holladay Home for the Elderly	Patient assessments Inservice training of staff Review of medication delivery Review of staff qualifications Chair quality control committee
Coca-Cola World Wide Hospitality Team (2002 Olympics)	Development and buying of supplies for a simple ambulatory clinic and first aid station Assessment and triage of individuals attending the Olympics Teaching and inservices to staff concerning altitude sickness and frostbite (s/s to watch for, emergency treatment, etc). Teaching individuals (staff and attendees) about prevention methods for frostbite and altitude sickness
The Orthopedic Specialty Hospital (TOSH)	Patient Care (medical and surgical) Care of orthopedic injuries Development of care plans for orthopedic and surgical patients Medical-surgical nursing care Discharge planning and education
IHC Blood Services	Lead blood procurement teams that travel throughout intermountain west Pre-donation assessments

	Nursing care of individuals participating in blood donation, therapeutic phlebotomy, plasma donation, and autologous transfusion procedures
	Patient teaching
	Quality control methods and teaching
Olsten Kimberly Quality Care	Home care of pediatric ventilated patients
	Home care of special needs individuals (pediatric and adult)
	PRN staffing in hospitals, extended care facilities, and ambulatory clinics
	Non-critical medical transport flight nursing
	Medical-surgical nursing
Gastroenterology Associates	Medical-surgical nursing
	Assist with and monitor patients receiving sedation and endoscopic procedures
	Patient teaching and follow-up
Zion's Care Center	Staff education and inservices
	Quality control
	Development of individualized plans of care
	Unit staffing and scheduling (RN, LPN, and aide)
	Team leading and Charge Nurse duties
Holy Cross Hospital	Intermediate Care unit medical-surgical nursing
	Team leading/Charge nurse
	Patient education

Area of Research Expertise

Research	**Research Area**
Perceptions of Nurse-managers on Success-related Qualities of Newly Graduated Registered Nurses (Unpublished)	Qualitative
Content Validity of *Craven Clinical Judgment in Nursing Scale*, (Unpublished)	Tool development and content validity
Processes Used by Nursing Faculty When Working with Underperforming Students in the Clinical Area: A Theoretical Model Derived from Grounded Theory	Grounded theory

Scholarship: Publications/Grants/Presentations

Publications

Chapter reviews for the following text:

Smeltzer, S. C., Bare, B.G., Hinkle, J. L., Cheever, K. H. (2007) Brunner & Suddarth's Textbook of Medical-Surgical Nursing (11a ed.). Philadelphia: Lippincott, Williams, & Wilkins -- reviewed chapter 17 (End of Life Care), and chapter 18 (Preoperative Nursing Management).

Comparison Review of 2 Fundamentals of Nursing texts:
Kozier, E. , Erb, G., Berman, A. J., and Burke, K. (2000) Fundamentals of nursing: concepts, process, and practice. (6th ed). Upper Saddle River, NJ: Prentice Hall Health
Taylor, C. Lillis, C. and LeMone, P. (2001) Fundamentals of nursing: the art and science of nursing care. (4th ed). Philadelphia: Lippincott
Chapter reviews for the following text:
Craven, R. F. and Hirnle, C. J. Fundamentals of nursing: human health and function. (4th ed). Philadelphia: Lippincott (unpublished) – reviewed 2 chapters (a) loss and grieving, and (b) skin integrity and wound healing.

Presentations

"Use of Current American Heart Association Guidelines for CPR, Infant Choking, and Automatic External Defibrillator in Emergency Situations" -- January 30, 2014 Holladay, Utah
"Clinical Assessment & Evaluation Processes for Nursing Students: A Literature Review" -- March 6, 2013 – UVU Nursing Research Conference, Orem, UT
"Analysis of Perceptions about Effective Nursing Faculty" (Poster Presentation) Oct. 25-26, 2007 – Utah Nurses Association, Park City, UT; July 18-21, 2007 – International Nurse Educators Conference in the Rockies, Breckenridge, CO
"Nursing Informatics Made Incredibly Easy" February 19, 2007 – Indiana University School of Nursing, Indianapolis, IN
"The Medical Professions and Interrogations" January 25, 2007 – UVSC Ethics Symposium, Orem, UT
"Care Plan for A Day" (Poster Presentation) June 24-26, 2005 – CINE, Chicago, IL
"Unpredictable Case Studies" June 24-26, 2005 – CINE, Chicago, IL
"Grand Rounds Group Presentations" June 24-26, 2005 – CINE, Chicago, IL

"Think Fast, the Unexpected Could Happen" Sept. 19, 2003 – NLN Education Summit, San Antonio, TX
"Think Fast, the Unexpected Could Happen" July 27, 2001 – 12th Annual Nurse Educators Conference in the Rockies, Copper Mt., CO
"Adverse Effects of Antihypertensive Medications & the Elderly" -- May 15, 2001
"Professionalism, Courtesy, & the Elderly" – Oct. 24, 2001
"Health Care Occupations" – January, 2001; March, 2000 – Evergreen Jr. High School

Professional Service Activities

Academic Service Activities	**Level**	**Year**
Program Evaluation Committee (chair)	Department	2012- present
BSN Revision Committee	Department	2010-2014
Master's Committee (chair)	Department	2008-2012
Curriculum Committee (chair)	Department	2010-2012
Graduate Programs Support Committee	University	2009-2012
Admission, Progression, Graduation (APG) Committee	Department	2005-2010

Northwest Accreditation Self-study support committee	University	2010
Faculty Rank, Tenure, Promotion Committee	Department	2002-2004 (chair: 2002 - 2004
Tenure committee	School	2002-2004
BSN Planning Committee	Department	1999- 2001
Curriculum Committee	Department	1996-1998; 2000-2001

Nursing Service Activities	**Year**
Expert Witness for Division of Occupational and Professional Licensing, Utah State	2015
Advisory Committee for Stevens-Henager College, Ogden Campus Nursing program	2007-present
Utah Cluster Acceleration Partnership (UCAP) for Health Care task force	2011-2012
President, Utah Nurses Association (UNA)	2000 - 2005
Continuing Education Committee (UNA)	1995-2000
Finance Committee (UNA)	1999-2010
Convention Core Planning Committee (UNA)	2000-present
President, Utah Nurses Foundation	2005-present
Elected Member – House of Delegates, American Nurses Association	2000-2012; 2015

Community Service Activity	**Year**
Member Cottonwood Homeowners Association Board	2008, 2009-2013, 2014-present
President	2000-2005; 2011-2012
Block Captain, Holladay City Emergency Council	2005-present
First Aid Instructor, BSA & YM/YM Camp Preparedness	2000, 2003, 2010, 2013

IX: Honors/Awards/Certifications

UVU Senate Faculty Excellence Award	2010
Who's Who Among America's Teachers	2005
UVSC Trustee's Faculty in Excellence Award	2004
Who's Who Among America's Teachers	2000

X: Professional Organization Membership

Nursing Organization	Role
Utah Organization of Nurse Leaders	Member
Utah Nurses Association	President (2000 - 2005)
	Continuing Education Committee
	Finance Committee
	Convention Core Planning Committee
Utah Nurses Foundation	President (2005 – present)
American Nurses Association	Member
	Elected Member – House of Delegates
National League for Nursing	Member
Sigma Theta Tau International	Member
American Federation of Teachers	Member

XI: Continuing Education (past 5 years)

Title	Sponsor	Dates
Utah Nursing 2015	UONL/ALC	March 20, 2015
Annual research conference	UVU Dept. of Nursing	March 11, 2015
Test construction & Item writing	Kaplan Nursing	January 30, 2015
Centennial Conference	Utah Nurses Association	Oct 10, 2014
Annual research conference	UVU Dept. of Nursing	February 26, 2014
Summer University	UVU	May 13-15, 2013
Annual Conference	Utah Organization of Nurse Leaders	March 2013
Annual research conference	UVU Dept. of Nursing	March 7, 2013
Love Being a Nurse	UVU MSN students	Nov 19, 2012
Annual Conference	Utah Organization of Nurse Leaders	October 4, 2012
Utah Nurses Association Annual Conference	UNA/Salt Lake City, UT	Sept. 29, 2012
Annual Research conference	Intermountain Health Care	Sept, 2012
Grounded Theory Workshop	Indiana University	May 29-31, 2012
Rubric Design Webinar		March 22, 2012
Nursing Research Conference	UVU Dept. of Nursing	March 7, 2012
Healthy Heart Conference	Intermountain Health Care	Feb. 3, 2012
Utah Nurses Association Annual Conference	UNA/Salt Lake City, UT	Sept. 2011