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Walden University

College of Education

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Melody Lynn Bethards

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University

2020

Abstract

Faculty Evaluation of Underperforming Nursing Students in Clinical Settings

by

Melody Lynn Bethards

MA, Drake University, 2002

BSN, Grand View College, 1997

Project Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Education

Walden University

August 2020

Abstract

Difficulty in evaluating underperforming nursing students in clinical settings is a problem for many nursing programs. The subjective nature of evaluations and faculty reluctance to provide negative evaluations have implications for subsequent patient care. A descriptive single case study research design was used to explore the experiences of clinical faculty evaluating underperforming nursing students in clinical settings at a U.S. Midwest community college. Gagné's learning outcomes and the National League for Nursing (NLN) Clinical Nurse Educator Core Competency: Implements Effective Clinical Assessment and Evaluation Strategies provided the conceptual framework for the study. The research questions focused on how nursing faculty identified, described, and evaluated students who are underperforming in traditional and simulation clinical settings. Twenty-one nursing clinical faculty recruited through purposeful sampling completed an online questionnaire and 11 completed semistructured interviews. Content and deductive analysis of data revealed 3 themes of nursing students' underperformance that correlated with Gagné's learning outcomes. Participants employed aspects of the NLN competency when evaluating underperforming nursing students in traditional and simulation clinical experiences. Analysis of study data also revealed a lack of policies to ensure objective, consistent clinical evaluation, and support underperforming clinical students. A policy recommendation related to evaluation and remediation for underperforming nursing students in clinical settings was developed to address this gap. Implementation of the policy recommendation has the potential to increase nursing student competence and success, which may result in improved patient care outcomes.

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Section 1: The Problem

The goal of undergraduate nursing education is to prepare student nurses for future practice. Experiences in clinical settings are an integral component of teaching nursing students to become safe, competent practitioners. According to O'Connor, 2014 (2014), clinical education provides an opportunity for nursing students to apply classroom information to real patient care situations and demonstrate nursing skills. Nursing students also develop communication skills needed for patient care, consider the implications of clinical decision-making, learn about different healthcare settings, and experience the various roles of the nurse during clinical rotations (O'Connor, 2014).

Nursing students can participate in clinical experiences in traditional or simulation clinical settings. Traditional clinical education occurs in healthcare settings such as hospitals, long-term care facilities, clinics, and community health. Clinical education in traditional patient care areas helps students develop essential skills needed when interacting with patients (Levett-Jones & Bourgeois, 2015). Due to increasing competition for a limited number of clinical sites and restrictions on students' ability to participate in specific patient care experiences, simulation clinical experiences have become an integral component of many nursing education programs in the United States (O'Connor, 2014). Simulation clinical experiences provide a structured setting where students can participate in patient care situations that may be unavailable in traditional clinical education settings (Larue, Pepin, & Allard, 2015). Simulation clinical experiences can replace up to 50% of traditional clinical experiences without impacting outcomes (Hayden, Smiley, Alexander, Kardong-Edgren, & Jeffries, 2014). Clinical

nursing faculty facilitate clinical learning experiences in traditional and simulation clinical settings.

The role of clinical faculty is to provide educational experiences for students in the clinical setting, ensure the safety of patients cared for by students, and evaluate students' achievement of clinical competencies (O'Connor, 2014). Faculty in clinical settings are often referred to as the gatekeepers of the profession because they have a responsibility to ensure students can provide safe, competent patient care upon graduation (Finke, 2013). Nurses need to have effective communication, leadership, organizational and critical thinking skills, and competence in the ability to perform nursing interventions to care for patients in an ever-changing healthcare environment (Theisen & Sandau, 2013). According to Gaberson, Oermann, and Shellenbarger (2015), the evaluation of students in clinical settings requires faculty to make subjective judgments about a student's ability to meet clinical competencies and provide safe patient care. Gaberson et al. asserted that nursing faculty have a responsibility to assign a failing grade to students who do not provide safe patient care or do not demonstrate the achievement of clinical competencies.

Nursing faculty must consider multiple factors when determining student achievement of clinical competence. Professional behaviors, the ability to apply theoretical knowledge and skills, and demonstration of critical thinking are some of the characteristics nursing faculty evaluate when supervising nursing students in clinical settings (Salm, Johner, & Luhanga, 2016). According to Lewallen and DeBrew (2012), clinical faculty can easily identify students who consistently meet or exceed established

program clinical competencies or students who provide unsafe patient care. However, Students who inconsistently meet clinical competencies are not as easily identified (Amicucci, 2012; Pijl-Zieber, Sylvia Barton, Konkin, Awosoga, & Caine, 2014). In this section, I will describe the local problem and the rationale for conducting this project study, present the guiding research questions, review the literature, consider the implications of poor evaluation of underperforming nursing students in the clinical setting.

The Local Problem

A survey conducted by nursing leadership at an associate degree nursing program in a Midwestern community college revealed that 57% of full-and part-time clinical nursing faculty reported passing a student who did not meet clinical competencies. Nursing clinical faculty who completed the survey reported wanting to give the student the benefit of the doubt because they thought the student would improve in the next course as the main reason for passing a student who did not meet clinical competencies. Not feeling comfortable failing a student whom they had limited time to observe and the fact that it was the student's first clinical experience were also listed as reasons for passing underperforming clinical students.

Students in the nursing program spend 45 to 180 hours in traditional or simulation clinical settings each semester. Nursing students must satisfactorily complete all elements of a clinical course to progress through the program. Faculty assign numeric scores for assignments completed during the didactic and laboratory portion of a course. Nursing clinical faculty assign a pass/fail grade for the clinical component of a course. Evaluation

of nursing students in clinical settings is an essential responsibility for all clinical nursing faculty at the college. Therefore, nursing faculty orientation includes education on clinical competencies, evaluation methods, and recognition of students at risk.

Nursing program faculty use a self-developed tool to evaluate nursing students in the traditional clinical setting weekly. The clinical evaluation tool consists of different sections representing the program outcomes. Each section includes a list of competencies related to the skills, knowledge, and attitudes expected for successful completion of the clinical experience. Students are required to provide written evidence of how they demonstrated the competency during the week. Faculty indicate the corresponding numeric score indicating if the student satisfactorily demonstrated the competency, needs improvement, or unsatisfactorily demonstrated the competency during the clinical day. Nursing clinical faculty must provide written documentation to justify the score given. A cumulative score of 78% or higher on all clinical evaluation tools for a course is required to pass the traditional clinical experience. Students who score 77.99% or lower receive a failing grade for the clinical component of a course.

Students receive feedback on performance in the simulation clinical setting via a faculty-developed tool. Nursing simulation faculty use the same assessment tool for all nursing students who attend simulation learning experiences. The tool consists of five sections. Each section includes behavioral expectations related to the skills and attitudes expected for successful completion of the simulation clinical experience. Faculty indicate if the student met the expectation or needs improvement. Faculty use the tool as a discussion point for student feedback and reflection. The tool is a supporting document to

the traditional evaluation tool. Meeting or not meeting simulation expectations has no bearing on a student's program progression or clinical pass or fail grade.

According to the nursing program director, clinical nursing faculty reported difficulty with evaluating students in traditional and simulation clinical settings, and students deemed underperforming by faculty have received passing clinical grades and progressed through the program. The passing of underperforming clinical students represents a gap in nursing education practice. The reason for this gap is unclear; therefore, the purpose of this project study was to explore the difficulty encountered by associate degree nursing program faculty at a Midwestern community college when evaluating underperforming nursing students in clinical settings.

Rationale

Evidence of the Problem at the Local Level

The ability to evaluate nursing students in the clinical setting is essential to ensure safe, competent nursing graduates. As the nursing simulation coordinator at the community college, I have observed students who have difficulty meeting course competencies in the simulation clinical setting. Clinical faculty often identify that the student also has difficulty meeting course competencies in the traditional clinical setting. Some clinical faculty will comment on the challenges they have documenting the behaviors of underperforming students on clinical evaluation tools. Vague statements such as "needs more experience," "has weak skills," or "requires a structured environment" are in clinical evaluations of nursing students at the college. According to the nursing program director, 25% of previous clinical assessments for

final semester students identified by faculty as having difficulty meeting clinical competencies included subjective comments and/or an objective score that indicated the student did not consistently meet all clinical competencies. Yet, the students still received a passing clinical grade for those courses.

Evidence of the Problem From the Professional Literature

Difficulty evaluating students in the clinical setting is a substantial problem in nursing education. Evaluating nursing students in the clinical setting is a complex process that relies on subjective assessment of clinical competencies related to psychomotor skills, application of knowledge, decision-making, organizational skills, communication skills, and attitude (Amicucci, 2012; L. Brown, Douglas, Garrity, & Shepherd, 2012; Rafiee, Moattari, Nikbakht, Kojuri, & Mousavinasab, 2014). Clinical faculty often use anecdotal notes to document student achievement of clinical competencies (Hall, 2013). Although clinical nursing faculty find the use of anecdotal notes beneficial to recall students' actions during clinical experiences, there is no established framework for subjective documentation of clinical competencies (Heaslip & Scammell, 2012). Furthermore, clinical faculty often have varying interpretations of how students demonstrate achievement of clinical competencies (Helminen, Tossavainen, & Turunen, 2014; Msiska, Smith, Fawcett, & Munkhondya, 2015). Student attitudes and behaviors and previous faculty experiences can add to the subjectivity of clinical evaluation processes (DeBrew & Lewallen, 2014; Hunt, McGee, Gutteridge, & Hughes, 2016a; Scanlan & Chernomas, 2016).

Clinical evaluations often require subjective documentation of a student's ability to meet clinical competencies. Rafiee et al. (2014) noted that the subjective nature of clinical evaluation makes it difficult to explicitly describe students who are not deemed unsafe by clinical faculty yet do not consistently meet clinical competencies. Vague terms such as "grey," "borderline," "marginal," "weak," "not at the same level as other students," and "unable to connect the dots" are used to describe clinical students who fall into this category (DeBrew & Lewallen, 2014).

Clinical faculty may incorporate student personality characteristics and attitudes that they believe could potentially affect interaction with patients, peers, and future employers into the clinical evaluation process (Amicucci, 2012; DeBrew & Lewallen, 2014). Characteristics such as "assertive," "complacent," "lack of interest," "not motivated," "disengaged," "uncaring," "lack of empathy," "inability to communicate," and "compromised professional accountability" are also used to describe underperforming clinical nursing students (DeBrew & Lewallen, 2014). Nursing students who exhibited unprofessional behavior while in school may continue similar behavior after gaining employment as a nurse (Luparell & Frisbee, 2019). Unprofessional behaviors and poor attitudes displayed by nurses can lead to a lack of empathy for patients, poor quality patient care, and medication errors (Eng & Pai, 2015; Haskins, Phakathi, Grant, & Horwood, 2014; Karlstrom, 2018; Scanlan & Chernomas, 2016).

Ambiguity regarding evaluating nursing students in the clinical setting can result in underperforming students passing clinical experiences (L. Brown et al., 2012; Larocque & Luhanga, 2013). According to DeBrew and Lewallen (2014), nursing faculty

are hesitant to assign a failing grade to students who display remorse or become emotionally upset when informed they are at risk of failing clinically. When faced with uncertainty about a student's clinical competence, faculty may give the student the benefit of the doubt and assign the student a passing clinical grade (Docherty & Dieckmann, 2015; Elliott, 2016). Other factors that influence clinical faculty to assign passing clinical grades to students deemed underperforming by faculty include lack of confidence about evaluation decisions, lack of support from nursing program administration, and fear of repercussions from the student or nursing program (L. Brown et al., 2012; Heaslip & Scammell, 2012; Larocque & Luhanga, 2013). Clarifying the evaluation process for underperforming students in the clinical setting may help to ensure that new graduate nursing students will provide safe, competent patient care. The earlier students at risk for clinical failure are identified, the sooner the faculty can intervene to assist the student.

Definition of Terms

I used the following definitions to guide the project:

Clinical competencies: A list of desired behaviors for nursing students in the clinical setting based on program or course objectives, intended clinical learning outcomes, or national standards (Gaberson et al., 2015; O'Connor, 2014; Ulfvarson & Oxelmark, 2012).

Clinical evaluation: The process of judging a nursing student's clinical performance to provide formative and summative feedback about their current status (Gaberson et al., 2015; O'Connor, 2014).

Clinical failure: The inability of a nursing student to meet clinical course objectives sufficient to allow progression within the program (Gaberson et al., 2015; O'Connor, 2014).

Clinical nursing faculty: Nursing faculty assigned to provide educational experiences for students in the clinical setting, ensure the safety of patients cared for by students, and evaluate students' achievement of clinical competencies. The terms *clinical mentors*, *nursing mentors*, or *clinical preceptors* are used to describe clinical nursing faculty in European countries (Gaberson et al., 2015; O'Connor, 2014).

Clinical setting: Traditional or simulation patient care settings in which nursing students apply theoretical learning to patient care situations and develop the essential skills necessary to provide safe, competent care after graduation (Levett-Jones & Bourgeois, 2015; O'Connor, 2014).

Simulation clinical experiences: Situations that represent realistic clinical scenarios and provide students opportunities to hone teamwork and communication skills, apply theoretical knowledge to make clinical decisions independently, implement nursing interventions, and analyze patient responses in a safe learning environment without risk of harm to real patients. These experiences include a prebriefing/preparatory phase, scenario phase, and debriefing phase (INACSL Standards Committee, 2016c; Jeffries & Jeffries, 2012)

Simulation clinical setting: The physical location where simulation clinical experiences take place and mirror, as closely as possible, traditional clinical settings with

lifelike manikins and/or live actors serving as patients (INACSL Standards Committee, 2016c; Jeffries & Jeffries, 2012).

Successful clinical nursing students: Nursing students who consistently achieve clinical competencies with minimal clinical nursing faculty assistance; are prepared to participate in clinical experiences; demonstrate the ability to think critically; can communicate effectively with patients, faculty, staff, and peers; demonstrate a positive attitude during clinical experiences; and can adapt to different clinical settings (Lewallen & DeBrew, 2012; O'Connor, 2014)

Traditional clinical experiences: A component of nursing education in which nursing students apply theoretical knowledge; implement nursing interventions; and interact with recipients of health services, clinical staff, and other healthcare professionals in the delivery of patient care under the direct supervision of clinical faculty or practicing nurses (Gaberson et al., 2015; O'Connor, 2014).

Traditional clinical setting: Hospitals, long-term care facilities, clinics, and community settings where nursing students participate in clinical experiences with recipients of healthcare services (Levett-Jones & Bourgeois, 2015; Murphy, Rosser, Bevan, Warner, & Jordan, 2012).

Underperforming clinical nursing student: A nursing student who exhibits deficits in the ability to meet clinical competencies; has difficulty adapting to new or different clinical settings; is often unprepared to participate in clinical experiences; demonstrates ineffective or inappropriate communication with patients, peers, faculty, and clinical

staff; and may not exhibit behaviors that overtly place patients at risk for harm (DeBrew & Lewallen, 2014; Elliott, 2016; O'Connor, 2014).

Unsafe clinical nursing student: A nursing student who communicates inappropriately with patients, faculty, staff, or peers; uses unprofessional language; fails to perform basic patient care; is dishonest; exhibits illegal, unethical, or immoral behaviors; and/or places a patient at risk for physical or emotional harm (Chunta, 2016).

Unsuccessful clinical nursing student: A nursing student who is deemed unable to pass the clinical course (Lewallen & DeBrew, 2012; O'Connor, 2014).

Significance of the Study

Failure to adequately evaluate underperforming nursing students can have consequences for the student, the educational institution, and the public (Larocque & Luhanga, 2013). The inability to adequately evaluate underperformance in nursing clinical settings can result in students not receiving necessary remediation and being ill-prepared as they progress through the nursing program (Vinales, 2015). Underperforming nursing students who pass due to inadequate clinical evaluation processes may eventually fail for behaviors that were present in previous clinical courses. Often this occurs in the final semester of the nursing program, resulting in a significant loss of time, money, and potential nursing career for the student (Larocque & Luhanga, 2013). Lack of clarity regarding the clinical evaluation process can have legal implications for the educational institution. The reputation of the nursing program may be diminished if faculty do not fail underperforming students (Larocque & Luhanga, 2013; Patton & Lewallen, 2015).

Social Change Implications

Employers and recipients of healthcare expect graduates of nursing programs to be prepared to provide safe, competent patient care upon graduation (Finke, 2013). Difficulty evaluating underperforming nursing students in the clinical setting may result in newly licensed nurses who are unprepared to provide safe patient care (Malihi-Shoja, Catherall, Titherington, Mallen, & Hough, 2013). Students who underperform in the clinical setting may still meet program academic standards, graduate, pass the written licensure exam, and enter the workforce (Hunt, McGee, Gutteridge, & Hughes, 2012). Several local healthcare facility nursing administrators report the hiring of newly registered nurses who are not competent in the skills necessary to provide safe patient care.

Local setting social change implications. Insight from this project study will help faculty gain a better understanding of evaluating underperforming nursing students in clinical settings. Changes to the community college nursing program curriculum, student clinical evaluation, remediation processes, and faculty orientation may occur because of this study. Early recognition of underperforming students can help ensure that all graduating nursing students can meet clinical competencies.

Far-reaching social change implications. Although I conducted this study at one institution, it may influence how other education institutions evaluate underperforming nursing students in the clinical setting. Overall, patient care may improve as the number of graduating nurses prepared to deliver competent, safe, high-quality healthcare increases. The results of this project study could inspire other nursing educators to

conduct research related to the evaluation of underperforming nursing students in clinical settings.

Research Questions

The local problem of associate degree clinical nursing faculty assigning passing grades to students deemed underperforming in the clinical setting prompted this project study. There is a limited understanding of why the problem exists. Understanding how clinical nursing faculty identify underperforming students and the factors that influence the evaluation of these students in both the traditional and simulation clinical settings could impact nursing curricula and help clinical faculty to determine whether a student should pass or fail. The primary research question for this project study was, What are the experiences of associate degree clinical faculty evaluating underperforming students in traditional and simulation clinical settings in a Midwestern state? I also explored the following subquestions:

1. How do clinical nursing faculty identify students who are underperforming in traditional and simulation clinical settings?
2. How do clinical nursing faculty describe students who are underperforming in traditional and simulation clinical settings?
3. How do clinical nursing faculty evaluate students identified as underperforming in traditional and simulation clinical settings?

Review of the Literature

I conducted an extensive search of the literature, including books, Google Scholar, and the Walden University Library using Health and Nursing Databases

CINAHL and Medline Simultaneous search, and Education Databases ERIC and Education Research Complete. Online search terms included *clinical education, clinical placement, nursing clinical education, traditional clinical setting, simulated clinical setting, simulation clinical setting, role of clinical nursing faculty, evaluating clinical experiences, evaluating simulated clinical experiences, evaluating simulation clinical experiences, assessment of clinical, evaluating students in clinical, competency-based clinical assessment, successful clinical students, unsuccessful clinical students, underperforming clinical students, failing clinical students, failing to fail clinical students, nurse educator competencies, clinical nursing faculty competencies, evaluation models, formative evaluation models, summative evaluation models, National League for Nursing (NLN) Nurse Educator Core Competencies, Robert Gagné, and Gagné's five learning categories*. The literature review includes a discussion of the conceptual frameworks for the project study as well as relationships between the role of clinical faculty, evaluation of students in clinical settings, deciding to pass or fail a student clinically, difficulty evaluating underperforming nursing students in the clinical setting, and failing to fail underperforming clinical nursing students.

Conceptual Frameworks

Gagné's five categories of learning (Gagné, 1972) and the National League for Nursing's (NLN) Clinical Nurse Educator Competencies (Shellenbarger, 2019) provided the conceptual framework for this project study. Gagné's five learning categories served as the guide for the different aspects of learning evaluated in clinical settings. Application of the NLN's Clinical Nurse Educator Core Competencies and the associated task

statements supported this study by providing best practice standards for assessing and evaluating nursing student clinical learning.

Gagné (1972) outlined five domains, or categories, that could be generalized to the learning of any topic. Gagné's (1972) five categories of learning are motor skills, verbal information, attitudes, intellectual skills, and cognitive strategies. The categories relate to one another; however, they are not sequential. Acquisition of each category is essential for successful learning. The categories include certain conditions necessary for learning and require different assessments of outcomes.

Motor skills are the ability to facilitate organized tasks in a specific sequence (Gagné & Medsker, 1996). Motor skills require hand-eye coordination and quick reaction time. Observation of the motor skills, opportunity to practice the skill, and feedback related to skills performance are relevant conditions. The retention of motor skills requires repetition.

Verbal information is the ability for students to repeat information in essentially the same form in which it was initially presented, without the use of references (Gagné & Medsker, 1996). Recalling verbal information provides meaning to the situation and emphasizes the relationship between content to be learned. The application of verbal information requires practice over time.

Attitudes are internal states that influence a learner's choice of personal actions (Gagné & Medsker, 1996). Interpersonal skills, beliefs, emotions, and behaviors are components of attitude. Behavior choices provide a mode of direct observation of beliefs

and emotions. Imitation and modeling others are relevant conditions for attitudes.

Reinforcement of desired behaviors is key to attitude learning.

Intellectual skills are the ability to apply information to different situations.

Learning of prerequisite skills and knowledge is required to apply intellectual skills. The ability to discriminate information, apply different skills and knowledge to a new situation, and combine information to perform a task or solve a problem are conditions relevant to intellectual skills.

Cognitive strategies are skills developed by the learner in the application of verbal information, intellectual skills, motor skills, and attitude to solve simple-to-complex problems (Gagné & Medsker, 1996). Opportunities to work with unique problems, asking learners to explore their decision-making, and observing others solve problems are relevant conditions. The opportunity to practice cognitive strategies is required to hone the skill.

Gagné's five categories of learning are useful for designing educational programs for military and career training (Gagné & Medsker, 1996). Rutherford-Hemming (2012) conducted a qualitative descriptive research design using Gagné's five learning categories as the theoretical foundation to explore the transfer of learning in a simulation environment. According to the author, Gagné's learning categories are essential for the transfer of learning. Gray-Miceli et al. (2014) used Gagné's five categories of learning to develop geriatric education modules to enhance the education of senior nursing students. According to the authors, Gagné's five categories of learning align with existing

educational frameworks for nursing education. Table 1 provides examples of how Gagné's categories of learning align with clinical nursing student outcomes.

Table 1

Gagné's Five Categories of Learning Applied to Clinical Nursing Student Outcomes

Gagné's category of learning	Example of clinical nursing student learning
Motor skills	Perform a sterile procedure
Verbal information	Identify equipment needed for a nursing intervention using medical terms
Attitude	Respectful communication with patient, families, and other members of the healthcare team
Intellectual skills	Identify patient needs based on assessment data
Cognitive strategies	Determine an alternative method for performing a sterile procedure and still maintain sterile principles

The NLN convened a task force in 2002 to conduct a comprehensive review of the literature related to nurse educator competencies, develop competencies for nurse educators, identify gaps in the literature, and identify areas of future research related to nurse educator competencies (Halstead, 2019). The efforts of the task force members resulted in the development of eight core competencies for nurse educators and 66 related task statements, which have become the foundation for the nurse educator's scope of practice. Published in 2019, the NLN Clinical Nurse Educator Competencies were specifically for clinical nurse educators and consists of six core competencies and 83 associated task statements (Shellenbarger, 2019). Because the focus of this project study was evaluation in clinical settings, the competency Implement Effective Clinical

Assessment and Evaluation Strategies and associated task statements were selected to guide the project study.

According to Patrick (2019), clear expectations for clinical assessment and evaluation allow faculty to focus on the achievement of student learning outcomes. The eleven task statements include the knowledge, skills, and attitude required for nurse educators to effectively assess and evaluate nursing students in clinical settings:

- Uses a variety of assessment and evaluation strategies to determine achievement of learning outcomes
- Implements both formative and summative evaluation that is appropriate to the learner and learning outcomes
- Engages in timely communication with course faculty regarding learner performance
- Maintains integrity in the assessment and evaluation of learners
- Provides timely, objective, constructive, and fair feedback to learners
- Uses assessment and evaluation data to enhance the teaching-learning process in the clinical environment.
- Demonstrates skill in the use of best practice in the assessment and evaluation of clinical performance.
- Assesses and evaluates appropriate clinical performance expectations.
- Assesses learner strengths and weaknesses in the clinical environment using performance expectations
- Documents learning performance, feedback, and progression

- Evaluates the quality of clinical learning experiences and the environment.
(p. 73-74)

The conceptual frameworks provided the foundation for developing the research questions/methodology, data collection tools, and data analysis for the project study. Gagné's five categories of learning (Gagné, 1972) informed the development of research questions, items on data collection tools, and analysis of data to explore faculty experiences evaluating nursing student clinical learning related to motor skills, verbal information, attitude, intellectual skills, and cognitive strategies. The NLN's Clinical Nurse Educator Competency Implement Effective Clinical Assessment and Evaluation Strategies and associated task statements (Patrick, 2019) provided the development of research questions, items on data collection tools, and data analysis to explore clinical faculty use of best practice standards when evaluating underperforming nursing students in clinical settings.

Evidence of the Problem in the Literature

Clinical nursing faculty have a responsibility to evaluate students in the clinical setting and determine if they meet the criteria to pass or fail. Most clinical evaluation tools are based on a list of competencies established by the nursing program (Gaberson et al., 2015). However, the evaluation of nursing students in clinical settings is often subjective, with no established framework for subjective documentation of clinical competencies (Heaslip & Scammell, 2012). Subjective interpretation of how students demonstrate a competency allows for differences in evaluation by instructors. Because this difference widely occurs, a review of the scholarly evidence related to clinical

evaluation is essential to understanding the problem of evaluating underperforming nursing students in clinical settings (Elliott, 2016). Include an understanding of not only what faculty evaluate, but also the role of faculty evaluating students in different clinical settings is essential.

Role of clinical faculty. Clinical nursing faculty in both traditional and simulation clinical settings have a responsibility to provide learning opportunities and performance-based feedback to prepare students for their role as a nurse after graduation. Nursing faculty in the traditional clinical setting support student learning by providing opportunities to apply classroom content in the practical setting, facilitating movement through the program, socializing students to the role of the nurse, and serving as gatekeepers of the nursing profession (O'Connor, 2014; Zlotnick et al., 2016). J. Brown, Stevens, and Kermodé (2012) found that clinical faculty helped students develop a sense of identity as a nurse, understand the role of the nurse and nursing culture, acquire nursing knowledge, develop essential nursing skills, and assume nursing professional values. An international study conducted by Zlotnick et al. (2016) identified similar roles for clinical instructors in Israel, Norway, and the United States. Study participants rated patient advocacy and upholding a high quality of patient care as significant roles of clinical faculty.

In comparison, the primary role of nursing faculty in the simulation clinical setting is to develop, implement, and facilitate evidence-based, realistic experiences that provide opportunities to apply classroom content, develop clinical reasoning skills, and reflect upon clinical decisions in a safe environment (INACSL Standards Committee,

2016a; Jones, Reese, & Shelton, 2014). Jones et al. (2014) identified reflective abilities, understanding of simulation as a teaching pedagogy, knowledge of student abilities, and professional values and identity as primary roles and responsibilities for facilitating learning experiences in the simulation setting. Findings in studies by Topping, et al. (2015) and Roh, Kim, and Issenberg (2019) support knowledge of simulation as a teaching pedagogy, facilitation, debriefing, and evaluation skills, professional values, and reflection as essential roles and responsibilities for simulation facilitators. Evaluation of students' clinical performance throughout the clinical experience is an essential role for nursing faculty in both traditional and simulation clinical settings (J. Brown et al., 2012; Roh et al., 2019; Topping et al., 2015; Zlotnick et al., 2016).

Clinical evaluation. The purpose and goals of the clinical experience determine the type of evaluation methods used. Formative assessment is used throughout the clinical experience to determine students' progression towards meeting clinical objectives (O'Connor, 2014; Spurlock & Mariani, 2019). Faculty use clinical formative assessment processes to identify students' strengths and weaknesses, provide performance feedback, determine relevant remediation activities, and assist students in developing a plan for meeting clinical learning objectives by the end of the clinical experience. Therefore, students should not be assigned a passing or failing grade for formative assessments (Jeffries & Jeffries, 2012; O'Connor, 2014). For summative evaluation, faculty determine students' achievement of clinical learning objectives at the end of the clinical experience and assign a passing or failing grade (O'Connor, 2014; Spurlock & Mariani, 2019).

Formative assessments and summative evaluation are essential in the traditional clinical setting to assist students in meeting clinical learning objectives and determining if the student will pass or fail the clinical experience (O'Connor, 2014). The International Nursing Association for Clinical Simulation and Learning (INACSL) Standards of Best Practice: SimulationSM Participant Evaluation (INACSL Standards Committee, 2016b) defines criteria for the use of evaluation methods in simulation clinical settings. Simulation learning experiences provide opportunities for students to hone communication, teamwork, and clinical decision-making skills in a safe learning environment where they can make mistakes without grading consequences. For this reason, formative assessment methods that focus on providing feedback on performance and supporting the learning process are preferred (Palominos, Levett-Jones, Power, & Martinez-Maldonado, 2019).

Studies by Msiska et al. (2015), Rafiee et al. (2014), and Watts, Ivankova, and Moss (2017) revealed that determining nursing students' progression towards and achievement of clinical objectives is a multifaceted and often subjective process. Msiska et al. (2015) conducted face-to-face interviews with 30 senior nursing students in Malawi. According to the authors, nursing students described the subjective nature of clinical evaluation as biased and unfair. Study participants also identified a lack of objectivity in clinical grading, that reported mistakes, or a lack of them, seemed to be the basis for grades, better relationships with clinical faculty resulted in better grades regardless of performance, and clinical site placement influenced grades.

Rafiee et al. (2014) and Watts, et al. (2017) found that subjectivity in clinical nursing evaluation can also be problematic for faculty. During face to face, semistructured interviews with eight nursing faculty and 40 nursing students in Iran Rafiee, et al. (2014) found that both nursing faculty and students identified the subjective nature of clinical evaluation as a problem. Study participants identified varying faculty interpretations of how to determine if students met clinical competencies, limited time to evaluate students, and faculty biases as problems of nursing clinical evaluation. The authors noted that the evaluation of traditional clinical learning is inherently problematic because it requires direct observation of students in unpredictable actual practice settings. Watts et al. (2017) found similar concerns in simulation clinical settings. Analysis of data from interviews with 21 simulation faculty from nursing schools in the southeastern United States revealed that perceived expectations of student performance behaviors, the type of simulation event, and individual faculty personal experiences and values influenced the evaluation of student performance during simulation learning experiences.

Competency-based evaluation tools provide objectivity during clinical performance assessment (Franklin & Melville, 2015; Wu, Enskär, Lee, & Wang, 2015). However, clinical faculty and students may have differing interpretations of competency terms on an evaluation tool (Almalkawi, Jester, & Terry, 2018; Burke et al., 2016; Helminen et al., 2014). Participants in a mixed-methods study by Burke et al. (2016) described terms on a clinical competency evaluation tool as complex, elaborate, repetitive, and overlapping. Almalkawi et al. (2018) conducted an integrative review of eight mixed methods studies regarding challenges faced by mentors when interpreting

nursing students' level of competency. Difficulties interpreting the language used to describe competencies was an emerging theme. Analysis of data in a study of 276 nursing students, 108 faculty, and 225 clinical mentors by Helminen, et al. (2014) revealed that difficulty interpreting terms on competency tools is a challenge for students as well. Sixty-seven percent (186) of students and 89% (200) of mentors reported having difficulties with the language used in the competency assessment tool. The authors noted that even with established practices, there could be difficulties in ensuring effective measures to determine competence.

Deciding to pass or fail a student clinically. As noted previously, most nursing programs use formative assessment methods only in simulation clinical settings; therefore, faculty documentation on summative evaluations in the traditional clinical setting determines the assignment of a passing or failing clinical grade. Studies by Amicucci (2012), Daly, Salamonson, Glew, and Everett (2016), DeBrew and Lewallen (2014), and Hunt, McGee, Gutteridge, and Hughes (2016b) explored the challenges of deciding to pass or fail a student clinically. Amicucci (2012) conducted a qualitative phenomenological study with 11 full-time clinical faculty in a northeastern U.S. state to explore faculty experiences of clinical grading. The terms “subjective” and “shades of gray” were used by faculty to describe the clinical grading process. The author found that clinical faculty are often hesitant to fail students because they want to provide them an opportunity to change or hoped they would improve in a future course. Study participants identified safety as a benchmark for passing; however, the definition of what constituted

safe practice varied among faculty in the study. All participants in the study expressed some level of dissatisfaction with the clinical grading process.

Faculty subjectivity, when determining if a student should pass or fail clinically, was also found by Daly et al. (2016). A review of 2339 clinical evaluations of nursing students from three different clinical courses on three different campuses of an undergraduate nursing program in Australia revealed that the strongest predictor of receiving a passing clinical grade was the clinical instructors' historical pattern of passing or failing students. According to the authors, faculty with a pattern of lenient grading were eight times more likely to pass a nursing student clinically than instructors with a pattern of strict grading. The authors concluded that clinical faculty with patterns of lenient grading would be more likely to pass underperforming or unsafe nursing students.

Results of a qualitative descriptive study conducted by DeBrew and Lewallen (2014) supported the fact that clinical faculty consider more than just the ability to meet clinical competencies when deciding to pass or fail a nursing student clinically. Nurse educators reported critical incidences such as attitude, ability to show progress, medication administration skills, ability to prioritize care, unsafe behaviors, anxiety, remorsefulness after an error, and seeking out learning opportunities. Unprofessional behaviors were used by faculty to determine students' clinical success or failure. Student factors considered during clinical evaluation included faculty emotions, perceptions of a student's desire to be a nurse, perceptions of cultural differences, and level of administrative support were also taken into consideration when evaluating clinical nursing students.

Hunt et al. (2016a) also explored the effect of underperforming nursing student behavior on faculty emotions. Analysis of transcribed data from 31 faculty from undergraduate nursing programs in England revealed that most underperforming nursing students responded positively to constructive feedback. However, some students responded with behaviors ranging from passive manipulation to aggressive intimidation, which led to varying levels of guilt and fear felt by the clinical faculty. Passive manipulation by students, such as bringing gifts, begging the evaluator not to fail them, and crying resulted in very high feelings of guilt and very profound feelings of fear. Diverting the faculty's attention by focusing on personal issues unrelated to the areas of underperformance resulted in high feelings of guilt and deep feelings of fear. Challenging evaluation decisions and competence of clinical faculty resulted in deep feelings of guilt and high feelings of fear. Openly made personal threats or displayed aggressive behaviors resulted in very profound feelings of guilt and very high feelings of fear. The authors concluded that emotions have a strong influence on a faculty's decision to assign a failing grade to nursing students who are underperforming in clinical settings.

Failing a nursing student clinically. Failing a student clinically can be an emotional and challenging process for faculty. Studies by Duffy (2013), Black, Curzio, and Terry (2014), Hunt, et al. (2016b), Poorman and Mastorovich (2014), Pratt (2016), and Stoker (2016) support the difficulty experienced by instructors when failing a student clinically. Scottish mentors who participated in the study by Duffy (2013) expressed feelings of failure as a mentor and guilt related to failing the student who was deemed weak. Nursing student mentors in England who failed a student in the clinical setting

reported a lack of confidence in their ability to assess students, anxiety, stress, frustration, and feelings of guilt and isolation (Hunt et al., 2016b). Feelings of guilt, blame, and discomfort related to failing the student were also reported by clinical faculty following the failure of a student in an undergraduate nursing program in the Eastern United States (Stoker, 2016).

Black et al. (2014) found similar emotional responses in a study of 19 mentors with students in their last clinical rotation in undergraduate nursing programs in the United Kingdom. Participants described feelings of stress, lack of confidence in their ability to evaluate students, questioning decisions, feelings of failure as a mentor, and intense feelings of guilt when failing a student because it was their final clinical rotation before graduating. In addition to feelings of guilt and self-blame, faculty participants in studies conducted by Poorman and Mastorovich (2014) and Pratt (2016) reported fear of retaliation by the students. Physical manifestations such as insomnia, feeling ill, and feeling physically and emotionally drained were reported by participants in studies by Duffy (2013) and Black et al. (2014).

Mentors in Black et al. (2014) and Stoker (2016) reported that viewing themselves as gatekeepers of the profession, the desire to protect the public from harm, a strong sense of obligation to prevent students who lacked the knowledge and skills to be safe practitioners from entering the workforce, and convincing themselves they had made the right decision helped them cope with the negative feelings related to failing a student clinically. Participants in studies by Duffy (2013) and Black et al. (2014) reported anger with previous mentors who had passed the student clinically. In the studies conducted by

Black et al. (2014) and Hunt et al. (2016b), participants admitted that faculty might assign underperforming nursing students a passing clinical grade and allow failing students to progress to avoid feelings of blame and fear.

Passing underperforming nursing students. The issue of passing underperforming nursing students in the clinical setting was brought to light in a seminal research study conducted by Duffy in 2003. Duffy (2003) discovered that clinical faculty found it difficult to document unsafe or questionable behaviors, which resulted in the failure to fail underperforming and unsafe students. Studies by L. Brown et al. (2012), Docherty and Dieckmann (2015), and Larocque and Luhanga (2013) further explored the issue of failing to fail underperforming nursing students. L. Brown et al. (2012) conducted a quantitative non-experimental design study to explore the experiences of nursing clinical mentors in Scotland related to passing students who should fail clinically. Participants identified difficulty proving their concerns were valid, feeling of pressure to pass a failing student because they believed the university or theory instructor would overturn the failure, and lack of confidence as reasons for passing a student who should have failed.

Clinical faculty in a study by Larocque and Luhanga (2013) shed light on reasons Canadian clinical faculty and preceptor's failed to fail nursing students who displayed unsafe or poor clinical performance. Participants in the study identified wanting to avoid the appeals process or student complaints, giving students the benefit of the doubt, and differing perspectives between the university and clinical faculty as reasons for passing students who should have failed. Consequences to the student who received a failing

clinical grade, such as loss of time, money, education, and career goals, were also taken into consideration. Docherty and Dieckmann (2015) found that failure to fail nursing students is an issue in the United States as well. Analysis of the data from 84 community colleges and universities in a western state revealed that 43% of respondents had given clinical students a higher grade than they wanted to provide, and 72.2% of respondents reported giving students the benefit of the doubt when determining clinical competence. Study participants cited lack of support for their decision to fail a student, knowing the student would be held back or removed from the program, and how far the student had progressed in the program as reasons for passing students whom they believe should have failed.

The common theme of support for the decision to fail an underperforming nursing student clinically was found in studies by Duffy (2003), L. Brown et al. (2012), Docherty and Dieckmann (2015), and Larocque and Luhanga (2013). L. Brown et al. (2012) concluded that it is vital for those responsible for evaluating nursing students in the clinical setting to have the confidence and support to fail students who should fail and protect the public from incompetent practitioners. Studies by Andrews and Ford (2013) and Dahlke, O'Connor, Hannesson, and Chettham (2016) further explored the reasons faculty may pass students who should fail clinically.

In a study by Andrews and Ford (2013), analysis of transcribed interviews with clinical faculty in Tasmania revealed the themes of role undertaking, role preparation, and overall experiences. Challenges related to role preparation as a clinical evaluator, assessment of students, and decision making about students' clinical competence

emerged as subthemes. Dahlke et al. (2016) found similar results in a study of clinical instructors in an undergraduate nursing program in Canada. Participants in the study reported that they were confident about having the information they needed, their level of knowledge, and their ability to guide nursing students in the clinical setting. Participants reported the desire for ongoing information and mentorship about how to teach and evaluate nursing students in the clinical setting.

Implications

Examining literature regarding the role of clinical faculty and evaluation of nursing students in clinical settings provided a foundation for exploring the experiences of clinical faculty evaluating underperforming nursing students. Early identification of students who do not meet clinical learning objectives and providing faculty with support and resources to address issues related to underperformance may reduce the risk of faculty passing students who have insufficient nursing skills and knowledge to provide safe patient care. Investigating the experiences of community college associate degree clinical nursing faculty evaluating underperforming nursing students provided information that I used to develop a policy recommendation regarding the formative assessment and remediation process for students deemed underperforming clinically at the research site.

In the policy document, I included recommendations for evaluation processes used in traditional and simulation clinical settings and the development of a clinical remediation policy. I explored how clinical faculty defined and evaluated underperforming in traditional and simulation clinical settings and compared clinical

evaluation tools used at the college to study results and evidence-based practices for clinical formative assessment and summative evaluation. Based on this comparison, I developed a clinical tool development policy that supported the use of objective measures for desired performance criteria on nursing clinical formative assessment and summative evaluation tools at the research site. The policy included training for clinical nursing faculty on the use of the formative assessment tool and a process for determining interrater agreement. The policy recommendation also included a clinical remediation policy as a resource to support underperforming nursing students.

Summary

The problem of evaluating underperforming nursing students in clinical settings is documented in the professional literature. The literature I reviewed in this section indicated that nursing faculty in traditional and simulation clinical settings have the responsibility for preparing nursing students to provide safe, competent patient care upon graduation. Yet, the roles, responsibilities, and evaluation methods may differ based on the clinical setting. There is evidence in the literature that clinical faculty in traditional and simulation clinical settings have similar definitions of underperformance, and subjective evaluation of nursing students is a problem in both clinical settings. Review of the literature also exposed the fact that determining to pass or fail a student clinically and the passing of underperforming students is an issue for nursing clinical evaluators in several U.S. states and other countries. A review of the literature revealed that the evaluation of nursing students in clinical settings is crucial to ensuring professional standards and high-

quality patient care; however, clinical nursing faculty may not receive adequate preparation for this role.

Exploring the experiences of faculty evaluating underperforming nursing students in clinical settings using a descriptive case study design provided insight into how faculty at a Midwestern community college defined and evaluated underperforming nursing students in clinical settings. I used the information gleaned from the study to recommend revisions to the study site's clinical formative assessment policies. Information I obtained from my study was also used to develop a clinical remediation policy for faculty to use when offering recommendations for improvement to students deemed underperforming during clinical formative assessments. Defined criteria and consistent formative assessment methods will support students' achievement of clinical competencies on summative evaluations, thereby improving overall patient care by increasing the number of graduate nurses prepared to deliver competent, safe, high-quality healthcare. In Section 2, I will describe the project study's methodology, including study design, sampling procedures, data collection, data analysis, and findings. Section 3 includes a discussion of the project, including rationale, description, evaluation plan, and implications. Appendix A contains the actual project. The last section of the document is Section 4, which includes reflections on the project study, implications, applications, directions for future research, and conclusions.

Section 2: The Methodology

Qualitative Research Design and Approach

I used a qualitative case study research design to explore faculty experiences evaluating underperforming students in clinical settings at one associate degree nursing program in a Midwestern state. Case study research designs should be employed when answering “how” and “why” research questions, when no control of behavioral events is required, and when there is a focus on contemporary events (Yin, 2014). As Yin (2014) noted, researchers use case study designs to explain real-life situations that may be too complex to explore through experimental or survey research designs. For this project study, I interviewed participants to gain a deeper understanding of faculty experiences related to evaluating underperforming nursing students.

Single case study designs provide in-depth understanding, expanded insights, and clarification of the significance of a particular topic or subject (Patton, 2015). The case for this study was the clinical faculty of one associate degree nursing program in a Midwestern state. According to Yin (2014), the purpose of a descriptive case study is to “describe a phenomenon in its real-world context” (p. 238). I explored the phenomenon of evaluating underperforming students in clinical settings in this project study. Nursing clinical instructors who had evaluated underperforming students in clinical settings participated in the study.

I also considered exploratory and explanatory case study designs for this study. According to Yin (2014), researchers use an exploratory case study design to identify questions for subsequent research and an explanatory case study design to explain how or

why a particular event occurred. Because I sought to describe the phenomenon of evaluating underperforming nursing students with a focus on one group of clinical nursing faculty in one nursing program, I deemed a descriptive single case study to be the most effective design. Other qualitative research designs considered for this study and found to be inappropriate were grounded theory, hermeneutic, and ethnography.

Researchers use a grounded theory research design to develop a theoretical model based on data from study participants (Creswell & Creswell, 2017). Gagné's (1972) five categories of learning and the NLN Clinical Nurse Educator Core Competency Implements Effective Clinical Assessment and Evaluation Strategies task statements (Patrick, 2019) provided a solid foundation for this study. If the purpose of this study were to explore the concept of underperforming in clinical settings, I could have used a hermeneutic research design. According to Patton (2015), researchers use a hermeneutic research design to explore the meaning of a topic within the context of a situation. The purpose of this study was to explore the experiences of faculty evaluating underperforming nursing students. Ethnography researchers explore behaviors within a cultural or entire social group (Ary, Jacobs, Sorensen, & Walker, 2013). I focused on the specific subset of nursing faculty who evaluate students in clinical settings for this study. I, therefore, concluded that a descriptive single case study design was the most effective for the study.

A quantitative research design was not appropriate to answer the research questions in this study. According to Creswell and Creswell (2017), quantitative research designs are best for describing trends or relationships among variables through the

collection of numeric data that can be analyzed using statistical procedures. Numeric data and statistical analysis would not have provided the information needed to explore and understand the experiences of faculty who evaluate nursing students in clinical settings. I opted to use a qualitative research design, specifically a descriptive single case study, for this reason.

Setting

A Midwestern community college associate degree nursing program was the study setting. A 2-year Associate in Applied Science (AAS) degree in Nursing and a Diploma in Practical Nursing are offered at the college. The nursing program is housed on five of the six campuses and admits as many as 130-150 students across the five campuses each fall and 96-100 students between the two larger-sized campuses each spring semester. The program employs 30 full-time masters-prepared nursing faculty. Clinical nursing faculty on the five campuses vary from three full-time faculty on the smallest three campuses, seven full-time faculty on the middle-sized campus, and 13 full-time and one part-time faculty on the largest campus. Many baccalaureate-and masters-prepared adjunct nursing faculty are employed each semester to meet clinical, laboratory, and simulation student learning needs. The number of adjunct clinical faculty varies in proportion to the number of nursing students enrolled on the campus each year.

Participants

I used both purposeful sampling and group characteristics sampling to select participants for the project study. Purposeful sampling involves selecting participants who can provide information that illuminates the research questions (Yin, 2014), whereas

group characteristics sampling involves selecting a group of participants who meet specific criteria (Patton, 2015). Because the purpose of the study was to gain an understanding of the experiences of clinical nursing faculty who evaluated underperforming nursing students, I purposefully selected only clinical nursing faculty for this study. I asked that only those clinical faculty with the characteristic of experience evaluating underperforming nursing students participate in the study.

Once Institutional Review Board (IRB) approval was obtained from Walden University (approval no. 08-03-17-0423783) and the study site and the pilot study of the questionnaire were complete, I obtained a list of clinical nursing faculty from the college. The list consisted of 20 full-time, one part-time, and 26 adjunct instructors. I invited only clinical faculty in the associate degree nursing program who had experience with at least one underperforming nursing student in the traditional or simulation clinical setting to participate in the study. I asked nursing faculty who did not evaluate students in clinical settings, administrative faculty with no clinical responsibilities, and clinical faculty who had never had experience with underperforming nursing students in either the traditional or simulation clinical setting to excuse themselves from the study. Failing to complete the questionnaire constituted voluntary withdrawal from the study.

I anticipated that at least 50% of clinical nursing faculty would meet the inclusion criteria and complete the online questionnaire. Two weeks after the initial e-mail invitation, 17 clinical faculty (36.17%) had completed the online questionnaire, so I sent a second e-mail regarding the study to potential participants. Three weeks after the initial e-mail invitation, 20 clinical faculty (43%) had completed the online questionnaire, so I

sent a third e-mail regarding the study to potential participants. The third e-mail request resulted in one additional participant making the final response rate 21 faculty members, or 45%.

There were four demographic questions in the online questionnaire (see Appendix B). In Question 1, I asked participants to identify themselves as full-time, part-time, or adjunct nursing faculty. Twelve full-time faculty members (57.14%), one part-time faculty member (4.76%), and eight adjunct faculty members (38.90%) completed the online questionnaire. In Question 2, I asked participants to identify how long they had been clinical nursing faculty. In Question 3, I asked participants to determine the number of underperforming nursing students they had evaluated in traditional or simulation clinical settings. Tables 2 and 3 summarize responses to these questions.

Table 2

Respondents' Number of Years as Clinical Nursing Faculty

Employment status	0-2 years	3-5 years	6-10 years	> 10 years	Total
Full-time	0	5	4	3	12
Part-time	0	0	1	0	1
Adjunct	1	4	0	3	8
Total responses	1	9	5	6	21

Table 3

Number of Underperforming Nursing Students Evaluated by Respondents

Employment status	1-3 students	4-6 students	7-10 students	> 10 students	Total
Full-time	3	5	0	4	12
Part-time	0	0	0	1	1
Adjunct	4	2	0	2	8
Total responses	7	7	0	7	21

For the final demographic question, I asked participants to identify the type of clinical setting where they had evaluated underperforming nursing students. Ten of the respondents (47.62%) had evaluated underperforming nursing students in traditional clinical settings only. Eleven of the respondents (52.38%) had evaluated underperforming nursing students in both traditional and simulation clinical settings. None of the respondents indicated they had evaluated underperforming nursing students in only simulation clinical settings.

The online questionnaire concluded by asking for volunteers to participate in the interview portion of the study. Eleven clinical faculty agreed to participate in the interview portion of the study. Saturation and redundancy of data occurred with the information provided by the 11 interviewees, so no additional volunteers were sought. All interview volunteers were female. Although not explicitly requested, interviewees provided demographic information related to employment status and types of clinical settings where they had evaluated underperforming nursing students when responding to Interview Question 1. "First, could you tell me about your experience with evaluating nursing students in general in the clinical setting?"

Seven interviewees identified themselves as full-time clinical faculty, three identified themselves as adjunct clinical faculty, and one identified themselves as part-time clinical faculty. One interviewee (9.0%) had evaluated underperforming nursing students in the traditional clinical setting only. Ten of the interviewees (91.0%) had evaluated underperforming nursing students in both traditional and simulation clinical settings.

Researcher-Participant Working Relationship

To establish and facilitate a mutually trusting relationship with the study participants, I provided participants with an informed consent form along with study information and my e-mail address and phone number so participants could contact me to ask questions. I also ensured that the participants' questions were addressed sufficiently before proceeding with any data collection. In addition, I informed participants that they could withdraw from the study at any time without consequences. Last, I informed participants that their identity would be kept confidential and that I would not use any identifying information when reporting study data.

Protection of Participant Rights

I developed two different informed consents for this study. The first consent provided details on participating in the online questionnaire portion of the study. This form included information about me as the researcher, the purpose of the study, the procedure for collecting study information via the online questionnaire, the anticipated length of time required to complete the questionnaire, the voluntary nature of completing the questionnaire, risks and benefits of participating in the study, steps to ensure the anonymity of participants and information provided, and contact information for the university and myself. The second consent provided information for individuals who volunteered to participate in the interview portion of the study. This form included information about me as the researcher, the purpose of the study, the procedure for gathering data during the interview, the anticipated length of time required to participate in the interview, the voluntary nature of participating in the interview, risks and benefits

of participating in the study, steps to ensure the confidentiality of participants and information provided, and contact information for the university and myself.

This study posed minimal risk to participants. Discussing the evaluation of underperforming students is something clinical faculty likely do during any given semester. There was a small risk that participation in the study might be distressing if participants discussed instances when they evaluated underperforming clinical students in ways that they regretted or realized were problematic. Participants might have concerns that participating in the study may pose a threat to employment if they shared information about evaluating underperforming students in a manner that might be deemed unacceptable to their employers. Once participants indicated the intent to participate, they were reminded of the risks and benefits of participating in the study, that participation is voluntary, and that they could withdraw from any part of the study at any time.

To protect the identity of study participants who completed the online questionnaire, I turned off the option to view e-mail I.P. addresses in the web-based survey platform used to collect responses. I kept all information provided by the interviewed study participants confidential, as indicated in the consents. I deleted names and contact information of interviewees from my university e-mail inbox and trash folders. I did not include any identifying information in the interview transcripts. Interviewees were randomly assigned a study code number and pseudonym.

Data Collection

I collected data from two different sources: a self-developed online questionnaire and individual semistructured interviews. Appendices B, C, and D contain the online

questionnaire, the protocol used for the semistructured interviews, and the e-mail to potential participants, respectively. Collecting multiple sources of evidence in case study research provides the potential for converging lines of information and triangulation of data (Yin, 2014). I derived questions on the online questionnaire and interview protocol from the literature related to evaluating underperforming clinical students, Gagné's five categories of learning, and ten of the 11 NLN Clinical Nurse Educator Core Competency Implements Effective Clinical Assessment and Evaluation Strategies task statements. I did not explore the evaluation of the clinical learning environment in this study, so the task statement: Evaluates the quality of clinical learning experiences and the environment was not applicable.

Online Questionnaire

I used a self-developed questionnaire (see Appendix B) for this study because previously developed instruments related to underperforming students in clinical settings did not include questions about evaluating students in both the traditional and simulation settings. Questionnaires, as a type of survey interview, are a valid form of evidence for an embedded case study (Yin, 2014). SurveyMonkey, a web-based survey platform, was used to gather responses. Demographic data of employment status as clinical nursing faculty, the number of years as clinical nursing faculty, and the number of underperforming nursing students evaluated were collected only to describe the case study participants. All other questions were open-ended and explicitly related to evaluating underperforming nursing students in clinical settings.

Pilot test of online questionnaire. After obtaining Walden University IRB approval and approval from the study site, I pilot tested the online questionnaire with a convenience sample of six clinical nursing faculty at the college (see Appendix E). I informed faculty participating in the pilot test of the purpose, voluntary participation, and right to withdraw from the study. I asked pilot participants to review the questionnaire for the time it takes to complete, wording, grammar, and understanding of responses, if the title reflected the purpose of the questionnaire, clarity of direction and content, language and reading levels, and if the content fit the purpose of the study. I excluded responses obtained during the pilot test from the research study.

Pilot test participants reported an average of 19.8 minutes to complete the online questionnaire. All participants agreed that the title reflected the purpose of the questionnaire, the content fit the purpose of the study, and the language and reading levels were appropriate for clinical nursing faculty. One participant recommended adding more information to the responses for the number of underperforming nursing students evaluated in clinical settings to prevent confusion with the question about years of experience. The words “I have evaluated” and “underperforming nursing students in the traditional and/or simulation clinical setting” were added to each response to clarify the intent of the question.

Two pilot test participants noted that the questions related to written information regarding an underperforming nursing student were too similar. I reworded one of the questions to clarify that it was asking about subjective words to describe an underperforming nursing student. According to two participants, the phrase “would you

typically use” may be confusing to faculty who have only evaluated a small number of underperforming nursing students in clinical settings. I replaced this phrase with “from your experience.” Based on feedback from one of the pilot test participants, the words “provide examples” was added to the question asking about how underperforming nursing student performed in each of the areas of clinical learning.

Semistructured Interviews

Interviews are an essential source of case study evidence (Yin, 2014). I conducted semistructured interviews using the interview protocol as a guide (see Appendix C). According to Patton (2015), interview protocols serve as a checklist to ensure relevant topics are covered with each study participant. Interviews were semistructured so participants could freely describe their experiences working with underperforming students from their perspectives.

Data Collection Processes

After making changes to the online questionnaire based on the pilot test, I sent an e-mail to all clinical faculty on the list provided by the study site inviting them to participate in the study. The e-mail contained a description of the study, a list of inclusion criteria, and a brief description of the study procedures (see Appendix D). A copy of the informed consent was attached to the e-mail. Participation in the online questionnaire was anonymous. At the end of the online questionnaire, participants had the option of e-mailing me to volunteer for the interview portion of the study. I sent an e-mail reminder 2 weeks and 3 weeks after the initial e-mail invitation to encourage more clinical faculty to participate in the study. After 4 weeks, the link to the questionnaire closed.

I contacted all respondents who volunteered to participate in the interview portion of the study via phone to confirm their willingness to be interviewed. During initial contact, interview volunteers could ask questions and withdraw from the interview if desired. I conducted interviews in person at a location and time agreed upon by the interviewee and myself. I informed participants that the interview location needed to allow for privacy and required up to 60 minutes of uninterrupted time. Most of the interviews occurred in a place away from student areas, and the interviewee's office or occupied classrooms. One interview occurred in a conference room at the interviewee's alternative workplace, and one occurred in the interviewee's home.

I asked interviewees to sign the interview informed consent and verified the affirmation of inclusion criteria and permission to record before beginning the interview. I gave interview participants a list of questions to reference and instructed that they could take a break or discontinue the interview at any time. I determined the interviewee's study number and pseudonym by having participants draw a number from a bag containing the numbers one through 11 and a name from a bag containing 15 different names.

Data Tracking Process

Once the online questionnaire closed, I downloaded the responses to my personal computer in a password-protected folder. I placed a copy of the online questionnaire responses on a dedicated thumb drive as a back-up, and the questionnaire on SurveyMonkey deleted. I obtained audio recordings of interviews to facilitate accurate transcription of interview information. I also documented field notes during each

interview to describe the physical setting of the interview, appearance, and behaviors of the interviewee, and to serve as an adjunct to the taped interview dialogue. Once interview transcripts were completed and approved by interviewees, I erased the interview audio recording. I saved the interview transcripts in a password-protected folder on my personal computer. I placed a copy of the interview transcript on the same dedicated thumb drive as the online questionnaire responses as a back-up. The thumb drive will be kept in a locked drawer at my home for 5 years then destroyed.

Role of the Researcher

As the Nursing Simulation Coordinator at the study site, I had an established professional relationship with many of the participants in the study. I did not directly supervise or evaluate any of the study participants. To ensure study participants separated my professional role from my role as researcher, I used only my Walden University e-mail to communicate information related to the study. When contacting study participants, I referred only to my role as a researcher and not a faculty member. Because interview participants knew me, there was a potential risk they included responses they thought would provide me with the information I desired. I tried to reduce this possibility by reminding the clinical faculty that their responses needed to be honest. Before each interview, I wrote reminders to myself not to engage in any conversation that was not related to the study interview and asked the interviewee to do the same.

I recognize that I may have had biases throughout this study process related to evaluating underperforming students in the simulation clinical setting. I began this study with the underlying assumption that clinical faculty have difficulty evaluating

underperforming nursing students in traditional clinical settings and that that underperforming clinical nursing student behaviors can be identified more easily in simulation clinical settings. I tried to curtail these biases by staying in touch with my perspectives during this study by writing reflective field notes after each interview session. I believe written recognition of my subjective thoughts, impressions, and biases helped me maintain transparency during this project study.

Data Analysis

Research findings for this project study consisted of demographic data and qualitative data from multiple sources. Demographic data were obtained through multiple choice and select all that apply questions on the online questionnaire. Results of demographic data were discussed previously (see Participants section). I gathered qualitative data through open-ended questions on the online questionnaire and semistructured interviews.

I used MAXQDA, a qualitative analysis software product, to sort study data from the online questionnaire and interview transcripts, organize the data into categories, identify codes, patterns, and discrepant cases, and determine subthemes and themes. To prepare the data for analysis in MAXQDA, I downloaded responses from each question on the online questionnaire into a separate Microsoft Word document. I transcribed the interview recordings using Dragon Naturally Speaking software. I verified the transcription with the interview recording. I sent the transcript to each interviewee to review for accuracy and to ensure it reflected what they recall sharing during the interview.

I started data analysis by sorting responses to the online questionnaire and interviews into categories based on the question number. For example, all responses to the online questionnaire Question 5 were placed together in a separate folder within the MAXQDA program. I used content analysis to review text and identify reoccurring words and phrases found in the online questionnaire responses. Then using the MAXQDA software, I organized the reoccurring terms and phrases into categories of similar terms or synonyms and identified a code word for each category of terms.

Once all interview transcripts were approved, I used the same process to code data from the interview transcripts. Next, I compared the codes developed from a review of the online questionnaire data and interview transcripts and combined matching categories. To organize the study data into subthemes, I using deductive analysis to compare the final set of categories generated from the online questionnaire and interview data to Gagné's five categories of learning and the applicable NLN Clinical Nurse Educator Core Competency Implements Effective Clinical Assessment and Evaluation Strategies task statements. Table 4 identifies information data used to develop themes to answer the research subquestions. According to Yin (2014), using the original theories on which the case study is based is a logical strategy to organize case study information. Finally, I organized the subthemes generated through deductive analysis into major themes to answer each of the research subquestions.

To achieve triangulation, I compared transcribed interview documents and online questionnaire data, alignment of data to study conceptual frameworks, and the peer review of analyzed data. Review of study data and interpretation by a colleague who will

critique the information, ask questions, and provide a different perspective enhances the credibility of the data analysis (Patton, 2015). The peer reviewer whom I selected had 10 years of experience in nursing education and has a doctorate in research.

Table 4

Information Used to Answer Research Subquestions

Research Subquestion	Online Questionnaire Data	Interview Data	Conceptual Framework
How do clinical nursing faculty identify students who are underperforming in clinical settings?	Question 5 Question 6 Question 7	Question 2 Question 3a Question 4a Question 5a Question 6 Question 7 Question 8	Gagné's five categories of learning
How do clinical nursing faculty describe students who are underperforming in clinical settings?	Question 8a Question 8b Question 8c Question 8d Question 8e	Question 3b Question 4b Question 5b Question 6 Question 7 Question 8	Gagné's five categories of learning
How do clinical nursing faculty evaluate students identified as underperforming in clinical settings?	Question 9 Question 10	Question 3c Question 4c Question 5c Question 6 Question 7 Question 8	NLN Clinical Nurse Educator Core Competency Implements Effective Clinical Assessment and Evaluation Strategies task statements

I provided the peer reviewer responses to the online questionnaire and all transcribed interviews. I used the interviewees' pseudonyms on the interview transcripts instead of any identifying information. Results of the peer review (see Appendix F) confirmed identified themes and alignment with Gagné's five categories of learning and the applicable NLN Clinical Nurse Educator Core Competency Implements Effective

Clinical Assessment and Evaluation Strategies task statements. The peer reviewer also provided recommendations for comparing additional theories and research evidence to data results, and suggestions for future research.

During deductive analysis of the data, I placed subthemes that that did not align with Gagné's five categories of learning and the applicable NLN Clinical Nurse Educator Core Competency Implements Effective Clinical Assessment and Evaluation Strategies task statements in a separate folder within the MAXQDA program. Once the analysis was complete, I reviewed these subthemes and compared them to the final study themes. I analyzed discrepant and rival data and considered possible reasons for their occurrence.

Data Analysis Results

As noted previously, there is evidence that nursing faculty at the study site have given passing grades to students who were deemed underperforming in the clinical setting. The goal of data analysis was to explore how nursing clinical faculty identify, describe, and evaluate underperforming nursing students in clinical settings and develop a project deliverable for the study site based on the results. Responses to open-ended questions on the online questionnaire and during interviews resulted in a large amount of data related to the experiences of nursing faculty evaluating underperforming nursing students in clinical settings.

Online Questionnaire Open-ended Question Findings

Questions 5 through 10 on the online questionnaire required open-ended responses. Participants were not required to post responses to every question and could exit out of the questionnaire at any point; as a result, not all participants answered every

question. Twenty-one faculty members responded to Questions 5, 7, 9, and 10. Fifteen faculty members responded to Question 6. Eighteen faculty members responded to Question 8: Subquestions A, B, and D, and 15 faculty members responded to Question 8: Subquestion C.

Open-Ended Question 5

In the first open-ended question, I asked participants to indicate subjective words they would use to describe a nursing student who was underperforming in the clinical setting. Terms related to personality traits such as lack of motivation, disengagement, and lack of confidence were used most by faculty to describe underperforming nursing students. Table 5 contains a summary of answers occurring two or more times.

Table 5

Summary of Words Used to Describe Underperforming Nursing Students in the Clinical Setting

Description	Number of occurrences
Lacks motivation/not motivated/unmotivated	6
Disengaged/detached	5
Lacks confidence/unconfident	5
Unable/lacks ability	3
Requires assistance/requires guidance/needs repeated direction	3
Lacks improvement/failure to show progression	3
Unable to correlate theory to practice	3
Unsafe	3
Evasive/often missing or difficult to find	2
Difficulty/difficult	2
Lacks critical thinking skills	2
Lacks focus/ disorganized	2
Lacks knowledge	2
Stands back and tries to let peers take over/does not participate in cares	2
Unprepared	2

Open-Ended Question 6

For Question 6, I asked participants to write a definition of an underperforming nursing student. Twelve of the respondents developed definitions that focused on a lack of critical thinking skills and the inability to achieve course or clinical competencies, implement nursing skills and interventions, and provide safe patient care. One faculty member defined an underperforming nursing student as someone "...who cannot pull concepts together from theory and demonstrate them at the basic nursing level in clinical to provide safe, efficient, and prioritized nursing care to a variety of patients." Three faculty members developed definitions that focused on the student's lack of interpersonal skills. One faculty member defined an underperforming nursing student as one who "Does not want to be part of the team, not a team player, thinks no one listens and does not respect other's opinions."

Open-Ended Question 7

How participants identified underperforming nursing students in clinical settings was explored in Question 7. Faculty members described a variety of subjective means for identifying underperforming nursing students, including observing interpersonal behaviors such as interactions with peers and staff and responses to feedback for improvement, monitoring organizational and time management skills, and eliciting information from patients and staff. Objective measures for identifying an underperforming nursing student included participation in pre and post clinical activities, the accuracy of medical records entries, responses to specific questions about their assigned patient's condition and medications, scores on pre and post clinical and

simulation assignments, observing the performance of specific nursing skills, and comparing clinical ratings from week to week. I future explored how clinical nursing faculty identify underperforming students during faculty interviews.

Open-Ended Question 8

In Question 8, faculty perception of how underperforming nursing student's clinical performance aligned with each of Gagné's (1972) five categories of learning were explored. I asked respondents to provide examples of how an underperforming nursing student demonstrated motor skills (performing nursing interventions), verbal information (expressing nursing knowledge and information verbally), attitude (interpersonal skills, beliefs, emotions, and behaviors), intellectual skills (apply information to different situations), and cognitive strategies (application of verbal information, intellectual skills, motor skills, and attitude to solve simple to complex problems) in the clinical setting. Table 6 lists the most common categories and examples provided by respondents for motor skills, verbal information, and attitude.

Motor skills. The most common category for motor skills related to students' inability to complete nursing procedures correctly in a timely manner without a significant amount of assistance from faculty. Three respondents provided examples of a student's inability to adapt to different equipment or apply information related to skills in a different setting. Four faculty members provided examples of students who performed procedures or skills unsafely, and one faculty member provided an example of a student who avoided opportunities to perform skills in the clinical setting.

Table 6

Most Common Categories and Examples of How an Underperforming Nursing Student Demonstrates Motor Skills, Verbal Information, and Attitude in Clinical Settings

Area of Learning	Most Common Category	Examples
Motor Skills	Not able to complete nursing procedures correctly or with minimal assistance	<ul style="list-style-type: none"> • Inability to apply sterile principles/not maintaining sterility. • Not prepared to complete a skill or procedure. • Requires step by step verbal instructions to perform a skill or procedure. • Cannot distinguish the difference in related skills (such as IM vs. SQ medication administration). • Unable to manage equipment/fumble with equipment.
Verbal Information	Unprepared to provide information to the instructor or patient	<ul style="list-style-type: none"> • Unable to explain rationale for doing a procedure or providing specific patient care. • Unable to educate the patient on medications or procedures ordered.
Attitude	Avoids interacting with the instructor, staff, peers, and patients	<ul style="list-style-type: none"> • Often found sitting in nurses' station or break room. • Do not initiate interactions with the patient; spend minimal time with the patient. • Often found on phone texting or accessing social media. • Do not offer to help peers or staff. • Isolated, quiet, withdrawn.

Verbal information. Seven respondents provided examples of students who were unprepared to provide information related to their assigned patient's clinical situation, medical condition, or prescribed medications. Six faculty members provided examples of students who refused to provide information verbally, avoided responding to questions, or became defensive when asked to provide information. Two faculty members' examples related to a student providing inaccurate information about a patient. Examples

from two other respondents related to requiring frequent prompting for the student to provide the expected information, and one faculty member provided the example of a student who was unable to use correct medical terminology.

Attitude. Students who avoided interacting with the instructor, staff, peers, and patients during clinical was the most common category of examples for attitude. Five faculty members provided examples of students who displayed a defensive attitude or became verbally defensive when given constructive feedback. Two respondents provided examples of students who did not take responsibility for their actions or blamed others for an error they made. The example of students showing up late for clinical was provided by two other respondents. Two faculty members provided examples of students who displayed an inappropriate emotional response in front of a patient, and one faculty member provided the example of a student who used unprofessional language with peers in front of the instructor, staff, and patients.

Intellectual skills. Examples of nursing students' inability to apply information from theory to clinical were described by five faculty members. Five other respondents shared examples of students who were unable to make connections between clinical concepts or recognize the relationship between patient situations. Four faculty members described cases where the student was unable to think critically or apply knowledge and skills at a higher level. According to one respondent, "they try to accommodate the patient's every slight wish, such as getting them water or fluffing their pillow, instead of completing necessary nursing care." Other respondents wrote, "they are able to memorize but limited in the ability to apply/analyze," "student cannot seem to grasp clinical

concepts,” and “they are unable critically think and prioritize care.” Two faculty described examples of students who did recognize the significance of abnormal laboratory or abnormal assessment and did not report those to the instructor or staff nurses. One respondent described a student who had difficulty applying knowledge to a patient situation because of anxiety, and another faculty member described a student who, in their opinion, lacked the effort required to apply information from the classroom to the clinical setting.

Cognitive strategies. Categories of examples for how underperforming students demonstrated cognitive strategies were divided evenly among most of the respondents. Three faculty provided examples of students who were unable to solve simple problems in the clinical setting. Three different respondents described students as task oriented. The example of students who were unable or unwilling to adapt to changing patient conditions or issues that occurred during a clinical day was described by three additional faculty members. Three other faculty members provided examples of students who did not modify behaviors when given feedback by faculty or staff. Two faculty members used the phrase “unable to see the big picture” to describe underperforming students in this category and one respondent described a student who avoided addressing complex problems when they occurred in the clinical setting by “hiding”. Table 7 includes a summary of specific examples provided by the faculty.

Table 7

Categories and Examples of How an Underperforming Nursing Student Demonstrates Cognitive Strategies in Clinical Settings

Category	Examples
Unable to solve simple problems	<ul style="list-style-type: none"> • Student does not demonstrate the ability to solve simple problems, let alone complex ones. Does not use resources she/he has been given to determine what to do. • Cannot apply previous situations or theory information to solve a problem. • The student only thinks at a basic knowledge level. Implements an intervention only because it was ordered, or that is what they were instructed to do. For example, the patient's oxygen level is low, so the student increases the O2 but cannot explain why they should do this.
Unable to adjust behaviors based on feedback	<ul style="list-style-type: none"> • When I redirect them, they express understanding, and I see the same practice occurring again. The student will state, "they know," and then proceed to do the same thing again. • Inability to self-critique or listen to/comprehend positive criticism. Fails to develop an action plan or set goals to improve clinical performance. • Does not readily understand and act on directions from others, asks to be shown a skill repeatedly, does not know when to ask for assistance.
Task oriented	<ul style="list-style-type: none"> • These students often operate consistently under the knowledge/comprehension level of Bloom's taxonomy. • They have difficulty applying the nursing process and thinking critically - have difficulty providing a rationale for their actions. • Complete assessment/tasks in the order they learned them. • Inability to prioritize.
Unable or unwilling to adapt to changing situations	<ul style="list-style-type: none"> • Unable to evaluate and re-assess when the expectations deviate from what was anticipated. • Unprofessional responses, such as crying or getting defensive when things don't go as expected.

Open-Ended Questions 9 and 10

How clinical faculty provide verbal and written evaluation feedback to underperforming nursing students in the clinical setting was explored in the last two

open-ended questions. In Question 9, I asked participants to describe the verbal feedback they provided, and for Question 10, I asked participants to describe the written feedback they provided. When responding to these two questions, faculty members reporting they would provide similar information to students in writing and verbally. Faculty members included multiple types of verbal and written feedback when responding to the questions.

Six faculty members reported they provide specific examples of underperformance during verbal feedback. Six faculty members said they provide specific examples of underperformance in written feedback. Identifying specific expectations for future clinical experiences on written feedback was reported by three respondents and three respondents during verbal feedback. Seven faculty members reported the use of a particular clinical evaluation tool or form for providing written feedback to students in the clinical setting. Six faculty members identified they require students to self-reflect during verbal feedback sessions.

In comparison, two faculty identified that they require students to self-reflect on written feedback. Including words of encouragement was noted by three respondents when providing verbal feedback and by two respondents when providing written feedback. Two faculty members noted they list recommended remediation activities during both verbal and written feedback.

When providing verbal feedback to underperforming nursing students, three faculty members also reported assisting students in exploring issues outside of school that may be affecting their clinical performance. One respondent stated they ask students what assistance faculty can offer, and one faculty member noted they always provide a

rationale for why the student must identify areas for growth and develop a plan for improvement. Two faculty members indicated that they include specific goals for the students to meet on written feedback, and one faculty member reported that they provide a variety of printed resources to underperforming students along with written feedback.

Throughout responses related to written and verbal feedback, faculty members reported using a process that included describing something the student did well, areas for improvement, and remediation plans. When referring to this process, one faculty member stated,

I use the sandwich method. I try to identify one thing that went well first, then discuss the areas that may have challenged the student. Once I have outlined the challenges, I swing back and end on a positive note and outline the remediation that will be required.

Semistructured Interview Findings

The semistructured interviews provided in-depth information related to faculty experiences with underperforming nursing students in both the traditional and simulation clinical settings. All eleven interview participants provided information for Interview Questions 1, 2, 3, 4, 6, 7, and 8. Four participants provided the example of a second student they deemed underperforming in either the traditional and/or simulation setting for Question 5. The other seven participants chose not to provide additional student examples. I aligned responses with pseudonyms assigned for the research study to protect the identity of study participants.

Interview Question 1

For Interview Question 1, I asked participants to share their experience with evaluating nursing students in general in the clinical setting. Responses to this question varied with no consistent themes other than the demographic data noted previously (see Participants section). Additional responses to this question included information regarding years of experience, levels of students evaluated, types of clinical units where students were evaluated, types of evaluation methods, and the interviewees' reflections of being a nursing faculty member and/or clinical faculty in a nursing program.

Interview Question 2

For Interview Question 2, I asked participants to share their definition of underperforming nursing students in the clinical setting. Carol defined an underperforming nursing student as "one who is not meeting the objectives of the clinical course or not meeting the objectives of the simulation." Laura, Cathy, and Jane provided very similar definitions. Definitions provided by Doris, Linda, and Racheal focused on participation in the clinical learning experience. According to Doris,

An underperforming student is not engaged. You may find them more, well one of two things, they are either sitting in the nurse's station or in they are in the patient's room all the time. But when you are in the room with them, they are really not doing anything of substance.

Linda supported this definition, "they just don't seem to understand the objectives, and even with remediation, they struggle with the intent of why they are there." Racheal defined an underperforming student as "somebody who didn't take the

initiative or responsibility for their own learning. Somebody who doesn't participate, especially in the clinical or lab setting. Someone who avoids attention avoids the interaction of the experience".

Safe practice was the focus of definitions provided by Sally and Janet. Sally stated, "an underperforming nursing student is one that is not keeping safety in mind when they are taking care of their patient" and Janet noted, "some of the weakness that came out was kind of glaringly, any medication errors, you know safety and medication administration is pretty black and white. You either do it, or you don't do it".

Jean and Betty provided definitions that focused on the student's ability to apply course information in the clinical setting. Jean stated, "my biggest thing is that I can't see them transferring what they have learned in the classroom or lab to the clinical side. They can't either replicate it or make it applicable in the live practice". According to Betty, an underperforming student is "one who lacks the ability to apply and analyze theory content to caring for a patient and has that difficulty recognizing priority concerns."

Interview Questions 3, 4, and 5

Interview Questions 3, 4, and 5 consisted of five subquestions to explore the experience of faculty evaluating an underperforming nursing student in different clinical learning environments. Responses to Question 3 provided information regarding the experiences of faculty evaluating a nursing student in the traditional clinical setting, whereas responses to Question 4 provided information related to the experiences of faculty evaluating a nursing student in the simulation clinical setting. Jane had no experience evaluating underperforming students in the simulation clinical setting and,

therefore, did not respond to Question 4. In Question 5, I provided the opportunity for interviewees to share experiences of evaluating an additional underperforming nursing student in either the tradition or simulation clinical setting. Janet, Jean, and Laura shared information about evaluating another nursing student who was underperforming in the traditional clinical setting. Linda shared information about evaluating an additional nursing student who was underperforming in both the traditional and simulation clinical settings.

Interview Subquestion 3a, “How did you identify that the student was underperforming [in the traditional clinical setting]?” For Janet, Cathy, Racheal, Doris, and Jane, unsafe practice when administering medications in the clinical setting was the key indicator of an underperforming student. According to Racheal, “med passes are a pretty good indicator, that first red flag.” Cathy echoed this example by stating, “I first identified it during medication administration pass. The student was unable to recall information about medications”.

Jane, Doris, and Janet shared specific examples of unsafe medication administration by the underperforming nursing student. Jane stated,

She really didn't realize that medications really needed to be given at the time they're supposed to be given. She came and told me that she was going to go have her supper. I let her go have her supper thinking she would pick up on it when she got back, that she needed to give this [medication]. When we discussed this, she didn't realize there was anything that needed to be given.

Doris identified that the student was underperforming when

I had instructed them to pull medication out of the patient's drawer, do not open the packages up until I get there. When I walk up to give meds with them, here is this whole cupful of meds and all the wrappers in the garbage.

Janet provided a similar example

The student had already scanned all the medications and opened them and put them all in a med cup. She had already started to give the patient the medications. I had to try to determine by color what she had in her cup because she wasn't able to recall. I said, now you have already given a couple of those, there is nothing we can do, but I want you to check his blood pressure and apical now, and his blood pressure was 80 over 50. Then we went on to her second patient, and on the second patient, she did the same thing.

Lack of preparedness and time management was the primary indicator of an underperforming student for Carol, Linda, and Sally. According to Carol, "the student had time management issues and arrived in clinical tardy." Linda identified the student as underperforming when

Initially, the student was very anxious and repeated things back to me, so I would have to constantly reaffirm and repeat very simple directions. That was my first trigger with that individual. So, working throughout the clinical experience, I would ask them to come prepared, either reading or certain proof things, and they still wouldn't do that.

Sally stated,

I had asked her to do a central line dressing change at clinical. She had wanted to go ahead and watch a video before, and I told her we really don't have time when we're on the floor. I explained to her that you need to be prepared whenever you come to the clinical. For all the skills that you have done, you need to be prepared.

Jean and Betty identified students as underperforming when they were unable to apply skills and knowledge from class or laboratory to the clinical setting. Jean stated, "she wasn't bringing anything forward from theory or anything that we had discussed previously for her to build on. She wasn't able to apply it later on". According to Betty, "the student was unable to answer a lot of questions regarding medications and lab values. Particularly this underperforming student had a really hard time discussing the why behind certain cares and medications that the patient was given". Laura identified the underperforming student through a lack of engagement with peers and the instructor, "Any of the post conferences or any of the interactions I would have with her, she didn't say anything unless I really prompted her to say something."

In addition to the critical indicators of an underperforming nursing student identified above, Doris, Sally, Racheal, Janet, and Linda also described deficient interpersonal skills, inappropriate behaviors, and emotional responses demonstrated by the underperforming nursing students. Sally added that the student was "very belligerent; she was very upset that I wouldn't let her watch the video in clinical." Racheal included, "there were some professionalism issues as well with this particular student. They just

really didn't understand that level of a professional nurse, what communication is appropriate". Doris also noted, "when other students would come up with suggestions or an explanation of what needed to be done, they would jump in and say, 'oh no.' If they came up with something and somebody tried to challenge them, they would get offended and not interact with anyone". According to Linda

This particular student had very poor relationships with the clinical nurses that they worked within the department; it wasn't just one; it was every week. I saw either not informing them of changes in the condition of their patient, not doing an assessment, and charting that they did it. Then we get very defensive when asked about that with the nurses they were working with as well as myself.

Janet described the following behaviors demonstrated by the student in her example.

I had to give her a lot of guiding, and the longer we stood there, the more frustrated she became. I could tell she was upset. She was angry with me when she left. That following evening the student began to send me emails and text messages at home explaining that she was very upset. After I probably got the 6th email from her. I did tell her that I felt like we had kind of exhausted our conversation.

Interview Subquestion 4a, "How did you identify that the student was underperforming [in the simulation clinical setting]?" Lack of engagement was the key indicator of an underperforming student in the simulation clinical setting for Carol, Laura, Cathy, and Doris. According to Cathy, "the student was not engaged in teamwork, was not engaged with the client, and did not switch roles when prompted." Laura noted,

“she would always be in the back of the room. She would never be up dealing with the patient directly”. Doris provided a similar example. “In the actual scenario, when they were interacting, kind of hanging back not really being involved as one of the team members.” Carol stated, “the student stood in the corner, and the student was not engaged during the simulation experience, did not take part in the debrief or pre-brief, did not take part in the calculation of medications.”

For Jean, Linda, Racheal, and Betty, underperforming students in the simulation clinical setting were identified by focusing on tasks rather than activities that involved higher-level thinking. Racheal noted, “you get into the simulation setting, and they’re doing a skill that is very simple and doesn’t require a lot of critical thinking, like taking vitals or just passing a medication pill.”. Jean stated, for this one, the most obvious thing to me is they choose to document or something that involves them taking the least invasive, critical thinking role. The role that allows them to step outside of being involved”. According to Betty,

I think one way you can definitely tell underperforming students in the simulation setting is their participation in pre and post-debriefing, and you can definitely tell during simulation; these students are the students that want specific tasks, something basic that doesn’t require critical thinking or collaboration with the team members.

Linda noted,

That student would hold back, was not getting in the middle of the simulation.

Would wait for cues from other team members from other members to tell them

what they needed to do next versus knowing what needed to be next in the sim.

Lacked initiative during that simulation.

For Janet and Sally, the inability to apply skills and knowledge from class or laboratory was the critical indicator of underperforming in the simulation clinical setting. Sally stated, “the student had no idea to do a focused assessment on the respiratory patient. The simple things like the O₂ sat, getting the vital signs right away, and making sure the oxygen was on”. Janet provided the following example:

The student had assumed the role in the simulation of medication administration.

First, initially had a lot of difficulty calculating the flow rate per hour and how much medication that would be. They totally missed that concept that when we give IV medication boluses, we give it down at the site. If this had been a real situation, it would have taken hours for the patient to receive that.

Laura also identified emotional responses and behaviors demonstrated by the student who was underperforming in the simulation setting. According to Laura, “she seemed very defensive in a lot of debriefs.” Laura shared an incident when Laura and another clinical instructor counseled the student regarding her behavior, “it was a long talk. At one point, the student just got angry and thrust her arms down and lunged at the clinical instructor”.

Interview Subquestion 5a, “How did you identify that the student was underperforming [in the traditional or simulation clinical setting]?” Janet, Jean, and Laura shared information about an additional student who she deemed underperformed in the traditional clinical setting. Linda shared information about another student whom she

considered underperformed in both the traditional and simulation clinical setting. The key indicator of underperformance for Jean was the student's lack of self-awareness. Jean described an occasion when the clinical group was discussing how a patient's situation could be interpreted differently based on the patient's culture and country of origin. Jean noted, "the student was very opinionated. She considers herself very open but, at the same time, doesn't portray that at all times and doesn't see it in herself. So, making sure she kept her opinions out and provided unbiased care."

Communication issues were the key indicator of underperformance for Laura, Janet, and Linda. For Laura, the student's inability to communicate information about the patient was the key indicator, "I would go around and do rounds with the student. 'What's going on with your patient?' She could never tell me what was going on. I really think she did not know." Janet identified language barriers as the underlying cause of communication issues. Janet noted that the student was unable to administer IV medications even after providing the student with hands-on teaching and additional remediation sessions.

According to Janet,

Even with the one-one-intervention, she was just unable to put all the steps together in order to administer IV medications independently. I really felt like it was a language barrier and that the country she had come from, she said that she had never seen medical equipment like that.

The student in Linda's example demonstrated ineffective communication in both the traditional and simulation clinical setting. According to Linda,

In sim, I think she knows some of it but isn't willing to say it out loud because she might be wrong. I am seeing similarities in the clinical setting with her not speaking up, not verbalizing that she has the knowledge. I can't tell if it's a true knowledge deficit, or they are not speaking up because they are not real sure.

Interview Subquestions 3b, 4b, and 5b. For Interview Subquestions 3b, 4b, and 5b, I asked participants to identify a specific area of clinical learning where the student underperformed more than in other areas. I verbally provided a list of Gagné's (1972) Categories of Learning if the participant requested clarity, examples, or a definition for areas of clinical learning. Some participants stated they had difficulty narrowing examples to just one area where the student was underperforming and were permitted to provide more than one area if desired. Faculty in studies by Lewallen and DeBrew (2012), MacLeod (2015), and Mossey, Montgomery, Raymond, and Killam (2012) identified underperformance in several areas of clinical learning. Table 8 provides a summary of responses to Interview Subquestions 3b, 4b, and 5b.

Interview Subquestion 3c, "Share with me how you documented the student's performance on the clinical evaluation tool [in the traditional clinical setting]." All participants identified the use of a clinical evaluation tool to document student performance. Providing specific examples of areas of concern were described by Betty, Doris, Janet, Linda, Racheal, and Sally. Doris, Jane, Janet, Racheal, and Sally reported documentation of expectations for future clinical days. Carol, Doris, Cathy, Jane, and Sally noted the inclusion of remediation activities.

Table 8

Summary of Responses to Interview Subquestions 3b, 4b, and 5b, “Was There a Specific Area of Clinical Learning Where the Student Underperformed More Than in Other Areas?”

Specific area of clinical learning	Number of times identified			Total number
	3b: Traditional Clinical setting	4b: Simulation clinical setting	5b: Traditional and/or simulation clinical setting	
Interpersonal skills/professionalism	3	6	3 traditional and simulation	12
Apply knowledge - no specific area identified	3	3	Not identified	6
Apply knowledge - safe medication administration specifically identified	4	Not identified	1 traditional	5
Critical thinking	3	2	Not identified	5
Perform nursing interventions	2	2	Not identified	4
Verbalize knowledge	Not identified	Not identified	2 traditional and simulation	2
Time Management	1	Not identified	Not identified	1
Prioritization	Not identified	1	Not identified	1

Interview Subquestion 3c, “Share with me how you documented the student’s performance on the clinical evaluation tool [in the traditional clinical setting].” All participants identified the use of a clinical evaluation tool to document student performance. Providing specific examples of areas of concern were described by Betty, Doris, Janet, Linda, Racheal, and Sally. Doris, Jane, Janet, Racheal, and Sally

reported documentation of expectations for future clinical days. Carol, Doris, Cathy, Jane, and Sally noted the inclusion of remediation activities.

Betty, Carol, Doris, Laura, and Racheal discussed specific time frames for clinical evaluation documentation. Racheal described the use of weekly evaluations. Doris and Carol noted they documented at the time of an incident of underperformance. Laura and Betty shared that they completed documentation weekly and at the time of an incidence of underperformance.

Linda and Cathy stated they documented how the student met specific clinical objectives. Betty and Linda described evaluation tools as formative and summative. Jean and Cathy noted the deduction of points from the clinical evaluation score. Carol, Cathy, Jane, Janet, Linda, and Racheal documented required remediation activities, and Carol indicated that she recorded completion of remediation.

Completion of a document, in addition to the clinical evaluation tool, was described by Carol, Doris, Jean, Janet, Laura, Linda, Racheal, and Sally. Racheal described the additional form as

A way to document at another level that the student's been underperforming, this is why, this is what the remediation is, these are the resources that were offering them, to prove that I was reaching out to these individuals in case there is ever a need to reflect on documentation more specifically about a certain behavior or underperformance.

Interview Subquestion 4c, "Share with me how you documented the student's performance on the clinical evaluation tool [in the simulation clinical

setting].” All participants identified the use of an evaluation tool to document student performance in the simulation clinical setting. Providing specific examples of areas of concern were described by Cathy, Linda, Racheal, and Sally. Carol, Jean, and Janet noted documenting if the student met specific simulation learning objectives.

Doris and Linda stated they provided words of encouragement on the evaluation tool. Janet noted the inclusion of remediation activities, and Doris commented that she was objective in her documentation. Laura described completing a paper separate from the evaluation tool to document the incident of underperformance.

Interview Subquestion 5c, “Share with me how you documented the student’s performance on the clinical evaluation tool [in the traditional or simulation clinical setting].” Janet, Jean, Linda, and Laura shared information about documenting underperformance on the evaluation tool for an additional student in the traditional clinical setting. These faculty noted that they recorded how the student met specific clinical objectives/competencies. Linda and Jean identified deducting points from the clinical evaluation score and documenting expectations for future clinical days. Laura described completing a weekly evaluation tool, having the student self-reflect on the incident, and completing a student action report.

Interview Subquestions 3d, 4d, and 5d, “Tell me how progression decisions were made about the student. In other words, whether to pass him/her for the clinical rotation, advance him/her in the program, etc.? [in the traditional or simulation clinical setting].” Interview participants identified a variety of processes used to determine the progression of underperforming nursing students in the traditional

and simulation clinical settings. Participants identified a collaborative decision-making process and grades in the final grade in the classroom portion of a course as the standard means for determining progression for the students deemed underperforming in the traditional and simulation clinical settings. Participants identified scores on clinical evaluation tools as another means for determining progression for students considered underperforming in the traditional setting.

Collaboration. Carol, Doris, Jane, Janet, Laura, Linda, and Sally identified a collaborative process with the student, other clinical faculty, the lead clinical or course faculty member, and nursing program administration for students they deemed underperforming in the traditional clinical setting. Betty, Linda, Janet, and Sally identified a similar process for the student they considered underperforming in the simulation clinical setting.

Sally stated, “we flip-flop students, so they have more than one instructor the whole time, and we visited about her performance. We like to give them a chance, one chance, and then see if she can perform it the next time.” Doris noted, “the student went for two makeup days even though they had not missed any clinical to let somebody else evaluate their skills as well as give them the opportunity to maybe try to step up.”

Laura, Linda, and Janet provided specific examples of collaboration with lead faculty and administration. According to Laura,

I talked to the clinical lead and said, ‘you know this really isn’t right,’ and she said, ‘yeah, I agree.’ We all sat in a room, the four of us, the student, the clinical

lead, and the dean, and I. I think either the dean or the clinical lead said, ‘well, you have been unsuccessful in course.

Linda shared the following example:

I was a stakeholder in the whole decision. I was the one seeing the lack of preparedness, and at the end of it, it came down to unsafe practice for me. I shared that with the course lead for that instruction, and the dean became involved, and so did student services. So, it was an accumulation of me being the direct observer and then meetings with the department head to determine if they could continue.

Janet provided a similar example,

I think probably the burden of passing or not passing relies heavily on the clinical instructor that has had the student. Then it is usually discussed with the program chair. Sometimes the program chair would recommend that all the clinical faculty get together and make a determination if the student should repeat a course and not go on.

Final grade in the didactic portion of the associated course. Cathy, Jean, Laura, and Racheal asserted that a failing grade in the classroom portion of a clinical course is often the determining factor of the progression of students deemed underperforming in the traditional and simulation clinical settings. Laura noted, “at the end of the semester, I didn’t feel like I had enough written not to pass her, and I knew she wasn’t going to pass the course from the classroom part.” Jean responded, “the student failed the theory portion as well. So, I guess it wasn’t dependent on the clinical or the simulation. The student failed theory, so they were no longer in the program at that

point”. Racheal shared, “with the evaluation tool, it was extremely challenging to have a student fail in the clinical setting. Whether they pass or fail often comes back on their theory course work”.

Scores on clinical evaluation tools. Betty, Cathy, and Jean identified final scores on the clinical evaluation tool as the determining factor of progression for students they deemed underperforming in the traditional clinical setting. Betty shared the example of assigning a failing clinical score, “I documented at length any area that she was not performing in and why she was not performing in this area. She did fail to pass clinical, achieving 70% accumulation on her weekly clinical evaluations”. Jean provided examples of assigning passing scores for both students she deemed underperforming. For one student, Jean noted, “a few scores on the clinical evaluation tools were below 78%. Overall, she met the requirements of an average of 78% on all the clinical evaluation tools to pass.” For the second student, Jean stated, “the student had some issues in a few different situations, she did earn a passing grade after she finished above the 78%.”

Interview Subquestions 3e, 4e, and 5e “Do you know the outcome of the student, did he or she complete the program?” The purpose of asking Interview Subquestions 3e, 4e, and 5e was to explore the progression status of the students deemed underperforming by interview participants. During the semistructured interviews, faculty shared their experiences of evaluating 14 different underperforming students in the traditional clinical setting, ten different underperforming students in the simulation clinical setting, and one student who was deemed underperforming in both the traditional and simulation clinical setting. According to faculty respondents, one of the

underperforming students in the traditional clinical setting and the student who was deemed underperforming in both the traditional and simulation clinical setting were still in the clinical course at the time of the interview. Faculty stated they did not know the progression outcome for two students in the traditional clinical setting and one student in the simulation clinical setting. Table 9 includes a summary of responses related to progression outcomes for the 20 students remaining.

Table 9

Summary of Responses to Interview Subquestions 3e, 4e, and 5e, “Do You Know the Outcome of the Student? Did he or she Complete the Program?”

Clinical Setting	Number of students identified as underperforming by faculty	Progression Outcome	
		Received passing grade in the clinical course	Completed program/eligible to take the nursing licensure exam
Traditional	11	5 (45%)	4 (36%)
Simulation	9	6 (67%)	3 (30%)
Totals	20	11 (55%)	7 (35%)

Interview Questions 6, 7, and 8

The intent of Interview Questions 6, 7, and 8 were to provide participants the opportunity to share additional information related to evaluating students they deemed underperforming in clinical settings. I asked participants to share their perception of evaluating underperforming students in specific clinical settings for Interview Question 6. In Interview Question 7, I asked the faculty to identify the biggest challenge of evaluating nursing students in clinical settings. I offered participants the opportunity to share any final thoughts related to evaluating underperforming nursing students in clinical settings for Interview Question 8. Responses to these questions yielded a variety of responses

related to the faculty experiences when working with underperforming students in clinical; however, not all information provided related directly to the research questions for this project study. I included data specific to the research questions in this section.

Interview Question 6, “Is there a difference between evaluating underperforming clinical students in the traditional versus simulation clinical setting? If so, how would you describe the difference?” Carol, Jean, and Jane maintained that there was no difference between evaluating underperforming students in the traditional and simulation clinical settings. According to Carol, “as long as you are evaluating them against those objective competencies, they would be fairly evaluated.” Jean noted, “if they are underperforming, they are underperforming, and you can usually see it pretty quickly in either setting.” Sally shared that underperformance has different implications based on the setting, “In the clinical setting, you have lives at risk so small mistakes can really change the outcome of the patient. In the simulated setting, you identify it to the student, and we have debriefing and talk about it”.

Betty, Jean, and Doris identified that the ability to recognize underperforming behaviors differs between the two types of clinical settings. Jean noted, “I feel like the simulation setting is easier to evaluate them as a group than in clinical. There are more nurses in there you should hold each other accountable for decisions”. According to Betty,

Sim is a lot of team approach. If you have a strong team sometimes that can mask the weakness of the underperforming student, whereas in traditional clinical

having that one-on-one conversation with that underperforming student, you can get more of a grasp on their thought process.

Doris stated,

In simulation, you really see how they interact as a team and can see how they communicate. In the traditional setting, you cannot be with them a hundred percent of the time, so you don't know what's going on when they are in that room with that patient or are just talking with the nurse when you're not there to observe it.

Betty and Rachael shared that underperformance is viewed differently in the traditional and simulation clinical settings. According to Betty, "In sim as long as they are reflecting on areas that could have been improved on, it is difficult to say they underperformed in the simulation. Racheal noted, "We view simulation as a safe place for learning to occur and for mistakes to happen so just based on the simulation setting, I don't think there's a whole lot that can be done to hold the student back." Sally shared that underperformance has different implications based on the setting, "In the clinical setting, you have lives at risk so small mistakes can really change the outcome of the patient. In the simulated setting, you identify it to the student, and we have debriefing and talk about it".

Interview Question 7, "What do you see as the biggest challenge related to evaluating underperforming nursing students in clinical settings?" Jane, Racheal, Doris, and Sally identified student attitudes and behavioral issues as the most significant challenge related to evaluating underperforming nursing students in clinical settings.

Betty and Jane identified the clinical evaluation tool as the biggest challenge. Betty stated, “I think it's really a challenge finding an appropriate tool that is not overly subjective. According to Jane, “I may think they performed very poorly that day; however, it is hard to get the score to reflect that.”

Interview Question 8, “Is there anything else you would like to tell me about your personal experiences with evaluating underperforming students that may help me with this research?” Cathy shared concerns with using the clinical evaluation tool for underperforming students, “there really is not the ability to show the picture of the underperforming student due to how the tool is set up. Therefore, you could have a student who is performing poorly, but based on the tool, it does not reflect a poor score”. Doris shared concerns with faculty inconsistency when evaluating underperforming students, “One instructor really holds the students to the policy and procedures. Someone else lets them kind of fudge on it a little bit”. Additional participant responses to this question varied widely with faculty sharing information on topics related to the role of adjunct clinical instructors, limited support systems for underperforming students, and lack of support for faculty when a student is deemed underperforming.

Discrepant and Rival Data

Only nursing clinical faculty who had experience with at least one underperforming nursing student in the traditional or simulation clinical setting participated in the study. The online questionnaire was targeted towards the participants' experiences with underperforming students; therefore, all data from the online questionnaire fell within expected parameters. Due to the nature of the semistructured

interviews, participants provided a more extensive range of responses. As noted previously, I began this study with the underlying assumption that clinical faculty have difficulty evaluating underperforming nursing students. Most interviewees described an uncomfortable emotional response or difficult ethical dilemma when asked to describe the most significant challenge related to evaluating underperforming nursing students. Field notes about facial expressions and voice tone for most of the interviewees included words like “concern,” “worry,” “frustration,” and “tearful.” However, this was not the case for two of the interviewees.

During interviews, Betty and Carol described specific experiences of evaluating underperforming nursing students in the traditional and simulation clinical settings. Neither interviewee described the experience of evaluating underperforming students as uncomfortable or difficult. Both interviewees identified the clinical evaluation tool as the biggest challenge of evaluating underperforming nursing students. Words on the field notes to describe facial expressions for both participants when answering this question were “calm” and “confident.”

Specific reasons for this rival data are unclear. There was no similarity related to the experience or age of the two participants. Betty had 4 years of experience evaluating undergraduate clinical nursing students in higher acuity settings, and Carol had 11 years of experience evaluating clinical nursing student students in a variety of clinical settings. Although age was not explicitly requested, field notes for Betty describe her as “younger” and Carol as “older.” Underperformance for the student in the traditional clinical setting related to medication administration for Betty and time management for Carol. Both

interviewees described underperforming nursing students in the simulation clinical setting as “task oriented” and “unable to see the big picture.”

It is interesting to note that neither Betty nor Carol, at any time during the interview, identified underperformance in terms related to student attitude, unprofessional behavior, or lack of interpersonal skills, as was the case for all other interviewees. The fact that Betty and Carol did not focus on student personal behaviors and attitudes might account for why they did not describe the experience as difficult or uncomfortable. However, the reasons they did not focus on those attributes is not evident in data collected during this study.

Themes

Subthemes identified through deductive analysis were aligned with each research subquestion to develop the following themes:

Research Subquestion 1: How do clinical nursing faculty identify students who are underperforming in clinical settings?

- Demonstrate unprofessional behaviors/lack interpersonal skills/lack of engagement/not prepared for clinical experience: (Gagné’s category of learning: Attitude)
- Unable to apply skills and knowledge/task oriented (Gagné’s category of learning: Intellectual skills)

Research Subquestion 2: How do clinical nursing faculty describe students who are underperforming in clinical settings?

- Lack of interpersonal and teamwork skills/behavioral issues (Gagné's category of learning: Attitude)
- Unable to apply information to different situations (Gagné's category of learning: Intellectual skills)
- Unable to perform nursing interventions (Gagné's category of learning: Motor Skills)
- Demonstrates inability to critically think during clinical situations (Gagné's category of learning: Cognitive strategies)

Research Subquestion 3: How do clinical nursing faculty evaluate students identified as underperforming in clinical settings?

- Use evaluation formative and summative tools and forms (NLN Clinical Nurse Educator Core Competency task statements: Documents learning performance, feedback, and progression and Implements both formative and summative evaluation that is appropriate for the learner and learning outcomes).
- Provide specific examples and expectations complete evaluations weekly and at the time of the incident (NLN Clinical Nurse Educator Core Competency task statement: Provides timely, objective, constructive and fair feedback to learners).
- Identify student strengths and areas for improvement. (NLN Clinical Nurse Educator Core Competency task statement: Assesses learner strengths and weaknesses in the clinical environment using performance standards).

- Compare performance to clinical objectives/competencies (NLN Clinical Nurse Educator Core Competency task statement: Assesses and evaluates appropriate clinical performance expectations).
- Collaborate with other faculty/program chairs regarding student performance (NLN Clinical Nurse Educator Core Competency task statement: Engages in timely communication with course faculty regarding learner performance).

Discussion of Findings

The first goal of completing this study was to determine what criteria the faculty used to identify nursing students who are underperforming in clinical settings. A review of the examples provided by study participants found behaviors that indicate the inability to successfully demonstrate Gagné's learning categories of Attitude and Intellectual skills were used to identify underperforming nursing students in both the traditional and simulation clinical settings.

Faculty used behaviors related to Gagné's Attitude category of learning most often to identify an underperforming student. Study participants identified the inability to apply skills and knowledge at an expected level, which aligns with Gagné's Intellectual skills category of learning as the next most common indicator of an underperforming student. These findings align with previous studies that identified lack of interpersonal skills, poor communication skills, and inability to apply theory to practice as "red flags" indicative of possible clinical failure (Duffy, 2013; Luhanga, Koren, Yonge, & Myrick, 2014; MacLeod, 2015; Vinales, 2015).

The second goal of completing this study was to determine how faculty describe nursing students who are underperforming in clinical settings. How respondents in this study described underperforming nursing students provides insight into the situations and behaviors faculty might encounter and, therefore, need to manage during traditional and simulation clinical experiences. Descriptions of underperforming students provided by study participants aligned with Gagné's learning categories of Attitude, Intellectual skills, and Cognitive strategies.

Words and phrases related to Gagné's Attitude category of learning were used most by respondents to describe underperforming students in both the traditional and simulation clinical settings. Faculty provided statements associated with a lack of interpersonal skills most often. These findings support studies conducted by Eng and Pai (2015), Grant, Robinson, Catena, Eppich, and Cheng (2018), Karlstrom (2018), and Scanlan and Chernomas (2016) that identified the poor communication skills, lack of personal responsibility, and unethical behavior as the reason nursing students failed clinically. Clinical educators in studies by Scanlan and Chernomas (2016) and Karlstrom (2018) concluded that unprofessional behaviors such as lack of self-awareness, lack of acceptance of responsibility, unable to reflect on practice, and inability to use feedback to improve practice as unsafe for patients. Eng and Pai (2015) found a statistically significant association between interpersonal skills and nursing competence. Descriptions of the interpersonal skills of underperforming nursing students in the simulation clinical setting align with a study by Grant et al. (2018) who described learner types that can result in difficult simulation debriefing situations

Statements from faculty related to Gagné's Intellectual skills category of learning focused on the application of theory to practice. The finding of underperforming nursing students' difficulty applying nursing knowledge and skills information in the clinical setting supports studies conducted by Scanlan and Chernomas (2016) and Potter (2018), who identified the inability to apply expected theoretical knowledge as a common thread in clinical failures. Karlstrom (2018) and Lee, Kelley, Alfes, Bennington, and Dolansky (2017) found that students' inability to apply or retain previously learned and discussed theoretical knowledge were indications of unsafe practice.

References related to the inability to consider all aspects of a problem or focusing on specific tasks rather than the application of nursing skills and knowledge were used by faculty when describing underperformance associated with Gagné's Cognitive strategies category of learning. Inconsistent use of terms to describe behaviors associated with Gagné's Cognitive strategies category of learning in the peer-reviewed nursing education literature was a barrier to finding previous studies supported by these findings. The terms clinical judgment, critical thinking, and clinical reasoning are often used interchangeably in the nursing literature (Victor-Chmil, 2013). Descriptions of underperforming nursing students' inability to apply cognitive strategies provided by faculty in this study align with descriptions of nursing students who lacked clinical reasoning skills in studies by Hunter and Arthur (2016) and Harmon and Thompson (2015).

The final goal of completing this study was to explore how faculty evaluate nursing students who are underperforming in clinical settings. Determining how

respondents in this study evaluate underperforming students can provide insight as to why students deemed underperforming may receive a passing clinical grade. Themes related to clinical evaluation strategies of underperforming nursing students aligned with the following NLN Clinical Nurse Educator Core Competency: Implements Effective Clinical Assessment and Evaluation Strategies task statements

- Implements both formative and summative evaluation that is appropriate for the learner and learning outcomes.
- Documents learner performance, feedback, and progression.
- Provides timely, objective, constructive, and fair feedback to learners.
- Engages in timely communication with course faculty regarding learner performance.

Information related to documenting student performance based on clinical criteria, feedback, and progression on formative and summative evaluations occurred most often. Faculty used formative and summative clinical evaluation forms in the traditional clinical setting for documentation of underperforming students. The faculty used a formative simulation assessment tool to document student performance in the simulation setting. Due to the formative nature of simulation learning experiences in the nursing program, summative evaluations are not utilized. Supplemental forms were used in both the traditional and simulation clinical settings to document specific instances of underperformance and plans for improvement.

Information regarding written plans for improvement from the online questionnaire included written goals with timeline and consequences of not meeting plan,

outlined remediation that will be required, and a paper trail of recommendations, remediation. Specific examples of remediation activities included reviewing procedures, completing nursing care plans, and reviewing course information. Written remediation plans for underperforming nursing students in clinical settings supports previous studies by Allen and Molloy (2017), Bearman, Molloy, Ajjawi, and Keating (2013), Duffy (2013), Elliott (2016), Hunt, et al. (2016b), Killam and Heerschap (2013), Luhanga et al. (2014), and Zasadny and Bull (2015). Documentation of remediation plans that include measurable goals, information about available resources, and validation of completion is an effective strategy for improving clinical performance.

Clinical progression at the study site is not based on performance during simulation clinical experiences, which limited information related to documentation of clinical progression to evaluation tools used in the traditional clinical setting. Traditional clinical progression in the nursing program is primarily dependent on numeric scores on the formative assessment tool or an accumulation of scores on the summative evaluation tool. Use of a formative assessment process with underperforming nursing students in traditional clinical settings supports previous studies by Bearman et al. (2013), Hunt et al. (2016b), Jamshidi, Molazem, Sharif, Torabizadeh, and Najafi Kalyani (2016), and Zasadny and Bull (2015). Studies by Pires et al. (2017), Leigh, Stueben, Harrington, and Hetherman (2016), Park, Ahn, Kang, and Sohn (2016), and Solheim, Plathe, and Eide (2017) support the finding of simulation learning experiences as formative assessment. Use of numeric scores to determine clinical progression and the use of anecdotal notes to document specific instances of nursing students' underperformance in clinical settings

supports findings in studies conducted by Hall (2013), Helminen, et al. (2014), Hughes, Johnston, and Mitchell (2019), and Paskausky and Simonelli (2014).

Faculty participants identified challenges using program clinical evaluation tools to evaluate underperforming nursing students in clinical settings accurately. Challenges using existing clinical assessment tools to evaluate underperforming nursing students in clinical settings supports a common theme found in previous studies exploring evaluation of nursing students' clinical performance (Almalkawi et al., 2018; Burke et al., 2016; DeBrew & Lewallen, 2014; Hall, 2013; Helminen et al., 2014; Msiska et al., 2015; Paskausky & Simonelli, 2014; & Rafiee et al., 2014). The use of complex academic language and subjective terms, similar performance statements for different levels of students, and lack of objective measures for behavior were identified as barriers when using clinical tools to adequately evaluate underperforming nursing students in clinical settings were noted in these studies.

Participants reported providing objective clinical performance feedback weekly that included specific student actions, areas of strength, and areas for improvement. Providing objective, timely, and constructive feedback to underperforming nursing students that includes identification of strengths and areas for improvement supports findings in studies conducted by Adamson et al. (2018), Allen and Molloy (2017), Hall (2013), Plakht, Shiyovich, Nusbaum, and Raizer (2013), and Solheim et al., (2017). Researchers in these studies concluded that documentation of feedback sessions is essential for supporting summary evaluation decisions related to student performance in clinical settings. Constructive feedback can increase self-esteem, encourage, and motivate

students to improve performance, and provides information about progress. Feedback at the time of an incident or action, rather than discussing the incident later allows the student to connect their performance directly to a clinical situation.

Difficulty providing feedback to underperforming students in clinical settings was noted by faculty in the study. The finding of faculty concerns when giving feedback for improvement supports findings in studies conducted by Black et al. (2014); Couper, 2018; Docherty and Dieckmann (2015), Duffy (2013), Hunt et al. (2016b), Kennedy and Chesser-Smyth (2017), Larocque and Luhanga (2013), Poorman and Mastorovich (2014), Pratt (2016), and Stoker (2016). Fear of retribution, self-guilt, unwanted emotional responses from students, and the increased amount of time required are cited as reasons faculty do not give constructive and objective feedback to underperforming students. Underperforming nursing students who receive ineffective feedback may incorrectly perceive they are meeting clinical expectations, which may prevent students from accessing resources necessary to improve performance (Adamson et al., 2018; Mahsood, Jamil, Mehboob, Kibria, & Rehman Khalil, 2018).

During semistructured interviews, clinical faculty identified the importance of collaboration with other clinical faculty, course faculty, and program administration regarding the evaluation of underperforming nursing students. Collaboration with other nursing faculty and program administration to address issues related to student underperformance supports previous studies by Dahlke, et al. (2016), DeBrew and Lewallen (2014), Helminen, et al. (2014), Hughes, Johnston, and Mitchell (2018), and Power and Albaradura (2018). Assistance with decision making related to evaluation and

support for decisions related to assigning a passing or failing clinical grade is essential for clinical faculty working with underperforming nursing students.

Project Deliverable

Through the study, I aimed to gain a greater understanding of the reasons faculty at the college may assign passing clinical grades to underperforming nursing students. Data analysis results revealed that faculty at the study site could identify and describe behaviors that indicate a nursing student is underperforming, which may potentially put patients at risk for harm. Results also revealed that faculty clinical evaluation methods aligned with best practice standards for evaluating nursing students in clinical settings. Clinical nursing faculty who participated in the study noted that the decision to pass or fail a student clinical is a multifaceted process. Since the initial research subquestions did not expose reasons faculty at the study site might pass underperforming clinical students, I compared the information found during data analysis to existing formative assessment processes at the study site.

Analysis of study data indicated that nursing students underperformed most in the areas of attitude and interpersonal behaviors. A review of existing clinical evaluation tools used at the study site found an emphasis on psychomotor skills, verbal information, and the development of plans of care. The tools included subjective terms and phrases such as “appropriate,” “occasional,” and “demonstrated understanding.” Guidelines for the use of clinical formative assessment tools at the study site included student self-evaluation and allowed faculty to indicate that students met assessment criteria based on student reporting, even if faculty did not observe the criteria.

In a review of evaluation processes at the study site, I found that an interrater agreement process is used to determine evaluator consistency in the simulation clinical environment. However, no policy, procedure, or guidelines for determining interrater reliability or interrater agreement is in place for traditional clinical site formative assessment or summative evaluations. Several faculty study participants identified the use of remediation for students deemed underperforming in clinical settings. Faculty guidelines for the use of the traditional clinical formative assessment tool include the assignment of remediation for an unsatisfactory rating or score of less than 78%. Yet, the study site does not have a clinical remediation policy or procedure.

Ineffective clinical evaluation tools, lack of consistent clinical evaluation methods, and lack of clinical remediation processes emerged as factors that may contribute to passing underperforming clinical nursing students. Therefore, the project deliverable developed for study was a policy recommendation that addressed formative assessment policies, procedures, and guidelines to support faculty when evaluating underperforming nursing students in clinical settings.

Summary

This study supports the previous findings of peer-reviewed literature that identified characteristics of underperforming clinical nursing students, faculty descriptions of underperforming clinical nursing students, and the experience of nursing faculty evaluating underperforming nursing students in clinical settings. Specifically, clinical nursing faculty identify a lack of interpersonal skills, poor communication skills, and the inability to apply classroom information in the clinical setting as early indicators

of underperformance (Duffy, 2013; Luhanga et al., 2014; MacLeod, 2015). The findings of this study confirm previous studies which described underperforming nursing students as demonstrating weak interpersonal, teamwork, communication and self-reflection skills, unable to apply nursing knowledge and skills in the traditional or simulation clinical setting, and lacking problem-solving skills at a level necessary to provide safe patient care (DeBrew & Lewallen, 2014; Grant et al., 2018; Harmon & Thompson, 2015; Hunter & Arthur, 2016; Karlstrom, 2018; Potter, 2018)

Gagné's five categories of learning (Gagné, 1972) and the NLN Clinical Nurse Educator Competencies (Shellenbarger, 2019) were appropriate guides to explore the experiences of faculty evaluating underperforming nursing students in clinical settings. Terms used by faculty to identify and describe underperforming nursing students in clinical settings aligned with Gagné's five categories of learning (Gagné, 1972). Behaviors associated with Gagné's attitude, intellectual skills, and cognitive strategies categories of learning applied to the clinical setting were used by faculty to describe underperforming nursing students. The faculty used similar criteria to identify and describe underperforming nursing students in both the traditional and simulation settings. Faculty practices when evaluating underperforming nursing students in clinical settings correlated with several of the NLN Clinical Nurse Educator Core Competency: Implement Effective Clinical Assessment and Evaluation Strategies task statements (Shellenbarger, 2019).

This study substantiates studies exploring faculty experiences evaluating underperforming nursing students in clinical settings. A formative assessment process,

written action plans for remediation activities, anecdotal notes to document specific instances of underperformance, timely and constructive feedback, and collaboration with other faculty and nursing program administration are essential when evaluating underperforming nursing students (Bearman et al., 2013; Dahlke et al., 2016; Duffy, 2013; Hall, 2013; Helminen et al., 2014; Hughes et al., 2019; Hunt et al., 2016b; Leigh et al., 2016; Luhanga et al., 2014; Power & Albaradura, 2018). Findings in this study also validate the challenges of using subjective clinical evaluation tools to evaluate underperforming nursing students and the negative emotional and personal effect on faculty when evaluating nursing students who are underperforming or deciding to assign a passing or failing clinical grade to an underperforming nursing student (Almalkawi et al., 2018; Black et al., 2014; Burke et al., 2016; DeBrew & Lewallen, 2014; Docherty & Dieckmann, 2015; Duffy, 2013; Hunt et al., 2016b; Larocque & Luhanga, 2013; Msiska et al., 2015; Poorman & Mastorovich, 2014; Pratt, 2016; Rafiee et al., 2014; Stoker, 2016).

In the next section of this project study, I will describe the project developed based on analysis of the study data, comparison to existing clinical evaluation processes at the study site, and review of the current literature related to evaluating nursing students in clinical settings.

Section 3: The Project

Introduction

In Section 2, I discussed the findings of this study, which I conducted to explore the experiences of faculty evaluating underperforming nursing students in clinical settings. In this section, I will detail the project (a policy recommendation paper) that I developed based on the results of my study and findings from a literature review. Appendix A includes a copy of the project study.

The goal of the policy recommendation was to suggest possible changes that may improve formative assessment processes in traditional and simulation clinical settings to help ensure that all students who graduate from the research site nursing program have met clinical competencies. I offer suggestions for a clinical formative evaluation tool development policy that includes the expectation of objective, measurable criteria. I also recommend a clinical evaluator interrater reliability policy to help ensure consistency when different clinical faculty are evaluating students. Finally, I suggest a clinical remediation policy to guide faculty when providing resources for clinical performance improvement.

Rationale

I chose a policy recommendation for the project because it offered me the opportunity to propose suggestions to the nursing program administrators and leadership team that could address the problem of evaluating underperforming clinical nursing students. I based the policy recommendations on the results of data analyses I conducted to explore how nursing faculty evaluated underperforming students in traditional and

simulation clinical settings at the research site. The data analysis pointed to a need to revise the nursing program's traditional and simulation clinical formative assessment tools to allow for early identification of underperforming nursing students.

The policy recommendation includes suggestions for changes to criteria and terms used on formative assessment tools to correlate with definitions of underperformance identified by faculty and found in the literature. During the analysis of the study data, I also identified the lack of policies to ensure consistent evaluation and support underperforming clinical students at the research site. I addressed the problem of inconsistency in evaluation between different faculty within the policy recommendation through the development of a clinical evaluator interrater reliability policy. Last, I recommended the development of an evidence-based clinical remediation policy for faculty to use when offering resources for clinical improvement in the areas of attitude/interpersonal behaviors, application of theory to clinical situations, clinical decision-making, motor skills, and verbal information. I will present the policy recommendations to the director of nursing and nursing leadership team at the research site for consideration and possible adoption.

Addressing the Problem and Theoretical Framework

A policy recommendation paper was an appropriate genre for my project because it allowed me to provide possible solutions to the problem of evaluating underperforming nursing students in clinical settings identified at the research site during my study. I based the recommendations on the results of my study and strategies and recommendations found during a search of available literature. The policy paper's conceptual framework

was Gagné's (1972) five categories of learning and the NLN Clinical Nurse Educator Competency: Implement Effective Clinical Assessment and Evaluation Strategies associated task statements (Patrick, 2019). I used the five categories of learning and the associated task statements as a foundational guide for my study.

Review of the Literature

I conducted this literature review to gain knowledge about the project's specific genre, a policy recommendation, and identify scholarly evidence of best practice strategies for inclusion in the policy recommendation (see Appendix A). I restricted the search to peer-reviewed publications within the last 5 years (2014–2019). I searched Walden University Library journal holdings using health and nursing databases CINAHL and Medline and education databases ERIC and Education Research Complete and Google Scholar.

To find literature pertinent to the project genre, a policy recommendation, I used the search keywords and phrases *policy*, *policy development*, *policy recommendation(s)*, *research and policy development*, *healthcare education policy development*, and *nursing education policy development*. These search terms yielded many scholarly publications; however, most described existing government healthcare and education policies, recommendations for new or expanded government and global healthcare education policies, and strategies for encouraging nursing education student participation in government healthcare policy discussions. To find more relevant literature, I extended the search to include the keywords and phrases *nursing clinical education policies*, *nursing program policy development*, *policy development in higher education*, *higher education*

policies strategies, nursing education policy strategies, policy-driven change, assessment-driven policy changes in higher education, policy implementation, the policymaking process, and policy formation. I used the keyword search terms and phrases *nursing student clinical evaluation, formative clinical evaluation, interrater-reliability,* and *clinical remediation* to search for strategies to include in the policy recommendation document.

Project Genre: Policy Recommendation

Policies are directives, rules, or guidelines related to a specific issue (Kitaw & Aseffa, 2017). A policy recommendation is the section of a policy that describes suggested actions to address the issue (Wong, Green, Bazemore, & Miller, 2017). Government regulators, public and private organization decision-makers, and individuals are typical target audiences for policies (DeMarco & Tufts, 2014; Vedung, 2017a). According to Weible and Cairney (2018), *policy actors* are individuals who have access to policy-making processes. Vedung (2017a) described three main categories of policies: regulatory, economic, and informative. Regulatory policies contain mandates that individuals must follow or face negative consequences. Economic policies direct the giving or taking away of resources. Informational policies are designed to influence decision-makers to consider new or alternative measures to address an issue. Higher education systems are affected by regulatory, economic, and informational policies at the international, national, state, and institutional levels (Scott, 2017). For this project, I developed an informational policy for influencing nursing education policy actors at the institutional level.

Policy formats. Policy documents can be presented in a variety of formats. The purpose of the policy determines the format selected, the complexity of the issue, and the target audience (International Center for Policy Advocacy [ICPA], 2017; Wong et al., 2017). DeMarco and Tufts (2014) and Vedung (2017a) emphasized the importance of knowing the expertise and characteristic of target policy actors to develop the appropriate policy document. The seriousness of the issue, timing of the policy document; culture, values, and beliefs of the organization; existing policies; and setting where the policy may be adopted are also important considerations when determining the policy format (Biswas & Paczynska, 2015; DeMarco & Tufts, 2014; Turnpenny, Jordan, Benson, & Rayner, 2015; Weible & Cairney, 2018).

The policy brief format is used to share research and policy recommendations to policy actors who are not experts on the issue or policy decision-makers who are too busy to read a more detailed document (Biswas & Paczynska, 2015). Policy briefs should be a maximum of 1,500 words or four pages in length (ICPA, 2017). Although longer, policy white papers are the preferred document for detailed exploration of the issue with a variety of policy recommendations (DeMarco & Tufts, 2014; Vedung, 2017a; Wong et al., 2017). Due to extensive data elicited from my research study and the need for various recommendations based on the analysis of study data, I developed a policy white paper for presentation to nursing education policy actors.

Policy document structure. All policy documents should be written in clear professional language, avoiding technical jargon (DeMarco & Tufts, 2014; Kitaw & Aseffa, 2017). Components of a policy document can vary based on the format, however,

should include an executive summary, background information, policy recommendations, implications, and sources of information (DeMarco & Tufts, 2014; ICPA, 2017; Kitaw & Aseffa, 2017; Wong et al., 2017). DeMarco and Tufts (2014) and Kitaw and Aseffa (2017) highlighted the importance of starting with an executive summary to provide an overview of the policy document for busy policy actors and entice them to continue reading the remainder of the document. The executive summary should stand alone, consist of no more than two paragraphs, take up only half of a double-spaced page, and include the specific issue addressed in the policy document, significant findings, and focus of policy recommendations (DeMarco & Tufts, 2014; ICPA, 2017).

The second component of the policy document should start with a detailed description of the issue with the goal of convincing policy actors that a problem exists and needs attention (Kitaw & Aseffa, 2017; Wong et al., 2017). In this section, policy writers should introduce general ideas and move to specific details supported by current references (DeMarco & Tufts, 2014). According to DeMarco and Tufts (2014), using current references informs the reader that the topic is relevant and facilitates understanding of the extent of the issue.

Next, the policy writer should describe the impact of the problem in a local context, using established organizational terms, and relating the problem to current organizational policies (ICPA, 2017; Wong et al., 2017). Policy writers should use everyday language to describe relevant study information, including who conducted the study, methods, results, conclusions, and how the study relates to the problem (Kitaw & Aseffa, 2017). Lack of policies, failure of existing policies to address the problem, and

other relevant policy information that may provide a link to policy recommendations should also be included (DeMarco & Tufts, 2014; ICPA, 2017).

The third component of policy writing involves identifying specific policy actions to address the problem (Wong et al., 2017). Policy recommendations are what should happen to address the issue (Kitaw & Aseffa, 2017). Recommendations must be relevant, credible, and feasible and therefore come from study conclusions supported by evidence (DeMarco & Tufts, 2014; Kitaw & Aseffa, 2017). Weible and Cairney (2018) note that policy recommendations should lead to changed behaviors, not the need for more policy development. The policy writer should keep a narrow focus and use an active voice when describing policy recommendations (DeMarco & Tufts, 2014).

The fourth component of a policy document is a discussion of the implications of adopting or not adopting the policy recommendations (DeMarco & Tufts, 2014; Kitaw & Aseffa, 2017). Wong et al. (2017) recommended addressing opposing arguments that may impede action. Weible and Cairney (2018) noted that policy writers should also consider the implications of existing policies. Declarations should be concise, supported by evidence, and written with respect to a reader who may oppose the policy recommendations (DeMarco & Tufts, 2014). The policy document should conclude with a restatement of the problem, how the policy specifically addresses the issue, and benefits of the policy implementation (ICPA, 2017).

The policy document should include a reference list to support the critical components of the policy and provide readers with information about cited sources (DeMarco & Tufts, 2014; ICPA, 2017). Kitaw and Aseffa (2017) also recommended

including dissemination and evaluation plans that indicate when, how, and where policy actors receive the policy document. An evaluation plan conducted informationally through conversations with stakeholders or formally using a survey is necessary to verify policy implementation (Kitaw & Aseffa, 2017). According to the authors, once implementation has occurred, an assessment of policy impact is essential for determining the effectiveness of policy recommendations. Kitaw and Aseffa (2017) emphasized the importance of developing relationships with decision makers and stakeholders.

Policy and research. Policies are an effective way to disseminate research findings to decision-makers (Kitaw & Aseffa, 2017). For policy actors to make informed decisions, policy recommendations should be based on research and analysis of available data related to the issue (Biswas & Paczynska, 2015). Kuh et al. (2015) note that evidence related to student learning should be used when developing educational policy recommendations. While evidence is essential to support policy decisions, related professional narratives and personal stories in a policy document can be powerful tools to move decision-makers to action (Colebatch, 2018; Davidson, 2017). I used the results of my study, including the personal stories of faculty evaluating underperforming students in clinical settings, and strategies found in the current literature as the foundation to generate the recommendations found in my policy white paper.

Policy and change. Resistance to new policy implementation or revisions to existing policies may occur (Batras, Duff, & Smith, 2016). Faculty may resist changes to teaching and assessment methods resulting from new policy implementations (Kuh et al., 2015; Scott, 2017). Change interferes with established patterns of behavior and may be

perceived as a threat to personal or professional security (Salam & Alghamdi, 2016).

Additionally, faculty may see the implementation of policies that address program outcomes as interfering with the traditional concepts of academic freedom and autonomy (Scott, 2017).

Policy Recommendations: Strategies to Improve Clinical Formative Assessment

Processes

Formative assessment is an integral component of nursing education (Oermann & Gaberson, 2016). Clinical nursing faculty use formative evaluation as a diagnostic tool to identify student's strengths and weaknesses then develop a plan of action to help students gain skills and knowledge to meet clinical outcomes (McDonald, 2017). According to Konopasek, Norcini, and Krupat (2016), plans for student improvement should be specific, monitored by faculty, and include an expectation that shows evidence of completion. Clinical formative assessment supports student learning best when it is part of an on-going process using a valid and reliable assessment tool that provides objective feedback on clearly defined clinical competencies (Lewallen & Van Horn, 2019).

Analysis of data from my study revealed that formative assessment processes at the study site lacked essential components to support clinical learning for underperforming nursing students.

Clinical formative assessment tool development. Measurable formative assessment tools are essential to ensure that nursing student clinical competencies are identified accurately before summative clinical evaluation (Helminen, Coco, Johnson, Turunen, & Tossavainen, 2016). Assessment tools should have a theoretical foundation

and established validity and reliability (Afifi, 2017; Baumgartner, Häckter Ståhl, Manninen, & Rydholm Hedman, 2017; Higham et al., 2019). Clinical formative assessment tools must contain objective measurements that are relevant to the clinical learning environment, leveled to the student, and provide opportunities to assess technical and non-technical skills (Baumgartner et al., 2017; Higham et al., 2019; Pires et al., 2017; Reljić, Lorber, Vrbnjak, Sharvin, & Strauss, 2017).). Students should have the opportunity to write their own clinical learning goals. In a study conducted by Baumgartner et al. (2017), the authors found that students who wrote their own clinical goals were more engaged in the learning process.

Objective statements for different levels of performance deemed satisfactory and specific criteria that define unsatisfactory performance are essential for consistency in evaluation (Higham et al., 2019; Skúladóttir & Svavarsdóttir, 2016). Subjective and ambiguous terms on clinical evaluation tools may be interpreted differently based on the situation, which can result in a perception of faculty bias (Brigley, 2018). Clinical faculty education should include information regarding the alignment of the assessment tool with program and clinical outcomes, how to use the assessment tool, and definitions of objective terms, and how to evaluate soft skills such as communication and professionalism (Baumgartner et al., 2017; Brigley, 2018; Pires et al., 2017; Rafii, Ghezeljeh, & Nasrollah, 2019). Opportunities to practice using the tool in cases of satisfactory and unsatisfactory performance are necessary to ensure effective and objective assessment (Baumgartner et al., 2017; Higham et al., 2019).

A review of clinical evaluation tools used at the study site revealed subjective terms and phrases, which could lead to inconsistent formative assessment. The review also revealed that the description of satisfactory, needs improvement, and unsatisfactory measurements on tools in the traditional clinical included a subjective aspect.

- Satisfactory: Student is consistently able to meet criteria independently or with *occasional* supportive cues
- Needs Improvement: Student is unable to meet criteria independently and consistently requires *frequent* cues and prompting.
- Unsatisfactory: Student is unable to demonstrate behavior, procedure, and or intervention(s) *appropriately*.

Therefore, all clinical competencies found on traditional clinical tools require are subjective assessment, whether they contain a subjective term or not. Based on my study results,

literature findings, and comparison of best practice in development of formative assessment tools to existing formative assessment processes used at the research site, I will recommend that clinical assessment tools are specific to the clinical learning environment, are theoretically based, show evidence of content validity, include only objective, measurable terms, and assess both technical and non-technical skills. Also, I will recommend policies for faculty education regarding clinical assessment tools.

Consistency in formative assessment. Consistency in assessment is imperative when more than one clinical faculty member is responsible for completing a formative assessment for a cohort of nursing students (Dunbar, 2018). According to Dunbar (2018),

inconsistency can lead to inequity in student assessment, dissatisfaction among students, and passing students with varying levels of clinical competence. Interrater reliability can be used to determine rater consistency for clinical assessment (Higham et al., 2019). Interrater reliability of a clinical assessment tool is the measurement of the extent to which different faculty assign the same rating to an objective measure on the clinical assessment tool (Dunbar, 2018; Phillips et al., 2019). According to Gwet (2014), interrater reliability (IRR) is a calculation of how well raters can consistently differentiate items on a measurement scale and is the preferred method in research studies. In contrast, interrater agreement (IRA) measures the extent to which different raters assign the same value for an item they observe. Interrater agreement is often used to determine consistency when rating performance.

Bajpai, Bajpai, and Chaturvedi (2015) describe the percentage of exact agreement as the most straightforward IRA to understand. IRA is calculated by taking the exact agreements of a rating divided by the total number of ratings. Percentages of exact agreement between raters of 80 to 90 percent are acceptable (Wilhelm, Rouse, & Jones, 2018). Faculty participants in my study identified a lack of consistency in the clinical assessment as a contributing factor to the passing of underperforming nursing students at the research site. Therefore, I recommended the establishment of an interrater agreement policy for all faculty who are responsible for evaluating the same level of nursing students in different clinical sites or different levels of students in the same clinical site.

Clinical remediation. Formative assessments serve as an early warning system to identify underperforming clinical students and provide guidance for developing targeted

remediation activities (Konopasek et al., 2016; McHugo, 2017; van der Vleuten, Sluijsmans, & Joosten-ten Brinke, 2017). Successful remediation programs require a commitment from the administration, faculty, and students (Custer, 2018; Mee & Schreiner, 2016; Thilges & Schmer, 2020). Students should participate in remediation as soon as faculty note early indicators of underperformance to provide ample opportunities to improve and meet clinical objectives (Chou, Kalet, Costa, Cleland, & Winston, 2019; Custer, 2016; McHugo, 2017; Mee & Schreiner, 2016). There is evidence that assurances from students that they will improve, giving students more time to improve, and waiting until patterns of poor performance emerge before implementing remediation do not lead to improved clinical performance (Chou et al., 2019; El Hussein & Fast, 2020; Williamson, Quattromani, & Aldeen, 2016).

Remediation should be mandatory, initiated by faculty, include completion timeframes, progress monitoring, and evidence of completion (Chou et al., 2019; Coelho, Zahra, Ali, & Tredwin, 2019; Custer, 2016; Fenske & Price, 2016; Forsythe & Johnson, 2017; Mee & Schreiner, 2016). Underperforming students may not have the self-assessment skills to recognize the need for remediation (Fenske & Price, 2016; Forsythe & Johnson, 2017). Linking remediation to consequences emphasizes that remediation is a high priority for the program (Custer, 2016; Mee & Schreiner, 2016). Effective remediation processes are guided by policies and focus on supporting student success rather than punitive measures for poor performance (Chou et al., 2019; Custer, 2016; van der Vleuten et al., 2017).

Remediation plans should be developed through a collaborative process with the student and remediation faculty and individualized to support students' clinical learning goals. The remediation plan must include measurable behavioral goals, consist of a variety of faculty lead evidenced-based remediation strategies in all three domains of learning (psychomotor, cognitive, and affective), include a process for monitoring behaviors in the clinical setting, a timeline for completion, and plans for follow-up assessment (Chou et al., 2019; Coelho et al., 2019; Custer, 2016; Fenske & Price, 2016; Forsythe & Johnson, 2017; Mee & Schreiner, 2016). Effective remediation takes time; therefore, plans need to include multiple opportunities for the student to practice and hone insufficient skills, knowledge, and attitudes and a plan for relapses that may occur (Mee & Schreiner, 2016; Vacha-Haase et al., 2018). There is evidence that simulation-based learning experiences can serve as a diagnostic tool to identify reasons for performance gaps and for remediating clinical deficits in psychomotor skills, applying knowledge to practice, clinical decision making, communication, and teamwork (Camp & Legge, 2018; Fenske & Price, 2016; Guerrasio & Aagaard, 2018; Nadir et al., 2019; Unsworth, Melling, Tuffnell, & Allan, 2016).

Students may demonstrate deficits in more than one area of clinical performance requiring different remediation strategies (Custer, 2016; Williamson et al., 2016). Faculty should develop a separate remediation plan for each area of clinical underperformance (Chou et al., 2019; McHugo, 2017; Sparks et al., 2016). Clinical professional behaviors and interpersonal skills are difficult to measure objectively (Pires et al., 2017; Regan et al., 2016; Vacha-Haase et al., 2018). Clinical faculty may refer a student for remediation

in one area of underperformance, only to discover underlying deficits in professional or interpersonal skills requiring remediation once the process begins (McHugo, 2017; Sparks et al., 2016). Not all issues impacting clinical performance are appropriate for remediation. Issues such as physical or behavioral health diagnosis, financial problems, family issues can all affect clinical performance. In these cases, the student should be referred to college services, and remediation for the clinical deficit scheduled after these issues are addressed (Chou et al., 2019; Nadir et al., 2019; Vacha-Haase et al., 2018; Williamson et al., 2016).

Several faculty participants in my study identified the use of remediation activities for students deemed underperforming in the clinical setting. There are references to referral for remediation on the study site clinical evaluation tools. According to the study site nursing leadership, there is no clinical remediation policy or guidelines for implementing clinical remediation. Therefore, I recommended the development of an evidence-based clinical remediation policy.

Project Description

The project consists of a policy recommendation paper to suggest strategies to improve formative evaluation processes for underperforming clinical nursing students, thereby reducing the risk of passing students who may not meet clinical competences. Policy recommendations included revisions to the program's existing clinical formative assessment tools to include only objective measures. I also recommended an interrater agreement policy for clinical assessment to promote consistency in the evaluation of students attending clinical learning experiences. Lastly, the recommendations included

the development of a clinical remediation policy to support underperforming clinical students.

Needed Resources and Existing Supports

Implementation of the policy recommendations for revision to the existing clinical formative assessment tools will require program faculty time, and training regarding the interrater agreement process will require contracted and adjunct clinical faculty time. The integration of an evidence-based remediation policy will also require faculty time. If clinical remediation includes simulation learning experiences, space in the college's simulation center will be required, as well as dedicated simulation faculty time. Existing supports include the dean of health and public services, the director of nursing education and the nursing program leadership team who have verbalized a commitment to ensuring that all students who graduate from the nursing program have met clinical competencies.

Potential Barriers and Potential Solutions to Barriers

A potential barrier to the adoption of the policy recommendations might be faculty resistance to change the current formative assessment processes. A task force of clinical faculty from different courses developed the current clinical evaluation tool. Faculty may be comfortable with the process in place and see no reason for the change. According to Kuh et al. (2015), faculty may view the implementation of new program policies as interfering with their academic freedom. As noted previously, the formative assessment processes at the college do not adhere to best practice standards found in the literature. Kalb, O'Conner-Von, Brockway, Rierson, and Sendelbach (2015) and

Yurumezoglu and Isbir (in press) noted that faculty might be resistant to implement evidence-based teaching practices due to lack of awareness of evidence-based teaching practices, lack of time to search empirical evidence, differences of opinions about what constitutes evidence-based teaching practice, or satisfaction with the status quo.

Providing an information brochure for faculty outlining how the policy recommendations align with and build upon, existing formative assessment processes may help facilitate support. According to Batras et al. (2016), strategies for promoting change need first to include consideration of how the change fits with existing policies and organizational culture. I could also provide faculty with an annotated bibliography to increase awareness of empirical evidence supporting the policy recommendations.

The amount of faculty time and commitment required to develop and implement the policy recommendations may be a significant barrier (Custer, 2016; Kuh et al., 2015). One way to decrease the amount of faculty time needed to implement changes related to clinical formative assessment tools is to assign the work to task forces. A task force consisting of a representative from each clinical course could complete revisions to clinical formative assessment tools. Since an interrater agreement process supports consistency for the simulation clinical formative assessment tool, a task force consisting of a faculty member from the simulation clinical setting and a faculty member from the traditional clinical setting can develop an interrater agreement policy that is consistent for all clinical formative assessment tools. The development of a remediation team that includes faculty and representatives from student services would be a way to decrease the workload on individual faculty (Custer, 2016; McHugo, 2017). Since the program uses

adjunct faculty in traditional and simulation clinical settings, it would be beneficial to include adjunct clinical faculty members on these taskforces to gain their perspectives.

Implementing the changes over time would be another way to reduce demands on faculty. The overall goal of the project recommendations is to decrease the risk of clinically underperforming students who are lacking the necessary skills and knowledge to provide safe patient care graduating from the nursing program. Therefore, it would be best to initially develop a remediation policy and strategies for clinical courses in the last semester of the program. A task force consisting of the faculty from clinical courses in the final semester of the program, simulation coordinator, laboratory coordinators, and student support services can work together to generate remediation strategies. The task force can develop additional remediation strategies for prior clinical courses each semester until there are adequate remediation strategies for all clinical courses.

Implementation and Timetable

The project implementation process starts with submitting the policy recommendation to the director of nursing education and nursing program leadership team for consideration. The nursing faculty association (NFA), who is responsible for curriculum decisions, has the final decision regarding the adoption of the policy recommendations. Per the director of nursing education, once I submit the project (policy recommendations) for consideration, I will be scheduled to attend a nursing program curriculum committee meeting to present the policy recommendations and answer questions. Then the curriculum committee will determine if all, or some, of the policy

recommendations, will be presented to the NFA for further discussion and vote. Table 10 includes the proposed implementation dates.

Table 10

Proposed Implementation Dates

Steps of implementation	Proposed Timeframe
Present policy recommendation to curriculum management committee and nursing leadership team for consideration.	August 2020
Present approved policy recommendations to NFA for final vote.	September 2020
Revise clinical evaluation tool, create interrater agreement policy, and develop remediation policy	October – November 2020
Present revised clinical evaluation tool, and new interrater agreement and remediation policy to curriculum management committee and nursing leadership team.	December 2020
Present approved clinical evaluation tool, interrater agreement policy, and remediation policy to NFA for final vote.	December 2020
Update student and faculty policy manuals to include new clinical evaluation tool and clinical remediation processes.	December 2020
Implement new clinical policies	Spring 2021 semester

Roles and Responsibilities of Student and Others Involved

I had the responsibility for the development of policy recommendations that were deemed beneficial to the study site based on results on the analysis of my study data and grounded in evidence-based practice and research. I am currently the simulation coordinator at the study site, and I am well known to the director of nursing education, the nursing program leadership team, and the nursing faculty. I have ample opportunities to explain the policy recommendations and benefits to the program. The director of nursing education, nursing program curriculum committee, and nursing faculty at the

study site will be responsible for reviewing the policy recommendations and making decisions regarding the adoption of the policy recommendations.

Project Evaluation Plan

Policy evaluation is essential to ensure that policies are relevant and continue to support the organization's goals and objectives (Vedung, 2017b). The policy purpose will determine the type of evaluation used (Centers for Disease Control and Prevention [CDC], 2014). Evaluation type and schedule are determined during the policy formation process (Colebatch, 2018). Educational policy evaluation methods should align with the purpose of the policy (Diem, Young, & Sampson, 2019). I designed the policy recommendation to provide nursing leadership at the study site, evidence-based information regarding changes to clinical formative assessment processes. Therefore, the evaluation method will focus on the implementation, effectiveness, and impact of the information provided.

Type of Evaluation and Justification

Evaluation can occur at different points in the policy process and by a variety of stakeholders. The point at which the policy evaluation occurs determines the type of assessment used (Vedung, 2017b). The purpose of formative evaluation is to determine if a policy is appropriate and feasible before it is implemented (CDC, 2014). Nursing leadership at the study site will be responsible for formative evaluation of my policy recommendations because they will determine which, if any, of the recommendations to implement. If part or none of the policy recommendations are adopted, I will interview nursing leadership at the study site to determine the reasons for the decision.

The overall goal for evaluating the project is to determine if the policy recommendations improved formative assessment processes at the college. If the policy is adopted and formative assessment processes do not improve, it will be essential to understand why improvement did not occur; therefore, I recommended conducting process, outcome, and impact evaluations. According to the CDC (2014), process evaluation is used to determine if the policy was implemented correctly, outcome evaluation is used to measure the effectiveness of the policy, and impact measurement is used to assess if the policy implementation achieved the intended goal. Process evaluation will occur if the decision is made to adopt all or part of the policy recommendations and will consist of a survey sent to members of the nursing leadership team and curriculum management committee. Questions on the survey will focus on how the integration of recommendations into the clinical formative assessment processes, how information was disseminated to students and faculty, and identified challenges or barriers to implementation.

Outcome evaluations will occur at the end of each semester, which includes a clinical course for the first 2 years. Evaluation of policy outcomes is a necessary precursor to impact evaluation (CDC, 2013a). According to Vedung (2017b), pre-impact evaluations can provide valuable insight when analyzing impact evaluation data. I will conduct the evaluation via a survey of all clinical faculty in traditional and simulation settings. Survey questions will focus on the application of policy recommendations during clinical formative assessment and the benefits and challenges of implementing the policy recommendations for students and clinical faculty.

Impact evaluation will occur 2 years after the implementation of the policy recommendations to ensure that at least one cohort of students has graduated from the associate degree nursing program. The problem of nursing faculty at the study site potentially passing underperforming students was the foundation for my study. Ensuring that all students who graduate from the nursing program have met the required clinical competencies to provide safe patient care would be the best impact measure for the policy recommendation. Clinical formative assessment processes are just one aspect affecting nursing student clinical competence; therefore, it is not possible to prove that the policy implementation alone influenced results. Vedung (2017b) noted that impact evaluation is the most challenging type of evaluation because events and situations not related to policy implementation can affect the results.

Comparing groups before and after implementation is one way to assess policy impact (CDC, 2013b; Vedung, 2017b). I based the policy recommendations on data analysis from my study exploring faculty experiences evaluating underperforming clinical students; therefore, the impact evaluation questions will have the same focus. I will send a survey to clinical faculty with questions related to the use of clinical formative assessment tools, consistency in evaluation processes, and structured clinical remediation opportunities. Comparing clinical nursing faculty experiences before and after implementation will provide insight into how the policy recommendations impacted the evaluation of underperforming students.

Key Stakeholders

Clinical nursing faculty. Nursing faculty at the study site expressed feelings of guilt, frustration, and anger related to working with underperforming students in clinical settings. Faculty identified issues using formative evaluation tools and inconsistency among faculty evaluating students in clinical settings. Also, some clinical faculty who assigned remediation activities to underperforming students noted the students had no change in skills, behavior, or attitude after completing remediation activities. If the policy recommendations are effective, faculty may be able to feel a sense of satisfaction, accomplishment, and pride when working with underperforming students.

Nursing program. Evaluation information would be beneficial to the nursing program. I will share the results of evaluations with the nursing leadership team in aggregate form. Process evaluation results will provide information about what worked well during the implementation process, and improvements required for future policy implementation. Outcome evaluation results will provide the leadership team with information about successes and challenges when applying the policy recommendations to real student situations. The nursing program can use this information to revise guidelines as needed. Impact evaluation results will provide information about faculty perceptions before and after the policy implementation regarding evaluating underperforming nursing students. This information can be used by the program to determine if the policy recommendations decreased the risk of underperforming clinical nursing students receiving a passing clinical grade, and policies should remain in place or if revisions to policies are required.

Project Implications

Ineffective clinical formative assessment and lack of targeted remediation strategies can result in underperforming nursing students failing subsequent clinical courses or the program. A delay in graduation or not graduating from the program could prevent students from improving their socioeconomic and professional statuses, especially for students served by the college who belong to ethnic minority and socially disadvantaged groups. Therefore, policy recommendations that support student success could have the potential to lead to positive social change for these students.

Implications for Healthcare Employers and Recipients of Healthcare

Healthcare facilities throughout the state employ nursing program graduates. Nursing students are eligible to take the licensure exam in different states; therefore, a small percentage of graduates choose to move out of state with the intent of taking the licensure exam and seeking employment in those states. There is evidence that students who underperform in the clinical setting may pass the written licensure exam (Hunt et al., 2012). Healthcare employers expect that students who are successful on the NCLEX exam have the skills and knowledge required to enter the workforce as a new nurse. Improved clinical formative assessment processes will help ensure that all nursing program graduates will have the foundational skills and knowledge to provide safe patient care.

Implications for Local Stakeholders

Students. Underperforming nursing students at the study site comprise the most important stakeholder group for this project. The policy recommendations I developed

are intended to provide direct benefits to the students who are deemed underperforming in clinical sites. Suggested revisions to clinical formative assessment tools and the development of an interrater agreement policy were designed to provide clear objective measures for clinical evaluation. Objective criteria will reduce the chance that students are evaluated subjectively regardless of the clinical setting or faculty. The policy recommendation for a clinical remediation process will support student learning, which may increase the likelihood of clinical success.

Policy recommendations may also impact the licensure exam pass rate for students graduating from the nursing program. Licensure exam pass rates are one factor considered by nursing program accreditation bodies. The National Council of State Boards of Nursing [NCSBN] (2020) will launch a new version of the national licensure exam for nurses in 2023. This new version of the licensure exam titled NCLEX Next Gen (NGN) will consist of clinical case studies with associated questions presented in a variety of formats. Exam questions will focus on nurse and patient interactions and clinical decision making based on patient needs and expected patient outcomes (NCSBN, 2019). High-performance clinical skills and knowledge will be essential for examinees to pass the NGN exam. Students who are unable to pass the exam will be unable to enter the workforce, which could impact the students earning potential.

Nursing program and college. Ineffective formative evaluation processes may result in passing underperforming nursing students in one clinical course who may then fail the next clinical course because they do not have the skills or knowledge to be successful. Nursing students at the study site are permitted to repeat an unsuccessful

course only if a seat in the class is available. Unsuccessful students go on a waitlist if no seat is available. Per the director of nursing education at the study site, over 40 unsuccessful students are waiting to reenter the program at any given semester. Large numbers of students on waitlists can negatively affect the nursing program's image. This negative image could result in a reduction in the number of students who apply to the program and potentially impact the college financially.

Summary

In Section 3, I provided a detailed description of a project developed to help improve clinical formative assessment processes at the study site. In this section, I also offered summary findings of a literature review conducted to gain insights regarding the project genre (policy recommendation). The project involved a policy recommendation paper based on the results of a study I conducted, evidence found in the available literature, and a review of current clinical formative assessment processes at the study site. Appendix A of this document includes the project recommendations. In Section 4, I will provide overall reflections regarding the project development process.

Section 4: Reflections and Conclusions

This section contains a reflection on the project discussed in Section 3 (the policy recommendation paper). I will include an analysis of the strengths and limitations of the project and recommendations for alternative solutions to the local problem of faculty having difficulty evaluating underperforming nursing students in clinical settings. I will also reflect on my growth as a scholar, project developer, and leader. Finally, I will reflect on the importance of the project and consider its implications and applications for nursing education and future research.

Project Strengths and Limitations

The genre for the project, a policy recommendation, is one of the project's strengths. I developed the policy document based on best practices from an extensive review of the literature on policy development. Recommendations presented in the policy document are relevant to the nursing program because they are based on findings of a study conducted at the institution, a review of the existing program policies, and literature related to areas identified during the analysis of study data.

The goal of the policy recommendation was to improve clinical formative assessment processes at the study site. In the study I conducted, faculty participants identified several processes related to clinical formative assessment processes that contributed to difficulty evaluating underperforming nursing students in clinical settings. The faculty who participated in the study confirmed the problem of potentially passing clinically underperforming nursing students; therefore, the goal of the project is relevant to students, faculty, nursing program administration, and the college.

Recommended changes will require faculty time and training. Resources at the college to support time for faculty projects and training make the implementation of the recommendations feasible. Nursing faculty at the college created the current clinical assessment tools, so it is reasonable to expect that they can make the recommended revisions. Faculty can receive release time for projects such as clinical tool revisions and development of a remediation policy. The nursing program can incorporate training required to use the tool and establish clinical tool interrater agreement during existing faculty in-service days.

Although the recommendations in the policy document are feasible and make use of available resources, some factors may limit the adoption and implementation of remediation recommendations. Nursing program faculty may resist implementing the recommended changes due to the increased demands remediation processes will place on clinical faculty. Counseling underperforming students, completing remediation plans, monitoring process after remediation, and determining completion of remediation will increase the workload of clinical faculty. I recommended the formation of a remediation team to address this possible barrier. Some of the clinical experiences in the nursing program are a total of only 5 days, which will limit the time to complete the recommended evidence-based remediation processes before summative evaluations are due. It will be necessary to ensure that remediation referral occurs early in the clinical rotation and that only remediation activities that can be completed in a short time frame are assigned.

Recommendations for Alternative Approaches

The local problem of clinical faculty expressing difficulty evaluating underperforming nursing students prompted this project study. I could have explored the problem in several ways. I could have interviewed an equal number of adjunct faculty and full-time faculty or novice and experienced clinical educators to see how their experiences compared. Focusing on the experiences of students who had been deemed underperforming by clinical faculty and comparing those experiences to best practice in clinical evaluation could have been another way to explore this problem.

I also could have recommended alternative approaches to address the study results. Study results revealed that the clinical evaluation tool used at the college and a lack of remediation opportunities to support clinical students could be contributing factors to why faculty may pass students deemed underperforming in clinical settings. Rather than developing a policy recommendation focusing on formative assessment processes overall, I could have focused the project only on the evaluation tool or just on the lack of a remediation process. Given that the study results revealed faculty were able to identify and describe underperforming nursing students, the project could have been a professional development activity related to clarifying terms on the existing clinical evaluation tool and providing faculty an opportunity to practice evaluating situations of underperformance in clinical settings. Because no clinical remediation policy exists at the college, a policy recommendation would still be necessary to address the lack of remediation processes.

Scholarship, Project Development, and Leadership and Change

My project study and policy recommendations contribute to scholarship in nursing education. According to the Accreditation Commission for Education in Nursing (2017), scholarship activities should support end-of-program student learning outcomes. The policy recommendations I developed will assist nursing students' achievement of program outcomes related to clinical competencies. Through the process of the study and project development, I have grown as a faculty scholar. As a nurse educator, I recognized the importance of applying evidence-based practice strategies to ensure the best outcomes in the courses I teach. Completing this project study has helped me realize that I also must promote evidence-based practice strategies throughout the entire curriculum to ensure the best possible outcomes for all students.

Zook, Price, Rogers, and Curci (2019) reconceptualized scholarship as expectations of professional achievement consisting of critical features. According to the authors, an insatiable intellectual curiosity and in-depth knowledge of a specific area of inquiry are two critical elements of professional achievement. The question of why some clinical faculty assigned underperforming nursing students passing clinical grades prompted the project study. This question led to a desire to gain a greater understanding of faculty experiences evaluating underperforming nursing students.

Sustained intentional efforts are also a critical feature of professional achievement, according to Zook et al. (2019). Although it has taken longer than anticipated for me to complete the project study and I have hit several roadblocks along the way, I have never given up the efforts to complete the study and, eventually, my

degree. Adding value to the field of study and society is another critical feature.

Understanding the experiences of faculty evaluating underperforming clinical students has implications for nursing education. Improving formative assessment processes has implications for society by ensuring that all nursing students who graduate are prepared to provide safe, competent care. Another critical feature of professional achievement is making scholarly works available for public critique. I plan to submit my project study as a manuscript for publication so other nursing education scholars can review it.

Completing the project study and policy recommendations has also helped me grow as a nurse educator, simulation educator, and simulation coordinator. During the process of completing this project, I have gained knowledge related to the experiences of nursing and simulation educators when working with underperforming nursing students. I have begun implementing changes to improve formative assessment processes for nursing students who attend simulation clinical experiences. As the nursing program simulation coordinator, I have provided direction to other nursing simulation faculty related to addressing issues with underperforming students. As a result of exploring best practice for developing formative assessment tools, I have made recommendations for changing not only the tools used in the nursing program simulation clinical setting, but also formative assessment tools used in the paramedic, respiratory care, and health occupations programs where I also serve as simulation coordinator.

Project Development

A survey at the study site indicating that several nursing faculty members had clinically passed students whom they deemed underperforming was the reason for

conducting this project study. My initial assumption was that the faculty members had difficulty identifying underperformance in the clinical setting. Based on that assumption, I envisioned my project to be a faculty workshop on identifying underperformance in clinical settings. However, analysis of the research data and comparison to existing literature related to identifying underperformance in clinical settings showed that faculty were able to identify, describe, and evaluate underperformance in clinical settings. Because my original assumptions were dispelled, I had to analyze the results from a different perspective, leading me to explore the processes in place that could be impacting the faculty experience when working with underperforming students.

When exploring the processes in place at the study site, I discovered a lack of objectivity on clinical formative assessment tools, a lack of support and resources for faculty who identify underperforming clinical students, and a lack of resources for students who are deemed underperforming in clinical settings. I still considered a faculty development workshop as my project because I knew it would be easy to implement. However, since the analysis of the study data and processes at the study site revealed there was not an issue with faculty knowledge or understanding of what defines underperformance, a faculty development workshop would not have been appropriate. Of the remaining project genre options, a policy recommendation was the best approach to address the gaps in processes discovered at the study site.

As a member of the leadership team at the study site, I had concerns about the feasibility of implementing the changes outlined in the policy recommendation. Nursing faculty at the college are resistant to change, even when they know it is in the best

interest of students. As with many other nursing programs in the United States, there is a shortage of full-time nursing faculty, and the program hires many adjunct faculty to fill in the gaps. Also, several faculty members choose to participate in only the required committee assignments. Some faculty do not join project committees even when provided additional compensation, leaving a smaller number of nursing faculty to serve on these committees. To ensure that all nursing students who graduate have met clinical competencies, it is necessary to address the clinical formative assessment processes at the study site. To help reduce the impact of implementing all the policy recommendations at once, I have offered the alternative options of smaller task forces, including adjunct faculty on task forces, and implementing the recommendations over time.

Leadership and Change

Change requires adaptive leadership skills to engage and motivate others (Arthur-Mensah & Zimmerman, 2017). The final decision to adopt and implement the recommended changes lies with the nursing program faculty. I can utilize adaptive leadership skills in my role as a member of the leadership team at the study site to help facilitate the implementation of the policy recommendations. Arthur-Mensah and Zimmerman (2017) identified six adaptive leadership skills that can help facilitate change in organizations where resistance may exist. Adaptive leaders need first to assess the organization's potential for change from a birds-eye view. The project study and the policy recommendations have been my life's work for the last several years. However, for the nursing program faculty, it will be new information, and I need to recognize that they will not have the same passion and emotional connection to the recommendations

that I do. According to Arthur-Mensah and Zimmerman (2017), effective leaders also need to identify challenges within the organization that can prevent change and understand the emotional stress the change process may have on followers. Previously in this document, I have noted several organizational and personnel challenges that may prevent the adoption and implementation of my policy recommendations and offered alternative approaches to address these challenges. As a leader, I will need to be prepared to provide different alternative implementation approaches if required.

Maintaining attention during the change process and providing solutions to challenges are also crucial adaptive leadership skills (Arthur-Mensah & Zimmerman, 2017). As a nursing faculty member at the study site, I will be available to provide support, mentorship, and assistance during the change process. Arthur-Mensah and Zimmerman (2017) encourage adaptive leaders to support the voices of people who are impacted by changes but maybe forgotten during the process. Adjunct clinical faculty will be affected by any changes related to clinical processes; therefore, I have encouraged the inclusion of adjunct faculty in the implementation process. Lastly, Arthur-Mensah and Zimmerman (2017) stressed the importance of leaders giving power to the people who will be responsible for the changes. Because I am invested in the success of the recommendations, it will be difficult for me to turn the implementation of the recommendations over to others. However, I know this will be the best chance of success, so I will serve as a guide and mentor rather than dictating the implementation of the changes.

Reflection on the Importance of the Work

By completing this project study, I gained valuable insight into challenges experienced by nursing faculty at the study site when evaluating underperforming students in clinical settings. Ineffective evaluation of underperforming clinical nursing students can result in the assignment of a passing grade to students who have not met all clinical competencies. Gaining a better understanding of why faculty experienced challenges evaluating underperforming nursing students supported the need for the policy recommendations of revising clinical formative assessment tools, establishing an interrater agreement policy, and developing a clinical remediation policy. Implementation of these policy recommendations will improve clinical formative assessment processes at the college to ensure that all students who receive a passing clinical grade have met all clinical competencies and are prepared to provide safe patient care.

Implications, Applications, and Directions for Future Research

The intended purpose of this project study was to explore the experiences of faculty evaluating underperforming nursing students in clinical settings. As noted previously in this document, improved clinical evaluation processes that may result from implementation of the policy recommendations have positive social implications for students at the study site and recipients of healthcare provided by nursing program graduates. Improved clinical formative assessment processes may increase student graduation rates, whereby improving employment options and earning potential. Ensuring that all nursing students who graduate from the program are prepared to deliver competent, safe, high-quality healthcare may improve outcomes for recipients of

healthcare. The results of this study may encourage other healthcare education programs with a clinical component to review or revise their clinical formative assessment processes.

This qualitative project study provides direction for future research related to the evaluation of underperforming nursing students in clinical settings. There is a shortage of published research related to formative assessment and underperformance in simulation settings; therefore, there is a need for additional studies in these areas. Eight adjunct clinical nursing faculty participated in this study; however, the college employs more than 50 adjunct clinical nursing faculty. It would be interesting to replicate the study with only adjunct clinical nursing faculty and compare the two study results. This project study was conducted at a community college in a Midwestern city in the United States. Replicating the study in a university setting or community college in a different region of the United States would further add to the body of knowledge related to the experiences of evaluating underperforming nursing students in clinical settings.

Conclusion

The purpose of this project study was to explore the experiences of clinical faculty evaluating underperforming nursing students in clinical settings. The overall aim of the study was to gain an understanding as to why some faculty may assign passing clinical grades to nursing students who do not meet all clinical course competencies. Based on the results of the study, I developed a policy recommendation paper to improve clinical formative assessment processes at the study site. As a nurse educator, I have the responsibility to provide resources, so nursing students who graduate from the program

are prepared to provide the highest quality care. In the words of nursing pioneer Florence Nightingale, “For the sick, it is important to have the best” (Great Britain Parliament House of Commons, 1855, p. 343). By recommending policies that verify nursing students who receive a passing clinical grade have met all clinical course competencies, I can help ensure all patients receive the best care possible.

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Appendix A: Policy Recommendation

Executive Summary

Problem

Nursing faculty at the college experience challenges when evaluating underperforming nursing students in clinical settings.

Methods

In 2018 I conducted a qualitative descriptive case study of nursing clinical faculty at the college. I collected information from 21 faculty through an online questionnaire and 11 faculty through semistructured interviews. Using conceptual and deductive analysis, I developed themes based on the study data. Study results indicated that nursing faculty at the college were able to identify and describe students who are underperforming clinically and utilized best practice standards for evaluating nursing students in clinical settings. However, study participants identified several challenges in applying existing nursing program clinical formative assessment processes to students deemed underperforming.

Results and Recommendations

A policy recommendation paper was developed with suggestions to help improve clinical formative assessment processes and support underperforming students in the nursing program. I based the recommended strategies to improve clinical formative assessment processes and support underperforming nursing students on a comprehensive review of related literature. Below is a summary of these findings, along with recommendations:

- **Subjective Clinical Formative Assessment Tools**
 - **Research Result:** Faculty identified challenges using program clinical evaluation tools to accurately evaluate, provide feedback, and hold accountable underperforming nursing students.
 - **Recommendation:** Revise clinical formative assessment tools to align with evidence-based guidelines.

- **Inconsistency in Clinical Evaluation**
 - **Research Result:** Faculty expressed concerns related to inconsistency among faculty when evaluating underperforming nursing students.
 - **Recommendation:** Establish a clinical evaluation tool interrater agreement policy.

- **Student Clinical Remediation**
 - **Research Result:** The use of remediation for clinical underperformance was inconsistent; in some cases, remediation assignments did not align with identified areas of underperformance, and faculty identified lack of improvement after students completed assigned remediation activities.
 - **Recommendation:** Develop an evidence-based education practice clinical remediation policy

Conclusions and Implications

Improved clinical formative assessment processes and evidence-based remediation strategies can promote successful completion of clinical competencies for students identified as underperforming in clinical settings. Consistency among clinical faculty assessing underperforming nursing students will help ensure that all students who receive a passing clinical grade have demonstrated the attitude, intellectual skills, and cognitive strategies required for success in future clinical experiences. Supporting student clinical success will help ensure that all graduates of the nursing program have the clinical skills and knowledge to provide safe patient care.

Background of Existing Problem

Faculty at the study site identified similar challenges evaluating underperforming students in clinical settings as those found in the nursing education literature. Even though clinical faculty recognized characteristics and behaviors consistent with underperformance, they acknowledged giving passing clinical grades to underperforming students due to challenges using existing clinical formative assessment processes. Ineffective clinical formative assessment processes used for students can lead to challenges evaluating students summatively, resulting in students who have not met clinical competencies progressing through the program. The purpose of the policy recommendations contained in this document is to improve clinical formative assessment processes within the nursing program. I based the policy recommendations provided on an extensive literature review and the results of a qualitative descriptive case study of clinical faculty conducted at the college.

Summary of Findings

Clinical faculty who participated in the study identified a lack of interpersonal skills, poor communication skills, and the inability to apply classroom information in clinical settings as early indicators of underperformance. Faculty descriptions of characteristics and behaviors displayed by underperforming students aligned with Gagné's (1972) attitude, intellectual skills, and cognitive strategies categories of learning applied to the clinical setting. Descriptions of clinical underperformance were consistent in the traditional and simulation clinical settings.

Faculty practices when evaluating underperforming nursing students in clinical settings correlated with the following NLN Clinical Nurse Educator Core Competency: Implements Effective Clinical Assessment and Evaluation Strategies task statements

- Implements both formative and summative evaluation that is appropriate for the learner and learning outcomes.
- Documents learner performance, feedback, and progression.
- Provides timely, objective, constructive, and fair feedback to learners.
- Engages in timely communication with course faculty regarding learner performance.

Analysis of study responses revealed that faculty have challenges applying effective assessment strategies with underperforming nursing students using existing nursing program clinical formative assessment processes. Faculty identified difficulty applying criteria and scoring rubrics to underperforming students and inconsistency among faculty evaluating students in clinical settings. Study participants also identified

concerns with subjectivity when using clinical assessment tools. Faculty in the study reported feelings of anxiety, fear of retribution, and related to providing feedback to underperforming nursing students. Participants in the study noted that working with an underperforming clinical nursing student was time-consuming and took time away from the rest of the students in the clinical group.

Faculty identified attitude, intellectual skills, and cognitive strategies as indicators of underperformance; however, examples of remediation activities focused on reviewing procedures, completing nursing care plans, and reviewing course information. The policy recommendations include suggested revisions to the clinical formative assessment tool used within the nursing program and the establishment of an interrater agreement policy for clinical assessment. Other recommendations include the development of an evidence-based education practice clinical remediation policy with suggested strategies mapped to Gagné's (1972) categories of learning applied to the clinical setting.

Outline of Recommendations and Supporting Evidence

Analysis of Existing Policy: Clinical Formative Assessment Tool Development

The nursing program section of the college healthcare simulation manual contains guidelines for the development of the formative assessment tool used in the simulation clinical setting. The guidelines include areas for inclusion on the tool and faculty directions for using the tool; however, there are no criteria for the development of competencies for each area. A review of the nursing program faculty manual describes clinical formative and summative evaluation processes and faculty directions for scoring students. There was no policy or guidelines for the development of traditional clinical

assessment or evaluation tools found. Several competencies found on clinical evaluation tools used in the nursing program contain subjective terms and phrases. The description of satisfactory, needs improvement, and unsatisfactory measures on the traditional clinical formative assessment tools include terms that lead to the subjective measurement of all clinical competencies. Table 1 consists of a summary of subjective terms found on clinical formative assessment tools.

Table 1

Summary of Subjective Terms and Phrases Found on Study Site Clinical Formative Assessment Tools

Subjective Term/Phrase	Practical Nursing Program Traditional Clinical Tools	Associate Degree Nursing Program Traditional Clinical Tools	Simulation** Clinical Tool	Total
Appropriate(ly)*	16	25	1	42
Occasional*	2	5	0	7
Frequent*	2	5	0	7
Related	2	4	0	6
Actively	2	2	0	4
Timely	2	2	0	4
With guidance	0	4	0	4
Common	0	2	0	2
Demonstrates understanding	0	1	0	1
Minimal	0	1	0	2
Total Responses	26	51	1	78

* The term Appropriate(ly) is found in the clinical competencies and assessment

measures. Terms Occasional and Frequent are found in the assessment measures.

**The same formative assessment tool is used in both programs.

Policy Recommendation: Revise Clinical Formative Assessment Tools

I am recommending a revision of clinical formative assessment tools using the following best practice guidelines.

- Clinical formative assessment tools align with the nursing program philosophy.
- Establishment of clinical formative assessment tool content validity through an expert review process.
- Clinical competencies apply to the clinical learning environment where the tool is used.
- Passing or failing grades are not assigned for clinical formative assessment.
- Develop clinical formative assessment competencies using the following guidelines:
 - Competencies are in the form of objective statements.
 - Includes competencies for technical and non-technical skills.
 - Measurement criteria consist of objective statements for levels of performance that would be deemed satisfactory, needs improvement, and unsatisfactory.
 - Measurement criteria are leveled to the learner.
- Includes a section for students to write their own clinical goals.
- Clinical faculty will attend an annual education session that includes information regarding the alignment of the assessment tool with program and clinical outcomes, how to use the assessment tool, definitions of objective terms, and how to evaluate non-technical skills, and opportunities to practice using the tool in cases of satisfactory and unsatisfactory performance.

Evidence

Objective formative clinical assessment tools are essential to accurately identify nursing students' strengths and areas for improvement before summative clinical evaluation (Helminen, Coco, Johnson, Turunen, & Tossavainen, 2016; O'Connor, 2014; Spurlock & Mariani, 2019). Aligning clinical assessment tools with program theoretical or conceptual frameworks validates the role of assessment in clinical experiences (Higham et al., 2019). The establishment of content validity ensures that the clinical assessment tool measures what it is designed to measure (Afifi, 2017; Higham et al., 2019). Clinical competencies not directly related to the clinical setting are difficult for faculty to assess (Baumgartner, Häckter Ståhl, Manninen, & Rydholm Hedman, 2017). Because opportunities to improve performance are part of the clinical formative assessment process, students should not be assigned a passing or failing grade (Jeffries & Jeffries, 2012; O'Connor, 2014).

Studies by Afifi (2017), Baumgartner et al. (2017), and Reljić, Lorber, Vrbnjak, Sharvin, and Strauss (2017) provide insight into best practice for the development of clinical formative assessment tools. To prevent misinterpretation by students or evaluators, clinical competencies and measurement criteria should be void of ambiguous or subjective terms. Measurement criteria should be leveled to the learner to ensure that the assessment of students' is not above or below their expected level of skills and knowledge. Students who wrote their own clinical goals are more engaged in the learning process (Baumgartner et al., 2017). Higham et al. (2019) and Pires et al. (2017) conducted studies exploring the assessment of non-technical skills (NTS) such as

communication, professionalism, interpersonal skills, critical thinking, and teamwork.

The number of competencies related to NTS should be limited to improve consistency in assessment. The authors emphasize the importance of developing objective, measurable competencies for NTS like those designed for technical skills.

Training for clinical faculty is imperative to ensure accurate, consistent formative assessment (Baumgartner et al., 2017; Brigley, 2018; Pires et al., 2017; Rafii, Ghezaljah, & Nasrollah, 2019). Information regarding the alignment of assessment tools with program and clinical outcomes will provide a foundation for clinical assessment competencies (Higham et al., 2019). Providing clear, concise definitions of objective terms will reduce misinterpretation (Baumgartner et al., 2017). Education about how to recognize and evaluate nontechnical skills will help promote consistency in evaluation throughout the program (Brigley, 2018; Pires et al., 2017; Rafii et al., 2019). Directions for how to use the assessment tool and opportunities to practice assessment in cases of satisfactory and unsatisfactory performance using video examples will help ensure effective and objective assessment (Baumgartner et al., 2017; Higham et al., 2019).

Analysis of Existing Policy: Consistency in Clinical Formative Assessment

A review of the nursing program faculty manual found an interrater reliability process for student papers with rubrics, but no interrater reliability or interrater agreement policy or guidelines for traditional clinical formative assessment tools. There is a statement indicating the use of an interrater reliability process for the formative assessment tool used in the simulation clinical setting found in the nursing program

section of the college healthcare simulation manual; however, there is no description of the process.

Policy Recommendation: Establish a Clinical Evaluation Tool Interrater Agreement Policy.

I am recommending the establishment of an interrater agreement policy. The interrater agreement is the percent of exact agreement between raters using the same tool to observe and rate the same person. The recommended percentage of exact agreement is 80 percent. The policy should apply to all faculty responsible for evaluating the same level of nursing students in different clinical sites or different levels of students in the same clinical setting. Determination of interrater agreement should occur at least every 2 years, at the time of new clinical faculty hires, or if there are changes made to the evaluation tool.

Evidence

There is evidence that inconsistency in evaluation leads to dissatisfaction among students, passing students with varying levels of clinical competence, and distrust among faculty evaluators (Dunbar, 2018; Rafiee et al., 2014; Watts, Ivankova, & Moss, 2017). According to Gwet (2014), interrater agreement (IRA) measures the extent to which different raters assign the same value when observing an item. IRA is used when determining consistency to rate performance. Percentage of exact agreement is the most straightforward IRA to understand because it is calculated by taking the exact agreements of a rating divided by the total number of ratings (Bajpai, Bajpai, and Chaturvedi, 2015).

Wilhelm, Rouse, and Jones (2018) indicate that percentages of 80 to 90 exact agreement between raters is acceptable.

Analysis of Existing Policy: Clinical Remediation

There are references to remediation for written assignments, psychomotor skills, exams, standardized tests, and program restarts in the nursing program faculty manual. Faculty guidelines for the use of the traditional clinical formative assessment tool include the expectation of remediation assignments for an unsatisfactory rating, score less than 78%, and at the discretion of the clinical instructor. No policy or guidelines for assigning clinical remediation activities was found.

Policy Recommendation: Clinical Remediation Policy

I am recommending the development of an evidence-based clinical remediation policy. Remediation should be mandatory and focus on supporting students' success. Remediation policy should include the following:

- Defined expectations of students, faculty, and administration.
- Method of informing students about remediation expectations before program entry and during the program orientation.
- Process for early identification and mandatory referral by faculty.
- Written plans for each clinical area requiring remediation. Plans should include measurable behavioral goals, a process for monitoring behaviors in the clinical setting, timeline for completion, follow-up assessment plans, and required evidence of completion.
- Evidence-based method of determining reasons for performance gaps.

- Variety of remediation opportunities for psychomotor, cognitive, and affective learning domains.
- Multiple opportunities for students to practice and hone insufficient clinical skills, knowledge, and attitudes before the summative evaluation.
- Plan for relapses that may occur.
- Support services to address causes of clinical not underperformance appropriate for referral to remediation.

Gagné's categories of learning applied to nurse education (Gray-Miceli et al. (2014) can provide a framework for organizing clinical remediation activities. Table 2 provides sample clinical remediation activities mapped to Gagné's categories of learning.

Evidence

Evidence-based nursing program clinical remediation processes can improve student success, faculty satisfaction, and patient safety (Chou, Kalet, Costa, Cleland, & Winston, 2019; Mee & Schreiner, 2016). Underperforming students may not have the self-assessment skills to recognize the need for remediation; therefore, remediation should be mandatory (Chou et al., 2019; Coelho, Zahra, Ali, & Tredwin, 2019; Fenske & Price, 2016; Forsythe & Johnson, 2017). Linking remediation to consequences emphasizes that remediation is a high priority for the program (Custer, 2016; Mee & Schreiner, 2016). There is evidence that assurances by a student that they will improve or giving students more time to improve on their own do not result in improved clinical performance (El Hussein & Fast, 2020; Williamson, Quattromani, & Aldeen, 2016).

Table 2

Sample Remediation Activities for Gagné's Five Categories of Learning Applied to the Clinical Setting

Gagné's Category of Learning Applied to the Clinical Setting	Sample Remediation Activities
<p>Motor Skills Implement organized tasks in a specific sequence</p>	<ul style="list-style-type: none"> • Replication of procedure/skill situation in laboratory setting followed by self-assessment of recording using a procedure/skill checklist. • Review of procedure/skills videos followed by practice in the laboratory.
<p>Verbal Information Describe information without the use of references</p>	<ul style="list-style-type: none"> • Repeated self-recordings of related information. • Practice verbally explaining medical information to persons, not in the medical field.
<p>Attitude Interpersonal skills, beliefs, emotions, and behaviors that influence personal actions.</p>	<ul style="list-style-type: none"> • Self-reflection assignment regarding how behaviors impacted patient safety. • Replication of situation or event in simulation setting followed by self-assessment of recording using a non-technical skills (NTS) evaluation tool.
<p>Intellectual Skills Application of information to different situations.</p>	<ul style="list-style-type: none"> • Opportunities to practice situation/event and related principles in simulation clinical scenarios based in different healthcare settings and/or with varying patient populations followed by self-assessment of recording mapping program concepts to nursing actions.
<p>Cognitive Strategies Application of attitude, verbal information, intellectual skills, and motor skills, and to solve simple-to-complex problems.</p>	<ul style="list-style-type: none"> • A computer-based interactive simulation learning experience designed to promote clinical decision making and includes a scoring rubric. • Participation in complex manikin-based simulation learning experience followed by self-evaluation of video using Lasater Clinical Judgement Rubric (LCJR).

According to Chou et al. (2019), participation in remediation should begin as soon as faculty note early indicators of underperformance. Issues affecting clinical performance such as physical or behavioral health diagnoses, financial matters, or family issues are not appropriate for remediation; therefore, students should be referred to

college services, and remediation for the clinical deficit scheduled after these issues are addressed (Chou et al., 2019; Nadir et al., 2019; Vacha-Haase et al., 2018; Williamson et al., 2016).

Remediation plans should be individualized, contain measurable behavioral goals, consist of a variety of faculty lead evidenced-based remediation strategies in the psychomotor, cognitive, and affective domains of learning, and include multiple opportunities for students to practice and hone insufficient skills, knowledge, and attitudes before summative evaluation (Chou et al., 2019; Coelho et al., 2019; Fenske & Price, 2016; Mee & Schreiner, 2016; Vacha-Haase et al., 2018). Each area of clinical underperformance requires a different remediation plan (Chou et al., 2019; McHugo, 2017; Sparks et al., 2016). Simulation-based learning experiences have been successfully used as a diagnostic tool to identify reasons for performance gaps and as a tool for remediating clinical deficits. (Camp and Legge, 2018; Fenske & Price, 2016; Guerrasio & Aagaard, 2018; Nadir, et al, 2019; Unsworth, Melling, Tuffnell, & Allan, 2016). According to Mee and Schreiner (2016) and Vacha-Haase, et al. (2018), remediation plans should also include a process for monitoring behaviors in the clinical setting, a timeline for completion, plans for follow-up assessment and relapses that may occur.

Implementation

If the proposed recommendations for changes to clinical formative assessment process are adopted, implementation will be the responsibility of clinical nursing faculty. Implementation will require administrative support for faculty time to revise clinical formative assessment tools and training. Because the nursing program employs many

adjunct clinical faculty, it is recommended that adjunct faculty participate in the development and implementation of the recommendations. Space in the college's simulation center and dedicated simulation faculty time will be required if simulation learning experiences will support clinical remediation.

Summary

The overall goal of the project discussed was to present the director of nursing, the nursing program curriculum committee, and the nursing faculty, with several policy recommendations for consideration. The recommendations aim to help improve clinical formative assessment processes whereby reducing the number of clinically underperforming nursing students who may graduate from the program. These recommendations were based on a qualitative descriptive case study conducted at the college and on strategies found within the related professional literature. Assessment of the effectiveness of adopted recommendations will occur through outcome and impact evaluation. Outcome evaluation will occur at the end of each semester for the first 2 years of implementation. The evaluation will consist of an online survey of all clinical faculty in traditional and simulation settings with questions that focus on the application of policy recommendations during clinical formative assessment and the benefits and challenges of implementing the policy recommendations for students and clinical faculty.

Impact evaluation will occur 2 years after the implementation of policy recommendations to ensure at least one cohort of students has graduated from the associate degree nursing program. The policy recommendation writer will send a survey to clinical faculty with questions related to the use of clinical formative assessment tools,

consistency in evaluation processes, and structured clinical remediation opportunities.

Comparing clinical nursing faculty experiences before and after implementation will provide insight into how the policy recommendations impacted the evaluation of underperforming students.

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Appendix B: Online Questionnaire

Title: Faculty Evaluating Underperforming Nursing Students in Clinical Settings Questionnaire**Introduction (first section):**

Thank you for participating in this research study about faculty evaluation of underperforming nursing students in clinical settings.

This online questionnaire consists of three (3) demographic questions and six (6) open-ended questions related to the process of evaluating underperforming nursing students in clinical settings. The questionnaire will take less than twenty (20) minutes to complete.

Demographic Information (second section):

1. Employment Status as Clinical Nursing Faculty
 - _____ Full-time
 - _____ Part-time
 - _____ Adjunct

2. Years as Clinical Nursing Faculty (include time employed as a clinical faculty with any nursing program)
 - _____ Minimal–2 years
 - _____ 3–5 years
 - _____ 6–10 years
 - _____ Greater than 10 years

3. Number of underperforming nursing students you have evaluated in traditional and/or simulation clinical settings
 - _____ I have never evaluated an underperforming nursing student in a clinical setting.
 - _____ I have evaluated 1 – 3 underperforming nursing students in the traditional and/or simulation clinical setting.
 - _____ I have evaluated 4 – 7 underperforming nursing students in the traditional and/or simulation clinical setting.
 - _____ I have evaluated 8 – 10 underperforming nursing students in the traditional and/or simulation clinical setting.
 - _____ I have evaluated more than 10 underperforming nursing students in the traditional and/or simulation clinical setting.

Open-ended Questions (third section):

Consider students in both the traditional and simulation clinical settings and all your experience as a clinical instructor when answering these questions.

1. From your experience, what subjective words would you use to describe a nursing student who is underperforming in the clinical setting?

2. From your experience, write a definition of an underperforming nursing student in the clinical setting.
3. From your experience, indicate how you identify a nursing student who is underperforming in the clinical setting.
4. From your experience, provide examples of how underperforming nursing students perform in each of the following areas of clinical learning:
 - a. Motor skills (performing nursing interventions)
 - b. Verbal information (expressing nursing knowledge and information verbally)
 - c. Attitude (interpersonal skills, beliefs, emotions, and behaviors)
 - d. Intellectual skills (apply information to different situations)
 - e. Cognitive strategies (application of verbal information, intellectual skills, motor skills, and attitude to solve simple to complex problems)
5. From your experience, what verbal feedback do you give a nursing student identified as underperforming in the clinical setting?
6. From your experience, what written feedback do you give a nursing student identified as underperforming in the clinical setting?

Thank you and Invitation to Participate in Interview (fourth section):

Thank you for completing this questionnaire. Your input will provide valuable information related to understanding faculty experiences of evaluating nursing students in clinical settings.

I would like to invite you to also participate in an interview to further explore your personal experiences of evaluating nursing students in clinical settings. Interview questions will focus on the experiences of faculty evaluating underperforming nursing students in clinical settings. Interviews will take approximately forty (40) to sixty (60) minutes. Please complete the information below if you would be willing to participate in the interview:

Name:

Email:

Best phone number to contact you:

You will be contacted if you are selected for the interview portion of the study. You will be asked to sign an additional consent form if you participate in the interview portion of the study.

Appendix C: Interview Protocol

- Informed consent signed
- Affirmation of inclusion criteria
- Permission to record the interview

Thank you for your willingness to participate in the interview portion of this case study research project on evaluating underperforming nursing students in clinical settings. I will be asking you several questions about your personal experiences evaluating underperforming nursing students in traditional and simulation clinical settings. Consider all your experience as a clinical instructor when answering these questions.

Feel free to take as much time as you need to respond to the questions. You need answer only those questions you wish to answer. May I now start to record your interview?

1. First, could you tell me about your experience with evaluating nursing students in general in the clinical setting?
2. How would you define an underperforming nursing student in the clinical setting?
3. Identify one student whom you considered to be underperforming in the traditional clinical setting. Do not mention the student's name. Tell me about the experience you had working with this student.
 - a. How did you identify that the student was underperforming?
 - b. Was there a specific area of clinical learning where the student underperformed more than in other areas? If so, what area was that? What did you observe that caused you to consider the student underperforming in that specific area?
[If faculty is not sure what is meant by this question give the examples of ability to perform nursing interventions, verbalize nursing knowledge, apply interpersonal skills, beliefs, emotions, and behaviors, verbalize nursing knowledge and information, apply information to different situations, and/or apply intellectual skills, motor skills, and attitude to solve simple to complex problems.]
 - c. Share with me how you documented the student's performance on the clinical evaluation tool.
 - d. Tell me how progression decisions were made about this student – in other words, whether to pass him/her for the clinical rotation, advance him/her in the program, etc.
 - e. What was the outcome with this student? Did he or she complete the program?
4. Identify one student whom you considered to be underperforming in the simulation clinical setting. Do not mention the student's name. Tell me about the

experience you had working with this student [if faculty does not have experience with a student in the simulation clinical setting, skip to question 5].

- a. How did you identify that the student was underperforming?
 - b. Was there a specific area of clinical learning where the student underperformed more than in other areas? If so, what area was that? What did you observe that caused you to consider the student underperforming in that specific area?
[If faculty is not sure what is meant by this question give the examples of ability to perform nursing interventions, verbalize nursing knowledge, apply interpersonal skills, beliefs, emotions, and behaviors, verbalize nursing knowledge and information, apply information to different situations, and/or apply intellectual skills, motor skills, and attitude to solve simple to complex problems.]
 - c. Share with me how you documented the student's performance on the clinical evaluation tool.
 - d. Tell me how progression decisions were made about this student – in other words, whether to pass him/her for the clinical rotation, advance him/her in the program, etc.
 - e. What was the outcome with this student? Did he or she complete the program?
5. Were there other students who were underperforming in a different way in either the traditional or simulation clinical setting? [If the first example was about a student who lacked psychomotor skills, for example, ask about students who were underperforming because they had issues with verbal information or interpersonal skills.] Could you tell me about your work with him/her? (Repeat questions a, b, c, d, and e above.)
 6. Is there a difference between evaluating underperforming clinical students in the traditional versus simulation clinical setting? If so, how would you describe the difference?
 7. What do you see as the biggest challenge related to evaluating underperforming nursing students in clinical settings?
 8. Is there anything else you would like to tell me about your personal experiences with evaluating underperforming students that may help me with this research?
 9. What questions do you have for me related to this research?

Thank you again for your participation. I appreciate your willingness to share your personal experiences with me. Your responses will provide valuable information about evaluating underperforming students that can help other faculty members.

Appendix D: E-mail to Potential Participants

Dear Clinical Nursing Faculty,

My name is Melody Bethards, and I am a doctoral student at Walden University. I would like to invite you to take part in a research study about faculty evaluation of underperforming nursing students in clinical settings.

I am inviting full-time, part-time, and adjunct clinical nursing faculty who have experience with at least one (1) underperforming student in the traditional or simulation clinical setting to be in the study. Underperforming clinical nursing students are students who demonstrate difficulty meeting clinical competencies, whether they passed or failed the clinical experience.

You might already know me as the Nursing Simulation Coordinator, but this study is separate from that role.

If you agree to be in this study, you will be asked to:

- Complete an online questionnaire consisting of three (3) demographic questions and six (6) open-ended questions related to the process of evaluating underperforming nursing students in clinical settings. The questionnaire will take less than twenty (20) minutes to complete.
- At the end of the online questionnaire, you will be asked if you would be willing to volunteer for the interview portion of the study. Interview questions will focus on the experiences of faculty evaluating underperforming nursing students in clinical settings. Interviews will take approximately forty (40) to sixty (60) minutes. You will be asked to sign an additional consent form if you participate in the interview portion of the study.

Your participation in this study is voluntary. You are free to accept or turn down the invitation. No one at the community college will treat you differently if you decide not to be in the study. If you decide to be in the study now, you can still change your mind later. You may stop at any time.

Attached to this email is the questionnaire study consent form. If you feel you understand the study and inclusion criteria well enough to make a decision about it, please indicate your consent by clicking the link at the bottom of the consent form to begin the online questionnaire.

Sincerely,

Melody L. Bethards, EdD Student

melody.bethards@waldenu.edu

Attachment: Consent Form

Appendix E: Pilot Test of Questionnaire

Introduction (first section):

Thank you for participating in pilot testing this online questionnaire. Your time and effort are appreciated. This questionnaire will be used to conduct research on faculty evaluation of underperforming nursing students in clinical settings.

When piloting this questionnaire, you will be asked to:

1. Track the time it takes to complete this questionnaire.
2. Examine questionnaire for wording, grammar, and understanding of responses
3. Answer the following questions:
 - a. Does the title reflect the purpose of the questionnaire?
 - b. Are the directions clear and concise?
 - c. Are the language and reading levels appropriate for the clinical nursing faculty population?
 - d. Is the content clear and concise?
 - e. Does the content fit the purpose of the study?

Space to reply to pilot test questions will be found at the end of the questionnaire.

Thank you and Pilot Test Questions (last section):

Thank you for completing the pilot test of this questionnaire. Please answer the following questions:

1. How much time did it take you to complete the questionnaire? Do not include the time it takes you to complete the pilot test questions.
2. Did the title reflect the purpose of the questionnaire? If not, how would you recommend the title be changed?
3. Are the directions clear and concise? If not, how would you recommend the directions be changed?
4. Were there any wording or grammar errors? If so, please indicate the question number.
5. Were you able to understand the intent of the responses? If not, which responses would you recommend be changed?
6. Are the language and reading levels appropriate for the clinical nursing faculty population? If not, what changes would you recommend?
7. Is the content clear and concise? If not, what changes would you recommend?
8. Does the content fit the purpose of the study? If not, what changes would you recommend?

Appendix F: Findings From Peer Review of Collected Data

Research Question 1: How do clinical nursing faculty identify students who are underperforming in clinical settings?

Several responses related to applying theory to clinical application. Review Benner Novice to Expert theory which has the assumption that application can occur without theory.

Theory assumptions focus on knowledge and skills attainment in the absence of model theory which notes the challenges for NGNs (Duclos-Miller, 2011; Stacey & Hardy, 2011). Benner theory explores what has long been referenced in the nursing profession as “following a nurse’s intuition” as a basis for decision making. The concepts of “knowing that” versus “knowing how” are used to describe a nurse’s intuition which can impact their skill performance (Benner, 1984).

Theme: Underpinning of Blooms Taxonomy or higher order thinking related to student learning. Comments related to student not knowing the knowledge and thus could not apply (makes sense as without knowledge the student cannot advance on the taxonomy. Doesn’t retain concepts (again knowledge). Others reference critical thinking, application, or being comprehensive which points to other levels of the taxonomy.

Several responses to medication administration- why this skill and not others?

Consideration: some responses are specific to applied skills while others relate to the students’ level of soft skills. Organization, communication, prioritization. Just as students are first identifying they can perform a task as “performing” consider looking at how often the applied skill is referenced vs a soft skill (which can be related to higher order thinking).

Research Question 2: How do clinical nursing faculty describe students who are underperforming in clinical settings?

Traditional Clinical

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Comparing Traditional Clinical and Simulation Learning Experiences

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Simulation Learning Experiences

Nice alignment to Gagnés Category of Learning. My feedback is related to above notes that there is existing research that supports that knowledge and skills attainment can be achieved without theory. It appears from the participant responses and Gagnes theory that the assumption is that the presence of theory frames student learning. I feel your subthemes are well supported to Ganges Category of Learning.

I was intrigued by the difference in responses from traditional setting to simulation setting. Clinical setting was heavily focused on skills vs simulation that focuses more on teamwork, collaboration with little mention of skills. This supports that faculty do have a clear understanding of the purpose and evaluation of student learning in simulation.

However, I would recommend that educators and leaders need to develop a clear expectation (similar to what simulation organizations have done) related to the purpose and evaluation methods of traditional clinical learning experiences. It was noted that faculty are just as focused on skills tasks yet articulate that students lack critical thinking. Are the student's focused on skills because their faculty are focused on skills (specifically medication administration)?

Research Question 3: How do clinical faculty evaluate students identified as underperforming in traditional clinical settings?

Note: Feedback addresses evaluation tools or some type of communication to student. Research demonstrates that remediation is effective in improving student learning yet no comments on evaluating the underperforming student. How is reflecting or discussing going to improve a psychomotor skill? In your lit review- is reflection or documentation the most common evaluation method utilized in underperforming students?

National League for Nursing's [NLN] (2019) Nurse Educator Core Competency

Good alignment to NLN competency and themes. No changes or considerations proposed.