Exploring the Issue of Failure to Fail in a Nursing Program

Abstract

A study using a qualitative descriptive design was undertaken to explore the issue of “failure to fail” in a nursing program. Individual in-depth interviews were conducted with nursing university faculty members, preceptors, and faculty advisors (n = 13). Content analysis was used to analyze the data. Results indicate that: (a) failing a student is a difficult process; (b) both academic and emotional support are required for students and preceptors and faculty advisors; (c) there are consequences for programs, faculty, and students when a student has failed a placement; (d) at times, personal, professional, and structural reasons exist for failing to fail a student; and (e) the reputation of the professional program can be diminished as a result of failing to fail a student. Recommendations for improving assessment, evaluation, and intervention with a failing student include documentation, communication, and support. These findings have implications for improving the quality of clinical experiences.

Keywords: preceptorship, “failure to fail”, unsafe students, nursing programs

There is a growing universal demand for well-prepared professional nurses, and society has entrusted nursing schools with the task of preparing such individuals (Parrott, 1993; Ralph, Walker, & Wimmer, 2008, 2009). It is within this context that clinical preceptors and university faculty have an academic and professional responsibility to teach, supervise, and evaluate students’ clinical performance to ensure that each graduate of their program is competent. However, there is evidence that some clinical preceptors and university faculty experience difficulty in identifying and making decisions to fail students who display incompetent or unsatisfactory practice (Allen, 2002; Bogo, Regehr, Power, & Regehr, 2007; Brown, Neudorf, Poitras, & Rodger, 2007; Hawe, 2003). Therefore, a multidisciplinary qualitative study was conducted to explore the issue of “failure to fail” in a preceptorship experience from the perspectives of three professional programs: education, nursing, and social work. In this article, the perspectives of nursing preceptors, faculty advisors, and faculty will be presented.

Literature review

Clinical experience is regarded as the key component of undergraduate nursing education (Courtney-Pratt, FitzGerald, Ford, Marsden, & Marlow, 2012; Billings & Halstead, 2005; Budgen & Gamroth, 2008; Croxon & Maginnis, 2009; Levett-Jones, Fahy, Parsons, & Mitchell, 2006). In the final year of some nursing programs, students are paired with a preceptor and a faculty advisor for the duration of their clinical or preceptorship experience (Bourbonnais & Kerr, 2007; Mohide & Mathew-Maich, 2007; Myrick & Yonge, 2005). While the preceptor provides the day-to-day teaching and supervision of the student, the faculty advisor acts as the link between the educational institution and the practice setting. A university faculty member directs the teaching and learning process (Bourbonnais & Kerr, 2007; Myrick & Yonge, 2005), provides support to preceptors and students, and is ultimately responsible for assigning the final grades, which are based on preceptors’ and faculty advisors’ feedback (Myrick & Yonge, 2005).

It is within this context that preceptors and faculty advisors have an academic, legal, and professional responsibility to teach, supervise, and evaluate students’ clinical performance to ensure that the graduates are competent and practice safely (Boley & Whitney, 2003; Johnson & Halstead, 2005; Smith, McKoy, & Richardson, 2001; Tancala, Scheffer, & Roberts, 2011). Part of the responsibility includes assigning failing grades to students who display incompetent or unsafe practice. However, there is evidence that some clinical instructors and preceptors have difficulty in identifying and managing students who display incompetent or unsatisfactory clinical performance (Boley & Whitney, 2003; Brown
et al., 2007; Diekelmann & McGregor, 2003; Duffy, 2004; Gainsbury, 2010; Heaslip & Scammell, 2012; Hunt, McGee, Gutteridge, & Hughes, 2012; Jervis & Tilki, 2011; Luhanga, Yonge, & Myrick, 2008; Tanicala, Scheffer, & Roberts, 2011; Scanlan, Care, & Gessler, 2001; Scholes & Albarran, 2005). This difficulty may arise from inconsistent interpretations of what is unsafe student clinical behavior, varying faculty views among faculty about how to intervene in potentially unsafe learning situations, and missing or unclear program policies (Brown et al., 2007; Duffy, 2004; Scanlan et al., 2001).

A number of other possible reasons for failure to report unsafe or unsatisfactory student performance have been identified in the literature. These include reticence on the part of clinical instructors to identify or resolve the student problems early enough in clinical placement (Duffy, 2004; Luhanga et al., 2008); lack of preparation or confidence in the evaluation role (Bogo et al., 2007; Duffy, 2004; Heaslip & Scammell, 2012; Jervis & Tilki, 2011; Luhanga et al., 2008; Scanlan et al., 2001); the threat of the university’s appeal system (Duffy, 2004; Dudek, Marks, & Regehr, 2005; Gainsbury, 2010; Jervis & Tilki, 2011; Luhanga et al., 2008); fear of potential legal implications (Boley & Whitney, 2003; Dudek et al., 2005; Raths & Lyman, 2003; Smith et al., 2001); time required (Diekelmann & McGregor, 2003; Dudek et al., 2005; Duffy, 2004; Gainsbury, 2010; Scholes & Albarran, 2005); a view of failing as uncaring (Scanlan et al., 2001; Luhanga et al., 2008); perceived pressure from educational institutions to pass students for reasons of finances and reputation (Gainsbury, 2010; Hawe, 2003; Jervis & Tilki, 2011); lack of documentation (Dudek et al., 2005; Duffy, 2004; Luhanga et al., 2008; Cleland, Knight, Rees, Tracey, & Bond, 2008); belief that student failure reflects a teaching failure (Hawe, 2003; Jervis & Tilki, 2011; Luhanga et al., 2008); a view that failing a student at the end of the program is unfair because of the significant personal cost to the student (Hawe, 2003; Ilott & Murphy, 1997; Luhanga et al., 2008; Parker, 2010); and pressure from the student to pass (Gainsbury, 2010; Jervis & Tilki, 2011; Scanlan & Care, 2004).

Faculty and preceptors who do not assign a failing grade to borderline or unsafe students must realize that by doing so they are doing harm not only to the student but also to the nursing profession. The profession is accountable to society, and by inference, nursing faculty and preceptors are also morally and ethically accountable to the profession (Luhanga et al., 2008; Luhanga, Myrick, & Yonge, 2010). Furthermore, there may also be legal implications and consequences (Boley & Whitney, 2003; Smith et al., 2001; Johnson & Halstead, 2005; Redmond & Bright, 2007; Parker, 2010). Faculty can be sued for either failing or passing an unsafe or incompetent student (Chasens, DePew, Goudreau, & Pierce, 2000; Osinski, 2003; Smith et al., 2001). As gatekeepers to their professions, preceptors and faculty have a duty to ensure that only students with appropriate knowledge, skills, and values necessary to serve clients are admitted to professional practice, thereby protecting society from incompetent or unsafe practitioners (Hrobsky & Kersbergen, 2002; Hunt et al., 2012; Tanicala et al., 2011; Redmond & Bright, 2007). Thus, there is a need to further explore the issue of failure to fail unsafe or incompetent students within professional programs (Luhanga et al., 2008).

Methodology

A qualitative descriptive design was employed to answer the following research question: What are the perceptions of nursing preceptors and faculty regarding failure to fail nursing students who display unsafe or poor performance during preceptorship experiences? According to Sandelowski (2000), a qualitative descriptive study is the method of choice when straight descriptions of phenomena are desired.

Ethics

Ethics approval was granted by both the university’s and the health care organization’s ethics board. To ensure confidentiality, a code number replaced participants’ names on the tape recordings, transcripts, and field notes. All potentially identifying characteristics were removed from transcripts and the educational institution where the “failure to fail” issue occurred was not identified. All data and field notes were stored in a locked filing cabinet in the principal investigator’s office and only the researchers had access to them. Upon completion of the study, code sheets containing participants’ demographic information were destroyed.

Sample

Participants were recruited from a midsize university and hospital situated in a Canadian province. Preceptors, faculty members, and faculty advisors were sent, via electronic distribution, a study information flyer inviting
interested potential participants to e-mail or call one of the researchers. Those who responded were then provided with a copy of the information letter, consent form, and interview guide by e-mail or mail. Participants were asked to return the consent by mail or e-mail. Researchers followed up by telephone or e-mail to arrange a time, date, and individual interview location. Participants could consent to either a face-to-face or telephonic interview. To accommodate three participants, one group interview was conducted.

A purposive sample of 13 was obtained using predetermined criteria, such as previous professional experience in preceptorship teaching (Patton, 2002). Participants did not necessarily have to have experience with a student who had failed or was at risk of failing. Preceptors and faculty advisors were also from different practice settings, including hospitals and community health care settings. One faculty advisor was from a community setting and two from acute care settings. Three preceptors were from acute care settings and two from community settings. Five university faculty members participated.

Data collection

Each participant was interviewed once for a period of one to two hours. Interviews were conducted between June 2010 and August 2011 by one of the researchers. Interviews were semi-structured and questions evolved according to the participant’s responses and emerging themes. Questions were derived from the literature and were open-ended as follows: Imagine having to communicate to a student that he or she has not met the clinical course objective in the final placement. What would it be like being the one dealing with such a student?
1. In your experience as preceptor or faculty member, have you ever failed or considered failing a student in their final preceptorship placement?
2. How was this situation managed, and what was the outcome?
3. Did you ask for any assistance? If so explain, what kind of assistance did you receive or ask for?
4. In your experience as a clinical educator or faculty member, do you think some students pass placements even when their performance is questionable? If so, Explain.
5. What are some of the factors that prevented you from failing a student in the past?
6. What do you think are the challenges and consequences of failing a student on preceptorship placement?

Prior to each interview, demographic data were obtained from participants. Field notes were used to expand on interviews.

Data analysis

Content analysis was used to analyze the responses to the open-ended questions. Qualitative content analysis is the analysis strategy of choice in qualitative descriptive studies (Sandelowski, 2000). The analysis focuses on the subjective interpretation of the content of the text (Hsieh and Shannon, 2005) and is a systematic process of coding and identifying themes.

A research assistant entered all transcriptions into the NVivo version 8 for computer-assisted qualitative data management. All data were analyzed independently by the two nursing researchers. Then, the researchers met several times to compare their analyses and to reach consensus on content and themes.

Rigor

The rigor of the study was ensured through the following mechanisms. Credibility was achieved by comparing the analyses of experienced researchers (Holloway, 1997), using a wide range of informants (preceptors, faculty advisors, and university faculty) (Houghton, Casey, Shaw & Murphy 2013; Shenton, 2004), engaging with the participants during one to two-hour interviews, and using excerpts from participant transcripts (Sandelowski, 1986). Fittingness was enhanced by collection of data from different settings (Guba & Lincoln, 1981). The researchers ensured there was a comprehensive audit trail for future use by others to ensure confirmability.

Findings

Five university faculty members, three faculty advisors, and five preceptors participated in the research. Five major themes emerged from the data: (a) failing a student is a difficult process; (b) both academic and emotional support are required for students and preceptors/faculty advisors; (c) there are consequences for programs, faculty, and students when a student has failed a placement; (d) at times, personal, professional, and structural reasons exist for failing to fail a student; (e) however, the reputation of the professional program can be diminished as a result of failing to fail a student. Findings are
presented according to the identified categories or themes. Direct quotes are used to give meaning to themes (Sandelowski, 1986).

**It’s a difficult process**

One of the guiding interview questions was, “Imagine having to communicate to a student that he or she has not met the clinical course objective in the final placement. What would it be like being the one dealing with such a student?” The majority of the participants acknowledged that this would be one of the most challenging or hardest things to do with a student, as illustrated by the following comments:

Well, it’s very frustrating to have a student that’s unable to keep up because you are always up on pins and needles. You’re always covering for them, picking up after them, and when you have to tell them that you’re not ready to pass, like they get really angry and, tears and the whole gambit of emotions. (Preceptor)

It’s certainly very difficult because you know that this is not what the student wants to hear . . . You start to question why is it that we got a student into say fourth year . . . and launch them into a preceptorship experience . . . and you know the student is anticipating completing the program . . . and ready to move on. (Faculty)

Participants indicated that students, who are at risk of failing in the professional or final year, often have serious issues that cannot be easily remedied. As shown in the following quotation:

. . . for some students, maturity, level of confidence, it may be a challenge for them as they move into a preceptorship experience where they’re no longer in a secure situation in a group with a clinical educator. (Faculty)

**Academic and emotional support**

Both academic and emotional support is required for students, preceptors, and faculty advisors:

Offer that support and guidance [to the failing student] . . . Give them time to think about it . . . You have to help them work through. Em, but ultimately, you support the student in coming around eventually to recognize in that failure at this point and time is an important step . . . . (Faculty)

In contrast, other participants raised concerns regarding lack of support from the educational institutions, as illustrated in the following citation:

. . . there’s a girl [RN] who, her last student she just, she gave up. Like she truly gave up . . . . She’s gonna pass whatever . . . that’s basically what she did-gave up, because she was frustrated. As much as she tried to tell the student like you have to do this, you have to do this, was just disregarded. And she didn’t really feel she had backup from the college either or the university.. (Preceptor)

**Consequences of failing a student**

For a student, failing a placement can be a significant loss experience: loss of self-esteem, time, education money, certification, and career.

I don’t think any of us want to see somebody throw four years of their life out the window . . . . (Preceptor)

Faculty may receive negative ratings and blame themselves; this can be a time-consuming process causing extra workload and may result in an appeal.

. . . , the challenges are I think on a personal level you feel like you have failed as an educator in your job. (Faculty)

**Reasons for failing to fail a student**

Participants identified possible reasons for failure to fail underperforming or unsafe students. In an effort to avoid appeal processes or vocal students, faculty or preceptors can give students the benefit of the doubt, thus “fail to fail” the student. A decision not to fail a student can also be based on wanting to avoid a false failure (due to approximation), recognizing that there are differing perspectives between the clinical setting and the university, and a lack of time to take on the extra workload involved in mentoring a failing student.

Sometimes I think it’s also a function of your preceptors; who have unrealistic expectations for students. (Faculty)

I’ve heard people say you know what, she’s not safe, she should be out of here, and then we hear from the university . . . no we have to pass her. (Preceptor)

**Consequences of failure to fail**

Participants in this study identified that failure to fail unsafe or underperforming students may have implications not only for the student but also for the educational program, the public, and profession. For example, the reputation of the program can be diminished as a result
of failing to fail a student. There can also be a potential loss of placements due to perceptions about the program and students.

One participant described her feelings after hearing that the borderline or underperforming student to whom she had had earlier given the benefit of the doubt, had failed her registered nurses licensing examination.

I know with my student, I was sort of like, whether or not I should pass her. I opted to pass her and then I found out from one of her colleagues that when she wrote the provincial exam, she didn’t pass. So I said to myself, you know what, that could be a blessing in disguise. (Preceptor)

Preceptors’ evaluations need to be respected by the university. When the university overturn their decisions and fails to fail a student, preceptors may feel betrayed and devalued by their university colleagues, and experience a loss of trust in the university system.

It’s frustrating. You think “I’m not taking another student!”… You know my opinion is not valued. I’m telling you this person is unsafe to be out there. And it’s just not listened to. (Preceptor)

If partners in the field lose faith in the university’s ability to uphold standards, they may decide that preceptoring or mentoring a student is not worth their time and effort.

... so if a student fails for whatever reason there’s potential loss of funding. And while that shouldn’t be a driving factor, in who fails and who is successful … those were realities that we have to kind of navigate through, while always upholding the integrity of the program, the integrity of the clinical expectations. (Faculty)

Discussion

Although only a small number of preceptors, faculty advisors, and faculty members participated in this study, and the use of a convenience sample may have captured those who have had a negative experience, the findings corroborate findings from previous studies or what has been highlighted in the literature (Allen, 2002; Boley & Whitney, 2003; Cleland et al., 2008; Dudek et al., 2005; Duffy, 2004; Gainsbury, 2010; Hawe, 2003; Heaslip & Scammell, 2012; Hunt et al., 2012; Ilott & Murphy, 1997; Jervis & Tilki, 2011; Luhanga et al., 2008; Scanlan et al., 2001; Scholes & Albarran, 2005; Smith et al., 2001) that failing a student is a difficult process and at times avoided. In a study by Hawe (2003) many examples of failing grades given by preceptors who were overruled by faculty were reported. Similar findings have been reported by other authors (Duffy, 2004; Gainsbury, 2010; Jervis & Tilki, 2011; Luhanga et al., 2008; Patton, 2010; Scholes & Albarran, 2005; Seldomridge & Walsh, 2006). However, failing a student in a preceptorship experience can become necessary because of dangerous and/or unprofessional practices (Chui, 2010; Cowburn, Nelson, & Williams, 2000; Hunt et al., 2012).

A decision to fail a student can be a challenging time for everyone involved and may result in an appeal, or legal action (Boley & Whitney, 2003; Dudek et al., 2005; Redmond & Bright, 2007; Smith et al., 2001). However, the courts have overwhelmingly supported faculty decisions regarding grade assignment, as long as the grade is not arbitrary or capricious (Boley & Whitney, 2003). Making administrators aware of the courts’ support and the importance of patient safety may help them endorse clinical failures (Speers, Strzyzewski, & Ziolkowski, 2004). Preceptors and university faculty must ensure that the process in which the decision to fail a student was undertaken is made clear to the student (Cowburn et al., 2000) and that due process needs of the students are met (Boley & Whitney, 2003; Smith et al., 2001). Redmond and Bright (2007) suggest that it is critical that faculty fully understand their legal obligations and how to fulfill them in order to protect themselves and educational institutions from liability. Yet, university faculty, both full-time and sessional, may have little training regarding their legal obligations in the role of gatekeeper (Redmond & Bright, 2007).

Strategies should be implemented to strengthen the preceptor–faculty advisor–university team, beginning with the development of a clear definition of the roles and responsibilities including student evaluation. Team meetings are recommended to discuss failing or underperforming students. To improve the communication of expectations, there should be a checklist of basic skills required in preceptorships that are provided to students and preceptors. There should also be training for new faculty and preceptors which could consist of a handbook and/or simulations followed by continuing faculty development workshops. Content should include helping students to set personal goals, communicate, and become critical thinkers and ethical decision-makers. Emphasis should be placed on the importance of communication and documentation between the preceptors and faculty, how to work with problem/exceptional students, and legal obligations.

Based on the results of this study and the literature, case studies were created to better prepare preceptors and faculty advisors when making decisions about whether to fail students having difficulty meeting the
objectives of their final practicum. The next steps are to implement and evaluate this strategy, which is meant to help provide emotional and academic support to all involved (Biggs & Schriner, 2010).

Insufficient documentation has been cited in the literature as one of the reasons for giving students a satisfactory evaluation even when concerns have been expressed regarding their clinical competence (Cleland et al., 2008; Duffy, 2004; Dudek et al., 2005; Luhanga et al., 2008; Seldomridge & Walsh, 2006). Boley and Whitney (2003) contended that it is the duty of faculty to recognize unsafe or unsatisfactory student practice, to apply grading standards consistently, and to confer a failing grade if it is justified. However, as stated earlier, there is discrepancy of opinion among faculty regarding appropriate interventions in such situations (Brown et al., 2007; Scanlan et al., 2001) and no policies and procedures to guide them (Bogo et al., 2007; Brown et al., 2007; Scanlan et al., 2001; Redmond & Bright, 2007). Research is needed to better understand how conflicts are resolved over differing opinions on how to manage a student who displays unsafe or poor performance.

Scanlan et al. (2001) reported that few schools of nursing have policies and processes in place to guide clinical evaluation. Therefore, faculty members often implement ad hoc processes on a case-by-case basis (Gallant, MacDonald, & Higuchi-Smith, 2006; Furness & Gilligan, 2004; Redmond & Bright, 2007). However, such processes can lack objectivity, openness, and transparency and frequently neglect to respect the student’s right to due process (Gallant et al., 2006). Preceptors and faculty need clear guidelines on the actions to be taken and they must be involved in the development of such policies. This could facilitate and ensure their implementation.

This study revealed that participants experienced feelings of frustration, disappointment, and relief during the process of failing incompetent students (Duffy, 2004; Gainsbury, 2010; Hastings, 2010; Hrobsky & Kersbergen, 2002; Ilott & Murphy, 1997; Luhanga et al., 2008; Siebert, Clark, Kilbridge, & Peterson, 2006). Although it is often difficult for preceptors to discuss their feelings regarding failures of students, doing so may provide important information that can be used as a guide in the counseling and mentoring of future preceptors and clinical faculty (Hastings, 2010). More research is needed to better understand the feelings of preceptors and the role these play in decisions about failing students. Participants recognized how difficult the experience of failing is for a student and how students also experience many feelings. Further research is needed to explore the experiences of students who are failing their preceptorship experience.

To institute any changes, administrative support in the form of adequate resources and rewards, such as recognition of preceptorships as a valued form of education in nursing is necessary. As well, funding for practice learning and the provision of continual training are essential to develop empowering preceptorship experiences for students, preceptors, and faculty advisors (Barlow et al., 2006; Chui, 2010; Furness & Gilligan, 2004).

Conclusion

The purpose of this research was to explore the perceptions of nursing preceptors and faculty about evaluating a student who displays unsafe or poor performance during preceptorship experience and the issue of “failure to fail” such students. The decision to fail a student in the final nursing preceptorship is difficult and rife with feelings and consequences. Thus, some preceptors and faculty fail to fail students who display incompetent or unsatisfactory clinical performance because they recognize the potential consequences of their decision. Educational programs, support, and policy and procedure development and implementation are needed to guide preceptors and faculty when facing difficult and underperforming students. Further research is needed to examine the experience of students and the effectiveness of educational and support programs for preceptors, faculty, and students.

References


