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Exploration of the Relationships between and among Role Strain, Faculty Stress, and Organizational Support for Clinical Nurse Faculty Faced with a Decision to Assign a Failing Grade

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EXPLORATION OF THE RELATIONSHIPS BETWEEN AND AMONG ROLE STRAIN, FACULTY STRESS, AND ORGANIZATIONAL SUPPORT FOR CLINICAL NURSE FACULTY FACED WITH A DECISION TO ASSIGN A FAILING GRADE

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ABSTRACT

Despite a stressful process, Clinical Nurse Faculty (CNF) are ultimately responsible for assigning a grade indicating that a student successfully met clinical course outcomes and standards of safe practice required to progress (Amicucci, 2012). The purpose of this descriptive correlational study was to explore the relationships between perceived role strain (PRS), perceived faculty stress (PFS), and perceived organizational support (POS) for CNF who faced the decision to assign a failing grade to a student in a clinical practicum. A national sample of 390 predominantly full-time, female, experienced CNF teaching in undergraduate and graduate nursing programs completed the online survey consisting of the *Role Strain Scale* (RSS), *Faculty Stress Index* (FSI), and *Survey of Perceived Organizational Support* (SPOS). Cronbach alpha scores ranged from .93 to .97 for all instruments. Neuman's system model served as a framework underpinning the constructs.

Findings revealed statistically significant relationships between and among PRS (M = 2.96, SD .67), PFS (M = 1.86, SD .95), and POS (M = 4.36, SD 1.52) for CNF. Inverse relationships between PRS and POS (r = -.601, n = 390, p = .000), and PFS and POS (r = -.613, n = 390, p = .000) and a strong positive relationship between PRS and PFS (r = .822, n = 390, p = .000) were identified. Moreover, CNF engaged

in making changes to their teaching practices reported higher degrees of PRS as did CNF teaching full-time in both classroom and clinical spheres, or enrolled in a doctoral program.

Open-ended responses indicated this was a significant issue for undergraduate and graduate CNF. Approximately half of the sample reported changes in their teaching practices following the deliberation to assign a failing grade including changes in communication, evaluation process, documentation practices, remediation concerns, absence of administrative support, course revisions, external pressure and stress, revision of the evaluation instrument, unsafe students, and professional growth including increased confidence to assign a failing grade.

Further research is necessary to evaluate of the effectiveness of strategies to support evidenced-based educational teaching and practices in nursing education, particularly for the student-at-risk for failure.

Chapter I

INTRODUCTION

The goal of nursing education, including clinical experiences, is to assist the students' development of the knowledge, skills, attitudes, and values necessary for the provision of safe, quality nursing care (Johnson & Halstead, 2005). The clinical experience enhances students' learning (Killam, Luhanga, & Bakker, 2011) and affords students an opportunity to integrate, synthesize, and build on previous knowledge and skills with actual patients (Stokes and Kost, 2005). In essence, it is an opportunity for the student to *think like a nurse* (Tanner, 2006) demonstrating caring abilities, and performing psychomotor, communication, and cognitive skills through direct interaction with patients and their families.

Emotional Struggle

Meisenhelder (1982) coined the term *emotional struggle* first in 1982 in the context of clinical evaluation stating "even when a student consistently demonstrated unsafe clinical practice and fails to meet course expectations, failing a student often presents an emotional struggle for the instructor" (p. 348). The struggle to assign a failing grade encountered by clinical faculty is not unique to nursing. It has been reported in education (Hawe, 2003), occupational therapy (Ilott, 1995; Ilott & Murphy, 1997), medicine (Dudek, Marks, & Regehr, 2005; Speer, Solomon, & Fincher, 2000), and social work (Cowburn, Nelson, & Williams, 2000). Other descriptive terms found in the literature include a sense of failure, feelings of mental

exhaustion and being emotionally drained, tremendous turmoil "during a difficult and agonizing process" (Ilott and Murphy, 1997, p. 310). Duffy (2003) described it as "horrendous, traumatic, and draining" (p. 38) requiring an inordinate amount of time and support. Additionally, Ilott & Murphy (1997) reported the decision to assign the failing grade was viewed as a "troublesome responsibility" (p. 314) evoking emotional turbulence, extreme anxiety, trepidation, anger, exhaustion, self-doubt, and sadness followed by relief, guilt, and feelings of personal failure (Duffy, 2003; Ilott & Murphy, 1997). Anger revolved around the ideas that previous assessors failed in their professional responsibility by *passing the buck,* neglected to assign a warranted failing grade, or that unsuitable students had not been effectively *weeded out* (Duffy, 2003).

Clinical nurse faculty members are responsible to uphold safe clinical practice thereby failing students who fail to meet the required standards (Glasgow, Dreher, & Oxholm, 2012). An exact number is impossible to document, as nursing programs (both undergraduate and graduate) are not required to report this statistic. Duffy (2003) reported 46% of assessors surveyed "agreed that students were sometimes allowed to pass practice placement assessments when in fact their performance was unsatisfactory" (p. 7).

Safe Practice

The current and emerging healthcare system is intricate, ambiguous, and complex. High acuity practice environments and the engagement of new technologies incorporating highly specialized interventions for patients with high

acuity and co-morbidities are the norm. Patient safety remains a primary focus and priority (Flanagan, 2005), and is increasingly a significant component of nursing education (Valiga, 2012). The American Nurses Association ([ANA], 2008) challenges nursing programs to prepare graduates who demonstrate the essential knowledge, skills, attitudes, values, and competencies necessary to function as professional nurses within this challenging health-care environment. Nurse educators are obligated professionally and ethically to uphold safe clinical practice (Rosenkoetter and Milstead, 2010). Therefore, nursing faculty have an academic, legal, and ethical responsibility to students and the public to ensure that graduating nursing students are safe, competent practitioners prepared to provide quality care upon graduation (Glasgow et al., 2012; Johnson & Halstead, 2005; Wren & Wren, 1999).

Competence

Professional nursing standards and guidelines used to determine competence and expected learning outcomes in the preparation of professional nurses are found in *The Essentials of Baccalaureate Education for Professional Nursing Practice* (American Association of Colleges of Nursing [AACN], 2008), *The Essentials of Master's Education in Nursing* (AACN, 2011), *Criteria for Evaluation of Nurse Practitioner Programs* (National Task Force on Quality Nurse Practitioner Education, 2012) and *The Essentials of Doctoral Education for Advanced Nursing Practice* (AACN, 2006). The emphasis of the ANA's *Nursing: Scope and Standards of Practice* (ANA, 2010) is on the nursing profession's responsibility to shape and guide

any process for assuring nurse competence, outlining specific competencies and their measures. Additionally, the ANA *Code of Ethics with Interpretive Statements* (2008a) states that the development, maintenance, and implementation of professional standards in clinical, administrative, and educational practice advance the profession. Various regulatory agencies (such as the National Council of State Boards of Nursing [NCSBN], 2012) define standards for regulation of practice to protect the public by "ensuring minimal competence for entry-level RNs" (www.ncsbn.org/4220.htm). "Assurance of competence is the shared responsibility of the profession, individual nurses, professional organizations, credentialing and certification entities, regulatory agencies, employers, and other key stakeholders" (www.nursingworld.org/MainMenu Categories/ThePracticeofProfessionalNursing/NursingStandards/Professional-Role-Competence.html).

Clinical Nursing Faculty

Under the guidance of clinical nursing faculty (CNF), students bridge the gaps between theory, research, and practice (Whalen, 2009). CNF promote students' professional growth toward reflective and problem-solving abilities, practical skills (Jerlock, Falk, & Severinsson, 2003), desire for life-long learning, and deep understanding (Valiga, 2012). In the landmark report sponsored by the Robert Wood Johnson Foundation (RWJF), *The Future of Nursing: Leading Change, Advancing Health*, the Institute of Medicine (IOM) stated "nurses need to attain requisite competencies to deliver high-quality care" (IOM, 2010). Assurance that clinical learning outcomes are being met is crucial for patient safety and the success of the

nursing program (Amicucci, 2012; Larocque & Luhanga, 2013; Oermann, 2004). It is an opportunity to insure that graduating nursing students have "attained sufficient knowledge and skills for entry level clinical practice" (Wren & Wren, 1999, p. 73).

Moreover, CNF act as the gatekeepers to the profession, ensuring students are competent upon completion of the nursing program (Gazza, 2009; Hrobsky & Kersbergen, 2002). Each state's Nurse Practice Act outlines the expectations of competence; graduation from the nursing program should indicate achievement of the minimum competencies for safe practice (Johnson & Halstead, 2005). Significant consequences of graduating marginally competent novice nurses include increased patient safety risks, poor standards of nursing care, and a loss of the public's confidence in the nursing profession (Larocque & Luhanga, 2013; Scholes & Albarran, 2005). Furthermore, the school of nursing experiences a decline in passing rates on the National Council Licensure Examination for Registered Nurses (NCLEX-RN), negative opinions of the nursing program by the community at large, and a decline in admissions (Oermann, 2004) each with the potential to negatively influence the persistent nursing shortage.

Clinical Evaluation

Competence in clinical courses is as much a prerequisite to graduation as satisfactory grades in academic courses (Smith, McCoy, & Richardson, 2001). Neither classroom nor clinical evaluations reveal the complete picture of the student's competence, but rather are complementary in understanding the student's readiness to progress to the next level. Clinical evaluation is critical and equal to academic grades

and evaluations (Caputi, 2010). CNF ultimately are responsible for assigning a grade (Larocque & Luhanga, 2013); a passing grade indicates that a student successfully met the clinical course outcomes and met the standard of safe practice required to progress to the next level (Amicucci, 2012).

Evaluation of students' performance is complex, and inherently subjective (Amicucci, 2012; Caputi, 2010; McGregor, 2007; Scanlan & Care, 2008; Seldomridge & Walsh, 2006; Tanicala, Scheffer, and Roberts, 2011). Fairness and objectivity are essential throughout the evaluation process in order to avoid accusations that the evaluation was arbitrary or capricious (Glasgow et al., 2012; Smith et al., 2001; Wren & Wren, 1999). The subjective nature of the clinical evaluation contributes to faculty anxiety, self-doubt, and hesitancy when faced with the decision to assign a failing grade, as students tend to seek recourse via the legal system (Duffy, 2003; Smith et al., 2001; Wren & Wren, 1999). Fear of litigation can influence CNF's decisions to assign a failing grade for poor clinical performance (Boley and Whitney, 2003; Johnson, 2009; Scanlan & Care, 2004, 2008; Skingley, Arnott, Greaves, & Nabb, 2007; Smith et al., 2001).

Furthermore, evaluation of a student’s performance is time consuming (Duffy, 2003; Scanlan & Care, 2008). This appraisal involves the assessment and evaluation of students' critical thinking, use of therapeutic interventions, communication, teaching, research, leadership and management, professionalism, and adherence to standards of practice applied to actual patient care across the continuum of clinical areas (Arcand & Neumann, 2005; Seldomridge & Walsh, 2006; Smith et al., 2001).

Evaluation strategies often include direct student observation, written assignments, skills testing, student's conference contributions, and self-assessment (Lewallen & DeBrew, 2012; Oermann, Yarbrough, Saewert, Ard, & Charasika, 2009). Each is used as a mechanism to reveal student's thinking, knowledge, and abilities (Scanlan & Care, 2008). Clinical evaluation requires CNF to make a value judgment of students' performance (Caputi, 2010; Oermann, Saewert, Charasika, & Yarbrough, 2009; Scanlan & Care, 2008; Seldomridge & Walsh, 2006); this is one means of evaluation of students' achieved knowledge, values, and skills (Glasgow et al., 2012; Loyola, 2010; Oermann, Saewert et al., 2009; Scanlan, Care, & Gessler, 2001).

Learning outcomes are an important consideration in evaluating the student's success and progression in the nursing program. Clinical evaluation instruments typically include specific course objectives and competencies delineating the learning outcomes, based on the professional nursing standards and guidelines. Often these evaluation tools lack psychometric evidence for reliability confounding the evaluation process (Luhanga, Yonge, & Myrick, 2008a).

The summative evaluation, on completion of the clinical course, summarizes the evidence supporting CNF's judgment that a student has or has not met the educational goals and the standards for competence and safety (Scanlan, Care, & Gessler, 2001; Skingley et al., 2007). Assignment of a clinical grade is a direct outcome of the evaluation process (Amicucci, 2012; Scanlan et al., 2001; Smith et al., 2001).

Stressors Encountered by CNF

Research has identified multiple stressors encountered by CNF, such as heavy workload (Oermann, 1998b; Kaufman, 2007), balancing teaching activities with demands of students and clinical staff (Oermann & Gaberson, 2009), pressure to maintain clinical competence and certification through engagement in practice (Clark and Springer, 2010; Oermann, 1998b), teaching students lacking insight or inadequately prepared students (Duffy, 2003; Goldenberg and Waddell, 1990; Greathouse, 1993; Whalen, 2009), and the persistent faculty shortage (Cangelosi, Crocker, & Sorrell, 2009; Kaufman, 2007). Inexperienced faculty encounter more difficulty in identifying the red flags associated with failing a student early in the clinical practicum compounding the stress encountered in the decision to assign a failing grade (Teeter, 2005). Lewallen and DeBrew (2012) reported faculty who spent a significant amount of time trying to remediate a student "struggled with the decision to assign a failing grade" (p. 393).

The impact of failing a clinical nursing student can contribute to CNF's decision to abandon clinical teaching (Luparell, 2007), lead them to question their decision to enter nursing education, promote negative feelings towards nursing education (Symanski, 1991), or increase the degree of role strain experienced (Oermann, 1998b; Piscopo, 1994) particularly if the failure is over-turned. Hawe (2003) noted assessors who "spent time considering assessment information and agonizing over their decisions only to have them ignored and/or reversed" (p. 375) experienced anger, a loss of confidence in their judgment, and feelings of wanting to abandon the

profession. Feelings of frustration were reported in response to an administrator overturning and invalidating decisions (Duffy, 2003; Hawe, 2003). Furthermore, this emotional struggle has the potential to affect the CNF's performance, health, and satisfaction, with far-reaching and lasting consequences (Johnson & Halstead, 2005; Larocque & Luhanga, 2013; Scanlan et al., 2001).

Deterrents to Assigning a Failing Grade

Duffy (2003) found significant deterrents to assigning a failing grade to be inexperience, low confidence, and lack of support. Additional reasons for this include difficulties in documenting affective and attitudinal performance deficiencies (Duffy, 2003), a sense of personal failure (Duffy, 2003; Ilott & Murphy, 1997), guilt and blame, a self-protective act against "overwhelming distress" (Ilott & Murphy, 1997, p. 309), belief that a student would be a good classroom teacher, or to avoid a legal challenge (Hawe, 2003; Lewallen & DeBrew, 2012; Scanlan et al., 2001).

In an effort to avoid assigning a failing grade, some faculty hoped a student would attain competency in the next clinical practicum, so they *passed the buck* or gave *benefit of the doubt* (Duffy, 2003; Ilott & Murphy, 1997; Larocque & Luhanga, 2013; Luhanga et al., 2008a, 2008b; Scholes & Albarran, 2005; Walsh & Seldomridge, 2006), or gave the student another chance (Amicucci, 2012; Scanlan et al., 2001). Duffy (2003) and others (Lewallen & DeBrew, 2012) noted that the students' level in the program influenced the assessor's approach to assigning a failing grade. Duffy reported an unwillingness to assign a failing grade early in the program related to "the belief that students need time to learn" (Duffy, 2003, p. 51).

Similarly, students at the end of the program were unlikely to earn failing grades because of significant personal consequences to the student (Duffy, 2003; Hawe, 2003; Smith et al., 2001). Concerns about the effects of a failure on a student's self-esteem and feelings of personal worth were reported as reasons to avoid assigning a failing grade (Amicucci, 2012; Duffy, 2003; Meisenhelder, 1982).

Lewallen and DeBrew (2012) reported CNF found failing a student emotionally difficult. The dilemma was viewed as more intense when the act of assigning a failing grade was perceived as an uncaring act particularly when failing students who were generally viewed as good students (Duffy, 2003; Meisenhelder, 1982; Scanlan, et al, 2001). Hawe (2003) noted that faculty felt this "should somehow mitigate an unsatisfactory or unacceptable performance and thus a fail should not be conferred" (p. 376). In the same way, failure was seen as the last resort and to be avoided whenever possible (Amicucci, 2012).

Ramifications

Assessors, who admitted to allowing the undeserving student to pass, later experienced regret as well as additional guilt and shame (Duffy, 2003; Mc Sherry & Marland, 1999). Passing an unsafe or unsatisfactory student does not serve the student, the profession or the public well (Duffy, 2003; Glasgow et al., 2012; Johnson & Halstead, 2005; Larocque & Luhanga, 2013; Skingley et al., 2007).

The Problem

Unfortunately, not all nursing students will succeed (Glasgow et al., 2012; McGregor, 2007). The responsibility of CNF remains the protection of the public's

well-being by ensuring only safe competent nurses enter into nursing practice (Amicucci, 2012; Larocque & Luhanga, 2013). Evaluations of a student's performance provide the basis for CNF's decision to advance the student to the next level or to assign a failing grade (Scanlan & Care, 2004, 2008). CNF are compelled to assign a failing grade to students who fail to meet the required standard, competencies or learning outcomes (Amicucci, 2012; Glasgow et al., 2012; Smith et al., 2001). Nevertheless, CNF find the decision to assign a failing grade to a nursing student to be complex, highly stressful (Amicucci, 2012; Larocque & Luhanga, 2013) and emotionally difficult (Lewallen & DeBrew, 2012).

The Neuman System Model (NSM) (1989, 1995, and 2002) provides a lens to examine this dilemma. NSM states all components of the system are interrelated; a change in one area will affect a change in another. CNF are an integral part of student nurses' educational system. From the NSM framework, examination of relationships among perceived role strain, perceived faculty stress, and perceived organizational support for CNF faced with the decision to assign a failing grade may disclose possible relationships, their depth, and influence. Dr. Betty Neuman granted permission to adapt NSM for this study (Appendix A)

Purpose of Study

The purpose of this descriptive correlational study is to explore the relationships among perceived role strain, perceived faculty stress, and perceived organizational support for CNF faced with the decision to assign a failing grade to a student in a clinical nursing practicum. To date, these relationships have not been studied, particularly in the context of the experience of CNF. Exploring these relationships may be the first step in identifying the factors that influence CNF's decision-making process in assigning the failing grade, and provide insights into understanding perceived role strain, perceived faculty stress, and perceived organizational support experienced by CNF. Furthermore, the findings may facilitate a deeper appreciation of potential effects of student failure as related to faculty and retention. Findings may inform educational supportive practices for faculty facing the decision to assign a failing clinical grade.

Definition of Terms

The terms perceived role strain, perceived faculty stress, perceived organizational support, struggle to assign a failing grade, and associated terms are defined or described in context of this research study.

Perceived role strain was initially conceptually defined as a perceived difficulty in fulfilling role demands and expectations, which intensifies with increases in the number and complexity of role demands (Goode, 1960). Hardy & Hardy (1988) further clarified the conceptual definition of role strain as an internal response, "a subjective state of emotional arousal in response to the external condition

of role stress" (p. 165) evidenced by feelings of frustration, tension, or anxiety. In the Neuman System Model (NSM) (1989, 2002), perceived role strain represents a developmental variable as the degree of role strain appears to vary with experience (Mobily, 1991; Oermann, 1998a; O'Shea, 1982). For this study, perceived role strain is operationally defined by score on the *Role Strain Scale* (RSS) (Mobily, 1991) revised by Oermann (1998a). Permission to use the scale has been secured (Appendix B and C).

Perceived faculty stress is conceptually defined as a unique and multidimensional profession-specific stress encountered in higher education resulting from a perceived environmental threat including excessive demands and insufficient resources (Gmelch, Lovrich, & Wilke, 1984), high expectations, self-doubt, excessive time constraints, inadequate organizational resources, and the absence of consistent guidelines for pay, promotion, and career advancement (Gmelch, Wilke, Lovrich, 1986). In the NSM, it represents a sociocultural variable influenced by the institution and its members. Perceived faculty stress is operationally defined for this study by score on the *Faculty Stress Index* (FSI) (Gmelch et al., 1984). Permission to use the scale (Appendix D) and adapt the scale (Appendix E) has been obtained.

Perceived organizational support is conceptually defined as employees' "global beliefs concerning the extent to which the organization values their contributions and cares about their well-being" (Eisenberg, Huntington, Hutchison, & Sowa 1986, p.501). Perceived organizational support has been shown to moderate environmental stressors (Gutierrez, Candela, & Carver, 2012). As such, it represents

a psychological variable in the flexible line of defense in the NSM, exhibiting the ability to flex in response to a perceived stressor. Perceived organizational support is operationalized in this study by score on a shortened version of the *Survey of Perceived Organizational Support* (SPOS) (Eisenberger et al., 1986) used by Gutierrez, Candela, and Carver (2012). Permission to use the scale has been obtained (Appendix F and G).

Struggle to assign a failing grade describes CNF's stressful experience and emotional struggle encountered during the final summative evaluation process involving a clinical nursing student deemed unsafe or who failed to attain the required clinical practicum competencies and learning outcomes.

Clinical nursing faculty (CNF) are nurse educators directly involved with instructing, over-seeing, facilitating, or supervising pre-licensure and graduate students in assigned clinical nursing practica (Oermann, 2004). Additionally, CNF are responsible for evaluating the students' performance in the clinical nursing practicum in order to advance the student to the next level in the nursing program (Larocque & Luhanga, 2013; Oermann & Gaberson, 2009). CNF maintain current professional nurse licensure and adhere to the assigned clinical agency's policies, procedures, and protocols (Oermann & Gaberson, 2009). In the NSM, CNF represent the client system.

Student refers to an undergraduate or graduate student enrolled in any accredited nursing program actively participating in the clinical practicum component of a nursing course.

Clinical practicum refers to student nurses' supervised clinical experience which is designed as part of or complementary to a nursing theory course within an accredited nursing program for either an undergraduate or graduate nursing degree.

Clinical evaluation refers to the evaluation process including formative and summative assessments related to the clinical practicum. This evaluation determines the student's successful attainment of the required course competencies, objectives, or desired learning outcomes necessary to progress in the nursing program and provides the basis for the CNF's decision to advance the student to the next level or to assign a failing grade.

Failing grade is the grade earned by a student who is unable to meet the objectives and competencies of the clinical practicum in a satisfactory manner (Johnson & Halstead, 2005). The student may exhibit a pattern of unsafe clinical practice involving unacceptable risk (Scanlan et al., 2001) which was identified through direct observation, close monitoring, feedback from colleagues, and written assignments (Luhanga et al, 2008c). The failing grade is assigned for questionable competence in clinical practice where knowledge and psychomotor skills were deficient, and/or where motivation and interpersonal skills were inadequate (Lewallen & DeBrew, 2012; Luhanga et al, 2008b). Killam and her colleagues (2011) further clarified student behaviors warranting a failing grade to include a pattern of "any action, attitude, or behavior related to ineffective interpersonal interactions, including communication and relationship difficulties; knowledge and skill incompetence, including deficits and failures of appropriate application; and projections or

reflections of an unprofessional image" (p. 445) including deficits in ethical behaviors, professionalism, and attendance as evidence of failure to meet the required competencies and learning outcomes (Glasgow et al., 2012).

Delimitations, Inclusion/Exclusion Criteria

The study is designed to survey CNF able to read and write English, have access to the internet, and who have been confronted within the past six years with a decision to assign a failing grade to a nursing student who was deemed unsafe or who failed to attain the required competencies and learning outcomes in the clinical practicum. Inclusion criteria for the participants include having taught as clinical nurse faculty for at least one clinical practicum, currently teaching either full-time or part-time, or were teaching full-time or part-time, in an accredited nursing program (diploma, associate, baccalaureate, and graduate programs in schools of nursing, colleges, universities, either private and public) when the participant was confronted with the decision to assign a failing grade to a nursing student in a clinical practicum.

Clinical nursing faculty members who have not been confronted with a decision to assign a failing grade to a nursing student in a clinical practicum are excluded. CNF not affiliated with an accredited nursing program, currently teaching in a licensed practical or vocational nurse program, and unable to read and write English are also excluded. This cross sectional study is designed to measure perceived role strain, perceived faculty stress, and perceived organizational support at a single point in time.

Theoretical Rationale

General system theory as interpreted through the *Neuman Systems Model* (NSM) (Neuman, 1989, 1995, 2002) provides the broad basis for linking the concepts of perceived role strain, perceived faculty stress, and perceived organizational support. Boulding (1956) described general systems theory (GST) as "the skeleton of science in the sense that it aims to provide a framework or structure of systems on which to hang the flesh and blood of particular disciplines and particular subject matter in an orderly and coherent corpus of knowledge" (p. 208).

Von Bertalanffy is credited with outlining GST. The basic principles of GST include an understanding of the system as living and complex with parts (or subsystems) concurrently interacting collaboratively or in concert with one another. Consequently, multiple aspects are investigated simultaneously. Furthermore, the open system exhibits a degree of predictability. The dynamic network of interconnecting elements leads to system-wide changes in an effort to maintain equilibrium of the forces within and outside the system. This goal-directed system focuses on the central objective supported by lesser objectives. The system is guided by feedback from the internal and external environments, which enables adaptation and an appropriate response (Berrien, 1976).

NSM builds upon these principles. Neuman (2011) posits that the open system has a propensity to seek and maintain a balance among various internal and external stressors which seek to disrupt it. Neuman contends these stressors, which are inherently neutral, have the capability of exerting either positive or negative

effects, as well as either possible or actual effects as perceived by the client system. Perceived role strain, perceived faculty stress, and perceived organizational support are factors that CNF and the client system encounter in the work environment.

Numerous studies have used the NSM as the theoretical framework (Gigliotti, 1997, 1999, 2007, 2012; Lowry, 2012). Similarly, this research study utilizes the NSM as a framework to explore the relationships among perceived role strain, perceived faculty stress, and perceived organizational support.

Research Questions and Hypotheses

1. What are the relationships between and among role strain, faculty stress, and perceived organizational support for CNF faced with a decision to assign a failing grade to a clinical nursing student?

2. What change(s) occurred in CNF teaching practices after the deliberation to assign a failing clinical grade?

Assumptions:

1. All CNF experience varying degrees of role strain, faculty stress, and organizational support.
2. The degree of role strain, faculty stress, and organizational support experienced varies with timing and conditions.
3. CNF will report honest and authentic responses to the survey questions.

Hypotheses:

1. Perceived role strain is not associated with perceived organizational support for CNF faced with a decision to assign a failing clinical grade.

2. Perceived role strain is not associated with perceived faculty stress for CNF faced with a decision to assign a failing clinical grade.
3. Perceived faculty stress is not associated with perceived organizational support for CNF faced with a decision to assign a failing clinical grade.
4. There are no relationships between and among perceived role strain, perceived organizational support, and perceived faculty stress for CNF faced with a decision to assign a failing clinical grade.
5. Perceived role strain is not associated with selected faculty characteristics for CNF faced with a decision to assign a failing clinical grade.

Significance of the Study

Nursing is a practice discipline. Students learn the theory component in the classroom and apply this knowledge to patient care in the clinical environment (Johnson & Halstead, 2005; Smith et al., 2001). Nursing faculty (including CNF) are responsible to ensure practitioners are safe and competent, protecting the public's well-being by preventing unsafe students from entering into practice upon graduation (Amicucci, 2012).

Although assigning a failing grade to a student is never an easy decision, it is imperative that CNF assign a failing grade to students with poor or unsafe clinical performance. Their commitment and responsibility to nursing education, the profession, society, and ultimately to patient safety must warrant that faculty do the *right thing* (Smith et al, 2001) and fail the student who has not attained the required competencies or met the course learning outcomes regardless of the stress incurred by

assigning a failing grade to an incompetent, unsafe, or marginal student in clinical practice (Amicucci, 2012; Glasgow et al., 2012; Smith et al., 2001).

In light of the nursing faculty shortage, it is crucial to recognize any effects this stressful experience may have on faculty. Recognition may be the first step to alleviate faculty stress and prevent an emotional struggle. To date, the literature has not addressed the effects of perceived role strain, perceived faculty stress, and perceived organizational support endured by CNF faced with a decision to assign a failing grade to a student in a clinical practicum or how this event affects their career path. This study will attempt to fill this gap in knowledge thereby informing best educational practices and furthering nursing science.

Chapter II

REVIEW OF THE LITERATURE

The purpose of this literature review is to explore perceived role strain, perceived faculty stress, and perceived organizational support as potential factors contributing to CNF's emotional struggle to assign a failing grade to a clinical nursing student. The NSM is presented as the theoretical framework to enhance understanding of possible associations amongst the variables. The literature addressing each of these complex concepts is presented as distinct bodies of knowledge.

Numerous electronic databases were searched including EBSCO, Cumulative Index to Nursing and Allied Health Literature (CINAHL), PubMed, MEDLINE, ScienceDirect, and ProQuest to review peer-reviewed journals in the English language literature. The search, initially limited to publications within 2000-2013, yielded a paucity of role strain studies in nursing education and therefore the search was broadened to include the years 1990-2013. Inspection of reference lists identified additional studies. In an effort to provide the historical context of the research, the review is presented from oldest to most recent. Faculty stress builds from a review of the literature concerning faculty in higher education, finally shifting to CNF.

Initial search terms consisted of ‘role strain, faculty stress, organizational support, and faculty’ yielded a disproportionate number of articles addressing faculty

stress and organizational support outside of nursing education. The search was narrowed with the additional terms including 'higher education, nursing education, nurse educator, clinical nurse educator, clinical nursing faculty, clinical practicum, clinical evaluation, unsafe nursing student, and nursing student failure'. Terms were entered individually or in combinations. A scant amount of literature, predominantly qualitative studies, pertaining to role strain in CNF and student evaluation was retrieved, with the majority of the empirical studies being international studies focused on mentors and lecturers. Although hundreds of empirical abstracts and theoretical publications were reviewed, 30 empirical studies and numerous theoretical publications most relevant to the focus of the study are included in this review. Empirical studies include both quantitative and qualitative research. Literature not specifically addressing any of the three variables was excluded. Moreover, due to variations in educational systems, studies completed outside of the United States were carefully evaluated for inclusion as empirical evidence.

Theoretical Framework

The Neuman systems model (NSM) serves as the underlying framework for this research study exploring the relationships between perceived role strain, perceived faculty stress, and perceived organizational support for CNF engaged in a struggle to assign a failing grade. NSM, a complex model, was initially designed as an organizing framework for graduate nursing courses in 1970 (Neuman & Young, 1972). For more than the past four decades, it has been used internationally in nursing research. Although it continues to be used to study nursing practice, nursing

education, and to guide nursing research, the NSM has more recently been used in interdisciplinary, multidisciplinary, and transdisciplinary research to study the health of individuals, families, and communities (Louis, Gigliotti, Neuman, & Fawcett, 2011).

Neuman's Model

Neuman (1995) proposed the idea of *wholism* as "optimizing a dynamic yet stable interrelationship of spirit, mind, and body of the client in a constantly changing environment and society" (p. 10). The theorist argues that each subsystem (or part) has the potential of influencing the perception of the whole as a result of dynamic interactions (Neuman, 1989, 1995). Neuman further argues this dynamic energy exchange implies movement towards or away from stability "which has a direct relationship to predictability" (1995, p. 11).

The *client system* (an individual, family, group, community, or an aggregate) is considered an open, living system consisting of physiological, psychological, sociocultural, developmental, and spiritual variables; these variables interact simultaneously within the internal and external environments in an effort to maintain system stability (Neuman, 1989, 1995, 2002; Neuman, 2011). The NSM is based on reactions or potential reactions to identified stressors and existing resources noting a continuous exchange of information and energy (known as the input and output) with the environment (Neuman, 2002). Neuman (1995) described stressor(s) as "tension producing stimuli or forces occurring both within the internal and external environmental boundaries of the client/client system" (p.23). The *internal*

environment is the source of intra-personal stressors. The *external environment*, that is the environment outside the client system, is the source of inter- and extra- personal stressors. The *created environment* is proposed to be subconsciously developed by the client system as a coping mechanism (Neuman, 1995, 2002; Neuman, 2011). Perception of the stressors arising from *intrapersonal*, *interpersonal,* or *extrapersonal* forces is interpreted as either positive or negative as determined by the client system.

In assuming the role of CNF, nurses encounter a variety of intrapersonal, interpersonal, or extrapersonal stressors having "the potential for disrupting system stability by penetrating the system lines of defense and resistance" (Neuman, 2002, p. 324). Although role strain (a developmental variable) and faculty stress (a sociocultural variable) exist in some degree for all faculty (Mobily, 1991; Oermann, 1998a), given the right time and conditions, these variables may be perceived as significant stressors (Neuman, 2011) by individual CNF members.

Neuman's Lines of Defense

The interrelationships of these variables determine the degree of resistance available in Neuman's *flexible line of defense* (FLD), *normal line of defense* (NLD), *and lines of resistance* (LR), representing layers of resources that defend against a stressor threatening system stability and thereby maintaining optimal client system stability and wholeness (Louis, Neuman, & Fawcett, 2002; Neuman, 1995). The normal line of defense refers to the client system's adaptation level of health established over time; this represents the norm for the individual, from which deviation is determined (Neuman, 2002). In Neuman's model, the *flexible line of*

defense (FLD) attempts to maintain optimal system stability. The FLD is described as "a protective, accordion-like mechanism [concentric ring] that surrounds and protects the normal line of defense from invasion by stressors" (Neuman, 1995, p. 46). It is the outer boundary, the first line of defense and the first protective mechanism capable of changing rapidly in response to the client system needs. Neuman maintains the FLD is activated in response to a stressor, and is able to expand to provide greater protection for the client system whereas contraction provides less protection (Louis et al., 2002). For CNF, perceived organizational support represents the FLD potentially moderating the interacting variables (Gigliotti, 1997) perceived role strain and perceived faculty stress.

Stressors and the FLD

Neuman (1995) contends that a stressor, such as the struggle to assign a failing grade, has an undetermined potential to disturb a client's usual stability level at different points in time depending on condition and timing. Specifically, "the particular interrelationships of the client variables [in the FLD] at any point in time can affect the degree to which a client is protected by the flexible line of defense against a possible reaction to a single stressor or combination of stressors" (p. 20-21). Gigliotti (2012) proposed the variables in the FLD are interrelating with one another, not strictly interacting with one another, an important consideration when evaluating the invasion of the NLD.

When the FLD, such as perceived organizational support, fails to protect the client system against environmental stressors (such as the struggle to assign a failing

grade), the result may be the invasion of the normal line of defense such that "the interrelationships of the variables [in the flexible line of defense] determine the nature and degree of system reaction" (Neuman, 1995, p. 21). This may be seen in the influence of role strain and faculty stress on the CNF's struggle to assign a failing grade to a student who has not met the required learning outcomes. The degree of reaction as seen in the degree of struggle and distress experienced by CNF indicates the extent of the "system instability resulting from the stressor invasion of the normal line of defense" (Neuman, 2002, p. 322). Figure 1 offers a visual of these relationships.

Figure 1. CNF's struggle to assign a failing grade viewed through lens of NSM

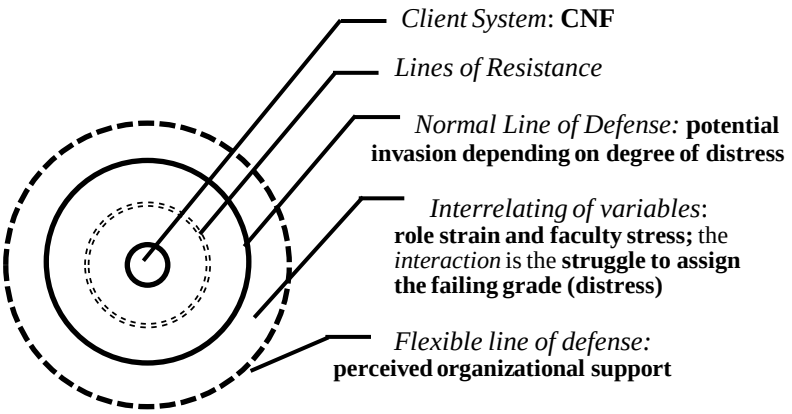

Figure 1: Neuman systems model as a framework to view CNF's struggle to assign a failing grade. From *The Neuman Systems Model* (3rd ed.) (p. 26), by B. Neuman (Ed.), 1995, Norwalk, CT: Appleton & Lange. Copyright (1972) by Betty Neuman. Adapted with permission.

NSM, Nursing Education, and the CNF

Schools and programs of nursing are sub-systems within institutions of higher education. Their primary objective is the graduation of safe competent nursing

students who have attained sufficient knowledge, skills, attitudes, and values necessary for entry-level clinical practice under the direction of nursing faculty (Glasgow et al., 2012; Johnson & Halstead, 2005; Wren & Wren, 1999). The experiences of faculty in higher education, particularly CNF, are better understood in terms of the framework proposed in the NSM.

To better understand CNF's struggle to assign a failing grade to a nursing student in a clinical practicum, perceived role strain, perceived faculty stress, and perceived organizational support will be examined using the NSM. Testing the relational propositions between the FLD (viewed as perceived organizational support) and the interacting variables (perceived role strain and perceived faculty stress), it is possible to explore the CNF's struggle to assign a failing grade. The proposed Conceptual-Theoretical-Empirical Structure (Fawcett, 2005) for the current study captures the relationships between NSM and the empirical indicators similar to a CTE proposed by Gigliotti (1999). The instruments, the SPOS (Eisenberger et al., 1986), the RSS (Mobily, 1987), and the FSI (Gmelch et al., 1984), are based on systems theory principles and are congruent with NSM as outlined in Figure 2.

Figure 2. Proposed conceptual-theoretical-empirical (C-T-E) structure based on Fawcett (2005) and Gigliotti (1999).

Neuman's Concepts	Environmental Stressors	Flexible Line of Defense (FLD)	Interacting Variable in FLD	Interacting Variable in FLD	Normal Line of Defense
NSM	Intra- , Inter-, Extra-personal Stressors	Psychological Variable	Sociocultural Variable	Developmental Variable	Potential Invasion
Theoretical Linkages	Employed as Clinical Nurse Faculty	Perceived Organizational Support	Perceived Faculty Stress	Perceived Role Strain	Struggle to assign a failing grade
Empirical Indicators	Participant Demographic Characteristic Questionnaire	SPOS Survey of Perceived Organizational Support (Eisenberger et al., 1986)	FSI Faculty Stress Index© (Gmelch, 1984)	Role Strain Scale (Mobily, 1987)	Open-ended question responses

Perceived Role Strain

Williamson (1972) explored role strain in nursing faculty functioning in academic roles, acknowledging the disharmony between the clinical and academic worlds of the nurse faculty. Smith (1979) reported faculty role strain in terms of time constraints, workload, maintenance of clinical skills, and dissonance between personal and institutional needs and expectations.

Hardy and Hardy (1988) clarified role strain as the response to role stress in which role obligations are "vague, irritating, difficult, conflicting, or impossible to meet" (p.165). Contradictions between two role obligations (or role expectations) perceived by an individual results in role strain (Basirico, Cashion, Eshleman, &

Strickland, 2006). Perceived role strain (PRS) is the response to role stress despite the root cause.

Role strain is observed as role ambiguity, role conflict, role incongruity, role incompetence, and role overload. Role ambiguity involves the need for clarification of role expectations, ways to fulfill the role, and consequences of role performance. Role incongruity involves the internal conflict when role expectations are incongruent with personal values and attitudes. Role incompetence refers to the absence of requisite skills, knowledge, and ability to execute an assumed role successfully. Role conflict acknowledges competing or incompatible role expectations. Kahn and his associates (1964) identified three categories of role conflict: inter-sender conflict where demands of two individuals are in conflict (that is CNF and the clinical agency), intra-sender conflict where the aims are mutually exclusive (for example, feeling pressure to seek funding while funding sources are fewer), and inter-role conflict where demands from two roles are in direct conflict (such as desiring to commit more time to teaching but being pressured to focus on research and publication). Role overload was described as a complex conflict where role expectations demand more time and energy than is available for a quality performance, exerting pressure for a change in behavior (Kahn, Wolfe, Quinn, & Snoek, 1964).

Role Strain in the CNF Role

In a descriptive study, O'Shea (1982) explored role orientation and role strain in 453 CNF employed at NLN accredited baccalaureate programs in clinical practice

with students. In this national study, O'Shea used her newly developed *Role Strain Instrument* (RSI) (Cronbach's $\alpha = .90$). The RSI presented clinical situations involving students, patients, and CNF as a means to measure role strain in the subcomponents of role conflict, role ambiguity, and role overload. O'Shea reported greater variation in the amount of role strain compared to role orientation experienced by this sample of CNF. Strong correlations between role strain and role conflict ($r_c = .794$, $p < .001$), role ambiguity ($r_c = .814$, $p < .001$), and role overload ($r_c = .497$, $p < .001$) were found.

O'Shea determined no statistically significant relationship between CNF's role orientation and the amount of experienced role strain. However, several correlations were observed between role strain and years in position ($r_c = .222$, $p < .001$) and with years teaching ($r_c = .251$, $p < .001$). O'Shea concluded, "a small tendency for strain to be less as the amount of time increased" (p. 309). It appeared experienced CNF, those with formal teaching preparation, and those in their present teaching position for an extended period tended to report less role strain. Role strain incidents identified most frequently involved students and student performance or inability to provide patient care, interpersonal conflicts, and poor communication. Faculty overload, conflicts with agency personnel, lack of formal preparation for teaching, and lack of clinical practice were also identified as factors contributing to faculty role strain. A major study limitation is the homogenous sample in terms of program types and sample characteristics.

Development of the Role Strain Scale

Similarly, Mobily (1987, 1991) examined role strain in 102 (69.4% response rate) full-time tenure track CNF employed at four randomly selected NLN accredited nursing programs representing four NLN geographical regions with the tripartite mission of teaching, research, and service. The aim of the study was two-fold: to explore the degree and sources of role strain, and the relationships between role strain and selected socialization experiences and personal characteristics. The sample of CNF was predominantly doctorally prepared (n = 64, 62.8%) with 10 or more years of teaching experience (74.5%), teaching undergraduate students (67%) for an average of 10 hours per week in clinical instruction, and involved exclusively in clinical teaching (2.9%) or had both clinical and classroom responsibilities (71.6%). Only 25.5% of the respondents were limited to the classroom exclusively (Mobily, 1991).

The researcher-developed instrument consisted of 44-items, and space for respondents to write in additional sources of stress and the extent to which each was perceived as a source of stress (Mobily, 1987). Items were ranked on scale of 1 (*never*) to 5 (*nearly all the time*) where 5 indicated the highest degree of perceived stress contributing to role strain. Respondents reported nine work-related situations as current or previous sources of stress ($M \geq 3.5$) including *having adequate time to meet role expectations* (M = 4.1), *coping with the number of expectations of the job* (M = 4.0), *feeling pressured to secure outside funding in a time of limited availability* (M = 3.8), *having job demands interfere with other activities of personal importance*

such as family, leisure, and other interests (*M* = 3.7), and *feeling like the workload is too heavy and impossible to finish during the normal work week* (*M* = 3.7) (Mobily, 1991). Computation of the total scale mean score revealed 50% of the respondents reported experiencing moderate to high degrees of perceived role strain (18% high, 32% moderate, 38% low, and 12% minimal).

Positive relationships were found between role strain and CNF's experiences and specific characteristics such as degree held, level of student, clinical responsibility, and hours in clinical (Mobily, 1991). Faculty development opportunities, orientation, current enrollment in a doctoral program, being married, and having children also were found to have statistically significant relationships to the degree of role strain. Role overload and time constraints were identified as major sources and primary areas of role strain (Mobily, 1991), similar to other studies (Goldenberg & Waddell, 1990; Langemo, 1988; O'Shea, 1982).

Study limitations include sample size and no variation in institutional accreditation affiliation. Gaps remaining in the literature included role strain experienced in part-time faculty, methods for faculty support, and the experience of CNF not associated with an NLN-accredited program or in a university setting.

Role Strain and Student Level, Education, and Employment Status

In a descriptive study, Oermann (1998a) explored the differences in role strain based on the level of the student, CNF education, and employment status (part-time or full-time). A random homogeneous sample of 226 predominantly full-time experienced CNF (71.68%, M = 12 years of experience) from Midwestern associate

degree (ADN) and baccalaureate (BSN) NLN accredited nursing programs participated. Oermann adapted Mobily's *Role Strain Scale* (1991) to consist of 23 statements describing potential stress sources for CNF. Oermann (1998a) reported the scoring procedure remained unchanged as faculty rated work-related situations that were or had been stressful. The original seven subscales were maintained but with fewer items (Oermann, 1998a). The Cronbach alpha for the entire scale was reported as .93 with reliability coefficients for five subscales ranging from .86 (Role Overload) to .51 (InterSender Conflict); Role Ambiguity and InterRole Conflict were not reported as each subscale consisted of one item. The revised instrument was piloted with 16 CNF, establishing content validity. The role strain score was calculated as total scale mean score; subscale mean scores were also calculated.

Oermann (1998a) reported significant differences between the ADN and BSN faculty groups for both InterRole Conflict ($t = 2.57$, $p < .01$) and in Role Ambiguity ($t = 2.37$, $p < .01$). Role conflict between teaching and research was prevalent for BSN faculty attempting to balance teaching and scholarly activities. However, Oermann reported an overall low degree of role strain in this sample with a total role strain score of 2.90 ($SD = .62$). This is a very different finding compared with Mobily's (1991) study where 50% of the CNF reported moderate to high degrees of role strain.

Oermann (1998a) noted education made a significant difference in total role strain reported. Doctorally prepared faculty experienced the highest degree of role strain (F [5,215] = 3.69, $p = .003$). Doctorally (PhD) prepared CNF reported the most role strain ($n = 44$, $M = 3.12$, $SD = .43$) compared to BSN ($n = 28$, $M = 2.58$, $SD =$

.48) and Master's prepared CNF (*n* = 146, 64.6%, *M* = 2.94, *SD* = .61). In comparing the groups, the doctorally prepared faculty scored significantly higher degrees of Role Overload, InterRole Conflict, and InterSender Conflict (F [5,215] = 5.96, $p < .01$; F [5,215] = 3.26, $p < .01$; F [5,215] = 3.86, $p < .01$ respectively).

The level of the student also influenced CNF reported role strain. CNF teaching sophomores in BSN programs reported the highest role strain scores (*M* = 3.38) compared to CNF teaching other levels of students. The clinical site did not appear to influence role strain scores for either group but employment status did. Full-time CNF reported higher degrees of role strain (*n* =162, 71.68%, *M* = 2.98, *SD* = .63) than their part-time counterparts (*n* = 56, 24.78%, *M* = 2.60, *SD* = .44). Role Overload was significantly higher ($t = 4.58$, $p < .01$) for full-time CNF than the part-time CNF (Oermann, 1998a).

Upon further exploration of her findings, Oermann (1998b) identified the predominant work-related stressors acknowledged by CNF were: *coping with job expectations associated with their clinical teaching roles* (*M* = 3.58, *SD* = .85), *feeling drained at the end of a clinical teaching day physically* (*M* = 3.50, *SD* = .93) *and emotionally* (*M* = 3.43, *SD* = .87), *job demands that interfere with activities of personal importance* (*M* = 3.36, *SD* = .92), *heavy workload* (*M* = 3.36, *SD* = 1.10) and p*ressure to maintain clinical competence or a clinical practice without time to do so* (*M* = 3.27, *SD* = 1.21). *Feeling unable to satisfy the work-demands of constituencies* (*M* = 3.22, *SD* = .98) ranked seventh while *teaching inadequately prepared students* (*M* = 3.22, *SD* = .82) ranked eighth of 11stressors identified.

Faculty in the BSN programs reported higher degrees of stress in job demands that interfere with activities of personal importance, coping with job expectations as CNF, and heavy workload including balancing the tripartite mission of the university (teaching, research, service) whereas this was not an expectation for the ADN faculty.

CNF reported several work-related stressors associated with clinical teaching and role strain. Stressors included role overload, having too many expectations and conflicts associated with clinical teaching and executing the teaching role. Stressors included feeling unable to satisfy the diverse work demands (of patients, students, and agency personnel), needing support, teaching unprepared students, and maintaining clinical competency without time available to do so. A major limitation was the homogeneous sample isolated to four NLN accredited programs in four Midwestern United States.

Nonetheless, Oermann's study (1998a, 1998b) offered a slightly different understanding of the degree of role strain reported by CNF. Workload remained a significant contributing factor to the degree of CNF role strain regardless of the school setting.

Components of Role Strain

Four components of role strain were studied in a mixed methods study by Lanagan (2003). Fifteen full-time CNF teaching in four BSN programs, and 22 staff nurses from four corresponding teaching and non-teaching hospitals participated in the study. The participants responded to questionnaires and participated in focus groups in an effort to identify role expectations, role overload, role conflict, and

ambiguity in relation to faculty practice. Tape-recorded focus group sessions were transcribed verbatim, coded, and analyzed (Lanagan, 2003). Interrater reliability was reported as 85% with rigor ensured through member checking and triangulation. An expert external reviewer ensured dependability and confirmability of findings. Demographic information was analyzed for frequencies and measures of central tendencies (Lanagan, 2003).

CNF and staff nurses agreed on CNF role expectations as teacher, guide, and supervisor for students, and student preparer for the clinical experience delivering safe patient care. However, Lanagan (2003) identified considerable confusion amongst the CNF and staff as to who was responsible to teach and evaluate first-time technology interventions.

Staff nurses reported less role overload when paired with clinically practicing CNF while role overload was higher for staff nurses with a five patient assignment when the ratio of students to staff was 1:3-4 (Lanagan, 2003). CNF role overload focused on time constraints and exhaustion related to additional heavy workload. CNF identified a lack of time to accomplish all course objectives and activities as a predominant theme. CNF described *feeling there is never enough time* to interact with students optimally and feeling frustrated with the need to carry over questions and activities from one week to the next (Lanagan, 2003).

Role conflict was generally an issue for staff nurses who expected CNF were safe, competent, knowledgeable clinicians functioning as teachers and supervising students enhanced by clinical practicing (Lanagan, 2003). Conversely, CNF reported

difficulty in maintaining a clinical practice while balancing the tripartite mission, pursuing a terminal degree, serving on committees, and engaging in research and publication (Lanagan, 2003).

Role ambiguity was troublesome for the staff nurses although not directly a function of CNF practice status. Many staff nurses reported poor CNF communication, citing an inadequate understanding of students' abilities or levels of functioning (Lanagan, 2003). This emphasized the staff's lack of clarity of students' skills and knowledge, explicit expectations, guidelines, or goals and objectives to facilitate appropriate assignments. Conversely, CNF reported communication as a source of role ambiguity in terms of not knowing changes in patient conditions necessary to adjust student assignments. CNF also reported a perceived lack of recognition and appreciation for their clinical practice (Lanagan, 2003).

This study confirmed previous findings that CNF experience difficulty in role expectations, role overload, role conflict, and role ambiguity (Mobily, 1991; Oermann, 1998a; O'Shea, 1982). This study is limited by sample size, sample characteristics, and sample affiliations. This study did not address faculty role strain involving failing students.

Role Strain and Job Satisfaction

Approaching role strain and work-stressors from a different perspective, Whalen (2009) explored the relationships among role strain (termed work-related stressors) and job satisfaction (role strain operationalized). Additionally, Whalen examined the relationships between selected background factors (number of years of

experience as a clinical teacher, clinical teacher training, and holding a second job) and role strain (work-related stressors) among part-time CNF.

Whalen (2008, 2009) completed an online descriptive, multivariate correlational study involving 91 part-time CNF (including adjunct faculty) teaching at two universities BSN programs in a Western State. The sample was appreciably different from the samples previously reported. None of the part-time CNF in this sample held a PhD; forty-two percent were Master prepared while 49% were Baccalaureate prepared, and 69.2 % held a second job. Whalen's sample were predominantly inexperienced educators with 56% having taught for 2 years or less, 81.3% indicating less than 4 years total teaching experience, 64.8% new to the institution within last 2 years.

Whalen adapted Mobily's RSS (1987). The revised instrument, referred to as the *Potential Work-Related Stressors Survey* (PSS), consisted of 30 potential role stress-inducing situations (role strain) and a single open-ended question to provide the respondent an opportunity to document a situation not presented within the instrument. Utilizing Mobily's (1991) original five- point Likert-type scoring scale measuring 1 (never) to 5 (nearly all the time), respondents indicated the degree of role strain perceived for each work-related situation. Whalen measured the degree of job satisfaction on the abridged *Part-time Clinical Teaching Job In General index (*aJIG). However, Whalen's methodology to revise the RSS was flawed in that fourteen of the original items were excluded without rationale.

Whalen (2009) reported the PSS combined mean score 2.55 (*SD* = 0.554; Cronbach's α = .818) representing a total mean score of a low degree of role strain for this sample. Statistical analyses revealed no relationships among teacher experience, teacher education, holding a second job, and Whalen's work-related stressors (role strain). A weak negative relationship between Whalen's work-related stressors and job satisfaction (r = -.29, p < .001) was reported. Whalen's work-related stressors (role strain) proved to be a predictor of job dissatisfaction (β = -.296, p < .007) with an inverse relationship noted between role strain (work-related stressors) and job satisfaction.

The top five work-related stressors identified by Whalen's (2009) sample ranked from highest stress situations were *being physically drained* (*M* = 3.08), *working outside regular hours*, *dealing with too many expectations*, *being emotionally drained*, and *insufficient monetary compensation* (*M* = 3.00). Additional work-related stressors (role strain sources) identified in the open-ended question primarily focused on managing student problems such as working with unprepared or poorly prepared students, dealing with failing students, clinical group size, student evaluations, and grading clinical papers. Many of the respondents' remarks identified the need for better teacher preparation and clinical nurse faculty orientations, and clearer communication of expectations among administrators, staff, and students. Whalen (2009) reported CNF found clinical teaching as well as the clinical evaluation process of student performance in the clinical practicum stressful.

Whalen reported the data from the aJIG tool violated the normality assumption, jeopardizing her results. The sample size and characteristics were limited. It is unclear why the RSS was revised in the manner described. No explanation was provided why the factor analysis was completed on the revised instrument of 30-items not the original RSS instrument of 44-items. As presented, Whalen's revised RSS is not trustworthy for use.

Role Strain and Socialization

Clark (2013) recently completed a mixed-methods study of CNF. The study aim was to generate a theory of the socialization process of new clinical nursing faculty, to determine the characteristics essential to be an effective clinical faculty, and to evaluate the degree of role strain experienced by new clinical faculty (Clark, 2013). The sample consisted of 10 mid-western clinical nurse educators (M_{age} = 42.7 years) employed at three nursing schools (2 in Licensed Practical Nurse (LPN) programs, 7 in ADN programs, 1 in a BSN program). Five CNF were employed full-time, four part-time, and one per diem. Each CNF member had 2 years or less experience in the CNF role. A Master's degree was the highest degree held by three CNF while the remaining seven had completed a BSN degree (Clark, 2013).

Clark (2013) used Knox and Morgan's five-point Likert-type *Nursing Clinical Teacher Effectiveness Inventory* (NCTEI) modified by Gignac-Caille, Mobily's (1991) five-point Likert-type *Role Strain Scale* (RSS) modified by Oermann (1998a) (Cronbach's α = .93), and a researcher-developed demographic questionnaire to gather the quantitative data. Qualitative data were collect in two focus groups (n = 5;

n = 3). Each focus group met for a single session, while two participants unable to attend the focus groups were interviewed using a semi-structure format to collect the qualitative data. Themes were validated with member checks and incorporated into subsequent interviews (Clark, 2013).

Clark (2013) reported a range of individual role strain scores from 2.1 to 3.4. The highest scoring item was *coping with the number of expectations of my job* whereas the lowest scoring items were *feeling pressure for better job performance over and above what I believe is reasonable* and *feeling that the goals and values of the institution/department are incongruent with personal goals and values*. The added item *going to school myself and trying to teach and work outside at the same time* was consistently scored 5 (nearly all the time).

Scores on the NCTEI ranged from 3.5 to 4.9; higher scores indicated more positive teacher characteristics. The means for the five individual categories ranged from 4.378 to 4.663 where the evaluation category scored the highest mark similar to Knox and Mogan's original findings in 1985 (Clark, 2013).

Clark identified several significant positive correlations between the NCTEI and the RSS. The years of clinical teaching at the same school correlated positively with *receiving insufficient recognition for my clinical expertise* ($r = .781$, $p = .008$) and *receiving insufficient recognition for my teaching performance* ($r = .704$, $p = .023$) as did the number of years of experience teaching current students correlate positively with *stimulates student interest in the subject* ($r = .705$, $p = .034$). Qualitative results revealed five stages of an emerging theory: *beginning the role*, *employing strategies*

to survive in the role, *coming to a turning point in the role*, *sustaining success in the role*, and lastly *finding fulfillment in the role* (Clark, 2013). The clinical nursing faculty in this study appeared to progress sequentially through these stages in the socialization process (Clark, 2013). Communication and perceived support were major themes.

A major limitation of this study was the sample size, homogeneity, and a limit in the number and type of programs represented. The degree of role strain experienced by this sample was not reported.

Role Strain, CNF Successful Role Transition, and Intent to Stay in Academia

Cranford (2013) examined role strain experienced by 246 CNF employed within 31 Southeastern United States public colleges and universities, and to what degree role strain predicted satisfaction with role transition and intent to stay in academia. Additionally, age, years in practice, and educational level were examined in regards to the degree of perceived role strain.

This experienced sample ($M_{clinical\ experience}$ =16.5 years, *SD* = 8.87, range 1- 41 years versus in the faculty role for 1 - 32 years) was predominantly white (85%), Master's prepared (66%), and had a mean age of 50.6 years (*SD* = 9.22, range 28 - 72 years; median age 56.5 years). Sixty percent taught in BSN programs and 62% reported teaching in BSN and MSN programs. Cranford did not report other types of programs represented.

To measure role strain, Cranford created a 16-item four-point Likert-type instrument ranging from (1) *strongly agree* to (4) *strongly disagree*; reliability and

validity were not mentioned. The means for items ranged from 1.68 (SD = .73; *agree* to *strongly agree*) to 2.85 (SD .80; *disagree*). Items marked as agree and strongly agree included items related to feeling exhausted and the work is never finished whereas items marked with disagree and strongly disagree included items related to teaching and time management. The primary concerns identified were feelings of exhaustion, the never-ending work, unrelated job-related expectations, being unaware of multiple role expectations, conflicting demands and policies, feeling caught between students and administration, and workload. Workload and time constraints, lack of a formal mentor, and lack of perceived support were also identified in the open-ended question as significant concerns.

Role ambiguity was a significant predictor of role strain ($r = .66$, $p < .01$, $t = 13.89$, $F = 192.82$) explaining 44% of the variance ($\beta = .47$, $t = 8.18$, $p < .01$), as was interpersonal support ($r = .59$, $p < .01$, $t = 11.17$, $F = 38.23$) explaining 6% of the variance ($\beta = .26$, $t = 4.54$, $p < .01$). Although self-assessed instructional competency (a variable not previously identified) was found to be a significant predicator of role strain ($r = .37$, $p < .01$, $t = 6.18$, $F = 124.75$), it explained a mere 1% of the variance ($\beta = .14$, $t = 2.75$, $p < .01$).

Role strain explained a significant portion of the variance in role transition ($r = .59$, $p < .01$, $t = 11.25$, $F = 126.63$) and intent to stay in academia ($r = .33$, $p < .01$, $t = 5.49$, $F = 30.12$) explaining 34% and 11% of the variance respectively. Although age, years of clinical experience, and education level in this homogenous sample did not explain a significant portion of the variance in perceived role strain (Cranford,

2013), it is important to consider a shift in the influence of these characteristics as the diversity of CNF increases. Variation in the degree of role strain, or underlying contributing factors, for undergraduate verses graduate faculty was not addressed.

Summary of Role Strain

Studies confirmed role strain was experienced by CNF (Clark, 2013; Cranford, 2013; Langemo, 1988; Mobily, 1991; Oermann, 1998a; O'Shea, 1982; Whalen, 2009). Role ambiguity significantly increased perceived role strain (Cranford, 2013; Lanagan, 2003). Increased workload and heavy workload with its clinical component were perceived as most stressful (Clark, 2013; Cranford, 2013; Langemo, 1988; Oermann, 1998a, 1998b; O'Shea, 1982; Whalen, 2009). Job expectations including self-imposed expectations, and time constraints contributed appreciably to CNF perceived role strain (Clark, 2013; Cranford, 2013; Oermann, 1998a, 1998b; Whalen, 2009). Researchers reported the most frequent perceived role strain incidents involved students and student performance or inability to provide patient care (Oermann, 1998a; O'Shea, 1982; Whalen, 2009). Specific examples included retaining failing students, providing individual clinical supervision, dealing with and failing clinically unsafe students, managing student problems such as working with unprepared or poorly students, the number of clinical students, student evaluations, and grading clinical papers (Oermann, 1998b; O'Shea, 1982; Whalen, 2009).

Fulfilling research requirements contributed to CNF perceived role strain (Oermann, 1998a). Role overload and time constraints were identified as major

sources and primary areas of role strain (Cranford, 2013; Goldenberg & Waddell, 1990; Langemo, 1988; Oermann, 1998a, 1998b; O'Shea, 1982; Whalen, 2009). It is important to note that several researchers identified an association between failing students in clinical and perceived role strain (Oermann, 1998a; O'Shea, 1982; Whalen, 2009). Others identified an association between role strain and perceived support (Clark, 2013; Cranford, 2013). Many of these studies were focused on CNF in mid-western states.

The literature failed to report differences or similarities for faculty based on undergraduate compared to graduate programs. The degree of role strain and its contributing factors in graduate faculty programs compared to undergraduate programs has not been reported. Variations in the degree of role strain experienced by CNF based on geographical locations have not been explored.

Faculty Stress

Until the early 1980s, stress encountered by faculty in higher education had not been the focus of occupational stress research whereas stress in various other professions was studied in depth. The early studies of occupational stress in people-oriented professions such as police officers, administrators, teachers, and dentists revealed a greater vulnerability to occupational stress than workers in a product-oriented profession (Gmelch et al., 1984).

Development of Faculty Stress Index (FSI)

Gmelch and his associates (1984) conducted an exploratory national study of 1,221 faculty with equal representation based on academic rank (assistant, associate,

and full professor) and according to 8 Biglan clusters of academic disciplines from 40 doctoral-granting public and 40 doctoral-granting private American universities. Gmelch et al. (1984) intended to identify work situations faculty perceived as stressful within research, teaching, and service, and if all sources of stress were similar among the disciplines.

The final version of researcher developed *Faculty Stress Index* (FSI) consisted of three subscales "with a substantial degree of measurement stability" (Gmelch, 1984, p. 482) including teaching stressor scale (Cronbach's $\alpha = .77$, $r = .89$), research stressor scale (Cronbach's $\alpha = .71$, $r = .59$) and service stressor scale (Cronbach's $\alpha = .79$, $r = .90$). The test/retest produced a mean item reliability coefficient of .83 signifying a high degree of consistency in the instrument (Gmelch, 1986). The teaching subscale included nine items addressing grading, student evaluations, dealing with poorly prepared students and student complaints, inadequate time for class preparation, repetitious teaching assignments, and recognition for teaching efforts, lecturing, and preparing new courses (Gmelch et al., 1984).

The FSI used a five-point Likert-type scale ranging from 1 (*slight pressure*) to 5 (*excessive pressure*). Scores of 4 and 5 indicated considerable stress related to the particular work situation. The stressors identified by approximately half of this sample, ranked from the most stressful, were *imposing excessively high self-expectations*, *securing financial support for my research*, and *having insufficient time to keep abreast with current developments in my field*. Forty percent of the respondents identified an additional 3 stressors as major sources of stress: *receiving*

inadequate salary to meet financial needs, *preparing a manuscript for publication*, and *feeling that I have too heavy a workload, one that I cannot possibly finish during the normal workday*. Five of the 10 stressors most frequently identified by this sample related to time and resource constraints. Additionally, *demanding self-imposed standards* and *finding time to necessary to keep abreast with current developments in one's field* were the most significant stress-producing items for all faculty in all disciplines. The FSI was found in its entirety in *Coping with Faculty Stress* (Gmelch, 1993).

Gmelch and his associates (1984) statistically tested mean scores for differences amongst the 8 academic disciplines based on Biglan's tridimensional model: hard/soft, life/nonlife, pure/applied. The difference of means test for independent samples, two-tailed t-test at .05 level of significance, was employed. These disciplinary groupings yielded "far more similarity than difference in the way faculty from across academia views the sources of stress in their work" (p. 486). These researchers concluded, "strong evidence for the existence of a general, diffuse problem of stress in university settings as opposed to the existence of more discipline-specific problems" (p.486). However, it is interesting to note the Biglan disciplinary category labeled Hard Life-system Applied (HLA) (n = 97) was statistically different from the mean (t = 18.04, p < .05) in all cases within the *Teaching Stressor Scale* at a 95% confidence level. The disciplines in the HLA category (nursing, medicine, pharmacy, behavioral sciences, dentistry, health technology, veterinary medicine, other health fields, and agriculture) identified a higher degree of stress associated

with teaching. Regardless of the discipline, faculty identified teaching as more stressful than research or service activities.

Factor Analysis of FSI

In a follow-up analysis of the *National Study* (Gmelch et al., 1984), Gmelch, Wilke, and Lovrich (1986) completed a factor-analysis of the results in an attempt to further understand the multidimensionality of faculty stress and its implications for faculty. Gmelch and his associates (1986) explored the relationship between several identifiable dimensions of faculty stress, that is specific professional characteristics (discipline, tenure, and rank) and faculty personal attributes (age, gender, and marital status), in an effort to identify specific factors in higher education which contributed to faculty stress. The factor analysis yielded a five-factor stress model.

The five identified distinct dimensions of perceived stressful conditions or situations accounted for 86% of the total common variance. The first factor, *reward, and recognition* accounted for 55% of the variance. The items appeared in teaching, research, and service encompassing inadequate rewards, unclear expectations and evaluative criteria, and insufficient recognition of community service. This dimension was found to be unique to faculty having not been previously identified in occupational stress research (Gmelch et al., 1986).

The second factor, *time constraint* accounted for 12% of the variance. This dimension included interruptions, meetings, paperwork, and lack of preparation time whereas the third factor, *departmental influence* accounting for 7% of the variance addressed the department-level influences particularly with the chairperson and lack

of impacting decision-making essential to faculty life. The fourth factor, *professional identity* accounted for 6% and addressed the faculty's professional reputation as a scholar, ability to publish, present at conferences, secure grant funding and research support, embracing excessively high self-expectations, and advancement. Lastly, the fifth factor, *student interaction* accounted for 6% of the variance. This factor addressed instruction, evaluation, advising, and working with inadequately prepared students. *Professional identity* and *student interaction* are unique to faculty (Gmelch et al., 1986).

Further exploration of the relationships revealed higher levels of perceived stress were associated with lower rank, untenured status, and particular disciplines (Gmelch et al., 1986). Similar to previous findings, women perceived greater stress compared to the men in terms of time constraints and professional identity. Of the five dimensions Gmelch and his associates identified for faculty, three are profession-specific, namely *reward and recognition, professional identity,* and *student interactions*.

Faculty Stress and Intent to Leave Academia

Based on the work of Gmelch et al. (1986), Barnes, Agago, and Coombs (1998) explored the effects of faculty stress and faculty intention to leave academia. Barnes and her associates presumed the stressors identified by Gmelch et al. (1986) (reward and recognition, time constraints, influence, and student interaction) would have a direct effect on faculty intent to leave academia, recognizing these effects may be moderated by *interest in discipline* and *sense of community*. Utilizing the Carnegie

Foundation for the Advancement of Teaching's *1989 National Survey of American Professorate* as the database, a sample of professors' responses (male = 2,311; female = 759) from 306 US colleges and universities were reviewed. The sample, predominantly male Associate Professors, represented faculty with full-time appointment for at least 9 months in a tenure-track position, ranked as Assistant Professor or higher with no plans to retire within next 5 years. The database survey did not provide any specific measures for professional identity thereby precluding consideration of this stressor.

Barnes and her colleagues (1998) revealed statistically significant higher levels of stress were associated with faculty's greater intent to leave academia. Time constraint had the strongest relationship (R^2 = .11) whereas sense of community was an important predictor associated with faculty's intent to leave academia adding 9-11% to the explained variance (*p* values omitted). The model including time commitment and sense of community accounted for 21% of the variance in intent to leave academia. The all-inclusive model equation explained 23% of the variance of faculty intent to leave academia; this confirmed time commitment and sense of community were the most important predictive variables respectively (*r* = .30, -.24). Prediction of intent did not vary by gender, tenure status, and academic discipline. Similarly, these variables were not predictive of faculty intent to leave academia. Faculty stress was indeed related to intent to leave academia.

Faculty Stress and Multiple Roles

In a different survey of faculty, Dey (1994) explored the multiple roles faculty assume within the context of work, family, and outside activities. Specifically, Dey explored differences in perceived sources of stress based on faculty tenure status, race, and gender assuming all faculty perceive stress in varying degrees. Dey reviewed the data from the *1989-1990 Higher Education Research Institute (HERI) Survey* conducted by the Higher Education Research Institute at the University of California at Los Angeles; this national survey is conducted every three years.

Dey reviewed 4,000 of 35,480 full-time undergraduate teaching faculty at 392 U.S. two-year colleges, four-year colleges, and universities. The researcher attempted to balance the sample responses contained in the covariance structured model analysis by creating eight groups based on three dichotomous variables: tenure status, race (white versus nonwhite since little variation in ethnicity was observed), and gender. Eighteen items designed to capture the extent of perceived faculty stress were extracted from the original survey data. These items represented a broad range of potential sources of stress encountered by faculty within a past two-year period. Faculty rated these items on a 3-point Likert-type scale: *not at all*, *somewhat*, and *extensive*.

Dey (1994) found similar stressors within the groups but with large differences across groups. Time pressures and lack of personal time was identified as common sources of stress for this faculty group, similar to Gmelch and his associates (1984). However, cross-tabular analyses revealed large differences across groups for

both stressors. For example, among white-tenured faculty, only one-third of the men reported time pressures as an extensive stress source whereas half of the women reported this as an extensive stressor.

Faculty teaching loads, research and publishing demands, and review and promotion concerns were identified as the next most commonly reported source of stress within groups, while revealing differences across groups. Managing household responsibilities emerged as the most common source of stress outside the workplace. Tenured faculty generally reported more stress than non-tenured faculty. Fund-raising was equally stressful for all faculty members regardless of tenure status.

A confirmatory factor analysis of this data revealed 4 dimensions: *time constraints*, *home responsibilities*, *governance activities*, and *promotion concerns*. This sample of faculty did not experience the dimensions similarly leading Dey (1994) to conclude, "the factors are not invariant among faculty" (p. 318). Different faculty groups perceived varying degrees of stress as well as different dimensions and kinds of stress.

Faculty Stress and Time Stress

In a similar study of the HERI data base, Lindholm and Szelényi (2008) examined the *2001-2002 Higher Education Research Institute (HERI) Faculty Survey* responses in an effort to explore the differences within the affective dimension of faculty experience, particularly in *time stress*, across academic disciplines based on the Biglan academic groupings. This overall sample of 37,840 represented full-time undergraduate teaching faculty from 358 U. S. colleges and universities. A factor

analysis was completed with *time stress* and the remaining 19 stress related items. Time stress was a composite measure of *time pressures* and *lack of personal time* resulting from the factor analysis (Cronbach's $\alpha = .83$). These two items were measured on a 3-point Likert-type scale from *extreme* to *not at all* indicating the faculty's degree of perceived stress over the previous two years.

Regression analysis was completed with seven independent variables-demographic characteristics (age, race, marital status, parental status), professional characteristics (employment status, degree, tenure), time investment (hours spent weekly in teaching, research, community service), personal and professional activities (commuting, teaching at multiple institutions, consideration to retire or leave academia), job satisfaction measure, institutional culture and climate (community service orientation, diversity climate, etc.), and institutional type, control, and affiliation. Descriptive analyses revealed 55% of the women sampled indicated extensive stress compared to only 37 % of the men. Regression analyses to discern within group differences (using standard Beta coefficients at $p < .001$) revealed faculty in the hard life applied fields ($n = 1,846$), such as nursing, indicated the highest degree of time stress (51%). Between groups differences (using t tests at $p < .01$) revealed total proportion of variance in time stress ranged from 17.6% to 25.6% with the hard pure life fields such as biochemistry scoring the highest.

Demographic characteristics had varying degrees of influence on the level of time stress. Age was noted to be a relatively strong negative predictor of time stress for all faculty across disciplines with older faculty experiencing less stress than

younger faculty. Characteristics such as employment status and professional degrees had positive effects on time stress for a variety of disciplines. Gender, race, and life style characteristics had positive and negative effects on specific disciplines. For example, faculty in hard life applied fields, such as nursing, who identified themselves as parents, experienced a positive effect on time stress.

The time investment variable of hours per week spent on administrative activities was the most consistent positive predictor of time stress in all disciplines. Time spent on research and scholarly writing was a positive predictor of time stress in three select Biglan disciplinary groups, one of which included nursing faculty. Hours spent in household and childcare responsibilities were positive predictor of stress in several Biglan disciplinary groups, again one in which nursing faculty was included.

A variety of professional activity measures revealed positive effects on select disciplines with consideration of leaving academe within the last 2 years as consistent positive predictor across all disciplines. Recent consideration of early retirement was a positive predictor for nursing faculty and faculty in the hard pure life fields. Lastly, the variable job satisfaction exhibited a negative effect on time stress for all faculty in all Biglan disciplinary groupings; this suggests a safeguarding effect against time stress (Lindholm & Szelényi, 2008). This study highlighted several areas of perceived stress by nursing faculty namely parenting, scholarly activities, research, and consideration of leaving academia, which included retirement.

Similarly, Berrett (2012) reviewed the results of the 2010-2011 HERI survey of 23,824 full-time and 3,547 part-time faculty members who taught undergraduate

students in four-year institutions. Berrett reported faculty continued to identify self-imposed high expectations, lack of personal time, working with underprepared students, and financial pressures with budget cuts as leading sources of faculty stress (Berrett, 2012). Despite faculty reporting inadequate perceived support, faculty members placed higher value on teaching over service and research. Faculty reported spending less time in class teaching than in previous years and had less time available to devote to students. Faculty identified factors including fewer full-time faculty to share the burdens of institutional service, shared governance, and research as universities increasing dependence on part-time and adjunct faculty as an explanation (Berrett, 2012).

Faculty Stress and CNF

In an exploratory study of 208 baccalaureate nurse faculty in four mid-western states, Langemo (1988) explored how nurse faculty viewed their positions, their likes and dislikes associated with teaching, their perceptions of themselves, their students, and their work-related stressors, as well as the factors nurse faculty believed precipitated, caused, prevented, or alleviated burnout in academia. Langemo developed a 3-scale questionnaire consisting of the *Burnout Scale, Self-perception Scale,* and *Student Perception Scale*. The reported alpha coefficients for these scales were .91, .78, and .72 respectively. The top four principal causative factors of burnout were identified as *overload and/or inequality of load, lack of positive reinforcement, lack of competent leadership, and faculty conflict*. *Pressure to research and publish* ranked ninth.

The four factors identified most often to alleviate or prevent burnout were *reasonable workload and expectations*, *support and respect from administration*, *recognition of teaching excellence*, and *clear expectations/job descriptions*. Langemo observed faculty who worried about students' actions and learning outside of the clinical setting reported higher burnout scores. Overload was identified as a principle work-related stressor for nurse faculty similar to O'Shea's (1982) findings.

Faculty Stress and CNF: Sources and Levels of Faculty Stress

In a different exploratory, descriptive study, Goldenberg and Waddell (1990) surveyed 70 full-time Canadian nurse educators at baccalaureate nursing programs to explore the sources and levels of perceived stress, coping strategies and effectiveness of female nurse faculty. Additionally, Goldenberg and Waddell explored the relationship between stress, coping, and academic responsibilities in teaching, research, and community service. The authors developed the *Stress-Coping, Anxiety Inventory* to capture the data. Participants were asked to rank the stressors and coping strategies using a 5-point Likert-type scale. The leading stressors identified according to highest rank included *heavy workload* (primarily clinically-oriented) identified by 83% of the respondents followed by *retaining failing students* (66%), *provision of individual clinical supervision* (62%), *failing clinically unsafe students* (61%), *and meeting research requirements* (55%). *Increased workload* and *heavy workload with its clinical component* were perceived as most stressful corresponding to the findings of O'Shea (1982) and Langemo (1988).

Faculty Stress and Job Satisfaction among Nursing Faculty

In an online descriptive correlational study, Chung and Kowalski (2012) surveyed a nationwide convenience sample of full-time Master and PhD prepared nursing faculty to examine how mentoring relationships influenced faculty stress, empowerment, and job satisfaction. Faculty represented 660 Commission on Collegiate Nursing Education (CCNE) accredited programs. The sample (n = 959; M_{age} = 53 years) was predominantly white, married, and not presently supporting dependent children or holding a second job. Four instruments (Gmelch's FSI, Cronbach's α = .93; Dreher and Ash's mentoring scale, Cronbach's α = .94; Spreitzer's psychological empowerment scale, Cronbach's α = .90; and NSOPF job satisfaction scale, Cronbach's α = .81) were used in the study to measure the concepts.

Chung and Kowalski (2012) reported violation of homogeneity of variance assumptions for the faculty stress and job satisfactions variables. However, the researchers justified the results based on the robust sample size; significance levels were set to $p < .01$, and Bonferroni alpha was adjusted to .016. The mentored group (M = 2.54, SD = .67) reported significant less faculty stress on Gmelch's FSI (1984) F (1, 9470 = 11.23, p = .001, x^2 = .01, power = .92) compared to the non-mentored group (M = 2.70, SD = .73). Chung and Kowalski (2012) identified faculty stress significantly influenced job satisfaction inversely (β = -.426, t = -12.851, p = .0005) as did tenure status (β = -.094, t = -2.722, $p < .007$). The model explained 47% of the

variance in job satisfaction (R^2 = .468). This study reported faculty stress negatively affected job satisfaction among nursing faculty (Chung & Kowalski, 2012).

Summary of Faculty Stress and CNF

Many stressors contributing to nursing faculty stress were identified. Several new stressors were reported, namely lack of colleague and administrative support, changes in the educators' demographics with increased turnover and more part-time or adjunct nurse educators. Regardless of the discipline, educators identified teaching as more stressful than research or service activities (Gmelch et al., 1984). These studies outline the perceived stressors encountered by CNF- heavy work load with multiple work demands including supervising students in clinical practicum and meeting research requirements, working with problematic students, retaining or failing clinically unsafe students, low salary and financial pressures (Goldenberg and Waddell, 1990; Langemo, 1988). Difficulties with students were noted in several of the studies as a cause of faculty stress (Gmelch et al., 1984, 1986; Goldenberg and Waddell, 1990; Oermann, 1998; Whalen, 2009). Faculty stress was cited as negatively affecting job satisfaction among nursing faculty (Chung & Kowalski, 2012). Additionally workload (Langemo, 1988), few rewards and recognition, and time constraints including maintaining clinical competence, and lack of perceived support were identified as significant stressors for nurse educators (Clark, 2013; Cranford, 2013).

Perceived Organizational Support

Perceived organizational support (POS) denotes the employees' perception of the extent to which the organization values their contributions and cares about their well-being (Eisenberger et al., 1986). It is built on the idea of reciprocal commitment between the organization and the employee developing over time (Stamper & Johlke, 2003). Furthermore, POS is "assurance that aid will be available from the organization when it is needed to carry out one's job effectively and to deal with stressful situations" (Rhoades & Eisenberger, 2002, p.698). Rhoades and Eisenberger identified three major categories of POS antecedents being *fairness of treatment*, *supervisor support*, and *rewards and favorable job conditions*. Consequences addressed *organizational commitment*, *job-related affect*, *job involvement*, *performance*, *strains*, *desire to stay with the organization*, and *withdrawal behaviors*.

Organizational support theory suggests POS is further developed with the employees' propensity to assign the organization humanistic characteristics (Eisenberger et al., 1986; Rhoades & Eisenberger, 2002). This forms the basis for the employees' view of favorable or unfavorable treatment (seen in fairness, supervisor support, and organizational rewards and job conditions) (Rhoades & Eisenberger, 2002). This is emphasized when the supervisor is perceived as the organizational agent whereby an employee's perception of favorable treatment increases their POS.

SPOS: Survey of Perceived Organizational Support

Although POS is associated with affective organizational commitment and supervisor support, "POS is a distinctive construct that the Survey of Perceived

Organizational Support (SPOS) measures with high reliability" (Rhoades & Eisenberger, 2002, p. 699). POS reinforces the employees' beliefs that the organization values increased performance with recognition and rewards affecting job satisfaction, commitment, and intent to stay.

The SPOS consists of 36 commitment statements intended to evaluate the extent to which an employee agreed with each item. The SPOS is a seven-point Likert-type scale with anchors ranging from *strongly disagree* to *strongly agree*. In an attempt to control for response bias, 50% of the items were worded negatively. The unidimensionality and high internal reliability of the SPOS supports the original and subsequent versions of the questionnaire (original 36-item, 17-item, and 8-item versions) (Rhoades & Eisenberger, 2002). Loading values ranged from .43 to .84 with the majority of the items loaded greater than .65.

Eisenberger et al. (1986) tested the original SPOS on a sample of 361 employees from 9 diverse industries (including teachers as one category). Perceived support accounted for 93.9% of the common variance. In the factor analysis, perceived organizational support explained 48.3% of the total variance. A reliability coefficient (Cronbach's alpha) of .97 for the scale was reported. Individual item correlations ranged from .42 to .83 (M = .67, median = .66) indicating strong loading on a single main factor. These findings confirmed, "employees develop global beliefs concerning the degree to which the organization values their contributions and cares about their well-being" (Eisenberger at al., 1986, p. 503).

Subsequently, Eisenberger and his colleagues (1986) tested the 17-item version SPOS containing the highest loading items with a sample of 97 private high school teachers in an effort to test the effect of exchange ideology on the employee's POS on absenteeism. A factor analysis of the responses revealed POS accounted for 50% of the total variance. Further statistical analysis confirmed the POS scale identifying a single factor independent of exchange ideology. The reported reliability coefficient was .93.

POS on absenteeism was strongly influenced by the strength of the employee's exchange ideology where the main effect of POS on absenteeism accounted for 8% of the variance in days absent ($p < .01$) and 4.2% of the variance in the periods of absence ($p < .05$). For employees with high or moderate exchange ideology, POS produced 50% fewer absent days (t (62) = 2.58, $p < .01$) than those with low exchange ideology (t (62) = 2.00, $p < .025$). The relationship of the employee's POS and efforts for low absenteeism were influenced by magnitude of the strength of the employee's exchange ideology (Eisenberger et al., 1986) where employees with a strong exchange ideology reciprocated POS with greater efforts for attendance and desire to achieve organizational goals.

In a meta-analysis of the literature, Rhoades and Eisenberger (2002) identified 73 independent studies in a variety of industries including education, health, government, manufacturing, farm, and others, which utilized various versions of the SPOS. On average, the studies used 13 items (ranging from 3 to 36) to measure antecedents and consequences; the internal consistency reported in the

studies ranged from .77 to .98 with the average Cronbach's α = .90 regardless of which version was employed (Rhoades and Eisenberger, 2002). Since that time, the SPOS has been used in more than 330 research studies with good reliability reported (http://www.psychology.uh.edu/pos/publication_authors.asp).

POS and Organizational Commitment

In a longitudinal study encompassing 1 year, Panaccio and Vandenberghe (2009) explored the relationships of POS and organizational commitment to employee psychological well-being controlling for the influence of work-related stressors (role ambiguity, role conflict, and role overload) in a sample of 220 predominantly Canadian employees and managers (47% male, M_{age} = 36.10, *SD* = 8.81, $M_{organizational\ tenure}$ = 7.64, SD = 6.81). Included within organizational commitment were three distinguishable components of affective, normative, and continuance commitment. Affective commitment referred to the *employee's identification and involvement* within the organization; normative commitment referred to the employee's *sense of obligation* to the organization and the idea of reciprocity, whereas continuance commitment referred to the *employee's perceived sacrifice associated with leaving and lack of employment alternatives* (Panaccio & Vandenberghe, 2009).

Panaccio and Vandenberghe (2009) measured POS through a shortened version of the SPOS consisting of eight high-loading items from the 36-item SPOS; a reliability coefficient of .93 was reported. The researchers found positive relationships between POS and both affective commitment (β =.70, $p < .001$) and

normative commitment (β = .39, p < .001). Additionally, perceived sacrifice showed a positive relationship (β = .23, p < .01) whereas the second component, lack of employment alternatives, had a negative relationship with POS (β = -.30, p < .001). POS was correlated with employee well-being (r = .45, p <.01) mediated by affective commitment whereas POS was related negatively to perceived lack of employment alternatives leading to a negative relationship with well-being (Panaccio & Vandenberghe, 2009).

Panaccio & Vandenberghe (2009) suggested POS contributed to the employees' sense of self-worth; employees who had an emotional attachment to the organization as a consequence POS, perceived greater confidence and self-esteem as well as adequate resources necessary to cope with work demands (Panaccio & Vandenberghe, 2009). In contrast, POS was negatively related to role ambiguity (β = -.25, p < .001) and role conflict (β = -.20, p < .001). Role ambiguity and role conflict were also negatively related to employee well-being (β = -.36, p < .001 and β = -.24, p < .05 respectively) which suggested POS "may partly contribute to well-being via a reduction of role stressors" (Panaccio & Vandenberghe, 2009, p. 232).

POS, Role Stress, and Work Outcomes

In a homogenous sample of 235 salespeople (75% male, M_{age} = 41, $M_{work\ experience}$ = 11.5 years, $M_{organizational\ tenure}$ = 5 years, and 35% with BS degree), Stamper and Johlke (2003), in a cross-sectional study, examined the relationships between POS, work stressors in role conflict and role ambiguity, and work attitudes in job satisfaction and intent to stay. Similar to Panaccio and Vandenberghe (2009),

Stamper and Johlke (2003) used a shortened version. A six-item version of SPOS (Cronbach's α = .94) yielded comparable results. Role ambiguity, role conflict, and POS were once again determined to be distinct constructs. Similar to Panaccio and Vandenberghe (2009), strong relationships were identified where POS was negatively related to role ambiguity ($\Delta F = 34.48$, $p \leq .001$, $\beta = -.38$, $R^2 = .15$) and role conflict ($\Delta F = 19.52$, $p \leq .001$, $\beta = -.29$, $R^2 = .12$) yet was a positive predictor of job satisfaction ($\Delta F = 30.55$, $p \leq .001$, $\beta = .36$, $R^2 = .14$) and intent to remain ($\Delta F = 17.97$, $p \leq .001$, $\beta = .28$, $R^2 = .10$). Additionally, POS buffered the negative relationship between both role ambiguity and job satisfaction ($\Delta F = 11.38$, $p \leq .001$, $\beta = .46$, $R^2 = .39$) along with role conflict and the intent to stay ($\Delta F = 4.61$, $p \leq .05$, $\beta = .38$, $R^2 = .20$) (Stamper & Johlke, 2003).

In contrast, no relationship was found between POS and task performance ($\Delta F = 2.21$, $p \geq .05$). However, there was a significant interaction between role conflict and POS in predicting task performance ($\Delta F = 5.73$, $p \leq .05$, $\beta = .43$, $R^2 = .17$), while the interaction between role ambiguity and POS was insignificant ($\Delta F = .40$, $p \geq .05$) (Stamper & Johlke, 2003).

POS and Role Conflict, Political Skill, and Burnout

In a cross-sectional study, Jawahar, Stone, and Kisamore (2007) used the 17-item SPOS scale (Cronbach's α = .94) to evaluate the relationships between POS, role conflict, political skill, and burnout (termed emotional exhaustion) in a sample of 120 software development specialists (74% male, $M_{age} = 41$, $M_{work\ experience} = 16.07$, $SD = 8.12$ $M_{organizational\ tenure} = 3.67$, $SD = 1.84$). Jawahar et al. found POS influenced

emotional exhaustion (β = -.27, t (111) = -3.13, $p < .01$; sR^2 = .06) as did role conflict (β = .39, t (112) = 4.45, $p < .001$; sR^2 = .12) where "sR^2 indicated an incremental change in R^2 for a given variable beyond all other variables" (p. 151).

Moreover, a significant interaction between POS and role conflict was observed (β = .13, t (111) = 1.93, $p < .05$; sR^2 = .02) influencing emotional exhaustion, whereas the relationship between role conflict and emotional exhaustion was weaker at higher levels of POS (Jawahar et al., 2007). Further analyses revealed role conflict was significantly related to emotional exhaustion only at low levels of POS ($R^2 = .02, p < .05; \beta$ = .21, t (55) = 1.93, $p < .05$). This moderating effect of POS on the role conflict-emotional exhaustion relationship was observed where high levels of POS "had a buffering effect and mitigated the negative effects of role conflict on emotional exhaustion" (Jawahar et al., 2007, p. 154).

POS and Nursing

In a cross-sectional correlational internet study, Gutierrez et al. (2012) examined the relationships between organizational commitment, global job satisfaction, developmental experiences, work values, POS, and person-organization fit among a stratified sample of 1049 nursing faculty from NLN accredited programs (92% female, M_{age} = 56.26, SD = 8.81, 60% with organizational tenure of 0-10 years). This team of researchers used a shortened version of the SPOS consisting of nine of the highest-loading items from the original SPOS scale (Cronbach's α = .95) which addressed the underlying constructs of the study. A structural equation model (SEM) deemed a good fit (χ^2 (174, N = 570) = 301.10, $p < .00005$, NNFI = .97, IFI = .98,

CFI = .98, SRMR = .03, RMSEA = .04, and its associated confidence interval at 90% = .03, .04) (Gutierrez et al., 2012). Additionally, R^2 scores ranged from .32 to .76 ($p <$ .001) with .54 as the median. Further analysis revealed moderate to strong relationships between the various factors with adequate discriminate validity (r = .29 to .85) (Gutierrez et al., 2012).

The SEM revealed POS exerted strong significant direct effects ($p < .001$) on global job satisfaction (r =.79), normative commitment (r =.52), developmental experiences (r = .53) and perceived person organizational fit (r =.59) as well as indirect effects on affective commitment (β = .80, $p < .001$), normative commitment (β = .20, $p < .01$), work values (β = .36, $p < .001$), and perceived-person organizational fit (β = .20, $p < .01$). These indirect effects were mediated by various interactions of POS and the other factors (Gutierrez et al., 2012).

Gutierrez et al. (2012) reported 62% of the variance in global job satisfaction was attributed to POS, whereas POS contributed to the variance in normative commitment, perceived-person organizational fit, and developmental experiences through an assorted combination of POS and the factors accounting for 49% to 64% of the variance. POS appeared to positively predict nurse faculty commitment (both affective and normative) to their academic organizations (Gutierrez et al., 2012).

POS and CNF

Clark (2013) and Cranford (2013) identified the need for organizational support in terms of faculty support necessary in transitioning into the CNF role as well as CNF's growth and confidence development in the role. Similarly, in a recent

phenomenological qualitative study of 11 full-time CNF with at least 2 years of experience as CNF, Amicucci (2012) explored the CNF's experience in assigning a grade to a nursing students' clinical performance. Analysis of transcribed interviews by Amicucci (2012) revealed five essential themes: *subjectivity and shades of grey* involving the idea of competency; *safety as a benchmark* in respect to patient safety and student competency ; *opportunity for change* as several participants voiced the desire to give the student a chance embracing the idea that a clinical failure is life changing for the student; *wishful thinking* as CNF expressed hope for student improvement, administrative support, or a classroom failure eliminating the need for the CNF to assign a failing grade; and lastly, *discontent and disappointment* in terms of clinical group size, lack of student motivation and effort, clinical evaluation tools, and most importantly, inadequate perceived support.

In a similar qualitative study of 13 Canadian preceptors representing CNF (5), faculty advisors (3), and preceptors (5) from a single nursing program, Larocque and Luhanga (2013) explored the issue of neglecting to assign a failing grade (referred to as *failure to fail)* in a single nursing program. Participants were experienced CNF, faculty advisors, and preceptors but were not required to have had an experience with a failing student or one who was at risk of failing (Larocque & Luhanga, 2013). It is not clear how many participants, if any, did not have personal experience with a failing student.

Larocque and Luhanga (2013) explored the participants' perceptions through individual semi-structured interviews, guided by 6 open-ended questions based on the

literature; additional questions evolved from participant responses. Member checks, in-depth interviews, and reviews of transcripts by experienced researchers' ensured credibility while confirmability was ensured through a comprehensive audit trail.

Larocque and Luhanga (2013) identified CNF, faculty advisors, and preceptors desired support in evaluating an unsafe or poorly performing student. A content analysis of the data revealed five major themes: (a) *failing a student is a difficult process* for both the preceptor and teacher as well as the student in a final semester; (b) *both academic and emotional support are required for students and preceptors/faculty advisors* which was often not forthcoming from the institution; (c) *there are consequences for programs, faculty, and students when a student has failed a placement* including loss of self-esteem, self-blaming, extra-workload, and possible litigation or appeal ; (d) *at times, personal, professional, and structural reasons exist for failing to fail a student* including lack of time, increased work-load, and to avoid legal actions; (e) and lastly, *the reputation of the professional program can be diminished as a result of failing to fail a student* (Larocque & Luhanga, 2013). Support from administration and colleagues were identified as essential and often lacking for CNF.

The findings of the qualitative studies completed by Amicucci (2012), Larocque and Luhanga (2013) are very similar; both emphasize the need to carefully examine POS and CNF.

Summary of POS

POS is a distinct concept although closely related to other concepts such as organizational commitment. As a result of POS, employees experienced higher degrees of confidence, self-esteem, and well-being through reduced role stressors (Panaccio & Vandenberghe, 2009). Significant negative relationships between POS and role ambiguity and role conflict were identified (Panaccio & Vandenberghe, 2009; Stamper & Johlke, 2003). Higher levels of POS led to a weaker relationship between role conflict and emotional exhaustion (Jawahar et al., 2007) such that POS appeared to mitigate the negative effects of role strain seen as role conflict on emotional exhaustion (Jawahar et al., 2007). Gutierrez et al. (2012) also found POS mediated the effects of a variety of factors. Nurse faculty commitment to their academic institutions was directly related to the degree of POS (Gutierrez et al., 2012).

CNF identified the need for organizational support as a necessary component in the process of assigning a failing grade (Clark, 2013; Cranford, 2013). In particular, Amicucci (2012) reported CNF experienced disappointment and negative feelings associated with the perceived lack of organizational support from the institution. CNF and preceptors in Larocque and Luhanga's (2013) qualitative study identified the lack of academic, administrative, and emotional support, which appeared to exacerbate the difficulty encountered in the process of assigning a failing grade. To date, clinical nurse faculty POS has not been quantified during the time

when confronted with the decision to assign a failing grade to a nursing student in a clinical practicum.

Conclusion

Hardy and Hardy (1988) described the components of role strain as role ambiguity, role conflict, role incongruity, role incompetence, and role overload. Many studies, focused on these components, revealed CNF experience varying degrees of perceived role strain (Lanagan, 2003; O'Shea, 1982; Mobily, 1991; Oermann, 1998a, 1998b; Whalen, 2009; Clark, 2013; Cranford, 2013). Several researchers identified an association between perceived role strain and dealing with failing clinical students (Goldenberg and Waddell, 1990; Langemo, 1988; Oermann, 1998a; O'Shea, 1982; Whalen, 2009). Clark (2013) and Cranford (2013) identified an association between perceived role strain and the need for support.

Teaching was identified as the most stressful activity involved in faculty workload and time constraints and source of perceived faculty stress (Berrett, 2012; Gmelch, 1984; Langemo, 1988; Oermann, 1998a, 1998b). CNF identified a variety of stressors including heavy workload, time spent with students in clinical practicum (Clark, 2013; Cranford, 2013; O'Shea, 1982; Langemo, 1988; Oermann, 1998a; Whalen, 2009), problematic students (Gmelch et al., 1984, 1986; Oermann, 1998b; O'Shea, 1982; Whalen, 2009), and retaining or failing clinically unsafe students (Goldenberg and Waddell, 1990; Oermann, 1998b; Whalen, 2009). An association was identified between faculty stress and lack of perceived support for CNF (Langemo, 1988).

Perceived support was identified as a critical component in the process of assigning a failing grade (Amicucci, 2012; Clark, 2013; Cranford, 2013). The

perceived lack of support from the institution led CNF to report experiences of disappointment and negative feelings and appeared to intensify the difficulty experienced by CNF to assign a failing grade to a nursing student in a clinical practicum (Amicucci, 2012).

The degree of influence CNF characteristics exert on each of the three key variables is uncertain; the findings are inconclusive. Years in CNF position, years teaching, formal preparation for teaching, and years of clinical practice reduced perceived role strain (O'Shea, 1982); conversely, Whalen (2009) failed to find any relationship with these characteristics and role strain. Highest degree held (Lanagan, 2003; Oermann, 1998a), employment status, college setting, and number of hours spent in clinical were related to the degree of role strain (Oermann, 1998a) as was enrollment in a terminal degree program (Clark, 2013; Lanagan, 2003; Oermann, 1998a). Workload, including teaching and time constraints, lower rank, gender, and inadequately prepared students were contributors to faculty stress (Dey 1994; Gmelch, 1984; Oermann, 1998a, 1998b). Lindholm and Szelényi (2008) identified those who were parents, experienced higher degrees of faculty stress. Age was a negative predictor of faculty stress as less stress was reported by older faculty. However, age was not a significant factor in the study of CNF done by Gutierrez et al. (2012).

Specific students' characteristics were consistently reported as stressors. Whalen found working with failing students, number of students in the clinical group, completing student evaluations and grading papers were significant stressors for

CNF. Student level (Oermann, 1998a), unprepared students, and failing students were associated with role strain and faculty stress (Goldenberg and Waddell, 1990; Oermann, 1998a; O'Shea, 1982; Whalen, 2009).

There is a paucity of literature addressing the CNF struggle to assign a failing grade in a clinical practicum. While a variety of undergraduate programs are represented in the literature, graduate programs are not specifically addressed. Studies are limited to small homogenous samples with limited generalizability. The exploration of the relationships between perceived role strain, perceived faculty stress, and perceived organizational support for CNF engaged in an emotional struggle to assign a failing grade to a nursing student in a clinical practicum is expected to fill this gap and perhaps yield new insight to shape educational practices and policy.

Chapter III

METHODOLOGY AND PROCEDURES

Introduction

The purpose of this descriptive correlational study is to explore the relationships between perceived role strain, perceived faculty stress, and perceived organizational support for CNF who have faced the decision to assign a failing grade to a student in a clinical practicum. Perceived role strain is the dependent variable (DV), while perceived faculty stress and perceived organizational support are the independent variables (IV) for analysis. To date these relationships have not been studied, particularly in the context of the experience of CNF. This chapter will provide an overview of the research question, study design, target population, and recruitment plan, explanation of the statistical determination of sample size, detailed description of the demographic questionnaire (Appendix H) and the three instruments, ethical considerations, a description of the proposed approach to data collection and lastly, a discussion of the anticipated statistical methods to be used in data analysis.

Research Questions

What are the relationships between and among role strain, faculty stress, and perceived organizational support for CNF faced with a decision to assign a failing grade to a nursing student in a clinical practicum?

What change(s) occurred in CNF teaching practices after the deliberation to assign a failing clinical grade?

Hypotheses

Hypothesis 1. Perceived role strain is not associated with perceived organizational support for CNF faced with a decision to assign a failing clinical grade.

Hypothesis 2. Perceived role strain is not associated with perceived faculty stress for CNF faced with a decision to assign a failing clinical grade.

Hypothesis 3. Perceived faculty stress is not associated with perceived organizational support for CNF faced with a decision to assign a failing clinical grade.

Hypothesis 4. There are no relationships between and among perceived role strain (DV), perceived organizational support (IV), and perceived faculty stress (IV) for CNF faced with a decision to assign a failing clinical grade.

Hypothesis 5. Perceived role strain (DV) is not associated with selected faculty characteristics (IV) among CNF faced with a decision to assign a failing clinical grade.

Research Design

A descriptive correlational design was used to test hypotheses addressing interrelationships among perceived role strain, perceived faculty stress, and perceived organizational support for clinical nurse faculty faced with the decision to assign a failing grade to a student in a nursing clinical practicum. A descriptive correlational design is appropriate as it examines "the variables in a situation that has already

occurred or is currently occurring" (Burns & Grove, 2009, p. 246). To date, an examination of these variables collectively is not reported in the literature. Although the qualitative study done by Amicucci (2012) documented some of the experiences of CNF in assigning a grade to a clinical nursing student, there appears much more to be learned. Inclusion of an open-ended research question in this study afforded the participant an opportunity to share their experiences, illuminate insight, and promote deeper understanding of the CNF struggle and experience when confronted with the decision to assign a failing grade in clinical practicum. Additionally, this study examined relationships among perceived role strain and selected demographic characteristics relevant to the study to develop an understanding of the influence of faculty characteristics.

Setting

The setting is the physical location where the study is conducted (Burns & Grove, 2009). This study was designed as an internet questionnaire posted to SurveyMonkey™, a World Wide Web survey delivery and data-collecting tool. An internet survey provided easier access to diverse populations, is cost-effective, and efficient (Ahern, 2005). This design afforded the participant flexibility and convenience to answer the questionnaire electronically at a time and place most convenient to the participant (Cantrell & Lupinacci, 2007). Data was collected exclusively online and automatically captured when the questionnaire was submitted via SurveyMonkey™.

Sample

A national convenience sample was sought of clinical nursing faculty (CNF) who previously confronted a decision to assign a failing grade to a nursing student in a clinical practicum. Participants were solicited through a CCNE membership list previously used by Chung (2011). Furthermore, members of the Professional Nurse Educator and members of the Clinical Nurse Educators LinkedIn groups, and members of the Nurse Educator listserv (NRSINGED) were solicited in an attempt to obtain data from a large diversified sample.

Inclusion criteria for the participants included having those faculty who had taught as clinical nurse faculty for at least one clinical practicum, presently teaching either full-time or part-time, or were teaching full-time or part-time, in an accredited professional nursing undergraduate or graduate program (including diploma, associate, baccalaureate, and graduate programs in schools of nursing, colleges, universities, private and public) when the CNF was confronted with the decision to assign a failing grade to a clinical student within the last six years. Participants were able to read and write English.

Sample size and Statistical Power

The sample size sought must be *large enough* to identify relationships among the variables (Burns & Grove, 2009). In this descriptive correlational study, several key variables and selected demographic variables were considered. A power analysis was required to enhance the probability that the statistical analysis will detect existing significant relationships, and correctly reject a null hypothesis when it is false where

the effect size is large enough to detect more than trivial findings (Burns & Grove, 2009). The goal was for a sample sufficient in size to achieve an acceptable level of power (.80 or higher) to reduce the risk of Type II error by failing to identify significant findings when present (Burns & Grove, 2009). A power greater than .80 may exceed the investigator's resources in terms of available participants (Cohen, 1992).

A review of the literature failed to disclose an effect size (to what degree the phenomenon exists) for each of the variables in this study. In respect to effect size for correlations, Cohen (1992) identified .10 as small, .30 as medium, and .50 as large. Polit (2010) stated "in the absence of any other information, to estimate no more than a small-to-medium effect size of .20" (p. 202) noting .20 was the average correlation coefficient used in hundreds of nursing studies (Polit, 2010). A priori power analysis was completed using G power 3.1.9 for a correlation: point biserial model with an effect size of 0.20 (two-tailed statistical test ±1.96, effect size 0.20, $p \leq$ .05, power .80), determined a required minimum sample size of 193 (http://www.psycho.uni-duesseldorf.de/abteilungen/aap/gpower3/) (Faul, Erdfelder, Buchner, & Lang, 2009). In contrast, an a priori power analysis using G power 3.1.9 for a multiple regression (F test accuracy mode) with similar parameters (effect size .20, $p \leq .05$, power .80, and 5 variables) determined a required minimum sample of 70 participants.

The relationships among and between perceived role strain, perceived faculty stress, and perceived organizational support collectively have not been studied

previously. Neither have their relational properties been studied in terms of NSM, therefore a small-to-medium effect size was estimated since it is a new area of research. For this study, a minimum sample of 193 (effect size 0.20, $p \leq .05$, power .80) was sought. The study surpassed expectations achieving a sample size of 390. In post priori analysis using G Power 3.1.9, the sample size (N =390) assured a power of >.95 in all statistical analyses.

Recruitment of Research Participants

Initially, participants were recruited via an electronic invitation through several avenues: 1) purchased list of 6,694 individual faculty members from the 660 CCNE accredited programs in the United States identified on the CCNE website (Chung, 2011); 2) members of two LinkedIn groups: the Professional Nurse Educators Group and Clinical Nurse Educators Group, and 3) members of NRSINGED listserv. Additionally, prospective participants were asked to forward the invitation to colleagues known to have abandoned nursing education. Written permission to distribute the electronic invitation was sought from the professional organizations and listserv (Appendix I, J, and K).

The recruitment email or post to NRSINGED listserv and LinkedIn group discussion boards (Appendix L and M respectively) introduced potential participants to the study. It included a brief description of the study, an invitation to participate, and provided a hypertext link for interested participants to access the study on SurveyMonkey™. Upon entering the study, the participant was greeted by the Direct Online Solicitation Script (Appendix N), which served as the Letter of Solicitation.

The Direct Online Solicitation Script included the title and purpose of the study, a simple explanation of the procedure to complete the 4-part questionnaire posted as an online survey, the primary investigator's contact information and affiliation with Seton Hall University as doctoral candidate in College of Nursing, assurance of confidentiality at all times, the researcher's responsibilities, disclosure of any risks and benefits, and the participant's right to refuse participation or to withdraw at any time prior to submitting the online survey without penalty. Participants were asked to reflect on the time when the participant considered assigning a failing grade to a clinical nursing student. Participants were asked to provide data including years in teaching position, formal preparation for teaching, highest degree held, certification status, the level of student who was failing the clinical practicum, and approximate number of clinical students that semester. The RSS, FSI, SPOS, and researcher-developed demographic questionnaire were described briefly and sample questions were provided. Submission of the survey on SurveyMonkey™ implied consent by the participant to participate in this research study.

A follow-up reminder email (Appendix O) or post (Appendix P) to the discussion boards and listserv was sent 10 days later, thanking those who have responded, and encouraging non-respondents to complete the study. This served to maximize the highest possible participation rate. The questionnaire was available on SurveyMonkey™ for 22 days during the end of May, 2014 to middle of June, 2014 which achieved a large sample.

Prior to launching the national survey, the composite questionnaire was completed online by several eligible volunteer CNFs, confirming user-friendliness and the completion time of approximately 20 minutes. These volunteers' responses were not included in the study data analysis and remain in a separate confidential file accessible only to the investigator. The entire questionnaire was expected to be completed in approximately 20 minutes. The time the participants actually spent to complete the survey ranged from 5 minutes to 119 minutes with an average of 18.6 minutes (SD .73, median = 16, mode = 13).

Eligibility was determined by the participant meeting the inclusion criteria. The survey started with two filter questions. A 'yes' response to the following, "During the past six years, were you teaching full-time or part-time in an established accredited professional nursing program when confronted with the decision to assign a failing grade to a nursing student in a clinical practicum?" and “Have you taught as a clinical nurse faculty member for at least one clinical practicum?” allowed the participant to continue in the survey. A 'no' response to either question disqualified the participant. All ineligible participants were forwarded to a customized disqualification page where they were thanked for their interest in the study by means of the Skip Logic Disqualify Respondent feature found in SurveyMonkey™.

Protection of Research Participants

Approval was sought from Seton Hall University’s Institutional Review Board (IRB) prior to the onset of the study; Seton Hall University’s IRB exempted the study. The National Institute of Health *Protecting Human Research Participants* was

completed by the researcher within the past two years (Appendix Q). Participants were provided a secure link from which to access the study questionnaire on SurveyMonkey™ through an encrypted connection. Study responses were kept strictly confidential throughout data collection and viewed solely by the researcher. Access to the completed questionnaires was protected by an access code accessible only to the researcher.

The SurveyMonkey™ *Web-link Collector* was in effect throughout the data collection process collecting IP addresses as a means of preventing duplicate submissions. No attempt was made to identify owners of IP addresses or participants. Participants were instructed to refrain from completing the survey more than once. When a participant exited prior to submitting a completed survey, a reminder email was sent encouraging the participant to consider completing the survey. The hypertext link allowed the participant to return to complete the survey when using the same computer; this required the participant to enable cookies on their computer. It is unclear if any participants elected this option.

Data was stored on a USB memory stick key stored in a locked file cabinet in the researcher's residence. Participants were assured study responses will be reported only in aggregate form.

Risks and Benefits

A potential risk existed for participants to experience psychological stress as a result of recalling a situation believed to be a source of stress while answering the survey. Efforts to address potential concerns include an explanation of the study's

purpose, risks, and benefits expected from participation, and assurance of confidentiality of information. The researcher acknowledged the potential bias of a self-administered survey by a self-selected sample. It is unknown if potential participants were unwilling to participate because of the study topic. Participation was voluntary and as such, a participant could choose not to respond to the survey or to exit the survey at any time prior to submission without fear of repercussions. It is impossible to ascertain how many CNF read the invitation but choose not to participate.

Participants were encouraged to speak with a counselor of their choosing should they believe it necessary as a result of participating. No participants requested assistance from the researcher, none were directed to contact human resources within their institution or counselor of their choosing for assistance. Fifteen recipients emailed the researcher with positive and negative comments regarding the study topic, length of the survey, or apologizing for not being able to participate at the time. One email was received encouraging others to participate in the study!

No monetary compensation was provided to participants in exchange for their participation. The direct or personal benefits of participation remain unknown. The study results revealed information concerning the relationships among perceived role strain, perceived faculty stress, and perceived organizational support among CNF. The benefits of evaluating these relationships revealed the frequency of this dilemma in nursing education, and may assist in the design and implementation of supportive educational practices to ensure CNF do the *right thing* (Smith et al., 2001) and fail the

student who has not attained the required competencies or met the course learning outcomes.

Instruments

Operationalization of Variables

This study focused on three variables: perceived role strain, perceived faculty stress, and perceived organizational support. Instruments intended to measure these constructs are designed to obtain a summed and averaged score (total scale mean score) to describe the participant. Perceived role strain is operationally defined as the total scale mean score obtained in the *Role Strain Scale;* higher scores indicate greater degree of perceived role strain. Perceived faculty stress is operationally defined as the total scale mean score obtained in the *Faculty Stress Index*; higher scores indicate greater degree of perceived faculty stress. Perceived organizational stress is operationally defined as the total scale mean score obtained in the *Survey of Perceived Organizational Support*; higher scores indicate greater degree of perceived organizational support.

Extraneous factors, which may influence CNF perceptions of role strain, faculty stress, and organizational support, are operationalized as demographic information including age, gender, race/ethnicity, highest degree held, employment status, years as CNF, employment in other direct patient care role, and an open-ended response. An open-ended question allowed the respondents an opportunity to elaborate on their experience or identify issues not exposed in the survey questions

(O'Cathain & Thomas, 2004). This assisted the researcher in further understanding the phenomenon.

Role Strain Scale (RSS). The *Role Strain Scale* (Mobily, 1987) is a 44-item, five-point Likert-type scale designed to measure the degree to which each statement describes current or past work-related stress or source of stress. The items, derived from the literature, are ranked from 1 to 5 (*never, rarely, sometimes, frequently,* and *nearly all the time*). Higher values indicate high degrees of perceived role strain and higher intensity as a source of stress leading to role strain. Face and content validity were confirmed by an expert panel of five nurse educators. Additionally, a job stress expert established content validity for the RSS and subscales (Mobily, 1991). Mobily reported Cronbach's alpha of .96 (pilot study) and .92.

Mobily (1991) identified seven subscales in the RSS consistent with the literature. Role ambiguity (Cronbach's $\alpha = .85$) included seven items such as *feeling uncertain of what administration thinks of me*. Role overload (Cronbach's $\alpha = .84$) included eight items such as *feeling pressured to do more work than I currently am*. InterSender conflict (Cronbach's $\alpha = .71$) included four items such as *feeling unable to satisfy the conflicting demands of my various work-related constituencies (i.e. administration, colleagues, students, clinical agency personnel and patients)*. IntraSender conflict (Cronbach's $\alpha = .64$) included nine items such as *having adequate time to meet role expectations*. InterRole conflict (Cronbach's $\alpha = .53$) included four items such as *feeling that research and publication expectations take time needed for my teaching responsibilities*. Role incongruity (Cronbach's $\alpha = .78$)

included seven items such as *feeling torn between the demands of the profession and those of the institution*. Lastly, role incompetence (Cronbach's α = .70) included five items such as *being concerned that I do not have sufficient clinical expertise*.

Perceived role strain is reported as the total scale mean score (range from 1 to 5) obtained from summing the participant's responses to each item, then calculating an average to produce a total scale mean score. In an attempt to describe the degree of role strain experienced by CNF, Mobily (1991) established a scale using the mean and standard deviations in scale units: minimal (*M* = 1 - 2.4), low (*M* = 2.5-2.9), moderate (*M* = 3.0-3.4), and high (*M* = 3.5 or above).

Mobily's RSS (1987) was adapted by Oermann (1998a) to include 23-items. A pilot study confirmed content validity. The RSS shortened version maintained good reliability with Cronbach's alpha .93 (Oermann, 1998a) similar to Mobily (1987). Oermann's shortened version was used also by Clark (2013); however, coefficient reliability was not reported. To promote efficiency and limit the over-all number of items participants will encounter in this study, Oermann's shortened version was used.

The *Role Strain Scale* (Oermann, 1998) was used to measure CNF's perceived role strain. It included 23 items reflecting sources of role strain. The participants rated items representing the extent to which the participant experienced role strain in their CNF role at the time when failing a clinical student was under consideration. Items were scored on a 1 (*never*) to 5 (*nearly all the time*) scale and were averaged to calculate the total scale mean score. Higher scores reflected higher perceived role

strain. The RSS has been used in CNF populations with high reliability and validity (Clark, 2013; Oermann, 1998a). In the current sample, internal consistency was high as well (Cronbach $\alpha = .93$) as was Oermann (Cronbach $\alpha = .93$) and similar to Mobily (1987).

Faculty Stress Index (FSI) is designed as a 45-item five-point Likert-type scale, intended to measure faculty stress, ranking from *slight pressure* (1) to *excessive pressure* (5), and included *not applicable*. Several items were worded negatively to reduce agreement bias; this bias occurs when a respondent chooses all similar responses regardless of item content (Polit & Beck, 2012). The FSI generates a total score ranging from 0 to 225 from which the total scale mean score (range between 0 and 5) is computed for the entire scale by summing the items and dividing by 45, the total number of items.

The FSI evolved from the 30-item Administrative Stress Index, an examination of previous studies, and items suggested in 20 faculty diaries (stress logs) of work-related stress; validity was not quantified (Gmelch et al., 1986). The reliability coefficient reported was a Cronbach's alpha of .93 for the entire original scale (Gmelch et al., 1984) confirming good internal reliability. Test/retest completed at the two-week interval yielded a mean item reliability coefficient of .83 signifying "a high degree of consistency of measurement in the items finally included in the national faculty survey" (Gmelch et al., 1986, p. 271).

The FSI measures five dimensions of faculty stress: reward and recognition, time constraints, departmental influence, professional identity, and student

interaction. The final version of the FSI consisted of 3 subscales that contribute to the average total scale score "with a substantial degree of measurement stability" (Gmelch et al., 1984, p. 482). Included are the teaching stressor scale (Cronbach's α = .77, *r* = .89), research stressor scale (Cronbach's α = .71, *r* = .59) and service stressor scale (Cronbach's α = .79, *r* = .90).

The teaching subscale included nine items addressing grading, student evaluations, interaction with poorly prepared students and student complaints, inadequate time for class preparation, repetitious teaching assignments, and recognition for teaching efforts, lecturing, and preparing new courses (Gmelch et al., 1984). An example is *having inadequate time for teacher preparation*.

The research subscale included six items addressing professional meetings, preparing manuscripts for publication, maintenance of expertise, recognition for research performance, and criteria for evaluation of research and publications. *Securing financial support for research* is an item example in this subscale.

The service subscale included seven items addressing community service, recognition and rewards for community service, finding time for service; *not having clear criteria for evaluating service activities* is an item example in this subscale. Examples of the top stressors identified include *excessively high self-expectations* and *finding the time necessary to keep abreast with current developments in one's field*.

In an attempt to accurately measure and reflect CNF faculty stress, the scale was adapted with permission (Appendix E). It was surmised that a score of *not applicable* indicated the respondent never experienced the item. The revised FSI

remained a six-point Likert-type scale ranging from *never* (0) to *excessive pressure* (5).

In the current study, the *Faculty Stress Index* (FSI, Gmelch, 1984) was used to measure the degree of perceived faculty stress experienced by CNF. It included 45 items reflecting potential sources of faculty stress. Items were scored on a 0 (*never*) to 5 (*excessive pressure*) scale and were averaged to calculate the total scale mean score. Higher scores on this scale indicated higher degrees of perceived faculty stress. The FSI was previously used with faculty in a wide variety of disciplines with good reliability and validity (Gmelch et al., 1984). In the current sample, internal consistency was higher than previously reported (Cronbach $\alpha = .97$).

Survey of Perceived Organizational Support (SPOS) measures employees' perception of the extent to which the organization or institution values their individual contributions and cares about their well-being (Eisenberger et al., 1986). The SPOS is a 36-item seven-point Likert-type scale anchored from 1 (*strongly agree*) to 7 (*strongly disagree*). Half the items on the scale are negatively worded to control for agreement bias (Eisenberger et al., 1986). Based on social-exchange theory, the items represent "possible evaluative judgments of the employees by the organization and discretionary actions that the organizations might take in diverse situations to benefit or harm the employee" (Eisenberger et al., 1986, p. 501). Perceived organizational support is reported as the total scale mean score obtained from summing the participant's responses to each item, then calculating an average to produce a total scale mean score.

A reliability coefficient (Cronbach's alpha) of .97 for the scale was reported (Eisenberger at al., 1986). Individual item correlations indicated strong loading on a single main factor with the item-total correlations ranged from .41 - .83 (M = .67, median = .66). Perceived organizational support accounted for 93.9% of the common variance and 48.3% of the total variance despite the diverse content of the items (Eisenberger et al., 1986). A factor analysis with Varimax rotation and a two-factor solution was completed. The factor known as perceived organizational support loaded higher on all 36 items compared to the possible second factor; the lowest value for perceived organizational support loaded was greater than the highest for the secondary factor.

Construct validity was provided by a confirmatory analysis done by Shore and Tetrick (1991) in a subsequent study. Using a sample of 330 employees (272 men, 58 women, M_{age} = 47.39, $M_{organizational\ tenure}$ = 22.48), Shore and Tetrick confirmed the 17-item version of the SPOS was unidimensional (M =3.44, SD = .72, Cronbach's α = .95, X^2 = 364.68 (df 119), p < .001], *NFI* [normed fit index] = .906) and was distinct from affective and continuance commitment. However, it was unclear if perceived organizational stress (POS) was distinguishable from satisfaction (Shore & Tetrick, 1991).

Many studies have used shortened versions of the SPOS. In fact, "the majority of the studies on POS use a short form from the 17 highest loading items in the SPOS" (Rhodes & Eisenberger, 2002, p. 699). Shortened versions have shown excellent Cronbach's coefficient alpha scores. A 17-item version achieved an internal

reliability score of .93 or greater (Eisenberger et al., 1986; Jawahar et al., 2007; Panaccio & Vandenberghe, 2009), as did an 8-item version and 9-item version (Gutierrez et al., 2012). Likewise, a 6-item version of the highest loading factors used by Stamper and Johlke (2003) achieved an internal reliability score of .94. Sample items include *the organization values my contributions to its well-being* and *help is available from the organization when I have a problem*.

Using a random sample of voluntary full-time community college employees (n= 266, M_{age} =48 years, $M_{organizational\ tenure}$ = 12 years, 82% white, 43% nonacademic staff, 36% educators, 12% administrators, 10% unidentified position), Worley, Fuqua, and Hellman (2009) examined four versions of the SPOS (the original 36-item version, a 16-item version, an eight-item version, and a three-item version). Worley et al. (2009) sought to examine the underlying factor structure of the SPOS, confirm the internal consistency reliabilities of the shortened versions, examine the intercorrelations of the factor score, and lastly explore the convergent validity of the scales measuring affective commitment, organizational participation, and organizational communication. Four sets of analyses were completed. A correlation matrix confirmed only one factor should be interpreted (Worley et al., 2009) accounting for 44.14% of the variance compared to 5.05% by a second potential factor. Application of an oblique rotation confirmed the unidimensionality of the SPOS as previously established.

Reliability coefficients for all four versions were high (the original 36-item version scored Cronbach's α =.96, a 16-item version scored Cronbach's α =.95, an

eight-item version Cronbach's α =.93, and a three-item version scored Cronbach's α =.81). The item-total correlations for the total 36-item scale ranged from .33 to .83 with the item-total correlations mean =.63 and median .65. These are very similar to the original psychometrics established in 1986. Shorter versions scored similarly. The 16-item version item-total correlations ranged from .50 to .86 with a mean = .71 and a median .70. The eight-item version item-total correlations ranged from .70 to .84 with a mean =.75 and a median = .73. The three-item item-total correlations ranged from .64 to .67 with a mean =.66 and a median = .67. Strong correlations were validated between the 36-item version and both the 16-item and eight-item versions. All scales were found to be a reliable measure of POS.

Gutierrez et al. (2012) used a nine-item SPOS version consisting of nine of the highest loading items from the original 36-item version, which ranged from .74 to .83 (Eisenberger et al., 1986). This shortened version of the SPOS, which maintained good reliability (Cronbach's α = .95), is a seven-point Likert-type scale anchored from 1 (*strongly agree*) to 7 (*strongly disagree*) identical to the original scale. Questions from the original scale included numbers 4, 8, 9, 10, 17, 21, 23, 25, and 27; two items (questions 17 and 23) are reverse coded.

The SPOS shortened version used by Gutierrez et al. (2012), represents the underlying constructs being examined in the present study. It was used to control the over-all burden placed on the participant and maintain efficiency. Items 5 and 7 on the shortened SPOS were reverse scored maintaining the integrity of the original

statements. Calculation of the total mean score, obtained as per the original protocol, range from 1 to 7.

The *Survey of Perceived Organizational Support* (Eisenberger et al., 1986) was used in this study to measure CNF's perceived organizational support. It included 9 items reflecting sources organizational support. Items were scored on a 1 (*strongly disagree*) to 7 (*strongly agree*) scale and averaged to calculate the total scale mean score. Higher scores on the SPOS indicated greater degree of perceived organizational support experienced. The SPOS has been used with CNF with excellent reliability and validity (Gutierrez, 2012). In the current sample, internal consistency was high (Cronbach $\alpha = .95$) as in Gutierrez' study.

Demographic Questionnaire (Appendix H) contains items drawn from the literature relevant to this study (Andres, 2012). Personal characteristics include age, gender, and race/ethnicity. Professional characteristics include employment status, highest degree held, years in teaching, type of nursing program and program accreditation affiliation, and region. In addition, professional characteristics describing the participant at the time when failing a clinical student was under consideration include employment status, rank, highest degree held, formal preparation for teaching, certification as Clinical Nurse Educator status, primary area responsible for, number of students in the clinical group, employment in other direct patient care role, support personal, nursing program type and program accreditation affiliation, enrollment in doctoral program, years at institution, years of nursing

practice and years as CNF, the level of student who was failing the clinical practicum, and assignment of clinical failure.

The complexity of the phenomenon lent itself to further exploration of respondents' perspectives using an open-ended question as has been done in many research studies, including in nursing (Hinkin & Cutter, 2013). The open-ended question eliminated a predetermined set of limited responses. It provided an opportunity for the participants to describe their experience in their own words, including if a change in teaching practices occurred. These descriptions enhanced the researcher's understanding of CNFs' struggle to assign a failing grade and are appropriate for examining complex issues or processes (Waltz, Strickland, & Lenz, 2010).

Data Collection Procedures

Data were collected electronically from a national sample of clinical nurse faculty in the United States via SurveyMonkey™ during a 20 day period from May 28, 2014 to June 18, 2014. Participants received an electronic invitation to gain access to the encrypted study questionnaire consisting of the three individual instruments, the researcher-created demographic questionnaire, and one open-ended question. Participants accessed the questionnaire through an embedded URL link starting with "https://" indicating it is a secure encrypted connection where the participants' responses are encrypted as well. Privacy was maintained as only the researcher was able to access responses from SurveyMonkey™ by means of a security code.

Individual participants entered their responses online following the directions. Items were organized according to each instrument with three to five items on each page, which advanced as the participant advanced through the questions using the navigation buttons. A response was required for questions one through 79 which concerned role strain, faculty stress, and organizational support. Participants left clicked on a button corresponding to the desired response for the item or type a numerical response as instructed, followed by a left click on the desired navigation button (Next, Save and Exit, Done and Submit). The survey advanced by means of the 'Next' button until responses to all the items were recorded, or the participant chose to exit the survey. Responses were saved each time a respondent clicked on the 'Next' navigation button.

The last item was the open-ended question where eligible participants typed a response followed by clicking the "Done and Submit" navigation button. Eligibility was dependent on answering yes to question 106, "Did any change(s) occur in your teaching practices after your deliberation to assign a failing clinical grade?" One hundred-eighty of the eligible participants provided a written response to the open-ended question. Upon completion of the survey, a participant left clicked on the 'Done and Submit' button to submitted the survey. Participants were greeted with a 'thank you for participating' message and confirmed successful submission of the survey. A progress bar was utilized to encourage the participant to complete the survey.

Of the 6,694 potential CNF identified by Chung (2011), 50 were identified as faculty who had previously opted out of receiving emails from SurveyMonkey™, 206 were identified as no longer associated with the provided email addresses, 6,191 failed to respond, and 247 responded to the email invitation. Additionally, 367 responses initiated from the link posted on the LinkedIn discussion boards or the listserv were collected from SurveyMonkey™ Web-link Collector.

Although 614 responses were collected in total, 92 were disqualified as not meeting the eligibility criteria, and 132 were deemed incomplete and excluded from data analysis. Consequently, the final sample was 390 representing a completion rate of 63.52 %. It is impossible to estimate how many LinkedIn or listserv group members read the announcements. Subsequently, it is impossible to calculate an accurate response rate.

Electronic copies of SPSS data files, analysis output files, and personal notes were stored on USB memory stick keys to insure confidentiality. Two backup copies were created on additional USB memory stick keys and labeled as *reviewed data files*. USB memory stick keys and files related to the study (electronic and hard copies) were kept in a locked cabinet with a duplicate copy stored in a safety deposit box for safekeeping. Data was accessible exclusively to the researcher with the exception of the open-ended responses as these were reviewed in an aggregate file by two qualitative researchers to confirm themes and categories.

Data Analysis Procedure

Data were entered directly into IBM SSPS® Statistics Desktop for Windows, Version 22 (2013) through a set function of SurveyMonkey™ for analysis. Prior to conducting statistical analyses on the research data, the researcher examined all data for accuracy of data entry and outliers. Outliers were examined to determine if the data should be discarded. No errors were identified.

Descriptive Statistics of Sample Characteristics

Univariate descriptive analysis provided the researcher with a systematic view of each individual variable's quantitative data; it provided a way to organize, summarize, and view the data in graphic form (Polit, 2010). Descriptive statistics were computed to describe the sample in terms of central tendencies including means, standard deviations, and frequency distributions, percentages and graphs as appropriate for continuous and categorical variables. Variability was also assessed for the variables. Frequency tables are used to further describe the sample, particularly for categorical data.

The continuous variables included age, years teaching as CNF, years in teaching position, and number of clinical students in the clinical group at the time when the participant considered failing a clinical student. Categorical variables included gender, race/ethnicity, highest degree held, employment status, as well as those describing the same during the time of the confrontation and included formal preparation for teaching, highest degree held, employment status, rank, program type and accreditation source, region, enrollment in graduate program, level of student

who was failing the clinical practicum at the time when the participant considered failing a clinical student. Dichotomous variables included gender, Certified Nurse Educator status, employment in another direct care role, enrollment in doctoral program, and assignment of failing grade.

Normality and Linearity

Data distributions were examined for normality and linearity prior to inferential analysis. Data were statistically analyzed with statistical significance set at the 95% confidence interval level, providing a .05 level of significance ($p \leq .05$) for all statistical testing.

Descriptive Statistics of Instruments

All three instruments (RSS, FSI, and SPOS) used Likert-type scales. Descriptive statistics were used to describe the responses from participants on each of the three instruments using frequencies, central tendency and dispersion, percentages, and graphs to assist in the identification of patterns in the data and to facilitate interpretation of findings (Burns & Grove, 2009). Cronbach's alpha coefficients for internal consistency and reliability for each instrument were calculated prior to performing additional statistical analyses (Burns & Grove, 2009) and compared to previous studies.

Bivariate descriptive statistics were used to describe relationships between variables. When a relationship was suspected, correlation analysis provided a way to describe the direction magnitude of a relationship between two variables (Polit, 2010). Graphs revealed a linear relationship if one existed. A scatterplot was used

for each set of correlations to picture the relationship between two variables and determine the magnitude and direction of the relationship between the variable pairs (Hinkle, Wiersma, & Jurs, 2003). When a relationship was revealed, multivariate statistics were used when three or more variables were included in the same analyses (Polit, 2010).

Inferential Statistics to Test Hypotheses and Research Questions

Hypotheses 1, 2, and 3 are testing similar relationships and as such were addressed as a group. Both parametric and non-parametric statistical testing was done since the sample was slightly non-normally distributed. Pearson's product-moment correlation and Spearmen's rho were used to test the relationships among the key variables- perceived role strain, perceived faculty stress, and perceived organizational support. Relationships were identified in both. A linear regression further revealed the sources of variance. Additionally, determining the regression line provided a visual representation of the functional relationship between the two variables (Polit, 2010). The individual instruments were scored according to the original author; each is reported as a total mean score referred to as the mean henceforth.

Specific codes were assigned to the items appearing on the composite instrument and placed into the codebook (Andres, 2012) for clarification of individual items. Data recoding was used to recode items that required reverse scoring. Dummy coding was used with demographic variables that were grouped for statistical analysis including highest degree. Highest degree was grouped into doctorates (including all

doctoral degrees) and other (including all Master's, Baccalaureate, and Associate degrees); supporters were grouped into colleagues and administration, which included all others. Dichotomous variables, including CNE status, employment in another direct patient care role, enrollment in PhD program, primary area of responsibility, and employment status, were dummy coded to facilitate statistical analysis.

Pearson's Product-moment Correlation Coefficient

Hypotheses 1, 2, and 3 required the calculation of the Pearson's product-moment correlation coefficient (also known as Pearson's *r*) as the variables were measured on an interval level. Three assumptions were required for these analyses: the sample is a random sample of the population, the variables have a bivariate normal underlying distribution (that is the scores for each variable have a normal distribution), and the scores are homoscedastic (such that the variability of each variable is similar to one another) (Polit, 2010). However, the assumption of normality was violated as the scores were slightly skewed therefore the non-parametric analyses were also conducted using the Spearman rho correlation coefficient (Green & Salkind, 2008). Scatterplots were reviewed revealing linear relationships existed.

Pearson's product-moment correlation described the linear relationship between the two variables being tested (Hinkle et al., 2003) in terms of direction and magnitude. Pearson's *r* was computed for two variables measured on an interval scale assuming a normal distribution and a linear relationship. Since restriction of the range for the variables, low reliability of instruments, and homogeneity will affect the

size of *r*, efforts were made to avoid these. Adequate heterogeneity should provide enough variation in the scores to reveal an existing relationship.

Calculation of the correlation coefficient (*r*) revealed the extent to which two variables are related, that is the direction and magnitude of any relationship between two variables. The possible range from absolute values of 0 to 1 where .00 indicates no relationship between the variables (Polit, 2010) and 1 indicates the strongest possible relationship. The ordinal scale describes the strength of the relationship. The *r* value of ≤ .30 indicates *little correlation* if any between the variables. In contrast, an *r* value ≥ .90 indicates a very *high correlation*. A positive value indicates a positive relationship whereas a negative value indicates a negative relationship where the variables are inversely related.

Pearson's *r* indicates the magnitude of the relationship in terms of variance for each correlation. It represents the proportion of individual differences in a variable (total amount of variance) that can be associated with the other variable's individual differences (variance) (Hinkle et al., 2003) being considered in each hypothesis. The square of the correlation coefficient (r^2), known as the coefficient of determination, is the preferred measure of the magnitude of the relationship between variables (Polit, 2010). The square of the correlation coefficient (r^2) indicates the percentage or proportion of the variance in one variable that can be associated with the variance in the second variable, or the shared variance (Hinkle et al., 2003); the proportion in one variable that can be explained or accounted for by the other variable in each hypothesis.

Multiple Regression

The relationships between and among perceived role strain, perceived faculty stress, and perceived organizational support in hypothesis 4 were evaluated through computation of a multiple regression. "Multiple regression yields an equation that provides the best prediction possible, given the correlations among all the variables" (Polit, 2010, p. 224) based on a linear relationship.

In this analysis, perceived role strain represented the dependent variable while perceived faculty stress, and perceived organizational support represented the independent variables. Regression analyses were performed to examine the relationships between the key variables (perceived role strain, perceived faculty stress, and perceived organizational support). These analyses attempted to describe the amount of variance each variable contributes to the identified associations. The assumptions underlying multiple regression are multivariate normality with normal distribution, linearity, and homoscedasticity. Residual scatterplots were reviewed to assess for violation of assumptions. Outliers were carefully investigated and evaluated.

Additionally, it is necessary to avoid highly intercorrelated independent variables which lead to multicollinearity (difficulty in rejecting the null hypothesis), with misleading and difficult to interpret results (Polit, 2010). Bivariate correlations $\geq .85$ need to be carefully examined. Caution must be heeded in respect to combinations of variables and the possibility of multicollinearity. SSPS was set to avoid multicollinearity by establishing *tolerance* within SSPS analyses.

Multiple Correlation Coefficient

The multiple correlation coefficient (*R*) summarized the relationships between the variables (Polit, 2010). Similar to Pearson's *r*, *R* range is between 0.00 and +1 with higher values signifying a stronger relationship between the variables yet not providing an indication as to the direction of the relationships. *R* is always larger than the highest Pearson's *r* for the set of variables with the strongest correlation.

The multiple correlation coefficient (R^2) indicates the proportion of the variance in the dependent variable accounted for by the independent variables; R^2 also provides a way to evaluate the accuracy of the multiple regression equation since 1.0 indicates a perfect correlation with 95% certainty. The inclusion of each additional variable in the regression identifies the increased proportion of variance explained (Polit, 2010). The less correlated the variables are to one another, the larger the increment in the explained variance but the smaller the increment in the value of *R*. Effect size was calculated by means of the partial Eta squared where small effect size is .01, medium is .06, and large is .14 (Bannon, 2013).

Hypothesis 5 was tested by means of several statistical tests. T-tests were used to evaluate the differences of means scores between 2 groups, or 2 levels within the characteristic (e.g. males / females). Specifically, t-tests were performed to evaluate the differences in perceived role strain between groups in terms of assigning the failing grade as well as if any change occurred following the deliberation to assign the failing grade. Levene's test for variance equality was reviewed; failure to find significance suggested equal variance in the groups. Effect sizes (Cohen's d) were

calculated for *t*-tests found statistically significant using the online effect size calculator (http://www.uccs.edu/~lbecker/). This calculation is based on the *t*-test value for between subjects and the degrees of freedom [Cohen's $d = 2t / \sqrt{(df)}$].

One-way analysis of variance (ANOVA) of independent samples was used when the variable had two or more groups to identify if the groups mean scores differed. Skewed distributions for several characteristics (continuous variables) caused these to be collapsed into new multiple level variables (independent variables); variables included age, years practicing as RN, years teaching nursing, years in CNF role, and years employed at institution. Post-hoc comparison (Bonferroni) was not necessary to further delineate which group was significantly different as no differences were identified.

Qualitative Analysis Plan to Address Open-ended Question

Research Question: What change(s) occurred in your teaching practices after your deliberation to assign a failing clinical grade?

Respondents' written responses ($n = 170$) varied from 2 to 307 words. The responses were analyzed by means of conventional content analysis, a data analysis strategy used in a variety of disciplines including nursing, to analyze qualitative data in a consistent, systematic and objective way (Waltz et al., 2010). The NVivo platform within Survey Monkey™ was used to analyze the text and assign categories. Frequencies were calculated.

Preliminary analysis of reading through all open-ended responses provided the researcher an opportunity to consider the data's contribution to the overall study

(O'Cathain & Thomas, 2004). Conventional content analysis (Busch, De Maret, Flynn, Kellum, Le, Meyers... Palmquist, 2012) allowed the researcher to generate categories, and themes from the respondents' responses. This categorical scheme explicitly linked the conceptual background with the qualitative data, provided frequency, intensity, and nature of the characteristics, and formed the foundation for inferences and conclusions (Waltz et al., 2010).

All responses were read and reread to reveal their essence and core concepts (Polit & Beck, 2012), analyzed, grouped, and coded into categories according to words and phrases (Waltz et al., 2010). A coding frame facilitated the identification of patterns and themes (Burns & Grove, 2009; O'Cathain & Thomas, 2004). Categories and sub-categories were formed.

No a priori categories were established; categories were derived directly from the data in an effort to maintain the integrity of the data limiting constraint or bias. Two expert, qualitative PhD prepared CNF served as the external reviewers to review the findings for appropriateness and confirm dependability. Results are reported in aggregate form with frequencies reported and verbatim comments to illustrate themes while maintaining confidentiality (O'Cathain & Thomas, 2004).

Summary

A descriptive correlational design was used to examine the relationships among perceived role strain, perceived faculty stress, and perceived organizational support for CNF who have faced the decision to assign a failing grade to a student in a clinical practicum within the past six years. A four-part survey consisting of the

RSS, FSI, and POS, and researcher-created demographic questionnaire was administered online via SurveyMonkey™ to a convenience sample of CNF. The data was automatically uploaded into SSPS®, the statistical software for analyses through a function on SurveyMonkey™. Data were reviewed and evaluated for violations of assumptions. Descriptive statistics, bivariate, and multivariate statistics were completed on the collected quantitative data including *t*-tests, ANOVAs, correlations, linear regression, and multiple regressions. Effect sizes were calculated for significant *t*-tests. Conventional content analysis was applied to data reported in open-ended responses. The NVivo platform within Survey Monkey™ was used to analyze the text. Results and findings were interpreted and reported.

Chapter IV

FINDINGS

Introduction

The purpose of this descriptive correlational study was to explore the relationships between perceived role strain, perceived faculty stress, and perceived organizational support for CNF who have faced the decision to assign a failing grade to a student in a clinical practicum. A cross-sectional survey design was used, data collected at a single point in time; no attempt was made to manipulate any of the study variables. The study instrument consisted of 107 questions (106 closed questions and 1 open-ended question) related to role strain, faculty stress, perceived organizational support, and several demographic characteristics. This chapter presents an overview of the data collected using narrative and tabular descriptions of the findings. Following the presentation of the data, a review of the statistical testing is presented. Lastly, the statistical analyses and results of the research questions are presented.

Mean total scores, standard deviations, Cronbach's coefficient alpha, scale statistics including mean, variance, standard deviation, and inter-item correlations were calculated for *Role Strain Scale* (RSS), *Faculty Stress Index* (FSI), and the *Survey of Perceived Organizational Support* (SPOS). The demographic data describing the sample included personal characteristics such as location, age, gender,

and race/ethnicity. Professional characteristics included employment status, highest degree held, years in teaching, type of nursing program and program accreditation affiliation, and institutional regional location. In addition, professional characteristics describing the participant at the time when failing a clinical student was under consideration and included employment status, rank, highest degree held, formal preparation for teaching, certification as Clinical Nurse Educator status, primary area responsible for, number of students in the clinical group, employment in other direct patient care role, supportive personal, nursing program type and program accreditation affiliation, enrollment in doctoral program, years at institution, years of nursing practice and years as CNF, the level of student who was failing the clinical practicum, and assignment of clinical failure.

Presentation of Results

Data were collected during a 20 day period in late May to early June 2014 from a national sample of clinical nurse faculty (CNF) in the United States. The sample consisted of CNF over the age of 18, who functioned full-time or part-time in CNF role at an accredited nursing program within the past 8 years, and were able to understand and read English. Study participants were recruited from a pool of 6,694 nursing faculty members at 660 CCNE public and private accredited nursing programs within the United States (Chung, 2012), and through memberships of CNF in LinkedIn groups and the Nurse Educator listserv. Although initially 614 individuals accessed the online survey, the final sample consisted of 390, a 63.52%

completion rate. Given the nature of the study design, it is impossible to calculate an accurate response rate as previously mentioned.

Univariate Analyses

This national sample of 390 CNF were predominantly women (*n* = 366, 93.8 %) who largely identified themselves as Caucasian/White (*n* = 348, 89.2 %). The remaining CNFs identified their ethnicity/race as a minority. Hispanic/Latino were identified more often (*n* = 10, 2.6 %) followed by African American (*n* = 7, 1.8 %), multi-racial (*n* = 5, 1.3 %), Asian and Mediterranean (each *n* = 3, 0.8%), Black/Islander and American Indian/ Alaskan Native (each *n* = 1, 0.3%), and lastly 12 participants (3.1 %) preferred not to disclose their ethnicity. The participants ranged in age from 29 to 75 years (*M* = 53.6, *SD* 9.17), with the median age of 55 years, and mode of 58 years.

Sample participants were from institutions in all regions of the United States (Evans, 2013) with the largest faction from the Northeast (*n* = 127, 32.6 %) and the fewest participants from the Northwest (*n* = 15, 3.8 %). These findings are reasonable given that the Northeast has the greatest number of nursing programs (*n* = 154) and the Northwest has the fewest (*n* = 24). Table 4.1 further describes gender and regions.

Table 4.1

Gender and institutional regional location (N= 390)

Characteristic	*n*	%	Number of CCNE accredited programs
Gender			
Females	366	93.8	
Males	24	6.2	
Institution regional location			
Northeast (ME, VT, NH, MA, CT, RI, NY, NJ, PA)	127	32.6	154
Southeast (MD, DE, DC, VA, WV, NC, SC, GA, FL)	63	16.2	125
North Central (ND, SD, MN, WI, MI)	22	5.6	71
Central (NE, IA, KS, MO, IL, IN, OH)	30	7.7	152
South Central (OK, AR, TX, LA, KY, TN, MS, AL)	48	12.3	128
Northwest (WA, OR, MT, ID, WY, AK)	15	3.8	24
Southwest (CA, NV, UT, AZ, CO, NM, HI)	85	21.8	81

The sample was principally full-time employees (n = 314, 80.5 %) with part-time faculty (*n* = 28, 7.2%), adjunct faculty (*n* = 35, 9 %), retired faculty (*n* = 9, 2.3 %), and participants reporting no longer in academia (*n* = 4, 1 %) represented. The participants were generally experienced CNF having taught nursing for an average of 14.54 years (*SD* 9.67, median = 11 years, mode = 10 years); several taught for as long as 48 years. The highest degree held was nearly evenly split between a Master's degree (*n* = 192, 49 .2%) and a doctoral degree (*n* = 189, 48.46 %). Eight participants reported their highest degree as a BSN. Surprisingly, one participant reported the highest degree as an Associate in Art. Table 4.2 further delineates these sample characteristics.

Table 4.2

Highest degree currently held (N= 390)

Characteristic	*n*	%
Highest degree currently held		
Associate in Art	1	0.3
Bachelors	8	2.1
Master's in nursing	4	1.0
Master's clinical focus	76	19.5
Master's educational focus	84	21.5
Master's administrative focus	16	4.1
Master's non-nursing	2	0.5
Master's Public Health	1	0.3
Master's not specified	9	2.3
DNP	58	14.9
PhD in nursing	89	22.8
PhD non-nursing	22	5.6
EdD in Nursing	3	0.8
EdD non-nursing	15	3.8
DScN	2	0.5

Faculty members reported teaching currently in a variety of nursing programs including undergraduate and graduate programs. The majority of the sample reported currently teaching in Baccalaureate programs (*n* = 285, 73.10 %) with the fewest teaching in Diploma programs (*n* = 6, 1.5 %). Several CNF (*n* = 94, 24.1 %) identified teaching in both an undergraduate and a graduate program. Graduate programs included Master's, PhD and DNP. The CCNE was the predominant accrediting body for programs that participants taught in (*n* = 301, 77.2 %) whereas

71 programs (18.2 %) were accredited by the NLNAC, 41 programs (10.5 %) were accredited by ACEN, 8 (2.1 %) were not accredited, and 24 (6.2 %) participants reported not remembering. Table 4.3 further describes these sample characteristics.

Table 4.3

Current programs and accreditation source (N = 390)

Characteristic	*n*	%
Type of nursing program currently teaching in		
Diploma	6	1.5
Associate	44	11.3
Baccalaureate	285	73.1
Master's	148	37.9
PhD	28	7.2
DNP	71	18.2
Current nursing program accrediting body		
CCNE	301	77.2
NLNAC	71	18.2
ACEN	41	10.5
Not Accredited	8	2.1
Do not remember	24	6.2

Three hundred thirty-two participants (85.1 %) were employed full-time, whereas 58 (14.9%) participants were part-time. The predominant roles reported were instructor (*n* = 152, 39 %) or assistant professor (*n* = 134, 34.4%). Other roles identified included associate professor (*n*= 64, 16.4 %), professor (n = 24, 6.2 %), lecturer (n = 6, 1.5%), faculty associate (*n* = 3, 0.8%), course coordinator (*n* = 2, 0.5 %), administrator (*n* = 1, 0.3 %), other (*n* = 2, 0.5%), and Clinical Nurse Educator (*n* = 1, 0.3%). The highest degree held at the time when a failing grade was under

deliberation was a graduate degree, specifically a doctoral degree (*n* = 129, 33.08 %), followed by a Master's degree with a clinical focus (*n* = 111, 28.5 %) or educational focus (*n* = 103, 26.4 %). A Master's degree was held by 64.61% (*n* = 252) of CNF. Table 4.4 further depicts the highest degree held at the time of deliberation.

Table 4.4

Highest degree held at time of deliberation (N = 390)

Characteristic	*n*	%
Associate in Art	1	0.3
Bachelors	15	3.8
Master's in nursing	6	1.5
Master's clinical focus	111	28.5
Master's educational focus	103	26.4
Master's administrative focus	24	6.2
Master's not specified	3	0.8
Master's not in nursing	5	1.3
DNP	29	7.4
PhD in nursing	58	14.9
PhD not in nursing	18	4.6
EdD in Nursing	4	1.0
EdD not in nursing	9	2.3
DScN	2	0.5
Other not specified	2	0.5

Participants in this sample taught in all types of nursing programs at the time of deliberation with the majority having taught in Baccalaureate programs (*n* = 276, 70.8%), followed by Master's programs (*n* = 113, 29%), Associate programs (*n* = 58, 14.9%), DNP programs (*n* = 24, 6.2%), Diploma programs (*n* = 13, 3.3%), and PhD programs (*n* = 12, 3.1%). Nearly 17% (*n* = 65) of the sample taught in both

undergraduate and graduate programs. Programs were accredited by CCNE (*n* =286, 73.3 %), NLNAC (*n* = 97, 24.9%), ACEN (*n* = 35, 9%), or a combination of one to three accreditations (*n* = 54, 13.85 %). Twenty-seven participants reported not knowing their program's accreditation source. See Table 4.5 for further delineation.

Table 4.5

Accreditation sources at time of deliberation (N= 390)

Program type	*n*	%
Accreditation Sources		
Commission on Collegiate Nursing Education (CCNE)	286	73.3
National League for Nursing Accrediting Commission (NLNAC)	97	24.9
Accreditation Commission for Education in Nursing (ACEN)	35	9.0
Multiple Accreditation Sources		
CCNE, NLNAC, ACEN	7	1.8
CCNE, NLNAC	34	8.7
CCNE, ACEN	11	2.8
NLNAC, ACEN	2	0.5
Do not know	27	6.9

The participants (N =390) reported practicing as a Registered Nurse on average 23.85 years (SD 10.14, Median = 25, Mode = 20, range 2 - 50 years) whereas on average the participants were employed as a CNF for 8.85 years (SD 8.3, Median 6, Mode = 2, range < 6 months to 46 years). The average tenure time at the institution where deliberation to assign a failing grade occurred for this sample was 6.18 years (SD 6.49, Median = 4, Mode = 2, range months to 48 years).

For the most part, participants engaged in one to several activities in preparation for the CNF role. A preponderance of CNF (*n* = 279, 71.5%) attained a

graduate degree, 56.7% (*n* = 221) had taken courses related to education, 62.1% (*n* = 242) attended faculty development courses, 64.4% (*n* = 251) attended professional conferences, and 12.1% (*n* = 47) attained a Post Master's Certificate. Two hundred fifty-three (64.4%) identified 'orientation to the faculty role' as preparation for the CNF role. A limited number of participants (*n* = 53, 13%) had taken courses to become certified nurse educators, and 8.5% (*n* = 33) were Certified Nurse Educators. A meager group of participants (*n* = 17, 4.4%) reported no preparation prior to assuming the role of CNF.

In this sample, the majority (*n* = 289, 74.1%) of participants were not enrolled in a doctoral program during the time when they deliberated assigning a failing grade, however, 101 (25.9 %) participants reported enrollment in a doctoral program during the time when they deliberated. Participants identified their primary area of responsibility as both classroom and clinical (*n* = 322, 82.6 %). Slightly less than half (*n* = 186, 47.7%) were employed in another direct patient care role in addition to teaching. Table 4.6 further delineates these characteristics.

Table 4.6

Area of primary responsibility, other employment at time of deliberation (N= 390)

Characteristic	*n*	%
Primary area of responsibility		
Clinical only	68	17.4
Classroom and Clinical	322	82.6
Employed in another direct patient care role in addition to teaching		
Yes	186	47.7
No	204	52.3

Participants frequently identified more than one individual who was supportive throughout the deliberation process. Most often participants identified colleagues (*n* = 313, 80.3%) as individuals who offered support. Additional individuals identified included Chairperson (*n* = 196, 50.3%), Dean (*n* = 110, 28.2%), administrators other than the Dean (*n* = 103, 26.4 %), and mentor (*n* = 76, 19.5%). Eleven participants (2.8%) preferred not to say.

The number of students in a clinical group varied from one to 20 (*N*= 272, *M* = 8.79, *SD* 2.55; Median = 8; Mode = 8). Approximately 39% (*n* = 144) of the sample was responsible for 8 clinical students during the time when experiencing deliberation to assign a failing grade. Eighteen participants indicated they could not remember the exact number of students in the clinical group; these participants were excluded from the statistical analyses for this variable only (see Table 4.7).

Table 4.7

Number of students in the clinical group (N = 372)

Number of clinical nursing students	*n*	%
1	2	0.5
2	1	0.3
3	1	0.3
4	3	0.8
5	8	2.2
6	35	9.4
7	25	6.7
8	144	38.7
9	21	5.6
10	88	23.7
11	4	1.1
12	24	6.5
13	1	0.3
14	2	0.5
15	3	0.8
17	1	0.3
18	4	1.1
19	2	0.5
20	3	0.8

Participants reported all levels of students as failing a clinical nursing practicum (see Table 4.8). Participants mainly identified junior (*n* = 134, 34.3%) and senior (*n* = 133, 34.1%) students although freshmen (*n* = 28, 7.2%), sophomores (*n* = 27, 6.9%), Clinical Nurse Leader students (*n* = 3, 0.8 %), Accelerated students (*n* = 4, 1 %), ADN students (*n* = 3, 0.8 %), and graduate students (*n* = 53, 13.6%) were also identified. Specifically, junior and senior students in their second semesters were the

largest groups identified (*n* = 75, 19.2% and *n* = 71, 18.2 % respectively). The overwhelming majority (n = 322, 82.56%) of the failing students were junior, senior, and graduate students. Five participants (1.3%) did 'not remember' the students' level.

Table 4.8

Level of student failing clinical practicum (N = 390)

Level of student failing clinical practicum	*n*	%
Undergraduate Students		
ADN in first year	2	0.5
ADN in second year	1	0.3
Freshman	28	7.2
Sophomore	27	6.9
Junior first semester	59	15.1
Junior second semester	75	19.2
Senior first semester	62	15.9
Senior last semester	71	18.2
Clinical Nurse Leader	3	0.8
Accelerated	4	1.0
Graduate Students		
Graduate preparing for a clinical role	51	13.1
Graduate preparing for a NON- clinical role	2	0.5

The majority of the sample reported assigning the failing grade (*n* = 322, 82.6%) whereas 17.4% (*n* = 68) failed to assign the earned grade. More than half the sample (*n* = 207, 53.1 %) reported no changes in their teaching practices following the deliberation to assign a failing grade. In contrast, 183 participants (46.9%) reported changes in their teaching practices following the deliberation to assign a

failing grade. Of these, 179 (97.8 %) participants responded to the open-ended question.

Normality and Linearity

Several frequency histograms revealed the sample appeared skewed to varying degrees. Additionally, normal probability plots, labeled as Normal Q-Q plots, were examined. Several of the Q-Q plots for the variables appeared as nearly a straight line.

Data were statistically analyzed with statistical significance set at the 95% confidence interval level, providing a .05 level of significance ($p \leq .05$) for all statistical testing. Nearly all tests of normality, specifically the Kolmogorov-Smirnov, were significant indicating the sample was not normally distributed (i.e. age: Kolmogorov-Smirnov = .102, *df* 390, $p = .000$) (see Table 4.9). This finding suggests a violation of the assumption of normality in this large sample.

Table 4.9

Sample characteristics indicative of violating normality if sample <200 (N= 390)

Characteristic	Kolmogorov-Smirnov	*p*	Skewness	Std. Error of Skewness	Kurtosis	Std. Error of Kurtosis
Age	.102	.000	-0.537	.124	-.119	.247
Yrs taught	.165	.000	1.043	.124	.462	.247
Yrs as CNF	.196	.000	2.240	.124	6.917	.247
Yrs as RN	.064	.001	-0.029	.124	-.616	.247
Yrs employed at institution as CNF	.178	.000	1.560	.124	2.406	.247

Note. *df* = 390.

However, Pallant (2013) and others contend the tests of normality are "too sensitive with large samples" (p. 59). Tabachnick and Fidell (2013) argue "in a large sample, a variable with statically significant skewness often does not deviate enough from normality to make a substantive difference in the analysis" (p. 80). Tabachnick and Fidell (2013) further argue the risk for underestimation of variance related to a negative kurtosis disappears in large samples of more than 200.

Additionally, normality was reviewed in terms of the ratio between skewness and the standard error of skewness as well as kurtosis and the kurtosis standard error (Bannon, 2013). A ratio value of approximately two or less implies the sample is normally distributed. As such, if either skewness or kurtosis reported as less than two to three times the standard error of the respective measure, than the sample is assumed to be normally distributed (see Table 4.10). Several characteristics of the sample are identified as non-normal distribution including age, years taught nursing, years employed at institution, and years employed as CNF. Scores obtained for the RSS, FSI and SPOS were determined to be normally distributed.

Table 4.10

Evaluation of sample normality via ratios (N= 390)

Characteristic	Skewness	Ratio	Kurtosis	Ratio
Age	-.537	4.33	-.119	0.48
Yrs as RN	-.029	2.34	-.616	2.49
Yrs taught	1.043	8.41	.462	1.87
Yrs as CNF	1.560	12.58	2.406	9.74
Yrs employed at institution	2.240	18.07	6.920	8.02

Note. Standard Error of Skewness = .124; Twice Standard Error of Skewness = .248. Standard Error of Kurtosis = .247; Twice Standard Error of Kurtosis = .494.

The data were furthermore examined carefully for outliers. Histograms were reviewed for isolated extreme scores, and boxplots were examined. No scores were identified by SPSS as extreme points defined as three box-lengths from the edge of the boxplot. However, SPSS did identify several scores more than 1.5 box-lengths from the edge of the box assumed to be outlier scores. These scores were further examined.

After calculation of the means, scores were evaluated. As per Pallant (2013), means and 5% trimmed means were evaluated to determine if the extreme scores had a strong influence on the mean (Pallant, 2013). The trimmed mean was compared to the sample mean for each of these characteristics (see Table 4.11) with very little variation identified. For instance, the trimmed mean for age (53.87) remained very similar to the sample mean (53.60) both within the 95% Confidence Interval of 52.69

- 54.51. The means were all very similar therefore no outliers were excluded (see Table 3.1). Careful evaluation of these scores revealed these scores were those of CNF with either minimal or extensive years of experience. This researcher determined both extremes were of interest in the current study.

Table 4.11

Sample characteristics: Means compared to Trimmed Means (N= 390)

Characteristic	Mean	SD	Trimmed Mean	Change	95% Confidence Level
Age	53.60	9.17	53.87	+.27	52.69 - 54.51
Yrs as RN	23.85	10.14	23.85	.00	22.84 - 24.86
Yrs taught	14.54	9.67	13.87	-.67	13.58 - 15.50
Yrs as CNF	8.85	8.30	7.98	+.87	8.02 - 9.68
Yrs employed at institution	6.18	6.49	5.43	+.75	5.54 - 6.83

Alternatively, Bannon (2013) suggests defining outliers as values that are greater than or less than two standard deviations from the mean. Several scores were identified as greater than two standard deviations (see Table 4.12).

Table 4.12

Sample characteristics: Raw mean intervals plus or minus 2SD to identify outliers (N = 390)

Characteristic	Mean	SD	2SD	Low Interval	High Interval	Scores Range	# Cases (n/ %) < 2SD	# Cases (n/ %) >2SD
Age	53.60	9.17	18.34	35.26	71.94	29 - 75	14/ 3.6	4/1.1
Yrs as RN	23.85	10.14	20.28	3.57	44.13	2 - 50	1/ 0.3	5/1.4
Yrs taught	14.54	9.67	19.30	-4.80	24.11	1 - 48	0	69/14.6
Yrs as CNF	8.85	8.30	16.60	-7.75	25.45	0 - 46	0	15/ 3.9
Yrs employed at institution	6.18	6.49	12.98	-6.80	19.16	0 - 48	0	15/ 3.9

Note. Score range: Less than 6 months was indicated with 0.

Scores were reviewed by comparing the statistical analyses before and after the outliers are removed to see if the values differed; in this study, the results remained similar (see Table 4.13).

Table 4.13

Sample characteristics: With and without outliers included in analysis

Characteristic	Outliers Included (N = 390)				Outliers Excluded (N = 372)			
	Mean	SD	Median	Mode (n, %)	Mean	SD	Median	Mode (n, %)
Age	53.60	9.17	55	58 (27, 6.9)	54	8.07	56	58 (27, 7)
Yrs as RN	23.85	10.14	25	20 (40, 10.4)	23	9.98	24	20 (40, 10.4)
Yrs taught	14.54	9.67	11	10 (45, 11.6)	14	9.36	11	10 (45, 11.5)
Yrs as CNF	8.85	8.30	6	2 (40, 10.3)	8	7.74	6	2 (40, 10.4)
Yrs employed at institution	6.18	6.49	4	2 (54, 13.8)	6	6.33	4	2 (54, 14)

Despite removal of the outliers, the Kolmogorov- Smirnov and Shapiro-Wilk tests of normality remained significant indicating the large sample remained non-normal. In an attempt to address the non-normal distribution, data transformation was performed yielding a persistent non-normal distribution. Therefore, the decision was made to use the data in the original format but to collapse several significantly skewed continuous variables into categorical variables to facilitate statistical testing (see Table 4.14). Categories were determined by dividing the original data approximately into thirds thereby maintaining the mean in the middle group and attempting to retain similarly sized groups.

Table 4.14

Continuous variables collapsed into categories (N= 390)

Variable	Category	n	%
Age	29 - 48	95	24.9
	49 - 60	209	46.4
	61 - 75	86	28.7
Years as RN	2 -19	122	30.5
	20 - 29	140	35.9
	30 - 50	128	33.6
Years taught nursing	1 - 8	101	31.4
	9 - 16	140	36.4
	17 - 48	149	32.2
Years employed as CNF	≤ 3	123	31.9
	4 -10	150	39.0
	11 - 46	114	29.1
Years employed at institution	≤2	126	32.7
	3 - 6	139	36.1
	7 - 48	125	31.2

As previously mentioned, several statisticians argue a large sample is not significantly influenced by skewness such that no substantive difference is evident in analysis testing (Tabachnick & Fidell, 2013). Accordingly, this researcher opted to explore the results of parametric and non-parametric statistical tests. Statistical testing was completed with the raw data as well as the collapsed groups; no significant differences resulted. It is interesting to note, the Spearman rho correlation coefficient was very similar to the Pearson's *r* in correlation calculations for

hypotheses 1, 2, and 3. This was attributed to the large sample size as previously mentioned.

Description of Major Study Variables

The online survey administered electronically via Survey Monkey™ consisted of the three research instruments, the Role Strain Scale (RSS), Faculty Stress Index (FSI), and Survey of Perceived Organizational Support (SPOS). The distribution of scores was evaluated for violation of normality. Bell curves were reviewed with little abnormality observed. Tests of normality were statistically significant inferring the sample was abnormally distributed (see Figure 3).

Figure 3. Tests of normality for RSS, FSI, SPOS.

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
RSS	.049	390	.026	.994	390	.112
FSI	.060	390	.002	.980	390	.000
SPOS	.069	390	.000	.972	390	.000

a. Lilliefors Significance Correction

*Figure 3***.** Tests of normality for RSS, FSI, and SPOS revealed significance for all instruments regardless of test reviewed.

However, as previously argued, a ratio comparison failed (see Table 4.9) to reveal a significant violation to skewness and kurtosis (see Table 4.10) inferring the sample was normally distributed. Boxplots and Q-Q Plots were reviewed. A single outlier 1.5 boxplot distances from the edge of the boxplots was observed on RSS and

FSI; neither outlier was eliminated as it was deemed to not exert undue influence based on the large sample size.

Perceived Role Strain. The *Role Strain Scale* (RSS, Oermann, 1998a) was used to measure CNF's perceived role strain. It included 23 items reflecting sources of role strain. Items were scored on a 1 (*never*) to 5 (*nearly all the time*) scale and averaged to calculate the total scale mean score. Higher scores reflected higher perceived role strain. The RSS was previously used in CNF populations with good reliability and validity (Clark, 2013; Oermann, 1998a). In the current study, internal consistency was excellent (Cronbach $\alpha = .93$) similar to that reported by Oermann (1998a) and Mobily (1987). Total scale scores ranged from 23 to 105 scale units ($M = 68.58$, SD 14.94, median 69, mode 64). Mean scores ranged from 1.00 to 4.52 scale units ($M = 2.96$, SD .67, CI 2.89 - 3.03, median 2.95).

Perceived Faculty Stress. The *Faculty Stress Index* (FSI, Gmelch, 1984) was used to measure the degree of perceived faculty stress experienced by CNF. It included 45 items reflecting potential sources of faculty stress. Items were scored on a 0 (*never*) to 5 (*excessive pressure*) scale and averaged to calculate the total scale mean score. Higher scores on this scale indicated higher degrees of perceived faculty stress. The FSI has been used with faculty in a wide variety of disciplines with good reliability and validity (Gmelch et al., 1984). In the current study, internal consistency was higher than previously reported (Cronbach $\alpha = .97$). Total scale scores ranged from 4 to 213 scale units ($M = 83.52$, SD 42.58, median 80.5, mode

47). FSI mean scores ranged from .09 to 4.52 scale units (*M* = 1.88, *SD* .95, CI 1.76 - 1.95, median 1.79).

Perceived Organizational Support. The *Survey of Perceived Organizational Support* (SPOS, Eisenberger et al., 1986) was used to measure CNF's perceived organizational support. It included 9 items reflecting sources organizational support. Items were scored on a 1 (*strongly disagree*) to 7 (*strongly agree*) scale and averaged to calculate the total scale mean score. Higher scores on the SPOS indicated greater degree of perceived organizational support experienced. The SPOS has been used with CNF with excellent reliability and validity (Gutierrez, 2012). In the current study, internal consistency was excellent (Cronbach α = .95). Total scale scores ranged from 9 to 63 scale units (*M* = 39.28, *SD* 13.65, median 41, mode 34). SPOS mean scores ranged from 1 to 7 (*M* = 4.36, *SD* 1.52, CI 4.21 - 4.52, median 4.56).

Analysis of the Research Questions

The first research question asked, what are the relationships between and among role strain, faculty stress, and perceived organizational support for CNF faced with a decision to assign a failing grade to a nursing student in a clinical practicum? Five null hypotheses were posed. Bivariate descriptive statistics were used to describe relationships between the major variables- perceived role strain, perceived faculty stress, and perceived organizational support.

Hypothesis 1. The null hypothesis of no relationship between perceived role strain and perceived organizational support for CNF faced with a decision to assign a failing clinical grade was rejected as a significant inverse association between

perceived role strain (measured by RSS) and perceived organizational support (measured by SPOS) was revealed for CNF faced with a decision to assign a failing clinical grade. Preliminary analyses disclosed no violation to the assumptions of normality, linearity, and homoscedasticity. The scatterplot identified a linear relationship between perceived role strain and perceived organizational support as well as a modest, negative correlation between these variables (see Figure 4). Pearson's product-moment correlation was used to investigate this relationship. A strong inverse relationship (r = -.601, n = 390, p = .000) was identified. Low levels of perceived organizational support were associated with high levels of perceived role strain such that as perceived organizational support decreased, perceived role strain increased proportionally.

Figure 4. Correlational scatterplot: RSS and POS

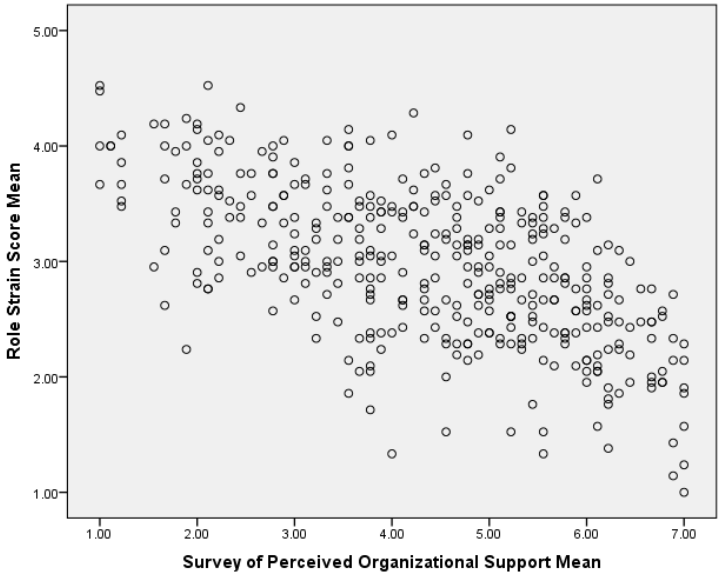

Figure 4. This scatterplot of RSS and POS suggests an inverse relationship between the two constructs.

Hypothesis 2. Similarly, the null hypothesis of no relationship between perceived role strain and perceived faculty stress for CNF faced with a decision to assign a failing clinical grade was rejected. Preliminary analyses revealed no violation to the assumptions of normality, linearity, and homoscedasticity. The scatter plot clearly suggested a strong positive relationship (see figure 5). Subsequently, Pearson's product-moment correlation was used to explore this relationship. A significantly strong positive relationship (r = .822, n = 390, p = .000) was identified between perceived role strain (as measured by RSS) and perceived faculty stress (as measured by FSI) for CNF faced with a decision to assign a failing clinical grade. As perceived faculty stress increased, perceived role strain increased likewise. This was the strongest relationship between perceived role strain and the major variables.

Figure 5. Correlational scatterplot: RSS and FSI

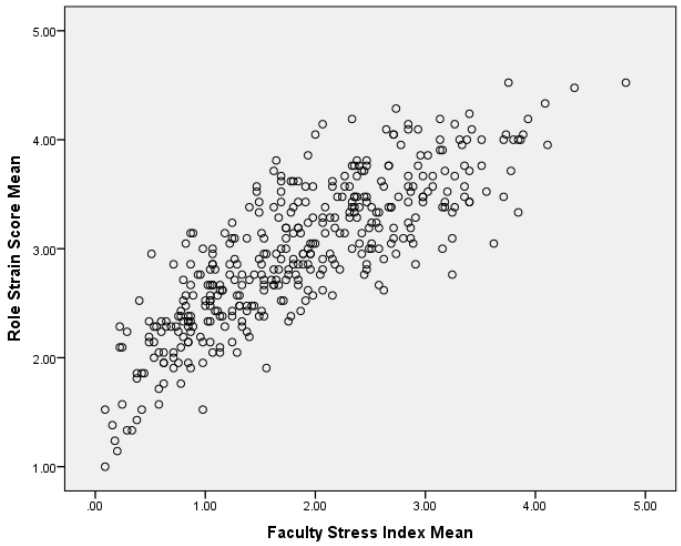

Figure 5. This scatterplot of RSS and FSI suggests a strong positive relationship between the two constructs.

Hypothesis 3. The null hypothesis of no relationship between perceived faculty stress and perceived organizational support for CNF faced with a decision to assign a failing clinical grade was also rejected. Once again, preliminary analyses ensured assumptions of normality, linearity, and homoscedasticity were not violated. The scatterplot revealed a moderately strong negative relationship (see Figure 6); Pearson's product-moment correlation was used to examine this relationship as well. A moderately strong, significant inverse relationship (r = -.613, n = 390, p = .000) was identified between perceived faculty stress (measured by the FSI) and perceived organizational support (measured by the SPOS) for CNF faced with a decision to assign a failing clinical grade, with low levels of perceived organizational support associated with high levels of faculty stress. That is to say, as the perceived organizational support decreased, faculty stress significantly increased.

Figure 6. Correlational scatterplot: POS and FSI.

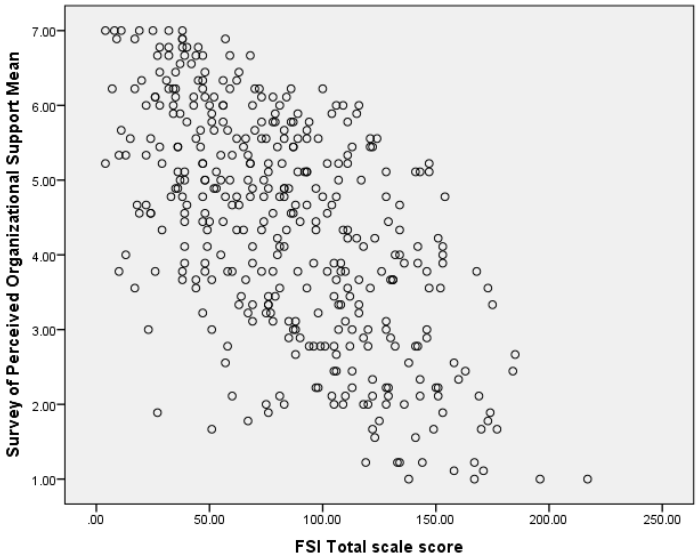

Figure 6. Scatterplot suggests a strong inverse relationship between the constructs.

Hypothesis 4. The null hypothesis of no relationships between and among perceived role strain, perceived organizational support, and perceived faculty stress for CNF faced with a decision to assign a failing clinical grade was also rejected. The scatterplot distribution was rectangularly shaped with most scores concentrated towards the center and was absent of outliers defined by Tabachnick and Fidell (2013) as values more than or less than 3.3 in the standardized residual (see Figure 7). Additionally, the Normal P-P Plot formed a straight line for the bottom left to the top right suggesting no deviation from normality (Pallant, 2013) (see Figure 8). Lastly, the Mahalanobis distance (11.331) provided by SPSS is below the critical value (16.27) indicative of outliers present. In conclusion, a normal distribution was assumed; assumptions of linearity, and homoscedasticity were not violated.

Figure 7. RS Regression Scatterplot

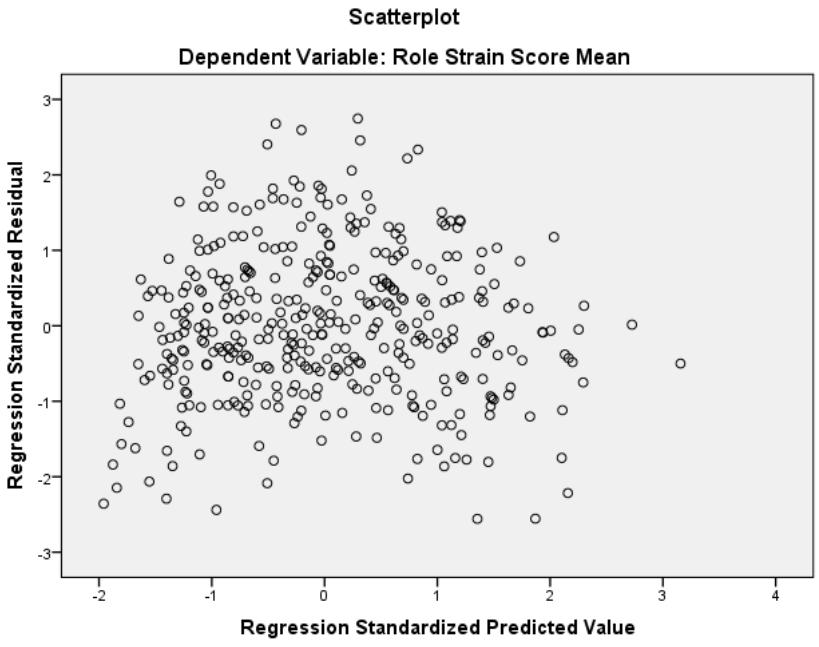

Figure 7. No outliers > 3.3 SD revealed on the scatterplot.

Figure 8. RS regression P-P Plot

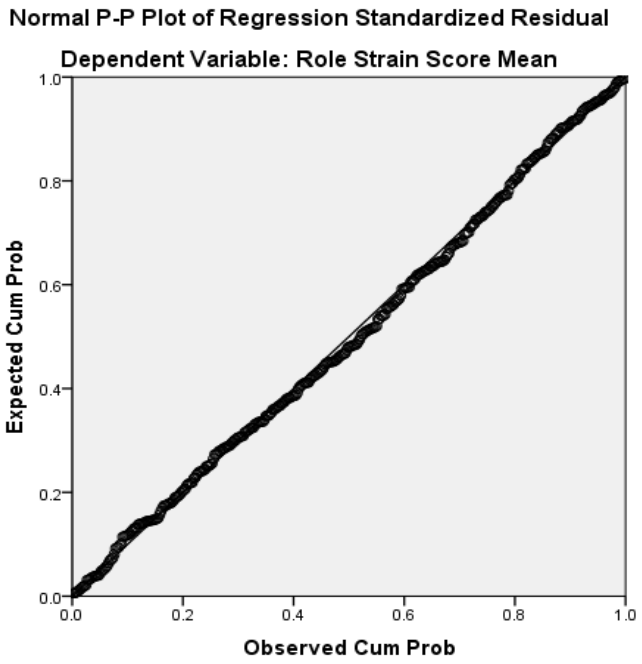

Figure 8. RS regression P-P Plot confirmed no concern for deviation from normal.

A multiple regression analysis was employed to further explore the relationships among the major variables. Preliminary analyses conducted ensured no assumptions (normality, linearity, multicollinearity, and homoscedasticity) were violated. Multicollinearity was assumed absent as the previously calculated Pearson's product-moment correlation were < .9, the tolerance values are >.10, and the Variance inflation factor (VIF) was 1.6 which is well below 10 (Pallant, 2013). A standard multiple regression analysis revealed relationships between and among the dependent variable perceived role strain (measured by the RSS), and the independent variables of perceived organizational support (measured by the SPOS) and perceived faculty stress (measured by FSI) for CNF faced with a decision to assign a failing

clinical grade; specifically, how much variance in perceived role strain can be explained uniquely by perceived faculty stress and perceived organizational support. Furthermore, the analysis revealed the relative contribution of each of these.

All variables were entered simultaneously into the model. Table 4.15 displays the correlations between the variables (r), the standardized regression coefficients (β), the part correlation coefficient (sr_i^2), and R^2. The regression model was significantly different from zero, F (2, 387) = 433.738, p = .000, power .99 with R^2 at .69. Power values were calculated using the G*Power program. Both variables' contributions were statistically significant. Faculty stress is the major unique contributor to perceived role strain (β = .727, p = .000) making a significant contribution to perceived role strain when POS is controlled for. In contrast, perceived organizational support made a minor significant contribution (β = -.156, p = .000) to the CNF's perceived role strain.

Table 4.15

Standard Multiple Regression of perceived role strain, perceived faculty stress, perceived organizational support (N = 390)

Variables	RS	FS	POS	Unstandardized coefficients B	Standardized coefficients Beta (β)	Part correlations (sr_i)	(sr_i^2)
RS	1						
FS	.822**	1		.512	.727	.574	.329
POS	-.601**	-.613**	1	-.069	-.156	-.124	.015
Mean	2.96	1.86	4.36				
SD	.67	.95	1.52				

Note. **p <.000 RS is perceived RS measured on Role Strain Scale (Oermann, 1998); FS is perceived FS measured on Faculty Stress Index (Gmelch, 1984); POS is measured on Survey of Perceived Organizational Support (Eisenberger, 1986).

The regression model explained 69.2% (R^2 = .692, p = .000) of the shared variance due to perceived faculty stress and perceived organizational support. The adjusted R^2 (.69) indicates more than two-thirds of the variability in perceived role strain is explained by perceived faculty stress and perceived organizational support. The multiple correlation coefficients were calculated for perceived faculty stress ($.574^2$) and perceived organizational support ($-.124^2$) as was the effect size (partial Eta squared, η^2) for each variable. The unique contribution of perceived faculty stress was 32.9% indicating perceived faculty stress is a larger unique contribution to perceived role strain when the overlap is removed. The unique contribution of perceived organizational support was calculated as 1.5% of the variance when

isolated. Perceived faculty stress had a much larger effect size of .737 compared to perceived organizational support which measured a moderate effect size of .069.

In summary, perceived faculty stress accounted for 32.9% of the variance in perceived role strain scores whereas perceived organizational support accounted for a mere 1.5% of the variance.

Hypothesis 5. Lastly, the null hypothesis of no relationships between perceived role strain and selected faculty characteristics among CNF faced with a decision to assign a failing clinical grade was rejected as well. Perceived role strain is associated with selected faculty characteristics among CNF faced with a decision to assign a failing clinical grade.

In an effort to determine what characteristics of CNF appeared to effect the level of perceived role strain, multivariate analysis of variance was used to test several CNF characteristics including gender, highest degree held, CNE status, employment in another direct patient care role, enrollment in a doctoral program, and area of primary responsibility. In these independent samples *t*-tests, the characteristics were considered the independent variables while perceived role strain remained the dependent variable. Multiple independent *t*-tests revealed only four faculty characteristics were statistically significant- employment status, enrollment in a doctoral program, area of primary responsibility, and changes in teaching practices as a result of the deliberation to assign a failing grade (see Table 4.16).

Table 4.16

Sample characteristics, independent sample t-tests, significance, effect size (N= 390)

Variable	*n*	*M*	SD	t	*p*	t^2	Cohen's *d*	effect-size *r*	Eta sq η^2	Effect size
Employment status				4.575**	.000	20.93	.46	.23	.05	moderate
Full-time	332	3.02	.66							
Part-time	58	2.60	.59							
Enrollment in doctoral program				-2.023*	.044	4.51	.21	.10	.11	moderate
No	289	2.94	.64							
Yes	101	3.09	.67							
Where primary responsibility				3.219*	.001	10.36	.33	.16	.03	small
Clinical only	68	2.73	.63							
Clinical/didac	322	3.01	.67							
Change in teach				-2.89*	.005	7.89	.29	.15	.02	small
No	207	2.89	.63							
Yes	183	3.08	.66							
Assign F grade				.863	.39	.745				
No	68	3.02	.70							
Yes	322	2.95	.66							
Gender				-1.388	.166	1.93			.01	
Males	24	2.78	.73							
Females	366	2.97	.66							
Race				.958	.338					
Caucasian	349	2.99	.66							
All others	41	2.89	.58							
Highest degree				-.145	.885	.021				
Doctorate	122	2.95	.67							
All others	268	2.96	.67							
Were you a CNF				1.322	.187	1.75			.004	
No	357	2.97	.67							
Yes	33	2.81	.63							
Second Job				.70	.485	.487				
No	204	2.98	.65							
Yes	186	2.94	.68							

Note. **p* ranged from .000 - .044

Those CNF who were employed full-time at the time when failing a student in a clinical practicum was under consideration had significantly higher degrees of perceived role strain, M = 3.02, SD .66, t (983.26) = 4.909, p = .000, η^2 = .05, compared to the mean of perceived role strain experienced by part-time faculty (M = .2.60, SD .59). Similarly, CNF enrolled in a doctoral program reported higher levels of role strain, M = 3.09, SD .67, t (168.043) = -1.979, p =.049, η^2 = .11, than those not enrolled in a doctoral program (M = 2.94, SD .64). CNF whose primary responsibility was clinical exclusively reported significantly less perceived role strain, M = 2.73, SD .63, t (97.93) = -3.174, p = .002, η^2 = .03, than those who were responsible for classroom and clinical areas (M = 3.01, SD .67). Lastly, CNF who reported no change in their teaching practices following the deliberation to assign a failing grade report significantly less perceived role strain, M = 2.89, SD .66, t (376.308) = -2.827, p = .005, η^2 = .02 , than those who did engage in altering their teaching practices (M = 3.08, SD .63). The effect sizes for these four t-tests were identified as small for primary responsibility and change in teaching practice to moderate for employment status and enrollment in a doctoral program.

Additional independent sample *t*-tests considering gender, race, CNE status, employment in a second patient care role in addition to teaching, and assignment of the failing grade were not significant. Several characteristics at the time of deliberation were tested as collapsed groups in an ANOVA; none were found to be statistically significant. Table 4.17 further depicts these findings.

Table 4.17

ANOVA of Collapsed Data Groups (N = 390)

Collapsed Variable	*p*
Rank	.642
Years teaching nursing	.239
Highest degree	.268
Years as CNF	.239
Years employed at institution	.408
Level of student	.864

The second research question, what change occurred in CNF teaching practices after the deliberation to assign a failing clinical grade, was answered through an analysis of the participants' open-ended responses. The responses were analyzed by means of conventional content analysis, utilizing the NVivo platform within Survey Monkey™, to identify categories and themes.

Analysis of the Open-ended Question

Analysis of the open-ended responses (*N* = 179) revealed a rich data source to better understand the CNF's struggle to assign a failing grade. Ten broad categories were identified- communication, evaluation process, documentation, stressful experience, remediation, absence of administrative support, course revisions, evaluation instrument, and professional growth. Further exploration revealed three to eight themes within each category. Often a single response contained several comments which fit into up to four of the ten categories.

Analysis of Qualitative Data into Categories

The majority of responses (*n* = 89, 49.7%) addressed **communication**. Themes included providing clearly defined expectations of students, need for more timely feedback to students, keeping others (dean, chair, coworker, advisor) aware of concerns and struggling students, collaboration with chair or coworkers, and use of early warning reporting systems (e.g. Starfish). Others reviewed weekly goals with students as an opportunity to provide feedback to students. One participant wrote, "*More frequent meeting with individual students to assess their perceptions of clinical performance and let them know areas where I believe they are doing well and areas they need to look at for improvement."* Others wrote, *"I became more explicitly clear about low performance sooner"* or "*Daily feedback to students rather than waiting until mid term"* or "*I make sure the student hears the concerns in the moment so that they aren't taken by surprise. I also try to get a sense of any concerns early in the clinical rotation and offer any remediation available to the student.*"

The **evaluation process** was often noted in the open-end responses. Sixty-five (36.3%) participants noted the necessity for early identification of problems, deficits, and a student at risk for failing affording the student more time for improvement. Many identified the need for ongoing evaluation and formative mid-term evaluations whereas others required self-evaluations as an "*opportunity to identify areas of weakness that needed to be addressed before the end of the course*." Another participant wrote, "*I also had the students complete a mid-term self-evaluation using the clinical assessment tool. We reviewed the tool together to*

ascertain areas of strengths and areas that need improvement. We made a performance plan for areas needing improvement." The provision of a variety of evaluation methods such as simulation, clinical lab experiences, and clinical assignments, afforded CNF additional opportunities for evaluation of knowledge, skills, attitudes, and values.

Documentation was the third most frequently identified theme in 47 (26.2%) entries. The importance of documenting all student interactions (written, emails, phone calls, conferences, face to face contact) on a weekly basis was identified by more than 25% of the participants. Many noted the need for more detailed anecdotal records. One participant wrote, "*More meticulous and meaningful documentation"* while another wrote, *"Much more detailed written weekly evaluations.*" The idea of gathering adequate documentation for support of a decision was noted by several participants. The following are examples of such entries. "*After assigning the grade, I became more diligent in gathering and keeping paperwork related to students I identified early in the semester as having potential to fail the course*" while another wrote, "*I became more aware of the need to document concerns throughout the clinical experience so that I had 'proof' that the student had earned the failing grade."*

Remediation was noted in 18 (10%) entries. Participants mentioned early intervention, referrals to lab or resource center, and the use of performance improvement plans clinical action plans, or contracts. One participant wrote, "*Not waiting for things to improve on their own or following gentle nudging/reminder.*" while another wrote, "*ability to recognize the need to establish a clinical action plan*

for students in the clinical area; ability to address clinical student needs (skills, knowledge, or attitudes) to enhance their success; able to discuss issues with students needing additional direction or guidance in clinical." Remediation often accompanied an entry concerning evaluation procedures.

Absence of administrative support was identified by several participants (*n* = 17, 9.5%) as seen in verbalizing 'no support' or observed in over-turning of the failing grade. One participant simply wrote, "*I was not supported by my department chair or dean of the college*" and yet another wrote, "*What is more frustrating is that my decisions to fail a student (supported by policies and documentation of clinical failure) are often over turned by the Dean.*" Another summoned it up like this, "*I also felt extremely sad that I was not supported and the administration was fearful of law suits from students who would challenge faculty and/or the school"* whereas another participant wrote, "*I felt ultimately this student was unsafe to practice but did not feel supported in the dean's office to fail that student.*" Several other participants wrote, "*Not much other than I knew that I could not fail a student in clinical regardless of what they did wrong and regardless of proper documentation. Administration would not support the decision especially if the student was a minority or a male.*" Another CNF wrote, "*I stopped putting a lot of energy in going through the process of giving students a failing grade. The culture believes that if they are passing in the classroom, is well liked or complains then they should move forward*" and yet another remarked "*there is hell to pay for the teacher when a*

student fails." Only one participant remarked positively, "*more confidence in assigning a failing grade knowing I would receive support."*

Course revision was identified by 16 participants (8.9%). Revisions to the syllabus were mentioned most often, referring to changes in assignments, due dates, course content, and exam material. Additional entries identified the creation of new policies including "e*stablished a procedure for remediation which included additional clinical time," "sought clear policies for 'clinically unsafe'," "developed and using a student clinical readiness tool with each student to clarify expectations and personal learning goals," "created protocol to evaluate failing grades during semester,"* and *"developed an evidenced based plagiarism prevention program." One new procedure was identified as "established a procedure for remediation which included additional clinical time.*"

External pressure and stress was identified by nearly 8% (*n* = 13) of the participants. One participant remarked, "*The amount of grief and paperwork one would have to go through to fail a student, not to mention calls from the parent, ultimately made it not worth the while nor was it worth the stress to fail the student. At a time when student evaluations were a large part of obtaining tenure or promotion, it was not worth the trouble it produced nor the stress it caused to fail the student*." This remark was similar to another CNF's experience, "*this produced so much stress with grievance of the grade..."* Another remarked the student was allowed to repeat the course again, "*I then had to go through the whole process again the next semester and had to contend with the graduate student's threats and angst to*

the point which brought enormous stress to me." Another CNF had a similar experience, "*I failed a student, she appealed, decision was supported, and she still failed, however it caused a lot of stress*." A different participant wrote, "*Administration will not allow students to fail a clinical course based on clinical performance. There is extreme pressure to pass students along or there are consequences for faculty*."

Unsafe students was identified by nearly 7% (*n* = 12) of the participants particularly in terms of "*safety the top priority*" and inconsistent application of policies. One participant remarked, "*Tried to intervene earlier, tried to change curriculum practices so that as a senior you should not fail basic safety issues. These should be caught much earlier, but everyone passes these students and then as a senior faculty we are expected to prevent unsafe graduates. That is not fair to the student regardless of the money it brings into the institution*." while a second noted a similar experience, "*passing someone on to their senior year who is clearly unsafe was inexcusable and I believe happened because it was the easiest course of action for the faculty*." Another participant went further saying, "*Passing a marginally competent or incompetent student into the workforce is a greater failure than failing a student clinically, indeed, failing a student clinically requires moral courage, a clear understanding of personal and professional values and strong sense of professional commitment*." And still another participant remarked, "*I find it difficult when we must keep students who are significantly unsafe in the clinical setting. It impacts the remaining students and is, in my opinion, dangerous."* A participant

remarked, *"I realized the importance of failing clinically dangerous nurse practitioner students early and that some are just not going to be safe. If was very disheartening. I also realized the responsibility I had not to allow a student to graduate and take care of pediatric patients if that student was not safe in a clinical setting*."

The **evaluation instrument** was changed in several institutions following the CNF's deliberation to assign a failing grade. Fourteen participants (7.8%) noted revision of the evaluation instrument as necessary in an effort to create a more objective evaluation instrument with "*clearly defined policies on clinical grading,*" and to "*hold students accountable at each level for core content*." Another participant wrote, "*Redesign the clinical evaluation form for uniformity, consistent expectations, and grading*." A different participant wrote, "*I reviewed the clinical evaluation tool and worked with curriculum to ensure that it was clear and accurate. Changes were made to increase clarity*."

Rubrics were suggested by several participants, "*created a clinical grading rubric to give students at the beginning of the clinical semester to clarify clinical expectations*" and "*I supported development of a standardized rubric/evaluation for all students that included evaluation of didactic clinical knowledge and clinical skills in addition to number of clinical hours."* Several participants mentioned the need for consistency by all faculty members and the need to eliminate "*bending the rules.*"

The last category identified was **professional growth** of the CNF. Participants (n = 8, 4.5%) identified more confidence in their ability to assign a

warranted failing grade. One participant stated, "*more confidence in assigning a failing grade knowing I would receive support"* while others offered a deeper understanding, "*I became more confident in my ability and respected my judgment more when it came to failing a student*," and another remarked, "*I was never again hesitant to fail a student clinically for lack of performance*," and yet still another, "*I finally understood that my primary responsibility is to the patient and not to the studen*t."

Summary

Clinical nurse faculty who participated in this study reported moderate levels of perceived role strain (*M* = 2.96, *SD* .67) as described by Oermann (1998a), a low degree of perceived faculty stress (*M* = 1.88, *SD* .95) on a scale of 0 to 5, and a moderate to high degree of perceived organizational support (*M* = 4.36, *SD* 1.52) on a scale of 1 to 7.

The analysis of the data collected in this study provided by a national sample of CNF revealed that as perceived organizational support decreased, perceived role strain increased (*r* = -.601 *n* = 390, *p* = .000) as did perceived faculty stress (*r* = -.613, *n* = 390, *p* = .000). In contrast, as perceived faculty stress increased, perceived role strain increased (*r* = .822, *n* = 390, *p* = .000).

Faculty stress accounted for nearly twice the variance than perceived organizational stress (r^2 = 67.6%, r^2 = 36% respectively). After controlling for POS, the major unique contributor to perceived role strain was faculty stress (β = .727, *p* = .000). Even so, perceived organizational support made a minor significant

contribution (β = -.156, p = .000) to the CNF's perceived role strain. The multiple regression analysis revealed significant relationships between and among perceived role strain (measured by the RSS), and the independent variables of perceived organizational support (measured by the SPOS) and perceived faculty stress (measured by FSI) for CNF faced with a decision to assign a failing clinical grade. The regression model explained 69.2% (R^2 = .692, F (2, 387) = 433.738, p = .000, power .99) of the shared variance in perceived role strain explained by perceived faculty stress and perceived organizational support. More than two-thirds of the variability in perceived role strain was explained by perceived faculty stress and perceived organizational support (R^2 = .69). The unique contribution of perceived faculty stress was 32.9% indicating perceived faculty stress was a larger unique contribution to perceived role strain when the overlap is removed. In contrast, the unique contribution of perceived organizational support was 1.5 % of the variance.

Furthermore, CNF who were employed full-time at the time when failing a student in a clinical practicum was under consideration had significantly higher degrees of perceived role strain (t (983.26) = 4.909, p = .000, η^2 = .05) as did CNF enrolled in a doctoral program (t (168.043) = -1.979, p =.049, η^2 = .11). Charged with exclusively clinical teaching as their primary responsibility, CNF reported significantly less perceived role strain (t (97.93) = -3.174, p = .002, η^2 = .03) as did CNF who reported no change in their teaching practices following the deliberation to assign a failing grade (t (376.308) = -2.827, p = .005, η^2 = .02). Additionally, specific CNF characteristics including gender, race, CNE status, employment in a second

patient care role, rank, highest degrees, years teaching nursing, years as CNF, years employed at the institution, student level, and assignment of a failing grade were not statistically significant. Full-time CNF, teaching in both classroom and clinical spheres, enrolled in a doctoral program, and engaged in making changes to their teaching practices, reported statistically significant higher degrees of perceived role strain.

Analysis of the open-ended responses revealed ten categories of concern and changes in the CNF teaching practices following the deliberation of assigning a failing grade. Nearly 50% of CNF identified communication as the primary area of concern. Other areas of concern included the evaluation process (36.3%), documentation practices (26.2%), remediation concerns (10%), course revisions (8.9%), external pressure and stress (8%), unsafe students (6.7%), revision of the evaluation instrument (7.8%), and absence of administrative support (9.5%), and lastly, professional growth and increased confidence to assign a failing grade (4.5%). Numerous themes were identified within each of the categories further revealing the depth of CNF concerns surrounding the assignment of a failing clinical grade.

Chapter V

DISCUSSION OF FINDINGS

Introduction

In this chapter, an overview of the study lays the foundation for interpretation of the findings supported by Neuman's system theory and current literature. The purpose of this descriptive correlational study was to explore the relationships between and among perceived role strain (PRS), perceived faculty stress (PFS), and perceived organizational support (POS) for CNF faced with a decision to assign a failing grade to a nursing student in a clinical practicum.

Study Overview

In light of the global nursing shortage, researchers more recently reexamined PRS experienced by CNF (Clark, 2013; Cranford, 2013, Larocque & Luhanga, 2013). Recent studies revealed the continued presence of CNF's emotional struggle (Amicucci, 2012; Killam et al., 2011) and desire for organizational support (Amicucci, 2012; Clark, 2013; Cranford, 2013, Larocque & Luhanga, 2013) in assigning a failing grade. To date, no studies had examined PRS, PFS, and POS for CNF faced with the decision to assign a failing grade.

Perceived role strain was measured on the RSS (Mobily, 1991). Total scale scores ranged from 23 to 105 scale units (*M* = 68.58, *SD* 14.94, median 69, mode 64). Mean scores ranged from 1.00 to 4.52 scale units (*M* = 2.96, *SD* .67, CI 2.89 - 3.03,

median 2.95). Overall, the sample reported a moderate degree of role strain (*M* = 2.96, *SD* .67) as initially defined by Mobily (1991). This is slightly higher than samples previously reported by Mobily (1991) (*M* = 2.55, *SD* .55), Oermann (1998a) (*M* = 2.90, *SD* .62), and Whalen (2009) (*M* = 2.55, *SD* .55). It is not surprising this sample reported a moderate degree of stress based on the study focus.

The Sample Characteristics

The national sample consisted of 390 CNF recruited from a pool of 6,694 nursing faculty members at 660 CCNE accredited nursing programs within the United States (Chung, 2011), and through memberships of CNF in LinkedIn groups and the Nurse Educator listserv during a three week period in early summer of 2014. The sample was predominantly full-time Caucasian female CNF (80.5%, 89.2%, and 93.8 % respectively) with an average age of 53.6 years (SD 9.17) which is similar to findings of the AACN (2014) where "the average age of doctorally prepared faculty was 61.6 years, 57.6 years for associate professors, and 51.4 years for assistant professors" (p. 6). Slightly more than 70% (n = 275, 70.5%) of the sample was older than 50 years which is similar to the findings of 2013 National Workforce Survey of RNs (2013 NWSR) sponsored by the National Council of State Boards of Nursing [NCSBN] and the Forum of State Nursing Workforce Centers which revealed 68.5 % of faculty (n = 938) were older than 50 years. Similarly, the 2013 NWSR also reported the majority of nurses surveyed were Caucasian (n = 41,880, 83%) which is comparable to this study's findings. Nearly 11% of the current sample was of a racial/ethnic minority which is less than the 13.1% reported by AACN (2014). The

current sample consisted of 6.2% male nursing faculty which is slightly higher than the 5.5% of male faculty reported by AACN (2014).

The majority of CNF had a graduate degree (49.2% master's degree and 48.46% doctorate) which is similar to the AACN Annual Report (2014) noting 51.3% of nursing faculty are doctorally prepared. Clinical nurse faculty in the current study taught nursing for an average of 14.54 years (SD 9.67). Slightly more than 73% were currently teaching in BSN programs, while 24.1% taught in both undergraduate and graduate programs. A majority of the programs (77.2%) were accredited by the CCNE as 86.3% of all nursing programs are affiliated with CCNE (AACN, 2014).

Characteristics at the Time of the Deliberation

The characteristics at the time of the deliberation included an average of 23.85 years (SD 10.14) practicing as a RN. On average, these educators were employed as CNF for 8.85 years with an average institutional tenure time of 6.18 years (SD 6.49). Approximately 48% of sample was employed in another direct patient care role in addition to teaching, 8.5% identified themselves as a CNE, and 25.9% were enrolled in a doctoral program at the time of deliberation. This sample of CNF was predominantly Master's prepared faculty (64.62%) with 30.77% doctorally prepared, and taught both didactic and clinical components (82.6%) in CCNE accredited BSN programs (73.3% and 70.8% respectively). Fewer CNF (17%) taught in both undergraduate and graduate programs compared to the 24.1% currently teaching in undergraduate and graduate programs. The mean number of students in a clinical group ranged from 1 to 20 with an average of 8 to 9 students. The majority of failing

students were identified as junior (34%) and senior students (34%) whereas less than 0.2% were CNL or accelerated students; 14% were graduate students.

More than half the sample reportedly utilized several methods as preparation to assume the role of CNF including attainment of graduate degree, enrollment in education theory courses, and participation in faculty development opportunities, professional conferences, and an orientation program. Colleagues and chairpersons (80.3% and 50.3% respectively) were identified most often as supportive throughout the deliberation process. A preponderance of the sample (82.6%) reported assigning the failing grade, yet less than half the sample (n = 183, 46.9%) reported changes in teaching practices following the deliberation to assign a failing grade. Of these 183 respondents, 97.8 % (n = 179) responded to the open-ended question.

Research Question 1

The first research question asked, what are the relationships between and among perceived role strain (PRS), perceived faculty stress (PFS), and perceived organizational support (POS) for CNF faced with a decision to assign a failing grade to a nursing student in a clinical practicum? The research question was followed by five null hypotheses posed at the onset of the study. The study findings failed to support any of the null hypotheses therefore each null hypothesis was rejected. The findings revealed statistically significant relationships between and among PRS, PFS, and POS for CNF faced with a decision to assign a failing grade to a nursing student in a clinical practicum.

PRS and POS

In hypothesis 1, a strong inverse relationship was revealed between PRS and POS (r = -.601, n = 390, p = .000) for CNF faced with a decision to assign a failing clinical grade. Low levels of POS were associated with high levels of PRS such that as POS declined, PRS rose proportionally for CNF. This relationship was strongly suggested by the work done by Amicucci (2012) where CNF identified *discontent and disappointment* resulting from the lack of administrative support in assigning a failing clinical grade. In terms of NSM, this inverse relationship depicts Neuman's tenet concerning the accordion-like characteristics of the FLD. As the POS levels fluctuate (the psychological variable), the flexible line of defense adjusts accordingly. It appears PRS (the developmental variable) is a significant stressor requiring higher levels of POS to maintain system stability.

PRS and PFS

In hypothesis 2, a strong positive relationship was identified between PRS and PFS (r = .822, n = 390, p = .000) for CNF faced with a decision to assign a failing clinical grade whereby as PFS increased, PRS increased likewise. This finding was previously identified in empirical studies particularly in terms of higher degrees of stress in nursing faculty (Dey, 1994; Lindholm & Szelényi, 2008). Given the subjectivity of the clinical evaluation (McGregor, 2007; Scanlan & Care, 2008; Seldomridge & Walsh, 2006; Tanicala, Scheffer, and Roberts, 2011), it is logical the correlation between these two constructs is strong. In terms of NSM, the direct correlation between PRS (the developmental variable) and PFS (the sociocultural

variable) is consistent with the tenets of NSM. Both variables are interacting within the FLD to maintain a perfect equilibrium within the system with both stressors proportionally increasing or decreasing.

PFS and POS

In hypothesis 3, similar to the relationship between PRS and POS, a moderately strong inverse relationship (r = -.613, n = 390, p = .000) was identified between PFS and POS for CNF faced with a decision to assign a failing clinical grade, with low levels of POS associated with high levels of PFS. That is to say, as POS decreased, PFS significantly increased. This finding supports the findings of Clark (2013) and Cranford (2013) where lack of perceived [organizational] support was a significant stressor for nurse educators. Similarly, this relationship is supported by the tenets in NSM; a perfect balance between PFS and POS, two stressors found in the FLD, is observed comparable to the relationship observed between PRS and POS in hypothesis 1. As the POS levels fluctuate (the psychological variable), the flexible line of defense adjusts accordingly. It appears PFS (the sociocultural variable) is also a significant stressor requiring higher levels of POS to maintain system stability.

PRS, POS, and PFS

In hypothesis 4, the linear combination of POS and PFS was significantly related to PRS and accounted for a significant amount of variability in PRS, R^2 = .692, F (2, 387) = 433.738, p = .000, power .99; the combination of PFS and POS explained 69.2% of the variance. Further analysis revealed perceived faculty stress

(PFS) explained 32.9% of the variance (β = .727, *p* = .000, effect size .737) whereas POS explained 1.5% (β = -.156, *p* = .000, effect size .069) of the variance in PRS.

This study is the first study to look at the relationship of these constructs for CNF. These variables are interacting simultaneously (as viewed in the CNFs' emotional struggle to assign a failing grade) in NSM flexible line of defense potentially causing a fracture in the normal line of defense. This, according to the tenets in NSM, will cause an invasion in the normal line of defense and is clearly evident in the responses to the open-ended question.

PRS and Selected CNF Characteristics

In hypothesis 5, a relationship was revealed between PRS and selected faculty characteristics among CNF faced with a decision to assign a failing clinical grade. This hypothesis was supported for only four characteristics, specifically employment status, enrollment in a doctoral program, area of primary responsibility, and for those CNF who identified a change in teaching practices as a result of the deliberation to assign a failing grade.

Similar to findings of previous empirical studies (Lindholm & Szelényi, 2008; Oermann, 1998a), full-time CNF had significantly higher degrees of PRS (*t* (983.26) = 4.909, *p* = .000, η^2 = .05). Higher degrees of PRS (*t* (168.043) = -1.979, *p* =.049, η^2 = .11) were experienced by CNF enrolled in a doctoral program; this finding is similar to previously reported findings (Oermann, 1998a). It is surmised the added stress and time requirements of graduate school impacted CNF perceived role strain. Clinical nurse faculty charged primarily with only clinical reported significantly less

PRS (t (97.93) = -3.174, p = .002, η^2 = .03) than those who were responsible for classroom and clinical areas. Likewise, CNF who reported no change in their teaching practices following the deliberation to assign a failing grade reported significantly less PRS (t (376.308) = -2.827, p = .005, η^2 = .02). This seems reasonable as CNF involved in teaching both clinical and didactic would be more invested in their faculty position and perhaps engaged in a greater degree of time constraints and heavier workload as identified in previous empirical studies (Clark, 2013; Cranford, 2013; Goldenberg & Waddell, 1990; Langemo, 1988; O'Shea, 1982).

The findings did not support an association between PRS and other characteristics including gender, race, rank, highest degree, CNE status or years as CNF, employment in a second patient care role in addition to teaching, level of student, and assignment of the failing grade. Although previous empirical studies (Lindholm & Szelényi, 2008; Oermann, 1998a), identified older faculty as experiencing less PRS, this was not supported in the current study as PRS did not significantly vary according to age. Years of teaching experience and facility tenure also failed to have statistically significant relationships with PRS.

In terms of NSM, these characteristics are viewed as intrapersonal, interpersonal, and extrapersonal stressors interacting with the main variables within the FLD. The findings confirmed employment status, enrollment in a doctoral program, area of primary responsibility, and a change in teaching practices as a result of the deliberation to assign a failing grade were significant stressors to be addressed accordingly by the system. It appears PRS increased in response to these stressors

affirming the need for POS to strengthen the FLD. The degree of POS necessary to adequately strengthen the FLD was not addressed in this study. Further analysis of the data may shed an elementary understanding of the relationship. Further research is recommended to better understand the role POS plays in mitigating PRS.

Research Question 2

The second research question asked what change(s) occurred in CNF teaching practices after the deliberation to assign a failing clinical grade. An analysis of 179 open-ended responses from nearly 46% of the total sample answered this question. Changes in teaching practices revolved around ten categories including communication, evaluation process, documentation practices, absence of administrative support, remediation procedures, course revisions, external pressure and stress, evaluation instruments, unsafe students, and professional growth. Three to eight themes composed each category.

Communication

Communication was the primary area of change for the majority of CNF (*n* = 89, 49.7%). Themes included providing clearly defined student expectations and goals (written and verbal) with more timely feedback (particularly with respect to progress and areas requiring improvement), keeping others (dean, chair, coworker, advisor) aware of concerns and progress of struggling students, collaboration with chair or coworkers, and use of early warning reporting systems (e.g. Starfish). Several participants asserted the importance of students being made aware of deficits as soon as emerging to provide time and opportunities to overcome deficiencies

whereas others emphasized a weekly discussion with students-at-risk for failure. Additionally, coaching students was identified by several respondents.

Reported feedback was provided to students on a regular basis which focused on their behaviors with the primary goal "to provide insight to the learner in the attainment of the desired skills, attitudes and behaviors" (Loyola, 2010, p. 25) and to assist students in changing behavior in an effort to attain the course competencies and demonstrate successful clinical performance. The importance of written as well as verbal communication with students was emphasized by several respondents.

Evaluation Process

In the current study, following the deliberation of assigning a failing grade, 36.3% (n = 65) of sample CNF reported changes to the *evaluation process* including ongoing evaluation with frequent feedback to students, formative mid-term evaluations, self-evaluations, early identification of problems and students-at-risk for failing to afford students more time for improvement. The formative assessment, or the midterm evaluation, is designed to advise the student of their progress, identify areas of concern, develop a plan and timetable to address these, and lastly be informed of the consequences should improvement fail to occur. Conversely, the summative assessment, the final evaluation, is designed to judge the student's competency measured against the benchmarks outlined in the evaluation tool. This appraisal involves the assessment and evaluation of students' critical thinking,

therapeutic interventions, teaching, communication, research, leadership and management, professionalism, and adherence to the standards of practice (Smith et al, 2001).

Evaluation of the students' clinical performance is "challenging, emotionally charged and a complex process" (Brown, Neudorf, Poitras, & Rodger, 2007, p. 30). It is essential for society, the nursing program and the student that the evaluation be fair and objective (Glasgow et al., 2012; Scanlan et al., 2001; Wren & Wren, 1999). Honest, timely, and objective feedback conveyed with respect and fairness is less likely to be challenged by students (Johnson, 2009). It is imperative CNFs provide fair student evaluations supported with sound objective evidence, afford students due process, and adhere to the nursing program's written policies in an effort to reduce the incidences of grievances and legal actions (Glasgow et al., 2012; Wren & Wren, 1999). Furthermore, institutions/organizations (e.g. administrators) can better support CNF and their decisions based on institutional policies and procedures where fair evaluation processes are employed, required documentation is secured, transparency is maintained, and due process are applied.

Documentation Practices

Changes in *documentation practices* was identified by 26.2% (n = 47) of CNF including documenting all student interactions (written notes, emails, phone calls, conferences, face to face contact, contracts/performance plans, written warnings) on a weekly basis with more detailed anecdotal records of student behaviors and progress. Several respondents remarked their subsequent documentation was more objective

and detailed. These changes reinforce the idea that CNFs' thorough documentation in anecdotal records and of counseling sessions provides sound written evidence of the clinical observations of students' performance as a basis for evaluations and a means for guiding learning (Oermann & Gaberson, 2009).

Remediation Procedures and Course Revisions

Changes in *remediation procedures* and practices were reported in 10% (*n* = 18) of the entries including early intervention, referrals to lab or resource center, and the use of performance improvement plans, clinical action plans, or contracts. Moreover, nearly 9% (*n*= 16) of CNFs reported *course revisions* targeting the syllabus, changes in assignments, due dates, course content, examination material, and the creation of new policies.

Several respondents reported utilizing simulations; some as a means of initially evaluating student skills and identifying weaknesses while others reported using simulation as a method of remediation. Evans and Harder (2013) suggested an evidenced-informed model of student remediation through simulation in an effort to facilitate theoretical knowledge to clinical competence. Although it is theorized remediation will foster improvement in a student's clinical performance, there is no evidence to support this assertion. Future research is required to document the effectiveness of remediation strategies including simulation (Evans & Harder, 2013).

Absence of administrative support

Absence of administrative support was identified by 9.5 % (*n* = 17) of CNF with an absence of support defined as 'no support' from the department chair, assistant

dean, and Dean or observed in the over-turning of the failing grade by the Dean. These findings are consistent with previous empirical reports where the absence of academic, administrative, and emotional support appeared to exacerbate the CNF's emotional struggle (Larocque and Luhanga, 2013). The perceived lack of organizational support led CNF to report experiences of disappointment and negative feelings resulting in more strain encountered throughout the process (Amicucci, 2012). Perceived [organizational] support was recognized as a critical component in the process of assigning a failing grade (Amicucci, 2012; Clark, 2013; Cranford, 2013). Furthermore, lack of POS increased CNF perceived role strain as support was vital in reducing PRS (Cranford, 2013). However in the current study, open-ended responses did not identify POS as a major factor but rather appeared to play a relatively minor factor in PRS. This qualitative finding is surprising as the sample reported moderate POS scores (M = 4.36, SD 1.52, median 4.56). Perhaps respondents were focused exclusively on reporting changes made following the deliberation and not on the POS perceived as a basis for change.

Further analysis revealed 19% of the respondents (n = 74) reported POS scores less than 2.84 (M-1SD). It would seem this subgroup of CNF experienced higher degrees of PRS related to the absence of administrative support, POS, in regards to assigning a failing grade. Based on the open-ended responses, it appears this subgroup of CNF is reluctant to assign a failing grade to future student. Further research is required to better understand the role of POS in assigning a failing grade.

External pressure and stress

External pressure and stress was identified by nearly 8% (*n* = 13) of the participants. Several CNF described feeling reluctant to assign the failing grade and unwilling to invest a lot of energy as has been previously reported (Scanlan et al., 2001). Moreover, CNF cited concerns regarding personal ramifications.

Whalen (2009) observed CNF found the entire clinical experience stressful, referring to both clinical teaching and student clinical performance evaluation. The idea of 'passing the buck' or giving a student the 'benefit of the doubt' was noted in the current study as well as previous empirical studies (Boley & Whitney, 2003; Duffy, 2003; Ilott & Murphy, 1997; Larocque & Luhanga, 2013; Luhanga et al., 2008a, 2008b; Scholes & Albarran, 2005; Walsh & Seldomridge, 2006).

Failure to fail remains a significant issue in nursing education (Duffy, 2003; Larocque & Luhanga, 2013; Sprinks, 2014; Watson & Harris, 1999). Boley and Whitney (2003) argued the CNF is responsible to assign the failing grade when warranted. Further research to explore the role and effectiveness of guiding policies and procedures focused on the unsafe or failing clinical student at colleges, universities, and nursing schools is needed and may add clarity to the decision making process.

Revision of evaluation instruments

Nearly 8% (*n* = 14) of CNF identified necessary changes to the *evaluation instrument* in an effort to create more objective evaluations with defined policies, consistent expectations, and uniformity in clinical grading. Amicucci (2012) also

identified evaluation tools as source of CNF's discontent and disappointment. The absence of adequate psychometrics for most clinical evaluation instruments is noteworthy. Clinical evaluation instruments are generally not standardized. Some evaluation instruments are norm-referenced (students are compared to one another) while others are criterion-referenced (students compared to a predetermined criteria, outcomes, or competencies). Moreover, the evaluation process requires the CNF to be cognizant of personal bias, beliefs, values, and attitudes that may influence the evaluation process (Oermann & Gaberson, 2009). Several respondents' comments addressed their biases, beliefs, values, and attitudes in regards to evaluations.

Unsafe student

Unsafe student was a concern identified by nearly 7% (n = 12) of the participants in terms of safety as the top priority and inconsistent application of policies. Amicucci (2012) also identified safety as a major concern for CNF citing *safety as a benchmark* as an essential theme in respect to patient safety and student competency.

Although clinical competence is verified in continuous ongoing assessment in clinical practice (Duffy, 2007), it is the evaluation of the students' performance and attainment of course competencies which is required to protect the public from unsafe nursing practitioners (Ilott, 1995; Glasgow et al., 2012). Several previous empirical studies have addressed unsafe students in the clinical arena (Lewallen & DeBrew, 2012; Luhanga et al., 2008b; Killam et al., 2011; Scanlan et al., 2001). Several open-ended responses implied the need for guidelines and policies to deal with these

students. Guidelines ensure consistent and effective identification of unsafe students (Brown et al., 2007). It is imperative these students be identified early to afford time and opportunities for specific behaviors to be changed and ensure consistency and fairness.

Professional growth

The last category identified by nearly 5% (n = 8) of CNF was *professional growth* whereby CNF reported gains in confidence and respect of their judgment in terms of assigning a failing grade. This finding has not been reported previously in the literature.

The sample was experienced as practicing nurses (M = 23.85, SD 10.14) although 70% were employed in the CNF role for 10 years or less, teaching both didactic and clinical, and employed by the institution for 6 years or less at the time of deliberation to assign a failing grade. Perhaps these characteristics portray CNF who are more focused on professional growth issues. This new finding, professional growth, reinforces the notion that the effort to maintain competency standards has undeniable personal outcomes for CNF.

Although the open-ended responses indicated the experience was difficult in many ways, the responses also indicated the struggle afforded them an opportunity for learning and growing. Respondents identified opportunities to create innovative ways to facilitate student engagement and learning, facilitated student development and socialization, created new objective evaluation tools and strategies, revised courses and assignments, used feedback for reflection and self-improvement, and

acted as a change agent and leader. Several respondents mentioned the need for further development of the student-teacher connection particularly in terms of knowing and intentionality (Gillespie, 2005).

Conclusion

Responses to the open-ended question were overall enlightening. The open ended responses implied for many, the experience was indeed a learning experience and prepared them for a future encounter with a student-at-risk for failure in a clinical practicum. Changes made by CNF to their teaching practices were, for the most part, positive, concrete, and appeared to facilitate the CNF role. The CNF who reported changes to their teaching practice appeared to be more invested in their role as CNF. As such, it was not surprising the data suggest the degree of PRS was higher for CNF who actively sought ways to learn from the experience and engaged in a deliberate change(s) in their teaching practice.

In terms of NSM, all stressors are perceived as neutral. The decision to assign a failing grade became an impetus for change and adaptation, thereby strengthening the system as a whole. The changes described in the open-ended responses generally appeared system oriented as improvements to grading practices for students and faculty as well as opportunities for personal growth in the CNF role.

Although previous empirical studies found a relationship between age, experience, and PRS, it is uncertain why these relationships were not documented in the current study. Perhaps older faculty members are encountering more PRS related to the faculty shortage and the increased demands of time constraints and workload

previously reported in the literature as suggested by Cranford (2013). Furthermore, it is uncertain how POS moderates PRS for CNF. Further analysis and research is required to better understand these variations.

Limitations

Several limitations were identified in the current study. Bias was inherently introduced by the online survey design as a result of participants' self-selected participation. It is possible participants had previously encountered negative experiences that prompted their participation. It is unknown if potential participants were unwilling to participate because of the study topic. Additionally, the survey was lengthy potentially precluding some participants from completing the study.

Although a large national sample was achieved through this online study, some areas were under represented; the northeast represented a larger portion of the sample (32.6%). An accurate response rate was impossible to calculate based on the online design. The survey was available to approximately 15,000 CNF through LinkedIn; however, the LinkedIn groups are comprised of international memberships and it is not known how many are US CNF. Furthermore, although the email invitation and reminder was relatively simple to execute, it was impossible to encourage recipients to open, read, and participate in the study; similarly, it was impossible to determine how many LinkedIn members actually saw the posted announcement, or how many email invitations were forwarded to potential participants. Likewise, it was impossible to identify the percentage of email invitations that were sent to spam folders. It is unknown how many CNF were

exposed to the study versus how many elected to participate. As cited in other web-based studies (Evans, 2013), exclusion of potential participants with limited accessibility to the Internet was a limitation.

Moreover, the filter question concerning employment in an accredited program within the last eight years may have eliminated potential participants. Several potential respondents emailed the researcher reporting the need for their individual program IRB's approval thereby eliminating their ability to participate in the study.

Although the responses to the open-ended question furthered the researcher's understanding of the experience, the method of collecting these responses made it impossible to drill down and gain a deeper understanding. At times, written responses were exceptionally brief making it impossible to understand exactly what the respondent intended, leaving it open to the researcher's interpretation.

In summary, the findings of study add to the limited understanding of PRS experienced by CNF faced with a decision to assign a failing grade. Furthermore, the findings are congruent with the Neuman System Model as it appears to be a systems issue. It is hoped best practices will come forth based on these findings as well as recognition of PRS experienced by CNF. However, caution must be exercised in embracing the findings as the sample consisted of predominantly faculty (73.1%) from BSN programs.

Acknowledging PRS is the first step in fostering change. These findings may provide a foundation for the development of policies and procedures to thwart student

failure, and where student failure is inevitable, these findings may facilitate the creation of delineated policies and a process of assigning a failing grade as a first step in alleviating a degree of PRS.

Chapter VI

SUMMARY, CONCLUSIONS, RECOMMENDATIONS AND IMPLICATIONS

Introduction

This chapter provides an overview of the study and implications for nursing education and future research. This study explored the relationships between perceived role strain (PRS), perceived faculty stress (PFS), and perceived organizational support (POS) for CNF faced with the decision to assign a failing grade to a student in a clinical practicum. Relationships between and among PRS, PFS, POS as well as PRS and selected faculty characteristics were empirically tested.

Summary

The Sample

The national sample consisted of 390 CNF predominantly full-time Caucasian females (80.5%, 89.2%, and 93.8 % respectively) with an average age of 53.6 years (SD 9.17). Slightly more than 70% (n = 275, 70.5%) of the sample was older than 50 years. Nearly 11% of the current sample was of a racial/ethnic minority, and 6.2% were male. The majority of CNF had a graduate degree (49.2% master's degree and 48.46% doctorate) and taught nursing for an average of 14.54 years (SD 9.67). Approximately 73% were currently teaching in BSN programs and 24.1% taught in

both undergraduate and graduate programs predominantly accredited by the CCNE (77.2%). This sample is similar to CNF reported in the literature.

Characteristics at the Time of the Deliberation

Clinical nurse faculty characteristics at the time of the deliberation included practicing as a RN for an average of 23.85 years (SD 10.14), employment as a CNF for 8.85 years (SD 8.3) with an average tenure time at the institution of 6.18 years (SD 6.49). Approximately 48% of sample was employed in another direct patient care role in addition to teaching and 25.9% were enrolled in a doctoral program. A small minority was certified as CNE (8.5%), while the majority was Master's prepared faculty (64.62%) with another 30.77% doctorally prepared. As preparation to assume the role of CNF, the sample CNF reported several methods with more than half of the sample reporting more than one preparation method. Methods included attainment of graduate degree, enrollment in education theory courses, and participation in faculty development opportunities and professional conferences, and lastly participation in a CNF orientation program.

The majority of the sample taught both didactic and clinical components (82.6%) in CCNE accredited BSN programs (70.8%). The number of students in a clinical group ranged from 1 to 20 with an average of 8-9 students in a clinical group. The majority of failing students were identified as junior (34%) and senior students (34%) whereas less than 0.2% were CNL or accelerated students and 14% were graduate students. Colleagues and chairpersons were identified most often as supportive throughout the deliberation process (80.3% and 50.3% respectively).

Research Question 1 and Related Hypotheses

The survey consisted of a researcher generated demographic questionnaire and three established instruments: 1) the *Role Strain Scale* (RSS, Oermann, 1998) (Cronbach α = .93), a 23-item Likert-type scale scored from 1 (*never*) to 5 (*nearly all the time*), was used to measure PRS; the mean scores ranged from 1.00 to 4.52 scale units; 2) the *Faculty Stress Index* (FSI, Gmelch, 1984) (Cronbach α = .97), a 45-item Likert-type scale scored from 0 (*never*) to 5 (*excessive pressure*), was used to measure PFS; the mean scores ranged from .09 to 4.52 scale units ; 3) The *Survey of Perceived Organizational Support* (SPOS, Eisenberger et al., 1986) (Cronbach α = .95), a 9-item Likert-type scale scored from 1 (*strongly disagree*) to 7 (*strongly agree*), was used to measure POS; the mean scores ranged from 1 to 7.

Clinical nurse faculty in this study reported moderate levels of perceived role strain (M = 2.96, SD .67), a low degree of perceived faculty stress (M = 1.88, SD .95), and a moderate degree of perceived organizational support (M = 4.36, SD 1.52). Pearson's product-moment correlation used to investigate bivariate relationships between PRS, PFS, and POS revealed that as POS decreased, PRS increased proportionally (r = -.601 n = 390, p = .000) as did PFS (r = -.613, n = 390, p = .000). These inverse relationships contrast the strong positive relationship between PRS and PFS such that as PFS increased, PRS increased (r = .822, n = 390, p = .000). From this, the researcher concluded POS was indeed a critical factor in PRS and PFS but the extent to which POS influenced PRS or PFS is unclear from this study and will necessitate further investigation.

A standard multiple regression analysis, variables entered simultaneously, revealed statistically significant relationships between and among PRS and the independent variables PFS and POS for CNF faced with a decision to assign a failing clinical grade. The regression model explained 69.2% (R^2 = .692, F (2, 387) = 433.738, p = .000, power .99) of the shared variance in PRS from PFS and POS. PFS accounted for nearly twice the variance compared to POS (r^2 = 67.6%, r^2 = 36% respectively). After controlling for POS, the major unique contributor to PRS was PFS (β = .727, p = .000), which explained 32.9% of the variance with a very large effect size (.737). POS provided a minor significant contribution of 1.5 % to the variance in PRS (β = -.156, p = .000, moderate effect size of .069).

Multivariate analyses revealed CNF who were employed full-time at the time when failing a student in a clinical practicum was under consideration had significantly higher degrees of PRS (M = 3.02, SD .66, t (983.26) = 4.909, p = .000, η^2 = .05) compared to part-time faculty (M = .2.60, SD .59). Similarly, CNF enrolled at that time in a doctoral program reported higher levels of PRS (M = 3.09, SD .67, t (168.043) = -1.979, p =.049, η^2 = .11) than those not enrolled in a doctoral program (M = 2.94, SD .64). CNF whose primary responsibility was the clinical realm exclusively reported significantly less PRS (M = 2.73, SD .63, t (97.93) = -3.174, p = .002, η^2 = .03) than those responsible for both classroom and clinical areas (M = 3.01, SD .67). Lastly, CNF who reported no change in their teaching practices following the deliberation to assign a failing grade reported statistically significantly less perceived role strain (M = 2.89, SD .63, t (376.308) = -2.827, p = .005, η^2 = .02) than

those who altered their teaching practices (M = 3.08, SD .66). Small effect sizes were measured for primary responsibility and change in teaching practice whereas moderate effect sizes were measured for employment status and enrollment in a doctoral program.

Additional independent sample *t*-tests considering gender, race, CNE status, employment in a second patient care role in addition to teaching, and assignment of the failing grade were not statistically significant. Furthermore, several characteristics at the time of deliberation were collapsed into groups including years teaching nursing, years as CNF, years employed at the institution, years practicing as a RN, and age. These characteristics were tested in an ANOVA; none were found to be statistically significant.

CNF who were employed full-time teaching in both classroom and clinical spheres at the time when failing a student in a clinical practicum was under consideration had significantly higher degrees of PRS (t (983.26) = 4.909, p = .000, η^2 = .05) as did CNF enrolled in a doctoral program (t (168.043) = -1.979, p =.049, η^2 = .11). CNF charged with exclusively teaching clinical as their primary responsibility reported significantly less PRS (t (97.93) = -3.174, p = .002, η^2 = .03) as did CNF who reported no change in their teaching practices following the deliberation to assign a failing grade (t (376.308) = -2.827, p = .005, η^2 = .02). These findings infer full-time CNF, teaching in both classroom and clinical spheres, enrolled in a doctoral program, and engaged in making changes to their teaching practices, have statistically significant higher degrees of PRS.

Research Question 2

The second research question addressed what change(s) occurred in CNF teaching practices after the deliberation to assign a failing clinical grade, and was answered through a conventional content analysis to identify categories and themes within open-ended responses. These categories are all components of the larger system and revealed a possible breakdown in terms of the system. The majority of the sample (82.6%) reported assigning the failing grade, yet slightly less than half the sample (n = 183, 46.9%) reported changes in teaching practices following the deliberation to assign a failing grade. Of these 183 participants, 179 (97.8 %) responded to the open-ended question.

Ten categories containing numerous themes were identified, further revealing the depth of CNF concerns surrounding the assignment of a failing clinical grade. The crisis stimulated CNF to evaluate their teaching practices and make changes deemed necessary. The majority of CNF responding to the open-ended question (49.7%) identified communication as the primary area of concern requiring a change in practice. Other areas of concern included the evaluation process (36.3%), documentation (26.2%), remediation procedures (10%), absence of administrative support (9.5%), course revisions (8.9%), external pressure and stress (8%), revision of the evaluation instrument (7.8%), unsafe students (6.7%), and lastly, professional growth and increased confidence to assign a failing grade (4.5%).

The qualitative data revealed a rich source of information to better understand the significance and experience of the CNF faced with the decision to assign a failing

grade. The current study revealed the continued presence of an emotional struggle as recently reported (Amicucci, 2012; Killam et al., 2011) and desire for organizational support (Amicucci, 2012; Clark, 2013; Cranford, 2013, Larocque & Luhanga, 2013).

Conclusions

To date, this is the first study to examine PRS, PFS, and POS for CNF faced with the decision to assign a failing grade, and the first study to utilize NSM as a framework underpinning the study of these constructs. The national robust sample yielded a rich data set. The findings reinforced the applicability of employing NSM in that the variables appeared to interact simultaneously within the FLD maintaining system equilibrium and stability. The Neuman system model provided a means to look at the phenomenon in a clear explicit manner and to process the open-ended responses.

Although some of the findings were expected such as a strong correlation between PRS and PFS, it is surprising that POS contributed a very small portion of variance to PRS as support has been identified as a crucial factor for CNF in several recent empirical studies (Cranford, 2013; Larocque & Luhanga, 2013). Higher levels of PRS were reported by full-time CNF, teaching in both classroom and clinical spheres, or enrolled in a doctoral program as previously reported (Oermann, 1998a) while other personal characteristics were not statistically significant factors. Additionally, CNF engaged in making changes to their teaching practices reported higher degrees of PRS. This study did not provide insight into the reasons for these findings. Perhaps CNF are more invested in their faculty position and therefore

engaged in more time constraints and workload as previously identified in the literature.

The study achieved a nationwide sample from all areas of the United States and included graduate faculty. CNF reported experiences with undergraduate students as well as graduate students in the open-ended responses. The responses of CNF engaged with graduate students were similar to that of CNF involved with undergraduate students.

Recommendations for Nursing Education

Although the quantitative findings affirm the need for CNF to receive adequate POS to combat increased levels of PRS, the qualitative findings are not so clear. The findings suggest Deans and administrators need to raise their awareness of the issues surrounding CNF concerns and the struggle to assign a failing grade requiring adequate organizational support, maintain effective communication, and provide explicit means for evaluation in terms of process and instruments. CNF need to know administrators 'have their back' and will support their judgments and recommendations for student progression. More importantly, deans and administrators have the means to insure adequate organizational support is afforded CNF to provide rigorous student evaluations to maintain the nursing program's reputation. Intentional actions are indispensable in providing these resources to CNF and should be a priority. The development and implementation of clear policies and procedures regarding students-at-risk for failure and remediation measures as well as adopting objective consistent evaluation processes are practices that may lessen PRS.

Lastly, it is important to recognize this may be a systems issue. Proactive efforts on the part of all parties (CNF, administrators, and students) may facilitate successful outcomes for all involved. CNF need to understand their role and be equipped to successfully execute all facets of the role with system support; similarly, students need a clearer understanding of expectations, objectives, competencies, and goals. CNF are charged with being the gatekeepers to the profession. It is imperative CNF do the *right thing* and assign the failing grade when warranted.

Implications for Future Research

This study was not designed to predict how PRS is affected by POS and PFS, nor was the study aimed at exploring sources of stress, both of which warrant future study. Furthermore, this study was not intended to explore the degree of POS necessary to adequately strengthen the FLD although this too is a needed area of future study. Further analysis of the data collected in this study may provide an elementary understanding of these relationships. However, further research is recommended to better understand the role POS plays in moderating PRS, to explore how PRS is affected by POS and PFS, and to explore how much POS is necessary to adequately support CNF in their role.

Additionally, further research is necessary to explore the existence of guiding policies and procedures focused on students-at-risk for clinical failure as well as the effectiveness of such policies and procedures. The literature suggests policies and procedure will add clarity and support for the decision making process. A systematic review of these practices utilized in nursing programs throughout the United States

may shed light on better or best practices which can reduce CNF stress and role strain.

Furthermore, evaluation of the effectiveness of strategies to support evidenced-based educational practices, particularly in terms of the student-at-risk for failure, is necessary. It is paramount for educators to develop a body of knowledge specific to evidenced-based teaching practices in nursing education similar to the body of knowledge developed for evidenced-based nursing practice.

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APPENDICIES

APPENDIX A

PERMISSION TO ADAPT NEWMAN SYSTEM MODEL

Jeannie Couper
Doctoral Student in Nursing PhD Program
Seton Hall College of Nursing
South Orange, NJ
Advisor: Jane Dellert

Dr. Betty Neuman
PO Box 77
Watertown, OH 45787

October 22, 2013

Dear Dr. Neuman,

It was my pleasure and joy to speak with you on the phone this evening about incorporating the NSM into my doctoral study design. Thank you for spending time with me to answer my questions.

I am requesting permission to adapt the NSM schematic as outlined on page 19 in the attached document. I appreciate any feedback you have to offer in the way I am interpreting the variables in light of the model.

Thank you so very much for your time and effort on my behalf.

I am enclosing a SASE as you requested.

Respectfully,

Jeannie

Jeannie Couper

Request honored by the NSM author, Betty Neuman
10/28/13 - Betty Neuman, PhD, FAAN.

APPENDIX B
PERMISSION TO USE ROLE STRAIN SCALE

Permission to use RSS
Jeannie Couper
To: paula-mobily@uiowa.edu
Sent: Monday, July 15, 2013 10:56 AM
Hello Dr. Mobily,
I am very interested in reviewing your tool "Role strain scale" used in your study (1991) and the most recent study published by Clark (2013). I am enrolled full-time at Seton Hall University pursuing a PhD in nursing. I have entered the dissertation phase and am currently exploring the relationships of role strain, faculty stress, and support experienced by clinical nurse educators. I would very much like to consider using your tool if it indeed captures what I am attempting to study.

I have not been successful in locating the 'Role strain scale' tool for review. I would appreciate if you could provide me with a copy of the tool, scoring procedures, and any stipulations for its use.

I look forward to hearing from you. Thank you for considering my request.

Sincerely,
Jeannie

Jeannie Couper, MSN, RN-BC
RWJF NJNI Nursing Faculty Scholar
Seton Hall University College of Nursing
400 South Orange Avenue
South Orange, NJ 07079

Permission to use RSS
Mobily, Paula R [paula-mobily@uiowa.edu]
To: Jeannie Couper
Tuesday, July 30, 2013 11:33 AM

Hi Jeannie,
Thank you for your patience. I am happy to give you permission to use and/or modify my Role Strain Scale for your dissertation if you decide it would be helpful. I have attached some documents that may be helpful to you. One is information from my actual dissertation about the scale that you may find useful and the other is the complete scale.

I wish you luck with your research!

Best Regards,
Paula
Paula R. Mobily, PhD, RN
Professor Emeritus
College of Nursing
The University of Iowa email: paula-mobily@uiowa.edu

APPENDIX C
PERMISSION TO USE REVISED ROLE STRAIN SCALE

Permission requested
Jeannie Couper
Sent: Monday, February 17, 2014 3:24 PM
To: Marilyn Oermann, Ph.D. [marilyn.oermann@duke.edu]

Hi Dr. Oermann,

Thank you again for the articles you forwarded to me. I am closer to conducting the study addressing perceived role strain, faculty stress, and organizational support for clinical nurse faculty. Since my initial email several months ago, Dr. Clark forwarded me your revised 23-item scale Role Strain Scale (1998) you revised from Dr. Mobily's original work.

I have received permission from Dr. Mobily to use her scale; however, I request your permission to use your revised scale.

I am looking forward to seeing how these variables influence the CNF decision to assign a failing grade to a clinical nursing student. I appreciate your support.

With gratitude and appreciation,

Jeannie Couper, MSN, RN-BC

RWJF NJNI Nursing Faculty Scholar
Seton Hall University College of Nursing
400 South Orange Avenue
South Orange, NJ 07079
Telephone: c 973-902-9929

Permission requested
Marilyn Oermann, Ph.D. [marilyn.oermann@duke.edu]
Monday, February 17, 2014 6:48 PM
To: Jeannie Couper

HI Jeannie, This email confirms my permission to use and adapt the tool. Marilyn Oermann

Marilyn H. Oermann, PhD, RN, ANEF, FAAN
Professor & Director of Evaluation and Educational Research
Duke University School of Nursing
DUMC 3322, 307 Trent Drive
Durham, NC 27710
Editor-in-Chief, *Nurse Educator*
Editor, *Journal of Nursing Care Quality*
919-684-1623
marilyn.oermann@duke.edu

APPENDIX D

PERMISSION TO USE AND ADAPT FACULTY STRESS INDEX

RE: Request to use the Faculty Stress Index
Jeannie Couper
Sent: Wednesday, August 07, 2013 7:47 PM
To: Walter H Gmelch [whgmelch@usfca.edu]

Dear Dr. Gmelch,

I am a PhD student at Seton Hall University College of Nursing preparing to conduct a research study addressing role strain, faculty stress, and perceived organizational support experienced by clinical nurse educators. After reading your book *Coping with Faculty Stress*, I believe the Faculty Stress Index is an excellent instrument to capture the phenomena of interest. Please advise me as to the protocol to secure your permission.

I look forward to your response.

Best Regards,
Jeannie Couper

Jeannie Couper, MSN, RN-BC
RWJF NJNI Nursing Faculty Scholar
Seton Hall University College of Nursing
400 South Orange Avenue
South Orange, NJ 07079

RE: Request to use the Faculty Stress Index
From: Walter H Gmelch [whgmelch@usfca.edu
Sent: Friday, August 09, 2013 3:15 PM
To: Jeannie Couper
Subject: Re: Request to use the Faculty Stress Index

Dear Jeannie:

I will be pleased to grant you permission to use the FSI. My only request are to cite the copyright (Copyright: Walter H. Gmelch, University of San Francisco) and provide me a summary of the results.

Best of luck with your research.

Walt

Walt Gmelch

Professor of Organization and Leadership
School of Education
University of San Francisco
(415) 422-2108

APPENDIX E
PERMISSION TO ADAPT FACULTY STRESS INDEX

Request to adapt the Faculty Stress Index
From: Jeannie Couper [mailto:jean.couper@shu.edu]
Sent: Monday, February 24, 2014 7:36 AM
To: Walter H Gmelch
Subject: RE: Request to adapt the Faculty Stress Index

Hello Dr. Gmelch,
Thank you again for permission to use the FSI. I am seeking your permission to adapt the scale.
I am interested in adapting the scale in such a way as to change N/A to never and be represented with a 0 on the scale. This appears to make the most sense in the survey of clinical nursing faculty. Thank you for consideration of this request.

Respectfully,
Jeannie

Jeannie Couper, MSN, RN-BC
RWJF NJNI Nursing Faculty Scholar
Seton Hall University College of Nursing
400 South Orange Avenue

Request to adapt the Faculty Stress Index
From: Walter H Gmelch [whgmelch@usfca.edu]
Sent: Monday, February 24, 2014 11:20 AM
To: Jeannie Couper
Subject: RE: Request to adapt the Faculty Stress Index

Hi Jennie!

As long as your advisor is OK with the psychometrics of this change, it is fine with me.

Best of luck,

Walt

APPENDIX F

PERMISSION TO USE SPOS

From: Jeannie Couper [jean.couper@shu.edu]
Sent: Wednesday, August 07, 2013 3:34 PM
To: reisenberger2@uh.edu
Subject: Request to use the SPOS

Dear Dr. Eisenberger,

Thank you for maintaining the 'Perceived Organizational Support Website' as I found it to be most helpful. I am a PhD student at Seton Hall University College of Nursing preparing to conduct a research study addressing role strain, faculty stress, and perceived organizational support experienced by clinical nurse educators. I am very interested in using the SPOS as I believe it will capture the phenomena of interest. Please advise me as to the protocol to secure your permission.

I look forward to your response.

Best Regards,

Jeannie Couper, MSN, RN-BC
RWJF NJNI Nursing Faculty Scholar
Seton Hall University College of Nursing
400 South Orange Avenue
South Orange, NJ 07079

Request to use the SPOS

From: Eisenberger, Robert W [reisenbe@Central.UH.EDU]
Sent: Wednesday, August 07, 2013 3:34 PM
To: Jeannie Couper
Subject: Request to use the SPOS

Hi Jeannie,
Thanks for your interest in POS. I am happy to give permission for you to use the SPOS.

Best of luck with your research.

Cordially,
Bob

Robert Eisenberger
Professor of Psychology
College of Liberal Arts & Soc. Sciences
Professor of Management
C. T. Bauer College of Business
University of Houston reisenberger2@uh.edu
(302)353-8151

APPENDIX G
PERMISSION TO USE SPOS USED BY GUTIERREZ ET AL. (2012)

Permission to use SPOS
Jeannie Couper
Sent: Monday, February 24, 2014 10:44 AM
To: Antonio.Gutierrez@unlv.edu

Hello Dr. Gutierrez,
I am a doctoral student at Seton Hall University. I am in the process of writing the dissertation addressing faculty stress, role strain, and perceived organizational support for clinical nursing faculty.

I have secured permission from Dr. Eisenberger to use the SPOS. I am interested in using the nine-item version you and your colleagues used in your study of nursing faculty found in Gutierrez, A. P., Candela, L.L., & Carver, L. (2012). The structural relationships between organizational commitment, global job satisfaction, developmental experiences, work values, organizational support, and person-organization fit among nursing faculty. *Journal of Advanced Nursing, 68*(7), 1601-1614. doi:10/1111/j.1365-2648.2012.05990.x

I request your permission to use this nine-item version. I look forward to sharing my findings with you.

Respectfully,
Jeannie

Jeannie Couper, MSN, RN-BC
RWJF NJNI Nursing Faculty Scholar
Seton Hall University College of Nursing

Permission to use SPOS
Antonio.Gutierrez@unlv.edu [Antonio.Gutierrez@unlv.edu]
Sent: Monday, February 24, 2014 12:49 PM
To: Jeannie Couper

Hi Jeannie:

By all means ... please feel free to use it. Thank you for the courtesy of asking. :-)

Antonio

Antonio P. Gutierrez, PhD
Grant Writer & Coordinator
Center for Mathematics, Science, and Engineering Education (CMSEE)

College of Education - College of Engineering - College of Sciences
University of Nevada, Las Vegas
4505 Maryland Parkway, Box 453001, Carlson Education Building, Room 308
Las Vegas, NV 89154-3001
Phone: 702-895-3556; Fax: 702-895-4068

APPENDIX H
DEMOGRAPHIC QUESTIONNAIRE

INSTRUCTIONS: The following are possible personal and professional characteristics.

Please click the response that most accurately describes you.

1. During the past six years, *were* you teaching full-time or part-time in an accredited professional nursing program when confronted with the decision to assign a failing grade to a nursing student in a clinical practicum?

0 No

1 Yes

2. Have you taught as a clinical nurse faculty member for at least 1 clinical practicum?

0 No

1 Yes

3. What is your present employment status?

1 Full-time
2 Part-time
3 Adjunct
4 Retired
5 No longer in academia

4. What is your gender?

0 Male

1 Female

5. What best describes your race/ethnicity?

1 African
2 African American
3 Asian
4 Asian American
5 Black/Islander
6 Caucasian/White
7 Hispanic/Latino
8 American Indian/Alaskan Native
9 Native Hawaiian/Pacific Islander
10 Mediterranean
11 Other PLEASE SPECIFY _____
12 Prefer not to say

6. What is currently your highest degree held?

1 Bachelors
2 Master's- Clinical Focus
3 Master's- Education Focus
4 Master's- Administration Focus
5 Master's degree outside of nursing
6 DNP
7 PhD in Nursing
8 PhD outside of Nursing
9 EdD in Nursing
10 EdD outside of Nursing
11 DScN
12 Other: PLEASE SPECIFY __

7. What kind of nursing program are you currently teaching in? (Choose all that apply.)

1 Diploma
2 Associate
3 Bachelors
4 Masters
5 PhD
6 DNP

8. Which accrediting body is your nursing program accredited by?

1 Commission on Collegiate Nursing Education (CCNE)
2 National League for Nursing Accrediting Commission (NLNAC)
3 Accreditation Commission for Education in Nursing (ACEN)
4 None
5 I do not know

9. What part of the country is your institution located in?

1 Northeast: ME, VT, NH, MA, CT, RI, NY, PA, NJ
2 Southeast: MD, DE, DC, VA, WV, NC, SC, GA, FL
3 North Central: ND, SD, MN, WI, MI
4 Central: NE, IA, KS, MO, IL, IN, OH
5 South Central: CA, NV, UT, AZ, CO, NM, HI
6 Northwest: WA, OR, MT, ID, WY, AK
7 Southwest: CA, NV, UT, AZ, CO, NM, HI

INSTRUCTION: Type the best numerical response to the following questions.

10. What is your age in years? _____

11. How many years have you taught nursing? _____

INSTRUCTIONS: The following are possible personal and professional characteristics that may describe you *during the time when you faced the decision to assign a failing grade to a nursing student in a clinical practicum and you wrestled with the decision*. As you continue the survey, please reflect on your personal experience during that time.

Please click the response that most accurately describes you <u>during that time</u> when faced with the decision to assign a failing grade to a nursing student in a clinical practicum.

12. What *was* your employment status?

1 Full-time
2 Part-time

13. What *was* your rank at *that time*?

1 Instructor
2 Assistant Professor
3 Associate Professor
4 Professor
5 Other: PLEASE SPECIFY_____
6 I do not remember

14. What *was* your highest degree held?

1 Bachelors
2 Master's- Clinical Focus
3 Master's- Education Focus
4 Master's- Administration Focus
5 Master's degree outside of nursing
6 DNP
7 PhD in Nursing
8 PhD outside of Nursing
9 EdD in Nursing
10 EdD outside of Nursing
11 DScN
12 Other: PLEASE SPECIFY __

15. *Were* you enrolled in a Doctoral program at the time?

0 No
1 Yes

16. What activities *had you engaged in* as preparation for the clinical nurse faculty role? (Choose all that apply.)

1 Graduate degree
2 Post Master's Certificate
3 Professional conferences
4 Orientation to faculty role
5 Faculty development courses
6 Courses related to education
7 Courses to become Certified Nurse Educator
8 No preparation

17. *Were* you a Certified Nurse Educator?

0 No
1 Yes

18. What area *was* your primary responsibility?

1 Clinical only
2 Classroom and Clinical

19. During that time, *were* you employed in another direct patient care role?

0 No

1 Yes

20. What kind of nursing program *were you teaching in*?

1 Diploma 4 Masters

2 Associate 5 PhD

3 Baccalaureate 6 DNP

21. What accrediting body *was* your nursing program accredited by? (Choose all that apply)

1 Commission on Collegiate Nursing Education (CCNE)

2 National League for Nursing Accrediting Commission (NLNAC)

3 Accreditation Commission for Education in Nursing (ACEN)

4 None

5 I do not know

22. Who did you feel supported by *while* you were confronted with the decision to assign a failing grade to a student in a clinical practicum?

1 Colleagues 4 Administration other than Dean

2 Chairperson 5 Dean

3 Mentor 6 Prefer not to say

INSTRUCTION: Please type the best numerical response to the following questions.

23. How many students *were* in your clinical group? (Enter 0 if you do not remember)

_____

24. How many years had you been *employed at your institution* when you were confronted with the decision to assign a failing grade to a student in a clinical practicum? _____

25. How many years had *you practiced nursing* as a Registered Nurse? _____

26. How many years had you been *employed as a clinical nurse faculty* member? ___

INSTRUCTIONS: Please click the response that most accurately describes the <u>failing student</u> encountered at the time when you were confronted with the decision to assign a failing clinical grade.

27. What was the level of the student who *was failing* the clinical practicum?

1 Freshman
2 Sophomore
3 Junior first semester
4 Junior second semester
5 Senior first semester
6 Senior last semester
7 Graduate preparing for clinical role
8 Graduate preparing for non-clinical role
9 I do not remember

28. *Did* you assign a failing grade?

0 No
1 Yes

29. *Did any change*(s) occur in your teaching practices after your deliberation to assign a failing clinical grade?

0 No
1 Yes

INSTRUCTIONS: Type a response that most accurately describes your experience.

30. What change(s) occurred in your teaching practices *after* your deliberation to assign a failing clinical grade?

_____
_____
_____
_____
_____

APPENDIX I
PERMISSION TO POST TO PROFESSIONAL NURSE EDUCATORS GROUP

Permission requested for LinkedIn group: PNEG
Jeannie Couper through LinkedIn
Sent: Monday, December 30, 2013
To: Mary Gambino [mgambino@kumc.edu]

Hello,
I am in the midst of pursuing a PhD in Nursing at Seton Hall University. I am interested in including the group members in the study as the study targets clinical nurse educators. I need written permission to be submitted with the IRB application granting permission to post a description of the study with an invitation to participate, and a link to access the study for the group members.

If possible, please send written permission via email. I greatly appreciate your assistance.

Jeannie Couper, MSN, RN-BC
RWJF NJNI Nursing Faculty Scholar
Seton Hall University College of Nursing

Permission requested for LinkedIn group: PNEG
January 2, 2014

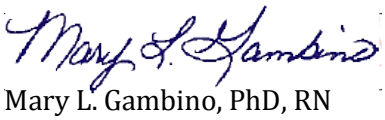
Jeannie Couper
jean.couper@shu.edu
RWJF NJNI Nurse Faculty Scholar
PhD Student in Nursing at Seton Hall University

Dear Ms. Couper:

As the Professional Nurse Educators Group **LinkedIn** group manager, I hereby grant permission to post a description of your clinical nurse educator study with an invitation to participate, and a link to access the study for the group members, pending receipt of your final IRB approval. If you also wish to post your invitation on the PNEG listserv, you will need to contact Nancy at (319) 335-7075.

We hope you will consider submitting your findings for publication in the *Journal of Continuing Education in Nursing*. Best wishes for excellent participant recruiting.

Sincerely,



Mary L. Gambino, PhD, RN
Assistant Dean for Community Affairs
Director of Nursing Continuing Education
Clinical Assistant Professor
University of Kansas School of Nursing
MS 4043; 3901 Rainbow Blvd.
Kansas City, Kansas 66160
(913) 588-1695

APPENDIX J
PERMISSION TO POST TO CLINICAL NURSE EDUCATOR GROUP

Request for permission
Jeannie Couper

Sent: Monday December 30, 2013
To: Barbara Switzer [bswitzer33@yahoo.com]

Hello Barbara,

I am in the midst of pursuing a PhD in Nursing at Seton Hall University. I am interested in including the CNE group members in the study as the study targets clinical nurse educators.

I need written permission to be submitted with the IRB application granting permission to post a description of the study with an invitation to participate, and a link to access the study for the group members.

If possible, please send an email to my school address: jean.couper@shu.edu.

I greatly appreciate your assistance.

Respectfully,
Jeannie Couper

Jeannie Couper, MSN, RN-BC
RWJF NJNI Nursing Faculty Scholar
Seton Hall University College of Nursing

Request for permission
Barbara Switzer [bswitzer33@yahoo.com]

Sent: Tuesday, December 31, 2013 9:15 AM
To: Jeannie Couper
Subject: Request for Permission

Voluntary participation is fine for an academic professional study of clinical nurse educators. You can provide a link on the Clinical Nurse Educators LinkedIn discussion board.

Sincerely,
Barbara

APPENDIX K
PERMISSION TO POST TO NRSINGED LISTSERV

Re: Written Permission Needed/Granted.
Nurse Educators E-mail List [NRSINGED-owner@lists.uvic.ca]

ent: Sunday, January 12, 2014 1:06 PM

o: Jeannie Couper

To whom it may concern:

Jeannie Couper, "Jeannie Couper <jean.couper@shu.edu>" is a subscribed member of the e-mail discussion list NRSINGED, hosted for twenty plus years at the University of Victoria; as such Jeannie Couper is entitled to use all of the NRSINGED list resources for her Nurse Educator related purposes.

Other Nurse Educator list members have used the list membership participation to complete their surveys/studies towards completing advanced study degrees within the twenty plus year's list history.

"Jeannie Couper <jean.couper@shu.edu>" is also entitled to written permission to post a description of the clinical nurse educator study with an invitation to participate, and a link to access the study for the group members. She definitely does have "that" permission to interact with the two thousand NRSINGED list membership.

Thank you,

NRSINGED

***
*** ***NRSINGED Member's Subscription Options are at
http://lists.uvic.ca/mailman/listinfo/nrsinged
The Uvic Mailman-NRSINGED Archive is at
http://lists.uvic.ca/mailman/private/nrsinged/

APPENDIX L
RECRUITMENT EMAIL

Subject: Recruiting Clinical Nurse Faculty to participate in research study

Dear colleague,

I am recruiting a national sample of clinical nurse faculty members, who have faced the decision to assign a failing grade to a student in a nursing clinical practicum, to participate in an online research study. As a doctoral student at Seton Hall University, I am studying the interrelationships among perceived role strain, perceived faculty stress, and perceived organizational support for clinical nurse faculty faced with the decision to assign a failing grade to a student in a nursing clinical practicum.

You are invited to participate by following the link below to access the study questionnaire on SurveyMonkey™ through an encrypted connection. Feel free to forward this email to your colleagues; particularly those you know have left academia. Click on the link or paste the link into your browser: **https://surveymonkey-CNF-rolestrain-facultystress-organizationalsupport.com**.

The survey will close on xx-xx-2014. If you have any questions, please feel free to contact me. Thank you for your time and participation!

Best Regards,
Jeannie Couper

Jeannie Couper, MSN, RN-BC
RWJF NJNI Nursing Faculty Scholar
Seton Hall University College of Nursing
400 South Orange Avenue
South Orange, NJ 07079
jean.couper@shu.edu

APPENDIX M
RECRUITMENT POST FOR LISTSERV AND DISCUSSION BOARD

Subject: Recruiting Clinical Nurse Faculty to participate in research study

Dear colleagues,

I am recruiting a national sample of clinical nurse faculty members, who have faced the decision to assign a failing grade to a student in a nursing clinical practicum, to participate in a voluntary online research study. As a doctoral student at Seton Hall University College of Nursing, I am studying the interrelationships among perceived role strain, perceived faculty stress, and perceived organizational support for clinical nurse faculty faced with the decision to assign a failing grade to a student in a nursing clinical practicum. The time expected to complete the survey is approximately 20 minutes. All information will be kept confidential and secured on USB memory sticks secured in a locked office.

You are invited to participate by following the link below to access the study questionnaire on SurveyMonkey™ through an encrypted connection. Feel free to forward this email to your colleagues; particularly those you know have left academia. Click on the link or paste the link into your browser: **https://surveymonkey-CNF-rolestrain-facultystress-organizationalsupport.com.**

If you have any questions, please feel free to contact me. Thank you for your time and participation!

Best Regards,

Jeannie Couper MSN, RN-BC

RWJF NJNI Nursing Faculty Scholar

PhD student at Seton Hall University

jean.couper@shu.edu

APPENDIX N
ONLINE SOLICITATION SCRIPT

Welcome to the research study titled "An exploration of the relationships between and among role strain, faculty stress, and organizational support for Clinical Nurse Faculty (CNF) faced with the decision to assign a failing grade." The primary investigator, Jeannie Couper, RN-BC, MSN, is a doctoral candidate at Seton Hall University, College of Nursing. You may contact her at Seton Hall University, College of Nursing, 400 South Orange Avenue, South Orange, NJ 07079, Telephone 973-761-9097, jean.couper@shu.edu. Her advisor, Dr. Jane Cerruti Dellert, can be contacted at Seton Hall University College of Nursing, 400 South Orange Avenue, South Orange, NJ 07079, Telephone: 973-761-9283, FAX: 973-761-9607, jane.dellert@shu.edu. If you have any questions concerning the study and your rights as a participant, you may contact Dr. Mary F. Ruzicka, Director of Internal Review Board, Seton Hall University at Telephone: 313-6314, FAX: 973-275-2361, irb@shu.edu.

The purpose of this descriptive correlational study is to explore these relationships as the first step in identifying the factors that influence CNF's decision-making process in assigning the failing grade, and provide insights into understanding perceived role strain, perceived faculty stress, and perceived organizational support experienced by CNF. Furthermore, the findings may facilitate a deeper appreciation of potential effects of student failure as related to faculty retention as well as inform educational supportive practices for faculty facing the decision to assign a failing clinical grade.

As a participant, you are asked to complete a 4-part online survey with an expected completion time of approximately 20 minutes. Participants are asked to reflect on the time when the participant considered assigning a failing grade to a clinical nursing student. Submission of the survey implies your consent to participate in this research study.

The survey consists of the Role Strain Scale (RSS), Faculty Stress Index (FSI), Survey of Perceived Organizational Support (SPOS), and researcher-developed questionnaire. The RSS, FSI, and SPOS are all Likert-type scales. The Role Strain Scale consists of 23-items such as *dealing with students who are inadequately prepared or poorly motivated*. The Faculty Stress Index consists of 45-items such as *being unclear as to the scope and responsibilities of my job*. The Survey of Perceived Organizational Support consists of nine-items such as *the organization is willing to extend itself in order to help me perform my job to the best of my ability*. The researcher-developed questionnaire consists of a total of 30 questions; 6 fill-ins, 23 multiple-choice, and one open-ended response. For example, these questions concern years in teaching position, formal preparation for teaching, highest degree held, and certification status.

Participation is voluntary and as such, a participant can choose not to respond to the survey or to exit the survey at any time prior to submission without fear of repercussions. A potential risk exists for participants to experience psychological stress as a result of recalling a situation believed to be a source of stress while

answering the survey. Participants are encouraged to speak with a counselor of their choosing should they believe it necessary as a result of participating.

Responses will be accessible exclusively to the primary investigator, Jeannie Couper, RN-BC, MSN. Confidentiality will be maintained at all times. Data will be secured in a confidential file on USB memory sticks accessible only to the investigator to maintain confidentiality. Results will be reported solely in aggregate form as responsibilities of the researcher.

Participants are to refrain from completing the survey more than once. If a participant exits the survey prior to submission, the hypertext link will allow the participant to return to complete the survey when using the same computer (same IP address). Reentry to a survey requires the participant to enable cookies on their computer.

No monetary compensation will be provided to participants in exchange for participation. The direct or personal benefits of participation are unknown. The study results may reveal information concerning the relationships among perceived role strain, perceived faculty stress, and perceived organizational support among CNF. The benefits of evaluating these relationships may reveal the frequency of this dilemma in nursing education, and assist in the design and implementation of supportive educational practices to ensure CNF do the *right thing* (Smith et al., 2001) and fail the student who has not attained the required competencies or met the course learning outcomes.

Thank you for your time, energy, and consideration to participate in the online research study!

Jeannie Couper, MSN, RN-BC

Seton Hall University Doctoral Student

APPENDIX O
FOLLOW-UP RECRUITMENT EMAIL

Subject: Thank you!

Dear colleagues,

A heart-felt thank you to all those who have participated in my online research study! Your time and energy expended on my behalf are much appreciated. I look forward to reporting the findings.

I urge those who have not yet responded, to please participate by following the link below to access the study survey on SurveyMonkey™ through an encrypted connection. Feel free to forward this email to your colleagues; particularly those you know have left academia. Click on the link, or paste the link into your browser: **https://surveymonkey-CNF-rolestrain-facultystress-organizationalsupport.com.**

The survey will close on xx-xx-2014. If you have any questions, please feel free to contact me. Thank you for your time and participation!

Best Regards,

Jeannie Couper

Jeannie Couper MSN, RN-BC

RWJF NJNI Nursing Faculty Scholar

PhD Student at Seton Hall University

South Orange, NJ 07079

(973) 902-9929

jean.couper@shu.edu

APPENDIX P
FOLLOW-UP RECRUITMENT POST FOR DISCUSSION BOARDS

Subject: Thank you!

A heart-felt thank you to all members who have participated in my online research study! Your time and energy expended on my behalf are much appreciated. I look forward to reporting the findings.

I urge those members who have not yet responded, to please participate by following the link below to access the study survey on SurveyMonkey™ through an encrypted connection. Thank you for forwarding this email to your colleagues; particularly those you know have left academia.
Click on the link, or paste the link into your browser:
https://surveymonkey-CNF-rolestrain-facultystress-organizationalsupport.com.

If you have any questions, please feel free to contact me. Thank you for your time and participation! Best Regards, Jeannie Couper MSN, RN-BC, RWJF NJNI Nursing Faculty Scholar, PhD student at Seton Hall University, jean.couper@shu.edu

APPENDIX Q

NIH CERTIFICATE OF COMPLETION

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Jeannie Couper** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 02/26/2014

Certification Number: 1415429