NURSING ETHICS AND FAILURE TO FAIL IN CLINICAL NURSING EDUCATION

by

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ABSTRACT

The phenomenon of failure to fail (FTF) was introduced into nursing literature in 1990 by Annette Lankshear, a British nurse educator who published a study examining nurse preceptors' failure to fail students performing poorly during a clinical preceptorship (Duffy, 2013). In the United States (US), most undergraduate nursing programs utilize full-time faculty to teach in the classroom and clinical settings. Clinical nursing faculty (CNF) are responsible for training, evaluating, and assigning clinical performance grades for up to 10 students who may be enrolled in their clinical group. Limited research has been published in the US exploring the phenomenon of FTF in clinical nursing education. A gap in the literature also exists examining the level of ethical responsibility a clinical nursing faculty believes they assume after evaluating a student's clinical performance as unsatisfactory. This cross-sectional, descriptive qualitative study was guided by deonance theory and duty orientation and focused on eight female CNF who teach, evaluate, and assign clinical performance grades to groups of students enrolled in two associate and two bachelor's degree nursing programs in the south part of a southern state. This study sought to answer two research questions: 1) what reasons do clinical nursing instructors provide for assigning a passing clinical performance grade to a student they assess as unsatisfactory; and 2) what ethical responsibility does a clinical nursing instructor assume in the student clinical performance evaluation and grade assignment process? The study produced evidence of inconsistencies in the clinical performance evaluation systems used by each program, variances in reporting student failure to meet clinical performance objectives, subjective descriptors used

on current clinical performance evaluation tools, and grading leniency that could be factors contributing to FTF in clinical nursing education.

DEDICATION

I dedicate this work in loving memory to my parents, August Eugene (Gene) Wiggins and Elouise Hoover Wiggins. You taught me the value of an education and the opportunities it would afford me. Your love and support have guided me through my life and educational journey.

LIST OF ABBREVIATIONS AND SYMBOLS

ANA	American Nurses Association
CNF	Clinical Nursing Faculty
CPET	Clinical Performance Evaluation Tool
DT	Deonance Theory
DO	Duty Orientation
FTF	Failure to Fail
ID	Interpretive Description
NCSBN	National Council of State Boards of Nursing
NLN	National League for Nursing
RN	Registered Nurse
ROL	Review of Literature
UK	United Kingdom
US	United States

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CONTENTS

LIST OF TABLES

CHAPTER I:

INTRODUCTION

The term failure to fail (FTF) is defined as "the allocation of a passing grade to a nursing student who has failed to deliver a satisfactory performance in the clinical setting" (Hughes et al., 2016, p. 55). The phenomenon of FTF was introduced into nursing literature in 1990 by Annette Lankshear, a British nurse educator who published a study examining nurse preceptors' FTF students performing poorly during a clinical preceptorship (Duffy, 2013). FTF in clinical nursing education is a problem having profound implications for students, faculty, nursing professionalism, and patient safety (Hughes et al., 2016). Clinical nursing faculty (CNF) who fail to evaluate a student's unsatisfactory clinical performance accurately is guilty of misleading the student, potentially jeopardizing patient care, placing the student's future instructors at a disadvantage, and could put themselves at risk of a claim of educational malpractice (Christensen, 2016).

Undergraduate nursing programs employ full-time nursing faculty to teach in the classroom and/or clinical setting. Adjunct CNF are also utilized in many nursing programs to fill critical gaps created by a rising shortage of academic nurse educators (McAfooes, 2016). The National Council of State Boards of Nursing (NCSBN) requires that an undergraduate nurse faculty hold a minimum master's degree in nursing, but not specifically in nursing education (NCSBN, 2021). Each state board of nursing establishes its ratio of CNF to students with the average ratio being 1:10 (Jackson et al., 2008). The role of CNF usually requires training, evaluating, and assigning clinical performance grades for students enrolled in the clinical group

(Bonnel, 2015). CNF are professionally and ethically obligated to assess each student's ability to perform at a level of competence that guarantees the safe and accurate delivery of patient care (Bonnel, 2015; Christensen, 2016; Earle-Foley et al., 2012).

Preceptorship clinical experiences are incorporated into many BSN and some ADN nursing programs in the US to provide students with one-on-one teaching, guidance, and support from a nurse preceptor (Gubrud, 2016). A nurse preceptor is defined as "an individual at or above the level of licensure that an assigned student is seeking who may serve as a teacher, mentor, role model, or supervisor in a clinical setting" (NCSBN, 2021, p. 1). Registered nurses (RN) currently employed by clinical agencies are typically identified by their organization's leadership to serve as nurse preceptors for nursing programs. A nurse preceptor facilitates and evaluates student learning in a clinical area for a specified period, typically ranging from 180-240 hours (Gubrud, 2016). A preceptor should be a clinical expert and willing to serve as a clinical teacher, mentor, and role model (Gubrud, 2016). Preceptorships are used at different levels in a nursing program but are often useful at the senior level (Gubrud, 2016). Nursing faculty facilitate the preceptorship by meeting with the preceptor to review objectives, expected learning outcomes, assignments, required documents, and performance evaluations, and serve as a consultant (Gubrud, 2016). The preceptor also conducts formative and summative evaluations of the student's clinical performances to determine if the learning outcomes are being achieved and reports the results to the nurse faculty (Gubrud, 2016). Although preceptorships are utilized in undergraduate programs in the US, most research on the phenomenon of FTF in nursing education has examined preceptors from Australia, the United Kingdom (UK), and Canada (Black et al., 2014; Duffy, 2013; Earle-Foley et al., 2012; Hughes et al., 2016; Hunt, 2019; Larocque & Luhanga, 2013; Luhanga, 2014; Vinales, 2015).

Nursing programs establish outcomes (also referred to as student learning outcomes or expected outcomes) for each course in the curriculum. Outcomes represent the integrated knowledge, skills, and abilities or competencies that students are expected to demonstrate upon completion of each course and at the completion of the program (Sullivan, 2016). Competency statements are important in assessing student learning because they are the foundation that drives an evaluation (Sullivan, 2016). Exam scores are usually used to measure knowledge of the content taught in the classroom setting. However, clinical competency is determined through an evaluation of a student's performance(s) during each clinical experience. CNF are responsible for evaluating a student's ability to perform at a satisfactory level. The clinical experience is the ideal time for the clinical instructor to observe each student's performance to identify and correct weaknesses in a student's clinical skills and knowledge (Paskausky & Simonelli, 2014). CNF serve as gatekeepers to the nursing profession in that they have an essential role in ensuring students are safe and competent practitioners (Anthony & Wickman, 2015; Black et al., 2014; Chunta & Custer, 2018). When evaluating clinical performances, nursing students should be held to the established standards of nursing care, with the outcome being the provision of safe, quality patient care (Bonnel, 2015). FTF historically occurs when a CNF evaluates a student's clinical performance as unsatisfactory or unsafe but fails to document the behavior on the clinical evaluation form.

The principles of service and duty guide the nursing profession and offered a theoretical framework to guide this study. Hannah et al. (2014) defined duty orientation (DO) as the representation of an individual's volitional orientation to loyally serve and faithfully support other members of the group, to strive and sacrifice to accomplish the tasks and missions of the

group, and to honor its codes and principles. DO is described as understanding one's responsibilities of fidelity and loyalty to a given group and its moral codes (Hannah et al., 2014).

The 2015 American Nurses Association (ANA) Code of Ethics for Nurses with interpretive statements and the 2018 National League of Nurses Competencies for Academic Clinical Nurse Educators were the conceptual frameworks that also guided this study. Nurse educators represent two professions known for upholding high moral and ethical standards. When a nurse educator FTF an unsafe student, they violate moral and ethical standards of nursing and education. Assigning a passing clinical grade to a student who is not performing at a competent level is dishonest, unprofessional, and violates ethical principles of nursing (Anthony & Wickman, 2015; Black et al., 2014).

The CNF and nursing student relationship are based on collaboration, understanding, mutual trust, respect, equality, and accountability (Christensen, 2015). Nursing students have the right to a reliable and valid clinical performance evaluation that reflects the achievement of clinical competencies needed to function within the role of a novice nurse (Bonnel, 2015; Frank, 2020). Providing students with an ongoing formative evaluation allows CNF to keep students informed of their progress toward achieving clinical outcomes (Bonnel, 2015; Christensen, 2015; Frank, 2020). Routine performance evaluations can also serve as an opportunity for the instructor to raise awareness when a student is not demonstrating clinical progression or failing to maintain clinical competence.

When a CNF recognizes that a student is not performing at a satisfactory level, it is their ethical and professional duty to intervene (ANA, 2015; Black et al., 2014; Christensen, 2015; Earle-Foley et al., 2012; Fitzgerald et al., 2020; Hughes et al., 2016; Hunt, 2019; Lachman et al., 2015; NLN, 2020; Winland-Brown et al., 2015). An unsatisfactory clinical performance warrants

immediate verbal notification by the instructor at the time of the incident, especially if the infraction could result in causing harm to a patient (Frank, 2020). Depending on the incident, it may be advisable to remove the student from the clinical setting for the remainder of the clinical day (Bonnel, 2015). It is always best practice for a CNF to document any incident of unsatisfactory clinical performance and provide the student with a copy (Bonnel, 2015; Christensen, 2015; Frank, 2020). Attaching the document to the student's clinical performance evaluation record is also recommended in the event of future occurrences (Frank, 2020). CNF are also ethically and legally bound to report any student performance incident involving a patient to the proper clinical setting administrators (Christensen, 2015).

Early identification of student performance issues should be followed by developing a written remediation plan (Bonnel, 2015; Christensen, 2015; Chunta, 2016; Chunta & Custer, 2018; Frank, 2020). A student at risk for failure should be notified in writing (Bonnel, 2015; Christensen, 2015; Chunta, 2016; Chunta & Custer, 2018; Frank, 2020). If a student continues to perform at an unsatisfactory level, the CNF is ethically and professionally obligated to issue a failing grade (Bonnel, 2015; Christensen, 2015). Killam et al. (2011) recommend that regardless of the level of unsafe behavior all incidents should be formally noted. Allowing an incompetent nursing student to progress through a program is unethical and threatens the credibility and effectiveness of the educational program (Kemper et al., 2004).

For the 20th straight year, the American public has ranked nurses as the most honest and ethical professionals in the annual Gallup Poll (Saad, 2022). The public's trust in nursing could quickly erode if the profession does not attend to maintaining ethical standards in academia today (Ganske, 2010). It is essential to examine the ethical implications occurring when a CNF fails in their duty to assign a failing grade to a student demonstrating unsafe clinical behavior

(Earle-Foley et al., 2012; Ganske, 2010; Larocque & Luhanga, 2015). This issue impacts the entire health care profession and patients (Earle-Foley et al., 2012; Larocque & Luhanga, 2015). When an incompetent health care practitioner is allowed to progress in an educational program, a serious breach of ethical responsibility occurs, placing patients at risk and endangering the profession's integrity (Harding & Greig, 1994).

Statement of the Problem

CNF are responsible for overseeing the clinical performances of each student in their clinical group. It is a CNF's professional and ethical obligation to observe and accurately evaluate a student's performance during each clinical experience. When a student fails to perform at a satisfactory level during the clinical experience, the CNF also has a professional and ethical responsibility to notify the student that their performance is unsatisfactory and issue a failing clinical performance grade. If a student is never made aware that their clinical performance is not satisfactory, they will not recognize the need to correct unsatisfactory behavior. When a CNF fails to assign a failing grade to a student performing at an unsatisfactory level during the clinical experience, the student could either cause patient harm or death.

Purpose of the Study

The purpose of this descriptive qualitative study was to explore the phenomenon of FTF in undergraduate nursing programs in the US. The study focused on CNF who train, evaluate, and assign clinical performance grades to groups of students completing either an associate or Baccalaureate clinical nursing course and have experienced students who were not performing at a satisfactory level. The goal of the study was to determine why this phenomenon may be occurring so measures can be established to eliminate this unethical educational practice.

Significance of the Study

Assigning a failing grade can be a difficult decision for a CNF. However, failing to assign a failing grade to a student performing at an unsatisfactory level in the clinical setting has the potential for causing harm or even death to a patient. CNF play a crucial role in establishing a strong, safe nursing workforce (Maloney, 2019). CNF should be very concerned if a student routinely demonstrates inconsistent and incorrect skill performance, errors in judgment, or poor communication skills since these types of behaviors are reflective of dangerous practices (Killam et al., 2011). When a CNF identifies a student who is not satisfactorily meeting the course objectives, it is their legal and ethical responsibility to deny the student's progression (ANA, 2015; Bonnel, 2015; Christensen, 2015). Passing an unsafe student causes difficulties for employers and staff education specialists when the hired graduate student cannot perform at the expected entry-level of competency and safety (Chunta, 2016). Determining causes contributing to the phenomenon of FTF in nursing education can raise awareness and support a need for continuing nursing educational development to close a potentially lethal gap in clinical educational practice.

Research Questions

The overarching research questions prompting this study were 1) what reasons do clinical nursing faculty provide for assigning a passing grade to a student whose performance they evaluate as unsatisfactory; and 2) what do clinical nursing faculty believe are their ethical responsibilities in the student clinical performance evaluation and grade assignment process?

Assumptions

The primary assumption of this study was that some CNF fail to issue a failing grade to students who perform at an unsatisfactory level in undergraduate ADN and BSN programs in the

US. This assumption was based on my experience as a CNF for the final clinical nursing course in an ADN program. The clinical objectives for our curriculum require students to maintain competency in previously learned skills to achieve a satisfactory clinical grade and advance through the program. However, an increased number of students have been progressing to the final clinical nursing course and are unable to independently perform many previously learned basic nursing skills despite my prompting and remediation.

Limitations

Limitations identify potential weaknesses in a study and are usually related to the research method, data collection, and data analysis (Webb, 2016). A potential limitation of this study could have occurred during the data collection phase if participants were not willing to admit that they have failed to assign a failing grade to a student performing at an unsatisfactory level. Measures were taken to ensure anonymity and confidentiality and were clearly stated in the informed consent and restated before initiating each interview.

Delimitations

Delimitations narrow the scope of a study to specific participants, sites, or phenomena (Webb, 2016). This study only included full-time CNF teaching in undergraduate ADN and BSN programs in a southern US state.

Summary

FTF in clinical nursing education is a problem with profound implications for students, faculty, nursing professionalism, and patient safety (Hughes et al., 2016). CNF who fail to accurately evaluate a student's unsatisfactory clinical performance are performing a disservice to the student, violating ethical principles of nursing, and placing patient safety at risk. Researching

the phenomenon of failure to fail in nursing education was needed to determine why it is occurring and develop measures needed to eliminate this dangerous educational practice.

CHAPTER II:

REVIEW OF THE LITERATURE

The purpose of this chapter was to provide a literature review of currently published data on the topic of nursing ethics and FTF in clinical nursing education. In nursing education, the term FTF is defined as "the allocation of a passing grade to a nursing student who has failed to deliver a satisfactory performance in the clinical setting" (Hughes et al., 2016, p. 55). Clinical nursing faculty (CNF) serve as gatekeepers to the nursing profession in that they have an essential role in ensuring students are safe and competent practitioners (Anthony & Wickman, 2015; Black et al., 2014; Chunta & Custer, 2018). CNF have a professional and ethical obligation to observe and accurately evaluate a student's performance during each clinical experience. When a student fails to perform at a satisfactory level during the clinical experience, the CNF also has a professional and ethical duty to make them aware of their unsatisfactory performance and issue a failing clinical performance grade. FTF occurs when a CNF evaluates a student's clinical performance as unsatisfactory or unsafe but fails to document the behavior and assigns a failing grade.

Theoretical Framework

The theoretical frameworks of deonance theory (DT) and duty orientation (DO) guided this research. Deonance (a neologism) is derived from the Greek word deon referring to a duty of obligation (Folger, 2012). In 2012, business professor Robert Folger published a book chapter presenting a theoretical analysis of the duties and obligations people experience and how they influence their behavior in business organizations (Folger, 2012). He also introduced deonance

theory (DT) which he described as a process theory proposing a hypothetical construct, a psychological state of deonance, generated when a situation conjures beliefs about the relevance of moral directives (Folger, 2012). DT focuses on behaviors that are commonly perceived as reasonable, appropriate, legitimate, and justifiable (Folger, 2012). DT takes an empirical approach (descriptive rather than prescriptive) to study business conduct with tools derived from the behavioral sciences (Folger, 2012).

Deonance theory (DT) was also used to form the theoretical basis for duty orientation (DO) (Hannah et al., 2014). Hannah et al. (2014) believed that when faced with ethical choices, individuals who have a high sense of DO tend to activate higher levels of deonance (Hannah et al., 2014). The authors assessed the construct validity and predictive validity of a measure of DO across five studies and six samples and determined that DO mediates the relationship between ethical leadership and ethical and unethical behaviors, and between transformational leadership and ethical behavior (Hannah et al., 2014).

Hannah et al. (2014) developed the construct of duty orientation (DO) to advance knowledge about ethical behavior in business organizations. The authors described DO as an individual's volitional orientation to loyally serve and faithfully support other members of the group, to strive and sacrifice to accomplish group tasks and missions, and honor its codes and missions (Hannah et al., 2014). DO also represents an understanding of one's responsibilities of fidelity and loyalty to a given group and its moral codes (Hannah et al., 2014). They propose that those with a high sense of duty often make judgments on ethical issues through the lens of their duty to a group (Hannah et al., 2014). DO and DT have been used as theoretical frameworks when examining business ethics, but both frameworks also applied to the topic of nursing ethics and FTF in nursing education.

DO and DT are ethical codes of duty and standards of moralistic behavior utilized in the business profession to safeguard the public against unethical business practices. The nursing profession is also guided by a similar set of ethical codes of duty and standards of moralistic behavior incorporated into the ANA Code of Ethics. The code of ethics was established to protect patients from unethical nursing practices. The NLN established Competencies for Academic Clinical Nurse Educators which are a set of behaviors that all clinical nursing faculty are expected to exhibit to protect students from incompetent educators. Business and nursing are similar in that both professions have an ethical duty to exhibit moralistic behavior when providing services to others.

Conceptual Framework

Maxwell (2013) defines a conceptual framework as a combination of experiential knowledge, prior theory, and research; a system of concepts, assumptions, expectations, beliefs, and theories that supports and informs research. In a broader sense, the conceptual framework is the broader ideas and beliefs that one holds about a phenomenon studied (Maxwell, 2013).

This research was also guided by the conceptual frameworks of the ANA's 2015 Code of Ethics for Nurses with interpretive statements and the NLN (2018) Competencies for Academic Clinical Nurse Educators. Both documents include assumptions, expectations, and beliefs that guide nursing practice.

American Nurses Association (ANA) Code of Ethics for Nurses

The revised (2015) American Nurses Association (ANA) Code of Ethics for Nurses with interpretive statements is a dynamic document consisting of two components: the provisions and the interpretive statements. Nine provisions are included that are broad and non-contextual statements used to describe a nurse's obligations (ANA, 2015). Each provision also includes a

set of interpretive statements (ANA, 2015). The interpretive statements provide more specific guidance on the application of each obligation to current nursing practice (ANA, 2015). Several provisions and specific interpretive statements directly address the ethical obligations required of nurse educators.

Provision three requires each nurse to promote, advocate for, and protect the rights, health, and safety of the patient. Provision three interpretive statements (ANA, 2015, p. 11) that apply to nursing ethics and FTF in nursing education include the following:

> 3.3 Nurse educators, whether in academics or the healthcare setting, must ensure that basic competence and commitment to professional standards exist before nurse graduates enter into practice;
>
> 3.4 Nurses are responsible for reporting any errors or near misses to the appropriate authority, ensuring disclosure of the mistakes to patients, and establishing processes to investigate these errors to prevent a recurrence. Errors should be corrected, remediated, and never concealed or condoned through silence; and
>
> 3.5 When a nurse becomes aware of inappropriate or questionable practices, they must express their concern to the person involved, and report it to maintain patient safety and protect the integrity of the profession.

CNF are legally and ethically bound to the same standards and are obligated to report near misses and errors. Patient errors must be reported to the patient, clinical facility, and nursing program. Nursing students must be made aware that their mistakes will be acknowledged and reported by their instructors. When a student makes a clinical error, they should be offered remediation and issued a failing grade if warranted by school policies.

Provision five addresses the duties a nurse owes to themselves (as well as to others), including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth. In provision five, interpretive statements are associated with nursing ethics and FTF in clinical nursing education. They include the following:

> 5.3 Nurses integrate their personal and professional identities, embrace the values of the nursing profession, and merge them with their personal values;
>
> 5.4 Personal integrity is an aspect of the wholeness of character requiring reflection and discernment and whose maintenance is a self-regarding duty; and
>
> 5.5 Competence is a self-regarding duty. Nurses must maintain competence and strive for excellence no matter the role or setting. (ANA, 2015, p. 20)

CNF should preserve the wholeness of character and integrity during the clinical performance evaluation and grading process (Lachman et al., 2015). CNF have a professional duty to provide each student with an honest evaluation of their clinical performance. Ignoring a student's clinical mistakes is dishonest, unethical, and demonstrates poor character. Often, identifying performance problems, providing feedback, and referring the student for remediation resolves performance issues. However, if performance problems persist, the student may warrant a failing grade. Failure to assign a failing grade gives the student a false level of clinical competence and places patient safety in jeopardy.

Through individual and collective effort, nurses establish, maintain, and improve the ethical environment of work settings and employment that foster safe and quality health care conditions. Provision six' interpretive statements are related to nursing ethics and FTF in clinical nursing education. They include the following:

> 6.1 Virtues are learned and habituated attributes of moral character predisposing one to meet moral obligations and do what is right. A good nurse displays attributes of moral character such as knowledge, skill, wisdom, patience, compassion, honesty, altruism, and courage. Virtues are necessary to affirm and promote values of human dignity, well-being, respect, health, and independence. Nurses must create, maintain, and contribute to morally good environments which enable them to be virtuous;
>
> 6.2 A nurse is obligated to foster an ethical environment constructed for the equitable, fair, and just treatment of all. Nurses, in all roles, must also reflect the values of the profession and nurture excellent nursing practice and support others to fulfill their ethical obligations; and
>
> 6.3 Unsafe or inappropriate activities or practices should not be condoned or allowed to persist. (ANA, 2015, p. 23)

CNF serve as role models and should behave as paragons of virtue. Moral character includes honesty and courage. Students must be able to trust that their CNF is being honest. CNF must have the courage to do the right thing for their students even if it is uncomfortable. Being honest with a student who is not performing at a satisfactory level takes great courage, but it is the right thing to do. Issuing a passing clinical performance grade to a student who is not performing at a satisfactory level is unethical and compromises patient safety. When a student is not made aware of a performance mistake (or near miss), they are led to believe that they are performing at a competent level. This practice is unfair and unsafe. CNF must reflect the values of the profession and nurture excellent nursing practice. Unsafe practices should not be allowed to persist, and it is the CNF's ethical and legal responsibility to act. A student cannot learn from their mistakes if they are not notified when they make a mistake.

Provision seven addresses the nurse's responsibility to advance the profession through research and scholarly inquiry, the development of professional standards, and the generation of nursing and health policy. These are the provision seven interpretive statements related to nursing ethics and FTF in clinical nursing education. They include the following:

> 7.1 All nurses must participate in the advancement of the profession through knowledge development which is gained through research and scholarly inquiry; and
>
> 7.2 Nurse educators must promote and maintain optimal standards of education and practice in every setting where learning activities occur. They must also seek to ensure that all graduates possess the knowledge, skills, and moral dispositions essential to nursing. (ANA, 2015, p. 27)

The literature revealed that FTF is a global issue in healthcare educational programs including nursing. FTF is a dangerous educational practice that places patient safety at risk. Further exploration, through scholarly inquiry, is required to determine the cause and develop measures to resolve it from continuing to occur in undergraduate nursing programs.

National League of Nurses (NLN) Competencies for Academic Clinical Nurse Educators

In 2005, the NLN established specific competencies for academic nurse educators. In 2018, competencies were established for academic clinical nurse educators working within an academic program and responsible for assessing a nursing learner's clinical performance (NLN, 2018). The competencies include the following: 1) function within the education and health care environments (including function in the clinical educator role; operationalize the curriculum; and abide by legal requirements, ethical guidelines, agency policies, and guiding framework); 2) facilitate learning in the health care environment; 3) demonstrate effective interpersonal communication and collaborative inter-professional relationship; 4) apply clinical expertise in the health care environment; 5) facilitate learner development and socialization; and 6) implement effective clinical and assessment evaluation strategies.

The competencies require clinical educators to be accountable for abiding by legal requirements, ethical guidelines, agency policies, and guiding frameworks within education and healthcare. Additionally, clinical educators are required to implement effective clinical and assessment evaluation strategies (NLN, 2020). Fitzgerald et al. (2020, p. 4) stated, "Nurse educators teach in both classroom and clinical settings and are bound to professional standards set forth by peers from both nursing and nursing education." As previously stated, nursing students entrust their CNF to guide them in delivering safe and competent patient care. CNF have a legal and ethical duty to accurately assess a student's clinical performance and assign the grade earned. If a student is not performing at a competent level, they should not receive a passing clinical grade.

Review of Literature

A comprehensive literature search was conducted using CINHAL Plus with a full-text electronic database. The search terms included “failure to fail” and “unsafe nursing student,” or “clinical nursing instructor” or “student nurse clinical performance evaluation” or “nursing ethics.” Additional search criteria included publications written in English and published in or after 2010. The initial search yielded 128 publications. After reviewing abstracts, 76 publications were omitted for lack of relevance. Of the 52 remaining publications, 27 were chosen for an initial literature review because of their relevance to nursing ethics and FTF in nursing education. The 27 publications included eight qualitative research studies, one quantitative research study, one mixed-method research study, 12 professional journal articles (including a literature review), and the National League of Nursing and American Nurses Association websites. A subsequent review yielded three articles on failure to fail in other healthcare educational programs. One article presented a systematic review of FTF in medical, dental, and nursing schools, and two studies focused on medical school programs.

Themes

Themes emerging from the literature related to nursing ethics and failure to fail in nursing education include the following:

1. The phenomenon of failure to fail is a global issue occurring during clinical experiences in a variety of healthcare educational programs;
2. Global differences in models used for clinical instruction in undergraduate nursing programs;
3. Nursing ethics serve a role in the phenomenon of failure to fail in nursing education; and

4. Unsafe students require an action plan and remediation.

Failure to Fail in Healthcare Educational Programs

The phenomenon of FTF is not unique to nursing education. FTF is a global issue occurring in the clinical component of other healthcare educational programs. Yepes-Rios et al. (2016) published a systematic review of international literature from 2005 to 2015 examining the phenomenon of FTF and the experiences and perceptions of evaluators from medical, dental, and nursing educational programs. This systematic review of twenty-eight studies included 19 published in nursing education, six in medical education, and three in dental education (Yepes-Rios et al., 2016).

Yepes-Rios et al. (2016) identified seven common barriers CNF listed for not failing underperforming students. These included 1) personal considerations; 2) professional considerations; 3) trainee-related considerations; 4) unsatisfactory evaluator development; 5) unsatisfactory evaluation tools; 6) institutional culture; and 7) consideration of available remediation for the trainee. They also identified enablers supporting an educator's willingness to fail a failing trainee including 1) duty to patients; 2) duty to society; 3) duty to the nursing profession; and 4) institutional support (backing, by colleagues, when submitting a failing evaluation, evaluator development, strong assessment systems, and opportunities for students after failing) (Yepes-Rios et al., 2016).

Guerrasio et al. (2014) reviewed results from a survey study of six medical, four osteopathy, five physician assistant, and four nurse practitioner programs in the US to determine institutional barriers to placing failing students on probation or dismissing students and identified variations in the use of probation and dismissal and a wide range of barriers, including legal concerns for FTF. Respondents believed some students were allowed to graduate who failed to

earn passing performance grades, and the likelihood of a student being placed on probation or being terminated was highly variable (Guerrasio et al., 2014). Gingerich et al. (2020) interviewed 22 physicians in British Columbia about their experiences supervising trainees who demonstrate incompetence. The physicians believed that all trainees should be capable of learning and progressing by applying what they learn to subsequent clinical experiences (Gingerich et al., 2020). They believed that underperformance was unexpected and sought alternate explanations when underperformances occurred (Gingerich et al., 2020). Therefore, disbelief prevented confident documentation of performance and delayed identification of underperformance (Gingerich et al., 2020).

Global Differences in Models Used for Clinical Education in Undergraduate Nursing Programs

The review of the literature revealed that a variety of clinical instruction models are being utilized in undergraduate nursing programs around the world.

In the US, undergraduate nursing programs utilize several models for clinical education (Gubrud, 2016). The traditional teaching model is commonly used in both ADN and BSN programs (Niederhauser et al., 2012). In the traditional model of clinical nursing education, a faculty member oversees a group of six to eight students in an acute care unit for a 4 to 8-hour shift (Niederhauser et al., 2012). The ratio has increased with some state boards of nursing allowing up to 10 students per clinical group (Louisiana State Board of Nursing [LSBN], 2020).

Preceptorship is another model incorporated into many BSN and some ADN nursing programs in the US (Gubrud, 2016). Preceptorships provide a student with one-on-one teaching, guidance, and support from a nurse preceptor (Gubrud, 2016). This model is used in conjunction with the traditional model to provide additional clinical training. A nurse preceptor facilitates and

evaluates student learning in a clinical area for a specified period, typically ranging from 180-240 hours (Gubrud, 2016). Preceptorships are used at different levels in a nursing program but are often useful at the senior level (Gubrud, 2016).

Undergraduate nursing programs in Canada also utilize the traditional and preceptorship models. In a recent email correspondence, Oosterbroek (2022) explained,

> In Canada it is much the same as in the US, clinical is delivered in groups of 8 students and one clinical instructor on a nursing unit for anywhere from 3-12 weeks. In Canada, most programs offer clinical experiences in a variety of units such as medicine, surgery, pediatrics, and maternal-child, and in Alberta, some programs (ours included) involve clinical practice experiences in rural community hospitals. Rural hospitals provide an exceptional, unique learning experience as care is typically provided across the lifespan in a smaller setting. Some of these acute rural facilities have small ORs and ICUs and deliver babies. Clinical instructors are both hired seasonally/hourly and are continuing instructors who provide clinical teaching. Preceptorship is utilized in Canada for the final consolidation course only.

The preceptorship model is used exclusively in undergraduate nursing programs in the United Kingdom. Black et al. (2014) wrote,

> In the United Kingdom, to satisfy the requirements of the Nursing and Midwifery Council (NMC) in order to register as a qualified nurse, student nurses must undertake a pre-registration nursing course that encompasses 4600 hours of theory and practice. The theory-based education is undertaken in an NMC-approved Higher Education Institution (University) and should comprise 2300 hours (50% of the course) with the practice component of the course taking place in the practice setting and totaling at least 2300 hours (50%) over the 3 years of the course. Students must complete the required component of each year of the course before progressing to the next year. Students should therefore have been successful in all practice experiences or placements, and related competencies before progressing to the final practice experience prior to registration. The final placement is normally at least 12 weeks or 3 months in duration. While in practice, each student is assigned a mentor who assesses the student nurses in practice, and they make the decision whether a student is competent and fit for practice.

Australia uses several clinical educational models. In a recent email correspondence, Hughes (2022) clarified,

> In Australia, the university manages the theoretical and clinical components of the course, however, there are a number of different models of supervision used here for clinical placement/practicum. Generally, the supervisors (often called clinical facilitators)

> manage groups of 8 (although in some models we have group supervision where a group of 3 clinical facilitators supervises 30-40 students). These clinical facilitators can be employed by the university or hospital and are often on a contract/casual basis. We also use the preceptor model in some cases too for example community nursing. So, nursing faculty teach clinical components in the labs and "oversee" the placement or have overall responsibility, but clinical facilitators closely supervise the student placement experience.

Role of Nursing Ethics in Failure to Fail in Nursing Education

Nursing ethics serve a critical role in the phenomenon of FTF in nursing education. Anthony and Wickman (2015) used the ethical principles of autonomy, justice, beneficence, and nonmaleficence as the organizing framework in their review examining appropriate student, preceptor, and faculty roles and responsibilities when ensuring a structured research experience. The article included a link to the Table 1 which listed each ethical principle and the roles and responsibilities assumed by a student, preceptor, and faculty (Anthony & Wickman, 2015).

Table 1

Ethical Principles across Student, Preceptor, and Faculty Responsibilities

Ethical Principles	Student's Responsibility	Preceptor's Responsibility	Faculty Responsibility
Autonomy	Performs patient care to the level of expectation of specific clinical unit.	Supervises student and promotes independence as student acclimates to unit expectations and patient load.	Ensures that student knows scope of practice according to progression in nursing program and assigned facility expectations.
Justice	Treats all patients equally and is non-judgmental.	Ensures that student is familiar with hospital and unit expectations and makes student feel welcome on unit. Treats student with fairness and respect.	Provides student and preceptor with comprehensive orientation to role and is available to intervene immediately when problems or errors occur.
Beneficence	Wants to do good. Feels a professional duty to care for patients.	Provides both positive and corrective feedback to ensure quality and safe patient care.	Takes an active role in preceptor assignment to ensure student success. May reassign student to another preceptor if student-preceptor relationship becomes adversarial.
Nonmaleficence	Refrains from doing any acts that could cause harm or are knowingly harmful. Looks to the preceptor for guidance when unsure. Admits to deficits in knowledge.	Provides guidance in situations that are unfamiliar to student to ensure patient safety. Alerts faculty member if the student is assessed as unsafe to promptly address issues and concerns.	Removes unsafe students from the clinical setting and may assign remediation activities as indicated and/or fail the unsafe student if necessary.

Phrases like “moral integrity,” “ethical duty,” and “gatekeepers to the profession” were used throughout the literature review on the topic of nursing ethics and FTF. Nurse mentors interviewed by Black et al. (2014) felt a sense of moral integrity or duty to the profession to protect patients from unsafe students. Earle-Foley et al. (2012) discussed how the theory of virtue ethics applied to nurse preceptors. They argued that a good preceptor applies the virtues of compassion, integrity, justice, and practical reasoning to recognize the safety risks involved with allowing an incompetent student to progress in an educational program. Hunt’s grounded theory study (2019) explored attributes required to be an effective practice assessor and found that emphasis was placed on the role of gatekeeper to the profession to ensure the entry criteria remained well monitored to protect the integrity of everyone already within the profession.

In January 2015, the ANA released a revised Code of Ethics for Nurses with Interpretive Statements which also introduced nine provisions. In July, Winland-Brown et al. (2015) published the first of two articles explaining provisions one through four which specified the RN's duties to patients and accountability in practice. In September, Lachman et al. (2015) published an article addressing the remaining five provisions. Provisions five and six discussed ethical issues related to boundaries of duty and loyalty while provisions seven through nine concentrated on the nurse’s ethical duties beyond individual patient encounters (Lachman et al., 2015). This code applies to all nurses including nurse educators.

Hannah et al. (2014) published an article on the topic of duty orientation and ethical behavior in organizations. They defined duty orientation as an individual’s volitional orientation to loyally serve and honor the codes and principles of their group (Hannah et al., 2014). This article was included in the review because it describes organizations or duty-bound professions

such as nursing. The nursing profession has an established set of ethical principles and duties that each nurse is expected to uphold including nurse educators.

Action Plan and Remediation

Several sources suggested developing an action plan for improvement when a nursing student is not meeting clinical objectives. A key concept in Duffy's (2013) study of 10 mentors was that once a weak student is identified, an action plan should be established to correct the weakness. Christiansen (2015) suggested that CNF develop a written document immediately following the first unsatisfactory clinical performance evaluation. Early recognition of deficient performances and intervention may resolve issues and allow successful completion of the course. The plan should include a specific description addressing all areas where the student is not meeting clinical performance objectives or program requirements. This document should be signed by the instructor/preceptor and student, a signed copy issued to the student, and the original placed in the student's file. If the student is deficient in skill performance, a remediation plan will require them to spend time practicing skills in the skills lab until proficiency is established. Vinales (2015) suggested mentors periodically meet with a student to discuss their progress and implement remediation if required. Chunta (2016) suggested providing strategies for managing students with unsafe behaviors including initiation of early remediation. Chunta and Custer (2018) noted that potential problems should be promptly reported to the faculty member, ensuring that any concerns are identified early in the preceptor experience and that the student is provided with learning opportunities designed to correct any deficits. Frank (2020) stated that best practices included giving students clear feedback regarding observed deficiencies, documenting a warning of pending course failure, and developing a remediation plan.

Gaps in the Literature

After a thorough review, three gaps in the literature were identified. The first gap is a lack of research conducted in the U.S. on nursing ethics related to failure to fail in nursing education. Only one study in this review was published in the U.S. A second gap is a lack of research examining nurse faculty who are responsible for teaching groups of students enrolled in U.S. undergraduate nursing programs. Most literature on this topic examines nurse mentors or preceptors in the U.K. and Canada who are responsible for supervising one student during a preceptorship. The third gap is a lack of research examining what ethical responsibilities a CNF assumes in the clinical performance assessment process and grade determination process, especially when they choose to assign a passing grade to a student who fails to perform at a satisfactory level in the clinical setting.

Summary

This chapter provided a comprehensive review and discussion of literature related to nursing ethics and failure to fail in clinical nursing education. Four themes emerging from the literature include the phenomenon of failure to fail is a global issue occurring during clinical experiences in a variety of healthcare educational programs, global differences in models used for clinical instruction in undergraduate nursing programs, nursing ethics serve a role in the phenomenon of failure to fail in nursing education, and unsafe students require an action plan and remediation. It should also be noted that while most of the literature has examined nurse preceptors from Canada, the U.K., and Australia, a paucity of research has been implemented in the U.S. on the topic, and none focuses specifically on the viewpoint of full-time CNF in undergraduate nursing education.

CHAPTER III:

METHODOLOGY

Research Approach

The purpose of this descriptive qualitative study was to explore the phenomenon of FTF in undergraduate nursing programs in the US. The study focused on full-time CNF who train, evaluate, and assign clinical performance grades to groups of students completing either an ADN or BSN clinical nursing course and experienced students who were not performing at a satisfactory level. The goal of the study was to determine why this phenomenon may be occurring so measures can be established to eliminate this unethical educational practice.

Research Questions

The overarching research questions prompting this study were 1) what reasons do clinical nursing faculty provide for assigning a passing grade to a student whose performance they evaluate as unsatisfactory; and 2) what do clinical nursing faculty believe are their ethical responsibilities in the student clinical performance evaluation and grade assignment process?

Method

An interpretive description (ID) design was used for this cross-sectional qualitative study. ID uses a small-scale qualitative investigational approach to examine a clinical phenomenon of interest, capture themes, and patterns within subjective perceptions, and generate an interpretive description capable of informing clinical understanding (Thorne et al., 2004). Since little information exists on the phenomenon of FTF in clinical nursing education, utilizing ID methodology increases awareness of a clinical issue that jeopardizes patient safety. ID retains the

coherence and integrity of a theoretical approach to the development of knowledge but also includes design variations according to the specific features of context, situation, and intent (Thorne, 2016). ID allows for advancing knowledge surrounding educational experiences without sacrificing methodological integrity, often seen in long-established qualitative approaches (Thompson Burdine et al., 2020). Using ID in qualitative research creates an interpretive account based on informed questioning and uses reflective, critical examination techniques to guide and inform disciplinary thought (Thorne et al., 2004).

Design

ID studies provide a theme or integrative description of a phenomenon of applied or practice interest in a way the disciplinary objects of the study are made explicit within the interpretations (Thorne, 2016). To accomplish this, ID designs use a variety of ways to search out and explore features or elements of a common issue but seek to gain an understanding of them that honors their inherent complexity (Thorne, 2016). ID designs are structured to ensure that the intrinsic value of all expressed perceptions is acknowledged without assuming that what is perceived is always or necessarily true (Thorne, 2016). ID designs ground the interpretive, analytic conclusions generated within both the individual and collective representations of data, demonstrating how individual instances contribute to the general pattern within the process (Thorne, 2016).

Institutional Review Board (IRB) Approval

A study proposal was submitted to the University of Alabama Institutional Review Board (IRB) on July 15, 2022. A letter of approval was received on July 25, 2022.

Participants

A purposeful sample of full-time CNF teaching in ADN or BSN programs approved by a southern state board of nursing were chosen as participants for this study. ID suggests using a purposive sample to identify participants with a significant experiential background in the phenomenon, at the inception of the study, who can produce data that will ring true (Thorne, 2016).

Inclusion/Exclusion Criteria

Inclusion criteria required that each participant be a full-time CNF responsible for teaching, evaluating, and assigning a clinical performance grade to a group of undergraduate nursing students enrolled in a clinical nursing course in an ADN or BSN program. Participants must also have answered "yes" to the pre-screening question "have you ever assigned a passing grade to a student and later questioned your decision?" Exclusion criteria included nurse preceptors, adjunct CNF, or CNF who taught in a licensed practical nurse (LPN) or licensed vocational nurse (LVN) program.

Sample Size

Thorne (2016) suggests considering the amount of existing knowledge about the phenomenon in question to direct the decision of sample size with a lower limit set at the minimum number to elucidate the knowledge desired. Since little has been published regarding the phenomenon of FTF in clinical nursing education, using a small sample size was appropriate for this study. The sample size range for this study was eight to twelve participants. Data saturation was met using eight full-time CNF as the sample size for this study.

Setting

Thorne (2016) recommends that a qualitative research interview be conducted in a comfortable environment for the participant. Each participant was given the option of a live video conference interview or a face-to-face interview. Literature supports the use of both face-to-face and live video conference interviews. A live interview allows participants to articulate a perspective on the research topic in a manner that is not possible when completing a written survey (Thorne, 2016). Live video conferencing interviews also offer a convenient option for the interviewer and participants. In a recent qualitative research study, participants reported that Zoom video conferencing was a positive experience noting several strengths including convenience and ease of use, enhanced personal interface to discuss personal topics (e.g., parenting), accessibility (i.e., phone, tablet, and computer), timesaving with no travel requirements to participate in the research and therefore more time available for their family (Gray et al., 2020). All participants chose the live video conference option for their interviews. Each permitted the interview to be recorded. They also opted for a telephone interview for the follow-up interview.

Data Collection Procedures

Recruitment

To enhance data security, encrypted emails were sent to the deans of three BSN and three ADN programs in the south part of a southern state. The emails included the electronic informed consent agreement, description of the study, the purpose of the study, procedures for data collection, plan for reporting study results, potential risks and benefits of participation, confidentiality agreement, and contact information for the principal investigator (PI). The email requested each dean assist in recruitment by forwarding the email to their full-time clinical

nursing faculty. The email also included a request for each dean to reply if any additional IRB approval was required by their school before the recruitment was initiated.

One BSN program did not reply, and the state BSN program did not require further IRB approval. The faith-based BSN program and the ADN programs required that the study protocol be submitted to their IRB for review. Within two weeks, all programs granted permission, and electronic recruitment letters were sent to each program's full-time clinical nursing faculty.

Nine signed consent forms were received. One participant was disqualified from the study because they had no experience teaching a group of students in the clinical setting and therefore did not meet the study criteria. Upon receipt of the signed consent, participants were contacted to schedule a date and time for their interview.

Data Collection

Data were collected during eight individual semi-structured live recorded interviews using Zoom video conferencing software. Each interview was recorded, lasted from 35-45 minutes, and follow-up telephone interviews lasted approximately 15 minutes. Gray et al. (2020) reported the economic advantage of using video conference software for geographically dispersed participants. Gray et al. (2020) also noted a disadvantage of using Zoom was the risk of technical difficulties that could arise while setting up and conducting the interviews and uploading or using the interview recording. While technology difficulties are always a risk, some may be overcome if the interviewer is proficient in using their chosen platform (Gray et al., 2020). No technical difficulties occurred during any of the interviews.

Each video-recorded interview was watched and manually transcribed onto a Word document. An additional review of the recordings was done to assure the accuracy of the words being transcribed. Subsequent reviews of the recordings allowed the researcher to further analyze

the data, focus on body language and voice inflections, and recognize themes. Data saturation was reached by the eighth interview. Thorne (2016) believed that documenting subjective and conceptual happenings during research engagement becomes a core element to inform the inductive analysis process. ID requires concurrent data collection and analysis to confirm, test, explore, and expand on the concepts that begin to form when entering the field (Thorne, 2016). Thorne (2016) also stated that with ID, the researcher is seeking knowledge inductively generated from within the data and developed within the context of the data. Therefore, any ideas, conceptual frameworks, theories, or preconceptions derived from reflections that the researcher brings into the study should be carefully noted and regularly examined to assure that they are not influencing what the researcher hears and sees (Thorne, 2016).

Data Analysis

The data collected and transcribed during each interview was analyzed using Colaizzi's seven-step process. Colaizzi's seven-step process provides a rigorous analysis, with each step staying close to the data and the result yielding a concise yet all-encompassing description of the phenomenon being studied and validated by the participants who created it (Morrow et al., 2015). Colaizzi's method depends on rich first-person accounts of experience coming from face-to-face interviews, written narratives, blogs, research diaries, or online interviews (Morrow et al., 2015). For this study, each interview was video recorded, saved, and reviewed multiple times following Colaizzi's data analysis process (see Table 2).

Table 2

Colaizzi's Descriptive Phenomenological Method

Step	Description
Familiarization	The researcher familiarizes him or herself with the data, by reading through all the participant accounts several times
Identifying significant statements	The researcher identifies all statements in the accounts that are of direct relevance to the phenomenon under investigation
Formulating meanings	The researcher identifies meanings relevant to the phenomenon that arise from a careful consideration of the significant statements. The researcher must reflexively "bracket" his or her pre-suppositions to stick closely to the phenomenon as experienced (though Colaizzi recognizes that complete bracketing is never possible).
Clustering themes	The researcher clusters the identified meanings into themes that are common across all accounts. Again bracketing of pre-suppositions is crucial, especially to avoid any potential influence of existing theory.
Developing an exhaustive description	The researcher writes a full and inclusive description of the phenomenon, incorporating all the themes produced in step 4.
Producing the fundamental structure	The researcher condenses the exhaustive description down to a short, dense statement that captures just those aspects deemed to be essential to the structure of the phenomenon.
Seeking verification of the fundamental structure	The researcher returns the fundamental structure statement to all participants (or sometimes a subsample in larger studies) to ask whether it captures their experience. He or she may go back and modify earlier steps in the analysis in light of this feedback.

Data Security

Thorne (2016) recommended storing all interview data, including notes and recordings, electronically to protect against loss and to maintain data security. After each interview, the recording was downloaded and saved on an external hard drive that was stored in a locked box in the researcher's home office. Transcriptions of each interview and data tables were also saved on

the same external hard drive as the recordings. To maintain confidentiality and anonymity, each participant was given a pseudonym. Pseudonyms were used when referencing any data associated with each participant.

Summary

Nursing ethics and FTF in clinical nursing education is a topic worthy of exploration. The purpose of this descriptive qualitative study was to explore the phenomenon of FTF in undergraduate nursing programs in the US. Exploring nursing ethics and FTF in clinical nursing education can provide answers to two important questions: 1) what reasons do clinical nursing instructors provide for assigning a passing clinical performance grade to a student they assess as unsatisfactory; and 2) what ethical responsibility does a CNF assume in the student clinical performance evaluation and grade assignment process?

Understanding why CNF assigns passing grades to students who are not exhibiting satisfactory clinical performances could raise awareness of potential barriers prohibiting the issuance of a failing grade. Determining a cause for this patient safety issue could encourage nursing program administrators or their curriculum committees to re-evaluate the current clinical performance evaluation and grading assignment process and make changes to improve the process and eliminate barriers. Understanding what a CNF perceived as their ethical responsibility in the performance evaluation and grade assignment process could also raise awareness of misconceptions regarding a nurse's ethical obligation as a patient advocate. The data collected during the eight interviews revealed important data that can be added to the literature on this patient safety issue.

CHAPTER IV:

FINDINGS

The purpose of this descriptive qualitative study was to explore the phenomenon of FTF in undergraduate nursing programs in a U.S. southern state. The study focused on full-time CNF who train, evaluate, and assign clinical performance grades to groups of students completing either an ADN or BSN clinical nursing course and have experienced students who were not performing at a satisfactory level. The goal of the study was to determine why this phenomenon may be occurring so measures can be established to eliminate this unethical educational practice. An interpretive description (ID) design was used for this cross-sectional qualitative study. The overarching research questions prompting this study were 1) what reasons do clinical nursing faculty provide for assigning a passing grade to a student whose performance they evaluate as unsatisfactory; and 2) what do clinical nursing faculty believe are their ethical responsibilities in the student clinical performance evaluation and grade assignment process?

Recruitment Process

The University of Alabama IRB approved the qualitative research study in July 2022. An electronic (email) recruitment letter (see Appendix A) was sent to the deans of three BSN programs (state public, private faith-based, historically black and minority university (HBMU)) and three ADN programs (all part of a state community and technical college system). Each recruitment letter included attachments of the consent form (see Appendix A) and the UA IRB study approval letter (see Appendix A). The recruitment letter also requested the deans' reply and

acknowledge whether their institution's IRB approval would be required before they could forward recruitment letters to their faculty.

The dean of the HBMU did not reply to the email or a follow-up telephone call. The state university did not require further IRB approval and forwarded the recruitment letters to their BSN faculty. The faith-based university and ADN programs required further review of the study protocol, which was sent immediately. Within two weeks, all programs granted permission, and electronic recruitment letters were sent to each program's full-time clinical nursing faculty.

Setting

The participants taught at a school of nursing (SON) in two educational settings: university and community college. The state university SON is part of a large multi-disciplinary health science center located in the medical district of an urban city. The SON offers a traditional BSN program, a career alternative RN program (CARE), an RN to BSN program, and a variety of master's and doctorate programs. There are approximately 40 full-time nursing faculty with approximately 75 students accepted into the traditional BSN program each spring and fall.
The private, faith-based university SON offers a traditional BSN program with an average class size of 20 students and a student-to-faculty ratio of 10:1. This university is located approximately 15 miles from the state university's BSN program. The total enrollment at the university is less than 2000 students with 79% female and 20% male (1% undisclosed). The nursing program has approximately 15 full-time faculty and accepts students in the fall semester.

The ADN programs are part of a state-wide community and technical college system. The first ADN program has a SON at the state's largest community college and has its campus located less than a half mile from the state university SON. This SON campus also offers an LPN to RN Transition program and another campus offers an LPN program. The ADN program has

approximately 40 full-time clinical nursing faculty and graduates an average of 125 students every spring and fall semester. The second ADN program has a SON at a rural community college located approximately 150 miles west of the larger metropolitan ADN program. This smaller community college offers an ADN program on one campus and an LPN program offered on a nearby campus. The ADN program has nine full-time faculty and accepts students into the program in the spring and fall.

Participants

Signed consent forms were received from four African Americans (AA) and five white females. One AA participant was disqualified because they did not have experience teaching a group of students in the clinical setting. It should also be noted that males were included in the study, but no signed consent forms were received from any male participants. Participants ranged in age from 38-65 years old. They had been teaching anywhere from three to greater than 20 years. Two participants held doctorate degrees, three were enrolled in doctoral programs, and three currently held a master's in nursing degree. Two participants taught at a state public university, two at a private, faith-based university, two in an urban ADN program, and two in a rural ADN program.

Table 3

Participant Demographics

Pseudonym	Age, Race, and Gender	Years of Teaching Experience	Highest Degree Obtained	Program Type	Nursing Courses Taught
Yvette	55 W F	1-5	PhD (c) Nursing Science	BSN state university	Jr. 1 adult med-surg
Traci	58 W F	1-5	MN	BSN Faith-based	1st-semester adult med-surg
Leslie	54 W F	11-15 2-BSN 12-ADN	MN (EdD Nursing Ed student)	BSN state university	Sr. 1st semester Critical Care
Shannon	48 AA F	6-10	MN	urban ADN	3rd-semester adult med-surg
Jamee'	54 AA F	1-5	DNP (c)	ADN (rural)	3rd-semester adult med-surg
Jenny	65 AA F	>20	PhD	ADN (rural)	1st-5th semester adult med-surg
Elizabeth	38 W F	1-5	MN	ADN	1st semester
Sara	54 W F	16-20 7-BSN 8- ADN	DNP	BSN	Jr. and Sr. med-surg

Notes. AA- African American, W-white, F-female; ADN-associate degree in nursing, BSN-Bachelor of Science in nursing, MN-master's in nursing, DNP- doctor of nursing practice c-candidate, PhD-doctor of philosophy c-candidate

Emerging Themes Related to First Research Question

Through qualitative data analysis of eight transcribed individual interviews, two themes were identified related to the first research question, what reasons do clinical nursing faculty

provide for assigning a passing grade to a student whose performance they evaluate as unsatisfactory?

Theme 1: Differing Evaluation Systems and Grading Requirements

Frequency of clinical evaluation. The frequency in which a student's clinical performance was evaluated differed between the BSN and ADN programs. In both BSN programs, the clinical instructor provided weekly verbal feedback on the student's clinical performance. Two participants at the faith-based university required a weekly meeting with each student to discuss their clinical performance, while the state university participants only met with a student if an issue occurred during the clinical experience that warranted a discussion. The state university participants explained that if they identified that a student was not performing accurately in clinical, they would have a conversation at that time with the student about the error, but it did not necessarily get documented on the evaluation. Both BSN programs issued a written formative performance evaluation at midterm and a final summative evaluation was provided at the end of the rotation. Both ADN programs used a grading evaluation tool that included objectives and specific clinical behaviors that applied to each objective. Students were graded weekly on their ability to meet the objectives and perform the clinical behaviors during the clinical experience.

Clinical performance grading systems. Differences were noted in the clinical performance grading systems used in each BSN and each ADN program. The state university used letter grades with numeric equivalents and the faith-based university used a numeric grade. The urban ADN program used excellent, satisfactory, or unsatisfactory and the rural ADN program used satisfactory, unsatisfactory, or needs improvement (until mid-term). Afterward, the

grading choices were limited to satisfactory or unsatisfactory. Table 4 defines the grading systems used by each program.

Table 4

Clinical Performance Grading Systems

Type of School	Scoring System
State University *Letter Grade and Numeric Equivalent*	A=5 Consistently exceeds expectations at a high level of independence, meets competencies at an excellent level B=4 Sometimes exceeds expectations at a high level independent of verbal cues, meets competencies at a very good level C=3 Meets expectations, requires occasional to frequent verbal cues, meets competencies at a good level D=2 Consistently fails to meet expectations, requires frequent verbal cues, meets competencies at a poor level F=1 Fails to complete assigned tasks, appears to be unsafe and/or behaves unprofessionally, not safe alone (Yvette, personal communication, 8/13/22)
Faith-based *Numeric Grade*	4= Consistently achieves expected level at a superior manner 3= Frequently achieves expected behavior above the expected level 2= Consistently achieves expected behavior at a safe level 1= Achieves expected behavior below expected level but demonstrates improvement 0= Unable to achieve expected behavior at a safe level (Traci, personal communication, 8/28/22)
Rural ADN	Beginning of the semester until the midterm student can earn: Satisfactory (2.5)- Performs safely without instructor prompts. Needs Improvement (2.0)- Performs safely with minimal instructor prompts. Unsatisfactory (1.75)- Requires supervision and habitual instructor intervention. ***After the midterm student can only earn a: Satisfactory or Unsatisfactory*** (Jamee, personal communication, 9/24/22)
Urban ADN	Excellent- Consistently meet outcomes at a high level. Satisfactory- Meets outcomes at a safe level. Unsatisfactory- Does not meet outcomes at a safe level (Shannon, personal communication, 9/4/22)

Subjective grading scales. The data revealed that the clinical performance evaluation systems used by each program included subjective descriptors that equated to the level of performance a student exhibited to earn a certain grade. Evaluators used their discretion to define each subjective descriptor attached to a grade. See Table 5.

Table 5

Clinical Performance Grading Systems (Subjective)

Type of School	Scoring System
State University	A=5 ***Consistently*** *exceeds expectations* at a ***high*** level independent of verbal/directive cues, meets competencies at an ***excellent*** level
	B=4 ***Sometimes*** *exceeds* expectations at a *high* level independent of verbal cues, meets competencies at a ***very good*** level
	C=3 Meets expectations, requires ***occasional*** *to* ***frequent*** verbal cues, meets competencies at a *good* level
	D=2 ***Consistently*** fails to meet expectations, requires frequent verbal cues, meets competencies at a ***poor*** level
	F=1 Fails to complete assigned tasks, *appears to be* unsafe and/or behaves ***unprofessionally***, ***not safe*** alone
	(Yvette, personal communication, 8/13/22)
Faith-based	4= ***Consistently*** achieves ***expected*** level at a ***superior*** manner
	3= ***Frequently*** achieves ***expected*** behavior ***above expected level***
	2= ***Consistently*** achieves ***expected*** behavior at a ***safe*** level
	1= Achieves ***expected*** behavior ***below*** **expected** level but demonstrates ***improvement***
	0= Unable to achieve ***expected*** behavior at a ***safe*** level
	(Traci, personal communication, 8/28/22)
Rural ADN	Beginning of the semester until the midterm student can earn:
	Satisfactory (2.5)-Performs ***safely*** without instructor prompts, accurate, ***accountable, proficient, coordinated, confident, organized****, f*ocuses on the patient/support & processes.
	Needs Improvement (2.0)-Performs ***safely with minimal*** instructor prompts, ***minimal*** assistance in focusing on pt/support & processes, safety & accountability are ***questionable and at times*** inaccurate, ***lacks*** efficiency, coordination, difficulty organizing, needs supporting **cues *recurrently,***

Type of School	Scoring System
	anxious, worried, and flustered at times-Focuses more on skill rather than the patient & process Unsatisfactory (1.75)-Requires supervision and ***habitual*** instructor intervention, ***frequent*** support cues, unable to perform alone, safety is ***often questionable***, inaccurate, ***no accountability, inefficient, disorganized, anxiety, disrupting or omitting*** behavior Focuses on skill and/or self, **s*ubjective or emotional*** rationale rather than scientific ***After the midterm student can only earn a Satisfactory or Unsatisfactory*** (Jamee, personal communication, 9/24/22)
Urban ADN	Excellent- ***Consistently*** meet outcomes at a ***high*** level; demonstrates initiative and ***creative*** application of nursing process, performs psychomotor skills with *expertise.* Meets competency at an ***excellent*** level. Satisfactory- Meets outcomes at a ***safe*** level; integrates facts, makes ***relevant*** observations with ***appropriate*** nursing interventions, and performs psychomotor skills competently without prompting. Meets competency at a ***satisfactory*** level. Unsatisfactory- Does not meet outcomes at a ***safe*** level; occasionally integrates facts and makes ***some*** relevant observations. ***Not always*** safe alone. **Performs *at risk*. *Not always*** accurate and ***consistent.*** (Shannon, personal communication, 9/4/22)

Note. subjective words bolded

Differing reporting methods. There were differences noted in the methods used by the BSN and ADN programs to report instances when a student failed to meet a clinical performance objective. Both BSN programs utilized a clinical (or learning) contract to document instances when a student failed to meet a clinical objective. A clinical or learning contract is a written agreement between the clinical instructor and the student which clearly defines what a learner must do to achieve a specific learning outcome or clinical performance objective (Gallant et al., 2006). One participant reported that their school policy allowed the faculty to discard the clinical contract from the student's permanent record if the student's behavior improved.

Both ADN programs utilized an "Unsatisfactory Clinical Performance" document to record instances when a student failed to meet a clinical performance objective. An "Unsafe Clinical Performance" form was completed when a student displayed unsafe behavior during the clinical experience that had the potential to jeopardize patient safety. Both programs reported that these forms were part of the student's permanent record. One program reported that unsafe clinical performances were tracked as the student progressed through the program.

BSN faculty reported different reasons and instances for implementing a clinical contract. One faculty reported that they put a student on a clinical contract for unprofessional behavior because the student showed up 45 minutes late for the clinical experience (Yvette, personal communication, 8/13/22). Another faculty reported that they would not necessarily "whip out a clinical contract" if one of their senior-level nursing students displayed unprofessional behavior but would have a private conversation with the student to discuss their behavior (Leslie, personal communication, 9/3/22).

Theme 2: Variances in Reporting Unmet Performance

Reported incidents. The first interview question asked participants to explain their clinical evaluation process, clinical objectives, and each objective's expected behaviors. All participants stated their program required reporting incidents when a student failed to meet a clinical objective. Participants admitted using verbal counseling, anecdotal notes, clinical contracts, and unsatisfactory or unsafe clinical performance reports to record the occurrences. A follow-up question asked participants to determine factors that influenced their decision to report or not report an incident. The data revealed variances among participants who reported incidents of a student's failure to meet a clinical objective and those who chose not to report a clinical incident.

All participants cited unprofessional behavior as a reportable incident. Four participants cited specific incidents when a student exhibited unprofessional behavior that warranted reporting. Two participants strongly believed that a student's failure to arrive at the clinical setting on time was an unprofessional behavior that warranted reporting. Yvette discussed a time when a student failed to notify her that they would be late for clinical. She explained,

> So, I had one student one time that, showed up late to clinical, like 45 minutes late and I sent her home. I said you missed report, you've missed your prep time. You need to go home. I sent her home, put her on clinical contract stating that if you are late again, it will result in you being unsuccessful. You know, if you are unprofessional, you will be considered unsuccessful in this course. I just outline very specific behaviors that I expect them to achieve. And, if they don't achieve it, then they will be unsuccessful. (Yvette, personal communication, 8/13/22)

Elizabeth also felt that tardiness was a reportable incident and explained,

> I have given unsatisfactory grades for tardiness if they don't call to let me know they are going to be late. If they don't communicate to me that they will be late, they are getting an unsatisfactory. They get one warning and I write them up if they do it again. There is nothing worse to a nurse than having to wonder where their relief is. (Elizabeth, personal communication, Jan. 16, 2023)

Yvette also shared an example of another unprofessional behavior exhibited by a student who was caring for a patient with mental and physical disabilities. The patient was about to be transferred to a skilled nursing unit and had dried food on their gown and looked disheveled. Yvette instructed the student to bathe and assist the patient with grooming/oral care, change their gown, and pack their belongings for transfer. Yvette returned to the patient's room later and noticed they had not been cleaned. She went to the student and asked whether they had cleaned the patient, and the student said yes. Yvette brought the student back into the patient's room and explained,

> I can see they have not been cleaned up and you didn't do what I asked you to do. I said that is a blatant lie, and unprofessional and I need you to pack up your stuff and go home. We will do a clinical contract; this is not acceptable behavior. As far as I'm concerned, I trust that if I ask you to do something if we are working together as a team, because

> nursing is a lot of teamwork, right, that you will be honest with me. Blatantly lying to me is completely unprofessional and completely unsafe. (Yvette, personal communication, 8/13/22)

Leslie discussed an incident of unprofessional behavior displayed by a student at the nursing station. She explained,

> I gave an unsatisfactory, but it should have been an unsafe, to a student who was "laying" at the nurse's station and not watching their patient being weaned off the vent. I asked the student if they were ill, they said no, and I said then you should be in the patient's room keeping a close eye on them as they are being weaned from the vent. I had already counseled her about hanging out at the nurse's station all the time. I told the student; your clinical mate is now in your patient's room watching the patient because you are out here at the nurse's station. The student found absolutely nothing wrong with that. I told them if you don't feel you need to watch your patient then you can go, and she got an attitude with me. While she was going to get her belongings, I completed an unsatisfactory clinical performance form. I handed her the completed unsatisfactory form and told her to sign it. She signed it and flung the paper back at me. (Leslie, personal communication, 9/3/22)

Jamee discussed an incident where a student's personal misbehavior resulted in an unexcused clinical absence. Jamee explained,

> The student was a no-show for clinical today. She called me later this morning to say that she was driving to clinical, got pulled over by the police for a broken taillight, had a suspended driver's license, got a ticket, and the police would not let her drive the car because of the suspended driver's license. The student just called to tell me that they were still trying to get their license renewed and might have to miss an additional clinical day. I told her that if she missed another clinical day, she would be dismissed from the course for missing too many clinical days. I felt bad for the student, but I have to follow the clinical attendance policy because of state board rules for the number of clinical hours. (Jamee, personal communication, 9/24/22)

All participants agreed that performing at an unsafe level during the clinical experience warranted reporting. Yvette felt that blatant disregard for patient safety and unsafe medication administration were priority reportable offenses. She explained,

> If you don't know why you are giving a medication or checking the patient's 2 identifiers before giving a medication or turning the patient every 2 hours, which can cause significant harm, as far as I'm concerned, that is not good nursing care and I'm not accepting it (Yvette, personal communication, 8/13/22)

Leslie referred again to the student she discussed earlier who was sitting at the nurse's station instead of watching her ICU patient get weaned from the ventilator. Leslie believed this behavior was both unprofessional and unsafe and listed both when she wrote the student up for their unsatisfactory clinical performance. She explained,

> I had already counseled the student about hanging out at the nurse's station all the time. I told her that her clinical mate is now in your patient's room watching the patient because you are out here at the nurse's station. The student found absolutely nothing wrong with that. I told them if you don't feel you need to watch your patient then you can go, and she got an attitude with me. When I handed her the unsatisfactory form, she signed it and threw it back at me. (Leslie, personal communication, 9/3/22)

Shannon discussed three incidents of students performing at an unsafe level in the clinical setting. She explained,

> Failing to follow concrete instructions warrants an unsafe or unsatisfactory write-up. Medication administration for me is very serious. I express this in orientation, we talk about it a lot in clinical. This is not the area where I cut corners and I think that failing to recognize that is an unsafe action because this is where we can do the greatest harm by not following instructions. I had a student draw up heparin in a syringe ordered for subcutaneous injection and the student attempted to give it IV. I also had a student who tried to start an IV on a patient without me or another nurse present and ended up sticking themselves with the needle. I also had a student contact me at about 5:30 on their clinical day saying that they were just getting off from working overnight and she was running late for clinical. I told her I didn't think that would be safe for her or the patients because she would be functioning in an impaired state. I issued the student an unsatisfactory grade because she knew she had clinical scheduled for that day and should not have scheduled herself to work the night before clinical. (Shannon, personal communication, 9/4/22)

Jamee felt that when a student goes rogue and does not follow instructions or when a student fails to accept responsibility when they do something wrong is unsafe and a reportable offense. She explained,

> Yes, I have sent a student home before. In fact, it was a senior-level student. I shared a group with another faculty. I had 10 in critical care, and the other instructor had 10 in med surg. The other faculty did things one way, and I did things a bit differently. The student got abrupt with me saying they didn't like the way I did things in clinical. I told her right then that I can't teach you today and I also can't have you on the floor impeding the learning experience for the other students. So, today, you need to go home. (Jamee, personal communication, 1/23/23)

Jenny felt that students who caused patient harm and those who displayed a nonchalant attitude about making a mistake warranted reporting. She discussed a situation when a student was so nervous when performing at the bedside but refused to address their performance issues. She explained,

> I had a student who was telling me they could perform and didn't need any medication to keep them calm. But when the student got to the bedside and put a patient in jeopardy by not making sure that the air was out of the syringe before pushing a medication, I stopped them and gave the student an unsatisfactory grade. I thought the student should have been dismissed but we have another hurdle which is administration. (Jenny, personal communication, 1/31/23)

Sara discussed a student who continuously performed at an unsafe level at the bedside. She explained,

> I have a student in mind. For the life of them, this student could not give medications. It took her 10 minutes to pour 30 cc of medication into a medication cup. I don't want to say what I really think about the student and why she couldn't do it, but she could not do the skill. It was a disaster. The student was so unsafe at the bedside. (Sara, personal communication, 10/11/22)

Unreported incidents. Several of the participants discussed times when the student failed to meet a clinical objective, but they decided not to report the incident. Leslie, who teaches senior-level students in the critical care setting, discussed why she doesn't always report when a student fails to meet expected clinical objectives. She explained,

> I won't whip out the clinical contract on the first instance. I think everybody deserves to learn from their mistakes initially. Now…if the mistake has been pointed out, they are aware of it and continue to do it, then that's a problem. But, initially, I don't feel that punitive action should be implemented the 1st time they make a mistake or at least the first time I have seen them make the mistake. It may have happened in other courses, but I am not privy to that information. My teaching philosophy is that I'm going to pull you aside, talk about the problem, make you aware of the problem, what was not acceptable, and what is expected based on this issue. If they continue to do the same thing, then I put them on a clinical contract. I feel that if they continue to do something wrong (after becoming aware) then they have made a personal choice to do something that they know is wrong. (Leslie, personal communication, 9/3/22)

Traci discussed a time when she had ongoing problems with a student during the clinical experience but chose not to report it. She explained,

> I had a male student last semester who is very smart but struggled with concepts, dosage calculations and in clinical he didn't understand anything I was saying. He was amazing with the patients, but he would try to draw up medication with one hand instead of doing it correctly. I felt like I was talking to a spot on the wall with him when we were going over things and he would try to talk around me, and I was like….no dude you are not going to try to talk your way around this. Then when I was using the grading tool to grade his work, I knew he needed more work but he had earned the points according to the rubric so I couldn't take the points away from him. I was not the only instructor who felt he needed more, but he met the grading requirements to pass. He's a senior now…how…I don't know. (Traci, personal communication, 8/28/22)

Shannon shared a tragic story about a former student that has altered her decision to report a student for a clinical incident if the student is failing the theory portion of the course. She explained,

> When I see a student failing the theory portion of the course, substantially…I don't add the extra burden of you're also failing the clinical and making them fail their clinical too. I say that because in the past, I had a student who failed and the summer he failed out of nursing school, he ended up killing himself and 2 siblings. So, I'm always mindful of compounding stress on a student. (Shannon, personal communication, 9/4/22)

Faculty leniency in grading. The two participants with less than five years of teaching experience reported being lenient with their school's skills checkoff policy. Both participants had the same skills checkoff policy which requires students to perform the skill without asking questions or being prompted by the instructor. If unsuccessful, the student is supposed to be referred to the remediation coach for assistance. Once remediated, the student is rescheduled to perform the skill checkoff again. If unsuccessful a second time, the student would be dropped from the course. Jamee discussed a time when she was observing a student during a skills check-off and explained,

> I had a student who was an LPN, and we were doing skills (trach care). She got all the critical points, but she was asking questions throughout the process. I couldn't tell if it was nerves or whether she truly didn't know. I was on the line determining whether she

> really knew how to do this or not. So, I asked another faculty to perform the skill with her and evaluate the performance. She did better with the other faculty (Jamee, personal communication, 9/24/22)

Elizabeth explained,

> Our first check-off (which I don't agree with) is sterile wound care. Wounds are not sterile and so why are we doing this skill? But I understand the point is to maintain a sterile field. I would say that I am a little more lenient because it is their first checkoff and I let them get over their jitters for the 1st checkoff. So, if they screw up, I say stop, you did something wrong. Now retrace your steps. If they can verbally tell me where they are wrong, great then we continue. If they can't I make them restart. If they still can't get it after the 2nd time, I send them for remediation. Now, when I do catheter insertion check-offs, I'm like ok guys, this is when you can kill someone if you do it wrong. This is when your sterile technique practice is of the utmost importance and if they can't do it after 2 tries, they go to remediation (Elizabeth, personal communication, 10/7/22)

Leslie explained,

> I don't think I have ever passed a student that I felt was unsafe. I've had lots of students that I felt were just lazy, but they were not unsafe. Like, they didn't do anything unsafe in clinical. They might not make the best nurse in the world just because of their attitude, laziness…you know, personality stuff. But I mean I can't grade a student based on their personality (Leslie, personal correspondence, 9/3/22)

Factors allowing poor performers to achieve passing grade. One interview question asked participants to discuss a time when a student received a passing grade, but they questioned whether the student was performing at a safe enough level to pass the course. Participants listed several factors that contributed to a student achieving a passing grade while performing poorly in the clinical setting.

One factor included the program grading system used by participants who taught in the BSN programs. Yvette explained,

> Our program uses a number grading system with 5 as the highest and 0 is the lowest. Even though the student may have gotten all 3's and barely passed the clinical performance or made 3's and 2's in clinical performance, that number is only a portion of the total grade. The student achieved the number that allowed them to pass. So, it pulled them up high enough to get to 77 to pass. So, you see what I'm saying? You could give low grades in clinical but if their paperwork grade is high enough to pull them up, they still pass the course. So, you could actually be skirting by in clinical, but the paperwork

> can pull you up enough to pass you in the course. (Yvette, personal correspondence, 8/13/22)

Jamee discussed how the grading rubric affected the grade earned by the student who had clinical performance issues. She explained,

> When I was using the grading tool to grade his work, I knew he needed more work. But he had earned the points according to the rubric so I couldn't take the points away from him. I was not the only instructor who felt he needed more, but according to the rubric, he met the grading requirements to pass. (Jamee, personal communication, 9/24/22)

Leslie explained,

> I think we have all had students in clinical who get through and pass based on the grading criteria. But that doesn't necessarily mean that I want to wake up and see them at the head of my bed. They may not have met the criteria to fail, but they are not going to be the most stellar nurse out there. (Leslie, 9/3/22)

Sara discussed a student who she felt was dangerous in the clinical setting yet passed the course because of their program's grading system and evaluation tool. She explained,

> I remember having a student and I didn't know what to do with them. I was at the nurses' station and the student came to me and said they needed to give insulin to a patient whose blood sugar was 68. I said that we were not giving insulin for a glucose of 68. The student became argumentative and insisted that the blood glucose of 68 required insulin. A nurse came up to the student and said stop arguing. You don't know what you are talking about, and your faculty is trying to tell you that you are wrong. This was a junior-level student who already had learned about diabetes in theory. This was just a scary student. I wrote the student up as unsafe, but they did progress a bit throughout the semester. Our evaluation scores students 0-4. 0=not passing 1= below the standard performance 2=expected behavior. Even though the student scored a lot of 1's, the student still ended up passing their clinical evaluation. I don't know how that happened, but it did. Obviously, our grading and evaluation tool allowed this to occur. (Sara, personal communication, 10/11/22)

Emerging Themes Related to Research Question Two

Two themes emerged from the interviews related to the second research question: What ethical responsibility does a clinical nursing instructor assume in the student clinical performance evaluation and grade assignment process?

Theme 1: Patient Safety

Each participant's agreed that their ethical obligation in the evaluation and grading process was to assure that patient safety was maintained when a student rendered care.

Do no harm. Yvette discussed a time when she recognized that a student was not performing at a safe level and the nurses working with the student also expressed their concerns about the student's poor performance. During her conversation with a nurse, they said, "Don't fail him because of me." Yvette told the nurse,

> Would you want this student taking care of your mom and the nurse said absolutely not. I asked would you want him working with you and she said of course not. I said then why do you want me to pass him? I don't care if the student is Doogie Howser and smart as all get out, I'm not going to pass them. If they don't have the professionalism to recognize that they have deficits and the professionalism to work safely in an environment under supervision, why on earth would I set them free to go work unsupervised? As far as I'm concerned, that was a bad on me if I let that happen. I feel that the bad behavior has to stop, and it has to stop with me. I'm not going to let somebody put someone's life at risk (Yvette, personal correspondence, 8/13/22)

Traci agreed that her ethical responsibility focused on safety. She discussed the procedure she used in clinical to prevent a student from causing harm to a patient. She explained,

> My ethical responsibility is all about safety. Do no harm. I tell students that if you and I are doing something and I say "uh um" that means for you to freeze your hands and stay still. Or if I lay my hand on your shoulder and say "um" that means stop. I'm not going to verbalize in front of a patient what you are doing wrong. I am very good about telling students what signs I will give in clinical for them to stop (Traci, personal communication, 8/28/22)

When asked what her ethical obligation was in the evaluation process, Leslie explained,

> I want to make sure that when I open my eyes, I am looking at a nurse who knows what they are doing when they are taking care of me. Society holds me accountable for producing these types of caregivers. So that's my ethical obligation. I have to answer for the people I produce (Leslie, personal communication, 9/3/22)

Shannon felt that treating all patients the same was an example of doing no harm and explained,

> Students need to remove stereotypes and treat all patients equally. For example, last week we had a patient who was a pediatrician and the student felt they had to do more for the

> patient because they were a pediatrician. But I expressed to the student that if you are doing the right thing by the patient every time you walk through the door, you don't have to elevate your standards because they are already elevated. So, it doesn't have to change because you are the VIP of a hospital (Shannon, personal communication, 9/4/22)

Jamee felt it was her obligation to recognize an unsafe situation and determine if the student knew how to perform at a satisfactory level in that situation. She explained,

> It is imperative that we uphold the profession in that if a student is not safe, they don't move forward. I tell all my students that it's not personal. But I also say God forbid I wake up one day and see you at my bedside, I want to know you are going to take care of me safely. I have to go home and be able to sleep well at night because I did what I was supposed to do to protect the patients. They are counting on me to make sure I am on top of my game. (Jamee, personal communication, 9/24/22)

Jenny explained,

> My ethical obligation as a nurse and instructor is to do no harm and to share my knowledge to help students obtain the knowledge to carry out into the profession. My ethical obligation is to my community, myself, the healthcare providers, and my profession (Jenny, personal communication, 10/6/22)

Elizabeth believed patient safety was her priority ethical obligation and explained,

> My students are aware that all of my expectations circle back to patient safety. If a student tries to ambulate a patient to the bathroom by themselves and they should not be doing that and that patient falls, not only is that student going to be mortified because they just caused harm to a patient, they are also getting an unsafe clinical evaluation grade the patient is also suffering (Elizabeth, personal communication, 10/7/22)

Sara felt that her obligation was to make sure the student was rendering safe patient care during the clinical experience. She explained,

> My main job is that I have to make sure that a student is safe at the bedside. It's about the safety of the patient. I know I say this at least once each clinical day that it is about safety not about perfection. When I am evaluating a student, I am looking at how safe they are. Do I have to remind them to do every single little thing? I tell them that I am not going to be in your ear in a year telling you what to do. So, are you going to get to the bedside, not know what to do and say oh well, I didn't do that right but its ok because no one will know (Sara, personal communication, 10/11/22)?

Theme 2: Honest and Fair Evaluations

Seven participants expressed their feelings of being ethically bound to be honest and fair with a student when evaluating their performances in the clinical setting. Yvette explained,

> Most of them appreciate that I am tough but fair. To me, that's the best evaluation you can get. They get lots of experience in my group and get the autonomy to do things. When I see and they see that they can do something independently and correctly, that is a huge accomplishment for them and for me too. It shows them that preparation pays off. When they earn my trust, I can give them more responsibility. This doesn't work out each semester but when it does, it's nice. Giving them that boost of confidence when they do something right is also part of my ethical obligation. I am obligated to recognize when they are not being successful in the course, but I am also obliged to let them know when they are doing well too (Yvette, personal communication, 8/13/22)

Leslie explained,

> I'm ethically bound to be honest in their evaluations because we are trying to produce safe and competent and critically thinking nurses to care for our community. I don't want to see their names on the list of nurses being reported to the board of nursing. (Leslie, personal communication, 9/3/22)

Leslie also shared a time when she had to assign a failing grade to a student. She knew the student was not performing at a satisfactory level and knew that reporting the student was the right thing to do. But she also blamed herself. She explained,

> I bawled my eyes out each time I had to fail a student in my first instructor position. It made me feel like a failure. I sat in my dean's office and cried. The dean reminded me that I was not failing the student, the student failed themselves. I told her that I feel like if I had done a better job teaching then they wouldn't have failed. It made me question whether I had explained myself good enough to where they understood. Did I maybe ignore their learning style? Did we just have personality clashes? Sometimes I question it initially, but in the end, I know that what I did was the right thing to do (Leslie, personal communication, 9/3/22)

Shannon discussed her initial feelings, as a new faculty member, about being honest when evaluating a student. She explained,

> When I first started it was an uncomfortable feeling. As I have continued to learn and grow in previous experiences, I have learned to remove some of the emotional subjective components and replace that with an objective point of view. I have tried my best to explain unsatisfactory or unsafe behaviors in accordance with the expected policy and procedures. (Shannon, personal communication, 9/4/22)

Jamee shared an experience she had with a student who had a history of satisfactory performances but made an error so egregious that it had to be addressed. She explained,

> I felt bad for the student. But, as I said, I have an obligation to the patients. I tell the student that even though you did everything else right today, what if the patient lost their life because of this one error you made? You can't take it back. I don't know if this is right to tell students, but I tell them that each of them is a potential walking lawsuit and I have to make sure they do everything right because I have an obligation. And if I let a student slide, one day they are going to be at someone's bedside and need to do that one skill they did wrong in my clinical and it will be on me because I didn't address it (Jamee, personal communication, 9/24/22)

Jenny discussed her thoughts on having to correct a student, in front of a patient, when they were about to make an error. She explained,

> If I observe a student performing a process or procedure incorrectly, I stop it and don't let it go any further. As a new faculty member, I was kind of uncertain about doing that in front of a patient. As a seasoned faculty, it doesn't bother me to stop a student in front of a patient. I have a duty to protect the patient, the public and to educate that student. Because if I turn a blind eye to the mistake, the student will think they did it right and continue to do it wrong until they hurt somebody (Jenny, personal communication, 10/6/22)

Elizabeth expressed her frustration with repeatedly witnessing her first-level students make the same mistakes because they failed to practice their skills. She explained,

> It pisses me off because I am a very levelheaded person. I know they are learners and I know what is easy for me is hard for them and that they are still learning. But if I give them extra time to practice, and they don't, and still don't know what to do…that's it! (Elizabeth, personal communication, 10/7/22)

Sara discussed the student she mentioned earlier in the interview whose clinical performances were so gravely deficient Sara had to dismiss the student from the course. The student had already failed a clinical nursing course and this failure meant the student would be dismissed from the program. The student appealed to the school admissions, progression, remediation, and graduate (APRG) committee. Sara expressed her frustration about the situation, saying that none

of the student's prior clinical instructors reported any instances of poor performance on the student's clinical evaluations. Sara explained,

> It pisses me off because now I'm the bad guy. They'll say it's personal and you don't like me. So, when the dean came to the APRG committee meeting and heard the student's prior faculty say how bad the student had been in clinical the dean said Then show me where you wrote that in their evaluation when they were in your clinical because I see here that you gave her a B on her clinical evaluation? There is no documentation on the evaluation where you say she is a poor weak student. This student did not suddenly get this way. Absolutely not (Sara, personal communication, 10/11/22)

Summary

In this descriptive qualitative study, eight full-time clinical nursing faculty (four from an ADN program and four from a BSN program) shared their stories about teaching, evaluating, and assigning clinical grades to groups of undergraduate nursing students in the clinical setting. Participants described the clinical performance process used in their program to evaluate and assign grades and shared situations when a student achieved a passing clinical grade, but they questioned whether the student was safe enough to pass. Participants described factors that influenced their decision to issue a failing clinical performance grade and shared feelings about what their ethical obligations were when evaluating a student's clinical performance and issuing a grade. After repeated review and analysis of each interview transcript, two major themes (and sub-themes) emerged to address each of the two research questions. Each theme and sub-theme was discussed and supported by quotes extracted from participant interviews.

CHAPTER V:

DISCUSSION

This chapter includes an overview of this qualitative study, significant findings, and consideration of the findings considering existing research. A discussion of the implications related to nursing education, practice, and research is included as well as the limitations of the study and recommendations for further research.

Overview of the Study

In the United States (US), most undergraduate nursing programs require that full-time faculty teach in the classroom and clinical settings. Clinical nursing faculty are responsible for training, evaluating, and assigning clinical performance grades for up to 10 students who may be enrolled in their clinical group. Sometimes, students advance through a nursing program without obtaining the knowledge and skills required to provide safe patient care. The term failure to fail (FTF) is defined as "the allocation of a passing grade to a nursing student who has failed to deliver a satisfactory performance in the clinical setting" (Hughes et al., 2016, p. 55). FTF in clinical nursing education is a problem having profound implications for students, faculty, nursing professionalism, and patient safety (Hughes et al., 2016).

The impetus for this study was to address several gaps in the literature related to nursing ethics and FTF in clinical nursing education. The first gap was the lack of research conducted in the US on the topic of FTF in undergraduate clinical nursing education. A thorough examination of the literature produced one study published in the US on the topic. A second gap was a lack of research examining clinical nurse faculty (CNF) responsible for teaching groups of students

enrolled in US undergraduate nursing programs. Most literature on this topic examined nurse mentors or preceptors in the UK and Canada responsible for supervising one student during a preceptorship. The third gap was a lack of research examining what ethical responsibilities a CNF assumed in the clinical performance assessment process and grade determination process, especially when they chose to assign a passing grade to a student who failed to perform at a satisfactory level in the clinical setting.

The purpose of this descriptive qualitative study was to explore the phenomenon of FTF in undergraduate nursing programs in a US southern state. The study focused on full-time CNF who train, evaluate, and assign clinical performance grades to groups of students completing either an ADN or BSN clinical nursing course and have experienced students who were not performing at a satisfactory level. The goal of the study was to determine why this phenomenon may be occurring so measures can be established to eliminate this unethical educational practice.

The overarching research questions prompting this study were 1) what reasons do clinical nursing faculty provide for assigning a passing grade to a student whose performance they evaluate as unsatisfactory; 2) what do clinical nursing faculty believe are their ethical responsibilities in the student clinical performance evaluation and grade assignment process?

To achieve this goal, an interpretive description (ID) design was used to frame this cross-sectional qualitative study. Duty orientation (DO) and deonance theory (DT) were the theoretical frameworks that guided this research. The 2015 American Nurses Association (ANA) Code of Ethics for Nurses with interpretive statements and the 2018 National League of Nurses Competencies for Academic Clinical Nurse Educators were the conceptual frameworks that also guided the study.

Significant Findings

This section discusses findings from the study as they related and responded to the research questions and consideration of those findings considering existing research.

Research Question 1: Reasons for Assigning Passing Grades to Students with Unsatisfactory Performance

To gain an understanding of what factors might influence CNF to assign a passing grade to a student they evaluated as unsatisfactory, the interview began by asking participants to describe their program's clinical performance evaluation system. After reviewing the data, the first theme emerged revealing inconsistencies in the clinical performance evaluation systems used by each program. Sub-themes included variances in the frequency of evaluations being performed and documented, inconsistencies in grading systems, subjective grading scales, and different methods used to report incidents when students failed to meet clinical performance objectives. This does not suggest that there is only one universal way to evaluate and grade a student's clinical performance. However, the presence of inconsistent and subjective clinical performance evaluation practices could represent a series of contributing factors supporting why some students are assigned a passing grade when their clinical performance is evaluated as unsatisfactory.

The data revealed variances in the frequency with which clinical performance evaluations were performed and documented. Some participants reported using a clinical performance evaluation tool (CPET) to document a student's weekly clinical performance grades. Some participants provided verbal performance feedback each week, but written performance evaluations (and grades) were issued at mid-term and at the end of the rotation. Verbal feedback is appropriate when faculty are engaging with students during each clinical experience. Routine

performance evaluations let the student know whether they are meeting the clinical objectives. They can also serve as an opportunity for the instructor to notify a student when they are not demonstrating clinical progression and prompt the initiation of remediation.

The literature addressed and supported the practice of continuous performance feedback. Providing students with an ongoing formative evaluation allows clinical nursing instructors to keep students informed of their progress toward achieving clinical outcomes (Bonnel, 2015; Christensen, 2015; Frank, 2020). Gray and Donaldson (2012) recommended that grading practice systems be subjected to ongoing evaluation and monitoring because evaluation tools used descriptive language which lessened their reliability, validity, and effectiveness.

Participants also described and provided a copy of the CPET used by their program. When reviewing each CPET, it contained subjective descriptors like *consistently, sometimes, occasionally, and frequently* to measure instances when a student exhibited a behavior. However, none of the CPETs included a reference range for how many instances were required to meet a specific descriptor. It was left to the discretion of the CNF to assign a value to these descriptors allowing for the subjective issuance of grades on the CPET. Subjective descriptors listed on CPETs could be the greatest factor contributing to a failure to fail in nursing education because student grades are determined by how a CNF defines each descriptor.

For over 50 years, nursing literature has reported issues with the subjective influences permeating clinical evaluation grading systems. In 1978, Gould reported that instructors and students often voiced frustration and dissatisfaction with the evaluation process claiming ambiguous, biased, and subjective grading by faculty, and interpretation of grading standards varied greatly from instructor to instructor, course to course, and school to school. Gould (1978) added that although satisfactory and unsatisfactory grading scales are widely accepted by many

curricula, research studies have failed to substantiate the motivational advantages and disadvantages cited by the proponents of this system. Orchard (1992) stated that conclusions about a student's performance reflect the instructor's perception of what performance constitutes professional nursing practice and the assessment is based on both objective and subjective criteria. Because of the subjective elements in such evaluation decisions, there is a danger that some decisions about student performance may be biased and unfair (Orchard, 1992). Heaslip and Scammell (2011) added that while grading systems were more differentiated than pass-or-fail systems, neither was value-free as they all relied on the judgment of the assessor.

Norman et al. (2002) evaluated five tools that assessed student competency in six health-related professions in the UK and found no method to be adequate for assessing clinical competency. In 2010, Walsh et al. published a preliminary report on a group of BSN faculty who developed a clinical performance evaluation tool (CPET) intended to accurately measure Quality and Safety Education for Nurses (QSEN) competencies. The faculty believed that

> …an efficient evaluation tool is essential when measuring the clinical performance of undergraduate nursing students. It is also important that this evaluation tool accurately assesses the critical competencies that students must demonstrate in the clinical setting. The tool should be unambiguous, succinct, and adaptable to a wide variety of clinical experiences and faculty (Walsh et al., 2010)

Donaldson and Gray (2012) conducted a systematic review of literature (ROL) that focused on exploring issues of grading in practice, including reliability, validity, and the implications for mentor preparation and support. The ROL included grading practices used in nursing, midwifery, medicine, and allied health in the United Kingdom. They discovered that most clinical performance evaluation tools (CPET) used descriptive accounts of performance and the perceived value assigned to earn a certain grade. They concluded that the reliability, validity, and effectiveness of grading practices had yet to be proven and ongoing evaluations should be

done to build the evidence. Heaslip and Scammell (2011) reported on a study they conducted to develop a standardized CPET. In their tool, they assigned a specific number to each grade. They felt that this would increase reliability when used by mentors to determine a student's clinical performance grade. However, some assessors reported difficulty using the tool when evaluating students in the practice setting.

Weaver et al. (2007) agreed that using explicit descriptors as grading criteria could reduce grade inflation. Their study on the evaluation of medical students showed that 71.4% (n=80) of the mentors used the descriptors and 70.5 % found them useful. However, when students were asked if they found the descriptors useful, they perceived inconsistent use of descriptors by their evaluators. The students felt that the grading was not fair because different mentors marked them differently. The researchers added that the differing perceptions raised concerns about the quality assurance of the grading systems.

The results of this study added to the existing literature on the topic. Participants discussed the reporting systems used by their programs to document instances when a student failed to meet a clinical objective. Participants from both ADN programs discussed the use of unsatisfactory or unsafe clinical performance documents that served as official notification of poor clinical performance and became part of their student files. Both BSN programs used a clinical contract to document performance issues. One BSN program attached it to the CPET while the other BSN program discarded it if the student's behavior improved.

The literature offered little data regarding specific forms used to document instances when a student fails to meet the clinical objectives. Bonnel (2016) discussed using anecdotal notes to record specific patterns of both positive and negative clinical behaviors to use as a summative evaluation and recall during student-faculty conferences. Orchard (1992) analyzed

policies and procedures concerning clinical evaluation practices of Canadian diploma and generic baccalaureate nursing programs (A=81). Even though 78 of 81 respondents reported the existence of written policies and procedures, little evidence of actual forms existed. Wallace (2013) used the term learning contract to describe an articulated plan or mutually agreed upon agenda that would provide a nursing student with learning opportunities related to their learning needs. However, no literature was available on the use of a clinical contract to report performance issues.

The second theme emerging from the data identified variances in reporting students who failed to meet clinical performance objectives during the clinical experience. Sub-themes included variances between when incidents were and were not reported by faculty and instances when faculty used leniency when grading a student's clinical performance All participants admitted that they were required (by school policy) to report any instance when a student failed to meet clinical performance objectives during the clinical experience. Some shared cases when they reported a student who failed to meet the clinical objectives. Others explained times when they failed to follow policy and chose not to report the student. All participants admitted that unsafe clinical behavior warranted reporting. Some participants also shared that their program's grading system was structured in a way that sometimes allowed a student to pass when they should have been held back.

The variances seen in this theme are linked to the first theme in that they also appeared to be influenced by the CNF's subjective (and lenient) grading practices. It was interesting to note that all participants agreed that they would report a student if they were performing at an unsafe level and verbalized that FTF was a dangerous educational practice. However, participants who admitted to not following the policy and lenient grading practices voiced no association between

their subjective and lenient grading practices and FTF. This theme also supports that subjectivity and grading leniency are major factors contributing to why some students are assigned a passing grade when their clinical performance is evaluated as unsatisfactory.

Literature also supports subjectivity and grading leniency as common factors influencing decisions to assign a passing grade to students who were evaluated as unsatisfactory. Most literature on FTF in nursing education includes qualitative studies from the perspective of nurse preceptors and nurse mentors who are responsible for training one nursing student during a preceptorship. One US qualitative study by DeBrew and Lewallen (2014) offered the perspective of CNF teaching clinical groups of students. Many studies cited the reason for FTF was the moral and emotional toll felt by preceptors who were faced with issuing a failing grade (Black et al., 2014; Duffy, 2003; Earle-Foley et al., 2014; Hunt et al., 2016; Luhanga et al., 2008; Luhanga et al., 2014; Luhanga et al., 2016b; Vinales, 2014; Yepes-Rios et al., 2016). Some also stated a lack of administrative support when they wanted to issue a failing grade (Black et al., 2016; DeBrew & Lewallen, 2014; Luhanga et al., 2008b; Laroque & Luhanga, 2013; Luhanga et al., 2014; Luhanga et al., 2014b). Another study reported mentors giving students the benefit of the doubt when they were not sure (Luhanga et al., 2008).

Grading lenience was also noted when reviewing the literature on FTF. Nurse preceptors cited personal feelings of self-doubt in their decision-making abilities when determining whether students were prepared to pass the clinical rotation and others expressed feelings of guilt when faced with the decision of assigning a failing clinical grade to a student displaying unsafe behavior (Anthony & Wickman, 2015; Black et al., 2014; DeBrew & Lewellen, 2014; Duffy, 2013; Earle-Foley et al., 2012; Frank, 2020; Hughes et al., 2016; Larocque & Luhanga, 2013; Luhanga et al., 2014; Paskausky & Simonelli, 2014; Vinales, 2015).

Gingerich et al. (2020) interviewed 22 physicians in British Columbia about their experiences supervising medical trainees who demonstrate incompetence. The physicians believed that all trainees should be capable of learning and progressing by applying what they learn to subsequent clinical experiences (Gingerich et al., 2020). They believed that underperformance was unexpected and sought alternate explanations when underperformances occurred (Gingerich et al., 2020). Therefore, disbelief prevented confident documentation of performance and delayed identification of underperformance (Gingerich et al., 2020).

Research Question 2: Faculty's Ethical Responsibility When Evaluating and Assigning Clinical Grades

Two major themes emerged from the study that addressed the second research question. The first theme focused on the CNF's sense of obligation to ensure that patient safety was maintained when a student was delivering care during the clinical experience. All participants agreed that their highest priority was to protect the patient from harm. Several participants specifically referred to their obligation to uphold the ethical principle of non-maleficence or do no harm.

Literature on FTF supported the practice of reporting unsafe students. Many studies cited instances when educators recognized that a student was not performing at a satisfactory level, it was their ethical and professional duty to intervene (ANA, n.d.; Black et al., 2014; Christensen, 2015; Earle-Foley et al., 2012; Fitzgerald et al., 2020; Hughes et al., 2016; Hunt, 2019; Lachman et al., 2015; NLN, 2020; Winland-Brown, 2015).

The second theme addressed the CNF's ethical obligation to provide a student with an honest and fair clinical performance evaluation. The ROL also addressed the practice of providing a student with an honest and fair clinical performance evaluation. Christensen (2015)

believed the clinical instructor and nursing student relationship were based on collaboration, understanding, mutual trust, respect, equality, and accountability. Others wrote that nursing students had the right to a reliable and valid clinical performance evaluation that reflected the achievement of clinical competencies needed to accept the role of a novice nurse (Bonnel, 2015; Frank, 2020). CNF should preserve the wholeness of character and integrity during the clinical performance evaluation and grading process (Lachman et al., 2015).

Strengths and Limitations of the Study

A strength of this study is its relevance to undergraduate nursing education. The study addressed a gap in the literature by examining the experiences of CNF teaching groups of undergraduate nursing students in the US. Previous studies focused on the experiences of nurse mentors or preceptors from countries outside the US. This study can serve to narrow the gap and further inform the profession.

The study was limited by the geographical area, the small number of schools represented, and the small sample size. Participants were in one region of one southern state and only two ADN and two BSN programs were included in the study. Although data saturation was met using eight participants, using a larger sample may have allowed for the collection of additional relevant data. A larger school sample may have provided additional information on other clinical performance evaluation systems being used by other programs.

Implications and Recommendations

Nursing Practice

The data produced from this study have important implications for nursing practice. RNs often get opportunities to work with nursing students and observe them performing in the clinical setting. It is a nurse's ethical and professional obligation to protect patients from harm by

stopping and reporting a nursing student who is not accurately performing in the clinical setting. This researcher recommends clinical affiliates educate and encourage nursing staff to communicate with CNF and report when they observe a nursing student who is not performing at a competent level during the clinical experience.

Nursing Education

The results of this study have major implications for nursing education. The data revealed inconsistencies in the clinical performance evaluation systems being used to assign clinical performance grades by some undergraduate nursing programs. The verbiage used on the CPETs (to describe the level of a student's performance) is being left up to the discretion of the CNF to interpret. The study also revealed that the point distribution used on grading rubrics in some programs allows more points to be earned by completing clinical paperwork and fewer points placed on clinical competency. Two participants revealed that their program's disproportionate grading system has allowed students to pass the course because they can complete the paperwork even when they scored low on clinical performance.

Based on the results of this study, this researcher recommends undergraduate nursing programs:

1. Review and consider revising CPETs to omit subjective verbiage used to describe the level of behavior the student exhibits to earn a grade and replace it with verbiage that specifically quantifies behaviors a student must demonstrate to earn a specific grade;
2. Review grading rubrics and points allocated to written assignments to determine whether students are earning enough points on written assignments to pass even if they are failing to meet clinical performance objectives;

3. Provide full-time (and adjunct CNF) with annual professional development to review policies and procedures for evaluating and assigning clinical performance grades;
4. Encourage faculty to discuss (during faculty meetings) whether students are meeting or failing to meet clinical performance objectives. Data generated from these discussions could prompt a need for curriculum revision and/or policy changes; and
5. Provide full-time (and adjunct CNF) professional development opportunities to raise awareness of the dangerous practices of grading leniency and failure to fail in clinical nursing education.

Nursing Research

A paucity of literature exists on the topic of nursing ethics and FTF in undergraduate nursing education in the US. This study has generated an improved understanding of the experiences of CNF teaching groups of undergraduate students and the issues they encounter when a student fails to perform at a competent level. The study also illuminated the flaws seen with CPETs and grading rubrics used to evaluate and grade clinical competency. The inconsistencies in these grading tools are allowing FTF to occur. The study also raises awareness of the ethical issue of grading leniency which jeopardizes patient safety.

This researcher recommends that future research must focus on current CPETs and grading rubrics used in US undergraduate nursing programs to evaluate if these inconsistencies are contributing to FTF. Research focusing on developing a standardized CPET and grading rubric to use when evaluating clinical performances could serve as useful tools to decrease the chance of FTF occurring in US undergraduate nursing education. This researcher also

recommends that future research focus on determining the existence of other factors that may contribute to FTF. Lastly, future research is needed to focus on the ethical implications arising from FTF in undergraduate nursing education.

Summary

The purpose of this study was to address several gaps in the literature related to nursing ethics and FTF in clinical nursing education. The data produced from this study raises awareness of the issues seen in the clinical evaluation grading systems being used in some undergraduate nursing programs that are allowing FTF to occur. This dangerous patient safety practice violates ethical principles of nursing and must be addressed, and measures are taken in schools of nursing to abolish its practice.

For the past 20 years, the American public has ranked nurses as the most honest and ethical professionals in the annual Gallup Poll (Saad, 2022). CNF have a moral and ethical responsibility to promote patient safety and assign a failing clinical grade to any student who is not performing at a safe level in the clinical setting (Earle-Foley et al., 2012). Factors contributing to FTF must be identified and solutions formulated to end this dangerous practice, preserve the integrity of the nursing profession, and maintain the public's trust. CNF must be educated about the dangerous precedence set by issuing a passing clinical performance grade to a student who is not performing at a satisfactory level in the clinical setting. Providing support and assuring CNF that assigning a failing grade to an unsafe student would be in the best interest of the student, the program, and the public could lead to the resolution of this dangerous patient safety issue.

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APPENDIX A:

IRB APPROVAL LETTER AND INFORMED CONSENT

THE UNIVERSITY OF ALABAMA® | Research & Economic Development
Office for Research Compliance

July 25, 2022

To: Cheree Wiggins
Dept. of ELPTS
Capstone College of Nursing
Box 870358

From: Carpantato T. Myles, MSM, CIM, CIP [redacted]
Director & Research Compliance Officer

Re: **Notice of Approval**

IRB Application #:	e-Protocol 22-04-5555
Project Title:	"Nursing Ethics and Failure to Fail in Nursing Education"
Submission Type:	New
Approval Date:	July 25, 2022
Expiration Date:	July 24, 2023
Funding Source:	None
Review Category:	Exempt
Approved Documents:	Informed Consent Document

Dear Cheree Wiggins:

The University of Alabama Institutional Review Board has approved your proposed research. Therefore, your application has been approved according to 45 CFR part 46. Approval has been given under exempt review category 2 *as outlined below:*

(2) Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met: (iii) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by §46.111(a)(7).

The approval for your application will lapse, as noted above. If your research will continue beyond this date, please submit the Continuing Review to the IRB as University policy requires before the lapse. Please note any modifications made in research design, methodology, or procedures must be submitted to and approved by the IRB before implementation. Please submit a final report form when the study is complete.

Please use reproductions of the stamped IRB-approved informed consent form to obtain consent from your participants.

All the best with your research.

166 Rose Administration | Box 870127 | Tuscaloosa, AL 35487-0127 | 205-348-8461
Fax 205-348-7189 | Toll Free 1-877-820-3066 | rscompliance@research.ua.edu

Informed Consent

Please read this informed consent carefully before you decide to participate in the pilot study.

Project Title: Nursing Ethics and Failure to Fail in Clinical Nursing Education

Investigator's Name and Position:
Cheree' Wiggins, EdD(c), MN, RN
Doctorate Student

Consent Form Key Information

- Participate in a one-hour interview about evaluating a nursing student's clinical performance
- Review transcript of interview data for accuracy
- Data collected will be kept anonymous
- Participation is voluntary

Purpose of this Research Study
The purpose of this descriptive qualitative study is to explore the phenomenon of failure to fail in undergraduate nursing programs in a southern state in the United States. The study will focus on clinical nursing faculty (CNF) who train, evaluate, and assign clinical performance grades to groups of students completing either an associate or Baccalaureate clinical nursing course and have experienced students who were not performing at a satisfactory level. The goal of the study is to determine why this phenomenon may be occurring so measures can be established to eliminate this unethical educational practice.

What will you do in the study?
You will be asked to participate in an interview and review the transcript of the interview at a later date for accuracy. You will have the choice of attending an in- person or video conference interview. The in-person interview will be audio recorded and the video conference interview will be audio visually recorded. You can skip any question that makes you feel uncomfortable. You can stop the interview at any time.

Time Required
The interview will take approximately 45 minutes to 1 hour to complete. Review of interview transcript to determine accuracy will also take approximately one hour.

Risks
There are no anticipated risks involved to you if you volunteer to participate in this study.

Benefits
There are no direct benefits to you for participating in this research study. The study may help us understand why some clinical nursing faculty decide not to assign a failing grade to a student who is not performing at a satisfactory level in the clinical setting.

Confidentiality
The information you provide for the study will be handled confidentially. Your name and other information that could be used to identify you will not be collected or linked to the data. In any written reports or publication, only aggregate data will be presented. Your interview data will be destroyed when the study is completed.

Voluntary Participation
Your participation in this study is completely voluntary.

Right to Withdraw from this Study
You have the right to withdraw from the study at any time without penalty. There is no penalty for withdrawing. If you would like to withdraw after your interview has been completed, please contact the researcher as described above. Upon withdrawal any materials associated with your participation in the study will be destroyed.

Compensation/Reimbursement
You will receive no payment for participating in this study.

If you have questions about the study or need to report a study related issue please contact, contact:

Name of Principal Investigator: **Cheree' Wiggins, EdD(c), MN, RN**
Title: **Doctorate Student**
Telephone: **(504) 450-6022**
Email address: **cwiggins2@crimson.ua.edu**

Name of UA Faculty Supervisor: **Sara K. Kaylor, EdD, RN, CNE**
Associate Professor
The University of Alabama
Capstone College of Nursing
skkaylor@ua.edu

If you have questions about your rights as a participant in a research study, would like to make suggestions or file complaints and concerns about the research study, please contact: Ms. Tanta Myles, the University of Alabama Research Compliance Officer at (205)-348-8461 or toll-free at 1-877-820-3066. You may also ask questions, make suggestions, or file complaints and concerns through the IRB Outreach Website at http://ovpred.ua.edu/research-compliance/prco/. You may email the Office for Research Compliance at rscompliance@research.ua.edu.

Agreement:

☐ I agree to participate in the research study described above.

☐ I do not agree to participate in the research study described above.

☐ I agree to video (audio, photograph) in the research study described above. (If applicable).

☐ I do not agree to video (audio, photograph) in the research study described above. (If applicable).

Signature of Research Participant Date

Print Name of Research Participant

Signature of Investigator or other Person Obtaining Consent Date

Print Name of Investigator or other Person Obtaining Consent

UA IRB Approved Document
Approval Date: 7-25-22
Expiration Date: 7-24-23

APPENDIX B:

DEMOGRAPHICS

Age Range (check box)

30-40 ☐

41-50 ☐

51-60 ☐

60-70 ☐

>70 ☐

Gender (check box)

Female ☐

Male ☐

Prefer not to say ☐

Years of Teaching Experience (check box)

1-5 ☐

6-10 ☐

11-15 ☐

16-20 ☐

>20 ☐

Education (check box)

Masters in Nursing ☐

Masters in Nursing Education ☐

DNP ☐

CRNA ☐

PhD ☐

EdD ☐

APPENDIX C:

INTERVIEW QUESTIONS

1. What course do you teach and at which level (of the program) are your students?
2. How many clinical nursing courses have your students completed prior to enrolling in your course.
3. Describe the clinical performance grading system and evaluation process in place at your school of nursing.
4. Discuss a time when one of your students received a passing clinical grade but you questioned whether they were safe enough to pass the course and move on.
5. What factor(s) influenced your decision to not issue assign the student a failing grade?
6. What clinical behaviors do you believe warrant a failing/unsatisfactory/unsafe grade?
7. What do you believe are your ethical obligations when evaluating a student's clinical performance?
8. How does it make you feel when you have to address a student who exhibits unsatisfactory or unsafe behavior?