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Nurse Anesthesia Program Administrator's Decision-Making in Determining Interventions for a Student Exhibiting Unsatisfactory Clinical Performance

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Nurse Anesthesia Program Administrator's Decision-Making in Determining Interventions
for a Student Exhibiting Unsatisfactory Clinical Performance

A Dissertation

Submitted to the Graduate Faculty of the
University of New Orleans
in partial fulfillment of the
requirements for the degree of

Doctor of Philosophy
in
Educational Administration

by

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May, 2019

Dedication

To my husband, Gary Bonanno, and my son, Christopher Bonanno, this would not have been

possible without your love and support. I love you both with my all my heart and soul. You two

are my world.

Table of Contents

List of Figures

List of Tables

Abstract

The purpose of this grounded theory study is to define the process that nurse anesthesia program administrators use to determine if a student nurse anesthetist's unsatisfactory clinical performance warrants intervention by the program. There is little room for error in anesthesia practice as mishaps typically result in significant injury and death. Students who exhibit unsatisfactory clinical performance may pose an immediate risk to patient safety as well as a future risk if allowed to progress in the program. The lack of guidance in the form of clearly articulated expectations and processes contribute to the emotional strain nurse anesthesia faculty and administrators experience when observing unsatisfactory clinical performance. From the data collected in the interviews with ten nurse anesthesia program administrators, a five-phase decision-making model entitled the Nurse Anesthesia Program Administrator Decision Making Model was developed. The five phases of the model include: receiving the feedback, validating the concern, assessing accountability and planning for remediation, removing the student from clinical training and moving to dismissal, and notifying the student of the decision. The guiding principle of this model is the importance of following institutional and program policies throughout the process. This study is intended to provide guidance to nurse anesthesia program administrators who are faced with a student demonstrating unsatisfactory clinical performance regarding what behaviors may require an intervention by the program.

Keywords: nurse anesthesia education, unsatisfactory clinical performance, clinical training, dismissal, remediation, clinical failure, unsafe clinical performance

CHAPTER ONE

Introduction

Certified Registered Nurse Anesthetists (CRNAs) have been providing high quality anesthesia care in the United States for over 150 years (American Association of Nurse Anesthetists [AANA], 2016). Nurse anesthesia is an advanced practice nursing specialty that requires graduate level educational (masters or doctoral) preparation. Applicants must have earned a Bachelor of Science degree in nursing with a minimum grade point average (GPA) of 3.0, possess an unencumbered license as a registered nurse, and have a minimum of one year of experience as a critical care nurse to meet eligibility criteria for admission into a nurse anesthesia program (Council on Accreditation of Nurse Anesthesia Educational Programs [COA], 2018). Nurse anesthesia education takes place in both classroom and clinical settings. The curriculum builds on prior nursing knowledge and skills, especially those skills gained in the care of critically ill patients (COA, 2018). Graduates of nurse anesthesia programs must meet eligibility requirements for licensure as an advanced practice registered nurse (APRN) and certification as a CRNA. The program administrator of the graduate program must verify that all academic and clinical educational requirements prescribed by the COA are met and that graduates are competent to provide anesthesia (National Board for Certification and Recertification of Nurse Anesthetists [NBCRNA], 2019). This study sought to examine the decision-making process of nurse anesthesia program administrators regarding whether intervention was necessary for a student exhibiting unsatisfactory clinical performance.

Statement of the Problem

A significant amount of teaching and learning in nurse anesthesia education takes place in the clinical setting as graduates of nurse anesthesia programs are required to have a minimum

1

of 2000 practice hours and complete a minimum of 600 anesthesia cases (COA, 2018). In the

clinical setting, the ability to integrate theory into practice is essential to student success (Collins

& Callahan, 2014). Students are paired with a clinical educator (CRNA or anesthesiologist) to

provide anesthesia care to patients undergoing real surgical cases (Smith, Swain, & Penprase,

2011). The clinical educator has a responsibility to ensure safe patient care in the operating room

while effectively balancing the role of clinician and teacher (Burns, Beauchesne, Ryan-Krause,

& Sawin, 2005; Christensen, 2016). It is in this clinical arena where a student, interacting with a

clinical educator, acquires professional and personal skills, and develops knowledge, skills,

attitudes, values, and competencies essential for entry into the nurse anesthesia profession

(Smith, et al., 2011; Burns, et al.,).

The role of the clinical educator is crucial in assessing and evaluating student

performance (Christensen, 2016; Van Wormer, 2009). The academic program relies on the

clinical educator to provide the student with an accurate daily evaluation of individual student

performance in the clinical environment based on defined program expectations (Van Wormer,

2009). The daily evaluations are then reviewed by the student's assigned faculty advisor who

reports concerns regarding a student's safety and competency to the program administrator.

Clinical educators concerned about a student's clinical performance may also contact the

program administrator directly. Unfortunately, clinical evaluation tools used by nurse anesthesia

programs are not validated or standardized instruments (Collins & Callahan, 2014). Thus, the

evaluation process depends upon the judgement of the clinical educator to decide whether the

student's clinical performance was satisfactory or unsatisfactory, which is especially important

when a student is not performing at the expected level of safety and/or competency (Christensen,

2016; Van Wormer, 2009). A special interest group of the COA just completed a Delphi Study

to validate a standardized clinical evaluation tool that can be used by all nurse anesthesia programs (COA, 2019). This tool entitled the *Common Clinical Assessment Tool* will be available to nurse anesthesia programs in the summer of 2019.

Ideally, clinical educators should inform the student, faculty advisor, and/or the program administrator whenever there are concerns about clinical performance (Christensen, 2016). Providing such information in a timely manner ensures that the student is afforded a remediation plan within a specified period for improvement (Garside & Nhemachena, 2013). However, clinical educators are often reluctant to document poor performance for fear that they may be named in a lawsuit filed by the student, or that such documentation may result in the student failing a course or being dismissed from a program (Dudek, Marks, Regeher, 2005; Earle-Foley, Myrick, Luhanga,& Yonge, 2012; Irby & Millam, 1989; Killam, Luhanga & Bakker, 2011; Luhanga, Yonge, & Myrick, 2008). In fact, clinical educators often give students the benefit of the doubt when they are not performing at an expected level, unless there is clear evidence that they are not safe (DeBrew & Lewallen, 2014).

There is little room for error in anesthesia practice as mishaps are typically associated with significant patient injury and/or death (Attri, Makhni, Bala, Kumar, & Jain, 2016). The most common anesthesia accidents result in a lack of oxygen supplied to the patient (hypoxia), or from a lack of vigilance in monitoring the patient (AANA, 2009). Nurse anesthesia students, under the supervision of a clinical educator, are responsible for the patient's oxygenation and ventilation, hemodynamic stability, and ensuring adequate anesthesia depth in response to surgical stimulation. Therefore, unsafe or underperforming students pose an immediate risk to patient safety as well as a future risk if allowed to progress to clinical practice (Killam, et al., 2011; Schenarts & Langenfeld, 2017). It is important that clinical educators can confidentially

assess and report poor performance and that they document actual behaviors of concern (Wren & Wren, 1999). Furthermore, when the student evaluation does not accurately reflect actual student clinical performance, the program administrator misses a critical window of opportunity to make an informed decision on student progression status and whether the student should be provided an opportunity to improve. A student may be allowed to progress when remediation is indicated. When student clinical performance and professional demeanor fall well below the expected level, there may be grounds for dismissal from the program (Christensen, 2016; Wren & Wren, 1999).

Dosch, Jarvis, and Schlosser (2005) examined student attrition in nurse anesthesia programs and found that the mean overall attrition rate was 5.41%. The authors reported, "the most common reason for attrition was withdrawal, followed by academic dismissal, and clinical dismissal" (p. 277). While dismissal for issues related to clinical performance ranked third, poor clinical performance was listed as a reason for both withdrawal and academic dismissal. These findings highlight what is known about the results of decision-making for poor performing students in nurse anesthesia programs. However, the lack of guidance for program administrators regarding how to manage nurse anesthesia students who do not perform satisfactorily in clinical is a significant concern, which is why this study is warranted.

Background of the Problem

The literature on decision-making in nurse anesthesia programs is limited. However, the scholarship on decision-making as it relates to poor student performance in other health profession educational programs offers a context from which to better understand the need for this proposed research. For example, in counselor education programs, "it is inevitable that some students who are impaired or inappropriate will be admitted to counselor education programs"

4

despite intensive admissions procedures that evaluate personal characteristics in an effort to screen students (Frame & Stevens-Smith, 1995, p. 121). Regardless of the specialty, students enrolled in health profession programs that involve direct patient care must be monitored and evaluated on their clinical performance to protect patients from harm (Christensen, 2016; Van Wormer, 2009).

In some disciplines such as counselor education, the term "impairment" is a term used to describe behavior that interferes with professional functioning (Frame & Stevens-Smith, 1995). This term refers to unsatisfactory behavior that may include the inability or willingness to uphold professional standards or skills needed to reach an acceptable level of competency or the inability to control stress or reaction (Frame & Stevens-Smith, 1995). The authors also stated that supervisors should conduct ongoing assessment and evaluation to determine limitations of students, either personal or professional, that could affect performance and they should recommend remediation or counseling as needed. While recognizing that the welfare of the client is the priority, counselor educators must also be concerned about student counselor impairment and potential harm to clients. Considering the similarities related to patient vulnerability, nurse anesthesia educators must also be accountable to protect patients from students who pose a risk to patient safety (Christensen, 2016; Schenarts & Langenfeld, 2017; Wren & Wren, 1999).

The decision of whether to offer remediation to underperforming students is likewise a challenge in nursing education. Tanicala, Scheffer and Roberts (2011) developed a multiphase project to facilitate a move toward a culture of safety in clinical nursing education. According to Tanicala, et al. (2011), nurse educators are "professionally, legally, and ethically" (p. 155) expected to protect patients from the potential of a student causing harm in the clinical setting.

Actual hands on clinical training is essential in the training of future healthcare professionals. Clinical educators who are dealing with a student exhibiting unsafe clinical performance face numerous ethical challenges including: feeling unprepared to evaluate students, concern about the possibility of litigation by students who feel they were not evaluated fairly, feeling a sense of personal failure and guilt, and feeling unsupported in their decision (Docherty, 2018; Earle-Foley, et al, 2012). According to Earle-Foley et al, (2012), "preceptors have an ethical responsibility to address unsafe practice of students and take action to prevent unsafe practitioners from progressing in nursing programs (p. 32). Allowing students who provide unsafe care to continue in a nurse anesthesia or other health profession educational program threatens patient safety as well as professional integrity (Earle-Foley, et al., 2012).

Similarly, Capozzi and Rhodes (2005) explored ethical issues in medical education related to the conflict between a physician residency-training program's responsibility to its young physician trainees and its responsibility to protect the patients entrusted to its care. Specifically, their research examined how often a resident should be allowed to falter before being dismissed and what steps, if any, should be taken to correct inappropriate behavior. According to Capozzi and Rhodes (2005), "residents with major uncorrectable deficiencies in clinical are not helped by being retained and his or her future patients are better served by prompt decisions and clear unambiguous communication" (p. 2354). When residents exhibit unprofessional behavior or character deficiencies such as having a disregard for patient safety, falsifying records, or failing to care for patients, dismissal is the appropriate response unless the behavior is rectified immediately (Capozzi & Rhodes, 2005). Faculty face a more difficult decision when the student's behavior is subtler, and unprofessional behaviors occur over a period of time and in a variety of locations. Finally, consistent with nurse anesthesia students, if a

physician trainee continues to perform at a level below the acceptable standard despite multiple opportunities to correct the behavior, then the he or she must be dismissed from the training program (Capozzi & Rhodes, 2005).

Preventing harm to patients is "the primary reason for dismissing a resident with a major clinical or behavioral deficiency" (Capozzi & Rhodes, 2005, p. 2354). Training programs are responsible for the actions of their residents and because of their supervisory positions, faculty members, schools and healthcare institutions are legally liable for harm resulting from resident's actions (Capozzi & Rhodes, 2005). Therefore, they are obligated to take measures to ensure the safety of current and future patients. A second reason for dismissing a poorly performing student is professional self-regulation (Capozzi & Rhodes, 2005). According to the authors, allowing an incompetent resident to complete a training program and obtain credentials undermines the trust that society has placed in the medical profession" (Capozzi & Rhodes, 2005, p. 2354). The third reason is that failing to dismiss a poorly performing student sets a poor example for other residents who may have to cover for a colleague's poor performance. Timely dismissal emphasizes the program's commitment to clinical excellence, patient safety, professionalism and self-regulation (Capozzi & Rhodes, 2005; Schenerts & Langenfeld, 2017). Finally, although administrators and faculty in healthcare profession training programs fear litigation over the dismissal, when the decision follows a due process, it is appropriate and ethical (Christensen, 2016; Schenarts & Langenfeld, 2017).

Irby and Milam (1989) analyzed the legal context for evaluating and dismissing medical students based on clinical performance using a case study approach. According to Irby and Milam, medical school faculty members are reluctant to offer candid evaluations of medical student and resident clinical performance for fear of litigation. They noted that "while medical

faculty have high expectations for themselves and their peers, they seldom write negative clinical evaluations of students and are rarely willing to fail or dismiss students who are not meeting clinical practice standards" (p. 639). This is consistent with the scholarship of Killam, et al. (2011) and Luhanga, et al. (2008) who found that due to the potential of being named in a lawsuit, clinical educators in nursing education are often reluctant to document poor performance.

The challenges related to decision making regarding what to do when a student in a health professions education program does not meet expectations for clinical performance are evident in the literature (Christensen, 2016, Teeter, 2005; Wren & Wren, 1999). Administrators and faculty in schools of nursing, schools of medicine and other allied health professions have described personal, legal, and ethical dilemmas when making such decisions (Christensen, 2016; Wren & Wren, 1999). Given the inherent risks related to anesthesia, ensuring that graduates of nurse anesthesia programs have the knowledge and skills necessary for safe practice is essential. However, there is a gap in the literature related to how nurse anesthesia program administrators decide whether a student's unsatisfactory clinical performance warrants an intervention by the program.

Purpose of the Study

The purpose of this qualitative study was to define the process that nurse anesthesia program administrators use to determine if a student nurse anesthetist's unsatisfactory clinical performance warrants intervention by the program. The lack of guidance in the form of clearly articulated expectations and processes contributes to the emotional strain faculty often experience when observing unsatisfactory performance in an anesthesia student (Christenson, 2016). Therefore, this study is necessary for understanding what constitutes unsatisfactory

8

behavior in the clinical area, examining specific student behaviors that prompt the program administrator to first attempt remediation, and learning the specific behaviors that are not tolerable and warrant immediate dismissal from the nurse anesthesia program.

Grounded theory methodology was used to explicate the nurse anesthesia program administrator's decision-making and to describe the process regarding student remediation and dismissal from nurse anesthesia programs. Grounded theory is a research method in which theory is developed from the data collected using an inductive approach (Charmaz, 2006; Creswell, 2013). Through data interaction, a theory focused on process or action is developed that is "grounded" in the participant's viewpoints and supported by participant's statements (Creswell, 2013, p. 83). Thus, utilizing grounded theory methodology in this study may offer new ways for conceptualizing the problem under study.

Research Question

This research study was guided by the following question: *What is the decision-making process of a nurse anesthesia program administrator in determining interventions for unsatisfactory clinical performance by a student?*

Theoretical Framework

Path-Goal theory was used to inform the development of the research question to explicate how nurse anesthesia program administrators adapt their leadership behavior to individual student needs and to the situation, to improve student performance (House, 1996). Path Goal theory is a leadership theory that is concerned with how a leader influences a subordinate's perceptions of work goals, personal goals, and paths to achieving those goals (House, 1971). This theory is a process in which leaders (program administrators) select specific behaviors suited to the needs of followers (nurse anesthesia students) and the working

9

environment (nurse anesthesia program) to provide motivation for goal achievement. Path-Goal theory assumes that leaders are flexible and able to adapt their behavior to the situation at hand, thereby motivating subordinates to perform effectively (Lussier & Achua, 2007). This theory was applied in developing interview questions that focus on the processes used to identify students exhibiting unsatisfactory performance as well as leader behaviors selected to improve student performance or to inform students that they are dismissed from the program.

Significance of the Study

This research is critical because of the necessity to ensure safety in nurse anesthesia practice. This study contributes to the scholarship on practice and research of nurse anesthesia educational programs.

Practice

Nurse anesthesia program administrators rely on accurate clinical evaluations by clinical educators to make informed decisions regarding whether nurse anesthesia students are functioning at the expected level in clinical practice. Students not performing satisfactorily can cause a significant burden to the clinical educator, faculty and program administrator commensurate with increased vigilance, and monopolization of time and effort focused on ensuring the student has either the opportunity for improvement and/or is afforded due process prior to dismissal from the program (Wong & Li, 2011; Christensen, 2016; DeBrew & Lewallen, 2014). Further, such unsatisfactory performance in the clinical setting poses a risk to patient safety, which has the potential for malpractice liability for the student, the clinical educator, the clinical agency, and the nurse anesthesia program (Christensen, 2016; Killam, Montgomery, Luhanga, Adamic & Carter, 2010).

Program administrators are required to validate that graduates have met both the academic and clinical requirements of the program as well as the program outcomes prescribed the COA. Included in the program outcomes is the ability of the graduate to provide safe and competent anesthesia care (COA, 2018). In nurse anesthesia education, failure related to academic or clinical performance typically results in the student withdrawing from the program or being dismissed from the nurse anesthesia program (Collins & Callahan, 2014; Earle-Foley, et al., 2012). The lack of guidance in the form of clearly articulated expectations and processes contributes to the emotional sequelae faculty often experience when failing, or failing to fail, an anesthesia student. Thus, findings from this study offer defined criteria for unsatisfactory and unsafe clinical performance. Furthermore, findings contribute to what we know and understand of the decision-making processes of program administrators when considering options for a student who is underperforming in clinical. Finally, this study illuminates the decision-making process of a nurse anesthesia program administrator in choosing remediation over dismissal, which allowed for the articulation a clear process for a dismissal trajectory.

Research

While there is a plethora of research related to the phenomena of unsatisfactory clinical performance in undergraduate nursing programs and medical school programs, there is a gap in the literature regarding unsatisfactory clinical performance in nurse anesthesia programs. Clinical educators are responsible for ensuring the safety of patients while supervising student nurse anesthetists. Unfortunately, the actual process of determining the competency and safety of clinical performance is ill defined and fraught with ambiguities and inconsistency in documenting clinical performance (Dudek et al., 2005; Jervis & Tilki, 2011; Scanlan, Care, & Gessler, 2001; Tanicala, et al., 2011). Little research has captured how clinical educators in

11

nurse anesthesia weight the numerous factors involved in rendering this decision regarding safety to practice, including how and what they attempt to remediate and how they evaluate those activities (Duffy, 2013). Consistently missing in the literature is an exploration of the decision-making processes that both the clinical educators and program administrators engage in while making the determination to remediate, fail, and dismiss a student. This study contributes to the body of knowledge and fills a gap in the literature on this topic.

Definition of Terms

This section describes the key terms utilized in this research study.

Nurse Anesthesia Program

According to the COA (2018), a nurse anesthesia program is "an educational curriculum that is designed to provide both didactic and clinical components to prepare a competent nurse anesthetist. The word program is commonly used for all types of nurse anesthesia schools including programs and institutions. In the case of a branch campus, program refers to an educational unit within a larger institution such as a university" (p. 35).

Council on Accreditation for Nurse Anesthesia Educational Programs (COA)

The COA (2018) explained, "The COA accredits nurse anesthesia programs within the United States and Puerto Rico that award post-masters certificates, masters, or doctoral degrees, including programs offering distance education" (p. i). Graduation from a COA accredited program is required: (1) as the basis for ascertaining eligibility for federal programs under selected legislation, (2) to sit for the National Certification Examination, (3) for licensing in state rules and regulations, and (4) as a condition of employment.

Unsafe Clinical Performance

Unsafe clinical performance or practice is defined as "behavior that places the client or

or staff in either physical jeopardy (risk of causing physical harm) or emotional jeopardy (risk of emotional or psychological harm due to student anxiety or stress" (Scanlan, et al., 2001, p. 26).

Clinical Educator (Clinical faculty)

A clinical educator or clinical faculty (CRNA or anesthesiologist) "is responsible for teaching nurse anesthesia students during the perioperative period and for evaluating their clinical progress. When students are administering anesthesia, such instructors must be CRNAs or anesthesiologists with staff privileges in anesthesia" (COA, 2018, p. 29).

CRNA Program Administrator (CRNA Program Director)

The COA (2018) indicated, "A full-time program administrator is a CRNA who by title and function directs the organizational administration of a nurse anesthesia program; providing leadership and oversight of all aspects of the educational program including but not limited to governance, didactic and clinical curriculum, recruitment and evaluation. The workload may include a reasonable teaching commitment. Engagement in direct patient care activities, including supervising nurse anesthesia student clinical performance, does not quality as meeting organizational administrative duties" (p. 41).

Clinical Evaluation (Formative Evaluation)

Clinical evaluation includes "Student assessments that help identify problems and areas that require improvement, as well as measure progress and achievement of objectives" (COA, 2018, p. 31).

Academic Dismissal

Academic dismissal involves professional evaluation of a student's academic and/or clinical performance and disciplinary dismissal involves violation of institutional rules, policies, codes of conduct, or legal infractions, (Kaplin & Lee, 2014; Wren & Wren, 1999).

CHAPTER TWO

Literature Review and Theoretical Framework

This chapter offers a review of the literature related to the decision making of nurse anesthesia program administrators in determining interventions for a student exhibiting unsatisfactory clinical performance. This review includes scholarship on clinical education and evaluation, unsatisfactory behavior in the clinical setting, and administrative decisions regarding remediation or dismissal due to students' unsatisfactory clinical performance. Although this study focused on nurse anesthesia program administrators, an understanding of similar concepts from other health disciplines was necessary to fully elucidate the administrative challenges that exist when a student exhibits unsatisfactory clinical performance. This chapter concludes with a discussion on Path-Goal theory, the theoretical framework that guided this research study.

Literature Review

The education of all health disciplines including physicians, nurses, and allied health practitioners takes place in both the classroom and clinical setting. There are nearly 53,000 CRNAs practicing in the United States, who provide more than 45 million anesthetics each year in a safe and cost-effective manner (AANA, 2019). As of 2019, there are 121 nurse anesthesia programs accredited by the Council on Accreditation for Nurse Anesthesia Educational Programs (COA) and over 2500 students enrolled in nurse anesthesia programs nationwide (COA, 2019). Although information exists on the number of nurse anesthesia programs and student enrollment, there is limited research specific to unsatisfactory clinical performance in nurse anesthesia education. Therefore, literature related to undergraduate nursing and medical students was included to inform this study. The following key topics emerged from the review of literature: clinical education, evaluation of clinical performance, attrition in nurse anesthesia

programs, unsafe clinical performance, the decision to fail, legal and ethical issues related to student dismissal, and the landmark case regarding student dismissal.

Clinical Education

The education of students in a variety of health disciplines involves a clinical education component that provides students with hands on training while caring for patients. The mainstay for clinical education of healthcare professionals involves clinical educators who are tasked with providing students a reality-oriented experience as well as socialization into the profession (Earle-Foley et al., 2012). The importance of the clinical component of nursing education in supporting effective nursing practice and optimal patient care was evident in a literature review conducted by Sawatzky, Enns, Ashcroft, Davis, and Harder (2009). They found that clinical nursing training is an essential core component of nursing education as patients may experience adverse outcomes at the hands of inexperienced trainees.

The experiences and attitudes of nurse anesthesia students are influenced by the characteristics and behavior of certified registered nurse anesthetist (CRNA) clinical educators. Drawing from a survey administered to 696 student registered nurse anesthetists (SRNAs), Elisha and Rutledge (2011) identified characteristics and behaviors of clinical educators that positively influence clinical learning. Students ranked these characteristics and behaviors on a scale with one (1) being most important and five (5) being least important as follows: 1) calmness during stressful events, 2) use of non-threatening communication, 3) clear communication, 4) allowing students to make independent decision; and 5) being humorous. The use of non-threatening and clear communication and allowing students to make independent decisions are key elements of adult learning principles. While the majority of CRNA clinical educators are expert clinicians, few have received education on adult learning principles or how

to be effective teachers (Burns et al., 2006). This study supports the need to educate clinical educators on principles of adult learning, specifically the need for clear communication regarding expectations related to clinical performance as well as promoting students to make clinical decisions congruent with their level in the program (Burns et al., 2006). Further, "if expectations for clinical performance were clearly stated, agreed on by all anesthesia faculty members, and explained to students, this uniformity could improve the quality of clinical educator constructive criticism and evaluation" (Elisha & Rutledge, 2011, p. 41). Providing clinical educators with an understanding of program policies and expectations for completing the clinical evaluation (Killam, et al., 2010; Burns et al., 2006), as well as informing them of how the evaluation is used by the nurse anesthesia program may lead to a more objective evaluation that is submitted timely.

Several characteristics of CRNA clinical educators found valuable by students have been identified in research (Smith, et al., 2011; Elisha & Rutledge, 2011). The perception of what characteristics are effective in the clinical setting are different for CRNAs and SRNAs. Smith, et al. (2011) used a descriptive, quantitative research approach to determine how SRNAs and CRNA clinical educators at a large Midwestern teaching hospital perceived effective clinical teaching characteristics previously identified by Katz (1984). Data was collected via a questionnaire distributed to 125 CRNAs and 50 SRNAs with a 54% response rate (n=89). Although "analysis of variance indicated a high-level of consistency within each of the groups (Friedman test, 289.21; p<.001)," when the Kendall coefficient analysis was used the results (Kendall coefficient 0.145) did not support congruence in the ranking. However, three effective teaching characteristics scored in the top five for both SRNAs and CRNAs: stimulates student involvement, appropriately encourages independence, and maintain calmness during stress. The

results of this study are similar to the study by Elisha and Rutledge related to the benefits of a clinical educator encouraging independence and remaining calm. Given the number of hours of clinical education required for nurse anesthesia students, the effectiveness of clinical educators contributes to the success of both students and the nurse anesthesia program.

Evaluation of Clinical Performance

Due to an increased demand for accountability, health care professions are establishing methods to demonstrate competency of their graduates (Englander, Cameron, Ballard, Dodge, Bull, & Aschenbrener, 2013). Assessment of clinical performance and competence is an ongoing challenge for both academic faculty and clinical educators in health profession programs (DeBrew & Lewallen, 2014; Englander, et al., 2013). In nursing education, faculty are responsible and accountable for clinical evaluation of students because "the outcomes of such evaluation have a major effect on the student's progress in the course and even status in the program" (Christensen, 2016, p. 36). Issues related to the assessment of nursing students in clinical practice was evident in a literature review conducted by Chambers (1998). Clinical evaluation relies on observation of performance of one individual by another, which is inherently subjective. While academic knowledge is routinely tested prior to health profession students entering clinical practice by means of licensure exams and/or certification exams, determining competence in clinical practice can be difficult. Obtaining clinical competence prior to a student graduating provides assurance that the graduate can provide safe patient care. Clinical competence expectations are defined by respective health care disciplines and are used in evaluation tools to facilitate accurate and objective evaluation of clinical performance (Englander, et al., 2013). Chambers (1998) defined competence as "ability" and competent as "having the required ability, knowledge or authority; effective, adequate" (p. 202). However,

17

despite a clear definition, individuals have different perceptions of competence, based on

personal experiences, values and beliefs.

Clinical evaluation tools are used by clinical educators to document the clinical

performance of students. Clinical evaluation tools vary by program, but as the tool must meet

the COA standards, there is some similarity. There is currently a lack of standardization and

consistency among clinical educator evaluation of student registered nurse anesthetists' (SRNAs)

competencies during their clinical education in the United States. The clinical evaluation tools

currently used by nurse anesthesia programs are not "standardized among programs, which

suggests a lack of instrument validity" (Collins & Callahan, 2014, p. 65). This lack of

established validity in the clinical evaluation tools has caused concern regarding the ability of the

evaluation tool to detect a student who is having clinical issues (Collins & Callahan, 2014). One

reason for this deficit is that a common clinical assessment tool (CCAT) that is competency

based and methodologically validated does not exist. Thus, the evaluation process is dependent

upon the judgment of the clinical educators who decide whether the student's clinical

performance was satisfactory or unsatisfactory; which is especially important when a student is

not performing at the expected level of safety and/or competency. The COA standards require

that formative and summative evaluations of each SRNA be conducted for counseling students

and documenting student achievement (COA, 2018; Van Wormer, 2009). In 2015, a focus group

consisting of nurse anesthesia educators was assembled. From their comments, it was determined

that development of a CCAT would improve the ability to more accurately assess students'

clinical competencies. In 2016, the COA appointed a CCAT Special Interest Group (SIG) to

develop a standardized assessment instrument that is competency based and reflective of the

COA Practice Doctorate Standards. A competency-based evaluation instrument was developed

by the SIG and a Delphi study was conducted to validate the instrument (COA, 2019). This study included sending the instrument to participants including nurse anesthesia program administrators, clinical educators, and students. The final version of the CCAT was approved by the COA in January 2019, and the tool will be available to programs in mid-2019 after the implementation process is finalized (COA, 2019). Nurse anesthesia program administrators rely on CRNA clinical educators to document the clinical performance of students so that students not meeting clinical performance expectations can be identified early. Thus, the lack of a standardized evaluation tool in nurse anesthesia education is a concern for many program administrators as decisions related to a student's progression in the program rely on clinical evaluations.

Van Wormer (2009) described the objectives of evaluating nurse anesthesia students in clinical practice: "protecting the public, satisfying student expectations, meeting institutional requirements and compliance with the COA standards" (p. 285). The evaluation of students is based on their level of complexity within the educational program and on specific behaviors related to their clinical performance (Van Wormer, 2009). Congruent with the findings of Collins and Callahan (2014), valid, reliable and easy to interpret clinical evaluation tools used in nurse anesthesia education facilitate effective clinical evaluation of students. Van Wormer identified barriers to effective evaluations, which are consistent with the literature reviewed. Such barriers include the clinical educators: not completing the evaluation, providing verbal feedback that is inconsistent with written documentation of poor performance, or giving positive feedback regardless of student performance (Van Wormer, 2009). Nurse anesthesia program faculty and administrators rely on clinical educators to evaluate and document student performance objectively and accurately (Van Wormer, 2009). Whereas the evaluations completed by the

19

clinical educators inform the decision making of the program administrator, it is of concern that these evaluations may not accurately convey the true merits of a student's clinical performance.

Specific to nurse anesthesia education, Wong and Li (2013) surveyed 10 expert CRNA faculty members and 25 academic faculty members to determine intrapersonal and interpersonal characteristics that these faculty members considered important for safe and unsafe nurse anesthesia practice. At least 80% of the faculty members included being vigilant and ethical as characteristics important for safe practice. The same percentage (80%) viewed being lackadaisical and having poor critical thinking skills as characteristics of unsafe practice. Based on the findings, vigilance is essential to patient safety in anesthesia and students must be able to make critical, informed decisions in clinical.

Attrition in Nurse Anesthesia Educational Programs

The majority of nurse anesthesia programs have admission criteria (GPA, GRE, and critical care experience) which inform faculty decision of who to admit from a usually large applicant pool (Collins & Callahan, 2014). However, meeting admission criteria does not ensure successful progression or graduation. Although attrition in nurse anesthesia programs is relatively low, programs must report attrition rates to the COA annually. The average attrition rate for programs is five percent, however, the attrition rate ranges from zero to thirty percent. Moreover, when even one nurse anesthesia student is not successful, valuable individual as well as institutional resources are wasted. Ouellette, Courts and Lincoln (1999) used a descriptive survey design to investigate the characteristics of nurse anesthesia programs and applicants to nurse anesthesia programs in the United States and to determine reasons for attrition. The survey was sent to 86 nurse anesthesia program directors with an 83% response rate. The survey included general questions about the program, which included specific questions regarding

student attrition. Of the programs, 63% identified the number of students who did not complete the program in 1994. Poor academic and/or clinical performance was the most common reason for attrition, and family and personal issues were other factors named (Ouellette et al., 1999; Collins & Callahan, 2014).

Dosch, Jarvis, and Schlosser (2005) conducted a study of attrition in nurse anesthesia programs and found that the mean overall attrition rate was 5.41%. The authors reported "the most common reason for attrition was withdrawal, followed by academic dismissal, and clinical dismissal" (p. 277). While dismissal for issues related to clinical performance ranked third, poor clinical performance was listed as a reason for both withdrawal and academic dismissal. Therefore, poor clinical performance is a significant concern in nurse anesthesia education.

Unsafe Clinical Performance

In all healthcare disciplines, emphasis is placed on the importance of early identification of the unsafe student (Killam, et al. 2010), and the need to treat such students fairly (Scanlan et al., 2001). There are differing opinions of what constitutes unsafe student practices and the appropriate interventions for dealing with an unsafe student (Killam, et al. 2010). In addition to not meeting expectations for competencies, unprofessional behaviors such as dishonesty, being disrespectful, lying to a clinical educator, hiding mistakes, or lacking accountability also constitute unsafe clinical performance (Killam, et al., 2010). Scanlan et al., (2001) examined issues related to fair and just treatment for undergraduate nursing students who were not meeting the minimum expectations for clinical performance. They defined unsafe as "behavior that places the client or staff in either physical jeopardy… or emotional jeopardy" (p. 26). The authors noted that it is critical to ensure fairness and justice in situations where a clinical educator "must fail or dismiss a student from a clinical course, recommend dismissal for a program, or, more

seriously, determine a student to be professionally unsuitable based on his or her clinical performance" (Scanlan et al., 2001, p. 24). Further, the authors recommended that students be afforded due process and that institutional policies are followed. In decision-making regarding clinical performance issues, adherence to program policies by the program administrator will be a factor in the event a student files a grievance or a lawsuit. The authors also acknowledged the gap in the literature regarding a defined course of action for students who are deemed unsafe. There is a lack of research that addresses how decisions are made to determine safe performance from marginally safe performance, how to deal with unsafe performance, and timeframes to determine clinical failure.

Similar findings regarding the difficulty faced by faculty members in making difficult decisions related to nursing students who demonstrate unsafe clinical practice were found by DeBrew and Lewallen (2014). These authors used a critical incident technique to conduct a qualitative study using semi-structured interviews asking twenty-four nurse educators to describe a time when they had to decide whether to pass or fail a student as determined by their clinical performance. The study yielded findings describing how student factors and faculty factors influence the clinical evaluation. The student factors most commonly resulting in a sub-standard evaluation included: poor communication (written and verbal), unsafe medication administration, being unable to prioritize patient care, and being unprepared (DeBrew & Lewallen, 2014). The faculty factors that were found to influence evaluation of student performance included: personal beliefs and feelings; emotions (failing a student in clinical was difficult); sensing that a student did not want to be a nurse; cultural differences that led to a behavior; and administrative support (or lack of) to fail a student. In fact, clinical educators stated that they often afford students the benefit of the doubt when they are not performing at an

expected level, unless there is clear evidence that they are unsafe (DeBrew & Lewallen, 2014).

Faculty are legally and ethically responsible to provide an accurate evaluation of the student even if it means the student is not able to progress.

Clinical educators experience additional workload and stress when the student they are assigned to is not meeting expectations and poses a risk to patient safety (Earle-Foley et al., 2012). When a student exhibits unsafe clinical performance, clinical educators face numerous ethical challenges including: feeling unprepared to evaluate students, concern about the possibility of litigation by students, feeling a sense of personal failure and guilt, and feeling unsupported in their decision (Earle-Foley et al., 2012). According to Earle-Foley et al., (2012), "preceptors have an ethical responsibility to address unsafe practice of students and take action to prevent unsafe practitioners from progressing in nursing programs" (p. 32). Allowing students who provide unsafe care to continue in a nursing or other health profession educational program threatens patient safety as well as professional integrity (Earle-Foley et al., 2012).

The decision to offer remediation to students exhibiting unsatisfactory clinical performance is a challenge for many health profession education programs. Cleland, Leggett, Sandars, Costa, Patel, and Moffat (2013) conducted a systematic review to synthesize the available evidence and to clarify how and why remediation interventions may work to improve clinical performance primarily in medical students. Of the 2113 studies found in the initial search, 31 studies were deemed eligible for inclusion. Due to the complexity of the issue and the lack of reporting on the precise nature of the studies included, the authors were not able to identify which, if any, components of remediation made a difference. The authors further noted that there is an ethical dilemma associated with supporting students to progress in clinical training, despite continued poor performance.

In nursing education, student learning in the clinical setting cannot comprise patient safety. Killam et al. (2010) conducted a study to describe the viewpoints of undergraduate nursing students and their clinical educators about unsafe clinical practices. They used *Q* methodology to "systematically measure the respondent's subjectivity or viewpoints" (p. 4) as they asked 57 students and 14 clinical educators to sort 39 unsafe student practice statements generated from a literature review and two focus group sessions with undergraduate nursing students. Killam et al. (2010) used centroid factor analysis with varimax rotation, which resulted in three dimensions of unsafe practices that characterize an unsafe student: "compromised professional accountability, incomplete praxis, and clinical disengagement" (p.1). A shared attribute among these three features identified that covering up mistakes is considered an unsafe clinical practice. These findings indicate that violations of professional standards and expectations are associated with a student being considered unsafe in clinical.

Throughout the literature, it is evident that clinical educators are uncertain about assessing clinical performance and uncertain about their responsibility and accountability in regard to students not performing satisfactorily in clinical. Jervis and Tilki (2011) conducted a qualitative study (n=14) using interviews and focus groups to explore why nursing mentors were reluctant to report students who were not performing adequately in the clinical setting. Data analysis revealed three recurring themes. The first theme, complexity in assessing students, emerged from the common thread that assessing clinical performance in borderline students is not straightforward and decisions are often delayed by not knowing how to proceed. The second theme, difficulty with assessing attitudes, actually referred to behaviors that preceptors believed reflected poor attitudes in students such as lacking interest and motivation. The third theme,

confidence about assessment decisions reflected the preceptors' lack of confidence in their

assessment of skills and their reliance on support of faculty.

Nurse educators are "professionally, legally, and ethically" expected to protect patients

from the potential of a student causing harm in the clinical setting (Tanicala, et al., 2011, p.155).

To facilitate a move toward a culture of safety in clinical nursing education, Tanicala et al.

developed a multiphase project. This article focused on the first phase of this project which was

intended to assist nurse educators to "establish an evidence base for determining passing or

failing nursing student behaviors" (Tanicala et al., 2011, p. 155). Using a qualitative approach,

focus groups were conducted with faculty from baccalaureate nursing programs to learn how

student behaviors during clinical practice could result in a failing grade. The major theme that

emerged, context and patterns, resulted from participants emphasis on the need for educators to

recognize "that time, place, and type of student behavior impact how student behaviors are

evaluated regarding passing or failing in a clinical course" (Tanicala et al., 2011, p. 157). These

findings further emphasize the numerous factors that influence decisions regarding a student's

performance in the clinical setting and that such decisions are rarely concrete or easy to

determine.

Decision to Fail

There is significant research evidence documenting the concern of clinical educators and

faculty in healthcare professions including nursing, to fail students based on clinical performance

(Christensen, 2016; DeBrew & Lewallen; Brown, Neudorf, Poitras, & Rodgers, 2007). Clinical

educators typically lack formal education regarding how to evaluate students (Smith et al., 2011),

and acknowledge that assigning a failing grade is a challenging responsibility (Christensen,

2016; Dudek, et al., 2005; Duffy, 2013). Luhanga, et al. (2008) examined the process of

evaluating an unsafe nursing student in a grounded theory study. Participants initially included 22 nursing preceptors for baccalaureate nursing students in the final clinical practicum course and a select number of preceptors who had no direct preceptor experience. Data was collected via individual semi-structured interviews and document analysis. Although five major categories emerged relating to unsafe practices, the category of grading issues was the focus of this manuscript. The participants expressed concern that university faculty will sometimes assign a passing grade despite a preceptor's concerns about a student's clinical performance. Participants reported the following reasons for failure to fail borderline or unsafe students: lack of experience, not wanting to cause the student to incur personal cost, feelings of guilt, not wanting to assume extra workload, lack of an appropriate evaluation tool and time to complete the evaluation, and finally, pressure to ensure students graduated because of the nursing shortage. Further, a role of the preceptor is a gatekeeper to the profession and despite voicing reluctance to recommending failing grades to borderline students; preceptors stated they would not want to work with these students when they graduated (Luhanga et al., 2008; Wren & Wren, 1999). These findings are consistent with other studies previously discussed and demonstrate the need for a clear process for identifying and reporting unsatisfactory clinical performance and even more importantly, deciding whether remediation or dismissal is warranted (Christensen, 2016).

Clinical educators have a professional responsibility to protect patients from unsafe practice (AANA Code of Ethics, 2018). Duffy (2013) conducted a grounded theory of registered nurses who served as mentors for undergraduate students and had reported failing a student. Duffy found that the mentors had difficulty with the following concepts: identifying the weak student, creating opportunities for success and deciding to fail. The concept "deciding to fail" exposed the emotional consequences involved in a failed assessment for both the student and the

26

mentor (p. 36). The author recommended training for clinical educators that emphasized the importance of informing faculty members of concerns about a student's performance as early as possible.

Dudek et al. (2005) provided similar insight into why clinical educators "fail to fail" the poorly performing student. Participants in their qualitative study among physician clinical supervisors, acknowledged that they often do not fail students even when clinical performance is judged as unsatisfactory due to uncertainty as to what to document, concern for an appropriate remediation plan, uncertainty as to how a failing evaluation would affect the students overall program evaluation, and fear of an appeal or litigation**.** Consistent with the findings of other research studies, students underperforming in clinical practice may be allowed to progress and even graduate, posing a threat to patient safety (Christensen, 2016; Killam et al., 2010; DeBrew & Lewallen, 2014). The lack of guidance in the form of clearly articulated expectations and processes contributes to the emotional turmoil faculty often experience when failing, or inappropriately not failing, a nurse anesthesia student (Christensen, 2016).

Given that mishaps in anesthesia practice are typically associated with significant patient injury and/or death, unsafe or underperforming students pose an immediate risk to patient safety as well as a future risk to the public if they are allowed to progress to clinical practice (Killam, et al., 2011). Therefore, CRNA clinical educators must confidentially assess and document actual behaviors of concern and report poor performance to the program administrator (Wren & Wren, 1999). Furthermore, if the student evaluation does not accurately reflect actual student clinical performance, the program administrator misses a critical window of opportunity to make an informed decision on student progression and whether the student is provided an opportunity to improve. A student may be allowed to progress when remediation is indicated. When student

clinical performance and professional demeanor does not meet clinical objectives and falls below

expectations, there may be grounds for dismissal from the program (Wren & Wren, 1999).

Legal and Ethical Issues Related to Student Dismissal

One aspect of the program administrator's decision-making process involves due process

and the legal ramifications of student dismissal. Careful attention to due process issues are

important to ensure the student is treated fairly as there is the potential for litigation. Irby and

Milam (1989) analyzed the legal context for evaluating and dismissing medical students based

on clinical performance using a case study approach. According to Irby and Milam, medical

school faculty members are reluctant to offer candid evaluations of medical student and resident

clinical performance for fear of litigation. They noted that "while medical faculty have high

expectations for themselves and their peers, they seldom write negative clinical evaluations of

students and are rarely willing to fail or dismiss students who are not meeting clinical practice

standards" (p. 639). Written documentation supporting decisions made related to poor student

clinical performance is essential, as per the aforementioned studies, to ensure that future patient

safety is not at risk.

While educators may face anxiety about the potential for litigation following a dismissal

for poor clinical performance, legal decisions have most often sided with educational institutions

in such cases. Courts grant less protection for due process for students facing suspension or

dismissal because of deficient academic performance than with disciplinary dismissals (Kaplin &

Lee, 2014). According to Kaplin and Lee (2014) "students asserting claims of substantive due

process violations must demonstrate that they have been deprived of a liberty or property interest

or if the interest is not fundamental, that the action depriving them of a liberty or property

interest was arbitrary and capricious" (p. 556). Substantive due process claims of students who

challenge academic dismissals are not likely to succeed based on case law unless there is substantial evidence that the institution acted in an arbitrary and capricious manner (Kaplin & Lee, 2014). Further, the courts have historically deferred to the academic judgment of faculty and have demonstrated appreciation for the challenges faced by faculty.

Landmark Case for Academic Dismissal Due to Clinical Performance

The landmark court case for academic dismissal due to poor clinical performance is *Board of Curators of the University of Missouri et al., v. Horowitz, 435 U. S. 78, No. 76-695 (1978).* This case involved Horowitz, a medical student at the University of Missouri (UoM) Kansas City Medical School who was dismissed in the final year of study because of consistent poor clinical performance. As the student progressed in training, faculty continually expressed concerns about clinical performance in all clinical settings and complained about erratic attendance. The student was warned that without dramatic improvement, the result would be dismissal from medical school. After the student spent considerable time with seven reputable practicing physicians, these physicians ultimately recommended that the student be dismissed from medical school based on unsatisfactory performance. A Council then unanimously recommended dismissal from medical school and the Coordinating Committee and the Dean approved this decision. Horowitz appealed the decision in writing to the University Provost who after review of the record upheld the school's actions.

The case, *42*80 U.S.C.1983* was initiated in the United States District Court for the Western District of Missouri, when Horowitz sued the Board of Curators of the UoM alleging violation of constitutional rights when she was not afforded procedural due process prior to dismissal from medical school. The Supreme Court ruled that it did not need to decide whether the student was deprived of a "liberty" interest because even assuming the existence of a liberty

or property interest, the respondent was awarded at least as much due process as the fourteenth amendment requires. The respondent was fully informed of her clinical progress and the risk of either delayed graduation or dismissal (Kaplin & Lee, 2014). The university's decision was careful and deliberate. Although opportunities for remediation were provided, which the court recognized as due process, clinical performance remained unsatisfactory. Students enter the educational experience with rights, and litigation involving nursing programs has increased dramatically (Christensen, 2016). In many of these cases, the legal basis for the litigation is related to the concepts of due process, fair treatment, and confidentiality (Christensen, 2016). In nurse anesthesia education, program administrators have an obligation to notify the student of the concerns related to clinical performance and to provide the student due process, which may include the opportunity for remediation. In the event the clinical performance poses a direct threat to patient safety, the program administrator has a duty to protect the public from an unsafe student which may require that the student undergo remediation or that the student is dismissed from the program. (Christensen, 2016).

Summary of the Literature Reviewed

While clinical educators are responsible for ensuring the safety of patients when supervising student nurse anesthetists in the clinical setting, program administrators are ultimately responsible for decision making regarding students who exhibit unsatisfactory performance. Unfortunately, the actual process of determining the competency and safety of clinical performance is not well defined and fraught with ambiguities and inconsistency in documenting clinical performance (Scanlan, et al., 2001). Little research has captured how nurse anesthesia program administrators weigh the numerous factors involved in rendering this decision regarding safety to practice, including how and what they attempt to remediate and how

they evaluate those activities (Duffy, 2013). Consistently missing in the literature is an

exploration of the decision-making processes that program administrators engage in while

making the determination to remediate or fail and dismiss. Such an exploration was needed to

provide the in-depth information that contributes to clearly articulating criteria for safe and

competent clinical practice. Underlying these concerns was the need for nurse anesthesia

programs to have clearly defined criteria for safe and unsafe practices, and how these criteria are

be articulated, operationalized, and reported. This grounded theory study provides insight and

direction for this process.

Theoretical Framework

Program administrators in nurse anesthesia programs are the key leaders who ensure

personnel and practices are meeting both established best practices as well as the needs of local

stakeholders. These educational leaders engage in activities that range from classroom teaching

to curriculum development and assessment to critical decision-making regarding students.

Making decisions on student remediation or dismissal is one of the key leadership tasks of

program administrators and the central focus of this study. Leadership is defined in numerous

ways ranging from simplistic traits to a "more complex process involving interactions, emotions,

and learning" (Gregoire, 2014, p.10). The strategies used by leaders to influence subordinates

and others have been the focus of more recent research regarding leadership (Gregoire, 2014).

Successful leadership requires leaders to engage in behaviors that motivate subordinates in

different ways. Path-Goal theory falls under the broader category of Contingency/Situational

Theories of leadership and suggests that a leader's behavior has an effect on subordinate's

satisfaction and performance. This effect is dependent on a particular situation or context

(Gregoire, 2014; Ani, Oliver, Okpala, Dyages, & Akese, 2017). Path-Goal theory was used as a

lens from which to examine the leadership behaviors of nurse anesthesia program administrators in decision-making in determining interventions for a nurse anesthesia student due to unsatisfactory clinical performance.

Explanation of Path-Goal Theory

Path-Goal theory is a leadership theory that is concerned with how a leader influences a subordinate's perceptions of work goals, personal goals, and paths to achieving those goals (House, 1971). Path-Goal theory is based on Vrooms (1964) expectancy theory in which an individual will act in a certain way based on the expectation that the act will be followed by a given outcome (Clark, 2016). This theory is a process by which leaders select specific behaviors suited to the needs of followers and the working environment to provide motivation for goal achievement.

Path-Goal theory describes four types of behaviors of leaders: directive, supportive, participative, and achievement oriented (House & Mitchell, 1974; Polston Murdoch, 2013). The directive leader is authoritative and provides clarification of the desired expectations based on performance standards and policies. The supportive leader is concerned about subordinates and seeks to create a friendly environment to instill confidence and motivation. The participative leader includes subordinates in planning and decision making to promote the subordinate's acceptance of responsibility for actions. Finally, the achievement-oriented leader seeks to improve the subordinate's performance by setting high expectations and challenging goals to improve performance. Path-Goal theory assumes that leaders are flexible and that they able to adapt their leadership behavior to the situation at hand, thereby motivating subordinates to perform effectively (Lussier & Achua, 2007). These behaviors are based on two factors:

relationship behaviors such as respect and trust, or task behaviors such as organizing, scheduling, and observing work that is completed.

Path-Goal theory was chosen for this study of nurse anesthesia program administrators because it applies to many aspects of their role and addresses both how the student's behavior influences the leader's style and how the leader's style influences the student. Path-Goal theory was used as a methodological construct to develop the research question and to help explain how nurse anesthesia program administrators adapt their leadership behavior to best serve the individual student needs (House, 1996). For example, interview questions focused on the leadership style(s) used when: it is deemed that the unsatisfactory clinical performance of a nurse anesthesia student may be remediated, or when a student's clinical performance elicits a substantiated concern for patient safety.

Although the use of Path-Goal theory to inform studies related to organizational leadership effectiveness is evident in the literature, there was minimal scholarship on the application of Path-Goal theory in nursing education or in decision making related to student remediation and/or dismissal. However, according to Ani, et al. (2017), Path-Goal theory can be applied successfully in nursing education, research, practice, and administration. Path-Goal theory promises enhanced learning outcomes and effective mentorship, which pave the way for nurses to be successful in their academic program, and beyond that in actual clinical practice (Ani, 2017). This is relevant to nurse anesthesia students given that nurse anesthesia education builds on prior nursing education and experience.

To explore how different leadership theories and styles relate to nursing practice, Giltinane (2003) explored transactional leadership, transformational leadership, and situational leadership to learn how each of these theories and leadership styles related to nursing practice.

Although Path-Goal theory is not mentioned specifically, the use of its tenets is quite evident in each of these broader leadership theories. In clinical practice, leadership involves direct involvement in clinical care as well as continuously influencing others to improve the quality of care they provide (Giltinane, 2013). Giltinane concluded that there are various styles relevant to nursing practice, but no definitive theory that is most effective to guide nursing leaders. Furthermore, recognizing that there is no particular leadership style that is suitable for the various situations nurses face on a daily basis, there is a need for nursing leaders to be flexible in their leadership style and to be able to adapt the leadership style to different situations (Giltinane, 2013).

The limited evidence of application of Path-Goal theory is due to its criticism for being complex, confusing, and lacking support for validity (Northouse, 2016). The thought that this theory is complex is due to the adaptive leadership styles and the fact that a leader may need to use one or all of these behaviors to motivate and meet the needs of followers (Northouse, 2016). Despite these criticisms, Path-Goal theory was the best fit for this research because it offered me a framework for examining the leadership behaviors of nurse anesthesia program administrators, while also considering how students are affected by these behaviors, as the theory is based on the specific behaviors leaders select based on the needs of followers (the nurse anesthesia students).

Application of Path-Goal Theory to this Study

There appeared to be a need for researchers and theorists to broaden the conceptual basis for Path-Goal theory and the contexts for which it is used. It is evident that Path-Goal theory clearly applies to nursing and nurse anesthesia education. In clinical nurse anesthesia education, the principles of Path-Goal theory are relevant as students rely on program administrators, faculty, and clinical educators to mentor them into the profession as balanced nurse anesthesia

34

practitioners (Ani, et al., 2017). One of the primary goals of the nurse anesthesia program administrator is to produce highly trained nurse anesthetists prepared for clinical practice. When a student is not performing satisfactorily in clinical, the program administrator adapts the leadership style to address the needs of the student relevant to the situation. For example, if a student has made a critical medication error, the program administrator may first counsel the student (supportive), but may also use act on his or her authority and require the student be immediately removed from clinical activities and submit to a drug screen (directive). There may be certain situations where the program administrator's obligation to protect patients from unsafe practitioners requires a student be dismissed, and in delivering such news to the student the program administrator is likely to display a variety of leadership styles. In this case, the program administrator's decision is influenced by program and institutional policies as well as the need for accountability in ensuring patient safety. For the purposes of this study, I examined each of the leadership behaviors that comprise the Path-Goal theory: directive, supportive, participative, and achievement-oriented. An example of how each of the leadership styles applies to the decision-making of program administrators is described below.

Directive

The directive leader behavior is authoritative and provides clarification of the desired expectations based on performance standards and policies. Path-Goal theory posits that the leader is responsible for setting clear goals, clarifying paths to achieve goals, and implementing reward systems based on achievement of expectations related to performance (Mulki, Jaramillo, & Locander, 2009). According to House (1971), leaders use two distinct styles to motivate the behavior of employees: initiating structure and consideration. Initiating structure (also called instrumental leadership) aligns with the directive style of leadership that includes structure, clear

expectations, and direction to reduce role ambiguity and to link achievement with reward (Mulki et al., 2009). Path-Goal theory states the leader's task is to "define the goal for the organization, clearly define the path to achieve the goal, and remove obstacles to performance" (Landrum & Daily, 2012 p. 56). This application of Path-Goal theory informed this study's examination of program administrators who must inform students of expectations for clinical performance and professional conduct in the clinical setting, and the consequences a student may face if such expectations are not met (Ani et al., 2017, Christensen, 2016). Further, the program administrator is accountable for compliance with accreditation standards and institutional policies in decision making regarding students (COA, 2018).

In nurse anesthesia education, the program administrator assumes the directive leadership style when clearly defining and communicating program and institutional policies, and expectations for academic and clinical performance based on the level in the program. As noted by Christensen (2016), clear expectations for student performance should be set before the onset of the learning experience, be reasonable for students to achieve, and consistently applied. In situations where a student demonstrates unsatisfactory clinical performance, if the program administrator is weak, unsatisfactory performance may not be addressed allowing such performance to continue and flourish, which ultimately results in poor quality patient care (Bassett & Westmore, 2012). Ultimately, the nurse anesthesia program administrator decides what to do when a student demonstrates unsatisfactory performance and is responsible for ensuring that safe patient care is heavily weighted in the evaluation of students.

Supportive

Supportive leadership involves the leader creating a supportive and friendly environment by incorporating subordinate suggestions in decision-making. In nursing education, the

relationship between faculty and student affects learning (Christensen, 2016; Burns et al., 2006). The development of positive interpersonal relationships contributes to the ability of students to meet desired outcomes (Christensen, 2016). Students who are demonstrating unsatisfactory performance may lack confidence in their abilities, especially if they lack role models in their personal life who have been successful in higher education (Christensen, 2016). In nurse anesthesia education, students are all adult learners with different learning needs and they come from diverse backgrounds (Christensen, 2016; Burns et al., 2006). Many of the students are married and have children as well as aging parents. Students may experience personal or family responsibilities and challenges or crisis while in school, which can affect academic and clinical performance (Ani, et al., 2017).   Drawing from the supportive leadership style as described by the Path-Goal theory, the program administrator may decide that the student would benefit from counseling services as well as remediation in an attempt to improve clinical performance.

Participative

Participative leader behavior is somewhat of a combination of directive and supportive behaviors and its impact is dependent on the personality of the follower (Ani et al., 2017). Specifically, the participative leader includes subordinates in planning and decision making to promote the subordinate's acceptance of responsibility for actions. In nursing education, students are partners in the educational experience. When faculty view students as partners or colleagues, they are promoting student growth and achievement of educational goals. When a student is not performing at the expected level in clinical experiences, the program administrator can collaborate with other faculty, the clinical educator, and the student to adopt strategies that involve active student participation and accountability for determining learning experiences that will improve clinical performance (Christensen, 2016). Allowing students to have a role in

developing their own learning experiences can prove to be empowering to students who desire to

have their opinions valued and are open to working with the leader (Christensen, 2016; Ani, et

al., 2017). Further, when a student is not meeting clinical expectations, the program

administrator can require the student to participate in developing his or her own action plan for

improvement. Thus, the participative leadership behavior as described by Path-Goal theory

offers room for program administrators to involve a student in planning how to improve clinical

performance or to recognize that he or she is not a safe practitioner.

Achievement-Oriented

The achievement-oriented behavior is "also a combination of directive and supportive

leader behavior" concerned with using an inspirational approach to enhance the performance of

followers (Ani et al., 2017). Using the achievement-oriented style, the program administrator

seeks to inspire students to improve their performance by setting high expectations and

challenging goals as well as displaying confidence in the student's ability to achieve

performance goals (Ani et al., 2017). The expectations for meeting clinical objectives and level

of competence are identified and communicated to students at the beginning of the course along

with information about how the clinical grade will be determined (Christensen, 2016). With this

regard, a student who is not performing at the satisfactory level is notified in a timely manner,

provided specific feedback, and informed of what is required to demonstrate adequate

improvement. The faculty member documents the student's clinical performance on an on-going

and effectively communicates with the student about his or her progress in clinical. Further, if

the program administrator decides that remediation is warranted for a student who is

demonstrating unsatisfactory clinical performance, he or she can work with the faculty and

clinical educator to identify specific outcome measures that need to be achieved within a certain

timeframe (Ani et al., 2017). The achievement-oriented leadership behavior as described by Path-Goal theory is apparent in the role of the program administrator to define clinical performance expectations as well as requirements for successful completion of the program for students. The program administrator would incorporate achievement or lack of achievement in meeting expectations or requirements in decisions related to student progression.

Conclusion

Path-Goal theory assumes that leaders are flexible and adapt their leadership style in order to motivate individuals to perform effectively and achieve goals. While Path-Goal theory has been applied in studies related to the success of leaders to improve employee performance and satisfaction in other industries, its application is limited, and more research is required. Nurse anesthesia is complex and includes both academic and clinical learning. Program administrators must adapt their leadership style based on the needs of individual students to promote student success. This study was a new application of Path-Goal theory to inform the nurse anesthesia program administrator's decision-making process in determining whether a student's unsatisfactory performance warranted intervention by the program.

CHAPTER THREE

Methodology

The purpose of this study was to describe the decision-making process of nurse anesthesia program administrators in determining interventions for a student who exhibits unsatisfactory clinical performance. This chapter describes the research design, methodological approach, participant sample, data collection and analysis. This chapter also includes how the researcher ensured trustworthiness, and followed the process of reflexivity

Research Design

A qualitative design was selected for this research study. Qualitative research is an appropriate research design to help determine how people interpret experiences or interactions within a context (Merriam, 2009). According to Denzin and Lincoln (2011), "the word qualitative implies an emphasis on the qualities of entities and on processes and meanings that are not experimentally examined or measured" (p. 8). The qualitative design captures the meaning that people attribute to interactions and provides an explanation for why they may respond differently in various situations or contexts. Using a grounded theory approach (Charmaz, 2006), this study sought to answer the following question:

What is the decision-making process of a nurse anesthesia program administrator in determining interventions for unsatisfactory clinical performance by a student?

An interview protocol was developed with open-ended questions designed to elicit detailed responses from nurse anesthesia program administrators about how they defined unsatisfactory clinical performance and what approaches or processes were followed when a student exhibited unsatisfactory clinical performance (Appendix A).

Methodological Approach

This study used a grounded theory approach to explore the decision-making process of nurse anesthesia program administrators. Grounded theory was particularly appropriate for this study as a theory was not available to explain this process (Merriam, 2009). This approach is popular in healthcare fields including medicine and nursing, because it offers researchers a systematic and interpretive means to develop a theory that has the potential to guide practice (Creswell, 2013; Breckenridge, 2009). Grounded theory allows a philosophical model to be developed from the data collected using an inductive approach (Creswell, 2013; Komives, Longerbeam, Owen, Mainella, & Osteen, 2006). By determining common themes within the data set, a theory focused on process or action is developed that is "grounded" in the participants's viewpoints and supported by their statements (Creswell, 2013, p.83). Glaser and Strauss originated grounded theory as a research design in 1967 and held that theories should be "grounded in data from the field, especially in the actions, interactions, and social processes of people" (Creswell, Hanson, Clark, & Morales, 2007, p. 249). Glaser and Strauss later disagreed on the approach to grounded theory with Glaser positing that the approach should be less structured. Since the seminal work of Glaser and Strauss in 1967, many interpretations and applications of grounded theory have emerged (Coyne & Cowley, 2006).

This grounded theory study followed a constructivist approach employed by Charmaz (2006), which aligns with the interpretivists' tradition as the researcher's role and experiences influence the process of prioritizing questions. According to Charmaz (2006), this approach should be flexible with more emphasis on individual beliefs and values instead of research methods. Interpretivists believe that reality varies among individuals and groups based on experiences, knowledge, and expectations; therefore, reality should be interpreted in the

appropriate context (Rubin & Rubin, 2012). The researcher is a nurse anesthesia program administrator who has personal values and beliefs about her responsibility to ensure patient safety. Further, she has had the experience of having to make challenging decisions related to a student's unsatisfactory performance. In this study, emphasis was placed on the participants' view regarding their role and authority as a nurse anesthesia program administrator in making decisions related to unsatisfactory clinical performance. Theoretical sampling was done throughout the interviewing process to develop the theory that was grounded in data.

Sampling

Sampling in grounded theory research is sequential, beginning with purposeful sampling, then progressing to theoretical sampling when concepts begin to emerge (Draucker, Martsolf, Ross, & Rusk, 2007). Purposeful sampling was used to select the interview participants for this study, who were all nurse anesthesia program administrators. According to Creswell (2013), "purposeful sampling means that the inquirer selects individuals and sites for the study because they can purposefully inform an understanding of the research problem and central phenomenon in the study" (p. 156). There are 121 accredited nurse anesthesia programs in the United States located throughout seven designated regions (Table 3.1). The COA Faculty Standards require that the program administrator of a nurse anesthesia program is full time, doctorally prepared, experientially qualified, licensed as a registered nurse and advanced practice registered nurse, and has leadership authority and accountability for the program (COA, 2018). While the majority of programs are housed within a school or college of nursing, some are affiliated with schools of allied health and medicine. Of the 121 nurse anesthesia educational programs, 65% reside in schools of nursing and 35% reside in schools of allied health or other graduate schools (COA, 2018).

Table 3.1 **AANA Geographic Regions**	
AANA Geographic Regions	*States in the Region*
Region 1	Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Puerto Rico
Region 2	Georgia, Kentucky, North Carolina, South Carolina, Tennessee, Virginia, West Virginia
Region 3	Illinois, Indiana, Michigan, Wisconsin
Region 4	Arkansas, Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, Oklahoma, South Dakota
Region 5	Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming
Region 6	Delaware, Washington DC, Maryland, Ohio, Pennsylvania
Region 7	Alabama, Florida, Louisiana, Mississippi, Texas

Institutional Review Board (IRB) approval was obtained from the University of New Orleans prior to soliciting participants and data collection (Appendix B). As a nurse anesthesia program administrator, I have access to a listserv that includes all 121 nurse anesthesia program administrators. An email that described the purpose of the study was sent to the nurse anesthesia program administrator's listserv requesting participants for the study. This email included a brief demographic survey to be completed by interested participants (Appendix C). Twenty-four program administrators responded to the email and completed the initial demographic survey. Ten participants were selected to participate and the selection included a participant from six of the seven regions as well as all of the different types of school affiliations. The participant sample was proportional to the split in school affiliation types with seven participants from schools of nursing and three participants from other graduate school affiliations. The participants ranged in experience as a program administrator from four years to greater than twenty years. The selected participants were sent an email along with a consent form to participate and a

convenient time for a phone interview was set up. A description of the participants is included in

Table 3.2 below. The researcher identified one delimitation: that only nurse anesthesia program

administrators were interviewed, and others who have input to the clinical evaluation process

were not interviewed.

Table 3.2 **Participants' Demographics**			
Participant (pseudonym)	**School Affiliation Type**	**Geographic Region**	**Years of Experience as Program Administrator**
Katie	Nursing	Region 7	5
Danielle	Nursing	Region 7	5
Penny	Nursing	Region 2	>20
Josh	Health Professions	Region 7	>20
Rick	Nursing	Region 4	5
Bob	Nursing	Region 3	>20
Mickey	Health Professions	Region 2	>20
David	Nursing	Region 5	4
Luna	Nursing	Region 5	5
Sally	Medicine	Region 1	4

Data Collection

Individual interviews with participants were the main source of data collected (Creswell,

2013).   Interviewing is a method of data collection in qualitative research used when one cannot

observe behavior, feelings, or how people interpret the world around them (Merriam, 2009). A

semi-structured interview protocol that aligned with the theoretical framework and central

research question was used to guide the interviews (Appendix A). Interview questions were

designed to stimulate responses related to the interviewees: experiences, feelings, opinions,

knowledge, and background (Merriam, 2009). The protocol consisted of background questions

followed by questions pertaining to how the program administrator determined if clinical

performance by a student was unsatisfactory, and whether an intervention was warranted by the

program. Due to the sequential sampling of grounded theory, follow up interviews are sometimes

needed; however, follow up interviews were not necessary for this study.

Prior to the interview, an email (Appendix C) was sent to each participant that included

the purpose of the study and an attached consent form (Appendix D). Each participant signed

the consent form and returned it to me prior to the interview. All of the interviews were

conducted via phone. To ensure confidentiality, each participant selected a pseudonym. The

same interview protocol and semi-structured interview technique with additional probing

questions was used to obtain specific data from each interview participant (Merriam, 2009). A

slight modification in the interview protocol was made after the second interview to improve the

flow of the interview and to include a question specific to what constituted *unsafe* clinical

performance. The technique known as *responsive interviewing* was used: trust was established

between the researcher and the participants; the questioning was friendly and conversational; and

the pattern of questioning was flexible with additional probing questions or comments added to

allow for elaboration or clarification (Rubin & Rubin, 2012). The interviews ranged in time

from 57 to 100 minutes. Each interview was recorded using two digital voice recorders and was

transcribed verbatim. Data was stored in a secured, password protected, electronic location

accessible by the researcher. Data was collected as the theory process emerged until there was

nothing new, and each component of data uncovered was followed up on, to validate that the

researcher had a comprehensive understanding of the process discussed during the interview.

When no new insights become known, saturation was reached.

Document analysis involved collecting and reviewing documents identified as having relevance to the decision-making process under study. Specifically, the COA Standards for Accreditation and Accreditation Policies and Procedures were analyzed because all nurse anesthesia programs must be accredited by the COA and therefore, must comply with the COA Accreditation Standards and Policies (COA, 2018). The COA standards include requirements for admission to a nurse anesthesia program and program outcomes. The National Board for Certification and Recertification of Nurse Anesthetists (NBCRNA) eligibility requirements for certification were analyzed because program administrators are required to certify that graduates meet the eligibility criteria for certification. Theoretical sampling is "an active and ongoing process that controls and directs data collection and analysis" and is pivotal in building insight to evolving theory (Breckenridge, 2009, p. 114). Following the second interview, the AANA Code of Ethics (2018) and the AANA Professional Practice Standards (2019) were used as a reference during the interviews as violation of either ethical or professional standards were considered unsatisfactory performance. Finally, the student handbook from each of the participants' programs was requested, received, and reviewed specific to policies related to student progression, grounds for remediation and/or dismissal, and policies related to due process for students.

Data Analysis

The recorded interviews were read and re-read to identify relevant concepts and emerging themes. After each interview was completed and transcribed, the interview recording was listened to again and compared to the transcription as well as the previous interview transcriptions. In grounded theory, theoretical sampling occurs in response to emergent findings, rather than simply sampling the population characteristics such as purposeful sampling

46

(Draucker et al., 2007). Following the second interview, data analysis was constantly compared within each interview and between interviews to assess for similarities and/or differences and the interview protocol was modified slightly as findings emerged. In addition, memos were written to capture my thoughts and ideas throughout the coding and analysis process.

According to Charmaz (2006) "Coding is the pivotal link between collecting data and developing an emergent theory" (p. 46). In the constructivist's grounded theory approach, there are two main phases of coding. The initial phase involves coding of lines or segments of data, and the focused selective phase involves sorting and organizing the most significant initial codes (Charmaz, 2006). During the initial coding, I color coded the raw data using a mixture of in vivo, process, and emotion coding signaled by leads from repetitive phrases used by participants (Miles, Huberman, & Saldaña, 2014). The data was organized around concepts and constant comparative analysis was used as data was compared within the same interview as well as subsequent interviews (Chamaz, 2006). In the second phase, focused coding was completed by organizing and categorizing the most significant initial codes and comparing the interpretations, experiences, and actions of participants (Charmaz, 2006). During focused coding, rankings of clinical performance or behaviors, how the program administrator looked at concerns regarding a student's clinical performance, approaches used by program administrators, what influenced the decision-making, and processes were identified. To assist in achieving saturation in data analysis, theoretical codes were identified by conceptualizing how selective or focused codes were related and developing relationships between categories (Coyne & Cowley, 2006). Ultimately, the theoretical model, *The Nurse Anesthesia Decision-Making Model,* was developed which depicts the decision-making process of a nurse anesthesia program administrator in determining interventions for a student exhibiting unsatisfactory clinical performance.

The documents obtained were analyzed to determine consistencies and inconsistencies among programs as well as alliance with the COA accreditation standards and policies and NBCRNA eligibility requirements. The AANA Code of Ethics and the AANA Professional Practice Standards were analyzed as participants referenced violation of the standards as unsatisfactory clinical performance. The student handbooks from the various programs were analyzed to determine specific behaviors that resulted in the opportunity for remediation or behaviors that resulted in dismissal from the program. The handbooks were also reviewed to determine how students were afforded due process. The documents were coded using the same color codes used in the analysis of the interviews.

The process of constant comparison was followed throughout the analysis from initial coding to theory development. The interview findings were compared within each interview and between the subsequent interviews. This process was repeated until there was no new information properties or processes emerging indicating that theoretical saturation was achieved (Charmaz, 2006)

Trustworthiness

In qualitative research, rigor is demonstrated by the researcher's ability to accurately represent the experiences and voice of the participants, which establishes trustworthiness (Shenton, 2004). There are four elements of trustworthiness: credibility, dependability, confirmability and transferability, therefore, several strategies were used to ensure trustworthiness and these strategies are described below (Shenton, 2004).

To ensure credibility or internal validity, trust with participants was gained first by establishing a rapport with participants and informing them that there was no right or wrong answer to the questions asked (Shenton, 2004). While I did not know all of the participants

personally, all participants knew me because of my current role as vice-president of the COA. I disclosed to participants that I have personally experienced challenges with decision-making related to the clinical performance of students. I also used thick description, by providing contextual detail in describing the responses of participants (Shenton, 2004; Merriam, 2009). Member checking was used to ensure accuracy in the data by sending each participant a copy of his or her interview transcript, as well as the findings of the study. Participants were asked to review the transcripts and findings and to provide comments if indicated. No additional comments were provided by the participants (Shenton, 2004). The measures taken to ensure credibility overlap with the measures taken to ensure dependability. Dependability refers to whether the same results would be found if the study was repeated in the same context (Shenton, 2004). This was accomplished by providing details of the research design, data collection and analysis, and keeping a reflective journal that included an evaluation of each interview overall, my impression of the interview and my ideas related to emerging patterns. Confirmability refers to the concern for the researcher's ability to admit to and set aside predispositions to maximize objectivity (Shenton, 2004). Several methods to ensure objectivity were used including keeping an audit trail to demonstrate how the interviews and documents were coded and analyzed. Transferability, which refers to external validity, or how the findings of this study could be applied in another situation was accomplished by describing the participants, the data collected and the context (Shenton, 2004). In addition, a colleague who is a former nurse anesthesia program administrator with experience as a qualitative researcher, conducted a peer review of the findings and determined that the findings fit the study. Finally, to ensure trustworthiness, triangulation was used, as data was collected from multiple documents and interviews with diverse participants from different programs located throughout the United States.

Reflexivity

Reflexivity in the traditional interpretation is a process of critical self-reflection on one's biases, theoretical predispositions, and preferences when the researcher is a part of the setting, context, and social phenomenon he or she seeks to understand (Merriam, 2009). I am a CRNA with 24 years of clinical experience, 21 years as a faculty member in a nurse anesthesia program, and 12 years as the program administrator of a nurse anesthesia program. In addition, I currently serve as vice president and an educator member on the COA and in this role, participate in evaluating the compliance of other nurse anesthesia programs with COA educational standards. As the researcher, I bring certain biases to this study based on my administrative role that requires decision making related to a student's substandard clinical performance and my role on the COA, which requires decisions related to the compliance of other nurse anesthesia programs with the COA standards. I have required several students to undergo remediation due to unsatisfactory clinical performance, required students to be counseled by the campus assistance program, and dismissed students because of unsatisfactory clinical performance. In addition, I have been named in a lawsuit because of my decision to file code of conduct charges against a student due to clinical performance that was deemed a risk to patient safety, which resulted in the student being dismissed from the program. Making decisions regarding students who are not meeting expectations for clinical performance has been very challenging for me and the most difficult part of my job as a program administrator. In order to control for potential biases, I maintained a reflective journal throughout the process.

CHAPTER FOUR

Findings

The purpose of this grounded theory study was to define the process that nurse anesthesia program administrators use to determine if a student nurse anesthetist's unsatisfactory clinical performance warrants remediation or dismissal from the nurse anesthesia program. The research question guiding this study was: *what is the decision-making process of a nurse anesthesia program administrator in determining if unsatisfactory clinical performance by a student warrants intervention by the program?* This study included ten participants who were all program administrators of a nurse anesthesia program. Data was collected via semi-structured interviews to elicit detailed information about the decision to remediate or dismiss a nurse anesthesia student for unsatisfactory clinical performance. Despite the variation in the range of experience of the participants, there was no appreciable difference in how they responded to the interview questions regarding students exhibiting unsatisfactory clinical performance. This chapter presents the findings of this study and is divided into five main sections. First, a description of how participating program administrators communicate expectations for clinical performance and how clinical performance is evaluated. Second, descriptions of clinical performance rankings for borderline, unsatisfactory, and unsafe performance. Third, a model is presented of the phases involved in a program administrator's decision making regarding unsatisfactory clinical performance. This theoretical model represents the substantive theory that emerged, which is grounded in data and includes five-phases of the decision-making process and a guiding principle. Fourth, each phase of the decision-making process is described along with the factors that influence the respective phase. Fifth and finally, the chapter concludes with a section on additional and unanticipated findings of this study and a summary of findings.

<center>**Communicating Expectations of Clinical Performance**</center>

Although nurse anesthesia programs vary in curricular design and structure, the basic didactic and clinical requirements are prescribed by the Council on Accreditation of Nurse Anesthesia Programs (COA). The expectations for clinical performance are based on a student's level in the program with expectations increasing as the student progresses toward completion Programs are expected to make students aware of the performance expectations at each level. Likewise, clinical educators must also be aware of the expectations to properly evaluate student performance. All of the participants in this study had processes in place to communicate expectations of clinical performance to students as well as clinical educators.

Notifying Students of Expectations for Clinical Performance

The importance of informing students of expectations for clinical performance was evident in the responses from all participants. As informed by the interviews, programs attempt to make students fully aware of the clinical performance benchmarks set for them. Each participant described multiple modalities for informing students of these expectations to ensure a clear understanding. As Penny stated:

> The expectations for their clinical performance are in all of their clinical syllabi. So every semester they have a syllabus for their clinical practicum course. . … Those very same behaviors, expected behaviors, are on… their daily clinical evaluation forms that they distribute to their CRNA [Certified Registered Nurse Anesthetists] preceptors [clinical educators]. So they're aware of what's expected from semester to semester.

The expectations were also included in the program handbooks. As Josh noted:

<center>52</center>

Number one, it's certainly spelled out in the handbook of the program what the

expectations are, and each of our clinical courses has objectives that very much mirror

the council [COA] standards as to the objectives of what they're supposed to complete.

Not only are the expectations published in syllabi and the handbooks, the majority of participants

met with students and reviewed the expectations to ensure students understood what was

expected of them. Josh further explained:

I literally go through all of the policies and procedures and definitely set the expectations.

I have a PowerPoint presentation …that kind of deals with some of the things that

students have to deal with in clinical environment like showing up early and not being

late, attitude stuff and not competing with each other… I kind of set the tone with that

presentation and then I go through all of the policies and forms and schedules…

Participants felt it was important to inform students of what was expected of them even before

they were admitted to the program and then to remind them again prior to students beginning

their clinical training. Katie described:

Very early on we try to educate applicants on what our clinical expectations are, where

our clinical sites are, what our clinical attendance philosophy is, and really our

educational philosophy as it relates to clinical competency, clinical attendance and

clinical performance for SRNA's [Student Registered Nurse Anesthetists]. We do that

during the interview process.

Expectations for clinical performance are of such importance that they are often re-emphasized to

students during the program, as described by Rick:

...We also revisit the Student and Faculty Handbook in the weeks prior to them going out

to full-time clinical… we re-emphasize the areas that are specific to their clinical

experiences… we do have a semester-by-semester list of expectations for what they will need to achieve by the time that they get to the end of a given semester.

All of participating program administrators informed students of the respective program's expectations for clinical performance. The majority of participants described multiple modalities used to communicate the clinical performance expectations to ensure that students had a clear understanding. This is important, given that the clinical evaluation of nurse anesthesia students is based on the expectations for clinical performance.

Communicating Expectations to Clinical Educators

The COA Clinical Site Standards require that "the program appoints a CRNA clinical coordinator for each clinical site who possesses a master's degree (doctoral degree preferred) to guide student learning" (COA, 2018, p. 25). While participants felt it was important to educate CRNA clinical educators on the expectations for the clinical performance of students, they found it difficult to reach each individual clinical educator. Therefore, as Rick described: "The clinical coordinator is the liaison between our program and the clinical site." Although program administrators may not directly communicate with individual clinical educators, programs are required to conduct an annual site visit to meet with the clinical coordinator and other available anesthesia staff. Participants stated that they reviewed the expectations for clinical performance with the clinical coordinator during the initial site visit, as Katie described:

> …During that onboarding process for a new site or new coordinator, we'll discuss what
> our expectations are. Each one of our clinical sites has a clinical manual, which has our
> policies, procedures, expectations, and some what if questions.

In addition to reviewing the expectations, several participants provided the clinical site with a policy and procedure manual to keep on site as a reference. Participants also reviewed the

expectations with the clinical coordinator during the annual clinical site visit. As Rick stated: "we …have a clinical coordinator…we go over these expectations with them…individually [during] clinical site visits." The expectations were included on the daily clinical evaluation as an accessible reference for clinical educators. Josh noted:

> The primary way (we communicate expectations to clinical educators) is [in writing] at the beginning of the student evaluation that the faculty or preceptors complete. There is an overview of the expectations for clinical performance and it sort of talks about that the students should be compared to other students at the same level of experience…because sometimes we'll have both junior and senior level students at an individual clinical site at the same time and they need to obviously be held to different standards. We are careful about being sure that the clinical sites understand that.

Having the expectations visible on the evaluation form serves as a readily available resource to clinical educators to use when they are completing the evaluation. Further, it allows the clinical educator to see the expectations based on the student's level in the program. Penny echoed the need to include the expectations on the form so that they are readily accessible to the clinical educators:

> Well, you know, it's kind of hard when you have 200 CRNA preceptors, to get the word out to everybody. So a lot of what we do is for them actually to be able to look at the clinical evaluation form because the form is based on where the student is in the program….

The clinical educators essentially operate on the periphery of the program. The program administrator does not typically have face-to-face time with individual clinical educators unless the administrator does clinical practice at a clinical site. Several program administrators held

workshops for clinical educators, even offering continuing education credits, but attendance was low. Therefore, it is important to include the clinical performance expectations directly on the clinical evaluation form and to maintain open communication with the clinical coordinator.

Evaluating Clinical Performance

According to the COA, nurse anesthesia programs must have a systematic process for formative and summative evaluation of students' clinical performance (COA, 2018). All participants had a process that included a daily clinical evaluation of students that was completed by a clinical educator. On the program side, a faculty advisor or the clinical site coordinator typically reviews the daily evaluations and meets with the student twice a semester to review the student's progress. As Penny stated: "Students are evaluated on whether they are meeting the expectations for clinical performance based on their level in the program." The expectations for a student just beginning clinical training are quite different from the expectations for a student who is about to graduate.

Bob further explained the importance of this evaluation: "the better the quality of the feedback provided on the daily evaluation by the clinical educator, the more valuable it is to the program." The quality of the documentation on the evaluation is important for the program administrator. Participants valued documentation of the actual behavior(s) of the student by the clinical educator. For example, Bob described what he discusses with clinical educators when he is able to talk with them on his clinical practice day or during a workshop. He stated:

> I talk to them about …more an approach to it. Like write what you see and what you hear. Don't worry about getting anybody in trouble. Just be a tape recorder for me. I'll interpret the behavior if you can just report it objectively and accurately. This is what I saw the student do, this is what I heard the student say. That's really valuable.

The program relies on the clinical educator to objectively evaluate the student's clinical performance. Documenting the actual behaviors allows the program administrator to interpret that behavior and determine if there is a concern that requires addressing. In addition to the need for quality feedback, the timeliness of the evaluation was equally as important to participants as Rick explained:

> Something that I usually will try to make sure that we let clinical coordinators know is that a student shouldn't hear for the first time on their summative evaluation about an issue, like "Student A, you had this issue back in week two and now it's week 16 and that's a problem." We try to emphasize that students are receiving daily feedback, and if there are issues, that those issues should be dealt with, with the student, as close as possible to when that issue happened for the best learning to take place.

The daily evaluations by the clinical educator are vital in determining whether a student has met the expectations for clinical performance based on his or her level in the program. In addition, the daily evaluations are used by the program administrator to determine whether the student has passed the clinical practicum course and is able to progress in the program.

It was evident in the interviews with participants that decisions made regarding clinical performance were in part based on the evaluation and ranking of the clinical performance by the clinical educators. Participants were asked to describe the following rankings of clinical performance: exemplary, satisfactory, borderline, unsatisfactory, and unsafe. The descriptions of exemplary and satisfactory rankings by participants were in direct contrast to unsafe and unsatisfactory rankings and obviously were not associated with the need for intervention by the program. However, the three performance rankings that were associated with the possible need for intervention were borderline, unsatisfactory, and unsafe; therefore, the focus is on these three

rankings. The ultimate concern regarding these ranking is that if borderline behavior is not addressed timely and effectively, it can lead to unsatisfactory behavior. Likewise, if unsatisfactory behavior is not addressed in the same manner, it can lead to unsafe behavior and pose a threat to patient safety. The program administrator makes the final decision about what action (if any) is warranted based on the evaluation of clinical performance provided by the clinical educator. A discussion of participants' experiences with each of these problematic performance rankings follows.

Borderline Clinical Performance

Defining what constitutes borderline clinical performance was difficult for participants because the related behaviors are somewhat vague and have an insidious presentation. As Penny noted:

Well, and this isn't a good way to describe it. Sometimes we have students that what we call fly under the radar…The ones that are borderline are the ones that do the least they can possibly do, not only academically, but clinically. They don't reach out for learning experiences. They do exactly what they have to do and no more…they don't pop up on anybody's radar as being clinically unsafe. But they're just there. To me, that's kind of borderline.

With borderline performance, there is not a true concern regarding patient safety per se, but almost a sense of apathy on the part of the student. Katie further said:

I think borderline clinical performance is that there is not a growth or a noticeable deficit. There's nothing tangible to where the preceptor or the faculty can say whether it's cognitive, psychosocial or technical type of skill.

58

Participants were perplexed about what was really going on with the student exhibiting

borderline performance, as the feedback from clinical educators was often vague. Students with

borderline performance pose a challenge due to the inconsistency in performance. In addition,

several participants viewed the inability to see the big picture or the lack of situational awareness

as borderline. Mickey noted:

> They just do not have good…good situation awareness…That is a very difficult student
>
> to deal with. Again, it's something we struggle with, and we try to identify these things in
>
> our interview process, but I think situation awareness is the biggest thing…I guess the
>
> borderline students are the ones I feel are more task-oriented and not actually able to see
>
> the big picture and project how everything comes together. I don't have a better way to
>
> describe it.

The main concern with borderline performance is the need to prevent it from turning into

unsatisfactory clinical performance. As such, there is sometimes a need for the program

administrator to enhance the observation of the student to better understand what is going on, as

Bob described:

> You remember the movie Animal House? The Deltas…the fraternity was on double
>
> secret probation. ..We have used that phrase to … describe a student who …does … not
>
> need the remedy of probation, but at the same time, some of their behaviors are
>
> concerning and they have been counseled. So, they're kind of on the door step.
>
> Ordinarily… when we see behaviors that are concerning, we talk to them about it.

The majority of participants stated that they typically meet with a borderline student. Some

participants noted they would initiate an improvement plan for the student to help them better

meet clinical performance expectations. The decision to enhance observation or initiate

remediation depends on the specific behaviors that are of concern. Ultimately, the goal of the program administrator is to address the borderline performance concerns with the student promptly to prevent the behaviors from continuing or progressing to unsatisfactory performance.

Unsatisfactory Clinical Performance

When asked to describe unsatisfactory clinical behavior, participants went back to the published expectations for clinical performance based on the student's level in the program. For example, Rick described unsatisfactory behavior as follows:

I would describe unsatisfactory behaviors where the student is not meeting the objectives for where they should be in a given semester. I think it depends on what objectives they are. If it's one objective, and it's directly compromising the safety of the patient, well, then it just has to be one objective and that would be an unsatisfactory behavior…or maybe a couple of them are unsatisfactory, but the patient's wellbeing, or safety is not being compromised.

If a student was not meeting one or more of the clinical objectives or expectations this was considered unsatisfactory clinical performance. However, the concern was greater when the student was not meeting specific objectives that directly compromised patient safety. Some participants described unsatisfactory clinical performance based on different domains of performance and how a deficit in one or more of the domains constitutes unsatisfactory clinical performance. Josh added:

There are domains of performance that I really think about and there are sort of three big ones. One is just knowledge…and if they don't have knowledge that's not acceptable…The second is sort of the application of that knowledge and that's going to be more anesthesia related things. They can do a preop [preoperative

assessment],…develop an anesthesia plan, they have the technical abilities that they

need …I look at that domain because you can sometimes do pretty well in that domain

and without having great depth of knowledge if you are a really good nurse. I watch that

to be sure that knowledge and performance both go together...The third … I would call it

the affective domain where we're talking about communication abilities, do they accept

responsibility for their actions, do they know their limits, are they following policies, are

they on time, are they a hard worker, those sorts of things…

The clinical performance is considered unsatisfactory when the student is deficient in one the

performance domains described above. Therefore, insufficient knowledge, inability to apply

knowledge into clinical practice, or a lack of professional accountability are considered

unsatisfactory clinical performance. Katie, who shared the same sentiment, further explained

this:

Knowledge is often one of the first things. If the student is not performing well, clinically

or not meeting clinical expectations…we have found that there's kind of …three

categories …students are falling into. One can just be technical skills where they are not

actually physically performing certain tasks because of the technical aspects. The other

one is in the knowledge -kind of cognitive. The third is, I guess psychosocial…it's a

communication issue. A lot of times, you would say it's a personality conflict. It's really

more, communication…emotional expression, or some of those other kind of traits that

are causing the student to not meet clinical expectations.

Although unsatisfactory clinical performance includes deficits in knowledge, technical skills, or

professionalism, the lack of professionalism was a major concern for participants. For example,

Danielle described a student who exhibited unsatisfactory clinical performance:

61

A student arrives late…is unprepared, appears disheveled in their personal hygiene, just

something about them that's not quite ... Shirt not tucked in or scrubs not fitting well, hair

not tucked into the cap. I talk to the students about you never get a second chance to

make a first impression…. they're late, they can't answer questions, they don't look you in

the eye, they don't introduce themselves. They may be checking their phone a lot or you

have them go on a break and they're gone a little bit longer than most students who you

have taken a break.

The unprofessional behaviors seemed to indicate a lack of respect for the program, the clinical
site, the patient, and the profession.

Other participants identified a lack of preparedness for clinical cases as unsatisfactory
performance, as David provided in the following actual student example:

We had a student a few weeks ago that did not show up to clinical with adequate time to

have their room prepared for… a pediatric case. [He] came into the room with the peds

[pediatric] patient, did not have a mask to do the mask induction, did not have a suction

canister, had an adult Yankauer [suction device] for a pediatric case on a four month old

…chose to use an LMA as opposed to an endotracheal tube which was not appropriate

for a laparoscopic case…and just seemed to be a step behind in kind of anticipating what

was going to occur in the case, to the point that the preceptor decided to go ahead and

take over the case. It was somebody who had done pediatric cases before, so it was a day

that the clinical performance was below standard.

There is no excuse for not having the appropriate equipment for any case, especially a pediatric
case. Being prepared and having an anesthesia care plan are standard expectations for students

across programs. Penny went a step further in connecting a lack of preparedness to a lack of commitment to patient care. She went on to say:

> Some of this too has to do with attitude. Showing up on time. Being part of the team. Working with your student colleagues if there are some additional things that need to be done at the end of the clinical day…pitching in and helping. Other unsatisfactory behaviors are just not being prepared, not reading for your case, not having an idea of what it is you're supposed to do or a plan… so, I think the [unsatisfactory] students …don't really prepare, don't really internalize their academic knowledge, and work on applying it and making sense of it in taking care of human beings.

Teamwork and preparation are essential components of safe patient care, especially in the operating room. In addition, being unprepared seemed to indicate to the participants that the student did not take responsibility for the well-being of the patient or respect the duty to provide high quality and safe patient care. Further, some participants viewed unsatisfactory behaviors, including being unprepared or tardy, as a lack of motivation to provide proper care. Sally noted:

> The student who's always cutting corners. You know, we've had students who have told the clinical preceptors that faculty has excused them early for the day, when we hadn't. You have the student who's arriving late, is not set up for their cases, is not prepared. Has not seen their patients, is saying to their preceptors they have permission to get out early.

The student who appears to put more effort into not being at the clinical site than in learning how to provide safe anesthesia is exhibiting unsatisfactory clinical performance and a lack motivation to learn.

Finally, several participants noted that typically one negative report in the clinical setting does not necessarily indicate unsatisfactory performance. The majority even stated that they

look for a pattern of behavior as well as whether the student assumed responsibility, as Penny offered:

> Everybody has a bad day. Everybody has … different strengths. However, they have to progress in order to be able to provide safe care, consistently safe care. However, the inability of the student to be accountable for a mistake and/or continuing to make similar mistakes represents unsatisfactory behavior.

A pattern of bad behaviors was viewed as unsatisfactory, and even more so if the behaviors or mistakes were similar in nature. David provided further explanation:

> …We try to determine is this a one-time occurrence, or do we now have a pattern of incidents that are occurring that lead us to believe there's an issue of safety or competency with this student.

A pattern of unsatisfactory behavior posed a concern that the student may actually be more in the realm of unsafe and therefore required more urgent action.

Overall, unsatisfactory clinical performance encompasses a wide range of behaviors ranging from a knowledge deficit or inability to apply knowledge into practice to unprofessional behaviors such as being unprepared, tardy, or not respecting the professional norms. Although an isolated incident that was unsatisfactory did not usually indicate overall clinical performance was unsatisfactory, a pattern of concerning behavior did. The primary concern with unsatisfactory performance, as described by participants, is to identify it early and address those behaviors that could be improved so that patient safety is not compromised.

Unsafe Clinical Performance

Unsafe behavior was obviously considered unsatisfactory, but it was considered the most troubling type of unsatisfactory behavior. Participants described somewhat of a line crossing

that moved unsatisfactory behavior on the part of the student to unsafe. Many participants

described a zero tolerance for behaviors they considered unsafe that included unprofessionalism

and integrity violations. As Katie explained: "some behaviors that would be unsafe, are

unprofessional and violations of integrity…these are unacceptable in the clinical setting."

Although there were unprofessional behaviors described above as unsatisfactory, the

unprofessional behaviors described as unsafe involved violations of the professional code of

ethics or the professional standards. As Katie offered:

> If a student was falsifying charts or their case logs…not adhering to the AANA
>
> [American Association of Nurse Anesthetists] code of ethics and standards of care…. any
>
> type of violation or non-adherence to …standards and ethical behaviors.

Other areas that constituted unsafe behavior related to actual decisions made in the clinical

setting that posed a danger to a patient. Participants described unsafe behavior in a manner

similar to the following description by Rick:

> In terms of behaviors, yeah, [unsafe] is anything that is threatening the patient's
>
> wellbeing, and it could be their physical wellbeing, it could be their emotional wellbeing,
>
> psychological. I mean, if the student is not treating the patient in an appropriate way, and
>
> it's deemed to be unsafe behavior…Anything that's compromising or affecting patient
>
> safety.

Unsafe behavior included a threat to the physical, psychological, or emotional well-being of the

patient. Penny shared the same thoughts as Rick and defined unsafe behavior as: "Just about

anything that's going to damage a patient." This included a lack of integrity or the inability to

properly communicate on the part of the student. Bob expressed similar thoughts and discussed

how a combination of a lack of integrity, medication errors, and poor communication pose a danger to patients. He described unsafe behavior in the example below:

> Likelihood of harm to the patient. Lack of integrity would also be unsafe. If somebody mixed up a milligram of epinephrine in a syringe instead of 50 milligrams of ephedrine and then lied about it, that's not good. If somebody tries to conceal their errors, that is not good. Communication can be unsafe…So I think poor communication, lack of integrity or lying is unsafe, and things that might cause a patient harm.

Appropriate administration of medication is essential in anesthesia care. A medication error is considered a preventable error, and the outcome of a medication error can range from no harm to death of the patient (Dhawan, Tewari, Sehgal, & Sinha, 2017). Therefore, a medication error can be considered unsafe, depending on the medication and the patient's status. However, such an error is considered egregious when the student does not take accountability for the medication error or tries to conceal it because this could inhibit the clinical educator from understanding what is actually happening to the patient and deciding on the appropriate intervention.

Other participants elaborated on how inappropriate communication can be considered unsafe. Several participants described students being not only disrespectful to clinical educators in the actual clinical setting, but also argumentative. Katie offered:

> We recently have had a student who had multiple unsatisfactory performances for her professional aspects. Her communication and emotional expression was often inappropriate. She made comments that offended preceptors…While she was trying to have discourse in a conversation with the preceptor, she would often argue or dismiss the preceptor's comments, or she would disregard them to where she would just say, I know that, I know that…She was very unprofessional in her interactions.

Appropriate and effective communication is vital not only in anesthesia, but in all of healthcare as the number one cause of errors in healthcare is poor communication (Shitu, Hassan, Thwe Aung, Tuan Kamaruzaman, & Musa, 2018).

There was consensus among participants that unsafe clinical behavior includes: violation of ethical or professional standards, a lack of professionalism or lack of integrity, and/or inappropriate verbal or nonverbal communication. Further, any behavior that threatened patient safety was considered unsafe.

The Nurse Anesthesia Program Administrator's Decision-Making Model

The visual model that follows is a theory of nurse anesthesia program administrator decision-making regarding nurse anesthesia students exhibiting unsatisfactory clinical performance. This theory addresses the study's research question by describing the process that program administrators follow to decide whether a student's unsatisfactory clinical performance warrants intervention by the program. The emergent theory was derived from the data collected in interviews with ten program administrators. In alignment with the goal of grounded theory methodology (Creswell, 2013), a process was derived from the participants' viewpoint. The core concept that emerged is that participants share a unified goal of protecting the integrity of the profession. This model depicts a five-phase process that begins with receiving the concern and ends with notification of the student. The guiding principle of this model is following institutional and program policies, which program administrators do throughout the process. There is a possibility that phase four would be bypassed, if the student's behavior was egregious per the policy. A description of each phase and the influential factors follows the visual model. How influential factors weigh on the actual decision made by the program administrator may

vary and determine whether the program administrator is able to resolve a concern at one of the

earlier phases.

Figure 4.1. *The Nurse Anesthesia Program Administrator's Decision-Making Model*
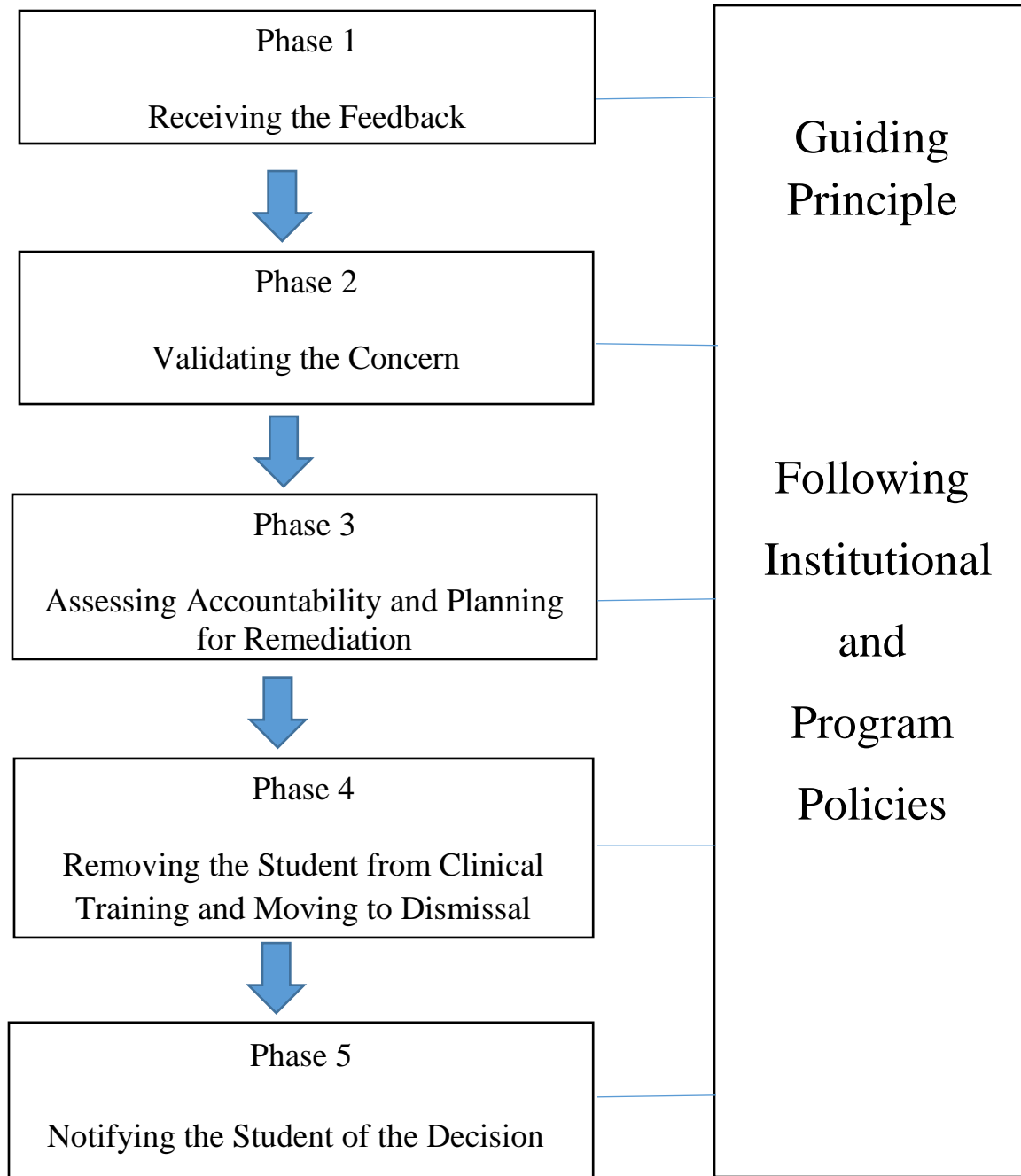
Note: Phase 3 may be by bypassed if the student behavior was egregious per the policy. If the student was unsuccessful in remediation, the program administrator would move to Phase 4.

Phase One: Receiving the Feedback

Phase one begins when a program administrator receives feedback from a clinical educator or clinical coordinator that a student is not meeting expectations for clinical performance. As described above, students are evaluated based on their level in the program, which is determined by the length of time they have been in the program or the number of anesthesia cases the student has performed. When faced with a concern that a student is not meeting expectations, the clinical educator documents the performance on the evaluation tool. However, depending on the issue, the clinical educator may notify either the clinical site coordinator and/or the program administrator via phone or email. The majority of participants stated that a phone call from the clinical site coordinator or clinical educator often precedes the receipt of a negative written evaluation. As Josh stated: "We do depend on the evaluation instruments a lot and most of the time I've already had a phone call from the clinical site." While it may take a few days for the written clinical evaluation to get to the program, a phone call alerts the program administrator immediately. Similarly, Penny stated: "Usually, …I have gotten a lot of concerned feedback or something dramatic has happened and somebody's picked up the phone and called me." Participants value the feedback provided on the evaluation tool as well as receiving the concern timely.

In addition, participants trust the clinical educators to immediately address patient safety concerns. Rick explained:

> We rely on our clinical preceptors [educator] and our clinical coordinators to be our eyes and ears when we are not in the clinical setting. Usually it's really not an issue for sites, preceptors and coordinators. If they notice that there's a safety issue with a student, we're usually apprised of that pretty quickly. It's very clear in our handbook that if any student

is deemed to be a safety concern, if the patient's wellbeing is being threatened, the

clinical site has the ability to remove that student.

The most important concern is to protect the patient from harm. The process of dealing with

students who pose a safety concern to patients varies among programs. Some participants gave

more responsibility to the clinical coordinator to remove the student from the operating room and

to begin investigating the concern. As Danielle explained:

> …we'll get an evaluation from a clinical site saying…per our evaluation, student is
>
> behind or seemed not to be meeting what the CRNA preceptor thought they should be
>
> meeting. That typically goes to our clinical coordinator of the program, and then… she
>
> always lets me know, but she lets the faculty advisor know…because time is sometimes
>
> of the essence with these situations…

Notifying the clinical coordinator facilitates the concern being brought to the attention of the

program timely. Participants also voiced the importance of having written documentation of the

actual behaviors observed that gave rise to the concern that the student was not meeting

expectations and exhibited unsatisfactory clinical performance, as Luna noted:

> …The documentation has to be consistent and without documentation, I'm hung out to
>
> dry because if someone would want to challenge a failing grade and I have
>
> documentation that's all over the place, then I'm forced to not be able to do what may or
>
> may not be in the best interest because you're not there, you're not witnessing this, you're
>
> just basing it off reports and the documentation that's provided.

All program administrators shared the importance of receiving clear, consistent, and timely

documentation of clinical performance by the clinical educator.

The feedback from clinical educators is the initial foundation that supports the program administrator through the next phases of the decision-making process. Program administrators rely on the clinical educator to provide accurate, objective and timely feedback of the nurse anesthesia student's ability to meet the expectations for clinical performance. Receipt of this feedback allows the program administrator to move promptly to the next phase of the decision-making model, which is *validating the concern*.

Phase Two: Validating the Concern

In phase two, the program administrator seeks to validate the concern expressed by a clinical educator that a student is not meeting expectations for clinical performance. The clinical training required in nurse anesthesia programs is rigorous and typically involves rotating to various clinical sites and working with a multitude of clinical educators. Participants recognize the pressure placed on students to meet expectations in clinical. When concerns are brought forth about clinical performance, all participants felt the need to be open-minded and to investigate both sides of the story. Participants offered various measures taken to ensure fairness to the student and to validate the concern to allow for an informed decision regarding the students' performance.   These measures included meeting with the student, meeting with the clinical educator, firsthand observation and obtaining a consensus.

Meeting with the student. When there was concern about clinical performance, participants unanimously felt that students had the right to tell their side of the story, therefore, students were encouraged to tell their account to the program administrator. David noted:

> Anytime we get a below standard level, or a below minimum level for whatever level
> they are in the program, we immediately call a meeting with them. We contact the

71

preceptor [clinical educator], kind of get both sides of the story, and then discuss with the

student.

Clearly, participants felt strongly that the student should have a voice and an opportunity to

present the context of the situation. Katie further explained:

When we're notified of a student who is not meeting those expectations…the first thing

we do is debrief and meet with the student. So, the student often will come to the office…

outside of the clinical setting so that we can discuss [the] observation, written evaluations

or whatever evidence there is that the students not meeting expectations. We present that

to the student and then we allow the student to share with us kind of what their viewpoint

is, what their experience is, and whether their story or what they've experienced is

congruent with what's been presented to us or what we've observed. We also allow them

time to provide a rationale as to why they may have performed a certain way, to give us a

little more information.

Participants definitely wanted to ensure that the student was treated fairly and objectively,

because this type of news can be disturbing for the student. As Bob stated: "...You

know, the students want to do good." This was echoed by Josh who went on to say:

I have the power to really ruin somebody's life if I don't be careful with that, so I really

try to be careful that I'm being fair. I need to be hard on the students when it's

appropriate, I also need to protect them if there's someone in the clinical environment

that's trying to railroad them.

Program administrators recognize their authority and the impact of their decisions. Likewise,

participants felt obligated to protect the student as well. Participants also worried about students

receiving conflicting feedback from the clinical educator. Giving the student the opportunity to explain their side is essential, as Penny offered:

> I sit down and give it [the evaluation] to the student and say, "This is the feedback that we received on this particular day that you were with the CRNA. Tell me what you think was going on." Always, we try to certainly always get the student's perspective because sometimes they're kind of caught out in left field. CRNA says, "Oh, you did great today," and then turns in an evaluation that says, "Oh, they sucked today." Sometimes they get that conflicting feedback.

Clinical educators are expert clinicians; however, they lack training in education and evaluation. Some clinical educators are not comfortable discussing concerns for clinical performance with the student and instead provide the concerns in writing on the evaluation form.

In addition to concerns about the *possibility* of conflicting feedback, is *the way* the feedback was presented to the student, as Bob expressed:

> I think students…they're vulnerable, and I think they are quite sensitive to tactless approaches from clinical faculty. So on the one hand, I think students need to know that the sun will still come up tomorrow if somebody criticizes you about something, especially when it's nothing personal. The fact that you couldn't lift enough ... I mean, you're still a fine human being, but they take these things to heart too much. And I think instructors do not couch their criticisms in enough of a tactful and personal constructive fashion.

The inherent stress of nurse anesthesia academic and clinical training may make students more sensitive, especially given the need to *perform* in the clinical setting. Therefore, when alerted to an issue related to clinical performance, the first concern for many participants was that

73

something could be going on personally with the student, as Josh stated: "The first thing that comes into my head is what's going on in their personal life, that's the first thing I think about." This concern for the student's well-being was evident as shared by Rick who pondered:

Has the student been sick? Has the student been taking medications? Is the student exhibiting some signs that they might be having issues with drug use or alcohol use? Are there things that could be going on with their mental well-being?

When there was a concern about clinical performance, the program administrators wanted to determine if something was going on in the student's personal life that could be a factor. In addition, due to the high incidence of drug abuse among anesthesia providers, participants were concerned that this could be a factor as well.

Overall, there was a shared belief on the part of the participants that student was afforded the opportunity to present his or her side of the story as well as the context of the situation. Participants also expressed genuine concern for the personal and professional well-being of the student.

Meeting with the clinical educator. It was important for the program administrators to meet with the clinical educators to hear their interpretation of the student's performance and to corroborate what was written on the evaluation. As Rick explained:

We learned a long time ago that I typically don't want the gossip…Sometimes I will follow up with preceptors or clinical sites, clinical coordinators, to get a little more information. As much as possible, I try to stick to what's written on the evaluation and not read into it, make assumptions or inferences. Then realize that usually the truth is somewhere in between what the preceptor has written on the eval and what the student recalls is happening in the clinical setting…It's …important …to hear what the clinical

site is saying….There are a lot of things going on, so making sure that we're doing an

assessment to see what exactly is contributing to the student's poor performance.

The perspective of the clinical educator allows the program administrator to understand more

about what actually happened and what else was going on in the operating room. This puts the

behavior in context. Further, the program administrators sought to determine if the clinical

educator evaluated the student based on the appropriate level expectations or whether the

particular educator had expectations that were out of touch with the student's level in the

program. For example, if a student was just beginning in clinical and has never done a particular

technical skill, such as an endotracheal intubation, the expectation should not be that the student

completes this skill at a proficient level.

By meeting with the clinical educator, participants were able to determine if the clinical

educator's expectations were consistent with the program as well as other clinical educators. In

addition, participants expressed the need to remind clinical educators that mistakes will happen

and are a part of the learning process. Bob noted:

> Part of it is consistency. I think if we insisted that students make no mistakes in the
>
> learning process, we would have very few graduates. We are tolerant of errors to a
>
> degree.

Undoubtedly, all healthcare providers, even those with experience, will make a mistake at some

point in their career. Therefore, many of the program administrators recognized that during the

learning process, there is the likelihood that some students will make a mistake as well. As a

result, some participants requested specific examples of what the student did in order to gain

more insight. Luna stated:

you could have really tough preceptors [clinical educators], you could have really soft

preceptors, so what I try to do is gather facts from different sources first off. I do talk to

every single preceptor that does report these deficiencies and ask for examples because if

I'm gonna talk to the student, I want to get the students insight, but I also want to say I

was told you did this…

A description of the actual observed behaviors allowed the program administrator to make the

interpretation of whether the behavior was actually considered unsatisfactory.

Firsthand Observation. All participants voiced the importance of firsthand observation

of a student's clinical performance by either the program administrator or a faculty member**.**

Many participants found it helpful to decipher what the concerns were. As Rick stated:

 Sometimes it's helpful when a student is having some poor performance, for us just to go

do a site visit. We have the benefit of being able to be within driving distance of most of

our clinical sites, so maybe one of us just needs to go down to do a site visit, just to figure

out what's going on.

The direct observation the student's behaviors and performance in clinical allowed participants

to identify the actual behaviors in the context of the operating room and not rely on the clinical

educator's description or interpretation of the behaviors. Danielle added:

…so if there is an issue, our policy is to have someone of the faculty go, and it's usually

me or the assistant program director, go and watch them in the operating room, and see

how they're doing...

 Katie routinely had faculty members available to assess student performance in the clinical

 setting: "We can observe firsthand whether or not there are any safety or, I guess, quality

 competency issues." Therefore, when the program administrator or a program faculty member

was available to observe the student firsthand, this was considered the best evidence in determining whether the concern was valid.

Selecting clinical educators. Participants spoke of "select clinical educators" that they trusted to provide an objective evaluation. When it was not possible for the program administrator or a faculty representative to evaluate the student directly, they relied on these clinical educators, as Rick stated:

> … we'll have the student work with a couple of specific people to get that feedback for the student, for the clinical coordinator and for us….we usually will say, "For the next week, have the student work with perhaps two or three people" who will give the student, the clinical coordinator and the program good-quality feedback about what's going on, to really just get a good evaluation, and [who] is also willing to take just a little extra time to teach the student and to help them work through that.

Clearly, some clinical educators are more confident and comfortable with evaluating students in clinical and are trusted by the program administrator or clinical coordinator to evaluate the student's clinical performance objectively. This provided validation of whether there was a concern. Penny stated: "So we do our best to put them with CRNAs who are going to constructively and objectively evaluate them."

Objective feedback by the clinical educator of the clinical performance allows the program administrator to determine if the student is actually exhibiting unsatisfactory clinical performance. Clearly, program administrators trust the ability of selected clinical educators to provide more accurate and objective feedback that informs decision-making.

Getting a consensus. Program administrators valued the input of more than one clinical educator to validate whether a student's clinical performance was unsatisfactory. As Mickey noted:

> Unless it's something that is a very critical safety issue, very rarely would I make any distinction based on any one clinical preceptor. I would look at a preponderance of the evidence to see if I see the same themes being repeated from preceptor to preceptor.

Given the variability among clinical educators described above, a consensus among clinical educators that there was a problem with a student's clinical performance was valuable to the program administrator and provided stronger evidence that the concern was valid. As Bob explained:

> It's difficult…Maybe I see somebody in the airport that I think is fat, and that's my prejudice. But, if five of us independently, who don't know each other, see this person walking by saying, "They have a weight problem," then that's where the objectivity in the process comes about. So I think ... every instructor has their own, based on their own history, their own understanding, their own maturity, etc. Every instructor brings their own subjectivity to the process. But when you get five people in a week that work with this guy who say, "Are you doing okay?" Then that's objective…. So, I think we look for consensus as a validator that there's objectivity in the process.

Exploring areas of concern, including seeking the opinion of other clinical educators allows the program administrator to make a better-informed decision. Katie described this as she stated:

> We try to find out is this the complete picture of what was happening with the student? Is there any more information that we can obtain to either validate or show congruence with what's being reported to us? After that, we call in the student again, and speak to

them…to find out the information from them as much as possible. Then consider the best

route for either remediation and/or disciplinary types of procedures related to the severity

of the unsatisfactory behavior.

In other words, participants wanted to see the full picture of what was going on with the student

clinically, so that the next steps could be determined. As Rick stated:

We're really just trying to get a 30,000-foot view of what is going on with the student and

what is going on with the situation, because a lot of times when the clinical site is

contacting us, they're wanting some next steps…wanting to know what we want to

happen with the student. The best way that we can give that guidance to the clinical site is

really just to try to get a good understanding of what's going on….

The interviews revealed that all participants were committed to seeing the *big picture* and

thoroughly investigating concerns about a student's unsatisfactory clinical performance. Having

a consensus among clinical educators that a student was unsatisfactory added validity to the

evaluation and was influential in the program administrator's decision making.

Ultimately, the decision of whether the clinical concern was valid and required further

action depended on the hearing both sides of the story, the objectivity of the evaluation, the

gravity of the situation, and whether this was a one-time issue versus a pattern of behavior.

Having more than one clinical educator express a concern for the student's clinical performance

was also a factor in the program administrator's decision regarding what action to take.

Phase Three: Assessing Accountability and Planning for Remediation

There were similarities in the how program administrators described the approaches used

in the management of students who exhibited unsatisfactory performance. Despite the variation

in program affiliation types and regional locations, there was uniformity in overall process that

program administrators followed in their decision-making. Therefore, phase three presents a

series of steps involving the student after the investigation is completed. These steps include

determining whether the student is accountable, developing an individualized remediation plan

and timeline, meeting with the student at scheduled times, using simulation, and selecting certain

clinical educators to objectively evaluate the student.

Determining student accountability. Whether the student accepted accountability for

their actions was repeatedly noted to be an important determinant in the participant's decisions

regarding a student's unsatisfactory performance. When a student accepted responsibility for his

or her actions, participants were more inclined to give them a second chance and to be invested

in helping the student succeed. As David explained:

> …some [students] take right off on the runway and others use the whole runway to take
>
> off and barely make it up over the trees, but you know what, they still made it up into the
>
> air, and they still fly. …What I'm looking for…is attitude or acknowledgement of the
>
> student in these struggling situations, because experience has told me [that student] going
>
> to be successful…

All participants shared the importance of student accountability regarding clinical performance.

In fact, if a student accepted accountability for his or her actions, the program administrator was

more likely to offer the student the opportunity for remediation. It was felt by participants that a

student who was accountable for their actions was more likely to overcome challenges. Bob

expounded on this further:

> They talk about internal and external locus of control. When you got a student that sticks
>
> his chest out, pulls his stomach in, and says, "Just tell me what I need to do," they're
>
> taking responsibility. When you got a student that tells you, "Oh, this is poor pitiful me.

My husband, my kids, my drive, my flat tire, my ... " That's all outside stuff that they are

a victim of, and I'd much rather see the first than the second even if ... I mean really that

kind of stuff happens to all students, and everybody has flats… . Everybody's got those

things, but some people seem to dwell on their powerlessness in the face of these

externals. Other people tend to just step up and say, "You know what? I got obstacles. So

does everybody, and I'm going to surmount them. Just tell me what I need to do to get

through this probation."

Participants recognized that life happens, so to speak, and that students will face obstacles while

in the program. However, the students are already professional registered nurses and are

expected to overcome obstacles and keep things in the right perspective.

In the following example, a student committed a serious and dangerous medication error,

but accepted responsibility for his action and exhibited remorse. This accountability and remorse

weighed substantially in Josh's decision not to dismiss the student, and to require remediation

instead. Josh offered this account:

So I had a student and there was systems issues involved. This was a very good student at

one of the private rotations, the patient was hypotensive, needed ephedrine. He picked up

the vial out of the, they have tackle boxes with the drugs in it. He picked the vial up,

diluted it and gave it as he should have except it wasn't ephedrine, it was epinephrine.

The patient went into V-TAC, had to be shocked and went to the CCU overnight and lots

of hoo rah about that. This kid had just immediately after they got the patient to the ICU

calls me and says, "I need to see you right now." I said, "Fine, I'm here right

now."…Starts crying and explaining what's going on and "I'm so sorry I just about killed

somebody, I don't know if I can do this or not." I mean just totally owning it. That's

somebody who yes of course I had to take disciplinary action on him buts it's not

somebody who needed to be dismissed.

Program administrators value student accountability and are receptive to alternative interventions when the student is honest and remorseful. The ability of the student to understand and reflect on the deficiency in clinical performance informed the decision making by the program administrator, as Mickey went on to say:

Some of the things I would look for is whether or not the student clearly understands the nature of the deficiency that they have. In other words, are they reflective? Are they a reflective provider? Do they learn from their mistakes, and do they accept responsibility, or do they deflect, and do they say, "Well, you know, it's not me. It's the preceptor. It's not me. It's the surgeon. It's not my fault. My wife had a bad night at home last night with me, and it's not my fault." I look for people to accept responsibility, and then to reflect on that, and then move ahead from there.

When a student exhibited unsatisfactory clinical performance, but accepted accountability for his or her actions, the program administrator felt there was some hope for improvement.

Establishing an individualized remediation plan. If a student appeared to accept responsibility, a structured remediation plan focused on improving the student's identified deficiencies was instituted. Participants expressed a desire to be supportive of students. Katie stated: "We try to get the student to buy in very early on that it's not a punitive process. The goal is to make the student better and to get them back into …good standing." Not only did participants want the student to feel supported, they wanted the student to realize that remediation was not punishment. Further, participants wanted the student to understand that the ultimate goal of remediation was improvement in clinical performance and continued

progression in the program. Therefore, an explanation was provided to the student, goals of the remediation plan were outlined, and the progress of the student was tracked. Danielle offered:

> We spell out exactly when we're going to meet, what item or skill or critical thinking that they need to work on, and then we check in with them every two weeks….For example, myself or the clinical coordinator will go over to [hospital]and meet with the clinical preceptor and the student to see how things are going, because we always want to get the student's side of the story about how things are going.

Program administrators were genuinely committed to developing an individualized remediation plan designed to help the student improve on specific deficiencies. The desire for participants to help a student with clinical performance challenges was obvious.

Scheduled meetings and timeline. When a student is placed on a remediation plan or probation, participants emphasized the need to have regularly scheduled meetings with the student to assess the progress in improving clinical performance. In addition, the meetings provided an opportunity to determine if the student sincerely desired to remain in the program. Bob described it this way:

> Well during probation, we sit down with them every week… We require them to have an evaluation not 80% of the time but every day during their probation. They generally are able to come up with that. We look not for an absolute perfect…, but just improvement in those areas that they had trouble with, a sincere desire to stay, and a motivation to do better.

When meeting with a student on a remediation plan, program administrators focused on whether the student showed improvement in the area of concern. In addition, the student's attitude was important as the program administrator wanted to see if the student demonstrated a genuine

commitment to the program. All participants had a specified time period for remediation; however, there was significant variation in the time period allowed ranging from two weeks to a maximum of one academic semester. Some participants such as Bob only allowed one remediation period, and he notified students of this up front. He stated:

> If we put them on probation, [its] four weeks….by policy, we do not allow ourselves to put a student on probation again. If his sins are serious enough, the only remedy is dismissal. And he knows it, and we know it.

Other participants allowed renewal of the remediation period to give the student every opportunity to improve. In response to a question regarding remediation, Katie stated:

> It's only renewed in 30-day increments, so it's 30, then 60, then 90. Within that 30-day period, the student has a lot of stipulations related to kind of enhanced clinical performance expectations. The students are aware that there are certain supervision ratios that are no longer allowed. If a student is in remediation or probation, we want to give them every opportunity to succeed.

While variability in the allotted time for remediation exists, there were very clear rules and policies. Program administrators discussed the importance of establishing a clear timeline for the student to show improvement and to meet the established goals for improving clinical performance. Clearly, the participants wanted to help the student be successful. At the end of the established timeline for remediation, the student's progress was reviewed. As Danielle explained:

> At the end, if they meet the benchmarks that we set up for the remediation, then they will come off the remediation plan and we will say, "You are off remediation, and you've

moved on to this level." Per our handbook, we have other things that feed into that. You

can't be in remediation forever.

Again, the participants emphasized the need to establish and adhere to that timeline in

accordance with the program policy and the need to notify the student of the decision at the end

of the remediation period.

There was a consensus among participants that there should be regularly scheduled

meetings with the student to assess whether there was improvement in the noted area(s) of

deficiency. The established timeline for the student to meet the established goals was likewise

important and therefore emphasized during the scheduled meetings.

Remediation activities. Participants described specific activities that were used to

facilitate improvement for the student on remediation. Such activities included simulation, being

assigned to selected clinical educators, and being assigned to selected clinical sites.

About half of participants included simulation as part of the remediation plan. As Rick

explained, simulation can be very beneficial to students who are struggling with certain skills or

concepts. He offered the following example of how simulation was helpful:

> …bringing them back up to school and having them do skills or simulation labs. If the
>
> student's having trouble placing a spinal or if the student's having trouble with their
>
> overall induction sequence or emergence or whatever, we try to bring them into an
>
> environment where a faculty member such as myself or our assistant program
>
> director…can actually have our own eyes on the student and give the student an objective
>
> evaluation.

Simulation was beneficial for students who needed to practice a particular skill or process. The

simulation lab also provided a controlled and less chaotic environment that the operating room.

85

Penny agreed and explained that certain areas of weakness in skills or knowledge could be identified and improved using simulation. She informs students on remediation:

> …[we need to] .really work closely with you and bring you into simulation lab. And let's work on some of the areas where I'm getting feedback about your weaknesses, some of your technical skills.

Program administrators and faculty members in nurse anesthesia programs are experienced educators and may be more equipped to teach students certain skills than clinical educators. Likewise, Josh found that the use of simulation benefited students who were not meeting expectations and he provided an example of one student, he stated "Once we got him sort of up to speed in the sim lab so that he really could handle those, he went back out to the clinical arena and did great." Simulation proved to be an important modality to foster improvement. In addition, some participants used simulation to directly observe a student who demonstrated unsatisfactory clinical performance and to identify the student's knowledge or skill deficits. Simulation provided the student an opportunity to practice in a safe learning environment.

In addition to the use of simulation, participants relied on selected clinical educators who were not only committed to help the students improve, but also willing to provide accurate and objective evaluation of the student's clinical performance. As Penny stated:

> You know, there are some CRNAs, it doesn't matter who the student is, they think they're the grandest thing that ever walked on the face of the earth. And it could be a student that everybody else is struggling with. The student gets placed with a CRNA and it doesn't matter if you can't do anything right, you're still a great person because they just don't know how to evaluate because they don't want to be the bad guy. So, we do our best to put them with CRNAs who are going to constructively and objectively evaluate them.

Due to the known variability among clinical educators in evaluating students, many program administrators identified certain clinical educators who are willing to provide the program with an accurate and objective evaluation of the student. Rick used the same strategy, but he solicited help from the clinical coordinator as well. He stated:

> Well…we have a pretty standard approach, so what we … have the student do is work with either the clinical coordinator, or a few preceptors that truly have an understanding of what our clinical objectives are for the program. We try to solicit feedback according to those objectives.

When the clinical coordinator or clinical educators were knowledgeable about the expectations and objectives for clinical performance, the feedback provided on the evaluation could be linked back to whether the objectives were met.

The clinical site assignment was also considered important when managing a struggling student; therefore, certain clinical sites were selected for students on a remediation plan. As Bob stated:

> We wouldn't send a student on probation to all of our sites. At some sites, they're a little too loving. You know. I mean, all flowers will grow if given sufficient time, sunlight, and water. And that's their attitude. That's a great attitude, but that's not the attitude that you want in a student that's struggling a little bit. You need some people to be a little more direct and show them the way…Some clinical coordinators are more invested in keeping an eye on students than others. So again, we won't send them just anywhere.

Program administrators selected sites where the clinical coordinator had more of an interest in the student being successful and where the clinical educators as a group recognized the

87

importance of holding the student accountable for meeting the expectations for clinical performance.

When a student who demonstrated unsatisfactory clinical performance showed accountability, various efforts were made to help the student improve. Such efforts included establishing an individual remediation plan, having scheduled meetings during remediation and a timeline, and remediation activities such as simulation and assigning the student to select clinical educators and facilities.

Phase Four: Removing the Student from Clinical Training and Moving to Dismissal

The profession of nursing has long been recognized as one of the most *trusted* professions (Siegel, 2018). Nurse anesthesia is the oldest advanced practice-nursing specialty and for over 150 years, CRNAs have prided themselves on provided high quality, safe anesthesia care. The importance of acting in professional manner and demonstrating integrity is vital for nurse anesthetists who are caring for patients who are vulnerable due to being sedated or unconscious and are, as a result, unable to advocate for themselves. Therefore, phase four includes the following factors that influence the program administrator's decision-making regarding a student's unsatisfactory clinical performance: intolerable unprofessional behavior, being under the influence, and violating the standard of care. These factors are important considerations for program administrators as they represent a threat to patient safety.

Intolerable unprofessional behavior. Although some participants expressed the significance of integrity in students, some described the same concept using an actual example. Josh puts it in the forefront as he stated:

Now there is one thing that truly ... A line that they cannot cross and that is if I ever

catch them in a lie or being dishonest in some way, that will be something that clearly is

indicated as unsatisfactory performance …and, depending on the nature of it, dismissal.

While program administrators would attempt remediation for certain unprofessional behaviors,

dishonesty was not one of them. This same sentiment was shared by Katie and Luna who voiced

intolerance of a dishonest student who falsified a record. Katie provided this example:

So, I had a student who was falsifying her, it was her case tracking log. It was an integrity

issue and professionalism. Clinically, she was also demonstrating some behavior that had

some integrity issues. I guess it was one report, but as soon as we found out, we found

that there was a pattern of behavior unbeknownst to us. That student was immediately

dismissed from the program. She falsified her educational experiences. She also tape-

recorded her preceptors and other staff members in the clinical setting without their

permission. That is a violation of our clinical policy.

Falsification of the record of educational experiences alone indicates that the student is not

trustworthy. The additional concern is that if the student would falsify one record, then he or she

would likely falsify others. Luna experienced a similar issue with a student who falsified her

daily clinical evaluations. She offered:

Another instance would be students that were falsifying documents and that one was a

little more challenging because it was a daily evaluation that they were falsifying and the

site reported that they were wondering why they didn't have evaluations on this student

and I thought it was because we just switched clinical tracking systems and they were

having trouble accessing the daily evaluations. Then when I called the student, the

student admitted he was falsifying documentation.

89

This behavior was considered not only unethical and unprofessional, but also unforgivable in Kathy's view. She added "there's no way to circumvent being unethical." In other words, remediation was not possible for such behaviors. The program administrators did not trust a student who was unethical, lacked integrity, or was dishonest with the care of vulnerable patients.

Being under the influence. There was no tolerance by participants for a student who presented to clinical under the influence of alcohol or drugs. In addition to violation of program policies, this would be a violation of the hospital policies as well as the Board of Nursing for the respective state. A student who is impaired is a clear risk to patient safety. As explained by Rick:

"…. I believe being under the influence of alcohol or drugs, …results in immediate dismissal, as does the refusal to give a drug or alcohol test when you're requested to do so." If there was a suspicion that a student was under the influence, a blood or urine test would be required and if refused by the student it would result in dismissal as well.

Although immediate dismissal of a student was described as a rare event, participants agreed that being under the influence was one of the extreme situations that warranted immediate dismissal. Mickey goes on to say:

> …Very rarely is a student dismissed immediately, unless it's something of a very, very critical nature. If they don't come in on time sober. If there's something along those lines…Again, we've had substance issues, and I had a student with a substance issue. We dismissed the student from the program.

Being under the influence not only poses a serious risk to the patient; but the program administrator is also concerned that the student may have a substance abuse disorder. There is a

high incidence of substance abuse among anesthesia due in part to stress and the availability of controlled drugs in the workplace (Wright, McGuiness, Moneyham, Schumacher, Zwerling, & Stullengarger, 2012). If substance abuse disorder is not recognized and treated, it can be fatal (Wright, et al., 2012). Therefore, being under the influence resulted in immediately removing the student from patient care and following the institutional policies.

      Violating the standard of care. The American Association of Nurse Anesthetists (AANA) professional standards guide the practice of nurse anesthesia and nurse anesthetists are required to adhere to these standards (AANA, 2019). The COA standards require that nurse anesthesia programs demonstrate how their curriculum aligns with the standards and how graduates demonstrate adherence to the standards (COA, 2018). Penny enlightens us with a description of an actual student who clearly violated the standard of care by breaching sterile technique on a patient undergoing open-heart surgery. This behavior threatened the safety of the patient and resulted in a recommendation for dismissal. Penny said:

> Let me give you an example, he [student] was putting in a central line, in the operating room, before a heart case… the patient was already draped. The heart surgeon is standing behind them, of course, tapping his foot… and he [the student] was not a novice in this. But, he was also was a very… cavalier kind of person. So he's gowned and gloved and he reached up and instead of having someone remove the sheath…covering the central line, he put it up in his mouth over his mask. He had his mask on and his sterile gloves…and removed it like that….a breach in the standard....unprofessional. He did little things all the time that were just not quite bad enough…. This was the straw that broke the camel's back. He was done. He was dismissed from the program.

A breach in sterile technique during placement of a central venous catheter poses a serious risk of infection in the patient. Blatantly disregarding the standard of care is egregious and demonstrates total disregard for the patient's well-being. Therefore, it is also one of the extreme situations that resulted in dismissal without attempt at remediation. Other participants shared similar stories of a student who violated the standard of care. Mickey stated:

> We had a student who was not attentive, and it was noted that the student was not attentive, was very talkative around the operating room, and just did not have good situation awareness, and made a couple of minor drug errors. But then on one occasion, …we were using Forane [anesthetic gas] at the time, and when the preceptor came back into the room, the student was not paying attention, had left the vaporizer on 4%, and the patient's blood pressure was in the 60s. It was a very dangerous situation. Luckily, nothing happened to the patient, but again, it caused quite a commotion. The student was immediately dismissed from the clinical site, and sent back to our department, and then went through due process here and was recommended for dismissal.

Although there can be numerous distractions in the operating room ranging from music to conversations, the AANA standards require vigilance in monitoring the patient. The student in this example made a dangerous medication error, which was not the first medication error, therefore, this student was dismissed. In a similar example, Katie described a student who violated the standard of care regarding medication administration. This was one of many concerns regarding this student's safety and lack of improvement despite remediation. This led to her decision to dismiss the student. She stated:

> If a student fails out of the clinical portion of the program or is dismissed or not obtaining clinical competencies, it usually will boil down to either safety and/or integrity. A clinical

failure, for us, has been one that's unsafe and they are unsafe repeatedly for that level.

Despite remediation, despite us working with them, despite preceptor intervention, the

student might make frequent mistakes. I had a student who had 5-6 errors and just could

not keep up. Pushed inappropriate medication. Really jeopardized patient safety and was

… a clinical dismissal.

When a student has been afforded the opportunity to remediate, yet continues the same type of

errors that violate the standard of care continue, the program administrator is left with no other

choice than to dismiss the student. As Katie added:

I had another student who was a failure in that she broke the standards of care repeatedly.

She would put patients to sleep without a pulse ox [oxygen saturation monitor] being

audible or even on, the EKG leads weren't on. It's one thing if it just happens one time,

but then it began a pattern to where we believed that after working with her she was

unsafe. She ended up being dismissed.

As mentioned previously, even though one issue or clinical error may be considered

unsatisfactory, program administrators were open to working with the student to improve

through a remediation plan. However, when a pattern of behavior existed, especially after

remediation, the student was considered unsafe and participants moved to dismissal. Mickey

stated:

Usually, the dismissals result from repeated errors of the same type. On a rare occasion,

we have gone immediately to a dismissal, but it's usually something that compromises

patients' safety or whatever…Just about every time we've ever had to dismiss a student is

where we've had students…who have had deficiencies in several areas. We will put them

on probation. We'll then send them to one or two different clinical sites, and when the

same deficiencies occur again, then it goes back to that committee and they say, "They're

just not getting any better." Some of them are related to judgment. Usually it comes down

to …they just don't get the big picture. It's issues of judgment.

Repeating the same type of error despite the program's attempts at remediation resulted in

dismissal. In addition, if the student had poor clinical judgement or decision-making, or failed to

consider everything going on from the operative standpoint, this compromised patient safety and

often led to dismissal.

Adherence to the AANA professional standards is a requirement for nurse anesthesia

students to protect patient safety. Violations of the standards has legal implications for the

student, the program, and the clinical site. Therefore, violations of the professional standards are

factored into decision making by the program administrator. At times, this behavior eliminated

the offer of remediation, and led to immediate dismissal.

The safety of patients weighed heavily in the decision making of program administrators

regarding a student who has exhibited unsatisfactory clinical performance. Participants

described behaviors that result in dismissal of a student from clinical training and ultimately the

nurse anesthesia program including, intolerable unprofessional behavior, being under the

influence, violating professional standards, and failed remediation. The program administrator

has a duty to uphold the integrity of the nurse anesthesia profession and therefore, must

sometimes make the decision to dismiss a student who is a threat to patient safety.

Phase Five: Notifying the Student of the Decision

When a student exhibited unsatisfactory clinical performance and the program

administrator determined that an intervention was warranted, the student was first notified when

the program administrator was validating the concern. If a remediation plan was instituted, the

student was involved in the planning process. If the program administrator's decision was to move to dismiss the student, the student was notified that they would be removed from clinical training and that institutional and program policies would be followed. If the final decision was to dismiss the student from the program, the student was notified of that decision. As Penny described talking to a student about impending dismissal:

…This [was] your remediation plan, you haven't followed this. We are now concerned that you're not going to be successful in this semester…and we have a third witness in [the room]... I never talk to student alone when I'm talking to them about… a high likelihood of dismissal… So there is a process and it's a very formal process.

Guiding Principle: Following Institutional and Program Policies

The importance of having strong institutional and program policies regarding clinical performance was voiced by all participants. Program administrators described how they careful followed institutional and program policies when faced with challenging student issues. Such policies were considered by participants to be important not only for the protection of the institution, but also to protect the rights of the student. As Rick stated:

I think having good policies and procedures are important, not only for the administrative route, but also for everyone involved, including the students. I mean, I think the student has a right to see what processes and policies are being followed and that's important when it comes to due process as well.

As discussed by all participants, students were made aware of the policies using multiple modalities. Obviously, there were some variations in the policies among programs. While no program allowed for immediate dismissal from the program, all program administrators had the authority to immediately dismiss a student from clinical training to protect patient safety while

the steps in the policy were being followed. This afforded time for due process proceedings to occur and to determine the ultimate fate of the student. A panel typically made this type of decision. Participants valued and adhered to the policies, which included documenting all events and meetings with the student and/or clinical site leading up to a dismissal hearing if applicable. As Penny stated:

> I think we have our policies pretty well laid out. We document everything, every conversation we have with a student. Of course, we have all of our clinical evaluations. We document discussions that faculty have about the students in a clinical evaluation committee meeting.

Strict adherence to policies and procedures and thorough documentation was considered essential throughout the process. In addition, program administrators referred to the policies to guide their decision-making. For example, in response to a question about how institutional policies influenced his decision-making, Josh stated:

> I think in a good way…I do believe that what they do that is helpful is knowing what due process is down the road and how that's going to play out, makes you be careful that the decision you're making now would withstand those future processes…I think about things like what kind of documentation do I have, is it solid enough to support this, if I were an outsider listening to this on an appeal would I come to the same conclusion.

All participants repeatedly expressed the need for thorough documentation when making a difficult decision about a student's ability to progress in a nurse anesthesia program. Some participants also deemed gaining administrative support early in the process necessary. Bob provided this humorous but sincere example:

I'm perfectly willing to climb the tree, to climb out on the branch, to saw the branch off, but I want a nice fluffy pile of paper underneath me when I hit the ground. The place can get sued for the types of decisions that we ordinarily have to make, so to me that means that it is a corporate decision. I wouldn't make the final decision to dismiss without sitting down with my dean and showing him the four weekly summary evaluations written during the probationary period, describe to him what's going on. Maybe there's something there that I'm not seeing. Maybe …I'm not being thoroughly objective…..
And he's the person that doesn't know this student from Adam, that looks at our documentation and says, "Yes, it's a go," in almost all cases. I mean, they don't question our ability to discern good versus not so good performance, and I feel like that's a good housekeeping seal of approval.

Although such decisions are difficult, participants recognized that it was their responsibility to dismiss a student who was a threat to patient safety. However, program administrators valued the Dean's opinion and guidance and sometimes used the Dean as a sounding board during the process. Josh added: "If I have any doubt about those things then I may go talk to the Dean and say here's what I want to do and here's what I'm thinking." Having the administrative support gave participants confidence that they were making the right decision.

Program administrators expressed the importance of having institutional and program policies in place regarding students who exhibit unsatisfactory clinical performance. Strict adherence to such policies and thorough documentation were equally important. In the event of an adverse decision, such as dismissal from the program, the policies ensured the student was afforded due process.

Additional Findings

During the interviews, additional findings were considered noteworthy by the researcher because participants described them as challenges they face when students are not meeting clinical expectations. There was a somewhat consistent theme regarding hesitancy on the part of clinical educator to provide written documentation of unsatisfactory clinical performance because he or she did not want to be responsible for the student failing. In addition, participants described personality conflicts between students and clinical educators that influenced the objectivity of the clinical evaluation.

Clinical Educators Avoidance of Documenting Performance

Several participants described a challenge in obtaining any written documentation from the clinical educators when a student was not meeting expectations. Without written documentation, participants felt their hands were tied and this delayed them in making a decision of remediation or dismissal. As Katie noted:

> There is hesitancy for preceptors [clinical educators] to complete evaluations. I think with the litigious society that live in, a lot of preceptors have heard of complaints, grievances, appeals, whatever, with students and either faculty or preceptors…… They don't want to tell us, or they'll say it but they won't write it. They don't want to be "the one" to get the student in trouble or get them kicked out. They see it as more the evaluation can be used against them, versus used to help them.

When the clinical educator does not notify the program administrator of a concern regarding a student's clinical performance, the concerning behaviors are allowed to continue as neither the student nor the program administrator are aware of the problem. Participants expressed the need to receive concerns about a student's clinical performance in writing. Luna spoke of a student

who she received verbal notification of safety concerns by clinical educators, but the written documentation was not provided. Therefore, she had to send the student to another site, which delayed action. She stated:

> At this point, I'm like I don't know where we're at, but documentation wise it does not support a failure at this point in time…I'm not comfortable graduating her, so we're going to send her to another clinical site…the documentation has to be consistent and without documentation, I'm hung out to dry...

Undoubtedly, participants were concerned about having a student progress in the program who was not meeting expectations for clinical performance. However, the written documentation is necessary to support the program administrator's decision.

Program administrators rely on clinical educators to inform them of any concerns about a student's ability to provide safe care. Participants expressed challenges in communicating directly with clinical educators to emphasize the importance of written documentation clinical performance, especially if when concerns about clinical performance exist. Participants felt that some clinical educators were reluctant to provide a negative evaluation of a student due to the fear of litigation, or being responsible for a student failing or being dismissed

Personality Conflicts

Participants described issues related to incompatibility of a clinical educator and a student that posed a problem in clinical education and evaluation. In simple terms, personality conflicts existed and affected program administrator decision making. As Bob explained:

> If there's a personality conflict, we won't necessarily throw them back in that until they emerge bloody and dead or unscathed. So we won't necessarily insist, but on the other

hand, they don't have to work with people they don't like when I don't have to work with

people I don't like.

Participants expected that because the students in a nurse anesthesia program have worked as

registered nurses in intensive care units, they had experience in working with difficult people or

someone they may not like. Further, participants, like all of us, have to work with people they

don't necessarily like, because it is reality. Bob went on to say that although he listened to

student concerns related to personal conflicts, the student needed to be realistic. He added: "So

we don't force them into situations that they are terribly uncomfortable with. At the same time,

we don't let them skate and just work with people that are going to buy them chocolates for

lunch." In essence, if working with a particular clinical educator truly made the student

uncomfortable, the program administrator did not force the student to be assigned to that person.

However, the student could not just avoid working with a clinical educator just because it was

more challenging. Danielle provided an example of a personality conflict that resulted from a

previous relationship between a student and a clinical educator. She offered:

> I have a student that we relocated because of a past significant other issue at a clinical
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> site, the student is a great student, but it was just a personality problem with them being
>
> there together, and one potentially supervising the other, and I couldn't allow that to
>
> happen, so I had to move the student.

There was a concern that the existence of a prior relationship was a conflict that could influence

either the student's clinical performance, or the clinical educator's evaluation because of the

potential for bias.

While personality conflicts are common in any profession or job setting, in the operating

room, taking care of the patient must be primary concern. Program administrators were

supportive of students who may be over-sensitive or feel bullied by the clinical educator, but also felt that students must be mature enough to work through some inherent conflicts. Participants described the existence of somewhat mean-spirited clinical educators who may be hypercritical and expressed the need to carefully consider negative evaluations by those clinical educators.

Summary of Findings

This grounded theory study examined the decision-making process of nurse anesthesia program administrators regarding whether a student's unsatisfactory clinical performance warranted intervention by the program. Important to the decision-making process was how clinical educators ranked the clinical performance of students who were not meeting expectations. In the interviews, participants described three ranking of clinical performance that influenced their decision-making: borderline, unsatisfactory, and unsafe. A five-phase process emerged that was grounded in data: receiving the feedback; validating the concern; assessing student accountability and planning for remediation; removing the student from clinical training and moving to dismissal; and notifying the student of the decision. There is a possibility that phase three would be bypassed depending on the student's behaviors. The central focus of the entire five-phase process is following institutional and program policies.

Though program administrators felt an obligation to help a struggling student improve clinical performance, they also believed it was their duty to protect the integrity of the profession. Therefore, when there was threat to patient safety, a remediation plan was instituted. If the student did not improve with remediation, he or she was ultimately dismissed from the program. There were extreme cases when remediation was not attempted such as when the student demonstrated flagrant unprofessionalism, a lack of integrity, or impairment. Instead, the

101

student was dismissed from clinical training and the program administrator moved to dismiss the student from program following the institutional policies.

CHAPTER FIVE

Discussion

This grounded theory study examined the decision-making process of nurse anesthesia program administrators regarding unsatisfactory clinical performance of nurse anesthesia students. One of the primary goals for the nurse anesthesia program administrator is to produce highly trained nurse anesthetists prepared for clinical practice. Mishaps in anesthesia practice are typically associated with significant injury and/or death. Therefore, unsafe or underperforming students pose an immediate risk to patient safety as well as a future risk if allowed to progress to clinical practice (Killam, et. al. 2011). When student clinical performance and professional demeanor fall below the expected level, the program administrator faces the challenge of deciding whether to attempt remediation or move to dismissal from the program (Wren & Wren, 1999). However, the current lack of guidance for program administrators regarding how to manage nurse anesthesia students who do not perform satisfactorily in clinical is a major concern and was the impetus for this research study.

The research question that guided this study was: W*hat is the decision-making process of a nurse anesthesia program administrator in determining interventions for unsatisfactory clinical performance by a student?* This study provides insight regarding what constitutes unsatisfactory behavior for nurse anesthesia students in the clinical area, what specific student behaviors prompt the program administrator to first attempt remediation, and what specific behaviors are not tolerable and may warrant dismissal from a nurse anesthesia program.

Summary of Findings

This chapter begins with a summary of findings of this study including a discussion of the theoretical model derived from the data collected. Next, the findings are situated in the

existing literature and to Path-Goal theory, the theoretical framework that guided this study. Lastly, recommendations for programs, practice and research are discussed followed by a conclusion.

Nurses Anesthesia Program Administrator Decision-Making Model

The theoretical model derived from this study, *The Nurse Anesthesia Program Administrator's Decision-Making Model* (figure 4.1), depicts the decision-making process of nurse anesthesia program administrators regarding their response to a student who exhibits unsatisfactory clinical performance. This model shows a five-phase process that begins with R*eceiving the Feedback* and ends with *Notifying the Student of the Decision*. The guiding principle of the entire process is following institutional and program policies. The third phase, *Assessing Accountability and Planning for Remediation*, may be bypassed if the student behavior was egregious per the policies. In addition, if the student was unsuccessful in remediation, they would move to Phase 4, *Removing the Student from Clinical Training and Moving to Dismissal*.

Phase one, *Receiving the Feedback*, begins when the program administrator receives feedback from a clinical educator or clinical coordinator that a student is not meeting expectations for clinical performance. It is important that the feedback from the clinical educator is accurate, objective, and timely to alert the program administrator to a potential problem. In phase two, *Validating the Concern*, the program administrator validates the feedback received from the clinical educator. This includes the program administrator hearing both sides of the story (the student and the clinical educator), determining the objectivity of the evaluation and the gravity of the situation, and examining whether the student's unsatisfactory clinical performance was a one-time issue, or a pattern of behavior. Phase three*, Assessing Accountability and Planning for Remediation*, is based on the surprisingly uniform approaches used by program

104

administrators to manage students that exhibit unsatisfactory performance. Such approaches

include, determining whether the student is accountable, developing an individualized

remediation plan and timeline, meeting with the student at scheduled times, using simulation,

observing the student in clinical firsthand, and selecting certain clinical educators to objectively

evaluate the student. The fourth phase, *Removing the Student from Clinical Training and*

Moving to Dismissal, reflects the program administrator's responsibility to uphold the integrity

of the nurse anesthesia profession and protect patients from harm, including dismissal of a

student who is deemed a threat to patient safety. The fifth and final phase, *Notifying the Student*

of the Decision, closes the loop in the decision-making process as the student is informed of any

future steps, including remediation or dismissal. The guiding principle of the entire decision-

making process of a program administrator faced with issues of unsatisfactory clinical

performance is *Following Institutional and Program Policies.* Such policies guide decision-

making and have legal implications that require strong documentation as well as evidence of due

process for the student. Ultimately, policies guide the process, and serve as a reference to both

the program administrator and the student.

Research Findings in Context

The comparison of the findings of this study with the existing literature yielded some

noteworthy similarities and differences. There were many similarities between what participants

revealed during their interviews and the current literature related to unsatisfactory clinical

performance that is focused primarily on nursing students, medical students, and residents. The

interviews with participants revealed the complexity of the decision-making process of a nurse

anesthesia program administrator regarding a student's unsatisfactory clinical performance that

adds a new perspective and insight to the current literature. In addition, participants provided

definitions of clinical behaviors in the context of anesthesia practice that are foundational to the decision-making process.

Clinical Expectations and Evaluation

Nurse anesthesia program administrators are responsible for ensuring that nurse anesthesia students acquire the knowledge, skills and abilities for entry into practice, which requires consistent and accurate evaluation of clinical performance. Research shows that in the education of various healthcare professions, there are some students who encounter difficulty in meeting professional standards requiring remediation, or dismissal (Brown, et al., 2007; Conran, et al., 2018; Duffy, 2013; Earle-Foley, et al., 2012; Jervis & Tilki, 2011; Killam, et al., 2011;Teeter, 2005;). The participants in this study revealed significant challenges with identifying, evaluating and managing students exhibiting unsatisfactory clinical performance (Duffy, 2013; Earle-Foley, et al., 2012; Jervis & Tilki, 2011; Killam, et al., 2011; Teeter, 2005). Participants also referenced personal, legal, and ethical dilemmas related to decisions involving unsatisfactory clinical performance that was consistent with the current literature (Earle-Foley, et al., 2012, Teeter, 2005), which were further complicated when clinical evaluations lacked objectivity, quality, and timeliness. Many participants had difficulty getting the clinical educators to complete an evaluation. Penny stated: "I can't make the [clinical educator] fill out the evaluation" and Sally added: "Sometimes you can hand a [clinical educator] an evaluation and they don't fill it out." University and program policies regarding clinical evaluation are extremely important when a student is not meeting expectations for clinical performance, as is the need for a process to manage underperforming students (Christensen, 2006; Gallant, MacDonald, & Higuchi, 2006).

The existing literature revealed some inconsistencies and overlap in the definitions of borderline and unsatisfactory clinical performance and this was evident in the participant's responses (Scanlan, et al., 2001; Schenarts & Langenfeld, 2017). However, there was clear consensus among participants in defining unsafe clinical performance, which aligned with the findings in the literature.

Borderline clinical performance was described by participants as the most difficult to assess and manage due to inconsistencies. This finding was similar to Killam, et al., (2010) who noted that assessing clinical performance in borderline students is not straightforward and decisions are often delayed by not knowing how to proceed. Sally said:

> Borderline clinical performance…That's the hardest student, because the incompetent
>
> student, where patient safety is an issue, it's very clear. With the borderline student, you
>
> are getting the report from maybe one or two CRNAs, every so often.

Participants described the importance of addressing concerns with borderline students as soon as possible to facilitate improvement. Such, timely communication with students facilitated a move toward satisfactory performance.

The definition of *unsatisfactory* clinical performance covered a broad spectrum in the literature, as well as in the findings in this study that ranged from *borderline* to *unsafe*. The student factors most commonly resulting in an unsatisfactory evaluation included: poor communication (written and verbal), unsafe medication administration, inability to prioritize patient care, and lack of preparedness (Brown et al., 2007; DeBrew & Lewallen, 2014). Participants' defined *unsatisfactory* clinical performance as not meeting expectations for clinical performance, but other behaviors they considered as unsatisfactory included anything from tardiness, medication errors, and unprofessionalism. The majority of unsatisfactory behaviors

resulted in remediation. In some instances, *unsafe* was folded into comments regarding the *unsatisfactory* rating. Participant responses clearly labeled unsafe behaviors as *unsatisfactory*; however, not all *unsatisfactory* behaviors were considered *unsafe* (Table 5.1). This prompted the researcher to separate the terms during interviews, asking for a specific definition of *unsafe*. Participants provided similar examples of unsatisfactory performance. Penny offered:

> Some of this too has to do with attitude…unsatisfactory behaviors are just not being
>
> prepared, not reading for your case, not having a… plan… having some sense of these
>
> are the complications that I've read about that can happen in this case.

The definition of *unsafe* clinical behavior by participants aligned with established research. *Unsafe* clinical behavior was defined by participants as follows: a threat to patient safety, a lack of integrity, violating professional standards, falsification of records, lying, and not being accountable for actions (see Table 5.1 below). This is consistent with the definition of unsafe behavior that is commonly referred to in the literature by Scanlan et al., (2001) "behavior that places the client or staff in either physical jeopardy… or emotional jeopardy" (p. 26). In addition, unprofessional behaviors such as dishonesty, being disrespectful, lying to a clinical educator, hiding mistakes, or lacking accountability, and covering up mistakes, constitute unsafe clinical performance (Brown et al., 2007; Killam, et al., 2010; Luhanga et al., 2008). Violations of professional standards and expectations are associated with a student being considered unsafe in clinical (Christensen, 2016; Killam et al, 2010). Further, noteworthy is the fact that rarely would one clinical error or issue be considered unsafe. Sally noted:

> ... You can't just have one med error….that's involving patient safety, and so now this
>
> student is [unsafe} and a failure and we're going to ask for dismissal. They (students)

have to demonstrate a pattern of not being safe with the patient. Patterns would have to be established.

Table 5.1 **Unsatisfactory versus Unsafe Clinical Performance**	
Unsatisfactory Clinical Performance	*Unsafe Clinical Performance*
Not meeting expectations	Lack of Accountability for clinical performance
Late	Pattern of clinical errors
Unprepared	Lack of Integrity
Medication Errors	Dishonesty; falsification of records
Skill or Knowledge Deficit	Under the influence
	Threat to Patient Safety
	Unprofessional communication or conduct

A concept that was apparent in the participant responses that was consistent with the literature (Cleland, et al., 2013; Gallant, et al. 2006), was the belief that when a student exhibits unsatisfactory clinical behavior, the program administrator would attempt remediation. However, if the behavior was considered unsafe, the program administrator moved to dismissal. Table 5.1 above differentiates unsatisfactory and unsafe clinical performance.

Phase One: Receiving the Feedback

Receiving timely, written feedback on the clinical evaluation from the clinical educator when a student is not meeting expectations is critical to the decision making of the program administrator as it allows the opportunity to remediate a student if deemed appropriate (Garside & Nhemachena, 2013). However, as voiced by the participants and supported by the literature, clinical educators are often reluctant to document poor performance for fear of litigation, or that

such documentation may result in the student failing a course or being dismissed from a program (Dudek, et al., 2005; Earle-Foley, et al, 2012; Irby & Millam, 1989; Killam, et al., 2011; Luhanga, et al., 2008). Further, clinical educators may question their ability to evaluate the student and are uncertain about what to document (Dudek, et al., 2005; Earle-Foley, et al., 2012). Therefore, often clinical educators afford students the benefit of the doubt when they are not performing at an expected level, unless there is clear evidence that they are unsafe (DeBrew & Lewallen, 2014).

A concern voiced by participants is that clinical educators for nurse anesthesia students change daily. So, if multiple clinical educators are working with one student, and none of them reports clinical concerns, a pattern of poor behavior may go unrecognized and obscure a safety concern. Consistent with the findings of other research, when the program administrator is not made aware of unsatisfactory clinical performance, the student may be allowed to progress and even graduate, posing a threat to patient safety (Christensen, 2016; Killam et al., 2010; DeBrew & Lewallen, 2014). Furthermore, the program administrators rely on the feedback from the clinical evaluation to make an informed and timely decision on student progression status and whether the student should be provided an opportunity to improve. In order to improve the clinical supervision and evaluation of students, education for clinical educators on the importance of their role and their responsibility to provide feedback to the student and the program is needed. This is challenging given the number of clinical educators, however exploring different platforms or venues to provide such education would be worth the effort.

Phase Two: Validating the Concern

Participants agreed that a negative evaluation of clinical performance requires validation in context to ensure that the student was treated fairly. This is consistent with the current

literature, which emphasizes the importance of understanding the student's perspective and clarifying the situation with the student (Teeter, 2005), as well as analyzing the context of the situation and the type of behavior that occurred (Tanicala et al., 2011). Program administrators listed a variety of approaches used to validate the concern including directly observing the student and getting a consensus from other clinical educators to determine if in fact, the student's performance was not satisfactory. Sally stated:

> We are pretty quick… if an issue is identified and we feel it's a patient safety issue. We'll probably call that student wherever they are… and ask them to come back to their home base here. Then, we sit down with the student and get their side of the story, and try to come to an agreement with… is this truly a problem or not? If it is a problem, we keep the student out of clinical until we develop a remediation plan.

The inconsistencies among clinical educators in evaluating the clinical performance of students reported by participants posed a challenge in determining what, if any, intervention is needed. These findings are related to existing studies that found similar issues related to inconsistent evaluations by clinical educators (Dudek, et al. 2005; Jervis & Tilki, 2011; Scanlan, et al. 2001; Tanicala et al. 2011).

In fact, some clinical educators were described as hypercritical while others were described as easy because they give every student a great evaluation regardless of the performance (Luhanga, et al. 2008; Van Wormer, 2009). This concern is the basis for having selected clinical educators to work with the student or having a faculty member directly observe the student in clinical. Numerous factors influence decisions regarding a student's performance in the clinical setting and such decisions are rarely concrete, thus the need to investigate reported concerns (DeBrew & Lewallen, 2014; Gallant, et al. 2007; Killam, et al., 2010).

Phase Three: Assessing Accountability and Planning for Remediation

Managing a student with unsatisfactory clinical performance poses a definite challenge for nurse anesthesia program administrators. Research supports the need to intervene early in such situations to improve the student's chance of success (Cleland, et al., 2013; Gallant, et al., 2006). Program administrators respect the fact that almost all students will make a mistake at some point and that it is important to allow students to learn from their mistakes. Further, when a student accepts accountability for his or her action, participants were more inclined to offer the student a chance to remediate. The management of students who were underperforming in clinical were similar to approaches described in the existing literature (Brown, et al. 2007; Cleland, et al. 2013; Gallant, et al. 2006; Teeter, 2005). The following steps were taken: determining student accountability, development of an individualized remediation plan, scheduled meetings and a timeline, remediation activities including simulation, and assigning the student to selected clinical educators or a clinical site. These approaches are similar to a student-centered remediation process for nursing students proposed by Gallant, et al., (2006) which included meeting with the student, developing learning goals and a learning contract that detail performance concerns and a timeline for showing improvement. Evidence suggests that all participants genuinely wanted students to be successful. David stated:

> … We are humans, we do make mistakes, so we do try to work with somebody….Usually, we give multiple chances. There isn't just one big smoking gun item that will lead immediately to dismissal…It usually leads to that probation, and then on from there.

Participants consistently spoke of the need to afford the student opportunities to improve performance.

Phase Four: Removing the Student from Clinical Training and Moving to Dismissal

The participants were proud of their profession and committed to ensuring that patient safety, as well as the integrity of the profession, was protected. These findings are consistent with literature that supports the expectations for nurse educators to protect patients from the potential of a student causing harm in the clinical setting (Tanicala, et al. (2011). The professional standards for nurse anesthetists serve as credible evidence of the profession's commitment to safe, quality care for patients (Christensen, 2016; Tunajek, 2006); therefore, participants considered violations of these standards as unsafe. Allowing students who provide unsafe care to continue in a nurse anesthesia or other health profession educational program threatens patient safety as well as professional integrity (Earle-Foley, et al., 2012). David stated:

> If someone is unsafe, ultimately as program director [administrator] I am the gatekeeper
> to the public, and I cannot graduate an unsafe practitioner. I cannot allow an unsafe
> practitioner to keep practicing.

Participants voiced the need to dismiss a student who demonstrated unsafe clinical performance (Table 5.1) and this was aligned with the existing literature in other healthcare disciplines. For example, Capozzi and Rhodes (2005), recommended dismissal for physician residents who exhibited unprofessional behavior or character deficiencies such as having a disregard for patient safely, falsifying records, or failing to care for patients. In fact, in physician residency programs, preventing harm to patients was the main reason for dismissal of a student, and professional regulation was the second most common reason for dismissal (Capozzi & Rhodes, 2005). This likely explains the reason program administrators felt obligated to take measures to ensure the safety of current and future patients, as not doing so undermines the societal trust placed in the profession (Capozzi & Rhodes, 2005; Earle-Foley, et al., 2012).

Phase Five: *Notifying the Student of the Decision*

This final phase of the decision-making model indicates the importance of notifying the

student of the decision following the policies of the institution and the program. This meeting is

a formal part of the process and it is recommended that the program administrator not meet with

the student alone (Brown, et al. 2007). Having two people in the room allows one person to

speak to the student while the other person documents the discussion (Schenarts & Langefeld,

2017). During this meeting, the student is informed of the reasons for the decision, his or her

rights regarding due process, and the options for appealing the decision (Christensen, 2016;

Schenarts & Langenfeld, 2017).

Guiding Principle: Following Institutional and Program Policies

Program administrators faced with decisions regarding student progression depend on the

institution to have solid policies to guide them through the process and to protect them in the

face of litigation. This includes careful attention to ensuring that written documentation supports

decisions made related to unsatisfactory clinical performance as well as fair treatment for the

student. This aligns with the existing literature that explains that the courts will typically uphold

the decision to dismiss a student due to poor clinical performance when there was a thorough

review of the record, institutional policies were followed, and the student was afforded due

process (Conran, et al., 2018; Kaplin & Lee, 2014). Further, the courts have historically deferred

to the academic judgment of faculty and have demonstrated appreciation for the challenges faced

by faculty (Kaplin & Lee, 2014). David explained the importance of written policies and

procedures:

> Whenever we get on that road towards even remediation, we have that all these spelled
>
> out in the student handbook, in our policies and procedures for our program that are in

line with what the institution has as well. So, we follow what is in the policies… We are

the ones who *decide* about probation [remediation], but we do exactly what the policy

says…In the past [we had] a student [who] was dismissed from the program and then re-

instituted in the program by the dean, because the dean thought that the policy was not

followed…[This]… then lead to some issues in the program…preceptors [clinical

educators] refused to work with this unsafe practitioner, and … [the behaviors]

continued, so… [the student was dismissed] a second time…So yes, the policies

absolutely dictate what we do.

All other participants shared similar examples and emphasized the importance of having strong

institutional and program policies in place and strictly adhering to those policies.

Additional Influences of Program Administrator Decision-Making

It was evident in the participants' responses that the decision-making process of a nurse

anesthesia program administrator regarding a student exhibiting unsatisfactory clinical

performance was guided by institutional and program policies. However, equally as evident was

that individual program administrator's do not just rely on written policies. A number of

variables influence the program administrator's decision making which are not captured in

written policies. Such variables may include personal challenges the student is facing and the

context of the situation where the concerning behavior occurred. It is the responsibility of the

program administrator to interpret the student's behavior based on the clinical evaluation or a

composite of clinical evaluations, to determine whether the student was or was not meeting

expectations for clinical performance, and to decide on whether an intervention is warranted.

Connection to Theory

Path-Goal theory is a leadership theory that is concerned with how a leader influences a subordinate's perceptions of work goals, personal goals, and paths to achieving those goals (House, 1971). This theory is a process by which leaders select specific behaviors suited to the needs of particular followers and the working environment to provide motivation for goal achievement (Clark, 2016). Historically, Path-Goal theory has been used to inform studies related to organizational leadership and effectiveness. However, Ani, et al. (2017), described the application of Path-Goal theory in nursing education, research, practice, and administration. As applied in nursing education, "Path-Goal theory promises enhanced learning outcomes and effective mentorship," which pave the way for nurses to be successful in their academic program, and beyond that in actual clinical practice (Ani, 2017, p. 95). This is relevant to nurse anesthesia students given that nurse anesthesia education builds on prior nursing education and experience.

Path-Goal theory was applied to this study, which aided in developing interview questions that focused on the processes used by program administrators regarding interventions for a student with unsatisfactory performance and adaption of leader behaviors to meet the needs of the student. In the interviews, participants indirectly described using each of the four leadership behaviors that comprise the Path-Goal theory: directive, supportive, participative, and achievement-oriented at different stages of the decision-making process, depending on the individual student.

This study was a new application for Path-Goal theory; however, the findings of this research clearly support its use as program administrators adapted their leadership style, behavior, or response to motivate struggling nurse anesthesia students to improve clinical performance (Lussier & Achua, 2007). This theory was chosen because it applies to many

116

aspects of the program administrator's role in motivating and supporting all students and addresses the reciprocal influence of the program administrator and the student. Participants described different situations when a student was not performing satisfactorily in clinical and how they adapted their leadership style to address the individual needs of the student relevant to the situation. A description of each of the leadership behaviors and supporting examples are included below.

Directive

The directive leader behavior is authoritative and provides clarification of the desired expectations based on performance standards and policies. Program administrators assume the directive leadership style by clearly defining and communicating program and institutional policies, expectations for clinical performance, and professional conduct in the clinical setting, and the consequences a student may face is such expectations are not met (Ani et al., 2017; Christensen, 2016; Mulki, et al., 2009). Josh stated that he meets with students and "I literally go through all of the policies and procedures and definitely set the expectations." Rick went a step further and described his role in enforcing the policies: "I see my role as the administrator in making sure that they follow the rules and the policies of the program." All participants noted the importance of clear and direct communication to students regarding program policies.

Supportive

Supportive leadership involves the leader creating a supportive and friendly environment by incorporating subordinate suggestions in decision-making. Nurse anesthesia students often experience personal challenges that affect academic and clinical performance (Ani, et al., 2017; Burns et al., 2006; Christensen, 2016). David provided this example of adapting his leadership behavior in support of a student:

117

I think in students that are struggling, the role [of the program administrator] goes a little

beyond just mentor to kind of problem solver, trying to figure out why the student is

struggling, what extra resources they need, which is something that not all students are

going to need…So depending on the situation, I can be giving encouragement...

Sometimes it's really to help figure out what is best for a student…Because sometimes

life occurs, and you know what, school isn't slowing down so how can we best adapt

things for the student to be able to continue on to achieve their dream.

This commitment to supporting a student was shared by Danielle who added:

…When they're so distressed by a personal event you don't want to distress them more. It

can be very, very difficult to walk that line…I feel it's my responsibility to support them,

and get them through.

Participants wanted to know if there was anything going on with the student personally

that would influence the clinical performance and sought out additional resources to support the

student if necessary, including counseling services.

Participative

Participative leader behavior is a combination of directive and supportive behaviors (Ani

et al., 2017). Specifically, the participative leader includes subordinates in planning and decision

making to promote the subordinate's acceptance of responsibility for actions. The use of this

style was evident is Josh's response to a question about how he adapted his leadership style in

specific student situations. He stated:

In general, I like to give people the opportunity to be a part of the decision-making

process. I do not like top down leadership for the most part, so I would say that my style

if I can is I would describe it more as leading from the middle.

Participants felt it was important to meet with the student and to work together with that student to develop an improvement plan. Katie said:

> When we're notified of a student who is not meeting those expectations… the first thing we do is debrief and meet with the student…so that we can discuss observation, written evaluations or whatever evidence there is that the students not meeting expectations. We present that to the student and then we allow the student to share with us kind of what their viewpoint is, what their experience is, and whether their story or what they've experienced is congruent with what's been presented to us or what we've observed.

The participative leadership behavior is used by program administrators to facilitate student accountability and in working with students to remediate clinical performance. This approach is "appropriate when the subordinate shows a lack of judgment or when procedures have not been followed" (Polston-Murdoch, 2013, p. 16). The student participates in setting goals and timelines for improvement in clinical performance.

Achievement-Oriented

The achievement-oriented behavior is "also a combination of directive and supportive leader behavior" concerned with using an inspirational approach to enhance the performance of followers (Ani et al., 2017, p. 100). The program administrator uses this behavior in defining clinical performance expectations and inspiring students to improve by setting high expectations and challenging goals (Ani et al., 2017). As Bob offered:

> I try to figure out what the students need and try and give it to them. Some students need a little kick in the behind if that can be delivered without disrespecting them, but to try and motivate them a bit. Other students are fragile at times. Sometimes students don't

119

understand what's happening to them, or they're really not resilient and they need a lot

more ... Even though they're adults, they need a lot more support.

Other participants expressed similar commitment to inspire and motivate students to achieve

their goal of becoming nurse anesthetists.

Summary

Path-Goal theory was an appropriate theory to guide this study. Although this study

represented a new application for Path-Goal Theory, outside of industry and other organizations,

it applied to this study as nurse anesthesia program administrators are committed to student

success and strive to motivate nurse anesthesia students to be successful in their academic and

clinical training.   The study's findings may guide other researchers to apply Path-Goal theory to

research studies involving leaders or administrators in higher education or health professions

education programs. The application of Path-Goal theoretical principles by leaders of health

profession education programs, may enhance student satisfaction, learning, and success, and

ultimately the success of the program (Ani, et al., 2017).

Limitations of the Study

There are several limitations of this study. First, due to time constraints and geographical

differences, the interviews could not be done face to face. This was considered a limitation as

non-verbal expressions of participants were not observed. Next, participants may not have been

completely frank in their responses fearing that they may not have correctly handled a situation

with a student who exhibited unsatisfactory clinical performance. This was mitigated by

informing participants that the purpose of this study is strictly to determine the decision-making

process and that there are no right or wrong answers. Finally, only nurse anesthesia program

administrators were included in this study. The decisions made by program administrators are

directly impacted by the clinical evaluations received from CRNA clinical educators and the perspective of clinical educators was not included in this study.

Recommendations

While conducting this study, recommendations for education, practice and future research were identified based on the findings and theory that emerged. The recommendations specific to each category are discussed in this section.

Implications for Programs

Policies regarding clinical evaluation are extremely important when a student is not meeting expectations for clinical performance (Gallant, et al., 2006). In addition, the lack of clear processes or guidance for clinical evaluation results in a lack of objectivity (Gallant, et al., 2006). Similar to other healthcare professions, clinical educators in nurse anesthesia sometimes lack the educational background and knowledge to objectively evaluate students, feel unprepared to evaluate students, or they are hesitant to document poor clinical performance. Clinical educators for nurse anesthesia students need education on numerous topics. Clinical educators need education on how to assess, accurately and objectively evaluate, and provide timely feedback regarding clinical performance concerns (Duffy 2013; Elisha & Rutledge, 2011; Wren & Wren, 1999). In addition, education for faculty and clinical educators on the topics below would be beneficial for students, clinical educators and the nurse anesthesia program. The following topics would be useful for clinical educator training: sharing performance expectations with students, documenting clinical performance, evaluating underperforming students, conveying feedback to students, providing timely feedback to students, communicating with the program timely, and managing students on a remediation plan. Such education could take place at state or national meetings or workshops or via learning modules offered through a web-enhanced format.

Implications for Practice

Nurse Anesthesia students are licensed registered nurses with clinical experience in acute intensive care. Therefore, the importance of following standards of care and professionalism was addressed in undergraduate nursing education. Further, admission to nurse anesthesia programs is very competitive. Due to the keen competition, often times nurse anesthesia programs assume that issues related to clinical practice or professionalism would be rare or nonexistent. However, challenges in clinical education for students continue in spite of prior nursing education. Participants noted the increased stress added to their already challenging job when dealing with a struggling student. Although this study is intended to provide guidance, program administrators may benefit from a mentoring program or support platform to discuss issues related to unsatisfactory clinical performance. Clearly, participants wanted to talk about their challenges therefore, exploring effective strategies to manage such students may be helpful. Perhaps time at venues such as national or state nurse anesthesia meetings could be devoted to having an open discussion forum about managing students with unsatisfactory clinical performance to provide needed support for program administrators.

In addition, participants expressed concerns about clinical agencies refusing to accept students with clinical performance concerns. There is competition among nurse anesthesia programs for clinical sites, especially those that allow full-scope of practice. The clinical agency has a contract with the institution that allows the program to "use the facility for learning experiences" (Christensen, 2016, p. 45). Such contracts often state that the agency can request removal of a student who exhibits clinical performance that does not meet the standard of care (Christensen, 2016). The program administrator must accept responsibility for ensuring that students' practice safely and when there is an issue with a student, it must be dealt with properly

and timely so that clinical training opportunities for future students are not compromised (Christensen, 2016).

Finally, a core concept that emerged from this study is that participants share a unified goal of protecting the integrity of the profession. The importance of professional self-regulation has practice implications because program administrators do not want an unsafe practitioner entering the profession and threatening the profession's reputation or patient safety (Schenarts & Langenfeld, 2017).

Implications for Research

While this study sought to determine the decision-making process of nurse anesthesia program administrators regarding students exhibiting unsatisfactory clinical performance, research is needed to examine the emotional turmoil that program administrators experience when dealing with struggling students. The researcher empathized with many of the participant's responses as they described such decisions as "painful" and the "stuff that keeps you up at night." Other researchers identified similar concerns regarding the stress of dealing with challenging students for educators in nurse anesthesia (Chipas & McKenna, 2011; Wong & Li, 2011) and in other health care professions (Earle-Foley, et al., 2012). In fact, the process is described as challenging, emotionally charged, and complex (Brown, et al., 2007). Future research dedicated to examining the emotional and mental health aspects of the management of unsatisfactory clinical performance by program administrators is warranted. Further, research focused on the emotional toll of such students on clinical educators would likewise be beneficial.

Research regarding the strategies used by program administrators and clinical educators to help students improve clinical performance would be quite useful. It would be important to note whether certain strategies such as simulation were more beneficial when used for students at

certain levels in the program. Research is also needed that examines the clinical educator's perspective regarding how to identify, evaluate and report concerns of students who are not meeting expectations. Additionally, research focused on the perspective of students who either were placed on a remediation plan or were dismissed from a program due to unsatisfactory performance would add a significant contribution to the existing body of literature.

Finally, the COA will be releasing a Common Clinical Assessment Tool to provide standardization to the evaluation of nurse anesthesia students. The tool was validated after a three round Delphi study. Research is needed to determine whether the quality and consistency of the clinical evaluations completed by clinical educators is improved with the use of this tool.

Conclusion

This chapter summarizes the finding of this grounded theory study that revealed the decision-making process of nurse anesthesia program administrators to determine whether a student's unsatisfactory clinical performance warrants intervention by the program. Such decisions regarding student progression are among the most challenging facing program administrators. This study contributes to the existing body of literature on decision-making as it relates to poor student performance in other health profession education programs by offering the unique perspective of nurse anesthesia program administrators. This is the first study of nurse anesthesia program administrators' decision making regarding underperforming students. The results provide support and guidance for current and new nurse anesthesia program administrators.

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131

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Appendix A: Interview Protocol

Research Question

What is the decision-making process of a nurse anesthesia program administrator in determining interventions for unsatisfactory clinical performance by a student?

Sub-Question	Interview Questions
	Introductory Questions: • Tell me about your path to becoming a program administrator. • Tell me about your program. • How many students do you admit per class? • How many students are typically enrolled in the program?
1. How do Nurse Anesthesia Program Administrators view the significance of their leadership on student registered nurse anesthetists (SRNAs)?	• How do you describe your role as a nurse anesthesia program administrator working with students? • How has that role changed? • How does your role change in in certain situations • Can you give an example?
2. How do Nurse Anesthesia Program Administrators assess clinical performance of student nurse anesthetists?	• How are expectations for clinical performance communicated to students? • Describe how a SRNA's clinical performance is evaluated. • How do you assess a student's safety and quality during clinical anesthesia?
3. How are CRNA clinical educators trained regarding clinical evaluation of SRNAs?	• What is the process for communicating expectations for student clinical performance to CRNA clinical educators? • How are CRNA clinical educators trained regarding the clinical evaluation tool?
4. What differentiates satisfactory clinical performance from unsatisfactory clinical performance?	• Tell me about a time when you had a student(s) not meeting expectations for clinical performance. • What are important things you look for when dealing with a student exhibiting poor clinical performance? • How do you define unsatisfactory clinical performance? • How do you differentiation unsatisfactory clinical performance in an SRNA from satisfactory clinical performance? • How would you define unsafe clinical performance? • How do you objectively evaluate a student when clinical performance does not meet expectations? • (Prompts: do you 'test' them? With Socratic-style questioning? Present case study examples or vignettes to ascertain how they would handle a specific situation. • Can you provide an example of a student who exhibited **exemplary** clinical performance?

Sub-Question	Interview Questions
	• Can you provide an example of a student who exhibited **unsatisfactory** clinical performance?
5. How does the Nurse Anesthesia Program Administrator manage questionable or 'borderline' SRNA clinical performance?	• How would you define borderline clinical performance? • How do you differentiate between behaviors that exhibits 'borderline' satisfactory/unsatisfactory clinical performance from behaviors indicative of either satisfactory or unsatisfactory clinical performance? • Please provide me with an example of 'borderline' clinical performance by a SRNA. • What is the process you follow when you have identified a SRNA with questionable or 'borderline' clinical performance? [Prompts: What do you discuss with SRNA? What do you discuss with colleagues in the same clinical site? (i.e., building consensus of observations?) When and what do you discuss with the SRNA's faculty?] • Please provide me with an example of the process(es) you utilized to address questionable or 'borderline' SRNA clinical performance. (Prompts: remediation? Extra time with SRNA? Extra 'guided' clinical experiences? Etc.)
6. How does the Nurse Anesthesia Program Administrator manage unsatisfactory SRNA clinical performance?	• What process do you follow when you have identified a SRNA who exhibits unsatisfactory clinical performance? [Prompts: What do you discuss with the SRNA? What do you discuss with colleagues in the same clinical site? (i.e., building consensus of observations?) When and what do you discuss with the SRNA's faculty?] • Describe the approach you use for initial remediation? • What is the time typical time period allowed for remediation? • Describe what happens at the end of the remediation period? • Please provide me with an example of the process(es) you went through to address unsatisfactory SRNA clinical performance.
7. How does a Nurse Anesthesia Program Administrator differentiate pass versus fail in clinical performance?	• What is your definition of failure in the clinical aspect of nurse anesthesia education? • What specific behaviors (if any) would result in failure of the clinical aspect of a nurse anesthesia course? • How often do such student behaviors have to occur prior to clinical failure? • Describe all student behaviors that result in immediate dismissal. • Describe any student behaviors that warrant attempts at remediation. • How do your institutional policies influence your decision-making process?

University Committee for the Protection of Human Subjects in Research University of New Orleans

Campus Correspondence

Principal Investigator:	Brian Beabout, Ph.D.
Co-Investigators:	Laura Schluter Bonanno
Date:	September 7, 2018
Protocol Title:	Program Administrators' Decision-Making Regarding Remediation or Dismissal of a Nurse Anesthesia Student Due to Unsatisfactory Clinical Performance
IRB#:	02Aug18

The IRB has deemed that the research and procedures are compliant with the University of New Orleans and federal guidelines. The above referenced human subjects protocol has been reviewed and approved using expedited procedures (under 45 CFR 46.110(a) category (7).

Approval is only valid for one year from the approval date. Any changes to the procedures or protocols must be reviewed and approved by the IRB prior to implementation.

If an adverse, unforeseen event occurs (e.g., physical, social, or emotional harm), you are required to inform the IRB as soon as possible after the event.

I wish you much success with your research project.

Sincerely,

Ann O'Hanlon, Chair

UNO Committee for the Protection of Human Subjects in Research

Appendix C: Email recruitment

Title of Study: Program Administrator's decision-making in determining interventions for a student exhibiting unsatisfactory clinical performance

Recruitment script to be emailed to participants:

Clinical training is an essential element of nurse anesthesia education and it is imperative that graduates of a nurse anesthesia program are clinically competent. We are conducting research to better understand the decision making of nurse anesthesia program administrators regarding remediation and/or dismissal of nurse anesthesia students who exhibits unsatisfactory clinical performance. Because you are a nurse anesthesia program administrator, your insight could be extremely valuable to other nurse anesthesia program administrators, faculty, and clinical educators.

We would like you to participate in a phone or in person interview lasting not more than 90 minutes. A follow up interview may be needed. If you would like to participate in this study, please complete this brief survey, using the link below, regarding your educational preparation and years of experience as a nurse anesthesia program administrator. If you have any questions, please email me at lbonanno@uno.edu, Brian Beabout, PhD at bbeabout@uno.edu, or call Ann O'Hanlon, PhD at 504-280-7386.

Demographic Survey via email	1. How many years have you been a Certified Registered Nurse Anesthetist?
	   a. < 2 years
	   b. 2-5 years
	   c. 5-10 years
	   d. > 10 years
	2. How many years have you been a faculty member in a nurse anesthesia program?
	   a. < 2 years
	   b. 2-5 years
	   c. 5-10 years
	   d. >10 years
	3. How many years have you been a program administrator?
	   a. < 2 years
	   b. 2-5 years
	   c. 5-10 years
	   d. > 10 years
	4. What is your educational background (highest level)?
	   a. Masters degree
	   b. Doctor of Nursing Practice Degree or Doctor of Nurse Anesthesia Practice Degree
	   c. Doctor of Philosophy (PhD) degree
	   d. Doctor of Education (EdD) degree
	   e. Other

Appendix D: Consent Form

Brian Beabout, Associate Professor of Education
348F Education Building, University of New Orleans, 2000
Lakeshore Drive, New Orleans, LA 70148
bbeabout@uno.edu | (504) 280-7388

Dear Participant:

I am a graduate student under the direction of Dr. Brian Beabout, Ph.D, an associate professor at the University of New Orleans. I am conducting a research study focusing on the decision making process of a nurse anesthesia program administrator regarding whether a nurse anesthesia student's unsatisfactory performance in clinical warrants remediation or dismissal from a nurse anesthesia program. Should you choose to participate, you will be asked to participate in one (1) interview lasting no more than 90 minutes in length, with the potential for brief follow up interviews if you are willing. The interview will cover topics related to clinical performance and evaluation of nurse anesthesia students.

Your participation in this study entails informational risk. This is typical in studies that use interviews as you are sharing information about your decision making regarding students exhibiting unsatisfactory performance in clinical. As a participant in this study, you may choose the depth of information you are willing to share and may decline to answer any question you wish. Confidentiality is of utmost importance in this study. Your participation will be kept confidential and your real name (and other identifying information, including the name and location of your program, etc.) will not be used in any publications created from this research. Participation in this study is voluntary and refusal to participate will involve no penalty. You may discontinue participation at any time.

This research will ask you to think about your role as a nurse anesthesia program administrator related to the assessment of management of student clinical performance. We intend to use this study to describe the decision making process of nurse anesthesia program regarding whether to remediate or dismiss students who demonstrate unsatisfactory clinical performance. Specifically, I am looking to better understand what constitutes unsatisfactory behaviors in clinical and what behaviors warrant remediation and what behaviors warrant dismissal. By participating in this study, you are providing insight as to what influences the decision making process.
Again, to maximize confidentiality, no identifying information will be used in any publications resulting from this research. Interviews will be audio recorded and will be kept secure and will only be accessible by myself and Dr. Brian Beabout. If you have any questions about this study, please contact me at (504) 491-3521 or lbonanno@uno.edu or Dr. Beabout at (504) 280-7388 or bbeabout@uno.edu. If you have any questions about your rights as a research participant, please contact Dr. Robert Laird at rlaird@uno.edu.

Participant (print name)Researcher (print name)

Participant (signature)dateResearcher (signature)date

VITA

The author was born in Phoenix, Arizona. She obtained her Bachelor of Science degree in

Nursing in 1987. She practiced as a registered nurse for five years in critical care. In January

1993, she enrolled in the Master of Science degree program at Charity Hospital/Xavier

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CRNA for eleven years and teaching part-time, she enrolled in a Doctorate of Nursing Practice

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and graduated in 2008. In August, 2012, she began pursuing her PhD in Educational

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and works full-time as the program administrator of a nurse anesthesia program.