Failing students: a qualitative study of factors that influence the decisions regarding assessment of students' competence in practice

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GLOSSARY OF TERMS AND ABBREVIATIONS

MENTOR is the title used within this report to denote those registered nurses who take on the role of providing "support guidance and role modelling for students in the practice setting" (UKCC 1997, p.1). This title includes the terms preceptor, practice placement supervisor, clinical supervisor and all the other titles which different placements and universities currently use for this role.

LECTURER refers to a member of staff who is employed by the university to teach nursing. The term is used to encompass other names which are sometimes used to describe this role, e.g. nurse teacher, educator, tutor.

PLACEMENT refers to a community-based or clinical setting outwith the university in which the student is placed for experiential learning purposes (May et al 1997)

UNIVERSITY will encompass the term College and include Institutions of both Higher and Further Education

NBS	National Board for Nursing, Midwifery and Health Visiting for Scotland
NMC	Nursing and Midwifery Council
UKCC	United Kingdom Central Council for Nurses, Midwives and Health visitors

ABSTRACT

Although there exists a wealth of research regarding the issue of competence and the assessment of student nurses' clinical performance, the area of failing students in clinical placements has received very little attention. The sparse evidence available suggests that on occasion mentors 'fail to fail' students whose clinical competence is in question. Using a grounded theory research approach the aim of this research study was to uncover mentors' and lecturers' experiences regarding this issue and to explore their individual perceptions about why some student nurses are being allowed to pass clinical assessments without having demonstrated sufficient competence.

A theoretical sample of mentors and lecturers associated with three of the Universities in Scotland who offered the Diploma of Higher Education in Nursing volunteered to be interviewed for the study. The sample consisted of 14 lecturers and 26 mentors. Four categories and fourteen subcategories emerged from the data collected. Findings from the study reveal that students are passing clinical assessments even when there are doubts about their clinical performance. It is revealed that some mentors are unwilling to put pen to paper regarding these concerns which presents lecturers and subsequent mentors with difficult moral dilemmas. Lecturers identified the importance of following procedure when faced with a fail scenario. They also identified that weak students often had a history of problems within clinical practice but had often been given the benefit of the doubt and so progressed through the system. Mentors identified that failing a student was a difficult thing to do and that personal, emotional, as well as, practical issues influenced the outcome of their judgements regarding students' clinical performance. It emerged that preparing mentors for their role and responsibility in a fail scenario was vital as was adequate support from both education and practice.

CHAPTER 1
BACKGROUND TO THE STUDY

1.1 INTRODUCTION

The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), now the Nursing and Midwifery Council (NMC), offered two annual research scholarship awards to registered nurses, midwives or health visitors for Masters, Doctoral or Post-doctoral studies. In September 2000 I was awarded a scholarship to support my PhD project entitled 'A grounded theory investigation of factors which influence the assessment of students' competence to practice'. The scholarship has funded the first two years of this study, which, it is anticipated, will be completed in November 2004. This report details the findings and recommendations from data collection and analysis that have been conducted thus far.

1.2 BACKGROUND TO THE STUDY

It is well documented in the literature that diplomate nurses have deficits in some practical skills when newly qualified (Maben & Macleod Clark 1998, Runciman et al 1998). Indeed, it was the result of such concerns that prompted the investigations that underpinned the publication of 'Fitness for Practice' (UKCC 1999). As a result; time, effort and resources have been invested in implementing the recommendations of this report in order to ensure that qualifying students are indeed 'fit for practice'.

Determining fitness for practice involves nursing students fulfilling theoretical, clinical and professional criteria as laid down by the NMC and interpreted by each individual educational institution providing pre-registration education. Assessment of clinical practice has long been recognised as problematic (Watson et al 2002) but it was the findings from Watson & Harris's (1999) study that prompted the impetus to commence this research project. A key finding of this report, which looked at the support of students in practice placements in Scotland, was that some student nurses are being

allowed to pass clinical assessments without having demonstrated sufficient competence (Watson & Harris 1999). The first stage of their study involved focus group interviews with mentors. These focus groups revealed that some practitioners did not feel it was their role to fail students. As one mentor commented, "I don't think we can actually fail assessments. We can only put down what we feel, and if we're not happy, I think it's up to the college then to decide if they've actually failed their placement or not." (Watson & Harris 1999 p.51). As a result these researchers were prompted to include the following question in their subsequent survey; "In your experience, do students sometimes pass practice placements without having gained sufficient competence?" (Watson & Harris 1999 p.218). In response to this question, 125 mentors out of 272 (i.e. 46%), agreed with the suggestion that students were sometimes allowed to pass practice placement assessments when in fact their performance was unsatisfactory (Watson & Harris 1999). This particular finding is a matter of great concern given the implications for the profession, and, more importantly, the potential impact this may have on patient care and safety and public confidence.

Since the 1970's, when continuous assessment was introduced, responsibility for passing or failing students in the clinical area has rested with the registered nurse or mentor (Chambers 1998). Although it is advocated in the literature that lecturers should have a shared role with mentors in the clinical assessment of students (Clifford 1994, May et al 1997, Watson & Harris 1999) it is well documented (Wilson-Barnett at al 1995, Wheeler 2001) that for the majority of lecturers this recommendation has not been implemented in practice. The lecturer's role is predominantly interpreted as providing advice and support to mentors (Payne et al 1991, Wilson-Barnett at al 1995, Camiah 1997, Duffy & Watson 2001) but not to decide whether students pass or fail clinical assessments. If, as is suggested by Watson & Harris's (1999) research, some mentors do not see it as their role to fail students, then it is probable that some student nurses are currently becoming registered nurses when they may not actually be meeting professional standards. Indeed this echoes an earlier finding from an evaluative study of the three year diploma/degree pre-registration programmes of midwifery education which was commissioned by the English National Board in 1995 (Fraser et al 1998). Concerns were expressed during

interviews with midwife assessors that unsuitable students might 'get through' and register as midwives. Evidence emerged from this study that failing students was problematic and warranted further discussion (Fraser et al 1998). Lankshear (1990) uncovered similar findings to those outlined in these two more recent studies. As part of a wider study, investigating the attitudes of nurse tutors, clinical teachers and clinical assessors to the assessment of student nurses, one of the trigger questions within her interview schedule was "Do the right people pass and fail examinations and assessments?" (Lankshear 1990 p.35). This prompted discussion among her participants regarding 'failure to fail'. There was agreement among both the teachers and assessors participating in her study that a major problem was "the failure of ward staff to refer many students whose performance in the clinical setting was unsatisfactory" (Lankshear 1990 p.35). It should be noted however that this study was conducted prior to the implementation of the Diploma of Higher Education in Nursing and took place in two schools of nursing in the North of England, which at the time of the study still conducted statutory clinical assessments rather than continuous assessment. Therefore although not directly applicable to the current context in which students' clinical assessment takes place, this research does reveal that this issue has been an ongoing problem in the United Kingdom over the past decade.

The particular problem of 'failure to fail' is somewhat hesitantly addressed in the literature and, so far, does not appear to have been the exclusive focus of any investigation in the United Kingdom Nursing literature. Some tentative reasons as to why mentors allow students to pass practice placement assessments without having gained sufficient competence have been alluded to in the literature (May et al 1997, Fraser et al 1998, Watson & Harris 1999). It is frequently mentioned that mentors find assessment documentation confusing, obscure and full of educational jargon (Crotty 1993, Kent et al 1994, White et al 1994, May et al 1997, Duffy & Watson 2001). Deficient assessment documentation has been cited as a potential reason for students passing clinical placements when not sufficiently competent (Watson & Harris 1999). Also quoted as a reason is that placements are not sufficiently long to allow the student to gain competence (May et al 1997, Watson & Harris 1999). Another factor that has also

been alluded to, as a reason for allowing students to pass when not sufficiently competent, is that mentors have had insufficient time to work with students due to other commitments and therefore do not feel able to assess the students' competence (Watson & Harris 1999, Dolan 2003). When there are concerns regarding a student's clinical performance are these the actual factors that influence the mentor's decision? It may be that some mentors renege on their responsibility to fail a student, citing practical barriers as their defence.

Rather than reneging on their responsibility some mentors do take action. Although in Watson and Harris's (1999) study 30 of 272 (11%) of the mentors said that during their time as a mentor they had experience of having failed at least one student on a practice placement assessment, they all regretted having to take such action. While they recognised their professional responsibility to prevent students who were unsafe from becoming registered practitioners, they also found it difficult to take action which could have serious personal consequences for the student; i.e. discontinuation from their education programme. This finding supports concerns that have been raised elsewhere in the nursing and midwifery literature (Lankshear 1990, Fraser et al 1998, McAleer & Hamill 1997, Duffy & Scott 1998). Lankshear (1990 p.37) suggests that assessors fear the consequences of failing students as there is often "a distinct feeling that that failing a student opens up a hornets' nest". Duffy & Scott (1998) however suggest that failing a student may be interpreted as a personal failing on the part of the mentor. It would appear that even mentors who have come to the decision to fail a student face a number of personal and professional dilemmas.

Lankshear (1990) commented that 'failure to fail' had created frustration amongst the lecturers within the schools of nursing in which her study took place. Certainly anecdotal evidence within my own department suggested that this is not an uncommon problem and that such occurrences create moral and ethical dilemmas for the lecturers involved.

Given my personal interest in this subject area and the lack of research relating to the issue of students passing clinical assessments when not sufficiently competent, it appeared propitious to undertake a study that explored this dilemma.

1.3 AIM OF THE STUDY

Evidence presented so far suggests that on occasion mentors 'fail to fail' students whose competence is in question. The aim of this study is to uncover mentors' and lecturers' experiences regarding this issue and to explore their individual perceptions about why some student nurses are being allowed to pass clinical assessments without having demonstrated sufficient competence.

There is one main research question: *Why are some student nurses being allowed to pass clinical assessments without having demonstrated sufficient competence?*

CHAPTER 2
METHODOLOGY

2.1 GROUNDED THEORY

Grounded theory is a qualitative methodology that acquires its name from the practice of generating theory from research, which is 'grounded' in the data. The aim of the grounded theory approach is to develop explanatory theory about common social patterns. As Crooks (2001 p.25) suggests "grounded theory gives us a picture of what people do, what their prime concerns are, and how they deal with these concerns". Given this background grounded theory therefore provided a suitable framework for exploring, with mentors and lecturers, the various factors that may influence individuals when faced with the dilemma of whether to pass or fail a student on clinical placement.

The grounded theory approach has been used in nursing research since the 1970's (Backman & Kyngas 1999). Morse (1992) suggests that grounded theory is useful when little is known about a particular subject or problem area. Stern (1980) advocates its use to gain a fresh perspective in a familiar situation, especially in areas of change or incongruence. Given the dearth of research into this particular aspect of student assessment and the constant change that has been characteristic of nurse education over the past decade, grounded theory emerged as the most appropriate method of inquiry.

Data collection and analysis consistent with grounded theory methodology (Strauss & Corbin 1998) has been adopted for this study. The study at this point is not complete as the scholarship funded only the first two years of the project, but grounded theory continues to be utilised with the aim of finishing the project by November 2004.

2.2 DATA COLLECTION

Data collection commenced in February 2001 and is ongoing. Consistent with grounded theory methodology, data collection should only be discontinued once data saturation has

occurred (Streubert & Carpenter 1995). Data saturation has not yet been reached therefore further issues may emerge and will be reported in subsequent literature.

2.2.1 Sampling

A theoretical sample of mentors and lecturers associated with three of the Higher Education Institutions in Scotland who offer pre-registration nurse education provided the sample for the study. Theoretical sampling is central to grounded theory methodology. This type of sampling directs all data collection efforts towards gathering information that will best support development of the emerging theory (Glaser & Strauss 1967).

Four specific groups have participated in the study thus far:

(i) mentors with no direct experience of failing a student

(ii) mentors who had had experience of actually failing a student

(iii) mentors who although they had some concerns regarding a student's clinical performance had given a satisfactory clinical assessment

(iv) lecturers who had been involved in such situations

Volunteers were recruited using a variety of methods. All pre-registration nurse lecturers within the university departments were provided with information regarding the study which asked for volunteers to participate. This information was either communicated to the lecturers via the internal post or via e-mail. Mentors were recruited using several methods. One method was approaching mentors attending study days within the university premises, the other was sending written information to each of the clinical areas within the Trusts which had agreed to take part. On occasions at the request of nurse managers, I attended clinical meetings to inform staff directly about the study.

2.2.2 Participants

The participants consisted of 14 lecturers and 26 mentors. The lecturers were recruited from the Nursing Departments of three Scottish institutions offering the Diploma of

Higher Education in Nursing. Table 1 details the branch of the pre-registration programmes within which the lecturers worked. All, but one, of the lecturers who volunteered had been involved in a situation where a student's clinical competence was in question.

Table 1 Details regarding the branch programmes within which lecturers worked.

Branch	**No. of lecturers**
Adult	10
Mental Health	2
Leaning Disabilities	1
Child	1

The mentors were recruited from practice placement areas associated with these three institutions. Table 2 details information regarding the practice areas in which the mentors worked. Mentors who volunteered for the study fell into three categories:

(i) mentors with no direct experience of failing a student (n=6). These participants mainly made up the purposive sample at the commencement of the study

(ii) mentors who had failed a student (n=10)

(iii) mentors who had given a satisfactory clinical assessment despite concerns regarding a student's clinical performance (n=10)

Table 2 Details regarding the practice placement areas within which mentors worked.

Placement area	**No. of mentors**
Adult	14
Mental Health	5
Community	4

Child	3

2.2.3 Methods

The initial data collection method was one to one interviews with participants. Data collection commenced using unstructured interviews, moving to semi-structured interviews with ongoing data analysis. In the early stages of grounded theory a narrative from the participant's perspective is required to allow the field of enquiry to unfold (Glaser & Strauss 1967) therefore unstructured interviews were employed. Wimpenny & Gass (2000 p.1489) indicate that in grounded theory "ongoing analysis will influence the questions that are asked, with the direction of the interview becoming driven by the emerging theory". Theoretical sampling based upon the emerging theory did indeed bring a sharper focus to subsequent interviews, which meant a move later in data collection to semi-structured interviews.

Individual participants were interviewed for a maximum of 1 hour, on average an interview lasted 45 minutes and generated approximately 35 A4 pages of data. The interviews, with the participants' consent, were audio recorded. Interviews were arranged at approximately fortnightly intervals to allow for constant comparative analysis, thus enabling each interview to inform, develop and bring focus to subsequent interviews.

2.2.4 Ethical considerations and access negotiations

Ethical approval was sought and granted by the School of Nursing, Midwifery and Community Health Ethics Committee of Glasgow Caledonian University.

Access was required to members of teaching staff within the three sites that were to be used in the study, therefore approval for the study was sought and granted from each of

the Heads of Department. Ethics approval was required for access to mentors with the Trusts involved. Ethics Committees were approached and approval granted.

Couchman & Dawson (1995) state that the rights of any individual involved in a research study are: confidentiality, anonymity, voluntary participation, informed consent, not to be harmed, dignity and self-respect. Several measures were employed to ensure that confidentiality and anonymity were maintained. All audio and transcribed material was kept in a secure location with restricted access. Participants were assured anonymity by ascribing an ID code to each participant in the reporting of the data.

Once individuals participating in the study were assured of the confidentiality of the information they were imparting the issue of informed consent was addressed. Participants were fully informed of the nature of the research both verbally and in writing. Some researchers advocate the use of an informed consent form (Seaman 1987, Holloway & Wheeler 1996). Seaman (1987 p.28) indicates that the form and accompanying information sheet "must include all the information that the subject needs in order to make an informed decision to participate in the research or not". With this guidance an informed consent form was constructed which the participants were asked to complete.

Data collection was taking place simultaneously for my own PhD and as part of the scholarship awarded by the NMC. Therefore at the beginning of each session participants were informed both verbally and in writing about the boundaries of the scholarship and the PhD study.

Given the sensitive nature of some of the dilemmas that mentors may have faced when deciding whether to pass or fail a student in clinical practice there was the possibility that they may have felt some distress associated with revealing their experiences. Therefore a debriefing took place at the conclusion of the interview and as required, information regarding support services for staff was also provided.

2.3 DATA ANALYSIS

With grounded theory, data collection and analysis are linked from the beginning of the research, proceeding in parallel and interacting continuously (Wainwright 1994, Holloway & Wheeler 1996). Analysis of data was conducted as a continuous, ongoing process that was integrated with data collection and coding. Interviews were audio-taped then transcribed using secretarial support. Data analysis was conducted using the constant comparison technique as outlined by Strauss & Corbin (1998).

Three stages are apparent in this type of data analysis namely, open coping, axial coding and selective coding. Open coding is the initial process in grounded theory that involves breaking down, analysis, comparison and categorisation of data (Glaser 1978, Strauss & Corbin 1990). In open coding incidents or events are labelled and grouped together to form categories. Axial coding moves on to distinguishing relationships between categories and subcategories (Strauss & Corbin 1990), while selective coding can be described as the process by which categories are related to the core category which ultimately becoming the basis for the grounded theory (Glaser 1978, Strauss & Corbin 1990).

2.3.1 Rigour and trustworthiness

Koch (1994) presented a decision trail that she used to maintain rigour in a qualitative study she undertook. Her decision trail consists of ways of establishing trustworthiness through (i) credibility, (ii) transferability and (iii) dependability first proposed by Guba and Lincoln (1989).

(i) Credibility

A study is considered credible, suggest Guba and Lincoln (1989), when it presents such faithful interpretations that people having that experience would immediately recognise it 'as their own'. Credibility is further enhanced if other researchers or readers confronted

with the experience can recognise it, after having only read about it in a study. This aspect of credibility was addressed by asking lecturers and mentors unrelated to the study, to read the findings so far.

Patton (1990) says that credibility is particularly dependent on the credibility of the researcher. This is because the researcher is seen as the instrument of data collection and the centre of the analytic process. Therefore in order to enhance credibility researchers should make explicit what they bring in terms of qualifications, experience and perspective (Patton 1990). I have been a registered nurse teacher for 12 years. Working within nurse education over this time has meant that I have in my role as link lecturer, had experience of supporting several mentors who have faced the dilemma of whether to pass or fail a student in clinical practice. Also as a staff nurse, I had been involved in failing a student on clinical placement, an experience that I have never forgotten. The significance of exploring this area came when I read research findings which suggested that student nurses have sometimes been allowed to pass clinical assessments when in fact their performance was unsatisfactory (Watson & Harris 1999). So my perspective on commencing the study was to try and uncover the issues around failing students in clinical practice as it was something that had held my interest for a long time (Duffy & Scott 1998, Duffy et al 2000, Duffy & Watson 2001). Bowling (1997) also suggests the researcher should be honest about their theoretical perspective from the outset, this it is hoped, is evident in the reading of this study.

(ii) Transferability

Transferability relates to whether the findings of a qualitative study are applicable in situations other than the one studied (Seale 1999). An important aspect of the present study was whether the findings were applicable to other geographical areas within the United Kingdom. As Seale (1999) indicates readers of a research report make their own judgements about the relevance of the findings to their situation. Therefore an independent group of lecturers from Nursing Departments in England, Wales and Northern Ireland were asked to read and comment on the findings so far of the study. As Benton (1996) highlights the use of independent experts ensures conceptual clarity of the

data. These independent experts were asked to comment on the both the credibility and transferability of the findings. Postal and e-mail correspondence with these individuals allowed for verification of the findings. Statements such as the following were received from independent experts:

> *'These same issues came up at a meeting I had with managers a few days ago' (extract from E-mail correspondence from lecturer in Northern Ireland)*
>
> *'It's definitely a problem, preceptors are definitely reluctant to write down negative things about students' (extract from E-mail correspondence from lecturer in Wales)*
>
> *'Am in just the situation you describe with a third year student at the moment' (extract from postal correspondence from lecturer in England)*

Comments provided by these individual supports the transferability of the findings presented in this study.

(iii) Dependability

One of the ways in which the research may be shown to be dependable is to involve the participants. Sandelowski (1986) points out that the participants can play a major role in strengthening the trustworthiness of qualitative data. Once analysed the interpretations and findings of the study were returned to some of the participants to determine if I had presented a true picture from their perspective. The comments received from the three participants involved supported the view that the findings were compatible with their own perceptions on the topic area.

Another method of achieving dependability is to have another member of the research team independently categorise items as a check against bias. The aim is that another investigator should be able to analyse the data in the same way and reach the same

conclusions as the primary researcher (Bowling 1997). This approach was also carried out in this study. I had readily available access to a supervisory team as I am undertaking this research as part of my PhD studies. Following my initial analysis some transcripts from the main study were independently analysed by two experienced researchers from the Caledonian Nursing & Midwifery Research Centre whose analysis was congruent with my own interpretation, thus enhancing the rigour of the analysis.

2.4 CHAPTER SUMMARY

This chapter has outlined the methodological framework utilised within this study. Congruent with the grounded theory approach, theoretical sampling and constant comparative analysis have been central to this study. The ethical aspects associated with this research have been addressed within the chapter and the steps taken to ensure rigour and trustworthiness have been discussed.

Data from the forty interviews conducted so far with the support of the scholarship funding have been included in the analysis. The subsequent chapters explore the findings from the data. Four major categories with their sub-categories were identified:

- The current dilemmas
- The process of managing a failed clinical assessment
- Failing to fail
- Doing enough to pass

These four categories identified have been used as the framework to present the data in the forthcoming chapters.

CHAPTER 3
CATEGORY ONE: THE CURRENT DILEMMAS

When embarking on this study I was aware from my own experience that on occasions students are entering the register when in fact concerns were being expressed regarding their clinical competence. My initial question of participants was, "*What has been your experience regarding students who clinical performance has been weak or indeed unsatisfactory?"*

The category 'current dilemmas' emerged from the transcripts as participants described their perception of the issues associated with the area under study. The following three subcategories are related to this category:

(i) Existing problems
(ii) More fail theory than practice
(iii) Differing agendas

3.1 EXISTING PROBLEMS

One dilemma often encountered by lecturers is being told a student is not doing as well as the clinical staff would have anticipated and then finding out that the mentor is prepared to give the student a satisfactory clinical assessment anyway, as this participant comments:

> *'I have been called out and been told the student is not doing as well as they would have expected and then found that they were prepared to give the student a satisfactory assessment anyway'. (Participant 3L)*

Several other lecturers who participated in the study confirmed this view, as the following two quotes illustrate:

> *'The case that comes to mind immediately is a third year student I'm involved in at the moment because she was in one of my liaison areas and this student is just weeks*

away from completing and she's not managing to reach the required level on the experiential taxonomy that we use. Now problems have been highlighted with this student since the beginning of her 2nd year and it's been followed up and we've gone out and tried to support the various mentors but each time her final assessment's been done, she's reached the required level on paper...yet each time she has a new placement, early in the placement we get phone calls, 'We feel there's problems with this student'. (Participant 23L)

'…this student should have failed earlier but people didn't actually put pen to paper at that point about it, you know, in terms of actually failing the student. They would write comments. But they didn't actually write, fail the student'. (Participant 10L)

Mentors were also aware of this issue. This mentor who was recalling having failed a second year student commented:

'But he hadn't been failed in the past, he had nearly failed, he had scraped by, from what we could pick up. I mean I think there's been unofficial kind of mumbles to tutors and so on but nobody had actually put it down on paper that there was a problem'. (Participant 4M)

This data concurs with the findings of a previous study. The teachers in Fraser et al's (1998) study were aware of problems with a student midwife because of what assessors had said to them rather than any written evidence. As Fraser et al (1998 p.83) point out "…some listed competencies had been recorded as being achieved despite comments that her care was not up to the expected standard". Mentors not putting '*pen to paper*' has consequences for future mentors, the students themselves and the profession. Mentors who subsequently had to deal with weak students often felt angry and let down by colleagues. This is illustrated by this mentor who had been in the position of failing a third year student, she commented:

'I'm really quite angry as are some of my colleagues, being left to actually identify it… it's clear this problem didn't just manifest in the last six to twelve months'. (Participant 39M)

Participants also highlighted the personal consequences to the student when mentors 'failed to fail' students earlier in their programme. This lecturer talked about a third year student who had failed her final clinical assessment, she asserted:

> *'It should have happened at a much earlier stage in training… for the last year some problems from clinical areas have been identified… but people were giving her the benefit of the doubt. But really they've done the student no favours, because this student's now in a horrendous position…you know, her self esteem, telling family and friends she's not going to graduate, and that is wrong in terms of the personal effects on the student as well'. (Participant 24L)*

The other issue that is evident from this and other assertions is that many students frequently had a history, i.e. that problems had been identified earlier in the course. The two extracts above relate to situations where students had actually received a failed assessment and were about to be discontinued from their course. However, as other participants point out there are situations where there are professional consequences, as not all students identified as having problems, fail practice placement assessments, as these two lecturers indicate:

> *'We've known about them all the way through their placements but they've passed at the end of it'. (Participant 7L)*

> *'It was a male student and there was a problem, there had been a problem all the way through but he was just allowed to kind of escape'. (Participant 1L)*

These participants confirm that some students are entering the register when concerns have been expressed regarding their clinical competence. It also corroborates the findings of the Watson & Harris (1999) study, which found that students were sometimes allowed to pass practice placement assessments when in fact their performance, was unsatisfactory. These participants also reinforced my reasons for commencing this study. Identifying the existing problem that mentors on some occasions 'fail to fail' students, often led to participants discussing another dilemma, the apparent inconsistency between the number of students failing theoretical assessments in comparison to practice placement assessments. Thus emerged the second subcategory.

3.2 MORE FAIL THEORY THAN PRACTICE

The second subcategory to emerge was the issue of more students failing theory than practice. A major concern of many participants was the apparent anomaly between the number of students failing theoretical assessments compared to clinical assessments, as one participant comments:

> *'I do have concerns …well every theoretical assessment, there's a few will come down and some will come down and resit again, but the majority get through these practice assessments'. (Participant 23L)*

A view supported by another participant:

> *'More recently I've been concerned because I think there is strong anecdotal evidence that many students are passing clinical assessments when perhaps they shouldn't. I think even the numbers who pass compared to the numbers who fail. There's a very, very minute percentage I would say of students, who are discontinued or who have problems even with clinical assessment and straight away the law of averages, it doesn't really tie in'. (Participant 24L)*

There does seem to be an anomaly between the number of students that fail theoretical assessments with very few failing clinical assessments. Yet often the theory/practice elements are weighted equally, i.e. 50% theory and 50% practice, in pre-registration nursing programmes. This anomaly has been highlighted in the literature previously (Norman et al 2002) and is certainly something that requires further scrutiny both at a local and a national level. The following lecturer suggests one possible reason why:

> *'…from a statistical point of view, there is an anomaly, quite a severe anomaly between the practice in placements, and the course work, because if you look in the course work for example in a module, you'll get maybe a given percentage of failing. First diet is 10% maybe…You'll look at failing them for practice assessment and that will be 1%. So there's some sort of anomaly going on there…And I think it might be something to do with the reliability and validity of the practice assessment document'. (Participant 5L)*

Another participant reinforced this viewpoint:

'I think there's problems with clinical assessment tools. Now I'm not an expert on it but I have read a fair amount on it and from my reading I think there has never been a validated, reliable clinical assessment tool. So what are we measuring? It's still subjective'. (Participant 24L)

The issue of validity and reliability of practice assessment tools was the focus of a study by Norman et al (2002) which was commissioned by the National Board for Scotland to examine the reliability and validity of practice assessment procedures for student nurses and midwives. Seven institutions offering pre-registration nursing programmes were surveyed in order to ascertain how clinical competence was assessed. A main finding of the study was that the assessment tools used were unreliable and that no single method was appropriate for assessing clinical competence. One mentor within the current study commented that:

'People seem to put more rigour into academic know-how than they do the practice'. (Participant 40M)

The idea that more focus is placed on theory than on practice was a recurring concept in the data which demanded further exploration, this led to the development of the third subcategory 'differing agendas'.

3.3 DIFFERING AGENDAS

This conflict between what was seen as higher education institutions' agenda and professional issues led to the development of the third subcategory i.e. differing agendas. Several participants commented on the fact that higher education institutions failed to value practice, as this lecturer comments:

'…the university doesn't give enough focus on clinical assessment'. (Participant 7L)

Some lecturers and mentors in the study expressed the view that the agenda in higher education was 'bums on seats' i.e. retention of students, as this mentor illustrates:

> *'It's bums on seats, purely academic'. (Participant 8M)*

A view also expressed by another participant:

> *'The university is bums on seats. And whenever a student is out and then appeals, 100% of the time they come back. The only ones that we really see the back of properly are the ones that choose to leave themselves. Often they appeal and then they come back. We've actually got one at the moment who has an appeal and I don't, heaven help us if she comes back, because it's on clinical assessment that she's gone …theoretically she's managed to scrape through but she's now in the middle of an appeal and the area in which she worked for an extra 8 weeks in order to try and attempt to overcome this clinical problem, has said in no uncertain terms 'we're not having her back, forget it'. You know this is a professional issue here and the university always seems to… you know, they don't have that perspective on life'. (Participant 22L)*

This participant went on to point out that:

> *'… it is clearly stated in our programme, in our document that a student must be satisfactory theoretically, clinically and professionally. And so you know, I mean the clinical is as important as those other two things. And we know that. I just don't think the university sees it that way necessarily. They've got different desires for the student population'. (Participant 22L)*

Retention of students is certainly an issue for higher education institutions as income depends on student numbers, but it is also a very significant issue within nurse education itself given the current shortages of trained nurses. Several lecturers in the study discussed the difficulty of dealing with students who were problematic during theory modules, for example students who were continually late for, or indeed, not attending class regularly. Lecturers commented that these students, though displaying what they called '*poor professional behaviour'* from their perspective, where often retained within the programme to maintain progression rates. It is interesting that although nurse education in Scotland moved into higher education eight years ago in 1995 some lecturers do not feel comfortable with the system, feeling that professional values are

perhaps compromised because of the 'university' system. Lecturer participants also pointed out that university examination boards obviously scrutinise module results i.e. pass/ fail rates for each module and it is often the reasons for non-progression that are the subject of quality review and much debate, rather than the modules with 100% pass rate which are mostly the practice modules.

Although participants may have felt that retention of student numbers was an impetus to keep students in the system pressures which made discontinuing student on clinical grounds difficult were often centred around the issues of the appeal system, as this lecturer describes:

> *'…That's a thing that we're constantly being told about. Oh a precedent's been set, the student will get it on appeal'. (Participant 23L)*

Further discussion around the issue of 'appeals' will feature in Chapter 5 within the category: Failing to fail.

3.4 CHAPTER SUMMARY

This chapter highlighted the dilemmas currently facing lecturers and mentors with regard to students who have been identified as weak while on practice placement. The data confirms that lecturer and mentors are both aware that some students are passing clinical assessments although concerns have been expressed regarding their performance. It emerged that mentors often fail to put *'pen to paper'* despite having voiced concerns to lecturers regarding a student's performance. This meant that mentors in future placements were confronted with a student, or at worse a newly qualified practitioner, who had deficits in their competence. This chapter has also highlighted the anomaly between the numbers of students failing theory and practice. Given that it is suggested that few students fail on clinical grounds it would appear pertinent to have statistical evidence of such an anomaly. Some tensions between higher education institutions and practice have also been highlighted and would be worthy of further exploration. There are two main recommendations that emerge from this chapter:

- Firstly it is recommended that a national survey be conducted that establish the number of students who fail programmes on clinical grounds as opposed to academic grounds.
- Secondly it is recommended that further exploration of lecturers' views of the tensions that exist between maintaining professional values and working within higher education be undertaken.

CHAPTER 4
CATEGORY TWO: THE PROCESS OF MANAGING A FAILED CLINICAL ASSESSMENT

This chapter focuses on the process of managing a situation when a student has failed to meet the expected outcomes for a placement. The category 'The process of managing a failed clinical assessment' emerged from analysis of data from participants who had been involved in a situation where a student had failed a practice placement.

Four subcategories are associated with this category:

(i) Identifying the weak student
(ii) Developing a plan of action
(iii) The decision to fail
(iv) After the deed is done

The importance of following the correct procedure when dealing with a student who may potentially fail an assessment was an issue that came up repeatedly. As will be seen in Chapter 5, not following procedure is a major factor as to why some students are passing practice placement assessments without having demonstrated sufficient competence. In order to clearly articulate the problems that can emerge when procedure is not followed, this chapter provides insight into the process with which mentors and lecturers require to engage when the issue of clinical failure is a possibility.

4.1 IDENTIFYING THE WEAK STUDENT

Indications of failure can be present at any stage of a placement. Some participants identified that problems are evident from the start of a placement, as this mentor illustrates:

'I had a student fairly recently, at the beginning of the year, who from day one didn't really participate or attempt to participate. I mean I understand …there is a settling in period because it's a busy department…But her attitude towards everything, you know, I mean as I say practically from day one, she just was, she appeared to be unhappy to be here'. (Participant 31M)

This mentor had identified problems with the student from the outset but indicated that she gave the student a *'settling in period'*. Scanlan et al (2001) identified that it can take two to three weeks to recognise the failing student. This time period can be accounted for by the fact that the majority of mentors in this present study indicated that they were aware of problems within the first week of the placement but that they gave students time, usually two weeks, to become familiar with the clinical area and the team before addressing the students' problems. Some of the main problems that were identified by mentors were *'lack of practical skills', 'poor communication'* and *'lack of interpersonal skills'*. Several mentors in the study also talked about problems with students early in placement that centred on *'lack of interest'* and *'absence of professional boundaries'*. A point illustrated by the following extract:

'I've had difficulties with…I suppose two students…two students I found exceptionally difficult. And one was from [names university] and she was in her final 6 month placement. And basically it was just lack of interest. Sheer and utter lack of interest in anything that I said, anything that the patient said. She was very much wanting to talk about herself. We would go into a house and she would talk about living with her boyfriend and how they'd set up, you know, home, and totally, totally inappropriate. And you know, when counselled about that, you know, she would look at you as if, "Back down", and not change. I got the feeling she just thought this was all signed, sealed and delivered, you know, that this was just a sort of cruise through her final 6 months. So it was, it was difficult, you know'. (Participant 11M)

Once mentors had identified problems the process involved speaking to the weak student informally to give them an opportunity to demonstrate some improvement. For example some of the mentors indicated that if students were '*lacking in interest'* that they would take the time to explore with the student the reasons why. For some students this informal approach was beneficial. It prompted students to consider their practice, accept the constructive comments provided by the mentor and allowed the student to progress.

However as this mentor indicated some students lacked insight into their weaknesses and therefore providing informal cues was often unsuccessful in initiating change in the student's practice:

> '*She just was not picking up the signals that were pointed out to her'. (Participant 11M)*

Early identification of problems that were not resolving with informal feedback normally resulted in mentors actively seeking support in order to cope with the failing student. Having recognised the student's weaknesses mentors in this study generally attempted to contact the university to highlight the problem and to ask for support. This mentor illustrates this point:

> *'I mean at the time…we called a tutor and said we were having problems and that we needed help and then the tutor came in and gave us some advice on what to do'. (Participant 4M)*

Sharpe (2000) who undertook as study, which looked at practice placement failure of Diploma of Social Work students, reported that practice teachers regarded support from tutors as vital during difficult placements. For the majority of mentors in this present study dealing with a weak student was something they had not encountered before and therefore the need for support and guidance was essential, as this participant indicates:

> *'I had never failed a student before. I can honestly say I had never come across a student like this before and really didn't know how to approach it'. (Participant 34M)*

Initial contact by the mentor to the lecturer was usually by telephone. At this point in the process support often involved advice from lecturers regarding the importance of talking to the student formally and documenting such meetings. Mentors, as indicated previously, often spoke to students informally in the hope that they would *'pick up the signals'* and show some improvement but, as this lecturer highlights, formal written feedback is considered important at an early stage:

> *'…the mentor had spoken to her in passing about certain aspects of care that had to be improved. Now these were not documented. Although the mentor could come up with dates and times that she had spoken to the student, she herself admitted that they had been informal rather than formal'. (Participant 17L)*

A point supported by another participant:

> *'…and they've [the mentor] talked to the student but they haven't actually formally written it down, and the student has thought they were just blethering, they didn't realise it was part of their assessment. And that's been a difficulty'. (Participant 5L)*

Early initiation of formal processes emerged as an important aspect of the process of managing a failed clinical assessment. Not initiating formal procedure early or failing to contact a lecturer early on in the placement has implications for 'failure to fail' which will be discussed in Chapter Five in the subcategory 'Leaving it too late'.

Sharp and Danbury (1999) emphasise the importance of collecting and documenting evidence when faced with a fail scenario. They highlight that a clear, well-evidenced report not only supports the mentor's decision-making process but that it allows the student some protection against an irresponsible decision to fail (Sharp and Danbury 1999). The need for mentors to provide weak students with specific examples and documenting these was a recurring point within the transcripts from lecturers as this extract illustrates:

> *'They [mentors] say they're not happy and I always kinda try and kind of enforce and be positive about that and say, "Well if you have that feeling then it's usually based on something" and I need to go through the specifics of the assessment document with them… ask them to give me examples of things that the student hasn't done or things that they're not happy about. Specific examples'. (Participant 7L)*

If the mentor had contacted the university to ask for support then some of the participants described a situation where all three parties, namely mentor, student and lecturer met

together, identified the problems and commenced the formal process associated with a possible fail situation. This lecturer provides an example of such a situation:

> *'So I talk to the mentor, then get the student in, the three of us have talked and said 'You know we're not happy about this, this and this… give her specific feedback and give the student time to improve.' (Participant 7L)*

The majority of participants indicated that once specific problems have been identified there was a need to develop an action plan to support the student.

4.2 DEVELOPING A PLAN OF ACTION

Sharp and Danbury (1999) looked at the management of failing Diploma of Social work students and identified that following a three way meeting of student, practice teacher and tutor a remedial action plan was formulated. Some participants in this present study identified a similar process, as the following quotation illustrates the mentor, lecturer and student were all involved in this process:

> *'…the three of us sat down and identified exactly where improvements were to be made and exactly how we would measure that improvement had been made…so specific outcomes about specific behaviours were recorded in addition to the outcomes on the assessment form in that we could more accurately assess whether these outcomes had been achieved by breaking them down even further into more discreet behaviour modes and these were agreed by all parties at the meeting'. (Participant 17L)*

Developing a specific plan of action is seen as important for both the mentor and student as this participant highlights:

> *'And myself, the mentor and the student, what we will look at is what you would be expecting from the student by the end of the placement, the areas where the student maybe needs to develop, and then you would look at a negotiated plan or an additional action plan to help…that student to achieve his particular competencies by the end of the placement. And I feel, I think if it's done in that way a tripartite arrangement that supports the mentor. It also supports the student as well'. (Participant 5L)*

Several participants in this present study identified that tripartite arrangements, when in place, provided support to the mentor and student. Milner & O'Bryne (1986) identified that regular meetings and development of an action plan aids ongoing evaluation of the students' progress. The aim of developing an action plan is hopefully to enable the student to achieve a satisfactory outcome. Within this subcategory of 'developing a plan of action', some lecturers described their function as that of arbitrator, a role that has been recognised in the literature previously (Duffy & Watson 2001). One of the participant outlined this role:

> *'…the student's version and the mentor's version will be entirely different and the student's perception and the mentor's perception could be at opposite ends and somehow or other you've got to mediate and try and find the middle ground'. (Participant 12L)*

However, as another participant indicates, seeing both sides can be difficult:

> *'But it can be difficult, you know, when you've to sort of hear both sides of the story and try and help to sort something out.' (Participant 23L)*

In the situation of a possible failed assessment the lecturer had a dual role, to support the weak student and support the mentor. This dual responsibility had implications for the lecturer, as one participant indicated, a weak student meant more visits to the clinical area:

> *'I said I would visit on a weekly basis for support for the mentor, as well as the student'. (Participant 23L)*

Another participant reinforced this point:

> *'In and around the midway assessment I was probably in the ward for at least a couple of hours three or four days on the trot. After that the arrangement was that I would actually turn up in the ward unannounced for one hour per week. I had allocated it one hour plus travel per week for the remainder of the placement as I recall there was still 7 weeks to go. As it turned out I spent a lot more up there because things did not improve'. (Participant 17L)*

Spending more time in the practice placement area involved an increased workload for the lecturer. Several lecturers in the study indicated that when faced with a possible fail scenario they were not in fact relieved of other commitments in order to deal with such situations. Time had to found for such visits within their current workload and several lecturers indicated that they felt that the commitment required to support mentors and students during a fail situation was not recognised by their immediate managers. The issue of increased workload also applied to mentors. The consequences of supporting a weak student takes time and effort as this mentor highlighted:

> *'...it can be that you're doing double the work, because if everything has to be explained, then everything has to prepared and it can be exhausting'. (Participant 14M)*

During interviews the general feeling from mentors, who had been involved in failing students, was that they were trying to provide support to the student that would allow improvement in clinical performance and so ultimately result in a successful assessment. One of the strategies used by mentors was working almost constantly with the student as this mentor illustrates:

> *'...I did spend a lot of time with her [the student]. I worked every shift with her, our requirements are that you work at least 50% of their time that suit, but we worked every shift together'. (Participant 16M)*

As well as working more closely with the student there was a need to put more time aside for regular formal meetings to provide feedback for the student, as this mentor highlights:

> *'...we met every week for probably an hour... all these sessions were made formal in order that any points of improvement that were identified could be reported to both the student and the lecturer'. (Participant 16M)*

It is evident from the data above that mentoring failing students is a time consuming process. When I asked participants if they had been allocated time within their clinical workload to take account of the added mentoring commitment only one mentor indicated

that her immediate manager had made such provision. The importance of recognising the increased workload that a weak student in clinical practice presents to both lecturers and mentors is something that has to be acknowledged by both university management and managers in clinical placement areas.

Commencing formal processes associated with a fail situation resulted in different reactions from students. Burgess et al (1998) identified that students when faced with difficulties in placement reacted in different ways including: anger, frustration, disappointment and shock. Participants in the present study identified such reactions. Congruent with Burgess et al's (1998) findings having to deal with the student's anger and frustration was not uncommon, as this participant indicated:

> *'And latterly because I think she felt very stressed, which was understandable, and threatened because she knows there's a huge possibility the final outcome may not be favourable, her reaction was a combination of aggression and distress'. (Participant 27M)*

Another problem identified was that some students, in their anger, tried to undermine the mentor. One mentor spoke in detail about a student who went behind her back to other team members in an attempt to rally support for her view of her own practice. The result was that as well as having to deal with the emotional reaction of the student the mentor also had to deal with the disharmony this caused within the team.

Students' reaction when told about their weaknesses was a factor that influenced the success of the supportive measures that were provided by both mentors and lecturers in the present study. Lack of insight on the part of the student was highlighted by several participants as problematic, as this mentor indicates:

> *'...some of her responses I thought, she doesn't seem to appreciate the seriousness of this, you know. I would say things, you know, 'This is a problem' and she would say, 'Well I don't know why that's a problem because I did that when I was an auxiliary', you know. And I was saying 'But, yes but we're aiming for registration here and we expect a different level, a different level of responsibility', but she didn't seem to appreciate this'. (Participant 36M)*

Several mentors in the study talked about the frustration associated with students who lacked insight into their problems as this meant that any supportive measures put in place were not recognised a such by the student.

Other participants found themselves under constant pressure from the student. One participant talked about the constant pressure from the student as this quote illustrates:

> *'…she [the student] put the mentor under a lot of pressure…they devised an action plan, but every day the student was saying, 'Well do you think I'm going to reach the level, do you think I'm going to reach level 5'. And every time she did something, 'So do you think I'm going to reach level 5'. And it really put the mentor under a lot of pressure'. (Participant 23L)*

Dealing with students' reactions is something that will be examined further later in this chapter when the giving of the final assessment is discussed. In summary, the overall aim of the process outlined so far appeared to be to provide feedback and allow the student time to learn and develop before a decision was made as to whether the level of competence demonstrated constituted a fail. Where there was insufficient improvement the decision to fail the student had to be made.

4.3 THE DECISION TO FAIL

The final decision to fail a student was not taken lightly. Practical, but also emotional issues are associated with this subcategory. One of the main practical issues highlighted by participants was actually writing the final assessment. As this lecturer indicates, the mentor often needed support with this stage of the process:

> *'So he failed his midway assessment and we came to the final assessment and the mentor felt she needed a lot of support. She didn't know how to write this out…I went to her practice area, sat with her and helped her write out, I didn't do it, but helped her write out the clinical assessment, the final clinical assessment'. (Participant 10L)*

Mentors in the study also confirmed this need, as this quote illustrates:

'I phoned and asked the tutor for some help. I mean I wanted to do it properly, I didn't want this coming back on me. I knew it had to be watertight'. (Participant 14M)

The threat of appeal was mentioned by several of the participants and was an issue identified by Sharpe (2000). The report from the mentor who fails a student will inevitably be scrutinised by the examination board and therefore an accurate, clear and well-evidenced report is essential. Support from lecturing staff who are familiar with the process of writing up the clinical assessment was seen as vital by participants in the study in order that a *'watertight'* report could be written. Another way in which lecturers provided support was being present at the final meeting of the mentor and the student. It was evident from participants in the study that this tripartite arrangement was not established in each programme. Where procedure indicated that the lecturer be present at the final assessment this was seen as supportive, as this mentor points out:

'But the tutor was quite good, coming in as well, you know… I just remember feeling very uncomfortable and as I say, it was nice to have some support'. (Participant 4M)

Not all universities appeared to have protocols that included the link lecturer's presence at the final assessment, as one of the lecturer's comments:

'…if it's a fail, and there's very few I've got to say, then we would expect to be aware previously and I would expect each link person to go out for the final assessment. But, we haven't got a, got anything written that that's the case'. (Participant 23L)

As indicated in Chapter 1 the literature has advocated for some time that lecturers should have a shared role with mentors in the clinical assessment of students (Clifford 1994, May et al 1997, Watson & Harris1999). Given that mentors in this present study indicated the need for very direct support when faced with a fail scenario this provides further evidence of the value of institutions seriously considering this recommendation.

It emerged from the data that the decision to fail has emotional consequences for both the mentor and the student. As one lecturer described it such an interview can be *'heated and emotional' (Participant 17L).* While one mentor commented:

> *'It's very easy to pass a student but very, very difficult to fail a student'. (Participant 2M)*

A paper by Milner and O'Bryne (1986) examined the emotional issues involved in dealing with failing students in social work education. They commented that "failing a student, particularly on practice grounds, is an unpleasant, messy, emotionally fraught experience" (Milner and O'Bryne 1986, p.21). Both mentors and lecturers in this present study recalled the emotional aspects associated with giving a failed assessment. A mentor who had to tell a 2nd year student that he had failed an assessment recalled:

> *'I mean it does stick with you. As I say I can remember what he looked like and I can remember his reaction when we said, you know, "We've called the tutor here and we've called you up to tell you that you haven't passed your assessment". And you know the eyes started to well up and it was really quite, I mean I didn't feel too good after it… I just remember feeling as if I'd let him down'. (Participant 4M)*

Some of the words used by participants to describe the process of being involved in failing a student were *'horrendous', 'traumatic'* & '*draining'*, as this mentor indicates:

> *'…it's not a comfortable thing to do to fail somebody and it's quite a traumatic thing to do'. (Participant 11M)*

The stress associated with failing a student is recognised in the literature. Goldenberg & Waddell in 1990 conducted a study looking at the sources of occupational stress and coping strategies among nursing faculty members across eight Ontario Universities[1]. The sample of 70 subjects who completed the questionnaire/stress inventory developed for the study found that 'failing clinically unsatisfactory students' was perceived to produce high levels of stress in the faculty members. Burgess et al (1998) identified that following the process of dealing with a failed assessment practice teachers in their study

were left with mixed emotions. Congruent with Burgess et al's (1998) findings mentors in the present study were left with feelings that included '*sadness, 'anger', 'exhaustion'* and '*relief*'. The issue of a sense of personal failing when faced with a problematic student has also been raised in the literature (Burgess 1998, Duffy & Scott 1998). Several mentors indicated that they *'perhaps could have done more for the student'* and in some way felt that they had *'let the student down'*. As well as dealing with their own stressful feelings associated with a failed assessment the mentors in this current study also had to deal with the different reactions from the students. Students were often emotionally upset, as this mentor recalls:

> *'He just broke down in front of us, you know. And I felt absolutely terrible'. (Participant 4M)*

Having to deal with an angry reaction from the student was mentioned earlier in this chapter and as this one mentor illustrates you can be faced with an intimidating situation:

> *'And he was very, very angry… I mean I personally thought the student was going to hit me'. (Participant 16M)*

Another reaction on the part of the student was to deflect responsibility for the failed assessment onto the staff. Several participants reported the student blaming others as this quote indicates:

> *'… the student herself…put it down to personality and that the whole staff were against her because we all worked there together, knew each other and so we had ganged up on her'. (Participant 39M)*

Mentors in the study highlighted that dealing with the emotional aspects of a fail situation was difficult and was something for which they felt ill prepared. Some lecturers also commented on feeling ill prepared for dealing with the emotional reactions of the students. If they had been present at the final assessment meeting this had consequences for the lecturer-student relationship. As this lecturer illustrates, if you were involved in

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[1] In Canada clinical evaluation of student nurses is conducted by the faculty's clinical teachers.

the assessment process you also had to deal with the aftermath and emotional consequences:

> *'…she was very, very angry… very angry. Very angry with me… And I would have said that I had a fairly good relationship with that student. But she was very angry with me and she never, she wasn't able to re-establish the relationship, the relationship broke down totally. She just wasn't able to really accept that I could be involved with something like that'. (Participant 13L)*

Although students' reactions were often one of anger, mentors themselves also felt such emotions, particularly when having to deal with a student who should have been picked up earlier in the course. Some mentors directed their anger at other colleagues who had 'failed to fail' the student in earlier placements. This participant who was in the position of failing a third year student demonstrates this anger:

> *'I couldn't believe this student and yet she'd passed the other clinical assessments…I realised other mentors had passed her and I was so, so angry… why had they let her go on?…I couldn't believe it, don't they understand about professional responsibility' (Participant 39M)*

Some mentors however directed their anger at the university often questioning why such students had been allowed entry to the course in the first instance, as this mentor comments:

> *'This student should never have been allowed on the course'. (Participant 33M)*

Similar views have been expressed in social work literature. Burgess et al (1998 p.53) who conducted a Scottish wide study on unsuccessful placements identified that "practice teachers were taken aback by the seriousness of the problems and wondered how the students could have been selected for the programme in the first instance". Several mentors and lecturers in the present study expressed concern that the selection processes currently employed were neither rigorous nor effective at *'weeding out'* unsuitable students before commencement of a programme. Clearly emphasis needs to be placed on selection of applicants for nursing particularly regarding their motivation, attitude and

professional approach, as these are some of the main areas of concern expressed by participants who had been in the position of failing a student.

Having an understanding of the affective responses associated with a fail scenario illuminate the complexities associated with this situation. Interestingly when I asked each of the mentors if the issue of dealing with a fail scenario had been part of their mentorship programme all responded *'No'*. Therefore it would appear prudent to recommend that the topic of failure be included in mentorship training. In particular issues such as how to break bad news, dealing with emotional responses and how to record the decision should all be included.

4.4 AFTER THE DEED IS DONE

The final subcategory associated with 'the process of managing a failed assessment' relates to procedures after the student has received a failed assessment. It was the policy of the institutions that took part in the present study for students who had failed a clinical assessment to be given an opportunity to achieve the learning outcomes a second time in another placement, as this lecturer indicates:

> *'…the student has been moved somewhere else to be assessed by another individual'. (Participant 3L)*

When a student has failed a placement and has the opportunity to repeat the experience in another area a further issue raised by participants was whether information should be passed on to the next mentor, as this mentor who had failed a student indicates:

> *'...that was something else that concerned me, that there is no way of recording from mentor to mentor, or from placement to placement…that there was a problem with this person. The fact that I had all this difficulty and problem with her, and that this information wasn't available to the next mentor really concerned me'. (Participant 31M)*

The majority of lecturers in the present study all indicated that it was policy not to inform the next mentor that a student had had difficulties. The general feeling was that this was to prevent bias in the assessment. The issue of passing on information regarding a student's previously failed clinical assessment met with a mixed response from the mentors. Several participants were of the opinion that being aware of the student's problems or weaknesses would allow mentor and student to work immediately on the problems thereby allowing the student a better opportunity of success in the placement. This mentor indicates that having prior information may have been useful:

> *'... we get students, we have no background, we don't know what's happened previously to them... If I'd known that [mentions student's name] had failed previously I could have worked with her from day one, rather than losing a week or two while I sussed out her problems…I might have managed to get her up to scratch and not have had to fail her if I'd known from the start'. (Participant 27M)*

Other participants raised the negative view that such prior information may bias the mentor's judgement and result in an unfair assessment for the student. This mentor points out:

> *'...you do want to give people a clear shot at things, before you make a decision about, you know, about their clinical assessment'. (Participant 27M)*

Although Burgess et al (1998 p.60) argues that "the need for full and accurate information about the previous placement should outweigh concerns about the risk of labelling a student", many of the participants in the present study were unsure, as this mentor who had failed a student comments:

> *'I remember this lecturer coming up after the failed assessment to go over it with me…and it was at that point this teacher disclosed that the student had had serious problems before. Now I suppose in a way it's better not to know that before because I made, well as a ward we made a clean judgement about her…But I think, on the other hand I felt I should have known about that. I don't know whether, I don't know what difference it would have made'. (Participant 34M)*

Whether lecturers should share information regarding a student's previous performance in practice placements is a dilemma that requires further discussion and clarification. This dilemma had been identified previously (McAleer & Hamill 1997, Burgess et al 1998) and is obviously a policy issue that requires further debate.

The final stage in the process of failing a student involves the mentor's report being returned to the university and presented at an examination board were a fail decision would be recorded on the student's records. Recommendations are usually made at these boards regarding the students options, for example; repeat placement; carry specific learning outcomes to next placement; or, if appropriate, discontinuation. The favoured option, that emerged from the data was to have the student redo a placement however as this lecturer indicated the problems with the university system made this difficult:

> *'The constraints of the… academic year are a problem…With one module finishing on the Friday, and the next module's starting on the Monday, it sometimes can be very difficult to redo'. (Participant 5L)*

Given these constraints a mechanism used to allow students to achieve objectives was to hold over the repeat placement until there was a gap in the programme, often this was in the students' holiday period or in study weeks. As several lecturers commented this then put the students at a disadvantage as they lost study time for assessments or missed out on a holiday break, often perpetuating the student's problems. Lecturers indicated that the situation of a student failing a placement at the end of their programme was even more problematic. The mechanism utilised for students who are nearing the end of their programme and have failed involved the student using up holidays allocated at the end of the programme or doing a placement voluntarily, as this lecturer indicates:

> *'We've actually extended the student's term for another four weeks or maybe 8 weeks…It's voluntary on their part. They get no money and no bursary'. (Participant 5L)*

Adopting this approach, though trying to be helpful to the student, may not always be beneficial to the profession. A third year midwife in Fraser et al's study (1998) who was

in her final placement before qualifying required two extensions in clinical practice in order to achieve all the requirements for eligibility to register. Follow up a year after registration indicated that this student required a lot of support, lacked insight into her deficits and could not be left unsupervised to care for pregnant women with complications (Fraser et al 1998).

Another issue that arose within this category was that, after the deed was done, mentors felt aggrieved about the lack of feedback. The majority of mentors in this present study experienced lack of information after the placement had ended. They commented that they had not been informed of the outcome of having given the student a failed assessment. For example had the student actually been discontinued from the course, had the student repeated the clinical experience elsewhere and passed or had the student attained a successful appeal and been allowed to progress? This lack of information resonates with the findings of Sharpe's (2000) study, practice work teachers in her study said that they were not informed of the outcome of the institutions formal processes. Several mentors in the present study indicated that they had found out informally. A number of participants indicated the need for more information and also feedback as to how they had dealt with the situation, but none had been available to mentors in this current study, as was clearly illustrated by this quote:

> *'And I think it's important that we do get a feedback… But we don't. We don't hear anything from the university at all'. (Participant 16M)*

Some of the mentors talked about being left with a sense of *'unfinished business'* which was very frustrating. It would be pertinent to recommend that following a fail situation lecturers maintain contact with the mentors involved to provide information regarding examination boards decisions. It would also be beneficial if both the mentor and lecturer involved could have time to reflect together in order to learn from the situation, as it is an aspect of practice that is emotionally draining for the individuals involved. Burgess et al (1998) highlighted the need for debriefing after a failed clinical placement for both assessors and teachers, a strategy worth considering.

4.5 CHAPTER SUMMARY

This chapter outlined the process involved in failing a student. Problems are often identified early in the placement and students are given informal cues as to their lack of progress. Mentors often seek the advice of lecturers and if supportive of the mentor as well as the student then this is seen as valuable. A tripartite arrangement, when it is in place is seen as beneficial. Development of an action plan, regular meetings and clear documentation of areas of concern are important aspects of the process. The time consuming nature of supporting a failing student was identified. Also identified was that failing a student has emotional consequences for both the mentor and the student and that mentors often feel ill prepared for this aspect of the process. Mentors in the study questioned the effectiveness of selection process and highlighted the lack of communication between placements when a 'weak' student arrives in a clinical area. After the assessment process none of the mentors who had been involved in failing a student received any further information regarding the student and were unaware of whether the student had remained on the course. Six main recommendations emerge from this chapter.

- Firstly that mentorship training include the topic of dealing with a failed clinical assessment. It is recommended that this should comprise dealing with the practical aspects and procedure involved in a failed assessment as well as input regarding the emotional reactions associated with dealing with this issue.
- Secondly that, managers within the clinical and educational settings take cognisance of the time and emotional commitment required by both mentors and lecturers when faced with a possible fail scenario.
- Thirdly that tripartite arrangements be established with lecturers having a role in clinical assessment.
- Fourthly that selection processes in pre-registration courses be reviewed

- Fifthly that the issue regarding the passing on of information between placements once a student has failed a clinical assessment be debated by lecturers.
- Finally that mechanisms be put in place to enable debriefing after the event and to ensure that mentors are made aware of the final outcome if they have been involved in failing a student.

CHAPTER 5
CATEGORY THREE: FAILING TO FAIL

The main question when embarking on this research was: *Why are some student nurses being allowed to pass clinical assessments without having demonstrated sufficient competence?* The previous two chapters have highlighted current problems and identified the process involved in failing a student. This chapter identifies some of the reasons why some mentors are 'failing to fail' students.

This third category emerged from the data with four related subcategories:

(i) Leaving it too late
(ii) Personal consequences
(iii) Facing personal challenges
(iv) Experience and confidence

5.1 LEAVING IT TOO LATE

The previous chapter outlined the process a mentor follows when confronted with a weak student. One of the main issues to emerge from analysis of the data was that mentors did not always follow this process and, as such, often inadvertently contribute to the incidence of 'failure to fail'. One aspect of not following procedure was 'leaving it too late' in the placement before indicating to the student that there was a problem, as this lecturer illustrates:

> *'I've had experience where it has been identified too late. And in fairness the students have been allowed to progress, because they haven't had time to improve within that particular clinical area'. (Participant 24L)*

This type of situation does not appear to be uncommon, as another lecturer describes:

> *'There's a student who is in the pipeline at the moment… I went to see the mentor and the mentor said there were various incidents where this girl wanted things*

her way. She manipulated things so she didn't have to do them. And I said, 'Look this girl has got like three days to go and you know, was this discussed with her before?' And she said, 'No'. So I said 'You can't fail her'. (Participant 9L)

Scanlan et al (2001) identified that it can take two to three weeks to identify the failing student and therefore short placements can contribute to difficulties in identifying weak students. Participants in the present study indicated that placements were often between 4-6 weeks in duration in the early part of the programmes, with longer placements not occurring until the last year of the students' education. As mentioned in the previous chapter mentors often gave the students some time to settle into the clinical area and so did not initiate formal procedures until the second or third week of placement which is often too late. One aspect of the formal procedure, identified in an earlier chapter, was initiating contact with the link lecturer. It has been reported in the literature that practitioners when unsure about assessment will often defer to the 'academic expert' (Phillips et al 2000). The data from this present study suggests that in some situations 'failure to fail' occurs because mentors leave it too late in the placement before addressing the issues with the student. The result is that on asking expert advice they receive little support from lecturers and therefore do not feel able to record a failed decision, as this mentor illustrates:

'I tried to fail a student once and I was told by the lecturer or the tutor that that wouldn't do… that it was too late and the student would get through anyway'. (Participant 37M)

This mentor 'failed to fail' a student that she thought should not have passed because she left it too late in the placement before indicating to the student that there were problems. As mentioned in the previous chapter, highlighting the student's weaknesses early was an important part of 'the process of managing a failed clinical assessment' as the student had to be given the opportunity to improve their performance within the placement. 'Leaving it too late' relates to the appeals process as this lecturer comments:

'…if the student brought that to the programme leader and said, 'Well they didn't tell me there was a problem until the last week', then the student would have grounds for appeal'. (Participant 23L)

If there has been insufficient time and support given to the student then lecturers feel they cannot support a failed assessment, as the student will win on appeal anyway. Appeals were a recurring subject within the data. As was highlighted earlier (see Chapter 3 section 3.3) appeals within the university system often support the student, particularly when procedures have not been followed. That students might appeal and thus result in the mentors' decision being overturned was a reason suggested in Watson's (2000) study as to why mentors felt pressurised into recording a decision that was at odds with their own professional judgement. Data from the present study supports this finding. Sharpe (2000) cautions that assessors can become demoralised and feel that their professional role is undermined by tutors who fail to support them. It may well be the case that the student would win an appeal when it is 'left to late' but lecturers should be aware that suggesting to mentors that they cannot fail students does leave mentors feeling disempowered as this mentor illustrates:

> *'I suppose because not getting the best of support there was maybe a feeling of impotence in the sense that I had the…had the opportunity to stop this student going on but the way the system works it didn't allow it'. (Participant 38M)*

Powells and Powells (1994) discussing problematic issues in social work practice commented that failing a student as a near impossible task, as the assessment process was disempowering to practice teachers. Evidence from the present study indicates that this same issue appear applicable to nursing today. Indeed it has prompted Watson (2000 p.592) to recommend that there should be a change "in the philosophical approach to student assessment with a right to fail students being given more overtly to the mentors". When mentors are faced with situations such as those described above where they are told by lecturers that they cannot fail a student it is little wonder that mentors at times feel powerless and feel that they are unable to fail students.

Lecturers in the present study continually stressed the importance of following procedure and particularly the significance of the midway assessment in the whole process. This lecturer highlights this point:

'I, midway, would have expected the mentor or supervisor to have identified areas that the student might be weak or unsatisfactory in and that hopefully would give the student time to then reach that particular level'. (Participant 5L)

This point was supported by another participant:

'The mentor said 'No I'm not happy, we're going to fail him'. And I'm thinking you haven't given him a midway assessment, you haven't done this, you haven't, and they hadn't followed procedure. So I wasn't happy about them doing that'. (Participant 7L)

It is obvious that lecturers are well aware of the importance of following procedure and how the system works with regards to appeals. However it is evident from the data above that mentors may not be familiar with the significance of formally telling the student early in a placement of any problems and of the importance of the midway or interim assessment. It would seem pertinent that mentors are made aware of the formal procedures necessary when faced with a weak student and the importance of not 'leaving it too late' before identifying weaknesses to the student.

Another aspect associated with 'leaving it too late' was the fact that many of the participants in the study identified that very few students failed early in the programme, as this lecturer indicates:

'Earlier on they seem to be willing to give them too much leeway in terms of what's acceptable…The whole thing about attitudes and stuff like that, although they're not happy about it, they let it go because they're early in the course'. (Participant 7L)

Mentors in the study confirmed that the stage at which the student was at in the programme influenced whether they failed the student or not, as this mentor illustrates:

'Well my feeling is that they have been on the course…possibly only for a few months, or maybe a year. On the basis of that, I like to see them go on the satisfactory side'. (Participant 15M)

This reason was also confirmed by another participant:

> *'You know she wanted to stay in the course and I think she had to be given a chance because she had only been there 6 months. You know this was her first community*
>
> *placement…. and I think it would have been unfair to fail her at that stage'. (Participant 35M)*

Findings from this study support comments by Scanlan et al (2001) that there is an unwillingness to fail students especially early in a nursing programme. Scanlan et al (2001) observed that the prevailing belief amongst their clinical teachers was that student nurses need time to learn and that failing a student early in the programme did not allow the student ample opportunity to succeed. Confirming this observation some mentors in the present study who had been in the 'failure to fail' situation felt that students would pick up the necessary skills as they progressed, as this mentor rationalised:

> *'With it being her first placement…. I don't think failing her then would have done her any good. It wouldn't have done her confidence any good…You know she might have just packed in nursing then. She would find out hopefully what I was trying to get through to her. She would find out as she went on in nursing'. (Participant 30M)*

The belief that students would somehow pick things up later was also clearly illustrated by this mentor:

> *'For example about a depot administration. They might not be very sure of giving an injection, so we work with them, by the time that the placement comes to an end they are not really proficient now or competent enough to go ahead with that….so, like I hope that maybe as they go along, they will pick up on these practical issues. So that's why I feel I've got, I'll give them a satisfactory' (Participant 15M)*

Burgess et al (1998) identified that practice work teachers in social work 'shelved' assessment dilemmas in early placements in the hope that they would resolve in a future placement. It would appear that some mentors who are 'failing to fail' students early in nursing programmes harbour the belief that the students will become more proficient in

their skills as they move on in the course. However if such students, as they move through their clinical placements, continually meet mentors with similar views then the outcome appears to be students in their third year whom some mentors have described as *'diabolical'*.

The views above suggests that mentors need to be clearly informed of the their accountability with regards to student assessment no matter what stage of the programme the student is at. Leaving it until late in a students' programme had consequences for future mentors which will now be explored further.

5.2 PERSONAL CONSEQUENCES

Mentors in Watson and Harris's (1999) study who had failed a student during clinical placement reported that they had found it difficult to take action that potentially could have serious personal consequences for the student. Several participants in the present study expressed the view that this may be a reason for some mentors 'failing to fail'. A mentor who choose not to fail a third year student comments:

> *'…I didn't want her chucked off the course…that would have been the end of her'. (Participant 40M)*

The view expressed above indicates that when mentors are faced with the dilemma of failing students late in their nursing programme they may fail to do so because of the consequences to the student. One of the participants, a lecturer, recounted a recent experience with a student who was in her third year in her second last placement before qualifying. The ward sister and staff nurse who were co-mentoring the student had identified problems with this student early on in the placement and had expressed real concerns regarding her performance. As the lecturer recalls at midway assessment the problems were documented and an action plan identified with the lecturer, student and sister all present. With weekly visits the lecturer was aware that the student's performance was not improving. However things did not go as planned:

'... both the sister and the staff nurse went on annual leave and didn't complete the final assessment. I went in on the student's last day, asked to see her assessment and it hadn't been done. So there was this two week delay'. (Participant 25L)

As the student was in her rostered service module she went on to her next placement as programmed, as the lecturer recalls:

'Meanwhile she was in her next placement and…this student's new mentor asked to speak to me and said 'What's the story here? This student is awful'…And it was all, all the same things from the past, the previous placement'. (Participant 25L)

The lecturer awaited the return of the student's previous mentors from holiday so the assessment could be completed, fully expecting the assessment to be a fail. However this was not the case. When asked if she had queried the decision with the sister concerned she commented:

'Yes…and the sister said 'Oh I wouldn't want to jeopardise the student's future she's nearly finished'. Missing the whole point….instead of worrying, this is girl is qualifying in a couple of weeks, would I be happy that she looked after me or someone that I cared about'. (Participant 25L)

Another lecturer recounted a similar situation. This lecturer recalled an episode were a third year student who had been identified as weak in the first few weeks of placement was given a satisfactory assessment:

'…they said, yes, she had improved, she was more careful, she was managing to care for the patients, they'd been watching her. So it seemed like her progress, she had improved. And she was going to get a satisfactory assessment. That was fine…'. (Participant 9L)

However as this lecturer went on to point out after the assessment was complete and the student had left the meeting:

'…when I came back the staff nurses then told me the truth. And I could not believe it. I just couldn't believe it. They then said, 'Och she's a waste of

space. She's this, she's that'. I said, 'But you had a chance to fail her'. 'Well we knew that if we had, that would have been the end of her, you know. It would have been the end of her career'. And that girl got through'. (Participant 9L)

The prospect of ending a student's career was cited by a mentor in the study as the reason why she 'failed to fail' a student. Talking about a student, late into her second year, who had already failed a clinical assessment led this mentor to reveal:

'I wasn't going to put the final nail in her coffin'. (Participant 40M)

This mentor justified her position by commenting that:

'We all made mistakes as students'. (Participant 40M)

Mentors concerned that they would be responsible for the student being discontinued from the course was the main issue within this subcategory. Another matter of note was that mentors often took into consideration students' personal situations and circumstances when considering the consequences of failing a student. It is recognised in the literature that students are experiencing more stress related to finance with the majority of students having jobs, family commitments e.g. acting as student, spouse, parent, carer (Scanlan et al 2001). A point recognised by this participant in the study:

'…a number of students they have other jobs and they're absolutely exhausted. And many of the students nowadays are single parents'. (Participant 12L)

Mentors appear to be influenced by these external factors when coming to a decision whether to pass or fail a student, as this participant illustrates:

'You need to take into consideration their family life too because if they have problems in their family life…You've got to take it as overall'. (Participant 37M)

Another mentor who decided not to fail a student supported this view:

'...she had problems in her married life, she was divorced or getting divorced or separated, and she used to come and tell me all the problems about her husband and I think to fail her then, no it wouldn't have worked...everybody's got problems, if I can help them out, you know, I would'. (Participant 30M)

Another factor taken into consideration by the mentors in this study was the age and maturity of the student, as this mentor illustrates:

'Life experience... like the young ones, they don't have the same life experience so if the mature, older students come in you know, they have been through some kind of life events or life experience. And you get more from them than the young ones... Whereas somebody younger just starting their training, you know, that is the first thing they have come across. I, like most of my colleagues or people who are assessors like, you know, do have the tendency to go for the satisfactory side rather than the unsatisfactory side'. (Participant 15M)

It is well recognised that when mentors make a clinical performance judgement about an individual student the problem of subjectivity and socialisation arises. Watson et al (2002) suggested that if a mentor carries out an assessment over a period of time then a socialisation process takes place which may bias the assessment in either direction. It would appear from the data presented here that the mentor getting to know the student often means the student passing rather than failing. Given this evidence it would seem prudent to reinforce Watson et al's (2002) recommendation that a closer look at the clinical practice assessment is needed. As Watson et al (2002) comments consistency of even the most reliable tool is compromised if external factors can influence the outcome of a student's assessment.

5.3 FACING PERSONAL CHALLENGES

This subcategory emerged as participants talked about the personal challenges a weak student presented to a mentor. It is recognised that failing a student is a difficult thing to do (Fraser et al 1998, Watson & Harris 1999), as this participant reveals:

'I mean it's really difficult to sit down with somebody and say, 'Look I don't think you have achieved what you were supposed to achieve'... I know it's difficult'. (Participant 40M)

Failing a student can be viewed as an uncaring practice and given that one of the central tenets of the nursing profession is caring this may influence whether mentors fail to fail students. In fact a key issue reported in Fraser et al's (1998) study was that failing a student in practice placements is difficult for a 'caring' profession. A point reinforced in this present study by one of the mentors:

'...but I think most nurses are kind of generally nice people who don't like to hurt other people's feelings and I think that's got a lot of do with it'. (Participant 2M)

A view reiterated by this participant:

'...you want them to pass and do well you don't want people to fail'. (Participant 28M)

The difficulty of failing a student in practice is recognised in other professions with practice elements to their courses (Ilott 1996, Sharp & Danbury1999). IIott (1996) reported on a survey conducted with occupational therapy field work supervisors regarding the issue of failing students. Assigning a fail grade was identified by two-thirds of the 113 respondents as being the most problematic issue.

Another factor associated with 'facing personal challenges' was that when a student had qualities congruent with caring this made failing a difficult process, as this mentor describes:

'And you felt, you know, he was a decent enough guy. He was a kind person and you felt really, really bad that you'd hurt him. But at the end of the day you couldn't have him in the nursing profession'. (Participant 4M)

Borrill (1991) whose research focussed on failing social work students identified that assessors needed extra tutor visits and strong line management support when failing a

student, a point supported by participants in this present study (see Chapter 4, section 4.2). Duffy and Scott (1998) highlighted the feeling of personal failure a mentor experiences when dealing with a failing student. A point to emerge in this subcategory was the support needs of mentors when faced with this personal challenge of failing a student. Some lecturers recognised the needs of the mentors in this situation:

> *'…the mentor needed an awful lot of support….she had to be reassured that the student deserved to fail. And she had correctly sought support from her peers and confirmation from her peers… And she was quite concerned about how the university or myself would respond to it in terms of failing, her view was that we always took the part of the student'. (Participant 17L)*

Although all the lecturers in the study saw their role as support the mentor as well as the student and easily cited examples of its provision mentors' experience was varied. For example some mentors were happy with the support they have received:

> *"I think I've probably had concerns a few times. But the university's been quite good'. (Participant 14M)*

Other mentors had little or no support as these two mentors illustrate:

> *'I felt that I didn't have any support from lecturing staff and was just left'. (Participant 38M)*

> *'I phoned the university and tried to speak to someone… it was during the holidays. It would be during the summer holidays… so I mean I didn't ever get any support'. (Participant 35M)*

Sharpe (2000) identified this same issue with practice work teachers i.e. that tutors were not always available when needed. One of the mentors in the present study described how she had felt unsupported when she had a problematic student. Although she had made contact with the university she had to make several telephone calls before actually speaking to the appropriate lecturer. Although she felt the lecturer's advice was helpful there was no further offer of support from the lecturer. This mentor who decided not to fail the student was still unsure whether she had made the right decision, as this extract illustrates:

> *'But you know, but I don't know to this day if I dealt with it appropriately. I did my best but I don't think I had quite the support there could have been' (Participant 38M)*

Several participants offered the reason why such a situation may arise. Some mentors commented on the reduction of direct communication since the move of nursing programmes into the university setting, as this mentor indicates:

> *'The college was here, we could go over and have a, even like a stronger link and it was easier at that point I think to deal with these things. I think now, I think because the whole system is on such a grand scale that these links are not quite as obvious as they maybe used to be for getting the support'. (Participant 21M)*

It would appear that in some instances mentors have been faced with a weak student but have been unable to access the support that they need and consequently have allowed the student to progress by giving them a satisfactory assessment. The previous chapter highlighted the benefits of, and need for, adequate support from lecturers when faced with 'fail' situation. It would therefore seem prudent to suggest that mentors when dealing with failure not only need to know the kinds of support available to them, how to access this support quickly but also to be assured that they will receive the support from lecturers that they require.

Another personal challenge mentors face is lack of time. Phillips et al (2000) pointed out that assessors are short of time and constantly under pressure in the clinical environment. Fraser et al (1998) cited lack of time available to work with a student as a possible reason for one of the borderline students in their study achieving a pass. A view also supported

by Watson & Harris (1999) and Dolan (2003). The issue of lack of time for the role certainly appears to contribute to mentors' decision making processes particularly when faced with a weak student, as this mentor in the present study illustrates:

> *'the constraints of the service now… I think …we're sort of constantly fighting against the lower staffing levels, what the patients are expecting, there's all these things…it's so difficult for the students that you maybe give them allowances for that, and when their performance is maybe weak or they're not quite hitting the mark, I think they're not really getting the experience they're supposed to be getting because we're short staffed and we're using agency nurses and maybe we give the benefit of doubt'. (Participant 21M)*

Several mentors in the study indicated that when in doubt about a student's performance they were more likely to give a satisfactory assessment as they felt guilty at being unable to spend time working with a student on the areas of difficulty due to staff shortages and constraints of the service. Consequently they felt they had to allow the student to pass, as they had been unable to allow the student time to demonstrate improvement. In 1997 May et al identified increasing service pressures as a constraint on providing mentorship support for students, more concerning is the evidence provided here that such constraints result in giving students the '*benefit of the doubt'*. Lecturers in the study recognised that mentors have competing demands on their time and that when faced with weak student may have difficulty in fulfilling the extra commitment required in supporting a weak student. This lecturer highlights the problem:

> *'My own feeling is that students don't come particularly highly in the list of priorities that nurses have when they're at their work. You know quite rightly the patients are the highest priority and if they're busy then it is just seen as an inconvenience to have to arrange an hour of their time, you know, to sit out with a lecturer and a student and discuss this'. (Participant 3L)*

It is well recognised that in general mentors face various constraints on their mentorship role, i.e. lack of time, staff shortages, increasing service pressures (White et al 1994, May et al 1997, Watson and Harris 1999). However evidence here is that when faced with a weak student these pressures influence the decisions mentors make, often to the student's benefit. It is clear from the views expressed in this subcategory that mentors face a number of personal

challenges when faced with a weak student that influences their decision making processes. Further discussion surrounding the difficulty associated with failing students led to the development of the next subcategory.

5.4 EXPERIENCE AND CONFIDENCE

The experience and confidence of the mentor with regards their assessment role emerged as an important issue within the data with regards to the issue of 'failing to fail'. In the study by Scanlan et al (2001) mentioned previously (see Chapter 3) the issue of experience was raised with novice clinical teachers who were seen to have difficulty evaluating students' performance. Scanlan et al (2001 p.26) concluded "Uncertain about their role, novice clinical teachers are reluctant to fail students in clinical practice because they are unsure of the legitimacy of their judgements and their ultimate decision about the student's abilities". The problem of being faced with a failing student when in fact a mentor's own experience in the role of assessor is limited was highlighted by a mentor in this present study:

> *'Now that I'm getting more experience I understand that you have to, if people are unsatisfactory and if people are not fit to work, are not suitable to work, you know you have to fail them… But I think a lot of that comes with experience and I think for junior kind of mentors then that would be really difficult'. (Participant 2M)*

A lecturer also raised this point:

> *'I know that myself in wards talking to people, it's a whole confidence thing, it's a big thing. And it tends to be people who are very certain about their own practice who feel comfortable about saying, 'Oh this student is not OK'. And if they're kinda uncertain or more junior themselves they have less confidence in saying 'That student is not right'. (Participant 7L)*

As well as highlighting the importance of having experience and confidence as a mentor participants talked about the importance of adequate preparation for the role of failing a student. Evidence suggests that mentors generally feel ill prepared for their role in supporting pre-registration students (Wilson-Barnett et al 1995, May et al 1997) but that

they feel particularly vulnerable when faced with a problem student (Fraser et al 1998). As failing a student was an aspect of mentorship that they encountered infrequently, several mentors in this present study emphasised their need in this situation, as this quotation illustrates:

> *'I think it would be good if there was something there on useful criticism, constructive criticism, because we can all be very destructive and there's a way of telling students'. (Participant 37M)*

This concurs with the Burgess et al (1998) who emphasised the need for constructive criticism skills when dealing with a fail scenario. Adequate preparation and experience of the mentor was an important aspect of this subcategory as participants talked about the constant pressure failing students often placed on the mentor. A point this participant illustrates:

> *'…the student's obviously successful way of dealing with being criticised was to attack the person personally who was carrying out the criticism and to make all sorts of threats against the mentor's professional and personal lives and then threaten you with the lawyer. And it's obvious, once investigated…that this was the modus operanda because there had been difficulties with the student in the past which resulted in people giving her a satisfactory because they didn't want the hassle'. (Participant 17L)*

Fraser at al (1998) had indicated that students might manipulate mentors in order to achieve a pass in clinical assessment. It is evident from data within this current study that this can be that case. This mentor described a student who when she was told would have to improve her performance in order to achieve a satisfactory assessment constantly asked the mentor "*how am I doing…am I going to pass*". The mentor admitted she buckled under the pressure:

> *'By the end of that I just wanted rid of her. And that's a terrible thing to say…but that's how I felt'. (Participant 32M)*

This mentor described a similar situation and highlighted:

> *'And also it depends on the character of the student. Are they going to be nasty back to you? Are they going to sue you? Are they going to take you to an industrial tribunal? You know? You're living in an era of litigation and that does influence your decision'. (Participant 20M)*

The constant pressure that these particular students placed on their mentors led to satisfactory assessments. The two participants quoted above expressed concern that they had perhaps made the wrong decision, as this mentor indicates:

> *'...to this day I'm personally still worried that I've passed a student that I'm not 100% confident in her abilities, professionalism, the quality of care she delivers to patients'. (Participant 32M)*

While the other mentor recognised that the student she passed may well come across other mentors who come the same decision and that this may have consequences:

> *'...does that girl pass right through everything and out the other side, and I've contributed to that'. (Participant 20M)*

The experience of having encountered such problems had certainly made these individuals consider that they would deal with a similar situation differently on any future occasions. Some mentors identified that they had learned from the situation. For example they indicated that they would *'raise problems more clearly', 'raise problems with the student earlier', 'be more directive with students'* and that they would *'contact the university earlier'.*

The findings presented above highlighted the importance of preparation for mentors, particularly for their role when faced with a fail scenario. This subcategory also highlights the importance of experience and confidence of the mentor when faced with a student with problems.

5.5 CHAPTER SUMMARY

This chapter has outlined several reasons why some mentors are 'failing to fail' students. Not following procedure, for example not identifying problems early on to a student and thereby not giving the student sufficient time to improve was a reason identified. 'Leaving it too late' in the placement often meant that mentors, on approaching lecturers, received little support because of the threat of the appeals system. Another issue identified was that mentors are 'failing to fail' students early in their nursing programme. When subsequent mentors are then faced with the possibility of failing a student late on in their nursing programme this presents personal dilemmas for the mentor. Taking into consideration the possible consequences to the student, for example discontinuation, did on occasion sway mentors opinion in favour of the student. Mentors also admitted that they were influenced by other external factors when assessing a weak student particularly the student's personal qualities and circumstances. This chapter revealed that mentors face a number of personal challenges when faced with a fail scenario and that support from lecturers in this situation is paramount. Also revealed was that failing a student requires confidence, experience and adequate preparation. Four main recommendations emerge from this chapter.

- First of all it is recommended that mentors are made aware during mentorship programmes of the formal procedures that require to be followed when faced with a fail scenario.
- Secondly that mentors be reminded of their responsibility with regards students who are weak with particular emphasis on the fact that failure early in the programme is possible.
- Thirdly it is recommended that adequate support mechanisms for mentors be in place. Mentors should be aware of the support available to them, have easy access to this support and receive this support when requested.
- Finally congruent with Watson et al's (2002) recommendation further review and debate regarding clinical practice assessment is advised.

CHAPTER 6
CATEGORY FOUR: DOING ENOUGH TO PASS

This chapter highlights some of the factors influencing mentors' decision making processes when faced with the dilemma of whether to pass or fail a student. One of the 'existing problems' identified in Chapter 3 was that although mentors often voiced concerns to lecturers regarding a student's performance, these concerns were often not committed to paper and consequently the student attained a satisfactory assessment. Exploring this particular problem with participants led to discussion concerning borderline students. The category 'Doing enough to pass' emerged from the transcripts as participants discussed issues relating to borderline students.

Three subcategories are associated with this category 'Doing enough to pass':

(i) Not bad enough to fail
(ii) Giving the benefit of the doubt
(iii) Consequences of failing to fail

6.1 NOT BAD ENOUGH TO FAIL

Gilmore (1999) pointed out that it is possible for poor performers to 'get by' within the current clinical assessment system. Several participants in this present study supported this view. Most participants commented that although they recognised weaknesses in the student's performance, they did not feel that they actually constituted sufficient grounds on which to fail them, as this mentor exemplifies:

> *'…I didn't find her that good… you know, but she wasn't that bad …No, not enough to fail her'. (Participant 30M)*

Another participant expressed the view that students had to demonstrate a very poor performance before they were failed:

'... if it's really bad then it has to be unsatisfactory. I don't see any other reason apart from that'. (Participant 15M)

The view of this participant is consistent with findings from Lankshear's study (1990) which identified that it is only when major and consistent problems are evident that mentors actually fail students. This concept that students are 'not bad enough to fail' led me to explore with participants what student actions, behaviours or attitudes would constitute sufficient grounds for a failed assessment. Some participants in the present study expressed the view that they would only fail a student when 'unsafe' practice was demonstrated, as this participant illustrates:

'And if it was something I couldn't resolve, you know maybe unsafe practice…I've got no qualms about it at all, you know because it's for the patient at the end of the day'. (Participant 6M)

It is reassuring that some participants appear aware of their responsibility in relation to safeguarding patients, but what was unclear was what participants actually meant by 'unsafe practice'. I therefore asked participants to explain their understanding of this concept. A mentor in a psychiatric setting highlighted the following as 'unsafe practice':

'Ill treatment. Being abusive, verbally. Saying things which is detrimental to that person's health, you know. And obviously if they couldn't do medications properly'. (Participant 6M)

This mentor focused on 'unsafe practice' in relation to the patient's mental health as well as the physical task of administering medicines. A point of interest from Lankshear's (1990) study was that assessors felt they could only justify failing a student when the physical safety of a patient was a risk. This appeared to be substantiated by one participant in the present study who described an example of a student's unsafe practice:

'She was going away off and doing quite dangerous things you know, interfering with people's tracheostomy tubes and things unsupervised…'. (Participant 7L)

The example provided above is particularly worrying because of the direct implications for patient safety. Although a provocative example, several participants provided examples of practice where students lacked insight and knowledge yet were willing to go ahead and carry out care, often to the detriment of the patient. As well as poor technical skills or lack of knowledge some participants in this present study also considered students unsafe when they displayed inappropriate professional behaviour. For example this lecturer recalls:

> *'She, the student, went to one of the rooms and decided to have a wee sleep in the middle of the afternoon. That was one of the issues…the student didn't appear to be totally in control at other times. So this was quite clearly, unsafe practice'. (Participant 13L)*

Although some participants could provide examples of unsafe practice Scanlan et al (2001) have suggested that the definition of unsafe practice is unclear and that few universities have clearly defined standards in relation to safe and unsafe clinical practice. Current assessment documents used by the institutions under study appear to describe minimum standards of safe practice but it is up to individuals to discriminate whether a student is actually unsafe. Provided that patients are not put a risk it was evident that some mentors are willing to pass students as long as they are not '*really bad'* or considered '*unsafe'*. However this still leaves the dilemma that students who perhaps should fail are passing clinical assessments because they are not 'bad enough to fail' or totally 'unsafe'.

An important point to emerge from the discussion around this area was that participants indicated that it is difficult to fail a student who had an attitude problem. Assessors in Lankshear's (1990) study identified student nurses who should not have passed because of their attitude to patients, but they had felt unable to fail students on these grounds alone. This finding is supported in the present study and evidenced in accounts such as the following by one of the lecturers. This lecturer recounted a recent episode:

> ' *There was one particular one last year where this boy was telling lies and there were certain things that they [clinical staff] weren't happy about his performance,*

but in terms of being able to do basic things, he was OK because he had done them before… because he could do the tasks, you know, he was a care assistant. I was back and forth, back and forth but he ended up passing the placement'. (Participant 7L)

This participant went on to explain:

'Because although they had niggles they didn't feel they could put it down as him not meeting the criteria… He could do them… although there were certain aspects of his professional behaviour and attitude that they didn't like they found it difficult to say anything about that'. (Participant 7L)

This incidence where a student passed a clinical assessment despite concerns regarding his professional behaviour resonates with the findings of Phillips et al (2000) who ascertained that it was possible to satisfy written criteria but not be a good practitioner. Findings from the study conducted by Fraser at al (1998 p.86) indicated that assessment strategies often neglect what they called 'the softer elements of competence such as attitude and personality'. Certainly the lack of overt reference in the assessment document to the importance of attitude was the reason one mentor in the present study felt they had to pass a student, she recalls:

'The other staff on the ward were shocked that she was going to pass. They saw the fact that I had to pass her from, like from the assessment form, attitude, point of view, there was no way round it'. (Participant 18M)

It appears that the current documentation used by one of the institutions, which participated in this study, presented problems for a mentor when faced with a student who had an attitude problem and resulted in a satisfactory assessment against the mentor's better judgement. It would appear prudent to recommend that learning outcomes pertinent to professional behaviour and attitude be given prominence within assessment documentation. A point of significance is that lecturers recognise this as an issue but have as yet to address it when developing assessment documentation, as this participant indicates:

'I think as well sometimes though it's difficult…sometimes …it's the students' attitudes, you know. They've not got the kind of right attitude towards staff and

maybe towards the patients. Yet you can't, you know, to measure somebody's attitude, that's quite a difficult thing to do…and our documents don't really address it'. (Participant 13L)

Participants in the present study recognise that the assessment documentation which they currently use does not adequately address issues associated with '*students' attitudes'*. It appears from the findings presented above to be a contributory factor in the issue of 'failing to fail'. As participants identified that some students were 'not bad enough to fail', they discussed further reasons for giving some students the 'benefit of the doubt'.

6.2 GIVING THE BENEFIT OF THE DOUBT

McAleer and Hamill (1997) found that students may be given the benefit of the doubt when mentors come to a final judgement regarding their clinical competence, participants in the present study confirmed this viewpoint in comments such as:

'…there had been an improvement towards the last week or two. But we discussed about whether you know she should continue and the general feeling was give her, as I say, the benefit of the doubt'. (Participant 30M)

Interestingly, it appears that if students at least attempt to show some improvement in their performance then mentors are inclined to then give the individual a pass in their assessment. This view was supported by another mentor:

'She had bucked up her ideas, she had changed her demeanour and her attitude towards things, and if you're looking at the general performance level, then yes, I can say she passed it. And I can say she only just achieved it'. (Participant 32M)

The issue of 'borderline' students has been identified in the literature previously (Lankshear 1990, May et al 1997, Fraser et al 1998). Consistent with the findings of these previous studies mentors in the present study indicated that when students are borderline every effort is made to ensure a satisfactory assessment. This participant describes the process which he follows:

'So I feel that if, they're just about meeting the lowest criteria, I try to work it out, make it borderline…ask them to work a little bit harder to let them pass…I'm not going to say, well they've been unsatisfactory. Most of the times, I feel that well, I should let them move on'. (Participant 15M)

Fraser et al (1998) raised the issue of whether there should actually be borderline status in professional education. Given that mentors freely admitted that they passed students but only just, suggests that this idea is worth further exploration and debate within the profession.

Exploring the issue of 'giving the benefit of the doubt' revealed that some mentors felt that, although some students were indeed weak, it was enough to point out the deficit rather than fail the student as this participant illustrates:

'…you don't want to be that rotten…you don't want to fail them but you do want to say something that says there have been some problems'. (Participant 8M)

Several mentors commented that they would verbalise their concerns to a lecturer and perhaps allude to their concerns on the written documentation but that they would not fail a borderline student. However this course of action appears to lead to the situation that this participant found herself in. This lecturer was talking about a student who should have failed but didn't:

'And stupidly, what she [the sister] did was, she made comment about a variety of points about this student's performance, about her personality, her communication skills, but she still passed her. The comments didn't match up. And so, you're like that, I can't follow this... And it was so vague in places…And I felt a bit let down because they were then passing the buck to the next placement'. (Participant 25L)

This resonates with the findings of Fraser et al's (1998) study. A lecturer in Fraser et al's study, who found herself in a similar situation to that described above, noted that the assessor's comments were not explicit and did not reflect the gravity of concerns previously raised. Therefore no action could be taken. It would appear that mentors need to become more aware that they need to clearly document concerns regarding students.

As the following quotation indicates, unless students actually fail assessments and the evidence is documented then, within the current system, lecturers are powerless to do anything about the situation:

> *'But nothing was documented and there was no way anything could be done until she got, until she actually got an unfair assessment'. (Participant 17L)*

This view was supported by another lecturer:

> *'...if it's not there on paper then they've passed'. (Participant 23L)*

When mentors decide to give the students the '*benefit of the doubt'* it appears that they are not usually aware of the possible consequences of their actions i.e. that these students often progress in the programme without their problems being adequately addressed. When concerns are raised in a practice placement about a student, the lecturer often looks at the student's previous records or asks colleagues about the particular student. The majority of lecturers who were interviewed reported that they often uncover that such students often have a background of *'just passing'*, as this lecturer illustrates:

> *'We had this student who had a, people had voiced concerns about her, her standards, and she'd got to her third year. But her reports when you looked at them, it was, they were middle of the road'. (Participant 9L)*

This view was supported by another lecturer:

> *'I asked folks [other lecturers] and the comments were that, 'Yeah there had been attendance problems, there was this and that and the next thing'. So I went back to his reports and they were just kind of you know, on the line, and there was kind of repetitive things like attendance needs a bit addressing, communication skills will get better but like, that was OK in first year but when we had him in third year ...you weren't expecting communication kind of problems'. (Participant 1L)*

The notion that lecturers were often aware of a 'previous history' with particular students led me to question in other interviews the mechanisms by which lecturers became aware of these problem students to identify, if any, the formal mechanisms that were in place to

track these students. It seemed that formal mechanisms were not in place, rather informal and incidental comments were made about students as lecturers talked in the coffee room or in shared or open plan offices. Several lecturers identified *'hearing through the grapevine'* as the most common method of becoming aware of problem students, as this quotation highlights:

> *'I mean I hear people talking about certain students who have got into their third year, they're quite often talked about, like somebody was talking yesterday about a student, and [mentions colleague's name] said something about she was having difficulty with this particular student since first year'. (Participant 7L)*

It appears that lecturers become aware quite quickly of a student's previous history because of verbal comments via other colleagues or because of vaguely written clinical reports. It is recommended that there should be some sort of formal mechanism where lecturers record the verbal concerns raised by mentors regarding some students as this does not presently appear to be the case at present. The teachers in Fraser et al's (1998) study were aware of problems with a student midwife because of what assessors has alluded to in the comments section of the student's profile. However they lacked evidence because some listed competencies had been recorded as achieved. The issue that students may receive '*middle of the road'* or vague comments alluding to problems, but not actually fail, has indicated that another aspect of data collection is required in this present study. It has become evident that another avenue which requires exploration is examination of the written comments which are provided by mentors in assessment documentation. Ethical approval for this change in data collection has been sought and granted and will be conducted over the next 4-6 months. It is anticipated that this strategy will help in the refinement of a grounded theory relating to the study.

In summary it would appear that mentors when faced with a 'borderline student' will often pass the student giving the individual the 'benefit of the doubt' however passing a borderline student may not be in the professions best interests. Indeed it was concern for professional standards that prompted Gilmore (1999 Chapter 4 p.12) to pose the question

"What are the consequences for service providers and user, of decisions to employ nurses or midwives of borderline competence?" Although this question was not addressed directly in the present study the consequences of 'failing to fail' became evident and led to the development of the next subcategory.

6.3 CONSEQUENCES OF FAILING TO FAIL

An issue identified in Chapter 5 was that giving the students the 'benefit of the doubt' early in the programme often meant that students were in their third year before they actually failed a clinical assessment. A common situation revealed by participants was the scenario outlined below.

> *'Although some of her care was excellent, her contact with patients, she was a very kind caring person, but she just couldn't seem to integrate all the things that were going on and that you would expect a third year student to do. And at the end of the placement, the mentor said that she couldn't, you know, in all honesty, say that she had reached the appropriate level. She said she found particular problems with administration of medications…didn't seem to have the knowledge that you would expect a third year student to have in relation to administration of medicines, giving and receiving oral reports, and in general attention to detail. These were the three main things. Things like, I don't like to say basic nursing care, but things like meeting patient's hygiene needs, nutritional needs, that was fine, she had a very nice approach, but it was the more technical aspects of care and she would forget things. If there were lots of things going on, she would forget things'. (Participant 23L)*

Several participants gave similar examples of students in their third year who lacked not only essential psychomotor skills but also the ability to integrate and apply theory to practice. Similar problems have been identified with some newly qualified staff (Maben & Macleod Clark 1998, Runciman et al 1998) which suggests that perhaps they were students whom mentors had 'failed to fail'. This link was clearly outlined by one of the participants in the present study. This participant recounted an experience regarding a particularly problematic third year student who, when redoing a failed clinical placement, was identified at midway assessment as having the same problems as identified at the previous failed placement:

> *'Interestingly when it came to the midway assessment, the mentor identified the same areas of concern but not to the same degree…. Basically attitude, the way she spoke to people, the way in which her non-verbal communication was perceived by people. When it came to the final assessment, the final assessment came back as satisfactory. And when I spoke to the mentor after it, she said she would probably have failed her but it was too late in her training and she was a nice wee girl and with a wee bit of experience she would be OK. Informally she told me that you know, she probably wasn't of the standard but it should come with a bit of experience'. (Participant 17L)*

The outcome was that this person became registered and is practising. This lecturer was *'disgusted'* and *'thought it was the wrong decision'* which led him to comment that:

> *'…this idea of they can pass our course but that they do not have to register because we can decide not to sign their declaration of good character certificate is a load of rubbish. How can we comment on their character when as lecturers we haven't noted it any way through their training, we can't leave it to a gut reaction at the end. Its meant to be used as the last chance to save the public, but in my opinion its never used'. (Participant 17L)*

Several other lecturers in the study highlighted this view that they are not in a position to prevent students from registering, despite the need for the declaration of good character. Contrary to participants views in this study there have been instances where educational establishments have declined to provide the statutory declaration of good character and as a consequence, following professional misconduct hearings, students' application to the nursing register have not been supported (Castledine 2000). However in March 1998 the UKCC, rather than hearing such situations as misconduct cases, devolved the process to the Higher Education Institutions and their appeals system (Castledine 2000). Given that within this system the prevailing ethos is that students frequently win appeals there is a clear indication that the comments from participants regarding the declaration of good character requires further exploration. This aspect of data collection is currently under exploration using further theoretical sampling and any relevant findings will be reported in subsequent literature.

Students whom mentors have 'failed to fail' are entering the register and indeed Neary (2000) pointed out her concerns about the discrepancies between clinical reports and the

quality of recently qualified behaviour. The consequences of such a problem existing were clearly outlined by one of the mentors in the present study. This mentor who worked in a high dependency area commented:

> *'I have seen first hand someone who should never have been allowed to be registered'…this person had to actually be supernumerary for almost a year, and eventually left because it just wasn't working out. They were given all the support as I say, supernumerary in the region of about 11 months, and that's a big drain on the service alone. And just didn't seem to be able to have any grasp what his role was and no awareness at all of what he wasn't able to do. He would go ahead and try to do things, go ahead and do things without stopping to think 'I shouldn't really be doing this, I was asked not to do this'. And obviously that, in our area, that has a big impact on patient's safety… it was evident from day one and as I say I'm surprised that they allowed him to stay supernumerary for that length of time'. (Participant 21M)*

This mentor suggested that this individual should have been failed during his training as removing a registered practitioner from practice was seen as problematic:

> *'It's just, I think nowadays it's very difficult for the management to sort of constructively dismiss someone its a very difficult process to do'. (Participant 21M)*

Evidence such as this is particularly concerning for the profession and highlights the necessity to ensure that mentors if, and when, they have concerns about students are aware of the potential professional consequences of 'failing to fail'. Participants in the study talked about issues of responsibility when discussing the 'consequences of failing to fail'. Interestingly several lecturers commented that clinical practitioners hold educational staff responsible for this situation. This lecturer's comment typifies the problem:

> *'I've had qualified nurses say to me when I'm out visiting, 'How on earth did you let that person get through their training?'. And I ask them 'Why?, why do you say that?' 'Oh they're absolutely hopeless'… My response now is, 'Well they passed all their clinical assessments you know' (Participant 23L)*

Several lecturers provided similar comments regarding the fact that clinical practitioners hold them responsible for problems with newly qualified staff. The lecturers' view is that mentors who have 'failed to fail' are responsible, as this participants illustrates:

> *'And whenever I've been involved in talking to mentors, the sort of theme that will come is that students aren't able to do what they used to be able to do. And if you ask nurses why they think that might be so, then the blame seems to be attached to the educational part of the student's training and when you point out that these students all have had to pass clinical assessments all the way down the line to get where they are, the penny drops for some, that they've obviously been passed and if they think all these nurses are coming out at the end of three years unable to do certain things then other mentors have said in the past that they are able to do them when quite clearly they weren't'. (Participant 3L)*

Lecturers may feel that practitioners are holding them responsible for 'failing to fail' students, but lecturers commented that practitioners are perhaps not fully aware of their accountability in this situation. This lecturer comments:

> *'…others I think do not fully appreciate the enormity of their role as a clinical mentor. I honestly don't believe they stop and think that it's people like them who actually allow people into the professional register because the NMC take our word for it…And I don't honestly think when they're signing a clinical assessment that they're bearing in mind, 'I'm letting this person one step closer to entering a profession and actually being in charge some day of potentially vulnerable people''. (Participant 24L)*

Another lecturer also highlighted this issue that mentors may not be aware of the responsibility associated with their role:

> *'They seem to miss that link. That… they're accountability, I think, is very much in question and I don't know if that's made as clear as it should be to them that the onus is on them'. (Participant 25L)*

However some lecturers in the study did recognise that they may be responsible for this situation arising as mentors were often ill prepared for their role, as this participant indicates:

'I think we need to take some responsibility for that. We're not being clear enough about their role. And I think that needs to be addressed more vigorously in our mentorship preparation. There's no doubt… I think they should spend a whole day in this failure to fail. And from a point of view of their accountability'. (Participant 25L)

The literature supports the view that mentors feel ill prepared for their role (Wilson-Barnet et al 1995. May et al 1997) and there is often a lack of coherent support for mentors from lecturers (Cahill 1997). Given that mentors are ill prepared for their role in failing students it is recommended that mentorship programmes address the issue of accountability. It should also be recognised that the issue of responsibility in relation to 'failing to fail' lies not only with individual mentors, but also with individual lecturers, programme teams and management in the clinical areas, as this participant summed it up:

'I mean when you hear people saying, how did they ever get through their training, and they've got them as a staff nurse, and they're absolutely hopeless. Who's responsible at the end of the day?'. (Participant 23L)

6.4 CHAPTER SUMMARY

This chapter has highlighted issues relating to borderline students and the concept of unsafe practice. An important point raised by several participants was that students often only fail clinical assessments when it is impossible to avoid. It is evident that some mentors are willing to give weak students a satisfactory assessment as long as they are not 'really bad' or considered 'unsafe'. When the physical safety of a patient is put at risk mentors indicated that they would take action, however many participants identified that it was difficult to fail a student when the main concern was an attitude problem. The consequence of 'giving the benefit of the doubt' was also explored in this chapter. Consistent with the findings of previous studies mentors indicated that borderline students were often given satisfactory assessments. This raised the issue of the possible need for borderline status within the profession. Students who were given the 'benefit of the doubt' often had a previous history of problems that had been verbally relayed to lecturers but had not been committed to paper, either by the mentor or previous lecturers.

Giving students the 'benefit of the doubt' has consequences for the profession. Participants highlighted incidences where mentors had 'failed to fail' third year students despite concerns about their practice, consequently these students had become registered nurses. The issue of professional accountability was raised with the recognition that responsibility for 'failure to fail' lies with practitioners, lecturers, programme teams and management and not just individual mentors. Five main recommendations emerge from this chapter.

- First of all it is recommended that the distinction between unsafe practice and conditions that constitute a fail should be further debated and explored within nurse education programmes.
- Secondly it is recommended that borderline status be debated within profession.
- Thirdly it is recommended that learning outcomes pertinent to professional behaviour and attitude be given prominence within assessment documentation.
- Fourth it is recommend that there should be some sort of formal mechanism where lecturers record the verbal concerns raised by mentors regarding some students as this does not presently appear to be the case.
- Finally it is recommended that mentorship programmes address the issue of accountability and that mentors are made aware of the potential professional consequences of 'failing to fail'.

CHAPTER 7
CONCLUSION AND RECOMMENDATIONS

7.1 CONCLUSION

In this final chapter the recommendations for practice and future research that emerged from the findings of the study are presented. The aim of this study was to uncover mentors' and lecturers' experiences regarding the issue of students passing clinical assessments when not having demonstrated sufficient competence. Some of the dilemmas associated with this issue that currently face mentors and lecturers within the Scottish context have been uncovered in this research project. Participants in the study confirmed that students are passing assessments when there is in fact some doubt about their clinical competence and that some of these students achieve registration despite these misgivings. One of the main dilemmas to emerge was that although mentors may raise concerns about a student's performance verbally to teaching staff this is not always acted upon. Some mentors are unwilling to put pen to paper regarding these concerns and consequently the student receives a satisfactory clinical assessment. Participants in the study highlighted the dilemmas in relation to the validity and reliability of current clinical assessment tools which may contribute to the issue of 'failure to fail'. Concurring with previous research (Norman at al 2002) participants highlighted problems with assessment procedures which appear to contribute to the anomaly between the number of students who pass practice assessments as opposed to theory. Lecturers in the study also highlighted the tensions that arise when working in higher education and trying to retain professional values. The conflict between maintaining professional standards while ensuring retention of students was identified as particularly problematic for lecturer participants.

Mentors who had given unsatisfactory assessments identified the process that was involved in failing a student in clinical practice. The necessity of contacting the university early in the fail scenario was highlighted, as was the need for adequate support

and guidance. Mentors identified that failing a student was a difficult thing to do and that there were many emotional issues to deal with when presented with such a situation. The necessity of following procedure was acknowledged particularly the need to identify and document problems early on in the student's placement. The importance of developing a plan of action to support the student was recognised, as was the value of having a tripartite clinical assessment system. Participants discussed the time consuming nature of supporting a weak or failing student and talked about lack of recognition by their managers of the commitment required when faced with a fail scenario. Participants identified that current mentorship programmes failed to address the issue of failing students and that support from lecturers was vital both during and after dealing with a failing student.

Mentors who had 'failed to fail' students identified some of the reasons why some students are passing clinical assessments without having demonstrated sufficient competence. It emerged from the analysis of the data that mentors did not always identify and deal with problems early enough in the student's placement. Mentors not following procedure when it came to a fail scenario meant that lecturers could not always support the mentors' decision. Of significance was the threat of the university's appeals system which meant that individual mentors often felt pressurised into recording a 'satisfactory' decision that was at odds with their own professional judgement, particularly when they left it late in the placement before identifying problems. It emerged that few students fail clinical assessments early in nurse education programmes. Mentors who had 'failed to fail' students identified that they are unwilling to fail students early on in a nursing programme. Issues regarding a student's clinical competence are often left unresolved in early placements as some mentors harbour the belief that the problems will resolve as the student progresses through the programme and future placements. Consequently participants in the study identified that students are often in their third year before they receive their first failed assessment. This scenario presented further dilemmas for mentors. Some mentors who 'failed to fail' students identified that they did not want to be responsible for ending students' careers so late in a nursing programme and so consequently let them pass their assessments. Mentors also

acknowledged that when coming to a pass or fail decision regarding a weak student they are influenced by the students' personal circumstances. A particular personal dilemma for mentors was that failing a student was seen as incongruent with being a nurse who has caring central to her role. The need for support when faced with the personal challenge of failing a student was again reinforced by participants, given that lack of support from lecturers was identified as the reason for some mentors 'failing to fail' students. Significantly constraints on their mentorship role due to staff shortages, increasing work pressures and lack of time were all identified as contributing to the phenomenon of 'failure to fail'. Some mentors identified that they are reluctant to fail a student if they have had limited experience or confidence as a mentor. It emerged that mentors who lack confidence to assess may be more inclined to give a student a satisfactory assessment, particularly as they often do not feel adequately prepared for their role. The importance of adequate preparation for mentors particularly for their role in a fail scenario was emphasised by participants in the study.

An important issue to emerge was the concerns raised regarding borderline students. Participants debated the elements that constituted sufficient grounds on which to fail a student. Adamant that they would recognise and act upon unsafe practice, it was of interest that it was only when major problems were evident that mentors actually felt able to fail a student. Identified as particularly problematic was failing students on the grounds of an attitude problem. Inadequate assessment documentation appeared to be a contributory factor when there was a 'failure to fail' students on attitude grounds. Lecturers expressed their feeling of powerlessness when mentors failed to put pen to paper regarding concerns about a student's professional attitude and they questioned the value of the declaration of good character required by the NMC. Mentors were responsible for identifying this aspect of the student's practice yet often failed to highlight areas of concern regarding this aspect of performance.

It emerged that borderline students are often successful in their clinical assessments because mentors give them the benefit of the doubt. However it became apparent that giving the benefit of the doubt may not be in the professions best interests. The

consequences of 'failing to fail' were identified with participants citing examples where they could not leave third year students alone to examples where newly qualified practitioners had no insight into their strengths and weaknesses in clinical practice. While discussing the dilemmas surrounding 'failure to fail' the issue of responsibility was explored. Lecturers indicated that practitioners often blame the education system, while in reality, responsibility for this issue lies with both education and practice. It was recognised that individual mentors are professionally accountable for their judgements surrounding a student's clinical performance but that responsibility also lies with lecturers, programme teams and management in both education and practice.

Several recommendations for mentorship preparation, nurse education programmes and research emerged from the findings.

7.2 RECOMMENDATIONS FOR MENTORSHIP PREPARATION

The first recommendation is that mentorship training includes the topic of dealing with a failed clinical assessment. It is recommended that this should comprise dealing with the practical aspects of a failed assessment as well as input regarding the emotional reactions associated with this issue. It is important that mentors are made aware during mentorship preparation of the formal procedures that require to be followed when faced with a fail scenario. Topics should include; the issue of how to break bad news; dealing with student's responses; dealing with your own (mentors) responses and recording the decision. The second recommendation is that mentors be reminded of their responsibility with regards students who are weak with particular emphasis on the fact that failure early in the programme is possible and perhaps preferable to failure later in the programme. Thirdly it is recommended that mentors should be aware of the support available to them from education staff, have easy access to this support and receive this support when requested. Finally it is recommended that mentorship programmes address the issue of accountability and that mentors are made aware of the potential professional consequences of 'failing to fail'.

7.3 RECOMMENDATIONS FOR NURSE EDUCATION PROGRAMMES

The first recommendation is that programme teams have tripartite arrangements in place to support mentors in their clinical assessment role. Secondly it is recommended that lecturers should have a role in clinical assessment. Thirdly programme teams should ensure that mechanisms are put in place to enable debriefing after a mentor has been involved in a failed assessment. Fourthly there should be continued contact with mentors to ensure they are kept informed of the final outcome if they have been involved in failing a student. Fifthly it is recommended that there should be some sort of formal mechanism where lecturers record the verbal concerns raised by mentors regarding some students as this does not presently appear to be the case. The sixth recommendation is that the issue regarding the passing on of information between placements once a student has failed a clinical assessment requires to be debated. Seventhly it is recommended that learning outcomes pertinent to professional behaviour and attitude be given prominence within assessment documentation. Finally that managers within the clinical and educational settings take cognisance of the commitment required by both mentors and lecturers when faced with a possible fail scenario. It is important that programmes give attention both to the criteria against which students are judged and also to the structures, procedures and processes that underpin clinical assessment.

7.3 RECOMMENDATIONS FOR FUTURE RESEARCH

So far there has been very little research in the complex and difficult area of failed assessments. This study has made an important start, but there is long way to go. For example, it is recommended that a national survey be conducted that establish the number of students who fail programmes on clinical grounds as opposed to academic grounds. Secondly it is recommended that further exploration of lecturers' views of the tensions that exist between maintaining professional values and working within higher education be undertaken. It is also recommended that the distinction between unsafe practice and conditions that constitute a fail should be further explored with particular emphasis on exploring 'borderline status' in clinical assessment. Finally congruent with Watson et

al's (2002) recommendation further review and debate regarding clinical practice assessment is advised. This move would allow for development of reliability in clinical assessment tools used by the profession.

In conclusion, there has to be the recognition that some students need to fail. Potentially clinical assessment of student nurses can safeguard professional standards, patients and the general public. It is inevitable that some students will not be able to meet the required level of practice and it is essential that mentors do not avoid the difficult issue of having to fail these students.

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